



ZIMBABWE

**Monitoring and Evaluation
PLAN for
Zimbabwe HIV and AIDS National Strategic
Plan (2006 – 2012)**



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Acronyms

ART	Antiretroviral therapy
AU	African Union
BCC	Behaviour Change and communication
CDC	Centre for Disease Control
CT	Counseling and Testing
DA	District Administrator
DAAC	District AIDS Action committee
DAC	District AIDS Coordinator
DBO	Data Base Officer
DHE	District Health Executive
DHIO	District Health Information Officer
DMEAG	District Monitoring and Evaluation Advisory Group
EMCOZ	Employers Confederation of Zimbabwe
HBC	Home-based care
HIV/AIDS	Human Immunodeficiency Virus/ Acquired Immunodeficiency Syndrome
ID	Identity Card
IP	Implementing Partners
M&E	Monitoring and Evaluation
MoHCW	Ministry of Health and Child Welfare
NAC	National AIDS Council
NARF	National Activity Reporting Form
NHIS	National Health Information System
NMEAG	National Monitoring and Evaluation Advisory Group
NHL	National Health Levy
ODF	Organisational Detail Form
OI	Opportunistic infection
OVC	Orphans and other vulnerable children
PAAC	Provincial AIDS Action Committee
PAC	Provincial AIDS Coordinator
PHE	Provincial Health Executive
PHIO	Provincial Health Information Officer
PLWHIV	People living with HIV/AIDS
PMTCT	Prevention of Mother to child transmission of HIV
SADC	Southern African Development Community
SOP	Standard Operational Procedure
STI	Sexually-transmitted infection
TB	Tuberculosis
UNGASS	United Nations General Assembly Special Session on AIDS-Declaration of commitment
WAAC	Ward AIDS Action Committee
WFP	Ward Focal Person
ZACH	Zimbabwe Association of Church Hospitals
ZAN	Zimbabwe AIDS Network
ZBCA	Zimbabwe Business Council on AIDS
ZIMA	Zimbabwe Medical Association
ZNASP	Zimbabwe National AIDS Strategic Plan

CHAPTER 1: BACKGROUND

1.1 HIV and AIDS Profile

Zimbabwe has an estimated 1.6 million infected with HIV, the virus that causes AIDS (MoHCW: 2005). With such a number of people living with HIV and AIDS, Zimbabwe is faced with a serious epidemic that is having a profound social and economic impact on the nation. Women and young girls constitute about 56% of those infected by HIV. Of the 1.6 million who are infected, about 350,000 need treatment, care and support. An estimated, 3000 people die of AIDS every week, mainly young adults between the ages of 15 and 49 years and about 1 million children aged 14 years and below have lost one or both parents to AIDS (MoHCW, 2005).

1.2 National response to HIV & AIDS

The government of Zimbabwe has put together a multi-sectoral response articulated in the Zimbabwe National HIV and AIDS Strategic Plan (ZNASP) 2006 – 2010. The ZNASP provides both policy and strategic guidance on all HIV and AIDS interventions carried out by implementing partners (IPs) and stakeholders in Zimbabwe. The figure below summarizes the national response.

Fig 1: Strategic Components of ZNASP



1.3 Monitoring and Evaluation (M&E) Framework

In order to closely monitor and evaluate implementation and progress towards achieving the goals of the ZNASP, the National AIDS Council (NAC), with support from the multi-sectoral National Monitoring and Evaluation Advisory Group (NMEAG), developed the national M&E framework for HIV and AIDS. The M&E framework is to guide maintenance and implementation of the national M&E system. The M&E framework guides all stakeholders in effective measurement of inputs, outputs, outcomes, and impact of the ZNASP (2006-2010/2011). The logical progression from the National M&E Framework is to create a National M&E Plan.

1.4 The “THREE ONES” Principle

The national M&E plan has been developed in accordance with “THE THREE ONES” principle, which Zimbabwe subscribes to:

- One agreed HIV and AIDS action framework that provides the basis for coordinating the work of all partners and stakeholders
- One national AIDS coordinating authority with a broad-based multi-sectoral mandate
- One agreed country level M&E system.

The national strategy is in place (ZNASP) and the National AIDS Coordinating Authority (NAC) are in place and the development of the M&E plan completes the three ones. The plan is informed by the ZNASP and it enables Zimbabwe to systematically monitor implementation of the strategic plan and gauge progress towards the achievement of both national targets and international commitments in the fight against HIV and AIDS.

1.5 Global and Regional Commitments

The republic of Zimbabwe is a signatory to several *international global and regional commitments and declarations* on which the nation is supposed to report regularly. These include Millennium Development Goals (MDGs), the United Nations General Assembly Special Session on AIDS (UNGASS), Global Fund to Fight AIDS, Tuberculosis and Malaria (GFTAM), SADC and African Union. The indicators selected in this plan cater for reporting to these global and regional commitments, in addition to national monitoring and evaluation requirements.

CHAPTER 2: INTRODUCTION

2.1 Goal of the National M&E Plan

The National M&E Plan is aligned with the strategic priority areas of the ZNASP. The overall goal of the national M&E plan is to provide a systematic approach to tracking activities related to the ZNASP strategic areas. The plan articulates, by program area, details of what information is needed including: indicators, data sources, data collection methods, data flow, data analysis, data use and reporting, and feedback as well as the responsibilities of implementing partners and stakeholders. It outlines strategies for developing M&E capacity in terms of human, material and financial resources. It also includes a detailed costed Annual Action Plan.

2.2 Objectives of the M&E Plan

The objectives of the plan are to assist NAC, implementing partners, and stakeholders to:

- *Guide policy and planning of the national response*

This will be achieved by providing the data needed to inform policy makers and stakeholders and facilitate use of information for planning purposes at all levels by program managers

- *Strengthen coordination of all partners and stakeholders working in the area of HIV and AIDS*

This will be achieved by facilitating ongoing technical support to the NAC secretariat, implementing partners, and stakeholders and assist programme managers in meeting reporting requirements within the ZNASP strategic areas

- *Monitor effectiveness of programs*

Programme managers will be able to: assess effectiveness of activities and recommend improved, cost-effective HIV and AIDS related interventions based on the data obtained by the M&E system. This will also enable Zimbabwe to meet regional (SADC, African Union) and global (UNGASS, GF) reporting requirements on HIV and AIDS

- *Facilitate data dissemination among implementing partners and stakeholders*

National information needs such as; provision of data on progress toward achievement of targets, will be met and communities will be informed on the status of the HIV and AIDS epidemic and response in their area

- *Guide Resource Mobilization*

Essential data will be provided to national, bilateral and multi-lateral funding agencies to assess results of the financial assistance they provide and identify funding gaps.

2.3 Definitions and Concepts

Monitoring and evaluation are complementary processes. Below are some of the key internationally accepted concepts and definitions in relation to HIV & AIDS program monitoring and evaluation.

- (a) **Monitoring:** Monitoring is the continuous, routine daily and regular assessment of ongoing activities and/or processes. It aims to provide management and main stakeholders of an ongoing intervention with early indication (or lack thereof) towards the achievement of outputs.
- (b) **Evaluation:** Evaluation is the episodic assessment, as systematic and impartial as possible, of the overall achievements of activities and/or processes. It aims to understand the progress that has been made towards the achievement of an outcome at a specific point in time. All evaluations are linked to outcomes (impact) as opposed to only immediate results (outputs).
- (c) **Indicator:** An indicator is a statement that describes the level of performance achieved in relation to a set of aims and/or objectives. An indicator provides evidence that a certain condition exists or certain results have or have not been achieved,
- (d) **Data source:** Data sources are tangible sets of information, usually in the form of reports, survey results, monitoring forms from the field, or official government data sets. Data sources provide the values of the indicators at a specific point in time.
- (e) **Information products:** An information product is a standard report/document that NAC or other stakeholders produce at regular intervals after receiving data and analyzing these data.
- (f) **M&E results chain:** There are four levels of indicators (inputs, outputs, outcomes and impact).
 - **Inputs:** Inputs are the resources that are needed to implement the project and its activities. Inputs can be expressed in the form of the people, equipment, supplies, infrastructure, means of transport and other resources needed for a specific project or activity.
 - **Outputs:** Outputs are the immediate results of the activities conducted. They are usually expressed in quantities, either in absolute numbers or as a proportion of a population. Outputs are generally expressed separately for each activity.
 - **Outcomes:** Outcomes are the medium term results of one or several activities. Outcomes are what the immediate outputs of the activities are expected to lead to. Outcomes are therefore mostly expressed for a set of activities. They often require separate surveys to be measured.
 - **Impact:** Impact refers to the highest level of results, to the long-term results expected of the project. Impact therefore generally refers to the overall goal or goals of a project.

2.4 Components of the M&E plan

The UNAIDS developed, “*12 Component Framework for Developing a Functional National M&E System*”, was used as a guide when developing the Zimbabwe national M&E Plan. The twelve components are summarized below.

People, Partnership and Planning

- Organizational structure with HIV M&E functions
- Human capacity for HIV M&E
- Partnerships to plan, coordinate and manage the HIV M&E system
- National multi-sectoral HIV M&E
- Annual costed national HIV M&E work plan
- Advocacy, communications and culture for HIV M&E

Collecting, verifying and analyzing data

- Routine HIV programme monitoring
- Surveys and surveillance
- National and sub-national HIV data bases
- Supportive supervision and data auditing
- HIV evaluation and research

Using data for decision making

- Data dissemination and use

2.5 M&E Plan Development Process

Participatory and qualitative approaches were used in developing this National M&E Plan. The participatory engagement in the development of the M&E plan was spearheaded by the NAC and the NMEAG with assistance from the Global Management Solutions (GMS) Project. The plan builds upon and complements the national M&E framework and is informed by input from the NMEAG and findings from a situation analysis conducted in twenty (20) districts and stakeholders consulted at national level

CHAPTER 3: THE NATIONAL M&E PLAN

The data required for monitoring and evaluation of the HIV and AIDS programme comes from program monitoring, project evaluations, research studies, surveys and surveillance data. This M&E plan proposes how data will be collected from these activities.

3.1 National M&E System Structure

Within the framework of the Three-Ones Principles the National AIDS Council is charged with a mandate to coordinate and maintain the one national M&E system. The Public, Private, and Civil Society Sectors are the three key sectors driving the multi-sectoral response to the HIV and AIDS epidemic and are collaborating with NAC in the national M&E system. Within NAC, the M&E system is coordinated through the organization's decentralized structures which exist at national, provincial, district and ward levels. At national, provincial and district levels, NAC has M&E staff and at ward level, the organization is represented by a Ward Focal Person (WFP) who coordinates partners' activities and facilitates implementer registration and reporting. All implementers register annually at district level and submit their programme output data to the District AIDS Coordinator on monthly basis. From the DAC, the data flows upstream through Provincial to National level. At national level there is a department headed by a Monitoring and Evaluation Director.

3.1.1 National Monitoring and Evaluation Advisory Group (NMEAG) and M&E Task Forces

NAC is supported at national level by a multi-sectoral and multi-disciplinary National Monitoring and Advisory Group (MEAG). The NMEAG facilitates participation of all stakeholders [government, donors, bilateral and non-governmental partners] in national monitoring and evaluation activities. It also guides NAC on monitoring and evaluation issues as well as facilitates coordination, quality, and standards in monitoring and evaluation. It also advises on the operational research needs of the country. NAC is mobilizing M&E task forces in the provinces and districts which will support provincial and district M&E functions in the same manner as the NMEAG.

3.1.2 Sector Coordination

The different sectors of the national response are coordinated by different players who collect specific data. These are as follows:

Table 1: Sectors responsible for the national response

Sector	Coordinating body	Functions
Health sector	Ministry of Health and Child Welfare	The Ministry of Health and Child welfare collects data from all health-facility-based interventions, both private and public health facilities. The NHIS department in the Ministry and is responsible for collecting all health information while HIV and

		AIDS intervention data is collected by the AIDS and TB UNIT in the Ministry. The NHIS is represented at provincial and district level while the ATB unit is at national level and utilizes the Ministry's administrative structures for data management. With proper alignment the private medical sector should report to the national M&E system through the Ministry.
Civil Society Sector	Zimbabwe AIDS Network	Monitoring and Evaluation in the Civil Society sector is coordinated through the sector's umbrella body known as Zimbabwe AIDS Network (ZAN), which is represented down to provincial level. However, data is currently flowing from individual organisations in the sector directly to NAC.
Private Sector	EMCOS, Zimbabwe Business Council on AIDS (ZBCA) and ZIMA.	There are four key coordinating bodies in the private sector but for purposes of monitoring and evaluation of HIV/AIDS interventions, the national M&E system is coordinated by ZIMA and ZBCA. ZIMA has been identified as the coordinating structure for private medical practitioners, while ZBCA will be collecting data from the non-medical business sector. These require capacity strengthening for the function.

3.2 Data Management

3.2.1 Data Sources

The data required for monitoring implementation of the ZNASP will come from the various implementers working in specific program areas. This data is collected at different levels of the response through a series of data collection tools. The tools will include the following:

Table 2: Data collection tools, purpose and organization responsible

Tool	Custodian	Purpose
<i>Organizational Details Form (ODF)</i>	NAC	Registration of implementers. The registration is done annually.
<i>National Activities Report Forms (NARF)</i>	NAC	Completed by implementers on monthly basis for submission of core output indicators to the national M&E system.
<i>ART and PMTCT Registers</i>	MoHCW	For ART and PMTCT data capture from clients by health workers at facility level, from which data is extracted onto reporting forms.
<i>Form 1</i>	MoHCW (AIDS and TB Unit)	For data flow from health facilities through district to AIDS and TB unit at head office
<i>T-series</i>	MoHCW (NHIS)	For data flow within the NHIS from health facilities through district to national office.

<i>Primary data collection tools</i>	Implementing Partners	To be developed by every implementer of non-health interventions and private medical health implementers for data collection at activity level from which they will abstract data onto national reporting forms (NARF or MoHCW Form 1).
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3.2.2 Registration of Implementing Agencies

To ensure that all activities conducted in a given district are recorded and counted, every implementing partner operating in the district must register with the District AIDS Coordinator (DAC) by completing and submitting the *Organizational Details Form* (ODF). Upon registration, the implementing partner is issued a computer generated organization ID number. The organization receives instructions on how to complete the relevant section of the NARF and how to submit completed monthly forms to the DAC. Reporting guidelines are also provided to implementers at the time of registration. Registration with the DAC must be *renewed every year*. It is the responsibility of the Village AIDS Action Committee (VAAC), Ward AIDS Action Committee (WAAC), District AIDS Action Committee (DAAC) and Provincial AIDS Action Committee (PAAC) to ensure that all implementing agencies in their area are registered and have ID numbers.

3.2.3 Data collection from Health Facility Implementers (including public, private, mission, local authority)

Data collected from health facility implementers include: *CT, adherence counseling, PMTCT, STI, infection control, blood transfusion, OI, ART, laboratory tests, pediatric ART and male circumcision*. Health facility implementers that offer services in these programme areas enter the service provided and client information on forms and registers supplied to them by the AIDS and TB Unit and the NHIS MoHCW. Every month, data from the registers is consolidated onto the AIDS and TB Unit *Monthly Return Form 1* and then onto the NAC *National Activity Report Form* (NARF). At this stage the above data collection tools and processes are not being used by private practitioners and some private hospitals and nursing homes.

3.2.4 Data collection from non-Health facility Implementers

Data from non health implementers include: *CT, behavior change communication (BCC), condom promotion and distribution, advocacy, home based care (HBC), youth focused programmes, PLWHIV, nutrition support, OVC, income generation, and workplace activities*. These implementers collect data on program activities using their own *primary data collection tools* and every month they consolidate the data onto organization or project specific consolidation forms. In addition, the implementers complete the relevant section(s) of the NARF and submit it to the DAC.

