



**The State of HIV Monitoring and Evaluation  
Practice in the Caribbean and  
Meta-Analysis of Program Performance**

---

**Caribbean Health Research Council**

**September 2011**



# Table of Contents

---

Executive Summary.....	5
1. Introduction .....	9
2. Human Resources, Partnerships and Planning.....	13
2.1 Organizational Structures with HIV M&E Functions... ..	13
2.2 Human Capacity for HIV M&E.....	14
2.3 Partnerships to Plan, Coordinate and Manage the Monitoring and Evaluation system.....	15
2.4 HIV M&E Plan.....	17
2.5 Annual, Costed, National HIV M&E Work Plan.....	17
2.6 Communication, Advocacy and Culture for M&E.....	18
3. Data Collection, Verification and Analysis.....	20
3.1 Routine HIV Programme Monitoring.....	20
3.2 Surveys and Surveillance.....	21
3.3 National and Sub- national HIV databases.....	22
3.4 Supportive Supervision and Data Auditing.....	22
3.5 HIV Evaluation and Research Agenda.....	23
4. Data Dissemination and Use.....	25
5. Key Findings, Recommendations, Cross-cutting Themes and Priority Actions.....	26
5.1 Key Findings and Recommendations.....	26
5.2 Cross-Cutting Themes and Priority Actions.....	34

6. Conclusion.....	37
7. References.....	38
8.Appendices .....	40
Appendix 1 Acronyms.....	40
Appendix 2 Terms of Reference, Caribbean Regional Monitoring & Evaluation Working Group .....	42
Appendix 3 Interview/Discussion Guideline.....	45
Appendix 4 Selected CHRC Repository Information .....	47
Appendix 5 Priority Action and Related Recommendations.....	48
Appendix 6 List of Persons Interviewed.....	51

# Executive Summary

---

## Objectives of the Report

Given the considerable investments being made in developing, building, and strengthening monitoring and evaluation (M&E) capacity of national HIV programmes, it was essential to assess the status of M&E practice in the Caribbean. The report seeks to do the following:

- To determine the progress made, the obstacles to be surmounted, and the gaps to be filled;
- To review reports and conduct a meta-analysis of HIV program performance; and,
- To provide a framework for action by proposing ways to move forward with recommendations that could be implemented at either the national or regional level.

## Methods

With the aim to provide an overview of the status of M&E practice in the region and a meta-analysis of program performance, the report was produced using the following methods:

- i) Review and analysis of relevant country and regional reports and documents related to M&E practice to determine the status of the regional response to the HIV epidemic as it pertains to M&E; to identify cross-cutting themes of M&E practice in the region, and to identify the successes and challenges encountered with implementing and sustaining national M&E systems in the region; and,
- ii) Telephone interviews with regional stakeholders and country representatives to ensure that all perspectives are captured in the report and to confirm findings and conclusions.

## Findings

The report focuses on the 3 broad areas essential for a national HIV M&E system to be fully functional: Human Resources, Partnerships and Planning; Data Collection, Verification and Analysis; and, Data Dissemination and Use for Decision-Making.

Considerable progress has been made with the implementation of M&E systems, the formation of M&E Units where necessary, and the hiring of M&E focal points.

Key highlights are outlined below.

- The Caribbean Regional Strategic Framework on HIV and AIDS, 2008-2012 (CRSF) and the Caribbean Regional HIV and AIDS Partnership Framework, 2010-2014 both support strengthening M&E practice in the Caribbean.
- CHRC, a regional health institution, with funding from regional and international partners has adopted a lead role with respect to M&E.
- There is donor support for human resource capacity building in M&E.

- The culture of M&E is being developed and becoming an integral part of organizational structures in the Caribbean.
- Technical assistance and training for M&E is widely available for all countries that request support from regional organizations and or international institutions.
- Basic and advanced training curricula and training manuals have been recently developed by CHRC.
- Countries have made efforts to train key staff in M&E through various training opportunities available regionally and internationally.

Despite these key successes and the growing recognition of the value of M&E, it has received inadequate attention. Moreover, M&E practice must become a priority if the regional response to HIV and AIDS is to be strengthened and sustained.

### **Priority Actions— The Way Forward**

An overview of the status of these three broad areas implicitly recommends the need for increased coordination, the recruitment and mobilisation of new constituencies, the development of human resources, the initiation of new work, and advocacy for a stronger effort by national and regional stakeholders.

The report recommends three Priority Actions:

- 1: Provide Strong Leadership and Coordinate Effective Partnerships;**
- 2: Intensify Efforts to Build and Strengthen Human Capacity in the Region; and,**
- 3: Develop a Cohesive Communication and Data Dissemination Plan for the Region.**

Many of the 20 recommendations in the report are neither new nor surprising. Most target long-standing issues, such as the need for strengthening human capacity and the call for effective and functional coordination. What is new in 2011, however, is that the global economic crisis has resulted in decreased funding levels for national and regional stakeholders. Consequently, improved coordination and strong partnerships are essential to maintain the momentum gained and to garner the necessary support to move the field forward.

The 20 recommendations are grouped by the 3 Priority Actions are provided below.

#### **Priority Action 1 – Provide Strong Leadership and Coordinate Effective Partnerships**

*Recommendations to be implemented at the Country Level:*

- National M&E Reference Groups (NMERGs) with members working in the field of health should be established or strengthened in each country.
- Countries should develop a national costed annual/biennial M&E work plan with wide buy-in from all the sectors, and donors should be major stakeholders in its development.
- Align data collection and reporting with the national M&E plan, including a review of current forms, and streamlining of data collection to support data needs for client management, indicator reporting, and generation of annual performance reports.

- \*There is a need to develop national- and regional level inventories on surveys and surveillance, which should be updated periodically.
- It is encouraged that, rather than setting up various databases leading to inefficient use of resources, countries work with only one database, which they constantly improve and update.
- \*There is a need to develop an inventory of HIV evaluations or research at the country and regional levels; Countries and regional institutions should adopt, where appropriate, CHRC's Health Research Agenda and use this to coordinate other regional agenda to avoid duplication of efforts.

*Recommendations to be implemented at the Regional Level:*

- Develop a schedule of TWG meetings and incorporate this into the CHRC work plan.
- Identify "M&E champions"—high level stakeholders-- who are leaders and well recognized both technically and politically.
- The new Research, Evaluation and Policy Development Unit of CARPHA and/or CHRC needs to develop a strategy to ensure that researchers and policy makers interface and that research is translated into policy and influences programs.

**Priority Action 2 -- Intensify efforts to build and strengthen human capacity the Region**

*Recommendations to be implemented at the Country Level:*

- There is need to strengthen HIV M&E structures within the Ministries of Health.
- Strengthen existing skills in data management and report writing at the national level.
- Strengthen national capacity to conduct surveys through training, workshops and access to relevant literature.
- There is a need to develop guidelines for supportive supervision and data auditing of health programs.

*Recommendations to be implemented at the Regional Level:*

- Revise existing basic and advanced M&E curricula to ensure they focus on all the 12 components.
- Develop a regional capacity building plan that include these interventions: technical assistance, mentorships, internships, exchange visits, supportive supervision, and training; Strengthen the human capacity of regional organizations to better support countries with building, strengthening and sustaining M&E practice.

- Team national staff with staff from regional organizations to deliver in-country M&E training.

**Priority Action 3 -- Develop a Cohesive Communication and Data Dissemination Plan for the Region**

*Recommendations to be implemented at the Regional Level:*

- CHRC should develop an M&E communications and advocacy strategy
- Provide countries with guidance on assessing national stakeholders' information needs.
- Assist countries with developing a data dissemination and use plan that is included in the national HIV M&E plan.
- Strengthen the capacity of personnel at the national level to translate evidence into recommendations for decision making and policy targeted actions; CHRC should develop a cohesive Communication and Data Dissemination Plan for dissemination of M&E and other information products.

In conclusion, the report should be regarded as a dynamic document to be periodically updated as M&E practice moves forward. Moreover, sustained progress will require that regional and national stakeholders work together. The recommendations and priority actions in this report provide a tangible roadmap for all stakeholders to navigate the way forward as we walk the long road to implement fully functional M&E systems in the region.

\* Recommendations that should be implemented at both the Country and Regional Levels

# 1. Introduction

---

With more than US\$1.0 billion in funding for its HIV programmes over the last decade, the capacity of Caribbean governments to respond to the HIV epidemic has been strengthened. Moreover, countries in the Region have demonstrated some success with mounting a response to the HIV epidemic through the establishment of National AIDS Programmes (NAPs) in each country with oversight typically provided by the Prime Ministers' Office or the Ministry of Health.

With each NAP having the responsibility to coordinate and implement HIV-related activities identified in the national strategic plan, Caribbean countries have responded to the HIV epidemic with varying degrees of success. In particular, coordination of the response, strategic planning and treatment and care for persons living with HIV have improved over the last decade.

In part due to these efforts, HIV rates have remained at 1--2% in many Caribbean countries. And, although prevention programmes have reduced the number of new HIV infections, AIDS continues to be the leading cause of death among Caribbean adults 25 to 44 years of age and rates among most-at-risk populations are unacceptably high. Consequently, there remains much more to be done in the areas of advocacy, prevention, treatment, and care and support.

Having received a high level of political commitment and support from regional and international partners, the intensity of the response to HIV and AIDS has grown during the last decade. However, much of the funding for HIV/AIDS programs in the region were dedicated primarily to project implementation activities with little or no evaluation of the project's outcomes and impact. Consequently, both the monitoring and evaluation (M&E) of HIV/AIDS programs have been historically weak. And with the current global economic crisis and dwindling resources, governments are now compelled to demonstrate and sustain results with improved M&E practice. However, many national M&E systems are relatively feeble for a variety of reasons: inadequate human capacity, limited resources, and the lack of strong and steadfast leadership in some instances.

Although country M&E systems in the Region are not fully functional and operational, some progress has been made with the implementation of the system, formation of M&E Units where necessary, and the hiring of M&E focal points. Despite the growing recognition of the value of M&E, it has received inadequate attention. As a result, there is no fully functional and comprehensive M&E system for the national response to HIV in any Caribbean country.

Monitoring and evaluation must become a priority if the regional response to HIV and AIDS is to be strengthened. In addition, our fledgling M&E culture needs to be nurtured through training, advocacy, policy development and additional technical assistance.

Given the urgent need to build and strengthen M&E capacity at the national level, regional entities expected to provide M&E training and technical assistance to countries must also have adequate

financial support to maintain and strengthen their human resource capacities. This will allow regional organizations a solid platform from which to launch strong and sustained responses to countries' requests for technical guidance and support.

