Republic of Zambia

National AIDS Council

National HIV/AIDS/STI/TB Council

National Monitoring and Evaluation Plan (2011–2015)

(Building sustainable and efficient monitoring and evaluation systems in order to improve accountability of the national HIV and AIDS Response)

VERSION 1.4

May 2011

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PREFACE

The impact of HIV and AIDS in Zambia continues to unfold and highlight the need for concerted efforts among the various stakeholders. Its effect on production in all sectors of the economy led to the development of the HIV and AIDS policy to be coordinated by the National AIDS Council.

From the time the first HIV case was reported in Zambia in 1984, the pandemic reached its peak in the late 1990s to about 2004 when the prevalence rate reached 16% of the population. HIV incidence in adults aged 15–49 has been halved since 1990 and was estimated to be at a stable level of 1.6% in 2009 (2% in women, 1.2% in men) (NAC 2009 MOT Report). In 2009, an estimated 82,681 adults were newly infected with HIV (59% women, 41% men). This translated into 226 new adult infections per day. Although HIV incidence has stabilized, the absolute number of new HIV infections increased due to Zambia's expanding population. This emphasizes the urgent need to reduce the adult HIV incidence rate below the current level of 1.6%. In children aged 0–14, the number of new infections has gone down dramatically since peaking at 21,189 in 1996. The estimated number of new infections in children in 2009 is 9,196, translating into 25 new infections per day (a reduction of 130%). This is the combined effect of decreasing incidence in women and the introduction of the PMTCT programme.

Approximately 14.3% of Zambians are living with HIV, estimated at almost 1,000,000 adults (aged 15–49), and over 250,000 of these are receiving anti-retroviral treatment that allows them to live longer and healthier lives. Urban areas (20%) have higher HIV prevalence than rural areas (10%), and females (16.1%) are more likely to be HIV positive than males (12.3%). Women also tend to bear a disproportionate burden of care for the sick and otherwise affected, including more than 1.3 million orphans and children made vulnerable by HIV (JMTR, 2009).

Over the past years, at least three strategic frameworks have been consultatively developed in a bid to fight the scourge. The last strategic framework, NASF 2006–2010 had a well developed Monitoring and Evaluation Plan (MEP) aimed at ensuring its effective implementation. This MEP builds on the previous one and is aimed at ensuring that the implementation of the NASF 2011–2015 is on course. Hundred and four (104) indicators have been identified to measure the response stipulated in the 2011–2015 NASF. Of the 104 indicators, 9 are impact, 19 outcomes, and 38 output. The outcome and output indicators have further been categorized into the six themes, namely: prevention; expanding treatment, care, and support; mitigating socioeconomic impact; strengthening the decentralised response and mainstreaming HIV and AIDS; improving the capacity for monitoring and evaluation by all partners; and integrating advocacy, coordination, and leadership of the multisectoral response.

Hon. Kapembwa Simbao (MP)

Minister of Health and Chairperson of the Cabinet Committee on HIV and AIDS

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Chairperson

National HIV/AIDS/STI/TB Council

ACRONYMS

AIDS	Acquired Immune Deficiency Syndrome
ANC	Antenatal Care
ART	Antiretroviral Therapy
ARVs	Antiretrovirals
BCC	Behavioural Change and Communications
CATF	Community AIDS Task Force
CBOs	Community Based Organisations
CCM	Country Coordinating Mechanism
CDC	Centre for Disease Control
CHAZ	Churches Health Association of Zambia
CHWs	Community Health Workers
CPs	Cooperating Partners
CRIS	Country Reporting Information System
CSH	Communication Support for Health
CSO	Central Statistical Office
CTX	Cotrimoxazole
DACA	District AIDS Coordination Advisor
DATF	District AIDS Task Force
DDCCs	District Development Coordinating Committees
DHS	Demographic Health Survey
DOTS	Directly Observed Treatment Short-Course
DPOs	District Planning Officers
EDU	Epidemiology for Data-Users Training
EMIS	Education Management Information System
EU	European Union
FBOs	Faith Based Organisations
FGD	Focus Group Discussion
FNDP	Fifth National Development Plan
FPP	Focal Point Person
GBV	Gender-Based Violence
GF	Global Fund
GFATM	Global Fund to Fight Tuberculosis, AIDS, and Malaria
GIS	Geographical Information System
GRZ	Government of the Republic of Zambia
HBC	Home-Based Care
HIV	Human Immunodeficiency Virus
HMIS	Health Management Information System
IEC	Information, Education, and Communication

JAPR	Joint Annual Programme Review
JFA	Joint Financing Agreement
JMTR	Joint Midterm Review
LDT	Long-Distance Track Drivers
LMs	Line Ministries
M&E	Monitoring and Evaluation
MARPs	Most At-Risk Populations
MCH	Maternal and Child Health
MCP	Multiple and Concurrent Partner
MDGs	Millennium Development Goals
MEP	Monitoring and Evaluation Plan
MOE	Ministry of Education
MOH	Ministry of Health
MOT	Modes of Transmission
MSM	Men who have Sex with Men
MTEF	Medium Term Expenditure Framework
MTP	Medium Term Plan
NAC	National HIV/AIDS/STI/TB Council
NAPCP	National AIDS Prevention and Control Programme
NARF	National AIDS Council Activity Reporting Form
NASF	National AIDS Strategic Framework
NASP	National HIV/AIDS Intervention Strategic Plan
NASTAD	National Association for State and Territorial Directors
NDCPI	National Composite Policy Index
NGO	Nongovernment Organisation
NOP	National Operation Plan
NSA	National Statistical Act
OVC	Orphans and Vulnerable Children
PACA	Provincial AIDS Coordinating Advisor
PATF	Provincial AIDS Task Force
PDCC	Provincial Development Coordinating Committee
PEP	Post-Exposure Prophylaxis
PEPFAR	Presidential Plan for HIV/AIDS Relief
PLHIV	People Living with HIV/AIDS
PMTCT	Prevention of Mother-to Child-Transmission
RBM	Roll-Back Malaria
SAG	Sectoral Advisory Group
SBS	Sexual Behaviour Survey
SDA	Seventh-Day Adventists
SNDP	Sixth National Development Plan

STDs	Sexually Transmitted Diseases
STIs	Sexually Transmitted Infections
SWOT	Strengths, Weaknesses, Opportunities, Threats
TB	Tuberculosis
TDRC	Tropical Diseases Research Centre
TOT	Training of Trainers
UN	United Nations
UNAIDS	Joint United Nations Programme on AIDS
UNGASS	United Nations Global Assembly Special Session on HIV/AIDS
UNICEF	United Nations Children's Fund
UNZA	University of Zambia
USAID	United States Agency for International Development
USG	United States Government
VCT	Voluntary Counselling and Testing
WHO	World Health Organisation
ZASF	Zambia AIDS Strategic Framework
ZDHS	Zambia Demographic Sexual and Behavioural Survey
ZHFS	Zambia Health Facility Survey
ZNS	Zambia National Service
ZPCT	Zambia Prevention, Care, and Treatment
ZSBS	Zambia Sexual Behaviour Survey

GLOSSARY

Monitoring is the continuous process of collecting and analyzing data for performance indicators to compare how well a development intervention, partnership, or policy reform is being implemented against expected results (achievements of outputs and progress toward outcomes). Monitoring looks at what has been done, whereas evaluation examines the effectiveness of what is being done.

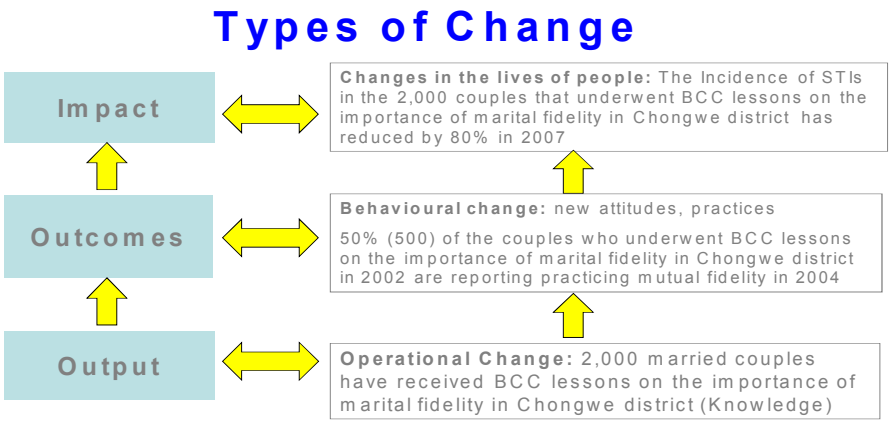
Outcome evaluation is an in-depth examination of a related set of programs, projects, and strategies intended to achieve a specific outcome; to gauge the extent of success in achieving the outcome; to assess the underlying reasons for achievement or nonachievement; to validate the contributions of a specific organisation to the outcome; and to identify key lessons learned and recommendations to improve performance.

The National AIDS Strategic Framework (NASF) 2011–2015 has an overall result to be achieved during its implementation period. Resources are used to implement different interventions expected to produce desired results which over time contribute to achieving the overall collective result. An effective Monitoring and Evaluation (M&E) system establishes a clear and **logical pathway** from the resources used to the achievement of the overall result. This pathway includes the following major components:

- *Inputs:* the financial, human, material, technological, and information resources used for the development intervention.
- *Activities:* actions taken or work performed through which inputs—such as funds, technical assistance, and other types of resources—are mobilized to produce specific results.
- *Outputs:* products and services that result from the completion of activities within a development intervention.
- *Outcomes:* intended or achieved short- and medium-term effects of an intervention's outputs, usually requiring the collective effort of partners. Outcomes represent changes in development conditions that occur between the completion of outputs and the achievement of impact.
- *Indicators:* quantitative or qualitative variables that allow the verification of changes produced by a development intervention relative to what was planned.
- *Target:* reference point or standard against which progress or achievements can be assessed. A target refers to performance achieved in the recent past by other comparable organisations, or what can be reasonably inferred to have been achieved in similar circumstances.

Result is a measurable or describable change resulting from a cause-and-effect relationship. Results therefore should be based on sound evidence that demonstrate cause and effect. This information should assist in making strategic choices and inform collective accountability. The change language must describe specific measurable, achievable, relevant, and time-bound results. Results are at three levels—output, outcome, and impact (see Figure 1).

Figure 1: Types of Change Attributed to Results



Logic Model is a management tool that describes a programme showing what the programme will do and what it will accomplish. It has a series of if–then relationships that, if implemented as intended, lead to the desired outcomes. It is the core for programme planning and evaluation. The Roll-Back Malaria (RBM) logic chain for the NASF 2011–2015, shown in **Box 1**, also draws on a human rights–based approach to programming, which ensures that outputs and outcomes reflect appropriate entitlements and responsibilities for rights holders and duty bearers, respectively.

Box 1: NASF Results Framework Logic-chain

IMPACT Results: Changes in the quality of life of Zambians—the impact results of NASF include such things as prevalence, reduction in HIV-related mortality and morbidity; produced by set of...

...OUTCOME Results: *Behavioural and institutional* changes resulting from the implementation of the NASF—such things as universally accessible prevention, treatment, and care services for all Zambians; reduction in the numbers of multiple concurrent sexual partners of men and women; increased level of abstinence among youth and the unmarried; increased condom use by men and women during risk sex (including with persons of unknown HIV status); resulting from a set of...

...OUTPUT Results: Operational changes—*products and services* developed by implementers (in public, private, and civil society sectors), identified and determined by careful analysis as necessary and sufficient to achieve the outcomes desired; resulting from...

…ACTIVITIES: Conducted by implementers according to their strategic and operational programmes as necessary and sufficient to achieve the OUTPUTS required.

Note: the activity-level of the above chain is described in programmatic plans.

Source: NASF 2011–2015

National M&E Plan: a comprehensive narrative document on all M&E activities. It describes key M&E questions to be addressed; what indicators to be measured; and how often, from where, and why the indicator data will be collected. It includes baselines, targets, and assumptions; how data are to be analyzed or interpreted; how often reports on the indicators will be developed and distributed; and how the 12 components of the M&E system will function.

M&E Plan and M&E System: the M&E plan documents all aspects of the M&E system; the M&E system consist of people and processes that work together in an enabling environment to achieve the 12 performance goals on an M&E system.

M&E Plan and M&E Work Plan: while the M&E plan is a narrative document that describes in detail how the M&E system will operate, an M&E work plan is an activity-based budget showing M&E tasks, responsibilities, timeframes, and cost. It is a costed list of activities for implementing an M&E plan.

M&E Plan and M&E Framework: both generally refer to the same thing. The M&E plan is called an operational framework in narrative format with indicators of the M&E system—the way the system will function, including other features. M&E framework may be referred to as a results framework or logic framework.

1 INTRODUCTION

1.1 Background

This National HIV/AIDS Monitoring and Evaluation Plan (MEP) is a companion to the new National HIV/AIDS Strategic Framework (NASF) for the period 2011–2015. This MEP not only provides for the monitoring and evaluation of the NASF 2011–2015, but also contains the operational plan of how it will be realized.

The first case of HIV was diagnosed in 1984 in Zambia. In 1986, the Government of the Republic of Zambia (GRZ) established the National AIDS Prevention and Control Programme (NAPCP) with assistance from the World Health Organisation (WHO) to ensure a coordinated response. Several plans were formulated and implemented, including the emergency short-term plan of 1987, the two Medium Term Plans (MTP1 and MTP2) of 1988–1992 and 1994–1998, respectively. The National HIV/AIDS Intervention Strategic Plan (NASP) and National MEP were developed for 2002–2005. These comprehensive plans focused on national level decision making and coordination. After 2005, these responses were further entrenched by the formulation and implementation of the National HIV/AIDS/STI/TB Strategic Framework for 2006 to 2010 and its accompanying National HIV/AIDS/STI/TB Monitoring and Evaluation Plan for 2006–2010. When these expired in 2010, NAC with its partners developed the NASF for 2011–2015, which outlines Zambia's response to HIV & AIDS in the next 5 years. This prompted the development of the MEP for 2011–2015, which will build on the experiences and lessons learned from the previous MEP for 2006–2010.

1.2 Sociodemographic Profile of Zambia

Zambia is a land-locked country located in South Central Africa. It is surrounded by Angola, Democratic Republic of Congo, Tanzania, Malawi, Mozambique, Zimbabwe, Botswana, and Namibia. Occupying a total land area of 740,724 square kilometres, it is administratively divided into 9 provinces: Central, Copper Belt, Eastern, Luapula, Lusaka, Northern, Northwestern, Southern, and Western. Each province is divided into a number of districts; there are a total of 73 districts in Zambia.

The population of the country has increased from 9,885,591 in 2000 to approximately 13,046,508 by the end of 2010 (CSO, 2011), representing an annual growth rate of 2.8%. Of this population, 49% (6,394,455) are males and 51% (6,652,053) are females. In terms of geographic distribution, the rural areas account for the majority of the population with 61%, while only 39% reside in urban areas. Lusaka and Copper Belt provinces have the highest populations at 2,198, 996 and 1,958,623, respectively. The age structure of the population indicates that Zambia has a predominantly young population with 42% falling within the sexually-reproductive age group of 15–49 (ZDHS, 2007).

According to the ZDHS of 2007, life expectancy at birth was 50 years[1] while the under-five mortality rate stood at 119 deaths per 1,000 live births. Adult literacy is estimated to be 68% (60.4 percent for women and 81.3 percent for men) with a combined (primary, secondary, and tertiary) enrolment ratio of 60.5.

The country is considered a low-income country with a GDP of US$13 billion and a per capita income of US$1,086 (at current prices) in 2009. In 2005, the unemployment rate was estimated at 12 percent. Mining and agriculture are the mainstays of the Zambian economy. Before the global economic crisis, copper mining accounted for 95% of the export earnings and contributed to approximately 45 percent of Government revenue. Agriculture is the largest employer with 70 percent of the labour force and the service industry employing 23%.

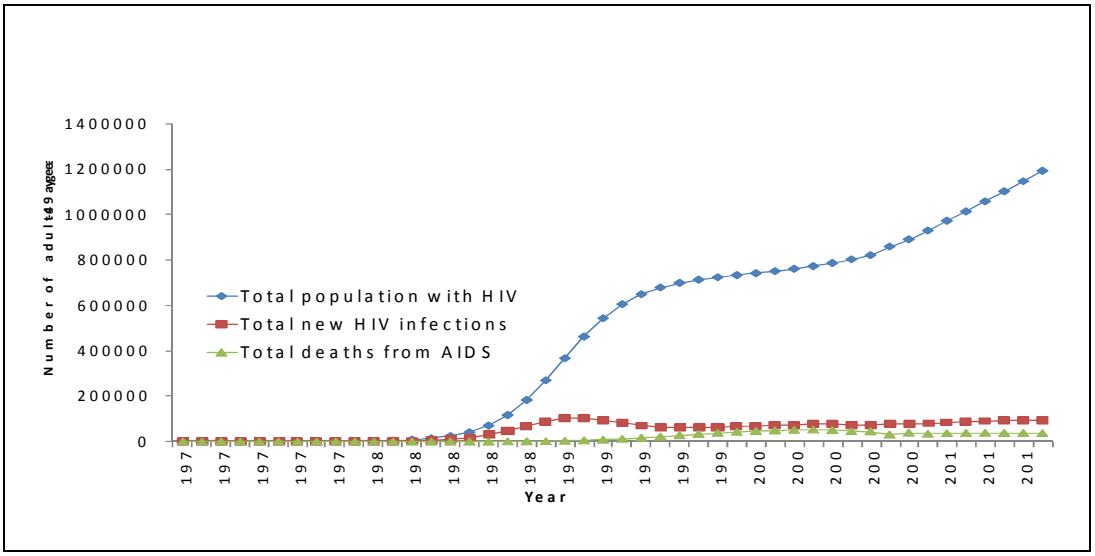
[1] ZDHS 2007

1.3 HIV Epidemic in Zambia

Zambia is regarded as one of the countries at the epicentre of the HIV & AIDS epidemic and is rated as having one of the highest HIV prevalence rates in the world. From 1984, when the first case of AIDS was diagnosed, the epidemic has spread rapidly over the years. By 2009, HIV prevalence was estimated at 14.6% of persons aged 15–49, and women (16.1 percent) lived with HIV more than men (12.3%) did. Urban areas (20 percent) had higher HIV prevalence rates than rural areas (10%).

HIV incidence in adults aged 15–49 was halved since 1990 and was estimated to be at a stable level of 1.6% in 2009 (2% in women, 1.2% in men (NAC 2009 MOT Report)). In 2009, an estimated 82,681 adults were newly infected with HIV (59% women, 41% men). This translated into 226 new adult infections per day. Although HIV incidence has stabilized, the absolute number of new HIV infections increased due to Zambia's expanding population. This emphasizes the urgent need to reduce the adult HIV incidence rate below the current level of 1.6%. In children aged 0–14, the number of new infections has gone down significantly since peaking at 21,189 in 1996. The estimated number of new infections in children in 2009 was 9,196, or 25 new infections per day (see Figure 2).

Figure 2: Trend of HIV Incidence Mortality in Relation to the General Population



Source: NAC HIV Estimates and Projections 2009

Based on the latest evidence generated to support scale-up efforts of the national response, the following drivers of the HIV epidemic have been identified:

Driver 1: Multiple and concurrent sexual partners (MCP) in the context of social norms:

Multiple and concurrent partner (MCP) behaviour is prevalent among all sexually active age groups and is manifested through sexual concurrency and networks, extramarital relationships, and secondary partners in transactional sex. There is evidence of some partner reduction, for example, a declining percentage of men and women report multiple partner behaviours.

Driver 2: Low and inconsistent condom use:

Condom usage remains low especially among key populations such as sex workers, people having casual sex, and discordant couples. Condoms are also not easily accessible to vulnerable and most at-risk populations such as inmates or learners in primary and secondary schools. Significant efforts have been made to empower women to take control of their sexual and reproductive health, but they have not been adequately empowered to effectively negotiate and/or demand the use of condoms.

Driver 3: Low rates of male circumcision in some provinces:

The national level of male circumcision remains low; 13% of men aged 15–49 report having been circumcised. Eastern (3.2%), Southern (4.4), and Central (5.7%) provinces have the lowest levels of male circumcision compared with Northwestern (71%) and Western (40.2%) provinces that have the

highest levels of male circumcision despite the potential for circumcision reducing the possibility of infection among men by 60%. According to the Demographic and Health Survey (2007), HIV prevalence among circumcised men was 10% compared to 12.5% among uncircumcised men.

Driver 4: Mobility and labour migration:

Most Zambians are mobile and often move from their home provinces in search of employment (migrant labourers). Provinces with highly mobile populations and many migrant labourers, such as Lusaka and Copper Belt, have been found to have high HIV prevalence. Limited targeted interventions exist for mobile and migrant workers.

Driver 5: Vulnerable and marginalized groups:

Sex work and having sex with other men remains illegal in Zambia; hence, access to HIV services is limited. There is also limited data on size estimation of sex workers, men who have sex with men (MSM), and their clients to adequately inform policy and facilitate access to services to most at-risk populations such as sex workers and MSMs.

Driver 6: Vertical mother-to-child transmission:

One out of 10 new infections occurs in children aged 0–14 and most are vertical transmissions from mother to child. Although prevention of mother to child transmission (PMTCT) has been rolled out to most health facility levels, uptake remains low for various reasons including stigma associated with HIV that has contributed to approximately 53% of deliveries occurring at home; delays in infant diagnosis for HIV; unmet needs for discordant couples; and inadequate male involvement in PMTCT.

In addition, these six drivers are often exacerbated by structural factors such as gender inequality, disparity in access to resources, discrimination and HIV-related stigma, and limited access to services.

1.4 The HIV and AIDS Response

The Government of Zambia and its cooperating partners and stakeholders have recognized the need to do more to effectively tackle the spread of HIV and AIDS. Zambia is a signatory to many important commitments related to HIV and AIDS, including the “Three Ones” principles which provide a useful framework for the development, management, and coordination of the HIV and AIDS response by ensuring that:

One agreed HIV and AIDS strategic framework provides the basis for coordinating the work of all partners: The Sixth National Development Plan (FNDP 2011–2015) and a related National HIV and AIDS Strategic Framework (NASF 2011–2015) were developed with broad participation of key stakeholders, including civil society, to ensure dissemination. Both documents are now finalized and approved for dissemination.

The 2011–2015 NASF is a national multisectoral framework for HIV and AIDS that provides strategic and policy orientation of the response. The framework marks a shift from business as usual to a focus on evidence and results-based planning and management of the response. The current NASF succeeds the outgoing NASF 2006–2010.

