Guidelines for National M&E Plan

Indicator & Targets

Information Products

HIV/AIDS
NNRIMS OPERATIONAL PLAN
2007 – 2010

NATIONAL AGENCY FOR THE CONTROL OF AIDS

NACA 2007

Proudly Nigerian

Key HIV/AIDS National Response Targets

- Reduction of HIV prevalence by 25% by 2010
- Prevention of 55% of new HIV infections by 2010
- Placing of 550,000 HIV positive persons on treatment by 2010
- Providing care and support services for 1.6 million HIV positive persons by 2010

Nigerian National Response information Management System Operational Plan

Funding for the production of this book was provided by the Federal Government of Nigeria.

Produced by the National Agency for the Control of AIDS (NACA)

Published by ……
ISBN …… June, 2007

Printed by …….
(phone)……..
(e-mail)……..

FOREWORD

A lot has happened to our health and socio-economic polity since the first case of AIDS was diagnosed in Nigeria in 1986. At its onset, many individuals, families, communities and businesses in Nigeria did not give much thought to what changes it would cause to our dear country as we knew it. We have all felt the devastation of the epidemic in one way or the other; there is no community or facet of the nation that has not been affected. Nigeria's burden of care epidemic now ranks third in the world. About 3.2 million people are estimated to be living with the virus in the country. However, there is hope, gradually but steadily the epidemic has started showing signs of slowing down and the prevalence rate has dropped from 5.8% in 2001, to 4.4 in the 2005 adult sero-prevalence survey.

To a large extent, this can be attributed to this administration's decision to tackle the epidemic by initiating a multi-sectoral response program aimed at preventing the spread of the virus, and mitigating its impact on Nigerians. The country and indeed international partners have committed huge political capital, human and financial resources in this regard in the past ten years. From the development a three year Interim Action Plan called the HIV/AIDS Emergency Action Plan (HEAP 2001-2003) to guide the multi-sectoral response to the epidemic (extended to 2004). To the HIV/AIDS National Strategic Framework (NSF 2005-2009) which builds on the achievements of HEAP while at the same time addressing the challenges encountered and emerging issues identified.

A system known as the Nigerian National Response Information Management System (NNRIMS) was also put in place to track the successes and challenges of these strategic plans. This system has also undergone significant changes leading to the development of the NNRIMS Operational Plan (2007 – 2010). The NNRIMS Operational Plan has been designed to function as a simple but robust monitoring and evaluation system that will facilitate tracking of progress in the implementation of the National HIV/AIDS response and inform programs, policies and service delivery as a part of the multi-sectoral HIV and AIDS response in Nigeria based on the National Strategic Framework (2005-2009).

Based on findings of where we are today in the HIV/AIDS epidemic, the NNRIMS Operational Plan has made projections on where we should be in 2010. It is our collective goal and therefore our responsibility which can only be achieved with the determination and cooperation from all our friends, partners and stakeholders.

I appeal to all Nigerians, Civil society organizations and development agencies to adopt and use this plan as Nigeria's HIV/AIDS strategic information guideline to subdue the epidemic within the next five years, under the coordination of the National Agency for the Control of AIDS (NACA).

Let me thank everyone that has been involved or contributed in one way or the other to the development of this monitoring and evaluation operational Plan.
May the Almighty God help us stop this epidemic (Amen).

Professor Umaru Shehu
Chairman
NACA Governing Board
June 2007

PREFACE

The transformation of National Action Committee on AIDS to an Agency – National Agency for the Control of AIDS (NACA) in April is a remarkable achievement in Nigeria's drive to lay a solid foundation based on the 'three ones' principle. Close on the heels of this is the development of the NNRIMS Operational Plan (2007 – 2010), an HIV/AIDS epidemic and response tracking and review guideline agreed to by all implementing partners and stakeholders.

The 'liberalization' of the National response under the rubric of a multi-sectoral platform, the strengthening of NACA and the application of the 'three ones' principle has led to better oversight, coordination, linkage, networking as well as increased access to and efficient utilization of resources. This has provided avenues for a multi-sectoral and multi-level fight against the scourge of HIV/AIDS. To do this, a well articulated monitoring and evaluation operational plan with the input of all stakeholders for Nigeria's response through the National Strategic Framework of Action became overwhelmingly necessary. This informed the development of this NNRIMS Operational Plan for 2007 – 2010. This document drew largely from the gaps and challenges recorded in the review of past efforts aimed at combating this pandemic examining the achievements, constraints, emerging issues, lessons learnt and recommendations. The outcomes provided the foundation on which this framework is built.

This document benefited largely from the contributions of all the stakeholders (public and private sector, civil society, USAID, CUC DFID in Nigeria and other bilateral agencies, international non-government organizations) and extensive consultations in the development process. The inclusiveness and consultations that resulted in the production of this NNRIMS Operational Plan (NOP) makes it unique. The contribution of all those that participated in the process is hereby acknowledged.

I hereby urge all stakeholders in Nigeria to align their support in HIV/AIDS to our national objectives, strategies, policies, systems and cycles as contained in this document so that the goal of a '25% reduction in the incidence of HIV/AIDS within the next five years will be achieved.

The achievement of all sectoral response targets of the national priorities outlined in this NOP will assist us all greatly in the control of HIV/AIDS, both nationally and internationally and lead us to our desired goal.
Thank you.

Professor Babatunde Osotimehin
Director General
NACA
June 2007

ACKNOWLEDGEMENTS******

This NNRIMS Operational Plan 2007 to 2010 is the result of seven months rigorous work and the combined effort and support of various individuals and organizations. The process drew resources (technical, financial, moral and spiritual) from all stakeholders. The process commenced with the review of the National response monitoring and evaluation system which provided the basis for the development of the NNRIMS Operational Plan (2007 – 2010).

NACA acknowledges the important role played by the members of the Technical Team for the vision in driving the process, providing oversight and linkages, mobilizing resources and facilitating the entire process. Special thanks go to the members of the Technical Team, for ensuring that this document was finalized. The Team includes: Akin Atobatele of USAID; Toyin Jagha of WB; Kola Oyediran of MEASURE Evaluation; Henry Damisoni of UNAIDS; Mrs. Oby Okwuonu of Fed. Min. of Women Affairs and Social Development; Mrs. Z.U. Momodu of Fed. Min. of Education; Mike Merrigan of FHI/GHAIN; Wole Fajemisin of NASCP/PATHS; Rose Iwueze NASCP/UNAIDS; Mukhtar Mohammed of CDC; Peter Edafiogho of IHVN; Prosper Okonkwo of APIN; Greg Ashefor, Wale Adeogun and Uchenna Onyebuchi from NACA; Godspower Omoregie of SFH; Chidozie Ezechukwu of NEPWHAN, and Roni Babangida Lawal of CiSHAN

NACA also appreciates the technical facilitation role of GAMET in producing the zero draft of the plan. The several visits by Rosalia……. and Marcello…….. and their technical inputs have in no small measure enriched the document.

The review of national response monitoring and evaluation system for HIV and AIDS in Nigeria was based to a large extent on documents and reports submitted to NACA from a broad range of stakeholders, in government, civil society , support groups and development partners. NACA appreciates their invaluable contributions. The entire National Monitoring and Evaluation Technical Working Group who reviewed and analyzed the national response must be commended. This document would not have been possible without their dedication and teamwork.

The Government of Nigeria and NACA acknowledge the financial, technical and logistical support provided by the following institutions: United Nations Systems in Nigeria (UNDP, UNAIDS, UNIFEM, UNFPA, WHO, UNODC, UNHCR and ILO, GAMET, USAID, DFID, CIDA, GHAIN, MEASURE Evaluation, World Bank team and the Action-Aid SIPAA.

All the staff of NACA provided valuable insights, helpful suggestions and support. I hope this document will be useful to all stakeholders in monitoring, evaluating and reporting efforts in fighting HIV and AIDS in Nigeria

Dr Kayode Ogungbemi
Director,
Strategic Planning, Research, Monitoring and Evaluation
NACA.
June 2007

STAKEHOLDERS' COMMITMENT

DECLARATION OF COMMITMENT TOWARDS THE IMPLEMENTATION OF THE NNRIMS OPERATIONAL PLAN IN NIGERIA

1. CONTEXT

"We the stakeholders involved in Nigeria's response to AIDS:

1.1. Realizing that the AIDS epidemic constitutes a national and global health crisis of unprecedented magnitude, that impacts on economic and social development worldwide and poses a security threat to nations.

1.2. Affirming the need to respond to this global and national emergency, through the coordination principles of 'Three Ones' namely:

- One National AIDS Coordinating Authority, (NACA) with a broad based multi-sector mandate
- One National Strategic Framework (NSF) for AIDS Action that provides the basis for the work of all partners
- One National Monitoring and Evaluation Framework (NOP), to track, monitor and evaluate the national AIDS response; within the national socio-legal framework.

1.3. Recognize the National Agency for the Control of AIDS (NACA), which has a broad based mandate as the One National coordination Authority.

1.4. Recognize the Nigeria National Response Information Management System Operational Plan (NOP) as the one monitoring and Evaluation Tool to track, monitor and evaluate the national AIDS response.

2. PRINCIPLES

We, on this 28th.day of June 2007 declare our commitment to the following principles:

2.1. National ownership and leadership of the AIDS response monitoring and evaluation at all levels.

2.2. Active involvement of all stakeholders in the planning, execution, tracking and reviewing of the HIV/AIDS trends and response at all levels.

2.3. Provide voluntary and timely information to feed into the nationally agreed Nigeria National Response Information Management System Operational Plan (NOP) of the AIDS response.

3. UNDERTAKINGS

Bearing in mind the above and that Nigeria is experiencing a generalized epidemic, we commit ourselves to make immediate and relevant decisions to address the complexities and challenges presented by the epidemic through information provided by the Nigeria National Response Information Management System Operational Plan (NOP); by building on the June 2001 UNGASS Declaration of Commitment on AIDS and other international, regional, and national agreements, and interventions of the National Strategic Framework.

We resolve to undertake the following:

3.1. Promote ***use of the NOP as the central system for data gathering, decision making, planning and programming*** of all AIDS activities implemented by the Stakeholders and partners.

3.2. Under the national leadership of NACA, engage with other stakeholders to ***update*** programmes and projects to promote compatibility with the NSF.

3.3. Strive towards synchronized ***planning and review cycles*** in line with the NACA led annual review and planning in order to maximize the use of national capacities and competencies.

3.4. Promote data collection, harmonized reporting procedures and timelines regarding the HIV epidemic within the context of the ***NNRIMS Operational Plan.***

3.5. Review ***individual agency M&E requirements*** to minimize additional and unnecessary management and reporting burden on national and state capacity.

3.6. Ensure adequate ***representation, feedback and accountability mechanisms*** of constituency views in the coordination mechanisms at all levels and within all sectors.

3.7. Ensure constituency representation in the ***various sub-committees*** of the National AIDS Partnership Committee on Monitoring and Evaluation, information and knowledge management among others to facilitate NACA's task in effectively fulfilling its coordinating role.

3.8. Continue to strengthen ***information sharing and knowledge management mechanisms*** within the constituency, availing information to NACA, partners and other various constituencies.

3.9. Promote and encourage the implementation of the principles of the 'Three Ones' at the State level.

3.10. Create a conducive environment for the advancement of science and research in Nigeria whilst adhering to highest ethical and scientific standards.

3.11. Promote best practices and lessons learnt both inside and outside of Nigeria, and foster regional cooperation in information sharing using the NOP as a guiding document.

3.12. Ensure that all data to be reported on HIV/AIDS response are reconciled and cleared with NACA Monitoring and Evaluation Unit.

3.13. Ensuring that the NOP's key targets are achieved. They are:–

- **Reduction of HIV prevalence by 25% by 2010**
- **Prevention of 55% of estimated new HIV infections by 2010**
- **Placing 550,000 HIV positive persons on treatment by 2010**
- **Providing care and support services for 1.6 million HIV positive persons by 2010**

IN WITNESS WHEREOF the undersigned, being duly authorized representatives of the parties hereto, have signed this Declaration of Commitment on the day and year first above written.

FOR NATIONAL AGENCY FOR THE CONTROL OF AIDS

……
……

BOARD CHAIRMAN **DIRECTOR GENERAL**

FOR THE DONOR COORDINATION GROUP

……
……

USG **DfID**

FOR THE CSO AND NETWORKS

……
……

CiSHAN **NEPHWAN**

FOR THE UN SYSTEMS

……
……

UNAIDS **WORLD BANK**

LIST OF ACRONYMS

AAIN	Action-Aid International Nigeria
AFPAC	Armed Forces Programme on AIDS Control
AIDS	Acquired Immuno-deficiency Syndrome
ANC	Ante-Natal Clinics
APIN	AIDS Prevention Initiative in Nigeria
ALGON	All Local Government of Nigeria
ARFH	Association for Reproductive and Family Health
ARH	Adolescent Reproductive Health
ART	Anti-Retroviral Therapy
ARV	Anti-Retroviral
BCC	Behavior Change Communication
CBOs	Community-Based Organizations
CCE	Consultative Constituent Entity
CCM	Country Coordination Mechanism
CDA	Community Development Association
CDC	Centre for Disease Control and Prevention (US)
CEDAW	Convention on the Elimination of Discrimination Against Women
CHAN	Christian Health Association of Nigeria
CHBC	Community and Home-Based Care
CIDA	Canadian International Development Agency
CiSNAN	Civil Society Network on HIV/AIDS in Nigeria
CJ	Chief Judge
CJN	Chief Justice of Nigeria
CRA	Child Rights Act
CSOs	Civil Society Organizations
CSW	Commercial Sex Worker
DFID	Department for International Development (UK)
ETG	Expanded Thematic Group
FBOs	Faith-Based Organizations
FCT	Federal Capital Territory
FEC	Federal Executive Council
FGN	Federal Government of Nigeria
FHI	Family Health International
FLE	Family Life Education
FMOH	Federal Ministry of Health
FMOL	Federal Ministry of Labour
FMOWA	Federal Ministry of Women Affairs
FMIGA	Federal Ministry of Inter-governmental Affairs, Youth Development & Special Duties
GFATM	Global Fund to fight AIDS, Tuberculosis and Malaria
GHAIN	Global HIV/AIDS Initiative Nigeria
GIPA	Greater Involvement of People Living With HIV/AIDS
HAF	HIV/AIDS Fund
HBC	Home-Base Care
HEAP	HIV/AIDS Emergency Action Plan
HCT	HIV/AIDS Counselling and Testing
HIV	Human Immuno-deficiency Virus
HSSP	Health Sector Strategic Plan
IAP	Interim Action Plan
IDPs	Internally Displaced Persons
IDU	Intravenous Drug User
IEC	Information, Education and Communication
ILO	International Labour Organization
INGO	International Non-Governmental Organization
IHVN	Institute of Human Virology Nigeria
LACA	Local Government Action Committee on AIDS

LDDs	Long Distance Drivers
LGA	Local Government Area M&E Monitoring and Evaluation
MAP	Multi-country AIDS Program
MARPs	Most At Risk Persons
MDGs	Millennium Development Goals
MoU	Memorandum of Understanding
MSM	Men who have Sex with Men
M&E	Monitoring and Evaluation
NACA	National Agency for the Control of AIDS
NDE	National Directorate of Employment
NAFDAC	National Agency for Food and Drug Administration and Control
NAPEP	National Poverty Eradication Programme
NARHS	National Adolescent and Reproductive Health Survey
NASCP	National HIV/AIDS/STI Control Programme
NASSRA	National Assembly Response to AIDS
NBCC	National HIV and AIDS Behavior Change Communication Strategy
NDHS	National Demographic and Health Survey
NEEDS	National Economic Empowerment and Development Strategy
NEPAD	New Economic Partnership for Africa Development
NEPWHAN	Network of People living With HIV and AIDS in Nigeria
NERB	National Ethical Review Board
NGO	Non-Governmental Organization
NHIS	National Health Insurance Scheme
NHVMAG	Nigeria, HIV Vaccine and Microbicide Advocacy Group
NiBUCAA	Nigerian Business Coalition Against AIDS
NIMR	Nigerian Institute of Medical Research
NIPRD	National Institute for Pharmaceutical Research and Development
NISER	Nigerian Institute for Social and Economic Research
NNRIMS	Nigeria National Response Information Management System for HIV/AIDS
NOPs	NNRIMS Operational Plan
NPC	National Planning Commision
NRCS	Nigerian Red Cross Society
NRR	National Response Review
NSF	National Strategic Framework
NURTW	Nigerian Union of Road Transport Workers
NYNetHA	Nigerian Youth Network on HIV/AIDS
OIs	Opportunistic Infections
OPS	Organized Private Sector
OVC	Orphans and Vulnerable Children
PABA	People Affected By AIDS
PAC	Presidential AIDS Council
PEP	Post Exposure Prophylaxis
PEPFAR	President's Emergency Plan For AIDS Relief
PESSP	Persons Engaged in Same Sex Practice
PLWAs	People Living With AIDS
PMAN	Performing Musicians Association of Nigeria
PMM	Patient Management and Monitoring
PMTCT	Prevention of Mother-To-Child Transmission
PSC	Partnership Steering Committee
PSI	Population Services International
PTC	Partnership Technical Committee
PSRHH	Promoting Sexual and Reproductive Health for HIV/AIDS reduction
PWG	Partnership Working Group
R&D	Research and Development
SACA	State Action Committee on AIDS
SEEDS	State Economic Empowerment and Development Strategy
SFH	Society for Family Health
SGF	Secretary to the Government of the Federation

SIPAA	Support to International Partnership against AIDS in Africa
SSG	Secretary to the State Government
SNR	Strengthening National Response
SPC	State Planning Commission
STIs	Sexually Transmitted Infections
SW	Sex Worker
TB-DOTS	Tuberculosis Direct Observation Treatment Scheme
UN	United Nations
UBE	Universal Basic Education
UNAIDS	Joint United Nations Programme on AIDS
UNDP	United Nations Development Programme
UNESCO	United Nations Educational, Scientific and Cultural Organization
UNFPA	United Nations Population Fund
UNGASS	United Nations General Assembly
UNICEF	United Nations Children Fund
UNIFEM	United Nations Development Fund for Women
UNODC	United Nations Office on Drugs and Crimes
USAID	United States Agency for International Development
USDOL	United States Department of Labour
VCT	Voluntary Counseling and Testing
WB	World Bank
WHO	World Health Organization

CONTENTS

LIST OF TABLES

LIST OF FIGURES

LIST OF ANNEXURE

Chapter 1 ******

INTRODUCTION

BACKGROUND

A. Nigeria the Country: Nigeria, the most populous country in Africa ,is located within 3º and 14º longitudes, and 4º and 14º latitudes. It has a landmass of 923,968 square kilometers. It is located in West Africa and shares international borders with the Republics of Cameroon, Chad, Niger and Benin (Chart 1). Nigeria is the seventh country with the largest oil reservoir and the tenth in the world with over 373 ethnic groups- Not clear Preliminary results of the most recent census put Nigeria's population at 140 million (NPC 2006) [1].

[1] NPC 2006

Figure 1: Map of Nigeria

Administratively, the country is divided into 36 states and a Federal Capital Territory (FCT). The states are semi-autonomous under the country's constitution with each having independent administrative, legislative and judicial system built to fit into the central system. The states and the FCT are further divided into smaller administrative units called local government areas or councils totaling 774. For political, population and economic analysis the states are grouped into six geo-political zones; South-West (SW), South-South (SS), South-East (SE), North-East (NE), North-Central (NC) and North-West (NW).

B. HIV/AIDS Epidemiology and Response Co-ordination: Nigeria recorded her first case of AIDS in 1986. Since then, the epidemic has steadily increased from 1.8% in 1991, to 5.8% in 2001 to 5% in 2003 and finally retrogressing to 4.4% in 2005. The low literacy level, high poverty level and poor health-seeking behavior of most Nigerians, as well as the limited access to health services and low status of women in society have significantly contributed to the spread of HIV in the country. During the military era when the first case of AIDS was confirmed and reported, the attitude of government and general population to the epidemic was denial. However, the advent of democratic rule in 1999 brought about a significant change in the attitude of government to the epidemic as well as the responses to it.

The attitude of denial gave way to admission and refocusing of the response from being health sector-led to a truly multi-sectoral one, coordinated at the federal level by National Governing Board and the National

Action Committee on AIDS (NACA) established in 2001 and transformed into an Agency through the Act of the National Assembly in 2007. The Agency is now called the National Agency for the Control of AIDS and has a Governing Board. At the state level, coordination is led by the State Action Committee on AIDS (SACA), which are transforming into Agencies for effective performance and sustainability, while the Local Government Action Committee on AIDS (LACA) holds forth at the Local Government level. Coordinating structures were put in place and an Interim Action Plan (IAP) was developed to combat the epidemic in 2000. This strategy was named the HIV/AIDS Emergency Action Plan (HEAP 2001-2003). In 2004, a review of the national HIV and AIDS response was carried out, which pointed to the need for a new plan, the National Strategic Framework (NSF 2005 – 2009)[2] that was developed through a widely consultative and participatory process.

C. Monitoring and Evaluation: As in most African countries, monitoring of the HIV epidemic in Nigeria was primarily through sentinel surveillance targeting pregnant women attending antenatal care services in line with the global guidelines from the World Health Organization (WHO). From 1999, when the country embraced a multi-sectoral response approach it became quite apparent that the HIV sentinel surveillance was grossly inadequate to monitor the epidemic and related responses. Against this background, Nigeria identified the need for a robust, standardized and unified monitoring and evaluation framework in 2002. The initiative resulted in the Nigeria National Response Information Management System (NNRIMS) framework[3] that was to guide monitoring and evaluation of interventions implemented under the HEAP. The NNRIMS framework was officially launched in April, 2004. The adoption of the 'Three Ones' principles provided additional push for NNRIMS.

The current HIV/AIDS epidemic characteristics and the rapid scale up of the national response has made it appropriate to revise the NNRIMS framework to align with issues articulated in the NSF as well as Nigeria's roadmap for moving towards Universal Access (UA) for prevention, treatment, care and support. The process will also provide an opportunity to address some of the weaknesses particularly an adequately budgeted operational plan to provide the basis for resource mobilization for monitoring and evaluation.

