NATIONAL HIV/AIDS/STI/TB MONITORING & EVALUATION PLAN 2006 - 2010

Sept 2006

National HIV/AIDS/STI/TB Council

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TABLE OF CONTENTS

PREFACE IV
ACKNOWLEDGEMENT V
LIST OF ABBREVIATIONS VI
1. INTRODUCTION 1
1.1 BACKGROUND 1
1.2 GLOBAL PERSPECTIVES ON M&E 3
1.3 A THEORETICAL FRAMEWORK FOR M&E 4
2. NATIONAL M&E PLAN 6
2.1 OVERVIEW 6
2.2 DATA SOURCES 9
2.2.1 ACTIVITY REPORT FORM 10
2.2.2 COHORT STUDY 12
2.2.3 EDUCATION MANAGEMENT INFORMATION SYSTEM 12
2.2.4 SPECIAL EDUCATION SURVEY 13
2.2.5 HEALTH MANAGEMENT INFORMATION SYSTEM 13
2.2.6 NATIONAL COMPOSITE POLICY INDEX (NCPI) SURVEY 14
2.2.7 SENTINEL SURVEILLANCE SURVEY 15
2.2.8 UNAIDS FINANCIAL RESOURCE FLOWS SURVEY 16
2.2.9 WORKPLACE SURVEY 16
2.2.10 ZAMBIA DEMOGRAPHIC AND HEALTH SURVEY (ZDHS) 17
2.2.11 ZAMBIA HEALTH FACILITY SURVEY 18
2.2.12. ZAMBIA SEXUAL BEHAVIOUR SURVEY (ZSBS) 19
2.2.13 SPECIAL STUDIES 19
2.3 TIMEFRAME FOR IMPLEMENTATION OF DATA SOURCES 20
2.4 INFORMATION PRODUCTS 20
2.4.1 OVERVIEW 20
2.4.2 QUARTERLY SERVICE COVERAGE REPORT 21
2.4.3 ANNUAL HIV/AIDS M&E REPORT 22
2.4.4 BIENNIAL UNGASS REPORT 23
3. CAPACITY BUILDING IN M&E 26
REFERENCES 29
APPENDIX 1: FEATURES OF A GOOD M&E SYSTEM 30
APPENDIX 2: NAC DATA FLOW WHEEL 31
APPENDIX 3:
LOGICAL FRAMEWORK, INDICATORS, BASELINES, TARGETS, DATA SOURCES 32
APPENDIX 4: UNGASS INDICATORS 38
APPENDIX 5: GFATM INDICATORS 41
APPENDIX 6: ADDITIONAL INDICATORS 44
APPENDIX 7: NAC ACTIVITY REPORTING FORMS (FOR NGOS/FBOS/CBOS/LMS) 50
APPENDIX 8:
SIX-MONTHLY SERVICE COVERAGE REPORTING FORMAT 60
ANNUAL HIV/AIDS M&E REPORT FORMAT 63
APPENDIX 9: UNGASS REPORT FORMAT 70
APPENDIX 10: STAKEHOLDER RESPONSIBILITIES 77
APPENDIX 11: TERMS OF REFERENCE OF M&E TECHNICAL WORKING GROUP 80
APPENDIX 12: LIST OF TWG MEMBERS WHO CONTRIBUTED TO THE M&E PLAN 81
APPENDIX 13: INDICATOR DEFINITIONS 82

PREFACE

The HIV/AIDS epidemic is the most serious challenge faced by Zambia since independence. Zambia is one of the worst-affected countries in the entire world. About 15.6 percent of the population ages 15-49 is currently infected and the prevalence has been near this level for the past decade. The consequence has been widespread death and massive suffering among the Zambian people. Consequently, the HIV/AIDS epidemic also brought about the mushrooming of street kids, a social problem which is threatening future generations and future national development prospects

Government therefore put in place legislation through an Act (Act No. 10 of 2002, The National HIV/AIDS/STI/TB Council) of Parliament on how the country could wage successfully a "war" against the scourge. Under this act of parliament, the National Aids Council (NAC) was established, whose mandate is to coordinate, monitor and evaluate inputs, activities, outputs and impacts of HIV/AIDS programmes. Therefore, for NAC to effectively carry out its mandate and to realise the third one i.e. having one national M&E system, it needed a very robust M&E Plan that would provide necessary information for the effective coordination, monitoring and evaluation of the country's National response to HIV/AIDS.

The first edition of the M&E Plan, 2002 2005 National HIV/AIDS/STI/TB M&E Plan worked towards developing a very robust M&E system as well as the harmonisation of various stakeholder M&E systems so as to feed into the national M&E system; a process set the set the third one in motion. National and global indicators from the national surveys were aligned with the national M&E system allowing easy reporting to international commitments such as UNGASS.

This second edition of the National HIV/AIDS/STI/TB M&E Plan is therefore aimed at providing and further improving the means for NAC to monitor the national response and provide effective leadership in the fight against the pandemic. This M&E plan is also aimed at strengthening the third one in general as well as strengthening the sub-structure level M&E capacity to coordinated and monitor the activities under the various HIV/AIDS interventions.

Seventy-eight (78) indicators have initially been identified as core set of measures to monitor the response. There are 4 indicators at impact level, 38 indicators under intensifying prevention (theme 1), 17 indicators under expanding treatment (theme 2), care and support, 5 indicators under mitigating socio-economic impact (theme 3), 8 indicators under strengthening the decentralised response and mainstreaming HIV and AIDS (theme 4), 3 indicators under improving the capacity for monitoring and evaluation by all partners (theme 5) and 3 indicators under Integrating Advocacy, Coordination and Leadership of the Multisectoral Response(theme 6)

Hon. A. Cifire (MP)
Minister of Health and Chairperson of the Cabinet Committee on HIV and AIDS.

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The success of developing the first edition of the National M&E Plan would not have been possible without the dedicated commitment of the following individuals: Dr. Buleti Nsemukila, Central Statistics Office, Dr. James Guwani, UNAIDS, Dr. Dean Phiri, Ministry of Health, Mr. Chibwe Lwamba, USAID/Zambia, Mr. Paul Chitengi, NAC, Mr. John Grove, CDC, and Ms. Chola Nakazwe Daka,Central Statistic Office. Other members of the NAC Technical Working Group who contributed significantly and whose tireless efforts are highly appreciated are listed in Appendix 12

NAC would also like to acknowledge the contributions of the members of the National Alliance of State and Territorial AIDS Directors (NASTAD) Zambia Team, listed in Appendix 12 in further reviewing and editing the national M&E Plan.

We are indebted to the cooperating partners that have continued to provide support to NAC in the finalization of this first edition.

We are equally indebted to the AIDS Task Forces and all Stakeholders in the fight against HIV/AIDS/STI/TB for their continued support for NAC, especially as we prepare to start implementing the second edition of the National HIV/AIDS/STI/TB M&E Plan. Without your tireless cooperation, all the effort that has gone into the development of this plan will be futile. We therefore also look forward to your continued support during the implementation of this plan.

Dr. Mushaukwa Mukunyandela
Chairperson
National AIDS Council

LIST OF ABBREVIATIONS

AIDS	Acquired Immune Deficiency Syndrome
ARV	Anti-retroviral treatment
BCI	Behavioural Change Intervention
BSS	Behavioural Surveillance Survey
CBOH	Central Board of Health
CBO	Community Based Organization
CDC	United States Centers for Disease Control and Prevention
DFID	Department for International Development
DPO	Disabled Persons Organizations
FHI	Family Health International
ZDHS	Zambia Demographic and Health Survey
ZSBS	Zambia Sexual Behaviour Survey
GFATM	Global Fund for AIDS, Tuberculosis, and Malaria
HIV	Human Immunodeficiency Virus
HMIS	Health Management Information System
M&E	Monitoring and Evaluation
MAP	Multi-Country AIDS Program
MOH	Ministry of Health
NAC	National AIDS Council
NASTAD	National Alliance of State and Territorial AIDS Directors
NGO	Non-governmental Organization
NORAD	Norwegian Agency for Development
PLWHA	Persons Living With HIV/AIDS
PMTCT	Prevention of Mother-to-Child Transmission
SIDA	Swedish International Development Agency
STI	Sexually Transmitted Infection
UNAIDS	Joint United Nations Programme on HIV/AIDS
USAID	United States Agency for International Development
VCT	Voluntary Testing and Counselling
WHO	World Health Organization
ZNBTS	Zambia National Blood Transfusion Services

1. INTRODUCTION

1.1. BACKGROUND

The first case of HIV/AIDS in Zambia was diagnosed in 1984. In 1986, the GRZ established the National AIDS Prevention and Control Program (NACP) with assistance from the WHO Global Program on HIV/AIDS. Several national plans were developed to face the challenge of curbing the emerging epidemic, with the first, the emergency short-term plan developed in 1987 to ensure safe blood and blood product supplies. Two Medium Term Plans, MTP 1 and MTP 2 covered the years 1988-1992 and 1994-1998 respectively. The National HIV/AIDS Intervention Strategic Plan and the National Monitoring and Evaluation Plan were developed for 2002 to 2005. These comprehensive plans focused on national level decision making and coordination. This plan and its counterpart, the Zambia HIV and AIDS Strategic framework, were updated and built upon the 2002 to 2005 plans.

To coordinate and support the development, monitoring and evaluation of the multi-sectoral national response for the prevention and mitigation of HIV/AIDS, STI and TB, the National HIV/AIDS/STI/TB Council (NAC) was established by an act of Parliament in December 2002. NAC is composed of a Council and a Secretariat. The Council's 15 members are drawn from civil society (including religious organisations) and the public and private sectors. Furthermore, the National HIV/AIDS Policy was published in 2005 to provide the directive and mandate for the national response.

For the current period, 2006 to 2010, the National HIV/AIDS Strategic Framework (NSF) was developed to prevent, halt and begin to reverse the spread of HIV and AIDS by 2010. The NSF defines six (6) themes which describe priority action areas: 1) Intensifying Prevention; 2) Expanding Treatment, Care and Support; 3) Mitigating the Socio-Economic Impact; 4) Strengthening Decentralized Response and Mainstreaming HIV and AIDS; 5) Improving the Monitoring of the Response; and 6) Integrating Advocacy and Coordination of the Multisectoral Response. Strategic objectives for each theme are outlined and described in Figure 1.

Monitoring and evaluation (M&E) is increasingly becoming a key component of programme design and management. Governments, donor organizations and programme managers are making conscientious efforts to ensure active and iterative monitoring processes are in place at every stage of the project life cycle. Most countries implementing HIV/AIDS programmes have national monitoring frameworks and a set of indicators linked to the UNGASS Declaration of Commitment on HIV/AIDS, selected in consultation with a broad range of stakeholders. The absence of a common operational M&E framework in most countries has crippled efforts to increase capacity for quality assurance, national oversight and adequate use of M&E for policy adaptation.

To facilitate effective coordination, the government, through NAC, developed a National HIV/AIDS M&E System to allow the country to track its progress towards the goals and objectives as stated in the National HIV/AIDS Strategic Framework (NSF). This document outlines the monitoring and evaluation framework, strategies and indicators to monitor the multisectoral response to HIV and AIDS in Zambia.

THEMES

I. Intensifying Prevention	II. Expanding Treatment, Care and Support	III. Mitigating the Socio-economic impact	IV. Strengthening the Decentralised Response and Mainstreaming HIV and AIDS	V. Improving the Monitoring of the Response	VI. Integrating Advocacy and Coordination of the Multi-Sectoral Response
STRATEGIC OBJECTIVES					
1. Prevent Sexual Transmission of HIV with a special emphasis on youth, women and high risk behaviours 2. Prevent Mother to Child Transmission 3. Prevent HIV transmission through blood and blood products 4. Prevent HIV transmission in health care and other care settings and promote access to post exposure prophylaxis treatment 5. Improve access to and use of confidential counselling and testing 6. Mitigate stigma and discrimination against HIV 7. Prevent HIV transmission through intravenous drug use 8. Support development and participation in HIV vaccine clinical trials	9. Provide Universal Access to ART including access to CCT at all Treatment Centres 10. Expand treatment for Tuberculosis, sexually transmitted infections (STIs) and other opportunistic infections (OIs) 11. Strengthen home/community- based care and support including access to comprehensive palliative care and pain management 12. Support the utilisation of alternative and/or traditional medicines which have scientifically demonstrated efficacy 13. Promote appropriate nutrition and positive living for PLHAs	14. Protect and provide support for orphans and vulnerable children 15. Provide social protection for people made vulnerable from the affects of HIV and AIDS 16. Promote programmes of food security and income/ livelihood generation for PLHA and their caregivers/ families	17. Mainstream HIV and AIDS into district level development policies, strategies, plans and budgets 18. Improve capacity of district, provincial and national planning mechanisms in multi-sectoral HIV and AIDS planning, monitoring and coordination 19. Mainstream HIV and AIDS into sector (private, public and civil society) development policies, strategies, plans and budgets 20. Develop and implement comprehensive workplace policies that take into consideration issues around education, awareness and prevention, treatment care and support 21. Support the development of workforce development strategies which prioritise the key sectors critical to the response to HIV and AIDS	22. Strengthen mechanisms and systems for monitoring and evaluation of the multi-sectoral response 23. Improve capacity of implementing partners for monitoring and evaluation of the situation and the response 24. Strengthen operational and behavioural research and access to information on best practice and cost effective interventions	25. Strengthen the institutional and legal framework 26. Improve coordination and resolve areas of duplication and gaps in the multi-sectoral response to HIV and AIDS to include resource management 27. Advocate for mainstreaming, effective policy implementation and fighting stigma and discrimination 28. Promote effective leadership for the multi-sectoral response for HIV and AIDS

This monitoring and evaluation plan recognizes that the fulfilment of NAC's coordination can only be as effective as the information it has on the implementation status for the various interventions as well as the impact and outcome of programmes. This has been factored into the monitoring framework which comprises outcome and impact indicators as well as programme performance output indicators with a strong linkage between the two levels of information reporting.

DEVELOPMENT OF THE 2006-2010 M&E PLAN

Participatory and qualitative methods were used in developing this M&E Plan. The use of the participatory approach was a critical feedback received from the development of the previous plan and as an important way of enhancing ownership and stakeholder buy-in, which are more likely to result in successful implementation of the 2006-2010 M&E Plan.

The development involved in-depth consultation with all sectors and stakeholders from the national, provincial and district levels. Between May-November 2005, NAC held consultative meetings with the 72 DATFs and 9 PATFs to develop District and Provincial Monitoring and Evaluation Plans. The findings from the district and provincial consultations and themes and strategies from the district and provincial M &E plans informed the content of the National M&E framework.

At the National Level, the NAC M&E TWG, with support from partners and stakeholders instituted the following processes:

- Desk reviews of various national and international M&E documents to ensure that the Zambia M&E Plan aligns to international M&E processes and plans
- Consultative meetings with key partners including the United Nations Agencies, US Government Agencies, International and Local NGOs, FBOs, Civil Society Organizations, PLWHAs, Private Sector, Academic Institutions and key government agencies
- Development of a draft 2006-2010 M&E Plan with list of core indicators
- Development of targets and baseline measurements for the indicators with a focus on Universal Access targets
- Presentation draft 2006-2010 M&E Plan with core indicators, targets and baseline data in a stakeholder forum for discussion and endorsement
- Finalization of the framework by incorporating the suggestions and recommendations that arise at the stakeholder forum

This document therefore provides a summary of input from these processes and presents the second edition of Zambia's M&E operational plan.

1.2. GLOBAL PERSPECTIVES

UNAIDS, World Bank and USAID among others have developed concepts and guidelines to facilitate and improve monitoring and evaluation practices in place in most countries. In Zambia the 2006-2010 HIV/AIDS Strategic Plan Framework clearly prioritizes effective M&E. The following principles have been identified as a basic requirement for forging stronger national M&E frameworks:

Global-Level Alignment: Commitment should be made by partners at the global level to align their basic needs for M&E for the purpose of accountability for funds, and to agree on core elements of a country-level M&E system that can address these needs (minimally, timely completion of the NARFs and submission to DATFs in districts in which global partners are providing services).

Core national system linked to the National HIV/AIDS Action Framework: Each National HIV/AIDS Action Framework should be accompanied by a core system for monitoring progress, including progress towards the realization of UNGASS and Millennium Development Goals (MDG), under the leadership of the national AIDS authority.

Agreed Investment Strategies for Data Quality Control: National-level stakeholders within the National HIV/AIDS Action Framework should utilize the M&E system map completed in 2005 and continue to make assessments of existing M&E systems a priority. Stakeholders should agree on how systems can be improved and how a shared core system can be established to provide high-quality data for analyzing country performance.

Investment in national capacity: National governments, AIDS authorities and the associated development partnerships must make the case for investing in essential capacity-building to meet national M&E needs. Production and dissemination of timely and useful reports can be powerful evidence to support system investment.

1.3. A THEORETICAL FRAMEWORK FOR M&E

Confusion between <u>Monitoring</u> and <u>Evaluation</u> concepts is common. There is a simple distinction between these concepts in that <u>Monitoring</u> is the routine, regular assessment of

ongoing activities and progress, while in contrast, Evaluation is the episodic assessment of overall achievements and the extent to which they can be attributed to specific interventions. In short, monitoring looks at what is being done while evaluation examines the effectiveness of what is being done. Evaluation draws from data generated by the monitoring system and links this to primary beneficiaries to determine the impact of programmes. Monitoring must be integrated within the programme management structure whilst evaluation with its comparative characteristics may not need such an integrated component. Effective M&E will have a clear logical pathway of results which encompasses the major levels that include inputs, outputs, outcomes and impacts. Figure 2.A & 2.B demonstrate these interconnections where:

i. **Inputs** are the people, training, equipment and resources that we put into a programme, in order to achieve delivery of services this information is particularly useful for planning at the local level;
ii. **Outputs** are the activities or services delivered, including HIV/AIDS prevention, care and support services, in order to either improve the well being of beneficiaries or change behaviours of beneficiaries;
iii. **Outcomes** are produced through the provision of good-quality, economic, accessible, and widespread services, key outcomes should occur. Outcomes are changes in behaviour or skills, especially safer HIV prevention practices and increased ability to cope with AIDS
iv. **Impact:** These are long term effects or changes e.g. in HIV/AIDS trends, AIDS-related morbidity, social norms, coping capacity in community etc. Therefore, it is the above-mentioned outcomes that lead to major measurable health impacts, particularly reduced STI/HIV transmission and reduced AIDS impact

Based on the interconnections articulated in the Figure 2.A & 2.B, all implementing partners should ideally collect complete input and output data. Far fewer implementing partners will assess outcomes and even fewer implementing partners and studies are required to assess impacts. A strong link therefore exists between a national HIV/AIDS M&E system - the goal of which is to track the progress made in terms of the national response - and the M&E systems of specific programmatic areas (such as PMTCT, clinical care, VCT, etc). The designing and implementation of programmes should address M&E components from the initial planning stages to ensure that data collected are useful in local planning in addition to meeting national indicator requirements.

A national M&E system provides a national overview to enable decision-making and track progress from a national perspective, while a programmatic-level M&E system collects data for use by the implementers of the HIV programme and for feedback to the national M&E system. Thus, a programme-level M&E system will collect more indicator data than what is required by the national M&E system - but as a minimum requirement it should collect **ALL** of the information that is needed to measure the national indicators.

Thus, a programme-level M&E system should use some of the data that it collects for feedback to the national level, whilst the balance of information that has been collected will be used at programme level. This implies the need for the information that is collected at local level to be useful to the person who collects that information the principle of **"COLLECT IT ONLY IF IT IS USEFUL TO USE".**

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

Figure 2.A: M & E Results Pyramid

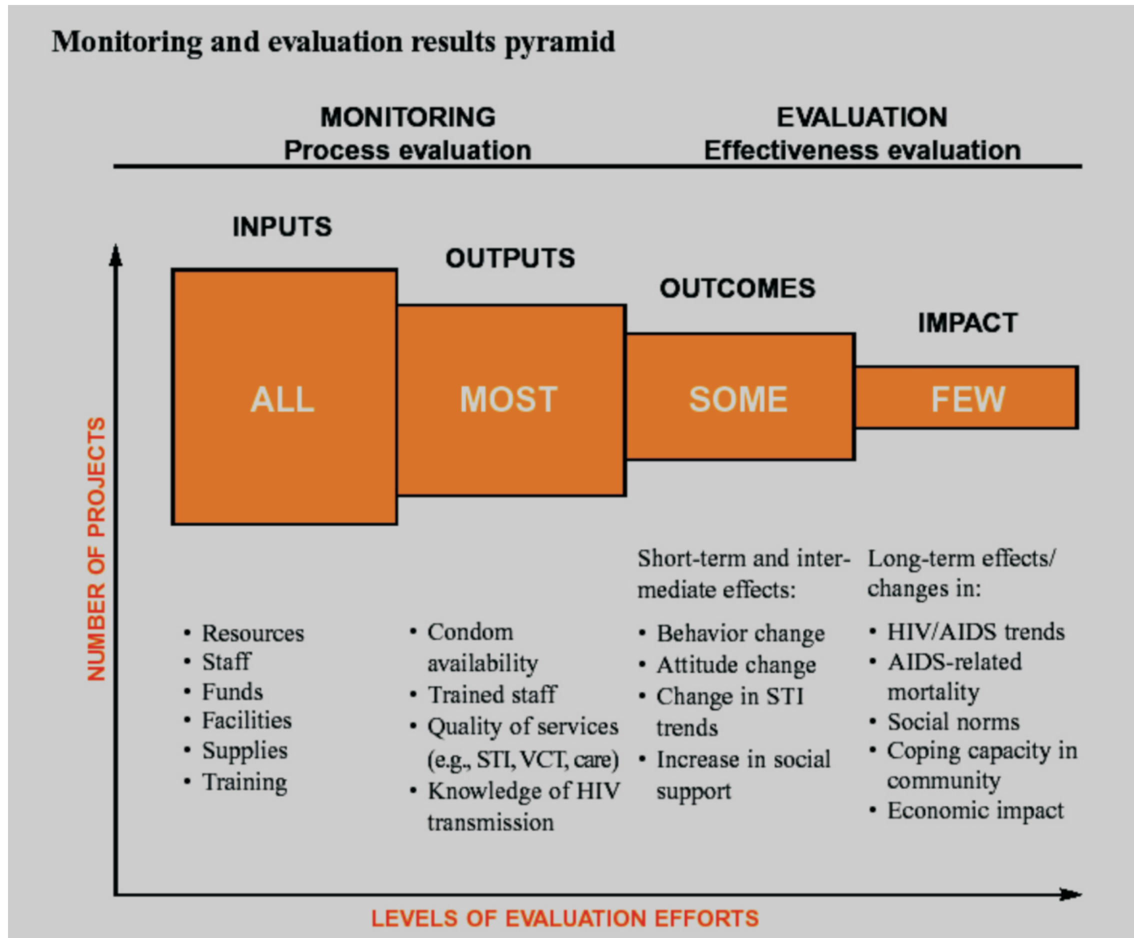
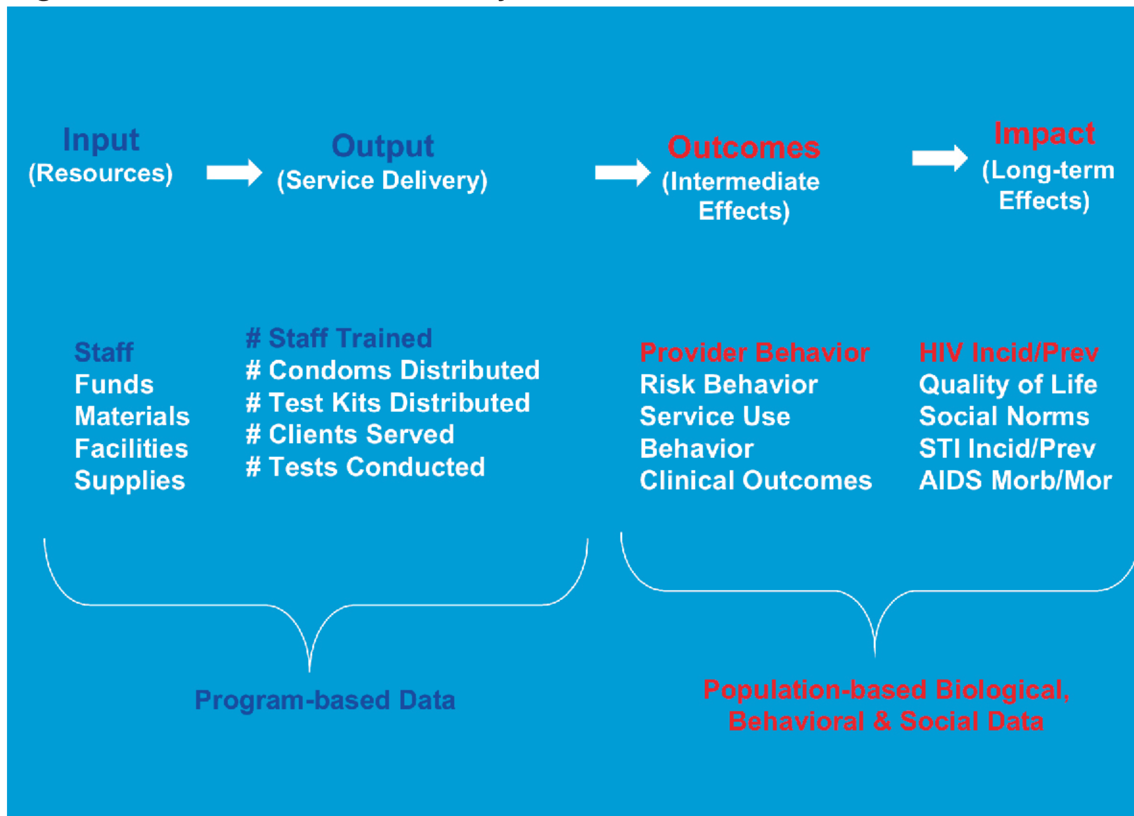


Figure 2.B: M & E Results Pathway



2. NATIONAL M&E PLAN

2.1. OVERVIEW

The 2006-2011 HIV/AIDS/STI/TB M&E operational plan is guided by the overall goal of the National Strategic Framework (NSF) for Zambia as outlined in Figure 1. The plan is organized according to the levels of M&E described in Section 1.2. The M&E logical framework is organized by the key programme areas that make up Zambia's response to the AIDS epidemic, and core M&E functions are so aligned as to enhance national leadership, monitoring, coordination, and management of the response at all levels. Following these organizing principles, the logical framework follows the general outline shown in Figure 2.A and Figure 2.B.

