

KINGDOM OF CAMBODIA
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MINISTRY OF HEALTH

The Principal Recipient
For
The Global Fund to Fight AIDS, TB and Malaria
(GFATM)

MONITORING & EVALUATION GUIDELINES

Version 3

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REVISED BY: MONITORING & EVALUATION ADVISOR AND
THE PRINCIPAL RECIPIENT MONITORING & EVALUATION TEAM



Principal Recipient

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ACRONYMS

AIDS	Acquired Immunodeficiency Syndrome
BSS	Behavioral Sentinel Surveillance
CCC	Country Coordination Committee
CCC-SC	Sub-Committee of the CCC
CDC	Communicable Disease Control Department
CDC-GAP	Centers for Disease Control and Prevention- Global AIDS Program
CENAT	National Center for Tuberculosis and Leprosy Control
CNM	National Center for Parasitology, Entomology and Malaria Control
DHS	Demographic and Health Survey
DOTS	Directly Observed Treatment Short-course
FHI	Family Health International
GFATM	The Global Fund to Fight AIDS, Tuberculosis and Malaria
HFA	Health Facility Assessment
HIV	Human Immunodeficiency Virus
HSS	HIV/AIDS Sentinel Surveillance
HSS	Health Systems Strengthening
KAPC	Knowledge, Attitudes, Practices & Coverage
KPMG	Klynved, Peat, Marwick, Goerdeler (Dutch accounting firm)
LFA	Local Fund Agent
M&E	Monitoring and Evaluation
MEASURE	Monitoring and Evaluation to Assess and Use Results
MICS	UNICEF Multiple Indicator Cluster Survey
MoH	Ministry of Health
NAA	National AIDS Authority
NAP	National AIDS Program
NCHADS	National Centre for HIV/AIDS, Dermatology and STD Control
NGO	Nongovernmental organization
OVC	Orphans and other vulnerable children
PMTCT	Prevention of mother-to-child transmission
PGA	Program Grant Agreement
PLWHA	People living with HIV/AIDS
PR	Principal Recipient
PRTRT	Principal Recipient Technical Review Team
RBM	Roll Back Malaria Program
SDA	Service Delivery Area
SR	Sub-Recipient
SSR	Sub-Sub-Recipient
STI	Sexually transmitted infection
TB	Tuberculosis
UNAIDS	Joint United Nations Program on HIV/AIDS
UNDP	United Nations Development Program
UNGASS	United Nations General Assembly – Special Session on HIV/AIDS
VCT	Voluntary counseling and testing
WHO	World Health Organization

Preface

This is the 3rd edition of the Monitoring and Evaluation (M&E) Guidelines of the Office of the Principal Recipient (PR) of the Ministry of Health in Cambodia. The first edition of these Guidelines, developed in July 2003 with technical assistance supported by WHO, UNDP and UNAIDS, focused on the 1st GFATM grant in Cambodia (HIV/AIDS under round 1). Two years later, after 3 more rounds of GFATM funding have been approved for all 3 diseases, the 2nd Edition of M&E Guidelines was developed to provide a framework for all six grants approved under Rounds 1, 2 and 4 in HIV/AIDS, Malaria and Tuberculosis (May 2005). At this point, another year later, with the 5th round of GFATM grants about to be launched in Cambodia, the 3rd Edition was produced.

The 3rd Edition of M&E Guidelines was developed in May 2006, with the technical assistance of the M&E International Advisor to the PR, extensive inputs of the PR Manager, the PR M&E Team, and the Sub-Recipients in May 2006. It incorporates recent updates in GFATM reporting policies and the latest developments in M&E. While this 3rd Edition of the guidelines remains consistent with the previous versions, its contents have been somewhat re-organized and augmented by liberal adaptations from GFATM's 2nd Edition of "*Monitoring and Evaluation Toolkit for HIV/AIDS, Tuberculosis and Malaria*", January 2006.

Several national and international sources were also consulted, such as Volume 3 of the Cambodian MoH's "*Health Sector Strategic Plan, 2003-2007*", which provides the MOH Framework for Monitoring and Evaluation, "*Monitoring and Evaluation Operations Manual for National AIDS Councils*" jointly published by the UNAIDS and World Bank (2002), "*National AIDS Programs: A Guide to Monitoring and Evaluation*" jointly published by UNAIDS/MEASURE (2000), "*Project Performance Assessment Report; Disease Control and Health Development Project; Kingdom of Cambodia (CR.N005-KH)*" published by the World Bank on April 21, 2004 and "*Joint Annual Health Sector Review 2004; Department of Planning and Health Information*, published by MOH-Cambodia 22-23 March 2004.

These guidelines have been prepared to assist with managing and implementing all M&E planning and reporting associated with the GFATM grants under Rounds 1, 2, 4 and 5 in Cambodia. They are intended to assist the M&E Technical Officers based in the PR office, and the respective Sub-Recipients' (SRs) as well as any Sub-Sub Recipients (SSRs) in fulfilling their M&E specific tasks and responsibilities, while ensuring that program activities work towards achieving their intended results.

The guidelines may be found to be comprehensive, but by no means exhaustive. The idea has been to demystify the basic concepts of M&E, and offer practical and realistic guidance on how they are applied under GFATM grants in Cambodia. Although written primarily with the SRs and PR in mind, other key stakeholders such as the CCC and CCC-SC members, PR Technical Review Teams (PRTRT members) may find these guidelines useful as a reference material to assist in their routine GFATM-related functions. It is essential to update these guidelines periodically as needed, in consultation with key stakeholders.

It is not important to measure everything, and all important things are not measurable.

Albert Einstein

**Office of the Principal Recipient, Communicable Disease Control Department
Ministry of Health, Cambodia
Monitoring and Evaluation Guidelines
3rd Edition**

A. INTRODUCTION

1. What is the Global Fund?

The Global Fund to Fight AIDS, Tuberculosis and Malaria (GFATM), a non-profit foundation, was established under the laws of Switzerland (referred to as the “Global Fund”) in January 2002 to attract, manage and disburse large amounts of additional financing to support locally-driven strategies to combat the three pandemics. AIDS, tuberculosis and malaria – which are both preventable and treatable – kill more than six million people every year. The Global Fund was founded on some important principles to guide all of its operations, from governance to grant-making:

- Operate as a **financial instrument**, not an implementing entity;
- Make available and leverage **additional financial resources**;
- Support programs that reflect **national ownership**;
- Operate in a balanced manner in terms of **different regions, diseases and interventions**;
- Pursue an integrated and balanced approach to **prevention and treatment**;
- Evaluate proposals through **independent review processes**;
- Operate **transparently and accountably**, employing a simplified, rapid and innovative grant-making process. (Source: GFATM Website. May, 2006).

The Global Fund allocates funding through proposal rounds. The most recent round of proposals (the 5th such round) was approved in September 2005. The Round 6 call for proposals was announced on 3rd May, 2006, with applications due on 3rd August, 2006.

2. GFATM Globally

As of 31 March 2006, the Global Fund has approved a total of **US \$ 5.2 billion** to over 350 grants in 131 countries through five rounds of proposals and including the latest grants to receive approval for Phase 2 (years 3 to 5 of the grant lifespan).

Of the US \$ 5.2 billion approved, **US \$ 2.1 billion** has been disbursed to public and private recipients in 127 countries. Through 2008, a total of US \$ 8.8 billion has been pledged and/or contributed to the Global Fund. Expected outcomes of grants approved in Rounds 1 – 5 after five years:

- More than 1.8 million people on antiretrovirals;
- 62 million clients reached with voluntary counseling and testing services for HIV;
- Over 1 million orphans supported through medical services, education and community care;
- 5 million additional tuberculosis (TB) cases treated under the DOTS treatment strategy;
- 264 million Artemisinin-based combination treatments for drug-resistant malaria delivered;
- 109 million bed nets financed to protect families from the transmission of malaria;

a) Grant progress to date:

As of 31 March, 2006, the GF had:

- signed grant agreements for 85% of the grants approved in rounds 1 through 5;
- disbursed a total of US \$2.1 billion to public and private recipients in 127 countries. (Source: GFATM website, May 2006.)

b) Phase 2 Funding

The Global Fund approves funding in principle for five years but initially commits funding for the first two years only. The end of this first phase is a critical milestone in the performance-based funding model used by the Global Fund. The Secretariat assesses the progress of grant-funded

programs and renewal of funding is based on grant performance, contextual considerations and availability of resources.

To ensure that grant funding continues to go where it is being managed and spent effectively, only grants with satisfactory performance (as measured against agreed targets) continue to receive funds during remaining years of the grant. In the event of insufficient finances, the Global Fund prioritizes Phase 2 funding for existing grants over the funding of new grants.

3. GFATM in Cambodia

In Cambodia, GFATM has approved proposals submitted during the first, second, fourth and fifth Rounds¹. The executing body of GFATM programs is called the Principal Recipient (PR), which, in Cambodia, is based within the Department of Communicable Disease Control (CDC), Ministry of Health (MOH). Thus, under Rounds 1, 2 and 4, six Program Grant Agreements (PGAs) between the GFATM and the PR were signed, or approved, as follows:

- **Round 1:** 1 PGA for HIV/AIDS component for US \$ 15.7 million/3 years².
- **Round 2:** 3 PGAs for HIV/AIDS, Malaria and Tuberculosis for the following US \$ amounts: 1) HIV/AIDS for \$14.7 million, 2) Malaria for \$9.9 million, and 3) TB for \$ 6.3 million, or a total of US \$ 31 million / 5 years³.
- **Round 4:** 2 PGAs for HIV/AIDS and Malaria were signed for the following US \$ amounts: 1) HIV/AIDS for \$ 8.8 million and 2) Malaria for \$ 5.2 million, or a total of US \$ 14 million /2 years.
- **Round 5:** In January 2006, 3 Program Components were approved under Round 5, including 1) HIV/AIDS, 2) Tuberculosis and 3) Health Systems Strengthening for a total of US \$ 21.2 million / 2 years. Grant negotiations and signing of 3 PGAs are anticipated for June 2006, with an expected start date of July 2006.

It is important to note, that Cambodia is one of the few countries to have been successful on four of 5 Rounds of GFATM applications for funding. Furthermore, Cambodia has already been awarded four Phase 2 grants under Rounds 1 and 2, indicating its recognized success in GFATM program implementation. Please refer to Table 1 below for further details.

Table 1: PGAs signed and Rounds approved to date in Cambodia

Basic Information on PGA/ per GF Round	Round 1	Round 2	Round 4	Round 5 ⁴ (approx.dates/ figures)
Date Signed	Jan 2003	Oct 2003	June 2005	June 2006 (?)
Grant Start Date	Sept 2003	Jan 2004	September 2005	July 2006 (?)
PGAs Approved/ Signed (% funding of total Round)	1. HIV/AIDS (100%)	1. HIV/AIDS (42%) 2. Malaria (39%) 3. TB (19%)	1. HIV/AIDS (63%) 2. Malaria (37%)	1.HIV/AIDS (76%) 2.TB (3.2%) 3.HSS (1.8%)
Funding Level 1) Phase 1 2) Phase 2	(in US\$ Million) 9.8 / 2 yrs 5.9 / 1 yr⁵	(in US\$ Million) 12.8 / 2 yrs 18.0 / 3 yrs	(in US\$ Million) 14.0 / 2 yrs n/a	(in US\$ Million) 21.2 / 2 yrs n/a
Total Funding (in US \$ Million)	15.7 / 3 yrs	30.8 / 5 yrs	14.0 / 2 yrs	21.2 / 2 yrs

¹ The 3rd round GFATM submission was not successful in Cambodia.

² Round 1 proposal was approved for a total of 3 years, therefore Phase 2 is only 1 year.

³ These amounts include Phase 1 and Phase 2 funds.

⁴ Dates and amounts to be confirmed later, after the PGAs are signed.

⁵ As mentioned before, Round 1 was approved for a total of 3 years only.

4. The importance of M&E activities, or simply: “Why M&E?”

a) To guide program management: Program managers need quality information to make adjustments and programmatic and technical decisions. M&E is essential for effective program management as it enables managers to:

- establish performance standards for program implementation;
- develop clear program implementation plans and monitor their execution on a regular basis;
- detect and address problems so that program revision and improvement become standard operating procedures;
- provide early evidence of long-term program effectiveness.

b) To secure continued funding: Following its performance-based funding principle, GFATM requires all country recipients (through Principal Recipients) to report accurate, timely and comparable program results data as a prerequisite to every financial disbursement, which is assembled through the M&E framework. **M&E is a basic requirement for all GFATM grants.** The GFATM mission is to raise money, allocate funds to projects, and show these funds are helping tackle HIV/AIDS, TB and Malaria. In brief, it aims to “raise funds, spend them, and demonstrate their contribution” in partnership with other international and national organizations. Therefore, continuous and rigorous monitoring and evaluation of the program inputs and performance is a critical requirement for continued funding.

5. Purpose of this book

To assist in managing and effective execution of the required M&E program activities related to all GFATM programs in Cambodia, to demystify the Performance-Based Funding concept and describe how it has been practically applied by GFATM to-date in Cambodia. This book aims to guide all relevant staff under all existing GFATM rounds of funding (from both SR and PR teams) in practical daily execution of their routine M&E functions. SRs may further adapt their guidelines to be used with their SSRs, as needed. This is the 3rd Edition of M&E Guidelines.

- **1st Edition:** The 1st Edition of PR’s M&E Guidelines, developed in July 2003, provided an introduction of the GFATM-related M&E framework, initial design and theoretical background, aiming to help SRs design and establish their respective M&E plans and systems. Since only HIV/AIDS component was approved under Round 1 grant, the 1st Edition of M&E Guidelines focused exclusively on HIV-related information.
- **2nd Edition:** The 2nd edition was developed in May 2005, nearly two years into the full implementation of the 2nd Round of grants (for HIV/AIDS, Malaria and TB). While most M&E systems were in place at that time, there was a need for further assistance with the operational, practical steps involved at each level of GFATM results reporting, thus the 2nd Edition was produced. The 2nd Edition was a natural progression and revision of the 1st one, and it incorporated indicators on Malaria and TB, in addition to those on HIV/AIDS., as well as the information from GFATM’s 1st M&E Toolkit (June, 2004).
- **3rd Edition:** In January 2006 the GFATM introduced substantive changes to its reporting formats and has released the 2nd version of its M&E Toolkit, which provides expanded information about key GFATM concepts, (such as Performance-Based Funding, Service Delivery Areas), and further fine-tuned previous material presented in the 1st GFATM M&E Toolkit (i.e., updating indicators based on the latest technical developments). Furthermore, in October 2005, GFATM approved the Round 5 funding request for Cambodia (for HIV/AIDS, TB and Health Systems Strengthening) thus bringing in another batch of new SRs, who needed a full introduction into GFATM procedures. All of these factors required another update of the M&E Guidelines. This 3rd Edition continues to build on the previous

two versions (following the same general M&E framework), while updating the information and new developments as they emerged from GFATM.

6. How does the 3rd Edition differ from the 2nd Edition?

The 3rd edition aims to convey updated information both on theoretical and practical aspects of the M&E requirements for the GFATM program in Cambodia, including updated GFATM M&E guidance, as presented in the 2nd version of GFATM M&E Toolkit, 2nd Edition, January, 2006. Specific changes include:

- Revised presentation of the M&E framework and performance-based framework;
- Extensive menu of revised and updated indicators, based on the latest technical resources in the three diseases, including two sets of “top 10” indicators for GFATM programmatic and outcome/impact reporting;
- Linking updated indicators and service delivery areas (SDAs) for the three diseases;
- Collaborative HIV/TB activities incorporated into HIV and TB components;
- Inclusion of cross-cutting " Health System Strengthening" section and relevant SDAs and indicators.
- Additional information on data collection methods, evaluation, and measuring quality;
- Updated information on further expansion of GF grants in Cambodia, through Round 5; Incorporate some “lessons learned” and experiences from implementation of the programs to-date.

7. Who are these Guidelines intended for?

- Designed as a practical toolkit and road map for SRs and PR’s staff (M&E technical officers and managers) to use in designing M&E Plans, to best reflect their individual programs, and implementation of all M&E activities.
- CCC members, CCC-Sub Committee members, PRTRT members, who play an important role of component program progress oversight, including joint PR report review, quality control and data validation.
- Stakeholders in the government sector, private sector and civil society, and donor institutions that are involved in the preparation, implementation and M&E of the national HIV/AIDS, malaria and TB programs in joint partnership.

8. What do these Guidelines attempt to do?

These M&E guidelines attempt to:

- introduce key M&E concepts;
- provide an extensive menu of indicators for HIV/AIDS, Malaria and TB;
- present and de-mystify a results-based disbursement concept under GFATM;
- present practical steps for implementing GFATM M&E / reporting system;
- provide clear description of SR and PR reporting requirements;
- describe the M&E roles of supporting GFATM structures (CCC-SC, PRTRT)
- provide clear instructions on designing M&E plans;
- present selection of simple data collection tools;
- present a selection of M&E tools (checklists) for assessment of program activities.

B. KEY CONCEPTS OF MONITORING AND EVALUATION (M&E)

As there have been many approaches to M&E, to ensure that all of those involved in GFATM project have the same common understanding of M&E, key concepts (as described in The GFATM M&E Toolkit) are introduced in this Chapter, although most discussion focuses on monitoring rather than evaluation.

