

**Joint GAMET/UNAIDS Monitoring and Evaluation Mission
to Namibia
6 to 10 November 2005**

End of Mission Debrief

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Report prepared by: Marelize Gorgens-Albino (GAMET), Mary Mahy (UNAIDS), Masauso Nzima (UNAIDS), Don Whitson (GAMET consultant)

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1 Background to the Mission

The Global AIDS Monitoring and Evaluation Team (GAMET) at the World Bank's Global HIV/AIDS Program (GHAP) has been involved in the M&E system in Namibia since 2003 through technical assistance provided by a GAMET consultant (refer to Annex 1 for more information about GAMET's work). In July 2006, the Government of Namibia's HIV Response Monitoring and Evaluation requested GAMET's renewed support for operationalising the national HIV M&E system in Namibia, given GAMET's experience working in other countries in the region.

The Joint United Nations Programme on AIDS (UNAIDS) Namibia office has worked closely with the RM&E unit over the past few years assisting with the development of the national HIV M&E plan among other issues. The Government of Namibia requested in-country assistance from the UNAIDS office in the form of a resident M&E advisor early in 2006. The advisor joined the RM&E team in October 2006.

Given the timing of the above events, it was agreed by the GRN, GAMET and UNAIDS that undertaking a joint monitoring and evaluation (M&E) mission to Namibia would be beneficial. It was a joint M&E mission because of the close working relationship between UNAIDS and GAMET, successful previous joint missions in the region and an international drive to harmonise technical assistance (as per the recommendations of the Global Task Team (GTT)).

1.1 Joint Mission Objectives

- To meet key partners and begin to build a partnership with them
- To understand the status of the M&E system and to offer concrete support in how to move forward the M&E system
- To discuss the scope of GAMET's future involvement with the operationalisation of GAMET's M&E system
- To provide guidance as to specific aspects of the new UNAIDS M&E advisor's role
- To advocate for the development of a national HIV M&E Road Map

1.2 Joint Mission Logistics

This joint M&E mission took place from 5 to 10 November 2006. The mission team consisted of Masauso Nzima (UNAIDS Regional Support Team in Johannesburg), Marelize Gorgens-Albino (GAMET at the World Bank), Donald Whitson (consultant to GAMET), and Mary Mahy (UNAIDS M&E advisor for Namibia).

1.3 Structure of the Joint Mission Report

This Joint Mission Report contains the joint observations of the mission team, as well as their recommendations. In Section 2 of the Joint Mission Report, the characteristics of a fully functional HIV M&E system is described as a foundation for Section 3 of the Report, which provides the mission team's observations of the status of the national HIV M&E system in

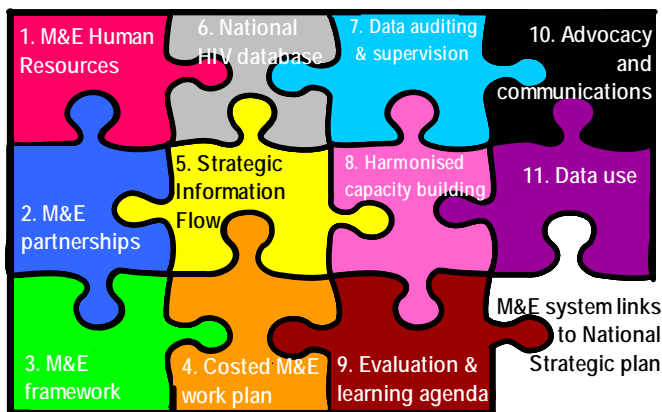
Namibia. Section 4 then provides key conclusions, and Section 5 proposes GAMET and UNAIDS's future involvement in operationalising the national HIV M&E system in Namibia.

2 What does a functional national M&E system look like?

Experience over the past five years in operationalising national HIV M&E systems in Sub Saharan Africa and beyond has shown that fully functional national HIV M&E systems have 11 characteristics:

1. HIV M&E **human resources** at the national, decentralized and implementer levels
2. Strong **partnerships to coordinate implementation** of the M&E system
3. A national M&E **framework** with which to measure outcomes
4. An **integrated, costed M&E work plan**
5. A **strategic flow of information** and data
6. A national HIV **database** with key information
7. Data auditing and **supervision procedures**
8. Harmonized M&E **capacity building**
9. A learning and **evaluation agenda**
10. Advocacy and **communication** for HIV M&E
11. Strategies for data dissemination and **data use**.

These 11 characteristics can also be considered as 11 components of a fully functional HIV M&E system.



Source: Gorgens-Albino and Nzima (2006)

These 11 components:

- a) Are a recipe or formula for operationalising a national HIV M&E system, removing the mystery and individual interpretation. It answers the question: "What is a national HIV M&E system?"
- b) Are a basis for assessment - e.g. using the Global Fund to fight AIDS, Tuberculosis and Malaria (GFATM) M&E self assessment checklist
- c) Are a basis for joint M&E mission reports, and concepts on which to base M&E system progress reports

- d) Are the basis for indicators on 'M&E of M&E'
- e) Are a way to formalise and structure M&E technical support that is provided to help operationalise a national HIV M&E system
- f) Are a clear basis for division of labour at country level and a formula for all partners to work together
- g) Are something around which to organise M&E Operations Plans, and
- h) Provide clarity about the skills and competencies needed for national HIV M&E systems - capacity building can be organised for each of the eleven components.

Thus, when assessing the status of a national HIV M&E system, these 11 components forms the taxonomy by which to organise the assessment and present the assessment results. Therefore, Section 3 provides the mission team's observations and recommendations in terms of each of these 11 components.

3 What is the status of Namibia's national HIV M&E system?

The mission team's observations and recommendations regarding the status of Namibia's national HIV M&E system, in terms of each of the 11 components described in Section 2 of this Joint Mission Report, were:

3.1 COMPONENT 1: HIV M&E human resources

3.1.1 Response Monitoring and Evaluation Unit at MoHSS, Department of Special Programmes

Observations

The RM&E unit is staffed; the senior staff (head of unit and advisor) are experienced and have been involved in the unit for at least a year, but the junior staff are new. This leaves the unit with the double challenge of operationalising a national system whilst building the team within the unit.