Many countries in the region have attempted to align themselves with the Three Ones principle with one National Strategic Framework, a National Coordinating Body, and one National M&E Framework. However, the National M&E Framework remains the least developed of the Three Ones.

This is because the entities responsible for implementing M&E systems are relatively new and have fragile institutional structures and weak platforms from which to advocate for M&E practice. Moreover, multisectoral national M&E systems are fairly new and governments are still grappling with the task of assuming a coordinating role across government entities, civil society and the private sector. These factors along with a lack of a favorable policy environment and inadequate human capacity involved in M&E work have made it difficult for a strong M&E culture to become established.

The ultimate goal is to establish and sustain a functional HIV/AIDS M&E system under the framework of the Three Ones. However, given the myriad of challenges, partners have agreed on a common definition of the components required for a national functioning M&E system.

### **Monitoring & Evaluation Organizing Framework**

A functional national HIV M&E System describes 12 components of a multi-sectoral HIV M&E system; it also defines a performance goal for each component and expected results if the component is functioning well [Figure 1].

- The *outer ring* represents the human resources, partnerships and planning required to support data collection and data use. It 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 analysed.
- The *centre* of the diagram represents the primary purpose of the M&E system: using data for decision making.

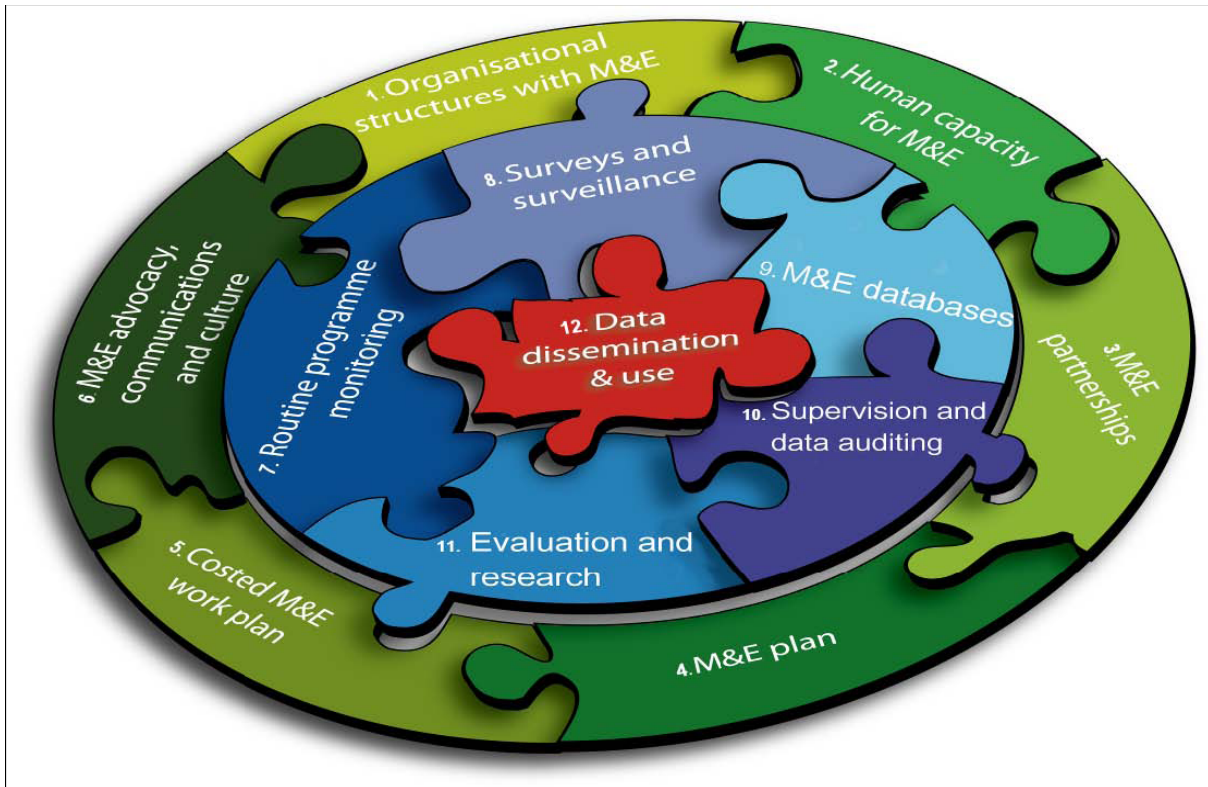


Figure 1. The 12 Components of a functional M&E System showing intersecting and interdependent parts of a larger whole

SOURCE: UNAIDS Monitoring and Evaluation Reference Group (MERG)

### Monitoring and Evaluation in the Region

As a result of the Caribbean Health Research Council's (CHRC) mandate to promote evidence-based decision making in the Region coupled with its historical presence in the region for more than 50 years, it is considered the lead agency responsible for M&E technical work. In the Caribbean, CHRC supports the implementation of M&E strategies by national governments to increase the use of strategic information for improvement of HIV program quality, performance and accountability.

Also, CHRC works in collaboration with the Caribbean Regional M&E Technical Working Group (TWG) to build the capacity of staff working in NAPs; to support the M&E functions of partner organizations; and to contribute to developing national and sub-regional M&E systems and components (Appendix 2).

With the considerable investments being made in developing, building, and strengthening M&E capacity of national HIV programs and key regional institutions, an overall assessment of the status of M&E practice is essential to determine the progress made, the obstacles to be surmounted, the gaps to be filled, and the ways forward.

## **Purpose of the Report**

The purpose of this report is to provide an overview of M&E practice and performance in the Caribbean. Its focus is the overall state of M&E practice in the Region and not the specific condition of M&E practice in individual Caribbean countries. Specifically, it seeks to identify common successes and challenges, to outline cross-cutting themes, and to recommend actions at both national and regional levels that will strengthen HIV M&E systems in the Region. This report will inform future collaborative planning for upcoming project directions involving CHRC and other key national, regional and international stakeholders.

This report was produced using the following methods:

- 1) Review of relevant reports and documents related to M&E practice such as current National HIV Strategic Plans, current National HIV M&E Plans, UNGASS reports, and M&E system assessments and the documents contained CHRC M&E Repository; and,
- 2) Telephone interviews with regional stakeholders and country representatives. The interview/discussion guide (Appendix 3) was designed to solicit information related to challenges encountered in implementing M& E systems in the region. Interviews were completed to ensure that the key findings and recommended actions are grounded within the Region's experience and scope. The list of persons interviewed is presented in Appendix 6.

## **Report Format**

The report's structure is based on the 3 broad areas required for a national HIV M&E system to be fully functional: Human Resources, Partnerships and Planning; Mechanisms through which data are collected, verified and analyzed; and, Data Dissemination and Use for Decision-Making

Chapter 2 focuses on Human Resources, Partnerships and Planning and includes six of the twelve components: organizational structures, human capacity, partnerships, M&E plans, costed work plans and communication and advocacy. Chapter 3 focuses on the second broad area of Data Collection, Verification and Analysis and includes the five components relevant to this area: routine programme monitoring, surveys and surveillance, databases, supportive supervision and data auditing and the HIV evaluation and research area. Chapter 4 covers the broad area of Data Dissemination and Use.

Chapter 5 highlights significant successes, identifies major challenges, lists recommendations, outlines cross-cutting themes and proposes broad priority actions to surmount the obstacles and fill the gaps identified. The report concludes with Chapter 6.

## 2. Human Resources, Partnerships and Planning

---

### **2.1 Organizational Structures with HIV M&E Functions**

*The performance goal is to establish and maintain a network of organizations responsible for HIV M&E at the national, sub-national, and service-delivery levels under the auspices of a national coordinating body. It focuses on leadership, human resources, organizational structure, roles, functions, and performance.*

Recognizing the need to address the problem of poorly coordinated HIV M&E activities and the need to align with the Three Ones principles; many countries operationalized the Three Ones through the development of a national coordinating body. Moreover, many countries formulated M&E plans, dedicated human capacity to M&E and created M&E Units where resources allowed for such an entity. Typically, HIV and AIDS M&E activities are coordinated through National AIDS Programmes (NAPs) or M&E Units in collaboration with Surveillance and Health Information Units at Ministries of Health.

National level entities have established organizational structures, such as NAPs. However, lower-level entities (regional health authorities, health facilities, civil society organizations, and other implementing partners) have weak M&E structures and, in some instances, are not aware of their M&E mandate. In countries, where there is M&E human capacity, for example Jamaica, M&E Units have been created to manage HIV M&E tasks in collaboration with other national partners.

Key government entities, organizations, and programmes—such as regional health authorities, voluntary counseling and testing sites, prevention of mother-to child-transmission (PMTCT) — perform selected M&E functions, but typically do not have defined M&E annual work plans and budgets, which is reasonable in some countries given their relatively small populations.

Within the civil society arena, the Caribbean HIV/AIDS Alliance (CHAA) and its partners at country level have a documented and well functioning M&E structure. Partly based in Trinidad and Tobago, the system covers activities and reporting systems in the four Eastern Caribbean countries where the CHAA implements activities. This system comprises of data collection and entry in countries, data verification at country offices, collation and data cleaning at the Trinidad Office and data analysis and use by the country teams. CHAA is also undertaking Integrated Biological and Behavioral Studies (IBBS) in several of the countries in which they implement programs.

There has been improved coordination of the national response, surveillance, prevention, and involvement of civil society in some countries as well as an increase in the number of UNGASS and Universal Access indicators that countries are able to report.

The key findings for Component 1: Organizational Structures with HIV M&E Functions are outlined on page 26 of Chapter 5.

## **2.2 Human Capacity for HIV M&E**

*The performance goal is to ensure adequate skilled human resources at all levels of the M&E system in order to complete all tasks defined in the annual costed national HIV M&E work plan. This component focuses on having a defined skill set for individuals and organizations at all levels, a work force development plan, a costed human capacity building plan, a standard curricula for organizational and technical capacity building and supervision, in-service training and mentoring.*

All key providers of data in the national response have focal points responsible for reporting on key information in the national response. Generally, staff with assigned responsibility for M&E meet the requirements of the post and have received significant training, coaching and mentorship. In spite of this, the status of this component has been generally weak and can be attributed to the lack of sufficient numbers of skilled and appropriately trained M&E professionals. HIV M&E functions are primarily donor-driven and performed to meet external donor reporting requirements; consequently, these functions are often performed in the absence of official, dedicated posts. Nonetheless, there are individuals who contribute to the M&E system through facilitating the collection and reporting of data to the HIV focal point at the NAP or M&E Unit.