1. Basic Definitions: For purposes of the Global Fund, the following *definitions* apply:

- a) Monitoring** refers to *routine tracking* of the key elements of program / project performance (usually inputs and outputs) through record-keeping, regular reporting and surveillance systems, as well as health facility observation and surveys. Monitoring helps program / project managers determine which areas require greater effort and identify areas which might contribute to an improved response. In a well-designed M&E system, monitoring contributes greatly towards evaluation.
- b) Evaluation** refers to *an episodic, retroactive examination at some point in time* in targeted results related to the program or project intervention. Evaluation attempts to link particular outputs (or outcomes) directly to an intervention after a period of time. Evaluation thus helps program managers determine the value of a particular program (or project). In addition, evaluation should also relate these program outputs to wider national trends in behavior (or other outcomes), and the impact on specific disease. There are three types of evaluation:
- **Process evaluation** involves an assessment of the processes involved in the program, such as program content, scope or coverage together with quality of implementation; typically conducted after a year of implementation to verify that all processes and systems are in place, and to make any corrective adjustments as necessary.
 - **Outcome Evaluation** is designed to demonstrate changes attributed to the intervention itself. The evaluation design should plausibly link observed outcomes to a well-defined program, and demonstrate that changes are not the result of non-program factors. It may be conducted after a minimum of 2 years of implementation, so cumulative data from outcome indicators could be reviewed and relevant trends mapped.
 - **Impact evaluation** should be able to attribute long-term changes to a specific program; however, pure scientific impact evaluations would require experimental studies and are thus very rare and quite expensive. Therefore, for practical purposes, monitoring impact indicators in conjunction with process and outcome evaluations have been considered to be sufficient to indicate the overall impact.

Not only does (performance) evaluation serve to ensure that funds are allocated correctly, but it also provides a **platform for programs to communicate evidence of progress internally and externally, and make the case for sustained funding.**

“The objectives and the methodology used in monitoring and evaluation are different. In general, evaluations are more difficult in view of the methodological rigor needed: without such rigor, wrong conclusions on the value of a program (or project) can be drawn. They are also more costly, especially outcome and impact evaluations, which often require population-based surveys⁶ or other rigorous research designs.”(GFATM M&E Toolkit; January 2006).

⁶ However, evaluation should leverage data and surveys that are nationally available and regularly undertaken, e.g. DHS surveys, vital registration or sentinel site disease data.

- c) Program** refers to an overarching *national or sub-national response* to the disease. Within a national program, there are typically a number of different areas of programming. For example, the HIV/AIDS program has a number of “sub-programs or projects” such as blood safety, sexually transmitted infection (STI) control, or HIV prevention for young people; these are grouped into functional Service Delivery Areas (SDAs) under GF grants .
- d) Project** refers to a *time-limited set of activities and objectives* supported by resources that aim at a specific population defined geographically or otherwise. It should be noted that projects and programs can also be defined by timeframes; – projects are usually short term whereas programs are usually longer term in scope.

In view of its wider scope (thematic, geographic, target population), **program** monitoring *tends to be more complex than project* monitoring and therefore requires strong coordination among all implementing agencies. For impact and outcome evaluations the design of the program/project must include its own baseline and follow-up assessments, measuring not only specific outcomes but also the level of exposure to the program/project and its activities.

- 2. M&E Framework: Input-process-output-outcome-impact.** Effective M&E is based on a clear, logical pathway of results, in which results at one level are expected to lead to results at the next level, leading to the achievement of the overall program goal. There are four major levels of the M&E framework; as presented in Box 1 below and Figure 1 on the next page.

For a program or project to achieve its goals, **inputs** such as money and staff time must result in **outputs** such as new or improved services, trained staff, persons reached with services, etc. These outputs are the result of specific **processes**, such as staff training, that should be included as key **activities** aimed at achieving the outputs. If these outputs are well designed and reach the populations for which they were intended (target populations), the program or project is likely to have positive short-term effects or **outcomes**, for example “increased condom use with casual partners”. These positive short-term outcomes should lead to changes in the longer-term **impact** of programs, measured in fewer “new cases of HIV/AIDS, TB or malaria”, etc. Monitoring of output or outcome indicators can also identify such relationships and give a general indication of program progress.

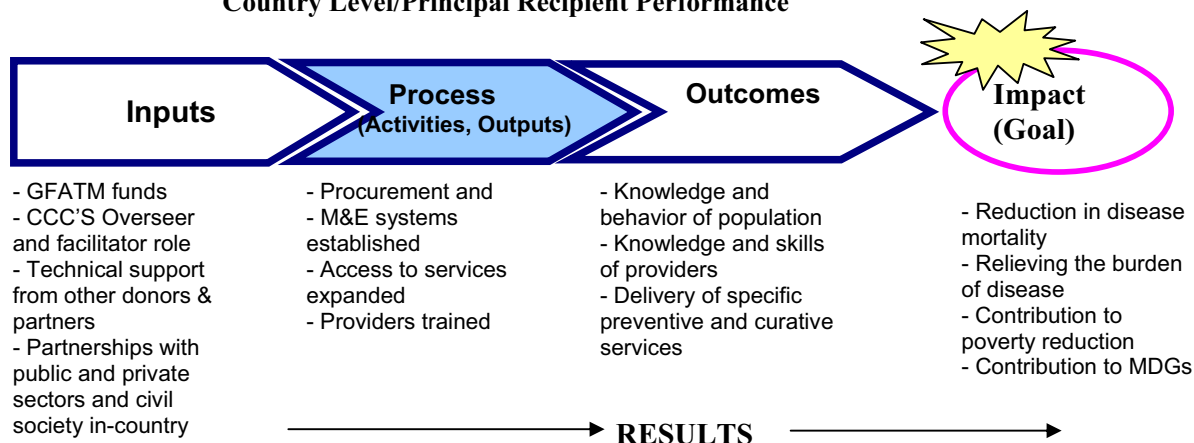
Box 1: Defining program results: outputs, outcomes and impact.

<u>Level</u>	<u>Description</u>
Inputs	Inputs are the people, training, equipment and resources that are put into a project, in order to achieve outputs.
Outputs/ Process	The activities, systems, actions or services delivered in order to achieve program outcomes, that would eventually lead to greater coverage, impact, etc. The processes associated with service delivery are very important and involve quality, unit costs, access and coverage.
Outcomes	The changes in key variables that indicate the successful implementation of a program, such as changes in behavior, or skills.
Impact	The fundamental objectives of the investment, including reduction in disease mortality or relieving the burden of disease (major measurable health impacts).

Assessing the impact of a program requires extensive investment in monitoring and evaluation efforts, and it is often difficult to ascertain the extent to which individual programs, or program components,

contribute to overall reduction in cases and increased survival. In order to establish a cause-effect relationship for a given intervention, studies with experimental or quasi-experimental designs may be necessary to demonstrate such long-term effect, or impact.

FIGURE 1: Results-Chain Framework*
Country Level/Principal Recipient Performance



* This is a causal pathway when results at one level are expected to lead to results at the next level in the direction towards achieving the program goal

3. Program Indicators are standard measures for checking on progress towards achieving program and project outcomes. Indicators can be quantitative and/or qualitative, have a time frame, and may highlight geographical and/or target groups. Indicators correspond to different levels of the M&E framework, therefore, there are input, output, outcome and impact indicators. It is important to distinguish between levels of the M&E framework, as the higher the level fewer indicators are measured. In practice, more *extensive set of indicators is needed to manage a program*, and *fewer indicators are needed for donor and international reporting*. Please see further discussion on most commonly used GFATM indicators (Top Ten) in Chapter C 16.

- a) Standard Indicators:** It is important to note that the **Global Fund** uses standard indicators already developed and agreed by technical partners, including WHO, UNAIDS, UNICEF, World Bank, USAID and CDC, ensuring consistency across organizations. This allows for comparisons among target population groups and ensures comparability of information across countries and over time.

In view of scarce M&E resources, emphasis is placed on monitoring program inputs and outputs to verify that a program progresses according to the agreed M&E plan.

- b) Target population** refers to the group of people who are in need of an intervention. It *can be the total population or a smaller, specific group such as young people*. In designing program interventions, target population should be defined as clearly as possible. The description of services provided should specify which populations and geographic areas are covered. Identifying target population comes from evidence-based knowledge on whom diseases affect most, directly and indirectly.

For example, in Cambodia, where HIV prevalence is concentrated within groups with specific risk behaviors, the target group may be defined as a sub-group of the general population that shares these same behaviors – such as, “men who have sex with men (MSM), people who use intravenous drugs (IDUs), or commercial sex workers (CSWs)”.

- c) Denominators:** In many cases, it may be difficult to determine the denominator, or population, to use when assessing, for example, coverage. The Global Fund, therefore focuses

on **numerators**, or the subset of the population that is affected or benefits from interventions. Denominators should also be included where possible (if percentages are given, **numerators should also always be reported** to allow assessment of coverage over time and across populations). Several publications⁷ may help readers in addressing the challenges faced in determining denominators when working with hidden populations or low and concentrated epidemics.

4. Methods of Data Collection: (Frequency and Sources)

- a) **Frequency of measurement:** depends on the level of the indicators within the M&E conceptual framework – taking into account both a reasonable time-frame for an expected change and program capacity for M&E. Indicators may demonstrate some change at different time frames, based on which level of results they represent. For on-going program reporting, GF and PR are focused on routine data collection which is monitored regularly (quarterly, six months, annually). Recommended measuring and reporting schedules are presented in Table 2 below:

Table 2: Indicator Levels and Recommended Reporting Schedules⁸

Level of Indicator	Recommended frequency of reporting	Examples of data collection methods used
Input/Process	Continuously	<ol style="list-style-type: none"> 1. Health services statistics 2. Health facility surveys 3. Program monitoring
Output	Quarterly, semi-annually, or annually	<ol style="list-style-type: none"> 1. Health services statistics 2. Health facility surveys 3. Program monitoring
Outcome	1 to 3 years	<ol style="list-style-type: none"> 1. Population-based surveys 2. Health facility surveys 3. Special studies
Impact	2 to 5 years	<ol style="list-style-type: none"> 1. Surveillance 2. Population-based surveys 3. Special studies

- b) **Data Sources / Measurement tools:** Different sources and measurement tools provide information on different indicator levels. Key sources are described below, and further summarized in Table 3 below:

- **Routine tracking of information:** Input, process and output indicators are monitored through various routine data collection systems, including: on-going health service records, regular reporting systems, health facility observation, client surveys and supervision visit reports. Information is usually compiled at the peripheral level and later forwarded to headquarters for aggregation.
- **Surveillance studies and surveys** provide information on long-term program changes, measured by outcome and impact indicators. Data on long-term impact come from surveillance systems, which in Cambodia, is collected by the national program for each disease (NCHADS for HIV/AIDS, CENAT for Tuberculosis and CNM for Malaria). Data for many **outcome** and **impact** indicators are collected through more costly and difficult population-based or health facility surveys, requiring some expertise in research methods. Outcome measurement is usually more difficult in view of the sensitivity and specificity of each indicator. This information, however, allows for assessing of long-term disease trends.

⁷ *Estimating the Size of Populations at Risk for HIV (UNAIDS/IMPACT/FHI, 2002); Guidelines for Sampling Orphans and other Vulnerable Children (UNICEF, 2003); Guide to Monitoring and Evaluation National HIV Prevention Programs for Most-at-risk Population in Low Level and Concentrated Settings* (currently under review)

⁸ Extracted from GFATM M&E Toolkit, January 2006.

Table 3: Measurement Tools

Measurement Tools	Main characteristics	Examples of measurement methods used
Health services statistics	1. Routine data collection at health facilities 2. Program monitoring	Data registered from various health facility registers
Health facility survey	Survey targeting health facilities to gather information on the availability of human resources, equipment, commodities and drugs and the type of services delivered.	1. Site based facility surveys (e.g. HIV/AIDS Service Provision Assessment) 2. SAMS (Service Availability Mapping Surveys)
Qualitative methods	Determine “what exists” and “why it exists” rather than “how much of it is there”. By asking the people to voice their opinions, views and experiences in their own way, qualitative methods aim to understand reality as it is defined by the group to be studied without imposing a pre/formulated questionnaire or structure (always developed by the researchers) on the population (<i>Maier B. Gorgen, R et al 1995</i>).	<ul style="list-style-type: none"> ● In-depth Interview (individuals, focus groups, key informants) ● Direct observation ● Interactive or projective technique (comments on posters, open-ended story/comment on story, role-play)
Operational research	Operational research (OR), also called targeted evaluation, complements M&E systems. Key objective of OR is to provide information to develop, improve or scale-up programs. While evaluation focuses on whether a change in results can be attributed to a program, OR focuses on whether the program is the right / best, program to achieve the desired results. It is a practical, systematic process for identifying and solving program- related problems.	Examples of OR: <ul style="list-style-type: none"> ● Adherence ● Equitable access ● Costs ● Linking prevention-treatment ● Different models of intervention
Sentinel site surveillance	Collect prevalence information from populations that are representative of the general population (such as pregnant women) or / and populations considered to be at high risk of infection and transmission. Can be linked to anonymous testing, with informed consent.	HIV sero-surveillance in pregnant women or in identified groups at high risk
Population-based surveys	A survey based on sampling of the target or general population, generally aims to represent the characteristics, behaviors and practices of that population. It requires sufficient sample size to represent the larger population and to be analyzed in sub-groups, by age, sex, region and target populations.	MICS, DHS and DHS+, AIS, BSS, PLACE, SAVVY

Source: GFATM M&E Toolkit; 2nd Edition, January 2006

5. Qualitative Information:

While most discussion in these M&E guidelines focuses on quantitative data, which formulates contractual requirements for GFATM reporting, it is important to emphasize the value of *qualitative* data in complementing, validating and providing a richer understanding of quantitative findings. Although qualitative approaches are not intended to be generalized to broader populations, and cannot measure trends, such data does put quantitative data into context and allows for a more expansive interpretation of quantitative indicators.

Qualitative data is also useful in addressing contextual responses to behavior change, essential in designing more effective communication campaigns, giving voice to the poor and vulnerable populations and providing better services to target groups.

Various methodologies are used in the collection of qualitative data including, among others, patient satisfaction surveys, desk reviews, patient/staff observation, mapping exercises, key informant interviews, focus groups, participatory rural appraisals, and rapid ethnographic studies.

Ideally, a mix of qualitative and quantitative methodologies should be used in data collection and analysis for better monitoring of program performance. Combining both methodologies will contribute to a more substantial understanding of program progress, maximize optimal use of data sources and reduce biases in the data.

6. Some Global Key Lessons Learnt in M&E

Successful M&E systems share some important characteristics. Most importantly, data should be used -for management and funding decisions- to sustain any M&E reporting system. Below is an illustrative list of key lessons extracted from the GFATM M&E Toolkit:

1. M&E systems must be as simple as possible. Most programs and projects collect far more data than they use. The more complex a M&E system, the more likely it will fail. It is important that data is used as a basis for ongoing decision making.
2. M&E systems must include a standardized core set of tools to collect and analyze data. If each implementing partner uses different systems or tools, the data cannot be analyzed or summarized effectively. The need for a standardized core set of tools does not preclude individual implementing partners from collecting additional situation-specific M&E data.
3. Good M&E requires both internal self-assessment and external verification. Thus, while implementing partners should collect and verify their own internal data, an external agency should verify the completeness and accuracy of the data collected by those implementing partners. Supervisory visits should be based on the analysis of internal self-assessment and externally verified primary data.
4. A specialized entity is required to collect, verify, enter and analyze primary M&E data from each partner. Without such an entity, reliable data collection, verification and analysis are unlikely to occur as Ministries and other public agencies are seldom equipped to manage such a process. Increased resources devoted to HIV/AIDS, TB and malaria should be used to build local capacity within such a national organization.
5. M&E must be built into the design of a program and must be operational when grant implementation begins, not added later. It is much harder and less effective to “retrofit” M&E after grant implementation is underway.
6. Sub national data are important for the national level data collection as they can be aggregated up to this level. However, sub national data are more relevant to program managers in making day to day decisions.
7. Data should be made available as widely and transparently as possible, and wherever possible placed in the public domain. M&E is about promoting the use of data.

No matter how sound an M&E system may be, it will fail without widespread stakeholder “buy-in.” Thus, a large-scale, participatory process in the development and implementation of M&E strategies is essential to build ownership and “buy-in” from the start.

C. ELEMENTS of GFATM Performance-Based Funding Framework

1. What is Performance-based Funding? The Global Fund raises money, allocates funds to programs, and demonstrates that these funds help fight HIV/AIDS, tuberculosis and malaria. In brief, it aims to “*raise funds, spend them and help prove their contribution to fight the diseases*” in partnership with other international and national organizations, and crucially with the projects which implement the grants. Central to the Global Fund mechanism, performance-based policy is to ensure raising, spending and proving the contribution of funds. Funds are released when progress against agreed targets is met. This requires that:

- Overall goals are clearly formulated;
- Services are clearly defined, grouped into service delivery areas, and related to goals;
- Indicators are chosen, targets set and progress reported regularly.

a) From Concept into Practice: While the concept of performance-based grant-making is not new, the Global Fund has been pioneering practical systems to implement this concept, while balancing program accountability and efficiency. This involves joint tracking of program progress and expenditures to demonstrate results and effective use of allocated resources. In practice the system works as follows:

- After a country proposal is approved under Round (1,2,3, etc.), the GFATM signs Program Grant Agreements (PGAs) directly with the PR (one per disease), who manage the funds in country. Each PGA contains clear budget and Intended Results (IRs) for which the PR is directly accountable to the GFATM. Similarly, the PR signs the Memoranda of Agreement (MOA) with its grantees, or Sub-Recipients (SRs), with clearly specified individual budgets and defined IRs.
- The PR submits all cumulative reports, to the GFATM together with regular (semi-annual in Cambodia) Disbursement Requests, through the Local Fund Agent (LFA)⁹. LFA reviews PR's plans and requests and makes recommendations to the GFATM, which then in turn makes the final disbursement decision.
- Disbursement of funds is driven by results, and calculated on PR's anticipated expenditures; including joint PR and SR financial forecasts (usually referred to as Results – Based Disbursement).

b) Key characteristics of Results - Based Disbursement:

2. Results-based disbursement is a management tool that links programmatic and financial monitoring, and a strategic mechanism to build evidence on results and a sound utilization of resources.
3. It helps to ensure that money is well spent relative to project goals, and ultimately services are provided to those affected by disease.
4. Funds raised do not belong to the Global Fund nor to the programs supported, but to the people who need services with urgency.
5. It develops evidence base and platform to advocate sustained and dependable funding.
6. Country ownership is essential; targets are derived from country proposals, and agreed by both sides prior to signing a PGA.
7. Reported results are used actively as the basis for continuous self-assessment and making adjustments in the existing programs (closing the M&E feedback loop).