The NASF articulates the national priorities[2] and impact level results for the HIV and AIDS response and revolves around four pillars (prevention; treatment, care, and support; impact mitigation; and response management) of the national multispectral response. Within each of the thematic pillars, specific Service Delivery Areas (SDAs) are identified based on their potential to contribute to the output, outcome, and impact results.

The framework takes cognisance of the decentralisation of the HIV and AIDS response implementation to sectors, including civil society and the private sector; provinces through the Provincial AIDS Task Forces (PATFs); districts through the District AIDS Task Forces (DATFs); and at the community level through the Community AIDS Task Forces (CATFs). It also incorporates gender and human rights dimensions to ensure accelerated implementation of universal access to prevention, treatment, care, and support of HIV and AIDS services.

[2] These are priorities set out in the 6th National Development Plan chapter on HIV and AIDS, June 11, 2010.

The programmes and strategies in the NASF were identified based on available evidence of their efficacy and alignment to the national Vision 2030, the Sixth National Development Plan (SNDP), the Poverty Reduction Strategy, the Millennium Development Goals (MDGs), and the National HIV/AIDS/STI/TB policy.

One national AIDS coordinating authority includes a broad-based multisectoral mandate: The National HIV/AIDS/STI/TB Council (NAC) has been established through legislation and is comprised of broad representation from several government ministries and civil society. The NAC is mandated with the responsibility to coordinate, monitor, and evaluate the implementation of the national multisectoral response aimed at turning the tide of the HIV crisis. The NAC was established through an act of parliament in 2002 and is comprised of permanent secretaries from the key social sector line ministries of government, representatives of civil society organisations, the media, traditional healers, and members of the public.

One agreed country-level monitoring and evaluation system is developed: To measure progress in achieving the results set out in National HIV&AIDS Strategic Framework, a national monitoring and evaluation system has been developed. The system is aimed at enabling HIV response managers to track progress in achieving HIV response results at the output, outcome, and impact levels and to provide timely feedback that enables HIV response managers to change plans and implementation practices to improve the response. The M&E system is expected to generate sustainable, high-quality, affordable, and timely information for decision making and accountability reporting by programme managers, policymakers, and donors.

1.5 Structure of the Harmonized National M&E Plan

The national M&E plan provides background information, defines what the M&E systems will measure (indicators linked to the objectives and results framework of the NASF and national operational plan), and explains how the system will operate to enable these measurements to take place. The M&E plan is organised in five sections as follows:

Section 1	**Introduction**
Section 2	Review of the national M&E system
Section 3	Objectives and goals of the M&E plan
Section 4	What will be measured with the M&E system
Section 5	How the M&E system will function
Annexure	Detailed description of typical content of each section, checklists, and explanatory matrixes

1.6 Process Used to Develop the M&E Plan

The development of the national M&E plan employed a participatory and consultative approach, involving a strong level of participation of HIV M&E stakeholders at all levels and ensuring their commitment to the successful implementation of the framework.

The M&E plan was further validated and approved by necessary government structures and key partners. To promote national buy-in and its use, efforts will be made to widely disseminate and build capacity on its implementation.

The National AIDS Council has—in partnership with a number of development partners, government institutions, the private sector and civil society organisations—undertaken a number of M&E system assessments in the past few years. These include the Global Fund (GF) assessment (2005), the national M&E system diagnosis (2009), the Joint Annual Programme Reviews (JAPRs) 2002–2007, the Joint Midterm Review (JMTR) 2008, and synthesis of the national M&E system in 2010. These and other studies have revealed a number of strengths and weaknesses in the national HIV and AIDS M&E system. The findings of the above collectively showed that the country has HIV M&E systems in place; some areas are functional and some areas require improvement, especially at subnational levels.

Areas in need of improvements include data quality, human and institutional capacity, harmonization and alignment of systems, data flow, programme evaluation, and operational research practices.

Opportunities exist that could be used to make improvements to the system: commitment from government and development partners, availability of M&E technical expertise within key government and partner institutions, and government decentralisation policy and global agreements that promote harmonization and alignment of national M&E systems.

However, threats also exist, especially the current global recession, over-dependency on donor funding, and high turnover of M&E experts. Based on findings of the M&E review process, the following recommendations will need to be addressed in the next five (5) years:

- Strengthen and decentralise the national M&E systems to the provinces and district.
- Strengthen institutionalised expenditure tracking and resource mapping system at all levels.
- Establish a functional integrated national HIV and AIDS database for use by all partners using internet-based systems.
- Strengthen harmonized national information systems to generate quality assured data through surveys, surveillance, research, evaluation, and routine monitoring systems.
- Generate accurate, timely, and reliable and relevant data to measure NASF results.
- Strengthen M&E and research information product dissemination and utilization systems at all levels.
- Promote national and local use of strategic information generated from the systems.
- Strengthen and scale up operational research and evaluation practices among partners to support policy, programming, and advocacy.
- Strengthen human and institutional M&E capacity at all levels to manage HIV M&E system efficiently and effectively.

2 GOALS AND OBJECTIVES OF NATIONAL M&E PLAN

2.1 Goal

The goal of the National Monitoring and Evaluation (M&E) Plan is to enable NAC and its partners to monitor the spread of the epidemic, to measure the efficiency of the national response to HIV and AIDS, and to evaluate the effectiveness of the national response using relevant, timely, and accurate HIV and AIDS data.

2.2 Objectives

The objectives of the national M&E plan are to:

1. Ensure availability and use of accurate, timely, and relevant data to monitor and evaluate the national HIV & AIDS response.
2. Strengthen human resource capacity at all levels, including for private and civil society sectors.
3. Mainstream the national M&E plan in other institutions and ensure harmonization and alignment in line with the “Three Ones” principles.
4. Promote M&E partnership and linkages between various sectors, partners, and stakeholders at different levels to enable information sharing, dissemination, and the use of data in planning interventions and reprogramming.
5. Harmonize research coordination mechanisms.
6. Strengthen capacities of stakeholders to use research information for decision making, programme development, policymaking, and resource allocation.

2.3 Expected Outcomes

By the end of the 5 years of the implementation of the M&E plan, NAC and its partners expect to achieve the following:

- All partners will “buy in” and use as common recipe the harmonized national M&E plan.
- Functional M&E units at national, provincial, and district levels will coordinate structures of national response.
- Common and nationally owned indicators and targets will inform monitoring and evaluation activities of the response.
- Harmonized indicators, tools, platforms, and reporting formats will be acceptable to all partners and will be functional at all levels.
- Improved quality, timely, accurate, and reliable data will support the national response.
- Optimal human and institutional capacity will be required to support functionality of the national M&E system.
- Improved strategic information and use of data for planning, programming, resource mobilization, and advocacy will be in place to scale up universal access of the response.
- All sector-specific, subnational, and organisational M&E plans and data will be properly linked to the national M&E system.
- Improved participation and sharing of relevant stakeholders and their data in the NAC M&E systems will exist.
- Stakeholders’ capacity for applied research will be strengthened.

3 WHAT THE M&E SYSTEM WILL MEASURE

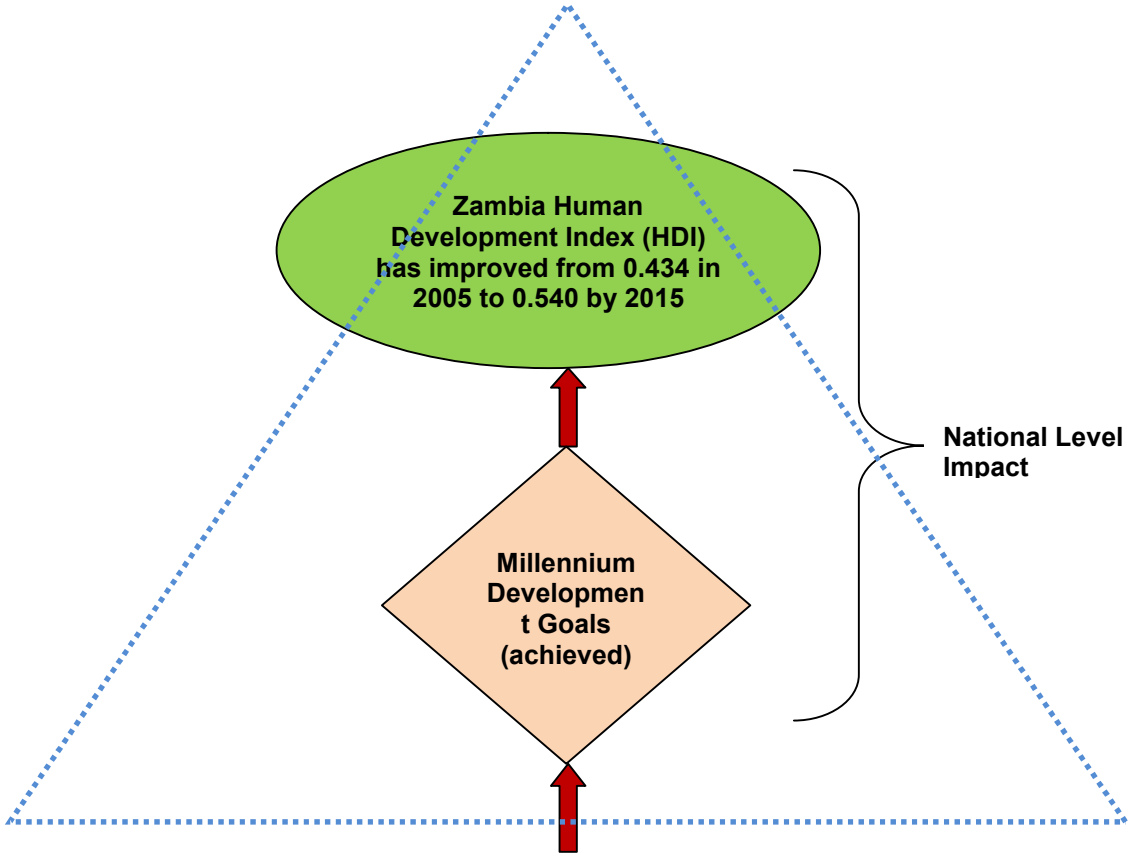
The current National AIDS Strategic Framework (NASF) 2011–2015 was developed using a results-based planning and management approach. A results framework exists for each key implementation area, identifying key results or milestones to be achieved in prevention, care and treatment, and the mitigation of HIV's impact on the population.

Results framework of the NASF is made of 5 impact results, 19 outcome results, and 60 output results. The indicators in the M&E plan will be based on these categories of results. The indicators will be measured at output, outcome, and impact levels of the results framework.

3.1 Impact Results

Figure 3 shows the linkage between the impact results of the NASF and the higher level development results of the Sixth National Development Plan (SNDP). See Appendix A for a more detailed log-frame.

Figure 3: Impact Level Results



Thematic Level Impact Results	
Prevention	By 2015, the rate of annual HIV new infections has reduced from 1.6% to below 0.8% (82,000 annual new infections to 40,000) by 2015
	Infants born of HIV positive mothers who are infected has reduced to less than 5%3 by 2015
Treatment, Care and Support	PLHIV who are alive at 36 months after initiation of antiretroviral therapy has increased to 85% by 2015
Impact Mitigation	Number of vulnerable households4 is reduced by 50% by 2015
Response management	The total NASF service coverage targets (output level results) that have been met in all four pillars has increased to 50% by 2013 and 90% by 2015

3 This is in line with the concept of Virtual elimination of MTCT of HIV. The Global target for virtual elimination is 5% at national level and 90% reduction in new infections between 2010 and 2015 [Source: Towards Universal Access to PMTCT – presentation to funders, May 10th 2010, UNAIDS]

4 It is estimated that there are 8000 vulnerable households (2010) - Source: A Supplement to NASF 2006-2010 Based on the Joint MTR held in 2008, NAC

Table 1: Key Indicators by Thematic Areas

Thematic area	Thematic Level Impact Results[5]	Indicators
Prevention	By 2015, the rate of annual HIV new infections has reduced from 64,000 annual new infections to 32,000	No of new infections by age, sex and geographical location annually
	Infants born of HIV positive mothers who are infected has reduced to less than 5%[6] by 2015	% of infants born to HIV infected mothers who are infected annually
Treatment, Care and Support	More PLHIV live longer: The % of PLHIV who are alive at 12 months after initiation of antiretroviral therapy has increased to 85% by 2015 from.... in 2011	% of PLHIV who are alive at 12 months after initiation of antiretroviral therapy
Impact Mitigation	More OVCs receive free external basic support: OVC under 18 years whose households received at least one type of free basic external support (medical, emotional, social/material and school related) to care for the child in the last twelve months has increased from 16% in 2009 to 25% in 2013 and to 40% by 2015.	% of orphans and vulnerable children under 18 years living in households, whose households received free of user charges and basic external support in caring for the children
		Ratio of orphans school attendance to non-orphan school attendance [by age, sex, geographical area]
Response Coordination and management	The enabling policy and Legal environment is improved: Between 2011 and 2015, the enabling policy and legal environment necessary for the implementation of the national multisectoral response to HIV & AIDS is adequately	National Composite Policy Index
	The National M&E system for HIV&AIDS has improved by 80% of result values of the NASF results framework by 2013 and 100% by 2015	% of organisations with functional M&E systems and linked to the national M&E system at national, provincial and district levels

[5] These results are harmonized with the inputs for the Sixth National Development Plan.

[6] This is in line with the concept of Vvirtual elimination of MTCT of HIV. The Global target for virtual elimination is 5% at national level and 90% reduction in new infections between 2010 and 2015 [Source: Towards Universal Access to PMTCT—presentation to funders, May 10th, 2010, UNAIDS]

3.2 Outcome and Output Results

The outcome results are shown according to the four pillars of the national response (see Table 2).

3.2.1 Pillar 1: Prevention

Table 2: Prevention Results and Indicators

Outcome Result	Indicator	Output result	Indicators
Social and Behaviour Change OC1.1] *More people have comprehensive knowledge*[7] *of HIV*: Female and Male aged 15- 49 years with comprehensive knowledge of HIV and AIDS has increased from 37% in 2007 to 53% in 2013, and to 74% in 2015, and increased from 35% in 2007 for people aged 15–24 years to 51% in 2013 and 70% by 2015	Percentage of 15-24 years who both correctly identify ways of preventing sexual transmission of HIV and who reject major misconceptions about HIV transmission [by gender, geographical location] [UNGASS]	[OP1.1] Females and males aged 15-24 accessing social and behaviour change programmes is increased from 30% to 50% by 2013 and to 80% by 2015	Number of 15-24 year olds reached with individual and/or small group level HIV prevention interventions that are based on evidence and/or meet the minimum standards required. [PEPFAR]
	The median age at first sexual debut [by gender, geographical location] [UNGASS]	[OP1.2] Most at risk population and vulnerable groups reached with HIV prevention programmes has increased from 15% to 25% by 2013 and to 50% by 2015	Number MARPS reached with HIV prevention programs [by age, sex, geographical area]
	Percentage of unmarried respondents who report at least 2 sexual partners	[OP1.3] In and out of school OVC aged 5-17 years reached with life skills based HIV education has increased from 20% in 2009 to 50% in 2013 and by 80% in 2015	Number of in and out of school [15-24 years] reached with life skills based HIV education in the last 12 months [by age, sex and geographical area]
	Percentage of 15-24 year olds who report being sexually active		Number of IEC materials distributed [by type, geographical area]
	Percentage of 15–49 year old who report using a condom with non-regular sexual partner		
	Percentage of males circumcised [by age, geographical area–province and district]		
[OC1.2] *Fewer persons have multiple and concurrent partnerships*: Female and male aged 15–49 in the general population who had concurrent partnerships in the last 12 months reduced from 35% for female and 70% for male in 2010 to less than 10% for female and remains that way by 2015, and to 30% by 2013 for Male and to 20% by 2015.	Percentage of females and males 15–49 years who had two or more concurrent partnerships in the last 12 months (by residence)	[OP1.4] Communities reached with social and behaviour change programmes focused on risks of multiple and concurrent partnerships has increased to 50% by 2013 and 80% by 2015	Percentage of communities in which comprehensive MCP programmes (including behaviour and social norm change programmes; family unit strengthening programmes, relationship skills for couples, and communication for social change programmes) have been implemented
			Number and percentage of community leaders trained in MCP

[7] Comprehensive knowledge means knowing that consistent use of condom during sexual intercourse and having just one uninfected faithful partner can reduce the chances of contracting HIV, knowing that a healthy-looking person can have HIV, and rejecting the two most common local misconceptions about HIV transmission and prevention

Outcome Result	Indicator	Output result	Indicators
		[OP1.5] Couples (stable and semi-stable relationships) reached with small group or individual social and behaviour change programmes increased to 35% in 2013 and to 70% by 2015	Number of couples who have been reached, through interpersonal communications, with behaviour change communication programmes and social change communication programmes that focus on MCP [by age, geographical area].
[OC1.3] Female and Male aged 15–49 who had multiple partners in the past 12 months who reported using a condom the last time they had sex has increased from 37% for Female and 50%[8] for Male in 2008 to 65 % in 2013 and to 75% for both Female and Male by 2015	Percentage of adults aged 15–49 who had more than one sexual partner in the past 12 months who report the use of a condom during their last intercourse	[OP 1.6] Female and Male aged 15–49 with a risk of MCP in the last 12 months reached with condoms increased to 40% in 2013 and 80% in 2015	Number of condoms distributed by type & geographical location
		[OP1.7] Female survival of rape accessing post rape care services (counselling, treatment, and legal support) increased from 20.2% in 2007 to 50% in 2013 and 80% by 2015.	% of female survival accessing PEP after rape
HIV Counselling and Testing [OC1.4] *More people test for HIV and know their results:* Females and Males aged 15–49 who ever received an HIV test in the last 12 months and know their results has increased from 15.4% in 2008 to 30% in 2013 and 50% by 2015	Percentage of the adult population aged 15–49 years counselled and tested for HIV and received their HIV test results in last 12 months		
		[OP1.8] Couples who were counselled and tested in the last 12 months increased to 20% in 2013 and to 50% by 2015	Percentage of couples who took an HIV test and collected results in the last 12 months.
		[OP1.9] Most at risk population who received an HIV test in the last 12 months and know their status has increased from 20% to 35% by 2013 and to70% by 2015 [*disaggregated by MARP category*	Percentage of MARP who receive an HIV test and know their status by age, sex and MARP categories (CSW, IDU, MSM)
Medical Male Circumcision [OC1.5] *More male are circumcised by a health professional:* male aged 15–49 years circumcised increased from 13% in 2007 to 21% in 2013 and 30% by 2015	Percentage of males circumcised in the intended population by age and geographical areas	[OP1.10] Male aged 15–49 years circumcised as part of the minimum package of MC for HIV prevention services increased from 13% (65,000) in 2007 to 30% (150,000) in 2013 and 50% (300,000) by 2015.[9]	Number of male circumcision performed according to national standards Number of facilities providing MC surgery as part of the minimum package of MC for HIV prevention services Number of infants and males (15-59yrs) circumcised within the reporting period who return at least once for post-operative follow-up care (routine or emergent) within 14 days of surgery % of adults and infants circumcised who experience one or more severe adverse effects 6 weeks after the operation within the last 12 months

[8] Baselines are from Zambia UNGASS National Report 2008/2009

[9] The targets for MC are set out in the Zambia National Male Circumcision Strategy 2010-2020

Outcome Result	Indicator	Output result	Indicators
		[OP1.11] MOH have 50% and 80% of all PMTCT centres integrated with male circumcision service in 2013 and 2015.	Number of PMTCT centres integrated with male circumcision services
		[OP1.12] Traditional leaders promote MC as an HIV prevention strategy as part of community mobilization efforts in 50% and 100% of communities with low MC practices by 2013 and 2015 respectively.	% of traditional leaders trained in community mobilization for MC in communities with low MC practices
Prevention of Mother to Child Transmission [OC1.6] *More HIV positive pregnant female receiving ARVs to reduce risk of transmission to child:* HIV positive pregnant Female who receive ART to reduce the risk of mother to child transmission is increased from 61%[10] (47,175) in 2009 to 85% (72,828) and to 95% (85,655) in 2015	Percentage of children on ART who are still alive after 12 months (survival rate)	[OP1.13] Pregnant women who were counselled during the ANC for their most recent pregnancy, who were offered and accepted a HIV test and received their test results in the last twelve months increased from 67%[11] in 2009 to 80% in 2013 and 95% by 2015	Number of pregnant women who were tested for HIV and received their results) Percentage of HIV-infected pregnant women who received Antiretrovirals to reduce the risk of mother-to-child transmission Number of HIV exposed babies testing positive at 6weeks, 12 months and 8 months by gender
		[OP1.14] Female aged 15–49 (including those living with HIV) accessing comprehensive family planning package increased by 33% in 2007 by to 41% in 2013 and by 50% in 2015	Number of females aged 15–49 (including those living with HIV) accessing comprehensive family planning package Percentage of HIV-positive pregnant women newly enrolled into HIV care and support services
		OP1.15] HIV-infected pregnant females who received antiretroviral (ARV) to reduce the risk of mother-to-child transmission increased from 61% (47175/79498) in 2009 to 85% (72828/85708)in 2013 and 95% (85655/90163) by 2015	Number of HIV positive pregnant women who received anti-retrovirals to reduce the risk of MTCT Number of HIV exposed infants receiving cotrimoxazole prophylaxis
Prevention with the Positives: [OC1.7] PLHIV aged15–49 years who reported having adopted and adhered to at least 2 key HIV prevention behaviours in the last 12 months has increased to X% by 2015	Percentage of PLHIV aged 15–49 years who reported having adopted and adhered to at least 2 HIV prevention behaviours in the last 12 months	[OP1.15] People Living with HIV/AIDS (PLHIV) reached with individual and/or small group level interventions that are based on evidence and/or meet the minimum standards increased from 30% in 2010 to 60% in 2013 and 80% in 2015	Number of PLHIV reached with individual/and or small group level interventions based evidence and meeting minimum standards.
[OC1.8] PLHIV newly tested who reported having disclosed their status to their sexual partners in the last 12 months has increased to X by 2015	Percentage of newly tested PLHIV who reported disclosing their status to their sexual partners in last 12 months		

[10] NDP 6—Chapter on HIV and AIDS (draft), 2010

[11] Zambia Sexual behaviour Survey 2009–MOH/ CSO/UOZ and Measure/USAID / not targets have been taken from the 6th NDP Chapter paper