The purpose of this National HIV/AIDS/STI/TB M&E Plan is to lay the conceptual foundation and operational mechanisms for Zambia's National HIV/AIDS/STI/TB M&E System. This M&E Plan provides a theoretical framework for M&E and a logical framework for organizing and prioritizing national efforts. It also provides a description of goals, measurable indicators by programme area, including baselines and targets (Appendix 3). The plan sets forth a description of data sources that will be used to gather necessary M&E information and calculate the recommended indicators as well as the flow of data from all the data sources. Finally, it describes M&E products and reports, plans for data utilisation and capacity building strategies to improve data quality and strengthen M&E systems at all levels. This M&E plan will guide all the stake holders working on HIV/AIDS to meet the national HIV/AIDS goals.

This M&E Plan also emphasizes Zambia's commitment to fighting the epidemic on an international level. Zambia is signatory to multiple international declarations, such as the United National Special Session on HIV/AIDS Declaration (UNGASS) and the Millennium Development Goals. Each of these documents outlines global goals towards which countries should direct their efforts. Zambia received significant resources from the World Bank under the MAP, and continues to receive from the UK Department for International Development (DFID) and Global Fund to fight AIDS, Tuberculosis, and Malaria (GFATM). This M&E Plan provides for the incorporation into the logical framework of specified international indicators and the data sources necessary to track these indicators. These efforts in M&E allow Zambia to contribute to global goals and highlight its role in these international initiatives.

This M&E plan identifies seventy eight (78) performance indicators that will be used to measure the national response to HIV/AIDS response. Four (4) of these are at the impact level, twenty six (26) at the outcome level and forty eight (48) at the output level. Table 1.1 outlines all the indicators, including the proposed data sources for each of the indicators. The 78 indicators are defined in Appendix 3.

Table 1.1: Indicators, levels, Area and Data Source

LEVEL, AREA, AND OBJECTIVE	CORE INDICATORS	DATA SOURCE
IMPACT INDICATORS		
HIV Prevalence	*1. Percent of adults aged 15-49 who are HIV infected*	DEMOGRAPHIC AND HEALTH SURVEY
HIV Prevalence	*2. Percent of 15-24 year olds who are HIV positive*	
HIV Incidence[1]	*3. % of pregnant women aged 15-19 who are HIV infected*	SENTINEL SURVEILLANCE
Prevention of Mother to Child Transmission	*4. % of infants born to HIV infected mothers who become infected*	HMIS
OUTCOME INDICATORS		
Theme 1: Intensifying Prevention		
Prevent Sexual Transmission of HIV	*5. % of 15-49 year olds using condoms during the last sexual act with non regular sexual partner*	SEXUAL BEHAVIOR SURVEY
	6. % of 15-19 year olds who report being sexually active	
	7. % of 15-24 year olds who report being sexually active	
	8. % of 15-24yr-olds who both correctly identify ways of preventing sexual transmission of HIV & reject major misconceptions of HIV transmission	
	9. Median age at first sexual debut	
	10. % of schools with teachers who have been trained in life skills education and taught it during the last academic year	EDUCATION MANAGEMENT INFORMATION SYSTEM
	11. % school children aged 10-18 who report receiving life skills education in school.[2]	
	12. % of unmarried respondents who report at least 2 sexual partners in the past 12 months	SEXUAL BEHAVIOR SURVEY
	13. % of married respondents who report at least 2 sexual non-regular partners in the past 12 months	
Voluntary Counseling and Testing (VCT)	*14. % of adult population (15-49 yrs.) counselled and tested for HIV and received their test results.*	SEXUAL BEHAVIOR SURVEY
Prevent Mother to Child Transmission (PMTCT)	*15. % of HIV positive pregnant women receiving a complete course of ARV prophylaxis to reduce MTCT*	HMIS
STI Treatment	*16. % of women and men with STIs at health care facilities who are appropriately diagnosed, treated and counselled according to national guidelines*	HEALTH FACILITY SURVEY
	17. % of facilities with observed STI treatment protocols	
Blood Safety	*18. % of health facilities that apply national guidelines for blood screening, storage, distribution & transfusions*	HMIS/SPECIAL SURVEY
	19. % of transfused blood units screened for HIV	HMIS
Theme 2: Expanding Treatment, Care and Support		
Anti-Retroviral Therapy (ART)	*20. % of persons with advanced HIV infection receiving ARV therapy*	HMIS
Tuberculosis (TB) Treatment	*21. Tuberculosis cure rate under DOTS*	HMIS
	22. Defaulter rate	
	23. Treatment success rate	
Care and Support	*24. % 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*	SEXUAL BEHAVIOR SURVEY

[1] Percent of pregnant women aged 15-19 who are HIV infected is used as a proxy for measuring incidence of HIV.
[2] Proposed indicator to be incorporated into EMIS (NAC to propose to MOE or to be included into Education Health Survey)

OUTCOME INDICATORS		
Theme 3: Mitigating the Socio-economic impact of HIV and AIDS		
Support for Orphans and Vulnerable Children (OVC)	*25. % 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*	SEXUAL BEHAVIOR SURVEY
	26. Ratio of current school attendance among orphans to that among non-orphans aged 10-14 years	
Theme 4: Strengthening the Decentralised Response and Mainstreaming HIV and AIDS		
Sectoral Mainstreaming	*27. % of public workplaces and large enterprises/companies with an HIV/AIDS policy and programme*	WORKPLACE-BASED SURVEY
	28. % of Districts with comprehensive HIV and AIDS costed annual work plans	NAC DESK REVIEW
Theme 5: Improving the Capacity for Monitoring and Evaluation by all Partners		
Monitoring and Evaluation	*29. % of Districts with M & E systems and databases providing information on HIV and AIDS activities.*	NAC DESK REVIEW
Theme 6: Integrating Advocacy, Coordination and Leadership of the Multisectoral Response		
Coordination	*30. # of networks/partnerships involved in the multi-sectoral response*	NAC ANNUAL REPORT
OUTPUT INDICATORS		
Theme 1: Intensifying Prevention		
Prevent Sexual Transmission	*31. # of IEC materials printed/produced and distributed*	NAC ACTIVITY REPORTING FORMS
	32. Number of peer educators trained in life skill	
	33. # of 15-24 yr olds who receive life skills based HIV/AIDS education (incl. through peer education)	
	34. Number of condom service outlets providing condoms to end users	
	35. # of male & female condoms distributed to end users	
Voluntary Counseling and Testing (VCT)	*36. # of clients tested for HIV at VCT and receiving their test results*	HMIS
	37. # of facilities providing VCT services	
	38. # of professional providers trained to provide VCT services	NARF
	39. # of lay/community providers trained to provide VCT services	
Prevent Mother to Child Transmission (PMTCT)	*40. # of professional providers trained in the provision of PMTCT services*	NARF
	41. # of lay/community providers trained to provide PMTCT services	NARF
	42. # of facilities providing PMTCT services	HMIS
	43. # of districts with facilities providing PMTCT services	HMIS
	44. # of HIV+ pregnant women receiving a complete course of ARV prophylaxis	HMIS
	45. # of HIV exposed infants seen in the first 1 month of life for check-up	HMIS
	46. # of HIV exposed infants receiving co-trimoxazole prophylaxis	HMIS
STI Treatment	*47. % of health facilities with STI drugs in stock and no STI drug stock outs of >1 month within last quarter*	NARF
	48. # of service providers trained in the diagnosis and treatment of STIs according to national guidelines	
Blood Safety	*49. # of individuals trained in blood safety*	NARF
	50. # of service outlets carrying out blood safety activities	
Infection Prevention	*51. # of service providers trained in national standards for infection prevention and health care waste storage and disposal*	NARF
	52. # of health care facilities conducting infection prevention and health care waste storage and disposal	
	53. # of traditional healers trained in infection prevention and use of sharp instruments according to national standards	

OUTPUT INDICATORS		
Theme 2: Expanding Treatment, Care and Support		
TB Treatment	54. *% of health facilities with all essential drugs for TB/OI in stock and no stock outs of >1 month in the last quarter.*	HMIS
Antiretroviral Therapy (ART)	55. *# of persons with advanced HIV infection on ART*	HMIS/NARF
	56. *# service providers trained to provide ART services*	NARF
	57. *# of community adherence supporters trained to provide ART services*	NARF
	58. *# of public and private facilities providing ART services*	NARF
	59. *% of HCFs providing ART services with no ARV drug stock outs of >2 weeks in the last 12 months*	HMIS/NARF
Care and Support	60. *Total Number of service outlets providing HIV related palliative care including TB/HIV*	NARF
	61. *Total number of individuals provided with HIV -related palliative care including TB/HIV*	
	62. *Total number of individuals trained to provide HIV palliative c are including TB/HIV*	
	63. *# of chronically ill people enrolled in community home based care progra mmes*	
	64. *# of PLWHAs support groups*	
	65. *# of PLWHA enrolled in PLWHA support groups*	
Theme 3: Mitigating the Socio-economic impact of HIV and AIDS		
Support for Orphans and Vulnerable Children (OVC)	66. *# of orphans and other vulnerable children receiving care and support from CBOs,/NGOs/FBOs/DPOs*	NARF
	67. *# of street children re -integrated/integrated into homes*	
	68. *# of CBOs/NGOs/ FBOs/DPOs receiving funding/technical assistance to provide care and support to OVCs*	
Theme 4: Strengthening the Decentralised Response and Mainstreaming HIV and AIDS		
Sectoral Mainstreaming	69. *# of workplaces, including line ministries, with developed workplace policies and programmes for HIV/AID*	WORKPLACE SURVEY/NARF
	70. *# of Line Ministries, FBOs, CBOs, DPOs, and NGOs with HIV and AIDS Action Plans*	
	71. *# of line ministries with HIV/AIDS budget line items*	
	72. *# of line ministries with full-time focal point persons for HIV/AIDS*	
	73. *# of employees trained to provide HIV behavior change services to fellow employees (incl. peer educators, counselors, etc,) at workplaces*	
	74. *# of employees reached through workplace programmes*	
Theme 5: Improving the Capacity for Monitoring and Evaluation by all Partners		
M&E	75. *75Number of organisations with functional M & E systems and linked into the national M & E system at national, provincial and district levels*	NARF
	76. *Number of persons trained in M & E at different levels*	NARF/SPECIAL SURVEY
Theme 6: Integrating Advocacy, Coordination and Leadership of the Multisectoral Response		
National Commitment, Leadership and Coordination	77. *Amount of funds spent on HIV/AIDS in the past 12 months*	UNAIDS FINANCIAL RESOURCE FLOW SURVEY
	78. *National Composite Policy Index (NCPI) score*	NATIONAL COMPOSITE POLICY INDEX SURVEY

DATA SOURCES

The M&E system for the national response to HIV/AIDS/STI/TB will draw information from a total of eleven (11) data sources. Nine (9) of these are surveys, one (1) is a health management information system and the other will be program reports that will be captured through an activity reporting form that NAC has developed (Appendix 7). As Table 2.1 shows, a cohort study, sentinel surveillance survey, education survey, workplace study, UNAIDS Financial Resource Flow Survey, and National Composite Policy Index Surveys will provide information for one indicator each. Additionally, the Zambia Demographic and Health Survey will provide information for two (2) indicators, the Health Facility Survey for five (5) and the Sexual Behaviour Survey for nine (9). The rest of the indicators will be drawn from the Health management Information System (16 indicators) and the aforementioned NAC Program Activity Reporting System (17 indicators).

2.2.1. Activity Report Form

a. Description & Guiding Principles

NAC Program Activity Report System refer to a generation of information from standard forms (Appendix 7) received by NAC on a regular basis from NAC grantees as well as non-grantees, including Government Line Ministries, implementing HIV/AIDS interventions. The form will summarize coverage achieved by organizations implementing HIV/AIDS interventions in the areas of prevention, care, support, and impact mitigation.

Guiding Principles

The implementation of the program activity reporting system will be participatory, interactive, integrated with each level of reporting involved not only to collect and submit data but also to be strengthened to analyze and utilize data at ALL the levels. This is further elaborated below:

Participatory: Stakeholders at all levels of information reporting should be involved in the entire process of planning; design and establishment, identifying capacity needs and development of capacity building plans; and implementation and review of the functions and reporting and incorporating revisions in the structure and functions.

Integrated: Stakeholders at all levels of reporting should be involved as active partners with monitoring and evaluation integrated as a core activity of their programmes. All levels should be capacitated to proactively analyze data collected and reported for their own management and planning purposes.

Interactive: translates into the need for each level to provide timely feedback on data reported and analyzed to the level where data was generated and submitted. There should be information sharing and close networking at all levels. This translates into a matrix type of reporting with interaction and information sharing taking place laterally among the stakeholders and vertically to the point of submission to the next level.

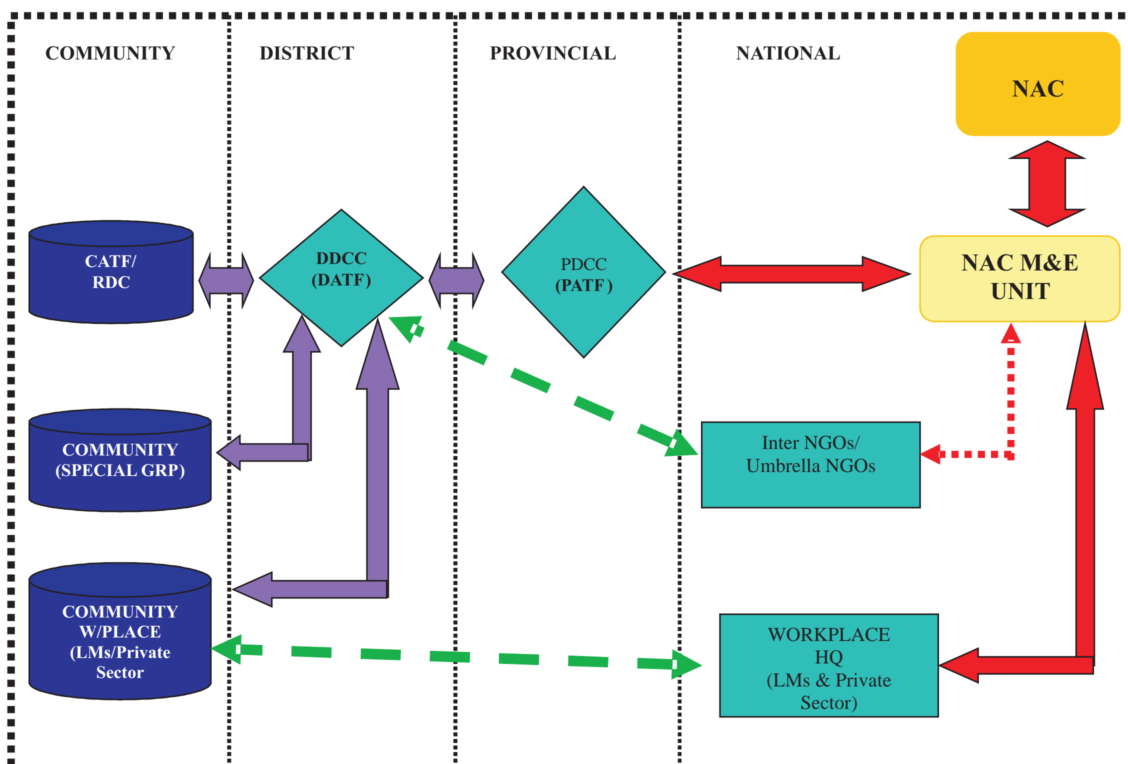
User-Friendly: The system and tools designed for data collection, analysis, storage, retrieval and reporting should be simple and straight-forward. The level of sophistication of data collection tools and data management tools (data bases, spreadsheets and in some cases at the community level, data entry registers) should be tailored to meet the information needs of each level of reporting.

b. What NAC Needs From This Data Source

1. # of IEC materials distributed (brochures/t-shirts/posters/books):
2. # of male and female condom pieces distributed (from non-health facilities).
3. # of condom service outlets providing condoms to end users
4. # of 15-24 year olds who receive life skills based HIV/AIDS education (incl. through peer education)
5. # of workplaces, including LMs, with developed workplace policies and programmes for HIV/AIDS
6. # of Line Ministries, FBOs,CBOs, DPOs and NGOs with HIV and AIDS Action Plans
7. # of line ministries with HIV/AIDS budget line items
8. of line ministries with full-time focal point persons for HIV/AIDS
9. # of employees reached through workplace programmes
10. # of employees trained to provide HIV behaviour change services to fellow employees (incl. peer educators, counsellors, etc)
11. # of PLWHA enrolled in PLWHA support groups
12. # of PLWHAs support groups
13. # of chronically ill people enrolled in CHBC programs
14. # of individuals trained to provide HIV palliative care including TB/HIV
15. # of individuals provided with HIV-related palliative care including TB/HIV
16. # of service outlets providing HIV related palliative care including TB/HIV
17. # of CBOs/NGOs/ FBOs/DPOs receiving funding/technical assistance to provide care and support to OVCs
18. # of street children re-integrated/integrated into homes

19. # of Orphans and Vulnerable Children (OVCs) receiving care and support from CBOs,/NGOs/FBOs/DPOs
20. # of institutions/organisation with full-time M&E persons
21. # of organisation with functional M&E systems and linked into the national M&E system at national, provincial and district levels
22. # of institutions/organisation with full-time M&E persons

c. Flow Of Information From This Data Source To NAC



COMMUNITY LEVEL: There are three types of communities that have been identified, the CATFs/RDCs, workplace (which includes the Line Ministries and Private Sector), and special groups, e.g., prisons, sex workers and other high risk groups like long distance truck drivers. Upon identification of the different community groups, the NAC activity reporting form (Appendix 7) will be distributed to all at community level, as long as they implement some HIV/AIDS/TB/STI activities. These three groups will then be expected to submit completed forms to the DATFs in their respective districts on a quarterly basis. Prior to the distribution of the forms, the DATFs will orient all communities where HIV/AIDS/STI/TB activities are implemented on the reporting forms and reporting requirements as prescribed in the M&E plan.

DISTRICT LEVEL: On a quarterly basis DATFs will receive completed forms from the community groups and collate them for submission quarterly to respective PATFs using the DATF reporting form NAC, together with PATF members will orient the DATFs on the reporting requirements for ALL HIV/AIDS activities through the reporting form prior to the distribution of the reporting forms.

PROVINCIAL LEVEL: At this level, the PATFs will collate ALL district forms in their respective provinces and submit them to NAC on a quarterly basis using the PATF reporting form (Appendix 7). Prior to collation, the PACAS with the PATFS will be expected to conduct quarterly supervisory visits to their respective districts to ensure data quality.

NATIONAL LEVEL: NAC will receive the activity reporting forms on a quarterly basis from ALL the provinces. The provincial collated reporting forms will be entered into the NAC database for easy retrieval of information and preparation of quarterly, bi-annual and annual reports, as well as, special ad hoc updates.

2.2.2. COHORT STUDY

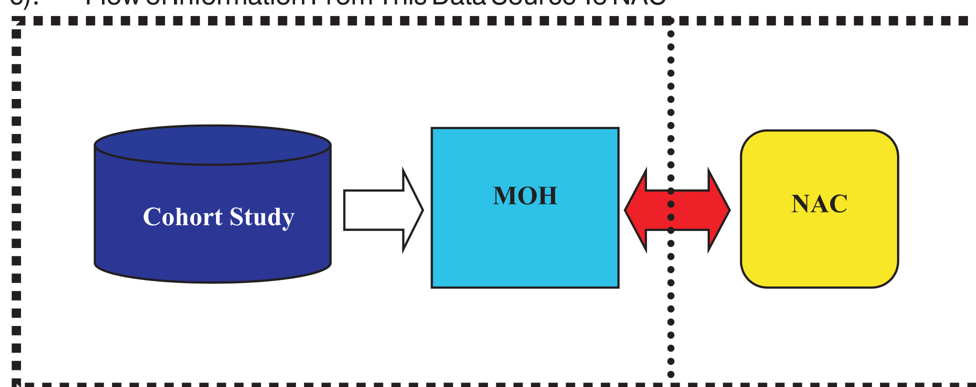
a). Description

Cohort studies are conducted for various purposes to monitor a group of individuals with similar characteristics to monitor the effectiveness of a service delivery program or behaviours that may occur to a particular group of individuals when exposed a particular event or situation. Zambia has had some experience in conducting cohort studies, for instance one study aimed at monitoring the behaviour changes in young people exposed to HIV prevention interventions. Cohort studies tend to be expensive, but if planned and built within interventions, they can become relatively cheaper.

b). What NAC Needs From This Data Source

1. % of infants born to HIV infected mothers who become infected[3]

c). Flow of Information From This Data Source To NAC



Cohort studies will be conducted as need arises by identified research Institutions such as TDRC.

2.2.3. Education Management Information System (EMIS)

c). Description

Sector studies on HIV/AIDS are regularly carried out to monitor the progress on mainstreaming of interventions in different sectors. In Zambia the Education sector has developed an Education Management Information System to collect information on routine basis. The aim of the system is to strengthen the Ministry's operation in the delivery of education services. Through this system, the Ministry will also include HIV/AIDS information. The Education sector is one of the few sectors with a strong response to HIV/AIDS.

d). What NAC Needs From This Data Source

1. % of schools with teachers who have been trained in life skills education and taught it during the last academic year

e). Flow Of Information From This Data Source To NAC

The EMIS will provide information on the performance of teachers trained in provision of life skills to young people in schools. Ministry of Education (MoE) will share the EMIS report with NAC to allow the M&E unit at NAC to derive the percent of teachers surveyed who were trained who report teaching life skills. NAC will support the implementation of the EMIS.

[3] Measuring this indicator will become routine under HMIS

2.2.4 SPECIAL EDUCATION SURVEY

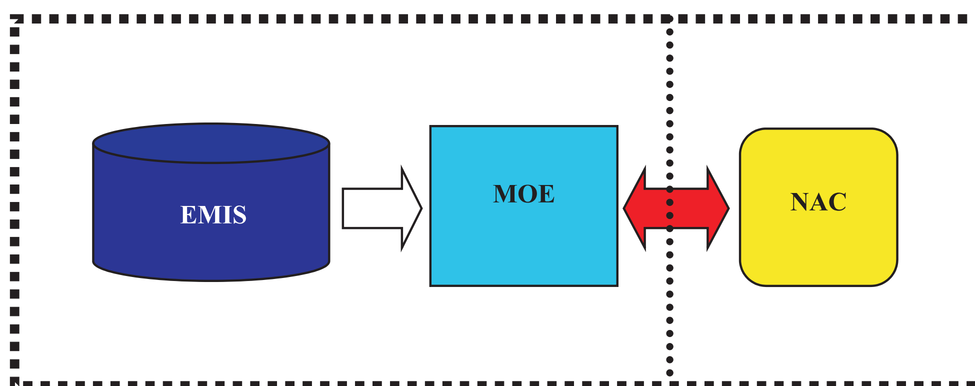
a) Description

This is a proposed indicator to be collected through the current EMIS system and as part of a special survey conducted by the Ministry of Education.

b) What NAC Needs from this Data Source

1. % school children aged 10-18 who report receiving life skills education in school.

c). Flow Of Information From This Data Source To NAC



2.2.5. Health Management Information System

a). Description

The primary clinical services monitoring system for Ministry of Health in Zambia is the Health Management Information System (HMIS). HMIS development began in 1995 with donor support as part of health care reform. The HMIS is managed by the Ministry of Health (MOH) and is a database of nationally aggregated health data intended for program management and policy decision-making. This information is tallied by health workers as they enter it. They aggregate the data monthly for their own use and submit quarterly reports to the District Health Management Teams (DHMT). The DHMT enters data from all clinics in the district and submits electronic data to the Provincial level quarterly where it is further cleaned, collated and submitted to MOH. The province does make programmatic decisions based on these data also.

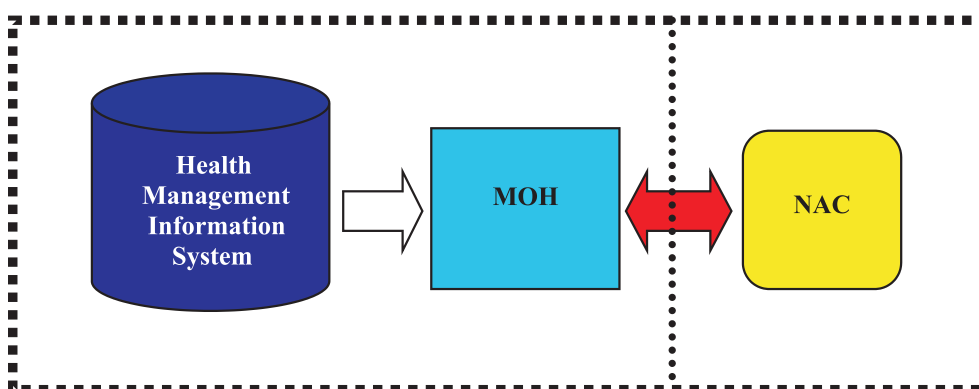
The HMIS was envisioned to cover information needs for every aspect of the health system. At present, it provides disease burden and health service delivery information. One intended use of the HMIS, which has not been put into operation, was as a supplies management tool, a need that persists. At the national level, the HMIS only collects client information in two age categories; below five-years of age and five- years old and above, which does not allow for monitoring targeted interventions to, or evaluations of, specific age groups. The national HMIS also does not collect gender. However, at the facility level, more disaggregated data is available. In 2006, the Ministry of Health identified and committed to launching a patient-level database known as the Continuity of Care: Patient Tracking Systems (CC:PTS), which provides for an electronic health record for all Zambians who are enrolled in care. Zambia is among the first of countries to adopt a national unique identification number for all citizens receiving health care. This number allows for standardized transferable data between various information systems. By 2010, it is envisioned that the system will be supporting 100% of sites with reliable electrical or solar power. Reports are produced to satisfy all HMIS indicators and allow for inclusion in to the national system.