Caribbean governments recognize the need to invest in human capacity development and efforts are currently underway to support the development of human capacity most notably in Jamaica and Trinidad and Tobago. It is important to note that the post of M&E Officer has been established in Nevis and is funded by the Ministry of Health. However, in other countries, for example St Vincent and the Grenadines and St Lucia, the end of World Bank grants have stalled M&E work due to the loss of dedicated staff at the end of the grant period. In these countries, M&E activities have been absorbed into the surveillance or health information units. Therefore, M&E is being performed without dedicated staff.

Throughout the region, a number of persons have received some sort of M&E training. Agencies such as the CHAA, CHRC, the Peace Corps and the Work Bank have conducted trainings directed at staff from the NAPs, M&E Units, line ministries, non-governmental organizations and faith-based organizations. Consequently, M&E Officers or focal points have benefitted from several M&E training opportunities, preceptorships, and mentorship programmes. However, national organizations with leadership roles in M&E still lack the personnel with skills to train, mentor and develop capacity at all levels. However, it should be noted that regional institutions tasked with providing countries with M&E support do not have adequate staff to carry out their mandate with respect to responding to all requests for technical assistance and training in a timely manner.

The rapid turnover of HIV focal points in the region, as has occurred in Barbados, has sometimes made it challenging to capitalize on M&E training. Moreover, throughout the region, there is an urgent need for further training in specialized areas such as advanced data analysis, database management, results-based management and programme evaluation.

There are generally no formal M&E human capacity development plans in most countries and capacity development has been ad hoc with staff accessing valuable training opportunities as they arise. The technical requirements of M&E posts, function and structure are not always well understood at the policy level; consequently, those in key established posts such as surveillance officer, research officer and quality assurance officer are responsible for critical M&E functions.

While M&E capacity has been developed significantly at NAPs, that of non-governmental organizations and facility level staff remains weak and is generally limited to data collection functions.

Few countries have committed to have M&E integrated within the health system and no formal assessments of human resource or capacity development needs have been conducted. Moving forward, we must ensure that HIV/M&E becomes an inherent and sustainable core function of the national HIV/AIDS response, as well as the national health sector response as a whole. A formal assessment of current staffing needs for M&E is still required in view of national-level needs for the availability of high quality data at all levels within the M&E system.

The key findings for Component 2: Human Capacity for HIV M&E are outlined on page 27 of Chapter 5.

### ***2.3 Partnerships to plan, coordinate and manage the M&E System***

*The performance goal for this component is to establish and maintain partnerships among in-country and international stakeholders that are involved in planning and managing the national HIV M&E system.*

The Caribbean Regional Strategic Framework on HIV and AIDS, 2008-2012 (CRSF) articulates the vision and collective priorities of Caribbean governments through their membership in and their support for the Pan-Caribbean Partnership against HIV/AIDS (PANCAP). The CRSF has six priority areas, one of which is M&E and research.

Moreover, the Caribbean Regional HIV and AIDS Partnership Framework, 2010-2014 supports a collaborative effort of the United States Government, Caribbean Community (CARICOM), Organization of Eastern Caribbean States (OECS) and 12 Caribbean governments. This framework has five Partnership goals; one of which—Strategic Information—aims to improve the capacity of national governments and regional organizations to increase the availability and use of quality and timely data to better characterize the epidemic and support evidence-based decision making for improved programs, policies and health services.

The three broad areas of focus for Strategic Information are surveillance, M&E, and health information systems. And, Objective 2.2 of the Partnership Framework supports the implementation of national M&E strategies to increase the use of strategic information for monitoring, evaluation, and improvement of HIV program quality, performance and accountability.

Moreover, both the CRSF and the Partnership Framework share fundamental priorities with monitoring, evaluation and research being strategic goals of both frameworks.

Several regional institutions or entities have contributed to monitoring the HIV epidemic, assessing progress in the response, and improving capacity for both at the national and regional levels.

The following is a list of some of the agencies or groups that have collaborated with Caribbean governments:

Caribbean HIV/AIDS Alliance (CHAA); Caribbean HIV and AIDS Regional Training Network (CHART); Caribbean Epidemiology Centre (CAREC); Canadian International Development Agency (CIDA); Caribbean Coalition of National AIDS Programme Coordinators (CCNAPC); Caribbean Health Leadership Institute (CHLI); Centers for Disease Control and Prevention (CDC); Caribbean Health Research Council (CHRC); Department for International Development (DfiD); Organization of Eastern Caribbean States HIV/AIDS Project Unit (HAPU); Global AIDS M&E Team (GAMET); Global Fund; MEASURE Evaluation; Latin American and Caribbean Council of AIDS Service Organizations (LACCASO); Pan Caribbean Partnership Against HIV/AIDS (PANCAP); PAHO HIV Caribbean Office (PHCO); President's Emergency Plan for AIDS Relief (PEPFAR); Joint United Nations Programme on HIV and AIDS (UNAIDS); United Nations Development Fund for Women (UNIFEM); University of West Indies (UWI); The United Nations Children's Fund (UNICEF); United States Agency for International Development (USAID); and the Caribbean Regional M&E Technical Working Group (TWG);

During the past few years, the Region has seen a growth in the number of agencies providing M&E technical assistance. This has sometimes led to duplication of effort and consequently, an increased burden on countries to respond to the requests of the various agencies. In light of this fact and concerns voiced by country stakeholders, a decision was taken in 2003 to convene a committee, known as the Caribbean Regional Monitoring & Evaluation Technical Working Group (TWG)

The M&E Technical Working Group (TWG) comprises representatives of institutions providing M&E technical assistance at no cost to the region. The overall mandate of the TWG is to maximize the timeliness, efficiency and effectiveness of efforts that address HIV-related M&E needs in the Caribbean. The activities and membership of TWG are outlined in Appendix 2.

At the national level, while there is some coordination and collaboration among stakeholders with respect to programmatic issues, there are no routine partner meetings around M&E issues to review country data and make programmatic adjustments. Coordination and collaboration on M&E issues are generally limited to the NAP or M&E focal points and although data are being submitted to the NAP and M&E focal points, regular feedback is not given to those who submit data.

In the Region, there are few functional national M&E, Reference or Health Sector Technical Working Groups (NMERGs). Moreover, national partners external to the Ministry of Health, M&E Units or NAPs are typically not involved in decision making as it relates to national M&E systems. The role of these partner agencies is limited to the provision of M&E and programme data to the NAP, M&E Unit and/or Ministry of Health as requested.

Communication between the NAP, M&E Unit or Ministry of Health and other national stakeholders is carried out as needed. In the case of external stakeholders, this is undertaken in accordance with the timelines for the completion of activities, and reporting of activities as outlined in donor-specific work plans. The role of international partners in M&E relates to (i) the provision of technical assistance, (ii) training and capacity building activities and (iii) the monitoring and reporting as per the requirements of donor agencies.

Overall, the HIV/AIDS M&E systems in the Region are able to meet all or most of the minimum requirements as they relate to donor reporting requirements and regional and international reporting commitments.

The key findings for Component 3: Partnerships to Plan, Coordinate, and Manage the M&E System are outlined on page 28 of Chapter 5.

## **2.4 HIV M&E Plan**

*The performance goal is to develop and regularly update a national M&E plan including identified data needs, national standardized indicators, data collection procedures and tools, and roles and responsibilities for implementation of a functional national HIV M&E system.*

National M&E Plans should include a multi-sectoral, 3-5 year implementation strategy for collection, analysis and use of data needed for program management and accountability purposes. Most plans should describe the data needs linked to a specific program, the activities required to satisfy the data needs and the specific data collection procedures and tools; the standardized indicators that need to be collected for routine monitoring and regular reporting; the components of the M&E system that need to be implemented; and how data will be used for program management and accountability purposes. The plan should also indicate resource requirement estimates and outlines a strategy for resource mobilization.

Many National Strategic Plans and HIV M&E Plans exist in the Caribbean. However, many plans are not current. This speaks volumes to the lack of human capacity, and unfortunately in some instances, the lack of commitment. National M&E plans are based on National Strategic Plans (NSPs) and as many country NSPs are not finalized, most countries do not have current M&E plans either. This has been a major constraint in executing a strong, comprehensive national response.

CHRC's M&E Repository illustrates the status of National Strategic and M&E plans in the region and provides a snapshot of the general HIV M&E situation in the Region (Appendix 4).

For those M&E plans that are current, they are fairly comprehensive, well-developed, and address many but not all of the 12 components of a national M&E system. However, the lack of human capacity and highly functional and effective country working groups to coordinate and implement the programmatic response continues to be a critical gap. In turn, this has impeded the integration of M&E into the health sector.

The key findings for Component 4: HIV M&E Plan are outlined on page 28 of Chapter 5.

## **2.5 Annual, Costed, National HIV M&E Work Plan**

*The performance goal is to develop an annual costed national M&E work plan, including the specific and costed HIV M&E activities of all relevant stakeholders and identified sources of funding. This plan is used for coordination and assessing progress of M&E implementation throughout the year.*

Few countries have developed a national annual multi-partner costed M&E work plan which would include priority 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; and a timeline for delivery of all products.

For countries with no national annual work plans, the current M&E plan, M&E draft plan or “expired” M&E plan is used to guide the development of all M&E work until the annual M&E work plan and accompanying budget are completed. Currently, M&E activities are directed largely by the reporting requirements of international donors for which there is an annual work plan and budget. As such, reporting on indicators places focus on specific tasks related to the development of M&E in the country as outlined in donor agreements and not necessarily all tasks linked to national priorities.

For the few countries that have a national HIV work plan that includes M&E activities, such as Dominica, these activities are mostly related to donor requirements and are not based on the M&E plan.

The key findings for Component 5: Annual, Costed, National HIV M&E Work Plan are outlined on page 29 of Chapter 5.

## ***2.6 Communication, Advocacy and Culture for HIV M&E***

*The performance goal is to ensure knowledge of and commitment to HIV M&E and the HIV M&E system among policymakers, program managers, program staff, and other stakeholders.*

Building a sound evaluative culture requires a conducive environment. Consequently, in the Region, there is a general lack of an institutionalized M&E culture and a crucial need to advocate for HIV M&E. While it is clear that the culture of M&E is growing, M&E continues to be externally driven, that is, M&E is more donor driven than being driven by the organizational culture in the Region.