The cut off date for data collection for all implementers is the 25th of each month. At the district level, the deadline for implementers to submit data to the DAC is the 15th of the following month and the deadline for the DAC to submit data to the PAC is the 20th of the month. The PAC then sends the data to the NAC HQ by the 31st of the month. Written protocols describing the data collection process have been established yet protocols are not correctly interpreted by all implementers in both health and non-health facilities.

3.2.5 Strategies to improve data collection, tools and methods

- Register all implementing partners in all districts
- Renew organizational registration annually
- The Department of Social Welfare, the DA's office, ZAN and the NAC review and revise the registration process of AIDS Service Organizations in districts
- Include the person responsible for registering NGOs at the DA's office in DAC quarterly review meetings
- Review and revise existing NARF data collection tools, clarify cutoff dates and reporting timeframes and add a component appropriate to the private sector
- Formal linkages between NAC and MoHCW put in place to establish clear roles and responsibilities and strengthen role of NHIS in data collection.
- Address the issue of parallel reporting systems and adopt a single harmonized system
- Develop a data dictionary to harmonize AIDS and TB, NHIS and NAC indicators
- Increase coordination and communication between the DMEAG and DHIO
- Develop appropriate curricula for initial and refresher trainings for all staff involved in data collection
- Develop and revise mentoring tools and checklists for continuous support and supervision of staff responsible for data collection
- Develop a district-based training and mentoring program for data collection staff coordinated and supervised by the DAC and District Health Information Officer (DHIO) with support and oversight from NAC HQ and PAC
- Develop a standard operation procedure (SOP) for data collection for all implementers that can be applied to their setting. The SOPs will be short and simple (one page) and posted in the records office
- Create a checklist to track and manage availability of all the primary data collection tools (forms, registers and NARF forms including procedures for ordering and distribution) in order to avoid stock-outs and improvisation of tools
- Provide adequate filing facilities and training in development and maintenance of filing systems
- Develop a strategy and protocol to collect data from private practitioners and private hospitals

3.3 Data Storage - Database Management

Data storage and management varies from district to district. In some places data is stored manually, in others it is stored electronically while in others there is a combination of manual and electronic storage. The NHIS MoHCW maintains an electronic database as does the AIDS and TB Unit. The NAC is working toward development of a protocol for sharing data collected via the NARF and other databases managed by the AIDS and TB Unit, NHIS MoHCW, the private sector, OVC, CRIS, and ZimDat.

3.3.1 Strategies to improve data storage and database management

- Conduct of an inventory of existing databases
- Standardize the existing manual data storage system and move toward an electronic database in all districts to manage NARF data

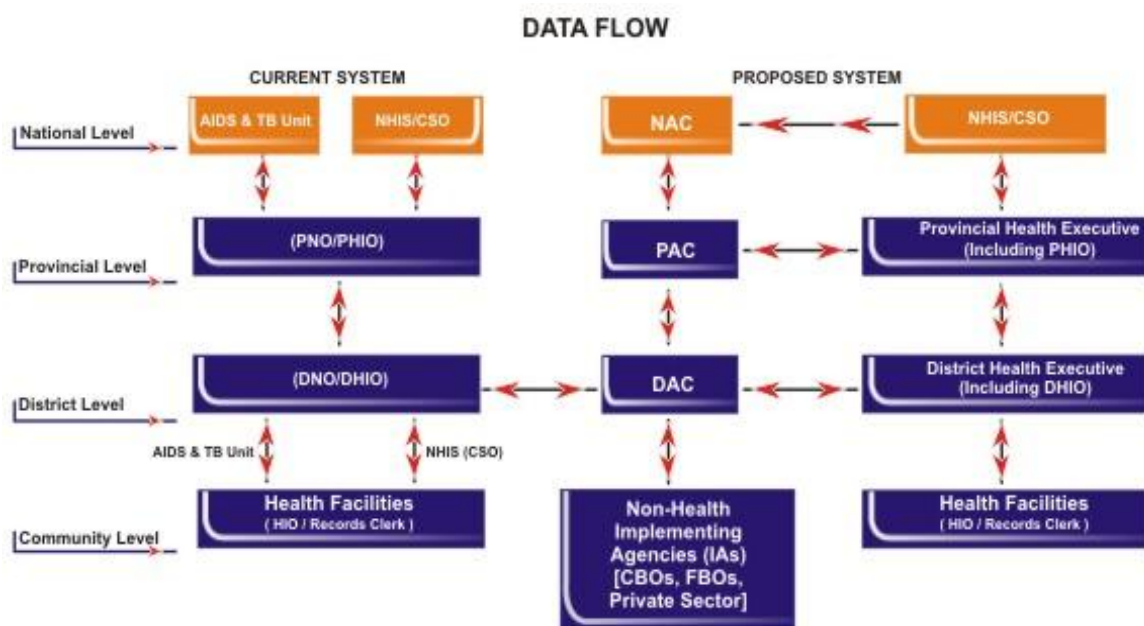
- Develop a mechanisms for sharing data from different HIV and AIDS related databases and provide programme managers access to complete disease surveillance and service coverage information online
- Develop a data dictionary to allow data sharing among existing databases (OVC, Private Sector) and national database at NAC HQ
- Establish and maintain district databases in all districts at DAC offices
- Establish and maintain provincial databases in all provinces at PAC offices
- Develop protocol for data sharing between NAC and NHIS that includes health sector data collected and managed by NHIS and non health data collected and managed by NAC. This protocol will include the appropriate role of the CSO

3.4 Data Flow and Transmission

Transmission of data in the right format, at the right time and to the right people is as important as collection of data. Transport, postal and delivery options at facilities differ from district to district which affects data flow and transmission. Implementing partners must use the most efficient and effective transmission means available in their district.

The following figure illustrates the existing flow of data and the proposed flow of data needed to implement the M&E plan.

Fig 2: Data Flow



3.3.1 Strategies to improve data flow and transmission

- In each district the DAAC or District Monitoring and Evaluation Advisory Group (DMEAG) will develop a data transmission system that flows from implementers to the DAC. All implementing agencies operating within the district will be informed of the system

- Multiple options or opportunities for data transmission that allow flexibility and take into consideration changes that might take place from time to time will be identified. Such options will include any visit to a health facility for supervision, patient transport, vaccine or drugs or gas delivery. In addition, transport from other sectors could be used as well as Expedited Mail Service (EMS)
- Issues related to transmission of forms will be discussed and addressed at the quarterly review meetings with the DAC and DMEAG
- Facilitate improvements in e-mail and telephone access from implementing partners to DACs and DHIOs to enable them to communicate verbally and/or electronically to address any issues with transmission of forms that might arise
- Provide cell phones and other technologies to each DAC and selected M&E focal persons at the WAAC level
- Establish electronic connectivity at every DAC office with the PAC office and NAC HQ to enable all districts to send reports by email. This will be achieved by accessing the free Internet connection currently provided by Healthnet in many districts

3.4 Data Quality and Assurance

There is a plan in place for data verification at the district, province and national level. However, due to lack of resources, it is not routinely implemented.

3.4.1 Strategies for improving data quality and assurance

- Provide resources needed to consistently implement the data verification plan at the district, province and national level
- Provide on the job training during data verification at the district, province and national level
- Provide ongoing training, supervision and mentoring to all staff involved in data verification

3.5 Data Analysis and use

A standard data analysis and use plan is critical for effective planning, coordination, and implementation of programme activities. The results of data analysis should inform all implementers in a timely manner so they can make appropriate changes in program management and resource allocation.

3.5.1 Strategies to improve analysis and use of data

- Develop an analysis plan for all levels of the M&E system that will serve as a guide on how to use data. The plan will also act as a template for the selection of key indicators for systematic monitoring at all levels (implementer, health facility, district, province and national)
- Develop standard training curricula for data managers, implementers, M&E staff and HIOs at all levels on data analysis and use
- Presentation of information and data on selected indicators will be a regular agenda item for quarterly district management meetings

- Develop simple data monitoring tools to facilitate use of data at all levels. One example is a flip chart template that includes a selection of the key indicators to tracks trends and progress over time

CHAPTER 4: INFORMATION PRODUCTS, DISSEMINATION & UTILIZATION

4.1 Data Reporting and Data Dissemination

A critical component of an M&E system is getting information collected back to decision makers, key stakeholders and implementers in a timely manner so it can be used for planning, management, supervision, coordination and implementation.

4.2 Strategies to improve reporting and dissemination

4.2.1 Reporting

- Reports will include data on selected key indicators by strategic area, baseline and progress towards achieving targets.
- Develop a training curriculum for implementing partners, stakeholders and DACs, and M&E officers on report writing, presentation of data and the role of dissemination in planning.
- Develop and/or strengthen a reporting plan that includes a standard set of regularly generated summary report templates. These reports will be generated quarterly, bi-annually and annually at the district, province and national levels
- Train DACs to be effective presenters and facilitators in order to improve the quality and utility of quarterly reports and meetings
- Provide on going support and mentoring to DACs enabling them to generate specialized reports that address the information needs of local implementing partners and stakeholders
- Provide equipment such as LCD projectors, laptops and flash drives to DACs to facilitate presentations at quarterly review meetings

4.2.2 Dissemination

- Develop a systematized approach for dissemination at all levels for implementers.
- Develop a data dissemination plan to include: which institutions and individuals receive reports, who sends out reports, the format of the reports and the best approach to get reports to the various institutions in a timely manner
- Establish mechanisms for stakeholders to give feedback to the DAC, PAC and NAC

4.2.3 HIV and AIDS Information Stakeholders

Primary Stakeholders

- AIDS Service Organization
- MOHCW
- Department of Social Welfare
- Other government ministries
- Central Statistical Office
- Academic institutions
- Local NGOs

Secondary Stakeholders

- Bilateral organizations
- UN Agencies

Tertiary Stakeholders

- Multilateral organizations (ESP, GFATM, World Bank)
- International NGOs
- SADC
- International reporting commitments

The following table lists priority and standard M&E reports to be prepared at different levels of the system.

Table 3: Priority and Standard M&E Reports at different levels

Report	Responsible	Key recipients
DAC District Quarterly Statistical Reports	M&E Officer, DAC	WAAC, VAAC, DA, DMO, NAC, PAC & District level implementers
District Health Information Quarterly Report	Health Information Officer/DMO	DAC, PMD, District implementers
NAC National Quarterly reports	NAC M&E Unit	All stakeholders, umbrella organizations, private sector, DAC, and PAC, MOH and CSO
Quarterly AIDS and TB Unit report.	AIDS/TB unit (Director)	MoHCW Dir of Preventive Services, Members of the planning pool, NHIS, NAC and PMOs
NAC M & E Bulletin	NAC	All stakeholders
NAC Annual M & E report	NAC M&E Unit (Director)	All stakeholders, umbrella organizations, development partners, private sector, DAC, PAC, Cabinet Committee, Parliamentary Health Committee
Annual AIDS and TB Unit report	AIDS and TB Unit (Director)	All stakeholders, umbrella organizations, development partners, private sector, DAC, PAC, Cabinet Committee, Parliamentary Health Committee
Thematic Reports	NAC and Stakeholders	All stakeholders, umbrella organizations, development partners, private sector, DAC, PAC, relevant government departments

Dissemination Mechanisms

- NAC website uploaded quarterly
- MOH&CW website uploaded quarterly
- ZIMDAT website
- Printed copies to all key stakeholders
- District Stakeholders Coordination meetings
- Provincial Stakeholders Coordination meetings
- National Partnership Forum
- Newsletter

CHAPTER 5: NATIONAL PERFORMANCE MEASUREMENT FRAMEWORK

5.1 National Performance Measurement Framework

This section provides the list of indicators that satisfies national, regional (SADC, AU), and global (UNAIDS, UNGASS) commitments. The list is organized by the ZNASP strategic areas and objectives and includes the following information; indicator type, frequency and responsible party for data collection, data source, baseline data and targets. Although baseline and some targets exist, they do not cover all program areas. ANNEX 4 shows a list of national indicators and their definitions.

The list of indicators tracks output, outcome and impact indicators. It should be emphasized that this approach **does not** prohibit or even discourage development and use of additional project specific indicators that are not included on this list. There are many process and output indicators that are essential for monitoring program activities and implementers are **encouraged** to collect them but these types of indicators are not meant to be directly captured by the national M&E system.

The process of developing the list of indicators included review of the following documents:

- ZNASP
- National M&E Framework
- NARF
- NAC supporting documents
- Program specific strategic plans
- SADC, Global Fund, PEPFAR and UNGASS reporting requirements

5.1.1 Strategies to Improve National Performance Measurement Framework

- Hold a stakeholders workshop annually to review the national M&E indicators
- NAC will spearhead the implementation of results of the above mentioned workshops
- NAC will collaborate with NHIS, CSO and stakeholders to establish appropriate and effective baseline and targets for all ZNASP program areas and at all levels
- Develop a data dictionary to assure indicators are harmonized with AIDS and TB Unit and NHIS MoHCW indicators
- NAC will train DACs and M&E officers in target setting
- NAC will work with NHL to develop additional indicators to effectively track rollout of ART services
- Review role of lab in national response to HIV and AIDS and develop additional appropriate lab indicators
- Commission a compilation of annual M&E Report on progress of implementation of the plan

CHAPTER 6: EVALUATION, SURVEILLANCE & RESEARCH

6.1 Evaluation, Surveillance and Research

Assessment of the extent to which objectives of the strategic plan (ZNASP) are met requires an array of periodic evaluations. These evaluations are critical to collection of specific outcome and impact indicators as well as evaluating some fundamental attributes of programs such as efficacy, equity, relevance, appropriateness etc. In a national program, whereas the monitoring component of program's Monitoring and Evaluation plan can be integrated into implementation plans, evaluation cannot because of its cost. The Evaluation component therefore has to be strategically planned for utilizing national surveys and surveillances, project evaluations and other similar researches.

Below are the surveillance systems and national surveys which will be utilized for the evaluation of the national response to HIV and AIDS in Zimbabwe:

Table 4: Description of Surveillance systems and national surveys

Survey Surveillance Evaluation Study	Description
1. <i>ANC sentinel surveillance</i>	The target group of this study is pregnant women. Its objective is to “establish HIV and Syphilis prevalence among antenatal clinic clients.” This serves to monitor the HIV and AIDS epidemic and to inform HIV and AIDS prevention and control interventions in Zimbabwe” (ANC Protocol 2009). The survey is conducted in 19 sentinel sites around the country as an anonymous, unlinked sero-survey. It is done every two years. It is coordinated by the Ministry of Health and Child Welfare with support from partners.
2. <i>Zimbabwe Demographic Health Survey (ZDHS)</i>	The ZDHS is a national population based survey conducted every five years. It is conducted by the Central Statistical Office (CSO). It collects information on fertility, nuptiality, sexual and reproductive health, family planning, nutrition of infants and mothers, maternal and child health, awareness and behaviour regarding HIV and AIDS. The 2005 – 2006 DHS also collected data on malaria prevention and treatment, domestic violence, Orphans and Vulnerable Children (OVC) and population based prevalence estimates for anaemia among men, women and children and HIV among men ages 15 to 49 years and women ages 15 to 59 years.
3. <i>Young Adult Reproductive Health and HIV and AIDS Survey (YAS)</i>	This survey is conducted by the Zimbabwe National Family Planning Council (ZNFPC). Its objective of this survey is “to generate a nationally representative population based estimate of HIV prevalence among young adults aged 15 – 29 years and to provide baseline data on reproductive health behaviours, coverage of AIDS care and prevention programs and quality and barriers to their use” (YAS report). The last survey conducted in 2001-2002 collected biological specimen for anonymous HIV testing to obtain estimates of HIV prevalence in the target group. Plans were to repeat the survey every three to five years, which has not been possible due to funding constraints.