Further, although the unit's mandate - to coordinate HIV M&E efforts in Namibia - is clearly defined in policy documents, the unit finds it challenging to execute its mandate. Reasons are threefold: *first*, its location in the organizational structure does not facilitate such multisectoral coordination; *second*, the extent of bureaucracy involved in obtaining data - for example, requesting data from the Health Information System unit at MoHSS's Primary Health Care Directorate requires a letter from the Principal Secretary's office; and *third*, name of the unit itself - the name 'response monitoring and evaluation unit' does not include the term 'national' and therefore does not make it clear to stakeholders that the unit is not only responsible for health sector HIV data, but for all HIV data housed in the country.

It was observed that all stakeholders are clear on the nature of RM&E unit's activities: the unit is supposed to *coordinate* monitoring and evaluation (not conduct all monitoring and evaluation activities by itself), and that the unit is supposed to coordinate *HIV* monitoring and evaluation.

It was, however, also observed that all stakeholders were not clear as to whether the unit was supposed to coordinate the monitoring and evaluation of the HIV response only, or whether it was *ALSO* responsible for coordinating the monitoring and evaluation of the malaria and TB programmes. The confusion stems from the fact that the Directorate of Special Programmes is responsible (and has programme officers for) three special programmes - HIV, TB and malaria - but only has one monitoring and evaluation unit (RM&E). Some stakeholders indicated that RM&E is only responsible for HIV response monitoring and evaluation, whilst others indicated that the unit is responsible for coordinating the monitoring and evaluation of the HIV response, TB response and malaria response.

In addition to coordinating HIV monitoring and evaluation (as per the National HIV M&E plan), the unit was also responsible for monitoring some of the health sector aspects of the HIV response: it was involved in running the patient monitoring system for ARVs in Namibia.

Recommendations

Although it is excellent that the unit is staffed, it is important that each member of the unit is assigned the responsibility for a specific aspect of operationalising the M&E system. This will enable the team members to build specific skills and enable them to coordinate the operationalisation of the national HIV M&E system. Therefore, it is recommended that the RM&E unit staff be assigned the responsibility of following up specific aspects of the national Integrated Action Plan for HIV monitoring and evaluation (see section 3.4).

It is recommended that the functions of the staff at the RM&E unit be reviewed to ensure that all typical functions that such a unit needs to play are in place. In other countries, the national HIV M&E units have an overall coordination function; an output monitoring system function; research coordination function; and an informatics function. In Namibia, given that MoHSS has a separate research unit, the research function does not need to be included as a function of the RM&E unit.

In addition the RM&E team should hire a team member who has informatics and information technology experience and who can provide continued expertise in this area. The need for technical expertise in terms of database issues will continue to evolve and cannot be solved through short term technical assistance.

Finally, it is recommended that the term 'national' be added to the name of the unit to ensure that the overall coordination role of the unit is emphasised.

3.1.2 Health Information System (HIS) Unit at MoHSS

Observations

The HIS unit is based in the Primary Health Care Directorate, and is responsible for all routine health sector data (not only HIV-related). The HIV aspects of this unit are currently being supported by the US Government through a technical advisor. The HIS software is currently being migrated to a new system by a consultancy team; the work was scheduled to start a week after the mission team left Namibia. The HIS unit has the capacity to analyse and conduct quality control of the data, and rigorous control processes have been and are being put in place.

The unit provides data based on written requests for information. Once written requests for information have been issued, data are provided. This system has resulted in delays in the RM&E unit receiving data from the HIS unit.

It was also observed that the partnership between the RM&E unit and the HIS unit can be strengthened.

During a field visit, excellent local examples of data use was observed, and it was clear that there are health facilities in Namibia where data are being collected for the purpose of it being used to help management make informed choices.

Recommendations

Given that the RM&E unit will request the same, standardized data set from the HIS unit every quarter when the RM&E unit prepares the quarterly HIV Service Coverage Report, it is recommended that a standard report be created in the new District Health Information Software that the HIS unit is in the process of installing. Such a standardized report can be provided to the RM&E unit on a quarterly basis, and will avoid the lengthy bureaucratic procedure of submitting a request to the Principal Secretary's office.

Prior to agreeing to such a standardized quarterly report, the RM&E unit should introduce the new HIV M&E system to the Primary Health Care directorate through a technical presentation with a clear focus on the role of the Primary Health Care directorate in the national HIV M&E system. This should be followed up by follow-up partnership building activities.

It will be necessary for the new team to work with each individual stakeholder to maintain its mandate to coordinate M&E for the national program. This will require a large amount of "footwork"; contacts, meetings and formal and informal agreements with all stakeholder and partners to ensure that they "buy in" to the M&E system and the Integrated Action Plan. In order for this to be successful, RM&E will need strong management support and alignment within the DSP and the MOH in general.

3.1.3 HIV M&E in sectors

Observations

There are sectoral coordination bodies ('umbrella organisations') for the private sector (NABCOA Namibia Business Coalition against AIDS), for civil society (Namibia National Association of NANASO), for associations of persons living with HIV (Lironga Eparu), but not for the public sector. Instead, the public sector is organized into cluster Ministries, with each Ministry in a cluster reporting to the cluster leader Ministry.

The need for and importance of monitoring and evaluation was recognized by the different sectoral bodies with whom the mission team interacted. NABCOA and Lironga Eparu even expressed the need to appoint an M&E officer, whilst NANASO had started to carry out some monitoring and evaluation activities - out of their own accord - to understand how civil society is responding to HIV.

There was a general understanding of the importance and relevance of M&E, and all stakeholders that the team spoke with were enthusiastic about being involved in the M&E system. The different sectoral coordination bodies were, however, not clear on the exact nature of their role in terms of M&E - in particular their role in terms of the HIV output monitoring system for non medical HIV interventions (see section ??).

Recommendations

It is recommended that the role of the sectoral coordination bodies in HIV M&E be clearly defined in terms of the HIV output monitoring system for non medical HIV interventions. In addition, a specific capacity building and human resourcing plan should be developed for the sectoral coordination bodies.