Greater attention should be aimed at ensuring that M&E is prioritized and that evidence-based decision making is a consistent feature of programme planning and delivery in the Caribbean. Selected individuals at the country and regional levels are committed to building a strong M&E culture, but generally, there is not a deep commitment at the level of country policy makers to develop and sustain M&E systems.

In spite of this, stakeholders at all levels are familiar with M&E and its importance and there is growing recognition that M&E is of relevance to not only HIV/AIDS, but other areas of public health. However, in many instances the importance attributed to M&E by national policy makers is primarily due to the significance that is placed on M&E by external agencies.

The recognition of persons with the responsibility for M&E functions has been through training in M&E and research. Opportunities for training have been mainly for persons at the level of the NAPs or M&E Units. To continue to build a culture for M&E, training should be extended to all sectors. However due to funding constraints, much-needed resources to support M&E and other related functions are not always readily available.

Information sharing has proven to be a challenge as there is limited dissemination of information on the performance of programmes. As a result, there is a need for the implementation of dissemination strategies as outlined in current M&E plans. There is recognition for the need for M&E, but no champions for M&E have been identified. Therefore, M&E has not been promoted with any considerable vigour at the highest levels of government in the region.

Some countries further along in M&E implementation, such as St. Vincent and the Grenadines, were in a state of transition as there were plans to focus more on M&E within the context of the wider health sector rather than M&E for HIV/AIDS only. However, as discussed in Section 2.2, the end of specific M&E funding from international agencies in some countries coupled with no dedicated funds provided by these governments for M&E posts have created a vacuum with no dedicated M&E focal points to work on integration of M&E in the health sector.

The key findings for Component 6: Communication, Advocacy and Culture for HIV M&E are outlined on page 29 of Chapter 5.

## 3. Data Collection, Verification and Analysis

---

### **3.1 Routine HIV Programme Monitoring**

*The performance goal is to produce timely and high quality routine program monitoring data.*

Data are generated through the activities of main programme areas such as testing and counseling, PMTCT, and care and support. However, much of the information is not captured. Moreover, in those instances where data are collected in country, a deep understanding of how to use these data does not exist. And data with no analysis will not generate the information required to improve programme quality. The quality of these data needs to be improved, but analysis can still provide some analytic feedback.

In many instances, programme monitoring for HIV is done through a country's national health reporting system. Invariably, it is the Health Information (HI) Unit or the Surveillance Unit data that support strategic and management decisions for the entire health sector. The national HIV M&E system typically draws on existing data from the HI and/or surveillance units. As such, the performance of the HIV M&E system is directly linked to the capacity of the HI or surveillance units. Generally, programme data are stored separately and because of this, collecting and verifying monitoring and evaluating data remain challenging.

Efforts to strengthen existing national HIV M&E systems have not generally contributed to strengthening the overall performance of the HI and/or surveillance units. To accomplish this, NAPs should invest in building the M&E capacity among programme managers who collect critical programme data as well as the staff at health information and surveillance units.

Although efforts to coordinate HIV M&E with the overall HI or surveillance units in countries have been ongoing, the coordination between both entities needs to be strengthened. Moreover, it would be advantageous to integrate data collection forms and data management systems. Data collection tools continue to be refined and modified to improve reliability and accuracy of data as countries in the Region have experienced challenges with the integration of new reporting requirements with existing standardized forms.

Infrastructure for data recording and processing is generally in place although supported primarily at the national level. HIV and AIDS reporting at the national and facility levels are compromised by issues of incomplete reporting and late reporting. This is symptomatic of M&E capacity gaps at all levels of the national response.

Data are not routinely reviewed at all levels for accuracy and consistency prior to submission to the next level within country M&E systems and responsibilities for data validation are maintained primarily at the national level. Generally, gaps exist surrounding the existence of effective feedback loops and the sharing of data by the national level focal points for program improvement

For several OECS countries, data collection and recording for most-at-risk populations outreach activities are collected, collated, and reported by the CHAA and partner non-governmental agencies with summary reports shared with the Ministry of Health and the NAP within each country.

The key findings for Component 7: Routine HIV Programme Monitoring are outlined on page 30 of Chapter 5.

### **3.2 Surveys and Surveillance**

*The performance goal is to produce timely and high quality data from surveys and surveillance.*

While the M&E plan and other national reports have identified and highlighted surveys to be conducted to provide information for programme monitoring and implementation, the lack of resources, absence of a clear research agenda, and limits on staff capacity contribute to surveys not being done.

The surveys and surveillance system needs to be strengthened as it provides critical information for the HIV response. The capacity to plan and conduct surveys is lacking and without a clear research agenda coupled with the lack of resources, the capacity of countries to conduct their own surveys remains weak. Moreover, there is generally a superficial understanding of what is required in terms of studies to be conducted to generate the type of information that is needed.

The completion of a few studies— men who have sex with men (MSM) and behavioral surveillance surveys (BSS)— in the region have provided some insights, but much remains to be done. Behavioral surveillance amongst the general and most-at-risk populations are not conducted regularly. As a result, these are conducted at intervals when approached by external sources.

Although biological surveillance has been conducted in the past (prison sero prevalence surveys), apart from the routine data collected from ante natal clinics, other surveys are conducted on an ad hoc basis and are usually externally driven.

Some countries have successfully implemented HIV-based surveillance; however many countries are in the process of fully implementing the system with assistance from regional partners such as CAREC and PHCO.

Generally, there are no official inventories of HIV-related surveys or information on where these surveys are stored for easy retrieval. However, some countries (e.g. Jamaica) have made significant progress in this regard. Nonetheless, for most countries, information on HIV-related surveys can be obtained from reports and through the personal experiences of key individuals. Moreover, information on surveys resides mainly with these individuals who have been involved in the administration and implementation of HIV programmes.

The general lack of recent population-based survey data in the Region is a cause for concern and should be addressed as a matter of priority. This information is critical to evidence-based programme design, particularly prevention programmes and programmes tailored to reach most-at-risk populations.

The key findings for Component 8: Surveys and Surveillance are outlined on page 31 of Chapter 5.

### **3.3 National and Sub- national HIV databases**

*The performance goal is to develop and maintain national and sub-national HIV databases that enable stakeholders to access relevant data for policy formulation, and program management and improvement.*

Typically, each country has more than one database for the capture of program monitoring data such as PMTCT and testing and counseling. These separate databases are seldom linked to each other, hence there is a high likelihood of duplication and poor resource use in this regard. Data from various programmatic areas are typically collated and routine HIV and AIDS data maintained in a single database at national level for national reporting. Databases used at the national level are functional (SPSS, Epi Info, Access). Spreadsheets such as Microsoft Excel are used as well.

Moreover, not all data captured by country HIV M&E systems are stored electronically and the lack of national integrated databases in many countries does not facilitate improved analysis or reporting.

With respect to laboratory data, only some countries have totally automated laboratory management systems. Generally, central laboratory data management systems are primarily paper-based, with selected laboratory reports generated electronically. Fully electronic laboratory systems exist, but data are often not integrated with other databases and data entry for HIV cases is primarily done at the Surveillance or HI Unit at the Ministry of Health.

Some countries have successfully implemented systematic patient monitoring and management systems. In the OECS countries prior to the Global Fund grant, patient management and monitoring systems were largely paper based and information on patients were neither abstracted nor aggregated at the facility or national levels to inform the care and treatment delivery system. The OECS in collaboration with the Centers for Disease Control (CDC) and PAHO/PHCO developed and implemented a patient monitoring system in the OECS that significantly improved the quality of patient information and management systems. The patient monitoring system (PMS) is an electronic database that contains all relevant information needed for patient management and reporting purposes. The PMS contains all of the World Health Organization (WHO) recommended data elements and additional information needed by the OECS and countries. Belize is another example of country that has successfully implemented a patient monitoring system.

The key findings for Component 9: National and Sub- National HIV databases are outlined on page 31 of Chapter 5.

### **3.4 Supportive Supervision and Data Auditing**

*The performance goal is to monitor data quality periodically and monitor and address obstacles to produce high quality data (valid, reliable, comprehensive, and timely data).*

In this regard, the Caribbean is still lacking since most processes related to this component are donor driven. Countries are yet to develop the required guidelines for data auditing and supportive supervision, as well as schedule the exercises in its work plan and conduct them as planned.

Although a few countries have written guidelines for development for supportive supervision, the guidelines are not closely followed. Nonetheless, verification of the quality, accuracy, and completeness of routine monitoring data is conducted by the country M&E Officer or HIV focal point with the responsibility for collating and reporting on the indicators.

Supportive supervision is conducted as part of the routine data collection process particularly for preparation of reports submitted to the OECS or UN agencies, such as UNGASS or Universal Access reports.

Limited guidelines for auditing routine data pertaining to programmes exist. Data auditing is conducted primarily at the National level. And in many countries, the process is synchronized with the time frames set for the submission of reports to external stakeholders.

Notably absent are improvement plans to help build capacity of the individuals collecting the data and by extension, improving on the quality of the data collected. Feedback on data submitted from routine HIV monitoring, with the aim of programme improvement, is not systematically shared with partner agencies or organizations. And the feedback provided often focuses on correcting the accuracy of submitted data, based on past experience. For example, feedback is provided where discrepancies are identified, particularly for testing and counseling, but not on a regular basis.

Data are collected, entered and reported; but generally, no feedback is provided regarding the actual use and impact of the data. Consequently, there is a disconnect between persons collecting the data at the national level and their partners which promotes a lack of interest in data verification from the data providers.

The key findings for Component 10: Supportive Supervision and Data Auditing are outlined on page 32 of Chapter 5.

### ***3.5 HIV Evaluation and Research Agenda***

*The performance goal is to identify key evaluation and research questions and coordinate studies to meet the national needs.*

Countries do not have a clear national evaluation and research agenda to prioritize research and evaluation activities. There are several factors impeding this effort: the lack of staff with relevant research experience and no dedicated funding for research which contribute to making attention to research a relatively low priority except where required or funded by external donors.

There has been some research and evaluation work in the Caribbean in recent years with BSS and MSM studies. However, neither NAPs nor Ministries of Health have comprehensive listings of research or evaluations conducted in their respective countries. This absence of an inventory of research and evaluation is a challenge to proper assessment of the health status and HIV/AIDS situation. Furthermore, copies of reports are not available either electronically or in hard copy in a single location.

Some countries such as Barbados and Dominica have initiated the process of creating a research agenda. And, more and more countries are producing HIV-related evaluation and research studies

with CHRC contributing significantly to the dissemination of these findings through its annual Scientific Meeting.