The HMIS was reviewed in 2005 and a three-year workplan has been developed to improve the system. The three-year plan includes expansion of the programmatic areas covered, sex and age disaggregation and capacity building at district and provincial level. This is currently being implemented.

b). What NAC Needs From This Data Source

1. # of public and private facilities providing ART services
2. # of districts with health facilities providing ART services (for PATF use only)
3. # of persons with advanced HIV infection receiving ART
4. # of community adherence supporters trained to provide ART services
5. # service providers trained to provide ART services
6. % of health facilities providing ART services with no ARV drug stock outs of >2 weeks in the last 12 months
7. % of health facilities with all essential drugs for TB/OI in stock and no stock outs of >1 month in the last 12 months
8. % of health facilities with STI drugs in stock and no STI drug stock outs of >1 month within last 12 months
9. # of service providers trained in the diagnosis and treatment of STIs according to national guidelines
10. # of HIV exposed infants receiving co-trimoxazole prophylaxis
11. # of HIV+ pregnant women receiving a complete course of ARV prophylaxis to reduce the risk of MTCT
12. # of professional health providers trained in the provision of PMCT services
13. # of lay/community health providers (including TBAs) trained to provide PMTCT services
14. # of facilities providing PMTCT services
15. # of districts with facilities providing PMTCT services
16. # of HIV exposed infants seen in the first I month of life for check up
17. # of male and female condoms distributed (indicate condoms pieces and not boxes; 1box = 144 pieces
18. # of clients tested for HIV at VCT and receiving their test results
19. # of professional providers trained to provide VCT services
20. # of facilities providing VCT services
21. # of lay/community providers trained to provide VCT

c). Flow Of Information From This Data Source To NAC



The twenty-two (22) indicators to be drawn from the HMIS will be collated on an Activity reporting Form (Appendix 7.d) MOH will extract the information from the HMIS and complete the Activity Reporting Form for submission to NAC quarterly.

2.2.6. National Composite Policy Index (NCPI) Survey

a). Description

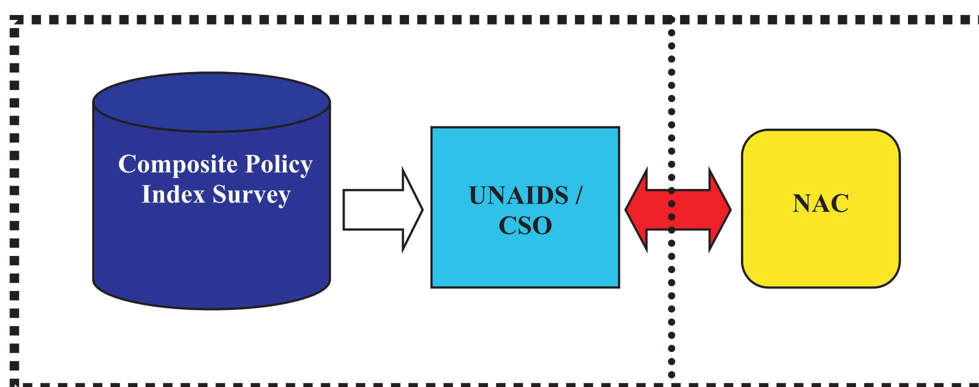
The composite index covers four broad areas of policy; strategic plan, prevention, human rights, and care and support. A number of specific policy indicators have been identified for each of these policy areas for this UNGASS indicator that is to be calculated biennially. A separate index is calculated for each policy area by adding up the scores (yes=1, no=0) for the relevant specific policy indicators and calculating the overall percentage score. The composite index is

calculated by taking the average of the scores for the four components. Where appropriate, the score for a specific policy indicator should be assessed with reference to the standards and criteria provided. The simple quantitative nature of the NCPI means that it does not give information on the effectiveness of national policies and strategies.

b). What NAC Needs From This Data Source

1. National Composite Policy Index (NCPI) score

c). Flow Of Information From This Data Source To NAC



2.2.7. Sentinel Surveillance Survey

a). Description

Biological surveillance of HIV has been primarily tracked through surveillance of sentinel populations. Zambia began sentinel surveillance for HIV at an early date in the epidemic (1990). Sentinel surveillance was limited in geographical coverage until 1993/1994. It is still the main tool to monitor trends.

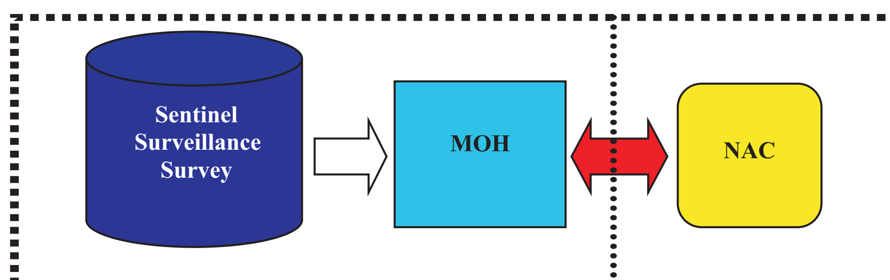
Surveillance data are presently collected from seven (7) urban, 12 rural and 5 transitional rural sentinel sites in the country, distributed throughout the 9 provinces that make up the country. Specified minimum samples for each type of site are set in advance and vary from year to year. Demographic data is collected before blood samples are drawn; variables include age, gravidity, level of education, marital status, occupation of the mother and her partner/spouse. Syphilis testing is done on site and, if positive, a woman is provided counselling and treatment. Remaining blood is labelled using unlinked identification numbers and sent to UTH and TDRC for HIV testing.

The prevention of parent-to-child transmission (PMTCT) programme and the monitoring system for that programme is up and running and being scaled up to all districts in Zambia.

b). What NAC Needs From This Data Source

1. % of pregnant women aged 15-19 who are HIV infected.
2. % of pregnant women aged 15-49 who are HIV infected
3. % of pregnant women aged 15-24 who are HIV infected (MDG)

c). Flow Of Information From This Data Source To NAC



MOH has been conducting this survey and will continue to do so biennially. This activity is included in the MoH strategic plans and budgeted for. Upon completion of the survey, MOH will submit a copy of the survey report to NAC for the NAC M&E Unit to capture indicators listed above.

2.2.8. UNAIDS Financial Resource Flows Survey

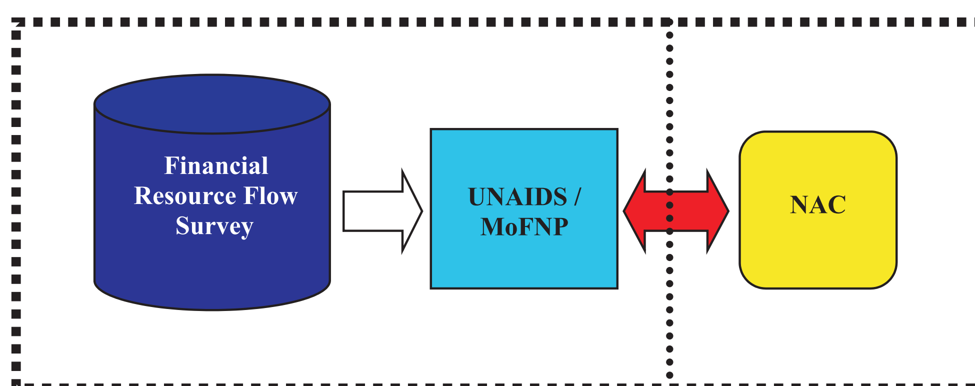
a). Description

This financial resource flow survey is recommended by the UNAIDS on a biennial basis in order to collect financial data to inform the UNGASS indicator about national government expenditures on HIV/AIDS programmes. Note however, that this information may be available as a part of the government expenditure reports and may be a subset of the information collected for the subsequent indicator listed above. The costs of any multilateral or bilateral international donor-funded government programmes should be excluded. Similarly, all NGO programmes (or parts of programmes) should be excluded, except for programmes that are funded by the national government. Allocated national funds comprise expenditure on the following four categories of programme, totals for each of which should be specified separately: STD control activities, HIV prevention, HIV/AIDS clinical care and treatment, HIV/AIDS impact mitigation.

b). What NAC Needs From This Data Source

1. Amount of funds spent on HIV/AIDS in the past 12 months

c). Flow Of Information From This Data Source To NAC



The financial resource flow survey will be implemented annually, guided by NAC Joint Financing Technical Working Group and under the supervision of the National AIDS Council. The JF TWG will therefore submit annual survey reports to the NAC Secretariat for inclusion into the NAC annual reports.

2.2.9. Workplace Survey

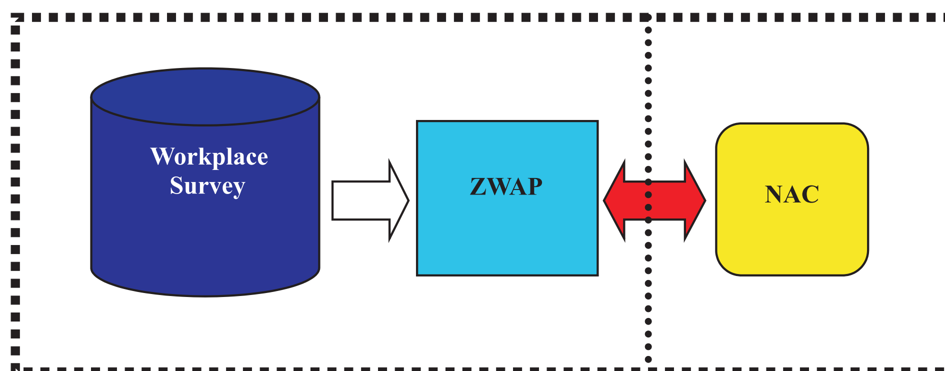
a). Description

Workplace studies are key sources of information on both public and private sector mainstreaming of HIV/AIDS interventions. The studies provide important information on the extent to which workplaces are developing policies to protect and mitigate the impact of HIV/AIDS on their respective employees, and the extent to which these policies are implemented. The workplace survey is conducted annually. In 2006 two databases were developed on access software. One database was developed to identify companies implementing workplace programmes / interventions and policies and a survey was conducted to collect this data. The data has been entered and a directory has been developed. The second database, 2006, is to capture quarterly service statistics at the private sector level.

b). What NAC Needs From This Data Source

1. % of workplaces and large enterprises with developed HIV/AIDS policies and programmes.

c). Flow of Information from this Data Source to NAC



The Zambia Business Coalition will take the lead in identifying a firm/institution to conduct the workplace study that will include the public and private sector. The survey will provide information on the proportion of large firms/institutions with HIV/AIDS policies and programmes. ZBCA will however need to enter into some memorandum of understanding with NAC to ensure that the implementation of the survey is institutionalised into the ZBCA activities or strategic plan. The survey will be implemented every other year with the first one scheduled for 2004.

2.2.10. Zambia Demographic And Health Survey (ZDHS)

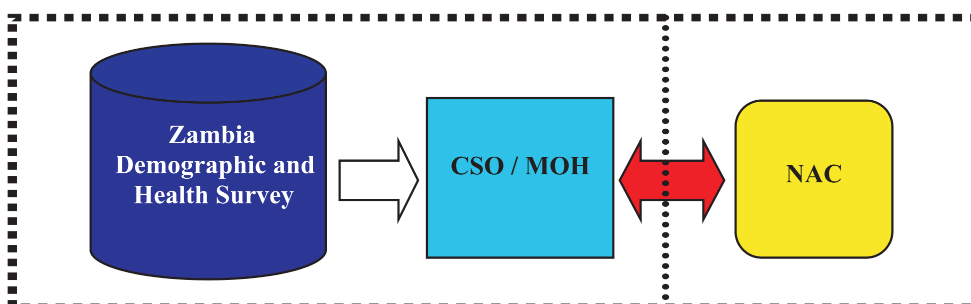
a). Description

The DHS is a robust instrument for tracking changes in knowledge and behaviour at a national level. This survey is conducted every 4-5 years. The methodology has been developed over 30 years of international experience and data are comparable both internally over the course of time, and externally with other countries in the region. The core DHS questionnaire emphasizes basic indicators and flexibility. It allows for the addition of special modules so that questionnaires can be tailored to meet host-country data needs. The standard DHS survey consists of a household questionnaire and a women's questionnaire. The Zambian DHS survey also contains a male questionnaire. A nationally representative sample of people ages 15-49 are interviewed. In addition, the data can be disaggregated by age, sex, educational level, and urban/rural status. The weakness of the DHS is that the survey is not designed to collect data for specific risk populations (except youth), and may not yield district level estimates (although the 2002 Zambia DHS did provide estimates for selected districts).

b). What NAC Needs From This Data Source

1. % of adults aged 15-49 who are HIV infected
2. % of 15-24 year olds who are HIV positive

c). Flow Of Information From This Data Source To NAC



2.2.11. Zambia Health Facility Survey (ZHFS)

a) Description

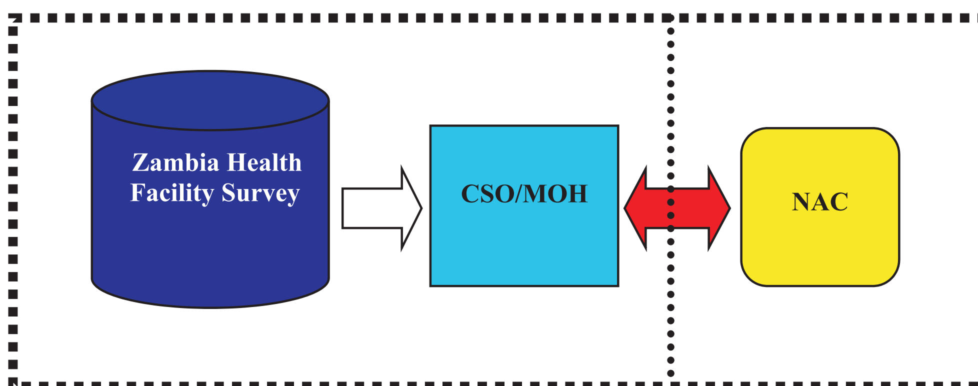
Health facility surveys are conducted to better understand provider/household linkages, provider performance, costs, quality and effectiveness, links between providers, and government-provider linkages. Health facilities can be used to monitor the distribution and use of public health resources or to evaluate the impact of public health programs. A health facility survey can be used to monitor program performance in the provision of a wide rate of services including those related to family planning, child health, maternal health, and sexually transmitted infections, including HIV/AIDS. Monitoring of health facilities entails collecting and analyzing data routinely on various inputs and outputs of services sites or client caseloads. It may track progress over time in terms of access to and quality of services for specific beneficiaries. Health facility surveys may be particularly useful in special purpose data collection efforts to yield information that might not be available from a routine health information system or from a non-functioning HIS. Indicators that might be derived from a health facility survey include service indicators, service site or facility indicators, staff indicators, client indicators, and staff-client interaction indicators.

Facility surveys may have several different components, including a facility census, a provider interview, a client exit interview, observation of services, and a review of records. Health facility surveys should ideally be conducted every 2-3 years. In the intervals between surveys, some indicators can be tracked using the other monitoring systems (e.g. tracking drug availability using a national logistics system). The 1998 and 2000 health facility surveys focused on the extent to which STIs were being managed according to national guidelines, the availability of trained staff in revised STI syndromic management as well as drug availability. In 2005 another health facility survey was conducted by CSO. This survey was an HIV and AIDS Service Provision Assessment Survey. It is recommended that whatever health facility survey that is conducted, the quality of service provision be assessed through a multiplicity of interviews and record reviews. This will ensure that appropriate indicators are provided for the M&E plan.

b). What NAC Needs From This Data Source

1. % of clients with STIs at health care facilities who are appropriately diagnosed, treated and counselled according to national guidelines
2. % of facilities with observed STI treatment protocols
3. % of health facilities that apply national guidelines for blood screening, storage, distribution & transfusions
4. % of districts with the minimal required blood units in stock and no stock outs of >1 week in the last 12 months?

c). Flow Of Information From This Data Source To NAC



2.2.12. Zambia Sexual Behaviour Survey (ZSBS)

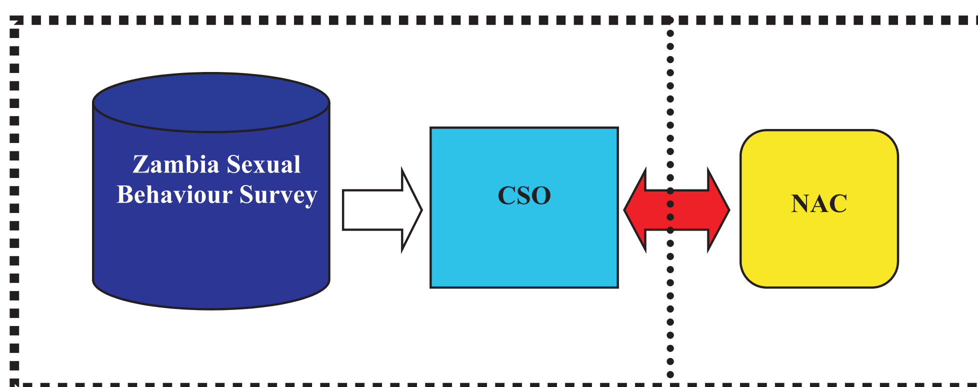
a). Description

The ZSBS is among the surveys that are been carried out in order to monitor the extent to which programmes to prevent HIV are succeeding. The ZSBS 2005 was a fourth in the series of these surveys after the 1998, 2000 and 2003 surveys. The main objective of the survey is to obtain national estimates of the core indicators detailed below e.g. Median age at sexual debut, condom use among sexually active adults, multiple sexual partnering, etc. The next survey is planned for 2007.

b). What NAC Needs From This Data Source

1. % of 15-49 year olds using condoms during the last sexual act with non regular sexual partner
2. % of 15-19 year olds who report being sexually active
3. % of 15-24 year olds who both correctly identify ways of preventing sexual transmission of HIV and reject major misconceptions of HIV transmission
4. % 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
5. % of 15-24 year olds who report being sexually active
6. Median age at first sexual debut
7. % of unmarried respondents who report at least 2 sexual partners
8. % of PLHAs accessing support services
9. % of orphans and other vulnerable children to whom community support is provided
10. Ratio of current school attendance among orphans to that among non-orphans aged 10-14 years
11. % both adult population (15-49) counselled and tested for HIV and received their test results.

c). Flow Of Information From This Data Source To NAC



The Zambia Central Statistics Office (CSO) will continue to implement the Sexual Behaviour Survey according to the current biennial schedule.

2.2.13. Special Studies

It is anticipated that between 2006-2010, various sub-strategies under the national plan will be reviewed by NAC and other cooperating partners. NAC will remain abreast of these studies so as to supplement information disseminated through the national M&E system. Examples of such studies could be:

- Effectiveness of community mobilisation campaigns;
- Cost efficiency and effectiveness of anti-retroviral therapies;

- Deployment of resources and information systems;
- Quality assurance of long-term care for PLWHA;
- Effective mass media approaches to prevention and uptake of counselling and testing.

2.3. TIMEFRAME FOR IMPLEMENTATION OF DATA SOURCES

Table 2.2 shows a summary of the eleven (11) sources of data for the eighty-six (78) indicators (see Table 2.1) that will be used to measure the national HIV/AID response. According to Table 2.2, the first set of surveys are scheduled for the years, 2006, 2008 and 2010. These include the Sentinel Surveillance, Health Facility Survey and HIV/AIDS workplace survey. The second set is for the years, 2005, 2007 and 2009, which include the PMTCT Cohort to be implemented by TDRC, Sexual Behaviour Survey to be implemented by the Central Statistics Office, the Education sector's HIV/AIDS workplace survey implemented by the Ministry of Education, and the National Composite Policy Index Survey to be implemented by a research/consulting firm yet to be identified.

Three additional data sources are scheduled for implementation annually, and these include the Health Management Information System (HMIS), UNAIDS Financial Resource Flow Survey and the Program Activity Reporting System. The HMIS will continue to be managed by MoH/CBoH, while a research or consulting firm will have to be identified for the implementation of the Financial Resource Flow Survey. for the program activity reporting system, the forms will be distributed to all stakeholders implementing HIV/AIDS activities by DATFs at district level, and as noted earlier, collated by PATFs at provincial level for submission to NAC. Discussions are currently underway for possibly identifying a consulting firm that could be facilitating the collation of these forms and preparing a final report to submission to NAC.

Table 2.2: Timeframe for Implementation of Data Source

Data Source	Lead Agency	2006	2007	2008	2009	2010
1. Sentinel Surveillance Survey	MoH					
2. ZHF Survey	CSO					
3. HIV/AIDS W/place Survey	ZBC					
4. Special Studies	TBD					
5. ZSBS Survey	CSO					
6. Education Management Information System (EMIS)	MOE					
7. National Composite Policy Index	UNAIDS					
8. Health Management Information System (HMIS)	MoH					
9. UNAIDS Financial Resource Flow Survey	NAC					
10. Program Activity Reporting System	NAC					
11. ZDHS Survey	CSO					

2.4. INFORMATION PRODUCTS

2.4.1. OVERVIEW

This National M&E operations plan will produce periodic information products, which will be compiled periodically by different stakeholders. The consolidated information products will be used by NAC for decision making and further planning. These are the following information products:

- Quarterly Service Coverage Report (NARF)
- Annual HIV/AIDS M&E Report
- Biennial UNGASS Report
- Periodic Information Systems Updates

*Entails Private Sector, NGOs, CBOs, FBOs, Public facilities report through their respective CATFs-DATFs- PATFs up to National AIDS Council M&E Unit.

In addition to these periodic information products, NAC would also respond to specific and ad hoc information needs of its stakeholders. Each of the periodic information products, and the process for accessing ad hoc information, has been described below:

2.4.2. Quarterly Monthly Service Coverage Report

NAC will produce a Quarterly Service coverage Report. This report will provide information on coverage statistics per HIV programme area, and will be based on the information provided by all stakeholders in the NAC Activity Report Form (NARF). The production of this report will also ensure that NAC meets GFATM requirements in terms of minimum reporting standards, as well as reporting to its other basket donors.

- Purpose of Report

The purpose of this report is to provide a quick overview of service coverage in each quarter to better inform implementers and funders of interventions of where gaps are and how to maximise resource utilisation.

- Data Sources for Report

The main and only data source for this report is the NAC Activity Report Form. Please refer to Section 2.2 and 2.3 of this Operations Plan for details regarding how this data will be collected and captured by NAC.

- Data Analysis

Once NAC has collected and captured the data on a quarterly basis, it will compile a quarterly Service Coverage Report, using standard analysis methodology (descriptive statistics). This statistical analysis will then be handed over in electronic format to NAC's M&E team for dissemination to stakeholders. NAC will disseminate directly to stakeholders (all organisations that submitted data).

It should be noted that for purpose of reporting to GFATM, as part of NAC's grant responsibilities, data for the GFATM grantees will be reported on separately, in addition to the overall data analysis mentioned above.

- Report Format

The format of this report will be based on the structure of the NAC Activity Report Form. A pro forma format has been included in **Appendix 8** of this Operations Plan.

- Report Compilation

This report will be compiled on a quarterly basis, within one month of the end of the quarter.

- Report Dissemination

This quarterly service coverage report will be disseminated to the stakeholders listed below through the following dissemination channels:

Table 1: Data Dissemination for Quarterly Service Coverage Report

STAKEHOLDER GROUPING	DATA DISSEMINATION THROUGH	ILLUSTRATIVE REPORT USES
MOH JAPR	Meeting/Reports	? Determine service coverage and future focus areas
TWGs (NAC)	Meetings/Reports	? Determine service coverage and future focus areas
MESSY	Meetings/Reports	? Information and planning purposes
Cooperating Partners	Meetings/Reports	? Determine service coverage and future focus areas
Partnership Forum	Meetings/Reports	? Use for policy guidance
JAPR Process	Meetings/Reports	? Consensus meetings
Youth Dissemination Channel	Meetings/Reports	? Policy Advocacy
Royal Foundation	Meetings/Reports	? Policy formulation and advocacy
Zambia National Association (ZNA)	Meetings/Reports	? For policy formulation, programme development and resource mobilization

2.4.3. Annual HIV/AIDS M&E Report

- Purpose of Report

The purpose of this report is to provide a comprehensive overview of Zambia's response to HIV/AIDS. This will be done by reporting on all indicators contained in NAC's national HIV/AIDS M&E system, and by providing key observations and guidance for future implementation. This report will be procedurally linked to the GRZ's annual work planning and budgeting process to ensure that issues raised that need adjustments and inclusion in the national budget are reflected where ever possible. This report will ensure effective use of information for decision-making.

- Data Sources for Report

The data sources for this report are all the eleven (11) core data sources mentioned in section 2.2, ?Table 2.1.?, and illustrated in sections 2.2.1? through 2.2.11?. Should new and improved data sources become available, NAC may also wish to supplement this report with additional data sources.

- Data Analysis

Data analysis will be carried out by determining the correct denominator and numerator values for each indicator. To ensure that the report is complete and that there are no gaps, a checklist of information will be developed, based on the contents of Appendix 3 and Table 2.1.?

It should be noted that all indicators should be reported on using “the last 12 months” as a time frame set up. All data should focus on the **last calendar year** (January - December), and this will be the de facto reporting period for the report. This will allow sufficient time for the report information to be used to guide work planning and budget for the following financial year.