3.1.4 HIV M&E at Ministries

Observations

Whilst Ministries have clearly made efforts (to a greater or lesser extent) to respond to HIV within their Ministries, their focus has not been on HIV monitoring and evaluation. This has been due to a number of reasons: Ministries are still in the process of learning how to respond to HIV (not all have been actively involved in HIV activities and therefore not involved in the monitoring of HIV activities); monitoring and evaluation is a new concept for the public sector; the national HIV M&E plan was only launched in September 2006; and HIV M&E is being driven by a unit at MoHSSS - not from, for example, the Office of the Prime Minister.

Some Ministries are scaling up so as to enable them to respond effectively to HIV, but there has not been a commensurate focus on the Ministries' roles in terms of HIV M&E: the Ministry of Regional and Local Government, Housing and Rural Development (MRLGHRD) is in the process of establishing a National HIV unit, but the Unit's role in terms of HIV M&E is not yet clear. There is also an HIV unit at the National Planning Commission - this unit is

responsible for coordinating HIV impact assessments - whose role in terms of the national HIV M&E system has not yet been clarified. The Central Bureau of Statistics also need to play a role in the national HIV M&E system and all HIV related surveys should be included in the National Master Statistical Plan.

The lack of concrete clarity has not been as a result of a lack of effort on the part of RM&E, but rather due to the fact that the National HIV M&E plan is new and significant advocacy efforts are still required to inculcate and integrate the M&E system into all national systems and into the 'national thinking'.

Recommendations

It is recommended that advocacy for the HIV M&E system be conducted with all government ministries at technical, senior decision making and political levels, and that the HIV M&E system be integrated with the HIV response plans of the various government ministries. This would include a clear understanding with each Ministry (MRLGHRD, National Planning Commission, etc.) as to its role in the national HIV M&E system.

Reporting from the government Ministries to the cluster lead ministry and to RM&E, in conjunction with reporting on activities taking place at the regional level, also need to be clarified with all government ministries to avoid double counting and set up clear procedures.

3.1.5 HIV M&E staff at the regional levels

Observations

Regional AIDS Coordinating Committees, District AIDS Coordinating Committees and Community AIDS Coordinating Committees are in place, but not all are functional. There are Regional AIDS Coordinators at each Regional Council. Whilst it is encouraging that staff have been appointed to coordinate the HIV response at the regional level, junior level staff were appointed, resulting in them not being able to effectively carry out their work. The junior establishment post level designated for the RACs have contributed towards a situation where RACs provide HIV services with the funding that the Region receives from government or development partners, as opposed to the region being responsible for coordinating, planning and monitoring the HIV service delivery efforts of all the other stakeholders (civil society, private sector and public sector) at the regional level.

Monitoring and evaluation of the HIV response at the regional level is not clearly defined in the job description of the RAC, or in the Terms of Reference of the RACOCs, DACOCs or CACOCs.

The challenges of HIV coordination at the regional level were discussed at a NAMACOC meeting and two solutions were proposed: appointing an additional staff member at the regional level, and elevating the position of the RAC to a more senior level.

Recommendations

The mission team supported the notion of appointing an additional person at the regional level; it also suggested that the additional person should focus on HIV M&E, particularly the output monitoring system for non medical HIV interventions. This output monitoring system will provide the region with information about who is 'doing what where' in terms of the HIV response on a quarterly basis. The region requires this information, at a minimum, to be able to coordinate the HIV response at the regional level.

Therefore, the mission team recommended that the RAC and 2nd staff member at the regional level's job descriptions be reviewed to include M&E, and that clarity be given to the regions as to the practical implication of their role to 'coordinate the HIV response'.

Further, it was also clear that during the next review of the Medium Term Plan III (MTP3) the issue of regional coordination vis-à-vis sectoral coordination needs to be clarified: whilst the MTP3 is based on sectoral coordination, the private and civil society sectoral coordination bodies are not permanent government structures and the sectoral model does not take into account the role of the regions in coordination. The coordination function of these entities must be underscored, as opposed to their role as implementers and funders of HIV services.

3.1.6 HIV M&E technical support

Observations

There is significant internal and external technical assistance for most aspects of the HIV M&E system. PEPFAR, UNAIDS, The World Bank, the Global Fund and others have either been involved in or are keen to continue to support the national HIV M&E system. This technical support, however, is not integrated and harmonised. The lack of harmonization has been in part due to the absence of a national HIV M&E costed work plan, which would have clearly spelt out and defined the roles of stakeholders in it.

As a result, it has been a challenge for the RM&E unit to coordinate technical assistance and to ensure that different types and forms of technical assistance links in with each other. All of these factors have resulted in challenges relating to managing technical assistance - both from the provider as well as the receiver of technical assistance.

Recommendation

Technical assistance for HIV M&E is essential, but needs to be better coordinated. For this reason, developing an Integrated Action Plan for HIV M&E (see section 3.4) to which technical support is linked to specific activities in the National Integrated Action Plan, is absolutely essential. This has worked superbly in other countries - where technical support that is provided is linked to specific activities in the Integrated Action Plan, stakeholders are able to work together on a practical and concrete level, instead of simply agreeing, on a conceptual level, 'we should collaborate'.

If all technical assistance is linked to the Integrated Action Plan, it implies that such technical support would have been requested by the Government and that all partners are aware of the proposed technical assistance.

3.2 COMPONENT 2: HIV M&E PARTNERSHIPS

Observations

The mission team observed during numerous interviews and meetings that the RM&E unit has the support and respect from other units and partners.

The RM&E unit has taken time and been successful in establishing a national HIV M&E committee. This committee consists of a very wide variety of stakeholders from all sectors - stakeholders with whom the mission team met, were quite proud to say 'we are members of the M&E committee'. Such a consultative and collaboration group is important, essential, and evidence of the level of interest in HIV M&E.

However, the size of the M&E committee has meant that the committee is too unwieldy and represents too many interests for it to be able to provide the technical guidance and leadership that is necessary in terms of operationalising the national HIV M&E system.