Outcome Result	Indicator	Output result	Indicators
Post Exposure Prophylaxis [OC1.9] *All persons who have been accidentally or forcibly exposed to HIV are given drugs to reduce the risk of primary infection*: People in need of PEP provided with PEP in accordance with national guidelines in the last 12 months remains at 100% in 2013 and 2015 (disaggregated by exposure: occupational, rape/sexual abuse, other non-occupational)		[OP1.16] Health facilities with PEP services available on site and being provided according to the national guidelines has increased from 43% in 2008 to 100% by 2015	Percentage of health facilities providing PEP services
	Percentage people in need of PEP who are provided with PEP in line with national guidelines in last 12 months	[OP1.17] Health Workers with reported needle prick injuries in health facilities has reduced from 6.7%[12] in 2008 in 4% by 2013 and to less than 2 % by 2015	% of health workers with reported needle pricks in the last 12 months
Sexually Transmitted Infections **[OC1.10]** *Fewer Females and males have STIs:* Female and Male who report having STI in the past 12 months has reduced for Female from 34% in 2007 to 17% in 2013 and to 5% in 2015 and for Male from 26%% 2007 to 13% in 2013 and5% in 2015	Percentage of male and females with STIs at health centres who are appropriately diagnosed, treated and counselled according to national guidelines Number of health facilities with STI drugs in stock and no drug stock outs of more than 1 month in last 12 months		
Blood Safety **[OC1.11]** *Donated blood units are screened for HIV and other TTIs in a quality assured manner:* Donated blood units that have been screened for HIV and TTIs using national testing guidelines is maintained at 100%[13] between 2010 and 2015	Percentage of donated blood units screened for HIV and TTIs in a quality assured manner Percentage of health facilities that apply national guidelines for blood screening, storage, distribution and transfusions	**[OP1.18]** MOH meet national demand of 100% of need using the r national blood transfusion of centrally collected blood screened for transfusion transmissible infections.	Number of donated blood units screened for HIV in blood centres/blood screening laboratories that have both: (1) followed documented standard operating procedures and (2) participated in an external quality assurance scheme

3.2.2 Pillar 2: Treatment, Care and Support

Table 3: Treatment, Care and Support Results and Indicators

Outcome Result	Indicator	Output Results	Indicator
Antiretroviral Therapy [OC2.1] More PLHIV survive longer on ART: Adults (15 and older, and children (0-14) with HIV still alive at 12 months after the initiation of ART increased for adults from 90% in 2010 to 98% in 2013 and to 98% in 2015; and increased for children from 80% in 2010 to 90% in 2013 and to 95% by 2015	Percentage of adults and children with advanced HIV infection receiving ART and still alive 12 months after initiation of treatment	**[OP2.1]** Children enrolled in HIV care and eligible for CTX prophylaxis (according to national guidelines) who are currently receiving CTX prophylaxis increased from 34% to 60% in 2013 and 100% up to 2015	Percentage of children enrolled in HIV care receiving cotrimoxazole prophylaxis in the last 12 months
		[OP2.2] Female and Male with advanced HIV infection receiving ART has increased from 68% in 2009 (283,863/434168) to 87% (420415/483236) in 2013 and to 90% (462,443/513826) in 2015	Number of persons with advanced HIV infection on ART (by age group; 0-5; 0-14; 15-24; 25+)

[12] Joint MID TERM Review of NASF report- Technical Report, January 2009, NAC

[13] Joint Mid—Term Review of NASF report- Technical Report, January 2009, NAC

Outcome Result	Indicator	Output Results	Indicator
		[OP2.3] Children (aged 0-14) eligible for HIV receiving ART has increased from 62% in 2009 to 79% in 2013 and to 95% in 2015	Number of children aged 0–14 receiving ART
		[OP2.4] Health facilities dispensing ART has increased from 355 in 2008 to 400 in 2013 and 500 by 2015	Number of public and private health facilities providing ART services (by Public, Private, Military and NGO) Number of HCFs providing ART services with no drug stock outs of more than 2 weeks in last 12 months
Outcome Result		**Output Results**	
TB/HIV co-infection: **[OC2.2]** *More PLHIV with TB/HIV co-infection are successfully treated*: PLHIV with new smear-positive TB who have been successfully treated increased from 41% in 2007 and 60 % in 2013 and to 75% by 2015	Tuberculosis cure rate under DOTS Percentage of estimated HIV-positive incident TB cases that received treatment for TB and HIV Treatment success rate	**[OP2.5]** The estimated HIV positive incident TB cases that received treatment for TB and HIV has increased from 40.6%[14] in 2007 to 60% 2013 and to 80% by 2015.	Percent of HIV-positive patients who were screened for TB in HIV care or treatment setting
Outcome Result		**Output Results**	
Community Home Based Care and Palliative Care **[OC2.3]** Male and Female children 0-17 yrs orphaned and vulnerable whose households receive at least one type of free basic external support in the past 30 days increased from 15.7% in 2008 to 25% in 2013 and to 50% by 2015	Percentage of orphans and other vulnerable children under 18 living in households whose households have received free of user changes, basic external support in caring for the children Ratio of current school attendance among orphans to that among non-orphans aged 10-14 years	**[OP2.6]** People receiving palliative care increased from 187,999 in 2007 to 100,000 in 2013 and 80,000 in 2015	# of individuals provided with HIV-related palliative care including TB/HIV

3.2.3 Pillar 3: Impact Mitigation

Table 4: Impact Mitigation Results and Indicators

Outcome Result	Indicator	Output Results	Indicator
Vulnerable Households and Food Security **[OC3.1]** *More people receive comprehensive and quality care at home and in the community*: Female and male aged 15-59 who either have been very sick or who died within the last 12 months after being very sick whose households received certain free basic external support to care for them within the last year increased from 41%[15] in 2009 to 50% in 2013 and 60% by 2015.		**[OP3.1]** Households[16] with vulnerable persons who received all three types (medical, emotional, and social/material) of support in the last year increased from 5.5% in 2007 to 10% in 2013 and 20% by 2015	Percentage of adults aged 18-59 who have been chronically ill for 3 or more months during the past 12 months and, including those ill for 3 or more months before death whose households have received, free user charges and basic external support in caring for the chronically ill person Percentage of eligible adults and children provided with Economic Strengthening services (such as practical life skills, entrepreneurship training, micro-financing etc.)

[14] Joint Mid Term Review of NASF report- Technical Report, January 2009, NAC

[15] Zambia Sexual behaviour Survey 2009–MOH/ CSO/UOZ and Measure/USAID

[16] Households will be disaggregated by type, Child, Female and or male headed, rural and urban

Outcome Result	Indicator	Output Results	Indicator
	Percentage of households affected by HIV/AIDS with stable income sufficient to meet minimum basic needs by geographical areas	**[OP3.2]** Females and males adult PLHIV who are clinically malnourished and who received nutritional support increased from 15% in 2007 to 25% in 2013 and to 50% in 2015.	Number of eligible clients who received Food and/or Other Nutrition services
Orphans and Vulnerable Children **[OC3.2]** *More OVC receive free external basic support*: OVC under 18 years whose households received at least one type of free basic external support (medical, emotional, social/material and school related) to care for the child in the last twelve months has increased from 16%[17] in 2009 to 25% in 2013 and to 40% by 2015	% of 15–49 years old living in households who have received free user charges, basic external support in caring for the children *Percentage of orphans and other vulnerable children under 18 living in households whose households have received free of user charges, basic external support in caring for the children*	**[OP3.3.]** A national framework for the protection, care and support of OVC developed	Number of Orphans and other vulnerable children receiving care and support from CBOs, FBOs, NGOs , DPOs
			Number of eligible OVC provided with Protection and Legal Aid services (PEPFAR)
		[OP3.4] Children under the age 18 years whose primary caregivers has made succession arrangement for someone else to care for the children in the event of their own inability to do so due to illness or death increased from 28%[18] in 2009 to 40% in 2013 and 60% by 2015	Number of street children integrated into homes and/or in ZNS practical life skills camps
		[OP3.5] Children under the age 18 years whose primary caregivers has made succession arrangement for someone else to care for the children in the event of their own inability to do so due to illness or death increased from 28%[1] in 2009 to 40% in 2013 and 60% by 2015	Number of street children integrated into homes
		[OP3.6] OVC aged 5-17 possessing three minimum basic material needs[19] increased from 49%[20] in 2007 to 60% in 2013 and to 85% in 2015	Percentage of OVC affected by HIV/AIDS trained in entrepreneur development and other empowerment initiatives by age, geographical areas % of OVC aged 5-17 provided with Psychological, Social, or Spiritual Support in the last 12 months

[17] Zambia Demographic and Health Survey 2007

[18] Zambia Sexual behaviour Survey 2009–MOH/ CSO/UOZ and Measure/USAID

[19] These needs are defined as a pair of shoes, two sets of clothing and a blanket.

[20] Zambia Sexual behaviour Survey 2009–MOH/ CSO/UOZ and Measure/USAID

Outcome Result	Indicator	Output Results	Indicator
		[OP50] The ratio of OVC and non-OVC currently attending school is increased from 0.93[21] in 2009 to 1:1 in 2013 and remains that way by 2015.	**Ratio of OVC to non-OVC attending school**

3.2.4 Pillar 4: Response Management and Coordination

Table 5: Response Management and Coordination Results and Indicators

Outcome Result	Indicator	Output Results	Indicator
Enabling Policy and Legal Environment **[OC4.1]** *The enabling policy and legal environment is improved*: Between 2011 and 2015, the enabling policy and legal environment necessary for the implementation of the national multisectoral response to HIV and AIDS is adequately strengthened	Domestic and international AIDS spending by categories and spending source	**[OP4.1]** Social and legal protection of vulnerable people and most at risk populations is strengthened: % of national policies and legal instruments reviewed and incorporated human and legal rights.	Number of unfavourable legal frameworks reviewed (e.g. IDU, MSM)
	National Composite Policy Index covering gender, workplace, stigma and discrimination, human rights, CSO involvement, prevention, TCS, Integration, mitigation services and M&E	**[OP4.2] Reduction stigma and discrimination:** Female and Male aged 15–49 expressing accepting attitudes toward people living with HIV and AIDS increased from 34%[22] in 2009 to 45% by 2013 and by 60% by 2015	Total amount of AIDS funds mobilized domestically and internationally by NAC and other partners based on the NASF funding needs
			Total amount of AIDS funds mobilized domestically and internationally by NAC and other partners based on the NASF funding needs
Coordination and Management: **[OC4.2]** Between 2011 and 2015, 100% of all public and private sectors, partners, provinces, districts and communities are coordinating and managing the implementation of the national response at their level in line with the National Strategic HIV and AIDS Framework	Percentage of districts with Strategic plans aligned in the ZASF in each fiscal year (2011, 2012, 2013, 2014 and 2015)	[OP4.3] National, sub-national and sectoral HIV and AIDS coordinating structures and systems are capacitated to effectively and efficiently coordinate and manage the national response.	Percentage of districts trained on 2011–2015 national M&E System rollout (which includes national M&E Plan, NARF and its data management procedures
			# of district trained in Multisectoral Annual Workplanning in line with the 2011–2015 ZASF
Outcome Result		**Output Results**	
HIV and AIDS, Gender and Human Rights Mainstreaming **[OC4.3]** Sectors that have mainstreamed HIV and AIDS, gender and human rights in sectoral policies, budgets and operational plans increased to 50% by 2013 and 100% by 2015	Percentage of SNDP Capital Projects mainstreamed with HIV and Gender		
	Percentage of line ministries with functional HIV/AIDS budget line items (functional means obligating at least 75% within the implementation period)	**[OP4.4]** Sectors that have conducted gender analysis and incorporated gender dimensions in their HIV and AIDS policies and operational plans increased to 75% by 2013 and 100% by 2015	Existence of revised gender policies and strategies to support improved access of women and girls

[21] Zambia UNGASS Report 2010

[22] Zambia Sexual behaviour Survey 2009–MOH/ CSO/UOZ and Measure/USAID

Outcome Result	Indicator	Output Results	Indicator
	Percentage of employees reached through work place programs	**[OP4.5]** Sectors that have annual HIV and AIDS operational plans that have budgeted and are monitoring gender, HIV/AIDS and human rights related activities have increased to 50% by 2013 and 80% by 12015.	Percentage of law enforcement officers trained in GBV and human rights approach
		[OP4.6] Public and private sector institutions that have developed and are implementing HIV and AIDS workplace programmes has increased from 500 in 2010 to 560 in 2013 and 600 by 2015	No. of workplaces with workplace policies and programmes
		[OP4.7] The national action plan on gender and HIV is fully implemented, monitored and periodically reviewed	No. of employees reached through workplace programmes
		[OP4.8] HIV and AIDS implementing partners capacity developed / strengthened in the areas of programme planning, resource mobilisation, service delivery, community mobilisation, monitoring, evaluation and reporting for 75% by 2015	
			No. of institutions provide with Training for capacity development for human and institutional development in the last 12 months
		[OP4.9] Health systems strengthened to support comprehensive coordination, management implementation, monitoring evaluation of the National Strategic Framework for HIV and AIDS by 2013	Percentage of staff with HIV-related tasks in their job descriptions
		[OP4.10] Communities systems strengthened to support the implementation of community based HIV and AIDS initiatives by 2013	Percentage of PATF that are functional with correct representation of partners Percentage of DATF that are functional with correct representation of partners
		[OP4.11] Local Authorities' have good governance and leadership of HIV and AIDS programmes at district level by 2013	Percentage of districts involving the DATF in the district planning process
		[OP4.12] Districts that have adopted CCE-CC approach to mainstream gender, human Rights and HIV and AIDS into Community-based development projects and programmes increased from 20 in 2009 to 73 by 2013 and remain at that level by 2015	Districts that have adopted CCE-CC approach to mainstream gender, human Rights and HIV and AIDS into Community-based development projects and programmes

Outcome Result	Indicator	Output Results	Indicator
Monitoring and Evaluation, and HIV Research **[OC4.4]** The national monitoring and evaluation system for HIV and AIDS has provided 80% of indicator values of the NSF results framework by 2013 and 100% by 2015.	Percentage of new partners utilizing partner's national GIS database to implement interventions for purposes of geographical equity	**[OP4.13]** Key planned research[23] studies and surveys conducted to generate evidence necessary for HIV and AIDS planning, resource allocation, service delivery and policy formulation; and evaluation of NASF increased to 70% by 2013 and to 100% by 2015	Number of research report dissemination forum held per year
	Percentage of organisations with functional M&E systems and linked into the national M&E system at national, provincial and district levels	**[OP4.14]** NAC has a framework for a multisectoral participatory Joint AIDS Annual Reviews of the NASF developed and agreed upon by all stakeholders by end of fiscal year 2011.	Percentage of implementers, NAC provinces, districts, sectors and sub-sectors who have experienced delays in receiving funding for their workplans in the last 12 months
		[OP4.15] The key HIV implementers using standardised M&E tools is increased to 80% by 2013 and to 95% by 2015	Percentage of planned information products (NARF, UNGASS, JAPR, NAC Annual reports etc) disseminated on time in the last 12 months
		[OP4.16] NAC coordinate the implementation of 80% of the planned research studies and surveys and results disseminated.	Percentage of provinces districts and sectors that have annual HIV workplans based on M&E products such as JAPR, Research and other sources
[OC4.5] The research national agenda is effectively and efficiently implemented to meet demand for empirical data (evidence) required to validate the performance of the NASF.	Percentage of research activities conducted according to national coordination research guidelines	**[OP4.17]** Stakeholders capacity for applied research is assessed and strengthened	Number. of HIV research conducted from the national HIV research Agenda (that have been conducted) and research results disseminated

3.3 Nationally Agreed Core Indicators

This section focuses on the national-level core indicators. Some of these indicators are either adapted or adopted from the UNGASS indicators.

The national indicators are important for two reasons. First, they help to evaluate the effectiveness of the national response, which reinforces the value of including these indicators in the national M&E framework. Second, when data from multiple stakeholders are analysed collectively, the indicators can provide critical information on the effectiveness of the response at the national level while simultaneously supplying the nation with comparative insights into the efforts of other national-level responses.

The national-level core indicators are divided into three categories:

1) National commitment and action—These indicators focus on policy and the strategic and financial inputs for the prevention of the spread of HIV infection, the provision of care and support for people who are infected, and the mitigation of the social and economic consequences of high levels of morbidity and mortality due to HIV and AIDS.

2) National level knowledge and behaviour—These indicators cover a range of specific knowledge and behavioural change outcomes, including accurate knowledge about HIV transmission, sexual debut, sexual behaviours, and school attendance among orphans.

[23] This will include DHS, AIDS Indicator Survey (AIS), Quality of Impact Mitigations Services (QUIMS), Sentinel Surveillance, Behavioural Surveys and Studies (various), TB and STI prevalence surveys among others

The new knowledge and behaviour indicators related to the most at-risk populations are relevant in Zambia given the concentrated epidemic of HIV as well as generalized epidemics. Similarly, with a concentrated epidemic, stakeholders are encouraged to collect data on general activities such as life skills education and sexual behaviours among young people as a means to track trends that could influence the nature of the national response in the future.

Four of the national indicators are also Millennium Development Goal (MDG) indicators. These indicators measure progress against MDGs, which are part of the Millennium Declaration adopted by all 189 member states of the United Nations General Assembly in 2000. These four indicators relate to knowledge among young people about HIV, condom use, school attendance among orphans, and the percentage of young people who are infected with HIV.

3) National-level programme impact—These indicators focus on the extent to which national programme activities have succeeded in reducing rates of HIV infection and its associated morbidity and mortality such as the percentage of young people infected with HIV.

They also capture programme outputs, coverage, and outcomes, for example, in preventing the transmission of HIV from mother to child, in providing treatment with antiretroviral therapy for those in need, and of services for orphans and vulnerable children.

Indicators chosen to measure the performance of the NASF are based on the results framework and the objectives of the strategic framework. The list of indicators was selected based on specific global and national criteria of a good indicator. The decision on the total number of indicators was also informed by the total number of objectives, results, and data sources.

All indicators have protocols and full definitions as shown. Some of the factors used to inform the choice of indicators included the following:

- Is it needed and useful?
- Does it have technical merit?
- Is it feasible to measure?
- Has it been field tested, or can it be used operationally?
- Is it coherent and balanced?
- Are data sources available?

Below is a list of core indicators that measure the results of the NASF and NOP:

Table 6: Core Indicators of the NASF and NOP (2011-2015)

Impacts of All efforts-What do we want to see (the Ideal Future in 5 years?)

Long term Result areas	Core Indicators
Pillar 1: Continue to reverse the spread of HIV in Zambia and reduce incidence by half in 2015	Modelled HIV incidence rate
	% of infants born to HIV infected mothers who are infected
	% of adults aged 15–49 who are HIV infected
Pillar II and III: HIV positive persons living longer, and their families and communities they live in, are accepted and cared for physically, mentally, emotionally and spiritually by 2015	% of adults and children with HIV still alive and known to be on treatment 12 months after initiation of antiretroviral therapy
	% of men and women aged 15–49 years expressing acceptable attitudes towards people living with HIV
	% of persons in need of impact mitigation services that expresses satisfaction with services that they receive
	Ratio of orphans and non-orphans aged 0–17 years who attend school
Pillar IV: National HIV Response is managed effectively by 2015	National Composite policy index assessment score

Individual Level Outcomes Result Areas	Individual Outcome Core Indicators
Reduced exposure to HIV	**% of never married young women and men aged 15–24 years who have never have sex in last 12 months**
	% of women and men aged 15–49 years who had two or more concurrent partnerships in the last 12 months.
	% of young women and men aged 15–24 years who have had sexual intercourse before the age 15 years (sexual debut)
Reduced per contact transmissibility	% of HIV infected pregnant women who received anti-retrovirals to reduce the risk of mother to child transmission
	% of persons who require pre-exposure prophylaxis (medicine to avoid HIV transmission) as per national guidelines
	% of males circumcised according to national standards (by age and location)
	% of men and women with advanced HIV infection receiving highly active anti-retroviral drugs
Better access to HIV related services	% of estimated HIV positive incident TB cases that received treatment for HIV and TB
Social norms have changed to encourage positive HIV related behavioural and attitude	% of 15-24 years who both correctly identify ways of preventing sexual transmission of HIV and who reject major misconceptions about HIV transmission
	% of men and women 15–49 years who have had more than one sexual partner in the last 12 months reporting use of condoms during their last sexual intercourse
	% of persons who agree that it is acceptable for condoms to given age 12–14 years old.
Society and structural outcomes	Society and structural outcome indicators
The three ones principles operationalised at national, provincial and district level	% of provincial/districts/sectors that have implemented the three ones by having a) an HIV action plan, b) held at least 4 coordination meetings in the last 12 months, and c) produced and disseminated at least 2 quarterly HIV service coverage reports in the last 12 months

HIV Prevention Programme	HIV Prevention Programme Indicators
PMTCT: All pregnant women have their partners know their status, and receive prevention counselling, support, treatment, as appropriate	% of pregnant women and their partners who were tested for HIV and who know their results
	% of HIV positive pregnant women enrolled in PMTCT programme
Family planning and HIV prevention for positive persons: HIV positive women and men do not have unplanned children	% of HIV positive women and men accessing family planning services and other prevention interventions
Blood products: All blood and products are free from HIV	% of blood and blood products screened for HIV, hepatitis and syphilis in a quality assured manner
Social change communication for the adolescents (10-14), youths (15-24yrs) and adults (25 and older): All persons (adolescent, youths and adults) receive appropriate messages and acquire competences to help them make decisions that would protect them against HIV transmission	% of population who have participated in at least 2 prevention services
	% of schools that provided life skills based HIV education in the last academic year
	% of peer education programmes that provide specific messages for MCP, abstinences and being faithful related norms