- Report Format

The format of this report will be based on the information needs of NAC and its stakeholders. **Appendix 8** contains a pro forma layout of the report. NAC will maintain this standard format to enable trend analyses. It should be noted that this report will reflect performance on ALL NAC indicators, irrespective of whether the indicator scores have changed for that particular year.

- Report Compilation

This report will be compiled on an annual basis by NAC. The person in NAC who will be responsible for this report is the NAC M&E Director, with key support from the other Program Directors. The report will be compiled during January and February each year, and will be ready by 1 March every year. This will be in time for the HIV/AIDS M&E Report Dissemination Seminar in March of the same year.

- Report Dissemination

This annual HIV/AIDS M&E Report will be disseminated to the stakeholders at the annual HIV/AIDS M&E Dissemination Seminar to be held every year. All stakeholders from the public sector, private sector and civil society will be invited to attend. In addition to the national Dissemination Seminar for M&E results, there might be a need to organise provincial/regional dissemination seminars as well to ensure adequate distribution to all districts.

2.4.4. Biennial UNGASS Report

Zambia is a signatory to the 2001 Declaration of Commitment on HIV/AIDS at the United Nations Special Session on HIV/AIDS (UNGASS). Part of this Declaration of Commitment includes a set of indicators that the Government of Zambia has agreed to report on to UNAIDS on a periodic basis. All 17 UNGASS indicators have been included in the log frame for Zambia HIV/AIDS M&E system. This will ensure that the data collection and analysis for the UNGASS indicators form part of the M&E processes within NAC, and that it is not treated as a report “outside the scope of NAC's M&E mandate”. Please refer to Appendix 4 for a list of all UNGASS indicators.

- Purpose of Report

The purpose of this report is to report to the UNAIDS on a periodic basis in terms of Zambia's progress in the fight against HIV/AIDS, by reporting on 17 specific indicators in a manner defined in the *UNAIDS Guidelines for the Construction of Core Indicators.*

- Data Sources for Report

The data sources for the 17 UNGASS indicators is as per the data sources specific in the *UNAIDS Guidelines for the Construction of Core Indicators,* and can be summarised as follows:

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- UNAIDS Survey on Financial Resource Flows
- NCPI Questionnaire Sexual Behavior Survey
- Workplace Survey
- Health Facility Survey
- PMTCT and ARV Programme Monitoring and Estimates (HMIS)
- Demographic and Health Survey/BSS
- HIV sentinel surveillance at antenatal clinics (Sentinel surveillance report)

- Data Analysis

Data analysis will be carried out as per the *UNAIDS Guidelines for the Construction of Core Indicators,* and the datasheets for each of the 17 indicators will be completed, disaggregated as per requirements.

- Report Format

The format of this report will be based on format provided by UNAIDS, and will consist of a statistical overview of the data for each indicator, as well as a narrative description to add quality and texture to the statistical overview. The report format for the UNGASS report can be found in Appendix 9 of this Operations Plan.

- Report Compilation

This report will be compiled on a biennial basis, as per the following schedule:

Table 2: UNGASS Reporting Schedule?

	National commitment & action	**National programme & behaviour**	**Impact**
2005	UNGASS Indicators # 1-2	UNGASS Indicators # 3-14	UNGASS Indicators #15-17
2007	UNGASS Indicators # 1-2	UNGASS Indicators # 3-14	UNGASS Indicators #15-17
2009	UNGASS Indicators # 1-2	UNGASS Indicators # 3-14	UNGASS Indicators #15-17
20011	UNGASS Indicators # 1-2	UNGASS Indicators # 3-14	UNGASS Indicators #15-17

The compilation of the UNGASS report is the responsibility of NAC, with technical support from the in-country UNAIDS office.

- Report Dissemination

This UNGASS report will be disseminated to the stakeholders listed below through the listed dissemination channels:

Table 3: Data Dissemination for UNGASS Report

STAKEHOLDER GROUPING	DATA DISSEMINATION THROUGH	ILLUSTRATIVE REPORT USES
1. MOH JAPR	UNGASS Report	For policy and programme planning/monitoring
2. TWGs (NAC)	UNGASS Report	For policy and programme planning/monitoring
3. MESSY	UNGASS Report	For policy and programme planning/monitoring
4. Cooperating Partners	UNGASS Report	For policy and programme planning/monitoring
5. Partnership Forum	UNGASS Report	For policy and programme planning/monitoring
6. JAPR Process	UNGASS Report	For policy and programme planning/monitoring
7. Youth Dissemination Channel	UNGASS Report	For policy and programme planning/monitoring
8. Royal Foundation	UNGASS Report	For policy and programme planning/monitoring
9. Zambia National Association (ZNA)	UNGASS Report	For policy and programme planning/monitoring

Based on the data dissemination strategy defined for this report, it is envisaged that copies of the report will need to be printed in hard copy format to ensure effective dissemination of data to all stakeholders.

2.4.5. Adhoc Information Updates

All M&E reports produced by NAC (Annual HIV/AIDS M&E report, quarterly Service Coverage Report and the UNGASS report) will be available on NAC's website1 for electronic download (in PDF or MS Word format). This will ensure that NAC stakeholders will be able to access up-to-date information. All HIV indicator data will be updated as and when new data becomes available in the NAC database.

In addition to these specific information products, some stakeholders might have specific information needs at some stage. Although NAC encourages the use of existing information products, it will assist if there are any specific and ad hoc information needs that are not covered in one of the above information products.

Such a request should be made in writing to NAC for their consideration. If possible, the request will be accommodated within the budget limitations of the M&E Unit. If it is not possible, the person/institution will be informed of the cost implications.

Whether or not there are cost implications for NAC to provide the ad hoc information need, NAC will respond in writing to the request for ad hoc information within 5 working days of receiving such a request. The response from NAC will include:

a) an acknowledgement that the request has been received
b) confirmation of whether NAC has the data/skills to provide the information that has been requested
c) if NAC is able to provide the information that is requested, the time frame involved for preparing the information

d) the name of the contact person at NAC who will handle this information request and submit the necessary information

The Provincial AIDS Task Forces (PATF) through the offices of the Provincial AIDS Coordinating Advisors (PACA) will further analyze the process NARF data sets from NAC M&E Directorate to generate province reports. These provincial reports will provide the provincial picture in terms of the national response with respective district information.

This information will be presented at the Development Coordinating Committee meetings while the same information will be share with all the stakeholders in the province and districts.

3. CAPACITY BUILDING IN M&E

Introduction

In recognition of existing gaps in M&E skills and infrastructure, NAC will facilitate the development and strengthening of existing M&E systems at the National, Provincial and District levels to support the realization of the M&E plan. The strategy would include institutional capacity building, strengthening of existing structures and systems, building linkages between ongoing systems, and development of procedures and guidelines for implementation.

Sustainability measures also include technical guidance, close supervision, periodic and continued capacity building through on site mentoring and coaching. Infrastructure development based on assessments and lessons learned during implementation may have to be phased based on resources available. However, a Master Plan for nation-wide roll out is a prerequisite and should be acquired through a thorough assessment survey to identify informatics, logistics and capacity needs.

Institutional capacity building and infrastructure strengthening would be done through:

- Recruitment (subject to availability of funds)
- Infrastructure development
- Training and Development (capacity building trainings to be conducted for District Coordinating Advisors (formerly UNVs) and key M&E staff through PAF and CDC funding)
- Informatics development and support (appropriate to the level of implementation and as identified by a Needs Assessment undertaken)

For human resource, NAC will facilitate pre and in-service training for a cadre of national M&E officers. Additionally, strategic approaches should be used to build the skills of CATFs, DATFs and PATFs in M&E to ensure that they facilitate the coordination and collation of information at the respective levels.

Currently, there is a massive scale-up of activities involving national and cooperating partners to engage in the fight against HIV/AIDS in Zambia. There is increasing need to ramp up effective prevention, care, and treatment programs to a national scale in order to save lives and make progress toward targets set by the Government of the Republic of Zambia (GRZ). Government, and cooperating partners alike, all require regular (quarterly, semi-annual and annual) performance data to substantiate the investment with political bodies. As outside financial support shifts increasingly to direct budget or project support to the government, the demand for M&E will grow steadily from within Zambia as opposed to sole pressures of the past from outside donors. The need to build M&E, data management, and information systems skills is at a peak.

As outlined in previous pages, NAC headquarters requires reliable and valid information to inform the public and government about the success and areas of improvement for HIV/AIDS policies and activities. Information is required from community, district and provincial levels to build the picture of the overall effectiveness of HIV/AIDS activities. These accountabilities must be satisfied. In addition to accountability, data must be used for planning and determining areas of program improvement.

At present, there is an unprecedented opportunity to build human and structural monitoring and evaluation (M&E) capacity in Zambia. This opportunity applies to HIV and AIDS programs and staff and beyond to other sectors such as agriculture and economic development.

From 2006-2010, NAC will launch an ambitious capacity building program that improves reporting and builds M&E and information system skills at the national, provincial, and community levels. While a central aim of this program is indeed to improve reporting, particularly in the use of the NARF, another equal goal is to improve use of M&E approaches and tools to support decision-making and program improvement at these levels. Part of achieving this goal is to better engage key M&E partners such as Ministry of Health, Ministry of Finance, and Central Statistics Office. A final goal is to contribute to professionalizing M&E by promoting sustainable models of training and research within institutions in Zambia, such as the University of Zambia (UNZA), the Zambian Evaluation Association (ZEA), and the Monitoring and Evaluation Support System (MESSY).

National level

NAC must continue to provide leadership with other national entities to proliferate solid M&E practice throughout provinces and districts in Zambia. Additionally, NAC has its own information needs such as tracking key HIV/AIDS-related activities, and facilitating the provision of data to global bodies (e.g. UNAIDS). At present, NARF forms based on the previous National HIV/AIDS Strategic Plan have been distributed throughout the country and at least 2 quarters of data have been compiled and reported. Provincial AIDS Coordinating Advisors (PACAs) and District AIDS Coordinating Advisors (DACAs) have been staffed in the majority of provinces and districts in Zambia. These key advisors help to ensure timely collection of data for the national reporting system. While data is now flowing in to NAC, data quality, use, and feedback for decision-making needs to be strengthened. The next phase, therefore, is an aggressive human and structural capacity development plan and activities.

Centrally, NAC will promote improved performance of M&E among individuals, organizations, and community groups. Factors which relate to performance include:

- Clearly defined performance expectations for M&E among NAC staff, PACAs, DACAs, PATFs and DATFs;
- Regular performance feedback;
- Adequate working environment with appropriate tools, including information systems;
- Motivation and incentive;
- Skills and Knowledge.

A traditional view of training tends to immediately develop programs that deal with the last category (skills and knowledge). However, we know that all of the above categories are related in terms of successful performance of a task to realize effective results. Based on this orientation, key objectives for capcity building from 2006-2010 at the national level are:

- Finalize staffing in the NAC M&E Unit to include a Director;
- Streamline data collection;
- Establish memoranda of understanding (MOU) with data-providers at all levels:
- Incorporate data from private sector workplaces and private sector health providers;
- Clarify and operationlize data flow to include CRIS;
- Launch a national M&E training program to include PACAs, DACAs, and key partners from provincial and district administrations and health offices;
- Launch a national M&E manual and training curriculum that can used to train new M&E staff and re-train as appropriate;
- Establish training and re-training services within Zambia for M&E/IT based as a long-term strategy (UNZA)

Regarding training for NAC staff, the following topics and skills will be of particular emphasis:

- Improved routine data quality verification and validation in collaboration with other key national stakeholders;
- Improved understanding, use, coordination, and harmonization of key data systems in Zambia. Examples include CRIS, Continuity of Care: Patient Tracking System, and HMIS.
- Creation and implementation of operational procedures for reporting, data analysis and use, feedback, and public communications;
- Establishment of MOUs with data providers;
- Identification of new or existing tools for collection and use of private sector and civil society data;
- Strategies and tools to provide M&E supervision to PACAs and DACAs;
- Strategies to support PACAs and DACAs to train on basic and advanced M&E approaches and skills;
- Improving basic and advanced information system support to PACAs, and DACAs;
- Increased ability to support target setting through workshop components developed by TA providers and used in conjunction with currently approved M&E training modules;
- Increased support to DATFs and PATFs to develop local data utilization strategies to enhance the use of current data in local HIV decision-making;

- Enabling support for improving reporting strategies which will facilitate the timely submission of data and the development of mechanisms for the return of data to DATFs and PATFs. So that comparisons can be made between districts and provinces annually (to identify and share best practices) as well as longitudinally.

Several cooperating partners have joined NAC in a joint capacity building plan developed in 2005 to coordinate activities. Cooperating partners at present include USG (CDC & USAID), UNAIDS, SHARe, NASTAD, UNZA. For the period 2006-2010, NAC will continue to establish technical assistance priorities for these partners and recruit additional assistance as needed.

There will be different needs and priorities for capacity building at provincial, district and and community levels.

Provincial level
At provincial level, the following strategies and activities will be implemented:

- Development of a trainer-of-trainer curriculum to assist PACCAs in on-going skills building and training with DACA and DATF members in areas including data collection, analysis, and utilisation of local data in district planning and program implementation.
- Development of reporting strategies which will facilitate the timely submission of data and the development of mechanisms for the return of data to DATFs and PATFs. So that comparisons can be made between districts and provinces annually (to identify and share best practices) as well as longitudinally
- Develop the self assessment tools to improve data utilization at Provincial level
- At this level, the PATFs will collate ALL district forms in their respective provinces and submit them to NAC on a quarterly basis using the PATF reporting form.

District level
At district level, the following strategies and activities will be implemented:

- Data collection tools to be used at district level have been developed by NAC. These tools will be used by the DATFs to collect and report data from the districts. In order to ensure that quality data is submitted all districts will be trained on how to collect and report data using these forms.
- The initial phase of trainings and piloting of these tools in districts have been conducted by NAC, while the other trainings will be done by PATFs.
- Increased DATF target setting skills through workshop components developed by TA providers and used in conjunction with currently approved M&E training modules.
- Develop the self assessment tools to improve data utilization and enhance decision-making at district level.
- The DATF will collect and consolidate the data into a district report and submit this report directly to the PATFs on a monthly basis.

Community level
At community level, the following strategies and activities will be implemented:

- There are three types of communities that have been identified, the CATFs/RDCs, workplace, (which includes the Line Ministries and Private Sector) and special groups, e.g., prisons, sex workers, persons with disabilities, people living with HIV/AIDS, youth and other high risk groups like long distance truck drivers.
- The majority civil society organisations and the Private Sector Organisations are implementing HIV/AIDS programme activities at community level. However, a few of these organisations have well developed M&E systems.
- The NAC activity reporting form (Appendix 7) will be distributed to all of the organisations/groups at community level, as long as they implement some HIV/AIDS/TB/STI activities. Prior to the distribution of the forms, the DATFs will orient all communities where HIV/AIDS/STI/TB activities are implemented on the reporting forms and reporting requirements as prescribed in the M&E plan These groups will also be trained on how to collect, analyse and utilise data using the NARF by the DATFs.
- Given the varied nature of the programme activities which are being undertaken by these organisations and the diversity of their capacities, a simple M&E system will be developed.

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Appendix 1:
Features of a Good M&E System

M&E UNIT	
i)	An established M&E unit within NAC
ii)	A budget for M&E that is about 10% of the national HIV/AIDS/STI budget
iii)	A significant national contribution to the national M&E budget
iv)	A formal (M&E) link with the research institutions
v)	A formal (M&E) link with leading NGOS, donors and CBO
vi)	Behavioural/social science expertise in the M&E unit or affiliated with the unit
vii)	Data processing and statistical expertise in the M&E unit or affiliated with the unit
viii)	Data dissemination expertise in the M&E unit or affiliated with the unit

CLEAR GOALS	
i)	Well-defined national programme goals and targets
ii)	Guidelines and guidance to districts and regions or provinces for M&E
iii)	Clearly defined strategies for utilizing data for planning purposes at the district and province level
iv)	Guidelines for linking M&E to other sectors
v)	Co-ordination of national and donor M&E needs

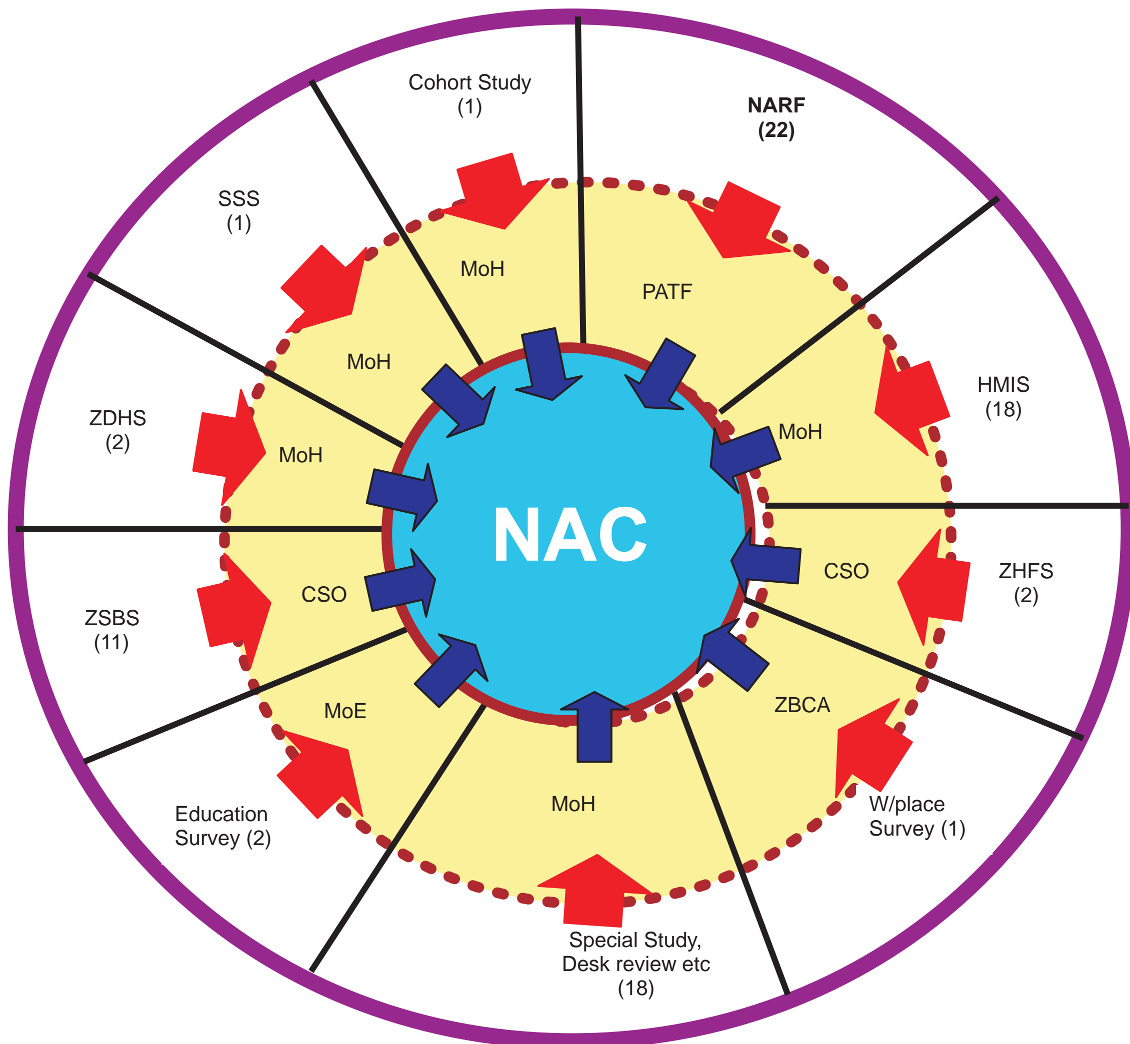
INDICATORS	
i)	A set of priority indicators and additional indicators at different level of M&E
ii)	Indicators that are comparable over time
iii)	A number of key indicators that is comparable with other countries

DATA COLLECTION & ANALYSIS	
i)	An overall national level data collection and analysis plan
ii)	A plan to collect data and analyse indicators at different levels of M&E
iii)	2nd generation surveillance, where behavioural data are linked to HIV/STI surveillance data

DATA DISSEMINATION	
i)	An overall national level data dissemination plan, including the timely return of data and reports to districts and provinces
ii)	A well-disseminated informative annual report of the M&E unit
iii)	Annual meeting to disseminate, discuss M&E and research findings with policy-makers & planners
iv)	A clearinghouse for generation and dissemination of findings
v)	A centralised database or library of all HIV/AIDS/STI-related data, including ongoing research
vi)	Co-ordination of national and donor M&E dissemination needs

Source: Adapted from UNAIDS, UNDP, UNFPA, UNDCP, UNESCO, WHO, World Bank, Measures and Partners (June 2000). National AIDS Programme: A Guide to M&E. Geneva, Switzerland.

Appendix 2:



Appendix 3:
Logical Framework Indicators, Baselines, Targets & Data Sources

Ref No.	INDICATORS	SEX	BASE-LINE	TARGETS			FREQ OF COLLECTION	DATA SOURCE	RESPO ORG
				2005	2007	2009/10			
GOAL: **Reduce HIV/STD transmission among Zambians and reduce the socio-economic impact of HIV/AIDS**									
IMPACT INDICATORS									
PMTCT 1.	% of pregnant women aged 15-19 who are HIV infected[1]		15% ('03)	11%		12%	Biennial	SSS	MoH
HIV Prevalence 2.	% of adults aged 15-49 who are HIV infected		16% ('03)			6. 9%	Every 4 yrs	DHS	CSO
3.	% of infants born to HIV infected mothers who become infected		39% ('03)	31%[4]		20%	Biennial	Cohort Study	TDRC
Estimate of HIV Incidence 4.	% of 15-24 year olds who are HIV positive		8% ('03)			5.8%	Every 4 yrs	DHS	CSO
OUTCOME INDICATORS									
Theme 1: Intensifying Prevention									
Prevent Sexual Transmission of HIV: 5.	% of 15-49 year olds using condoms during the last sexual act with non regular sexual partner	Males	41.6 ('03)	37.5	44.0	50.0	Biennial	SBS	CSO
		Females	34.3 ('03)	28.8	36.0	50.0			
6.	% of 15- 19 year olds who report being sexually active	Male	24.5 (03)	25.3	23.0	22.0	Biennial		CSO
		Female	48.8 ('03)	40.7	34.0	30.0			
7.	% of 15-24 year olds who report being sexually active	Males	33.2 ('03)	34.5	32.0	30.0	Biennial	ZSBS	CSO
		Females	27.7 ('03)	25.4	24.0	22.0			
8.	% of 15-24yr-olds who both correctly identify ways of preventing sexual transmission of HIV & reject major misconceptions of HIV transmission	Males	35.6 ('03)	46.1	70.0	90.0			
		Females	31.3 ('03)	40.5	70.0	90.0	Biennial	ZSBS	CSO
9.	Median age at first sexual debut	Males	16.5 ('03)	18.5					
		Females	16.5 ('03)	18.5			Biennial	ZSBS	CSO
10.	% of schools with teachers who have been trained in life skills education and taught it during the last academic year		60 (05)	70.0	85.0	100	Annual	Ed. Survey	MoE
11.	% of school children aged 10 – 18 who report receiving life skills education in school.[2]	Male					Annual	Ed. Survey	MoE
		Female							
12.	% of unmarried respondents who report at least 2 sexual partners in the past 12 months	Males	7.5 ('03)	7.0	6.8	6.5	Biennial	ZSBS	CSO
		Females	2.4 ('03)	2.7	2.5	2.0			
13.	% of married respondents who report at least 2 sexual non-regular partners in the past 12 months	Male	1.6 (03)	2.0	1.5	1	Biennual	ZSBS	CSO
		Female	0.0 (03)	0.0	0.0	0.0			

[1] Percent of pregnant women aged 15 – 19 who are HIV infected is used as a proxy for measuring incidence of HIV

[2] Proposed indicator to be incorporated into EMIS (NAC to propose to MoE or to be included in Education Survey)

Ref No.	INDICATORS	SEX	BASE-LINE	TARGETS			FREQ OF COLLECTION	DATA SOURCE	RESPO ORG
				2005	2007	2009/10			
	Voluntary Counselling and Testing (VCT)								
14.	% of the adult population aged 15-49 years counselled and tested for HIV and received their HIV test results	Males	8.5 ('03)	7.2	10.0	20.0	Biennial	ZSBS	CSO
		Females	7.9 ('03)	9.2	12.0	25.0			
	Prevent Mother to Child Transmission								
15.	% of HIV+ pregnant women receiving a complete course of ARV prophylaxis to reduce the risk of MTCT		39% ('03)	70%		70.0	Annual	HMIS	CBoH
	STI Treatment								
16.	% of women and men with STIs at health care facilities who are appropriately diagnosed, treated and counselled according to national guidelines.	Males	10 ('05)	10	30	50	Biennial	ZHFS	CSO
		Females	10 ('05)	10	30	50		ZHFS	
17.	% of facilities with observed STI treatment protocols		15 (05)	15.0	35.0	60.0		ZHFS	
	Blood[5] Safety:								
18.	% of health facilities that apply national guidelines for blood screening, storage, distribution & transfusions[5]		80 ('05)	80%		100%	Annual	ZHFS	CSO
19.	% of transfused blood units screened for HIV			100	100	100	Annual	HMIS	MoH
	Theme 2 **Expanding Treatment, Care and Support**								
	Anti-Retroviral Therapy:								
20.	% of persons with advanced HIV infection receiving ARV therapy	Males	25.0 (05')	25%	40%		Annual	HMIS	MoH
		Females	25.0 (05')	25%	40%		Annual	HMIS	MoH
	TB:								
21.	Tuberculosis cure rate under DOTS		65 % (2004)	74%	75%	80%	Annual	HMIS	MoH
22.	Tuberculosis defaulter rate		6% ('02)	5%	4%	3%	Annual	HMIS	MoH
23.	Treatment success rate		79% ('03)	83%	85%	90%	Annual	HMIS	MoH
	Care and Support								
24.	% 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	Male						ZSBS	CSO
		Female							
	Support for Orphans and Vulnerable Children (OVC):								
25.	% of orphans and other vulnerable children under 18 living in households whose house holds have received free of user changes, basic external support in caring for the children	Males					Biennial	ZSBS	CSO
		Female					Biennial	ZSBS	CSO
		Total	13.4	13.4%	25%	50%			
26.	Ratio of current school attendance among orphans to that among non-orphans aged 10-14 years	Males					Biennial	ZSBS	CSO
		Females							