Recommendations

It is essential that there is one group who can lead the operationalisation of the M&E system: a 100-person committee cannot provide technical leadership as there are simply too many members of the committee. For this reason, it is recommended that a **national HIV M&E management committee** be established, as a subset of the national HIV M&E committee. The management committee's scope of work would be to provide leadership and to guide the operationalisation of the national HIV M&E system, using the Integrated M&E Action Plan as a guiding framework.

The M&E management committee should be headed by RM&E, should include HIS as a deputy chair, and should include those HIV M&E technical advisors that are in Namibia. It should also include the chairs of the other TWGs that are currently in the country: surveillance technical working group and the informatics technical working group. It is, however, essential that the TWG not be run by external technical support, but by RM&E as the agency of government mandated to operationalise the national HIV M&E system in Namibia.

Minutes of meetings should be kept, so that all persons, including those who provide technical support in HIV M&E to Namibia but who are not resident in Namibia, can be kept abreast of developments.

It is also recommended that all external HIV M&E technical support be harmonized by linking specific support activities to the national HIV M&E Integrated Action Plan (see section 3.4 of this Joint Mission Report).

3.3 COMPONENT 3: M&E FRAMEWORK

Observations

Namibia launched its national HIV M&E Plan in September 2006. It is a good plan - concise and operational in nature. The Plan contains a set of core indicators, defines data sources for the indicators, describes the standard reports that RM&E will produce and how these will be disseminated, and defines some aspects of managing the M&E system in Namibia.

There are some weaknesses in the M&E Plan, which can be addressed in revisions and by producing supplementary materials. There are three specific aspects that are not in the M&E Plan: HIV M&E advocacy and communications; procedures for supervision and data auditing; and reference to output monitoring guidelines that need to be developed (and that most stakeholders will be trained in).

In discussions with stakeholders, it was also clear that some stakeholders had heard of or interacted with the national HIV M&E plan, but not all stakeholders. This is not due to a lack of effort by RM&E, but rather because the M&E plan was only launched two months prior to the scoping mission, and because an M&E advocacy and communications plan had not yet been put in place to guide the roll out of the M&E system documentation.

Recommendations

It is recommended that an HIV M&E advocacy and communications plan be developed and included in the Integrated Action Plan (see section 3.4 of this Joint Mission Report), that the M&E plan be widely disseminated to stakeholders at all levels through a structured process, that supervision and data auditing guidelines for the M&E system be developed, and that output monitoring guidelines be developed for reporting of all non medical HIV services to regions on a quarterly basis.

3.4 COMPONENT 4: COSTED HIV M&E INTEGRATED ACTION PLAN

Observations

A national M&E Plan has been launched, a 5-year M&E work plan was developed by RM&E, and a detailed 12-month work plan exists but is not costed. This is an excellent starting point, however, more is needed as both plans focus more on start-up costs than on ongoing costs for, recurrent activities; costs have been under estimated in some areas and over estimated in other areas; and activities focus primarily on the work for which the RM&E unit is responsible.

Recommendations

It is recommended that a national HIV M&E Integrated Action Plan be developed for the remainder of the MTP3 period. The HIV M&E Integrated Action Plan is an agreement on how to

implement what is in the national HIV M&E plan. It defines responsibilities of all actors; it can be considered a master plan of all HIV M&E activities. It is an extension of the 3rd of the Three Ones (one national HIV M&E system), in the sense that it is ONE, national, and costed work plan / action plan for the duration of the MTP3 that defines the roles of all stakeholders in HIV M&E.

Developing such an Integrated Action Plan will not be a time consuming activity, as some HIV M&E work plans have already been developed and costed; the Integrated Action Plan can therefore be developed by using the current RM&E detailed action plan and the technical support plans of development partners as a basis. Developing an Integrated Action Plan would therefore entail grouping the two sets of existing work plans into one document, reviewing it to check for activity gaps and overlaps, and then expanding / shortening / removing / changing activities so that the Integrated Action Plan reflects the entire gamut of activities necessary to operationalise the M&E system - all the required activities, but only the required activities. Development partners then indicate which activities they will be able to support, and align their plans with that of the Integrated Action Plan. Therefore, developing this Integrated Action Plan may lead to some activities in development partner action plans for M&E being changed to reflect the changing reality and agreed consensus around what is necessary.

The Integrated Action Plan has proven to be useful because:

- **It would assist DSP to fulfill its coordination role:** DSP is not only responsible for the coordination of HIV implementation, but also for the coordination of HIV M&E;
- **It is a resource mobilisation tool:** It enables RM&E to determine the exact amount of financial and human resources that are needed for the M&E Plan implementation, included in MTEF;
- **It is a progress monitoring tool for the M&E Committee:** It enables stakeholders to plan and work together on a practical level, around a specific theme (M&E);
- **It would facilitate harmonised commitment:** It is commits development partners to supporting specific aspects of the M&E system; and
- It would define who should be **members** of the M&E Committee.

3.5 COMPONENT 5: STRATEGIC INFORMATION FLOW

There are four principal types of strategic information that must be provided in order for the national HIV M&E system to be functional:

- Surveys and surveillance (this includes both routine surveillance and periodic surveys)
- Routine data for clinical (medical, health facility level) HIV services (data from HIS)

- Routine data for non-clinical (non-medical, community level) HIV services (routine data about HIV programmes/projects from civil society, private sector, and public sector that are not implemented in the health sector)
- Development partner, thematic and sectoral monitoring systems

Observations and recommendations about each of these four types of data sources have been described hereunder.

3.5.1 Surveys and Surveillance

Observations

HIV biological surveillance is routine carried out every two years amongst pregnant women at antenatal care clinics. Routine surveys include the DHS every five years, and the household income and expenditure survey. The DHS currently being carried out, will not include an HIV biomarker for estimating the HIV status of the general population. There are not any surveys to assess the quality of HIV-related services (required for one of the UNGASS indicators), and no national workplace survey, although a partial survey was carried out by NABCOA.

Recommendations

In the national HIV M&E advocacy and communications plan to be developed (see section 3.3), activities should be included to promote the collection of all appropriate data, and on the use of data for decision making.

Discussions are ongoing at MoHSS about which populations are most at risk to infection. Surveys should be undertaken to determine the sizes of these populations, the HIV prevalence amongst these populations and extent of associated risk behaviours.

