The Canadian Journal of Program Evaluation Vol. 28 No. 3 Pages 103–120
ISSN 0834-1516

M&E COMPETENCIES IN SUPPORT OF THE AIDS RESPONSE: A SECTOR-SPECIFIC EXAMPLE

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Abstract: The Joint United Nations Programme on HIV/AIDS (UNAIDS) led a consultative process to develop a self-assessment tool for HIV monitoring and evaluation (M&E) leadership competencies. The tool seemed fit-for-purpose in M&E staff recruitment and professional development. The willingness to use the self-assessment was related to the pragmatic and reality-based nature of the tool. A competency-based approach to M&E training was well accepted by professionals working at national and service-delivery levels. However, there is a need to update the HIV M&E competencies to adapt to specific M&E challenges in the broader context of aid effectiveness and to reflect a maturing evaluation profession.

Résumé : Le Programme Commun des Nations Unies sur le VIH/SIDA (ONUSIDA) a mené un processus de consultation pour élaborer un outil d'auto-évaluation pour les compétences en leadership en suivi et évaluation (S&É) du VIH. L'outil semble apte au but en recrutement du personnel et développement professionnel pour suivi et évaluation. La volonté d'utiliser l'auto-évaluation a été liée à la nature pragmatique et fondée sur la réalité de l'outil. Une approche axée sur les compétences en formation S&É a été bien reçue par les professionnels qui travaillent à des niveaux

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nationaux de prestation de services. Cependant, il est nécessaire d'actualiser les compétences VIH S&É pour s'adapter aux défis spécifiques au S&É dans le contexte plus large de l'efficacité de l'aide et pour refléter la maturation de la profession d'évaluation.

In 2003, global AIDS reporting revealed that shortcomings in national monitoring and evaluation (M&E) systems presented one of the most pressing challenges for achieving the time-bound targets set out in the 2001 United Nations General Assembly Special Session (UNGASS) Declaration of Commitment on HIV/AIDS (DoC) (UNAIDS, 2003). There were few human resources for HIV M&E, inadequate physical infrastructure, low organizational capacity, and insufficient funds (Rugg, Peersman, & Carael, 2004). Since then, substantial investments in M&E have been made. For example, more than US$1.5 billion was requested for M&E support in proposal rounds 7, 8, and 9 of the Global Fund to Fight AIDS, Tuberculosis and Malaria (Global Fund) for all three diseases (Peersman & Plowman, 2012).[1] Other major donor initiatives, such as the US President's Emergency Plan for AIDS Relief (PEPFAR), have also provided M&E funding and other support to supplement resources from country governments (Porter et al., 2012).

Several international organizations also started to provide ongoing M&E technical assistance in countries heavily affected by HIV and AIDS. For example, UNAIDS launched its M&E Advisor Program in 2004, placing resident M&E support in more than 60 country and regional offices to help build national M&E capacity to strengthen the AIDS response. UNAIDS M&E advisors typically work with local counterparts in national AIDS programs to maintain a comprehensive HIV M&E system that includes appropriate M&E activities at national, subnational, and service delivery levels. A review in 2009 found a marked increase in the number of countries with a basic national HIV M&E system in place, but there were still crucial gaps in M&E capacity (Peersman, Rugg, Erkkola, Kiwango, & Yang, 2009).