The key findings for Component 11: HIV Evaluation and Research Agenda are outlined on page 32 of Chapter 5.

## 4. Data Dissemination and Use

---

*The performance goal is to disseminate and use data from the M&E system to guide policy formulation and program planning/improvement, thus promoting evidence-based interventions and decision making.*

Data collection is done routinely and collated at the national level to satisfy reporting requirements to external stakeholders. However, a systematic method for providing feedback to those organizations and facilities who supply the information for the generation of reports does not exist in most countries. Notwithstanding the fact that stakeholders have access to the information that is being produced, it is only made available to them when requested and not through a structured data dissemination plan.

Typically, there are no data analysis plans in use for data generated from routine programme monitoring, surveys, surveillance, research and evaluation. Local human resource capacity to assist with data analysis is limited and in some instances deficient. Moreover, templates for standardized information products are tailored largely towards the reporting requirements of donors. Reports produced for these stakeholders are generally of good quality.

Although data and information are readily available, they are not made easily accessible to stakeholders and there is no inventory of what data are sent to which agencies. Data dissemination and use are mentioned in M&E plans where such plans exist; however, formal plans or strategies for data dissemination and use do not exist, nor is there a structured schedule for data and information dissemination. Moreover, timelines are not strictly adhered for those countries that do have a dissemination plan.

Information products (reports) are developed from the templates designed for both clinical and programmatic data. The reports that are produced are of good quality, and meet the information needs of national, regional and international stakeholders. Some stakeholders are not aware of data that are available as there is no defined schedule for data sharing other than regularly scheduled or ad hoc meetings.

There is some evidence of information use and some national stakeholders request data to prepare papers and reports to guide HIV programming. However, provision of feedback to facilities and organizations supplying information for preparing reports remains weak, thereby contributing to a lack of appreciation of the need for data.

The key findings for Component 12: Data Dissemination and Use are outlined on page 33 of Chapter 5.

# 5. Key Findings, Recommendations, Cross-Cutting Themes and Priority Actions

---

This chapter highlights significant successes, identifies major challenges, outlines cross-cutting themes, and proposes broad actions to surmount the obstacles and fill the gaps identified.

## ***5.1 Key Findings and Recommendations***

### **Human Resources, Partnerships and Planning**

#### **Component 1: Organizational Structures with HIV M&E Functions**

##### **Successes**

- A clear M&E mandate for the Ministry of Health or NAP is articulated in national M&E plans. This clearly shows that the culture of M&E is being developed and becoming an integral part of their organizational structures.
- Technical assistance for M&E is widely available for all countries that request support from regional or international institutions.
- CHRC, a regional organization, with funding from regional and international partners has adopted a lead role with respect to M&E.

##### **Challenges**

- Most Caribbean countries lack a comprehensive M&E framework according the 12-component structure.
- Most Ministries of Health do not have a human resource structure for M&E. Given the small size of some country populations in the Caribbean, this is expected. However, for the larger and more developed countries a human resource structure should exist. Moreover, the existing organizational structures in countries do not have adequate technical staff required to fulfill their M&E mandate as it relates to some of the 12 components (for example, research and evaluation, supportive supervision and data auditing, surveys and surveillance, and database management). Consequently, there is poor capacity to implement the M&E mandate.
- The current global economic crisis and the lengthy recruitment procedure involved in the establishment of new government posts compromise the ability of Ministries to appoint persons to carry out requisite M&E functions.
- M&E activities are largely donor driven

## **Recommendation**

1. There is need to strengthen HIV M&E structures within the Ministries of Health. As some countries have more functional M&E structures and systems than others, best practices sharing among countries should be considered.

## Component 2: Human Capacity for HIV M&E

### **Successes**

- An M&E basic training curriculum and training manual was developed by CHRC.
- An advanced training curriculum was recently completed by CHRC.
- Countries have made efforts to train key staff in M&E through various training opportunities regionally and internationally.
- There is donor support for human resource capacity building.
- Trainings have been conducted in many of the countries.
- CHRC has an internship programme.

### **Challenges**

- Many countries do not have a formal M&E human capacity plan. In the absence of a plan, investments in building human capacity building are not well coordinated.
- There is a lack of adequate capacity at regional organizations, such as CHRC, to address all the requests by countries for M&E support.

### **Recommendations**

2. Revise existing basic and advanced M&E curricula to ensure they focus on all the 12 components.

3.(a) Develop a regional capacity building plan that include these interventions: technical assistance, mentorships, internships, exchange visits, supportive supervision, and training.

3.(b) Strengthen the human capacity of regional organizations to better support countries with building, strengthening and sustaining M&E practice.

4. Team national staff with staff from regional organizations to deliver in-country M&E training.

### Component 3: Partnerships to plan, coordinate and manage the M&E system

#### **Successes**

- The Caribbean Regional Strategic Framework on HIV and AIDS, 2008-2012 (CRSF) and the Caribbean Regional HIV and AIDS Partnership Framework, 2010-2014 both support strengthening M&E practice in the Caribbean.
- The Caribbean has a multi-sectoral regional M&E TWG, with a mandate to coordinate HIV M&E activities and to act as a consultative group. Its terms of reference are provided in Appendix 2.

#### **Challenges**

- Regional TWG meetings are not scheduled regularly and as such the TWG is not highly effective; the failure to have a fully functional and effective technical working group at the regional level is a major gap.
- Communication about HIV M&E developments and outputs at the regional level needs strengthening.

#### **Recommendations**

5. Develop a schedule of TWG meetings and incorporate this into the CHRC work plan. M&E systems in the region can be significantly strengthened from strategic guidance, oversight and technical input from the regional TWG.

### Component 4: HIV M&E Plan

#### **Successes**

- National HIV M&E plans where they are current are explicitly linked to the NSP. For those M&E plans that are current, they are fairly comprehensive, well developed and address many but not all of the 12 components required for a functional national M&E system.

#### **Challenges**

- Many countries do not have current M&E plans.
- Many plans do not fully describe the implementation of all 12 components of a national HIV M&E system, there is often no mention of a capacity building plan, and the plan does not provide guidelines for data auditing and supervision.
- Most countries in the region do not have fully functional national M&E reference working groups (NMERG).

## **Recommendation**

6. National M&E Reference Groups (NMERGs) with members working in the field should be established or strengthened in each country. The main function of the NMERG would be to guide the development of M&E within each country including the implementation of the M&E plan. The NMERG would identify the areas of focus for the M&E system and support the implementation of selected activities. The Caribbean Regional M&E TWG could provide guidance to countries with respect to establishing or strengthening these country working groups. For those countries with human capacity challenges, merging existing surveillance working groups with the M&E working group may be desirable.

## Component 5: Annual, Costed, National HIV M&E Work Plan

### **Challenges**

- Most countries do not have a national multi-partner, multi-level M&E work plan that is costed. Activities are sometimes not well coordinated and this often leads to duplication of effort and failure to leverage resources.

### **Recommendations**

7. Countries should develop a national costed annual/biennial M&E work plan with wide buy-in from all the sectors, and donors should be major stakeholders in its development. The plan should be based on the 12 components of a functional national M&E system; showing the critical step-by-step activities that will be conducted to strengthen each component; or, it can be based on any other country-specific format. CHRC could provide countries with guidance for this activity.

## Component 6: Communication, Advocacy and Culture for M&E

### **Successes**

- HIV M&E culture has firmly taken root, but is growing slowly.

### **Challenges**

- There are no clear national or regional high-level officials identified as M&E champions who actively endorse M&E actions.

- M&E materials are not readily available to stakeholders e.g., other implementers, umbrella organizations, and national and sub-national level partners.

## **Recommendations**

8. Identify “M&E champions”—high level stakeholders-- who are leaders and well recognized both technically and politically. The M&E champions would advocate for development of an M&E culture and evidence-based decision making with heads of ministries and their technical staff. They would advocate for the use of data for policymaking and decision making, and would communicate the importance of M&E at national and other high-level fora.

9. CHRC should develop an M&E communications and advocacy strategy, a concise but concrete document outlining how CHRC intends to reach all its important stakeholders with M&E information. The strategy could include using print media to disseminate information products on HIV M&E and other relevant health-related data. This should outline the types of information to be shared, the time-lines for communication and the communication mechanisms to be utilized.

## **Data Collection, Verification and Analysis**

### Component 7: Routine HIV Programme Monitoring

#### **Successes**

- Most national HIV/AIDS M&E plans contain operational definitions of indicators for routine program monitoring, reporting forms, and data flow charts for both non-health and health implementers.

#### **Challenges**

- In countries, the harmonization of M&E systems, especially indicators, data collection, and reporting tools and templates needs to be improved across partners and service delivery areas.

- Databases “not being linked” makes it difficult to manage data.

- Data quality guidelines are not available for program monitoring.

- Reporting is still very poor among the private sector health facilities.

#### **Recommendations**

10. Align data collection and reporting with the national M&E plan, including a review of current forms, and streamlining of data collection to support data needs for client management, indicator reporting, and generation of annual performance reports.

11. Strengthen existing skills in data management and report writing at the national level.

## Component 8: Surveys and Surveillance

### **Successes**

- Several national HIV M&E plans clearly stipulate the importance of surveillance, and identifies all the key surveillance activities required to generate the data for measuring the outcome and impact indicators to monitor the national strategic plans.

### **Challenges**

- Human capacity to design and analyze survey and surveillance data is limited.
- Formal inventories of surveys exist in only a few countries.

### **Recommendations**

12. There is a need to develop national- and regional level inventories on surveys and surveillance, which should be updated periodically.
13. Strengthen national capacity to conduct surveys through training, workshops and access to relevant literature.

## Component 9: National and Sub- national HIV databases

### **Successes**

- Many countries in the region have implemented patient monitoring systems (e.g. OECS, Belize).

### **Challenges**

- Various partners maintain different databases at the national level that are not linked to each other leading to duplication of effort.
- The databases capture donor-specific information instead of capturing information pertaining to the response in general.
- The databases are often not linked, leading to duplication of effort.
- Human capacity to manage the databases at the national level needs strengthening.

### **Recommendations**

14. It is encouraged that, rather than setting up various databases leading to inefficient use of resources, countries work with only one database, which they constantly improve and update. Ministries can conduct a strengths, weaknesses, opportunities, and threats analysis of the available databases to inform its choice.

## Component 10: Supportive Supervision and Data Auditing

### **Challenges**

- Many countries do not have supportive supervision or data auditing guidelines and where they exist, supportive supervision and data auditing were not scheduled regularly;
- Capacity to conduct supportive supervision and data auditing is weak since some country personnel working in these areas are not trained.