A survey to measure the quality of HIV-related services is needed. There are plans to do an exercise using HIVQual, however this focuses primarily on the quality of medical services. Quality assessments of non-medical HIV interventions need to be conducted (or put in place) as well. In addition, a national workplace survey is required before 2008, when the next UNGASS report is due.

For harmonization and synchronization purposes, all surveys should be included in the National Statistical Plan.

3.5.2 Routine Data: Medical (clinical) HIV services

'Medical/clinical HIV services' refer to all HIV services provided at health facilities by either MoHSS or a non governmental health care provider. It includes, for example, PMTCT, VCT, STI treatment, and universal precautions. This aspect of the M&E is the responsibility of the

HIS unit at the Primary Health Care Directorate. It also includes information about clinical services, logistics and commodities.

Observations

In December 2006 the HIS Unit will complete the migration of existing data into a new MS Access-based system, the District Health Information System (DHIS). This migration will not include the modification or addition of indicators. The current computerized HIS includes a few indicators related to HIV; other HIV-related indicators are currently being collected through parallel systems. It is envisaged that all data collection for medical HIV services will be included in the new HIS and therefore remove the need for parallel systems.

In early 2007, the HIS unit will carry out a review of the indicators and will update the system to include those HIV indicators for which MoHSS is responsible for data collection. This will be followed by an update of the entire information system, from the central database to patient registers. The timeframe and target data for completion of the entire process was not entirely clear to the mission team.

Data quality is maintained by checking data for internal consistency at the central level, as well as through annual supervision visits where summary data are verified against facility-level records. Both of these procedures are planned to continue after the HIS is reviewed and updated.

An important issue to consider during the redesign is the availability and use of data at regional and district levels. During a field visit, the team observed concrete examples of data use at the facility level, where the regional hospital in Omaheke uses HIS data to evaluate how the clinic is functioning and where improvements can be made.

Recommendations

Data access between the units of the DSP should be made routine from the point of view of the HIS. That is, once the RM&E unit defines the indicator set that it requires from the HIS unit, the HIS unit should report on a routine basis without the need for specific requests. Ideally, these data needs should be taken into consideration when the HIS is reviewed so pre-defined reports can be programmed into the system. A further development would include making the data available through a network, whereby RM&E can independently access the data it requires in real-time.

Also, it is essential that the RM&E unit is part of the HIS review process in January 2007; their involvement will ensure that all HIV indicators for which DSP is responsible are included in the HIS review.

3.5.3 Routine Data: Non-Medical HIV Services

'Non-medical HIV services' include all HIV services provided at community level - it includes *HIV prevention activities* such as peer education, workplace programmes, and HIV impact

mitigation activities such as orphan and elderly support. It also collects data concerning capacity building for HIV service delivery, the existence and implementation of costed HIV work plans, and data on the 'M&E of M&E'.

Observations

Currently, civil society and the private sector, through the sectoral coordination bodies (NANASO, Lironga Eparu and NABCOA), collect some data about non-medical HIV service coverage, but this is not done systematically or routinely. In addition, development partners report to RM&E on request, but not on a routine basis. During the short period of the mission the team was not able to ascertain the details about all of the different data systems that exist in Namibia. Nevertheless, one system for routinely collecting data about HIV services are necessary to ensure that data are received from all stakeholders.

There is mention in the M&E Plan of a new national output monitoring system for all non-medical HIV interventions (reporting formats are, for example, included in the plan). This national output monitoring system has not yet been operationalised.

At the present time, the output monitoring system is designed using a sectoral model of data flow. In it, implementers of HIV interventions report to their sectoral coordination bodies (i.e. private sector report to NABCOA, civil society reports to NANASO, associations of persons living with HIV report to Lironga Eparu, and the public sector reports to the cluster ministries).

There are a number of challenges with a purely sectoral model: first, it leaves out the regional councils (for whom data about HIV services delivered in their regions are essential to enable them to properly coordinate HIV service delivery in their regions); second, the sectoral coordination bodies are not government-sanctioned or permanent structures such as the regional councils; and third, not all HIV implementers are members of the sectoral coordination bodies.

On the other hand, sectors play an important role in the HIV response, and their involvement in the output monitoring system should not be discarded.

Recommendations

What is essential, is that a national output monitoring system for non medical HIV services be operationalised simultaneous to the national HIV M&E system being operationalised. Output monitoring guidelines need to be developed to clarify data flow and define each element on the form. All HIV implementers need to be trained in the use of the output monitoring guidelines.

Given the Government of Namibia's commitment to decentralization, it is logical that the output monitoring system for HIV services would need to be decentralized as well, as is the case in a number of other countries. This could imply a hybrid data flow - a hybrid between a purely sectoral model and a purely regional model of data collection. The Government and

partners need to agree on data flow that works for the country, and such data flow arrangements should be included in the output monitoring guidelines that will be developed.

A registration system for registering and updating the contact details and geographic areas of work of all HIV implementers should be linked to this new output monitoring system. Existing data sets - such as OVC mapping - can form the basis for undertaking this assessment.

The output monitoring system needs to be accompanied by a standardized training curriculum that can be used to train any stakeholder on the HIV output monitoring system for non medical HIV services.

The time and financial resources required to plan and fully implement such a system are significant and often underestimated (see Annex 2 for more lessons learnt in terms of the operationalisation of these types of systems in other countries). In most circumstances it takes one to two years from planning to full functionality. Operationalisation costs should be included in the costed Integrated Action Plan.

3.5.4 Development partner, thematic and sectoral monitoring systems

These include the M&E systems for development partners such as Global Fund, and PEPFAR, as well as special thematic and special groups such as home-based care groups.

Observations

The team observed that the principal development partners have reporting systems. In addition, some thematic groups including the private sector and some civil-society groups (e.g. NANASO) also collect information. These systems are parallel to the national system, and there is currently no regular formal mechanism for integrating their information into the national information system, although partners have expressed verbal commitment to alignment with the national M&E system.

Recommendation

RM&E will negotiate and agree with each partner to ensure alignment of indicators, data flow, information products and dissemination.

3.6 COMPONENT 6: NATIONAL HIV DATABASE

The National HIV database is a repository of information for all key indicators from the various information systems.