<p>4. Early Warning Indicator (EWI) survey</p>	<p>The EWI survey is conducted by the MOHCW and it assesses the Zimbabwe ART program so as to optimize prevention of HIV Drug Resistance. It is meant to be done yearly, in all sites providing ART for at least one year. However the first survey conducted in October 2008 included only 41 sites. Indicators collected through this survey are: percentage of individuals starting ART who are prescribed a standard regimen as described in the National Treatment Guideline (Target 100%), percentage of patients starting first line ART, lost to follow-up at 12 months of ART (Target <20%), percentage of persons starting first-line ART during a selected calendar month who are still on first-line ART 12 months later (Target >80%) and number of quarters in a year when patients did not go home without a prescription because drugs were not available in the dispensing pharmacy (Drug supply continuity) (Target 100%).</p>
<p>5. HIV DR Threshold survey</p>	<p>The Threshold Survey for transmitted HIVDR is a minimum-resource methodology based survey protocol which evaluates the extent of transmitted HIVDR in specified geographic areas of a country where ART has been scaled up and therefore has been widely available to the treatment-eligible population for at least 3 years^{2, 6}. The threshold survey classifies DR prevalence (for each drug or drug class) according to thresholds: < 5% low; 5 -15% medium; > 15% high. If prevalence is classified as < 5% to all relevant drugs, the HIVDR TS should be repeated two years later. If prevalence is classified in the high categories, additional surveys or more resource-intensive surveillance may be required, as well as additional public health actions. The first survey in Zimbabwe has done during the ANC Survey 2009 and samples of HIV positive specimens women (= < 25yrs) collected for genotyping. Geographic sites should have a minimum number of samples of 38 for analysis of the results.</p>
<p>6. HIV drug resistance monitoring</p>	<p>HIVDR prevention surveys support and builds upon EWI collection and includes viral load and HIVDR testing. This is a prospective survey to be conducted in Zimbabwe, which assesses success of ART in preventing HIVDR during first year of treatment. It identifies factors associated with the emergence of HIVDR which can be successfully addressed at the level of the ART site and program. Zimbabwe will begin with a pilot of 3 sites. Samples will be sent to WHO accredited laboratories for genotyping because Zimbabwe does not have the requisite equipment for the tests.</p>
<p>7. Midterm and Terminal Evaluation of ZNASP</p>	<p>The Zimbabwe National HIV/AIDS Strategic Plan (ZNASP) is a 5 year (2006-2010) national strategic plan developed to coordinate, monitor and strengthen implementation of the multi-sectoral response to HIV and AIDS. The National AIDS Council and partners has to conduct mid-term and terminal evaluations of the ZNASP. These evaluations will assess program achievements, impact and appropriateness of strategies, objectives and review targets. The MTR is scheduled for mid 2009.</p>
<p>8. National AIDS Spending Assessment (NASA)</p>	<p>The NASA is a resource tracking survey that collects data on actual expenditures for HIV and AIDS from private, public and external sources. The survey also collects actual expenditure by programme area and category of beneficiaries. Zimbabwe is conducting its first NASA in 2009 and has institutionalized it at district level. Plans are to make this an annual assessment which will provide the country with information on the distribution of HIV and AIDS expenditure, which when compared with beneficiary outputs, gives indication of effectiveness of the programmes in the national response.</p>

<p>9. Measurement of Access and Performance survey (MAP survey)</p>	<p>This survey is conducted in the sexual and reproductive health sector. It seeks to monitor the performance of product delivery systems and the resultant product availability, cost-effectiveness, coverage, quality, and equity of access to products. The survey is conducted by Population Services International (PSI) in Zimbabwe. Future rounds of this survey will serve as evaluations of progress in programme quality improvement following findings from the first round.</p>
<p>10. Tracking Surveys / Project TRAC</p>	<p>This is a national population based survey that is conducted annually. Project TRAC collects information on behavioural indicators in HIV prevention but additionally uses ‘segmentation’ analyses on at-risk populations to determine those with desired behaviors, and those not. This exercise enables program managers and communications specialists to identify the opportunity, ability and motivation factors that influence or correlate with desired behaviors in HIV prevention.</p>
<p>11. Multi-indicator cluster survey</p>	<p>This survey is part of an international initiative developed to measure progress toward an agreed set of goals that emerged from the 1990 World Summit for Children. It collects data on the situation of women, children and other vulnerable groups in the country. Zimbabwe is conducting MICS3 in 2009, which is expected to provide an update on key developmental indicators, including the MDGs on women and children. The Central Statistical Office is the coordinates this survey with support from UNICEF and other partners. The MICS is supposed to be conducted every 3 to 5 years subject to availability of funding from partners.</p>
<p>12. Behavioral Surveillance Survey (BSS+)</p>	<p>The BSS is an international population-based survey designed to study HIV trends and patterns in at risk populations. It enables a country to establish the estimated population of its sexual minorities and their characteristics such as MSM; WSW; and bisexuals. And the estimated prevalence of HIV within each sub-group. It also characterizes knowledge and personal risk perceptions of HIV among the sub-groups as well as assessing factors that determine vulnerabilities to HIV and risk-increasing sexual behaviors. It also assesses services provided to each sub-group and their access to prevention and treatment (including HIV testing, counseling and ARV treatment). Zimbabwe has plans to conduct the BSS in 2010 and thereafter conduct this survey every 2-3 years.</p>
<p>13. Operations Research in ZNASP</p>	<p>At this time, Zimbabwe does not have an OR plan in place and does not have a resourcing mechanism for such research. However, the recently instituted SADC initiative is expected to stimulate and strengthen research among National AIDS Councils within the region, including Zimbabwe. When this starts in Zimbabwe, the country is expected to set up an operations research agenda which will fill the gaps identified in research on the national response.</p>
<p>14. MIPA baseline study</p>	<p>Zimbabwe conducted the first MIPA baseline in 2008. This mapped where Zimbabwe was in the extent, levels and forms of participation of PLHIV in structures and programmes of the national response to HIV and AIDS. The plan is for Zimbabwe to conduct MIPA evaluations bi-annually.</p>
<p>15. HBC Evaluation</p>	<p>This evaluation provides a mapping of organisations in HBC, ascertain number of people on HBC, map strategies and approaches, and evaluate quality and effectiveness of programme services. The first evaluation was conducted in 2006. Plans are to do the evaluation every 2-3 years, resources permitting.</p>

16. Know Your Epidemic Study	This survey assists a country to determine the type of epidemic the country has, whether generalized or concentrated. It also determines the modes of transmission of HIV in the epidemic. Zimbabwe has plans to conduct the first survey in 2010. The survey has an added advantage over other surveys that estimate HIV prevalence in that the study covers More-at-risk populations (MARPS) and determines HIV prevalence among them.
17. Operations for the NAP for OVC Program	An operations research agenda was developed for the NAP for OVC programme. Currently four studies are under way under this agenda up to 2010. The studies are expected to inform programming strategies for children orphaned and made vulnerable by HIV and AIDS.

6.1.1 Strategies on Evaluation, Surveillance and Research

- Operationalize the *Research Advisory Committee and M&E task forces at all levels*
- Develop a database of national evaluations and researches underway (from SADC, MRCZ, Colleges and Universities)
- Facilitate periodic research meetings for sharing of findings at all levels
- Develop a national research agenda and evaluation plan
- Build research capacity in HIV and AIDS by providing fellowship for masters and PhD programs
- Build *operations research* capacity at all levels through the District Research Initiative (DRI)
- Facilitate integration of key outcome and impact indicators in national surveys
- Improve PMTCT data in preparation for transition from use of ANC surveillance data to use of PMTCT data to estimate prevalence among pregnant women
- Develop and carry out an evaluation of the M&E system to coincide with the ZNASP mid-term evaluation. The focus of the evaluation will be to assess the M&E approach to tracking the multi-sectoral response to HIV and AIDS
- Establish an HIV and AIDS research bulletin
- Conduct annual HIV and AIDS conference
- Develop a financial monitoring system to track M&E financial inputs and outputs

CHAPTER 7: STRATEGIES FOR M&E CAPACITY STRENGTHENING

7.1 M&E Staffing

Implementation of the M&E plan requires the establishment of an appropriate staff complement in NAC. Currently, the organization is suffering from high staff turnover because of low remuneration. The number of M&E staff positions is not adequate at national level. In addition, there are capacity gaps among the M&E staff.

7.1.1 Strategies to improve M&E staffing levels, knowledge and skills in M&E

- Conduct a skills and manpower audit and job evaluation among M&E staff in NAC, AIDS and TB Unit, NHIS and implementing partners,
- Develop a national training curriculum for M&E staff for both initial training and refresher training
- Hire and train additional staff to carry out M&E activities to fill identified gaps in staffing
- Develop annual province and district-based training plans for M&E personnel
- Conduct trainings skills building training as per plans
- Develop on the job continuous education and mentoring tools for use by M&E supervisory staff
- Introduce annual performance based rewards for well performing districts
- Review remuneration in order to retain staff

7.2 Coordination and Leadership for M&E

NAC has the mandate to coordinate the monitoring and evaluation of all HIV & AIDS interventions in Zimbabwe. To execute this mandate, NAC has established an M&E Unit with staff at HQ, province (PAAC) and district level (DAAC). See Annex 3 for TOR of NMEAG. There is no designated M&E staff at the sub-district (WAAC and VAAC) level. In addition, NAC has also established the Monitoring and Evaluation Advisory Group (MEAG). Composed of representatives from Zimbabwean National AIDS Council (NAC), Ministry of Health and Child Welfare, Development partners, Academic and Research Institutions, key implementing organizations, MEAG serves as a technical advice-giving and consultative group to the National AIDS Council of Zimbabwe. Plans are underway to establish similar M&E advisory groups at provincial and district levels. Technical Working Groups (TWGs) are created from member volunteers for specific tasks for a defined time period.

7.2.1 Strategies to improve coordination and leadership for M&E

- Develop terms of reference (TOR) for the TWGs of the NMEAG
- Develop TOR for provincial MEAG (PMEAG) and district MEAG (DMEAG)
- Develop operational guidelines for PMEAGs and DMEAGs
- Hold quarterly meetings of PMEAGs and DMEAGs
- Presentations on HIV and AIDS by the DAC and PAC will be done at the quarterly district and provincial *Health Management Team* meetings respectively
- Conduct regularly scheduled six monthly supervisory visits to implementing agencies, districts and provinces by members of the DMEAG, PMEAG and NMEAG (respectively)

- Hold quarterly meetings of the Minister of Health with Principal Medical Director of Disease Prevention, Permanent Secretary, Director AIDS and TB Unit, and NAC CEO
- Annual presentation on HIV and AIDS to the Cabinet Committee of Social Services and to the Parliamentary Portfolio Committee on Health will be done by NAC
- Appoint a member of the WAAC as an M&E focal person
- Strengthen PMEAGS and DMEAGs in each province and district

7.3 Equipment and Supplies

A minimum package of office furniture and equipment for all M&E units at national, provincial and district level has been determined and includes the following:

- Office space
- Office furniture (desk, 2 chairs, filing cabinet)
- Desk top computer with appropriate software for data processing and management
- One high capacity printer
- One photocopier
- Telephone, fax, emails
- Vehicle
- Binding machine

7.3.1 Strategies for Equipment and Supplies

- Develop policy to address how, when and to whom computers are supplied and distributed at each level
- Conduct an in depth inventory of the following:
 - Equipment at the all levels
 - Office space and leasing options
 - Consumables like printing paper, printer cartridges and writing material and establish a system of ordering and supplying these items
- Based on findings of the inventory assessment, conduct resource mobilization with development partners
- Network computers to facilitate horizontal sharing of information at all levels of the system including implementing partners and stakeholders
- Conduct relevant training in use of electronic technologies and equipment
- Establish IT support systems by training existing staff (DBOs), contracting, or hiring IT support staff
- Provide funding for vehicle repairs, maintenance, and fuel
- Explore and pilot alternative technologies such as, mobile/cellular transmission services powered by either solar or battery to alleviate problems caused by power outages

CHAPTER 8: IMPLEMENTATION OF THE M&E PLAN

8.1 Linkages, Integration and Partnerships

The National M&E Plan for HIV and AIDS is linked to other important policies and initiatives already under implementation. The success of the strategies of the plan therefore, depends on deliberate efforts to promote strong partnership among all the stakeholders. The implementation strategy is aimed at supporting M&E stakeholders at all levels to successfully operationalize the National M&E Plan. Similarly, the institutional framework is designed to facilitate effective coordination of M&E activities at all levels. The implementation strategy will target high priority areas of the M&E plan that need to be addressed for the plan to be quickly operationalized and efficiently implemented. The following categories of interventions will be prioritised for immediate implementation and gradual expansion:

- Human resources
- Equipment and supplies
- Data management and
- Leadership and coordination

8.2 Institutional Arrangements and roles and responsibilities

The NAC Board is responsible for implementing the multi-sectoral response to HIV and AIDS in Zimbabwe and so it has the mandate for overall plan supervision. At the National and sub-national levels, appropriate institutional arrangements and capacities will be created and resources provided to facilitate participation in M&E at all levels. Table 1 summarizes the institutional framework and roles and responsibilities for operationalising the M&E plan.

Table 6 M&E Institutional and Functional Linkages Framework and Roles and Responsibilities

Institution/Person	Responsibility
Political Oversight and support	
Cabinet Committee on Social Services.	Review Annual Report on ZNASP implementation. Review Policy direction based on report. Ensure adequate funding for national response.
Parliamentary Committee on HIV and AIDS.	Receive
NAC Management Committee	Enforcing accountability in the implementation of the National M&E Plan, including policy and program implementation.
Policy/Technical Coordination	
M&E Unit of NAC housed at NAC HQ	Provides overall day-to-day management of the implementation process of the M&E plan. Provides secretarial support services to the MEAG.
NMEAG	Provide technical oversight in the implementation of the National M&E Plan. Provide technical guidance on the implementation of the National M&E Plan.

	Provide technical advice to the Parliamentary Committee on HIV and AIDS, the Cabinet Committee on HIV and AIDS, NAC Board.
Minister, Secretary for Health, Principal Medical Director for Epidemiology, CEO/ NAC, Director AIDS and TB Unit	Quarterly review meetings to monitor progress in implementing ZNASP and achievement of national targets and regional and global commitments. Present Annual Report on implementation of ZNASP to the Cabinet Committee on Social Services.
Government Departments	Ensure active integration of M&E into their HIV & AIDS sector and support implementation efforts at the national, provincial and district levels. Planning and budgeting of M&E activities into their department budgets. Prepare program and financial reports and submit to NAC for monitoring purposes.
Civil Society Organizations and Private Sector Umbrella bodies (ZAN, ZBCA).	Ensure that M&E is mainstreamed in all their HIV and AIDS activities. Monitor and evaluate their HIV and AIDS activities and report to NAC M&E Department. Align their M&E programs in support of the National M&E Plan for HIV and AIDS. Provide program and financial reports. Conform to standards and norms set by the NAC M&E Department.
Development Partners	Provide requisite technical support. Assist the NAC M&E department in mobilizing needed resources. Support analytical work to inform policy implementation and M&E. Adhere to the agreed M&E plan, work plan and reporting requirements. Align their M&E initiatives to National M&E Plan for HIV and AIDS.
Operational level	
Health Facility record/data clerks	Order and maintain adequate stocks of data collection tools/forms. Distribution of tools/forms to all departments or units where they are needed within the health facility. Proper filing or storage of completed forms. Monthly consolidation of data/statistics. Preparation of analytical summaries based on templates. Timely presentation of consolidated statistics to senior facility managers.
Health facility senior management (RHC, polyclinic, hospital senior management)	Support and supervision to data clerks. Review facility statistics for accuracy and completeness. Review analytical templates and take appropriate action. Approve consolidated monthly statistics for submission to

	district level.
District Health Information Officer (DHIO)	Collect and collate data from all health facilities in the district. Support and supervise records clerks in health facilities. Fill data analysis templates for presentation to DHE. Timely submission of data to PHIO and to DAC. Training and mentoring of data clerks.
Provincial Health Information Officer (PHIO)	Collect and collate health data from all the districts in the province. Support and supervise records DHIOs. Fill data analysis templates for presentation to PHE. Timely submission of data to NHIS HQ. Training and mentoring of DHIOs.
DHE/PHE	
Non-health facility implementing agency M&E Focal Person.	Order and maintain adequate stocks of data collection tools/forms. Proper filing or storage of completed forms. Monthly consolidation of data/statistics. Preparation of analytical summaries based on templates. Timely presentation of consolidated statistics to senior facility managers.
VAAC and WAAC	Ensure that all implementing agencies operating in their area are registered. Appoint an M&E focal person in the VAAC/WAAC. Receive and review statistics from their area and take appropriate action.
DAC/M&E Officers at district level/DBOs	Supervise, support and mentor M&E focal persons at implementing agencies. Collection and collation of data and statistics from all the IAs in the district. Coordinate training for M&E in the district. Management of the district data base. Timely submission of reports.
PAC/M&E officers	Collection and collation of data and statistics from all the districts in the province. Supervision and support of M&E Officers level/DBOs at district level. Coordinate training for M&E in the province
DMEAG/PMEAG (These are subcommittees of the PAAC and DAAC that will focus on M&E).	Ensure that M&E is actively mainstreamed into HIV and AIDS activities in all provinces and districts Ensure that the M&E plan is being implemented according to plan.