### **Recommendations**

15. There is a need to develop guidelines for supportive supervision and data auditing of health programs. This can be led by the NMERGs and supported by regional technical support partners. This would improve the credibility and reliability of data and develop the capacity of implementers involved in this process. There is also need for training of supervisors in data auditing procedures such as i) observation of data collection and reporting processes; ii) documentation review; iii) tracing and verification of data; iv) cross-checks and v) spot checks.

## Component 11: HIV Evaluation and Research Agenda

**Successes** — The following strengths were noted:

- A few countries (for e.g. Barbados and Dominica) have embarked on the development of a national HIV research agenda.
- CHRC has contributed significantly to the publication of HIV-related research papers through its annual Scientific Meeting.
- CHRC has developed a Health Research Agenda for the Caribbean that includes research priorities for HIV

### **Challenges**

- There is no comprehensive inventory of HIV research and evaluation studies conducted in the region; therefore, there is no clarity on investment made or any measure of the size of this investment in research and evaluation.
- There is no clear structure for disseminating and using information generated from various research and evaluation studies carried out in the Caribbean. It is not clear how these results influence policy and programs, if at all.

### **Recommendations**

16.(a) There is a need to develop an inventory of HIV evaluations or research at the country and regional levels. It is recommended that the NAP, Ministry of Health or M&E Unit staff compile a listing of all HIV-related research and evaluation

conducted in each country. These reports will serve as the basis for the M&E NMERG to develop a research and evaluation agenda. Countries should also consider expanding this process to research and evaluation conducted across all areas of health.

16.(b) Countries and regional institutions should adopt, where appropriate, CHRC's Health Research Agenda and use this to coordinate other regional agenda to avoid duplication of efforts.

17. The new Research, Evaluation and Policy Development Unit of CARPHA and/or CHRC needs to develop a strategy to ensure that researchers and policy makers interface and that research is translated into policy and influences programs (i.e. packaging research results that are palatable to policy makers).

## **Data Dissemination and Use**

### **Component 12: Data Dissemination and Use**

#### **Successes**

- In only a few countries is there clear evidence of M&E information use in the review and development of the national strategic framework.

#### **Challenges**

- Information products are available, but not disseminated to the data providers or users at the country level.

- The data collection, dissemination and use process are not driven by stakeholders needs but rather by external reporting requirements.

#### **Recommendations**

18. Provide countries with guidance on assessing national stakeholders' information needs.

19. Assist countries with developing a data dissemination and use plan that is included in the national HIV M&E plan. It should show the type of information, templates, and timelines for major information products.

20 (a). Strengthen the capacity of personnel at the national level to translate evidence into recommendations for decision making and policy targeted actions.

20 (b). CHRC should develop a cohesive Communication and Data Dissemination Plan for dissemination of M&E and other information products.

## **5.2 Cross-Cutting Themes and Priority Actions**

During the interviews conducted, regional and national stakeholders and experts from many disciplines addressed several complex issues relevant to the twelve M&E components. As expected, there were not only many recommendations specific to each component, but also themes and proposed action items that were common to two or more components. Here we introduce these cross-cutting issues in their broader context.

### **Cross-Cutting Theme: There is an urgent need for Improved Coordination among M&E Stakeholders at the Regional and National levels**

#### **Priority Action 1: Provide Strong Leadership and Coordinate Effective Partnerships**

National governments and policy makers will ultimately play a critical role in making or inurning decisions that will affect the pace with which M&E practice is fully absorbed into the “management culture” of the Region. Consequently, it is important to cultivate political commitments and supportive policies to facilitate the growth of M&E practice.

Moving beyond entrenched systems and ways of working requires both independent, informed critique and changes in people’s knowledge and norms. This, in turn, requires concerted and consistent education and advocacy. Advocacy, education, and policy are related areas that can bring the values, perspectives, and voices of stakeholders into the process of developing and sustaining a strong M&E culture in the Caribbean.

The time and effort required to provide leadership and to coordinate and mobilize resources and partners is considerable. Nevertheless, an integrated approach accelerates the process, but requires effective management. The multisectoral partnership approach facilitates an accelerated process, develops momentum at the regional and national levels and facilitates broad participation and the achievement of results.

The regional response to HIV has gone a long way to cultivate excellent working relationships among the various stakeholders. This has enabled greater alignment and harmonization with government and within the donor community with the resultant effect of leveraging efficiency. However, strong leadership and well-coordinated, effective partnerships will be required to implement the M&E mandate in the shortest time possible. **The Regional M&E Technical Working Group (Appendix 2) with the necessary expansion and adjustments is well positioned to improve coordination and act as a regional “Think Tank” with respect to relevant M&E issues.**

(Related Recommendations: 5, 6, 7, 8, 10, 12, 14, 16, and 17; See Appendix 5)

## **Cross-Cutting Theme: There is inadequate human capacity in the Region to implement the M&E mandate**

### **Priority Action 2: Intensify efforts to build and strengthen human capacity in the Region**

Inadequate human capacity to implement the M&E mandate across the Region was noted. Implementation of the M&E mandate cannot be completed without sufficient appropriately skilled human resources to staff both the NAP and Ministries of Health. The recruitment and retention of sufficient numbers of trained, experienced M&E professionals are essential for conducting M&E activities and the functioning of M& E systems.

A shortage of these human resources remains one of the most significant obstacles to improved M&E practice. This shortage of health care workers stems from a variety of factors, including lack of training institutions focusing on the relatively new discipline of M&E, poor financing of national health programs, and structural adjustment policies that affect national hiring and salary levels in health care.

In addition to the challenge of recruiting skilled staff, many country programmes also report difficulties with staff retention. There is evidence that human resource development is taking place, but a major gap relates to the quantity of qualified staff that exist. There is a need to build human capacity through conducting human capacity assessments, development of capacity building plans, actual implementation of the capacity building, and monitoring the implementation of the capacity - building plan.

**A major focus should be human capacity building in the areas of M&E. The human capacity building plan should focus on all the 12 components of a functional HIV M&E system rather than invest in a few components while compromising the others. It should also be multi-sectoral and include the important sectors that contribute to the national M&E system. Continuous M&E capacity development should continue so as to ensure that a critical mass of M&E personnel is created as a way of addressing gaps in M&E practice. CHRC should intensify its efforts to work with regional tertiary level institutions to create public health courses, certificate or diploma programmes in M&E.**

(Related Recommendations: 1, 2, 3, 4, 11, 13, 15; See Appendix 5)

## **Cross-Cutting Theme: Dissemination and Use of Data is weak at both the regional and national levels**

### **Priority Action 3: Develop a Cohesive Communication and Data Dissemination Plan for Region**

The area of communication and data dissemination is a critical one that requires development and strengthening in the Region. From discussions with stakeholders and information gleaned from assessment reports, it appears that data collection, dissemination and use are not driven by national stakeholder needs, but rather by external reporting requirements. Moreover, there has been no comprehensive analysis of stakeholders' information needs at the national or regional levels.

Although data and information are readily available, they are not made easily accessible to stakeholders with reports, summaries and tables disseminated to partners and stakeholders mostly when requested. Also, there are no comprehensive inventories of what data are sent to which agencies. Data dissemination and use is often mentioned, but formal plans or strategies for data dissemination and use do not exist, nor are there a structured schedules for this endeavour.

**Using the CHRC M&E repository of documents as a platform, CHRC in partner with other agencies could develop an M&E communications strategy indicating how CHRC would inform national and regional stakeholders on M&E activities or other pertinent health-related activities and disseminate relevant information products to national and regional stakeholders. This could include the development of products for dissemination packaged for different audiences (knowledge transfer) which would facilitate uptake into policy.**

(Related Recommendations: 9, 18, 19, 20(a), 20(b); See Appendix 5)

## 6. Conclusion

There has been some progress in M&E practice over the last few years. However, as concluded by national and regional stakeholders much more remains to be done. Additional investment and new ways of working are required if functional M&E systems in the Caribbean are to become a reality. New collaborations are crucial to spark new work. The advancement of M&E practice also calls for long-term planning to ensure that all 12 components required for a functional M&E system are strengthened. Moreover, the requirement for strategic planning is essential to the field's evolution from a relatively small group of committed public health practitioners and academic researchers to a well-known, well-coordinated "product" among all stakeholders in the health sector.

This report offers recommended actions for accelerating and optimizing progress in the field. It is not a comprehensive blueprint covering everything that needs to be accomplished, but instead focuses on current priority areas only. The report should be regarded as a dynamic document rather than a static formula and be reviewed and periodically revised as M&E practice moves forward. It is likely that regional stakeholders might modify the report's framework later on to incorporate and better emphasize creative new concepts and additional cross-cutting themes.

The value of this report will be maintained by this broader review, by periodic updates based on broad consultation, and by incorporating new findings, technical developments, and evolving concepts. Its value will also be enriched by explicit expansion of the M&E dialogue. The recommendations, priority actions and cross-cutting themes described in this document offer an adaptable framework for the M&E field to measure and evaluate its progress.

As national and regional stakeholders walk the long road to implement fully functional M&E systems in the Region, there will always be challenges along the way. However, as an optimistic, hopeful and hard-working people, we can surmount all obstacles in our collective path if we choose to work together.