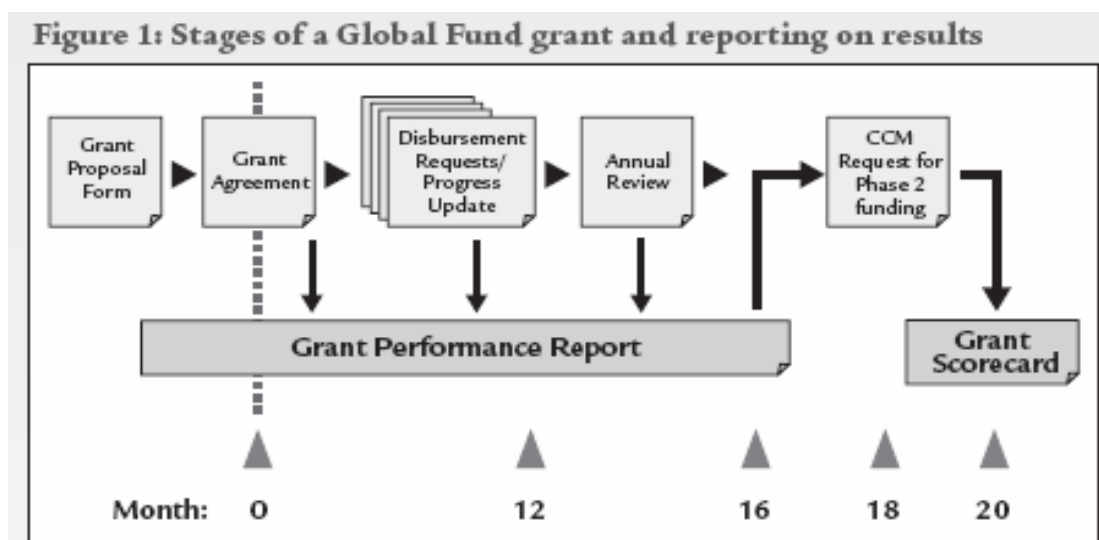
c) Demonstrating Results / Performance is based on how well different indicators can be measured, documented and verified against agreed targets set towards achieving the goals of the proposal. Therefore there are very strong incentives to have clear, simple, measurable and well communicated results on a regular basis (or a clear M&E plan). Wider measures of

⁹ Both results and resources are meticulously verified by the LFA (in Cambodia, this role is played by KPMG).

progress should also be reported, but **core performance will rely on a few clear and meaningful targets** for key program level indicators.

2. Three Stages of GFATM grants: The Global Fund has developed a set of tools in collaboration with technical partners to facilitate grant management and Performance-based Funding throughout the lifecycle of a grant, including: M&E attachments to the grant (M&E plans), Disbursement Requests and Progress Updates (Semi-Annual reporting formats), Annual Grant Performance Report, Grant Score Card, and the M&E Toolkit itself.

All these tools help track relevant performance targets and achievements through clear set of indicators and targets taken from the original proposal and built into the Grant Agreement. They are designed to ensure that reported data are analyzed and used for decisions at each stage.



The information collected is used at three main stages of performance evaluation:

a) Regular Disbursements (every 6 months as the default): Agreement on a few indicators of progress is used for regular Financial Release on a 6-month basis. Funds are released based on disbursement requests accompanied by progress updates of results against targets with an explanation or self assessment from the program. While it is not required to set targets (and report results) for every indicator in every reporting period, reporting periods should be aligned with the National information system. Grantees need to explain reasons for deviation of results from targets.

b) Annual reviews/reports (every 12 months): These collect the results for all indicators for the year and include a self assessment of progress, barriers, successes and failures. The Global Fund uses these updates to report on progress in program implementation across its portfolio, and as a key source of contextual information to interpret the minimal performance focus of results against targets. The Global Fund does not request a specific report format, therefore countries can use their own existing annual reviews or yearly program reports.

c) Phase 2 evaluation (from 18 to 20 months): GF funding is committed for an initial period of two years (Phase 1). After 18 months, the program makes a submission for Phase 2 funding to cover an additional three years (for a total of 5 years of funding). An overall review of performance is used as a basis for the Global Fund to recommend further funding into Phase 2. This includes a comprehensive report on results against targets, tracked against the goals of the proposal, and of the delivery of key services relevant to fighting the three diseases.

- A **Grant Scorecard** is prepared by the Global Fund combining the aggregate results with independent verification and assessment of data on the grant's performance. The Grant Scorecard becomes the basis for the Phase 2 funding decisions taken by the Board.
- Additional factors considered by GFATM in assessing the PR and SR performance, include:
 - track record on timely submission of reports to the PR,
 - program implementation results preferably at/above 85% of intended results,
 - program expenditures in line with project timeline,
 - timely procurement of essential goods that matches project timeline,
 - demonstration of proactive problem solving in case of implementation delays.

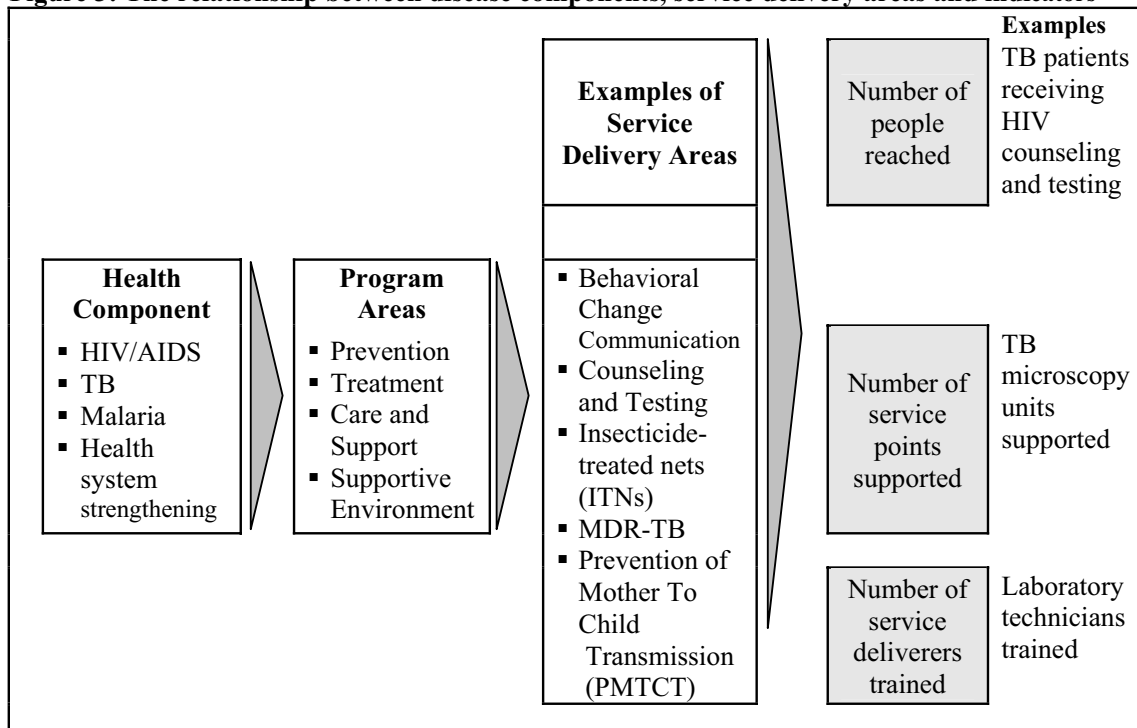
It is important to note that the aim of Performance-based Funding is to use reported results actively as the basis for self-assessment and decisions in programs and at the Global Fund. Results against targets are only the basis of a performance rating.

3. Defining Performance for GF grants

a) Monitoring and Evaluation Plan: The M&E plan should build on existing national programs and policies wherever possible. The M&E plan is a central part of grant applications, the grant agreement signed by both sides, and the basis for ongoing performance-based Funding. If a national M&E plan exists, the GF grants should use it as a basis for the GF M&E plans.

b) Service Delivery Areas and Activities: The core of measuring performance under GFATM programs is to identify activities, or **key services to be delivered**, under Service Delivery Areas (SDAs). Figure 3 below presents the relationship between disease components, SDAs and indicators. Each activity has corresponding **indicators** to report on program progress. Also, please note that Appendices 1-5 provide sample lists of disease-specific indicators and corresponding SDAs. These indicators should have further **targets or Intended Results** defined for periodic measurement over the PGA/MOA period in individual PR/SR M&E plans.

Figure 3: The relationship between disease components, service delivery areas and indicators



Source: GFATM M&E Toolkit; 2nd Edition, January, 2006.

Grants should only report on a *few indicators for defined service delivery areas* in line with achieving its goals and objectives. In general, a grant should report on a limited number of indicators per service delivery area (to show people reached by services, service points supported, and people trained). In general, GFATM aims to have about 5-10 *key indicators* per grant, with 15 reported in total, although Cambodian experience indicates that GFATM prefers more indicators at later stages.

c) Key Output Indicators (1st Top Ten GFATM list). The Global Fund *puts particular value on reporting of a set of “top ten” short-term indicators* measuring people reached with services that can be reported on internationally across the entire portfolio (see Table 4 below). These indicators allow frequent routine reporting, that can identify short-term changes in the program, and are therefore useful for regular disbursements of money. *They should be incorporated into grant reporting wherever the services are provided.* They are listed in Table 4 below:

Table 4: Top Ten Output Indicators for GFATM reporting:

	Top Ten Indicators for routine Global Fund reporting	Disease
1	Number of people with advanced HIV infection currently receiving anti-retroviral combination therapy (ARVs)	<i>HIV</i>
2	Number of a. new smear positive TB cases detected , b. new smear positive TB cases that successfully complete treatment and c. TB cases enrolled to begin second line treatment for multi-drug-resistant TB	<i>TB</i>
3	Number of ITNs (including retreatment kits for existing nets) distributed to people at risk (or, where appropriate, number of houses receiving indoor residual spraying according to national policy)	<i>Malaria</i>
4	Number of people with uncomplicated or severe malaria receiving anti-malarial treatment as per national guidelines (specify ACT/non-ACT)	<i>Malaria</i>
5	Number of people counseled and tested for HIV including provision of test results	<i>HIV</i>
6	Number of HIV-positive pregnant women receiving a complete course of anti-retroviral prophylaxis to reduce mother to child transmission (PMTCT)	<i>HIV</i>
7	Number of condoms distributed to people	<i>HIV</i>
8	Number of people benefiting from community-based programs (specify, a. Prevention; b. Orphan support; c. Care and support)	<i>HIV/TB/Malaria</i>
9	Number of cases treated for infections associated with HIV (specify, a. Preventive therapy for TB/HIV; b. STIs with counseling)	<i>HIV/TB</i>
10	Number of service deliverers trained according to documented guidelines (specify a. Health services b. Peer and community programs)	<i>HIV/TB/Malaria</i>

Source: GFATM M&E Toolkit; 2nd Edition, January, 2006.

d) Key Outcome and Impact Indicators (2nd Top Ten GFATM List): In the *medium to long-term (1-5 years)*, *outcome and impact indicators* showing changes in disease incidence or prevalence (behavior change) should be selected at the start of the program (see Table 5 below). These indicators are usually more difficult and costly to collect and normally reflect the contributions of all stakeholder efforts and programs in-country. Baselines are determined and targets are set for successive regular measurement over five years.

e)

Table 5: Top Ten Indicators for medium term outcomes and impact

	Top Ten Outcome and Impact Indicators	Disease	Source
1	Percentage of young women and men aged 15-24 who are HIV infected (HIV prevalence) (applicable to most-at-risk populations in concentrated/lower epidemics)	HIV	UNGASS
2	Percentage of adults and children with HIV still alive 12 months after initiation of antiretroviral therapy (extend to 2, 3, 5 years as program matures) (Reduced mortality)	HIV	UNGASS
3	Percentage of infants born to HIV infected mothers who are HIV infected (Reduced mother to child HIV transmission)	HIV	UNGASS
4	Percentage of young people aged 15-24 who had sex with more than one partner in the last year (Multiple Partners)	HIV	WHO/UNAIDS
5	Percentage of 15-19 year olds who never had sex (Primary abstinence) and percentage of 15-24 year olds who never had sex in last year of those who ever had sex (Secondary abstinence)	HIV	WHO/UNAIDS
6	Percentage of young people aged 15-24 reporting the consistent use of condoms with non-regular partners	HIV	WHO/UNAIDS
7	TB case detection rate and treatment success rate	TB	WHO StopTB
8	Estimated number of all active TB cases per 100,000 population (TB prevalence rate)	TB	WHO StopTB
9	Death rates associated with malaria: all cause under-5 mortality in highly endemic areas	Malaria	WHO RBM
10	Incidence of clinical malaria cases (estimated and/or reported)	Malaria	WHO RBM

Source: GFATM M&E Toolkit; 2nd Edition, January, 2006.

4. Component-Specific Reporting Framework: The term “component” refers to each major disease area of the GF program, i.e., HIV component, TB component, Malaria component. This chapter of the guidelines introduces selected (1) programmatic and (2) outcome and impact indicators for HIV/AIDS, TB, and malaria, but more extensive lists are enclosed in the Appendices 1-5. In addition, indicators for Health Systems Strengthening are provided in Appendix 8. Further details including supporting descriptions are enclosed in the Annexes to GFATM M&E Toolkit (2nd Edition). These indicators have been developed, discussed and agreed upon by a wide range of international and national experts and donors. Please note that: **Tables presented for each component do not aim to provide a comprehensive overview of all indicators.** Rather, they aim to provide users with a set of the most common indicators used for specific activity areas to use in their own M&E plans. For a complete listing of all existing indicators, readers are referred to the Annexes of the GFATM M&E Toolkit (2nd Edition, January 2006).

D. OPERATIONAL PROCEDURES: GFATM M&E System in Cambodia

1. National M&E Context: GFATM and the PR-Cambodia recognize the importance of harmonizing M&E systems to monitor progress towards goals and targets of existing global health initiatives. In Cambodia, development of a common National HIV/AIDS M&E Framework, lead by NAA and UNAIDS, occurred between June 2004-July 2005, with full participation of the PR M&E team. All GFATM HIV/AIDS M&E plans (one per disease component per every round) are synchronized with the final national framework.

For malaria and TB, the national data collection processes for these diseases are standardized, led by the national programs (CNM and CENAT) and integrated into the HIS. Since both the National Malaria Center (CNM) and National TB Program (CENAT) are Recipients of GFATM grants, they directly report their results to the PR, in accordance with the existing national systems.

Box 2: M&E System Components		
Component	Description	Responsibilities:
1. Overall system	Overall flowchart and database	Principal Recipient; Flow Chart: See Figure 4; Database; work-in-progress
2. Surveillance	National biological and behavioral surveillance; BSS, HSS, STI Survey	National Programs: a) NCHADS & NAA for HIV/AIDS, b) CNM for malaria c) CENAT for TB and TB/HIV Also: universities, research agencies
3. Research	Essential / basic research	Universities, research agencies National programs (NCHADS, CNM, CENAT)
4. Financial management and monitoring	Financial management monitoring of PR & SRs (resource use)	SRs, PR, PRTRT, CCC, CCC-SC, LFA (KPMG) and auditing firms.
5. Program activity monitoring	On-going monitoring of SRs program activities (the relevance, quantity & quality of services delivered by the SRs) Semi-Annual and Annual reporting	Sub-Recipients; PR in collaboration with PRTRT, CCC and CCC-SC National Programs (NCHADS, NAA, CNM, CENAT)

2. Components of M&E System: The program supported by GFATM has five M&E components, which are implemented by specialized entities, as shown in Box 2 above. Since the 1st Edition of these M&E Guidelines, the CCC and key stakeholders at the national level have been engaged in an intensive participatory process to build ownership and buy-in for the overall M&E system and program monitoring.

- a) **Overall system** comprises a flowchart, which describe precisely how data are collected and how the movement of information flows through the system.
- b) **Surveillance** comprises biological (serological), behavioral and social impact surveillance, providing information at the outcome and impact level. The primary responsibility for those activities lies with three national programs in Cambodia, NCHADS for HIV/AIDS, CNM for malaria and CENAT for TB.
- c) **Financial management monitoring system** has been developed and implemented by the PR, and it is described in the Financial Guidelines issued by the PR.

d) Program activity monitoring is conducted both by the SRs and the PR M&E team using two approaches:

- The SRs collect program data on a quarterly basis¹⁰, and provide updates to the PR. These results, identified program issues and follow-up are discussed in quarterly meetings on regular basis (every 4-6 months). The PR's M&E team conducts monitoring visits to observe program activities, spending about 4-6 weeks in the field. Any identified program issues are followed up.
- Without standardized guidance by GFATM on this issue, the PR M&E team developed and piloted its field monitoring methodology, with standard M&E tools (activity-specific checklists), and extensive Quality Assurance (QA) elements¹¹.

e) Database: The PR has commissioned a private Cambodian IT agency to develop a database in Microsoft Access. Pending development of this database, the M&E team has been tracking all program results in MicrosoftExcel worksheets.

f) Shared responsibility for M&E system: considering the scale of the GFATM funding in Cambodia and complexity of programs implemented by the Sub-Recipients, the M&E activities cannot be the sole responsibility of the PR M&E team, but must be shared among multiple stakeholders. Table 6 below summarizes data sources, responsibilities of different agencies for M&E and suggested time frames for measuring progress. Jointly, all the agencies involved in the M&E play an important role in shaping program direction.