1.1 GOAL AND OBJECTIVES OF THE NNRIMS OPERATIONAL PLAN (2007-2010)

A. Goal: The primary goal of the NNRIMS Operational Plan is to provide a simple and robust monitoring and evaluation system that will facilitate -

a) tracking of progress in the implementation of the National HIV/AIDS response and

b) using information to inform programs, policies and service delivery as part of the multi-sectoral HIV and AIDS response in Nigeria based on the National Strategic Framework (2005-2009)

[2] National Strategic Framework for Action, 2005 - 2009

[3] –Nigeria National Response Information Management System

B. Specific Objectives

1. To develop the requisite infrastructure for monitoring and evaluation in Nigeria
2. To develop the required human resource capacity across levels of the national response
3. To harmonize indicators and standardize data tools and collection systems
4. To coordinate and strengthen second generation surveillance and HIV/AIDS operational plan
5. To develop a database or clearing house for all strategic information on the national response
6. To define clear roles and responsibilities in monitoring and evaluation across different levels and sectors of the system
7. To facilitate efficient data transmission and feedback flow
8. To outline how data collected by NNRIMS should be used
9. To mobilize adequate financial and material resources to support full operationalization of the monitoring and evaluation plan (2007- 2010)

C. The National Strategic Framework (2005 - 2009)

The National Strategic Framework (NSF) seeks to reduce HIV incidence and prevalence by at least 25% and provide equitable prevention, treatment, care and support while mitigating its impact among women, children and other vulnerable groups and the general population in Nigeria by 2009. To realize this goal, a set of 8 objectives have been articulated and these are:

1. To increase program implementation rate by 50% from 2005-09 through improved coordination mechanisms and effective mobilization and utilization of resources.
2. To have 95% of the general population make the appropriate behavioral changes (safe sex, abstinence, etc) through social mobilization by 2009.
3. To increase access to comprehensive gender sensitive prevention, care, treatment and support services for the general population, PLHAs, orphans and vulnerable children by 50% in 2009 and mitigate the impact on the health sector.
4. To increase gender-sensitive non-health sectoral responses for the mitigation of HIV/AIDS by 50%.
5. To have 95% of specific groups make the appropriate behavioral changes (safe sex, abstinence etc) through social mobilization by 2009.
6. To strengthen national capacity for monitoring and evaluation of the response such that the national monitoring and evaluation plan is 100% implemented by 2009.
7. To build national capacity for research, knowledge sharing and the acquisition and utilization of new HIV and AIDS technologies.
8. To improve the policy environment (policies, guidelines, legislation) that supports safe sex practices, reduce stigma, promotes positive living and rights of women and the general population, particularly PLHAs.

1.2 METHODOLOGY: *The Development Process of the NNRIMS Operational Plan*

In 2006, NACA produced a concept note to guide review of the NNRIMS framework, development of an operational plan and harmonization of indicators. A committee was constituted to drive the process and included participants from:

- The National Agency for the Control of HIV and AIDS in Nigeria (NACA)
- Federal Line Ministries and Parastatals
- SACAs
- Donor and Implementing Partners
- Civil Society Organizations

The Global AIDS Monitoring and Evaluation Team (GAMET) of the World Bank was approached and kindly accepted to provide technical assistance for the development of the operational plan while WHO and MEASURE

Evaluation and NASCP consultants provided technical assistance in harmonizing indicators to be included in the plan. The GAMET support was a direct response to the Monitoring and Evaluation needs of Nigeria identified by a World Bank mission to Nigeria in early 2006[4]. A GAMET consultant worked with NACA, NASCP and other stakeholders to produce the first draft of the plan that provided the basis for technical inputs from stakeholders.

NACA mostly led the process of the development of the plan. The first draft of the document was produced in February 2007 and jointly reviewed at a Stakeholders' Forum in Lokoja, Kogi State[5]. Following this, a core group of reviewers drawn from a cross-section of participants at the Forum who were also members of the National Monitoring and Evaluation Technical Working Group synchronized the comments and input from various stakeholders, also made significant contributions to the finalization of the document. In May 2007, a target setting meeting was organized in Kaduna with support from UNAIDS and facilitated by CDC, USAID, NACA, NASCP and Development Partners to set realistic targets and established baseline for all indicators in the plan[6]. The final draft was circulated amongst stakeholders in June for final comments and the comments were incorporated to finalize the document.

[4] Trip Report. Review of M&E Activities in HIV/AIDS, Abuja, Nigeria, March 12-18, 2006. Dr. Rosalía Rodriguez-García, GAMET, Global AIDS Program, World Bank and Dr. Marcelo Castrillo, GAMET Consultant
[5] –Report of Stakeholder's Forum. Lokoja March 2007
[6] –Report of Target Setting meeting. Kaduna May 2007

MONITORING AND EVALUATION CONCEPTUAL FRAMEWORK

I. Background

Monitoring and evaluation is an essential process and tool to make informed decisions about operations management and service delivery, including efficient use of resources; determine the extent to which the program is on track and to make any needed corrections accordingly; and evaluate the extent to which the program/project is having or have had the desired impact. Monitoring and Evaluation is of vital importance to the successful implementation of programs since it is the only way of establishing what is being done and if the interventions being undertaken are making a difference. Establishing a Mnitoring and Evaluation comprehensive system to track HIV/AIDS spread and program is very critical. Furthermore, the epidemic is relatively new, and has the potentials of causing more damage to the human system and race, ,. There is no certainty of its new course of infection, and as such posing challenges different from many other issues in development. Continuous assessment is necessary that new interventions are constantly being proposed. Effort must be made to identify interventions that are more effective to make them more central in the national response. To effectively fulfill its mandate of -coordinating, the national response to HIV/AIDS, the National Agency for the Control of AIDS (NACA) and stakeholders need to understand the scope and effect of HIV interventions in Nigeria. In order to do this a functional and effective Monitoring and Evaluation (M&E) system needs to be in place. This section of the National M&E Plan provides:

- an overview of National Response M&E system on a conceptual level, and
- defines the denominators and numerators for each of the indicators highlighted in the indicators' matrix

*888The Monitoring and Evaluation strategy as given in this section will highlight the following:

- Objectives of the Monitoring and Evaluation strategy adopted by the plan.
- Programme /reporting levels.
- Levels of indicators to be generated.
- Monitoring and Evaluation activities (assumed formats)
- Institutional framework and structures for monitoring and evaluation of the national response.
- Reporting channels and linkages between the various actors in the Monitoring and Evaluation strategy.
- Coordination of the monitoring and evaluation activities at the National, sectoral and State levels.
- Data collection, analysis and dissemination.

11. National HIV/AIDS Monitoring and Evaluation System

On a generic level, a monitoring and evaluation system can be defined as a system designed to guide the process of collecting, analyzing and presenting specific data, based on pre-defined indicators, with the purpose of *quantifying* achievement (or levels of success) of a defined strategy and *guiding* future strategy and interventions. Based on this generic definition, the Nigeria National Response Monitoring and Evaluation system for HIV/AIDS consists of the following elements:

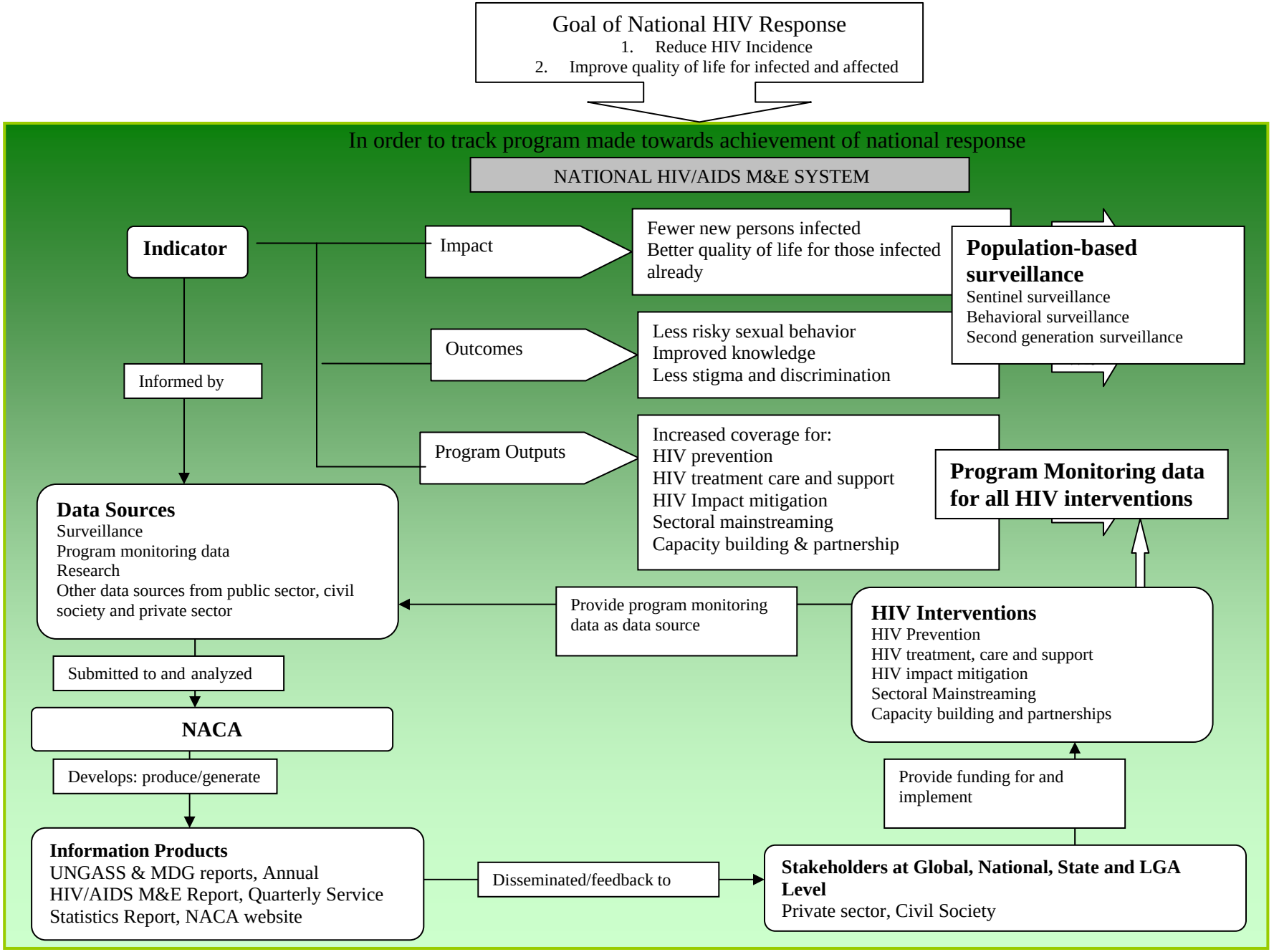
1. Understanding the ***overall goal/s*** of country's national response
2. Setting the quality standard (i.e. defining how we will know when we have achieved the overall goal/s). This is done by defining specific ***indicators,*** which would provide guidance as to whether the interventions have been successful in achieving the goal.
3. Further to the definition of a set of indicators, ***each indicator is also described in detail***, including what the indicator measures, how the denominator and numerator are calculated, how often the indicator will be measured and the strengths and limitations of the indicator.

4. Definition of the ***data sources*** from where information will be obtained for the measurement of the indicators
5. A detailed description of the ***information products*** that will be produced by the National Agency for the Control of HIV & AIDS on a periodic basis, using the data sources and plans for enhancing the use of this data and information for program and policy decisions.
6. The goal/s, indicators and data sources need to form the backbone of the Monitoring and Evaluation system, and it is clearly linked using a *conceptual framework* such as a logical framework[7].
7. A ***process flowchart*** that details the activities involved in the data collection, capture, analysis and presentation cycles, the sequencing of these activities as well as the responsibilities of the internal (to NACA) and external (to NACA) stakeholders responsible for the execution of these activities
8. Description of the ***responsibilities*** of the members of NACA's M&E unit
9. ***Annual work plan*** for the execution of the Monitoring Evaluation system, including the annual responsibilities of NACA's internal and external stakeholders
10. ***Annual operational budget*** to execute the Monoitoring and Evaluation work plan

Key elements of NACA's HIV/AIDS Monitoring and Evaluation system, as well as the relationships between the elements (see Figure 2)

[7] *This logical framework should not be separated from the M&E system itself, but the M&E system should be based on this framework, and the elements of the system itself should flow from this framework.*

Figure 2: Conceptual Framework



II. Relationship between National M&E System and Program-Level M&E System

A strong link exists between a national HIV/AIDS Monitoring and Evaluation system - the goal of which is to track the progress made in terms of the national response - and the Monitoring and Evaluation systems of specific programmatic areas (such as PMTCT, HIV Care and Treatment Patient Management and Monitoring system, VCT and OVC). A national M&E system provides a national overview to enable decision-making and track progress from a national perspective. A programmatic-level M&E system collects data for use by the implementers of the HIV program ***and*** for feedback to the national M&E system. Thus, a program-level Monitoring and Evaluation system will collect more data on more indicators than what is required by the national M&E system – but as a minimum requirement it should collect ALL of the information that is needed to measure the national indicators.

Thus, a program-level M&E system should provide some of the data that it collects to the national level, whilst the additional information that has been collected will be used at program level. This implies the need for the information that is collected at local level to be useful to the sector/partner who collects that information – the principle of "collect it only if it is useful to use".

The other link between the national M&E system and program-level M&E systems is that reporting to the national M&E system should be defined in the HIV program area's set of implementation guidelines. This will ensure implementers of programmes are clear on their responsibilities in terms of data collection for their own management purpose and for the purpose of providing data to the national M&E system.

Please refer to sectoral M&E plan (to be developed) by key sectors for a more detailed description of the status of program-level M&E systems for each of the HIV program areas.

III. Monitoring and Evaluation Reporting Levels

With the assumption that all implementers are operating in well-defined geographical area (e.g. Facility, Community, LGA and State), there will be three levels of reporting. While the two levels of reporting will consider information generated as a result of service delivery, the third will take care of information from special studies and research. At the lowest level, which is the implementation level each organization will have indicators to monitor the various activities of their programmes. A standard format will be supplied to the organizations to summarize only that information required for facility level reporting. At the second level, LGA will use a standardized form to summarize the information from the different implementers within the respective LGAs and forward it to their respective State AIDS Coordinating Agency (SACA). The third level of reporting will be the national level from special studies conducted by NGOs, development partners, HIV/AIDS networks and research institutions. NACA will then be responsible for national and international level dissemination of the information.

IV. Data Collection for National Monitoring and Evaluation

The monitoring and evaluation of the national response will be guided by NACA based on the Monitoring and Evaluation plan for the expanded national HIV/AIDS response. The M&E plan addresses the three main goals of HIV/AIDS prevention, mitigation and capacity building as given in the National Strategic Framework (NSF). The plan matrix highlights the envisaged Monitoring and Evaluation activities, the indicators for the

specific HIV/AIDS interventions, sources of data to generate the indicators, the frequency of data collection for the specific indicators, the responsible units for collection, processing, analysis and aggregation of data required for the monitoring and evaluation of the national response at different levels. The plan also elaborates the methodology for calculating the indicator (definition) to ease application by various actors.

The National Agency for Control of AIDS (NACA) will work with relevant stakeholders and partners to collect data for generating reports on the national response and for dissemination among the stakeholders and to the international fora. Care has been taken to explore the possibility of utilizing all available data sources before suggestions are made to use survey methods that are often times expensive. Baseline data for the NSF is available from the NDHS, NARHS, ANC sentinel surveillance programme records while data for some indicators will be available on annual basis and others will be available periodically. Survey based indicators will again be available during the final year of the NSF – 2008/9 from the NDHS and NARHS surveys.

Data for National Monitoring and Evaluation indicators will be obtained from five main sources:

a) Periodic national level survey like the NARHS 2005, NDHS 2003,
b) Programme service data records at national level, e.g. NNRIMS
c) Programme service data records at facility level, e.g. care and support for PLHAs records
d) Special studies, e.g. facility based surveys for STI services, survey of establishments.
e) Sentinel Surveillance which are conducted biennially by the Ministry of health, will be a key feature of the Monitoring and Evaluation plan.

For all the sources FMOH, USG, DfID, World Bank, WHO and other partners will make effort to improve the reliability of the data collected. The sentinel surveillance data is based on antenatal clinics including women of all age groups. It is the plan of the FMOH to continue tracking prevalence and also monitor incidence by sampling young women in the age group 15-24. The sentinel sites will also be expanded to target different regions of the country and different population groups to help generate estimates of HIV prevalence that are more representative nationally.

The surveillance reports will also consistently include information on behavioral changes over time in regard to the sexual and social transmission factors. The levels of infections in different population sub groups together with the behavioral surveillance data will guide the specific interventions to address the identified risk factors. The surveillance reports will, to the extent possible, disaggregate the prevalence and infection rates by sex, age groups and other social economic categories that would be of importance depending on the predisposed risk factors.

To ensure complete and timely reporting, it will be necessary to have a deliberate programme for capacity building for monitoring and evaluation at the State, LGA level and small CSOs.

V. Coordination of Monitoring and Evalution Activities

Coordination of the national response to HIV/AIDS is the core function of NACA. This role would ideally involve bringing together all actors who are involved in combating the epidemic for the harmonious implementation of HIV/AIDS activities. Equally, as a sub-activity of the agency, efficient implementation of the Monitoring and Evaluation Plan will require well-established coordination mechanisms at all levels of monitoring and evaluation. It is noteworthy that effective implementation of the plan will go a long way in enhancing the overall coordination role of the agency. The following sections describe the coordination mechanisms at different levels. The National Monitoring and Evaluation Coordination meeting will take as a priority the issues of developing and making available standardized national tools, SOP for data quality and production of nationally agreed information products.

A. National Coordination of the Monitoring and Evaluation Plan

NACA will convene bi-annual Monitoring and Evaluation coordination meetings to bring together key implementers of HIV/AIDS programmes and States to discuss the modalities of implementing the national Monitoring and Evaluation plan and to address whatever challenges may have arisen during the process. This forum will enable the NACA to have an ability to determine the practical usefulness of the plan to the stakeholders and to the agency .

B. State Coordination for Monitoring and Evaluation

State HIV/AIDS Committees (SACAs) will hold quarterly coordination meetings for all implementing partners to harmonize the data collection and reporting. The meetings should clearly define the activities to be reported on and agree on who should report in cases of overlap. For example, one organization providing money for income-generating activities to a family affected by HIV/AIDS and a technical input for income generation provided by another organization for the same household, the household should be counted once for income generation support. The meetings will help avoid duplication and overestimation of indicators.

The State HIV/AIDS focal person will facilitate and guide the state meetings.

The issue of data use will be broached at the meetings so that other partners/levels can use the data that is being collected to improve service delivery. Issue of supervisory data verification and quality should be of priority at state level coordination meetings.

C. Donors Coordination for Monitoring and Evaluation

Donor support will be very important to ensure effective and efficient implementation of the M&E Plan. Most donors will often require more information than is necessary for national level monitoring. However, there is a need for a harmonized information flow and the sets of data to be collected between the three parties; donors, NACA and the implementers.. NACA will establish an M&E forum with the key donors and development partners involved in the HIV/AIDS National response to regularly update them on the requirements of the Monitoring and Evaluation plan and to solicit their support for its implementation.

The forum will give an opportunity for the donors to have an input in the implementation of the M&E plan by way of reviewing the programme areas and the indicators.
For effective implementation of this plan, specific states will be assigned to donors and implementing partners who shall provide technical and financial support to the state to ensure full implementation of NNRIMS Operational Plan in the states. The support amongst other things will include capacity building, data collection, supervision, verification, analysis reporting and submission to the national system.

D. Coordination of Data Dissemination on HIV/AIDS

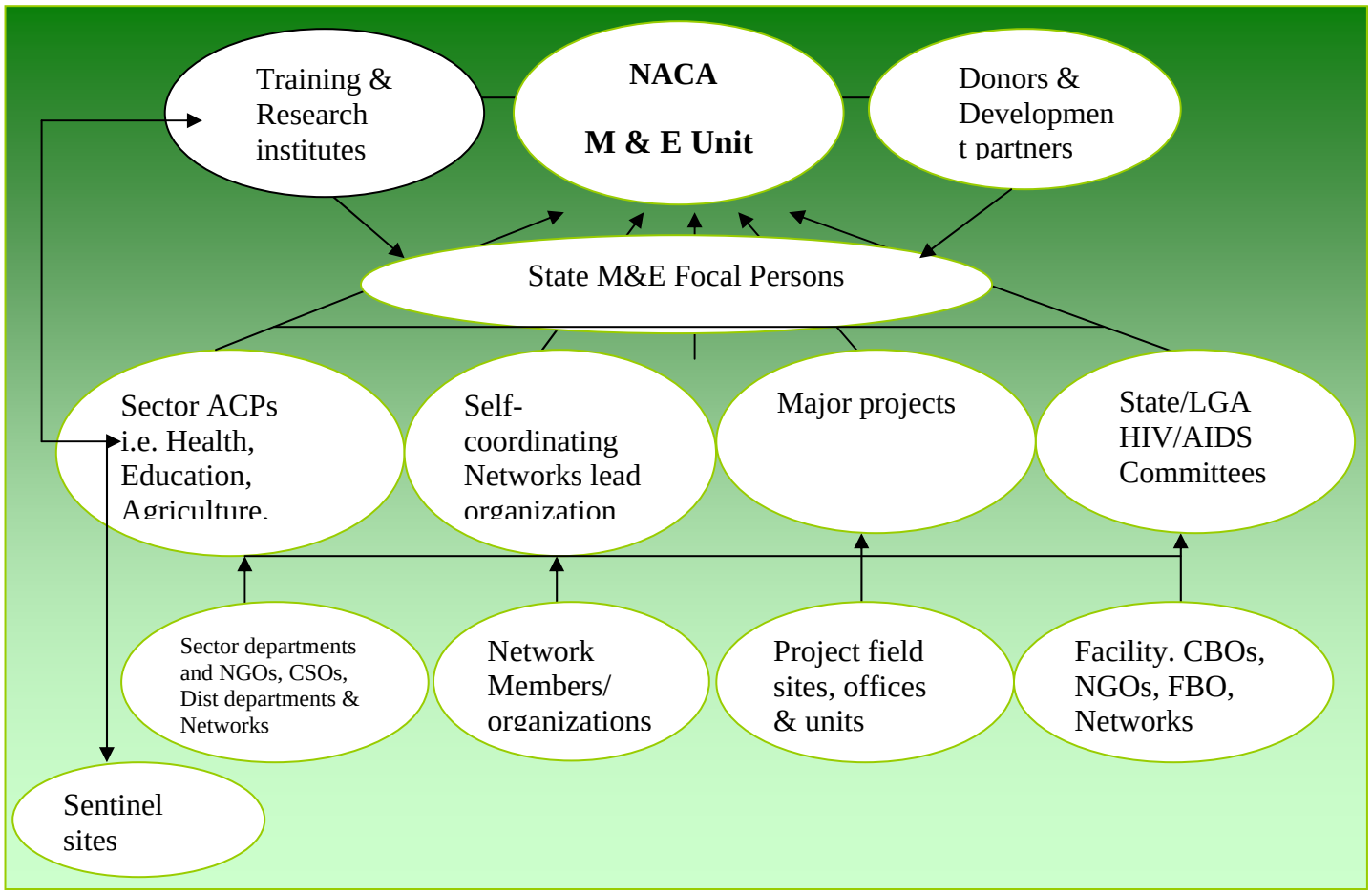
NACA will annually compile reports, which contain the indicators that would give the status of implementation of the National Strategic Framework. The purpose of this dissemination to the monitoring and evaluation strategy will be to:

- Share the data and information on HIV/AIDS for planning and programme development process, and to inform implementation and service delivery
- Give feedback on the efforts and resources committed to the national response and highlight issues that still require intervention
- Increase public commitment to the national response.