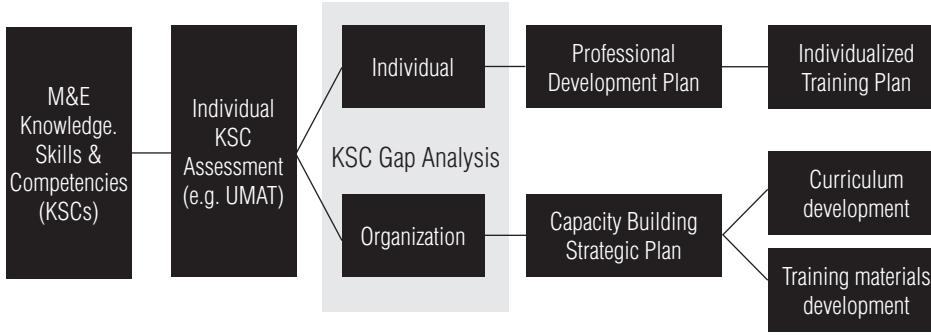
In this article, we will examine one of the core strands of UNAIDS' M&E capacity-building work: the establishment of core competencies for M&E leadership in national HIV M&E systems. We will discuss the challenges for HIV M&E in a changing aid environment, and make the case for updating the core M&E competencies to address the particular learning-related challenges involved in this work.

DEVELOPING CORE COMPETENCIES FOR M&E LEADERSHIP IN HIV AND AIDS

The M&E profession has developed as a field of practice rather than a traditional academic discipline or distinct program with its own professional criteria, although this is slowly changing as the profession matures. As a result, professionals involved in M&E of HIV—as in other health and development arenas—tend to have mixed educational and experiential backgrounds. Further, particular professional positions or teams of people responsible for M&E within a national HIV M&E system are required to complete a wide range of different duties. Particular challenges are thus faced, both in the recruitment of adequately skilled staff and in the development of strategies for appropriate M&E capacity-building. As a result, UNAIDS reasoned that defining core competencies for M&E functions at different levels of a national HIV M&E system would not only provide a solid foundation for the selection of M&E staff, but also enable more effective individual and organizational performance assessments and capacity-building at all levels (UNAIDS, 2009a).

The KSC framework (Figure 1)—which is rooted in pedagogy—was adopted as the conceptual framework on which to build this core competencies and capacity development approach. The framework, based on the work of Gagné (1985) and Merrill (2002), posits that learning is best accomplished when that which is to be learned is broken down into the *knowledge* (K) needed to be able to do the task and the *skills* (S) to execute it. *Competencies* (C) are the combination of the required knowledge and skills to execute complex tasks.

Figure 1
KSC Capacity Building Framework



UMAT = UNAIDS M&E advisor Assessment Tool

With support from UNAIDS, a multi-stakeholder workshop was held in 2009, including representatives from international and donor agencies, national AIDS programs, major training institutions, and selected universities (UNAIDS, 2009b). Workshop participants identified that one key cohort for which core competencies should be defined was that covered by the umbrella term "M&E leadership." This cohort was considered to include:

- M&E directors with responsibility for M&E of the country's AIDS response (located in the National AIDS Coordinating Authority [NACA] and/or the Ministry of Health or other government department)
- M&E directors within the organizational structures of the Principal Recipients of Global Fund grants
- Resident M&E advisors from international organizations (such as UNAIDS) whose specific role is to support the NACA (or equivalent) in the establishment and maintenance of the national HIV M&E system
- M&E leaders at decentralized government structures and in major nongovernmental organizations (NGOs) involved in the HIV response.

UNAIDS then tasked a small working group, under the auspices of the global HIV M&E Reference Group (MERG),[2] with defining specific core competencies for this M&E leadership cohort. The working group drew on the variety of job experiences of M&E leadership in the AIDS response and on work done by others in professionalizing the field of evaluation—for example, the United Nations Evaluation Group (UNEG, 2005), Stevahn, King, Ghere, and Minnema (2005), Ghere, King, Stevahn, and Minnema (2006)—to identify five key areas for M&E competency development (Table 1):

1. M&E leadership competencies
   Developing a vision for M&E; M&E advocacy, strategic and operational planning; M&E capacity-building; and M&E partnerships
2. Data collection and data management competencies
   Routine program monitoring; surveillance and surveys; data quality assurance; and data management systems
3. Evaluation competencies
   Evaluation design and methods and management of evaluations
4. Data analysis, dissemination, and use competencies

5. General management competencies
   Team management, financial management, coordination and collaboration, and strategic communication