Table 6: Role of different agencies and time frame by M&E level

Level	Data sources	Role of different agencies	Time frame
Inputs	Finance and program monitoring	1. All SRs submit quarterly/semi-annual progress reports; 2. PR, each PRTRT and CCC-SC routinely analyze and verify data; LFA	Progress within 6 months
Outputs Quantity	Finance and program monitoring	1. All SRs submit quarterly/semi-annual progress reports; 2. PR, PRTRT and CCC-SC routinely analyze and verify data; LFA validates reports	Progress within 1 year
Quality	Program monitoring using quality checklists	All SRs do internal quality assurance PR, each PRTRT and CCC-SC routinely carry out external quality verification	Progress within 1-2 years
Access And Coverage	Modules of behavioral surveillance and facility surveys	Access to prevention, care, mitigation services and coverage is included as a subset of behavioral surveillance, social impact surveys and facility surveys, and assessed when behavioral or facility surveys are used	Progress within 1-2 years
Outcomes	Behavioral surveillance and epidemiological Research	- to assess outcomes in 5-10 sites/1-2 years among specific target populations ¹² ; - contracted to independent agencies and use UNAIDS and FHI guidelines	Progress within 2-3 years
Impact	Biological surveillance and epidemiological research	-NCHADS (with MOH, WHO, UNAIDS and CDC), is responsible for national sentinel STI and HIV surveillance -CNM is responsible for national malaria surveillance -CENAT is responsible for national TB surveillance -Select studies conducted at the end of program to assess impact in specific areas/populations	Progress within 3-5 years
Overall System	Flowchart and database	PR will maintain overall flowchart and database	TBD by PR

Source: Adapted from *Monitoring & Evaluation Operations Manual for National AIDS Councils, a joint UNAIDS and World Bank publication (2002)*.

3. Principal Recipient's Role in M&E: Since the SRs implement program and the PR is their key oversight structure, together they play the central function in the M&E system and have close

¹⁰ However, the official reports to GFATM are submitted on semi-annual basis.

¹¹ SRs should refer to monitoring checklists enclosed in Appendix 6; these maybe adapted for internal use.

¹² Such as: garment factory workers, police and soldiers.

working relationship. The M&E Team of the PR office is responsible for performing the following functions:

- a. Prepare and develop M&E plans (overall as well as annual) for each PGA as a key document for PR's reporting to GFATM. PR is held accountable for their implementation by the LFA and GFATM;
- b. As a member of each of three PRTRTs, review SRs' technical quarterly, semi-annual and annual M&E plans and work plans;
- c. Compile the quantitative information received from the SRs (in collaboration with PR's Finance staff) into aggregated PR's reports (per PGA or disease component).
- d. Combine all qualitative information into narrative report and prepare all required reports (semi-annual, annual and other¹³) for the entire grant (PR's report to GFATM);
- e. Maintain a close relationship with the Planning Department of the MOH, ensuring that data from routine HIS is available to the PRTRT members;
- f. Liaise with implementing partners and other relevant institution and agencies on a variety of M&E issues (particularly UNAIDS and WHO);
- g. Supervise, monitor and evaluate the SRs in their implementation of the GFATM program grant according to the approved guidelines, ensuring that SRs internal monitoring is timely, systematic and accurate;
- h. Analyze, compile and communicate the implications from M&E data for program implementation, including modifications in geographic priorities, target groups, interventions and implementing partners;
 - i. Provide assistance to the SRs in processing any *reprogramming*, as needed (including budgetary re-allocation), following the PR financial guidelines;
 - i. Provide specific instructions and technical assistance to the SRs at critical funding junctions of the GFATM process (e.g., Phase 2 funding requests, every new Round) to facilitate and ensure compliance with GFATM technical reporting requirements;
 - j. Facilitate LFA's assessments of every report and disbursement request submitted to GFATM to ensure proper processing and timely disbursements;
 - k. Closely cooperate with GFATM appointed technical team from Geneva, on any ad hoc requests for information and their duty travel to Cambodia.
- l. On annual basis:
 - i. Review overall national program progress, with focus on geographic coverage and equity, program interventions and services to vulnerable groups;
 - ii. Strengthen the "feedback loop" by sharing the above information into the planning process towards better implementation by the SRs;
 - iii. Maintain an overall integrated M&E flowchart and database.

4. Roles of Other GFATM structures in M&E: Other structures and agencies within the GFATM system (SR, PRTRT, CCC-SC, LFA) provide additional review, technical support and policy support to the PR as presented in Table 6 above.

a. Country Coordinating Committee (CCC)¹⁴ - Role in M&E:

- Approve all M&E plans and annual work plans developed by PR, for submission to GFATM, verifying their consistency with the approved proposals;
- Receive and comment on summaries of the PR's implementation progress on periodic basis (quarterly/semi-annually) and formally approve the PR's annual report;
- Request release of follow-on funding from Geneva under existing PGAs once a satisfactory review of the PR's performance under initial funding has been completed by the CCCSC;
- Provide and facilitate communication and information flow between the programs and the partners regarding processes, requirements and performance;

¹³ Other performance assessment reports maybe prepared as per GFATM request.

¹⁴ Term of reference for the Management Processes, Structure and Membership in Cambodia. Prepared by the Sub Committee of the Country Coordinating Committee (CCCSC), Version 4, dated 19 December 2004.

- Liaise with the relevant Ministries, authorities and national programs which provide technical leadership for GFATM-supported activities and assure communication to all partners;
- Convene regular CCC meetings four times a year, and any special meetings approved by the Chairman and at least one member from each of the six constituencies.

b. CCC Sub-Committee¹⁵ - Role in M&E:

- Act as secretariat to the CCC to:
 - work closely with the PR to ensure that the CCC is kept fully informed of all activities, reports, and issues concerning the management of the GFATM funds received;
 - prepare, collect, collate and circulate for CCC meetings, all documentation including proposals, technical, financial, monitoring and evaluation reports;
 - prepare Minutes of CCC meetings;
- Keep all CCM partners informed on GFATM program development and act as the official communication and information focal point;
- Closely review and approve each grant's standard Semi-Annual and Annual reports (*Principal Recipient Disbursement Request and Progress Updates*) prepared by the PR. The PR will send to the CCCSC plans, reports and requests containing information on technical, management and financial aspects of the grants (as requested by GFATM, on a regular basis).
- Participate in key PRTRT meetings, during which all of the reports are discussed in detail.
- Liaise with the PR to prepare summaries of program progress for CCC Meetings;
- Prepare and conduct objective reviews of the PR's performance periodically and report on that performance to the CCC.

c. PR Technical Review Teams (PRTRT)¹⁶:

There are three PRTRTs that function as a technical body of experts supporting PR, in HIV/AIDS, TB and malaria. PRTRTs main tasks during project implementation are to:

- Review all Annual M&E plans and work plans prior to signing the PGAs, and on annual or bi-annual basis (as required by GFATM);
- Review all technical progress reports of each grant (per specific disease component) prepared by the PR (Semi-annual and Annual); examine any variance between the original proposal approved by GFATM and actual program implementation; understand the reasons behind it and review technical justification provided,
 - assess the ramifications of those delays for the continued implementation of the program;
- Review any interim assessment reports as needed;
- Provide clear recommendations (if any) and approval of the reports back to the PR no later than two weeks after receipt of documents for review;
- Ensure that grant activities, implemented by the SRs remain consistent with national policies and strategies; and recommend corrective measures as needed;
- Liaise, solicit, prepare and arrange meetings with SRs, as needed;
- Consider, assess and recommend to the PR specific programmatic adjustments required and/or actions to be taken, as needed;
- Participate in program monitoring visits conducted by the PR; as needed.

5. Reporting System: The existing GFATM reporting system links the financial management with technical program results and consists of seven consecutive steps (see Table 7) and Figure 4 (p. 22). The SRs submit semi-annual and annual progress reports in prescribed formats to the PR, which are compiled into aggregated PGA reports by the PR, according to specific SR and PR M&E Plans.

These reports are further reviewed and discussed by the PRTRT members during a meeting called for that purpose. Subsequently, the reports are reviewed by the CCC-SC members and if approved, finally submitted to the GFATM (through LFA). LFA reviews PR reports, (examining both financial management information and program results) and submits their recommendations directly to the

¹⁵ Ibid.

¹⁶ Ibid.

GFATM-HQ. GFATM-Geneva reviews finalized program results and LFA’s comments prior to making final decision on the next funding allocation (disbursement) request.

Table 7: The GFATM-Cambodia Reporting Sequence

Steps	Specific Action	Timeline (after end of reporting period)
1	SRs submit individual Semi-Annual Reports to PR	2 weeks
2	PR M&E team combines all SR reports into 1 grant (PR’s) report and sends it for technical review to PRTRT members	4 weeks
3	a) PR convenes PRTRT meeting to review and discuss reports; b) PRTRT <u>may</u> recommend changes to reports	5 weeks
4	PR incorporates changes (if any) and submits finalized report to CCC-SC for their review and endorsement	6 weeks
5	PR submits the report to LFA ¹⁷ (KPMG)	45 days
6	LFA (KPMG) scrutinizes reports on aspects (financial, M&E, procurement), drafts its recommendations to GF, submits report to GFATM	Not defined ¹⁸
7	GFATM reviews PR’s report and LFA’s comments; raises any other issues; approves and issues next financial disbursement	Not defined (as above)

a. Semi-Annual Reports: Semi-Annual Reports (termed the Principal Recipient’s Disbursement Request and Progress Update) are used to indicate progress against each main program objective and also function as the disbursement request mechanism. The results of program implementation progress are communicated through specific indicators, baseline (if applicable) by comparing actual results with intended results (targets) and submitted in specified format (see enclosed in Annex B). The reports also provide information on data sources, and reason for programmatic deviation (if any) in specific columns. The narrative portion of the report also describes other program results, issues, and lessons learned¹⁹ as well as planned changes in program and/or budget.

b. Annual Reports: The SRs are required to submit Annual Reports, following the format enclosed in Annex C. The Annual report, termed the Programmatic and Financial Progress Update, includes the following programmatic information: a) Aggregate program data for the previous year; b) “Success stories”, lessons learned and implications for future program design and operations; c) Information on the effectiveness of the procurement and supply management system, and d) Updated plans with the intended results for the next fiscal year and program budget broken down into similar periodic intervals. This report allows for a retrospective view of the program one year back.

6. Sub-Recipients’ Reporting Responsibilities

The SR’s M&E plan is a key legal document within the MOA, summarizing the contractual obligations of the SRs to the PR throughout the duration of the grant. SRs are responsible to deliver clear program results as defined in their M&E Plans.

¹⁷ In Cambodia, the LFA function is contracted by GFATM to KPMG.

¹⁸ This time frame is not specified by GFATM-HQ.

¹⁹ The SRs are encouraged to use the periodic reports as an opportunity to communicate any other additional information to the PR, that they may deem necessary.

- a. Each SR develops its individual M&E plan every two years, following the original proposal approved by the GFATM. Standard indicators should be used, quarterly targets (Intended Results) clearly defined, and agreed with by the PR and relevant PRTRT. Note: Not all indicators apply to all SRs.²⁰
- b. Each SR keeps an ongoing record of its achievements against the agreed indicators on quarterly basis. The monitoring functions performed by the M&E officers of all SRs include: desk monitoring, site visits and review meetings, etc. The SRs are encouraged to adapt the M&E tools (questionnaires and guides) presented in the Appendix 11, for their own specific program use to enhance monitoring.
- c. On Semi-Annual basis, each SR uses the “SR’s Disbursement Request and Progress Update” format to report its progress towards agreed targets. SRs present their draft reports during the SR’s Meeting, (about 10 days after end of the reporting period). The meetings provide an opportunity for discussing the SRs’ reports, and any program issues that have arisen. The final reports are due at the PR’s office in a standard format (signed hard copies), within two weeks from the end of each reporting period, as specified in the MoA.
- d. Quarterly Meetings; during the 1st year of implementing GF grants, Cambodian PR had to report on Quarterly basis, the SR’s meetings were also held on Quarterly basis. While the primary focus of these meetings was/is for the SRs to present their reports, these meetings also provided an excellent forum for information sharing among SRs and continued Quarterly monitoring of program progress by the PR.
After Semi-Annual reporting was introduced in January 2005), it was decided to keep the Quarterly meetings. It is understood, however, that official reports are required only twice (in January and July), while the other two Quarterly meetings (held in April and October) have a participatory monitoring function.
- e. The first quarter for the first year begins on the first day of implementation at the SR level. PR verifies the SR-reported data on a quarterly basis. The review will comprise of deskwork as well as site visits to observe program activities and interview both the field staff and counterparts.
- g. The SRs are expected to furnish any additional reasonable information in support of their reports to the PR (and LFA) for final consolidation and verification;
- h. The SRs are required to collaborate with the LFA’s questions that maybe raised about their reports, and passed on by the PR, aimed to facilitate the process of verification and validation of the PR reports prior to the official report submission to GFATM - Geneva.

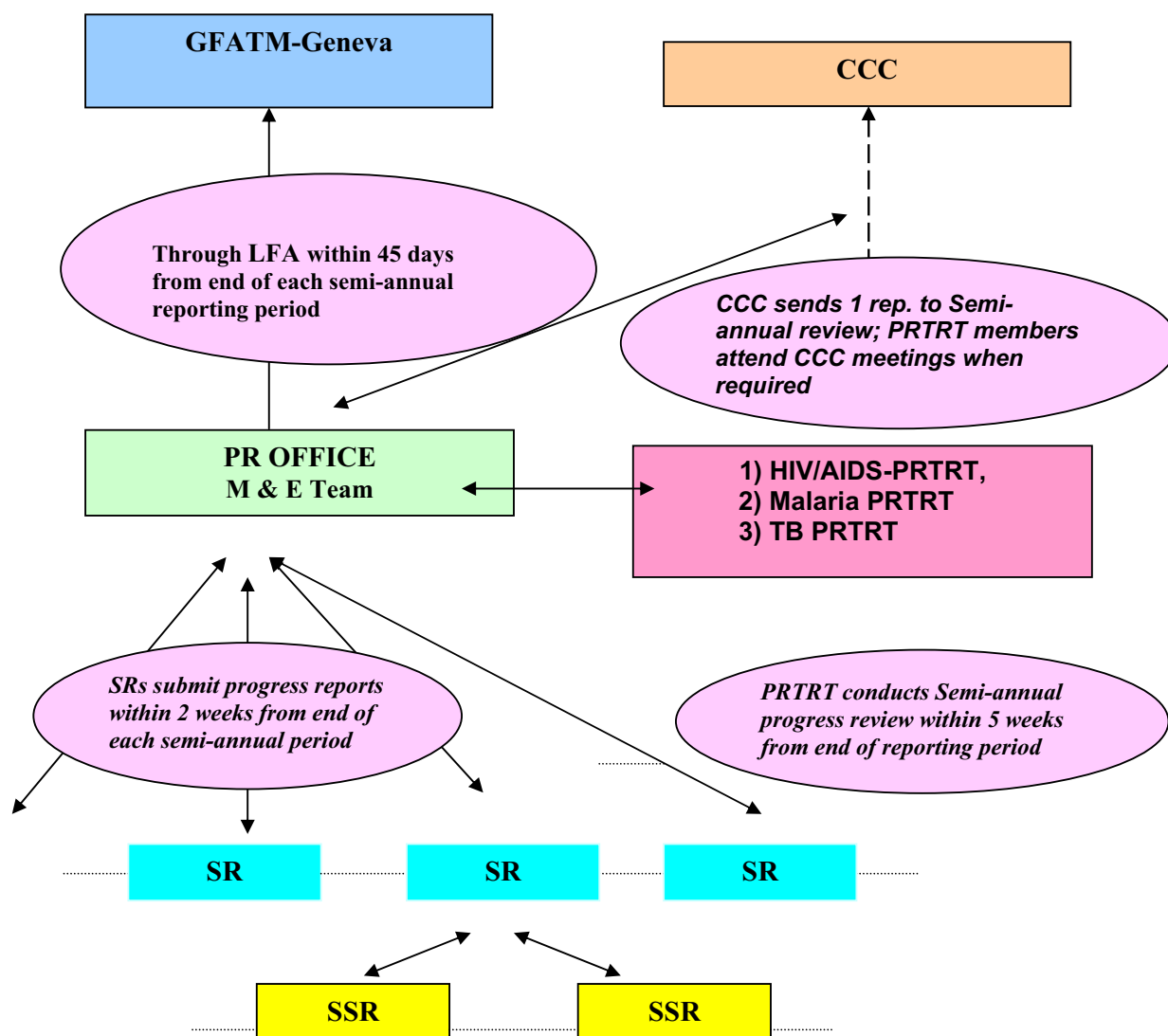
7. Principal Recipient’s Reporting Responsibilities

The PR’s M&E plan (synthesis of select elements from the SRs’ M&E Plans) is a key legal document within the PGA, summarizing the contractual obligations of PR to the GFATM throughout the duration of the grant.

- a. The PR reviews, analyzes and verifies all semi-annual reports from the individual SRs. Any questions raised and issues requiring clarification are resolved promptly by contacting the SRs directly, either via email, phone or face-to-face meeting, as needed.
- b. The PR aggregates the individual SRs’ results into one joint PR report every Semi-Annual period, using the Disbursement Request and Progress Update form, or PR’s M&E Plan (Annex A1 entitled: Intended Program Results and Budget) and submits it to the PRTRT for further feedback and verification.

²⁰ Refer to detailed instructions on how to develop M&E Plan and Workplan in Chapter D.