The dissemination will be done through the circulation of the annual state of HIV/AIDS national report, the annual surveillance reports, HIV/AIDS fact sheets and brochures, print and electronic media reports, supplements, panel discussions as well as public lectures, debates and discussions.

The sector HIV/AIDS focal persons and the State/LGA focal offices will also undertake to disseminate HIV/AIDS information within the sectors and States/LGAs respectively to complement the efforts by the NACA.

Figure 3: Monitoring and Evaluation Institutional Framework and Linkages



The above structure highlights the functional linkages that will enable the effective monitoring and evaluation of the national HIV/AIDS response. The following linkages, as illustrated in the above structure, highlight the data and information flow.

- Summarized report using the standard format to be submitted by the State to NACA. The sector and the National level Civil Society Organizations (CSOs) receive detailed reports that are necessary for program implementation monitoring.
- All implementing organizations including the LGA/facility, CSOs and networks will also give a summary report using standard forms developed by NACA to the LGA.
- Sectors will offer support supervision and technical back-up in monitoring and evaluation to States/LGAs, networks and major projects.
- Major projects like PEPFAR and the World Bank will offer support supervision and technical back-up in monitoring and evaluation to the States/LGAs, networks and field project units.
- Bi-annual coordination meetings convened by the NACA to monitor the implementation of the national Monitoring and Evaluation plan.
- National NGOs and Research Institutions will report directly to NACA any specialized studies and research activities. This will also be applicable to the various Sector initiated studies and researches. This will be fully operational when the National HIV/AIDS Research Plan is finalized.

E. **Indicators**

The Program areas for monitoring and evaluation of the National Strategic Framework can be divided into the broad areas of HIV/AIDS prevention, treatment and care, HIV/AIDS mitigation and National Capacity Building. Prevention of HIV transmission remains the key strategy in the response to HIV/AIDS but as the epidemic has matured, treatment and mitigation of the personal and community impact had to be addressed as another key strategy in the national response. The successful implementation of these strategies, needless to say, is dependent upon the capacity that exists at both the national and local levels.

At the program level, each activity that is implemented by the different partners and stakeholders will have input, process and outcome indicators that can be used to monitor progress. Consequently, at this level there are many indicators that individually contribute towards overall monitoring of different interventions. In order to facilitate monitoring at the national level by the NACA, an attempt has been made to identify a few indicators that can act as proxy or direct measures for the achievement of the NSF objectives. More detailed monitoring of program performance will remain within the domain of the lead actors from the program itself.

The selection of national indicators put the following criteria into consideration:

- Relevance to national HIV/AIDS program focus/interventions (NSF).
- Sensitivity of the indicators – ability of the indicator to detect change in the outcome
- Affordability – put into consideration data that is currently collected by other agencies
- Usefulness
- Ethics
- Repeatability - comparability across levels of monitoring and over time
- Measurability (mainly quantitative but consideration for qualitative)
- Validity
- Global commitment and declaration

Selection of the indicators has put into consideration both what and how the key players are currently monitoring the HIV/AIDS interventions. A deliberate attempt was made to build on these and come up with an optimal set of indicators that is sensitive and cost effective for national level monitoring.

The sections that follow outline the different program areas under the eight NSF objectives, the strategies and indicators. An indicator matrix table has been included as chapter 7.

A summary indicator reference sheet page is given as annex 1, to provide precise definition of the indicator and the way it is calculated. However, as an addendum to this plan, a document on detailed indicator reference sheet and list of indicators for measuring HIV/AIDS, which provides the precise definition of the indicator, the way the indicator is calculated, the frequency of generating the indicator, the responsible institution and the data limitations will be produced.

Chapter 3

DATA COLLECTION PLAN

Nigerian National Response Information Management System (NNRIMS) is a management information system designed to facilitate the systematic collection, storage, retrieval and dissemination of information on Nigeria's response to the HIV/AIDS epidemic in a manner that meets the needs of the country, its stakeholders and partners involved in the national response. The system was designed in alignment with global monitoring and evaluation needs, and has been agreed upon by major stakeholders as the core monitoring and evaluation system for the country, to track as well as review the national HIV/AIDS response.

NNRIMS tracks the response through a National Response Activity Report System – a generation of aggregate data on essential output indicators from a list of service delivery points using standard forms (Appendix-NNRIMS Activity Report Form). On monthly basis, NACA receives reports of validated data on output of services implemented from all Implementing Partners, Line Ministries, States and CSOs. The form summarizes coverage achieved by organizations implementing HIV/AIDS intervention in the areas of prevention, care and support, and impact mitigation[8].

NNRIMS also reviews the national HIV/AIDS response by utilizing research findings, routine and periodic data collection systems such as sentinel surveillance and special population based studies to determine the prevalence, level of progress and impact of the national response.

This chapter discusses the different routine and non-routine data collection methodologies currently being utilized in the country, the agreed national core indicators and standardized data collection tools; frequency of data collection; responsible organization for collecting the data; and data flow which describes where data is originated, collated, analyzed and levels of decision making.

1. NATIONAL INDICATORS

The national indicators are sets of nationally agreed indicators that will be utilized in tracking the progress made in the national response by all partners and provide relevant information that will inform future HIV/AIDS intervention plans, strategies and implementation. The indicator matrix is found in Chapter 7, which give details of the data source, frequency of reporting, baseline information as well as yearly targets from 2007 to 2010.
A listing of these indicators are found below in different levels

I. Impact Level Indicators

A. Prevention

- HIV Prevalence among young people aged 15-24
- HIV prevalence among general population aged 15-49

[8] NNRIMS Monthly Summary Form

- Percentage of HIV positive infants born to HIV-infected mothers

B. Improvement in Life Expectancy of PLWHA

- Percentage of adults and children with HIV still alive at 6,12 and 24 months after initiation of anti-retroviral therapy

II. Outcome and Output Level Indicators by Program Area

A. Prevention – Knowledge and Behaviors

Key Outcomes

- Percentage of young people aged 15-24 who both correctly identify ways of preventing the sexual transmission of HIV and who reject major misconceptions about HIV transmission
- Percentage of never–married young men and women aged 15-24 who have never had sex.
- Percentage of never married women and men 15-24 who had sex in the last 12 months, of all (never married men and women) respondents.
- Median age at first sex: The age by which one half of young men and women aged 15-24 have had penetrative sex (median age) of all young people surveyed.
- Percentage of women and men aged 15-49 who have had sex with a non-marital, non-cohabiting sexual partner in the last 12 months
- Percentage of women and men (disaggregate by young people and adults reporting the use of condom the last time they had sex with a non-marital, non-cohabiting sexual partner
- Percentage of high-risk groups reporting the use of condom the last time they had sex (with a non-marital, non-cohabiting sexual partner)
- Percent of sex workers who in the past 12 months did not use a condom consistently during sexual intercourse with a client

Key Outputs

- Number of people trained to provide HIV/AIDS peer education
- Number of people in the general population reached with HIV/AIDS prevention programs
- Number of people in high risk groups reached with HIV/AIDS prevention programs.
- Total number of condoms distributed by social marketing outlets in the country.

B. PMTCT

Key Outcomes

- Percentage of HIV positive pregnant women receiving a complete course of ARV prophylaxis to reduce the risk of PMTCT in accordance with nationally approved treatment
- Percentage of LGAs with at least one PMTCT centre offering the complete package of PMTCT services

Key Outputs

- Number of pregnant women who received HIV counseling and testing for PMTCT and received their test result

- Number of women receiving a complete course of antiretroviral prophylaxis to reduce the risk of mother to child transmission within a calendar year
- Number of health facilities providing a complete PMTCT package disaggregated by LGA.

C. Sexually Transmitted Infections

- Percentage of health facilities with capacity to appropriately diagnose, treat and counsel patients with STI
- Prevalence of syphilis among Pregnant Women
- Prevalence of syphilis among groups at high risk of HIV

D. Counseling and Testing

Key Outcomes

- Percentage of individuals who ever received counseling and testing for HIV and received their test result
- Percentage of high risk groups who received HIV counseling and testing services and received their test results in the last twelve months.
- Percentage of LGAs with specified number of service outlets providing HCT

Key Outputs

- Number of people provided with counseling and testing for HIV and received their test results.
- Number of HIV counseling and testing service outlets

E. Care and Treatment

Key Outcomes

- Percentage of people with advance HIV-infection currently receiving antiretroviral combination therapy
- Percentage of Local Government Areas with at least one health facility providing ART services and care and treatment for people in-line with national standards

Key Outputs

- Number enrolled in HIV care: (a) new, (b) current, and (c) cumulative ever at the facility by age and sex
- Number on ART: (a) new, (b)current, and (c)cumulative ever started in the country
- Number of service delivery points providing antiretroviral combination therapy
- Number of HIV-positive people receiving home based care
- Number of patients currently on care who are receiving INH prophylaxis (number of HIV clients on care who are receiving TB preventive therapy)- Number of HIV patients currently in care and receiving TB treatment
- Number of people with HIV receiving cotrimoxazole prophylaxis

F. Orphans and Vulnerable Children

Key Outcomes

- Percentage of Orphans aged 6 – 14 years in school.

- Percentage of orphans and vulnerable children whose households received free basic external support in caring for the child according to national guideline.
- Ratio of current school attendance rate among orphans to that among non-orphans, aged 10-14

Key Outputs

- Number of orphans and vulnerable children whose households received free basic external support in caring for the child

G. Medical Transmission/Blood Safety

Key Outcomes

- Proportion of women and men aged 15-49 reporting that the last health care injection was given with a set of new syringe and needle from an , unopened package
- Average number of injections per year
- Percentage of blood units transfused in the last 12 months that have been screened for HIV

H. Stigma and Discrimination

Key Outcomes

- Percentage of the general population with accepting attitude toward PLWHA

I. Monitoring and Evaluation

Key Outcomes

- Percent of health facilities reporting timely and complete data.

Key Outputs

- Number of SACAs and LACAs disseminating updated HIV information to stakeholders quarterly
- Number of organizations provided with formal training in Monitoring and Evaluation

J. Policy and Coordination

Key Outcomes

- Percentage of line ministries and large enterprises/companies that have HIV/AIDS workplace policy and programs- what about implementation of the policy
- Percentage of schools with teachers who have been trained in life-skills-based HIV/AIDS education and who taught it during the last academic year
- National AIDS Program Effort Index -
- Percentage and amount of national funds disbursed by governments on HIV/AIDS

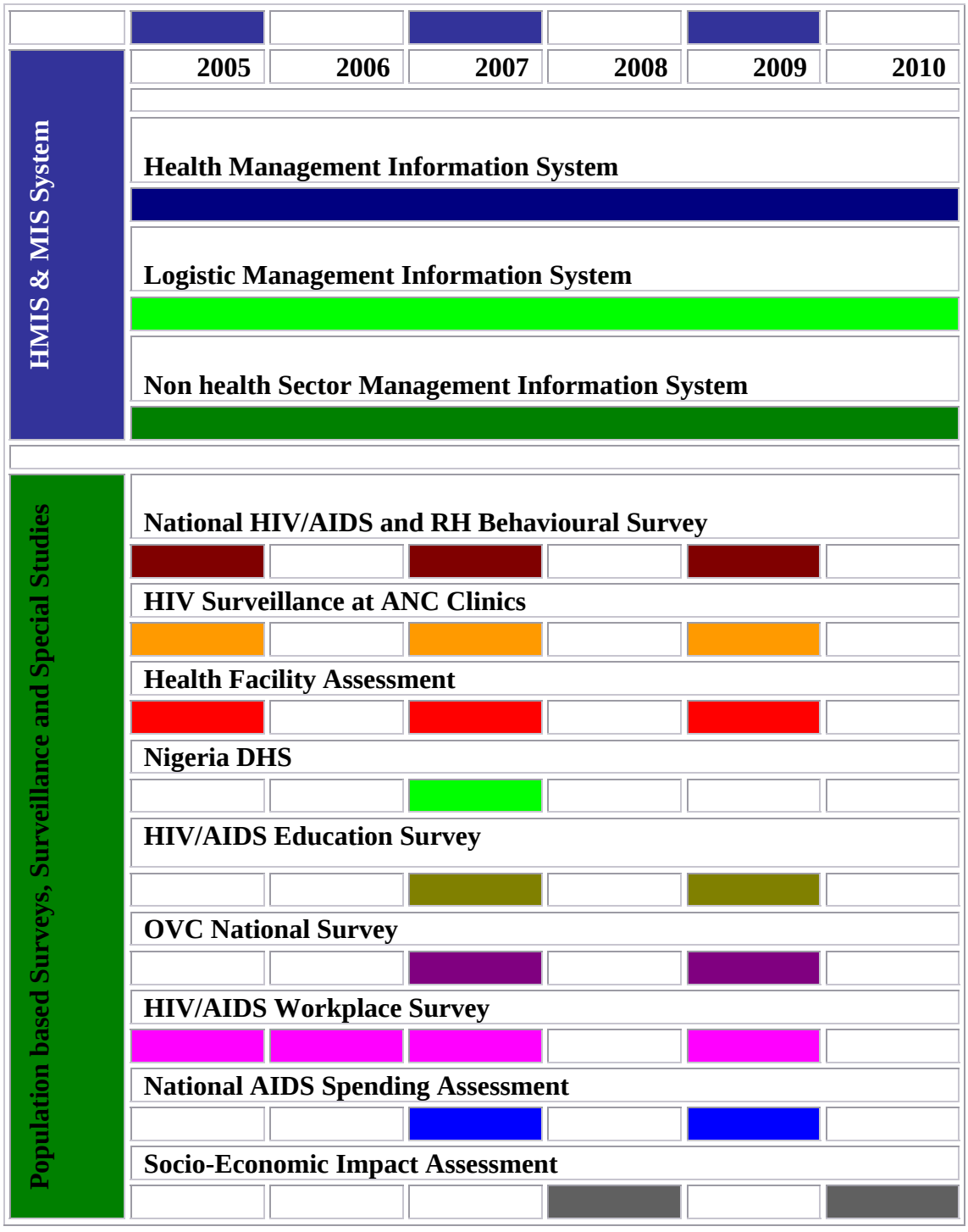
Key Outputs

- Amount of fund budgeted for HIV/AIDS by Donors
- Number of small and medium enterprises with workplace policy and programs

DATA SOURCES

The following data sources have been identified as key sources for providing information on the national and other indicators required to track trends in the epidemic and progress in the national response.

Table 1: Data Collection Timeline:–



Data sources for HIV/AIDS in Nigeria are obtained through non-routine and routine data collection methodologies.

1. Non-routine Data Sources

A. Nigeria's Second Generation Surveillance System

Traditional HIV surveillance systems tracked HIV infection or other biological markers of risk such as STIs. Since HIV infection among adults must be preceded by one of a limited number of behaviors, such as unprotected sex with an infected partner or injection with contaminated needles, if these behaviors change, there will be a change in the spread of HIV. Second generation surveillance systems monitor risk behaviors, using them to explain changes in levels of infection. Thus, second generation surveillance uses data from behavioral surveillance to interpret data gathered from sero-surveillance efforts (UNAIDS 2000). Nigeria's second generation surveillance system needs to be tailored to the dynamics of the epidemic. There are a number of second generation surveillance activities currently in place to provide decision makers with data on the profile and trajectory of the epidemic and indications about the effectiveness of the overall response.

B. HIV Sentinel Surveillance

HIV sero-prevalence surveys among pregnant women attending antenatal clinics in Nigeria have been carried out every two years since 1999. It is designed to provide information about the current HIV epidemic and its distribution among the general population throughout the country, focusing on selected demographic characteristics and geographical locations. It is coordinated by the FMOH and NASCAP and enables the Ministry of Health to monitor trends of HIV prevalence and make general population estimates and projections of the HIV/AIDS epidemic and its impact in the country. The data is collected through a sentinel survey conducted every 2 years amongst women attending antenatal clinics. Specimens generated are screened for HIV and syphilis antibodies. Once the data is collected and analyzed the Epidemic Projection Package (EPP) and Spectrum Group of Models are used to estimate and project adult HIV prevalence, while the burden of infection in the country is determined from the surveillance data obtained from ANC clients.

The results of HIV sentinel surveillance are disseminated at both national and state levels. This is done through dissemination meetings of stakeholders, including policy makers, HIV program managers, civil society and people living with HIV/AIDS. The information products include the report and a number of advocacy and information materials including wall charts, PowerPoint presentations and fact sheets.

C. National HIV/AIDS and Reproductive Health Behavioral Survey (NARHS)

The National HIV/AIDS and Reproductive Health Survey is a nationally representative survey aimed at providing information on key HIV and AIDS and reproductive health knowledge, attitudes and practices. The NARHS is conducted by NASCP throughout the country every two years.

Frequencies of the various outcome variables are then calculated and disaggregated by a number of demographic variables including age, sex, marital and educational status and geographical location. The report and its implications are made available through targeted dissemination to relevant stakeholders and to the public through a national dissemination workshop and the media.

Indicators collected from the NARHS include:

- Percentage of people aged 15 – 49 years who know two or more symptoms of STIs (disaggregated by age, sex, target population, zone and state and urban/rural).
- Percentage of young women and men aged 15 – 24 who both correctly identify ways of preventing the sexual transmission of HIV and who reject major misconceptions about HIV transmission. (Target: 90% by 2005; 95% by 2010).
- Percentage of young women and men who commenced sexual activity before the age of 15
- Percentage of young women and men aged 15–24 who have had sex with a non-marital, non-cohabiting sexual partner in the last 12 months.
- Percentage of young women and men aged 15–24 reporting the use of a condom the last time they had sex with a non-marital, non-cohabiting sexual partner.
- Percentage of people aged 15 – 49 years reporting the use of a condom during last sexual intercourse with a non-regular sexual partner (disaggregated by age, sex, target population, region and urban/rural).
- Percentage of people aged 15 – 49 years (male and female) who in the last 12 months voluntarily requested for HIV test and received their test results.
- Percentage of people aged 15 – 49 years (male and female) who in the last 12 months had a HIV test and received their test results.
- Median age at first sex: the age by which one half of young men and women aged 15-24 initiate penetrative sexual intercourse of all young people surveyed.

D. Behavioral Surveillance Survey (BSS) and Integrated Biological and Behavioral Surveillance Survey (IBBSS)

The Behavioral Surveillance Survey (BSS) is designed to systematically monitor trends in HIV risk behaviors over time in key population sub-groups thought to be at higher risk of HIV. The BSS is supported by NACA, DFID and SFH and carried out through a series of repeated cross-sectional surveys conducted at regular intervals on a national or sub-national scale. The first was conducted in 2002 and focused on youths only. The second was conducted in 2005 and focused on several additional population sub-groups identified by the National Technical Working Group on Behavioral Surveillance as being exposed to social and working environments often associated with higher risk behavior. These groups include commercial sex workers, uniformed services personnel, long distance truck and bus drivers and university students. Frequencies of various knowledge, attitude and behavioral outcome variables are disaggregated by group and a

number of demographic variables including age, sex, marital and educational status and geographical location

In 2007, NACA with support of the United Sstates of America (USA) government and technical assistance from various national government departments, NGOs, international and multi-lateral agencies is conducting Nigeria's first integrated biological and behavioral surveillance survey (IBBSS) in 6 states (Edo, FCT, Kano, Lagos, Cross River and Anambra). This exercise will replace the need for a 2007 round of the BSS and provide reliable data on HIV prevalence among these groups. The IBBSS will sample an additional two high risk groups about whom little is known in Nigeria, namely men who have sex with men (MSM) and injection drug users (IDU). Results will provide valuable input into the future design of the national second generation surveillance system.

The Federal Ministry of Health coordinates the BSS/IBBSS with financial and technical assistance from NACA, USG, DFID, SFH, FHI/Ghain and other partners. A BSS or IBBSS will be conducted on a biennial basis. Surveillance reports will be made available to the public through a national dissemination workshop, various media channels, national and international conferences and through targeted dissemination to relevant stakeholders.

Key indicators generated through the BSS and IBBSS

- HIV prevalence among groups surveyed (IBBSS only)
- Syphilis prevalence among groups surveyed (IBBSS only)
- Percentage of persons within each group who both correctly identify ways of preventing the sexual transmission of HIV and who reject major misconceptions about HIV transmission. (Target: 90% by 2005; 95% by 2010).
- Percentage of persons within each groups who have had sex with different types of partners including spouses/live-in partners, boyfriend/girlfriends, commercial and casual partners in the last 12 months.
- Percentage of persons within special groups reporting the use of a condom the last time they had sex with different types of partners including spouses/live-in partners, boyfriend/girlfriends, commercial and casual partners in the last 12 months.

2. Other Non-routine Special Studies

A. Health Facility Assessment

Due to the need to understand the effectiveness of HIV/AIDS services provided at health facilities as part of the HIV response, specific information about services at health facilities are needed. This can be collated through two sources – National Health Management Information System (NHMIS or HIV/AIDS MIS) or a specific health facility survey. Currently, the NHMIS and the HIV/AIDS MIS do not provide adequate information about the capacity, utilization and effectiveness of HIV related services at health facilities. Due to this, health facility survey through which additional information can be collected is presently required.

When the NHMIS is updated to include the periodic collection of this information, this data source could be amended. The health facility survey will then only be needed to verify the data received from the HMIS and hence done less frequently.

Responsibilities
Health facility assessment is conducted by the Federal Ministry of Health through its state and local government organs.