8.3 Communication and Dissemination of the M&E Plan

Launching of the plan

In view of the importance of the National M&E Plan for HIV and AIDS as one of the three central pillars of the nation's response to the HIV epidemic, the plan shall be officially launched at a high level to be attended by representatives of all national stakeholders from all levels as well as development partners.

Dissemination of the plan

It is important for all stakeholders contributing to the implementation of the ZNASP to be aware of and familiar with the M&E plan so that they are clear about their role and responsibility in ensuring effective tracking of activities to prevent the transmission of HIV and to treat and care for those living with or affected by HIV and AIDS. The plan will be distributed widely electronically and hard copies to umbrella/coordinating bodies of key stakeholders, individual implementing agencies and health facilities, development partners.

8.4 Technical Assistance to facilitate implementation of the plan

The NAC M&E department will be responsible for ensuring that the M&E plan is implemented in a timely manner. The NMEAG will provide necessary technical advice to the department. However, in view of the fact that members of the NMEAG are full time employees of their respective organizations, there will be need for outside Technical Assistance to support the M&E department in performing the tasks needed to ensure effective and timely implementation of activities in the plan. There will be need to build capacity in not only M&E but in leadership and management in general among elected leaders, policy makers, programme/project managers and health facility managers at all levels District and Provincial Health Executives as well as the national level managers. There is need to build a culture and skills in use of information, data and statistics for decision making and monitoring progress in achieving set national, regional and global targets.

Table 6: M&E Framework and Targets

HIV AND AIDS NATIONAL MONITORING AND EVALUATION PLAN 2006 – 2010										
STRATEGIC AREA: PREVENTION										
PROGRAMME AREA	INDICATOR	INDICATOR TYPE	(N/R/G) INDICATOR	FREQ	SOURCES OF DATA	TARGET				COMMENT
						BASE-LINE	2010	2011	2012	
	ZNASP Objective: To reduce the number of new HIV infections in both vulnerable groups and general population									
HIV Prevalence	1.1.1 HIV Prevalence among adult men and women (15-49 yrs)	Impact	National	2 yrs	HIV and AIDS Estimates	13.7% [2009]	13.5%	13.3%	13.1%	Past trends showing declining rate of decrease.
	1.1.2 HIV Prevalence among women aged 15-24 attending ANC	Impact	National	2 yrs	ANC Survey [MOHCW]	11.6% [2009]	11.0%	10.0%	8.6%	Targets set for MDG & Universal Access reports
	1.1.3 Percentage of young women and men aged 15-24 who are HIV infected	Impact	UNGASS 22	2 yrs	HIV and AIDS Estimates	7.5% ¹ [2009]	6.5%	5.5%	4.5% ²	Rate of decrease expected to decline
	1.1.4 Percent of more-at-risk population who are HIV infected	Impact	UNGASS 23	2 yrs	Special Study [UNAIDS]	Not known ³	-	-	-	MARPS are not well-defined and legalized hence never research in Zimbabwe. Country hopes to get funding to conduct a special study on MARPS.
	1.1.5 Percentage of HIV infected infants born to HIV infected mothers who are infected	Impact	UNGASS 25	Annual	Program Data, [MOHCW]	Not Known ⁴	-	-	-	MoHCW currently not collecting this indicator because of challenges in testing babies but expected to start in 2010.
PMTCT	To increase the uptake of PMTCT services among ANC women from 42 % to 90% by 2010									

¹ National HIV Estimates 2009

² Current trends – 19.9% (2002), 17.4% (2004), 13.1% (2006), 7.5% (2009), declining by 2n% (n=1, 2, 3...) every two years,

³ Zimbabwe failed to report on this indicator in the last two UNGASS reports because of non-availability of data. MARPS are not well-defined in Zimbabwe. Research has also not been possible in this area because some of the activities involving these groups are deemed illegal in the country.

⁴ Zimbabwe has not been collecting this indicator. The MoHCW has promised to start collecting the indicator in 2010 and the 2010 figure shall be the baseline.

PMTCT	1.2.1	Percent of health institutions with ANC facilities offering basic PMTCT services	Output	National	Annual	Program Data [MOHCW]	96% [2009]	96%	96%	96%	Some health facilities cannot be improved because of setup hence no further improvement expected
	1.2.2	Percent of health institutions with ANC facilities offering comprehensive PMTCT services (HIV testing and ARVs)	Output	GF	Annual	Program Data [MOHCW]	59% [2009]	64%	69%	75%	facilities with comprehensive PMTCT D - all health facilities
	1.2.3	Percent of pregnant women with known HIV status [N-number of women with HIV results; D-all women attending ANC]	Outcome	National	Annual	Program Data [MOHCW]	78% [2008]	80%	82%	84%	Rapid testing roll-out in progress. Increase expected
	1.2.4	Percent of infants born to HIV infected women tested for HIV within 12 months	Output	PEPFAR	Annual	Program Data [MOHCW]	4% [2008]	8%	12%	20%	Early infant diagnosis being rolled out, increase expected
	1.2.5	Percent of infants born to HIV infected women receiving any prophylaxis for PMTCT	Output	National	Annual	Program Data [MOHCW]	34% [2008]	65%	75%	100%	Based on women attending ANC
	1.2.6	Percentage of HIV infected pregnant women who receive anti-retroviral to reduce the risk of Mother to Child Transmission	Outcome	UNGAS 5	Annual	Program Data [MOHCW]	49% [2008]	60%	65%	75%	Increase expected as MER roll-out continues
	1.2.7	Percentage of HIV infected pregnant women who received ART for their own health	Outcome	National	Annual	Program Data [MOHCW]	5% [2008]	8%	12%	15%	MER roll-out in progress
CT	ZNASP Objective: To increase the number of adults (15-49years) accessing C&T services from 15% to 75% in 2010										
Counseling and testing	1.4.1	Percent of adults (15-49 years) that are counseled and tested for HIV in the past 12 months who know their results (by age and gender)	Outcome	UNGAS 7/GF	5 yrs	ZDHS	6% [2006]	10%	15%	20%	ZDHS 2005/6 presented male and female figures 15-24 years old, but data available. Baseline is average of the two figures.
	1.4.2	Percent of most-at-risk populations that are counseled and tested for HIV in the past 12 months who know their results (by age group and gender)	Outcome	UNGAS 8	2 yrs	Special Study [UNAIDS]	Not known	-	-	-	MARPS are not well-defined and legalized hence never research in Zimbabwe. Country hopes to get funding to conduct a special study on MARPS
	1.4.3	Number of people counseled and tested for HIV in the past 12 months (by age and gender)	Output	PEPFAR, GF	Annual	Program Data [PSI/MOHCW]	650,000 [2009]	700,000	800,000	900,000	Increase expected if CT outreaches continue and through scaling up of PITC
	1.4.4	Number of people testing HIV-positive (by age and gender)	Output	PEPFAR	Annual	Program Data [MOHCW/PSI]	190,000	200,000	210,000	230,000	Increasing last three years due to increase in access to T&C but rate of increase expected to decline as incidence declines.

Condoms											
To promote consistent condom use among most-at-risk populations											
	1.5.1	Percent of adults (15-49 years) who had sexual intercourse with more than one partner in the last 12 months who reported using a condom during their last sexual act	Outcome	UNGASS 7 GF	5 yrs	ZDHS	M-68.6% F-46.3% [2005/6]	M-67% F-45%	M-66% F-44%	M-64% F-43%	Expected to decline due to behavior change intervention being rolled out country-wide through GF round 8 but marginal.
	1.5.2	Percent of young people aged 15-24 reporting the consistent use of a condom with non-regular sexual partners in the last year	Outcome	GF	5 yrs	ZDHS	F -42.2% M-68% [2005/6]	F - 45% M-70%	F - 48% M-73%	F - 50% M-75%	Expected to increase due to behavior change intervention being rolled out by GF Round 8
	1.5.3	Number of male/female condoms distributed	Output	National	Annual	Program Data [MOHCW/PSI]	F: 5,276,705 M:95,463,490 [2008]	6,000,000 100,000,000	7,000,000 105,000,000	8,000,000 110,000,000	Condom promotion continuing and male condom uptake expected to increase more because of less cultural barriers
Most-at-risk populations											
ZNASP Objective: To increase coverage of all groups and sites from 10% to 50 % by 2010											
	1.6.1	Number of most-at-risk populations reached by an HIV prevention intervention	Output	National	Annual	Program Data [NAC]	300,000	350,000	400,000	500,000	Marginal increase expected because of absence of intervention for MARPS of national nature
	1.6.2	Percent of female and male sex workers reporting the use of a condom with their most recent client	Outcome	UNGASS 18	5 yrs	ZDHS	74% [2005/6]	76%	78%	80%	There no clear interventions for SW in Zimbabwe which can limit impact
	1.6.3	Percent of injected drug users reporting the use of a condom the last time they had sexual intercourse	Outcome	PEPFAR	3 yrs	Special Study [UNAIDS]	Not Known	-	-	-	There is no information about this and IDUs are believed to be a minority if present in Zimbabwe. The country would need funding to conduct a special MOT study to identify this.
	1.6.4	Percent of males reporting the use of a condom the last time they had anal sex with another man	Outcome	UNGASS 19	5 yrs	Special Study [UNAIDS]	Not Known	-	-	-	There is no information on this and MSM relationships are not legalized in Zimbabwe. The country needs funding to conduct a special study on this.
BC											
ZNASP OBJECTIVE: Increased adoption of safer sexual behavior and reduction in risk behavior among men and women											
	1.7.1	Percent of men and women (15-49) reached through mass media BCC (by age)	Output	National	5 yrs	KAP Survey (PSI)	M-67% W-73%	M-72% W-78%	M-77% W-83%	M-77% W-83%	Targets will increase due to BC programme but reach limit based on media accessibility
	1.7.2	Number of people reached through community outreach programs promoting HIV prevention including interpersonal communication	Output	National	Annual	Program Data [NAC]	Not Known	2,700,000	4,400,000	4,400,000	Indicator currently not being collected but to be collected from 2010. Targets provided in the GF Round 8 PF.

	1.7.1	Percentage of young women and men who have had sexual intercourse before the age of 15	Outcome	UNGASS 15	5 yrs	ZDHS	5 % [2005/6]	5 %	4.5%	4%	Comprehensive effort being done to reduce age at first sex.
	1.7.2	Number of people who have completed training on the national community BC course (Love & Respect or comparable).	Output	National	Annual	Program data [NAC]	100,000 [2009]	255,000	435,000	615,000	Targets are cumulative.
	1.7.3	Percent of married women and men reporting more than one sexual partner in the past 12 months	Outcome	National	2 yrs	NBCS [2008]	M- 28.1 % W- 6.2 %	M-26% F-5.2%	M-24% F- 5.2%	M-22% F-4.2%	The study is conducted every 2 years and we expect the targets to go down.
	1.7.4	Percent of never married men and women reporting sex with more than one partner in the past 12 months	Outcome	National	2 yrs	NBCS ⁵ [2008]	M-27.3 % W-10.5 %	M-25% W-9.5%	M: 23% F: 9.0%	M-21% F-8.5%	BC campaign impact expected to cause decrease in this indicator
	1.7.5	Percent of men and women 18-49 who had concurrent sexual relationships in the past 12 months	Outcome	National	2 yrs	NBCS [2008]	M- 9.6 %, W-2.5 %	M-9.0% W-2.4%	M-8.3% ; W-2.2%	M-7.7% F-2.1%	BC campaign impact expected to cause decrease in this indicator
Youth	ZNASP OBJECTIVE: TO PROMOTE, STRENGTHEN, SUPPORT AND COORDINATE THE YOUTH PROGRAMME IN THE NATIONAL RESPONSE TO HIV AND AIDS.										
	1.8.1	Percent of young people aged 15-24 who had sex with more than one partner in the last 12 months	Outcome	GF	5 yrs	YAS, ZDHS	W-1.8%; M-19.8%	W-1.7% M-19.8%	W-1.6% M-18.8%	W-1.5% M-17.8%	BC programme impact expected to cause decline
	1.8.2	Number of youth in school exposed to HIV&AIDS education	Output	GF	Annual	Program Data [NAC]	2,859,173 MESAC	3,380,955	3,380,955	3,380,955	The targets for 2010 to 2012 are the number of pupils in school from the MOESC
	1.8.3	Number of youth out-of-school exposed to HIV&AIDS education	Output	National	Annual	Program Data [NAC]	113,481 MESAC	150,000	180,000	200,000	Increasing support to the programme area expected increase coverage
	1.8.4	Number of youth in tertiary institutions exposed to HIV&AIDS education	Output	National	Annual	Program Data [NAC]	Not Known	45,000	50,000	60,000	There were no indicators to collect data from tertiary institutions up to end of 2009. Data will be collected from 2010 but targets based on enrollment and gradual programme scale-up.
	1.8.5	Percent of school teachers trained in life skill-based HIV education.	Output	National	Annual	Program Data [NAC]	17% MESAC	25%	35%	50%	There is a programme being rolled out which will increase targets.
Male Circumcision	To increase the number of males that undergo circumcision										
	1.9.1	Percent of men circumcised (15-29)	Outcome	National	5 yrs	ZDHS [2006]	10%	10.8%	11.7%	12.8%	Based on baseline and number added annually over men 15-29 population (ICDS 2008)

⁵ NBCS – National Behaviour Change Survey, an impact assessment survey for the behaviour change intervention in Zimbabwe. The baseline survey was conducted in 2008.