Figure 4: Reporting system for GFATM-supported grants



Note: GFATM= The Global Fund to Fight AIDS, Tuberculosis and Malaria, CCC=Cambodian Coordination Committee, LFA=Local Fund Agency, PR=Principal Recipient, SR=Sub-Recipient, PRTRT= Principal Recipient Technical Review Team, M&E=Monitoring & Evaluation, SSR=Sub-Sub-Recipient

- c. The PRTRT meetings are convened by the PRTRT Chairman of each disease component, (1 for HIV/AIDS, TB and Malaria)²¹. The purpose of the meeting is to hold a technical review and discussion of the semi-annual reports prepared by the PR. Any critical feedback and recommendations from the panel are subsequently incorporated by the PR and thus revised, reports are submitted to the CCC-SC.
- d. CCC's sub-committee meets every month (2nd Friday of the month) to review M&E reports, identify lessons learned, make strategic recommendations and decisions, and assist PR in problem solving pertaining to overall GFATM program management issues.
- e. During the semi-annual data-verification and program site visits (of individual SRs), the PR M&E team observes select program activities in various geographical locations (nationwide), by select SRs and the functioning of the SR's individual M&E systems to

²¹ The Health Systems Strengthening component does not have a separate PRTRT, but similar function in this case is performed by the CCC-SC.

track their results. PR M&E team uses standard M&E tools and quality-assurance checklists developed and adapted by the PR M&E team.²².

- f. PR's M&E team uses a combination of the following five monitoring methods:
- *Desk monitoring* -- to review regular program updates and determine the compliance of SR with MOA, based on the reports submitted by the SRs, by comparing the IRs with the reported results;
 - *Interviews with Program Managers and M&E officers* -- to find out about decision-making procedures, quality assurance and specific program operations systems put in place by the SRs, usually done at the beginning of each grant as part of M&E Assessment;
 - *Program Site visit(s)* – to see program activities, meet with SRs' field staff, review service records, charts, assure standards are being met; to examine how field-based data collection procedures feed into SR's reporting system. Examples of other field visit activities include: review of service records, physical stocks, facilities together with supporting documentation. Issues observed in the field are verified against reports and discussed in the quarterly meetings and followed-up further, as needed.
 - i. *Activity Assessment Checklists* – to assess appropriateness and overall quality of individual program activities, to give insight into areas that have remained stable or changed since last site visit;
 - *Review Meetings*- with members of the PRTRT on semi-Annual basis and representatives of the CCC-SC on monthly basis, as required.
 - *Quarterly SRs' meetings* – organized by the PR over 2-day period, with sessions divided by program sub-components (AIDS clinical, AIDS prevention, etc.), provides an opportunity for SRs to present their programmatic updates and discuss any implementation issues as needed. Issues brought up at this forum are further followed up in the program site visits.

8. Frequently asked GF M&E questions:

1. *Cumulative* (PR) versus *non-cumulative figures* (SR) – which should be reported to GFATM? This GF guidance has changed several times and created some confusion among the SRs.

PR Response: Indeed, the GFATM changed its position on this issue a couple times already. The current guidance requests that most indicators are reported on cumulative basis, and adding the baseline figure to it (if known).

- a. There are only a few indicators that must remain as *non-cumulative figures*, reflecting the situation where the same beneficiaries may access the same services multiple times during the reporting period (i.e., PLHAs receiving palliative care treatment, etc.) and cumulating them could create a significant double-counting of individuals. These indicators are clearly marked with a final phrase: “during this reporting period”.

2. What baselines should be used?

PR Response: a) Ideally, there would have been a nationwide baseline survey providing such information; use that if available. b) If there is no recent survey and this is a new activity, it is reasonable to start with a zero baseline. c) If this program activity has began under another funding source, *the accomplishment to-date* may be used as a baseline, but clearly indicate where it comes from (accomplished with USAID funding, etc.) in the “comments” column.

3. How should we report on an activity that involves civil works, which maybe in progress for a long time, but is not totally completed yet. How can partial progress be indicated?

²² Examples of 'program areas requiring quality-assurance checklists' and sample M&E checklist for assessment of specific program activities are presented in Appendices 6 and 7, respectively.

PR Response: Until the building, clinic, or other facility is providing services, please report on it “0” and provide appropriate qualitative information in the comments section.

3. Several larger SRs may receive funding from multiple donors and sometimes the activity reported to the GFATM is funded partially by other donors. How should these be reported?

PR Response; there are two cases in this situation:

a) GFATM ideally prefers to receive the results accomplished exclusively with GFATM funding. Many SRs for whom GFATM funding provides an opportunity to scale-up an existing activity, simply program it into another geographical area (like an OD or a province) and report it as such. That is clearly the most preferred approach, as the SR would use the existing reporting system and simply extract specific information from the larger database (such as the case with NCHADS under Round 4).

b) GFATM recognizes the reality of multiple international donor funding, particularly for large-scale national programs, and accepts the fact that in certain cases it is very difficult to “tease out” the results that have been contributed to by other funding from the GFATM’s (such as PSI’s national condom sales). Thus, GFATM may accept the national figures, as long as it is clearly stated in the planning process and incorporated into IRs (in the M&E plan). It is very important to state that results have been achieved by a combination of GFATM and “other funding sources” in the report (in the comment column). In that case, GFATM stresses that the contextual information should be provided.

4. Sometimes the activities are delayed and the Intended Results that were planned for the 1st reporting period are accomplished in the 2nd reporting period. How should that be reported?

PR Response: If results are delayed to the next Quarter, provide an explanation in the report for the 1st quarter and clearly report on them in following Quarter (when they were actually achieved). Special situation should be discussed briefly in the comments section.

5. The GFATM report format limits information and doesn’t allow for full presentation of project achievement by individual SRs. How can this be addressed?

PR Response: Footnotes and comments should be used to provide PR with any additional information needed to present the activities as fully as possible. Additional details should be provided to state specific case and enable both PR and LFA staff to clearly understand the situation and convey it properly to GFATM.

E. M&E Documentation Required for GFATM Grants

1. Summary of M&E Documents

- a) **Required Before Signing PGA/MoA for planning purposes:** The PR is required to submit a set of documents to the GFATM as part of the PGA. Similar set of corresponding documents is required of the SRs, to be submitted to the PR as part of their MoA with the PR. These documents are summarized in Table 8 below:

Table 8: List of M&E Documents Required for PGA and MoA

Annex Number	Document's Title	Content	Timeframe covered
a. Documents Required Before Signing PGA and MoA (Years 1-2)			
Annex A1	SR's Intended Program Results and Budget	M&E Plan	2 years (Yr 1 and 2)
Annex A2	SR's Detailed Annual Program Workplan	Workplan	1 year
Annex D1	SR's M&E Assessment Questionnaire	M&E capacity	n/a
b. Documents Required for Phase 2 Request for funding (Years 3-5)			
Annex A1	SR's Intended Program Results and Budget	M&E Plan	3 years (Yr 3-5)
Annex A2	SR's Detailed Annual Program Workplan	Workplan	1 year
c. Reports Required for On-Going Funding (reporting formats)			
Annex B1	SR's Disbursement Request and Progress Update	Semi-Annual Report	6 months (Jan-June, July-Dec)
Annex C1	SR's Annual Progress Report	Annual Report	1 year (Jan-Dec)

Sample Templates for the above documents are provided as Annexes A-D. Instructions and tips on how to complete each one of these formats are provided later in this section.

- b) **Reporting Formats on Performance (after PGA/MoA signed):** Beginning in January 2006, PR and SRs are required to submit semi-annual and annual reports according to the newly revised format for all existing rounds (Annex A1), for the on-going program progress. They provide information on program progress, financial spending and financial disbursement requests. On the basis of these forms GFATM releases the next financial installment.

The SR's M&E plan is a key legal document within the MOA, summarizing the contractual obligations of SR to the PR throughout the grant's duration.
similarly,
The PR's M&E plan (synthesis of select elements from the SRs' M&E Plans) is a key legal document within the PGA, summarizing the contractual obligations of PR to the GFATM throughout duration of the grant.

2. How to complete the GFATM M&E Plan Format (Annex A1)?

The Global Fund introduced the current version of the M&E plan format in January 2006. In Cambodia, this applied first to the upcoming Round 5 grants. Since July 2006, however, all SRs from all existing rounds are required to follow this format at the next planning cycle.

Note: For the most part, all elements of M&E framework (program goals, objectives, indicators and targets) have been largely defined in the approved proposal. The SRs and PR are obliged to follow those unless there are compelling reasons for changes (i.e., change in a national policy).

The following steps are proposed to facilitate this process:

- a. Based on the proposal, enter clear Goals and Objectives and complete the Impact Indicators Section. These describe the long-term plans for the program.
- b. Next, **define the services provided** to a population: these services are defined in terms of standard service delivery areas (SDAs) in these guidelines, based on the GFATM toolkit. The package of services needs to be specified carefully by target population group.
- c. Per each SDA, select specific indicators to monitor progress towards the program's objectives. One or two indicators with specified targets per main program objective per period are usually sufficient. Based on the GFATM toolkit, it is important to remember:
 - i. To extract indicators from existing M&E plans, in line with national strategies,
 - ii. Select simple indicators with existing tools to collect them.
 - iii. Ensure a good balance between periodic surveys and routine health statistics data. Surveys can complement information gaps in HMIS, in particular for outcome and impact indicators. However, surveys generally do not provide results as regularly as routine systems that report on semi-annual disbursements.
 - iv. Set baselines for each main indicator.
 - v. The majority of indicators will require results to be cumulative over each phase of funding, excluding baselines.
 - a. In a few cases,²³ results may be non-cumulative; these indicators will have a phrase "in this reporting period" in the end. These cases must be clearly discussed and agreed with the PR and GFATM.
 - vi. If results are in percentages, also provide numerators and denominators.
 - vii. Avoid double-counting the same individual within one program/ service area during each reporting period. However, it is acceptable to count the same person in multiple program / service areas (for example ARV and Palliative Care).
 - viii. Training refers to either new training or retraining of individuals and assumes that it is conducted according to national or international standards when these exist.
 - ix. Baselines are determined and targets are set for successive routine measurement over a five year period.
 - x. As much as possible, the timing of the measurement of these regular targets should be aligned with existing data collection and reporting systems.
- d. The level of Intended Results (Targets) must be set according to approved proposals, and divided (whenever possible) into quarterly and semi-annual figures. Most targets are expressed in a cumulative manner, incorporating the proposed level of achievement from one quarter to the next, except for those few special cases where such accumulation would produce significant double counting, such as "PLHAs accessing palliative care services".

SRs' M&E plans provide more information for monitoring purposes, however the PR's joint M&E plans (one per each PGA), extracts only key indicators for reporting to GFATM. SRs are encouraged to collect all information necessary to appropriately manage their programs; and to use their existing M&E systems to collect relevant data.

²³ Example: Number of people accessing palliative care.

- e. Existing baseline data may be used by SRs if the following three conditions are met:
- i. the surveys are recent (within the past 1-2 years);
 - ii. the geographical scope of the surveys corresponds to the area in which the program of work will be implemented; and
 - iii. methods used for data collection are adequate. If baseline data are unavailable for certain indicators, SR should indicate how this data will be collected in its M&E plan. Data from the 1st year of project can serve as baseline for the following years.

NOTE: It is essential that the **process of developing an SR's individual M&E plan is conducted in consultation with the finance and procurement units** to ensure that the program plans made are as realistic as possible, taking into account any internal budgetary and/or procurement constraints and realities. Furthermore, all the attachments (M&E plan, budget, workplan, procurement plan) should be consistent with each other.

3. How to complete GFATM Workplan Format (Annex A2)?

Under Round 1 and 2, SRs were not required to submit detailed workplans to the PR. In practice, this made PR monitoring of SRs very difficult. Several SRs demonstrated weaknesses in planning their work towards reaching results. Consequently, beginning with Round 4 GFATM, all PRs and SRs are required to submit a detailed annual activity workplan, closely linked to the M&E plan.

While many SRs have extensive experience in program management and implementation and in workplan design, some SRs need assistance with this task. The following steps may help this process:

- a. First develop a project M&E plan and enter the same project goals and objectives into the workplan format.
- b. Select and enter output and outcome indicators for every SDA and program objective, as appropriate.
- c. Identify major activities necessary to achieve the above objectives. These must be very specific and should have assigned timeframes, geographical sites and required resources (human, material, financial, and any partners etc). Activities should follow a logical sequence towards reaching program objectives. Please indicate the most appropriate time-frame for their execution and indicate with "x" in the appropriate Quarterly column.
- d. Complete the column of the "activity output". Specify an expected immediate result of each proposed activity in the workplan; for example: "X" number of providers trained, "Y" number of health facilities rehabilitated, etc, being as concrete as possible.

NOTE: Please ensure that all outputs in your workplan are consistent with the detailed budget and procurement plans submitted to the PR.

4. How to complete SRs' M&E Semi-Annual Report Format (Annex B1)?

The new reporting format was introduced by the GFATM in January 2006, for the Round 5 grants. However, as of July 2006, this format is required for all existing SRs under all existing Rounds.

Since the Semi-Annual reports provide the basis for financial disbursements, it is imperative that they are completed appropriately. The GFATM format for the Semi-Annual Report is called: "On-going Progress Update and Disbursement Request" and consists of two parts: (1) the progress update (M&E - specific) on the program and (2) the disbursement request (the financial portion). The time-frame covered is always cumulative, from the beginning of the grant through the end of the last reporting period.

The form should also be submitted to the Global Fund for every period in which a progress update is required, requesting disbursement, but also even in case where disbursement is not requested. Detailed instructions for the completion of the format are enclosed in Annex A1, together with the actual format. Below are some additional tips to facilitate completing these formats:

a. The Administrative Portion of the format:

1. General Grant Information: Please complete the official grant information in the top block; make sure to coordinate with your finance and admin team.
2. Progress Update Period: indicate the last 6 months for which this report provides an update;
3. Disbursement Request Period: this indicates the next 6-month period plus a 3-month buffer time for which the next tranche of funds is requested (i.e., a total of 9 months);

b. Section 1A: Program Progress

1. Program Objectives: Please copy them from your M&E plan
2. Impact/Outcome Indicators: As above, copy the same descriptions from the M&E plan;
 - Targets should also be exactly as specified in the M&E plan;
 - Results for these should be completed as available; if results are not available in this reporting period, they should be left blank.
3. SDAs, Indicators and Targets: As above, please copy them from M&E plan;
 - All indicators should be listed, even if sometimes they don't have specific results planned for this reporting period;
 - Targets as specified in the M&E plan
 - Results should be completed as achieved;
 - i. In most cases, the results should be cumulative (from the start of the program to the end of the last period covered by the Progress Update)
 - ii. In a few select cases, the results can be non-cumulative; i.e., covering only the last reporting period., only for those indicators previously agreed with the PR.
 - iii. If results are significantly different from the anticipated targets, the SR must provide reasons for the deviation (both if under- or over-achieved).
4. Overall Evaluation of Performance; in view of the results presented in the report, the NPs/SRs should provide a brief paragraph describing self-assessment of their own program performance, as compared to the expectations and commitments made in the MOA; this should be completed by the management of the organization;
5. Planned Changes in Program; the NPs/SRs should describe any planned changes in programmatic activities from the MOA;
 - this is a chance to discuss any anticipated re-programming or other program adjustments based on to-date performance and spending;
6. Other Program Results, Success Stories, Issues or Lessons Learned; this section provides an opportunity for the NPs/SRs to provide additional qualitative information that they may want to provide to the PR pertaining to the last reporting period.
 - This will provide "contextual information" later for the Phase 2 funding request.

c. Deadlines for submission of Semi-Annual Reports

1. Official Reports should be submitted to the PR office by 15 January and 15 July, respectively (SA for January-June is due on 15th July; SA for July-Dec is due on 15th January) both as hard and soft copies.
2. Prior to that, the SRs/NPs present their draft reports in the Quarterly SRs' meetings (between 12-15th of January and July, respectively).

5. How to complete SRs' Annual Report Format (Annex C1)

Annual Report formats have been changed from the Word file to the format similar to Annex B1 (semi-annual report). Since the results are exactly the same (cumulative from the beginning) all instructions for the Semi-Annual reports apply. The only difference pertains to the narrative portion, which in this case covers the last calendar year. Recently GF began to advise that the Annual Report undergoes a public review by the stakeholders in a meeting/workshop setting and that the report from that activity is submitted to GFATM. As the guidance is further developed and becomes clearer, it will be communicated to the SRs.

APPENDICES 1 TO 11:

Proposed Indicators:

- 1. Selected Programmatic Indicators for HIV/AIDS**
- 2. Selected HIV/AIDS Impact and Outcome Indicators**
- 3. Selected Programmatic Indicators for Tuberculosis**
- 4. Selected Impact and Outcome Indicators for Tuberculosis**
- 5. Selected Programmatic Indicators for Malaria**
- 6. Examples of appropriate Roll Back Malaria Impact and Outcome Indicators**
- 7. Selected Issues related to the interpretation of available data on malaria monitoring**
- 8. Selected Indicators for Health systems Strengthening**
- 9. Recommended Data Collection Tools (From 1st Edition)**
- 10. Phase 2 Funding Guidance from GFATM**
- 11. 7 Monitoring Tools adapted by PR (activity-specific)**

Appendix 1: Selected Programmatic Indicators for HIV/AIDS

Most of these indicators can be collected through monthly health statistics and annual program review. However, some may be best collected through surveys, such as school based surveys. Generic indicators measuring **number of people trained** and **service points supported** can be used for service delivery areas where these are not specifically defined.