3. Routine Data Sources

The Health Management Information System (HMIS) for the HIV component
This data source will be commissioned and funded by FMOH and the responsibility for data collection, analysis and reporting will rest with NASCP. A Quarterly Service Coverage Report will be based on information filled out on the HMIS Monthly Summary Forms, which all implementers of HIV interventions at the health facility level are required to fill. The HMIS Form will collect data that will feed the NNRIMS Monthly Summary Form for treatment, care and support components.

This monitoring form is the core of the National program monitoring process (collection of "coverage data" about the extent and coverage of HIV interventions). It will be distributed to all health facilities, which will complete the form on a monthly basis and use it to record information about HIV services provided.

This information will then be sent through the LGA to the states and finally the national level where such information will be analyzed and a service coverage report written and disseminated.

PMTCT
Between 2002 and 2004, the Nigerian National PMTCT task team, FMOH and other stakeholders identified a number of indicators required to make sound decisions about the status of the National PMTCT program. In addition to identifying specific indicators, several data collection instruments including registers and summary forms along with the instructional manual were produced. Furthermore a computerized Management Information System (MIS) and a comprehensive training curriculum for PMTCT data collection and reporting were developed in 2004 in collaboration with CDC and IHV-UMD.

The PMTCT/MIS has standardized tools and the FMOH maintains the central MIS database and provides technical assistance to the PMTCT sites for continued monitoring of the PMTCT program.

The National PMTCT indicators include those that are required for national level reporting as part of requirements for international agreements and progress towards International goals such as UNGASS and Millennium Development Goals; those required at national level for policy and decision making; as well as those required for program level decision making. These include indicators that measure geographic coverage, service provision, quality of care and impact of service delivery on the transmission of HIV to infants.

A systematic plan for periodic external data quality checks will be conducted by FMOH/NACA and other stakeholders. These checks will include a review of site registers and reporting forms for completeness and accuracy, as well as to verify that previously submitted summary forms corresponds with the information contained in the register. .

Tools
In order to collect PMTCT indicator service coverage data and to monitor service delivery, a set of six PMTCT registers have been developed. These registers capture appropriate healthcare delivery information required at clinical sites providing PMTCT services and include:

- General antenatal clinic register.
- The HIV/AIDS Counseling and Testing (HCT) Register.
- Partner register.
- The Labour and delivery register.
- Maternal follow-up register.
- Child follow-up register.

The first three registers are to collect pre-delivery information, the labour and delivery register collects information pertaining to delivery related PMTCT services and the last 2 provide post delivery information. Most of the information captured in the summary forms are however, collected from the VCT and Labour/Delivery Register.

The system also includes a number of summary forms for monthly collection of data and transmission back to the FMOH for collation and analysis. The information from the PMTCT will be used to calculate the national level and program level output and outcome indicators. The PMTCT Form will supply data needed to complete the PMTCT component of NNRIMS Monthly Summary Form.

ART
The ART program began in 2002 with a plan to provide ART for 15, 000 persons. At that time no M&E system was developed. In 2004 with support from partners including PEPFAR, NACA and FMOH developed a Patient Management and Monitoring System which was linked to an ART program monitoring and evaluation system.

However, with expansion of ART provision and HIV care to secondary and primary health facilities the system was modified to accommodate paper based data collection.

Tools
The HIV/ART Card
PMM forms including: Initial clinical evaluation form; Pediatric clinical evaluation from; Laboratory request and result forms; Pharmacy forms; and Adherence form.
Pre-ART register
ART register
ART monthly summary forms
Cohort analysis forms

Information from the registers is used to compile the National Monthly Summary Forms, which are transmitted through LGA to state and national levels, which have being designed to be compactable with NNRIMS Monthly Summary Form.

HIV Counselling and Testing (HCT)

The HCT service provision is being captured through the NNRIMS MIS. The HCT program has developed registers for capturing relevant information on the service provision. A process of harmonization of tools is ongoing.

Tools

The following tools are available in Nigeria to monitor and report on HCT

- Client Intake Form
- HCT Client Register
- HCT Client Register for Mobile Service
- HIV Request and Result Form

Combined Report-Requisition and Issue Form - HIV Test Kits

- HIV Testing Worksheet
- HCT Monthly Summary Forms

Orphans and Vulnerable Children (OVC)

Orphan and vulnerable children activities are handled by the private and public sectors (Federal Ministry of Women Affairs and Social Development).

Examples of programmes in this area include:

- HIV/AIDS awareness creation targeted at women and the girl child,
- addressing socio-cultural issues that put females at risk and its mainstreaming into all facets of the country's HIV response,
- providing females with women empowerment programs which is targeted at improving their lives and the sexual choices they have at their disposal.

The Federal Ministry of Women Affairs and Social Development is responsible for coordinating all orphan and vulnerable children program of the national response.

Tools

OVC Register

Initial OVC Assessment forms

OVC Enrolment form

Household Assessment form

OVC Termination form

Service delivery forms

MIS forms – which is the same with NNRIMS Monthly Summary Form

Other Routine Data Source

Other routine data tools for program such as Behavior Change Communication, Home Based Care, HIV/TB Collaboration, Laboratory Services, HIV Workplace Response

Implementation and Family Life HIV/AIDS Education have been developed and are undergoing review and harmonization. Currently data on most of these are collected through NNRIMS Monthly Summary Forms.

EVALUATION OF NATIONAL RESPONSE

In most National Monitoring and Evaluation Plan considerable attention and resource are devoted to the monitoring component with almost total neglect of the evaluation component. This plan will maintain a balance between monitoring and evaluation/review of the national response. To operationalize this, a sub-committee of the National Technical Working Group will be constituted to identify priority review issues. The sub-committee will work with a platform for Joint Evaluation/Review of National priority programmes that is in existence.

The Joint Evaluation/Review priority for the national response will include among others

1. Mid-term and end-term review of NSF
2. Periodic Evaluation and Review of National treatment program
3. Periodic Evaluation and Review of National prevention program
4. Periodic Evaluation and Review of Public sector response
5. Periodic Evaluation and Review of CSO response
6. National AIDS Spending Assessment

In addition, all donors and partners will be encouraged to evaluate the effectiveness and impact of their programmes periodically and submit the reports to NACA.

Data Flow

Health facilities collect data on a daily basis with forms and registers specially designed for each program intervention. The LGA Monitoring and Evaluation HIV/AIDS Focal Person collects data on a monthly basis from the facilities. The LGA Focal Persons collates the information from all LGA health facilities and sends summary tables to the SMoH (SASCP), also on a monthly basis. The SMOH /SASCP collates the information from all LGAs and on a quarterly basis, sends the summary data to NASCP and copies SACA. NASCP then collates the information from all States and sends the information to NACA and department of Health Planning and Research (DHPR) within FMOH on a quarterly basis.

It is the responsibility of NACA to collate information on the core indicators of the multi-sectoral national response on HIV/AIDS – (FMOE, FMOWA and other federal line ministries).

Monitoring and Evaluation Reporting Levels and Information Flow

Stakeholders implementing HIV/AIDS projects/programs are expected to report regularly on program indicators (see indicators matrix in Chapter 7) that are relevant to the type of activity they are undertaking. For all program indicators, the data collection formats at all levels (from lowest to national level) will be developed (NNRIMS – monthly summary form) and included in the monitoring and evaluation Operational Manual and distributed to all stakeholders. The proposed information flow between the different stakeholders and NACA are summarized in figures A and B. Standard reporting formats that summarized the program indicators will be supplied to LGAs and States

Facilities are expected to summarize their activities data on monthly basis from various registers e.g. Pre-ART, ART, PMTCT, OVC, BCC and Advocacy among others into NNRIMS monthly summary format. LGA Officials will go round the various facilities within the LGA and collect completed form.

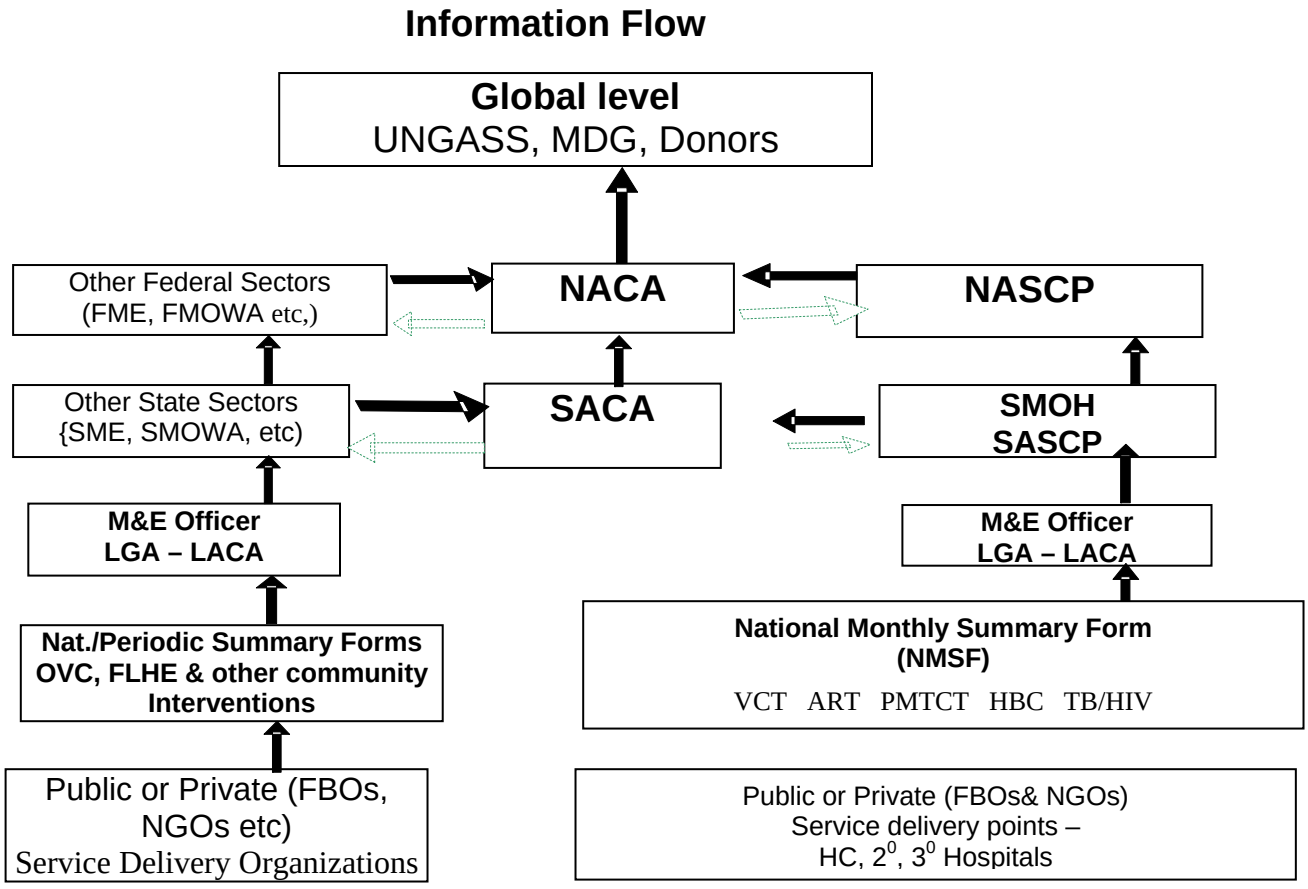
Local Government Area will gather data relevant to program indicators in the National Monitoring and Evaluation framework from all service providers e.g. health facilities, local CBOs, Non-governmental Organizations working in the LGA on HIV/AIDS. A copy of the report should be submitted monthly to the State Agency for the control of AIDS – confirm this.

State Action Committee on AIDS (SACA) will produce quarterly reports by compiling and analyzing data/reports received from LGAs. The state level information would include sector activities during the reporting quarter.

NACA will produce quarterly and annual reports by compiling and analyzing data/reports received from States, Federal Sector Offices (including MOH), Research Institutions, Multilateral and Bilateral Organizations.

Research institutions, associations, Universities and individual scholars are expected to send a copy of HIV/AIDS related study reports and papers to the National Agency for the Control of AIDS. NACA will make all collected research results centrally available for reference to users. The process of data collection and reporting from research studies and reports will be articulated in the National HIV/AIDS research plan to be developed. Linkage and integration between NNRIMS Operational Plan and National HIV/AIDS Research Plan will be fully described.

Figure 5: Data Flow Chart



Key: → - information flow
⇢ - Validation

National M&E systems typically focus on data collection and reporting from SDPs up to national and international stakeholders. This can lead to missed opportunities for feedback to State and local programmes. Often, local data are reported up to the national program, but are not used locally. Higher level information may not be reported back to the local level, and local data are not assessed in a broader context. These missed opportunities may prevent local programmes from making simple mid-course corrections that could positively impact the health of their communities. In addition, if information is not presented back in a manner that can be used by local programmes, there is little incentive to report quality data in a timely manner. This plan is designed to encourage data ownership and utilization at all levels. NACA also serves as clearing house for all HIV/AIDS data in the country. It is therefore mandatory for all sectors and partners to reconcile and validate data with NACA M&E unit. All data report within or outside the country without reconciliation and confirmation from NACA shall be considered not valid and representing national response data.

Data Quality Issues

Data quality needs to be monitored and maintained throughout the data collection process. Obviously data are most useful when they are of the highest quality; however, data quality often requires a trade off with what is feasible to obtain. Potential biases should be considered, identified and addressed before data collection begins, and closely monitored throughout. The highest quality of data is usually obtained through the triangulation of data from several sources.

It is also important to remember that behavioral and motivational factors on the part of the people collecting, collating, analyzing and reporting the data can also affect the quality. Examples of common biases in data collection include:
***Sampling bias*:** occurs when the sample taken to represent population values is not a representative sample

***Non-sampling error*:** all other kinds of incorrect measurement, such as courtesy bias, incomplete records, or non-response rates

***Subjective measurement*:** occurs when the data are influenced by the measurer
For each data set, the following data quality issues should be considered:

Coverage: Will the data cover all of the elements of interest? If not, what other data sets can be used to triangulate?

Completeness: Is there a complete set of data for each element of interest? If not, what is missing? Could missing data be obtained easily? What changes could be made to the system to solve this problem?

Accuracy: Has the instruments been tested to ensure validity and reliability of the data?

Duplication: Are the same people being counted more than once? What mechanism is in place to control for this?

Frequency: Are the data collected as frequently as needed, at each level? While the national program may only need the data annually, how often do state or SDP programs need the data?

Reporting Schedule: Do the available data reflect the time periods of interest? How do we reconcile different requests (i.e. US Federal Fiscal Year, Calendar Year, etc.). Also, bias may arise from issues of under reporting and over reporting.

Accessibility: Are the data needed collectable or retrievable? What are the barriers?

Power: Is the sample size big enough to provide a stable estimate or detect change?
As a result of the quest for data quality in Nigeria, Standard Operating Manual on Data Quality and audits have been developed or adapted for most programs and will continue to be reviewed and harmonized. Stakeholders will be encouraged to carry out data audit using developed/adapted national SOPs and others such as MEASURE Evaluation tools for auditing.

Chapter 4

DISSEMINATION AND USE OF DATA

I. Information Products

The National Agency for the Control of AIDS is responsible for the compilation, management and dissemination of all data collected through the national HIV/AIDS Monitoring and Evaluation sub-systems. NACA will provide the following periodic information products and maintain functional reporting relationship with National Bureau of Statistics, National Planning Commission and global HIV/AIDS organizations:

- Service Coverage Report
- Annual HIV/AIDS Monitoring and Evaluation Report
- Biennial UNGASS Report
- Biennial Triangular Analysis Report
- NACA Quarterly Newsletter
- Directory of SDPs on HIV/AIDS

Following is a brief description of each periodic information product.

A. Service Coverage Report (SCR)

NACA will produce a routine quarterly service coverage report on key HIV/AIDS program areas. This report will provide information on key service coverage statistics based on information received from states through NASCP, other sectors and implementing partners (grantees and non-grantees). Data sources will be presented in a structured format agreed amongst stakeholders, and is expected to contain cumulative data for the year-to-date, and also include the results of previous and current periods to enable trend analysis of individual indicators. Once data are captured, NACA will compile a periodic Service Coverage Report (SCR), using a standard analysis methodology to make conclusions and recommendations, before it is disseminated to stakeholders. It will be compiled on a quarterly basis within one month after the end of the period under review. The report will serve to better inform implementing partners and donor organizations of current intervention scale, gaps in service access and coverage, and how to maximize resource utilization. By doing so, the production of this report will also help ensure that NACA meets minimum global and international reporting requirements.

In summary the following channels will be followed for submission, compilation and approval:

- NASCP, SACAs, other sectors and IPs submit data to NACA Monitoring and Evaluation Director quarterly.
- NACA Monitoring and Evaluation unit collates and analyses the data.
- NACA's M&E Director reviews the draft report and presents it to the M&E TWG for comments and inputs. NACA M&E Director makes changes to the report and sends the final report for reproduction and dissemination at the national, state and LGA levels.

B. Annual HIV/AIDS Monitoring and Evaluation Report

The annual HIV/AIDS Monitoring and Evaluation report is intended to provide a comprehensive overview of the response to HIV/AIDS in Nigeria. This will involve reporting on all indicators contained in the national HIV/AIDS M&E Framework, and by providing key observations and guidance for future implementation. All data will focus on the previous calendar year (January – December), which this will be the de facto reporting period for the report. The report format will be based on information needs for the National response. NACA will maintain this standard format to enable trend analyses of the epidemic. The report compilation will be done on an annual basis by the NACA M&E Unit, with support from technical partners. The report will be compiled in January of each year, and will be ready by the end of the first quarter. NACA may also supplement this report with additional data sources as they become available.

This report will be procedurally linked to the national response annual work planning and budgeting process to ensure that the information is used for strategic planning purposes. The report will also serve as an annual review of NSF implementation progress.

C. Biennial UNGASS Report

Nigeria is a signatory to the 2001 Declaration of Commitment on HIV/AIDS from the United Nations General Assembly Special Session on HIV/AIDS (UNGASS). Part of this Declaration of Commitment includes a set of indicators that the Government of Nigeria has agreed to report on to UNAIDS on a biennial basis. All UNGASS indicators have been included in the national HIV/AIDS Monitoring and Evaluation Matrix.

The report to UNAIDS informs the international community on the progress made by Nigeria in the fight against HIV/AIDS. It is based on a standard set of international indicators required by all participating countries in accordance with definitions outlined in the UNAIDS (2005) "Guidance for the Construction of Core Indicators". Data Sources for the UNGASS indicators can be summarized as follows:

- UNAIDS Survey on financial resource flows.
- National Composite Policy Index (NCPI) questionnaire.
- School-based survey and education program review.
- Workplace survey.
- Health facility survey.
- PMTCT and ARV program monitoring and estimates from NASCP.
- Population-based surveys.
- HIV sentinel surveillance at antenatal clinics.

For each of the indicators, data entry and analysis will be completed and disaggregated according to the UNAIDS requirements. The report will consist of a statistical overview of the data for each indicator, as well as a narrative description to add quality and texture to the statistical overview. The compilation of the UNGASS report is the responsibility of NACA's Monitoring and Evaluation Unit, with technical support from the in-country UNAIDS office and other stakeholders. The following approval process will be followed: collection of data from relevant sources; preparation of the report by NACA's M&E Unit using the UNAIDS

format; submission of the report to the Monitoring and Evaluation Technical Working Group for review and validation; and finalization of desired changes by NACA's M&E Director, who will then send the report for production and dissemination to relevant stakeholders at Federal and State levels.

D. Biennial Report on Triangulated Analysis of the Epidemic and National Response

Understanding the dynamics of the HIV/AIDS epidemic in Nigeria requires that various data and results generated over time are synthesized. This will provide an integrated illustration of trends, priorities and the combined response of programming efforts and activities. The research, monitoring and evaluation reports over each two year period will be analyzed, synchronized and summarized into one information product. This will form the basis for the second generation HIV surveillance report by attempting to describe the trajectory of the epidemic through interpreting behavioral data in relation to HIV sero-surveillance and treatment outcomes. The report will include analysis of the epidemics and sub epidemics, explanations for sub epidemics and their major drivers. It will also include data on size estimation of the major drivers and the response targeted at them.

Data for the report will be drawn from routine sources and special studies including:

1. The HIV/AIDS HMIS
2. The Logistics MIS
3. Information systems of line ministries, development partners, research organizations, SACAs, LACAs, private sector, civil societies, networks and other sectoral responses.
4. National HIV/AIDS and Reproductive Health Surveys (NARHS)
5. Periodic Behavioral and Integrated Biological and Behavioral Surveillance Surveys (BSS and IBBSS)
6. HIV/AIDS Sentinel Surveys
7. Nigeria Demographic and Health Surveys
8. Health Facility Surveys and Assessments
9. HIV/AIDS Education Surveys
10. National OVC Surveys
11. National HIV/AIDS Workplace surveys
12. National AIDS Spending Assessments
13. Socio-Economic Impact Studies
14. Size estimation of high risk groups
15. Explanations of elevations sub epidemics and major drivers.

It is anticipated that analytical syntheses of the Nigerian National Response to the HIV/AIDS Epidemic will be carried out every two years. The report of the triangulated analysis will be forwarded to the Monitoring and Evaluation Technical Working Group for further review and inferences. Following this review, the NACA Monitoring and Evaluation Director will commence the reproduction and dissemination of the triangular report. It will be disseminated to all relevant stakeholders including policy and decision makers at national and state levels.

E. NACA Quarterly Newsletter

NACA will develop and maintain a quarterly newsletter that summarizes all relevant information on HIV/AIDS from the past reporting period. The content may include:

- Key results and conclusions from relevant surveys
- Successes and lessons learned from ongoing projects and activities
- Case studies and personal testimonies and opinions.

The target of the newsletter will be different partners and stakeholders in the fight against HIV/AIDS. To maximize its impact, the newsletter will be written and presented in a manner that can be easily understood by all stakeholders including non-professional audiences. it will form part of the documents that are disseminated every quarter at the HIV/AIDS feedback workshops, organized at Federal and State levels. This product will be produced by the Communication/Documentation Unit of NACA in collaboration with the Monitoring and Evaluation Unit of NACA.

II. Fora for Data Use and Dissemination

In addition to the aforementioned information products, a number of fora have been established to review progress in implementing the national HIV/AIDS response. These fora have a strong focus on the use and dissemination of data collected for the national HIV/AIDS Monitoring and Evaluation plan, and provide an opportunity to disseminate progress, lessons learned to various stakeholders and enhance evidence-based decision-making by policy makers and programme managers. Opportunities for data use and dissemination include the following:

- Nigerian HIV/AIDS Summit
- International Conferences on HIV and AIDS
- NACA Governing Board meetings
- Donor Coordination Group meetings
- National AIDS Conucil
- State level HIV/AIDS feedback workshops
- Expanded Team Group Meetings
- Monitoring and Evaluation Technical Working Group Meetings
- NACA's website

Brief Overview of these Fora for Data use and Dissemination.