[5]

Ref No.	INDICATORS	SEX	BASE-LINE	TARGETS			FREQ OF COLLECTI ON	DATA SOURCE	RESPO ORG
				2005	2007	2009/10			
Theme 4: Mitigating the Socio-economic impact of HIV/AIDS									
Sectoral Mainstreaming: 27.	% of workplaces and large enterprises/ companies with an HIV/ADS policy and programme		60 (05)	70.0	80.0	90.0	Annual	Workplace Survey	TBD
28.	% of Districts with comprehensive HIV and AIDS costed annual workplans		80% (05)	80%	100%	100%	Annual	NARF	DATF/PATF
Theme 5: Improving the capacity for Monitoring and Evaluation by s all Partners									
Monitoring and Evaluation 29.	% of Districts with M&E system and databases providing information on HIV and AIDS activities		0%		40	60	Annual	NARF	DATF/PATF
Theme 6: Integrating Advocacy, Coordination and Leadership of the Multicultural Response									
Coordination 30.	# of networks/partners involved in the multi-sectoral response							NAC Directory	NAC

Ref No.	INDICATORS	SEX	BASE-LINE	TARGETS							DATA SOURCE	RESPO ORG
				2005	2006	2007	2008	2009	2010	2011		
OUTPUT INDICATORS												
Theme 1 Intensifying Prevention												
Prevent Sexual Transmission 31.	# of IEC materials printed/produced and distributed	Printed/produced									NARF[7]	[8]NGOs/ LM[9]
		distributed										
32.	# of peer educators trained in life skills	Male										
		Female										
33.	# of 15-24 yr olds who receive life skills based HIV/AIDS education (incl. through peer education)	Males									NARF	NGOs/ LM
		Females										
Condom Distribution 34.	# of condom service outlets providing condoms to end users										NARF	NGOs/ LM
35.	# of male & female condoms distributed to end users	Male									NARF	NGOs/ LM
		Female										

[7] NAC Activity Reporting Form
[8] Non government organizations, including community based organizations (CBOs) & faith based organizations (FBOs)
[9] Line Ministries
There were 282 workplaces, 170 were reached and these had workplace programmes/policies. A total of 112 were not reached and therefore they had no workplace policies/programmes (JAPR, 2005)

Ref No.	INDICATORS	SEX	BASE-LINE	TARGETS							DATA SOURCE	RESPO ORG
				2005	2006	2007	2008	2009	2010	2011		
	Voluntary Counselling and Testing (VCT)											
36.	# of clients tested for HIV at VCT receiving their test results	Male									NARF	MoH
		Female										
37.	# of health care facilities providing VCT		400 (05')	400	500	600	700	800	1000	Annual	HMIS	ZVCT
38.	# of professional health care providers trained to provide VCT										NARF	MoH
39.	# of lay/community providers trained to provide VCT services										NARF	MoH
	Prevention of Mother to Children Transmission (PMTCT)											
40.	# of professional care providers trained to provide PMTCT		520 ('04)	500	500	500	500	500	3,500	Annual	HMIS	MoH
41.	# of lay,community providers trained to provide PMTCT			9,000	9,000	9,000	9,000	9,000	9,000	Annual	NARF/HMIS	PATF/MoH
42.	# of facilities providing PMTCT services		256 ('05)	256							NARF/HMIS	PATF/MoH
43.	# of districts with facilities providing PMTCT services		57 (05')	60	65	72	72	72	72	Annual	HMIS	MoH
44.	# of HIV pregnant women receiving a complete course of ARV prophylaxis to reduce the risk of MTCT		21,156 (05)	25,000	30,000	35,000	40,000	45,000	50,000	Annual	HMIS	MoH
45.	# of HIV exposed infants seen in the first 1 month of life for check-up										HMIS	MoH
46.	# of HIV exposed infants receiving co-trimoxazole prophylaxis	Male									HMIS	MoH
		Female										
	STI Treatment:											
47.	% of health facilities with STI drugs in stock and no STI drug stock outs of >2 weeks within last 12 months (by district)										HMIS/ DILSAT NARF	MoH
48.	# of service providers trained in the diagnosis and treatment of STIs according to national guidelines	Male										
		Female										
	Blood Safety											
49.	# of individuals trained in blood safety										HMIS	MoH
50.	# of service outlets carrying out blood safety activities										HMIS	MoH
	Infection Prevention											
51.	# of service providers trained in national standards for infection prevention and health care waste storage and disposal										HMIS	MoH
52.	# of health care facilities conducting infection prevention and health care waste storage and disposal										HMIS	MoH
53.	# of traditional healers trained in infection prevention and use of sharp instruments according to national standards	Male									NARF	THAPZ/ ZNCN
		Female										
	TB Treatment											
54.	% of health facilities with all essential drugs for TB/OI in stock and no stock outs of >2 week in the last 12 months										HMIS	MoH
	Anti-Retroviral Therapy											
55.	# of persons with advanced HIV infection on ART	Male									NARF/HMIS	MoH
		Female										
56.	# of service providers trained to provide ART										NARF/HMIS	MoH

Ref No.	INDICATORS	SEX	BASE-LINE	TARGETS 2005	2006	2007	2008	2009	2010	2011	DATA SOURCE	RESPO ORG
57.	# of community adherence supporters trained to provide ART services										NARF/HMIS	MoH
58.	# of public and private health facilities providing ART services										NARF/HMIS	MoH
59.	% of HCFs providing ART services with no drug stock outs of > 2 weeks in the last 12 months										NARF/HMIS	MoH
Care and Support												
60.	# of service outlets providing HIV related palliative care including TB/HIV										HMIS	MoH
61.	# of individuals provided with HIV-related palliative care including TB/HIV	Male									HMIS	MoH
		Female									HMIS	MoH
62.	# of service providers trained to provide HIV palliative care including TB/HIV	Male									HMIS	MoH
		Female									HMIS	MoH
63.	# of chronically ill people enrolled in community home based care programmes	Male									HMIS	MoH
		Female									HMIS	MoH
64.	# of PLWHA support groups										HMIS	MoH
65.	# of PLWHA enrolled in PLWHA support groups	Male									HMIS	MoH
		Female									HMIS	MoH
Theme 3 Mitigating the Social Impact of HIV and AIDS												
Support to Orphans and Vulnerable Children												
66.	# of orphans and other vulnerable children receiving care and support from CBOs,/NGOs/FBOs/DPOs	Male									NARF	NGOs/ LMs
		Female										
67.	# of street children re-integrated/integrated into homes	Male									NARF	NGOs /LMs
		Female										
68.	of CBOs/NGOs/ FBOs/DPOs receiving funding/technical assistance to provide care and support to OVCs										NARF	LMs
Theme 4 Strengthening the Decentralised Response and Mainstreaming HIV and AIDS												
Sectoral Mainstreaming												
69.	# of workplaces, including line ministries, with developed workplace policies and programmes for HIV/AID										NARF	LMs/ ZBC
70.	# of Line Ministries, FBOs, CBOs, DPOs and NGOs with HIV and AIDS Action Plans										NARF	NGO /LMs
71.	# of line ministries with HIV/AIDS budget line items										NARF	NGO/ LMs
72.	# of line ministries with full-time focal point persons for HIV/AIDS										NARF	NGO/ LMs
73.	# of employees trained to provide HIV behavior change services to fellow employees (incl. peer educators, counselors, etc,) at workplaces	Males									NARF	LMs/ ZBC
		Females										

Ref No.	INDICATORS	SEX	BASE-LINE	TARGETS							DATA SOURCE	RESPO ORG
				2005	2006	2007	2008	2009	2010	2011		
74.	# of employees reached through workplace programmes	Males									NARF	LMs/ ZBC
		Females										
Theme 5												
Improve the capacity for Monitoring and Evaluation for all Partners												
Monitoring and Evaluation (M&E)												
75.	# of organizations with functional M&E systems and linked into the national M&E system at national, provincial and district levels										NARF	NGOs
76.	# of persons trained in M&E at different levels										NARF	NGOs/ LMs
Theme 6												
Integrate Advocacy, Coordination and Leadership of the Multisectoral Response												
National Commitment, Leadership and Coordination												
77.	Amount of public funds spent on HIV/AIDS in the past 12 months										Financial Resource flow survey	UNAIDS
78.	National Composite Policy Index (NCPI) score										NCPI Survey	UNAIDS

Appendix 4:
UNGASS Indicators

Core Indicators for DoC Implementation 2006 reporting

NATIONAL

Indicators	Reporting Schedule	Method of Data Collection
GENERALISED EPIDEMICS		
National Commitment & Action		
Expenditures		
1. Amount of national funds disbursed by governments in low and middle income countries	Ad-hoc based on country request and financing	Survey on financial resource flows
Policy Development and Implementation Status		
2. National Composite Policy Index	Biennial	Desk review and key informant interviews
Areas covered: prevention, care and support, human rights, civil society involvement, and monitoring and evaluation		
Target groups: people living with HIV/AIDS, women, youth, orphans, and most-at-risk populations		
National Programmes: education, workplace policies, STI case management, blood safety, PMTCT coverage, ART coverage, and services for orphans and vulnerable children		
3. % of schools with teachers who have been trained in life-skills based HIV/AIDS education and who taught it during the last academic year	Biennial	School-based survey & education programme review
4. % of large enterprises/companies which have HIV/AIDS workplace policies and programmes	Biennial	Workplace survey
5. % of women and men with STIs at health care facilities who are appropriately diagnosed, treated and counselled	Biennial	Health facility survey
6. % of HIV positive pregnant women receiving a complete course of ARV prophylaxis to reduce the risk of MTCT	Biennial	Programme monitoring & estimates
7. % of women and men with advanced HIV infection receiving antiretroviral combination therapy	Biennial	Programme monitoring & estimates
8. % of orphans and vulnerable children whose households received free basic external support in caring for the child	Biennial	Population-based surveys
9. % of transfused blood units screened for HIV	Biennial	Programme monitoring/special survey
Knowledge, Sexual Behaviour and Orphans' school attendance		
10. ** % of young women and men aged 15-24 who both correctly identify ways of preventing the sexual transmission of HIV and who reject major misconceptions about HIV transmission **(Target: 90% by 2005; 95% by 2010)**	Every 4-5 years	Population-based surveys
11. Female and male median age at first sex		
12. % of young women and men aged 15-24 who have had sex with a non-marital, non-cohabiting sexual partner in the last 12 months		

13. ** % of young women and men aged 15-24 reporting the use of a condom the last time they had sex with a non-marital, non-cohabiting sexual partner		
14. ** Ratio of current school attendance among orphans to that among non-orphans, aged 10-14		
Impact		
15. **% of young women and men aged 15-24 who are HIV infected **(Target: 25% in most affected countries by 2005; 25% reduction globally by 2010)**	Biennial	HIV sentinel surveillance
16. % of adults and children with HIV still alive 12 months after initiation of antiretroviral therapy	Biennial	Programme monitoring
17. % of infants born to HIV infected mothers who are infected **(Target: 20% reduction by 2005; 50% reduction by 2010)**	Biennial	Estimate based on programme coverage
** Millennium Development Goals		

NATIONAL

CONCENTRATED/LOW PREVALENCE EPIDEMICS		
National Commitment & Action		
Expenditures		
1. Amount of national funds disbursed by governments in low and middle income countries	Ad-hoc based on country request and financing	Survey on financial resource flows
Policy Development and Implementation Status		
2. National Composite Policy Index		
Areas covered: prevention, care and support, human rights, civil society involvement, and monitoring and evaluation **Target groups**: Most-at-risk Populations	Biennial	Desk review and key informant interviews
National Programmes: HIV testing and prevention programmes for most-at-risk populations		
3. % (most-at-risk populations) who received HIV testing in the last 12 months and who know the results	Biennial	Programme monitoring/special surveys
4. % (most-at-risk populations) reached by prevention programmes	Biennial	Programme monitoring/special surveys
Knowledge and Behaviour		
5. % of (most-at-risk population(s)) who both correctly identify ways of preventing the sexual transmission of HIV and who reject major misconceptions about HIV transmission	Biennial	Special surveys
6. % of female and male sex workers reporting the use of a condom with their most recent client		
7. % of men reporting the use of a condom the last time they had anal sex with a male partner		
8. % of injecting drug users who have adopted behaviours that reduce transmission of HIV, i.e., who both avoid sharing equipment and use condoms, in the last 12 months (for countries where injecting drug use is an established mode of HIV transmission)		
Impact		
9.% of (most-at-risk population(s)) who are HIV infected	Biennial	HIV sentinel surveillance

GLOBAL

Global Commitment & Action		
1. Amount of bilateral and multilateral financial flows (commitments and disbursements) for the benefit of low and middle income countries	Annual	Survey on financial resource flows
2. Amount of public funds for Research and Development of preventive HIV vaccines and microbicides	Annual	Survey on financial resource flows
3. % of trans-national companies which are present in developing countries and which have HIV/AIDS workplace policies and programmes	Annual	Desk review
4. % of international organizations which have workplace policies and programmes	Annual	Desk review

Appendix 5:

GFATM Indicators

HIV/AIDS components

	Service delivery areas	Coverage indicators (per service delivery area)
Prevention	Information, Education, Communication	# of service deliverers trained
		# of HIV/AIDS radio/television programs/newspapers produced
		# of HIV/AIDS prevention brochures/booklets distributed
		# of peer educators active
	Youth education	# of service deliverers trained
		% of schools with teachers trained in life-skills based HVI/AIDS education
		# of young people exposed to HIV/AIDS education in school settings
		# of young people exposed to HIV/AIDS education out of school
	Condom distribution	# of service deliverers trained
		#/% of retail outlets and service delivery points with condoms in stock
		# of condoms sold through public sector
		# of condoms sold through private outlets
	Programs for specific groups	# of service deliverers trained
		#/percentage of sex workers & clients exposed to outreach programs
		#/percentage of men who have sex with men exposed to outreach programs
		#/percentage of mobile populations exposed to outreach programs
		#/% of injecting drug users reached by prevention services (use impact for % needle sharing)
		#/% of large companies with HIV/AIDS workplace policies and programs
	Voluntary counseling and testing	# of service deliverers trained
		#/% of districts with VCT services
		#/% of people receiving VCT
	Prevention of mother-to-child transmission of HIV (PMTCT)	# of service deliverers trained
		#/% of health facilities offering minimum package of PMTCT
		#/% of HIV-infected pregnant women receiving a complete course of antiretroviral prophylaxis to reduce the risk of MTCT
	Sexually transmitted infection diagnosis and treatment	# of service deliverers trained
		#/% of patients with STI comprehensive case management
	Post-exposure prophylaxis	# of service deliverers trained
		# of people who receive post-exposure prophylaxis
	Blood safety, universal precautions	# of service deliverers trained
		% of transfused blood units screened for HIV
		% of districts with access to donor recruitment and blood transfusion
Careandsupport	Palliative care	# of service deliverers trained
		#/% of health facilities with capacity to deliver basic level counseling and medical services for HIV/AIDS
	Support for orphans	# of service deliverers trained
		#/% of orphans and vulnerable children less than 18 years whose households received free basic external support in caring for the child
	Treatment for opportunistic infections	# of service deliverers trained
		# of people on treatment for opportunistic infection
		# of people on cotrimoxazole preventive therapy
	Prophylaxis for opportunistic infections	# of service deliverers trained
		Health facilities capable of providing advanced interventions for prevention and medical treatment for HIV infected persons
	HIV/TB	# of service deliverers trained
		Intensified TB case finding among people living with HIV/AIDS
		#s/% given counseling and voluntary testing
		#s/% on cotrimoxazole preventive therapy
		#s/% provided with antiretroviral therapy
Treatment	Antiretroviral treatment and monitoring	# of service deliverers trained
		#/% of people with advanced HIV infection receiving antiretroviral combination therapy
Supportive environment andcross-cuttingaspects	Strengthening of civil society services	# of organizations reached
		% total HIV/AIDS services delivered by civil society
	Stigma	# of service deliverers trained
		# of support groups of people living with HIV/AIDS fighting against discrimination
	Health systems strengthening	# of staff trained
		% of budget spent on health infrastructure
		% of patients who are accurately referred

	Service delivery areas	Coverage indicators (per service delivery area)
	Coordination and partnership development (national, community, public-private)	# of networks/partnerships involved
	Monitoring, evaluation, and operational research	# of service deliverers trained
		% of budget spent on monitoring and evaluation
	Procurement and supply management capacity building	# of service deliverers trained
		% of service delivery points with sufficient drug supplies
		% reduction in unit cost(s) of drug(s) and commodities

Tuberculosis components

	Service delivery areas	Coverage indicators (per service delivery area)
Prevention	Identification of infectious cases	# of service deliverers trained
		% of all estimated new smear positive TB cases detected under DOTS
	Prevention of transmission by treating infectious cases	# of service deliverers trained
		% of new smear-positive cases registered under DOTS who smear-convert at 2 months of treatment
	Prevention of TB in children	# of service deliverers trained
		# of children who have been vaccinated with BCG
		% of children who have been vaccinated with BCG
	Prevention of TB among PLWHA	# of service deliverers trained
		# of individuals dually infected with TB and HIV who receive isoniazid preventive therapy
		% of individuals dually infected with TB and HIV who receive isoniazid preventive therapy
Care &	Supporting patients through direct observation of treatment	# of service deliverers trained
		% of patients cared for with DOTS during intensive phase
Treatment	Timely detection and quality treatment of cases	# of service deliverers trained
		# and % of the population covered by DOTS
		# and % of treatment facilities implementing DOTS
		% of smear-positive TB cases registered under DOTS successfully treated
	Control of drug resistance	# of service deliverers trained
		% of new smear-positive cases registered under DOTS who default or transfer out of treatment
	Systematic monitoring of performance in case management	# of service deliverers trained
		# of sites with fully functional recording and reporting system
		% of treatment facilities submitting accurate, timely and complete reports
Supportiveenvironment andcross-cuttingaspects	Health systems strengthening	# of staff trained
		% of health facilities & laboratories involved in DOTS with capacity for DOTS
		% of budget spent on health infrastructure
		% of patients who are accurately referred
	Coordination & partnership dev (national, community, public-private)	# of networks/partnerships involved
	Monitoring, evaluation and operations research	# of service deliverers trained
		% of budget spent on monitoring and evaluation
	Procurement and supply management capacity building	# of service deliverers trained
		% of health facilities involved in DOTS with sufficient drug supplies
		% reduction in unit cost(s) of drug(s) and commodities

Malaria components

	Service delivery areas	Coverage indicators (per service delivery area)
Prevention	Insecticide-treated nets (ITNs)	# of service deliverers trained
		# of mosquito nets, long-lasting mosquito nets, pretreated nets or retreatment kits distributed
		# of Sentinel sites established for monitoring insecticide resistance
		Households owning an insecticide-treated net
		Children under 5 using an insecticide-treated net
	Malaria in pregnancy	# of service deliverers trained
		# of mosquito nets, long-lasting mosquito nets, pretreated nets or retreatment kits distributed
		# of pregnant women receiving correct intermittent presumptive treatment
		Pregnant women using insecticide treated nets
		Pregnant women receiving intermittent presumptive chemoprophylaxis
	Prediction and containment of epidemics	# of service deliverers trained
		Proportion of epidemics detected within two weeks of onset and properly controlled
	Indoor Residual Spraying	# of service deliverers trained
		# of homes and areas sprayed with insecticide

	Service delivery areas	Coverage indicators (per service delivery area)
	Information, education & communication (IEC)	# of service deliverers trained
		#s of targeted areas with IEC services
Treatment	Prompt effective antimalarial treatment	# of service deliverers trained
		# of patients with uncomplicated and severe malaria receiving correct diagnosis and treatment
		# of Health facilities with no reported stock outs of antimalarial drugs
		Children under 5 years of age with access to prompt effective treatment
		Patients with severe malaria receiving correct treatment
		Health facilities with no reported stock outs of antimalarial drugs
	Monitoring of drug resistance	# of service deliverers trained
		# of sentinel sites established for monitoring antimalarial drug resistance
	Home based management of malaria	# of service deliverers trained
		# of caretakers recognizing signs and symptoms of malaria
		Health care seeking behavior and use of appropriate antimalarials
		# of caretakers recognizing signs and symptoms of malaria
Supportenvironmentand cross-cuttingaspects	Health systems strengthening	# of staff trained
		% of budget spent on health infrastructure
		% of patients who are accurately referred
	Coordination and partnership development (national, community, public-private)	# of networks/partnerships involved
	Monitoring, evaluation and operations research	# of service deliverers trained
		% of budget spent on monitoring and evaluation
	Procurement and supply management capacity building	# of service deliverers trained
		% of service delivery points with sufficient drug supplies
		% reduction in unit cost(s) of drug(s) and commodities

HIV/TB components

	Service delivery areas	Coverage indicators (per service delivery area)
Prevention	TB prophylaxis for people living with HIV/AIDS	# of service deliverers trained
		Health facilities capable of providing basic interventions for prevention and medical treatment for people living with HIV/AIDS
		# of people living with HIV/AIDS on TB prophylaxis
Care and support	Cotrimoxazole preventive therapy during TB treatment	# of service deliverers trained
		Intensified TB case finding (among people living with HIV/AIDS)
		#/% of people on TB treatment accessing voluntary counseling and testing
		# on cotrimoxazole preventive therapy
Treatment	Antiretroviral treatment and monitoring	# of service deliverers trained
		#/% of people with advanced HIV infection receiving antiretroviral combination therapy
Supportiveenvironment andcross-cuttingaspects	Health systems strengthening	# of staff trained
		% of budget spent on health infrastructure
		% of patients who are accurately referred
	Coordination and partnership development (national, community, public-private)	# of networks/partnerships involved
	Monitoring, evaluation and operations research	# of service deliverers trained
		% of budget spent on monitoring and evaluation
	Procurement and supply management capacity building	# of service deliverers trained
		% of service delivery points with sufficient drug supplies
		% reduction in unit cost(s) of drug(s) and commodities

Integrated components

	Service delivery areas	Coverage indicators (per service delivery area)
Supportiveenvironmentand cross-cuttingaspects	Health systems strengthening	# of staff trained
		% of budget spent on health infrastructure
		% of patients who are accurately referred
	Coordination and partnership development (national, community, public-private)	# of networks/partnerships involved
	Monitoring, evaluation and operations research	# of service deliverers trained
		% of budget spent on monitoring and evaluation
	Procurement and supply management capacity building	# of service deliverers trained
		% of service delivery points with sufficient drug supplies
		% reduction in unit cost(s) of drug(s) and commodities

Appendix 6: Additional Indicators

IMPACT ASSESSMENT

Additional Impact Indicators
- HIV prevalence among all adults
- Syphilis prevalence among all adults
- HIV prevalence among populations at higher risk of HIV infection

OUTCOMES ASSESSMENT

Additional Behavioural Outcome Indicators
- # of sexual partners among adults aged 15-49
- % of young single people (aged 15-24) who had sex in the last 12 months
- % of young people (aged 15-24) who had sex with more than one partner in the last 12 months
- % of young single people (aged 15-24) who used a condom at last sex
- % of women aged 15-19 who non-marital sex with a man 10 years or older than them in the last 12 months
- % of men reporting sex with a sex worker in the last 12 months
- % of men reporting condom use the last time they had sex with a sex worker
- % of sex workers who report using a condom with their most recent client
- % of people aged 15-49 surveyed who have ever voluntarily requested an HIV test, received the test, and received their results (also last 12 months)

Additional Knowledge and Attitudinal Outcome Indicators
- % of respondents who believe that if a woman's husband has an STI, she can either refuse to have sex with him or propose condom use
- % of women and men who correctly respond to prompted questions about preventing maternal to child transmission of HIV through anti-retroviral therapy and avoiding breastfeeding
- % of people who refuse casual contact with PLWHA
- % of people who judge or blame PLWHA for their illness
- % of people who would feel shame if associated with PLWHA
- % of people who fear disclosing HIV status because of negative reaction
- % of people who support discrimination towards PLWHAs

MONITORING PROGRAMMES

HIV Prevention

Information, Education, and Communication (IEC)
Additional Output Indicators
- # of media HIV/AIDS radio/television programs produced and number of hours aired
- # of HIV/AIDS brochures/booklets produced and number of copies distributed
- # of staff and volunteers trained in HIV prevention and life skills
- # of HIV prevention meetings held and men/women reached
- % of young people exposed to HIV/AIDS training
- % of people in general population exposed to HIV/AIDS media campaign
- % of people from high-risk groups exposed to peer education/outreach programs

Prevention of Mother-to-Child Transmission (PMTCT)
Additional Output Indicators
- % of districts with active PMTCT programmes in accordance with national guidelines

Health facilities
- # of health facility sites providing at least the minimum package of prevention of mother to child transmission (PMTCT) services in the past 12 months
- # and % of health facilities with adequate capacity to monitor PMTCT
- # and % of PMTCT sites with appropriate referral linkages to comprehensive care and support services for people with HIV
- # of maternity facilities with appropriate referrals at the institutional level to link HIV positive women and their infants to care and support services
- # of condoms distributed in antenatal clinics
- # of facilities that offer appropriate infant feeding counseling (according to WHO or national standards) during post-test counseling at PMTCT sites