Condom supply, distribution and promotion: sufficient condoms are available to all persons who need it	Total number of male and female condoms available for distributions nationwide in the last 12 months per persons aged 15 years and above and per persons aged 15-19 years by sex and geographical areas
Male circumcision: All uncircumcised men in Zambia have been circumcised	% of PHC clinics that offer male circumcision services reached by such
Treatment Care and Support programmes	**Treatment Care and Support programmes indicators**
HIV testing, Counselling: Men and women and couples of all ages know their HIV status and are referred to appropriate support services	% of women and men 15 and above who received an HIV test in the last 12 months and who know their results in the last 12 months (by locations where service is provided).
Antiretroviral therapy: All Zambia men and women of all ages who need treatment, during any stages of their illnesses, receive it.	% of adult men and women and children with advanced HIV infection receiving ART
	% of TB patients who had an HIV test result recorded in the TB register
	% of estimated HIV positive incident TB cases that received treatment for TB and HIV
	% of ART facilities that provide nutritional support
Community and Home based care: Vulnerable individuals, families, households and communities they live in, are supported and cared for through home based care, rehabilitation and other services.	% of vulnerable households that received home based care and support at least once every week in the last six weeks
	% of child and grandmother headed household that received home based care at least once every week in the last six weeks
Traditional health therapies and alternative health remedies: Traditional health therapies and alternatives health therapist operate according to an agreed service provision framework that is complimentary to services provided at health facilities	% of registered practitioners trained in providing HIV related services
Impact mitigation programmes	**Impact mitigation programmes indicators**
Community systems for coordination of mitigation services: Communities are able to identify those who need HIV impact mitigation services, make decision about who should receive what kind of services at which point in time, and then plan for, coordinate and implement such services.	% of care centres that have a register, that have been updated in the last 3 months, of vulnerable households and the mitigation services provided
Service providers partners with community structures in the coordination and implementations of HIV mitigation services	Of services provided that report to and meet in person with the care centres about the services they have provided
Demand driven and integrated impact mitigation service provision: Vulnerable individuals and households are able to access the services that they need and improve their livelihood**.**	% of vulnerable households in need of mitigation services, reached by such services
	% of vulnerable persons in need of integrated mitigation services, reached by services providers by age, sex and geographical areas and type of services
Strengthening of social capital: Communities are able to identify and take collective responsibilities to care for vulnerable households, adults, children**,**	% of vulnerable households that feel that they can turn to friends, families and neighbours in time of need.
Response Coordination and Management	**Response Coordination and Management indicators**
Coordination and partnership: Stakeholders know their role in the HIV	% of development partners work plans that reflect the NASF results and HIV interventions that they intend to support

response, and work together in implementing their roles	% of stakeholders that express satisfaction that NAC, the sectors, sub-sectors, provinces and districts have implemented their coordination roles are defined in the NASF and NOP
Human resource Development: Adequate and competent human resources are available every year in all sectors to implement all aspects of the HIV response	% of posts, needed for an effective HIV response which are vacant
	% of staff in post who can competently perform all the HIV related tasks in their job descriptions
Joint Annual Planning: Stakeholders that work in the same sector jointly plan their HIV response interventions every year, keeping mind the principles of RBM, gender, and human rights	% of stakeholders (NAC, Sectors, sub-sectors, provinces and districts and implementing partners) that have submitted annual HIV Plans using the national planning template
HIV M&E and Research: Accurate and comprehensive information about the HIV epidemic and response available when needed to improve decisions about the HIV response	% of research from the National Research agenda that have been conducted and research results disseminated
	% of provinces, districts, sectors and implementing partners that have adapted HIV strategies and interventions and their annual work plans based on new HIV related information from joint reviews, research and other sources.
Resource management: Sufficient and appropriate human, material, technical, and financial resources are available on time to implement and manage the HIV response	Domestic and international AIDs spending by categories and financing sources
	Amount funds mobilized using the AIDS fund
Legal, ethical, and social rights provision and protection: Laws and Acts support persons living with HIV and AIDS and persons affected by HIV	National HIV Policy reviewed, revised and disseminated
	National composite policy index score

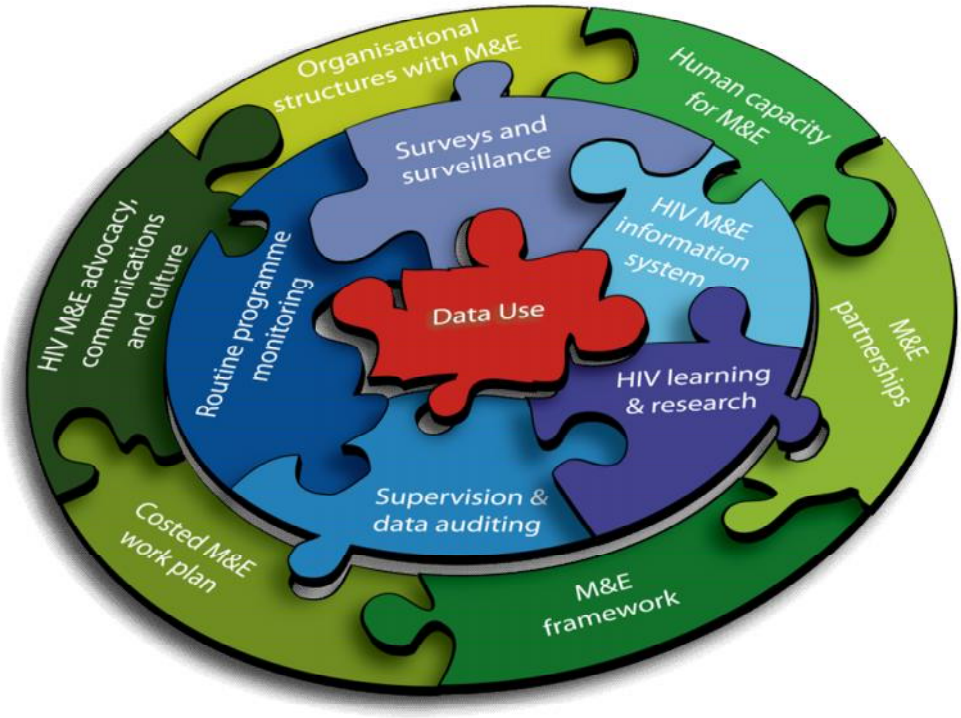
Other Indicators

The rest of the Indicators are included in the Appendix.

4 HOW THE M&E SYSTEM WILL FUNCTION

The national HIV and AIDS M&E plan has been developed in accordance with the 12 components of a functional and operational M&E system. These components emphasize the importance of managing HIV and AIDS results, that is, measuring results to distinguish success from failure and to assist in rewarding success, not failure. While the 12 components are interrelated, they are not implementation steps and are not necessarily sequential (The World Bank, 2007). To facilitate the functionality of the whole system, it is also important to ensure that each component is functional. The 12 components are usually grouped in three parts as illustrated in Figure 4.

Figure 4: The 12 Components of an HIV/AIDS M&E System



Source: UNAIDS (2007)

The national M&E system will operate as follows:

1. Enabling environment (Component 1–6). This links 6 components related to people, partnerships, and planning that support data production and data use, that is, in order for the enabling environment of HIV M&E to function, the following will need to be strengthened:

- Organisational structures with HIV M&E functions
- Human capacity for HIV M&E
- Partnerships to plan, coordinate, and manage the HIV M&E system
- National, multisectoral HIV M&E plan
- Annual, costed, national HIV M&E work plan
- Advocacy, communication, and culture for HIV M&E.

2. Data management processes (Component 7–11): This links 5 components related to data management processes—collection, capture, and verification of all types of HIV M&E data. The following will be the areas of major focus:

- Routine HIV programme monitoring;
- Surveys and surveillance;

- National and sub-national HIV databases;
- Supportive supervision and data auditing; and
- HIV evaluation and research agenda.

3. Data use (Component 12): This involves analyzing data to create information, which is then disseminated to inform and empower decision making at all levels.

The following is a detailed explanation of how the M&E system will operate in accordance with the 12 components outlined above.

4.1 Organisational Structures with HIV M&E Functions

The main objective of this component is to establish and maintain structures and a network of organisations responsible for M&E of HIV and AIDS at the national, subnational, and district levels. To achieve this, the Government has put in place a number of national support structures: 1) a high level Cabinet Committee of Ministers on HIV and AIDS, which provides policy direction and supervises and monitors the implementation of HIV and AIDS programmes; 2) the National AIDS Council (NAC); and 3) Secretariat, a broad-based corporate body, established through an Act of Parliament in 2002, with government, private sector, and civil society representation. The NAC is the national mechanism to coordinate and support the development, monitoring, and evaluation of a multisectoral national response to HIV and AIDS. Its overall mission is to prevent and combat the spread of HIV and AIDS and to reduce the personal, social, and economic impacts of the HIV and AIDS epidemic. The national HIV/AIDS/STI/TB policy of 2005 provides the directive and mandate for the national response. The NAC M&E and research directorate will coordinate the national M&E system.

At decentralised levels, NAC has established Provincial and District HIV and AIDS Task Forces (PATF and DATF). These are intended to operate as subcommittees of the decentralised development coordinating structures, the Provincial Development Coordinating Committees (PDCCs), and the District Development Coordinating Committees (DDCCs), respectively. Local level planning to support development of more strategic planning for HIV and AIDS at decentralised district level has been initiated. Districts have also been provided guidelines for mainstreaming HIV and AIDS into the district development plans and sector plans.

NAC will receive data from various partners. In order for the national HIV M&E system to function effectively, a variety of organisations need to improve their M&E capacities.

Deliberate efforts will be made to mainstream HIV and AIDS into already existing structures for planning and coordination of health and development programmes at the subnational level based on the thrust and focus of the SNDP. In addition to human resources, investment will be made to mobilize financial resources as well as basic infrastructure, equipment, and supplies.

NAC as the main coordination body of the response will continue to support and maintain a network of organisations and structures responsible for the M&E of HIV and AIDS at various levels. The networks and structures include HIV and AIDS Sectoral Advisory Group (SAG) and the M&E theme group. It will be necessary to continue to strengthen clarity of M&E mandates and capacity among partners in terms of planning, coordination, and management of the national M&E systems. The structures and reporting lines among various stakeholders will require further investment. The overall funding of the M&E system is currently donor driven as such sustainability measures will need to be put in place.

4.1.1 SWOT Analysis

Table 7 demonstrates the strengths and weaknesses that will need to be resolved in the next 5 years (2011–2015).

Table 7: Identified Organiastional Structures and M&E Functions Strengths and Weaknesses and Proposed Strengthening Activities

Strengths	Weaknesses	Proposed Strengthening Activities
• Coordinating structures on M&E system are all in place and functional • Well formulated M&E plan, guidelines are available • Good M&E operational manuals have been developed and are available • Clear reporting lines have been developed • National M&E structures in are in place • Clear mandate by Act of Parliament exists for NAC • Funding is available for M&E activities from cooperating partners • There is sufficient human resource for M&E activities at the national level • Mixed paper-based and electronic system M&E exist at NAC, MOH, and MOE and among CP	• Low motivation for community volunteer M&E focal point persons (FPPs) • Lack of enforcement of the NAC M&E mandate as enshrined in the Act • Weak coordination at subnational levels • Weak M&E capacity exists at provincial, district, and community level • There is inadequate IT equipment to support subnational M&E processes. • Weak evaluation culture • M&E systems is still paper-based • Weak collaborative activities between MOH and NAC • Parallel and weakly linked M&E subsystems by cooperating partners competing with the national systems • Poor staff motivation and high M&E staff turnover at all levels • Weak performance of the M&E theme group	• To strengthen the M&E mandate of NAC at subnational levels: • Advocate for more government budgetary allocation to HIV and AIDS M&E programmes • Provide regulatory framework on M&E based on the NAC Act • Procure and distribute IT equipment to support web-based M&E activities • Provide mechanisms to support evaluation and result based management • Improve the collaborative activities between MOH and NAC • Strengthen the harmonization and alignment of cooperating partners M&E systems and the national M&E systems • Institutionalise the PATFs and DATFs in the provincial administration and NAC respectively • Develop a performance- based funding mechanism for the establishment aimed at attracting and sustaining staff • Strengthen M&E enrolment

4.1.2 Performance Results

The following performance results will be reinforced during the 5 years (2011–2015):

- Effective leadership for M&E in key organisations;
- Clear job descriptions for M&E staff; adequate number of skilled M&E staff; and defined career path in M&E are provided;
- National commitment to ensure M&E system performance is sustained;
- Well-defined organisational structure, including a national HIV M&E unit; M&E units or M&E focal points in other public, private, and civil society organisations; written mandates for planning, coordinating, and managing the M&E system; and well-defined M&E roles and responsibilities for key individuals and organisations at all levels;
- Routine mechanisms for M&E planning and management, for stakeholder coordination and consensus building, and for monitoring the performance of the M&E system; incentives for M&E system performance are in place at all levels;
- Effective structures for data review and validation established and strengthened at all levels; and
- Key organisations achieve their annual work plan objectives for M&E.

4.2 Human Capacity for HIV M&E

The performance goal of HIV M&E human capacity building is to ensure that the national response have adequate skilled human resources at all levels of the M&E system in order to complete all tasks defined in the annual costed national HIV/AIDS M&E work plan. Not only is it necessary to have dedicated and adequate numbers of M&E staff, it is essential for this staff to have the right skills for the work. Human capacity building would focus on all levels; have measurable performance appraisal; include a capacity building plan with clearly defined outputs; and include ways to track progress over time. M&E human capacity building activities will include formal training, in-service training, mentorship, coaching, and internships. M&E capacity building will focus not only on the technical aspects of M&E, but also address skills in leadership, financial management, facilitation, supervision, advocacy, and communication.

Additional M&E staff will be mobilized at the national, provincial, and district level, including HIV M&E focal points at the Ministry of Health (MOH) and other line ministries as well as at subnational governmental levels and in organisations or facilities providing HIV and AIDS services.

Qualified human resources is needed at all levels (national, subnational, and delivery) for effective implementation of the M&E system. The development of a projected human capacity plan is also needed. The University of Zambia (UNZA) offers 3 weeks of training in M&E, which started in 2006. NAC also provides a short M&E training programme to support service delivery, and staff in NAC structures have been trained in National AIDS Council Activity Reporting Form (NARF) and general M&E.

4.2.1 SWOT Analysis

A number of strengths exist in terms of human resources, and this includes the presence of M&E capacity in umbrella organisations, availability of M&E reference materials, establishment of data use curriculum, and training models. Weaknesses include dependence on donor funding to support most of the M&E positions, and lack of M&E capacity at institutions reporting to umbrella organisations. The mechanism for the enrolment of M&E courses is unclear.

The human resource strategy will include advocating for government to take over funding of M&E positions at NAC level, building human resource capacity at subnational levels, and conducting Training of Trainers (TOT) for private sector and CSO umbrella organisations. See the Strengths, Weaknesses, Opportunities, Threats (SWOT) analysis and suggested strategies in Table 8.

Table 8: Strengthens and Weaknesses of the Human Capacity for HIV M&E and Proposed Strengthening Measures

Strengths	Weaknesses	Proposed Strengthening Activities
• There is strong human resource support for M&E activities • The existence of an M&E curriculum at UNZA provides capacity building • Availability of M&E reference materials is a special strength • Umbrella organisations have M&E capacity at national level • Human resource capacity exists to support M&E activities • Data use curriculum and training module has been put in place recently	• Most M&E positions are donor funded • Weak human resource capacity especially for new members of staff at national subnational • Unclear mechanism for systematic enrolment in the M&E courses • There is low motivation for M&E community volunteers • Institutions reporting to umbrella organisations do not have M&E capacity • There is low capacity in M&E at the subnational level	• Advocate for government take over M&E positions at NAC • Build human resources capacity at the subnational level • Conduct capacity building training for new staff members and new DATF members • Lobby cooperating partners to support M&E positions for staff in M&E at the subnational level • Train M&E staff on national HIV and AIDS, planning, RBM, emerging M&E issues • Conduct M&E TOT for private sector and CSO umbrella agencies • Conduct capacity-building training for subnational level stakeholders and CATFs • Engage a consultant to conduct a training needs assessment for HIV M&E skills and to develop a comprehensive 5-year human capacity development plan as part of the new NASF process • Engage a consultant to review the curriculum and duration of the M&E course provided at UNZA and to make specific recommendations for needed improvements

4.2.2 Performance Results

The following performance results will be reinforced during the 5 years:

- Defined skill set for individuals and organisations at national, subnational, and service-delivery levels;
- Work force development plan, including career paths for M&E;
- Costed human capacity building plan;
- Standard curricula for organisational and technical capacity building;
- Local and/or regional training capacity, including links to training institutions; and
- Supervision, in-service training, and mentoring.

4.3 Partnerships to Plan, Coordinate, and Manage the HIV M&E System

The main goal, under this component, is to strengthen and maintain partnerships among in-country and international stakeholders involved in planning and managing the national HIV M&E system. It is important that all stakeholders in HIV and AIDS work together. NAC has successfully established and maintained M&E partnerships through a national M&E theme group that meets regularly and includes all relevant stakeholders involved in M&E for HIV and AIDS programmes. Other examples of M&E partnerships in this country include conducting joint planning with key M&E stakeholders and conducting joint M&E activities like JAPRs with representatives from various organisations. Despite these efforts, partnerships between NAC and the health sector stakeholders involved in HIV and AIDS need to be strengthened further, along with partnerships between NAC and other public sector ministries and national umbrella organisations. To avoid duplication of effort, it is important to establish communication mechanisms with organisations that provide regular technical support in M&E, both in-country and internationally.

4.3.1 SWOT Analysis

Strengths of M&E partnerships include effective use of M&E partnerships in national processes such as multisectoral planning, United Nations Global Assembly Special Session on HIV/AIDS (UNGASS), NARF, and JAPRs. Weaknesses include weak links between NAC and other sectors and weak links between NAC and public sector organisations. Strategies for the next 5 years include facilitating strong collaboration between NAC and MOH; holding quarterly meetings with partners in CSOs, private sector, and government; and mobilizing resources to support monthly DATF meetings on M&E.

Some challenges are encountered with partnerships in terms of planning, coordination, and management of the HIV M&E system and with harmonisation of partners' sub-M&E systems. The national M&E systems need to be strengthened to improve data quality, integrate reporting channels, reduce duplication, and improve technical capacity. In addition, special attention should be given to support data use and information sharing at the subnational levels (provincial, district, and community). These will be the major areas of focus in the 2011–2015 MEP (see Table 9).

Table 9: Strengths and Weaknesses of the HIV/AIDS M&E System Partnerships and Proposed Strengthening Measures

Strengths	Weaknesses	Proposed Strengthening Activities
• M&E Partnerships exist through the enrolment • Partnerships with at subnational level using NARF with DATF and PATF • Effective use of M&E partners in national processes such as sectoral plan, JAPR, UNGASS, NARF	• Partnerships between MOH and NAC are not very strong • There are weak partnerships between NAC and other sectors (private, civil society) • There are also weak partnerships between NAC and public sector organisations on M&E • Weak partnerships between national M&E systems and donor M&E systems GFATM, PEPFAR	• Facilitate strong collaboration between NAC and MOH to enhance working group relationships • Conduct quarterly data audits to improve partnerships among NAC, MOH, PEPFAR, GFATM • Support PATF and DATF to form M&E subcommittees • Hold quarterly M&E meetings with public sector, CSO, and private sector partners • Mobilize resources to support monthly DATF meeting on M&E • Mobilize resources to support PATF bimonthly M&E meetings

4.3.2 Performance Results

The following performance results will be attained during the 5 years:

- Improved performance of national M&E theme group;
- Enhanced mechanism to coordinate all stakeholders;
- Local leadership and capacity for stakeholder coordination strengthened; and
- Routine communication channel to facilitate exchange of information among stakeholders.

4.4 National Multisectoral HIV M&E Plan

The 2006–2010 M&E plan is the basis for the current M&E plan, which seeks to further improve various aspects of the previous M&E plan. In addition, the multisectoral HIV M&E plan covers all aspects of the 12 components of a functional M&E system.

While a strong national level multisectoral M&E plan is in place, the sectoral level and the subnational/sector-specific M&E plans need to be strengthened, including those of other line ministries—except MOH and Ministry of Education (MOE). In addition, the private sector M&E plans must be strengthened to ensure they effectively generate data that should feed into the national level M&E plan.

The NAC M&E mandate is clearly defined in the National HIV Policy, NAC Act of parliament, and other relevant policy documents. A wide variety of stakeholders participate in the development and regular updating of the national M&E plan, including subnational authorities and representatives from civil society. The objectives of the national M&E plan is to explicitly be linked to the national HIV/AIDS strategic plan in order to ensure that relevant data are collected to measure the progress in the country's HIV response.

Because the national M&E plan is the basis for the implementation of a functional national HIV M&E system, it describes how all 12 components of the M&E system will be implemented over time. The national M&E plan describes a 5-year implementation strategy, indicates resource requirement estimates, and outlines a strategy for resource mobilization. The national M&E plan, and specifically the national indicators, adhere to explicit global and national technical standards and agreed best practices. The M&E plan also adheres to national laws; for example, the National Statistical Act (NSA) specifies that the CSO is responsible for all data collection in the country, which needs to be reflected in the flow of data within the M&E system. In addition to the national multisectoral M&E plan, different sectors, development partners, and subnational entities involved in the HIV response also develop their own M&E plans that detail how each will collect and report HIV data to contribute to the one national HIV M&E system. The national M&E plan is slated to be reviewed and updated regularly to make adjustments in data collection needs associated with revisions of the NASF and to strengthen M&E system performance based on periodic M&E assessments. See the Strengths, Weaknesses, Opportunities, Threats (SWOT) analysis and suggested strategies in Table 10.

4.4.1 SWOT Analysis

Table 10: Strengths and Weaknesses of the HIV/AIDS M&E System and Proposed Strengthening Measures

Strengths	Weaknesses	Proposed Strengthening Activities
• The national and multisectoral HIV M&E plans exist—or are available • The plan covers all 12 components of a functional M&E • The plan has buy-in of all partners hence serves a tool for harmonization • It has 78 national indicators covering Universal targets and UNGASS • The plan is multisectoral in nature; other aspects of the epidemic have been taken into account • M&E guidance document exists • Annual costed M&E plans exist	• M&E plan is yet to be realigned to the emerging 12 components • There are no subnational/ sector-specific plans • Some indicators in some thematic areas like advocacy, coordination, and mainstreaming are not well constructed or are inadequate • Existing targets are set at outcome and impact level • The M&E framework was not sufficiently costed for the 5 years	• Develop supplementary M&E plan to cater for the existing gaps • Develop indicators and targets through the M&E framework from input to impact • Cost M&E framework • Develop simple sub-national work plans for subnational, CSO, private sector, and public sector. • Realign national M&E plan according to the 12 components

4.5 Annual Costed National HIV M&E Work Plan

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

For the national HIV M&E plan to be operationalised, an annual costed national M&E work plan will be developed that describes the priority M&E activities for the year with defined responsibilities for implementation, costs for each activity, identified funding, and a clear timeline for delivery of outputs. This work plan enables NAC and the national M&E theme group to ensure that financial and human resources are mobilized and allows for monitoring progress toward implementation of one national HIV M&E system. The costed national M&E work plan reflects agreement on who will implement and finance each activity. The costed national M&E work plan is not the NAC work plan for M&E; rather, it is a joint work plan that integrates the HIV M&E activities of all relevant stakeholders. It allows all stakeholders to plan and work together in a harmonised way; this is why it is developed with input and agreement from all key stakeholders.

M&E work plans will also be developed at the subnational and service delivery levels to guide M&E implementation linked to the national HIV M&E system. The annual M&E work planning cycle will be closely linked to the overall budgeting cycle for HIV to ensure that funding can be secured for implementation of the plan. See the strengths and weaknesses in Table 11 below.