A. Nigerian HIV/AIDS Summit

Nigeria's biennial HIV/AIDS summit brings together a wide variety of members of the national and international HIV/AIDS community including scientists, government officials, donor agencies, program managers and implementers, PLHA, public and private organizations and journalists. Data presented at the Summit include significant research findings and implementation experiences describing the roll-out of interventions, successful strategies and new initiatives in the fight against HIV and AIDS in Nigeria.

B. International Conferences on HIV and AIDS

Nigerian scientists, government officials and HIV/AIDS program managers participate actively in the dissemination and exchange of experiences at international HIV/AIDS conferences. In 2005 Nigeria hosted the International Conference on AIDS and Sexually transmitted infection in Africa (ICASA). Data presented at this conference helped underscore the central role of basic, clinical and prevention science in the local, national and global response to HIV and AIDS and the need for evidence-based programming based on sound research and accurate data. The continued exposure of Nigerian nationals to state of the art research dissemination and programmatic lessons learned at African and other international conferences helps provide those engaged in the response to HIV and AIDS with the requisite information to improve the planning and implementation of HIV and /AIDS programs in Nigeria and abroad.

C. NACA Board Meeting

NACA Board Meetings is chaired by the Board Chair and brings together Board members once every quarter to review evidence detailing the trajectory of the HIV epidemic in Nigeria, the combined response and current priorities, and provide oversight and guidance to the national response.

D. National AIDS Council Meeting

Once a quarter, NACA and SACA's management and program staff meet to review program implementation progress within each state based on available input, output and outcome data. During the meeting, data is used to highlight recent successes and current challenges, and discussions are held to identify actions, resources and key stakeholders to overcome them. The meeting for the second and last quarters of each year should have in attendance Implementing Partners and major stakeholders to participate in the technical sessions.

E. State level HIV/AIDS Feedback Workshops

Once a quarter, SACA and LACAs stakeholders within the state meet to review various program implementations within the state against its HIV/AIDS challenges and targets. This meeting is designed to – Provide those engaged at all levels of the response to HIV/AIDS with information to improve the way their HIV/AIDS policies/programs are planned and implemented; Enable those working in the field of HIV/AIDS to be better prepared to meet the needs of those affected by and living with HIV/AIDS; Expand public awareness of the continued impact of, and state response to HIV/AIDS;

F. Donor Coordination Group Meetings

The donor coordination group meetings is chaired by DfID and meet quarterly. This serves as an opportunity for high-level representatives from major donor agencies in Nigeria to review progress in combating HIV/AIDS in Nigeria, to coordinate planning and the efficient allocation of implementation resources. Data from the national Monitoring and Evaluation system is used at these meetings to influence key decision making and increase commitment and responsible action based on evidence.

G. Expanded Team Group Meetings

Expanded Team Group Meetings bring together heads of donor and implementing agencies, NACA staff and selected SACA Project Members approximately two months. Data from routine management information systems is used to discuss progress, identify opportunities and improve coordination of the response.

H. Monitoring and Evaluation Technical Working Group Meetings

The national HIV/AIDS M&E Technical Working Group is comprised of focal persons from governmental departments, non-governmental organizations, the private sector, donor agencies, UN agencies, and coordinating bodies involved in HIV/AIDS prevention, treatment, care and support programmes. It is convened by NACA on a quarterly basis where topical M&E issues are discussed, presentations delivered on research and other initiatives and technical input is received for national M&E design and implementation issues. Once a year, members of the Technical Working Group will participate in an expanded annual HIV/AIDS M&E dissemination meeting, where the annual HIV/AIDS M&E report will be disseminated to relevant stakeholders during the first quarter of every year. All stakeholders including government, development partners, private sector, NEPWHAN and civil society groups will be invited to attend. In addition to the National Dissemination meeting for the HIV/AIDS M&E results, there may also be a need to organize similar dissemination meetings in states and local government areas.

I. NACA's website

All Monitoring and Evaluation reports produced by NACA (including the Annual HIV/AIDS M&E report, Service Coverage Report and the UNGASS report) will be available on the NACA's ***Portal*** for electronic download (in PDF and/or MS Word format). This will ensure that HIV/AIDS stakeholders and concerned members of the general public will be able to access up-to-date information and statistics. All HIV/AIDS indicator data will be updated in the NACA database as and when new data becomes available.

REVIEW OF THE NATIONAL MONITORING AND EVALUATION PLAN

It has been acknowledged that due to the changing nature of the epidemic in Nigeria and due to new research and technologies, the monitoring and evaluation of HIV/AIDS responses is a dynamic field. To keep abreast of these developments and compare progress versus plans, periodic reviews of the appropriateness of this M&E plan for tracking the national HIV/AIDS response are required. Revising the plan needs to be balanced with the need to maintain a solid core set of data to enable trend analyses over time.

To strike a balance between these 2 competing priorities, the following conditions have been agreed for the review of the National HIV/AIDS M&E plan:

1. The **overall M&E Operations Plan**, *including* the actual **indicators**, should be reviewed within 60 days of the annual review of the National HIV/AIDS Strategic

framework, or within 90 days of the development of a NEW National HIV/AIDS Strategic Framework;

2. The **data sources** for the indicators, as defined in the conceptual framework, may be revised if they can be updated with improved (more accurate or more timely) data sources;

3. Should **new information products** be required, these may be added to the current list of information products. However, the basic format and content of all information products should remain the same for as long as this M&E plan exists in its current format;

4. The **Monitoring and Evaluation work plan and operational budget** maybe adjusted annually when the NACA work plan and budget for the next fiscal year is prepared; and/or

5. Should the NSF not be reviewed within the next 2 years, this M&E plan should be reviewed in 2009.

Chapter 5

RESOURCES REQUIRED TO IMPLEMENT THE NNRIMS OPERATIONAL PLAN

The National Strategic Framework identified strengthening of the Monitoring and Evaluation system as one of its priority areas for focus and funding[9]. Resource mobilization is necessary for an effective national monitoring and evaluation. The national HIV/AIDS response has in the last couple of years attracted resources from a wide range of stakeholders which include the Federal and State governments, development partners, private sector, PEPFAR, the Global Fund, United Nation Systems, and a host of others. The coordination of monitoring and evaluation of HIV/AIDS programmes generally rests with the National Agency for the Control of HIV/AIDS at the national level, and with SACA, LACA, line ministries and CSOs at various levels. M&E units have already been established in most of these levels of implementation and coordination.

While NACA has an effective HIV/AIDS management information system, the multi-sectoral response to HIV in Nigeria dictates that the implementation of HIV program level M&E is a contribution of the different sectors, e.g. health, education, labor, CSOs, etc. This co-ordination role of the national AIDS program or its affiliates is one whose importance cannot be stressed strongly enough.

Even while it is recognized that many countries have limited funding for tracking projects goals and inputs sponsored by different donors and sectors, maintaining an overarching picture of the inputs required to run the M&E system effectively is crucial. To be sustainable, this must be in place as part of an effective and coherent national M&E system and the national response will advocate for increased resources to M&E sector and efficient use of resources from both within and outside the national program.

I. Funding to Implement the NNRIMS Operational Plan

There are wide variations in funding for HIV/AIDS programmes from country to country and if spending on the program is minimal, the amount dedicated to M&E systems for HIV will also be minimal. On the other hand, in some countries with relatively good resources for drugs and treatment, monitoring of the epidemic is either neglected, or funds for monitoring are allocated inefficiently. Donors wanting to see if their money is well spent often push for better monitoring and evaluation. In consequence, they also fund a disproportionate share of M&E activities. This has created anxieties for recipient countries, as the end of donor funding has in practice led to the collapse of many M&E systems.

Currently, it is estimated that most HIV/AIDS programming activities in Nigeria spend only 1.0 % of the entire program cost on Monitoring and Evaluation. Since a good M&E system is crucial to ensuring resources are well used, it is recommended that about 10 percent of the National HIV/AIDS budget be used for monitoring and evaluation activities, excluding the routine surveillance of HIV and risk behavior. NACA will also continue to advocate for Stakeholders at the different levels of implementation to allocate a minimum of 10% of the HIV/AIDS budget to M&E.
In order to ensure sustainability, it is advised that at all levels of the national response, no M&E activity should be entirely donor-dependent. Therefore the NNRIMS Operational Plan will be costed to estimate resources needed for full implementation of the national M&E system.

To achieve effective resource mobilization for the national M&E a clear identification of resource map, and funding requirements is essential. This would enable accurate identification of what the funding gaps are, and thus additional funding required.

Subsequently, NACA will identify and mobilize financial resources internally and externally to support the implementation of the NOP, from the private sector as well as the public. Annually, the M&E unit in NACA will prepare a joint M&E Priority Plan in collaboration with major Stakeholders in the Sector. This will be used as a consolidated tool to mobilize resources for national M&E from development partners and civil society, as well as the public and private sectors. NACA will also strengthen systems to track expenditure in order to re-allocate resources as necessary, as well as producing financial audits required by law.

II. Human Resources Capacity & Skills Development

The Nigerian National response is large and includes the Federal government, 36 states and the Federal Capital Territory as well as other stakeholders whose capacity need to be strengthened in Monitoring and Evaluation. Human capacity and skills development is key to enhancing national capacity for monitoring and evaluation. Capacity building plan for M&E shall be developed annually and implemented to achieve a full implementation of the national monitoring and evaluation plan by 2010.

Human capacity: Staffing is a major constraint to M&E in many countries. While M&E units or committees do exist in many national programmes, they are generally dramatically understaffed and their work is often limited to managing sero-surveillance systems. Human capacity will be considered in terms of numbers, salaries, capacities and qualities of performance. This relates to determining and organizing the appropriate number of staff that are needed, ensuring that their salaries are provided, and their capacities are relevant and updated. Processes to assess staff performance are critical and should focus on the productivity of staff and partners, but should focus more on the quality of their work.

***Capacity building*:** is vital if M&E systems are to be strengthened. If capacity cannot be maintained within the national program networks can be created to access outside skills as necessary. At a minimum, M&E units should have access to or be affiliated to an epidemiologist, a statistician, a social scientist, a data manager and a professional communications/documentation specialist, since available data are often poorly packaged and communicated.

The National Technical Working Group will provide the technical support required for M&E. The NTWG will complement the technical capacity of the central M&E unit. The NTWG will include representatives of academic institutions, NGOs and others in order to assure that data generated by these bodies are integrated into the NNRIMS. Furthermore, the credibility of information generated by the M&E unit will improve through the support of the NTWG.

On an annual basis, NACA and its stakeholders will assess the capacity of their M&E units in order to identify the M&E gaps/requirements of various entities in the national response. This will provide an opportunity for planning and providing M&E capacity building and skills development on a regular basis. To facilitate this provision, a comprehensive capacity development plan will be developed by NACA in collaboration with other stakeholders and will be reviewed on an annual basis.

Infrastructure: This refers to equipment, goods, office space, etc. in terms of amounts and qualities of each material per location, plus processes in place and resources allocated for maintenance. Vehicles and various office equipments (including computers and software) will be needed to facilitate the implementation of the plan. NACA will ensure that enough operating input is provided at the headquarters and in partner institutions and that processes and procedures are in place for their maintenance.

Leadership and Coordination of Monitoring and Evaluation: Another major challenge is the M&E program coordination and harmonization of reporting systems. This task becomes even more complicated with the decentralized nature of implementing agencies and coordination mechanisms with inadequate technical capacity to manage the M&E at the State and Local government levels.

NACA will provide the leadership required to ensure that effective operations are established with practical and operational conditions for carrying out project activities effectively. At the state, line ministry, CSO, development partner and private sector levels, focal persons for monitoring and evaluation work should be selected to provide support to the national response.

Organizational Culture: This is the dynamic entity that is expected to evolve from operationalizing the M&E system and people working together as well as specific policies, procedures, written goals, and objectives that created the system in the first place. Stakeholders in the national response to work together to determine the skills and structures needed to achieve the national M&E mandate.

NACA will provide the coordination required to maintain management style that focuses on goals and objectives through the guiding principles of the NSF. These values will be reflected in the objectives and actively supported by the team's leadership. The organizational culture that promotes ethical standards in the choice and implementation of HIV/AIDS intervention activities fosters recognition of the relationship between what needs to be done and those who are responsible for doing it.

Work planning: Internally, the National, State and LGA coordinating and implementing entities will produce and monitor the monthly, half-yearly, and annual work plans for individual staff members, implementing teams and the project as a whole. NACA, on behalf of the national response will determine the roles and responsibilities of the

external partners and ensure that coordination with other organizations is evident through internal reporting mechanisms and regular reviews of NNRIMS data for routine planning.

Chapter 6

ROLES AND RESPONSIBILITIES IN IMPLEMENTING THE NNRIMS OPERATIONAL PLAN

Table 2: Responsibilities of Stakeholders in NOP HIV/AIDS M&E Plan

STAKEHOLDER	OUTLINES OF RESPONSIBILITIES
NACA Board	The board members of NACA have been mandated to provide overall guidance and oversight to the national response. In terms of monitoring and evaluation, the Board of members will be responsible for: • Overall guidance and strategic direction to the NSF and appropriate responses • Advocate for allocation of adequate resources for M&E in the national response. • Promoting a culture of using information for decision-making
NACA DG	The DG of NACA should be responsible for: • Promoting the HIV/AIDS M&E system within the public and private sectors, and civil society, where possible • Use information from the M&E system to inform the national response • Ensure that sufficient resources (financial and human) are available to implement the national HIV/AIDS M&E system • Encourage bilateral donors to make reporting to the NOP compulsory for the implementers supported by bilateral donors • Facilitate the development of National HIV/AIDS Research Plan. • Ensure that no data on HIV/AIDS is reported to Global community without clearance from NACA.
NACA's Director of Strategic Planning, Research, Monitoring and Evaluation	As M&E at NACA, this person will be responsible for: • Providing overall leadership for M&E team at NACA • Supervision of work done by M&E team • First approval of all information products, before it is submitted to the Chairman for approval • Give guidance and attend meetings with NACA partners on M&E issues • Chair the platform for review and evaluation of National Response Priority Issues. • Approve monthly work plans of M&E division • Initiate and approve the procurement cycles for NACA-commissioned data sources • Clear, reconcile and confirm all HIV/AIDS data reported to stakeholders.

STAKEHOLDER	OUTLINES OF RESPONSIBILITIES
	• Approve the annual M&E budgets • Interpret the M&E report in terms of planning implications • Ensure that the NACA annual work plan take cognizance of the M&E results
Other NACA M&E team	The M&E team at NACA is the pivot around which the M&E system will be functioning. The team will be responsible for: • Implement the national HIV/AIDS M&E plan • Coordinate and manage the NNRIMS Report System • Coordinate and Chair the National M&E TWG • Facilitate the development of National HIV/AIDS research plan. • Develop monthly work plans for activities for M&E • Attend the national M&E technical working group and other sectoral Unit's M&E Steering Committee meetings • Liaise with all institutions that provide data sources for NNRIMS system • Provide periodic information products, as requested by NACA • Represent M&E interests of NACA at meetings, and investigate better ways of coordinating data gathering within Nigeria • Support HIV/AIDS M&E Dissemination Seminar/efforts. • Support the dissemination of all information products, as defined in this document • Prepare annual M&E work plan and operational budget • Ensure that all data is received for the annual HIV/AIDS M&E report – sending reminders and requests for information to all persons/agencies responsible for data sources (as defined in this document • Compile and manage approval of the annual HIV/AIDS M&E Report • Arrange funding for NACA-commissioned data sources
State Action Committee on AIDS	• Compile/update directories of facilities, NGOs and CBOs involved in HIV activities in their states and submit to NACA • Ensure timely & accurate completion, analysis and submission of NNRIMS summary forms • Disseminate the Quarterly Service Coverage Report form and other National Operational Plan Information products to state stakeholders • Reconcile, validate and clear all national data to be reported to Global Community with M&E Director of NACA
Chairman of State Action Committee on AIDS	• Submit names of service providers (health and non-health) NGOs and CBOs involved in HIV activities to NACA • Liaise and promote the completion and submission of NNRIMS forms • Disseminate the Quarterly Service Coverage Report and other NACA Information products to stakeholders • Use NACA information products where appropriate for planning • Complete the NNRIMS Form for all HIV interventions implemented by the State • Promote completion of the NNRIMS monthly summary Form in other

STAKEHOLDER	OUTLINES OF RESPONSIBILITIES
	ministries represented at State level • Ensure that the State House of Assembly and other arms of Government are informed of latest developments in terms of the progress with HIV interventions
Local Action Committee on AIDS	• Submit names of facilities, NGOs and CBOs involved in HIV activities to SACA • Liaise and promote the completion and submission of these forms • Disseminate the Quarterly Service Coverage Report form and other NOP Information products to LGA stakeholders.
Local Government --- Action Manager	• Submit names of service providers (health and non-health) NGOs and CBOs involved in HIV activities to NACA through SACA • Liaise and promote the completion and submission of NNRIMS forms • Ensure accurate and timely data collection from SDPs in the LGA • Disseminate the Quarterly Service Coverage Report form and other SACA/NACA Information products to stakeholders • Use NOP information products where appropriate for planning • Promote completion of the NNRIMS monthly summary Form in service delivery points (health and non-health) at LGA level
Civil Society Organizations (including NEPWHAN;	• Facilitate capacity building on M&E for its networks, NGOs etc • Facilitate completion and submission of NNRIMS forms • Clear all data on HIV/AIDS with NACA
Institutions responsible for data sources NOT commissioned by NACA	Different agencies are responsible for data sources. These agencies have the responsibility to: • Read through NOP and NACA's M&E system to ensure that they are familiar with its content • Ensure that they understand their responsibilities in terms of data submission to NACA • Submit the necessary data, disaggregated as per request • Wherever possible, use the information generated by the NOP system for decision making and improving of interventions
Institutions responsible for data sources commissioned by NACA	These agencies' responsibilities will be clearly defined in the agreement between NACA and the agency. However, in general terms these agencies will be responsible for providing good quality data sources that are based on international best practice, and that is relevant to the M&E system, as defined in this document.
Implementers of HIV Interventions	The Implementers of HIV interventions will be responsible for: • Completing the NNRIMS Form on a monthly basis and submit it to the LACA/SACA • Utilizing the information products from NACA for decision making
Funding Agencies	These agencies provide the fuel that is needed for the HIV engine to run. In terms of M&E, they will be responsible for: • **For all new contracts**: Ensuring that the contracts that they sign with implementers include reference to NACA's M&E system and that reporting to this system is clearly defined – in particular ensuring that

STAKEHOLDER	OUTLINES OF RESPONSIBILITIES
	the NNRIMS monthly summary Form is one of the reporting formats that is required • **For all existing contracts**: Ensure that service delivery points assisted by these implementers are requested to submit the NNRIMS Form to LACA/SACA on a monthly basis. • Reconcile, validate and clear all national data to be reported to Global Community with M&E Director of NACA • Support NACA through Technical and financial resources in building capacity & skills required to implement the NOP • Provide technical and financial resources to support full implementation of NOP in states assigned to stakeholder • Provide technical assistance for implementation of NOP.
Researchers and Research Institutions	The roles and responsibilities of researchers and research institutions will be to: • Work with NACA to develop National HIV/AIDS Research plan • Conduct research that is of a high standard – both in terms of substance and in terms of research protocols • Submit research proposals to the relevant ethical review committee before research is commenced • Familiarize themselves with NACA's research strategy (once it is developed) and ensure that, where possible, research is in line with the research strategy • Once research has been completed, disseminate research results and submit a copy to NACA • Facilitate compilation of annotated bibliography of Research studies conducted in Nigeria
National M&E Technical Working Group (NTWG)	This groups consist of all stakeholders and will advise on all issues associated to M&E – Please refer to Annexure 8 for a proposed Terms of Reference for the NTWG .

Chapter 7

NNRIMS OPERATIONAL PLAN INDICATOR MATRIX (2007 – 2010)

A. REDUCTION IN HIV INCIDENCE/PREVALENCE

IMPACT-LEVEL INDICATORS

INDICATORS	Data Source	Frequency of collection	Responsible Organization	Baseline (2005)	Target 2007	Target 2008	Target 2009	Target 2010	Remarks/Comments
1. Percentage of young people aged 15-24 who are HIV-infected	ANC/General Population Survey	Biennial	FMoH/NASCP	4.3%	3.9%	3.7%	3.4%	3.2%	Target is based on the NSF target of reducing prevalence by 25% every 5 years.
2. HIV prevalence rate in the general population	ANC/General Population Survey	Biennial	FMoH/NASCP	4.4%	4.0%	3.7%	3.5%	3.3%	Target is based on the NSF target of reducing prevalence by 25% every 5 years.
3. Percentage of HIV positive infants born to HIV-infected mothers	PMTCT MIS	Annual	FMoH/NASCP	45.0%	35.0%	30.0%	25.0%	22.5%	Baseline was estimated from international standards. Targets assume that: 1. HIV prevalence is static or reducing 2. PMTCT scale-up takes off according to plan 3. HAART is the therapy of choice

B. IMPROVEMENT IN LIFE EXPECTANCY OF PLHA

IMPACT-LEVEL INDICATORS

INDICATORS	Data Source	Frequency of collection	Responsible Organization	Baseline (2005)	Target 2007	Target 2008	Target 2009	Target 2010	Remarks/Comments
4a. Percentage of adults and children with HIV still alive after 6 months, after initiation of anti-retroviral therapy	PMM/ Cohort Analysis	Semi-annual	FMOH/ NASCP	98.0%	98.0%	98.0%	98.0%	98.0%	Targets assume 80-90% adherence rate. Reference: WHO 3" by 5" progress report 2004 of 7000 cohorts followed up over time in 24 different African Countries
4b. Percentage of adults and children with HIV still alive after 12 months, after initiation of anti-retroviral therapy	PMM/ Cohort Analysis	Semi-annual	FMOH/ NASCP	90.0%	91.0%	92.0%	93.0%	95.0%	Critical assumptions: international standards - improvements when adherence support through counseling is high and stage of entry into ART is early = 80%. The survival rates were computed in this form.
4c. Percentage of adults and children with HIV still alive after 24 months, after initiation of anti-retroviral therapy	PMM/ Cohort Analysis	Semi-annual	FMOH/ NASCP	85.0%	86.0%	87.0%	88.0%	90.0%	Critical assumptions: international standards - improvements when adherence support through counseling is high and stage of entry into ART is early = 80%. The survival rates were computed in this form.