## 7. References

---

Ameen A, Smith S, Hazel N and Watson-Grant S. Findings from the Assessment of the HIV/AIDS Monitoring and Evaluation System in St Vincent and the Grenadines. Caribbean Health Research Council. October 2010 [Unpublished]

Ameen A, Lloyd E, Casimir L, Samiel S, Smith S, Hazel N. Findings from the Assessment of the HIV/AIDS Monitoring and Evaluation System in St Lucia. Caribbean Health Research Council. June 2008 [Unpublished]

Caribbean Regional HIV and AIDS Partnership Framework, 2010-2014. Five-year Strategic Framework to Support Implementation of Caribbean Regional and National Efforts to Combat HIV and AIDS. 2010. Available from URL:  
<http://www.pepfar.gov/documents/organization/143196.pdf>

Caribbean Regional Strategic Framework on HIV and AIDS, 2008-2012. PANCAP. 2008 Available from URL:  
<http://www.pancap.org/docs/CRSF%20-%20FINAL%20EDITED%2024%2009%2008.pdf>

Caribbean Health Research Council. Health Research Agenda for the Caribbean. 2011  
Available at URL:  
<http://www.chrc-caribbean.org/files/Agenda/Agenda2011/Health%20Research%20Agenda%20for%20the%20Caribbean.pdf>

Caribbean Health Research Council. Lessons Learned from Coordinating and Implementing the Global Fund Grant Number MAE-305-G01-H between the Global Fund to fight AIDS, Tuberculosis and Malaria and the Organization of Eastern Caribbean States. 2010 [Unpublished]

Lloyd, E, Ameen A, Casimir L, Smith S, Hazel N, Stijnberg D. Findings from the Assessment of the HIV/AIDS Monitoring and Evaluation System in Dominica. Caribbean Health Research Council. July 2010 [Unpublished]

Lloyd, E, Ameen A, Casimir L, Smith S, Hazel N, Stijnberg D. Findings from the Assessment of the HIV/AIDS Monitoring and Evaluation System in St Kitts and Nevis. Caribbean Health Research Council. September 2010 [Unpublished]

Kusek J & Rist C. The World Bank. Ten Steps to a Results-Based Monitoring and Evaluation System. 2004. Available from URL:

<http://www.oecd.org/dataoecd/23/27/35281194.pdf>

Caribbean Health Research Council. Monitoring & Evaluation Country Plans for CHRC Member Countries. 2006-2011. CHRC Repository of Documents. [Unpublished]

UNAIDS. 12 Components Monitoring & Evaluation System Assessment. 2009. Available from URL:

[http://www.unaids.org/en/media/unaids/contentassets/documents/document/2010/1\\_MERG\\_Assessment\\_12\\_Components\\_ME\\_System.pdf](http://www.unaids.org/en/media/unaids/contentassets/documents/document/2010/1_MERG_Assessment_12_Components_ME_System.pdf)

UNAIDS. The Status of HIV in the Caribbean. 2010. Available from URL:

[http://www.unaids.org/en/media/unaids/contentassets/documents/countryreport/2010/2010\\_HIV\\_inCaribbean\\_en.pdf](http://www.unaids.org/en/media/unaids/contentassets/documents/countryreport/2010/2010_HIV_inCaribbean_en.pdf)

UNAIDS. 12 Components Monitoring and Evaluation System Strengthening Tool. 2009. Available from URL:

[http://www.unaids.org/en/media/unaids/contentassets/documents/document/2010/2\\_MERG\\_Strengthening\\_Tool\\_12\\_Components\\_ME\\_System.pdf](http://www.unaids.org/en/media/unaids/contentassets/documents/document/2010/2_MERG_Strengthening_Tool_12_Components_ME_System.pdf)

UNGASS Reports 2009-2010. CHRC Member Countries. Available from URL:

<http://www.unaids.org/en/dataanalysis/monitoringcountryprogress/2010progressreportsubmittedbycountries/>

## 8. Appendices

---

### Appendix -- 1 Acronyms

<b>AIDS</b>	Acquired Immune Deficiency Syndrome
<b>BSS</b>	Behavioral Surveillance Survey
<b>CDC</b>	Centers for Disease Control and Prevention
<b>CHAA</b>	Caribbean HIV/AIDS Alliance
<b>CHART</b>	Caribbean HIV and AIDS Regional Training
<b>CIDA</b>	Canadian International Development Agency
<b>CCNAPC</b>	Caribbean Coalition of National AIDS Programme Coordinators
<b>CHLI</b>	Caribbean Health Leadership Institute
<b>CHRC</b>	Caribbean Health Research Council
<b>CAREC</b>	Caribbean Epidemiology Centre
<b>CARICOM</b>	Caribbean Community
<b>CHART</b>	Caribbean HIV/AIDS Regional Training Network
<b>CDC</b>	Centers for Disease Control and Prevention
<b>CRSF</b>	Caribbean Regional Strategic Framework on HIV and AIDS, 2008-12
<b>DfID</b>	Department for International Development
<b>GAMET</b>	Global AIDS M&E Team
<b>HAPU</b>	Organization of Eastern Caribbean States HIV/AIDS Project Unit
<b>HI</b>	Health Information
<b>HIV</b>	Human Immunodeficiency Syndrome
<b>LACCASO</b>	Latin American and Caribbean Council of AIDS Service Organizations
<b>M&amp;E</b>	Monitoring and Evaluation
<b>MERG</b>	UNAIDS Monitoring and Evaluation Reference Group
<b>NMERG</b>	National Monitoring and Evaluation Reference Group
<b>MSM</b>	Men who have sex with men
<b>NAP</b>	National AIDS Programme
<b>OECS</b>	Organization of Eastern Caribbean States
<b>PANCAP</b>	Pan Caribbean Partnership Against HIV/AIDS
<b>PAHO</b>	Pan American Health Organization

<b>PEPFAR</b>	President's Emergency Plan for AIDS Relief
<b>PHCO</b>	PAHO HIV Caribbean Office
<b>PMS</b>	Patient Monitoring System
<b>PMTCT</b>	Prevention of Mother-to-Child Transmission
<b>TWG</b>	Regional Monitoring and Evaluation Technical Working Group
<b>UNAIDS</b>	Joint United Nations Programme on HIV and AIDS (UNAIDS);
<b>UNGASS</b>	The United Nations General Assembly Special Session
<b>UNICEF</b>	United Nations Children's Fund
<b>UNIFEM</b>	United Nations Development Fund for Women (UNIFEM);
<b>USAID</b>	United States Agency for International Development
<b>UWI</b>	University of West Indies
<b>WHO</b>	World Health Organization

## **Appendix 2 -- Terms of Reference, Caribbean Regional Monitoring and Evaluation Technical Working Group**

### **A. PURPOSE/RATIONALE FOR A CARIBBEAN REGIONAL MONITORING & EVALUTION TECHNICAL WORKING GROUP**

Over the past two years the Caribbean Region has seen a growth in the number of agencies providing M&E (M&E) technical assistance. This has led to duplication of effort and consequently, an increased burden on countries to respond to the requests of the various agencies. In light of this fact and the complaints received from countries, a decision was taken in 2003 to convene a committee, known now as the Caribbean Monitoring & Evaluation Technical Working Group.

The M&E Technical Working Group (TWG) will comprise representatives of institutions providing M&E technical assistance at no cost to the Caribbean region.

### **B. OVERALL MANDATE**

The overall mandate of the TWG is to maximize the timeliness, efficiency and effectiveness of efforts that address HIV-related M&E needs in the Caribbean.

### **C. KEY ACTIVITIES**

Key activities of the TWG shall include but not be limited to:

- Harmonization of indicators, tools and approaches used to generate strategic information related to HIV in the Caribbean
- Co-ordinate M&E technical assistance to Caribbean countries by:
  - Serving as the mechanism through which countries communicate their HIV M&E technical assistance needs
  - Facilitate co-ordinated activities between agencies providing M&E technical support and capacity building around data collection and reporting while aiming to minimize duplication of effort and the burden placed on countries
- Provide a forum for technical information sharing between agencies working in the area of M&E in the Caribbean.
- Serve a technical advisory role to PANCAP, other regional agencies and countries.
- Through its member agencies, support the operationalization of the Regional M&E Framework and assist in the development of a comprehensive regional M&E system that serves as an evidence base for programme and policy action.

## **D. MEMBERSHIP**

### ***a. Chairmanship***

The TWG will be chaired by a regional institution. The Caribbean Health Research Council will act as the Chair.

### ***b. Member Organizations***

Each agency will have no more than two (2) representatives at any one meeting.

- Caribbean Epidemiology Centre (CAREC)
- Caribbean Coalition of National AIDS Programme Coordinators (CCNAPC)  
CCNAPC will act as a conduit for NAP technical assistance requests to TA providers
- Caribbean Health Research Council (CHRC) - Chair
- Caribbean HIV/AIDS Regional Training Network (CHART)
- Caribbean HIV & AIDS Alliance (Caribbean Alliance)
- OECS HIV/AIDS Programme Unit (OECS HAPU)
- Pan Caribbean Partnership on HIV/AIDS (PANCAP PCU)
- United States Government (USG)
- Joint United Nations Programme on HIV (UNAIDS)
- World Bank (WB)
- Country representatives (M&E Specialists, M&E Officers)

### ***c. Protocol/ Criteria for inclusion of additional TWG member Organizations***

Any organization may join the TWG as long as they provide M&E technical assistance at no cost to the Caribbean region.

Each member organization is responsible for covering the cost of participation of its representative at TWG meetings.

## **E. TWG OPERATIONS (PROTOCOLS & PROCEDURES)**

### ***a. Meetings***

The TWG shall meet on a bi-monthly basis but may convene more often if necessary.

### ***b. Minimum level of participation***

The minimum level of participation for meetings shall be representatives of at least three member organizations. Members should make available their agency update when absent from meetings.

### ***c. Minutes***

Decisions of the TWG shall be recorded in the minutes of meetings. The organization recording the minutes should be rotated at each meeting. The minutes shall be circulated to all members no later than one week after the date of the meeting. Minutes can be shared with other organizations as deemed necessary.

### ***d. Technical Assistance***

The Annual TWG Work Plan and Technical Assistance Matrix will highlight priority M&E issues for the region and identify TWG member agencies best suited to take the lead on particular activities in particular countries. In the interest of ensuring timely M&E technical support, each agency is free to respond to direct requests for technical assistance, but should inform the Technical Working Group of its activities to ensure harmonization of effort with other agencies.

These Terms of Reference will be reviewed and updated annually.

## Appendix 3 -- Interview/Discussion Guideline

### Section I.

A (i) Three (3) broad areas are essential for a national HIV Monitoring and Evaluation (M&E) system to be fully functional. These three (3) broad areas are:

**1: Human resources, partnerships and planning**

(human capacity, organization structures, M&E partnerships, M&E plans, advocacy for M&E)

**2: Mechanisms through which data are collected, verified and analyzed**

(surveys and surveillance, databases, data auditing, evaluation and research, and programme monitoring)

**3: Data Dissemination and Use for Decision-Making**

Please place these three (3) areas in descending order with number 1 being the area that you deem to be the strongest in your national M&E system (or generally in the region, if you are a regional stakeholder) and number 3 being the area that you deem to be the weakest in your country (or generally in the region if you are a regional stakeholder).

Strongest 1.

↓ 2.

Weakest 3.

Please explain/comment.

A (ii) Please comment on the status of each of the three (3) areas in your country (or generally in the region if you are a regional stakeholder).