	Service Delivery Area	Output Indicators	Examples of Outcome Indicators
Prevention	Behavioral Change Communication – Mass media	<ul style="list-style-type: none"> HIV/AIDS information, education, communication (IEC) material broadcasted or distributed (radio & television programs/ newspapers) (number) 	<ul style="list-style-type: none"> People (by age and sex) who had sex with more than one partner in the last year(percentage) (Multiple Partners) (can be applied for MARP or population sub-groups)
	Behavioral change Communication- Community outreach	<ul style="list-style-type: none"> Young people reached by life-based HIV/AIDS education in schools (number and percentage) Schools with at least one teacher who has been trained in participatory life skills-based HIV/AIDS education and who taught it during the last academic year (number and percentage) UNGASS Young people reached by HIV/AIDS education in out-of-school settings (number and percentage) Young people 15-24 who both correctly identify ways of preventing the sexual transmission of HIV and reject major misconceptions about HIV transmission(percentage) UNAGSS Individuals (i.e., peer educators) trained (specify if trained for specific MARP sub-groups) (number) People reached by BCC prevention outreach and peer education (number) UNGASS (can be applied for MARP or population sub-groups) IDUs reached by HIV/AIDS prevention programs* (number and percentage) MSM reached by HIV/AIDS prevention programs* (number and percentage) Sex workers & clients reached by HIV/AIDS prevention programs* (number and percentage) 	<ul style="list-style-type: none"> IDU who have adopted behaviors that reduce transmission of HIV (percentage) UNGASS
	Condom distribution	<ul style="list-style-type: none"> Condoms sold through the private sector (number) Condoms distributed for free (number) Retail outlets and service delivery points with condoms in stock (number)(can specify between public and private) Key intervention areas covered with targeted condom outlets (areas with concentration of MARP) (number) 	<ul style="list-style-type: none"> Young people reporting the use of condoms the last time they had sex with a non-regular sexual Young people (15-24) reporting consistent use of condom with non-regular sexual partners in the last year (percentage)
	Testing and Counseling	<ul style="list-style-type: none"> People who receive HIV testing and counseling (including provision of test result)(number) Service outlets providing counseling and testing according to national standards (number) MARP who received HIV testing in the last 12 months and who know the results (number and percentage) UNGASS 	

		<ul style="list-style-type: none"> • PLWHA tested positive who have received counseling for positive prevention (number and %) 	
	PMTCT	<ul style="list-style-type: none"> • Health facilities providing the minimum package of PMTCT services(number and percentage) • HIV-positive pregnant women receiving a complete course of antiretroviral prophylaxis to reduce the risk of MTCT (number, %) UNGASS • HIV-exposed infants seen within 2 months of birth for check-up (number and percentage) • HIV-exposed infants and children receiving Cotrimoxazole prophylaxis treatment (number, %) 	
	Post-exposure prophylaxis	<ul style="list-style-type: none"> • People receiving post-exposure prophylaxis (number) 	
	STI diagnosis and treatment	<ul style="list-style-type: none"> • Patients with STIs at health care facilities who are appropriately diagnosed, treated and counseled (can be applied for MARP or population sub-groups) (number and percentage) 	
	Blood safety and universal precaution	<ul style="list-style-type: none"> • Districts with access to donor recruitment and blood transfusion (number and percentage) • Transfused blood units screened for HIV according to national guidelines (number, %) UNGASS 	
Treatment	Antiretroviral treatment and monitoring	<ul style="list-style-type: none"> • People with advance HIV infection receiving antiretroviral combination therapy (number and percentage) UNGASS • Health facilities that have the capacity and conditions to provide advanced HIV/AIDS clinical care and psychosocial support services, including providing and monitoring ARV (number and percentage) 	<ul style="list-style-type: none"> • Adults and children who are still on treatment after 6 months, 1,2,3,5 year from the initiation of treatment (percentage)
	Prophylaxis and treatment for opportun. infections	<ul style="list-style-type: none"> • PLHA receiving diagnosis and treatment for opportunistic infections (number and percentage) 	
Care and Support	Care and support for the chronically ill	<ul style="list-style-type: none"> • Adults aged 18-59 years who have been chronically ill for 3 or more months in the past 12 months due to HIV/AIDS, whose households received basic external support in caring for chronically ill adults (number and %) • Community organizations that received support to assist PLWHA (number) 	
	Support for orphans and vulnerable children	<ul style="list-style-type: none"> • Orphans and other children made vulnerable by HIV/AIDS (OVC) whose households received free basic external support in caring for the child (number and percentage) UNGASS • Community organizations that received support to assist OVC (number) 	<ul style="list-style-type: none"> • Orphaned children compared to non-orphaned children (10-14) who are currently attending school (percentage)

	Service Delivery Area	Output Indicators	Examples of Outcome Indicators
TB/HIV collaborative activities	Intensified case-finding among PLWAH	<ul style="list-style-type: none"> PLWHA receiving HIV testing and counseling or HIV treatment and care services who were screened for TB symptoms** (number and %) 	
	Prevention of TB disease in PLWHA	<ul style="list-style-type: none"> Newly diagnosed HIV positive clients given treatment for latent TB infection (number and %) 	
	Prevention of HIV in TB patients	<ul style="list-style-type: none"> Registered TB patients who receive HIV counseling and testing*** (number and %) 	
	Prevention of opportunistic infections in PLWHA with TB	<ul style="list-style-type: none"> HIV positive TB patients who receive co-trimoxazole preventive therapy (number and %) 	
	HIV care and support for HIV-positive TB patients	<ul style="list-style-type: none"> HIV-positive TB patients referred to HIV care and support services during TB treatment (number and percentage) 	
	Provision of antiretroviral treatment for TB patients during TB treatment	<ul style="list-style-type: none"> HIV positive registered TB patients who have begun or are continuing ARV, during or at end of TB treatment (number and percentage) 	

Supportive environment	Policy development including workplace policy	<ul style="list-style-type: none"> Large enterprises / companies that have HIV/AIDS workplace policies and programs (number and percentage) UNGASS Local organizations provided with technical assistance for HIV-related policy development (number) 	
	Strengthening of civil society and institutional capacity building	<ul style="list-style-type: none"> NGOs providing HIV/AIDS prevention, treatment, care and support services according to national guidelines(number) NGOs actively involved in planning, budgeting, monitoring and evaluation of HIV and HIV/TB activities (number) National Composite Policy Index (UNGASS) 	
	Stigma reduction in all settings	<ul style="list-style-type: none"> Policy madders attending sensitization workshops on HIV/AIDS and HIV/TB (number) 	

* For each of these sub-groups, the prevention package to apply must be clearly defined: outreach and peer education, exposure to targeted mass media, STI screening and / or treatment, HIV counseling and testing, substitution therapy and safer injection practice for IDUs, or others

** For this indicator, the number of new cases of TB diagnosed should also be reported (TB/HIV 2)

*** For this indicator, the number of registered TB patients who were found to be HIV positive should also be reported (TB/HIV 5)

Appendix 2: Selected HIV/AIDS Impact and Outcome Indicators

	Impact Indicators	Reporting schedule	Measurement	Reference
Impact Indicators	<ul style="list-style-type: none"> Young women and men aged 15-24 who are HIV infected (percentage) (HIV prevalence) (applicable to most-at-risk populations in concentrated/lower epidemics) 	Annual	HIV sentinel surveillance and population-based survey	UNGASS
	<ul style="list-style-type: none"> Adults aged 15-49 who are HIV infected (percentage) 	Annual	HIV sentinel surveillance and population-based survey	WHO/UNAIDS
	<ul style="list-style-type: none"> Adults and children with HIV still alive 12 months after initiation of antiretroviral therapy (extend to 2,3,5 years as program matures) (percentage) (Reduced mortality) 	Annual	Program monitoring	UNGASS
	<ul style="list-style-type: none"> Infants born to HIV infected mothers who are HIV infected (percentage) (Reduced mother to child HIV transmission) 	Annual	Estimate based on program coverage	UNGASS
	<ul style="list-style-type: none"> HIV seroprevalence among all newly registered TB patients (percentage) 	Annual	Routine HIV testing, sentinel surveillance, periodic special survey	WHO TB/HIV

	Impact Indicators	Reporting schedule	Measurement	Reference
Outcome Indicators*	<ul style="list-style-type: none"> Multiple partners : Young people aged 15-24 who had sex with more than one partner in the last year(percentage) (applicable for MARP or population subgroups) 	Every 2-3 years	Population-based survey	WHO/UNAIDS
	<ul style="list-style-type: none"> Primary abstinence : Young people (15-19) who never had sex in the last year of those who ever had sex (%) 	Every 2-3 years	Population-based survey	WHO/UNAIDS
	<ul style="list-style-type: none"> Secondary abstinence : Young people (15-24) who never had sex in the last year of those who ever had sex (%) 	Every 2-3 years	Population-based survey	WHO/UNAIDS
	<ul style="list-style-type: none"> Consistent condom use: Young people (15-24) reporting the consistent use of a condom with non-regular sexual partners in the last year (%) 	Every 2-3 years	Population-based survey	WHO/UNAIDS
	<ul style="list-style-type: none"> Young women and men who had sex before the age of 15 (age can be adapted- see guidelines) (percentage) 	Every 2-3 years	Population-based survey	UNGASS
	<ul style="list-style-type: none"> Adults and children who are still on treatment after 6 months, 1,2,3,5 years form the initiation of treatment (%) 	Annual	Program monitoring	WHO/UNAIDS
	<ul style="list-style-type: none"> Injecting drug users who have adopted 	Every 2-3	Special survey	UNGASS

behaviors that reduce transmission of HIV. (i.e. who both avoid sharing non sterile injecting equipment and use condoms,) in the last 12 months (for countries where injecting drug use is an established mode of transmission)(percentage)	years		
<ul style="list-style-type: none"> Orphaned children compared to non-orphaned children aged 10-14 who are currently attending school (%) 	Every 2-3 years	Population-based survey	UNAIDS/UNICEF
<ul style="list-style-type: none"> Young people (15-24) reporting the use of a condom the last time they had sex with a non-regular sexual partner (%) 	Every 2-3 years	Population-based survey	Adapted form UNAIDS Youth Guide, 2004
<ul style="list-style-type: none"> People expressing accepting attitudes towards PLWHA, of all people surveyed aged 15-49 (percentage) 	Every 2-3 years	Population-based survey	WHO/UNAIDS
<ul style="list-style-type: none"> Female sex workers reporting the use of a condom with every client in the last month 	Every 2-3 years	Special survey	UNGASS
<ul style="list-style-type: none"> Men who have had sex with a female sex worker in the last year (percentage) 	Every 2-3 years	Special survey	UNGASS
<ul style="list-style-type: none"> Men reporting the use of condom the last time they had anal sex with a male partner in the last 6 months (%) 	Every 2-3 years	Special survey	UNGASS

* HIV sexual behavior indicators should be analyzed together to assess behavior change (as important interactions can occur). Non-regular sexual partners: cohabitation may not be a good measure of non-regular partners in youth.

Appendix 3: Selected Programmatic Indicators for Tuberculosis

	Service Delivery Area	Output Indicators	Examples of Outcome Indicators
Tuberculosis	Identification of infectious cases	<ul style="list-style-type: none"> The numerator(number) of the outcome indicator can be used for routine reporting (number of new smear-positive cases detected) 	<ul style="list-style-type: none"> New smear-positive TB cases detected(diagnosed and reported to national health authority), among new smear-positive TB cases estimated to occur countrywide each year (number and percentage)
	Timely detection and quality treatment of cases	<ul style="list-style-type: none"> New smear-positive TB cases that successfully complete treatment among the new smear-positive TB cases registered during a specified time period(number and percentage) Population covered by ODTs (number, %) 	<ul style="list-style-type: none"> New smear-positive TB cases that successfully complete treatment among the new smear-positive TB cases registered during a specified time period(number and %)
	MDR-TB	<ul style="list-style-type: none"> TB cases enrolled to begin second line treatment, among TB cases identified as MDR-TB cases during a specified time period (number and percentage) TB cases that receive drug susceptibility testing, among TB cases suspected of MDR-TB during a specified time period (number and %) 	
	PPM (Public Private Mix)	<ul style="list-style-type: none"> Sputum smear-positive TB cases that originated from non-National Program Tuberculosis provider, among all TB cases diagnosed during a specified period of time (number and %) in the intervention areas Reporting units (such as districts) that have implemented PPM strategy (number and percentage) Health units (clinics, hospitals, institutions etc.) outside the national TB program (NTP) that are participating in some aspect of ODTs implementation (referral, diagnosis, treatment, reporting of TB cases), among all non-NTP health units (number and %) in the intervention areas 	

	Service Delivery Area	Output Indicators	Examples of Outcome Indicators
TB/HIV Collaborative	Intensified case-finding among PLWHA	<ul style="list-style-type: none"> PLWHA receiving HIV testing and counseling or HIV treatment and care services who were screened for TB symptoms (number and percentage)* 	
	Prevention of TB disease in PLWHA	<ul style="list-style-type: none"> Newly diagnosed HIV positive clients given treatment for latent TB infection (number and percentage) 	
	Prevention of HIV in TB patients	<ul style="list-style-type: none"> Registered TB patients who receive HIV counseling and testing (number and percentage)** (TB/HIV 4) 	

	Prevention of opportunistic infections in PLWHA with TB	<ul style="list-style-type: none"> HIV positive TB patients who receive Cotrimoxazole preventive therapy (number and percentage) 	
	HIV care and support for HIV positive TB patients	<ul style="list-style-type: none"> HIV-positive TB patients referred to HIV care and support services during TB treatment (number and %) 	
	Provision of antiretroviral treatment for TB patients during TB treatment	<ul style="list-style-type: none"> HIV positive registered TB patients who have begun, or are continuing, ARV during or at the end of TB treatment (number and percentage) 	

Supportive Environment	Laboratory	<ul style="list-style-type: none"> TB microscopy units that cover a population size within the recommended range, among all TB microscopy units (number and percentage) TB microscopy units for which slide re-checking results are available for a specified time period, among all TB microscopy units (number and %) 	
	Human resources	<ul style="list-style-type: none"> TB microscopy units with at least one laboratory technician trained in staining acid-fast bacilli (AFB) in the past 3 years, among all TB microscopy units (number and %) TB treatment facilities with at least one health care professional trained in TB case detection and treatment within the past 3 years, among all TB treatment facilities (number and percentage) Facilities with adequate staffing per level to enable implementation of DOTS (number and %) 	
	Community TB care (CTBC)	<ul style="list-style-type: none"> Reporting units implementing CTBC activities, among all reporting units (number and %) 	<ul style="list-style-type: none"> Treatment success rate for new smear positive cases in areas implementing CTBC (relative to success rates elsewhere)

* The number of new cases of TB diagnosed should also be reported (TB/HIV2)

** For this indicator, the number of registered TB patients who were found to be HIV positive should also be reported (TB/HIV 5)

Appendix 4: Selected TB Impact and Outcome Indicators

	Indicator	Target	Measurement	Reference
Impact indicators	TB prevalence rate. Estimated number of all active TB cases per 100,000 population at a given point in time	Halving of prevalence by 2015, relative to 1990	Measured by special surveys	JAMA article, WHO Global TB Control especially page 54)
	TB incidence rate. Estimated number of TB cases occurring per year, per 100,000 population (can be used for specific population sub-groups, e.g. annual incidence of TB in the prison system)		Measured by special surveys	JAMA article, WHO Global TB Control(especially page 54)
	TB mortality rate. Estimated number of deaths due to TB (all cases) per year, per 100,000 population	Halving of mortality by 2015, relative to 1990	Measured by special surveys	JAMA article, WHO Global TB Control(especially page 54)

	Indicator	Target	Measurement	Reference
Impact indicators	Case detection. New smear-positive TB cases detected (diagnosed and reported to the national health authority), among the new smear-positive TB cases estimated to occur countrywide each year (number and percentage)(TB1)	70% under DOTS, nationally by 2005	Annually and nationally via routine health information system PLUS estimates produced by WHO	WHO Global TB Control and Compendium of Indicators
	Treatment success rate. New smear positive TB cases that successfully complete their treatment among the new smear-positive TB cases registered during a specified time period. Successful completion entails clinical success with or without bacteriological evidence of cure (number and percentage)(TB3)	85% under DOTS nationally for the cohort of new smear-positive patients by 2005	Quarterly, routine health information system. Evaluated by cohort, ideally for all types of new and re-treatment cases	Compendium of Indicators
	Smear conversion rate. New smear positive TB cases that convert to smear-negative at the end of the initial phase of treatment, among new smear-positive TB cases registered during a specific time period (can also apply to any treatment cohort of cases) (number and percentage)	No international target. As a proxy (but not a replacement for) the treatment success indicator, above, the 85% level is nevertheless a general target	Quarterly, routine health information system	Compendium of Indicators

Appendix 5: Selected Programmatic Indicators for Malaria

	Service Delivery Area	Output Indicators	Examples of Outcome/ Impact Indicators
Prevention	Insecticide-treated nets (ITNs)	<ul style="list-style-type: none"> ITNs (including re-treatment kits) distributed to people (number) 	<ul style="list-style-type: none"> Households owning at least one ITN (percentage) Children under 5 who slept under an ITN the previous night (percentage)
	Malaria prevention during pregnancy	<ul style="list-style-type: none"> ITNs (including re-treatment kits) distributed to pregnant women (number) Pregnant women receiving correct IPT (number) 	<ul style="list-style-type: none"> Pregnant women who slept under an ITN the previous night (percentage) Pregnant women in stable endemic areas receiving intermittent preventive therapy (IPT) (percentage)
	Vector control (other than ITNs)	<ul style="list-style-type: none"> Specific geographical areas (districts, regions etc.) with IVM measures implemented* (number) Volumes of insecticide used for indoor residual spraying per house sprayed 	<ul style="list-style-type: none"> Houses in areas at risk of malaria transmission that were sprayed with insecticide in the past 12 months as proportion of houses targeted (percentage)
	BCC community outreach*	<ul style="list-style-type: none"> People reached by BCC community outreach activities (can be for specific groups) (number and percentage) 	<ul style="list-style-type: none"> People (can be for specific groups) who know the cause, symptoms, preventive measures and treatment of malaria (number and %)
Treatment	Prompt, effective anti-malarial treatment	<ul style="list-style-type: none"> People receiving anti-malaria treatment (as per national policy) (number) Health facilities with no reported stock outs lasting >1 week of nationally recommended anti-malarial drugs at any time during the past 3 months (%) 	<ul style="list-style-type: none"> Children under 5 years of age (and other target groups) with fever who received anti-malarial treatment according to national policy within 24 hours of onset of fever (percentage) Patients admitted with severe malaria receiving correct treatment at health facilities (%)
	Home based management of malaria*	<ul style="list-style-type: none"> People reached through home based management (can be for specific groups) (number) 	<ul style="list-style-type: none"> Children under 5 years of age (and other target groups) with fever who received anti-malarial treatment through home based management within 24 hours of onset of fever (percentage)
	Diagnosis	<ul style="list-style-type: none"> Malaria microscopy slides taken (number) Rapid diagnostic tests (RDTs) taken (number) 	<ul style="list-style-type: none"> Malaria cases that are laboratory confirmed (percentage) Facilities with malaria diagnostic equipment (percentage)
Supportive environment	Monitoring drug resistance	<ul style="list-style-type: none"> Functional sentinel sites for monitoring anti-malarial drug resistance (number) Studies of drug efficacy completed according to WHO protocol (number) 	
	Monitoring insecticide resistance	<ul style="list-style-type: none"> Functional sentinel sites for monitoring insecticide resistance (number) 	