PREVENTION: KNOWLEDGE
OUTCOME INDICATORS

INDICATORS	5. Percentage of schools with teachers who have been trained in life-skills-based HIV/AIDS education and who taught it during the last academic year	6. Percentage of young people aged 15-24 who both correctly identify ways of preventing the sexual transmission of HIV and who rejected major misconceptions about HIV transmission
Data Source	Annual School Survey, 3- year Baseline School Survey, Annual Report submitted by FMOE Desk Officers	Population-based survey (e.g. NARHS, NDHS)
Frequency of collection	Annual	Biennial
Responsible Organization	FMOE	FMOH, National Population Commission
Baseline (2005)	19%	25.9%
Target 2007	30%	37.7%
Target 2008	40%	43.7%
Target 2009	60%	49.6%
Target 2010	80%	55.5%
Remarks/Comments	***Assumptions*** • To certain level, capacity has been built • Most trained teachers would be employed in schools. ***Justification*** • Rapid increase in the number of trained Teachers due to Government policy which would have integrated the Life Skills curriculum in the National Teacher Training curriculum • 100% not realistic because of the difficulty in covering all schools (1°, 2°, 3°, Public and Private) in the country. • FMOE already implementing the policy on inclusion of FLHE curriculum in the National Teacher Training Curriculum • Aggressive employment of Teachers with FLHE training. The National Teacher's Corp Program started in Sept. 2006.	***Assumption:*** 40% increase in knowledge due to emphasis on mass education and awareness ***Justification:*** As specified in the National HIV/AIDS Policy through available programmes i.e. Peer Education and Life-skill Education.

PREVENTION: SEXUAL BEHAVIOR

OUTCOME INDICATORS

INDICATORS	7. Percentage of never–married young men and women aged 15-24 who have never had sex.	8. Percentage of never married women and men 15-24 who had sex in the last 12 months, of all (never married men and women) respondents	9. Median age at first sex: The age by which one half of young men and women aged 15-24 have had penetrative sex (median age) of all young people surveyed.	10. Percentage of young women and men aged 15-49 who have had sex with a non-marital, non-cohabiting sexual partner in the last 12 month
Data Source	Population-based survey (e.g. NARHS, NDHS)	Population-based survey (e.g. NARHS, NDHS)	Population-based survey (e.g. NARHS, NDHS)	Population-based survey (e.g. NARHS, NDHS)
Frequency of collection	Biennial	Biennial	Biennial	Biennial
Responsible Organization	FMOH, National Population Commission	FMOH, National Population Commission	FMOH, National Population Commission	FMOH, National Population Commission
Baseline (2005)	Male 62.7% Female 37.3%	Male 65.60% Female 34.40%	Male 20.1% Female 17.4%	Male 20.7% Female 10.7%
Target 2007	Male 68.6% Female 47.3%	Male 49.90% Female 26.10%	Male 20.3% Female 17.6%	Male 17.6% Female 9.10%
Target 2008	Male 71.6% Female 52.4%	Male 42.10% Female 22.00%	Male 20.4% Female 17.7%	Male 15.9% Female 8.2%
Target 2009	Male 74.5% Female 57.4%	Male 34.20% Female 17.80%	Male 20.5%% Female 17.9%	Male 12.4% Female 6.4%
Target 2010	Male 77.6% Female 62.4%	Male 26.40% Female 13.70%	Male 20.6% Female 18%	Male 7% Female 3.6%
Remarks/Comments	***Assumption:*** 40% increase in KAPB amongst special group including youth ***Justification***: As specified in the National HIV/AIDS Policy through available programmes i.e. Peer Education, Life-skill Education, HCT and Mass media/Community mobilization	***Assumption:*** 40% increase in KAPB amongst special group including youth ***Justification:*** As specified in the National HIV/AIDS Policy through available programmes i.e. Peer Education, Life-skill Education, HCT and Mass media/Community mobilization.	Sensitive indicator, no real target set however efforts must be made to ensure that it does not reduce by 0.1 annually.	***Assumption*** 40% increase in KAPB ***Justification*** As specified in the National HIV/AIDS Policy through available programmes i.e. Peer Education, Life-skill Education, HCT and Mass media/Community mobilization

PREVENTION: CONDOMS
OUTCOME INDICATORS

INDICATORS	11. Percentage of women and men (disaggregate by young people and adults) reporting the use of condoms the last time they had sex with a non-marital, non-cohabiting sexual partner	12. Percentage of high-risk groups reporting the use of condoms the last time they had sex (with a non-marital, non-cohabiting sexual partner)	13. Percentage of sex workers who in the past 12 months used a condom consistently during sexual intercourse with clients
Data Source	Population-based survey (e.g. NARHS, NDHS)	High Risk Survey (BSS), NARHS	High Risk Survey (BSS), NARHS
Frequency of collection	Biennial	Biennial	Biennial
Responsible Organization	FMOH National Population Commission	FMOH/NASCP/SFH	FMOH/NASCP/SFH
Baseline (2005)	Male 61.3% Female 43.8%	BSS Not yet released/Approved	BSS Not yet released/Approved
Target 2007	Male 67.5% Female 47.5%	90%	90%
Target 2008	Male 70.6% Female 52.6%	92%	92%
Target 2009	Male 61.3% Female 63.4%	95%	95%
Target 2010	Male 76.8% Female 69.8%	98%	98%
Remarks/Comments	***Assumption*** 40% increase in condom use amongst special group including youth ***Justification*** As specified in the National HIV/AIDS Policy through available programmes i.e. Peer Education, Life-skill Education, HCT and Mass media/Community mobilization.	Baseline to be obtained from 2005 BSS	Baseline to be obtained from 2005 BSS

PREVENTION: PMTCT

OUTCOME INDICATORS

INDICATORS	14. Percentage of HIV positive pregnant women receiving a complete course of ARV prophylaxis to reduce the risk of PMTCT in accordance with nationally approved treatment	15. Percentage of LGA's with at least one PMTCT centre offering the complete package of PMTCT services
Data Source	PMTCT/MIS	PMTCT facility mapping
Frequency of collection	Quarterly	Semi-annual
Responsible Organization	NASCP	NASCP
Baseline (2005)	3.0% (2005)	10% (based on fact that at least 100 sites exist in country presently
Target 2007	10%	17%
Target 2008	20%	30%
Target 2009	40%	50%
Target 2010	50%	76%
Remarks/Comments	Data for the target were based on the average of the figures submitted by all Implementing partners. It is also expected that Rapid Tests will be used during the period 2007 – 2010. Besides, some PMTCT centers will have side labs for testing.	This target is based on the NSF target of increasing implementation by 50% and using yearly agreed Universal Access Targets.

PREVENTION: BLOOD SAFETY/NOSCOMIAL/MEDICAL INJECTION TRANSMISSION

OUTCOME INDICATORS

INDICATORS	16. Proportion of women and men aged 15-49 reporting that the last health care injection was given with a new set of syringe and needle from, unopened package	17. Percentage of blood units transfused in the last 12 months that have been screened for HIV
Data Source	Population-based survey (e.g. NARHS, NDHS)	Special survey
Frequency of collection	Biennial	Biennial
Responsible Organization	FMOH, National Population Commission	FMOH/NBTS
Baseline (2005)	Not available	Not available
Target 2007	70%	85%
Target 2008	75%	90%
Target 2009	80%	95%
Target 2010	95%	98%
Remarks/Comments	This is based on fact that issues of shared needles are already seldom practiced in most urban centers and information to Health care workers is major intervention which should be feasible. Availability of commodities should be the main constraint	Obtain from NBTS. With a target of 100% by 2010 and using agreed yearly Universal Access Targets.

PREVENTION: SEXUALLY TRANSMITTED INFECTIONS

OUTCOME INDICATORS

INDICATORS	18. Percentage of health facilities with capacity to appropriately diagnose, treat and counsel patients with STI's.
Data Source	Health facility survey
Frequency of collection	Biennial
Responsible Organization	FMOH/NASCP
Baseline (2005)	Not Available
Target 2007	
Target 2008	
Target 2009	
Target 2010	
Remarks/Comments	This is an UNGASS indicator that Nigeria has had difficulty in responding to. Nigeria does not presently have a survey that captures the data and does not have funds to conduct the study separately. Any study done to generate this figure will have to be a sourced outside the FMOH. For Nigeria to prevent 55% of new infections by 2010, a minimum of 75% of health facilities must have said capacity.

PREVENTION: HIV COUNSELLING & TESTING
OUTCOME INDICATORS

INDICATORS	19. Percentage of individuals who ever received counseling and testing for HIV and received their test result	20. Percentage of high risk groups who received HIV counseling and testing services in the last 12 months	21. Percentage of LGA's with specified no. of service outlets providing HCT
Data Source	Population-based survey (e.g. NARHS, NDHS)	High Risk Survey (BSS)	High Risk Survey (BSS)
Frequency of collection	Biennial	Biennial	Annual
Responsible Organization	FMOH, National Population Commission	FMOH/NASCP/SFH	FMOH/NASCP
Baseline (2005)	8.3%	21% (BSS Not yet released/Approved)	Estimated at 15%
Target 2007	15%	29%	23%
Target 2008	20%	33%	40%
Target 2009	26%	37%	66%
Target 2010	31%	41%	98%
Remarks/Comments	These targets were based on the data from Implementing Partners	***Assumption:*** 21% in Baseline represents number of people who received result after testing; number represents sex workers. However 41% of them were tested and number targeted remained the same, however drop out rate decreased drastically	The comprehensive care package aims at having at least 3 HCT sites within a cluster located mainly within a local government area

PREVENTION: TREATMENT

OUTCOME INDICATORS

INDICATORS	22. Percentage of people with advance HIV-infection receiving (current) antiretroviral combination therapy	23. Percentage of Local Government Areas with at least one health facility providing ART services and care and treatment for people in-line with national standards
Data Source	PMM	Health facility survey
Frequency of collection	Semi-annual	Annual
Responsible Organization	FMOH/NASCP	FMOH/NASCP
Baseline (2005)	18% (2006)	Not available
Target 2007	25%	17%
Target 2008	40%	30%
Target 2009	60%	50%
Target 2010	85%	76%
Remarks/Comments	This is based on the Universal Access projection of HIV/AIDS services. This is considered feasible based on the scale-up plan for ART and the programmes available including PEPFAR and the GFATM grants	Based on the NSF with a scale-up access of HIV/AIDS services to 50% of the citizens and projecting using agreed yearly Universal Access Targets.

PREVENTION: OVC

OUTCOME INDICATORS

INDICATORS	24. Percentage of orphans and vulnerable children whose house holds received free basic external support in caring for the child	25. Ratio of current school attendance rate among orphans to that among non-orphans, aged 10-14
Data Source	Population-based survey (e.g. NARHS, NDHS)	Population-based survey (NHDS)
Frequency of collection	Biennial	5-years
Responsible Organization	FMWA, National Population Commission	FME, National Population Commission
Baseline (2005)	22000/1300000	.64 (NDHS, 2003)
Target 2007	8%	0.65%
Target 2008	10%	0.07%
Target 2009	15%	0.075%
Target 2010	20%	0.8%
Remarks/Comments	The OVC targeted through this program constitute only a fraction of the OVC's in the country. This program therefore aims at meeting the needs of only about 15% of orphans that are as a result of HIV and AIDS	population based survey

PREVENTION: POLICY AND COORDINATION
OUTCOME INDICATORS

INDICATORS	26. Percentage of Line Ministries and *Large Enterprises/Companies* that have HIV/AIDS workplace policy and programs	27. National AIDS program effort index (National Composite Policy Index)	28. Percentage and amount of national funds disbursed by governments on HIV/AIDS
Data Source	HIV/AIDS Work-place survey	National Composite Index Survey	Special Survey
Frequency of collection	Biennial	Biennial	Biennial
Responsible Organization	FMOL&P/NiBUCA	NACA	NACA
Baseline (2005)	46.9%	62%	2,000,000,000
Target 2007	53%	72%	7,000,000,000
Target 2008	60%	80%	9,000,000,000
Target 2009	71%	84%	12,000,000,000
Target 2010	80%	95%	15,000,000,000
Remarks/Comments	These will be percentages of all the large enterprises in the country	increase by 50%	1. Amount of national budget that goes to HIV 2. There is a need to calculate percentage of total budget that comes to HIV from all sources, including development partners and other donors

PREVENTION: STIGMA AND DISCRIMINATION

OUTCOME INDICATORS

INDICATORS	29. Percentage of the general population with **accepting attitude** toward PLHA
Data Source	Population-based survey (e.g. NARHS, NDHS)
Frequency of collection	Biennial
Responsible Organization	FMOH, National Population Commission
Baseline (2005)	65.2%
Target 2007	70%
Target 2008	85%
Target 2009	90%
Target 2010	95%
Remarks/Comments	Needs to be calculated in NARHS 2005

PREVENTION: STIGMA AND DISCRIMINATION
OUTPUT INDICATORS

INDICATORS	30. Number of people trained to provide HIV/AIDS peer education	31a. Number of high risk groups (female sex workers) reached with HIV/AIDS prevention programs.	31b. Number of high risk groups (armed forces) reached with HIV/AIDS prevention programs.	31c. Number of high risk groups (transport workers) reached with HIV/AIDS prevention programs.
Data Source	Program Report/Service Report	Program Report/Service Report	Program Report/Service Report	Program Report/Service Report
Frequency of collection	Semi-annual	Semi-annual	Semi-annual	Semi-annual
Responsible Organization	FBOs/Red Cross, CSOs, ARFH, UNICEF, FME and relevant line ministries	CSOs/Line Ministries	CSOs/Line Ministries	CSOs/Line Ministries
Baseline (2005)	43,000	58.2%	80.5%	64.2%
Target 2007	150,000	72%	90%	80%
Target 2008	310,000	81%	95%	85%
Target 2009	380,000	97%	95%	90%
Target 2010	440,000	97%	98%	95%
Remarks/Comments	Sources: NYSC and Oyo State LPE Youth empowering young people through the NYSC scheme in Nigeria. Oki W, Mulenga D, Bwakira C, Emmanuel JA, Osayin Y, Ogundipe A, Matt M. Int Conf AIDS. 2004 Jul 11-16; 15: abstract no. E10635. Director General - National Youth Service Corps, Abuja, Nigeria	Baseline provided by SFH	Baseline provided by SFH	Baseline provided by SFH

PREVENTION: CONDOM

OUTPUT INDICATORS

INDICATORS	32. Total number of condoms (male) distributed by social marketing outlets in the country
Data Source	Program Report
Frequency of collection	Annual
Responsible Organization	
Baseline (2005)	159,333,336 (2005)
Target 2007	192,793,337
Target 2008	212,072,670
Target 2009	233,279,937
Target 2010	256,607,931
Remarks/Comments	10% exponential rate was used to compute the condom distribution per year. This was based on the SFH figures only (which forms the bulk) and did not take into consideration other social marketing factors. However, we think this is justifiable as the condom use rate in the average condom use in the general population is 6%. The baseline figure is therefore a very rough estimate of the true picture, but at least we can assume that the projections are realistic.

PREVENTION: PMTCT

OUTPUT INDICATORS

INDICATORS	33. Number of pregnant women who received HIV counseling and testing for PMTCT and received their test result	34. Number of women receiving a complete course of antiretroviral prophylaxis to reduce the risk of mother to child transmission within a calendar year	35. Number of health facilities providing a complete PMTCT package
Data Source	PMTCT/MIS	PMTCT/MIS	Health-facility survey
Frequency of collection	Quarterly	Quarterly	2-year
Responsible Organization	NASCP	NASCP	NASCP
Baseline (2005)	<150,000	To be gotten from PEPFAR family	194 (2006) NACA's mapping of PMTCT sites
Target 2007	230,000	12,000	297
Target 2008	640,000	34,250	517
Target 2009	900,000	48,500	854
Target 2010	1,040,000	55,800	1,293
Remarks/Comments	Based on data from Implementing Partners	Based on data from Implementing Partners	Projections made using agreed yearly Universal Access Targets.

PREVENTION: COUNSELING AND TESTING
OUTPUT INDICATORS

INDICATORS	36. Number of people provided with Counseling and testing for HIV and received their test results. (cumulative)	37. Number of HIV counseling and testing service outlets
Data Source	Program Report	Program Report
Frequency of collection	Semi-annual	Semi-annual
Responsible Organization	FMOH/NASCP (SDPs)	FMOH/NASCP (SDPs)
Baseline (2005)	To be gotten from PEPFAR family	594 (2006) from NACA's mapping of HCT outlets in 35 states
Target 2007	350,000	911
Target 2008	1,000,000	1,584
Target 2009	1,400,000	2,614
Target 2010	1,600,000	3,960
Remarks/Comments	Based on projections on need to achieve Universal access to ART and the HCT scale up plan. This target does not include CT in PMTCT figures	Projections made using agreed Annual Universal Access

PREVENTION: TREATMENT
OUTPUT INDICATORS

INDICATORS	38. Number enrolled in HIV care: (a)new and (b) current (c) cumulative ever at the facility by age and sex	(a) New	(b) Current	(c) Cumulative
Target 2007		97,000	254,000	280,000
Target 2008		240,000	450,000	500,000
Target 2009		350,000	221,000	800,000
Target 2010		422,000	1,032,000	1,140,000
Remarks/Comments		Figures presented are for new cases only. All HIV+ population in the year less 10% attrition= new Rx +new BC&S	All HIV + population (old and new including treatment) =PC previous year – those convert to Rx+ new PC for the year	BC&S –new entry to Rx + new PC including attrition+ current Rx.
INDICATORS	39. Number on ART: (a)new (b)current and (c)cumulative ever started in the country	(a) All HIV+ new (within the year)	(b) Current (at end of reporting period)	(c) Cumulative (at end of reporting period)
Data Source	Program Report (PMM)	Program Report (PMM)	Program Report (PMM)	Program Report (PMM)
Frequency Of collection	Semi-annual	Semi-annual	Semi-annual	Semi-annual
Responsible Organization	FMOH/NASCP	FMOH/NASCP	FMOH/NASCP	FMOH/NASCP
Target 2007		46,500	107,500	126,500
Target 2008		93,500	187,000	220,000
Target 2009		143,000	308,600	363,000
Target 2010		187,000	467,500	550,000
Remarks/Comments				

PREVENTION: TREATMENT

OUTPUT INDICATORS

INDICATORS	40. Number of service delivery points providing anti retroviral combination therapy
Data Source	Program Report (PMM)
Frequency of collection	Semi-annual
Responsible Organization	FMOH/NASCP
Baseline (2005)	56
Target 2007	160
Target 2008	250
Target 2009	300
Target 2010	387
Remarks/Comments	Based on need to ensure that 50% of LGA (387) have at least one ART service delivery point by 2010 and using yearly agreed Universal Access Targets.

PREVENTION: PALLIATIVE CARE - 41. HOME BASED CARE 42. TB/HIV COLLABORATION 43. OPPORTUNISTIC INFECTIONS

OUTPUT INDICATORS

&EVALUATION

INDICATORS	41. Number of HIV/Positive people receiving Home based care	42. Number of HIV patients currently in care who are receiving TB Rx	43. Number of people with HIV receiving cotrimoxazole prophylaxis
Data Source	Program Report	Program Report(PMM)	Program Report(PMM)
Frequency of collection	Semi-annual	Semi-annual	Semi-annual
Responsible Organization	NGOs	FMOH/NASCP	FMOH/NASCP
Baseline (2005)	N/A	N/A	N/A
Target 2007	4,500	6,750	76,200
Target 2008	7,500	19,300	134,500
Target 2009	10,500	27,300	216,200
Target 2010	13,500	31,500	309,500
Remarks/Comments	A PR in GF has a target of 150 for yr1 & 300 for yr2. ***Assumption***: A progressive scale up of 10 of such Organizations yearly and an exponential increase of 2.5	Based on available data from IPs.	The assumption is that 30% (10% paeds, 10% adults, and 10% due to involvement of lower HF) of all HIV+ on care and Treatment are placed on CTX.