4.5.1 SWOT Analysis

Table 11: Strengths and Weaknesses of the \ HIV and AIDS M&E System and Proposed Strengthening Measures

Strengths	Weaknesses	Proposed Strengthening Activities
• There has been a multisectoral annual costed M&E work plan for the last 3 years • The M&E work plan has performance targets • The work plan is in line with the 6 thematic areas of the NASF • The plan includes activities and budgets of development partners and is reflected in government medium term expenditure framework	• The costing of the M&E work plan is not bottom top • It is difficult to know which funding source is accountable for which activity and result; in some cases, funders lack clarity on what activity/result they are funding • The annual work plan is not evidence-based; i.e., it fails to identify weaknesses in the system • There is no standardized unit cost supporting annual work plan • Lack of follow-up on M&E planned activities	• Involve stakeholder at the subnational level in the costing and development of annual work plan • Costed annual work plan should be supported by standardized unit cost • JAPR reports should involve annual work plan • Hold meetings with cooperating partners to develop a schedule for confirming pledged amounts in advance of the planned activities • Multisectoral annual work plan must be representative of CSO and private sector

4.5.2 Performance Results

The following performance results will be reinforced during the 5 years:

- The M&E work plan contains activities, responsible implementers, timeframe, activity costs, and identified funding.
- The M&E work plan explicitly links to the work plans and government Medium Term Expenditure Framework (MTEF) budgets of NAC.
- Resources (human, physical, financial) are committed to implement the M&E work plan.
- All relevant stakeholders endorse the national M&E work plan.
- The M&E work plan is updated annually based on performance monitoring.

4.6 Advocacy, Communication, and Culture for HIV M&E

The performance goal of this component is to ensure knowledge of and commitment to national HIV and AIDS M&E system among policymakers, programme managers, programme staff, and other stakeholders.

It is important to demystify M&E, create a supportive M&E culture, and reduce any negative connotations of M&E—especially at the subnational levels. One major way this can be done is through the implementation of a communication and advocacy strategy for M&E. Obtaining political support for transparency and accountability related to the HIV response is an important component of the communication and advocacy strategy that should be part of the M&E activities in the next 5 years. The strategy will use tailored messages for different audiences, including the general public. It will be important to emphasise that the national M&E system is not for government purposes alone, but that it is useful to all stakeholders in the HIV response. M&E fosters transparency but also requires a transparent environment to function effectively. One way to gain political support is to identify an “M&E champion”—a high-level official who can promote M&E among his or her peers to help foster an understanding of the importance of investing in quality data for policy formulation and programme decision making. The communication and advocacy strategy for HIV M&E will be part of the country’s NAC national HIV communication strategy to ensure that M&E is mainstreamed into all NAC functions as well as stakeholder programmes. See the strengths and weaknesses in Table 12.

4.6.1 SWOT Analysis

Table 12: Strengths and Weaknesses of the HIV and AIDS M&E System and Proposed Strengthening Measures

Strengths	Weaknesses	Proposed Strengthening Activities
• Multiple formats of strategic information reports exist • There is a culture of sharing M&E information by stakeholders to validate it • New reports are often launched to the public prior to wholesale country disseminations • Dissemination of reports to subnational levels use the office of PACA and DACA	• No communication and dissemination plan exists • Subnational dissemination of reports • Sharing and use of data and reports at the subnational level • Dissemination of indicator targets and achievements to senior-level policymakers	• Develop well structured dissemination plan to support sharing of reports • Build capacity at the subnational level to disseminate information • Strengthen use of the website and resource centres as channels of information dissemination • Increase collaboration between MOH and NAC • Strategically engage all partners to make input into key reports, i.e. ,NARF reports, HMIS statistical bulletins, etc. • Evaluate effectiveness of dissemination of reports at national and subnational levels • Conduct M&E advocacy workshops for senior staff in all sectors • Identify M&E champions at all levels and use them to advocate for M&E issues

4.6.2 Performance Results

The following performance results will be reinforced during the 5 years:

- The national HIV communication strategy includes a specific HIV M&E communication and advocacy plan.
- M&E is explicitly referenced in national HIV policies and the NASP.
- M&E champions among high-level officials are identified and are actively endorsing M&E actions.
- M&E advocacy activities are implemented according to the HIV M&E advocacy plan.
- M&E materials are available that target different audiences and support data sharing and use.

4.7 Routine HIV Programme Monitoring

The performance goal of this component is to promote production of timely and high-quality routine programme monitoring data using the NACMIS, Health Management Information System (HMIS), SMARTCARE, and Education Management Information System (EMIS).

NAC and subnational authorities already have a routine system to track the demand for and supply of HIV services. Standardized data from all providers, including facility and community-based HIV service providers, are collected on a routine basis. To guide decision making at all levels, the data needs of different stakeholders will need to be determined, and routine data will need to be made available in a timely fashion.

Standardized data to be collected includes inputs (resources such as staff, funds, materials and facilities, supplies); activities (interventions and services such as training and antiretroviral treatment); and outputs (immediate results such as number of staff trained and number of clients treated).

Routine data on facility-based HIV services is already part of the NACMIS as aggregate data from HMIS, a functioning national health information system that routinely collects data on HIV services at various health facilities. The national M&E unit at NAC will be strengthened to ensure that the data from facilities are captured in the national M&E system on a timely basis to allow for their inclusion in routine reports. In addition, routine data on community-based HIV services is also already completed, but there is need to strengthen its completeness, timeliness, accuracy, and reliability.

Experience has shown that establishing efficient routine data collection and reporting from community-based HIV services is challenging, but having this system can provide essential information needed by the NAC and subnational government levels to coordinate HIV service delivery and monitor the HIV response comprehensively. Efforts and mechanisms will be strengthened to ensure that data is obtained from all organisations providing community-based HIV services, such as those funded directly by the government as well as those funded through other sources including development partners. Sectoral databases also already exist that include data relevant to HIV programmes. These include social service information for orphans and vulnerable children and EMIS, containing HIV data from the education sector. NAC will ensure that all existing data sources are identified to establish appropriate links.

4.7.1 SWOT Analysis

The SWOT analysis in Table 13 shows the analyses of the HIV/AIDS M&E system.

Table 13: Strengths and Weaknesses of the Routine HIV and AIDS Program Monitoring System and Proposed Strengthening Measures

Strengths	Weaknesses	Proposed Strengthening Activities
• M&E data collection systems are already in MOH, NAC, GFATM, PEPFAR, MOE • Report system is paper based • Electronic system exist with SMARTCARE • HMIS recently revised and is being scaled-up	• Difference in reporting frequency among partners • SMARTCARE is donor driven • Underreporting exists • Parallel system between NARF, GF, PEPFAR, and MOH • Uncoordinated M&E system management • Minimal M&E feedback systems from top to bottom • Inadequate information on OVCs at district level	• Facilitate integration of multiple systems • Invest in electronic reporting system • Advocate for MOH to own SMARTCARE and other parallel systems • Facilitate improved harmonization of subsystems between GF, PEPFAR, • Harmonization of reporting intervals and timelines • Conduct quarterly M&E audits for core indicators • Develop mechanisms for data quality and improve report completeness

4.7.2 Performance Results

The following performance results will be reinforced during the next 5 years:

- Ensure data collection strategy is explicitly linked to data use;
- Clearly define data collection, transfer, and reporting mechanisms, including collaboration and coordination among the different stakeholders;
- Provide essential tools and equipment for data management (e.g., collection, transfer, storage, and analysis);
- Routine procedures for data transfer from subnational to national levels; and
- Provide well-defined and managed national HIV database to capture, verify, analyse, and present programme-monitoring data from all levels and sectors, including data on prevention, treatment, care and support, and finances.

4.8 National and Subnational HIV Databases

The performance goal of this component is to develop and maintain national and subnational HIV databases that enable stakeholders to access relevant data for policy formulation and programme management and improvement. The information system existing at NAC, MOH, and other partners consists of infrastructure (hardware), a database (software), and skilled individuals who use the databases to capture, verify, transfer, analyse, and share data. The roles and responsibilities may need to be established at national, subnational, and service-delivery levels to ensure an appropriate and timely data flow between the different levels. A national HIV database is not a prerequisite for a functional national HIV M&E system. However, an electronic data management system allows for the information to be captured in a way that facilitates data verification, data sharing, and data use.

NACMIS, EMIS, and HMIS exist as national databases, but they require optimal utilisation; it is important to build on these rather than establish other parallel systems. The future focus is to ensure that the existing national HIV databases include the following types of recent as well as historical data:

- Up-to-date registration information or a contact list of organisations involved in HIV programmes and M&E;
- Data on all national standardized HIV indicators specified in the national M&E plan;
- Data from various HIV-related data sources, including data from surveys and surveillance, routine facility-based programme data, and routine community-based programme data;
- Data on available resources;
- Information on supervisory visits;
- Inventory of HIV-related research and researchers;
- Information on HIV capacity building activities;
- Information on HIV M&E advocacy and communication activities;
  - National health campaigns and BCC interventions tracking
- Inventory of NAC documents, including all HIV-related information products.

4.8.1 SWOT Analysis

Zambia is moving toward upgrading its information systems to web-enabled interface to allow the general public to access data. In addition to the national HIV database, different stakeholders have their own databases. Relevant data from these databases will need to be linked with the national HIV database and/or transferred. Existing standard exchange formats would be used to facilitate data transfer between different databases. Other areas of strengthening are as shown in Table 14.

Table 14: Strengths and Weaknesses of the National and Subnational HIV and AIDS Databases and Proposed Strengthening Measures

Strengths	Weaknesses	Proposed Strengthening Activities
• Human resource to manage databases is available • HMIS database exists • EMIS data base exists • NACMIS database just completed • SMARTCARE database exists • CRIS training done at all levels	• Databases do not communicate with each other • Databases are donor driven • HMIS database location with planning department creates challenges • SMARTCARE is mostly functional in PEPFAR project areas • NACMIS is not fully tested • Weak national GIS system	• Rollout NACMIS to provincial levels and district levels • Invest to ensure all databases communicate with each other • Advocate for government ownership and leadership of key databases • Invest to operationalise web functionality for NACMIS • Invest in national GIS systems

4.8.2 Performance Results

The following performance results will be reinforced during the 5 years:

- Database(s) designed to respond to the decision-making and reporting needs of different stakeholders;
- Linkages between different relevant databases to ensure data consistency and to avoid duplication of effort; and
- Well-defined and managed national HIV database to capture, verify, analyse, and present programme monitoring data from all levels and sectors.

4.9 Supportive Supervision and Data Auditing

The performance goal of this component is to monitor data quality periodically and address any obstacles to producing high-quality verifiable data (i.e., data that are valid, reliable, comprehensive, and timely). Supportive supervision are implemented by NAC and MOH to provide oversight direct mentor of the performance of others and transferring the knowledge, attitudes, and skills essential for successful M&E of HIV activities. Experience has shown that data auditing offers an opportunity to take stock of the work done; critically reflect on it; provide feed-back to local staff; and where appropriate, provide specific guidance to make improvements.

Data auditing is also part of the national M&E system whereby NAC and its partners verify the completeness and accuracy of reported aggregated HIV programme data during the Provincial AIDS Task Force (PATF) meetings and direct subnational visit by the partners. This practice will need to be reinforced in the future because it is important to be confident about data quality. Regular data quality checks and provision of feedback will be important follow-up activities of NAC in collaboration with all partners as mechanism to improve or sustain data quality. Guidelines for supportive supervision may need to be consolidated and updated in order to communicate expectations and standardize procedures. Supportive supervision would be conducted with a sample of HIV service delivery organisations (i.e., not all providers) and used as a mechanism to strengthen local M&E capacity. Data auditing will be guided by the indicator protocols as well as protocols for data quality audits. Strategies will be put in place to ensure combined supportive M&E supervision with financial and/or programme implementation supervision are carried out in order to promote cost- and time-effective M&E practices (see Table 15 below for strengths and weaknesses).

4.9.1 SWOT Analysis

Table 15: Strengths and Weakness of the National HIV and AIDS Supervision and Data Auditing and Proposed Strengthening Measures

Strengths	Weaknesses	Proposed Strengthening Activities
• Three standing supervisory missions--Joint, NAC (PATF), and NAC/NASTAD are undertaken • Quarterly PACAs/DACAs meetings to facilitate data quality and auditing are held • PATF supervisory visits to district level are conducted • There are MOH and HMIS supervisory and data audit visits to districts • Findings are disseminated among concerned parties • All provinces and all categories are sampled, i.e., public sector, CSO, PS, etc.	• Irregular funding to provincial and district levels to undertake regular supervisory visits and audits • Weak and informal feedback loop on submitted reports and supervisory visit findings • Inability to capture data from the PS, indicating weak private public • Partnerships (PPP) • Failure by LMs to submit data through the national system • Lack of a mechanism to conduct supervision and data audits at national levels	• Facilitate the signing of MOU for between MOH and private sector • Mobilize funding for DATF meetings • Train PS in HIV and AIDS HMIS data management • Print updated PMTCT/VCT/ART supervision tools and guidelines • Disseminate PMTCT/VCT/ART supervision tools and guidelines • Conduct quarterly data reconciliation and data audits at national and subnational levels • Establish data reconciliation and data audit for provincial multisectoral committees • Conduct quarterly supervisory and data audit visits to subnational levels

4.9.2 Performance Results

The following performance results will be reinforced during the 5 years:

- Guidelines for supervising routine data collection at facility- and community-based HIV service delivery levels;
- Routine supervision visits, including data assessments and feedback to local staff;
- Joint supervision missions;
- Periodic data quality audits; and
- Supervision reports and audit reports.

4.10 HIV Evaluation and Research

The performance goal of this component is to promote a well-coordinated national evaluation and research plan, which results in well-coordinated studies to meet the identified needs and enhanced use of evaluation and research findings. Evaluation and research components need to be strengthened in the existing national M&E system. Partners appreciate the usefulness of evaluations and research but are one of the often neglected components of the comprehensive HIV M&E system. NAC have just launched the national research agenda, which promotes appropriate use of evaluation/research data to ensure that the planning of the HIV response is based on the best available evidence and that it guides ongoing programme improvement. NAC have also established a national process for identifying evaluation/research gaps relevant to the NASP and for coordinating evaluation/research partners, though its functionality will need to be supported technically and financially. Once fully implemented, it will help ensure that evaluation/research studies are responsive to the national needs and provide actionable results; that evaluation/research efforts are coordinated to avoid duplication of effort; and that study results are shared and available for use in decision making. In the future, efforts will be made to support key partners to regularly take stock of what is already happening at national research institutions and other relevant organisations and to invite these key stakeholders to become part of the national process. The national process needs to be strengthened in order to focus on:

- Governance structures for evaluation and research, including requirements for registration of studies and local dissemination of study findings;
- Reinforce ethical approval procedures and standards adherence;
- A prioritised agenda of biomedical, social sciences, and programme operations research; and
- Mechanisms for the use of evaluation and research findings in the planning, policy, and programme decision-making processes. This will include support formative research to inform design of evidence-based national health behavioural change and communications (BCC) interventions.

4.10.1 SWOT Analysis

Table 16: Strengths and Weaknesses of the National HIV and AIDS Evaluation and Research and Proposed Strengthening Measures

Strengths	Weaknesses	Proposed Strengthening Activities
• Draft research strategy with identified gaps and priority areas developed • National research ethics committee exist • National policy committee on research established • Research unit and research specialist are now in place at NAC • Joint reviews and evaluations in place (JARP, JMTR, etc.) • Two annotated research bibliography reports exist • First epidemiological synthesis conducted	• Weak evaluation practices among all partners • National research strategy and priorities need to be finalized and operationalised • Donor driven surveys still require approval abroad, causing delays in takeoff of studies • Limited research funds to support operational research • Weak coordination of researchers • Weak capacity of research institutions • Lack of an HIV and AIDS research coordination structure • Lack of capacity for evaluation and research by civil society organisations and the private sector	• Promote strong evaluation practices in the country • Finalize national research strategy and priority areas • Establish research funds to support researchers • Coordinate researchers' participation in conferences • Build research institutions with needed capacity to conduct research • To be part of RC at NAC, develop a comprehensive electronic inventory of all HIV and AIDS studies and research already conducted in Zambia • Conduct a workshop to validate the national HIV research plan/guide • Disseminate the national HIV research plan/guide at national and subnational levels • Conduct an annual HIV and AIDS research symposium for dissemination of HIV and AIDS research findings • Conduct quarterly HIV and AIDS researchers' meetings • Conduct evaluation studies on ART survival rate, impact of PMTCT, and impact of HIV and AIDS on youth programmes

4.10.2 Performance Results

The following performance results will be reinforced during the 5 years:

- Inventory of completed and ongoing country-specific HIV evaluation and research studies;
- Inventory of local HIV evaluation and research capacity, including major research institutions and their focus of work;
- National HIV evaluation and research agenda updated;
- Ethical approval procedures and standards adherence utilised and promoted;
- Guidance on evaluation and research standards and appropriate methods;
- National conference or forum for dissemination and discussion of HIV research and evaluation findings; and
- Evidence of use of evaluation and research findings (including supporting formative research to inform design of evidence based BCC interventions).

4.11 Surveys and Surveillance

The performance goal of this component is to produce timely and high-quality data for outcome and impact indicators through surveys and surveillance. Biological and behavioural surveillance surveys have been an integral part of the national M&E system essentially to determine the key drivers and the spread of the HIV epidemic in each country. HIV surveillance and surveys in Zambia focuses on the general population and the most at-risk populations like commercial sex workers. Other surveys conducted include capturing knowledge and attitudes of the general population; a school survey on HIV education and students' knowledge; a workplace survey on HIV policies and services; a survey of the quality of HIV services delivered at health facilities; a survey on the availability of condoms or other HIV prevention commodities; and an AIDS impact mitigation survey. Protocols and data collection tools based on international standards for surveys exist, such as the Demographic and Health Survey, the Sexual Behavioural Survey, and the Multiple Cluster Indicator Survey. The AIDS indicator survey is currently under consideration. NAC, in collaboration with partners, will continue to ensure adherence to standards in order to obtain high-quality data and compare results from repeated surveys over time. Existing surveillance and survey protocols would need to include data collection to support the construction of the emerging standardized national indicators defined in the national M&E plan. This can help prevent the need for additional data collection efforts and additional costs. NAC, in collaboration with Central Statistical Office, Ministry of Health, Education, Community Development and Social services, European Union (EU), Joint Financing Agreement (JFA), UN, and United States Government (USG) are critical partners.

4.11.1 SWOT Analysis

See Table 17 below on strengths and weaknesses affecting Surveys and Surveillance

Table 17: Strengths and Weaknesses of the National HIV and AIDS Surveys and Surveillance and Proposed Strengthening Measures

Strengths	Weaknesses	Proposed Activities
• Systems for surveys and surveillance are in place and protocols exist • Human resource for surveys and surveillance is available • Capacity to monitor impact and outcomes exists • Strong storage system for serum bank • Multiple data points for sentinel sites	• Donor driven survey • Weak funding by government • Reported sexual bias is affecting data reliability • Prevalence data continues to be unreliable due to ART programme • Weak leadership of MOH on sentinel surveys • Consider integrating SBS with DHS as it duplicate efforts • Weak systems on MARP	• Advocate for government funding and leadership of, especially MOH • Advocate for merging of DHS and SBS • Invest on incidence tool • Strengthening of surveys on MARP • Weak evaluation studies on impact of interventions • Build capacity of CSO to own and lead national surveys • Build capacity of MOH to coordinate second generation surveillance systems • Build capacity to develop research priorities and invest on operational research • Advocate for research funds

4.11.2 Performance Results

The following performance results will be reinforced during the next 5 years:

- Protocols for all surveys and surveillance based on international standards;
- Specified schedule for data collection linked to stakeholders' needs, including identification of resources for implementation;
- Inventory of HIV-related surveys conducted;
- Well-functioning biological surveillance system; and
- Well-functioning behavioural surveillance system.

4.12 Data Dissemination and Use

The performance goal of this component is to promote coordinated dissemination and use of data from the national M&E system to guide policy formulation and programme planning and improvement. Partners are constantly reminded of the most important reason for conducting M&E, which is to provide the data needed for guiding policy formulation and programme improvement. NAC and partners will be empowered to develop a detailed data use plan that will be included in the national M&E plan. This plan would link data needs and data collection efforts with specific information products for different audiences as well as a timetable for dissemination. It would also include activities to encourage data use, such as workshops to discuss the implications of M&E data for programme planning and improvement. Following any evaluation or survey activity, relevant data will be shared with interested parties at dissemination events, including GRZ meetings, international conferences, and partner meetings. Venues or events for potential presentation and dissemination will be explored on a case-by-case basis with partners.

The following evidence of data use will be promoted, which includes:

- The National Strategic Plan explicitly references the most up-to-date data on drivers of the HIV epidemic;
- HIV reports include accurate references to available M&E data; and
- HIV service implementers refer to M&E data in their HIV programming.

The following are a range of strategies to promote data dissemination and use, including ensuring ownership of data; ensuring dissemination of quality data in a timely manner; determining appropriate product information for different users; allocating sufficient resources for data dissemination; and providing assistance for data use.

4.12.1 SWOT Analysis

Table 18: Strengths and Weaknesses of the National HIV and /AIDS Data Dissemination and Use and Proposed Strengthening Measures

Strengths	Weaknesses	Proposed Strengthening Activities
• Websites and resource centres are in place to support dissemination of information • Availability of various data sets and reports from various surveys, reviews, etc. • Holding of routine stakeholder meetings at provincial and district levels facilitates dissemination of information • Availability of simplified version of technical reports • Communication strategy is in place and sets the vision and direction of information dissemination and use • M&E plan outlines M&E information products and their use • Data use curriculum and training module in place recently	• Collected data is often not used for decision making and programme management especially at subnational level and by CSOs and PSs • NAC resource centre and website, although in place, are not optimally functional • Limited data use and information sharing in private health facilities • Inadequate technical staff at subnational levels to process data to use friendly formats • Inadequate capacity for data packaging, especially at subnational levels • Inability to use data dissemination tools such as websites, press releases, and conferences at subnational level • Lack of publication of M&E reports in international journals even though different forums for information sharing and dissemination of data are available • Poor information on M&E data among partners/stakeholders	• Build and fully operationalise the NAC resource centre • Train civil society organisation in data use for programme management and decision making • Publish and/or disseminate research studies carried out on HIV on the MOH website • Train public sector staff in data use for programme management and decision making • Train private sector staff in data use for programme management and decision making • Train PACA and PATF members in data packaging techniques • Conduct provincial training and awareness workshops on data dissemination means • Train DACA and DATF members in data use for decision making • Operationalise and conduct routine district stakeholders meetings as a means of information sharing

4.12.2 Performance Results

The following performance results will be reinforced during the 5 years:

- The NASP and the National M&E Plan include a data use plan;
- Analysis of data needs and data users;
- Data use calendar to guide the timetable for major data collection efforts and reporting requirements;
- Timetable for national reporting;
- Standard format for reporting and data tabulation;
- Product information tailored to different audiences and a dissemination schedule; and
- Evidence of information use (e.g., data referenced in funding proposals and planning documents).