Women

- # and % of women who attend antenatal clinics with PMTCT services for a new pregnancy in the past 12 months
- # and % of women with known HIV infection among those seen at at antenatal clinics which offer PMTCT services in the past 12 months
- % of women who were counseled during antenatal care for their most recent pregnancy accepted an offer of testing and received their test results, of all women who were pregnant at any time in the 2 years preceding the survey
- % of clients at public antenatal clinics that attend clinics offering counseling and voluntary testing for HIV by trained staff, or referring to VCT services
- % of post-test counseling sessions for women attending antenatal clinics offering counseling and voluntary HIV testing that meet international standards for quality counseling, including referral for care where necessary
- % of HIV-infected pregnant women receiving a complete course of antiretroviral therapy to reduce the risk of MTCT (according to national/international guidelines)
- # and % of women who receive FP counseling during post-test counseling at PMTCT sites
- # and % of women who receive infant feeding during post-test counseling at PMTCT sites

Health personnel

- # and % of practicing skilled health personnel in obstetric setting with updated training in current standards of obstetric care that protect against maternal to child transmission
- # and % of practicing skilled health personnel in antenatal care setting with training in PMTCT services
- # and % of practicing skilled health personnel in antenatal care settings with training in PMTCT services (trained within the last 24 months)

Infants

- % of infants < 6 months who are exclusively breastfed among breastfeeding mothers
- # of infants born to HIV positive mothers who receive cotrimoxazole prophylaxis for the first year of life
- # of antenatal clinics providing HIV prevention programs to pregnant women (including partner communication strategies, education on HIV prevention during pregnancy through monogamy or condom use)
- # of antenatal clinics providing family planning counseling services during post-test counseling at PMTCT sites

VCT Cascade

- # of pregnant women who attend at least one ANC visit
- # of pregnant women who attend at least one ANC visit at an MTCT site
- # of pregnant women who receive counseling for HIV testing
- # of pregnant women accepting testing for HIV
- # of women receiving post-test HIV results
- # of pregnant women who receive positive HIV test results

Sexually Transmitted Infections (STIs) Treatment and Prevention

Additional Output Indicators

- % of patients with STIs at selected health care facilities who are appropriately diagnosed and treated (and counseled) according to national guidelines, of all STI patients at those centers
- % of patients with STIs who are given advice on condom use and partner notification and who are referred for HIV testing
- % of clients served by health facilities providing STI care that have a current supply of essential STI drugs and report no stock outs lasting longer than one week in the preceding 12 months
- % of men and women reporting symptoms of STIs in the last 12 months who sought care at a service provider with personnel trained in STI care, of all Rs in a pop'n-based or targeted survey aged 15-49
- % of health facilities with uninterrupted stock of drugs to treat STIs
- % of health facilities with staff trained to treat STIs
- Number and percent of health facilities providing STI care with both trained staff and uninterrupted supply of drugs

Safe Blood Supply and Universal Precautions

Additional Output Indicators

- % of districts or regions with access to blood transfusion services which do not pay blood donors, and do not recruit donors from among relatives of the patient
- % of health care facilities that have guidelines to prevent nosocomial transmission of HIV, adequate sterilization procedures, and surgical gloves in stock

Voluntary Counselling and Testing (VCT)

Additional Output Indicators

- # of health facilities with HIV testing that includes informed consent and respect for confidentiality
- % of districts that have at least one center staffed by trained counselors providing specialized HIV counseling and testing services free or at affordable rates
- % of post HIV test counseling sessions at VCT facilities that meet international standard for quality counseling
- % of clients served by VCT services that meet minimum conditions necessary to provide quality counseling and HIV testing services
- # of individuals (by gender) receiving VCT in the past 12 months
- % of HIV tests requested by VCT centers in a month period which followed recommended testing algorithms

HIV/AIDS Care and Support

Clinical Care
Additional Output Indicators

Training
- # of persons trained to monitor and evaluate HIV/AIDS care and support programs at the district level in the past 12 months *(program reports)*
- # of staff trained in HIV diagnosis, care, support, treatment
- Existence of medical and allied health training institutions providing training on HIV diagnosis, care, support and treatment, and number of graduates of these institutions in the past 12 months receiving this training *(interviews/record review)*
- % of graduates of medical school, nursing school, and continuing medical education facilities in the last 24 months trained in the natural history of HIV and in diagnosis and care of common opportunist infections

Strategy
- Existence of comprehensive HIV/AIDS care and support policies, strategies, and guidelines in line with current WHO or international standards *(interviews/record review)*
- Existence of national M&E capacity for HIV/AIDS care and support programs
  MOHP HIV/AIDS mainstreaming workplan and core team in place

Health facilities
- % of health facilities, including VCT and PMTCT sites, with referral linkages to comprehensive care and support services for people with HIV.
- % of health facilities that provide antiretrovirals that meet minimum WHO requirements for the provision of these
- % of laboratories with the capacity to monitor ARV therapy according to national/international guidelines
- % of health facilities with adequate capacity to monitor HIV/AIDS care and support services
- % of health care facilities at different levels of the health care system that have the capacity to delivery appropriate palliative care, treatment for OIs and referral for HIV-infected patients, according to national guidelines
- % of health care facilities that are currently stocked with nationally approved drugs to treat common opportunistic infections and to provide palliative care, and report no stock-outs in the past 12 months
- # and % of hospitals and major health clinics with waste management capacity in use

Patients
- % of persons who have been ill for 3 or more months during the past 12 months that received external medical, psychological, or social support.
- % of HIV patient records with antiretroviral prescriptions in line with national/international guidelines
- % of people discontinuing antiretroviral therapy
- % of people with advanced HIV infection receiving antiretroviral combination therapy
- # of PLWHA cared for by health facilities in the past 12 months (admitted/number of days)
- % of HIV-infected individuals with OIs treated according to standard guidelines
- # and % of districts implementing TB and HIV/AIDS treatment

Community and Home-based Care and Support
Additional Output Indicators
- % of district with community-based care for PLWHAs
- # of individuals reached by community and home-based care programs in the past 12 months
- # of PLWHA support groups and number of men/women enrolled
- # of community AIDS care projects and number of men/women enrolled
- # of staff and volunteers trained in HIV/AIDS care and support

Support of Orphans and Other Vulnerable Children
Additional Output Indicators
- # and percentage of districts with functional social welfare departments providing grants to OVC
- # of OVC receiving/benefiting from improved access to education
- # of OVC receiving/benefiting from improved health care
- # of OVC receiving/benefiting from psychosocial support
- # of OVC receiving/benefiting from protection activities
- # of OVC receiving/benefiting from sustainable nutritional/agricultural assistance
- # of OVC receiving/benefiting from food aid
- # of OVC receiving/benefiting from assistance to become more economically self-supporting
- # of OVC in households receiving/benefiting from assistance to become more economically self-supporting
- # of OVC receiving/benefiting from assistance to improve their housing/shelter situation

Resource Commitment and Coordination
Additional Indicators

Funding
- Funds allocated in national accounts for spending on HIV prevention and care programmes, per adults aged 15-49
- Level of financial resources commitments to HIV/AIDS activities (by funding source & intended use)
- Funds allocated to civil society/private sector for national response
- % of national budget allocated to HIV activities
- % of annual government expenditures on HIV/AIDS activities

Institutional
- NAC board and staff appointed and functional
- NAC workplans and budgets developed
- NAC financial, procurement, implementation, technical support and M&E systems established
- NAC fund disbursement ratios

Grants System and partnerships
- % of CBO-submitted subprojects of all CSO funding
- # of PLWHA-association-submitted projects and % of all CSO funding
- % of subgrantees submitting acceptable accounting and expenditure reports
- % of subprojects implemented effectively and meeting stated objectives
- # of public-private partnerships undertaking outreach activities with members, supported by NAC

Districts
- # of districts with institutionalized HIV/AIDS coordinating committees within new district assembly decentralized framework
- # and % of districts with HIV/AIDS workplans and budgets approved and funded
- # of districts implementing HIV/AIDS work plans

Multisectoral Response, Policy, and Mainstreaming

Additional Output Indicators

Policy
- Existence of comprehensive HIV/AIDS care and support policies, strategies, and guidelines in line with current WHO or international standards

Employers (all sectors)
- % of formal sector employers sampled with non-discriminatory policies and non-discriminatory practices in recruitment, advancements, and benefits for employees with HIV
- # or % of facilities enforcing policies guaranteeing access/rights to PLWHAs
- # or % of facilities enforcing policies guaranteeing access/rights to PLWHAs

Employees
- % of people in facilities who are aware of policies guaranteeing access/rights to PLWHAs
- % of people in facilities willing to report discrimination again PLWHAs
- % of formal sector employers sampled with non-discriminatory policies and non-discriminatory practices in recruitment, advancements, and benefits for employees with HIV
- % of people in facilities who are aware of policies guaranteeing access/rights to PLWHAs
- % of people in facilities willing to report discrimination again PLWHAs

Public Sector Services
- # and % of line ministries with HIV/AIDS workplans and budgets for employees
- # and % of health facilities providing HIV/AIDS care appropriate for level of facility
- # and % of primary/secondary/tertiary education institutions with HIV/AIDS program for their students
- # and % of districts with functional social welfare departments providing grants to OVC
- Total HIV/AIDS services delivered by public sector
- Budget line item for HIV/AIDS programs per ministry
- # and % of ministries with staff trained as HIV prevention peer educators, and with active peer educators
- % of line ministries that have incorporated HIV/AIDS prevention activities into their annual work plans and budget
- Enactment by of civil service workplace policies which set standard for HIV/AIDS employee awareness and antidiscrimination mainstreaming programs

Civil Society Services
- # of civil society organizations receiving NAC funding
- % of overall funding granted to civil society services
- # of new civil society partners introduced to HIV/AIDS programming with NAC support

- Total HIV/AIDS services delivered by civil society
- Development, integration and implementation of multisectoral national strategic plan (UNGASS)
- # of sectors with an HIV/AIDS impact assessment completed and disseminated to stakeholders

Democracy & Governance
- # of CBOs/NGOs including protection of human rights of persons living with HIV/AIDS in their mandate
- National laws protecting human rights of persons living with HIV/AIDS enacted and/or disseminated
- # of human rights violations filed for discrimination because of HIV
- Laws enacted/enforced to protect the rights of women and orphans to own and inherit property, including land
- # of widows/orphans in selected communities who have retained land ownership

Education
- Ministry of Education strategic plan and operational matrix for integrating HIV/AIDS in Ministry of Education completed and disseminated to stakeholders
- # of activities in operational matrix supported by Mission (through technical assistance or direct funding)
- # and % of working teachers and teacher trainees aware of professional policies on codes of conduct
- # and % of major teacher training institutions providing HIV/AIDS prevention and skills building training to protect teacher trainees
- # and % of major teacher training institutions preparing teacher trainees to teach family skills course
- # of communities/school districts in selected areas starting innovative approaches to teach a basic educational curriculum to out of school youth
- # of orphans and vulnerable children benefiting from improved access to education

Health
- Effective health information system set up/updated (by Ministry of Health) for reporting on HIV/AIDS and other priority health needs (e.g., prevalence, financing, human resources, utilization expenditures)
- Formal assessment of commodities needed for projected HIV/AIDS caseload developed for stakeholders
- Policies to increase access of persons living with HIV/AIDS to health care services implemented
- Policies to increase access of population to prevention and VCT services implemented

Economic Growth / Microenterprise
- Sectoral assessment of HIV/AIDS impact on trade completed by Ministry of Trade and disseminated to stakeholders
- Up to five new microenterprise or micro-finance interventions for populations affected by HIV/AIDS implemented per year
- At least one new microenterprise or microfinance intervention for populations affected by HIV/AIDS implemented per year
- % of microfinance partners funded by USAID providing any HIV prevention education to clients or employees directly or through linkages

Agriculture and Natural Resource Management
- Stocktaking/assessment of HIV/AIDS on agriculture sector completed
- Mission strategy to respond to HIV/AIDS impact on agricultural sector completed
- Assessment of HIV/AIDS impact on USAID-funded projects conducted and disseminated to stakeholders
- National laws/policies/regulations protecting widows right to own/inherit property enacted/or enforced
- HIV/AIDS and agriculture training conducted for the strategic objective team
- % of agriculture strategic objective partners including HIV prevention education, directly or through linkage with health organizations, to clients and staff
- Laws/policies/regulations protecting widows' rights to own/inherit land/property enacted and/or enforced

Human Capacity Development
- # and % of medical and paramedical training institutions providing training in HIV diagnosis, care, support. and treatment
- # of HIV/AIDS education and training courses with associated training materials developed, tested, and available according to
- local and national standards.
- # of persons trained in HIV/AIDS diagnosis, care, support, and treatment in the past 12 months
- # of persons delivering HIV/AIDS interventions and services for which they were specifically trained in formal courses
- # of service delivery personnel who have left their HIV/AIDS service delivery responsibilities in the past 12 months in the public sector

M&E
Additional Indicators

- % of NAC budget allocated to M&E
- # of persons trained for M&E of HIV/AIDS care and support at the district level in past 12 months
- Existence of national M&E capacity for HIV/AIDS care and support programs
- % of health facilities with adequate capacity to monitor PMTCT
- % of health facilities with adequate capacity to monitor HIV/AIDS care and support
- Joint semi-annual review regularly and with adequate documentation
- Trends in epidemic and behavior patterns tracked and disseminated to practitioners
- National response tracked and good practices disseminated

- Hold annual "Best Practices" conference
- Number of items on Checklist of Features of a good M&E System that have been achieved.

Research

- Occurrence of annual NAC-coordinated research dissemination conference
- # of abstracts submitted, and # accepted for annual NAC-coordinated research dissemination conference
- Development of functioning, accessible data base at NAC that registers HIV-related research in the country
- # of research proposals submitted to the NAC and # funded through the NAC

APPENDIX 7
NAC Activity Reporting Forms

a). CATF/CBOs/Line Ministries/Private Sector
b). DATF
c). PATF
d). MoH/CBoH

Appendix 7(a)

NARF for CATF/CBOs/LM/PS

1. REPORT DETAILS

Report date:		
Quarter reporting on	From: to:	
Province		
District		
Report Compiled by		
For more information / questions about the report, contact:	**Name:**	
	Tel number: **Fax:**	
	Email:	

2. ACTIVITIES

Themes and Indicators		Previous	New	Cumulative
INTENSIFYING PREVENTION OF HIV **Prevent Sexual Transmission**				
1. # of IEC materials distributed (brochures/t-shirts/posters/books):	printed			
	distributed			
2. # of 15-24 year olds who receive life skills based HIV/AIDS education (incl. through peer education)	Male			
	Female			
3. # of condom service outlets providing condoms to end users				
4. # of male and female condom pieces distributed (from non-health facilities).	Male			
	Female			
Infection Prevention				
5. # of traditional healers trained in infection prevention and use of sharp instruments according to national standards	Male			
	Female			
STRENGTHENING THE DECENTRALISED RESPONSE & MAINSTREAMING HIV AND AIDS **Sectoral Mainstreaming**				
6. # of FBOs, CBOs, DPOs and NGOs				
7. # of FBOs,CBOs, DPOs and NGOs with HIV/AIDS Action Plans				
8. # of FBOs, CBOs, DPOs and NGOs with full-time focal point persons for HIV/AIDS				
9. # of employees trained to provide HIV behaviour change services to fellow employees (incl. peer educators, counsellors, etc)	Male			
	Female			
10. # of employees reached through workplace programmes	Male			
	Female			

		Previous	New	Cumulative
EXPANDING TREATMENT, CARE AND SUPPORT **Care and Support**				
11. # of service outlets providing HIV related palliative care including TB/HIV				
12. # of individuals provided with HIV-related palliative care including TB/HIV	Males			
	Females			
13. # of individuals trained to provide HIV palliative care including TB/HIV	Males			
	Females			
14. # of chronically ill people enrolled in CHBC programs	Male			
	Female			
15. # of PLWHA enrolled in PLWHA support groups	Male			
	Female			
16. # of PLWHAs support groups				
MITIGATING THE SOCIO-ECONOMIC IMPACT OF HIV /AIDS **Support for Orphans and Vulnerable Children**				
17. # of Orphans and Vulnerable Children (OVCs) receiving care and support from CBOs,/NGOs/FBOs/DPOs	Male			
	Female			
18. # of street children re-integrated/integrated into homes	Male			
	Female			

19. # of CBOs/NGOs/ FBOs/DPOs receiving funding/technical assistance to provide care and support to OVCs				
IMPROVING THE CAPACITY FOR MONITORING AND EVALUATION BY ALL PARTNERS Monitoring and Evaluation				
20. # of organisation with functional M&E systems and linked into the national M&E system at national, provincial and district levels				
21. # of institutions/organisation with full-time M&E persons				

I verify that this information is complete and correct and that I have not misrepresented any information in this report

Signed: ____________________________________

Designation: ____________________________________

Date: _____________________________________

Appendix 7 (b)

NARF for DATF

1 REPORT DETAILS

Report date:			
Quarter reporting on	From:	to:	
Province			
District			
Report Compiled by			
For more information / questions about the report, contact:	Name:		
	Tel number:	Fax:	
	Email:		

2 ACTIVITIES

Themes and Indicators		Previous	New	Cumulative
INTENSIFYING PREVENTION OF HIV **Prevent Sexual Transmission**				
1. # of IEC materials distributed (brochures/t-shirts/posters/books):	# printed			
	# distributed			
2. # of 15-24 year olds who receive life skills based HIV/AIDS education (incl. through peer education)	Male			
	Female			
3. # of condom service outlets providing condoms to end users				
4. # of male and female condom pieces distributed (from non-health facilities).	Male			
	Female			
Infection Prevention				
5. # of traditional healers trained in infection prevention and use of sharp instruments according to national standards	Male			
	Female			
STRENGTHENING THE DECENTRALISED RESPONSE & MAINSTREAMING HIV AND AIDS **Sectoral Mainstreaming**				
6. # of FBO, CBOs, DPOs and NGOs				
7. # of FBOs,CBOs, DPOs and NGOs with HIV/AIDS Action Plans				
8. # of FBOs, CBOs, DPOs and NGOs with full-time focal point persons for HIV/AIDS				
9. # of employees trained to provide HIV behaviour change services to fellow employees (incl. peer educators, counsellors, etc)	Male			
	Female			
10. # of employees reached through workplace programmes	Male			
	Female			

		Previous	New	Cummulative
EXPANDING TREATMENT, CARE AND SUPPORT **Care and Support**				
11. # of service outlets providing HIV related palliative care including TB/HIV				
12. # of individuals provided with HIV-related palliative care including TB/HIV	Males			
	Females			
13. # of individuals trained to provide HIV palliative care including TB/HIV	Males			
	Females			
14. # of chronically ill people enrolled in CHBC programs	Male			
	Female			
15. # of PLWHA enrolled in PLWHA support groups	Male			
	Female			
16. # of PLWHAs support groups				
MITIGATING THE SOCIO-ECONOMIC IMPACT OF HIV /AIDS **Support for Orphans and Vulnerable Children**				
17. # of Orphans and Vulnerable Children (OVCs) receiving care and support from CBOs,/NGOs/FBOs/DPOs	Male			
	Female			
18. # of street children re-integrated/integrated into homes	Male			
	Female			

19. # of CBOs/NGOs/ FBOs/DPOs receiving funding/technical assistance to provide care and support to OVCs				
IMPROVING THE CAPACITY FOR MONITORING AND EVALUATION BY ALL PARTNERS Monitoring and Evaluation				
20. # of organisation with functional M&E systems and linked into the national M&E system at national, provincial and district levels				
21. # of institutions/organisation with full-time M&E persons				

I verify that this information is complete and correct and that I have not misrepresented any information in this report

Signed: ___________________________________

Designation: ___________________________________

Date: ___________________________________

Appendix (C)

NARF for PATF

1 REPORT DETAILS

Report date:			
Quarter reporting on	From: to:		
Province			
District			
Report Compiled by			
For more information / questions about the report, contact:	**Name:**		
	Tel number:	**Fax:**	
	Email:		

2 ACTIVITIES

Themes and Indicators		**Previous**	**New**	**Cumulative**
INTENSIFYING PREVENTION OF HIV **Prevent Sexual Transmission**				
1. # of IEC materials distributed (brochures/t-shirts/posters/books):	# printed			
	# distributed			
2. # of 15-24 year olds who receive life skills based HIV/AIDS education (incl. through peer education)	Male			
	Female			
3. # of condom service outlets providing condoms to end users				
4. # of male and female condom pieces distributed (from non-health facilities).	Male			
	Female			
Infection Prevention				
5. # of traditional healers trained in infection prevention and use of sharp instruments according to national standards	Male			
	Female			
STRENGTHENING THE DECENTRALISED RESPONSE & MAINSTREAMING HIV AND AIDS **Sectoral Mainstreaming**				
6. # of FBO, CBOs, DPOs and NGOs				
7. # of FBOs,CBOs, DPOs and NGOs with HIV/AIDS Action Plans				
8. # of FBOs, CBOs, DPOs and NGOs with full-time focal point persons for HIV/AIDS				
9. # of employees trained to provide HIV behaviour change services to fellow employees (incl. peer educators, counsellors, etc)	Male			
	Female			
10. # of employees reached through workplace programmes	Male			
	Female			

		Previous	**New**	**Cumulative**
EXPANDING TREATMENT, CARE AND SUPPORT **Care and Support**				
11. # of service outlets providing HIV related palliative care including TB/HIV				
12. # of individuals provided with HIV-related palliative care including TB/HIV	Males			
	Females			
13. # of individuals trained to provide HIV palliative care including TB/HIV	Males			
	Females			
14. # of chronically ill people enrolled in CHBC programs	Male			
	Female			
15. # of PLWHA enrolled in PLWHA support groups	Male			
	Female			
16. # of PLWHAs support groups				
MITIGATING THE SOCIO-ECONOMIC IMPACT OF HIV /AIDS **Support for Orphans and Vulnerable Children**				
17. # of Orphans and Vulnerable Children (OVCs) receiving care and support from CBOs,/NGOs/FBOs/DPOs	Male			
	Female			

18. # of street children re-integrated/integrated into homes	Male			
	Female			
19. # of CBOs/NGOs/ FBOs/DPOs receiving funding/technical assistance to provide care and support to OVCs				
IMPROVING THE CAPACITY FOR MONITORING AND EVALUATION BY ALL PARTNERS Monitoring and Evaluation				
20. # of organisation with functional M&E systems and linked into the national M&E system at national, provincial and district levels				
21. # of institutions/organisation with full-time M&E persons				

I verify that this information is complete and correct and that I have not misrepresented any information in this report

Signed: ____________________________________

Designation: ____________________________________

Date: ____________________________________

APPENDIX 7(d)

For MoH Only

1. REPORT DETAILS

Report date:			
Quarter reporting on	From:	to:	
Report Compiled by			
For more information / questions about the report, contact:	**Name:**		
	Tel number:	**Fax:**	
	Email:		

2. ACTIVITIES

Themes and Indicators		Previous	New	Cumulative
EXPANDING, TREATMENT, CARE AND SUPPORT				
Anti-Retroviral Therapy (ART)				
1. # of public and private facilities providing ART services				
2. # of districts with health facilities providing ART services ***(for PATF use only)***				
3. # of persons with advanced HIV infection receiving ART	Male			
	Female			
4. # of community adherence supporters trained to provide ART services	Male			
	Female			
5. # service providers trained to provide ART services				
6. % of health facilities providing ART services with no ARV drug stock outs of >2 weeks in the last 12 months				
TB Treatment				
7. % of health facilities with all essential drugs for TB/OI in stock and no stock outs of >2 weeks in the last 12 months				
STI Treatment				
8. % of health facilities with STI drugs in stock and no STI drug stock outs of > 2 weeks within last 12 months				
9. # of service providers trained in the diagnosis and treatment of STIs according to national guidelines	Male			
	Female			
INTENSIFYING PREVENTION OF HIV				
Condom Distribution				
10. # of male and female condoms distributed *(indicate condoms pieces and not boxes; 1box = 144 pieces)*	Male			
	Female			
Blood Safety/Infection Prevention				
11. # of individuals trained in blood safety				
12. # of service outlets carrying out blood safety activities				
13. # of service providers trained in standards for infection prevention and health care waste storage and disposal				
14. # of health care facilities conducting infection prevention and health care waste storage and disposal				
Prevention Mother-to-Child Transmission (PMTCT		**Previous**	**New**	**Cumulative**
15. # of HIV+ pregnant women receiving a complete course of ARV prophylaxis to reduce the risk of MTCT				
16. # of professional health providers trained to provide PMCT services				
17. # of lay/community health providers (including TBAs) trained to provide PMTCT services				
18. # of facilities providing PMTCT services				
19. # of districts with facilities providing PMTCT services ***(for PATF use Only)***				
20. # of HIV exposed infants seen in the first I month of life for check up				

21. # of HIV exposed infants receiving co-trimoxazole prophylaxis				
Voluntary Counselling and Testing (VCT)				
22. # of clients tested for HIV at VCT and receiving their test results	Male			
	Female			
23. # of professional providers trained to provide VCT services				
24. # of lay/community providers trained to provide VCT services				
25. # of facilities providing VCT services				

I verify that this information is complete and correct and that I have not misrepresented any information in this report

Signed: ________________________________

Designation: ________________________________

Date: ________________________________

Appendix 8

Six-Monthly Service Coverage Reporting Format& Annual HIV/AIDS M&E Report Format

FORMAT OF SIX MONTHLY SERVICE COVERAGE REPORT

1. *Foreword*

This should be a statement by the Head of NAC; The Director General. The report should be endorsed and approved by the National HIV/AIDS/STI/TB Council (NAC) prior to publication.