**Status of Area 1: Human resources, partnerships and planning**

(human capacity, organization structures, M&E partnerships, M&E plans, advocacy for M&E)

**Status of Area 2: Mechanisms through which data are collected, verified and analyzed**

(surveys and surveillance, databases, data auditing, evaluation and research, and programme monitoring)

### **Status of Area 3: Data Dissemination and Use for Decision-Making**

- A. (iii) Overall, how would you describe the “M&E culture” in your country or in the region if you are a regional stakeholder?
- B. (i) During the reporting period, what were the major successes of the national HIV Monitoring & Evaluation system? (country representatives)
- (ii) During the reporting period, what were the major successes of national HIV Monitoring & Evaluation systems in the region? (regional stakeholders)
- C. (i) During the reporting period, what were the major obstacles or gaps facing the national M&E HIV system? (country representatives)
- (ii) During the reporting period, what were the major obstacles or gaps facing national M&E HIV systems in the region? (regional stakeholders)
- D. What actions should be taken to surmount these obstacles or fill these gaps?
- E. Given CHRC’s mandate to strengthen national M&E systems in the region, how can CHRC contribute to addressing these deficiencies?

### **SECTION II.**

During the past months, country representatives have provided CHRC with information on the state of national M&E HIV systems in the region. CHRC is seeking to verify and update information. The questions asked in this section will require a yes/no response and will be specific to the country.

## Appendix 4 -- Selected CHRC Repository Information

	Country	National Strategic Plan	HIV M&E Plan	M&E Work Plan
1	Anguilla	2000	No	No
2	Antigua and Barbuda	2002-2005	Draft 2006	No
3	Bahamas	Draft 2007-2015	Draft 2008	Draft
4	Barbados	2008-2013	Draft 2008	Yes
5	Belize	2006-2011	2008	No
6	Bermuda	No	No	No
7	British Virgin Islands	Draft 2010	No	No
8	Cayman Islands	Draft 2005-2009	No	No
9	Dominica	2010-2014	Draft 2006	Draft
10	Grenada	2009-2015	No	No
11	Guyana	2008-2011	2007-2011	Yes
12	Jamaica	2002-2006 / Current Plan in Draft	Draft	Yes
13	Montserrat	Draft	Draft	Yes
14	St. Kitts	2009-2013	Operational Plan, 2009-2010	Yes
15	Nevis	2009-2013	2009	Yes
16	St. Lucia	2005-2009 / Current Plan in Draft	2009	Yes
17	St. Vincent and the Grenadines	2004-2009 / Current Plan in Draft	Draft	Yes
18	Suriname	2009-2013	2003-2013	Yes
19	Trinidad and Tobago	2010-2015	Draft	Yes
20	Turks and Caicos	No	No	No

## **Appendix 5 -- Priority Actions and Related Recommendations**

### ***Priority Action 1 -- Provide Strong Leadership and Coordinate Effective Partnerships***

#### *Recommendations to be implemented at the Country Level:*

# 6. National M&E Reference Groups (NMERGs) with members working in the field should be established or strengthened in each country. The main function of the NMERG would be to guide the development of M&E within each country including the implementation of the M&E plan. The NMERG would identify the areas of focus for the M&E system and support the implementation of the selected activities. The Caribbean Regional M&E TWG could provide guidance to countries with respect to establishing or strengthening these country working groups. For those countries with human capacity challenges, merging existing surveillance working groups with the M&E working group may be desirable.

# 7. Countries should develop a national costed annual/biennial M&E work plan with wide buy-in from all the sectors, and donors should be major stakeholders in its development. The plan should be based on the 12 components of a functional national M&E system, showing the critical step-by-step activities that will be conducted to strengthen each component; or, it can be based on any other country-specific format. CHRC could provide countries with guidance for this activity.

# 10. Align data collection and reporting with the national M&E plan, including a review of current forms, and streamlining of data collection to support data needs for client management, indicator reporting, and generation of annual performance reports.

\*# 12. There is a need to develop national- and regional level inventories on surveys and surveillance, which should be updated periodically.

# 14. It is encouraged that, rather than setting up various databases leading to inefficient use of resources, countries work with only one database, which they constantly improve and update. Ministries can conduct a strengths, weaknesses, opportunities, and threats analysis of the available databases to inform its choice.

\*# 16.(a) There is a need to start developing an inventory of HIV evaluations or research at the country and regional levels. It is recommended that the NAP, Ministry of Health or M&E Unit staff compile a listing of all HIV-related research and evaluation conducted in each country. These reports will serve as the basis for the M&E NMERG to develop a research and evaluation agenda. Countries should also consider expanding this process to research and evaluation conducted across all areas of health.

# 16.(b) Countries and regional institutions should adopt, where appropriate, CHRC's Health Research Agenda and use this to coordinate other regional agenda to avoid duplication of efforts.

*Recommendations to be implemented at the Regional Level:*

# 5. Develop a schedule of TWG meetings and incorporate this into the CHRC work plan. M&E systems in the region can be significantly strengthened from strategic guidance, oversight and technical input from the regional TWG.

# 8. Identify “M&E champions”—high level stakeholders-- who are leaders and well recognized both technically and politically. The M&E champions would advocate for development of an M&E culture and evidence-based decision making with heads of ministries and their technical staff. They would advocate for the use of data for policymaking and decision making, and would communicate the importance of M&E at national and other high-level fora.

\*# 12. There is a need to develop national- and regional level inventories on surveys and surveillance, which should be updated periodically.

\*# 16.(a) There is a need to start developing an inventory of HIV evaluations or research at the country and regional levels. It is recommended that the NAP, Ministry of Health or M&E Unit staff compile a listing of all HIV-related research and evaluation conducted in each country. These reports will serve as the basis for the M&E NMERG to develop a research and evaluation agenda. Countries should also consider expanding this process to research and evaluation conducted across all areas of health.

# 17. The new Research, Evaluation and Policy Development Unit of CARPHA and/or CHRC needs to develop a strategy to ensure that researchers and policy makers interface and that research is translated into policy and influences programs (i.e. packaging research results that are palatable to policy makers).

**Priority Action 2 -- Intensify efforts to build and strengthen human capacity the Region**

*Recommendations to be implemented at the Country Level:*

# 1. There is need to strengthen HIV M&E structures within the Ministries of Health. As some countries have more functional M&E structures and systems than others, best practices sharing among countries should be considered.

# 11. Strengthen existing skills in data management and report writing at the national level.

# 13. Strengthen national capacity to conduct surveys through training, workshops and access to relevant literature.

# 15. There is a need to develop guidelines for supportive supervision and data auditing of health programs. This can be led by the NMERGs and supported by regional technical support partners. This would improve the credibility and reliability of data and develop the capacity of implementers involved in this process. There is also need for training of supervisors in data auditing procedures such as i) observation of data collection and reporting processes; ii) documentation review; iii) tracing and verification of data; iv) cross-checks and v) spot checks.

*Recommendations to be implemented at the Regional Level:*

- # 2. Revise existing basic and advanced M&E curricula to ensure they focus on all the 12 components.
- # 3.(a) Develop a regional capacity building plan that include these interventions: technical assistance, mentorships, internships, exchange visits, supportive supervision, and training.
- # 3.(b) Strengthen the human capacity of regional organizations to better support countries with building, strengthening and sustaining M&E practice.
- # 4. Team national staff with staff from regional organizations to deliver in-country M&E training.

**Priority Action 3 -- Develop a Cohesive Communication and Data Dissemination Plan for the Region**

*Recommendations to be implemented at the Regional Level:*

- # 9. CHRC should develop an M&E communications and advocacy strategy, a concise but concrete document outlining how CHRC intends to reach all its important stakeholders with M&E information. The strategy could include using print media to disseminate information products on HIV M&E and other relevant health-related data. This should outline the types of information to be shared, the time-lines for communication and the communication mechanisms to be utilized.
- # 18. Provide countries with guidance on assessing national stakeholders' information needs.
- # 19. Assist countries with developing a data dissemination and use plan that is included in the national HIV M&E plan. It should show the type of information, templates, and timelines for major information products.
- # 20 (a). Strengthen the capacity of personnel at the national level to translate evidence into recommendations for decision making and policy targeted actions.
- # 20 (b). CHRC should develop a cohesive Communication and Data Dissemination Plan for dissemination of M&E and other information products.

\* Recommendations that should be implemented at both the Country and Regional Levels

## Appendix 6 – List of Persons Interviewed

Dr Brian Armor	Programme Director, HIV/AIDS Coordinating Unit Trinidad and Tobago
Ms. Roanna Bynoe	Monitoring and Evaluation Officer, HIV/AIDS Coordinating Unit Trinidad and Tobago
Ms Nadine Carthy-Caines	Coordinator National AIDS Programme, Nevis St Kitts and Nevis
Dr Martin Cuellar	Executive Director, National AIDS Commission Belize
Ms Curvelle David	Monitoring and Evaluation Officer, PANCAP Guyana
Dr Nicole Drakes	Assistant Director, National HIV/AIDS Commission Barbados
Dr Morris Edwards	Head, Strategy and Resourcing Division, PANCAP Guyana
Dr Peter Figueroa	Professor, University of the West Indies Jamaica
Ms Julie Frampton	Coordinator, National AIDS Programme Dominica
Dr Del Hamilton	Director, National AIDS Programme St Vincent and the Grenadines
Dr Jesse Henry	Director, National Infectious Disease Control Unit Grenada
Dr Sharlene Jarrett	Monitoring and Evaluation Officer, National AIDS Committee Jamaica
Ms Marver Jervis	Director, HIV/AIDS Center Bahamas
Ms Jacquelyn Joseph	Executive Director, PANCAP Office of the PR Global Fund Grant Guyana

Ms Erma Jules	Monitoring and Evaluation Coordinator, National AIDS Programme St Lucia
Ms Nadine Kassie	Senior Monitoring & Evaluation Officer, Caribbean HIV/AIDS Alliance Trinidad and Tobago
Dr Ernest Massiah	Director, Caribbean UNAIDS Trinidad and Tobago
Mr Roger McLean	Research Fellow, University of the West Indies Health Economics Unit Trinidad and Tobago
Ms Gardenia Richardson	Coordinator National AIDS Programme, St Kitts St Kitts and Nevis
Dr Deborah Stijnberg	Monitoring and Evaluation Coordinator, Ministry of Health Suriname
Dr James St Catherine	Director, OECS HIV/AIDS Programme Unit St Lucia
Ms Shelley Trim	Quality Improvement Coordinator, Caribbean HIV/AIDS Regional Training Network Jamaica
Ms Stephanie Watson-Grant	Country Portfolio Manager, MEASURE Evaluation United States of America
Ms Delcora Willams	National AIDS Programme Coordinator Antigua and Barbuda