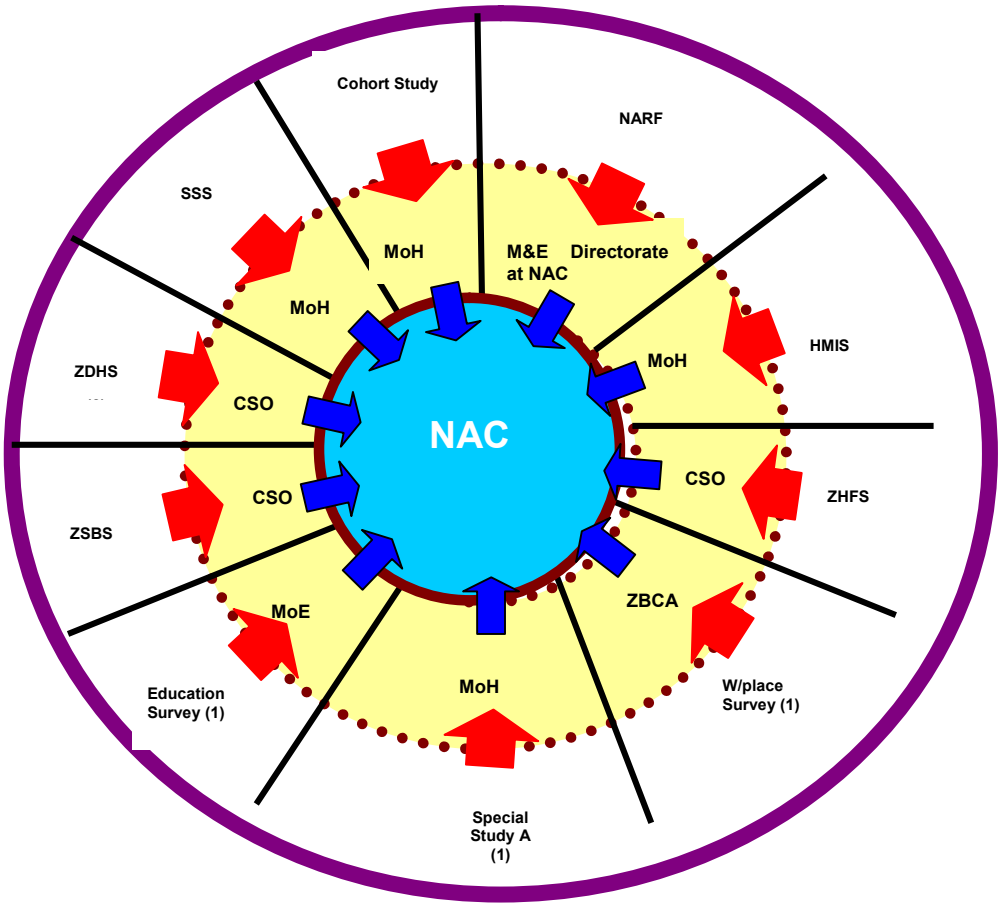
5 ROLES AND RESPONSIBILITY

NAC has a directorate of research, M&E, and research that houses the M&E unit that strives to create and coordinate a well-managed and functional national M&E system. The research M&E unit is supported by the national HIV and AIDS M&E theme group. There are two subtheme groups that fall under the national M&E theme group: a research subtheme group and an M&E core team subtheme group. The national HIV and AIDS M&E theme group provides overall technical guidance on the following:

- Implementation of the national HIV and AIDS M&E plan;
- Operationalisation of the NAC activity reporting form;
- The national HIV and AIDS research agenda; and
- Strategic input into the annual review process.

Figure 5 provides a conceptual framework for monitoring the HIV and AIDS multisectoral response. The outermost circle shows how the data will be collected (these data collection methods are elaborated on in the next section). The next circle shows the institutions that will have primary responsibility for managing the data-collection methods. The inner circle shows NAC as a primary recipient and user of this information.

Figure 5: Conceptual Framework for Monitoring and Evaluating the Response



5.1 Tools for Data Collection

The data collection for monitoring and evaluation will be undertaken using the following tools:

5.1.1 National AIDS Council Activity Report System

The NAC activity report system refers to a generation of information from standard forms received by NAC on a regular basis from subnational structures, including PATFs, DATFs, and government line ministries, implementing HIV and AIDS interventions. The form summarizes the coverage achieved by organisations implementing HIV and AIDS interventions in the area of prevention, care, support, M&E, and impact mitigation. These forms are collated at district, provincial, and national levels on a quarterly basis.

5.1.2 Cohort Study

The cohort studies are conducted for various purposes to monitor a group of individuals with similar characteristics to monitor the effectiveness of a service delivery programme or behaviours that may occur to a particular group of individuals when exposed to a specific event or situation. Cohort studies will be undertaken as required.

5.1.3 Education Management Information System (EMIS)

The MOE has an EMIS that collects information on a regular basis. The MOE will also collect HIV and AIDS information through this system. The primary output is the percentage of teachers who have been trained in life skills education and who taught it during the previous academic year.

5.1.4 Special Education Survey

This special survey by the MOE will collect information on the percentage of children aged 10–18 who report receiving life skills education in school. The information on this indicator will be collected through EMIS.

5.1.5 Health Management Information System (HMIS)

The HMIS is a database of nationally aggregated health data intended for programme management and policy decision making. This data is collected and collated from district clinics by the district health management teams that submit it electronically to the provincial level on a quarterly basis. The provinces further clean this data, collate it, and submit it to the MOH. The provinces also use this data for programmatic decisions.

5.1.6 National Composite Policy Index (NDCPI)

The National Composite Policy Index (NDCPI) covers four broad areas of policy, strategic plan, prevention, human rights, and care and support. A separate index is calculated for each policy area using specific policy indicators and calculating the overall percentage score.

5.1.7 Sentinel Surveillance Survey

Biological surveillance of HIV has been primarily tracked through surveillance of sentinel populations. Surveillance data is collected from a sample of urban, rural, and transitional rural sentinel sites in the country distributed throughout the nine provinces. Specified minimum samples for each type of site are set in advance and vary from year to year. Blood samples are drawn, and testing for syphilis is done on site while the rest of the samples are sent to University Teaching Hospita and Tropical Diseases Research Centre (TDRC) for HIV testing.

5.1.8 Financial Expenditure Tracking

Financial surveys are useful for showing how efficiently and effectively HIV and AIDS funds are utilised to achieve set national targets. NAC will carry out an annual expenditure tracking survey. Multilateral and bilateral international donors may also initiate specific resource tracking activities that target funded programmes. These include the Joint United Nations Programme on AIDS (UNAIDS) financial resource flow survey, the USG expenditure tracking exercise, and so forth.

5.1.9 Workplace Survey

These surveys provide information on the extent to which workplaces develop policies to protect and mitigate the impact of HIV and AIDS on their respective employees. This survey is conducted annually.

5.1.10 Zambia Demographic Health Survey (ZDHS)

The Zambia Demographic Health Survey (ZDHS) is a robust instrument for tracking changes in knowledge and behaviour at a national level. It is conducted every 5 years. It includes a household, female, and male questionnaire and is applied to a nationally representative sample of people aged 15–49.

5.1.11 Zambia Health Facility Survey (ZHFS)

The Zambia Health Facility Survey (ZHFS) is conducted to better understand provider/household linkages, provider performance, costs, quality and effectiveness, links between providers, and government-provider linkages.

5.1.12 Zambia Sexual Behaviour Survey (ZSBS)

The Zambia Sexual Behaviour Survey (ZSBS) is carried out to monitor the extent to which the programmes to prevent HIV are successful.

5.1.13 Special Studies

Special studies will be conducted to review some of the substrategies of the NASF. These studies will provide information on improving the quality of the HIV and AIDS response.

Table 19 shows the timelines for collecting data using these data sources.

Table 19: National Data Sources

Data Source	Institution	2011	2012	2013	2014	2015
Sentinel Surveillance Survey	MOH					
ZHFS	CSO					
ZSBS	CSO					
HMIS	MOH					
ZDHS	CSO					
EMIS	MOE					
Workplace Survey	NAC					
UNAIDS FRFS	UNAIDS					
Special Survey	NAC					
NACMIS	NAC					

5.2 Information Products

Quarterly NARF Report

NAC will produce the above report to provide information on coverage statistics per HIV programme area. It will be based on the information provided by all stakeholders in the NAC activity report Form. The production of this report will also ensure that NAC meets the Global Fund to Fight Tuberculosis, AIDS, and Malaria (GFATM) requirements in terms of minimum reporting standards and reports to its other basket donors.

Annual HIV and AIDS M&E Report

This report will provide a comprehensive overview of Zambia's response to HIV and AIDS. It will be done by reporting all indicators in NAC's national HIV and AIDS M&E system, and it will provide key observations and guidance for future implementation.

Biennial UNGASS Report

This report will be prepared to report to UNAIDS on a periodic basis in terms of Zambia's progress in the fight against HIV and AIDS by reporting on 17 specific indicators in a manner defined in *UNAIDS Guidelines for the Construction of Core Indicators.* This report is one fulfilment of Zambia signatory status to the 2001 Declaration of Commitment on HIV/AIDS at the United Nations Special Assembly Session on HIV/AIDS (UNGASS).

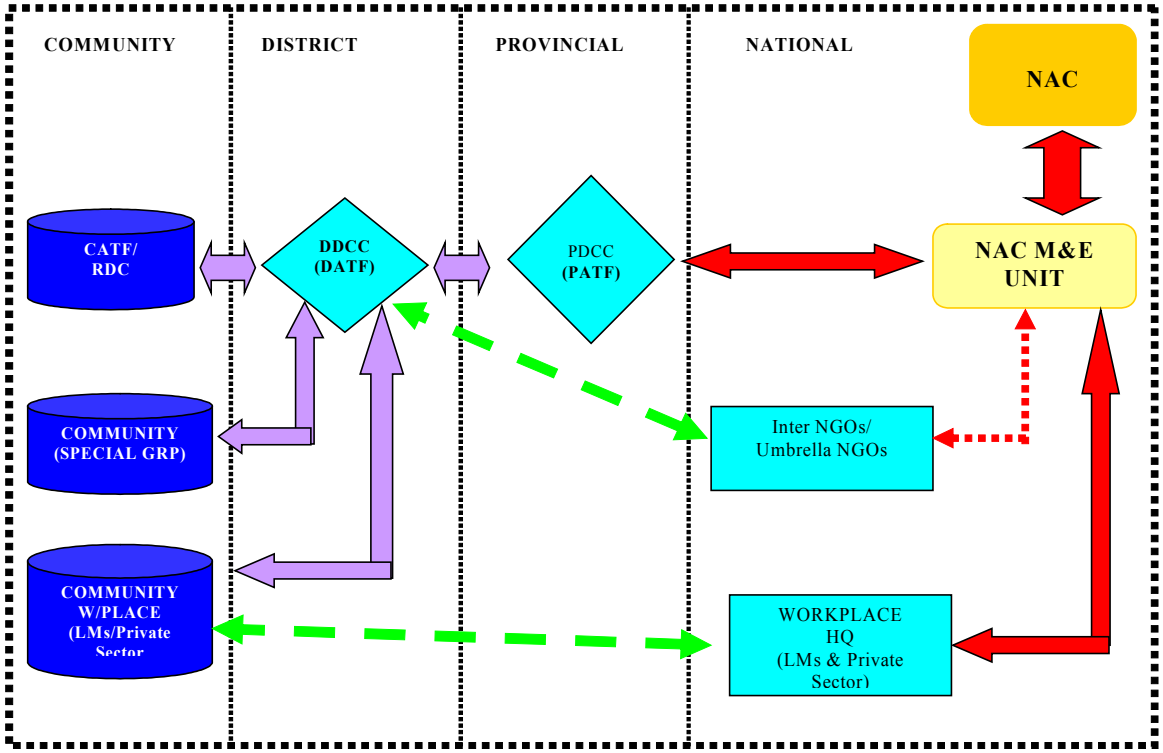
Ad Hoc Information Updates

NAC will post all M&E reports on its website, making them available for electronic downloading. This will ensure that NAC stakeholders are able to access up-to-date information. Based on this readily available information, NAC will also make specific information available to stakeholders upon request in writing.

Lines of Reporting

Figure 6 illustrates how information to be generated through the data sources mentioned above will be reported. Each of the data collection tools and the institutions shown in the figure can be linked to this reporting structure. It should be clearly understood that all the outputs of the M&E system eventually inform the processes of the NAC.

Figure 6: Structure of NAC Data Reporting System



APPENDIX A: LOGICAL FRAMEWORK

National Monitoring and Evaluation Logical Framework of the National Reponse 2011-2015

INDICATOR #	INDICATOR	DISAGGREGATION	PERCENTAGE		DATA SOURCE (Responsible)	Target	DATA COLLECTION AND REPORTING PERIOD
			NUMERATOR	DENOMINATOR			
Pillar 1: Prevention							
Impact Results 1.1 : By 2015, the rate of annual HIV new infections has reduced from 82,000 annual new infections to 40,000							
1.1	Number of new infections annually	By age, sex and geographical location	n/a	n/a	Spectrum (NAC)	• Baseline 2010: 64,901 (M 32,032 & F 36,003) • 2013: 47,676; • 2015: 32,451	Every 12 months
1.2	% of pregnant women aged 15-19 who are HIV positive	By residence	# of pregnant women who have undergone VCT as part of PMTCT programme and who are HIV positive in the past 12 months	# of pregnant women who have undergone VCT as part of PMTCT programme in the past 12 months	Health Management Information System (MOH)	• Baseline 2010: 9% • 2013: 5% • 2015: 3%	Every 12 months
1.3	% of adults aged 15-49 who are HIV positive	By residence (urban/rural), sex and age group (15 - 19, 20 - 24 and 25 - 49)	# of surveyed adults people who were tested for HIV serostatus who had a positive HIV test	# of surveyed adults tested for their HIV sero-status are positive	Zambia Demographic Health Survey (CSO)	• Baseline 2007: 14.3% • 2013: 12% • 2015: 12%	time period that survey was undertaken
1.4	% of 15-24 year-olds who are HIV positive	By age group, gender	# of surveyed 15-24 year-olds who were tested for HIV serostatus who had a	# of surveyed 15-24 year-olds tested for HIV serostatus	Zambia Demographic Health Survey (CSO)	• Baseline 2007: 16% • 2013: 10% • 2015: 8%	time period that survey was undertaken

			positive HIV test				
Impact Results 1.2: Infants born of HIV positive mothers who are infected has reduced to less than 5% by 2015							
1.5	% of infants born to HIV infected mothers who become infected	By sex	# of infants born to HIV-infected mothers who are HIV-positive at 12 months	# of infants born to HIV-infected mothers	Health Management Information System (MOH)	• Baseline 2007: 10% • 2013: 8% • 2015: <5%	Every 12 months
Outcome Results 1.1: More people have comprehensive knowledge in HIV and change in behaviour*: (Female and Male aged 15- 49 years with comprehensive knowledge of HIV and AIDS has increased from 37% in 2007 to 53% in 2013, and to 74% in 2015, and female and male aged 15 – 24 year comprehensive knowledge of HIV and AIDS has increased from 35% in 2007 to 51% in 2013 and to 70% by 2015)							
1.6	% of adults 15-49 years who both correctly identify ways of preventing sexual transmission of HIV and who reject major misconceptions about HIV transmission [UNGASS]	By sex, residence (urban/rural), age (15-24 and 25-49)	# of surveyed adults who gave correct answers to all 5 questions relating to HIV/AIDS	# of surveyed adults who gave answers to the 5 questions relating to HIV knowledge (as per UNGASS guidelines)	Zambia Demographic Health Survey (CSO)	• Baseline 2007: 37% • 2013: 53% • 2015: 74%	time period that survey was undertaken
1.7	% of young people 15–19 years who had sexual intercourse before the age of 15	By sex, residence (urban/rural)	# of surveyed people 15-19 who reported having intercourse before the age of 15	# of people 15-19 surveyed	Zambia Demographic Health Survey (CSO)	• Baseline 2007: M-6%; F-7.1% • 2013: M-4%; F-5.1% • 2015: M-3%; F-4%	time period that survey was undertaken
1.8	% of adults aged 15–49 who have had sexual intercourse with more than one partner in the last 12 months	By sex, residence (urban/rural), age (15-24 and 25-49)	# of surveyed adults who answered YES to the question on whether they have had more than one sexual	# of surveyed adults who answered the question on whether they had more than one sexual partner in	Zambia Demographic Health Survey (CSO)	• Baseline 2007: M-7.1%; F-1.1% • 2013: M-51, F-1% • 2015: M-2.1, F-0.5%	time period that survey was undertaken

			partner in the past 12 months	the past 12 months			
1.9	% of young people15-24 year who report being sexually active in the last 12 months	By sex, residence (urban/rural), age (15-24 and 25-49)	# of surveyed young people 15 - 24 who answered YES to the question on whether they have had sex more than once in the past 12 months	# of surveyed young people 15-24 who answered the question on whether they had sex more than once in the past 12 months	Zambian Sexual Behaviour Survey (CSO)	• Baseline 2007: M-19.5%; F-17.5% • 2013: M-15%; F-12% • 2015: M-10.5%; F-7.5%	time period that survey was undertaken
Output Result 1.1: Females and males aged 15-24 accessing social and behaviour change programmes is increased from 30% to 50% by 2013 and to 80% by 2015							
1.10	Percentage of schools that provided life-skills based HIV education in the last academic year	By location (urban/rural)	# of schools surveyed that provided life skills based HIV education in the last academic year	# of schools surveyed	Education Management Information System (MOE)	• Baseline 2007: 30% • 2011: 40% • 2012: 45% • 2013: 50% • 2014: 60% • 2015: 80%	Every 12 months
1.11	Number of 15-24 year olds reached with individual and/or small group level HIV prevention interventions that are based on evidence and or meet the minimum standards required (PEPFAR)	By sex, residence (urban/rural)	n/a	n/a	NACMIS	• Baseline 2007: 1.2m • 2011: 2m • 2012: 2.5m • 2013: 3m • 2014: 3.5m • 2015: 4m	Every 12 months
Output Result 1.2: Most at risk population and vulnerable groups reached with HIV prevention programmes has increased from 15% to 25% by 2013 and to 50% by 2015							

1.12	Percentage of people from MARPS (CSW, IDU, MSM) reached with HIV prevention programs	By MARP type, residence (urban/rural), sex, age (10-14, 15-19, 20-24, 25+)	# of MARPS reporting being reached with HIV messages and activities	Total # of MARPS surveyed	Behavioural Surveillance Survey (NAC, COH)	• Baseline 2009: 15% • 2013: 25% • 2015: 50%	Time period that the survey was undetaken
1.13	Number of people from vulnerable groups (mobile populations, prisoners, LDT) reached with HIV prevention programs	By vulnerable group type, residence (urban/rural), sex, age (10-14, 15-19, 20-24, 25+)	n/a	n/a	NACMIS (NAC)	• Baseline 2009: TBD • 2011: 300 • 2012: 400 • 2013: 500 • 2014: 600 • 2015: 700	Every 12 months
1.14	Number of PLHIV reached with minimum package of prevention with positives interventions	By residence (urban/rural), sex, age (10-14, 15-19, 20-24, 25+)	n/a	n/a	NACMIS (NAC)	• Baseline 2009: 450,000 • 2011: 500,000 • 2012: 500,000 • 2013: 500,000 • 2014: 700,000 • 2015: 1,000,000	Every 12 months
Output Result 1.3: In and out of school OVC aged 5-17 years reached with life skills based HIV education has increased from 20% in 2009 to 50% in 2013 and by 80% in 2015							
1.15	Number of in and out of school OVC (5-17 years) reached with life skills based HIV education in the last 12 months	By residence (urban/rural), sex, age (5-10, 11-10-14, 15-17)	n/a	n/a	NACMIS (NAC)	• Baseline 2009: 350,000 • 2011: 500,000 • 2012: 550,000 • 2013: 600,000 • 2014: 650,000 • 2015: 1,000,000	Every 12 months
Outcome Result 1. 2 :*Fewer persons have multiple and concurrent partnerships*: Female and male aged 15-49 in the general population who had concurrent partnerships in the last 12 months reduced from 35% for female and 70% for male in 2010 to less than 10% for female and remains that way by 2015, and to 30% by 2013 for Male and to 20% by 2011							
1.16	% of females and males 15-49 years who had a concurrent sexual partner in the last 12 months	By sex, residence (urban/rural), age (15-24 and 25-49)	# of surveyed adults reported having sex in the last 12 months	# of surveyed adults who reported having sex in the last 12	Zambian Sexual Behaviour Survey	• Baseline 2009: M-70%; F-30% • 2013: M-30%; F-10% • 2015: M-20%;	Time period that survey was undertaken

			who reported having sex with two or more overlapping sexual partners in the last 12 months	months	(CSO)	F-10%	
Output Result 1.4: Communities reached with social and behaviour change programmes focused on risks of multiple and concurrent partnerships has increased to 50% by 2013 and 80% by 2015							
1.17	% of communities in which comprehensive MCP programmes (including behaviour and social norm change programmes; family unit strengthening programmes, relationship skills for couples, and communication for social change programmes) have been implemented)	By type of community and programme	# of surveyed communities in which comprehensive MCP programmes are implemented in last 12 months	# of communities surveyed	Special survey (NAC)	• Baseline 2009: 30% • 2011: 40% • 2012: 50% • 2013: 60% • 2014: 70% • 2015: 80%	Time period that survey was undertaken
Output Result 1.5 Couples (stable and semi-stable relationships) reached with small group or individual social and behaviour change programmes increased to 35% in 2013 and to 70% by 2015							
1.18	Percentage of couples who have been reached, through interpersonal communications, with behaviour change communication programmes and social change communication programmes that focus on MCP	By, residence (urban/rural)	n/a	n/a	Special Survey (NAC)	• Baseline 2007: TBD • 2013: 35% • 2015: 70%	Time period that survey was undertaken
Outcome Result 1. 3: Female and Male aged 15-49 who had multiple partners in the past 12 months who reported using a condom the last time they had sex has increased from 37% for Female and 50% for Male in 2008 to 65 % in 2013 and to 75% for both Female and Male by 2015							