	1.9.2 Percent of men willing to be circumcised (15-29)	Outcome	National	5 yrs	ZDHS	Not Known	-	-	-	ZDHS for 2010 to provide a Baseline. MC strategic planning to be done soon will provide targets.
	1.9.3 Number of public institutions offering safe MC	Output	National	Annual	Program Data [MOHCW]	5 [2009]	-	-	-	MC strategic plan to decide strategic approach and targets
	1.9.4 Number of males circumcised (by age)	Output	PEPFAR/N	Annual	Program Data [MOHCW]	2,500 [2009]	30,000	60,000	100,000	Increase expected due to MC roll out
STI	To reduce the incidence of STI by 40% by 2010									
	1.10.1 Percent of adults (15-49years) that had an STI in the last 12 months (by age and gender)	Outcome	National	5 yrs	ZDHS	W- 4% M-3%	W-4% M-3%	W-3.9% M-2.9%	W-3.8% M-2.8%	2009 ANC and programme data showed increase in STI prevalence, hence minimal decline expected
	1.10.2 Prevalence of STI among sex workers	Impact	National	2 yrs	Special study [UNAIDS]	Not Known	-	-	-	Zimbabwe has not done such study before. MOT study expected to provide baseline
	1.10.3 Prevalence of syphilis among antenatal care attendees	Impact	National	2 yrs	ANC	0.6% [2009]	0.6%	0.59%	0.58%	Minimal decline expected because recent increase in 2009
	To ensure effective treatment of the STI by 2010									
Blood Safety	To screen all donated blood for HIV									
	1.11.1 Percent of donated blood units screened for HIV	Outcome	UNGASS 3	Annual	Program Data [NBTS]	100%	100%	100%	100%	Blood screening has been at 100% for some years now.
	1.11.2 Percent of donated blood units tested HIV positive	Outcome	National	Annual	Program Data [NBTS]	0.5%	0.5%	0.48%	0.47%	Mostly school children donating blood and decline is expected continuing prevention interventions in schools
Infection control	To reduce HIV infection from occupational exposure in health workers									
	1.11.3 Number of health workers reporting exposure	Output	PEPFAR	Annual	Program Data [MOHCW]	85 [2009]	75	60	50	Efforts continuing to reduce exposure risks for health workers
	1.11.4 Number of health workers receiving PEP	Output	National	Annual	Program Data [MOHCW]	41 [2009]	40	32	27	Average percentage receiving PEP 2007-9 used in the projections
TREATMENT AND CARE										
ART/OI	To rapidly increase the number of patients on treatment									

	2.1.1	Percent of adults and children with advanced HIV infection receiving anti-retroviral drugs (ARVs)	Outcome	UNGASS 4	2 yrs	Program Data [MOHCW]	A- 178,001 52% C- 19,018 54% [2009]	A- 260,000 76% C- 25,000 (71%)	A- 310,000 90% C- 30,000 (85%)	-	2010-11 targets based on ART strategy targets. 2012 targets expected from next ART strategic plan
	2.1.2	Number of people (children and adults) receiving ART through the private sector initiative	Output	National	Annual	Program Data [ZBCA/EM COZ]	Not Known	-	-	-	Private sector data currently not consolidated. Expected to be available from 2010.
	2.1.3	Percent of HIV positive incident TB cases that received treatment for HIV and TB	Outcome	UNGASS 6	Annual	Program Data [MOHCW]	-	-	-	-	Targets aligned with round 8 performance framework
	2.1.4	Percent of HIV infected children and adults known to be on treatment 12 months	Outcome	UNGASS 24	Annual	Program Data [MOHCW]	75% [2009]	86%	87%	88%	2010-11 targets based on ART strategy targets. 2012 targets expected from next ART strategic plan
	2.1.5	Percent of HIV infected children and adults known to be on treatment 24 months after initiation of ARVs	Outcome	National	Annual	Programme Data [MOHCW]	65.7%	68%	70%	72%	Gradual increase expected due to improvement in patient tracking
	2.1.6	Number of HIV-positive persons receiving cotrimoxazole prophylaxis	Output	National	Annual	Program Data [MOHCW]	398,546 [2009]	500,000	600,000	-	2010-11 targets based on ART strategy targets. 2012 targets expected from next ART strategic plan
	2.1.7	Number of health facilities initiating ART	Outcome	National, GF	Annual	Program Data [MOHCW]	117 [2009]	125	130	-	2010-11 targets based on ART strategy targets. 2012 targets expected from next ART strategic plan
	2.1.8	Number of health facilities providing ART follow-up services					187	220	240	-	2010-11 targets based on ART strategy targets. 2012 targets expected from next ART strategic plan
	2.1.9	Percent of health facilities dispensing ARVs which have experienced a stock out of at least one required ARV in the last 12 months.	Outcome	National	Annual	EWI / LMIS [MOHCW]	0%	0%	0%	0%	Based current state of resource availability and commodity distribution no stock outs expected
Laboratory Services	To strengthen basic laboratory services nation-wide to allow for a rapid ART roll-out										
	2.2.1	Percent of ART sites with capacity to perform clinical laboratory tests	Output	National	Annual	Program Data [MOHCW]	68% [2009]	89%	94%	98%	Cites with functional CD 4 count machines to all ART initiating sites. Objective to reach 100% but 100% functionality difficult to attain

	2.2.1 Percent of laboratories that are accredited according to national or international standards									
HBC	To increase access to effective HBC services for infected people by 75% by 2010									
	2.3.1 Percent of clients accessing minimum standard CHBC services in the last 12 months (by gender)	Outcome	National	2 yrs	HBC evaluation [NAC]	48%	52%	55%	58%	Increased coverage expected in line with new strategic plan
	2.3.2 Percent of HIV positive clients reporting an improvement in quality of life following enrollment into an HBC programme	Impact	National	2 yrs	HBC evaluation [NAC]	Not Known	60%	70%	80%	Currently not being collected but to be collected from 2010.
	2.3.3 Number of HIV positive clients on home based care	Output	National	Annual	Program Data [NAC]	165,244 [2009]	165,500	165,500	165,500	No increase expected because of ART programme
	2.3.5 Number of caregivers working in the HBC programme	Output	National	Annual	Program Data [NAC]	40,349	40,300	40,300	40,300	No increase expected because not much increase is expected in number of patients on HBC
MITIGATION										
PLHHIV										
	3.1.1 Number of PLHIV receiving standardized food package	Output	National	Annual	Program Data [NAC]	104,154 [2009]	105,000	105,000	105,000	Not expected to increase basing on current trends
	3.1.2 Number of PLHIV receiving medical assistance	Output	National	Annual	Program Data [NAC]	20,000 [2009]	20,000	20,000	20,000	Not expected to increase basing on current trends
	3.1.3 Number of PLHIV receiving psycho-social support	Output	National	Annual	Program Data [NAC]	56,600	60,000	65,000	75,000	Expected increase in line with strategy
	3.1.4 Percent of PLHIV participating in (a) coordination structures (b) programme activities of the response (by age and gender)	Outcome	National	Annual	MIPA SURVEY	Not Known	-	-	-	To be collected by MIPA survey
	3.1.5 Percent of support groups for people living with HIV with institutional capacity	Outcome	National	Annual	GF R8	Not Known	100	300	-	2012 target to be informed by MIPA survey
	3.1.6 Percentage of men and women expressing specific acceptance attitudes towards PLHIV	Output	National	Annual	ZDHS	M-11%, W-17% [2005/6]	M-15%, W-20%	M-20%, W-25%	M-25% W-30%	Gradual increase expected through continuing HIV/AIDS education
OVC	To provide free basic support in caring for at least 50% to 80% of OVCs									

	3.2.1	Percent of OVC (under 18 years of age) living in households that have received basic external support in caring for the child (by age and gender)	Outcome	UNGASS 10	5 yrs	ZDHS	21% (MIMS 2009)	22%	24%	25%	Increase expected in line with strategic plan targets (NAP for OVC targets)
	3.2.2	Number of children under 18 that have a chronically ill parent, live in a household where an adult aged 18-59 died in the past year or live in a household with an adult aged 15-59 who has been chronically in the past year	Outcome	WFFC 76	5 yrs	ZDHS	6% [2005/6]	5%	4%	3.5%	Decrease expected with decline in HIV prevalence
	3.2.4	Proportion of OVC aged 15-17 years that had sex before age 15,	Outcome	WFFC 80	5 yrs	ZDHS	M-7%, W-6% [2005/6]	M-6.8%, W-6.5%	M-6.5%, W-6.0%	M-6.0% W-5.8%	Decrease expected due to school related prevention programmes
	3.2.5	Percent of children aged 0-5 years who have birth certificates	Outcome	WFFC 62	5 yrs	ZDHS	37% (MIMS)	40%	45%	50%	Increase expected through increasing support to registry department
	3.2.6	Percent of OVC provided with food/nutritional assistance	Output	National	Annual	Program Data [MLSW]	30% (COI)	30%	30%	30%	No increase expected due to seasonal fluctuations
	3.2.7	Percent of OVC provided with psycho-social support	Output	National	Annual	Program Data [MLSW]	10% (COI)	12%	15%	18%	Marginal increase expected based on current trends
	3.2.8	Percent of OVC receiving school-related assistance	Output	National	Annual	Program Data [MLSW]	20% (COI)	35%	40%	50%	Increase expected due to revival of BEAM programme
Gender											
	3.3.1	Percent of women and girls who report being able to access and consistently use female and male condoms	Outcome	National	Annual	ZDHS	40%	45%	55%	60%	Increase expected from continuing condom promotion programme
	3.3.4	Percent of sexually abused women and girls provided with post-exposure prophylaxis (PEP)	Output	National	Annual	Program Data [MJPA]	Not Known	5%	5%	6%	Data not collected currently but expected from 2010.
Water and Sanitation		To increase access to safe water and sanitation by 60% to PLWHIV and OVC by 2010									
	3.3.1	Percent of PLWHIV that have access to safe water and sanitation	Outcome	National	Annual	MIPA Survey	Not Known	-	-	-	MIPA survey to collect baseline

MONITORING AND EVALUATION											
To provide a comprehensive tracking system to collect, enter, analyze and share information on HIV and AIDS in all provinces by 2010											
	4.1.1	National M&E calendar developed and implemented	Output	National	Annual	Program Data [NAC]	Not Available	1	1	1	To be developed from 2010

4.1.2	Percent of implementers with a designated and functioning M&E focal person	Output	National	Annual	Program Data [NAC]	58%	85%	90%	95%	Expected to increase as implementers appreciate the importance of M&E
4.1.3	Percent of implementers regularly reporting to the national M&E system	Output	National	Annual	Program Data [NAC]	85%	90%	95%	98%	Expected to increase with support for partner visits at district level
4.1.4	Number of functional district and provincial M&E task forces	Output	National	Annual	Program Data [NAC]	85	85	85	85	All currently holding quarterly meetings and trend to continue depending availability of coordination resources
4.1.5	Number of research projects, special studies and impact evaluations commissioned	Output	National	Annual	Program Data [NAC]	9	10	10	12	Expected to increase depending on resource availability
4.1.5	Number of M&E feed-back reports disseminated at district, provincial and national levels	Output	National	Annual	Program Data [NAC]	96	96	96	96	All levels producing reports, only need to increase circulation
4.1.6	Number of implementers provided with technical support in monitoring and evaluation	Output	National	Annual	Program Data [NAC]	500	500	500	500	Targets are not cumulative but based on estimated number of implementers in each province and this is a prevalence indicator because has to be continuous for many implementers
To effectively coordinate all national HIV programmes and strategies and ensure high quality and full funding										
4.1.7	Number of organizations (private sector, public sector, civil society) with HIV policies in place	Output	National	Annual	Workplace Baseline Survey	939	1020	1101	1200	To increase as workplace programme improves
Resource Mobilization			National							
4.1.8	Percent of funds allocated to M&E in national HIV and AIDS programmes (ESP, GF, NATF, NAP for OVC, AIDS & TB)	Output	National	Annual	Program Data [ALL]	10%	10%	10%	10%	Minimum expected by international guidelines

Annex I: Indicator Definitions

STRATEGIC AREA 1:	PREVENTION
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Programme Area 1:	HIV Prevalence
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Indicator	1.1.1 HIV Prevalence among adult men and women (15-49 yrs)
Purpose	To assess progress towards reducing HIV infection
Source	Demographic Health Survey, HIV Estimates
Numerator	Number of persons (15-49 years) who tested positive for HIV
Denominator	Number of persons (15-49 years) tested for their HIV infection status
Interpretation	The impact indicator gives a fairly good picture of relatively recent trends in HIV infection in locations where the epidemic is heterosexually driven. Both DHS and HIV Estimates are used as data source to ensure that the country is kept abreast of the HIV prevalence.

Indicator	1.1.2 HIV Prevalence among women aged 15-24 attending ANC
Purpose	To assess progress towards reducing HIV infection
Source	ANC Surveillance
Numerator	Number of antenatal clinic attendees (15-24 years) tested whose HIV test results are positive
Denominator	Number of antenatal clinic attendees (15-24 years) tested for their HIV infection status
Interpretation	This indicator (using data from antenatal clinics) gives a fairly good estimate of relatively recent trends in HIV infection in locations where the epidemic is heterosexually driven. To supplement data from antenatal clinics, an increasing number of countries have included HIV testing in population based surveys. If a country has produced HIV prevalence estimates from survey data these estimates should be included in the comments box for this indicator to allow for comparisons between multiple surveys.

Indicator	1.1.3 Percentage of young women and men aged 15-24 who are HIV infected
Purpose	To assess progress towards reducing HIV infection
Source	HIV Sentinel Surveillance
Numerator	Number of antenatal clinic attendees (15-24 years) tested whose HIV test results are positive
Denominator	Number of antenatal clinic attendees (15-24 years) tested for their HIV infection status
Interpretation	This indicator (using data from antenatal clinics) gives a fairly good estimate of relatively recent trends in HIV infection in locations where the epidemic is

	heterosexually driven. To supplement data from antenatal clinics, an increasing number of countries have included HIV testing in population based surveys. If a country has produced HIV prevalence estimates from survey data these estimates should be included in the comments box for this indicator to allow for comparisons between multiple surveys.
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Indicator	1.1.4 Percent of more-at-risk population who are HIV infected
Purpose	To assess progress on reducing HIV prevalence among most at risk populations
Source	Behavioural surveillance or other special surveys
Numerator	Number of members of the most at risk population who test positive for HIV
Denominator	Number of members of the most at risk population tested for HIV
Interpretation	Due to difficulties in accessing MARPs, biases in serosurveillance data are likely to be far more significant than in data from a more general population such as women attending antenatal clinics. Such concerns, if any, should be reflected in the interpretation.

Indicator	1.1.5 Percentage of infants born to HIV infected mothers who are infected
Purpose	To assess progress towards eliminating mother-to-child HIV transmission
Source	PMTCT Cohort reports
Numerator	Number of infants born to HIV infected mothers who are infected
Denominator	Number of infants born to HIV infected mothers
Interpretation	This indicator focuses on PMTCT of HIV through increased provision of ART medicines. The Spectrum HIV estimation modeling software takes into consideration the type of ARV regimen as well as additional factors that influence HIV transmission rates such as infant feeding practices.

Programme Area 2: Prevention of Mother to Child Transmission- PMTCT

Indicator	1.2.1 Percent of health institutions with ANC facilities offering basic PMTCT services
Purpose	To assess progress in increasing the provision of PMTCT services
Source	PMTCT progress reports
Numerator	Number of health institutions with ANC facilities offering basic PMTCT services
Denominator	Number of health institutions with ANC facilities
Interpretation	This indicator focuses on PMTCT through the provision of basic PMTCT services by health institutions with ANC facilities. Basic or minimum services can include counseling and usually the facilities refer clients to other centres offering comprehensive services

Indicator	1.2.2 Percent of health institutions with ANC facilities offering comprehensive PMTCT services (HIV testing and ARVs)
Purpose	To assess progress in increasing the provision of PMTCT services
Source	PMTCT progress reports
Numerator	Number of health institutions with ANC facilities offering comprehensive PMTCT services

Denominator	Number of health institutions with ANC facilities
Interpretation	This indicator focuses on PMTCT through the provision of comprehensive PMTCT services by health institutions with ANC facilities. Comprehensive services cover all aspects of PMTCT, from counseling to provision of ART services

Indicator	1.2.3 Percent of pregnant women with known HIV status
Purpose	To assess progress towards eliminating mother-to-child HIV transmission
Source	ANC Surveillance
Numerator	Number of ANC women with HIV results
Denominator	Number of ANC attendees
Interpretation	In order to protect themselves and yet to be born babies, it is important for the pregnant to know their HIV status.

Indicator	1.2.4 Percent of infants born to HIV infected women tested for HIV within 12 months
Purpose	To assess progress in preventing new infections and treatment of those infected
Source	PMTCT Records/Reports
Numerator	Number of infants born to HIV infected women who receive an HIV test
Denominator	Number of infants born to HIV infected women
Interpretation	The total number of infants born to HIV infected women who are tested for HIV to establish their serological status through a PMTCT program. This indicator reflects one goal of PMTCT, which is to prevent new infections to exposed infants and treat those who are infected.