	Coordination and partnership development (national, community, public-private)*	<ul style="list-style-type: none">• Networks/partnerships involved (number)• Community groups taking action on malaria (number)	
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*** These service delivery areas/ indicators are included due to their frequent use in Global Fund grants.**

Appendix 6: Examples of appropriate Roll Back Malaria Impact and Outcome Indicators, by type of malaria endemicity

	Indicator	Highly* endemic Malaria	Unstable* Malaria	Measurement	Remarks
Impact Indicators	Death rates associated with malaria: all-cause under-5 mortality rate in highly endemic areas	✓		Retrospective, ideally every 5 years using national household surveys (DHS, MICS, MIS)	To be interpreted alongside trends in intervention coverage Demonstration of impact could lag up to 5 years because reported mortality reflects the average rate over the 5 years preceding the survey.
	Incidence of clinical malaria cases (estimated and / or reported)	✓	✓	Epidemiological estimation model and/ or cases in HIS adjusted for completeness of HIS reporting	Epidemiological model uses local parasite infection prevalence and coverage of ITNs and IRS as input parameters which will determine the trend over time.
	Anaemia prevalence in children under 5 years of age	✓		Community-based surveys every 2-3 years (DHS, MICS, MIS)	Haemoglobin below 11g/dl or 8g/dl. Impact likely to be detectable within 1-2 years.
	Prevalence of malaria parasite infection	✓	✓	Cross-sectional, ideally measured every 2-3 years using household surveys (MIS or similar survey)	To be surveyed during the transmission season; impact likely to be detectable within 1-2 years.
	Laboratory-confirmed malaria cases seen in health facilities		✓	Continuous and immediate using the Health Information System (HIS)	To be interpreted alongside regularly updated estimates of HIS reporting completeness
	Laboratory-confirmed malaria deaths seen in health facilities		✓		
	Malaria-attributed deaths in sentinel demographic surveillance sites	✓	✓	Continuous and immediate	Observed trend might underestimate actual impact due to limited sensitivity and specificity of verbal autopsy.

Outcome Indicators	% of U5 children (and other target groups) with malaria/fever receiving appropriate treatment within 24 hours (community/ health facility)	✓		Community-based surveys	
	% of U5 children (and other target groups) with uncomplicated malaria correctly managed at health facilities	✓	✓	Health facility survey	
	% of U5 children (and other target groups) admitted with severe malaria and correctly managed at health facilities	✓		Health facility survey	
	% of children U5 sleeping under an ITN	✓	✓	Community-based surveys	
	% of households with at least one ITN		✓	Community-based surveys	
	% of pregnant women (and other target groups) sleeping under an ITN		✓	Community-based surveys	
	% of pregnant women on Intermittent preventive treatment (IPT) according to national policy	✓	✓	Community-based surveys/ or routine HIS	
	% of households in malaria areas protected by IRS	✓	✓	NMCP or Community-based surveys	

* Setting : Malaria is highly endemic in most countries of Central, East, and West Africa; malaria is more unstable and focal in parts of southern Africa, and areas of Africa, Ethiopian and Eritrean highlands and most areas outside of Africa (Source: World Malaria Report 2005)

Appendix 7: Selected issues related to the interpretation of available data on malaria monitoring

Area	Data available	Limitations	Recommendations
Burden and impact	Case and death reports from HIS or Integrated Disease Surveillance and Response	<ul style="list-style-type: none"> National total may not cover all districts and all months of the year Completeness of reporting varies over time and between countries Burden in health facilities frequently does not cover the total burden in the population (especially in Africa) 	<ul style="list-style-type: none"> Besides absolute numbers of cases and deaths, African countries should focus on reporting proportions of outpatients visits, hospital admissions and hospital deaths that are caused by malaria, form sentinel HIS sites in the highest endemic areas Countries should regularly (e.g. every 2 years) evaluate the completeness of HIS reporting
	All-cause under-5 mortality (in Africa) from DHS and MICS	<ul style="list-style-type: none"> Not specific to malaria Mortality data from birth history surveys reflect the situation and average 2.5 years before the survey, delaying the detection of intervention impact 	<ul style="list-style-type: none"> Add anaemia testing and parasite prevalence testing to community-based surveys Conduct regular surveys (e.g. every 2 years) for these acutely responding indicators
ITN coverage	DHS, MICS and other household surveys	<ul style="list-style-type: none"> Not all countries are covered MICS and DHS only every 5 years, thus available data are on average 3 years outdated In countries with only part of the population at risk of malaria, national coverage might underestimate effective coverage in populations at risk 	<ul style="list-style-type: none"> Conduct additional MIS in the interim between DHS and MICS surveys and where DHS and MICS are not conducted In areas of unstable and focal malaria risk, over-sample focal areas at malaria risk
Coverage of anti-malarial treatment	DHS, MICS and other household surveys	<ul style="list-style-type: none"> Using children under 5 years of age with fever as the denominator is not appropriate for population outside Africa where all age groups are at similar risk of malaria, and where fewer of the fevers are actually caused by malaria Not all countries are covered MICS and DHS only every 5 years, thus available data are on average 3 years outdated 	<ul style="list-style-type: none"> Use questionnaire as recommended in MIS package Outside Africa, consider using self-reported malaria instead of fever as the denominator group in surveys Conduct MIS in the interim between DHS and MICS surveys and where DHS and MICS are not conducted
IPT coverage	DHS, MICS and other household surveys	<ul style="list-style-type: none"> Not relevant to measure in areas and years where IPT has not (yet) been implemented 	<ul style="list-style-type: none"> Include in HIS reporting and conduct facility-based surveys in selected areas where IPT has been implemented
IRS delivery and coverage	Reports from countries	<ul style="list-style-type: none"> Reporting to WHO/WHOPES incomplete Definitions of IRS coverage variable and unclear 	<ul style="list-style-type: none"> Improve reporting to WHO/WHOPES of quantities of insecticides used WHO should develop standardized definitions of “population at risk of malaria”, “the denominator for IRS coverage”, and “IRS coverage” Countries should specify the

			<p>definition when reporting on IRS coverage</p> <ul style="list-style-type: none"> • Include questions on IRS coverage for piloting in household surveys
Drug resistance	Surveillance in sentinel sites	<ul style="list-style-type: none"> • The selection of sites varies between years and few sites are sampled repeatedly over time, thus it is difficult to infer time trends as these may be confounded by geographical variation 	<ul style="list-style-type: none"> • Sample selected sites repeatedly over time • Properly document study protocols • Include ACTs among therapies tested

Appendix 8: Selected Indicators for Health Systems Strengthening

Areas	Outputs	Outcomes	Impact
Service delivery	Health facilities in a district or a region that provide specialized services (Testing and Counseling (TC), PMTCT, ARV, STI, malaria treatment, TB/HIV collaborative activities, other) accordingly to national protocols and guidelines (number and percentage)	<ul style="list-style-type: none"> • Population covered by key services (TC, PMTCT, ARV, malaria treatment, TB treatment) (number and percentage) • Number of out-patient visits for HIV/TB/Malaria/inhabitant • Percentage increase in patient satisfaction 	Disease specific outcome/impact indicators should be included (e.g. increased TB detection and cure rate, malaria mortality)
	Health facilities supervised regularly according to national guidelines (number and percentage)		
	Districts with laboratories that have complete capacity and supplies to diagnose TB, malaria and HIV (number and percentage)		
	Number of HIV tests carried out expressed as a proportion of sexually active population (specify age groups)		
Human resources	Number of health workers (by category and discriminated urban/ rural and gender) per 100,000 inhabitants (by category)	<ul style="list-style-type: none"> • Health care personnel trained and deployed per category according to human resource development plan (number and percentage) • Percentage increase in patient satisfaction 	
	Annual output of trained health workers per 100,000 population (by category level)		
	Health workers (by category and region) who attended in-service training sessions (by type and length) according to national curriculum during the last year (breakdown by diseases if appropriate) (number and percentage)		
	Health facilities fully staffed per level of health care and per region and according to national standards (breakdown by disease program if appropriate) (number and percentage)		
Community Systems Strengthening	<ul style="list-style-type: none"> • Number of sites with community coordination focal points in place • Number of community workers trained for implementing community based activities • Number of existing NGO workers trained in a basic package of skills • Number of community based organizations with plans and regular monitoring systems 	<ul style="list-style-type: none"> • Percentage of local administrative units providing basic defined package of community services (home based care, outreach prevention, orphan care, training) 	
Information system & Operational research	Health facilities or districts reporting all indicators according to national guidelines (including using the National list of indicators) (number and percentage)	<ul style="list-style-type: none"> • Comprehensive health information management system • Complete disease specific report available on an annual basis • Behavioral surveys indicators available 	
	Health facilities or districts submitting timely reports according to national guidelines (number and percentage)		
	Number of surveys that include core		

	<p>indicators for three diseases implemented according to National M & E plan (specify type)</p> <p>Sentinel surveillance sites performing according to national standards (number and percentage)</p>	<p>every 4-5 years</p> <ul style="list-style-type: none"> Estimated HIV prevalence rate available on a biannual basis 	
Infrastructure	<p>Health facilities with arrangements for specialized services (CT, PMTCT, ARV, STI, TB/HIV services- specify which and how many) (number and percentage)</p>	<ul style="list-style-type: none"> Geographical access : Percentage of population living within reach of basic health services 	
Procurement and Supply management	<ul style="list-style-type: none"> Technicians (by region) that have been trained in procurement and supply management (number and percentage) Health facilities applying national regulations regarding procurement and supply management (number and percentage) Batches of anti-TB essential drugs (specify) that have a batch certificate showing acceptable quality testing results, among all batches of drugs procured during a specified time period (number and percentage) Total number of stock out days for any anti-TB essential drugs stocked (specify), among all storage facilities during a specified time period 	<ul style="list-style-type: none"> Number and percentage of health facilities or central warehouses with no drug stock out during the last month (or defined period) 	

APPENDIX 9: Recommended Data Collection Tools

Indicator	Data source
Impact level (health impact)	
Prevention	
1. HIV (and syphilis) prevalence among youth aged 15-24 years/ /military/police/garment factory workers/sex workers	HIV sero-sentinel surveillance
Mitigation	
2. Increased quality of life for PLWHA and orphans and other vulnerable children (OVC)	Household Surveys
Coverage/Outcome level (behavioral outcomes)	
Prevention	
3. Percentage of respondents who both correctly identify ways of preventing the sexual transmission of HIV and reject major misconceptions about HIV transmission and prevention	DHS, MICS and BSS
4. <i>Safer sexual practices</i> : youth (15-24) The (a) increased age of sexual inception and (b) reduced occurrence of unprotected sexual intercourse	Behavioral surveillance and social impact surveys
5. <i>Safer sexual practices</i> : adults (25-49) (for e.g. police, military personnel) Reduced occurrence of unprotected sexual intercourse with non-regular partner	Behavioral surveillance and social impact surveys
Mitigation	
6. Increased PLWHA/OVC household-coping capacities	Household Surveys
Output level (activities)	
Increased SR capacity	
7. SR staff appointed and functional	Direct observation
8. SR work plan and budgets developed	SR work plan and budget
9. SR financial, procurement, implementation, technical support and M&E systems established	SR progress reports
Increased public sector services	
10. The (a) number and (b) percentage of health facilities providing HIV/AIDS care appropriate for level of facility	Health facility surveys
11. The (a) number and (b) percentage of primary/secondary/tertiary education institutions with HIV/AIDS programs for their students	MoEYS reports

Increased civil society services	
12. Percentage of overall GFATM funding granted to NGOs	PR reports
13. Total HIV/AIDS services delivered by NGOs	PR reports
HIV/AIDS service: prevention	
14. The (a) number of HIV/AIDS radio/television programs produced and (b) number of hours aired	SR activity reports
15. The number of HIV/AIDS prevention brochures/booklets (a) developed and (b) distributed	SR activity reports
16. The number of (a) HIV prevention staff and (b) volunteers trained	SR training reports
17. The number of condoms sold/given	SR sales reports
18. The number of men/women receiving STI care from health facilities with trained staff and uninterrupted supply of drugs	SR clinic records
19. The (a) number and (b) percentage of men/women receiving HIV testing and counseling	SR clinic records
20. The (a) number and (b) percentage of women tested and receiving PMTCT if HIV-positive	SR facility reports
HIV/AIDS service: care	
21. Number of care (a) staff and (b) volunteers trained	Training reports
22. The (a) number of PLWHA support groups; (b) number of men/women enrolled; and (c) percentage of men/women enrolled	SR activity reports
23. The (a) number of community HIV/AIDS care projects; (b) number of men/women enrolled; and (c) percentage of men/women enrolled	SR activity reports
24. The (a) number of community orphan support projects; (b) number of orphan boys/girls enrolled; and (c) estimated percentage of orphan boys/girls enrolled	SR activity reports

Appendix 10: Phase 2 Funding Guidance²⁴ from GFATM (Request for Continued Funding)

1. The *Request for Continued Funding* for up to three additional years of a program should come from the CCM as the result of a broad, consultative process among country-level stakeholders. The *Request for Continued Funding* should be linked to the original approved proposal, and contain (i) a CCM self-assessment of progress for the first 18 months of the program based on the Principal Recipient(s)' *Disbursement Requests and Progress Updates, Fiscal Year Progress Report(s)* and *Audit Report(s)*, (ii) provide certain complementary information beyond the responsibilities of the PR(s), as relevant for the program, and (iii) indicate the proposed objectives, targets and requested funding from the Global Fund for up to three additional years of the program. The *Request for Continued Funding* may include as annexes any independent evaluation performed on the program, and other relevant documentation as appropriate.
2. The *Request for Continued Funding* must be submitted by the CCM to the Global Fund before the end of the 20th month of the program to allow sufficient time for the Fund's review and decision and avoid program disruptions. The Global Fund will provide further guidance and information on the Fund's review and decision process in due course.

Request for Continued Funding: Contents

1. **CCM self-assessment of progress for the first 18 months of the program** based on the information prepared by the Principal Recipient(s) (*Disbursement Requests and Progress Updates, Fiscal Year Progress Report(s), Audit Report(s)*)
2. **Complementary information**
 - a) A country profile on key health indicators related to the three diseases, as relevant for the program, extracted from the country's routine disease surveillance data compared to the baseline at the start of the program;
 - b) A description of the functioning of the CCM, including partnerships brought about among different constituencies as a result of the program;
 - c) A description of linkages between the program and other national initiatives/programs;
 - d) Information on the level of and distribution of overall national financial resources to the three diseases and broader purposes related to the program.
3. **Request for continued funding**
 - a) The proposed funding period and total amount requested from the Global Fund;
 - b) Objectives and performance targets, with appropriate baseline data;
 - c) Information on any planned changes in existing implementation arrangements; and
 - d) Funding available from other sources for the program.

²⁴ Note: Please be informed that at time of writing these guidelines, GFATM was in the process of reviewing their Phase 2 procedures; so further updates are pending.

Appendix 11:

7 Monitoring Tools developed by PR (activity-specific)

1. Training Activity Checklist
2. Peer Education Session Checklist
3. Clinical Service Activity Checklist
4. Special Health Education Event Checklist
5. Community-Based Activity Checklist
6. Headquarters M&E System Checklist
7. Assessment of ARV Sites-Checklist

Monitoring Tool # 1 **Training Activity Checklist**

Date:

Location:

Trainer(s):.....

Training session topic:

:

Monitored by:
(M&E Officer)

Participants:.....
(who/how many?)

Instructions: For each issue listed below, please circle the number representing how well you think the training was designed and conducted.

	<u>Poor /Adequate/ Very Well</u>					
1. Were the training objectives and schedule presented at the beginning?	Y / N					
2. What was the predominate style of training?	Interactive // Lecture					
3. Were the appropriate training materials available for all participants?	1	2	3	4	5	N/A
4. Did the trainers demonstrate good knowledge of the subject?	1	2	3	4	5	N/A
5. Was workshop content selected appropriately for the specific audience?	1	2	3	4	5	N/A
6. Was the new information presented clearly & sufficiently?	1	2	3	4	5	N/A
7. Were practical examples used to improve learning?	1	2	3	4	5	N/A
8. Did the trainers use teaching tools, such as overheads, flip charts, transparencies, etc.?	1	2	3	4	5	N/A
9. Were the participants engaged actively in the training?	1	2	3	4	5	N/A
10. Did the trainers encourage questions and discussion?	1	2	3	4	5	N/A
11. Were participants' questions answered appropriately?	1	2	3	4	5	N/A
12. Was time used efficiently?	1	2	3	4	5	N/A
13. Did the trainer summarize the session in the end?	1	2	3	4	5	N/A
14. Is there a feedback system among trainers within SR?	1	2	3	4	5	N/A
15. Was there an evaluation of the training in the end?	1	2	3	4	5	N/A

Comments:.....

Monitoring Tool #2

Peer Education Session Checklist

Date:

Location: **Facilitator(s): (1)**

Training session topic: **: (2)**.....

Monitored by: **Participants:**
(M&E Officer) (who/how many?)

Instructions: Please check the appropriate box.