1.19	% of adults aged 15-49 who had more than one sexual partner in the past 12 months who report the use of a condom during their last intercourse	By sex, residence (urban/rural), age (15-24 and 25-49)	# of surveyed adults who answered YES to the question on condom use during sexual intercourse with a non-regular sexual partner	# of surveyed adults who answered the question on condom use during sexual intercourse with a non-regular sexual partner	Zambia Sexual Behaviour Survey (CSO)	• Baseline 2009: M-50%; F-37% • 2013: M-60%; F-607% • 2015: M-75%; F-75%;	time period that survey was undertaken
Output Result 1.6 Female and Male aged 15-49 with a risk of MCP in the last 12 months reached with condoms increased by 2013							
1.20	Number of condoms distributed	By condom type (male/female), geographical location	n/a	n/a	NACMIS (NAC)	• Baseline 2010: M-40m; F-300,000 • 2011: M-200m; F-2m • 2012: M-200m; F-2m • 2013: M-200m; F-2m • 2014: M-200m; F-2m • 2015: M-200m; F-2m	Every 12 months
Output Result 1.7 Female survival of rape accessing post rape care services (counselling, treatment, and legal support) increased from 20.2% in 2007 to 50% in 2013 and 80% by 2015.							
1.21	% of women who accessed PEP after rape	By residence (urban/rural), age (15-24 and 25-49)	# of surveyed women who reported being raped in past 12 months who accessed PEP after rape	# of surveyed women who reported being raped in past 12 months	Special survey (NAC)	• Baseline 2007: 20% • 2013: 50% • 2015: 80%	time period that survey was undertaken
Outcome Result 1.4: **More people test for HIV and know their results: Females and Males aged 15-49 who ever received an HIV test in the last 12 months and know their results has increased from 15.4% in 2007 to 30% in 2013 and 50% by 2015**							

1.22	% of adults counselled and tested for HIV and received their HIV test results in last 12 months	By sex, residence (urban/rural), age (15-24 and 25-49)	# of surveyed adults 15-49 who received pre-test counselling, HIV testing and their HIV results in the past 12 months	# of surveyed adults 15-49	Zambia Demographic Health Survey (CSO)	• Baseline 2007: 15.4% • 2013: 30% • 2015: 50%	Time period that survey was undertaken
Output Result 1.8: Couples who were counseled and tested in the last 12 months increased to 20% in 2013 and to 50% by 2015							
1.23	% of couples who took an HIV test and collected results in the last 12 months	By residence (urban/rural)	# of couples who received pre-test counseling, HIV testing and their HIV serostatus results in the last 12 months	# of couples who have been seen by a VCT provider in the last 12 months	Health Management Information System (MOH)	• Baseline 2007: 5% • 2011: 10% • 2012: 15% • 2013: 20% • 2014: 30% • 2015: 50%	Every 12 months
Output Result 1.9: Most at risk population who received an HIV test in the last 12 months and know their status has increased from 20% to 35% by 2013 and to70% by 2015 [*disaggregated by MARP category]*							
1.24	% of people who are members of a MARP who receive an HIV test and know their status	By sex, age (15-24 and 25-49) and MARP categories (CSW, IDU, MSM)	# of surveyed people who are members of a MARP who received pre-HIV test counseling, HIV testing and their HIV serostatus results in the last 12 months	# of people who are members of a MARP surveyed	Zambia Behavioural Surveillance Survey (NAC, COH)	• Baseline 2009: 20% • 2013: 35% • 2015: 70%	Time period that survey was undertaken
Outcome Result 1.5: More male are circumcised by a health professional: male aged 15-49 years circumcised increased from 13% in 2007 to 21% in 2013 and 30% by 2015							

1.25	% of men seen at male circumcision services (MC) who are circumcised according to national standards	By age and residence (urban/rural)	# of men seen at MC services who have been circumcised according to national standards in last 12 months	# of men who have been seen at MC service in the past 12 months	Zambia Demographic Health Survey (CSO)	• Baseline 2007: 13% • 2013: 21% • 2017: 30%	time period that survey was undertaken
Output Result 1.10: Male aged 15-49 years circumcised as part of the minimum package of MC for HIV prevention services increased from 13% (65,000) in 2007 to 30% (150,000) in 2013 and 50% (300,000) by 2015							
1.26	Number of male circumcisions performed according to national standards	By age and residence (urban/rural)	n/a	n/a	Health Management Information System (MOH)	• Baseline 2007: 65,000 • 2011: 70,000 • 2012: 100,000 • 2013: 150,000 • 2014: 200,000 • 2015: 300,000	Every 12 months
1.27	Number of health facilities providing male circumcision (MC) surgery as part of the minimum package of HIV prevention services	By geographical location	n/a	n/a	Health Management Information System (MOH)	• Baseline 2007: 150 • 2011: 170 • 2012: 190 • 2013: 210 • 2014: 230 • 2015: 230	Every 12 months
1.28	Number of infants and men (15-59) circumcised within the reporting period who return at least once for post-operative follow-up care (routine or emergent) within 14 days of surgery	By age and residence (urban/rural)	n/a	n/a	Health Management Information System (MOH)	• Baseline 2009: I-1,674,947; M-2,726,484 • 2011: I-1,727,252; M-2,804,189 • 2012: I-1,781,048; M-2,884,108 • 2013: I-1,836,377; M-2,966,305 • 2014: I-1,833,283; M:3,050,845	Every 12 months

						• 2015: I-1,951,811; M:3,137,794	
1.29	% of infants and men who are circumcised within the past 12 months who experience one or more severe adverse effects within 6 weeks after the operation	By age, residence (urban/rural)	# of infants and men who are circumcised within the past 12 months who experience one or more severe adverse effects with 6 weeks after the operation	# of infants and men who are circumcised within the past 12 months	Health Management Information System (MOH)	• Baseline 2009: 2% • 2011: 1% • 2012: 1% • 2013: 1% • 2014: 1% • 2015: 0.50%	Every 12 months
Output Result 1.11: MOH have 50% and 80% of all PMTCT centres integrated with male circumcision service in 2013 and 2015.							
1.30	Percentage of PMTCT centres integrated with MC services	By geographical location	n/a	n/a	Health Management Information System (MOH)	• Baseline 2007: 20% • 2011: 30% • 2012: 40% • 2013: 50% • 2014: 70% • 2015: 80%	Every 12 months
1.31	% of traditional leaders trained in community mobilisation for MC in communities with low MC practices	By geographical location	# of traditional leaders trained in community mobilisation for MC in communities with low MC practices	# of traditional leaders trained in community mobilisation for MC	NACMIS (NAC)	• Baseline 2009: 20% • 2011: 30% • 2012: 40% • 2013: 50% • 2014: 60% • 2015: 100%	Every 12 months
Outcome Result 1.6: More HIV positive pregnant females receiving ARVs to reduce risk of transmission to child: HIV positive pregnant Female who receive ART to reduce the risk of mother to child transmission is increased from 61% [1](47,175) in 2009 to 85% (72,828) in 2013 and to 95% (85,655) in 2015							

1.32	% of children on ART who are still alive after 12 months (survival rate)	By age and residence (rural and urban)	# of children with advanced HIV infection who receive ARV combination therapy according to nationally approved guidelines in the last 12 months	# of children with advanced HIV infection in the last 12 months (estimated by # of children who are HIV infected by 20%)	Health Management Information System	• Baseline 2009: 69% • 2013: 80% • 2015: 95%	Every 12 months
Output Result 1.13: Pregnant women who were counseled during the ANC for their most recent pregnancy, who were offered and accepted a HIV test and received their test results in the last twelve months increased from 67% in 2009 to 80% in 2013 and 95% by 2015							
1.33	Number of pregnant women who were tested for HIV and received their results	By age (15-24, 25-49), residence (urban/rural)	n/a	n/a	Health Management Information System (MOH)	• Baseline 2009: 67,881 • 2011: 67,522 • 2012: 67,155 • 2013: 66,842 • 2014: 66,645 • 2015: 66,590	Every 12 months
1.34	% of HIV-positive pregnant women who received antiretrovirals to reduce the risk of mother-to-child transmission	By age (15-24, 25-49), residence (urban/rural)	# of HIV-positive pregnant women who receive Nevirapine during delivery	Estimated # of HIV positive pregnant women (Estimated # of births x HIV prevalence in pregnant women)	Health Management Information System (MOH)	• Baseline 2009: 61% • 2011: 71% • 2012: 73% • 2013: 79% • 2014: 85% • 2015: 90%	Every 12 months
1.35	Number of babies exposed to HIV *in utero* who tested HIV positive at 6 weeks, 8 months and 12 months	By sex, residence (urban/rural)	n/a	n/a	Health Management Information System (MOH)	• Baseline 2009: 78, 560 • 2011: 80,596 • 2012: 81,377 • 2013: 81,138 • 2014: 80,230 • 2015: 79,398	Every 12 months
Output result 1.14: Female aged 15-49 (including those living with HIV) accessing comprehensive family planning package increased by 33% in 2007 by to 41% in 2013 and by 50% in 2015							

1.36	Number of females 15 – 49 (including those living with HIV) accessing comprehensive family planning package	By age, residence (urban/rural), by HIV serostatus	n/a	n/a	Health Management Information System (MOH)	• Baseline 2007: 600,000 • 2011: 1m • 2012: 1.5m • 2013: 2m • 2014: 2.5m • 2015: 3m	Every 12 months
1.37	Number of HIV-positive pregnant women newly enrolled into HIV care and support services	By age (15–24, 25-49), residence	n/a	n/a	Health Management Information System (MOH)	• Baseline 2007: 67,881 • 2011: 67522 • 2012: 67155 • 2013: 66842 • 2014: 66645 • 2015: 66590	Every 12 months
Output Result 1.15: HIV-infected pregnant females who received antiretrovirals (ARV) to reduce the risk of mother-to-child transmission increased from 61% (47175/79498) in 2009 to 85% (72828/85708)in 2013 and 95% (85655/90163) by 2015							
1.38	Number of HIV-positive pregnant women who received antiretrovirals to reduce risk of mother-to-child transmission				Health Management Information System (MOH)	• Baseline 2009: 47,175 • 2011: 60,002 • 2012: 66,415 • 2013: 72,828 • 2014: 79,242 • 2015: 85,655	Every 12 months
1.39	Number of infants exposed to HIV *in utero* who received co – trimoxazole prophylaxis	By sex	n/a	n/a	Health Management Information System (MOH)	• Baseline 2009: 100,516 • 2011: 99,365 • 2012: 93,908 • 2013: 89,398 • 2014: 87,111 • 2015: 83,793	Every 12 months
Outcome result 1.7: PLHIV aged15-49 years who reported having adopted and adhered to at least 2 key HIV prevention behaviours in the last 12 months has increased to X% by 2015							

1.40	% of PLHIV 15-49 years who reported having adopted and adhered to at least 2 HIV prevention behaviors in the last 12 months	By sex, age, residence (urban/rural)	# of surveyed PLHIV who reported having adopted and adhered to at least 2 HIV prevention behaviors in the last 12 months	# of PLHIV surveyed	Zambia Sexual Behaviour Survey (CSO)	• Baseline 2009: NA • 2013: 90% • 2015: 95%	time period that survey was undertaken
Output Result 1.16: People Living with HIV/AIDS (PLHIV) reached with individual and/or small group level interventions that are based on evidence and/or meet the minimum standards increased from 30% in 2010 to 60% in 2013 and 80% in 2							
1.41	Percentage of PLHIV reached with individual/and or small group level interventions based on evidence and meeting minimum standards	By Setting: Number reached in a clinic/facility-based setting; Number reached in a community/home-based setting	n/a	n/a	Zambia Sexual Behaviour Survey (CSO)	• Baseline 2009: 30% • 2013: 60% • 2015: 80%	12 months (Jan - Dec)
Outcome Result 1.8: PLHIV newly tested who reported having disclosed their status to their sexual partners in the last 12 months has increased to 95% by 2015							
1.42	% of newly tested PLHIV who reported disclosing their status to their sexual partners in last 12 months	By age and residence (rural and urban)	# of newly tested PLHIV who reported disclosing their status to their sexual partners in last 12 months	# of newly tested PLHIV	Zambia Sexual Behaviour Survey	• Baseline 2009: N/A • 2013: 90% • 2015: 95%	12 months (Jan - Dec)
Outcome Result 1.9: All persons who have been accidentally or forcibly exposed to HIV are given drugs to reduce the risk of primary infection: People in need of PEP provided with PEP in accordance with national guidelines in the last 12 months remains at 100% in 2013 and 2015 (disaggregated by exposure: occupational, rape/sexual abuse, other non-occupational status)							

1.43	% people in need of PEP who are provided with PEP in line with national guidelines in last 12 months	By gender and exposure type: Occupational, Rape/Sexual Assault Victims, Other Non-Occupational status	# of persons in need of PEP provided with PEP for risk of HIV infection through occupational and/or non-occupational exposure to HIV in last 12 months	# of people in need of PEP in last 12 months	Health Management Information System	• Baseline 2008: 80% • 2013: 100% • 2015: 100%	12 months (Jan - Dec)
Output Result 1.17: Health facilities with PEP services available on site and being provided according to the national guidelines has increased from 43% in 2008 to 100% by 2015							
1.44	% of health facilities providing PEP services	By geographical location	# of facilities providing PEP services according to national guidelines in last 12 months	# of all health facilities in last 12 months	Health Management Information System	• Baseline 2008: 43% • 2011: 60% • 2012: 100% • 2013: 100% • 2014: 100% • 2015: 100%	12 months (Jan - Dec)
Output Result 1.18: Health Workers with reported needle prick injuries in health facilities has reduced from 6.7%[1] in 2008 in 4% by 2013 and to less than 2 % by 2015							
1.45	% of health workers with reported needle pricks in the last 12 months	By gender and geographical location	# of health workers with reported needle pricks in last 12 months	# of health workers in last 12 months	Health Management Information System	• Baseline 2008: 6.7% • 2011: 5% • 2012: 4.50% • 2013: 4% • 2014: 3% • 2015: 2%	12 months (Jan - Dec)

Outcome Result 1.10: Fewer Females and males have STIs: Female and Male who report having STI in the past 12 months has reduced for Female from 34% in 2007 to 17% in 2013 and to 5% in 2015 and for Male from 26%% 2007 to 13% in 2013 and5% in 2015							
1.46	% of male and females with STIs at health centres who are appropriately diagnosed, treated and counselled according to national guidelines	By gender, and age groups (0 - 20 and older than 20)	# of STI patients for whom the correct procedures were followed on (a) history taking, (b) examination, (c) diagnosis and treatment and (d) effective counselling on partner notification	# of STI patients for whom provider-client interactions were observed	Health Management Information Survey (MOH)	• Baseline 2007: F34%, M26% • 2013: F17%, M13% • 2015: F5%, M5%	12 months (Jan - Dec)
1.47	Number of health facilities with STI drugs in stock and no drug stock outs of more than 1 month in last 12 months	By region	# of health facilities that were surveyed where there were no drug stock outs or more than a week for the last 12 months	# of health facilities that have been surveyed	Health Management Information System	• Baseline 2009: 1500 • 2011: 1500 • 2012: 1500 • 2013: 1600 • 2014: 1800 • 2015: 2000	Every 12 months
Outcome Result 1.11: Donated blood units are screened for HIV and other TTIs in a quality assured manner: Donated blood units that have been screened for HIV and TTIs using national testing guidelines is maintained at 100%[1] between 2010 and 2015							
1.48	% of donated blood units screened for HIV and TTIs in a quality assured manner	By region	# of donated blood units screened for HIV and TTIs in a quality assured manner	# of donated blood units in last 12 months	Health Management Information System	• Baseline 2009: 100% • 2013: 100% • 2015: 100%	Every 12 months

1.49	% of health facilities that apply national guidelines for blood screening, storage, distribution and transfusions	By region	# of health facilities that apply national guidelines for blood screening, storage, distribution and transfusions	# of health facilities that have been surveyed	Health Management Information System	• Baseline 2009: 60% • 2013: 100% • 2015: 100%	Every 12 months
Output Result 1.18: MOH meet national demand of 100% of need using the r national blood transfusion of centrally collected blood screened for transfusion transmissible infections.							
1.50	Number of donated blood units screened for HIV in blood centres/blood screening laboratories that have both: (1) followed documented standard operating procedures and (2) participated in an external quality assurance scheme	By region and type of facility (blood centre/ blood screening labs)	n/a	n/a	Health Management Information System	• Baseline 2009: 102,581 • 2011: 110,000 • 2012: 115000 • 2013: 120000 • 2014: 130000 • 2015: 150000	Every 12 months
Pillar 2: Treatment, Care, and Support							
Impact Result 2.1 More PLHIV live longer: The % of PLHIV who are alive at 12 months after initiation of antiretroviral therapy has increased to 85% by 2015							
2.1	% of PLHIV who are alive at 12 months after initiation of antiretroviral	By age and residence (rural and urban)	# of PLHIV who are alive at 12 months after initiation of antiretroviral	# of PLHIV in the last 12 months	UNGASS	• Baseline 2009: 69% • 2013: 90% • 2015: 95%	Every 12 months
Outcome Result 2.1: More PLHIV survive longer on ART: Adults (15 and older, and children (0-14) with HIV still alive at 12 months after the initiation of ART increased for adults from 90% in 2010 to 98% in 2013 and to 98% in 2015; and increased for children from 80% in 2010 to 90% in 2013 and to 95% by 2015							

2.2	% of adults and children with advanced HIV infection receiving ART and still alive 12 months after initiation of treatment	By gender, age (0 - 12, 12+ to 24 , older than 24), residence(rural & urban) and gender	# of adults and children with advanced HIV infection who receive ARV combination therapy according to nationally approved guidelines and are still alive 12 months after initiation of treatment	# Of persons with advanced HIV infection (estimated by # of persons who are HIV infected x 20%)	Health Management Information System	• Baseline 2010: 90% • 2013: 98% • 2015: 98%	Every 12 months
Output Result 2.1: Children enrolled in HIV care and eligible for CTX prophylaxis (according to national guidelines) who are currently receiving CTX prophylaxis increased from 34% to 60% in 2013 and 100% up to 2015							
2.3	% of children enrolled in HIV care receiving cotrimoxazole prophylaxis in the last 12 months	By age and residence (rural and urban)	# of children enrolled in HIV care receiving cotrimoxazole prophylaxis in the last 12 months	# of children enrolled in HIV care	Health Management Information System	• Baseline 2010: 34% • 2011: 50% • 2012: 60% • 2013: 60% • 2014: 80% • 2015: 100%	Every 12 months
Output Result 2.2: Female and Male with advanced HIV infection receiving ART has increased from 68%[1] in 2009 (283,863/434168) to 87% (420415/483236) in 2013 and to 90% (462,443/513826) in 2015							
2.4	Number of persons with advanced HIV infection on ART	By gender, age and residence (rural and urban)	n/a	n/a	Health Management Information System (MOH)	• Baseline 2009: 283,863 • 2013: 420,415 • 2015: 462,443	Every 12 months

Output Result 2.3: Children (aged 0-14) eligible for HIV receiving ART has increased from 62% in 2009 to 79% in 2013 and to 95% in 2015							
2.5	Number of children aged 0–14 years receiving ART	By gender and residence (rural and urban)	n/a	n/a	Health Management Information System (MOH)	• Baseline 2009: 26,407 • 2011: 35,450 • 2012: 37,905 • 2013: 39,115 • 2014: 39,203 • 2015: 39,283	Every 12 months
Output Result 2.4: Health facilities dispensing ART has increased from 355 in 2008 to 400 in 2013 and 500 by 2015							
2.6	Number of public and private health facilities providing ART services	By type of facility (Public, Private, Military and NGO) and geographical location	n/a	n/a	Health Management Information System (MOH)	• Baseline 2008: 355 • 2011: 360 • 2012: 380 • 2013: 400 • 2014: 480 • 2015: 500	Every 12 months
2.7	Number of HCFs providing ART services with no drug stock outs of more than 2 weeks in last 12 months	By geographical location	n/a	n/a	Health Management Information System (MOH)	• Baseline 2008: 50 • 2011: 40 • 2012: 30 • 2013: 20 • 2014: 10 • 2015: 8	Every 12 months
Outcome Result 2.2: More PLHIV with TB/HIV co-infection are successfully treated: PLHIV with new smear-positive TB who have been successfully treated increased from 41% in 2007 and 60 % in 2013 and to 75% by 2015							

2.8	TB cure rate under DOTS	By gender, region and type of TB (smear negative and extra pulmonary, smear positive)	# of new smear-positive pulmonary TB cases registered under DOTS that are smear negative at the end of the initial phase of treatment in last 12 months	Total number of new smear-positive pulmonary TB cases registered under DOTS in the last 12 months	Health Management Information System (MOH)	• Baseline 2007: 41% • 2013: 60% • 2015: 75%	Every 12 months
2.9	Percentage of estimated HIV-positive incident TB cases that received treatment for TB and HIV	By gender, region and type of TB (smear negative and extra pulmonary, smear positive)	Total number of HIV positive clients in whom active TB is detected who are given treatment of TB infection and ART	Total number of HIV positive clients	Health Management Information System (MOH)	• Baseline 2007: 50% • 2013: 70% • 2015: 80%	Every 12 months
2.10	Treatment success rate		# of new smear-positive pulmonary TB cases registered under DOTS that subsequently were successfully treated in last 12 months	Total number of new smear-positive pulmonary TB cases registered under DOTS in the last 12 months	Health Management Information System (MOH)	• Baseline 2007: 86% • 2013: 90% • 2015: 95%	Every 12 months
Output Result 2.5: The estimated HIV positive incident TB cases that received treatment for TB and HIV has increased from 40.6 % [1] in 2007 to 60% 2013 and to 80% by 2015.							
2.11	Number of cases of HIV-positive patients who were screened for TB in HIV care or treatment setting	By age and gender	# of HIV positive patients who were screened for TB in HIV care or treatment	# of HIV positive patients in HIV care or treatment settings	Health Management Information System (MOH)	• Baseline 2007: 389 cases/100,000 inhabitants	Every 12 months

			settings			• 2011: 300 cases • 2012: 250cases • 2013: 200cases • 2014: 150cases • 2015: 100 cases	
Outcome Result 2.3: Male and Female children 0-17 yrs orphaned and vulnerable whose households receive at least one type of free basic external support in the past 30 days increased from 15.7% in 2008 to 25% in 2013 and to 50% by 2015							
2.12	% of orphans and other vulnerable children under 18 living in households whose households have received free of user changes, basic external support in caring for the children (repeated as indicator 3.6)	By age and residence (rural and urban)	# of orphans who are part of the household of the respondents and who are 18 years or younger whose households have received free of user changes, basic external support in caring for the children	# of orphans who are part of the household of the respondents and who are 18 years or younger	Zambia Demographic Health Survey	• Baseline 2009: 15.7% • 2013: 25% • 2015: 50%	12 months (Jan - Dec)
2.13	Ratio of current school attendance among orphans to that among non-orphans aged 10-14 years	By age and residence (rural and urban)	***Orphan school attendance:*** # of children who have lost both parents and are still in school; ***Non-orphan school attendance:*** # of children, both of whose parents are still alive, who live with at least one parent and who are still in school	***Orphan school attendance:*** # of children who have lost both parents; ***Non-orphan school attendance:*** # of children, both of whose parents are still alive, who live with at least one parent.	Zambia Demographic Health Survey (CSO)	• Baseline 2007: 1 • 2013: 1 • 2015: 1	time period that survey was undertaken