Indicator	1.2.5 Percent of infants born to HIV infected women receiving any prophylaxis for PMTCT
Purpose	To assess progress in preventing new infections and treatment of those infected
Source	PMTCT Records/Reports
Numerator	Number of infants born to HIV infected women receiving any prophylaxis
Denominator	Number of infants born to HIV infected women
Interpretation	The total number of infants born to HIV infected women who are receiving any prophylaxis through a PMTCT program. This indicator reflects one goal of PMTCT, which is to prevent new infections to exposed infants and treat those who are infected.

Indicator	1.2.6 Percentage of HIV infected pregnant women who receive anti-retroviral to reduce the risk of Mother to Child Transmission
Purpose	To assess progress in preventing mother-to-child transmission of HIV
Source	Numerator: Patient registers & summary reporting forms Denominator: Antenatal clinic surveillance surveys in combination with demographic data or estimation models such as spectrum
Numerator	Number of HIV infected pregnant women who received antiretroviral medicines to reduce the risk of mother to child transmission in the last 12 months
Denominator	Estimated number of HIV infected pregnant women in the last 12 months

Interpretation	Countries are encouraged to track and report on the actual or estimated % distribution of the various regimens provided in order to monitor trends in regimen use, and so that the impact of antiretroviral drugs on mother to child transmission can be modeled based on the efficacy of corresponding regimens.
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Indicator	1.2.7 Percentage of HIV infected pregnant women who received ART for their own health
Purpose	To assess progress in increasing the provision of ART services to infected pregnant women
Source	PMTCT progress reports
Numerator	Number of HIV infected pregnant women who received ART
Denominator	Number of HIV infected pregnant women
Interpretation	The indicator monitors (over and above the extent of preventing mother-to-child transmission) how the PMTCT programme is ensuring that the infected pregnant women are accessing ART for the purpose of their own health.

Programme Area 3: Testing and Counselling- T&C

Indicator	1.3.1 Percent of adults (15-49 years) that are counseled and tested for HIV in the past 12 months who know their results (by age and gender)
Purpose	To assess progress in implementing HIV testing and counseling
Source	Population-based surveys (Demographic Health Survey, AIDS Indicator Survey, Multiple Indicator Monitoring Survey)
Numerator	Number of respondents aged 15-49 who have been tested for HIV during the last 12 months and who know their results
Denominator	Number of respondents aged 15-49. The indicator must be presented as percentages for males and females and should be disaggregated by the age groups 15-19, 20-24 and 25-49. The denominator includes respondents who have never heard of HIV or AIDS
Interpretation	In order to protect themselves and to prevent infecting others, it is important for individuals to know their HIV status. Knowledge of one's status is also a critical factor in the decision to seek treatment.

Indicator	1.3.2 Percent of most-at-risk populations that are counseled and tested for HIV in the past 12 months who know their results (by age group and gender)
Purpose	To assess progress in implementing HIV testing and counseling among most-at-risk populations
Source	Behavioural surveillance or other special surveys
Numerator	Number of most-at-risk population respondents who have been tested for HIV during the last 12 months and who know the results
Denominator	Number of most-at-risk population included in the sample.
Interpretation	Accessing and/or surveying MARPs can be challenging. Consequently, data obtained may not be based on a representative sample of the national most-at-risk population being surveyed. Such concerns if found should be reflected in the interpretation of the survey data. Where different sources of data exist, the best available estimate should be used. Tracking MARPs over time to measure

	progress may also be difficult due to mobility and the hard to reach nature of these populations with many of them being hidden populations. Information about the nature of the sample should therefore be reported in the narrative to facilitate interpretation and analysis over time. To maximize the utility of these data, it is recommended that the sample used for the calculation of this indicator be used for the calculation of other indicators related to these populations.
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Indicator	1.3.3 Number of people counseled and tested for HIV in the past 12 months (by age and gender)
Purpose	To assess progress towards increased provision and uptake of T&C services
Source	MOHCW Programme Data
Numerator	Number of people counseled and tested for HIV
Denominator	N/A
Interpretation	The indicator seeks to report on the total number of people counseled and tested in one year.

Indicator	1.3.4 Number of people testing HIV-positive (by age and gender)
Purpose	To assess progress in implementing counseling and testing programme
Source	MOHCW Programme Data
Numerator	Number of people testing HIV positive
Denominator	N/A
Interpretation	Out of the total number of people counseled and tested in one year, this indicator now seeks to report the number found to be HIV positive, i.e. positivity rate in a year

Programme Area 4:

CONDOMS

Indicator	1.4.1 Percent of adults (15-49 years) who had sexual intercourse with more than one partner in the last 12 months who reported using a condom during their last sexual act
Purpose	To assess progress towards preventing exposure to HIV through unprotected sex with non regular partners
Source	Population-based surveys (Demographic Health Survey, AIDS Indicator Survey, Multiple Indicator Monitoring Survey)
Numerator	Number of respondents (15-49 years) who reported having had sexual intercourse with more than one partner in the last 12 months who reported using a condom during their last sexual act
Denominator	Number of respondents (15-49) who reported having had sexual intercourse with more than one partner in the last 12 months
Interpretation	This indicator shows the extent to which condoms are used by people who are likely to have higher risk sex (i.e. change partners regularly). The current indicator does not provide the level of consistent condom use.

Indicator	1.4.2 Percent of young people aged 15-24 reporting the consistent use of a condom with non-regular sexual partners in the last year
Purpose	To assess progress in preventing the sexual transmission of HIV among young

	people
Source	Demographic Health Survey
Numerator	Number of respondents reporting the consistent use of a condom with non regular sexual partners in the last year
Denominator	Number of respondents who reported have sex with non regular sexual partners
Interpretation	Condoms are most effective when their use is consistent rather than occasional. The current indicator will provide an overestimate of the level of consistent condom use.

Indicator	1.4.3 Number of male/female condoms distributed
Purpose	To assess progress in preventing HIV infections
Source	Programme Data
Numerator	Number of male and female condoms distributed
Denominator	N/A
Interpretation	This indicator requires that reporting be done separately for male and female condoms. The indicator can also be used as a proxy measure for condom use.

Programme Area 5: Most-at-Risk Populations (MARPs)

Indicator	1.5.1 Number of most-at-risk populations reached by an HIV prevention intervention
Purpose	To assess progress in implementing basic elements of HIV prevention programmes for MARPs
Source	Behavioural Surveillance or other special surveys
Numerator	Number of MARPs respondents who replied “yes” to both (all three for injected drug users) questions. Questions: 1. Do you know where you can go if you wish to receive an HIV test? 2. In the last 12 months, have you been given condoms e.g. through an outreach service, drop in centre or sexual health clinic? 3. For injecting drug users: In the last 12 months, have you been given sterile needles and syringes e.g. by an outreach worker, peer educator or from a needle exchange programme
Denominator	Total number of respondents surveyed
Interpretation	Accessing and/or surveying MARPs can be challenging. Consequently, data obtained may not be based on a representative sample of the national most-at-risk population being surveyed. Such concerns if found should be reflected in the interpretation of the survey data. Where different sources of data exist, the best available estimate should be used. Tracking MARPs over time to measure progress may also be difficult due to mobility and the hard to reach nature of these populations with many of them being hidden populations. Information about the nature of the sample should therefore be reported in the narrative to facilitate interpretation and analysis over time. To maximize the utility of these data, it is recommended that the sample used for the calculation of this indicator be used for the calculation of other indicators related to these populations.

Indicator	1.5.2 Percent of female and male sex workers reporting the use of a condom with their most recent client
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Purpose	To assess progress in preventing exposure to HIV among sex workers through unprotected sex with clients
Source	Behavioural Surveillance Survey for sex workers
Numerator	Number of respondents who reported that a condom was used with their last client
Denominator	Number of respondents who reported having commercial sex in the last 12 months
Interpretation	Condoms are most effective when their use is consistent rather than occasional. The current indicator will provide an overestimate of the level of consistent condom use. The trend in condom use in the most recent sexual act will generally reflect the trend in consistent condom use. If data available is for less than 12 months, this should be included in the comments section of the reporting tool.

Indicator	1.5.3 Percent of injected drug users reporting the use of a condom the last time they had sexual intercourse
Purpose	To assess progress in preventing sexual transmission of HIV
Source	Behavioural Surveillance Survey
Numerator	Number of respondents who reported that a condom was used the last time they had sex
Denominator	Number of respondents who report having injected drugs and having had sexual intercourse in the last month
Interpretation	Data obtained may not be based on a representative sample of the national injecting drug user population being surveyed. This should be reflected in the interpretation of the survey data.

Indicator	1.5.4 Percent of males reporting the use of a condom the last time they had anal sex with another man
Purpose	To assess progress in preventing exposure to HIV among men who have unprotected anal sex with a male partner.
Source	Behavioural Surveillance Survey
Numerator	Number of respondents who reported that a condom was used the last time they had anal sex
Denominator	Number of respondents who reported having had anal sex with a male partner in the last six months
Interpretation	For men who have sex with men, condom use at last anal sex with any partner gives a good indication of overall levels and trends of protected and unprotected sex in this population. The indicator does not give any idea of risk behavior in sex with women among men who have sex with both women and men.

Indicator	1.5.5 Percent of most-at-risk populations who both correctly identify ways of preventing the sexual transmission of HIV and who reject major misconceptions about HIV transmission.
Purpose	To assess progress in building knowledge of the essential facts about HIV transmission among MARPs
Source	Special behavioural surveys
Numerator	Number of most-at-risk population respondents who gave the correct answer to

	<p>all five questions:</p> <ol style="list-style-type: none"> 1. Can the risk of HIV transmission be reduced by having sex with only one uninfected partner who has no other partners? 2. Can a person reduce the risk of getting HIV by using a condom every time they have sex? 3. Can a healthy looking person have HIV? 4. Can a person get HIV from mosquito bites? 5. Can a person get HIV by sharing food with someone who is infected?
Denominator	Number of most-at-risk population respondents who gave answers including “don’t know” to all five questions
Interpretation	The belief that a health looking person cannot be infected with HIV is a common misconception that can result in unprotected sexual intercourse with infected partners. Rejecting major misconceptions about modes of HIV transmission is as important as correct knowledge of true modes of transmission. The indicator is useful in countries where knowledge about HIV and AIDS is poor because it permits easy measurement of incremental improvements over time. Surveying MARPS can be challenging such that data obtained may not be based on representative sample. This should come out in the interpretation of data.

Programme Area 6: Behaviour Change (BC)

Indicator	1.6.1 Percent of men and women (15-49) reached through mass media BCC (by age)
Purpose	To assess progress in scaling up the BCC to the communities as prevention a programme
Source	KAP Survey
Numerator	Number of people reached through BCC mass media
Denominator	Number of people reached through all BCC programmes
Interpretation	BCC Media is defined as any effort to effect change through newspapers, magazines, radio, television etc

Indicator	1.6.2 Number of people reached through community outreach programs promoting HIV prevention including interpersonal communication
Purpose	To assess progress in scaling up the dissemination of BCC messages to the communities
Source	Programme Reports
Numerator	Individuals reached
Denominator	N/A
Interpretation	<p>Community outreach is defined as any effort to effect change that might include peer education, classroom, small group and/or one-on-one information, education, communication (IEC) or behavior change communication (BCC) to promote strategies for prevention of HIV.</p> <p>Some programs have clear messages designed to reach a specific audience (i.e., abstinence messages to youth, use of condom, being faithful to one partner, delay sex debut, promote a HIV test etc,) which are fairly easy to</p>

	classify in this category. Remember that this may include a combination of approaches to reach the message to the target population.
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Indicator	1.6.3 Percentage of young women and men aged 15-24 who have had sexual intercourse before the age of 15
Purpose	To assess progress in increasing the age at which young women and men aged 15-24 first have sex.
Source	Population based surveys-DHS, AIDS Indicator Survey, MIMs
Numerator	Number of respondents aged 15-24 who report the age at which they first had sexual intercourse as under 15 years
Denominator	Number of all respondents aged 15-24 years
Interpretation	In countries where HIV prevention programmes encourage virginity or delaying of first sex, young people's responses to survey questions on this issue may be biased, including a deliberate misreporting of age at which they first had sex

Indicator	1.6.4 Number of people who have completed training on the national community BC course (Love & Respect or comparable).
Purpose	To assess progress in increasing the capacity of people as regards BC
Source	Programme Data
Numerator	Number of people who have completed training on the national community BC course (Love & Respect)
Denominator	N/A
Interpretation	This indicator requires reporting on trainings conducted by recognized institutions in the country

Indicator	1.6.8 Percent of women and men aged 15-49 who have had sexual intercourse with more than one partner in the last 12 months
Purpose	To assess progress in reducing the % of people who have higher-risk sex
Source	Population-based surveys (Demographic Health Survey, AIDS Indicator Survey, Multiple Indicator Monitoring Survey)
Numerator	Number of respondents aged 15-49 who have had sexual intercourse with more than one partner in the last 12 months
Denominator	Number of all respondents aged 15-49
Interpretation	This indicator gives a picture of levels of higher-risk sex. If people have only one sexual partner, the change will be captured by changes in this indicator. However, if people simply decrease the number of sexual partners they have, the indicator will not reflect a change, even though potentially this may have a significant impact on the epidemic spread of HIV and may be counted a programme success. Additional indicators may need to be selected to capture the reduction in multiple sexual partners in general.

Programme Area 7: YOUTH

Indicator	1.7.1 Percent of young people aged 15-24 who had sex with more than one partner in the last 12 months
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Purpose	To assess progress in reducing the percentage of young people who have higher-risk sex
Source	Population based surveys (DHS, AIS, MIMS)
Numerator	Number of respondents aged 15-24 who had sex with more than one partner in the last 12 months
Denominator	Number of all respondents aged 15-24
Interpretation	This indicator gives a picture of levels of higher risk sex. If people have only one sexual partner, the change will be captured by changes in this indicator. However, if people simply decrease the number of sexual partners they have, the indicator will not reflect a change, even though potentially this may have a significant impact on the epidemic spread of HIV and may be counted a programme success. Additional indicators may need to be selected to capture the reduction in multiple sexual partners in general.

Indicator	1.7.2 Number of youth in school exposed to HIV&AIDS education
Purpose	To assess progress in increasing knowledge among youth in school on HIV&AIDS
Source	Programme Data
Numerator	Number of youth in school exposed
Denominator	N/A
Interpretation	The indicator provides useful information on trends in the coverage of life skills based HIV education within schools. Reporting should be based precisely on the students who would have attended the lessons on HIV and AIDS. Double reporting should be avoided as much as possible. There should be separate reports for Secondary and Primary schools

Indicator	1.7.3 Number of youth out-of-school exposed to HIV&AIDS education
Purpose	To assess progress in increasing knowledge among youth out of school on HIV&AIDS
Source	Programme Data
Numerator	Number of youth out of school exposed
Denominator	N/A
Interpretation	The indicator provides useful information on trends in the coverage of life skills based HIV education for youth out of school. Depending on the type of activities, organizations reporting on this indicator should avoid as much as possible double reporting.

Indicator	1.7.4 NUMBER OF YOUTH IN TERTIARY INSTITUTIONS EXPOSED TO HIV&AIDS EDUCATION
Purpose	To assess progress in increasing knowledge among youth in tertiary institutions on HIV&AIDS
Source	Programme Data
Numerator	Number of youth in tertiary institutions exposed
Denominator	N/A
Interpretation	The indicator provides useful information on trends in the coverage of life skills

	based HIV education within tertiary institutions
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Indicator	1.7.5 Percent of school teachers trained in life skill-based HIV education.
Purpose	To assess progress towards implementation of life skills based HIV education in all schools
Source	Programme Data
Numerator	Number of school teachers trained
Denominator	Number of school teachers that responded
Interpretation	Indicator scores are required for all school teachers combined and for primary and secondary school teachers separately. The indicator provides useful information on trends in the coverage of life skills based HIV education within schools. However, substantial variations in the levels of school enrolment must be taken into account when interpreting this indicator.