Table 1
Essential Competencies for M&E Leadership

1.	*M&E leadership competencies*
1.1	Ability to develop and communicate a clear and compelling vision and mission for M&E.
1.2	Ability to manage the development of evidence-based, strategic, and operational plans for the program, including long- and short-term goals and objectives, risk assessments, and resource implications.
1.3	Ability to develop, regularly update, harmonize, and communicate M&E plans that include identified data needs, standardized indicators, data collection procedures and tools, as well as roles and responsibilities and budgets for implementing a functional M&E system.
1.4	Ability to integrate M&E planning and implementation processes of nongovernmental/civil society organizations into the respective national processes.
1.5	Ability to manage the planning and implementation of activities to build M&E capacity at individual, organizational, and system levels to support a unified and effective M&E system.
1.6	Ability to build and maintain partnerships among in-country and international stakeholders who have key roles in the operation of the M&E system.
2.	*Data collection and data management competencies*
2.1	Ability to manage the implementation of policies and procedures for routine monitoring, including reporting and data use for program management and improvement.
2.2	Ability to manage population-based surveillance and/or surveys, including identification of data needs, data collection planning (including budgeting) and implementation, data analysis, report writing, dissemination, feedback, and data use.
2.3	Ability to manage the implementation of data quality assurance policies and procedures appropriate to the type of data and data source, including supportive supervision and data auditing.
2.4	Ability to manage the implementation of data management systems and data sharing procedures.
3.	*Evaluation competencies*
3.1	Ability to manage the process for developing and implementing a strategy and infrastructure to support relevant HIV evaluations with actionable results.
3.2	Ability to manage the evaluation process including the use of evaluation findings for program improvement.
4.	*Data analysis, dissemination, and use competencies*
4.1	Ability to conduct and manage scientifically rigorous analyses of data relevant to the national HIV response, including national, subnational, and program level data.
4.2	Ability to manage the dissemination of information in a targeted and timely manner.
4.3	Ability to identify, articulate, and support strategic use of data for program management and improvement.

(continued next page)

Table 1. *(continued)*

5.	*General management competencies*
5.1	Ability to make sound decisions and lead a team to achieve results.
5.2	Ability to effectively negotiate funding for agreed-upon needs with a range of internal and external stakeholders.
5.3	Ability to identify gaps in financial monitoring policies, procedures, and systems and to provide pragmatic recommendations for improvement.
5.4	Ability to build networks within and outside the organization to address agreed-upon work priorities in an effective and efficient manner.
5.5	Ability to negotiate effectively to gain agreement and commitment to ideas and actions.
5.6	Ability to clearly articulate and communicate key messages about the work and the performance of the organization and to respond appropriately to communications from internal and external stakeholders.

Note. The table only lists the core competencies, not the underlying required knowledge and skill items.

The working group considered whether different competencies needed to be developed for M&E leadership positions at national, subnational, and service delivery levels, but concluded that core competencies overlapped extensively among the different delivery levels. Hence, one consolidated set of M&E competencies was considered appropriate for M&E leaders at all delivery levels.

The competencies and associated knowledge and skills requirements were presented in a self-assessment tool. This was intended to support each individual in drawing conclusions about his or her own professional strengths and weaknesses and to determine concrete actions to improve any deficiencies considered critical to job performance. Competency was assessed using a 6-point scale: entry, novice, proficient, skilled, mastery, expert. Each level was clearly defined. The scale was directly adopted from Ghere and colleagues (2006), as it was already validated and had been extensively used as part of a range of professional development work. Feedback and agreement from the MERG membership was obtained, and the final competency assessment tool was disseminated in 2010 through UNAIDS and its partner organizations (UNAIDS, 2010a, 2010b). We will hereafter refer to the M&E leadership competencies as M&E competencies, for short.