2. *Executive Summary*

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

3. *NAC Activity Report System Results for the half-year: [insert period being reported on]*

Themes and Indicator		PREVIOUS PERIOD	CURRENT PERIOD
INTENSIFYING PREVENTION **Prevent Sexual Transmission**			
1. # of IEC materials distributed (brochures/t-shirts/posters/books):	printed		
	distributed		
2. # of 15-24 year olds who receive life skills based HIV/AIDS education (incl. through peer education)	Male		
	Female		
3. # of male and female condoms distributed to ender users*(form health facilities)*	Male		
	Female		
4. # of male and female condoms distributed to ender users*(form non-health facility)s*	Male		
	Female		
Prevention of Mother to Child Transmission (PMTCT)			
5. # of HIV+ pregnant women receiving a complete course of ARV prophylaxis to reduce the risk of MTCT			
6. # of professional health providers trained in the provision of PMCT services			
7. # of lay/community health providers (including TBAs) trained to provide PMTCT services			
8. # of facilities providing PMTCT services			
9. # of districts with facilities providing PMTCT services			
10. # of HIV exposed infants seen in the first I month of life for check up			
11. # of HIV exposed infants receiving co-trimoxazole prophylaxis			
Voluntary Counselling and Testing (VCT)			
12. # of clients tested for HIV at VCT and receiving their test results	Male		
	Female		
13. # of professional providers trained to provide VCT services			
14. # of lay/community providers trained to provide VCT services			
15. # of facilities providing VCT services			
16. # of male and female condom pieces distributed (from non-health facilities).	Male		
	Female		
Infection Prevention			
17. # of traditional healers trained in infection prevention and use of sharp instruments according to national standards	Male		
	Female		
18. # of employees reached through workplace programmes			
EXPANDING TREATMENT AND, CARE AND SUPPORT **Care and Support**			
19. # of service outlets providing HIV related palliative care including TB/HIV			
20. # of individuals provided with HIV-related palliative care including TB/HIV	Males		
	Females		
21. # of individuals trained to provide HIV palliative care including TB/HIV	Males		
	Females		
22. # of chronically ill people enrolled in CHBC programs	Male		
	Female		

23. # of PLWHA enrolled in PLWHA support groups	Male		
	Female		
24. # of PLWHAs support groups			
Anti-retroviral Treatment			
25. # of public and private facilities providing ART services			
26. # of districts with health facilities providing ART services *(for PATF use only)*			
27. # of persons with advanced HIV infection receiving ART [10]	Male		
28. # of community adherence supporters trained to provide ART services	Male		
29.	Female		
30. # service providers trained to provide ART services			
31. # of service providers trained in the diagnosis and treatment of STIs according to national guidelines			
Support for Orphans and Vulnerable Children			
32. # of Orphans and Vulnerable Children (OVCs) receiving care and support from CBOs,/NGOs/FBOs/DPOs	Male		
	Female		
33. # of street children re-integrated/integrated into homes	Male		
	Female		
34. # of CBOs/NGOs/ FBOs/DPOs receiving funding/technical assistance to provide care and support to OVCs			
35. # of organisation with functional M&E systems and linked into the national M&E system at national, provincial and district levels			
36. # of institutions/organisation with full-time M&E persons			
37. # of workplaces, including LMs, with developed workplace policies and programmes for HIV/AIDS			
38. # of Line Ministries, FBOs,CBOs, DPOs and NGOs with HIV and AIDS Action Plans			
39. # of line ministries with HIV/AIDS budget line items			
40. of line ministries with full-time focal point persons for HIV/AIDS			
41. of employees trained to provide HIV behaviour change services to fellow employees (incl. peer educators, counsellors, etc)	Male		
	Female		
42. # of employees reached through workplace programmes			

[10]The private sector information was in the process of being integrated into the public sector HMIS

4. Status of NAC Activity Reporting System

This section should provide a brief summary of the prevailing situation as regards to the NAC Activity Reporting System, by stating the % of partners that have submitted the required number of NAC Activity Report Forms to NAC on time in the reporting period. This section should also indicate the percent of districts submitting the NAC Activity Reporting Forms with adherence to the reporting schedule. Conversely, this section should also provide information on the number of information products generated at substructure level as well as the success of data dissemination.

5. Conclusions and recommendations

This report should focus on presenting information in a format that is useful and applicable to the information needs of its readers. Thus, this section of the report should focus on key recommendations and suggested focus areas for inclusion in the annual HIV/AIDS M&E report. This should be an objective assessment, and the following headings are suggested:

a) Conclusions per programme area:

Intensifying Prevention

- Prevention of Sexual Transmission of HIV
- Prevention of Mother to Child Transmission
- Prevention of HIV transmission through blood and blood products
- Prevention of HIV transmission in health care and other care settings and promote access to post exposure prophylaxis treatment
- Improvement of access to and use of Confidential Counselling and Testing
- Mitigation of Stigma and Discrimination against HIV
- Prevention of HIV transmission through intravenous drug use
- Supporting the development and participation in HIV vaccine clinical trials

Expanding Treatment, Care and Support

- Provision of Universal Access to ART including access to CCT at all Treatment Centres
- Expanding treatment for Tuberculosis, sexually transmitted infections (STIs) and other Opportunistic Infections (OIs)
- Strengthening of Home/Community based Care and Support including access to comprehensive palliative care and pain management
- Supporting the utilisation of Alternative and/or traditional medicines which have scientifically demonstrated efficacy
- Promotion of Appropriate Nutrition and positive living for PLWHAs

Mitigating the Socio-economic impact

- Protection and provision of support for Orphans and vulnerable children
- Provision of Social Protection for people made vulnerable from the affects of HIV and AIDS
- Promotion of Programmes of food security and income/livelihood generation for PLHA and their caregivers/ families

Strengthening the Decentralised Response and mainstreaming HIV and AIDS

- Mainstreaming of HIV and AIDS into District level development policies, strategies, plans and budgets
- Improvement of the Capacity of district, provincial and national planning mechanisms in multi-sectoral HIV and AIDS planning, monitoring and coordination
- Mainstreaming of HIV and AIDS into sector (private, public and civil society) development policies, strategies, plans and budgets

- Development and implementation of comprehensive workplace policies that take into consideration issues around education, awareness and prevention, treatment care and support
- Supporting the development of workforce development strategies which prioritise the key sectors critical to the Response to HIV and AIDS

Improving the monitoring of the Response

- Strengthening mechanisms and systems for monitoring and evaluation of the multi-sectoral response
- Improving capacity of Implementing Partners for monitoring and evaluation of the Situation and the Response
- Strengthening operational and behavioural research and access to information on best practice and cost effective interventions

FORMAT OF NATIONAL ANNUAL HIV/AIDS M&E REPORT

1. Foreword

This should be a statement by the Head of NAC: The Director General. The report should be endorsed and approved by the National HIV/AIDS/STI/TB Council (NAC) prior to publication.

2. Executive Summary

This should be a two or three page summary of the overall report, with a focus on key statistics and changes in statistics, as well as a description of key trends and how these influence the implementation of HIV/AIDS interventions. This will also need to take into account the latest poverty reduction indicator data, and make a narrative reference to the linkage between HIV/AIDS and poverty reduction.

3. Annual M&E System Results

3.1 Impact Assessment

INDICATOR TO REPORT ON	PREVIOUS YEAR	CURRENT YEAR
1. % of infants born to HIV infected mothers who become infected		
2. % of pregnant women aged 15-19 who are HIV infected		
3. % of adult men aged 15-49 who are HIV infected		
4. % of 15-24 year olds who are HIV positive		

3.2 Outcomes Assessment

INDICATOR TO REPORT ON	PREVIOUS YEAR	CURRENT YEAR
1. % of HIV+ pregnant women receiving a complete course of ARV prophylaxis to reduce the risk of MTCT		
2. Tuberculosis cure rate		
3. % of teachers who have been trained in life skills education and taught it during the last academic year		
4. % of 15-24 year olds who report being sexually active		
5. Median age at first sexual debut		
6. % of 15-24 year olds who both correctly identify ways of preventing the sexual transmission of HIV and who reject major misconceptions about HIV transmission		
7. % of 15-49 year olds using condoms during the last sexual act with non regular sexual partner		
8. % of unmarried respondents who report at least 2 sexual partners		
9. % of the general population aged 15-49 years receiving HIV test results and post-counseling		
10. % of PLWHAs accessing support services		
11. % of OVCs to whom community support is provided		
12. Ratio of orphaned to non-orphaned children 0-18 years who are currently attending school		

13. % of clients with STIs who report having been diagnosed, treated and counselled according to national guidelines		
14. % of health facilities that apply national guidelines for blood screening, storage, distribution & transfusions[11]		
15. % of districts with the minimal required blood units in stock and no stock outs of >1 week in the last 12 months		
16. % of traditional leaders who store and use sharp instruments according to national safety guidelines		
17. % of persons with advanced HIV infection receiving ARV therapy [12]		
18. % of workplaces with HIV/AIDS policies and programmes		

3.3 Monitoring Programme Outputs

3.3.1 HIV PREVENTION AND ADVOCACY

a) ABCs of Safe Sex

INDICATOR TO REPORT ON	PREVIOUS YEAR	CURRENT YEAR
1. # of condoms distributed to end users		
2. # of 15-24 year olds who receive life skills based HIV/AIDS education (incl. through peer education)		

b) Information Education and Communication

INDICATOR TO REPORT ON	PREVIOUS YEAR	CURRENT YEAR
1. *# of IEC materials printed/produced and distributed*		

c) Blood Safety

INDICATOR TO REPORT ON	PREVIOUS YEAR	CURRENT YEAR
1. # of health care facilities conducting infection prevention and health care waste storage and disposal		
2. # of service providers trained in national standards for infection prevention and health care waste storage and disposal		

d) Prevention of MTCT

INDICATOR TO REPORT ON	PREVIOUS YEAR	CURRENT YEAR
1. # of HIV+ pregnant women receiving a complete course of ARV prophylaxis to reduce the risk of MTCT		
2. # of districts with facilities providing PMTCT services		
3. # of professional service providers trained in the provision of PMCT services		
4. of lay/community health providers (including TBAs) trained to provide PMTCT services		
5. # of HIV exposed infants receiving co-trimoxazole prophylaxis		
6. # of HIV exposed infants seen in the first I month of life for check up		

e) Treatment of STIs

INDICATOR TO REPORT ON	PREVIOUS YEAR	CURRENT YEAR
1. **%** of health facilities with STI drugs in stock and no STI drug stock outs of >1 week within		

last 12 months		
2. # of service providers trained in the diagnosis and treatment of STIs according to national guidelines		

f) Voluntary Counselling and Testing

INDICATOR TO REPORT ON	PREVIOUS YEAR	CURRENT YEAR
1. # of clients tested for HIV at VCT and receiving their test results		
2. # of people trained to provide VCT services		
3. # of facilities providing VCT services		

3.3.2 TREATMENT CARE AND SUPPORT

a) TB Treatment

INDICATOR TO REPORT ON	PREVIOUS YEAR	CURRENT YEAR
1. Tuberculosis defaulter rate		
2. % of health facilities with all essential drugs for TB/OI in stock and no stock outs of >1 week in the last 12 months		

b) Anti-Retroviral Therapy

INDICATOR TO REPORT ON	PREVIOUS YEAR	CURRENT YEAR
1. # of public and private facilities providing ART services		
2. % of HCFs providing ART services with no ARV drug stock outs of >1 week in the last 12 months		
3. # service providers trained to provide ART services		
4. # of persons with advanced HIV infection receiving ARV therapy [13]		

c) Community Home-Based Care

INDICATOR TO REPORT ON	PREVIOUS YEAR	CURRENT YEAR
1. # of PLWHAs support groups		
2. # of PLWHA enrolled in PLWHA support groups		
3. # of chronically ill people enrolled in community home based care programs		
4. # of service providers trained in providing home based care to chronically ill people enrolled in home based care programs		

d) Orphans and Other Vulnerable Children

INDICATOR TO REPORT ON	PREVIOUS YEAR	CURRENT YEAR
1. # of orphans and other vulnerable children receiving care and support from CBOs,/NGOs/FBOs		
2. # of CBOs/NGOs/ FBOs receiving funding/technical assistance to provide care and support to OVCs		
3. # of street children re-integrated/integrated into homes		

3.3.3 SECTORAL MAINSTREAMING

INDICATOR TO REPORT ON	PREVIOUS YEAR	CURRENT YEAR
1. # of workplace, including line ministries, with HIV/AIDS policies and programmes		
2. # of employees reached through workplace-based HIV/AIDS interventions		
3. # of employees trained to provide HIV behavior change services to fellow employees (incl. peer educators, counselors, etc)		
4. # of line ministries with HIV/AIDS budget line items		
5. # of line ministries with full-time focal point persons for HIV/AIDS		

3.4 Monitoring National Management and Commitment

INDICATOR TO REPORT ON	PREVIOUS YEAR	CURRENT YEAR
1. Amount of funds spent on HIV/AIDS in the past 12 months		
2. National Composite Policy Index (NCPI) score		

4. Status of National M&E system

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

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

b) Quality of data sources

DATA SOURCE	STATEMENT ABOUT QUALITY
1. PMTCT Cohort Study	
2. Sentinel Surveillance Survey	
3. ZDH Survey	
4. ZSB Survey	
5. ZHF Survey	
6. HIV/AIDS W/place Survey	
7. HIV/AIDS Education Survey	
8. National Composite Policy Index	
9. Health Management Information System	
10. UNAIDS Financial Resource Flow Survey	
11. Program Activity Reporting System	

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

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

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

5. *Implementing Partners and Development Partners*

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

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

6. *Conclusions and recommendations*

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

The following headings are suggested:

b) Overall conclusions and recommendations

c) Conclusions per programme area:

Intensifying Prevention

Prevention of Sexual Transmission of HIV

Prevention of Mother to Child Transmission

Prevention of HIV transmission through blood and blood products

Prevention of HIV transmission in health care and other care settings and promote access to post exposure prophylaxis treatment

Improvement of access to and use of Confidential Counselling and Testing

Mitigation of Stigma and Discrimination against HIV

Prevention of HIV transmission through intravenous drug use

Supporting the development and participation in HIV vaccine clinical trials

Expanding Treatment, Care and Support

Provision of Universal Access to ART including access to CCT at all Treatment Centres

Expanding treatment for Tuberculosis, sexually transmitted infections (STIs) and other Opportunistic Infections (OIs)

Strengthening of Home/Community based Care and Support including access to comprehensive palliative care and pain management

Supporting the utilisation of Alternative and/or traditional medicines which have scientifically demonstrated efficacy

Promotion of Appropriate Nutrition and positive living for PLWHAs

Mitigating the Socio-economic impact

Protection and provision of support for Orphans and vulnerable children

Provision of Social Protection for people made vulnerable from the affects of HIV and AIDS

Promotion of Programmes of food security and income/livelihood generation for PLHA and their caregivers/ families

Strengthening the Decentralised Response and mainstreaming HIV and AIDS

Mainstreaming of HIV and AIDS into District level development policies, strategies, plans and budgets

Improvement of the Capacity of district, provincial and national planning mechanisms in multi-sectoral HIV and AIDS planning, monitoring and coordination

Mainstreaming of HIV and AIDS into sector (private, public and civil society) development policies, strategies, plans and budgets

Development and implementation of comprehensive workplace policies that take into consideration issues around education, awareness and prevention, treatment care and support

Supporting the development of workforce development strategies which prioritise the key sectors critical to the Response to HIV and AIDS

Improving the monitoring of the Response

Strengthening mechanisms and systems for monitoring and evaluation of the multi-sectoral response

Improving capacity of Implementing Partners for monitoring and evaluation of the Situation and the Response

Strengthening operational and behavioural research and access to information on best practice and cost effective interventions

d) Policy implications of M&E data

7. *M&E Work plan*

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

8. *Bibliography / list of data sources consulted*

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

CHECKLIST AND RECORDING SHEET

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

Appendex 9
UNGASS Report Format

FOLLOW-UP TO THE DECLARATION OF COMMITMENT ON HIV/AIDS (UNGASS)

COUNTRY REPORT FORMAT

Reporting period: January-December 2002

PREAMBLE

The proposed generic reporting format is meant to assist National AIDS Councils (or equivalent) in drafting their national report to be submitted to the UN General Assembly on biennial basis as a follow-up to the Declaration of Commitment (DoC) signed in June 2001 at the UNGASS on HIV/AIDS

Countries should carefully review the *Guidelines on construction of core indicators – Monitoring the Declaration of Commitment on HIV/AIDS* (named hereinafter Guidelines) before embarking in any data collection exercise. As explained in the Guidelines, a total of 13 core indicators divided into three categories are supposed to be collected/reported on at national level to monitor the DoC on HIV/AIDS:

Category 1: Two indicators on national commitment and action
Category 2: Nine indicators on national programmes and behaviour trends
Category 3: Two indicators on impact.

The Guidelines provide countries with technical guidance on the definition of the core indicators, the measurement tools required for their construction and frequency of data collection. It is essential that countries follow those Guidelines to ensure quality of the reported information. Countries are also encouraged to report on additional nationally representative coverage indicators since this report will be used as baseline to monitor progress over time. While selecting data to be reported on, it is recommended to avoid anecdotal information.

For **2003** General Assembly Session, reporting is required for all three categories of indicators. In view of time constraints, the following is recommended to all countries:

Category 1: Collect information through desk reviews and survey on financial resource flows

Category 2: Compile existing data from (1) recent surveys such as DHS or MICS for those indicators requiring population-based information; (2) health facility, school-based, or workplace surveys for the other indicators. Countries are also encouraged to consult the following indicator database that contains data on some core indicators collected through household surveys: www.measuredhs.com/data.

Category 3: For HIV prevalence among young people, compile data from HIV sentinel surveillance (for countries with generalized epidemics) and recent specific surveys (for countries with concentrated or low epidemics). For HIV prevalence among infants, calculation of estimates needs to be done using programme coverage data.

2003 General Assembly Session
Target dates

End of data collection: 10 March 2003
Reporting to Geneva: 31 March 2003.

For **2004** General Assembly Session, no reporting on national indicators is required.

For **2005** General Assembly Session, reporting is required for all three categories of indicators. This means that countries that have not yet planned any surveys for collecting information on the second category of indicators need to do so as soon as possible and latest early 2003.

2005 General Assembly Session
Target dates

End of data collection:	30 September 2004
Reporting to Geneva:	28 February 2005

A total of four annexes should be attached to the national report: (1) the consultation/preparation process for the national report on monitoring the follow-up to the Declaration of Commitment on HIV/AIDS form; (2) the National Composite Policy Index Questionnaire; (3) the nine forms related to the National Programme and Behaviour Indicators; (4) the country M&E sheet.

TABLE OF CONTENTS

I. Status at a glance

II. Overview of the HIV/AIDS epidemic

III. National response to the HIV/AIDS epidemic

1. National commitment and action

2. National programmes and behaviour

IV. Major challenges faced and actions needed to achieve the goals/targets

V. Support required from country's development partners

VI. M&E environment

ANNEXES

ANNEX 1: Consultation/preparation process for the national report on monitoring the follow-up to the Declaration of Commitment on HIV/AIDS

ANNEX 2: National Composite Policy Index Questionnaire

ANNEX3: Nine national return forms national programme and behaviour indicators

ANNEX 4: Country M&E sheet

I. UNGASS REPORT STATUS AT A GLANCE

National Commitment & Action 1. Amount of national funds disbursed by governments in low and middle income countries 2. National Composite Policy Index
National Programmes: 3. % of schools with teachers who have been trained in life-skills based HIV/AIDS education and who taught it during the last academic year 4. % of large enterprises/companies which have HIV/AIDS workplace policies and programmes 5. % of women and men with STIs at health care facilities who are appropriately diagnosed, treated and counselled 6. % of HIV positive pregnant women receiving a complete course of ARV prophylaxis to reduce the risk of MTCT 7. % of women and men with advanced HIV infection receiving antiretroviral combination therapy 8. % of orphans and vulnerable children whose households received free basic external support in caring for the child 9. % of transfused blood units screened for HIV
Knowledge, Sexual Behaviour and Orphans' school attendance 10. % of young women and men aged 15-24 who both correctly identify ways of preventing the sexual transmission of HIV and who reject major misconceptions about HIV transmission 11. Female and male median age at first sex 12.. % of young women and men aged 15-24 who have had sex with a non-marital, non-cohabiting sexual partner in the last 12 months 13. % of young women and men aged 15-24 reporting the use of a condom the last time they had sex with a non-marital, non-cohabiting sexual partner 14. Ratio of current school attendance among orphans to that among non-orphans, aged 10-14
Impact 15. % of young women and men aged 15-24 who are HIV infected 16. % of adults and children with HIV still alive 12 months after initiation of antiretroviral therapy 17. % of infants born to HIV infected mothers who are infected

II. Overview of the HIV/AIDS epidemic

This section should cover the status of the HIV prevalence in the country during the period January-December 2002 based on sentinel surveillance and specific studies (if any) for Indicator 1 (HIV prevalence among young people) and estimates for Indicator 2 (HIV prevalence among infants).

HIV prevalence at a glance

% young people 15-24 years of age who are HIV infected
%of infants born to HIV infected mothers who are infected

Indicate Source

III. National response to the HIV/AIDS epidemic

1. National commitment and action

This sub-section should reflect the change in commitment made by national stakeholders in the fight against HIV/AIDS during the period January-December 2002. Commitment covers increased resources, expanded partnerships and multi-sectoral policy development.

National commitment at a glance

National Composite Policy Index
Government funds spent on HIV/AIDS

Indicate Source

2. National programmes and behaviour

This sub-section should cover progress made during the period January-December 2002 in specific HIV/AIDS programmes broken down by prevention and care/treatment.

National programmes at a glance

Prevention
% of schools with teachers who have been trained in life-skills-based education and who taught it during the last academic year
%large enterprises/companies that have HIV/AIDS workplace policies and programmes
%of HIV+ pregnant women receiving a complete course of ARV prophylaxis to reduce the risk of MTCT

Care/Treatment
% of patients with sexually transmitted infections at health care facilities that is appropriately diagnosed, treated and counselled
% of people with advanced HIV infection receiving ARV combination therapy

Indicate Source

This section should also reflect any changes in behaviour as a result of programmes' activities.

National behaviours at a glance

% of respondents 15-24 years of age who both correctly identify ways of preventing the sexual transmission of HIV and who reject major misconceptions about HIV transmission or prevention
%of people aged 15-24 reporting the use of a condom during sexual intercourse with a non-regular sexual partner
%of injecting drug users who have adopted behaviours that reduce transmission of HIV (*where applicable*)

Indicate Source

Finally, this section should address national efforts in impact alleviation, with a focus on orphans.

Impact alleviation at a glance

Ratio of orphaned to non-orphaned children 10-14 years of age who are currently attending school

Indicate Source

Whenever relevant, indicator scores should be reported by area of residence (urban/rural), gender, and the following age groups: 15-19, 20-24, 25-49. Countries are encouraged to report on additional indicators that contribute to an expanded national response.

IV. Major challenges faced and actions needed to achieve the goals/targets

This section should focus on key challenges faced throughout the reporting period that hindered the national response and remedial actions envisaged to ensure achievements of agreed targets by 2005 and 2010 (see page 4).

This section should also provide information on the country's data collection plan for 2005 reporting (see Table below).

Data collection plan (2005 reporting)	2003	2004	2005
Household surveys			
Health facility surveys			
School-based surveys			
Workplace surveys			
Desk review			

V. Support required from country's development partners

This section should focus on key actions that need to be taken by development partners to assist countries in achieving their goals/targets.

VI. M&E environment

The section should provide an overview of the current M&E system in the country based on a country sheet to be filled out and included as an annex (see Annex 4), and highlight – where appropriate – the needs for M&E technical assistance and capacity building to meet the 2005 requirements.

Appendix 10: Stakeholder Responsibilities

Within the context of the overall implementation plan, stakeholder responsibilities have been defined as follows:

STAKEHOLDER	OUTLINES OF RESPONSIBILITIES
Director General of NAC	The Director General of NAC should be responsible for: Promoting the HIV/AIDS M&E system within the public and private sectors, and civil society, where possible Use information from the M&E system to inform the national response Ensure that sufficient resources (financial and human) are available to implement the national HIV/AIDS M&E system Encourage bilateral donors to make reporting to the NAC M&E system compulsory for the implementers supported by bilateral donors
Director of M&E unit	As Director of M&E unit, this person will be responsible for: Providing overall leadership of M&E team at NAC Supervision of work done by M&E Specialist First approval of all information products, before it is submitted to the Director General of NAC for approval Give guidance and attend meetings with NAC partners on M&E issues Approve monthly workplans of M&E Specialist Initiate and approve the procurement cycles for NAC-commissioned data sources Approve the annual M&E budgets Interpret the M&E report in terms of planning implications Ensure that the NAC annual work plan take cognisance of the M&E results
NAC M&E Specialist	The M&E Specialist at NAC is the pivot around which the M&E system will be functioning. This person will be responsible for: Implementation of the national HIV/AIDS M&E plan Coordinate and manage the NAC Activity Report System Develop monthly work plans for activities for M&E Liaise with all institutions that provide data sources for national NAC M&E system Provide ad hoc information products, as requested by stakeholders Represent M&E interests of NAC at meetings, and investigate better ways of co-ordinating data gathering within Namibia Arrange the HIV/AIDS M&E Dissemination Seminar Arrange the dissemination of all information products, as defined in this document Prepare annual M&E work plan and operational budget Ensure that all data is received for the annual HIV/AIDS M&E report – sending

STAKEHOLDER	OUTLINES OF RESPONSIBILITIES
	reminders and requests for information to all persons/agencies responsible for data sources (as defined in this document Compile and manage approval of the annual HIV/AIDS M&E Report Arrange funding for NAC-commissioned data sources
PATFs/DATFs	Submit names of NGOs and CBOs involved in HIV/AIDS activities to NAC Liaise and promote the completion and submission of these forms Disseminate the Six-monthly Service Coverage Report form and other NAC Information products
Institutions responsible for data sources NOT commissioned by NAC	Different agencies are responsible for data sources. These agencies have the responsibility to: Read through NAC's M&E system and ensure that they are familiar with its content Ensure that they understand their responsibilities in terms of data submission to NAC Submit the necessary data, disaggregated as per request Wherever possible, use the information generated by the NAC M&E system for decision making and improving of interventions
Institutions responsible for data sources commissioned by NAC	These agencies' responsibilities will be clearly defined in the agreement between NAC and the agency. However, in general terms these agencies will be responsible for providing good quality data sources that are based on international best practice, and that is relevant to the M&E system, as defined in this document.
Implementers of HIV/AIDS Interventions	The Implementers of HIV interventions will be responsible for: Completing the NAC Activity Report Form on a monthly basis and submit it to NAC or its designated sub-contractor Utilising the information products from NAC for decision making
Funding Agencies/ Development agencies	These agencies provide the fuel that is needed for the HIV/AIDS engine to run. In terms of M&E, they will be responsible for: **For all new contracts**: Ensuring that the contracts that they sign with implementers include reference to NAC's M&E system and that reporting to this system is clearly defined – in particular ensuring that the NAC Activity Report Form is one of the reporting formats that is required **For all existing contracts**: Ensure that these implementers are requested to submit the NAC Activity Report Form to NAC on a monthly basis.
Researchers and Research Institutions	The roles and responsibilities of researchers and research institutions will be to: Conduct research that is of a high standard – both in terms of substance and in terms of research protocols Submit research proposals to the relevant ethical review committee before research is commenced Familiarize themselves with NAC's research strategy (once it is developed) and ensure that, where possible, research is in line with the research strategy

STAKEHOLDER	OUTLINES OF RESPONSIBILITIES
	Once research has been completed, disseminate research results to relevant stakeholders
Monitoring and Evaluation TWG	This group consists of all stakeholders and will advise on all issues associated to M&E – Please refer to **Appendix 11** for a proposed Terms of Reference for the M&E TWG.