Observations

The M&E five-year plan includes the development of a national database. There are other existing databases to which the national M&E database should link, including the HIS and DSP management information system. There are several software programmes available for such a database, including CRIS. Namibia has GIS capacity in-country for spatial analysis of data; DevInfo could also be used for GIS spatial analysis work at a rudimentary level.

There is a general understanding of the need for a database, but the technical specifications have not been developed. The national electronic data needs have not yet been defined concretely; this is an urgent need given the existence of the new M&E system. There is also a team at the Office of the Prime Minister that supports all government units with their IT needs: this team has offered support to RM&E and could assist with defining the unit's electronic data needs.

Recommendations

RM&E should develop Terms of Reference and database system document for developing a national HIV database and its linkages to other existing databases, information flow and utilization. Also, there should be a dedicated subcommittee of the HIV M&E committee that specifically looks into database and informatics issues. This team would need to consist of technical experts in the field of information management systems. The national HIV database should include the function to import data from the DHIS and from other data sources.

3.7 COMPONENT 7: DATA AUDITING AND SUPERVISION

Two types of data auditing and supervision should be carried out: supervision and data auditing of routine data about medical HIV services by MoHSS's primary health care directorate; and supervision and data auditing of routine data on non medical HIV services provided to the regions and sectoral coordination bodies.

Observations

For routine data about medical HIV services, the HIS unit routinely checks data for internal consistency and undertakes supervision visits to health facilities to verify data. For routine data about non-medical HIV services, guidelines are still to be developed.

Recommendations

Routine data auditing and supervision should be addressed as an integral part of the output monitoring system for non medical HIV services: written guidelines defining who will undertake supervision (regions to supervise implementers, and RM&E to supervise regions) and the process through which it will be undertaken, as well as standard report forms, should be developed and integrated into the Integrated Action Plan.

Supervision and data auditing responsibilities should be included in MoUs for sectoral coordination bodies and should be considered in MoUs with implementing line ministries.

3.8 COMPONENT 8: HARMONIZED CAPACITY BUILDING

USG through MEASURE Evaluation will carry out an M&E capacity assessment in early December. The recommendations from this assessment should be taken into included in the

Integrated Action Plan. Therefore, this component of a functional HIV M&E system was not focused on during the scoping mission.

3.9 COMPONENT 9: EVALUATION AND LEARNING AGENDA

This includes all special research, operations research, and evaluations (including impact evaluation). The mission team did not discuss this element in-depth during the mission. It was observed, however, that an HIV research strategy and agenda have not been developed, but the development of such a strategy is included in the M&E five-year plan. The mission team did not engage with stakeholders in enough depth to make additional recommendations on this element - this could be subject to a new mission.

3.10 COMPONENT 10: HIV M&E ADVOCACY AND COMMUNICATIONS

Advocacy for and communication about HIV M&E issues is essential to ensure data quality, improve reporting rates, create understanding about how to interpret data, promote data use, and ensure political buy in for HIV M&E processes and funding. Such advocacy and communications efforts need to focus on stakeholders at all levels and of all types -from political leaders to technocrats to sectoral coordination bodies and community-level providers of HIV services - and need to be managed well.

Observations

The development of the M&E plan provided an opportunity for the DSP to advocate for and communicate about HIV M&E. However, advocacy and communications are not specifically addressed in the M&E five-year plan and an advocacy and communications plan has not been developed.

Recommendations

The first MTP3 progress report that is being finalized, as well as the latest sentinel surveillance report should be disseminated as widely as possible, as this provides a strong opportunity to advocate for the importance of M&E. The report should generate several different information products aimed at different audiences, including the press, the general public, policy-makers, development partners and other stakeholders. A strategic effort should be made to present the products and efforts of the M&E system at government meetings or conferences relating to all aspects of HIV. Findings presented in well-designed media should be provided in ample supply to ensure all members of the HIV community are reached.

An concrete plan for advocacy and communications of HIV M&E issues should be developed and implemented. This should form an integral part of the Integrated Action Plan. It should focus on implementers at all levels, development partners and funders, coordinators of HIV services, including decentralized levels, policy makers and senior management down to the grassroots level, the press and the general public. The plan should have both an internal and external focus, as it cannot be assumed that others even within the Ministry and the DSP appreciate the importance of M&E for National HIV/AIDS response. Different messages need to be targeted at specific audiences.

3.11 COMPONENT 11: DATA DISSEMINATION AND DATA USE

Observations

Data use will be among the targets of the MEASURE Evaluation assessment. Among the various stakeholders that were met during the mission there is a general perception that data are not being used for program guidance and planning. However, as mentioned earlier, there was some limited evidence of data use at a regional hospital.

Recommendation

The recommendations from the MEASURE Evaluation assessment should be incorporated into the Integrated Action Plan as appropriate. As data become available, the information should be incorporated into all M&E advocacy and communications. Training in data dissemination and data use should form part of the Integrated Action Plan

3.12 HIV Policy and HIV M&E issues

The national HIV policy is being finalized. RM&E should advocate for a statement on compulsory reporting by all HIV implementers (e.g. in section 8.2.2 of the policy). Although this would not be legally binding, it would provide explicit evidence of the national commitment to one national M&E system and the importance of reporting.

Whenever possible, formal MoUs should be negotiated with sectoral umbrellas, regional councils, line ministries, development partners and other stakeholders clearly delineating their respective reporting and other M&E responsibilities. These should especially focus on the output monitoring system and responsibilities for supervision and data auditing. Responsibility for the costs for these activities should be defined during the negotiations and included in the Integrated Action Plan.

4 Conclusions

Namibia's national HIV M&E system has been thoroughly designed over a significant period of time and through Government consultation with other Government departments and civil society.

Experience in other countries has shown that the 'mission critical' task of the Response Monitoring and Evaluation Unit will be to effectively coordinate and harmonise the contributions of multisectoral actors in operationalising the system. Such harmonization and coordination efforts are part of a process and requires ongoing close involvement. Taking this experience into account, one of the main recommendations from this mission has been to develop a national HIV M&E Integrated Action Plan.