INDICATORS	44. Number of orphans and vulnerable children whose house holds received free basic external support in caring for the child	45. Percentage of Service Delivery Points submitting timely and complete reports
Data Source	Program Report	Program Report
Frequency of collection	Semi-annual	Annual
Responsible Organization	FMOW/UNICEF/NGOs	Line Ministries/NACA/SACAs
Baseline (2005)	22,000	40%
Target 2007	60,000	70%
Target 2008	70,000	80%
Target 2009	80,000	90%
Target 2010	100,000	90%
Remarks/Comments	Actual number per year includes GF and other sources	Analysis of report from Zonal M&E Officers from NASCP

ANNEX 1: Indicator Reference Table

A. REDUCTION IN HIV INCIDENCE/PREVALENCE
IMPACT-LEVEL INDICATORS

INDICATORS	Data Source	DEFINITION	PERCENTAGE		Value/Comments
			Numerator	Denominator	
1. Percentage of young people aged 15-24 who are HIV-infected	ANC/General Population Survey	Percentage of pregnant women aged 15-24 years attending ANC clinics who are HIV-infected (disaggregated by age, region and urban/rural)	Number of ANC attendees (aged 15-24) tested whose HIV test results are positive	Number of ANC attendees (aged 15-24) tested for their HIV infection status	This indicator is calculated using data from pregnant women attending ANCs in HIV Sentinel Surveillance sites.
2. HIV prevalence rate in the general population	ANC/General Population Survey	Percentage of pregnant women aged 15-49 years attending ANC clinics who are HIV-infected (disaggregated by age (15-24), region and urban/rural)	Number of ANC attendees (aged 15-49) tested whose HIV test results are positive	Number of ANC attendees (aged 15-49) tested for their HIV infection status	This indicator is calculated using data from pregnant women attending ANCs in HIV Sentinel Surveillance sites.
3. Percentage of HIV positive infants born to HIV-infected mothers	PMTCT MIS	Percent of HIV-infected infants born to HIV-infected mothers	n/a	n/a	Expressed as a simple mathematical formula: Indicator score = {T*(1-e) + (1-T)} * v where: T = proportion of HIV-infected pregnant women provided with antiretroviral treatment v = MTCT rate in the absence of any treatment e = efficacy of treatment provided

B. IMPROVEMENT IN LIFE EXPECTANCY OF PLHA

IMPACT-LEVEL INDICATORS

INDICATORS	Data Source	DEFINITION	PERCENTAGE		Value/Comments
			Numerator	Denominator	
4a. Percentage of adults and children with HIV still alive after 6 months after initiation of anti-retroviral therapy	PMM/Cohort Analysis	Percentage of people alive and known to be on treatment at 6, 12, 24, 36, etc. months after initiation of treatment. The indicator can be constructed as a minimum and maximum estimate of survival; depending on the inclusion criteria for the denominator (see options (a) and (b) below). Survival at 6, 12, 24, 36, etc. months after initiation of treatment	Number of people continuously on ART at 6, 12, 24, 36, etc. months after initiation of treatment.	: a) Minimum survival: Total number of individuals who initiated ART in the ART start-up group in the previous 6, 12, 24, 36, etc. months, including those who have stopped ART, those who have transferred out and people lost to follow-up. b) Maximum survival: Total number of individuals who initiated ART in the ART start-up group in the previous 6, 12, 24, 36, etc. months, excluding those who have stopped ART, those who have transferred out and people lost to follow up.	Method of measurement adapted from UNAIDS and WHO The strengths of this indicator lie in the ease of data collection, as any ART program should monitor patients on treatment and determine the number of individuals who survive beyond specific periods in time. This indicator may only be obtained from a limited number of advanced care/referral facilities and/or designated cohort studies while ART MISs are scaling up. As the latter become institutionalized and functional the data can be expected to become more comprehensive.
4b. Percentage of adults and children with HIV still alive after 12 months after initiation of anti-retroviral therapy					
4c. Percentage of adults and children with HIV still alive after 24 months after initiation of anti-retroviral therapy					

PREVENTION: KNOWLEDGE
OUTCOME INDICATORS

INDICATORS		5. Percentage of schools with teachers who have been trained in life-skills-based HIV/AIDS education and who taught it during the last academic year	6. Percentage of young people aged 15-24 who both correctly identify ways of preventing the sexual transmission of HIV and who reject major misconceptions about HIV transmission
Data Source		Annual School Survey, 3- year Baseline School Survey, Annual Report submitted by FMOE Desk Officers	Population-based survey (e.g. NARHS, NDHS)
DEFINITION			Percentage of young women and men aged 15–24 who, in response to prompted questions, say that (1) people can protect themselves from contracting HIV by having sex with only one faithful, uninfected partner, and (2) using condoms, (3) who know that a healthy-looking person can have the AIDS virus, and (4 & %) who correctly reject the two most common local misconceptions about AIDS transmission
PERCENTAGE	**Numerator**	Number of schools with staff members trained in and regularly teaching life-skills-based HIV/AIDS education	Number of young women and men aged 15–24 who, in response to prompted questions, say that people can protect themselves from contracting HIV by having sex with only one faithful, uninfected partner, and using condoms and know that a healthy-looking person can have the AIDS virus, and who correctly reject the two most common local misconceptions about AIDS transmission
	Denominator	Number of schools surveyed Indicator scores are required for all schools combined and for primary and secondary schools separately each by private/public status and by urban/rural setting. Church schools should be treated as private schools for this purpose. If school provides both primary and secondary education, information should be collected and reported separately for both levels of education	Number of young women and men aged 15–24 surveyed

PREVENTION: SEXUAL BEHAVIOUR
OUTCOME INDICATORS

INDICATORS	Data Source	DEFINITION	PERCENTAGE	
			Numerator	Denominator
7. Percentage of never–married young men and women aged 15-24 who have never had sex.	Population-based survey (e.g. NARHS, NDHS)	Percent of never married young women and men aged 15–24 who have never had sex	Number of never married young women and men who have never had sex	Number of never married young women and men aged 15–24 surveyed
8. Percentage of never married women and men 15-24 who had sex in the last 12 months.	Population-based survey (e.g. NARHS, NDHS)	Percent of never married young women and men aged 15–24 who have not had sex in the last 12 months preceding the survey	Number of never married young women and men who have not had sex in the past twelve months	Number of never married young women and men aged 15–24 surveyed
9. Median age at first sex: The age by which one half of young men and women aged 15-24 have had penetrative sex (median age) of all young people surveyed.	Population-based survey (e.g. NARHS, NDHS)	**Method of measurement (see M&E health sector framework)**		
10. Percentage of women and men aged 15-49 who have had sex with a non-marital, non-cohabiting sexual partner in the last 12 month	Population-based survey (e.g. NARHS, NDHS)	Same as indicator	**Number of women and men who reported sexual activity with non-marital, non-cohabiting partners in the last 12 months.**	**Number of Women and men surveyed.**

PREVENTION: CONDOM
OUTCOME INDICATORS

INDICATORS		11. Percentage of women and men age (disaggregate by young people and adults) reporting the use of condom the last time they had sex with a non-marital, non-cohabiting sexual partner	12. Percentage of high-risk groups reporting the use of condom the last time they had sex (with a non-marital, non-cohabiting sexual partner)	13. Percent of sex workers who in the past 12 months used a condom consistently during sexual intercourse with a client
Data Source		Population-based survey (e.g. NARHS, NDHS)	High Risk Survey (BSS), NARHS	High Risk Survey (BSS)
DEFINITION		Percentage of people aged 15-49 years reporting the use of a condom during last sexual intercourse with a non-regular sexual partner (disaggregated by age (15-24), sex, target population, region and urban/rural) , none cohabiting	Percentage of people within high risk groups reporting the use of a condom during last sexual intercourse with a non-regular sexual partner (disaggregated by age (15-24), sex, target population, region and urban/rural) , none cohabiting)	Percentage of people within high risk groups reporting the use of a condom during last sexual intercourse with a non-regular sexual partner (disaggregated by age (15-24), sex, target population, region and urban/rural) , none cohabiting)
PERCENTAGE	**Numerator**	Number of respondents 15-49 who reported having non regular (ie non marital,non-cohabiting) sexual partner in the last 12 months who also reported that a condom was used the last time they had sex with this partner.	Number of respondents (15-49) who reported having had a non-regular (i.e., non-marital and non-cohabitating) sexual partner in the last 12 months who also reported that a condom was used the last time they had sex with this partner	Number of respondents (15-49) who reported having had a non-regular (i.e., non-marital and non-cohabitating) sexual partner in the last 12 months who also reported that a condom was used the last time they had sex with this partner
	Denominator	Number of respondents 15-49, who reported they had a non regular sexual partner in the last 12 months.	Number of respondents (15-49) who reported having had a non-regular sexual partner in the last 12 months	Number of respondents (15-49) who reported having had a non-regular sexual partner in the last 12 months

PREVENTION: PMTCT

OUTCOME INDICATORS

INDICATORS	Data Source	DEFINITION	PERCENTAGE		Value/Comments
			Numerator	Denominator	
14. Percentage of HIV positive pregnant women receiving a complete course of ARV prophylaxis to reduce the risk of PMTCT in accordance with nationally approved treatment	PMTCT/MIS and statistical modelling	Percent of HIV-infected pregnant women receiving a complete course of antiretroviral prophylaxis to reduce the risk of MTCT	Number of HIV-infected pregnant women provided with a full course of antiretroviral prophylaxis to reduce MTCT according to the nationally approved treatment protocol in the last 12 months (PMTCT MIS)	Estimated number of HIV-infected pregnant women (modeled)	
15. Percentage of LGA with at least one PMTCT centre offering the complete package of PMTCT services	PMTCT facility mapping/Listing	Percentage of LGAs with at least one health facility providing a complete package of PMTCT services (disaggregated by State and zone)	Number of LGA with at least one PMTCT offering complete package of PMTCT services in the last 12 months	Number of all LGAs in the Country	

PREVENTION: BLOOD SAFETY/NOSOCOMIAL/MEDICAL INJECTION TRANSMISSION

OUTCOME INDICATORS

INDICATORS	Data Source	DEFINITION	PERCENTAGE		Value/Comments
			Numerator	Denominator	

16. Proportion of women and men aged 15-49 reporting that the last health care injection was given with a syringe and needle from an , unopened package	Population-based survey (e.g. NARHS, NDHS)	Proportion of women and men age 15-49 reporting that the last health care injection was given with a syringe and needle from an, unopened package	Number of those men and women from the denominator who mention that the last injection received was given with a syringe and needle from an unopened package	Number of men and women aged 15-49 who can recall receiving an injection in the last six months	
18. Percentage of blood units transfused in the last 12 months that have been screened for HIV	Special survey	Percent of blood units transfused in the last 12 months that have been adequately screened for HIV according to national or WHO guidelines	The number of blood units screened for HIV in the previous 12 months according to national guidelines	Three pieces of information are needed for this indicator: the number of blood units transfused in the previous 12 months;	

PREVENTION: SEXUALLY TRANSMITTED INFECTIONS
OUTCOME INDICATORS

INDICATORS	Data Source	DEFINITION	PERCENTAGE		Value/Comments
			Numerator	Denominator	
19. Percentage of health facilities with capacity to appropriately diagnosed, treat and counsel patients with STI	Health facility survey	Percentage of health-care facilities who are appropriately diagnosing, treating and counseling for STIs	Number of ealth facilities that follow national protocols for STI management	Number of health facilities surveyed for STI patients	

PREVENTION: HIV COUNSELING AND TESTING

OUTCOME INDICATORS

INDICATORS		20. Percentage of individuals who ever received counseling and testing for HIV and received their test result	21. Percentage of high risk groups who received HIV counseling and testing services in the last 12 months.	22. Percentage of LGAs with specified no. of service outlets providing HCT
Data Source		Population-based survey (e.g. NARHS, NDHS)	High Risk Survey (BSS)	Mapping/Listing
DEFINITION		Proportion of persons aged 15 – 49 years (male and female) who had received HIV counseling and testing and their result.	Proportion of persons aged 15 – 49 years (male and female) amongst the special groups who in the last 6 months had an HIV test and received their test results	Percentage of Local Government Areas with at least one health facility providing HCT services in-line with national standards
PERCENTAGE	**Numerator**	Number of respondents (15-49yrs) who answered YES to the first question; and Yes to the 4th question (i.e. received their results)	Number of respondents (15-49yrs) who answer YES to the first question; ; less than 12 months (a and b) to the second question; and Yes to the 4th question i.e. received their results	Number of LGA with accredited HCT centres (i.e. HCT centres that meet all the criteria)
	Denominator	Total number of respondents (15-49) who gave answers (including "don't know") to question 1	Total number of respondents (15-49) who gave answers (including "don't know") to question .	Total number of LGA
Value/Comments		The indicator was derived from responses to the following set of questions 1. Have you ever been tested for HIV/AIDS before? 2. If Yes, When was the last time you ever tested? a. Less than six months ago b. 6-12 months ago c. 12-23 months ago d. 24 months or more 3. Why was the test done? a. I asked for the test b. I was offered and accepted c. I was required to have it 4. Did you receive your results? a. Yes b. No	1. Have you ever been tested for HIV/AIDS before? 2. If Yes, When was the last time you were tested? a. Less than six months ago b. 6-12 months ago c. 12-23 months ago d. 24 months or more 3. Why was the test done? a. I asked for the test b. I was offered and accepted c. I was required to have it 4. Did you receive your results? a. Yes b. No	Standard for HCT - 1. Provider initiated HCT (ANC, STI, TB, FP/RH etc) 2. Client initiated HCT 3. Pre test counseling (risk reduction, basic HIV education,) 4. HCT testing using a nationally approved testing algorithm 5. Post test counseling 6. Care and Support Linkages 7. TB linkages 8. PMTCT linkages 9. Condom availability

PREVENTION: TREATMENT
OUTCOME INDICATORS

INDICATORS		23. Percentage of people with advance HIV-infection receiving (current) antiretroviral combination therapy	24. Percentage of Local Government Areas with at least one health facility providing ART services and care and treatment for people in-line with national standards
Data Source		ART MIS	Mapping/Listing
DEFINITION		Percentage of people with advanced HIV infection receiving ARV combination therapy (disaggregated by age, sex)	Percentage of Local Government Areas with at least one health facility providing ART services in-line with national standards (disaggregated by State and zone)
PERCENTAGE	**Numerator**	Number of people (i.e., adults and children) with advanced HIV infection who receive antiretroviral combination therapy according to the nationally approved treatment protocol (a) Number of people with advanced HIV infection receiving treatment at the beginning of the year Plus (b) Number of people with advanced HIV infection who commenced treatment in the last 12 months Minus c: Number of people with advanced HIV infection for whom treatment was terminated in the last 12 months (including those who died)	Number of LGA with at least one ART site offering complete package of ART services in the last 12 months
	Denominator	Number of people with advanced HIV infection. The denominator is estimated to be 15% of the total number of people currently infected (based on the most recent national Sentinel Surveillance data). Note: • Private sector antiretroviral provision should be included in the calculation of the indicator wherever possible and the extent of such provision should be recorded separately	Number of LGAs in the Country
Value/Comments			

PREVENTION: OVC
OUTCOME INDICATORS

INDICATORS		25. Percentage of orphans and vulnerable children whose house holds received free basic external support in caring for the child	26. Ratio of current school attendance rate among orphans to that among non-orphans, aged 10-14
Data Source		Household based survey (e.g., NDHS)	Household-based survey (NHDS)
DEFINITION		Percent of orphans and vulnerable children under 18 living in a household whose households have received, free of user charges, basic external support in caring for the child ORPHANS: All children under 18 who have at least one dead parent (mother or father) AND VULNERABLE CHILDREN: All children under 18 who have a chronically ill parent (mother or father) defined as a parent who has been very sick for 3 or more months during the last 12 months, regardless of whether or not the ill parent lives in the household	
PERCENTAGE	**Numerator**	Number of orphans and vulnerable children residing in households that received: a. health care support within the past 12 months; b. emotional support within the past 3 months; c. school-related assistance within the past 12 months; d. other social support, including material support, within the past 3 months; and e. all four types of support.	Percentage of orphans age 10-14 who are attending school.
	Denominator	All Orphans and vulnerable children identified in the survey.	Percentage of non-orphans of non orphans 10-14 who are attending school.
Value/Comments			

PREVENTION: POLICY AND COORDINATION
OUTCOME INDICATORS

INDICATORS		28. Percentage of Line Ministries and Large Enterprises/Companies that have HIV/AIDS workplace policy and programs	29. National AIDS program effort index (National Composite Policy Index)	30. Percentage and amount of national funds disbursed by governments on HIV/AIDS
Data Source		HIV/AIDS Work-place survey	National Composite Index Survey	Special Survey
DEFINITION			The average score given to a national program by a defined group of knowledgeable individuals asked about progress in over 90 individual areas of programming, grouped into 10 major components	
PERCENTAGE	**Numerator**	Number of employers with HIV/AIDS policies and programmes that meet all of the above criteria	n/a	
	Denominator	Number of employers surveyed	n/a	
Value/Comments				1. Allows for cross country, regional and international comparison of data 2. Identifies how resources are being mobilized within a country: a) Who pays? b) Who finances? c) Under what schemes? 3. Identifies how resources are being managed within a country 4. Identifies who provides HIV/AIDS services and who benefits from these services 5. Measures additionally 6. Provides possibility to conduct beneficiary analysis

PREVENTION: STIGMA AND DISCRIMINATION

OUTCOME INDICATORS

INDICATORS	Data Source	DEFINITION	PERCENTAGE	
			Numerator	Denominator
31. Percentage of the general population with ***accepting attitude*** toward PLWHA	Population-based survey (e.g. NARHS, NDHS)	Percent of women and men aged 15–49 expressing accepting attitudes toward people with HIV, of all women and men aged 15–49 surveyed who have heard of HIV	Number of women and men who report an accepting attitude on key questions	Number of all women and men aged 15–49 surveyed who have heard of HIV

PREVENTION: KNOWLEDGE
OUTPUT INDICATORS

INDICATORS	Data Source	DEFINITION	PERCENTAGE		Value/Comments
			Numerator	Denominator	
33. Number of people trained to provide HIV/AIDS peer education	Program Report/Service Report		n/a	n/a	Total number of people trained to provide HIV/AIDS peer education
34a. Number of high risk groups (female sex workers) reached with HIV/AIDS prevention programs.	Program Report/Service Report		n/a	n/a	Total number of high risk groups (female sex workers) reached with HIV/AIDS prevention programs.
34b. Number of high risk groups (armed forces) reached with HIV/AIDS prevention programs.	Program Report/Service Report		n/a	n/a	Total number of high risk groups (armed forces) reached with HIV/AIDS prevention programs.
34c. Number of high risk groups (transport workers) reached with HIV/AIDS prevention programs.	Program Report/Service Report		n/a	n/a	Total number of high risk groups (transport workers) reached with HIV/AIDS prevention programs.

PREVENTION: CONDOM

OUTPUT INDICATORS

INDICATORS	Data Source	DEFINITION	PERCENTAGE		Value/Comments
			Numerator	Denominator	
35. Total number of condoms (male) distributed by social marketing outlets in the country.	Program Report		n/a	n/a	TOTAL # of condoms distributed to end users

PREVENTION: PMTCT

OUTPUT INDICATORS

INDICATORS	Data Source	DEFINITION	PERCENTAGE		Value/Comments
			Numerator	Denominator	
36. Number of pregnant women who received HIV counseling and testing for PMTCT and received their test result	PMTCT/MIS		n/a	n/a	Total number of pregnant women who received HIV counseling and testing for PMTCT and received their test result
37. Number of women receiving a complete course of antiretroviral prophylaxis to reduce the risk of mother to child transmission within a calendar year	PMTCT/MIS		n/a	n/a	Total number of women receiving a complete course of antiretroviral prophylaxis to reduce the risk of mother to child transmission within a calendar year
38. Number of health facilities providing a complete PMTCT package	Mapping/listing		n/a	n/a	Total number of LGA with facilities that are providingomprehensive PMTCT services

PREVENTION: PMTCT

OUTPUT INDICATORS

INDICATORS	Data Source	DEFINITION	PERCENTAGE		Value/Comments
			Numerator	Denominator	
39. Number of people provided with Counseling and testing for HIV and received their test results.	HCT MIS/NHMIS		n/a	n/a	Number of the general population who received Counseling and testing for HIV and received their test results.
40. Number of HIV counseling and testing service outlets	Mapping /Listing		n/a	n/a	Total number of HIV counseling and testing service outlets

PREVENTION: TREATMENT
OUTPUT INDICATORS

INDICATORS	Data Source	DEFINITION	PERCENTAGE		Value/Comments
			Numerator	Denominator	
41. Number enrolled in HIV care: (a)new and (b) current (c) cumulative ever at the facility by age and sex	Program Report (PMM)				
(a) New			n/a	n/a	Figures presented are for new cases only.
			n/a	n/a	All HIV+ population in the year less 10% attrition= new Rx +new BC&S
(b) Current			n/a	n/a	All HIV + population (old and new including treatment) =PC previous year – those convert to Rx + new PC for the year
(c) Cumulative			n/a	n/a	BC&S –new entry to Rx + new PC including attrition + current Rx.
42. Number on ART: (a)new (b)current and (c)cumulative ever started in the country	Program Report (PMM)		n/a	n/a	
New (Within the year)	Program Report (PMM)		n/a	n/a	
Current (at end of reporting period)	Program Report (PMM)		n/a	n/a	
Cumulative (at end of reporting period)	Program Report (PMM)		n/a	n/a	
44. Number of service delivery points providing anti retroviral combination therapy	Program Report (PMM)		n/a	n/a	Total number of service delivery points providing anti retroviral combination therapy
41. Number enrolled in HIV care: (a)new and (b) current (c) cumulative ever at the facility by age and sex	Program Report (PMM)				
(a) New			n/a	n/a	Figures presented are for new cases only.

PREVENTION: PALLIATIVE CARE – HOME BASED CARE

OUTPUT INDICATORS

INDICATORS	Data Source	DEFINITION	PERCENTAGE		Value/Comments
			Numerator	Denominator	
45. Number of HIV/Positive people receiving Home based care	Program Report		n/a	n/a	Total number of HIV/Positive people receiving Home based care

PREVENTION: TB/HIV COLLABORATION

OUTPUT INDICATORS

INDICATORS	Data Source	DEFINITION	PERCENTAGE		Value/Comments
			Numerator	Denominator	
46. Number of HIV patients currently in care who commenced TB Rx	Program Report (PMM)	Total number of HIV patients currently in care who commenced TB Rx within the reporting period.	n/a	n/a	

PREVENTION: OPPORTUNISTIC INFECTIONS

OUTPUT INDICATORS

INDICATORS	Data Source	DEFINITION	PERCENTAGE		Value/Comments
			Numerator	Denominator	
47. Number of people with HIV receiving cotrimoxazole prophylaxis	Program Report (PMM)	Opportunistic Infections	n/a	n/a	

PREVENTION: OVC
OUTPUT INDICATORS

INDICATORS	Data Source	DEFINITION	PERCENTAGE		Value/Comments
			Numerator	Denominator	
48. Number of orphans and vulnerable children whose house holds received free basic external support in caring for the child	Program Report	Total number of orphans and vulnerable children whose house holds received free basic external support in caring for the child	n/a	n/a	

PREVENTION: MONITORING AND EVALUATION
OUTPUT INDICATORS

INDICATORS	Data Source	DEFINITION	PERCENTAGE		Value/Comments
			Numerator	Denominator	
49. Percentage of Service Delivery Points submitting timely and complete reports	Program Report		n/a	n/a	

ANNEX 2: Implementing Partners: National M&E System Development and Implementation

Program / Service Delivery Areas		Implementers (Public, CS, Private and IPs)	Data Collection Methodologies (HMIS, surveillance, etc.)	Responsible(s) for Data Collection	Data Flow, Collation and Reporting	Levels of Decision Making and Policy Formulation
Prevention	BCC: Mass Media	NACA, GHAIN, FHI, Society for Family Health, DFID, NGOs, FBOs	National HIV AIDS and RH Survey, NNRIMS	NARHS: FMOH/NASCP NNRIMS: SACAs and LACAs	NARHS: LGA → State → Fed	All Levels
	BCC: Community Outreach	NGOs, FBOs		SACAs, LACAs	LGA → State → Fed	All Levels
	Youth Education	FMOE, SMoE;	IS	Principals	LGA → State → Fed	National and State
		NGO/FBOs;				
		MOS&SD				
	Condom Distribution	SFH, NACA	NARHS, NNRIMS	LACA, SACA	LGA → State → Fed	All Levels
		Line Ministries				
		Private sector				
	Program Specific Groups (CSW, Migrants, MSM)	NGOs (SWAAN, SFH)	Questionnaires, Survey Report			
	VCT	FMOH, SMOH, GHAIN, IHVN, ICAP, APIN, AIDSRELIEF, FBOs, Private	HMIS, NNRIMS, NARHS, NHSS		SDP → FMOH (NASCP), NACA	National
	PMTCT	FMoH, SMoH, GHAIN, IHVN, ICAP, APIN, AIDSRELIEF, FBOs, Private	NNRIMS, NARHS, NHSS		SDP → FMoH (NASCP), NACA	National
	STI Diagnosis and Treatment	FMOH, SMoH, FBOs, Private	HMIS, NARHS, NHSS		LGA → State → Fed	
	Post Exposure Prophylaxis					
	Blood Safety	FMOH, Safe Blood Africa	Registers, HMIS		LGA → State → Fed	National
	Universal Precaution	ENHANCE	Guidelines,			
Care and Support	OVC	FMOWA, NGOs, FBOs	Action Plan, Guidelines		LGA → State → Fed	National
	TB	FMOH, FBOs	Summary Forms NNRIMS		LGA → State → Fed	National
	Support for Chronically Ill	FMOH, SMoH	Health Register		LGA → State → Fed	

ANNEX 3: NOP Implementation Plan

Activities and Tasks	Responsible	Period	Duration	Estimated Cost
Launching of NOP	NACA	July	1 day	1.5 million
Costing of NOP	NACA/ GAMET	July	2 weeks	N840,000=
Dissemination of NOP to Stakeholders	NACA	July	1 week	1 million
Pilot testing of NOP in six selected states				
Capacity building of six states on NOP	NACA	August	1 week	4.5 million
Piloting of NOP for data collation, analysis, information flow and decision making	NACA	Sept - Dec	4 months	3 million
Assessment of NOP piloting in six states	NACA	Jan 08	2 weeks	1 million

ANNEX 4: SWOT Analysis of NNRIMS Implementation 2004 – 2006

Below is a SWOT analysis of the implementation of NNRIMS:

Strengths	***Weaknesses***
• Created awareness about monitoring and evaluation as a core function of the response among program managers and donor partners. • Capacity for monitoring and evaluation developed at federal, state, local government and service delivery levels. • Facilitated the development of national Monitoring and Evaluation tools for major programmes in all sectors. • Mobilized increased financial and human resources for M&E at all levels.	• Absence of an operational plan and budget to operationalize the NNRIMS framework • Inability to fully provide guidance for monitoring and evaluating all issues articulated in the NSF and the country roadmap for moving towards Universal Access (UA) for prevention, treatment, care and support that was developed in 2006. • Proliferation of tools and systems for strategic information in Nigeria. • The system is well developed at the central level (NACA). However a lot more needs to be done to decentralize its operationalization to the sectors, states, local governments and service delivery points
Opportunities	***Threats***
• Development partners' willingness to support monitoring and evaluation • General stakeholder interest in monitoring and evaluation • Interest and willingness to harmonize and align programmes and support	• Limited funding for implementation of monitoring and evaluation activities (less than the 10% recommendation)

ANNEX 5: Format of Annual National HIV/AIDS Moni&E Report

1. *Foreword*

This should be a statement by the Director General of the National Agency for the Control of AIDS.
The report shall be approved by NACA Governing Board prior to its publication.