Appendix 11
Proposed Terms of Reference for M&E Technical Working Group

The National HIV/AIDS Council (NAC) Monitoring and Evaluation Technical Working (M&E TWG) group in Zambia is intended to advise on the planning, monitoring, evaluating and reporting of HIV/AIDS activities.

Mandate
The M&E TWG will advise on the implementation of the national M&E system. Specifically the TWG will conduct the following activities to fulfil its mandate:

M&E
- Advise and provide technical guidance in terms of planning and implementation of the national M&E system
- Advise on the operationalization of the NAC activity reporting system
- Provide strategic input into the annual review process

Information Systems
- Provide a mechanism to evaluate the effectiveness of IS on a periodical basis
- Ensure that the annual data collection mechanism is supported, functioning and appropriate
- Advise NAC on the maintenance of data, stand-alone software and the website
- Advise on ongoing support and training for NAC and user agencies in IS

Research
- Advise and provide technical guidance on the national research agenda
- Advise and provide technical guidance on the implementation of national surveys, studies and other HIV/AIDS related research
- Advise and provide input on the dissemination of research and survey findings and best practices at annual local and international HIV/AIDS conferences/meetings

Membership
The membership of the M&E TWG will be comprised of coordinating bodies from the Government (at least NAC and MOH), International groups, NGOs, and CBOs. The group will be chaired by an officer appointed by NAC.

Meeting times
The group will meet on a monthly basis. The venue of the meeting will be at the National AIDS Council. On a monthly basis the chair of the group will present its progress and key issues emerging to NAC.

Review of Terms of Reference
These TOR will be reviewed annually and changes made as deemed necessary by the M&E TWG group and passed by the Chair of NAC council.

APPENDIX 12:

List of TWG Members who contributed to the M&E Plan

No.	Name	Organization	Designation	Email
1	Chola N. Daka	CSO	Statistician	c_naks@yahoo.com
2	Simushi Virginia	MoH	Programmer Analysis	vsimushi@moh.gov.zm
3	Rosemary Mukupa	Care for Bus. Clinic	Matron- Vice Chair Workplace TWG	cfbmedic@zamnet.zm
4	Charles Nkunta	NAC	MIS Specialist	hpnkunta@yahoo.com
5	Paul Chitengi	NAC	M&E Specialist	mukondap@yahoo.com
6	Beyant Kabwe	ZNAN	M&E Specialist	beyantkabwe@yahoo.com
7	Catherine Mulikita	CHAZ	M&E Officer	nsansa2@yahoo.com
8	James Guwani	UNAIDS	M&E Advisor	guwanij@unaids.org
9	Augustine Mutelesha	ZANARA	M&E Specialist	amutelekesha@yahoo.com
10	Dean Phiri	MoH	M&E Specialist	deanphiri@yahoo.co.uk
11	Dr. M.C Chisembele	UTH Pediatrics	Vice Chair Safe blood	pintmini@yahoo.com
12	Jubra Muyanga	NAC	Vice Chair PMTCT/VCT TWG	jmuyanga@yahoo.com
13	Harvey Gwale	ZAMDHARP	Programme Officer	harveyngwale@yahoo.com
14	Faston Goma	St Johns Med. Center	Chief Med. Officer – Private Practice	gomafm@yahoo.co.uk
15	Sunil Mohanty	FHT(VSO Volunteer)	M & E Specialist	sunilmohanty@hotmail.com
16	Mwiya Chrispin	MOH	SHI	mwiyacm@moh.gov.zm
17	Moses Zeggetti	MoE	OVC Desk Officer/Vice Chair OVC	mozeovc@yahoo.com
18	Fubisha R.C	MoH-LGH	Paediatrician – Vice Chair RVTWG	fubisha@yahoo.co.uk
			Technical Assistances	
19	Mercy Zimba	SHARe	Data Analyst	Mercy.zimba@share.org.zm
20	Tomoko Sichone	JICA/NAC	HIV/AIDS & TB Prog. Coordinator	jicazb-gyoumu@jica.go.jp
21	Bupe M. Mumba	WFP	M&E Clerk	Bupe.mulemba@wfp.org
22	Ian Membe	CDC	M&E Advisor	Membei@zdczm.org
23	Chazanga Tembo	SHARe	Data Manager	Chazanga.tembo@share.org.zm
24	Annelien Groten	UNICEF	M&E Officer	
25	Rosemary Kumwenda	UNDP	Assistant Res. Rep. – Advisor HIV/AIDS & Poverty	rosemary.kumwenda@undp.org
26	Josefina Halme	UNDP	Programme Officer	Josefina.halme@undp.org
27	John Grove	CDC	M&E Team leader	grovej@cdczm.org
28	Chibwe Lwamba	USAID	HIV/AIDS Multi-sector Senior Advisor	clwamba@usaid.gov
			Zambia NASTAD Team	
1	Steven Tierney	NASTAD	Team Leader	
2	Owen Simwale	NASTAD	Team Member	Tolsh2002@yahoo.com
3	Maya Tholandi	NASTAD	Team Member	mtholandi@nastad.org
4	Hope Cassidy-Stewart	NASTAD	Team Member	
5	Tom Stopka	NASTAD	Team Member	
6	Lucy Slater	NASTAD	Team Member	slaterl@nastad.org

APPENDIX13
IndicatorDefinitions

DATASOURCE	INDICATORDESCRIPTION	PERCENTAGE		VALUE
		DENOMINATOR	NUMERATOR	
MTCT COHORT STUDY	1. %ofinfantsborntoHIV infectedmotherswho becomeinfected	n/a	n/a	Theformulaisasfollows:*Indicatorscore= {T*(1-e)+(1-T)}xv*,withT=%ofHIV infectedpregnantwomenwithARV treatment,v=MTCTrateinabsenceof treatmentande=efficacyoftreatment provided
SENTINEL SURVEILLANCE SURVEY	2. %ofpregnantwomenaged 15-19whoareHIVinfected	#of15-19yearoldANCattendees testedfortheirserostatus	#of15-19yearoldANCattendeeswhose HIVtestresultsarepositive	n/a
ZDHS	3. %ofadultsaged15-49who areHIVinfected	#ofpersonsage15–49testedfortheir HIVinfectionstatus	#ofpersonsage15-49whotestedpositive forHIV	n/a
ZDHS	4. %of15-24yearoldswho areHIVpositive	#ofpersonsage15–24testedfortheir HIVinfectionstatus	#ofpersonsage15-24whotestedpositive forHIV	n/a
HMIS	5. %ofHIV+pregnantwomen receivingacompletecourse ofARVprophylaxisto reducetheriskofMTCT	EstimatednumberofHIV-infected pregnantwomen(modelled)	#ofHIV-infectedpregnantwomenprovided withafullcourseofantiretroviral prophylaxistoreduceMTCTaccordingto thenationallyapprovedtreatmentprotocol (orWHO/UNAIDSstandards)inthelast12 months(programreportsorHMIS)	n/a
HMIS	6. Tuberculosiscurerate			
EDUCATION CENSUS	7. %ofschoolswithteachers whohavebeentrainedin lifeskillseducationand taughtitduringthelast academicyear	#ofschoolssurveyed	#ofschoolswithstaffmemberstrainedin, andregularlyteaching,life-skills-based HIV/AIDSeducation	n/a
ZSBS	8. %of15-24yearoldswho reportbeingsexuallyactive	#ofyoungwomenandmenaged15–24surveyed	#of15-24yearold womenandmenwho reporthavinghadsexinthepast12months priortothesurvey	n/a
ZSBS	9. Medianageatfirstsexual debut	n/a	n/a	Thismeasureisconstructedfromdataon currentvirginitystatusamongyoungpeople, notfromretrospectivequestionsaboutageat firstsex.Inhouseholdorspecialsurveys focusingonyoungpeople,respondentsare askedwhetherornottheyhaveeverhad penetrativesex.Acurveisplottedaccording tothepercentwhosaytheyhavehadsexby

DATASOURCE	INDICATORDESCRIPTION	PERCENTAGE		VALUE
		DENOMINATOR	NUMERATOR	
				eachsingleyearofage.Theageatwhichthe curveexceeds50percentistakentobethe medianageatfirstsex.Onaverage,people reportingtheyareacertainagewillbesix monthsolderthanthatage.(Forexample thosewhosaytheyare15willrangefrom thosewhoturned15onthedayofthesurvey tothosewhowillturn16thefollowingday. Assuminganevenagedistribution,theywill beonaverage15.5.)Halfayearshould thereforebeaddedtotheexactagesusedin thecalculationofthemedianageatfirstsex.
ZSBS	10. %of15-24yearoldswho bothcorrectlyidentifyways ofpreventingthesexual transmissionofHIVand whorejectmajor misconceptionsaboutHIV transmission	#ofyoungwomenandmenaged15–24surveyed	#ofyoungwomenandmenaged15–24 who,inresponsetopromptedquestions,say thatpeoplecanprotectthemselvesfrom contractingHIVbyhavingsexwithonly onefaithful,uninfectedpartner,andusing condomsandknowthatahealthy-looking personcanhavetheAIDSvirus,andwho correctlyrejectthetwomostcommonlocal misconceptionsaboutAIDStransmission	n/a
ZSBS	11. %of15-49yearoldsusing condomsduringthelast sexualactwithnonregular sexualpartner	#ofwomenandmenaged15–49who reportatleastonenon-marital,non-cohabitingpartnerinthelast12 months	#ofthosewomenandmeninthe denominatorwhousedacondomthelast timetheyhadsexwiththeirmostrecent non-marital,non-cohabitingpartner	n/a
ZSBS	12. %ofunmarriedrespondents whoreportatleast2sexual partners	#ofwomenandmenaged15–49 surveyed	#ofwomenandmenaged15–49who reportatleast2sexualpartnersinthelast12 months	n/a
ZSBS	13. %ofthegeneralpopulation aged15-49yearsreceiving HIVtestresultsandpost-counseling	#ofall15-49yearoldrespondents surveyed	#ofthegeneralpopulationaged15-49years receivingHIVtestresultsandpost-counselling	n/a
ZSBS	14. %ofPLWHAsaccessing supportservices	Alladultsaged18–59whowereill for3ormoremonthsduringthepast 12months,includingthoseillfor3or moremonthsbeforedeath	Womenandmenaged18–59whohave beenchronicallyillfor3ormoremonths duringthepast12monthsandwhose householdreceivedthefollowingsupport: 1.Medicalsupportatleastonceamonth duringillness AND 2.Emotionalsupportinthelast30days AND	n/a

DATASOURCE	INDICATORDESCRIPTION	PERCENTAGE		VALUE
		DENOMINATOR	NUMERATOR	
			3.Materialsupportinthelast30days AND 4.Socialsupportinthelast30days	
ZSBS	15. %ofOVCstowhom communitysupportis provided	ORPHANS:Allchildrenunder18 whohaveatleastonedeadparent (motherorfather) AND VULNERABLECHILDREN:All childrenunder18whohavea chronicallyillparent(motheror father)definedasaparentwhohas beenverysickfor3ormoremonths duringthelast12months,regardless ofwhetherornottheillparentlives inthehousehold	Numberoforphansandvulnerablechildren residinginhouseholdsthatreceived: a.healthcaresupportwithinthepast12 months; b.emotionalsupportwithinthepast3 months; c.school-relatedassistancewithinthepast 12months; d.othersocialsupport,includingmaterial support,withinthepast3months;and e.allfourtypesofsupport. Orphan(atleastonedeadparent)AND/OR vulnerablechild(atleastonechronicallyill parent)whosehouseholdhasreceived: 1.Medicalsupportwithinthelast12 months; AND 2.Emotional/psychologicalsupportwithin thelast3months AND 3.Materialsupportwithinthelast3months AND 4.Socialsupportwithinthelast3months AND 5.School-relatedassistancewithinthepast 12months.	n/a
ZSBS	16. Ratioofcurrentschool attendanceamongorphans tothatamongnon-orphans aged10-14years	***Orphans'schoolsattendance(1):*** #ofchildrenwhohavelostboth parents.	#ofchildrenwhohavelostbothparentsand arestillinschool.	***Calculatetheratioof(1)to(2):*** Indicatorscoresarerequiredforallchildren aged10–14yearsandforboys*and*girls, separately.Wherepossible,theindicator

DATASOURCE	INDICATORDESCRIPTION	PERCENTAGE		VALUE
		DENOMINATOR	NUMERATOR	
		Non-orphans'schoolattendance(2): #ofchildrenwhoseparentsareboth stillaliveandwholivewithatleast oneparent.	#ofchildren,bothofwhoseparentsarestill alive,wholivewithatleastoneparentand whoarestillinschool.	shouldalsobecalculatedbysingleyearof age(seesectiononinterpretation). Theminimumnumberoforphaned10–14-year-oldchildrenneededtocalculatethis indicatoris50
ZHFS	17. %ofclientswithSTIswho reporthavingbeen diagnosed,treatedand counseledaccordingto nationalguidelines	#ofSTIpatientsforwhomprovider-clientinteractionswereobserved.	#ofSTIpatientsforwhomthecorrect procedureswerefollowedon: (a)history-taking; (b)examination; (c)diagnosisandtreatment;and (d)effectivecounselingonpartner notification,condomuseandHIVtesting.	n/a
ZHFS	18. %ofhealthfacilitiesthat applynationalguidelinesfor bloodscreening,storage, distribution&transfusions [14]	#ofhealthfacilitiessurveyed	#ofhealthfacilitiesthatapplynational guidelinesforbloodscreening,storage, distribution&transfusions [15]	n/a
ZHFS	19. %ofdistrictswiththe minimalrequiredblood unitsinstockandnostock outsof>1weekinthelast 12months	#ofalldistrictssurveyed	#ofdistrictswiththeminimalrequired bloodunitsinstockandnostockoutsof>1 weekinthelast12months	n/a
ZHFS	20. %oftraditionalhealerswho storeandusesharp instrumentsaccordingto nationalsafetyguidelines	#oftraditionalhealerssurveyed	#oftraditionalhealerswhostoreanduse sharpinstrumentsaccordingtonational safetyguidelines	n/a
ZHFS	21. %ofpersonswithadvanced HIVinfectionreceiving ARVtherapy [16]	Estimatednumberofpeoplewith advancedHIVinfection(modelled, seebelow)	#ofpeoplewithadvancedHIVinfection whoreceiveantiretroviralcombination therapyaccordingtothenationallyapproved treatmentprotocol(orWHO/UNAIDS standards)(servicestatisticsfromprogram reportsorHMIS)	n/a
WORKPLACE SURVEY	22. %ofworkplaceswith HIV/AIDSpoliciesand programmes	#ofemployerssurveyed(30)	#ofemployerswithHIV/AIDSpoliciesand regulationsthatmeet*all*oftheabove criteria	n/a
HMIS	23. #ofHIV+pregnantwomen	n/a	n/a	TOTAL#ofpregnantwomenwhoareHIV

[14] Assumptionisthattherewillbeanincreasedreliancealtruisticinformednon-remuneratedblooddonors
[15] Assumptionisthattherewillbeanincreasedreliancealtruisticinformednon-remuneratedblooddonors
[16] 6,000asofMay7,2004,15,000targetedfor2004and100,000for2005.TheprivatesectorinformationhasnotyetbeenintegratedintothepublicsectorHMIS

DATASOURCE	INDICATORDESCRIPTION	PERCENTAGE		VALUE
		DENOMINATOR	NUMERATOR	
	receivingacompletecourse ofARVprophylaxisto reducetheriskofMTCT			positivereceivingacompletecourseofARV prophylaxistoreducetheriskofMTCT
HMIS	24. #ofdistrictswithfacilities providingPMTCTservices	n/a	n/a	TOTAL#ofdistrictswithfacilitiesthatare providingPMTCTservices
HMIS	25. #ofserviceproviders trainedintheprovisionof PMTCTservices	n/a	n/a	TOTAL#ofhealthworkerswhoaretrained intheprovisionofPMTCTservices.
HMIS	26. %ofhealthfacilitieswith STIdrugsinstockandno STIdrugstockoutsof>1 weekwithinlast12months	#ofallhealthfacilitiesthatprovide STIservicessurveyed	#ofhealthfacilitieswithSTIdrugsinstock andnoSTIdrugstockoutsof>1week withinlast12months	n/a
HMIS	27. #ofclientstestedforHIVat VCTandreceivingtheirtest results	n/a	n/a	TOTAL#ofclientstestedforHIVatVCT andreceivingtheirtestresults
HMIS	28. #ofpeopletrainedto provideVCTservices	n/a	n/a	TOTAL#ofpeopletrainedtoprovideVCT services
HMIS	29. #offacilitiesproviding VCTservices	n/a	n/a	TOTAL#offacilitiesprovidingVCT services
HMIS	30. Tuberculosisdefaulterrate			
HMIS	31. %ofhealthfacilitieswith allessentialdrugsforTB/OI instockandnostockoutsof >1weekinthelast12 months	#ofallhealthfacilitiesthatprovide TB/OIservicessurveyed	#ofhealthfacilitieswithallessentialdrugs forTB/OIinstockandnostockoutsof>1 weekinthelast12months	n/a
HMIS	32. #ofpublicandprivate facilitiesprovidingART services	n/a	n/a	TOTAL#ofpublicandprivatefacilities providingARTservices
HMIS	33. %ofHCFsprovidingART serviceswithnoARVdrug stockoutsof>1weekinthe last12months	#ofallhealthfacilitiesthatprovide ARTservicessurveyed	#ofHCFsprovidingARTserviceswithno ARVdrugstockoutsof>1weekinthelast 12months	n/a
HMIS	34. #serviceproviderstrained toprovideARTservices	n/a	n/a	TOTAL#serviceproviderstrainedto provideARTservices

DATASOURCE	INDICATORDESCRIPTION	PERCENTAGE		VALUE
		DENOMINATOR	NUMERATOR	
HMIS	35. #ofpersonswithadvanced HIVinfectionreceiving ARVtherapy [17]	n/a	n/a	TOTAL#ofpersonswithadvancedHIV infectiononanti-retroviraltreatment
HMIS	36. #ofcondomsdistributedto endusers	n/a	n/a	TOTAL #ofcondomsdistributedtoend users
NAC PROGRAM REPORTING FORM	37. #of15-24yearoldswho receivelifeskillsbased HIV/AIDSeducation(incl. throughpeereducation)	n/a	n/a	TOTAL#ofyoungpeopleaged15-24 exposedtolife-skills-basedHIV/AIDS educationinthepast12monthsthrough workshops,peereducationorother methodologies
NAC PROGRAM REPORTING FORM	38. #ofserviceproviders trainedinthediagnosisand treatmentofSTIsaccording tonationalguidelines	n/a	n/a	TOTAL#ofserviceprovidersthathave undergonetraininginthediagnosisand treatmentofSTIsaccordingtonational guideline
NAC PROGRAM REPORTING FORM	39. #ofworkplace,including lineministries,with HIV/AIDSpoliciesand programmes	n/a	n/a	TOTAL#ofworkplaces,includingline ministries,thathavedevelopedHIV/AIDS policiesandarealsoimplementing comprehensiveHIV/AIDSinterventions (preventionandcareandmitigation)fortheir employeesandspouses
NAC PROGRAM REPORTING FORM	40. #ofemployeesreached throughworkplace-based HIV/AIDSinterventions	n/a	n/a	TOTAL#ofemployeesandspousesthat havebeenapartofeitherHIVpreventionor care&supportinterventionsthathavebeen definedintheorganisation'sworkplace strategyinthepast12months
NAC PROGRAM REPORTING FORM	41. #ofemployeestrainedto provideHIVbehaviour changeservicestofellow employees(incl.peer educators,counsellors,etc)	n/a	n/a	TOTAL#ofemployeestrainedtoprovide HIVbehaviourchangeservicestofellow employees(incl.peereducators,counsellors, etc)
NAC PROGRAM REPORTING FORM	42. #oflineministrieswith HIV/AIDSbudgetline items	n/a	n/a	TOTAL#oflineministrieswithHIV/AIDS budgetlineitems
NAC PROGRAM REPORTING FORM	43. #oflineministrieswith full-timefocalpointpersons forHIV/AIDS	n/a	n/a	TOTAL#oflineministrieswithfull-time focalpointpersonsforHIV/AIDS

[17] 6,000asofMay7,2004,15,000targetedfor2004and100,000for2005.TheprivatesectorinformationhasnotyetbeenintegratedintothepublicsectorHMIS

DATASOURCE	INDICATORDESCRIPTION	PERCENTAGE		VALUE
		DENOMINATOR	NUMERATOR	
NAC PROGRAM REPORTING FORM	44. #ofhealthcarefacilities conductinginfection preventionandhealthcare wastestorageanddisposal	n/a	n/a	TOTAL#ofhealthcarefacilitiesconducting infectionpreventionandhealthcarewaste storageanddisposal
NAC PROGRAM REPORTING FORM	45. #ofserviceproviders trainedinnationalstandards forinfectionpreventionand healthcarewastestorage anddisposal	n/a	n/a	TOTAL#ofserviceproviderstrainedin nationalstandardsforinfectionprevention andhealthcarewastestorageanddisposal
NAC PROGRAM REPORTING FORM	46. #ofPLWHAssupport groups	n/a	n/a	TOTAL#ofsupportgroupsforPLWHAs
NAC PROGRAM REPORTING FORM	47. #ofPLWHAenrolledin PLWHAsupportgroups	n/a	n/a	TOTAL#ofPLWHAenrolledinPLWHA supportgroups
NAC PROGRAM REPORTING FORM	48. #ofchronicallyillpeople enrolledincommunity homebasedcareprograms	n/a	n/a	TOTAL#ofchronicallyillpeopleenrolled incommunityhomebasedcareprograms
NAC PROGRAM REPORTING FORM	49. #ofserviceproviders trainedinprovidinghome basedcaretochronicallyill peopleenrolledinhome basedcareprograms	n/a	n/a	TOTAL#ofserviceproviderstrainedin providinghomebasedcaretochronicallyill peopleenrolledinhomebasedcareprograms
NAC PROGRAM REPORTING FORM	50. #oforphansandother vulnerablechildren receivingcareandsupport fromCBOs,/NGOs/FBOs	n/a	n/a	TOTAL#oforphansandothervulnerable childrenreceivingcareandsupportfrom CBOs,/NGOs/FBOs
NAC PROGRAM REPORTING FORM	51. #ofCBOs/NGOs/FBOs receivingfunding/technical assistancetoprovidecare andsupporttoOVCs	n/a	n/a	TOTAL#ofCBOs/NGOs/FBOsreceiving funding/technicalassistancetoprovidecare andsupporttoOVCs
NAC PROGRAM REPORTING FORM	52. #ofstreetchildrenre-integrated/integratedinto homes	n/a	n/a	TOTAL#ofstreetchildrenre-integrated/integratedintohomes
NAC PROGRAM	53. #ofIECmaterials printed/producedand	n/a	n/a	TOTAL#ofIECmaterialsprinted/produced anddistributed

DATASOURCE	INDICATORDESCRIPTION	PERCENTAGE		VALUE
		DENOMINATOR	NUMERATOR	
REPORTING FORM	distributed			
UNAIDS FINANCIAL RESOURCE FLOW SURVEY	54. Amountof fundsspenton HIV/AIDSinthepast12 months	n/a	n/a	Surveyofnationalgovernmentexpenditure onHIV/AIDSprogrammes.Thecostsofany multilateralorbilateralinternationaldonor-fundedgovernmentprogrammesshouldbe excluded.Similarly,alllocalNGO programmesshouldbeexcluded,exceptfor programmes(orpartsofprogrammes)that arefundedbythenationalgovernment. Allocatednationalfundscomprise expenditureonthefollowingfourcategories ofprogramme,totalsforeachofwhich shouldbespecifiedseparately: 1.STDcontrolactivities 2.HIVprevention 3.HIV/AIDSclinicalcareandtreatment 4.HIV/AIDSimpactmitigation
NATIONAL COMPOSITE POLICYINDEX	55. NationalCompositePolicy Index(NCPI)score	n/a	n/a	Thecompositeindexcoversfourbroadareas ofpolicy: A.Strategicplan B.Prevention C.Humanrights D.Careandsupport Anumberofspecificpolicyindicatorshave beenidentifiedforeachofthesepolicyareas. Aseparateindexiscalculatedforeachpolicy areabyaddingupthescores(yes=1,no=0) fortherelevantspecificpolicyindicatorsand calculatingtheoverallpercentagescore.The compositeindexiscalculatedbytakingthe averageofthescoresforthefour components.Whereappropriate,thescore foraspecificpolicyindicatorshouldbe assessedwithreferencetothestandardsand criteriaprovided

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