Indicator	1.7.6 Percent of schools that provided life skills-based HIV education in the last academic year.
Purpose	To assess progress towards implementation of life skills based HIV education in all schools
Source	School survey or education programme review
Numerator	Number of schools that provided life-skills based HIV education in the last academic year
Denominator	Number of schools surveyed
Interpretation	Indicator scores are required for all schools combined and for primary and secondary schools separately. The indicator provides useful information on trends in the coverage of life skills based HIV education within schools. However, substantial variations in the levels of school enrolment must be taken into account when interpreting this indicator.

Indicator	1.7.7 Percent of young people aged 15-24 who both correctly identify ways of preventing the sexual transmission of HIV and who reject major misconceptions about HIV transmission.
Purpose	To assess progress towards universal knowledge of the essential facts about HIV transmission
Source	Population-based surveys (Demographic Health Survey, AIDS Indicator Survey, Multiple Indicator Monitoring Survey)
Numerator	Number of respondents aged 15-24 years who gave the correct answer to all five questions: <ul style="list-style-type: none"> 6. Can the risk of HIV transmission be reduced by having sex with only one uninfected partner who has no other partners? 7. Can a person reduce the risk of getting HIV by using a condom every time they have sex? 8. Can a healthy looking person have HIV? 9. Can a person get HIV from mosquito bites? 10. Can a person get HIV by sharing food with someone who is infected?
Denominator	Number of all respondents aged 15-24
Interpretation	The belief that a health looking person cannot be infected with HIV is a common

	misconception that can result in unprotected sexual intercourse with infected partners. Rejecting major misconceptions about modes of HIV transmission is as important as correct knowledge of true modes of transmission. The indicator is useful in countries where knowledge about HIV and AIDS is poor because it permits easy measurement of incremental improvements over time
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Programme Area 8: MALE CIRCUMCISION

Indicator	1.8.1 Percent of men circumcised (15-29)
Purpose	To assess progress in the prevention of HIV infections
Source	Population based survey-DHS
Numerator	Number of men circumcised
Denominator	Number of men who responded
Interpretation	The indicator gives a picture of the extent to which the male circumcision programme is faring and how this could be contributing to the reduction of new infections in the country

Indicator	1.8.2 Percent of men willing to be circumcised (15-29)
Purpose	To assess progress in the prevention HIV infections
Source	Population based survey-DHS
Numerator	Number of men showing willingness
Denominator	Number of men who responded
Interpretation	The indicator gives a picture of how the male circumcision programme is being accepted by men and its prospects of reducing of new infections in the country

Indicator	1.8.3 Number of public institutions offering safe MC
Purpose	To assess progress in scaling up the provision of safe MC
Source	MOHCW Programme Data
Numerator	Number of public institutions offering safe MC
Denominator	N/A
Interpretation	The indicator simply requires reporting on recognized / public institutions offering safe MC

Indicator	1.8.4 Number of males circumcised (by age)
Purpose	To assess progress in preventing HIV infections
Source	Programme Data
Numerator	Number of males circumcised
Denominator	N/A
Interpretation	The indicator gives a picture of the extent to which the male circumcision programme is faring and how this could be contributing to the reduction of new infections in the country

Programme Area 9: Sexually Transmitted Diseases (STIs)

Indicator	1.9.1 Percent of adults (15-49years) that had an STI in the last 12 months (by age and gender)
Purpose	To assess progress in the prevention of HIV infections
Source	DHS
Numerator	Number of adults that reporting having had STI in the last 12 months
Denominator	Number of respondents aged 15-49
Interpretation	In order to protect themselves and to prevent infecting others, it is important for individuals know whether they have not contracted STI after unprotected sex. Knowledge of one's status is also a critical factor in the decision to seek treatment.

Indicator	1.9.2 Prevalence of STI among sex workers
Purpose	To assess progress towards the reduction of new infections
Source	DHS
Numerator	Number of sex workers that contracted STI
Denominator	Number of respondents (sex workers)
Interpretation	Surveying sex workers can be challenging. Consequently, data obtained may not be based on a representative sample of the national population. This should be reflected in the interpretation of the survey data.

Indicator	1.9.3 Prevalence of syphilis among antenatal care attendees
Purpose	To assess progress towards reducing HIV infection
Source	ANC Surveillance
Numerator	Number of antenatal clinic attendees tested positive for syphilis
Denominator	Number of antenatal clinic attendees tested for any disease
Interpretation	This indicator (using data from antenatal clinics) gives a fairly good estimate of relatively recent trends in syphilis.

Programme Area: BLOOD SAFETY

Indicator	1.10.1 Percent of donated blood units screened for HIV
Purpose	To assess progress in screening of blood donations
Source	NBTS Programme Data
Numerator	Number of blood units screened for HIV
Denominator	Total number of blood units donated
Interpretation	If the blood screening laboratory follows documented and standardized procedures for the screening of blood, this implies a certain level of uniformity, reliability and consistency of performance by staff trained to use the standard operating procedures

Indicator	1.10.2 Percent of donated blood units tested HIV positive
Purpose	To assess progress in screening of blood donations and their status
Source	NBTS Programme Data
Numerator	Number of blood units tested HIV positive

Denominator	Total number of blood units tested for HIV
Interpretation	If the blood screening laboratory follows documented and standardized procedures for the screening of blood, this implies a certain level of uniformity, reliability and consistency of performance by staff trained to use the standard operating procedures.

Programme Area 11: INFECTION CONTROL

Indicator	1.11.1 Number of health workers reporting exposure
Purpose	To assess progress in the protection of health workers against infections whilst on duty
Source	MOHCW Programme Data
Numerator	Number of health workers reporting exposure
Denominator	N/A
Interpretation	Health workers play an important role in curbing the spread of infections through the treatment of patients. It is unfortunate that in the process of doing that, they also become vulnerable and therefore become a source of the infections. It is therefore important that they immediately report whenever they are exposed.

Indicator	1.11.2 Number of health workers receiving PEP
Purpose	To assess progress in the protection of health workers against infections whilst on duty
Source	MOHCW Programme Data
Numerator	Number of health workers receiving PEP
Denominator	N/A
Interpretation	The indicator requires reporting on whether the health workers are receiving immediate treatment once they are exposed to infections.

STRATEGIC AREA 2:

TREATMENT AND CARE

Programme Area 1:

OI/ART

Indicator	2.1.1 Percent of adults and children with advanced HIV infection receiving Anti-Retroviral drugs (UNGASS 4)
Purpose	To assess progress towards providing antiretroviral combination therapy to all people with advanced HIV infection (adults and children)
Source	National ART programme data
Numerator	Number of adults and children with advanced HIV infection who are currently receiving antiretroviral combination therapy. The numerator is generated by counting the number of adults and children who received antiretroviral combination therapy at the end of the reporting period.
Denominator	Estimated number of adults and children with advanced HIV infection. The denominator is generated by estimating the number of people with

	advanced HIV infection requiring (in need of/eligible for) antiretroviral therapy. The denominator estimate will come from sentinel surveillance and HIV modelling data such as HIV and AIDS estimates.
Interpretation	The indicator will monitor trends in ART coverage without attempting to distinguish between different forms of antiretroviral therapy, cost, quality or effectiveness of the treatment provided. The proportion of people needing antiretroviral therapy differs between adults and children. Access to antiretroviral therapy will also depend on factors such as cost of drugs service delivery infrastructure required and availability and uptake of voluntary counselling and testing services. The indicator should thus be disaggregated by sex and age (<15, 15+)

Indicator	2.1.3 Number of people (children and adults) receiving ART through the private sector initiative
Purpose	To assess the coverage of antiretroviral combination therapy to people with advanced HIV infection (adults and children) through the private sector initiative i.e. to know the number of people accessing ART in the private sector at any given time
Source	Private Sector ART programme data (private health practitioners and companies)
Numerator	Number of adults and children with advanced HIV infection who are currently receiving antiretroviral combination therapy from the private sector (private medical practitioners, private medical institutions and private companies). The number is generated by counting the number of adults and children who received antiretroviral combination therapy from this sector at the end of the reporting period.
Denominator	Not Applicable
Interpretation	The indicator will monitor the numbers accessing ART through the private sector initiative without attempting to distinguish between different forms of antiretroviral therapy, cost, quality or effectiveness of the treatment provided. The proportion of people needing antiretroviral therapy differs by age and gender because of the financial resources required to access ART in the private. Women and children do not have equal access to such financial resources as men. Access to antiretroviral therapy through private sector also depends on ability to access private service delivery and voluntary counselling and testing services. The indicator should thus be disaggregated by sex and age (<15, 15+)

Indicator	2.1.4 Percent of HIV positive incident TB cases that received treatment for HIV and TB
Purpose	To assess progress towards providing antiretroviral combination therapy and TB treatment to all people with advanced HIV and TB co-infection (adults and children)
Source	National ART programme data
Numerator	Number of adults and children with advanced HIV infection who are

	currently receiving antiretroviral combination therapy. The numerator is generated by counting the number of adults and children who received antiretroviral combination therapy at the end of the reporting period.
Denominator	Estimated number of adults and children with advanced HIV infection. The denominator is generated by estimating the number of people with advanced HIV infection requiring (in need of/eligible for) antiretroviral therapy. The denominator estimate will come from sentinel surveillance and HIV modelling data such as HIV and AIDS estimates.
Interpretation	The indicator will monitor trends in ART coverage without attempting to distinguish between different forms of antiretroviral therapy, cost, quality or effectiveness of the treatment provided. The proportion of people needing antiretroviral therapy differs between adults and children. Access to antiretroviral therapy will also depend on factors such as cost of drugs service delivery infrastructure required and availability and uptake of voluntary counselling and testing services. The indicator should thus be disaggregated by sex and age (<15, 15+)

Indicator	2.1.5 Percent of HIV infected children and adults known to be on treatment 12 months after initiation on ART
Purpose	To assess the survival rate of patients on antiretroviral combination therapy 12 months after initiation on ART. This will be a proxy indicator for impact of antiretroviral therapy programme.
Source	National ART Programme Cohort Analysis Data
Numerator	Number of adults and children with advanced HIV infection commenced on antiretroviral combination therapy who are still alive and on treatment 12 months after initiation.
Denominator	Total number of adults and children who were initiated on antiretroviral therapy in the relevant cohort.
Interpretation	The indicator will monitor trends in impact of antiretroviral therapy on patient survival without attempting to determine any other variable factors. The survival rate of people on antiretroviral therapy is expected to always differ between adults and children and men and women. It may also differ by treatment setting e.g. public sector and private sector. The indicator should thus be disaggregated by gender, age (<15, 15+) and setting (private, public)

Indicator	2.1.6 Percent of HIV infected children and adults known to be on treatment 24 months after initiation of ARVs.
Purpose	To assess the survival rate of patients on antiretroviral combination therapy 24 months after initiation on ART. This will be a proxy indicator for impact of antiretroviral therapy programme.
Source	National ART Programme Cohort Analysis Data
Numerator	Number of adults and children with advanced HIV infection commenced on antiretroviral combination therapy who are still alive and on treatment 24 months after initiation.
Denominator	Total number of adults and children who were initiated on antiretroviral

	therapy in the relevant cohort.
Interpretation	The indicator will monitor trends in impact of antiretroviral therapy on patient survival without attempting to determine any other variable factors. The survival rate of people on antiretroviral therapy is expected to always differ between adults and children and men and women. It may also differ by treatment setting e.g. public sector and private sector. The indicator should thus be disaggregated by gender, age (<15, 15+) and setting (private, public)

Indicator	2.1.7 Number of HIV-positive persons receiving cotrimoxazole prophylaxis
Purpose	To assess scale-up and coverage of cotrimoxazole prophylaxis to people with HIV infection (adults and children) by determining the number of people accessing cotrimoxazole at any given time and to identify gaps in drug supply to patients.
Source	ART Programme Data
Numerator	Number of HIV infected adults and children who are currently receiving cotrimoxazole prophylaxis. The figure is obtained by counting the number HIV positive persons receiving cotrimoxazole prophylaxis at the end of the reporting period without cumulating this number.
Denominator	Not Applicable
Interpretation	The indicator will monitor coverage and need for cotrimoxazole. Cotrimoxazole prophylaxis reduces the risk of opportunistic infections to HIV positive children and adults including pregnant women, infected children and exposed infants. Determining need for cotrimoxazole prophylaxis will assist in planning for commodity procurement and supply. The indicator should be disaggregated by sex and age (<15, 15+). Individuals are considered to be receiving cotrimoxazole if they have been prescribed and dispensed with the drug.

Indicator	2.1.8 Number of health facilities initiating ART
Purpose	To assess progress of decentralisation of ART service provision so as to determine accessibility of service to the general population
Source	National ART Programme Data
Numerator	Number of health facilities initiating HIV infected persons on antiretroviral therapy.
Denominator	Not Applicable
Interpretation	Accessibility of ART services to people living with HIV is affected by accessibility to ART initiating facilities. Efforts to decentralise services are meant to increase access and reduce access costs. The geographical distribution of sites will also be of interest. The indicator can thus be disaggregated by province and district.

Indicator	2.1.9 Number of health facilities providing ART follow-up services
Purpose	To assess progress of decentralisation of ART service provision so as to determine accessibility of service to the general population

Source	National ART Programme Data
Numerator	Number of health facilities providing follow-up services to HIV infected persons on antiretroviral therapy. The figure is obtained by counting the total number of sites providing follow-up services to ART patients at the end of the reporting period
Denominator	Not Applicable
Interpretation	Decentralisation of ART patients to follow-up sites decongests the ART initiating sites and reduces transport costs for patients to access services. It has potential to reduce patient defaulting as patients will start to find it easier to attend their appointments. It will also increase opportunities for patient follow-up by health providers as distances over which patients have to followed up will be reduced. The geographical distribution of sites will be important. The indicator can be disaggregated by province and district.

Indicator	2.1.10. Percent of health facilities dispensing ARVs which have experienced a stock out of at least one required ARV in the last 12 months.
Purpose	To monitor the drug supply and distribution situation in the country
Source	National ART Programme Data
Numerator	Number of health facilities dispensing ARVs which have experienced a stock out of at least one required ARV in the last 12 months.
Denominator	Total number of health facilities dispensing ARVs in the country during the reporting period
Interpretation	A drug stock out is a situation where a particular drug is out of supply and patients are not receiving the drug for a week or longer period. Drug stockout is a contributing programme factor to development of drug resistance among ART patients and is one of the early warning indicators monitored in drug resistance monitoring. Occurrence of stockouts may indicate existence of gaps in drug supply in the country or drug distribution in the country.