No	Specific Questions / Key QA Elements of PE Activity	Yes	No	N/A	Comments
1	Was the group meeting held at an appropriate place considering local circumstances?				
2	Were the participants seated comfortably; informal arrangement (i.e., semi-circle); see/hear clearly?				
3	Did the facilitator(s) talk loudly and clearly enough for the audience to understand?				
4	Were the objectives of the session introduced at the beginning?				
5	Was the session participatory and interactive?				
6	Was the HE ²⁵ content of the topic appropriate for the audience (easy to understand)?				
7	Were specific examples used to illustrate the points and link them to the participants' daily life?				
8	Did the facilitator use any materials to help convey the HE ¹ messages?				
9	Were the participants engaged in the discussion? If yes, how many people asked questions?				
10	During discussion, did the facilitator(s) listen to each comment/question and respond appropriately?				
11	Was there sufficient time for discussion?				
12	Did women in the audience participate actively also? (proportionate to # of women present)				
13	Did the facilitator offer any HE materials at the end of the session (such as leaflets, condoms, others)?				
14	At the end of the session, did the facilitator provide information about specific local site that offers relevant health (.....) services and/or counseling?				

²⁵ HE=Health Education

Monitoring Tool #3

Clinical Service Activity Checklist

Date:

Location:

Key Staff: (1)

Service Level/Type:

: (2).....

Monitored by:

(M&E Officer)

Instructions: Observe clinical service activities and assess quality standards adhered to by the SR, by checking the appropriate box.

	Indicators	Yes	No	n/a	Comments, if any
	Facility meets basic requirements for delivery of services (adequate space, light, water)				
	Health providers have appropriate equipment, supplies and medications.				
	Health providers see clients in private (exam rooms allow for privacy).				
	Clinical services are provided as planned (place, timing) according to schedule; (<i>ask some patients</i>).				
	Patient flow is efficient; (<i>how many on visit day?</i>) Waiting time is acceptable.				
	Service records are kept as planned (<i>observe actual recording process of in-coming patients</i>) --- Patient Register is up to date (<i>review</i>)				
	Providers treat clients with respect (<i>observe and ask some patients</i>).				
	Providers instruct the clients clearly about regimen compliance (<i>observe and ask some patients</i>)				
	Providers/admission clerk discuss a return/follow-up visit as appropriate (<i>observe and ask some patients</i>)				
	This service facility has received a supervisory visit in past 3 months? (<i>ask providers; see report</i>)				
	Facility has health education materials clearly displayed on the walls. (<i>observe</i>)				
	Facility has national guidelines clearly displayed on the wall. (<i>observe and review</i>)				
	Providers follow infection control procedures as per national guidelines (<i>ask providers, observe</i>)				
	Patients benefit from health education information while waiting to be seen. (<i>if yes, specify what</i>)				
	Facility has mechanism to make programmatic changes/ improvements based on clients feedback.				

Monitoring Tool # 4 Special Health Education Event Checklist

Date:

Location:

Key Staff: (1)

Special Event:

: (2).....

Monitored by:
(M&E Officer)

Participants:
(who/how many?)

Instructions: Please check the appropriate box.

No	Specific Questions / Elements of Special Health Education Activity	Yes	No	N/A	Comments
1	Was the special event held at an appropriate setting considering local circumstances?				
2	Was the timing of the event conducive to maximizing local audience?				
3	Estimate how many people attended the event, excluding the presenters/entertainer(s)? (# in several hundred, thousands; ---women/children (?))				
4	Were the local authorities present at the event? <i>(gov't and health as appropriate)</i>				
5	Was the selection of entertainers (singers, dancers, etc) appropriate (locally known and recognized)? --- How many entertainers performed? <i>(approx.)</i>				
6	Were the health educational sections of the program appropriate for the audience?				
7	Were the health educational sections of the program well interspersed/mixed in and balanced with the entertainment? (2 songs, info, 2 dances, info...)				
8	Was content of health education information presented in the event accurate and up to date?				
9	Was health education component interactive and participatory? How many people asked questions?				
10	During discussion, did the presenter(s) listen to each comment/question and respond appropriately?				
11	Were key health promotional messages, (or any supporting items) clearly displayed on the stage and/or in the general setting?				
12	Did the special event finish with information about specific local site that offers specific health (.....) services and/or additional information?				

Monitoring Tool 5 Community-Based Activity Checklist

Date:

Location:

Key Staff: (1)

Special Event:

(2).....

Monitored by:
(M&E Officer)

Participants:
(who/how many?)

Instructions: Please check the appropriate box.

No	Specific Questions / QA Elements of Community-Based (CB) Health Activity	Yes	No	N/A	Comments
1	The observed CB activity has a clear structure that guides its implementation. <ul style="list-style-type: none"> • written structure exists (<i>seen, copy taken</i>) • activity is implemented according to schedule • program design involved beneficiaries 				
2	The CB workers have clear roles and responsibilities.				
3	The CB workers provide the following services: <ul style="list-style-type: none"> • health education • medicine/bednets/other items (<i>circle & specify</i>) • facilitate Self-Help Groups 				
4	There are monthly/regular meetings of CB workers and their supervisors.				
5	The CB activity is linked to local HC, OD, or PHD.				
6	The CB activity is recognized by local authorities.				
7	The CB activity is linked to local Buddhist monks <ul style="list-style-type: none"> • has active participation of the monks 				
8	The CB activity is linked to other local organizations, networks. <ul style="list-style-type: none"> • NGO/GO/Business/Schools/etc (<i>circle & specify</i>) 				
9	The local community is aware of the CB activity. <ul style="list-style-type: none"> • considers it very useful / making good contribution 				
10	Positive direct results of the CB activity are recognized by: <ul style="list-style-type: none"> • the community (<i>patients supported, bednets distributed</i>) • direct beneficiaries (<i>services received</i>) 				
11	Positive indirect results of the CB activity are recognized by: <ul style="list-style-type: none"> • the community (<i>awareness improved</i>) • direct beneficiaries (<i>stigma reduced</i>) 				
12	There is a simple and clear monitoring system in place (allowing for data flow from beneficiaries, via CB workers, to SR HQs).				

Monitoring Tool #6

Headquarters M&E System Checklist

Date:

Location:

Key Staff: (1)

(2)-----

Monitored by.....

-Instructions: Please check the appropriate box.

No	Specific Questions / Elements of Operating Monitoring and Evaluation System	Yes	No	N/A	Comments
1	There is M&E system in place (written) ; <i>seen, copy taken</i> <ul style="list-style-type: none"> • M&E Unit • M&E Officer • M&E Plan (for GF, other donors, or joint) • M&E Plan linked to Work plan ? 				
2	Monitoring & supervision visits are conducted from HQ to field: <ul style="list-style-type: none"> • How often? (frequency) • By whom? • To see what? Objectives (activities, routine operations) • Does a schedule exist? • What M&E tools are used? • Are reports from visits drafted? • Follow-up on recommendations? 				
3	Data collection from field to HQs: <ul style="list-style-type: none"> • How are the reports sent in? (email, phone, letters) • Staff responsible? • How often? (Frequency) • Data sources/ data collection tools? • Quality Assurance methods used? 				
4	Data processing and analysis. <ul style="list-style-type: none"> • Software used • Staff involved • Methods used (verification, team review, etc.) • Trends/ Problems identified (?) 				
5	Generating Reports <ul style="list-style-type: none"> • GF formats understood and implemented? • Different formats from the field? • Different formats from other donors? • Time required to receive data and combine information? • Can results be tracked by specific donors? 				
6	Dissemination of reports/ Use of Data collected: <ul style="list-style-type: none"> • External: - for donor reporting - for National Programs/ HIS • Internal: - problem solving - feedback mechanism to program implementation; How? 				
7	Difficulties and/or constraints faced with using M&E system?				
8	Suggestions to resolve them.				

Monitoring Tool # 7

Assessment of ARV Sites - Checklist

Date:

Location:

Key Staff: (1)

Monitored by -----(2)-----

Instructions: Please check the appropriate box.

No	Specific Questions / Elements of ARV Administration and Management	Yes	No	N/A	Comments
1	How long SR had ARVs <ul style="list-style-type: none"> • Full, partial regimen ? (R 1 & R2) • Staff trained in ART? (Physicians, nurses, etc) 				
2	SR provides ARVs to the following AIDS patients by category: <ul style="list-style-type: none"> • Adults, Children, Pregnant women (PMTCT), Health staff (Professional Exposure) 				
3	Are National Guidelines followed? (ask) <ul style="list-style-type: none"> • What regimen(s) is/are used? • <i>Random patient chart review confirms(?)</i> 				
4	Patient Selection Process used: (<i>ask for written guidelines</i>) <ul style="list-style-type: none"> • Lottery, committee, (<i>circle all that applies</i>) • Other (?), specify • Time frame (<i>how long from confirmed eligibility to ARV?</i>) • Gender? 				
5	Numbers of Patients on ARVs to date? <ul style="list-style-type: none"> • In-patient • Out-patient • Pregnant women, Children, Health staff? <i>Circle category</i> 				
6	Out-Patient Follow-up & (CoC) <ul style="list-style-type: none"> • Frequency of visits (<i>weekly, bi-weekly, monthly</i>) • How many lost to follow-up? • Use of Existing support mechanisms <ul style="list-style-type: none"> - Home based care - counseling / Peer Education - Welfare support / Orphans, Vulnerable Children - Others? 				
7	Linkages with other key HIV/AIDS Services (<i>check & specify site</i>) <ul style="list-style-type: none"> • VCT, ANC • OI Care • Hospice Care / Palliative Care 				
8	How does SR monitor Quality of Care (QOC) ? <ul style="list-style-type: none"> • Patient Satisfaction Survey (<i>status and use?</i>) <ul style="list-style-type: none"> - frequency administered - feedback incorporated ? • Staff performance <ul style="list-style-type: none"> - frequency of supervision / by whom - providing instructions to patients - tools used (checklists, etc) What methods are used to improve Patients Adherence to Therapy?				
9	ARV Drugs Management at Pharmacy (visit) <ul style="list-style-type: none"> • appropriate storage conditions (w/security) • pharmacy staff trained in ARVs • How is ARV distribution supervised / monitored? 				
10	Any difficulties faced?				
11	Suggestions to resolve them				

Annexes A-D:

SUB-RECIPIENTS M&E FORMATS:

- Annex A1: SR Intended Program Results and Budget (M&E Plan)**
- Annex A2: SR Detailed Annual Program Workplan**
- Annex B1: SR Disbursement Request and Progress Update (SA Report)**
- Annex C1: SR Annual Progress Report Contents (Annual Report)**
- Annex D1: SR M&E Assessment Questionnaire**

Annex A2: Detailed Annual Work Plan

A. Country:	
B. Disease:	
C. PR-SR MoA number:	
D. Sub-Recipient:	
E. Program beginning date:	
F. Program end date:	

Program Activities	Link to Objective Number	Proposed Location	Year 2XXX												Y2007	Activity Outputs in Y1 and Y2	
			Q1			Q2			Q3			Q4					
			1	2	3	4	5	6	7	8	9	10	11	12			
<u>1. Project start up activities</u>																	
1.1.																	
1.2.																	
1.3.																	
1.4.																	
<u>2. Procuring Activities on Office Equipment and Vehicle, Drugs and Civil Works</u>																	
2.1.																	
2.2.																	
2.3.																	
<u>3. Project Implementation activities</u>																	
3.1.																	
3.2.																	
3.3.																	
<u>4. Workshops and Training Activities</u>																	
4.1.																	
4.2.																	
4.3.																	
<u>5. Supervision, monitoring and evaluation activities</u>																	
5.1.																	
5.2.																	

Annex B: Semi-Annual Progress Update and Disbursement Request

On-going Progress Update and Disbursement Request

(Progress Update and Disbursement Request Number)

(Reporting Period from --- to -----)

(Name of Sub-Recipient)

Section 1: Programmatic and Financial Progress Update

- A. Program Progress
 - I. Program Objectives
 - II. Impact/Outcome Indicators
 - III. Service Delivery Areas, Indicators, and Targets
 - IV. Overall evaluation of performance
 - V. Planned changes in the program, if any.
 - VI. Other program results, success stories, issues or lessons learned
- B. National Program/SR Comments on the Fulfillment of Conditions Precedent and/or Special Condition under grant agreement

Section 2: Financial Progress Update

- A. Program Expenditures
- B. Actual Expenditure Vs Budget and Cash Forecast for Next Three Quarter
- C. Cash Reconciliation for Period Covered by Progress Update
- D. Disbursement Request

Section 3: Cash Request and Authorization

- A. Cash Request
- B. Authorization

Section 4: Procurement Summary Report

- A. Cash Flow for 6 months
- B. Semi-annual Procurement Report

PR-SR Memorandum of Agreement (Annex C): *Annual Progress Report*
Contents

Country: CAMBODIA

Disease:

PR-SR MOA number:

Sub-Recipient:

Period:

I. Programmatic information:

a) Aggregate programmatic data for the annual reporting period:

Main program objectives to which the SR contributes:

Key indicators	Baseline (if applicable)	Intended results/ targets	Actual results/ targets	Data source	Reason for programmatic deviation

b) “Success stories”, lessons learned and implications for future program design and operations:

c) Information on the effectiveness of the procurement and supply management system, according to a few key indicators from a menu to be provided by the Global Fund

d) Updated plans with the intended results for the next year and program budget broken down into quarterly intervals. (Annex A duly filled) may be attached

II. Financial information:

To be provided as stipulated in the Financial Guidelines issued by the office of the Principal Recipient.

**Office of the Principal Recipient
Ministry of Health, Cambodia**

**ANNEX D1
ASSESSMENT QUESTIONNAIRE
for program MONITORING and EVALUATION
the Sub-Recipients (SRs) and National Programs (NPs)
GFATM**

Program Component for which proposal was approved by GFATM under Round 5:
HIV/AIDS **Tuberculosis** **Malaria** **Health Systems Strengthening**
(Tick 1 box), as appropriate

A. Administrative/Contact Information

1. Name and address of the organization:

2. Name & contact details of the focal point for GFATM Round 5 activities within the organization: (e.g., the proposed manager/coordinator for the program);

3. Name & contact details of the person in charge for M&E aspects of the GFATM Round 5 activities within the organization: (if identified/already functioning)

4. Please attach your organizational structure (comprehensive diagram, covering units from HQs to implementation level).

B. Previous Program and M&E Experience (general)

1. Please summarize your prior program experience in Cambodia, through listing prior grants, by donors, timeframes and coverage areas in a Table below. (you may add rows as necessary)

#	Title of Program/ project	Funding source/ Timeframe	Key areas of intervention	Geographical Location
1				
2				
3				
4				

2. Previous experience of the organization in monitoring and evaluation activities:

#	Title of Program/ project	Key M&E tools used (e.g. sample surveys, routine monitoring visits)	Any difficulties/ constraints faced
1			
2			
3			
4			

C. Existing Program Reporting System

Please describe your organization's reporting system through the following questions:

1. Reporting responsibility lies with:
 - a. A designated Reporting/M&E unit: Yes.....No.....
 - b. A designated M&E focal personnel: Yes.....No.....
 - i. (if yes, how many people?)
2. Briefly describe how your organization will collect and process program data:
 - a. Data collection system.....
.....
 - b. Verification of data.....
.....
 - c. Data analysis.....
.....
 - What computer software is used?.....
 - d. Report drafting/frequency.....
3. Briefly describe report flow (structure and/or staff):
 - a. Completion of reports.....
 - b. Dissemination of the reports
 - c. How is disseminated data used?
4. What types of monitoring and supervision activities are conducted?
 - a. Frequency.....
 - b. Responsible unit/staff:
 - c. Reports drafted.....
 - d. Recommendations drafted/ followed by.....

D. Prior M&E Experience:

1. Describe what existing health information your organization will make use of (e.g., Demographic Health Surveys, Health Information System, etc.)

.....

2- Has your organization conducted surveys or evaluations in the past?

- YES..... No.....

i. (if yes, please complete the table below:

Numb	Survey/Evaluation Title//Dates	Methodology	Coverage area/Sample size	When Results disseminated? / Report completed?
1				
2				
3				
4				

3. Does your organization plan to conduct surveys/evaluations in the future?

YES.....NO.....; if yes, please complete table below:

Numb	Survey/Evaluation Title//Dates*	Methodology	Coverage area/Sample size	When Results expected?
1				
2				
3				
4				

**Of particular interest are any studies conducted during the next 5 years.*

E. GFATM Round 5-proposal related questions:

1. To your knowledge, where there any changes made to the proposal by the TRP?

YES..... NO..... (skip to question 2)

- a. If yes, how was your proposal revised by the TRP?
- b. Was the budget revised?
- c. Are those changes reflected in your M&E plan?

2. Do you have prior GFATM grants in Cambodia? YES..... NO.....

- a. same program area: YES..... NO.....
- b. If yes, is there any overlap between indicators?

3. About your Round 5 proposal:
- a. How do you feel about the presented targets in the M&E plan?
 - i. Realistic.....
 - ii. Ambitious.....

 - b. When did you expect to begin program activities? (date).....
 - c. Would there be any implications if the start date was delayed? (comment)

4. Summarize basic information about your Round 5 M&E Plan:
- a. Baselines:.....
 - b. Data Sources.....
 - c. Other donor funding:.....
5. Please complete the ARV Table (for SRs with this activity) attached

F. Training Needs in M&E in your organization.

What are specific training needs on M&E aspects that may be addressed by the Principal Recipient's office? Tick ✓ within the appropriate boxes.

#	Training need	Absolutely vital	Essential	Desirable	Not needed
1	Basic Concepts of M&E				
2	Making M&E plans				
3	Design and use of M&E tools				
4	Hands on training in using M&E tools				
5	Indicators related to the disease component and their measurement				
6	Guidelines on filling up formats and progress reports				
7	Computerized M&E systems				
8	Any other- specify				

Thank you for your cooperation