LESSONS LEARNED FROM USING THE M&E LEADERSHIP COMPETENCIES

The M&E competencies were first piloted with UNAIDS M&E advisors in different regions. The advisors considered the range of com-

petencies included as highly relevant to their M&E work. However, during the pilot it was felt that a few knowledge and skills items needed to be added to reflect requirements specific to the UNAIDS M&E advisors' role in working with country partners. For example, an important aspect of the advisors' work is facilitating coordination of all stakeholders in support of *one* national M&E system and building sustainable M&E capacity: the "Three Ones" principles for effective country-level action on AIDS are *one* national strategic framework, *one* national coordinating body, and *one* M&E system (UNAIDS, 2004).

Hence, under competency 5.1 (see Table 1: "5.1 Ability to make sound decisions and lead a team to achieve results"), the following skill items were added:

- Provides M&E technical advice in a manner that encourages mutual learning and skill transfer in professional relationships with other experts from government, civil society, academic institutions, and bilateral/UN agencies and brokers technical assistance between experts and project managers.
- Provides technical support to the national AIDS coordinating authority to develop and implement its M&E functions without taking over control.

Overall, the pragmatic, reality-based set of KSCs was noted as essential to the advisors' willingness to use the self-assessment tool. Each UNAIDS M&E advisor was then encouraged to discuss personal areas for professional development with his/her supervisor during the yearly performance appraisal process. Based on the pilot feedback, a 5-point scale was introduced into the assessment tool to determine the importance of each specified KSC in the day-to-day work of each advisor (in addition to scoring competency levels). This helped to further prioritize capacity building within an individualized learning/training plan, a matter of particular importance given the organizational context of limited time and resources for professional development.

It was intended that, at an organizational level, the individual competency assessment results would be used to determine collective training needs, including the development of new training modules (as required). To avoid duplication of effort, and thus waste of resources, the intent was to catalogue existing M&E trainings from key training providers as a first step and, thereafter, to identify the

most appropriate training(s) for building specific competencies. The M&E competencies were used to label a range of trainings with KSC identifiers, but the cataloguing exercise was never completed due to (a) the vast volume of existing trainings, (b) a lack of transparency in training objectives and limited access to full training materials due to proprietary restrictions, and (c) contention within the MERG about a possible perception that KSC labelling of trainings could be implied as an endorsement of the training materials or a preferred choice of certain trainers or training institutions.

The use of the M&E competencies for focusing and evaluating trainings did prove successful. With support from Tulane University staff, a standardized KSC approach was used in the 3rd UNAIDS Global M&E Training in Bangkok, Thailand, in October 2008. The intensive two-week training included nine one-day modules with learning objectives related to key M&E technical and managerial competencies. Overall, more than 100 M&E professionals from 61 countries participated, including UNAIDS M&E advisors and M&E directors of national AIDS programs. The training evaluation found that the KSC approach enabled the delivery of high-quality training in terms of both relevance and effectiveness. The pre-post knowledge assessment and the feedback surveys indicated (a) important knowledge improvement in the majority of participants and (b) high satisfaction with the relevance of the learning objectives to job responsibilities and with the effectiveness of the training in meeting them. The KSC approach also provided a level of consistency and cohesion across the different one-day training modules as provided by different trainers. Participants made further recommendations for improvements, such as preparing participants in advance and/or providing multiple training tracks to target different "baseline" competency levels.

The KSC approach to M&E training was also well accepted by other HIV professionals. For example, 28 people designated as HIV Focal Points from the UN Department for Peacekeeping Operations (DPKO) were trained with a competency-based approach in the first DPKO-UNAIDS joint M&E training at the Regional Peacekeeping Training Facility in Entebbe, Uganda, in June 2012. The DPKO HIV Focal Points, who represented varied educational backgrounds and work experience, indicated their overall satisfaction with the KSC approach and showed increased M&E-related knowledge levels between pre- and post-training tests. The effect of the training on actual job performance was not assessed and would require more in-depth and longer-term follow-up.