2. *Executive Summary*

This should be a two or three page summary of the overall report, with a focus on key statistics and changes in statistics, as well as a description of key trends and how these influence the implementation of HIV/AIDS interventions.

3. *Annual M&E System Results*

A. REDUCTION IN HIV INCIDENCE/PREVALENCE

IMPACT-LEVEL INDICATORS

INDICATORS & REFERENCES	Data Source	Responsible Organization	Baseline (2005)	Previous year's Target	Previous year Result	Current Year Target	Current Year Result	Comments
1. Percentage of young people aged 15-24 who are HIV-infected			4.3% (2005)					
2. HIV prevalence rate in the general population			4.4% (2005)					
3. Percentage of HIV positive infants born to HIV-infected mothers			45.00%					

B IMPROVEMENT IN LIFE EXPECTANCY OF PLWHA

IMPACT-LEVEL INDICATORS

INDICATORS & REFERENCES	Data Source	Responsible Organization	Baseline (2005)	Previous year's Target	Previous year Result	Current Year Target	Current Year Result	Comments
4a. Percentage of adults and children with HIV still alive after 6 months after initiation of anti-retroviral therapy				4a. Percentage of adults and children with HIV still alive after 6 months after initiation of anti-retroviral therapy				
4b. Percentage of adults and children with HIV still alive after 12 months after initiation of anti-retroviral therapy			90.00%	4b. Percentage of adults and children with HIV still alive after 12 months after initiation of anti-retroviral therapy			90.00%	
4c. Percentage of adults and children with HIV still alive after 24 months after initiation of anti-retroviral therapy			85.00%	4c. Percentage of adults and children with HIV still alive after 24 months after initiation of anti-retroviral therapy			85.00%	

PREVENTION: KNOWLEDGE
OUTCOME INDICATORS

INDICATORS & REFERENCES	Data Source	Responsible Organization	Baseline (2005)	Previous year's Target	Previous year Result	Current Year Target	Current Year Result	Comments
5. Percentage of schools with teachers who have been trained in life-skills-based HIV/AIDS education and who taught it during the last academic year			19%					
6. Percentage of young people aged 15-24 who both correctly identify ways of preventing the sexual transmission of HIV and who reject major misconceptions about HIV transmission			25.90%					

PREVENTION: SEXUAL BEHAVIOR
OUTCOME INDICATORS

INDICATORS & REFERENCES	Data Source	Responsible Organization	Baseline (2005)	Previous year's Target	Previous year Result	Current Year Target	Current Year Result	Comments
7. Percentage of never married women and men 15-24 who had sex in the last 12 months, of all (never married men and women) respondents.			Male 65.6% Female34.4%	7. Percentage of never married women and men 15-24 who had sex in the last 12 months, of all (never married men and women) respondents.				
8. Median age at first sex: The age by which one half of young men and women aged 15-24 have had penetrative sex (median age) of all young people surveyed.			Female17.4 Male20.1	8. Median age at first sex: The age by which one half of young men and women aged 15-24 have had penetrative sex (median age) of all young people surveyed.				
9. Percentage of young women and men aged 15-49 who have had sex with a non-marital, non-cohabiting sexual partner in the last 12 month			Male20.70% Female 10.70%	9. Percentage of young women and men aged 15-49 who have had sex with a non-marital, non-cohabiting sexual partner in the last 12 month				

PREVENTION: CONDOM
OUTCOME INDICATORS

INDICATORS & REFERENCES	Data Source	Responsible Organization	Baseline (2005)	Previous year's Target	Previous year Result	Current Year Target	Current Year Result	Comments
10. Percentage of women and men age (disaggregate by young people and adults) reporting the use of condom the last time they had sex with a non-marital, non-cohabiting sexual partner			Male 61.3% Female 43.8%					
11. Percentage of high-risk groups reporting the use of condom the last time they had sex (with a non-marital, non-cohabiting sexual partner)								
12. Percent of sex workers who in the past 12 months used a condom consistently during sexual intercourse with a client			85.10%					

PREVENTION: PMTCT
OUTCOME INDICATORS

INDICATORS & REFERENCES	Data Source	Responsible Organization	Baseline (2005)	Previous year's Target	Previous year Result	Current Year Target	Current Year Result	Comments
13. Percentage of HIV positive pregnant women receiving a complete course of ARV prophylaxis to reduce the risk of PMTCT in accordance with nationally approved treatment			3.0% (2005)					
14. Percentage of LGA with at least one PMTCT centre offering the complete package of PMTCT services			10%					

PREVENTION: BLOOD SAFETY/NOSOCOMIAL/MEDICAL INJECTION TRANSMISSION

OUTCOME INDICATORS

INDICATORS & REFERENCES	Data Source	Responsible Organization	Baseline (2005)	Previous year's Target	Previous year Result	Current Year Target	Current Year Result	Comments
15. Proportion of women and men aged 15-49 reporting that the last health care injection was given with a syringe and needle set from a new , unopened package								
16. Percentage of blood units transfused in the last 12 months that have been screened for HIV								

PREVENTION: SEXUALLY TRANSMITTED INFECTIONS

OUTCOME INDICATORS

INDICATORS & REFERENCES	Data Source	Responsible Organization	Baseline (2005)	Previous year's Target	Previous year Result	Current Year Target	Current Year Result	Comments
17. Percentage of health facilities with capacity to appropriately diagnosed, treat and counsel patients with STI								

PREVENTION: HIV COUNSELING AND TESTING

OUTCOME INDICATORS

INDICATORS & REFERENCES	Data Source	Responsible Organization	Baseline (2005)	Previous year's Target	Previous year Result	Current Year Target	Current Year Result	Comments
18. Percentage of individuals who ever received counseling and testing for HIV and received their test result			8.30%					
19. Percentage of high risk groups who received HIV counseling and testing services in the last 12 months.			21%					
20. Percentage of LG with specified no. of service outlets providing HCT	Health facility survey		Estimated at 15%					

PREVENTION: TREATMENT
OUTCOME INDICATORS

INDICATORS & REFERENCES	Data Source	Responsible Organization	Baseline (2005)	Previous year's Target	Previous year Result	Current Year Target	Current Year Result	Comments
21. Percentage of people with advance HIV-infection receiving (current) antiretroviral combination therapy			18% (2006)					
22. Percentage of Local Government Areas with at least one health facility providing ART services and care and treatment for people in-line with national standards								

PREVENTION: OVC
OUTCOME INDICATORS

INDICATORS & REFERENCES	Data Source	Responsible Organization	Baseline (2005)	Previous year's Target	Previous year Result	Current Year Target	Current Year Result	Comments
23. Percentage of orphans and vulnerable children whose house holds received free basic external support in caring for the child			3%					
24. Ratio of current school attendance rate among orphans to that among non-orphans, aged 10-14			0.64 (NDHS, 2003)					

PREVENTION: POLICY AND COORDINATION
OUTCOME INDICATORS

INDICATORS & REFERENCES	Data Source	Responsible Organization	Baseline (2005)	Previous year's Target	Previous year Result	Current Year Target	Current Year Result	Comments
25. Percentage of Line Ministries and *Large Enterprises/Companies* that have HIV/AIDS workplace policy and programs			46.90%					
26. National AIDS program effort index (National Composite Policy Index)			62.0% (2005)					
27. Percentage and amount of national funds disbursed by governments on HIV/AIDS			#######					

PREVENTION: STIGMA AND DISCRIMINATION
OUTCOME INDICATORS

INDICATORS & REFERENCES	Data Source	Responsible Organization	Baseline (2005)	Previous year's Target	Previous year Result	Current Year Target	Current Year Result	Comments
28. Percentage of the general population with **accepting attitude** toward PLHA			65.20%					

PREVENTION: KNOWLEDGE

OUTPUT INDICATORS

INDICATORS & REFERENCES	Data Source	Responsible Organization	Baseline (2005)	Previous year's Target	Previous year Result	Current Year Target	Current Year Result	Comments
29. Number of people trained to provide HIV/AIDS peer education			43,000		29. Number of people trained to provide HIV/AIDS peer education			43,000
30a. Number of high risk groups (female sex workers) reached with HIV/AIDS prevention programs.			58.20%		30a. Number of high risk groups (female sex workers) reached with HIV/AIDS prevention programs.			58.20%
30b. Number of high risk groups (armed forces) reached with HIV/AIDS prevention programs.			80.50%		30b. Number of high risk groups (armed forces) reached with HIV/AIDS prevention programs.			80.50%
30c. Number of high risk groups (transport workers) reached with HIV/AIDS prevention programs.			64.20%		30c. Number of high risk groups (transport workers) reached with HIV/AIDS prevention programs.			64.20%

PREVENTION: CONDOM

OUTPUT INDICATORS

INDICATORS & REFERENCES	Data Source	Responsible Organization	Baseline (2005)	Previous year's Target	Previous year Result	Current Year Target	Current Year Result	Comments
31. Total number of condoms (male) distributed by social marketing outlets in the country.			159,333,336 (2005)					

PREVENTION: PMTCT
OUTPUT INDICATORS

INDICATORS & REFERENCES	Data Source	Responsible Organization	Baseline (2005)	Previous year's Target	Previous year Result	Current Year Target	Current Year Result	Comments
32. Number of pregnant women who received HIV counseling and testing for PMTCT and received their test result			<150,000	32. Number of pregnant women who received HIV counseling and testing for PMTCT and received their test result			<150,000	
33. Number of women receiving a complete course of antiretroviral prophylaxis to reduce the risk of mother to child transmission within a calendar year				33. Number of women receiving a complete course of antiretroviral prophylaxis to reduce the risk of mother to child transmission within a calendar year				
34. Number of health facilities providing a complete PMTCT package			194 (2006)	34. Number of health facilities providing a complete PMTCT package			194 (2006)	

PREVENTION COUNSELLING AND TESTING
OUTPUT INDICATORS

INDICATORS & REFERENCES	Data Source	Responsible Organization	Baseline (2005)	Previous year's Target	Previous year Result	Current Year Target	Current Year Result	Comments
35. Number of people provided with Counseling and testing for HIV and received their test results. (cumulative)								
36. Number of HIV counseling and testing service outlets			594 (2006)					

PREVENTION: TREATMENT
OUTPUT INDICATORS

INDICATORS & REFERENCES	Data Source	Responsible Organization	Baseline (2005)	Previous year's Target	Previous year Result	Current Year Target	Current Year Result	Comments
37. Number enrolled in HIV care: (a)new and (b) current (c) cumulative ever at the facility by age and sex								
(a) New								
(b) Current								
(c) Cumulative								
38. Number on ART: (a)new (b)current and (c)cumulative ever started in the country								
New (Within the year)								
Current (at end of reporting period)								
Cumulative (at end of reporting period)								
39. Number of service delivery points providing anti retroviral combination therapy			56					

PREVENTION: PALLIATIVE CARE – HOME BASED

OUTPUT INDICATORS

INDICATORS & REFERENCES	Data Source	Responsible Organization	Baseline (2005)	Previous year's Target	Previous year Result	Current Year Target	Current Year Result	Comments
40. Number of HIV/Positive people receiving Home based care								

PREVENTION: TB/HIV COLLABORATION

OUTPUT INDICATORS

INDICATORS & REFERENCES	Data Source	Responsible Organization	Baseline (2005)	Previous year's Target	Previous year Result	Current Year Target	Current Year Result	Comments
41. Number of HIV patients currently in care who are receiving TB Rx								

PREVENTION: OPPORTUNISTIC INFECTIONS

OUTPUT INDICATORS

INDICATORS & REFERENCES	Data Source	Responsible Organization	Baseline (2005)	Previous year's Target	Previous year Result	Current Year Target	Current Year Result	Comments
42. Number of people with HIV receiving cotrimoxazole prophylaxis								

PREVENTION: OVC

OUTPUT INDICATORS

INDICATORS & REFERENCES	Data Source	Responsible Organization	Baseline (2005)	Previous year's Target	Previous year Result	Current Year Target	Current Year Result	Comments
48. Number of orphans and vulnerable children whose house holds received free basic external support in caring for the child			22,000					

PREVENTION: MONITORING & EVALUATION

OUTPUT INDICATORS

INDICATORS & REFERENCES	Data Source	Responsible Organization	Baseline (2005)	Previous year's Target	Previous year Result	Current Year Target	Current Year Result	Comments
49. Percentage of Service Delivery Points submitting timely and complete reports			40.00%	49. Percentage of Service Delivery Points submitting timely and complete reports				

ANNEX 5 (continued): Format of Annual National HIV/AIDS Monitoring and Evaluation Report

4. Status of National M&E system

Due to its prominence, it is recommended that this section of the report should focus on the quality of data sources and the functioning of the national M&E system itself. This section should take the form of an objective assessment of the "health" of the M&E system, by means of the following headings:

a) Reporting on M&E system indicators in National M&E plan

b) Quality of data sources

c) Status of data flow to and from stakeholders, identification of bottle necks and recommendations for improvement

d) Status of NACA database and website, and recommendations for improvement

e) Comments on the quality and frequency of dissemination requests – particularly in light of the ad-hoc information needs which might have been submitted to NACA

5. Implementing Partners and Development Partners

This section should provide the following summative information about NACA's implementing and development partners, in tabular format:

DATA SOURCE	STATEMENT ABOUT QUALITY
1.	
2.	
3.	
4.	
5.	
6.	
7.	
8.	
9.	
10.	
11.	

INFORMATION ABOUT NACA PARTNERS	TYPE OF PARTNER	
	Development Partner	Implementing Partner
Number of partners		
Location of Partners		
Number of names on database		
Number of activities supported by partners		
Type of involvement		

6. Coc

conclusions and recommendations

This report should focus on presenting information in a format that is useful and applicable to the information needs of its readers. Thus, this section of the report should focus on key recommendations and suggested focus areas for the following year. This should be an objective assessment based on the results of the various indicators, and should not be a narrative report based on what the person writing the report feels is important.

The following headings are suggested:

a) Overall conclusions and recommendations
b) Conclusions per programme area:
   - Information, Education, and Communication
   - Promotion of Safer Sex Practices (ABCs)
   - Prevention of Mother-to-Child Transmission
   - STI Treatment and Prevention
   - Infection Prevention and Health Care Waste Management, including Blood Safety
   - HIV Counseling and Testing
   - Anti-Retroviral Therapy
   - TB Treatment
   - Community and Home-based Care and Support
   - Support for Orphans and Vulnerable Children (OVC)
   - Sectoral Mainstreaming
   - National management and commitment
c) Policy implications of M&E data

7. *Monitoring and Evaluation Work plan*

This section shall provide feedback on what has been achieved in terms of the work plan, identify gaps and suggest improvements for the next work plan. This section should summarize key M&E activities for the following 12 months. This should include major surveys to be undertaken, as well as anticipated research to be published.

8. Bibliography / list of data sources consulted

This section of the report shall list all of the data sources that have been consulted and used in developing this report. A checklist and recording sheet has been provided overleaf to allow for easy capture of data source references while the report is being compiled.

ANNEX 6: Checklist for Annual HIV/AIDS M&E Report

COMPLETE NAME OF DATA SOURCE	*AUTHOR/S*	*PUBLICATION DATE*	*PAGES AND/OR TABLES CONSULTED*

ANNEX 7: Terms of Reference for National M&E Technical Working Group (NTWG)

The NTWG is purely an advisory body for the National response of HIV/AIDS with NACA as the coordinating body. It is intended to advice on activities concerning all Monitoring, Evaluation and Information Systems activities in Nigeria.

Membership
Membership will comprised of coordinating bodies from the Government (at least NACA and NASCP), International groups, NGOs, and CBOs. The group will be chaired by an officer appointed by NACA.

Meeting times
The group will meet on a monthly basis. The venue of the meeting will rotate as best fits the membership. On a monthly basis the chair of each Subgroup will present its progress and key issues emerging to the National Technical Working Group (NTWG) on HIV/AIDS for information and appropriate action.

Review of Terms of Reference
These TORs will be reviewed annually and changes made as deemed necessary by the NTWG Subgroup and passed by the National TWG.

General Mandate
The activities of the NTWG will include, but not be limited to the following functions:

- Providing technical guidance on appropriate data collection methods, analytic strategies, dissemination of recommendations, selection and definition of indicators for national reporting
- Monitoring changing needs for M&E as country program and advise on prioritization of tasks and recommendations for outputs or products from working groups
- Support NACA in the review of the national HIV and AIDS M&E Framework (NNRIMS) and oversee its implementation and keep stakeholders in the national HIV/AIDS response informed of developments within other institutions and working groups.
- In conjunction with NACA, facilitate the development and adoption of a national integrated and costed M&E work plan in line with NSF and oversee its implementation and identify critical technical questions arising from M&E activities and organizing smaller working groups to address the questions and provide technical feedback on issues
- Developing and maintaining consensus around M&E strategies across partners and institutions and informally advocate for increased attention to and resources for M&E activities within the National response
- Advise on the development of country's multidisciplinary HIV and AIDS research agenda and review research proposals and refer them to the appropriate structure for approval
- Support NACA in the coordination, supervision and reporting on M&E activities at sub-national levels of M&E activities (data collection, analysis, dissemination) *(although the actual coordination will be conducted by NACA)*

- Identifying and recommending strategies for addressing the needs for capacity building at all levels thereby strengthening the states' M&E group along side national, sectoral and line ministries M&E units
- Perform other activities pertinent to M&E as may be requested by the Secretariat

ANNEX 8: List of Organizations that contributed to the NNRIMS Operational Plan

S/N	ORGANIZATION
1.	Armed Forces Program on AIDS Control (AFPAC)
2.	AIDS Prevention Initiative Nigeria (APIN)
3.	Association for Reproductive and Family Health (ARFH)
4.	Canadian International Development Agency (CIDA)
5.	Centre for Disease Control (CDC)
6.	Civil Society Network on HIV/AIDS in Nigeria (CiSNAN)
7.	Global HIV/AIDS Initiative Nigeria (GHAIN)
8.	Institute of Human Virology Nigeria (IHVN)
9.	Joint United Nations Program on HIV/AIDS (UNAIDS)
10.	MEASURE Evaluation
11.	National Agency for the Control of AIDS (NACA)
12.	National AIDS and STIs Control program (NASCP)
13.	Network of People Living with HIV and AIDS in Nigeria (NEPWHAN)
14.	Society for Family Health (SFH)
15.	Supporting the Nigerian Response to HIV/AIDS (SNR)
16.	United States Agency for International Development (USAIDS)
17.	World Bank
18.	World Health Organization (WHO)

ANNEX 9: References and Documents Used

1. NPC 2006: *National report on 2006 National Census*. Abuja. National Population Commission

2. NACA 2005: HIV/AIDS *National Strategic Framework 2005-2009*. Abuja: National Action Committee on HIV/AIDS.

3. NACA 2004: *Nigeria National Response Information Management System [NNRIMS] for HIV/AIDS: Guidelines & Indicators*. Abuja: National Action Committee on HIV/AIDS.

4. Trip Report. Review of M&E Activities in HIV/AIDS, Abuja, Nigeria, March 12-18, 2006.
Dr. Rosalía Rodriguez-García, GAMET, Global AIDS Program, World Bank and
Dr. Marcelo Castrillo, GAMET Consultant.

5. NACA 2007: *Report of Monitoring and Evaluation Stake holder's Forum. Lokoja March 2007*. National Agency for the Control of AIDS

6. NACA: *Report of NOP Indicator Matrix Target Setting Meeting. Kaduna May 2007*.
National Agency for the Control of AIDS

8 NACA 2004: *NNRIMS Monthly Summary Form*, Abuja (Reviewed in 2007).
National Agency for the Control of AIDS