Output Result 2.6: People receiving palliative care increased from 187,999 in 2007 to 100,000 in 2013 and 80,000 in 2015							
2.14	# of individuals provided with HIV-related palliative care including TB/HIV	By gender, age and residence (rural and urban)	n/a	n/a	NACMIS (NAC)	• Baseline 2007: 187,999 • 2011: 150,000 • 2012: 150,000 • 2013: 100,000 • 2014: 100,000 • 2015: 80000	Every 12 months
Pillar 3: Impact Mitigation							
Outcome Result 3.1: More people receive comprehensive and quality care at home and in the community: Female and male aged 15-59 who either have been very sick or who died within the last 12 months after being very sick whose households received certain free basic external support to care for them within the last year increased from 41%[1] in 2009 to 50% in 2013 and 60% by 2015							
3.1	% of households affected by HIV/AIDS with stable income sufficient to meet minimum basic needs by geographical areas	no disaggregation	# of households affected by HIV/AIDS with stable income sufficient to meet minimum basic needs by geographical areas	# of households affected by HIV/AIDS surveyed	Zambia Demographic Health Survey (CSO)	• Baseline 2007: 41% • 2013: 50% • 2015: 60%	time period that survey was undertaken
Output Result 3.1: Households[1] with vulnerable persons who received all three types (medical, emotional, and social/material) of support in the last year increased from 5.5% in 2007 to 10% in 2013 and 20% by 2015							

3.2	% of adults aged 18-59 who have been chronically ill for 3 or more months during the past 12 months and, including those ill for 3 or more months before death whose households have received, free user charges and basic external support in caring for the chronically ill person	By gender, age and residence (rural and urban)	# of adults aged 18-59 who have been chronically ill for 3 or more months during the past 12 months and, including those ill for 3 or more months before death whose households have received, free user charges and basic external support in caring for the chronically ill person	# of adults aged 18-59 who are chronically ill	Zambia Demographic Health Survey (CSO)	• Baseline 2007: 5.5% • 2013: 10% • 2015: 20%	time period that survey was undertaken
3.3	% of eligible adults and children provided with Economic Strengthening services (such as practical life skills, entrepreneurship training, microfinancing etc.)	By gender, age and residence (rural and urban)	# of respondents reporting receiving economic Strengthening services (such as practical life skills, entrepreneurship training, microfinancing etc.)	# of respondents	Zambia Demographic Health Survey (CSO)	• Baseline 2007: 5.5% • 2013: 10% • 2015: 20%	time period that survey was undertaken
Output Result 3.2: Females and males adult PLHIV who are clinically malnourished and who received nutritional support increased from 15% in 2007 to 25% in 2013 and to 50% in 2015							
3.4	Percentage of eligible clients who received Food and/or Other Nutrition services	By gender, age and residence (rural and urban)	# of eligible clients who received Food and/or Other Nutrition	# of clients surveyed	Special Survey (NAC)	• Baseline 2007: 15% • 2013: 25% • 2015: 50%	Time period that the survey was undertaken

			services				
Outcome Result 3.2: More OVC receive free external basic support: OVC under 18 years whose households received at least one type of free basic external support (medical, emotional, social/material and school related) to care for the child in the last twelve months has increased from 16%[1] in 2009 to 25% in 2013 and to 40% by 2015							
3.5	% of 15-49 years old living in households who have received free user charges, basic external support in caring for the children	By gender, age and residence (rural and urban)	# of 15-49 years old living in households surveyed who have received free user charges, basic external support in caring for the children	# of people living in households surveyed	Zambia Sexual Behaviour Survey (CSO)	• Baseline 2009: 16% • 2013: 25% • 2015: 40%	Time period that survey was undertaken
3.6	% of orphans and other vulnerable children under 18 living in households whose households have received free of user charges, basic external support in caring for the children (same as indicator 2.12)	By gender, age and residence (rural and urban)	# of orphans who are part of the household of the respondents and who are 18 years or younger whose households have received free of user changes, basic external support in caring for the children	# of orphans who are part of the household of the respondents and who are 18 years or younger	Zambia Demographic Health Survey (CSO)	• Baseline 2007: 41% • 2013: *60%* • 2015: 80%	Time period that survey was undertaken
Output Result 3.3: A national framework for the protection, care and support of OVC developed							
3.7	Number of Orphans and other vulnerable children receiving care and support from CBOs, FBOs, NGOs , DPOs	By gender, age and residence (rural and urban)	n/a	n/a	NACMIS (NAC)	• Baseline 2009: 422,118 • 2011: 1,000,000 • 2012: 1,100,000 • 2013: 1,210,000	Every 12 months

						• 2014: 1,331,000 • 2015: 1,464,100	
3.8	Number of eligible OVC provided with Protection and Legal Aid services (PEPFAR)	By gender, age and residence (rural and urban)	n/a	n/a	NACMIS (NAC)	• Baseline 2009: 63,318 • 2011: 100,000 • 2012: 110,000 • 2013: 121,000 • 2014: 133,100 • 2015: 146,410	Every 12 months
Output Result 3.4: Children under the age 18 years whose primary caregivers has made succession arrangement for someone else to care for the children in the event of their own inability to do so due to illness or death increased from 28%[1] in 2009 to 40% in 2013 and 60% by 2015							
3.9	Number of street children integrated into foster homes and/or in ZNS practical Life Skills Camps	By gender, age and residence (rural and urban)	n/a	n/a	NACMIS (NAC)	• Baseline 2009: 4,429 • 2013: 6,328 • 2015: 9,492	Every 12 months
Output Result 3.5: Children under the age 18 years whose primary caregivers has made succession arrangement for someone else to care for the children in the event of their own inability to do so due to illness or death increased from 28%[1] in 2009 to 40% in 2013 and 60% by 2015							
3.10	Number of street children integrated into homes	By gender, age and residence (rural and urban)	n/a	n/a	NACMIS (NAC)	• Baseline 2009: 4,429 • 2013: 6,328 • 2015: 9,492	Every 12 months
Output Result 3.6: OVC aged 5-17 possessing three minimum basic material needs[1] increased from 49%[2] in 2007 to 60% in 2013 and to 85% in 2015							

3.11	% of OVC affected by HIV/AIDS trained in entrepreneur development and other empowerment initiatives by age, geographical areas	By gender, age and residence (rural and urban)	# of OVC affected by HIV/AIDS trained in entrepreneur development and other empowerment initiatives by age, geographical areas	# of OVCs affected by HIV/AIDS	Zambia Sexual Behaviour Survey (CSO)	• Baseline 2007: 49% • 2013: 60% • 2015: 85%	Time period that survey was undertaken
3.12	% of OVC aged 5-17 provided with Psychological, Social, or Spiritual Support in the last 12 months	By gender, age and residence (rural and urban)	# of OVC aged 5-17 provided with Psychological, Social, or Spiritual Support in the last 12 months	# of OVCs aged 5-17	Zambia Demographic Health Survey (CSO)	• Baseline 2007: 49% • 2013: 60% • 2015: 85%	Time period that survey was undertaken
Pillar 4: Response Coordination and Management							
Outcome Result 4.1: The enabling policy and legal environment is improved: Between 2011 and 2015, the enabling policy and legal environment necessary for the implementation of the national multi-sectoral response to HIV and AIDS is adequately strengthened							
4.1	Domestic and international AIDS spending by categories and spending source	By category of expenditure, *(as follows: STD control activities, HIV prevention, HIV/AIDS clinical care & management, HIV/AIDS impact mitigation),* and by funding	n/a	n/a	NASA	• Baseline 2009: 14% • 2013: 25% • 2015: 35%	Every 12 months

		source					
4.2	National Composite Policy Index covering gender, workplace, stigma and discrimination, human rights, CSO involvement, prevention, TCS, Integration, mitigation services and M&E	By component (Strategic Planning, Human Rights, Prevention, Care and Support)	# of questions to which the country responded "YES"	# of questions in NCPI Questionnaire (20)	NCPI	• Baseline 2009: 1 • 2013: 1 • 2015: 1	n/a - all current policies will be captured in the questionnaire
Output Result 4.1: Social and legal protection of vulnerable people and most at risk populations is strengthened: % of national policies and legal instruments reviewed and incorporated human and legal rights.							
4.3	Number of unfavorable legal frameworks reviewed (e.g. IDU, MSM)	no disaggregation	n/a	n/a	Policy Review	• Baseline 2009: 1 • 2011: 1 • 2012: 1 • 2013: 1 • 2014: 1 • 2015: 1	Every 12 months
Output Result 4.2: Reduction stigma and discrimination: Female and Male aged 15-49 expressing accepting attitudes towards people living with HIV and AIDS increased from 34%[1] in 2009 to 45% by 2013 and by 60% by 2015							
4.4	Total amount of AIDS funds mobilized domestically and internationally by NAC and other partners based on the NASF funding needs	By category of NASF activities, as follows: (a) STD control activities (b) HIV prevention (c) HIV/AIDS clinical care and	n/a	n/a	NASA/ NCPI Resource Flow??	• Baseline 2009: $500M • 2011: $500M • 2012: $500M • 2013: $600 • 2014: $600 • 2015: $1Billion	Every 12 months

		management (d) HIV/AIDS impact mitigation, and by funding source					
Outcome Result 4.2: Between 2011 and 2015, 100% of all public and private sectors, partners, provinces, districts and communities are coordinating and managing the implementation of the national response at their level in line with the National Strategic HIV and AIDS Framework							
4.5	% of districts with Strategic plans aligned in the ZASF in each fiscal year (2011, 2012, 2013, 2014 and 2015)	no disaggregation	# of districts with Strategic plans aligned in the ZASF in each fiscal year (2011, 2012, 2013, 2014 and 2015)	Total # of districts	NACMIS	• Baseline 2009: 10% • 2013: 100% • 2015: 100%	Every 12 months
Output Result 4.3: National, sub-national and sectoral HIV and AIDS coordinating structures and systems are capacitated to effectively and efficiently coordinate and manage the national response							
4.6	% of districts trained on 2011 – 2015 national M&E System rollout (which includes national M&E Plan, NARF and its data management procedures)	no disaggregation	# of districts trained on 2011 – 2015 national M&E System rollout (which includes national M&E Plan, NARF and its data management procedures)	Total # of districts	NACMIS	• Baseline 2009: 0% • 2011: 50% • 2012: 100% • 2013: 100% • 2014: 100% • 2015: 100%	Every 12 months
4.7	Percentage of districts trained in Multisectoral Annual Work planning in line with the 2011 – 2015 NASF	no disaggregation	# of districts trained in Multi-sectoral Annual Work planning in line with the 2011 – 2015 NASF	Total # of districts	NACMIS	• Baseline 2009: 0% • 2011: 50% • 2012: 100% • 2013: 100% • 2014: 100% • 2015: 100%	Every 12 months

Outcome Result 4.3: Sectors that have mainstreamed HIV and AIDS, gender and human rights in sectoral policies, budgets and operational plans increased to 50% by 2013 and 100% by 2015							
4.8	% of SNDP Capital Projects mainstreamed with HIV and Gender	By type of project	# of SNDP Capital Projects mainstreamed with HIV and Gender	# of SNDP Capital Projects	NACMIS	• Baseline 2009: 0% • 2013: 100% • 2015: 100%	Every 12 months
4.9	% of line ministries with functional HIV/AIDS budget line items (functional means obligating at least 75% within the implementation period)	no disaggregation	# of line ministries with functional HIV/AIDS budget line items	# of line ministries	JAPR	• Baseline 2009: 30% • 2013: 100% • 2015: 100%	Every 12 months
4.10	% of employees reached through work place programs (same as 4.14)	By gender	# of employees reached through work place programs	Total # of employees	JAPR	• Baseline 2009: 50% • 2013: 100% • 2015: 100%	Every 12 months
Output Result 4.4: Sectors that have conducted gender analysis and incorporated gender dimensions in their HIV and AIDS policies and operational plans increased to 75% by 2013 and 100% by 2015							
4.11	Existence of Gender Analysis Report and 75% implementation of recommendation	no disaggregation	n/a	n/a	JAPR	• Baseline 2009: NA • 2011: Gender analysis Report • 2012: Operational plan implementation • 2013: Operational plan implementation • 2014: Operational plan implementation • 2015: Operational plan implementation	Every 12 months

Output Result 4.5: Sectors that have annual HIV and AIDS operational plans that have budgeted and are monitoring gender, HIV/AIDS and human rights related activities have increased to 50% by 2013 and 80% by 2015							
4.12	%. of law enforcement officers trained in GBV and human rights approach	By gender	# of law enforcement officers trained in GBV and human rights approach	Total # of law enforcement officers	NACMIS	• Baseline 2009: 30% • 2011: 50% • 2012: 70% • 2013: 100% • 2014: 100% • 2015: 100%	Every 12 months
Output Result 4.6: Public and private sector institutions that have developed and are implementing HIV and AIDS workplace programmes has increased from 500 in 2010 to 560 in 2013 and 600 by 2015							
4.13	No. of workplaces with workplace policies	no disaggregation	n/a	n/a	NACMIS	• Baseline 2009: 16 • 2011: 21 • 2012: 21 • 2013: 21 • 2014: 21 • 2015: 21	Every 12 months
Output Result 4.7: The national action plan on gender and HIV is fully implemented, monitored and periodically reviewed							
4.14	# of employees reached through workplace programmes (same as 4.10)	By gender	# of employees reached through work place programs	# of employees	NACMIS	• Baseline 2009: 500 • 2011: 1000 • 2012: 1500 • 2013: 2000 • 2014: 3000 • 2015: 5000	Every 12 months
Output Result 4.8: HIV and AIDS implementing partners capacity developed / strengthened in the areas of programme planning, resource mobilisation, service delivery, community mobilisation, monitoring, evaluation and reporting for 75% by 2015							
4.15	# of institutions provided with Training for capacity development for human and institutional development in the last 12	By type of training	n/a	n/a	NACMIS	• Baseline 2009: 100 • 2011: 300 • 2012: 600	Every 12 months

	months					• 2013: 1000 • 2014: 1500 • 2015: 3000	
Output Result 4.9: Health systems strengthened to support comprehensive coordination, management implementation, monitoring evaluation of the National Strategic Framework for HIV and AIDS by 2013							
4.16	% of staff with HIV-related tasks in their job descriptions	no disaggregation	# of staff with HIV-related tasks in their job descriptions	# of staff surveyed	NACMIS	• Baseline 2009: 30% • 2011: 80% • 2012: 100% • 2013: 100% • 2014: 100% • 2015: 100%	Every 12 months
Output Result 4.10:Communities systems strengthened to support the implementation of community based HIV and AIDS initiatives by 2013							
4.17	% of PATF that are functional with correct representation of partners	no disaggregation	# of PATF that are functional with correct representation of partners	Total # of PATFs	NACMIS	• Baseline 2009: 40% • 2011: 80% • 2012: 100% • 2013: 100% • 2014: 100% • 2015: 100%	Every 12 months
4.18	% of DATF that are functional with correct representation of partners	no disaggregation	# of DATF that are functional with correct representation of partners	Total # of DATFs	NACMIS	• Baseline 2009: 40% • 2011: 80% • 2012: 100% • 2013: 100% • 2014: 100% • 2015: 100%	Every 12 months
Output Result 4.11: Local Authorities' have good governance and leadership of HIV and AIDS programmes at district level by 2013							
4.19	% of districts involving the DATF in the district planning process	no disaggregation	# of districts involving the DATF in the district planning	Total # of districts	NACMIS	• Baseline 2009: 60% • 2011: 100% • 2012: 100% • 2013: 100%	Every 12 months

			process			• 2014: 100% • 2015: 100%	
Output Result 4.12: Districts that have adopted CCE-CC approach to mainstream gender, human Rights and HIV and AIDS into Community-based development projects and programmes increased from 20 in 2009 to 73 by 2013 and remain at that level by 2015							
4.20	Districts that have adopted CCE-CC approach to mainstream gender, human Rights and HIV and AIDS into Community-based development projects and programmes	no disaggregation	n/a	n/a	NACMIS	• Bas Baseline 2009: 20 • 2011: 50 • 2012: 60 • 2013: 73 • 2014: 70 • 2015: 73	Every 12 months
Outcome Result 4.4: The national monitoring and evaluation system for HIV and AIDS has provided 80% of Result values of the NASF results framework by 2013 and 100% by 2015.							
4.21	% of new partners utilizing partner's national GIS database to implement interventions for purposes of geographical equity	no disaggregation	# of new partners utilizing partner's national GIS database to implement interventions for purposes of geographical equity	Total # of partners	NACMIS	• Baseline 2009: 0 • 2013: 60% • 2015: 90%	Every 12 months
4.22	% of organizations with functional M&E systems and linked into the national M&E system at national, provincial and district levels	By geographical location	# of organizations with functional M&E systems and linked into the national M&E system at national, provincial and district levels	Total # of AIDS service organisations	NACMIS	• Baseline 2009: 40% • 2013: 100% • 2015: 100%	Every 12 months

Output Result 4.13: Key planned research[1] studies and surveys conducted to generate evidence necessary for HIV and AIDS planning, resource allocation, service delivery and policy formulation; and evaluation of NASF increased to 70% by 2013 and to 100% by 2015							
4.23	Number of research report dissemination forum held per year	By type of forum (local and international)	n/a	n/a	NACMIS	• Baseline 2009: 0 • 2011: 4 • 2012: 4 • 2013: 4 • 2014: 4 • 2015: 4	Every 12 months
Output Result 4.14: NAC has a framework for a multisectoral participatory Joint AIDS Annual Reviews of the NASF developed and agreed upon by all stakeholders by end of fiscal year 2011							
4.24	% of implementers, NAC provinces, districts, sectors and sub-sectors who have experienced delays in receiving funding for their workplans in the last 12 months	no disaggregation	# of implementers, NAC provinces, districts, sectors and sub-sectors who have experienced delays in receiving funding for their workplans in the last 12 months	# of implementers, provinces and districts, sectors and sub sectors	NACMIS	• Baseline 2009: 20 • 2011: 40% • 2012: 60% • 2013: 80% • 2014: 100% • 2015: 100%	Every 12 months
Output Result 4.15: The key HIV implementers using standardised M&E tools is increased to 80% by 2013 and to 95% by 2015							
4.25	% of planned information products (NARF, UNGASS, JAPR, NAC Annual reports etc) disseminated on time in the last 12 months	no disaggregation	# of planned information products (NARF, UNGASS, JAPR, NAC Annual reports etc) disseminated on time in the last 12 months	Total # of planned information products in the last 12 months	NACMIS	• Baseline 2009: 20% • 2011: 50% • 2012: 100% • 2013: 100% • 2014: 100% • 2015: 100%	Every 12 months

Output Result 4.16: NAC coordinate the implementation of 80% of the planned research studies and surveys and results disseminated							
4.26	% of provinces districts and sectors that have annual HIV work plans based on M&E products such as JAPR, Research and other sources	By region	# of provinces districts and sectors that have annual HIV work plans based on M&E products such as JAPR, Research and other sources	# of provinces districts and sectors that have annual HIV work plans	NACMIS or Special Survey	• Baseline 2009: 40% • 2011: 100% • 2012: 100% • 2013: 100% • 2014: 100% • 2015: 100%	Every 12 months
Outcome Result 4.5: The research national agenda is effectively and efficiently implemented to meet demand for empirical data (evidence) required to validate the performance of the NASF							
4.27	% of research activities conducted according to national coordination research guidelines	no disaggregation	# of research activities conducted according to national coordination research guidelines	# of research done in last 12 months	JAPR	• Baseline 2010: 30% • 2013: 60% • 2015: 80%	Every 12 months
Output Result 4.17: Stakeholders capacity for applied research is assessed and strengthened							
4.28	No. of HIV research conducted from the national HIV research Agenda (that have been conducted) and research results disseminated	no disaggregation	n/a	n/a	JAPR	• Baseline 2010: 5 • 2011: 10 • 2012: 10 • 2013: 15 • 2014: 20 • 2015: 20	Every 12 months

MEP Working Group

S/No	Name	Designation	Organisation
1	Mr. Osward Mulenga	Research, M&E Director	NAC
2	Mr. Alex Simwanza	Prevention and Multisectoral Response Director	NAC
3	Mr. Kevin Chilemu	M&E Officer	NAC/NASTAD
4	Mr. Paul Chitengi	M&E Advisor	LPCB
5	Mr. Mathew Ngunga	Senior M&E Technical Advisor	Futuresgroup
6	Mr. Beyant Kabwe	Research, M&E Director	CSH
7	Mrs. Catherine Mulikita	M&E Officer	CHAZ
8	Michael Gboun	M&E Advisor	UNAIDS
9	Mr. Bwalya Mubanga	M&E Specialist	NAC
10	Mr. Patrick Amanzi	M&E Officer	MOH
11	Mr. Arthur Kalila	Programme Manager	NASTAD
12	Mr. Harold Witola	Research Specialist	NAC
13	Mr. Ian Membe	M&E Associate Advisor	CDC
14	Prof. Sridutt Baboo	Prevention Theme Group Chair	UNZA
15	Mr. Steven Tembo	Consultant	Ruralnet Consultancy
16	Mr. Kaimfa Chandan'goma	Consultant	PETRICH Consultancy

Individuals/Groups Interviewed as part of Data Collection by Consultants

S/No	Name	Designation	Organisation
1	Dr. Ben Chirwa	Director General	NAC
2	Dr. Alex Simwanza	Prevention and Multisectoral Response Director	NAC
3	Mrs Elizabeth Choseni	CCM Coordinator	NAC
4	Mr. Ian Membe	M&E Associate Advisor	CDC
5	Mr. Osward Mulenga	Research, M&E Director	NAC
6	Dr. Rosemary Sunkutu	Senior Population Health and Nutrition Specialist	World Bank
7	Dr Kanyanta Sunkutu	HIV/AIDS Advisor	World Health Organisation
8	Chongwe DATF		DATF
9	Mrs Grace Chibowa	PACA-Lusaka	NAC
10	Lusaka PATF		PATF
11	Dr. Maxwell Bweupe	PMTCT Specialist	MOH