While the above examples underscore some of the benefits of using a competency-based approach to human resource development in HIV M&E, improving an organization's M&E capital relies on continued and consistent investments. Recent changes within the AIDS environment and within UNAIDS itself have resulted in a shift of organizational priorities away from M&E as a key support function. These changes have, in turn, negatively impacted the organization's investment in and attention to comprehensive M&E capacity-building.

In sum, the M&E leadership competencies seemed to provide a focused way for addressing human capacity issues in HIV M&E: they were adaptable to specific job requirements and contexts. Not surprisingly, the willingness of M&E professionals to use the competency self-assessment tool was directly related to the relevance of the selected KSCs to their job realities. The KSC approach was well accepted by M&E professionals working at the national level, but also had appeal for those working at the service delivery level. The utility of the HIV M&E competencies for increasing an organization's M&E capital depended very much on the organization's consistent and long-term investment in M&E capacity development.

As the AIDS response takes place within a broader development context, the ultimate value of the M&E competencies also depended on how well they addressed the challenges of aid effectiveness. The rest of this article discusses these specific challenges and what they mean for the M&E leadership competencies.

CHALLENGES FOR M&E OF HIV AND AIDS IN A CHANGING AID ENVIRONMENT

The AIDS response in developing countries is firmly entrenched within international development, a field that has exploded in size and complexity since what is widely acknowledged as its founding period post-World War II (Escobar, 1995; Grillo, 1997; Hobart, 1993; Parpart & Veltmeyer, 2004; Sachs, 1992). Granted, the claim to humanitarian imperative has remained essentially stable since 1947 when the first major pan-national development project was established.[3] US Secretary of State George Marshall's ([1947] 2002) statement that "Our policy is directed not against any country or doctrine but against hunger, poverty, desperation and chaos" could be used as a marketing slogan for an aid agency today.[4]

But since the Marshall Plan, international development has experienced an ongoing burgeoning of theory and approaches (at donor, development agency, and program level), plus a steady increase in the number of aid-related agencies (in both the developed and developing world). International development—and, since the late 1980s, the global response to AIDS—has exploded to a multi-billion-dollar industry with a highly technicalized and professionalized workforce plus complex inter- and intra-national architecture of state and non-state actors. In addition, there have been ongoing shifts in financial realities (in terms of funds committed and funds delivered, as well as to whom, what for, where, and how) and in points of geographical, thematic, and financial focus from donors.

This growth has not, however, led to a concomitant growth in impact, either within AIDS responses or within international development as a whole. As noted on the website of the Organisation for Economic Co-operation and Development (OECD, 2012): "[S]uccess [in international development] has not always been evident: lack of co-ordination, overly ambitious targets, unrealistic time- and budget constraints and political self-interest have too often prevented aid from being as effective as desired." Failure to achieve the timeframes set for reaching the Millennium Development Goals (MDGs) sparked a series of high-level forums on aid effectiveness—and resultant declarations of action—that are widely credited with reframing the aid environment in a way not seen in the previous 60-plus years of international development. At the conclusion of the Fourth High Level Forum on Aid Effectiveness held in Busan, South Korea, in 2012, the *Busan Partnership for Effective Development Cooperation* explicitly identified "a focus on results" as a shared principle for all signatories (Working Party on Aid Effectiveness, 2011, p. 3). The *Partnership* was signed by representatives of 158 countries and 46 international organizations (including the Bill and Melinda Gates Foundation; the Global Fund to Fight AIDS, Tuberculosis, and Malaria; the United Nations Development Group; and the World Bank). Furthermore, the signatories committed to "partner[ing] to implement a global Action Plan to enhance capacity for *statistics* to monitor progress, evaluate impact, ensure sound, results-focused public sector management, and highlight strategic issues for policy decisions" (Working Party on Aid Effectiveness, 2011, p. 5, emphasis added).