Operationalising the system is the most important and should start immediately, even as some documentation is being refined and finalized. The recommended priority recommendations and time table for the next six months would be to focus on these activities:

December 2006

- Complete the MEASURE M&E systems capacity assessment
- Create an Operationalisation Task Force with a 2-year life span to address the priority areas
- Develop an HIV M&E advocacy and communications plan, including a dissemination plan for the 2-year MTP Progress report and ANC surveillance
- Review job descriptions of RM&E unit to align it with the M&E unit's responsibilities

January 2007

- Develop an Integrated Action Plan, align internal and external technical assistance to it, and refine it during the MTR. This will require close collaboration with stakeholders.
- Develop the national output monitoring system and registration system for implementers
- Make data access between DSP and HIS unit routine - through the DHIS database being developed by the HIS unit

February to June 2007

- Operationalise the national output monitoring system
- Develop TOR for database linkages, recruit a consultant and manage the consultancy
- Advocate for MoUs with Line Ministries and sectoral umbrellas based on responsibilities in the Integrated Action Plan
- Develop an HIV research agenda for Namibia to identify research and survey needs
- Advocate for and mobilise resources for size estimation surveys, HIV prevalence and behavioural surveys for the major most-at-risk populations
- RM&E should negotiate and agree with each development partner to ensure alignment of indicators, data flow, information products and dissemination
- Address M&E human resource needs
- Participate in the Midterm Review of MTP3

5 Areas of involvement for GAMET and UNAIDS

The purpose of this mission was, in part, a scoping mission to determine how GAMET could assist the Government of Namibia in establishing a national HIV M&E system. It was also meant to confirm those areas of support where UNAIDS's M&E advisor should focus (taking into account that the UNAIDS M&E advisor already had a generic Terms of Reference). These two agencies work closely together and therefore their respective areas of support would motivate and complement each other.

The respective areas that GAMET and UNAIDS can support are described below. The areas cover many of the recommendations contained in the report. The areas of support have been organized per the Main Activities of the RM&E unit (as defined in their 2007 work plan).

AREA OF SUPPORT	GAMET's ROLE	UNAIDS's ROLE
RM&E Main Activity 1: Disseminate M&E Documents		
Promote the development of an advocacy and communications plan for M&E Disseminate M&E documents	Supply examples from other countries Comment on draft plan and documents	Assist with development of draft products for different audiences Support the implementation of the HIV M&E communications and advocacy plan
Support annual (progress) report and review of MTPIII	No direct role	Comment on draft report and align with previous documents Provide input to MTPIII review process Support DSP in setting up committee for review
RM&E Main Activity 3: Finalize Key Tools and Guidelines		
Development, costing and review of Integrated Action Plan	Conduct two 3-day workshops – one to develop the Integrated Action Plan and one to cost it Follow up missions to advise on bottle necks in terms of the national HIV M&E system operationalisation	Ongoing support for the operationalisation of the Integrated Action Plan, through participation in the national HIV M&E management committee
Provide orientation and technical support to the national M&E management committee	Provide a one day orientation, sharing experiences of how other countries have used their Integrated Action Plans to coordinate the national HIV response	Participate in the orientation
RM&E Main Activity 4: Implement National Programme Activity Monitoring System (or Output Monitoring System)		
Support for the development of the national HIV output monitoring system including guidelines and curricula	Support the development of output monitoring guidelines Supply draft guidelines and curricula from other countries Comment on draft curricula that have been developed	Assist with drafting output monitoring guidelines Comment on draft curricula Support the capacity building process Provide specialist input and supervision services, as necessary Support the operationalisation of the output monitoring system

AREA OF SUPPORT	GAMET's ROLE	UNAIDS's ROLE
RM&E Main Activity 5: Implement National M&E Database		
Advise on linking National HIV database systems -- Including CRIS, HIS and others	Assist with development of terms of reference for system consultant (who will describe how information systems can be linked). Help write the database system document with consultant	Provide comments on terms of reference Support the development of the database Advocate for more systematic data reports from HIS section
Develop functioning database for national monitoring; expand to regional level as possible	Provide examples of functional HIV databases from other countries	Conduct CRIS training Support RM&E unit to populate CRIS database
RM&E Main Activity 6: Build National Capacity for M&E		
Build capacity of RM&E unit to operationalize M&E system	Supply relevant background documentation as requested and provide technical input into documents as requested	Day-to-day capacity building and support as required by government, beyond the recommendations made in this report
Conduct advocacy and general M&E training workshops in country	No direct role	Advise on curricula for M&E advocacy workshops and general M&E training workshops
Develop skills in country to estimate and project HIV prevalence	No direct role	Conduct training and facilitate consensus workshop Promote the use of standard WHO/UNAIDS guidelines for HIV surveillance efforts
RM&E Main Activity 7: Build Research Strategy and Conduct Special Studies		
Analysis of DHS data on HIV	Possible support of MTP review as part of ASAP team – <i>future possible area of support to be investigated</i>	Assist unit in determining analysis to be undertaken and in producing required indicators for monitoring system Train staff on use of SPSS software for analysing DHS
Advocate for research on most-at-risk populations and a better understanding of the drivers of the HIV epidemic	Provide examples of protocols and size estimation studies that have been undertaken in other countries	Participate on DSP team developing research protocol for most-at-risk populations (specifically propose size estimation, behavioural and biological surveys) Advocate for an in-country prevention think tank meeting

Background to GAMET

Context

The World Bank is a committed partner in the fight against HIV/AIDS. The Global HIV/AIDS Program (GHAP) was set up in 2002 to strengthen institutional capacity across the World Bank to respond to the epidemic, provide specialized technical expertise and knowledge, and support cross-cutting and multi-sectoral engagement. GHAP also hosts the Global HIV/AIDS Monitoring and Evaluation Team (GAMET).

GAMET's Role

The central mission of GAMET is to improve the quality of HIV/AIDS monitoring and evaluation and build national capacity to support the achievement of the third "One" - one country-led and country-owned monitoring and evaluation system (M&E). GAMET works closely with UNAIDS and other global partners.