Briefly, the new environment can be characterized as one in which there is increased national ownership, focus on donor alignment with national government priorities, a streamlining of donor efforts

in-country, greater focus on policy and practice for clear, monitorable goals, and joint donor and recipient responsibility for achieving these goals. Such reframing relies heavily on the existence of competent M&E practitioners within developing countries. Yet competence, like effectiveness, is a term that is epistemologically and paradigmatically understood. The ways in which individuals or organizations define competence or effectiveness, and the components used to assess whether or not competence and effectiveness are reached, are directly related to the individual/organizational position on what is valued and prioritized. This is best seen through the approach taken to favoured forms of knowledge. The reference to use of "statistics" in the *Busan Partnership* is a striking example of this.

Development theorists have long criticized donors for placing emphasis on data that do not recognize or account for the "difficult-to-measure" social, cultural, and political processes that are required if positive social change is to occur. Participation, empowerment, community resilience, and ownership are buzzwords used by all development agencies. Furthermore, the United Kingdom's Independent Commission for Aid Impact (ICAI, 2011), identified such processes as "the most transformational" and most likely to achieve "a long-term, sustainable difference [that] empowers intended beneficiaries" (Independent Commission for Aid Impact, 2011, p. 7). Yet as noted by Cornwall, Pratt, and Scott-Villiers (2004):

[R]elational concepts—such as "partnership" and "ownership," as well as "participation"—that are so much part of what development organizations say they do … do not lend themselves easily to definitions or standardized procedures. (p. 4)

It has long been acknowledged that AIDS is a disease with profound social, cultural, and political dimensions. As early as 1988, it was noted that "our responses to the current epidemic will be shaped by contemporary science, politics, and culture" (Brandt, 1988, p. 361). Yet over the years, the response has become increasingly professionalized and specialized. At an official social and political sciences pre-meeting of the International AIDS Conference held in Washington, DC, in 2012, Parker (2012) contrasted what he described as a first decade response based on "the art of caring, construction of solidarity … creativity of cultural activism and pushing the limits of institutional arrangements" with the response of the current decade, in which the response is dominated by "technologies" of prevention and care that draw on heavily biomedical frameworks (Parker, 2012).

In a recent review of social and behavioural communications for HIV and AIDS, Peersman (2012) described the dominance of a "service provision model" of prevention and care.

In conjunction with this, the M&E of AIDS responses has focused on the search for "hard," attributable evidence, inevitably represented by quantitative data. Donor funding and requirements predominantly collect and report on a handful of standardized "results" indicators that require statistical measurement rather than quality assessment. The underlying paradigm here is a positivist one, in that numbers are considered "objective," essential evidence, while qualitative data are subjective (a term often misrepresented as being synonymous with "biased"), and therefore either are not considered evidence at all or are considered an optional extra. Thus the participation of marginalized and vulnerable groups—a key requirement of HIV interventions—is commonly measured by numbers of people attending meetings. The quality, level, or nature of participation often remains unrecorded, unassessed, and therefore unconsidered. The same is true in relation to assessing the nature of, or shifts in the nature of, participants' marginalization and vulnerability.

MAKING THE CASE FOR UPDATING THE M&E COMPETENCIES IN HIV AND AIDS

Thirty years into the AIDS response, attention is shifting back to the challenge of addressing (and therefore the challenges of assessing changes in) the sociocultural aspects of the disease. The Social Drivers Working Group established as part of the aids2031 initiative stated:

> Rather than seeing social forces as peripheral issues … today we must shift our focus to treat social forces as *fundamental* to the response. Only when we treat biomedical, individual, interpersonal and social factors with equal weight and rigor can we hope to facilitate individual resilience to HIV and support AIDS-competent communities. (aids2031 Social Drivers Working Group, 2010, p. 4, emphasis added)

While the Social Drivers Working Group was using "we" to refer to social and behavioural change specialists, it is a message that is equally (if not more) important for national governments. The aforementioned high level fora on aid effectiveness all emphasized the need

for donors to align their work with national programs, priorities, and frameworks (including M&E frameworks), which is in keeping with UNAIDS' own expressed intent of facilitating development of *one* national HIV M&E system. The M&E competencies remain highly relevant here, as they were intended for possible use by audiences including "those responsible for M&E of the national HIV response; those responsible for M&E of national HIV and AIDS programs," and "resident M&E advisors from international organisations … whose specific role is to support the National AIDS Coordinating Authority (or equivalent) in the establishment and maintenance of the national HIV M&E system" (UNAIDS, 2010b, p. 5).[5]

Yet the M&E competencies were developed in a period of high positivism and, in hindsight, are clearly of their time. Reference is made to "evidence" and "evidence-informed decision-making" without acknowledgement given to the longstanding debates regarding what should be considered evidence, what is excluded or overlooked, and the resultant potentially negative consequences for program learning (Gujit, 2008). Overall, the M&E competencies present a linear and rather unproblematized view of M&E in which there is no explicit reference to the "difficult-to-measure" in international (and national) AIDS responses. The M&E competencies (unintentionally) reinforce what Chambers, Pettit, and Scott-Villiers (2001, p. 4) described as a continuing widespread reliance on "control-oriented cultures" within international development. Baser et al. (2008, p. 84) noted that individuals and institutions involved in international development are continually involved in a "search for clarity and certainty," as part of which they create "the illusion of 'time-bound' activities carried out in a 'timely' manner." This illusion is particularly pervasive when it comes to M&E—even though M&E should actively support and promote ongoing learning in relation to "the social forces [that are] fundamental to the [AIDS] response" (aids2031 Social Drivers Working Group, 2010, p. 4). Gujit (2008, pp. 7–8) has argued:

> Continual critical reflection is the basis for active and shared learning [but] … development processes [such as AIDS responses] have certain characteristics that confound those seeking to apply mainstream thinking on assessment and learning. It … involves many actors and multiple types of activities, often requiring risk taking and precedent setting without clarity about a positive outcome. In such contexts, the types of monitoring and evaluation processes favoured by funding agencies sit

> uneasily … it is paramount that the process of assessment and learning furthers the transformation processes themselves.

The time is right for a revised version of the HIV M&E leadership competencies—a version that supports national M&E professionals in questioning (and revising) existing M&E frameworks that neither effectively capture, nor contribute to learning from, changes in social forces that can support HIV prevention or AIDS care work.

ACKNOWLEDGEMENTS

The authors would like to thank Mr. Taavi Erkkola (Senior Advisor, Data for Action Team/Evidence, Innovation and Policy Department, UNAIDS) for his input on the experiences of UNAIDS advisors with the M&E competencies. The views expressed in this article are the authors' and do not necessarily reflect the views of UNAIDS, the working group participants, or the MERG membership.

CONFLICT OF INTEREST

The authors affiliated to Tulane University were supported by UNAIDS to lead working groups for the development of the competency tool and the competency-based training for M&E leadership in the AIDS response.

NOTES

1 The Global Fund recommends that 5% to 10% of a proposal's total budget be allocated to M&E activities. Proposal budgets devoted on average 8.1% to M&E as a Service Delivery Area; in contrast, the more narrowly defined M&E cost category averaged only 3.7% of the total program budget.

2 See http://www.unaids.org/en/dataanalysis/datacollectionandanalysisguidance/monitoringandevaluationguidelines/.

3 The post-war European Aid Program is more commonly known as the Marshall Plan after the 1947 Harvard University speech made by George Marshall to announce the plan. Marshall was awarded the Nobel Prize for his work to develop the European Aid Program.

4 The authors recognize that this humanitarian sentiment was accompanied by explicitly neoliberal economic discourses.

5 The other audiences were defined as "M&E leaders at subnational levels of government and in major nongovernmental and/or civil society organisations involved in the HIV response" and "those in charge of M&E for Global Fund grants (i.e., principle [sic] recipients, subrecipients)" (UNAIDS, 2010b, p. 5).

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