GAMET helps strengthen national M&E capacity through an international team of M&E specialists, based primarily in developing countries. They provide rapid, intensive, flexible, practical and expert hands-on M&E support to more than 35 countries. About half of these countries now have M&E frameworks and operational M&E plans, but less than one third have M&E systems that are regularly reporting on key performance indicators.

GAMET and partners strive to harmonize their M&E support to national AIDS responses, to use available resources efficiently. As a key partner of UNAIDS, GAMET aligns itself with efforts of the international community to improve data collection, data flows and data utilization, and to generate and disseminate knowledge and good practices. GAMET seeks to facilitate the monitoring and evaluation efforts of other UN agencies, bilateral donors, and the Global Fund to Fight HIV/AIDS, TB and Malaria.

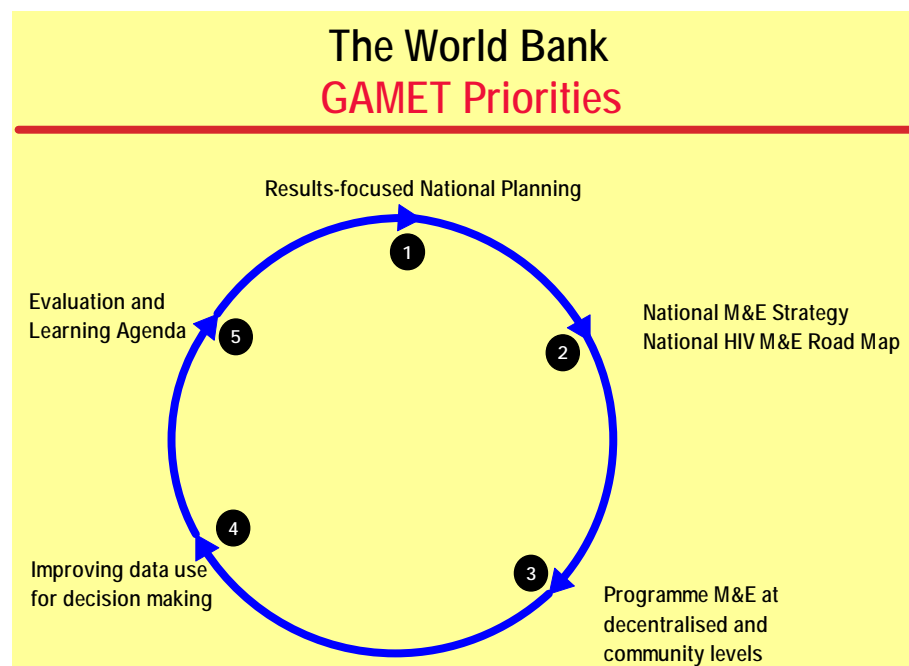
Another important role of GAMET is to support the M&E activities of World Bank projects, enhancing country capacity to implement, monitor and measure progress of the national AIDS response, and use the information for program improvement and learning.

Results

GAMET has five areas of work: (1) support the development of national M&E frameworks, operational plans and budgets; (2) improve data use for programming and decision-making; (3) improve evidence-based results information; (4) renewing national and international partnerships; and (5) generate and disseminate knowledge.

Lessons and Opportunities

- ✚ National leadership and country champions –supported by M&E capacity– are central to strengthening national data generation and management, and utilization of strategic information for decision-making and learning.
- ✚ Partnerships among donors support the government by (a) decreasing the burden of reporting, (b) leveraging resources and rationalizing technical support, and at times (c) pooling financial and other resources in support of national priorities.
- ✚ Partnerships among key national agencies and civil society actors and between these and the national AIDS authority around M&E are gaining in importance as the national HIV/AIDS response in many countries is scaling up and becoming more decentralized.
- ✚ Advocacy about the critical importance of good quality, comprehensive information continues to be a pivotal role for GAMET, UNAIDS and other partners as they support an enabling environment where AIDS information is valued as an indispensable tool for policymakers to track progress towards national goals in responding to the HIV/AIDS epidemic.



Experience with operationalising routine monitoring systems for non-medical HIV services

Country Experiences with Multi-sectoral output monitoring

Experiences in other countries highlight some of the challenges and present some solutions to the development of the output monitoring system. Monitoring of multi-sectoral activities is challenging, as the range of HIV/AIDS-related activities is broad and implementers are diverse. It is critical to create a culture of reporting and to build capacity of implementers to do so.

Data flow must be defined, including whether information will flow up vertically through sectors (e.g. private sector, public sector, civil-society and special groups), be consolidated for all sectors at decentralized levels (regions and districts), or some hybrid system. Care must be taken to avoid double-counting.

Another challenge includes the focus of development partners on large national surveys. These, by nature, are expensive, and are therefore usually performed at relatively infrequent intervals.

These challenges highlight the need for clear guidelines to be developed from the outset. Planning through a collaborative approach by involving key partners from the various sectors is crucial. One important principle to avoid double-counting is that the end-implementer should be responsible for reporting on their outputs. For example, it is the entity that provides the condom to the end-user that reports it, and not the intermediate supplier to that entity.

It is essential to develop clear written reporting guidelines and a national training curriculum for training implementers in reporting. Establishing a cadre of nationally accredited trainers can be a useful means to facilitate national training and re-training that will be necessary. Mentoring by experienced agencies is another useful means to implement the system.

In order to be successful, the RM&E unit will need to develop an advocacy and communications strategy to educate and inform partners, implementers and policy makers about the importance and requirements for reporting. One strategy to achieve this is to "brand" the reporting system by giving it a name and publicizing it.

Data should be available at the most local level possible in order to facilitate access and build a culture of reporting and data use among all implementers. Feedback mechanisms that provide information to decentralized levels during planning meetings is one strategy. Sectoral umbrella entities, such as NABCOA and NANASO can provide technical assistance to other organizations, as

well as assuming a role in data auditing and collation. This lessens the burden on the central RM&E unit.

Incentives for reporting can improve completeness and timeliness. These can include legal sanctions and requirements, as well as positive incentives. In Kenya, for example, only entities with a certificate of compliance with reporting obligations to the national AIDS program are eligible to apply for funding from the government and other major donors, including PEPFAR and the Global Fund. Facilitating reporting, including provision of simple reporting forms in booklet form, will also improve reporting.