Programme Area 2:

Laboratory Services

Indicator	2.2.1 Percent of ART sites with capacity to perform clinical laboratory tests
Purpose	To assess the availability and coverage of clinical laboratory testing services for ART in the country for ART initiation and patient monitoring. The indicator will also serve as a proxy measure of ART programme quality of service monitoring.
Source	National ART Programme Data
Numerator	Number of ART sites (initiating and follow-up sites combined) providing clinical laboratory test services to people living with HIV on site.
Denominator	Total number of ART sites (initiating and follow-up sites) in the country at the time of reporting.
Interpretation	Country ART programmes are encouraged to provide clinical laboratory testing services to HIV infected adults and children to determine eligibility

	for commencement on ART and to monitor effectiveness of treatment or emergence of complications in treatment. ART follow-up and initiating sites should therefore have capacity to perform the relevant tests such as CD4 count, liver function tests, hematology, serology, microbiology, chemistry tests and others. Capacity is in terms of equipment availability and functionality and availability of personnel to operate machines as well as consumables such as reagents. The indicator can be disaggregated by type of test and type of site (initiating and follow-up site)
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Indicator	2.2.2 Percent of laboratories accredited according to national or international standards
Purpose	To measure progress towards attainment of quality standards by laboratories in the country. The indicator will also be a proxy measure of the extent of laboratory capacity, quality and sustainability in the country.
Source	National ART Programme Data
Numerator	Number of laboratories in ART sites (initiating and follow-up) accredited according to national or international standards
Denominator	Total number of laboratories in ART sites (initiating and follow-up sites) in the country at the time of reporting.
Interpretation	Country ART programmes are encouraged to provide clinical laboratory testing services to HIV infected adults and children to determine eligibility for commencement on ART and to monitor effectiveness of treatment or emergence of complications in treatment. ART follow-up and initiating sites should therefore have capacity to perform the relevant tests such as CD4 count, liver function tests, hematology, serology, microbiology, chemistry tests and others. Capacity is in terms of equipment availability and functionality and availability of personnel to operate machines as well as consumables such as reagents. The indicator can be disaggregated by type of test and type of site (initiating and follow-up site)

Programme Area 3:

Community and Home Based Care

Indicator	2.3.1 Percent of clients accessing standard CHBC services in the last 12 months (by gender)
Purpose	To monitor coverage of standard CHBC services among people infected and living with HIV and AIDS in the country.
Source	CHBC Evaluation
Numerator	Number of clients accessing CHBC services who report receiving a package of services that meets national CHBC standards. This numerator will be generated by counting the number of individuals who report receiving CHBC services that meet the national standards from organisations providing community and home based care services in a national or population based survey or other equivalent survey
Denominator	Number of people living with HIV who report to have been receiving CHBC services. This denominator will be generated by enumerating of individuals who are receiving CHBC services from organisations providing

	community and home based care services in the national or population based survey or other equivalent survey
Interpretation	Individuals infected by HIV come to a point of being affected to require care from the community or home. This support can be social and clinical. The social services include psychological, spiritual, preventive and material assistance. The minimum standard package will include clinical, psychosocial, and material (food, clothing, shelter and financial as may be required by patients)

Indicator	2.3.2 Percent of HIV positive clients reporting an improvement in quality of life following enrollment into an HBC programme
Purpose	To assess the impact of HBC on quality of life HIV infected CHBC clients.
Source	CHBC Programme Evaluation
Numerator	Number of people living with HIV on community and home based care in the past 12 months whose quality of life improved for instance from being bed-ridden to home bound or returning to work.
Denominator	Number of people living with HIV who report having been on community and home based care in the past 12 months before the survey
Interpretation	The purpose of community and home based care programme is to provide a continuum of care for chronically ill people including people living with HIV in their community and home environments. CHBC has also developed critical linkages with other HIV interventions like antiretroviral therapy, testing and counselling and care for orphans and vulnerable children. However, quality of CHBC services is threatened by availability of resources to caregivers and caregiver motivation. There is always need to see whether CHBC is making a difference to justify resource requirements and investment in the intervention. Monitoring the number moving on the gradation of quality of life will also help in planning for future burdens. The indicator can disaggregated by gender and age (<15, 15+)

Indicator	2.3.3 Number of HIV positive clients on home based care
Purpose	To routinely monitor the coverage of CHBC services among people infected and living with HIV and AIDS in the country.
Source	National Programme Data (NAC)
Numerator	Number of clients accessing CHBC services at the reporting period. This value is generated by counting the number of individuals who are receiving the CHBC services from organisations providing the community and home based care services
Denominator	Not Applicable
Interpretation	Individuals infected by HIV come to a point of being affected to require care from the community or home. This support can be social and clinical. The social services include psychological, spiritual, preventive and material assistance. The minimum standard package will include clinical, psychosocial, and material (food, clothing, shelter and financial as may be required by patients)

Indicator	2.3.4 Number of caregivers working in the HBC programme
Purpose	To assess the caregiver-patient ratio in CHBC
Source	Program Data
Numerator	Number of secondary caregivers for clients on CHBC who are active in the programme at the reporting period. This data will be provided by the organisations supporting CHBC services who will be working with the caregivers.
Denominator	Not Applicable
Interpretation	CHBC programmes are affected by numerous factors at caregiver level including caregiver motivation and fatigue due to burden of patients, lack of incentives, shortage of caregiver kits and skill gaps. These factors must be monitored routinely to identify emerging gaps. The issue of male involvement in care-giving has been of concern for some time and a subject for advocacy which need continuous monitoring. There is also the involvement of children in care-giving for their parents and relatives which occurs whenever there are no community caregivers to take over the responsibilities. The indicator can hence be disaggregated by gender and age (<15, 15+).

STRATEGIC AREA 3:

MITIGATION AND SUPPORT

Programme Area 1:

PLHIV

Indicator	3.1.1 Number of PLHIV receiving standardized food package
Purpose	To assess the coverage of food and nutrition assistance among people living with HIV and AIDS who are in need of food assistance.
Source	Program Data (NAC)
Numerator	Number of PLHIV who were provided with standardized food package according to national standards. The data will be collected from organisations that are supporting people living with HIV by providing food assistance them. The indicator will be obtained by counting the number that received food assistance at the end of the reporting period
Denominator	Not applicable
Interpretation	Food assistance is one of the needs for some of the people living with HIV. Nutrition is a part of antiretroviral therapy whilst consistent food supply food is a requirement for people that are on ART. However access to food assistance may depend on availability and distribution of the food. Need for food assistance can also vary with season. The data will be disaggregated by gender and age (15, 15+) to monitor trends in access by each group.

Indicator	3.1.2 Number of PLHIV receiving medical assistance
Purpose	To assess the access to medical assistance by people living with HIV and AIDS when needed.
Source	Program Data (NAC)
Numerator	Number of PLHIV who were provided with medical assistance by organisations supporting people living with HIV. The data will be collected from organisations that are supporting people living with HIV. The indicator will be obtained by counting the number that received food assistance at the end of the reporting period
Denominator	Not applicable
Interpretation	Food assistance is one of the needs for some of the people living with HIV. Nutrition is a part of antiretroviral therapy whilst consistent food supply food is a requirement for people that are on ART. However access to food assistance may depend on availability and distribution of the food. Need for food assistance can also vary with season. The data will be disaggregated by gender and age (15, 15+) to monitor trends in access by each group.

Indicator	3.1.3 Number of PLHIV receiving psycho-social support
Purpose	To assess the coverage of psychosocial support among people living with HIV and AIDS.
Source	Program Data (NAC)
Numerator	Number of PLHIV who were provided with psychosocial support. The data will be collected from organisations that are supporting people living with HIV by providing psychosocial support them. The indicator will be obtained by counting the number that received psychosocial support at the end of the reporting period
Denominator	Not applicable
Interpretation	Psychosocial support is one of the needs for some of the people living with HIV. PSS complements counseling and testing and antiretroviral therapy for those who are on ART. However availability of psychosocial support to PLHIV may depend on availability of interventions in the community. Access by the people living with HIV may be affected by low uptake when beneficiaries are not educated about the benefits and where the environment is not supportive for open living. Uptake may differ by gender and age. The data can be disaggregated by gender and age (15, 15+) to monitor trends in access by each group.

Indicator	3.1.4 Percent of PLHIV participating in (a) coordination structures (b) programme activities of the response (by age and gender)
Purpose	To assess involvement and meaningfulness of involvement of people living with HIV in HIV and AIDS programmes
Source	MIPA Survey
Numerator	Number of PLHIV who report participating in coordination structures and programme activities for HIV and AIDS. The numerator will be obtained by counting the number that report participation at in least one of the two

	levels.
Denominator	Number of people living with HIV in the country. The denominator will be obtained from national estimates.
Interpretation	The MIPA principle recognizes six hierarchical levels of involvement for PLHIV which are target audience, contributor, speakers, implementers, experts and decision-makers. The goal of MIPA is to increase the number of people living with HIV participating in the response and to raise the level of participation on the hierarchy of participation. Participation levels would vary among people of different characteristics; gender, age, educational level, etc. the indicator can be disaggregated by these factors.

Indicator	3.1.5 Percent of support groups for people living with HIV with institutional capacity
Purpose	To monitor progress towards institutional capacity development of support groups for PLHIV.
Source	MIPA Survey
Numerator	Number of support groups for PHIV that will report having institutional capacity according to a defined national standard. The numerator will be obtained by counting the support groups that report having capacity in at least one of defined areas.
Denominator	Number of support groups identified in the survey
Interpretation	Support groups are a vehicle for provision of essential services for PLHIV like psychosocial support and for facilitating meaningful involvement. Ability of support groups to survive through turbulent times in resource availability and leadership challenges depends on presence of institutional capacity.

Indicator	3.1.6 Percentage of men and women expressing specific acceptance attitudes towards PLHIV
Purpose	To assess levels of stigma and discrimination against people living with HIV in the population
Source	Population based survey
Numerator	Number of men and women who report an acceptance attitude on all four of the questions: (a) If a member of your family became sick with the AIDS virus; would you be willing to care for him or her in your household? (b) If you knew that a shopkeeper or food seller had the AIDS virus, would you buy fresh vegetables for him /her?, (c) If a female teacher has the AIDS virus but is not sick, should she be allowed to continue teaching in school?, (d) If a member of your family became infected with the AIDS virus, would you want it to remain a secret?
Denominator	All respondents who report having heard about HIV and AIDS before in the survey
Interpretation	Stigma and discrimination are barriers to HIV testing and counseling and uptake and adherence to ART. Reduction of stigma and discrimination among men and women by cultivating acceptance attitudes among the

	people towards people with HIV will also promote open living by HIV infected persons which is a positive factor in HIV prevention. Attitudes will vary among men and women and children and adults. The indicator can be disaggregated by age and gender.
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Programme Area 2: OVC

Indicator	3.2.1 Percent of OVC (under 18 years of age) living in households that have received basic external support in caring for the child (UNGASS 10)
Purpose	To assess progress in providing support to households that are caring for orphaned and vulnerable children aged 0–17
Source	Population-based surveys like ZDHS or MIMS. After all orphaned and vulnerable children aged 0–17 in the house have been identified, the household heads are asked four questions about the types and frequency of support received, and the primary source of the help for <i>each</i> orphaned and vulnerable child.
Numerator	Number of orphaned and vulnerable children who live in households that received at least one of four types of support: medical, education, psychosocial and other social or socio-economic support like food, clothing, shelter, financial or instrumental help like household work, training for caregivers, childcare, legal service etc.
Denominator	Total number of orphaned and vulnerable children aged 0–17, where an orphan is defined as a child below the age of 18 and has lost one or both parents and vulnerable child is one that (i) has lost one or both parents; or (ii) has a chronically ill parent (regardless of whether the parent lives in the same household as the child); or (iii) lives in a household where, in the last 12 months, at least one adult died and was sick for three of the four months before he or she died; or (iv) lives in a household where at least one adult was seriously ill for at least three of the past 12 months.
Interpretation	External support is defined as free help coming from a source other than friends, family or neighbours unless they are working for a community-based group or organization. The indicator is recommended in all country settings with high HIV prevalence (5% or greater). It does not measure the needs of the household or the orphans and vulnerable children. Additional questions could be asked to measure expressed needs of families caring for orphans. The indicator implicitly assumes that all households with orphans and vulnerable children need external support and would overlook the fact that orphans and vulnerable children have equal need for external support. Therefore, it is important to disaggregate the information by other markers of vulnerability such as socioeconomic status of the household, dependency ratio, head of the household, etc. If sample sizes permit, it may be useful for programmatic purposes to investigate differences between values for this indicator for orphans versus other vulnerable children. It may also be – useful to look at data disaggregated by age and duration of orphanhood, as both play a key role in determining the type of support needed. For

	example, an orphan whose parent(s) died 10 years ago will need support of a different kind from one whose parent(s) died within the past year. When considering the four types of support separately, data for school-related assistance should be limited to children aged 5–17.
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Indicator	3.2.2 Number of children under 18 that have a chronically ill parent, live in a household where an adult aged 18-59 died in the past year or live in a household with an adult aged 15-59 who has been chronically ill in the past 12 months
Purpose	To assess level of vulnerability among children 0-17 years of age
Source	Population Based Survey
Numerator	Number of children aged 0-17 that are reported having a chronically ill parent or living in a household where an adult aged 18-59 died in the past year or live in a household with an adult aged 15-59 who has been chronically ill in the past 12 months in the survey.
Denominator	Not Applicable
Interpretation	Death or chronic illness of a parent or adult household member usually culminates in the eroding of family resources to leave the household unable to meet the basic needs of children. In the context of HIV and AIDS, this is a major cause of vulnerability among children aged 0-17.

Indicator	3.2.3 Proportion of OVC aged 15-17 years that had sex before age 15,
Purpose	To assess exposure risk to HIV for children through early sexual debut
Source	Population Based Survey
Numerator	Number of children aged 15-17 years who report having had sex before the age of 15 years in the survey.
Denominator	All children aged 15-17 years of age who respond to the question whether they had had sex before the age of 15 years
Interpretation	Teenage orphans and other vulnerable children are at the risk of engaging in early sexual activity because of lack of parental guidance and control. They are also likely to be unable to protect themselves and this exposes them to HIV. Risk levels may vary among boys and girls and children in and out of school. The indicator can be disaggregated by gender and school attendance.

Indicator	3.2.4 Percent of children aged 0-5 years who have birth certificates
Purpose	To assess the coverage of birth registration
Source	Population Based Survey
Numerator	Number of children aged 0-5 reported to have birth certificates in the household survey
Denominator	Number of children aged 0-5 in the population. The denominator will come from population census on projection based on age distribution from population based survey
Interpretation	Acquisition of birth a certificate is an instrumental right which enables children to access other rights like education. Orphaned and vulnerable

	children commonly face problems in acquiring birth certificates in the absence of adults who can assist them. The indicator can be disaggregated by gender.
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Indicator	3.2.5 Percent of OVC provided with food/nutritional assistance
Purpose	To assess coverage of food assistance to orphaned and vulnerable children
Source	Programme Data
Numerator	Number of OVC reported to have received food assistance by organisations assisting OVC with food and nutrition. The figure will be obtained by counting the number of children reported as receiving food assistance at the reporting period without cumulating number reported monthly
Denominator	Estimated number of OVC in the country from national estimates or population based surveys. The denominator will be used on the assumption that majority of OVC will require food assistance whenever available.
Interpretation	Food assistance is one of the main needs of orphaned and vulnerable children which mitigation programmes have to target. Availability of food in communities varies from region to region and seasonally. Access may also vary by gender. The indicator can be disaggregated by gender and geographical area. Because of the assumption of generalized need among all OVC, the indicator should be interpreted against national targets which will be based on timely needs assessments.

Indicator	3.2.6 Percent of OVC provided with psycho-social support
Purpose	To assess the coverage of psychosocial support to orphaned and vulnerable children especially those who are affected by HIV and AIDS.
Source	Program Data (NAC)
Numerator	Number of OVC who were provided with psychosocial support. The data will be collected from organisations that are supporting OVC by providing psychosocial support to them. The indicator will be obtained by counting the number that received psychosocial support at the end of the reporting period
Denominator	Estimated number of OVC in the country from national estimates or population based surveys. The denominator will be used on the assumption that all OVC require psychosocial support.
Interpretation	Psychosocial support is an integral intervention for OVC. PSS complements efforts to provide material needs, school attendance and antiretroviral therapy for those who are on ART. Access to PSS by children may be affected by availability of interventions in the community and low uptake when communities are not well educated about the importance and potential benefits of PSS for children. Uptake of PSS by children may differ by gender and age. The data can be disaggregated by gender and age (<5, 6-10, 10-15, 15-18) to monitor trends in access by each age group. Because of the assumption of generalized need among all OVC, the indicator should be interpreted against national targets which will be based on timely needs assessments.

Indicator	3.2.7 Percent of OVC receiving school-related assistance
Purpose	To assess coverage of educational assistance among orphaned and vulnerable children who are in need of the assistance.
Source	Program Data (NAC)
Numerator	Number of OVC reported to have been provided with education assistance by organisations supporting OVC educational assistance. The indicator will be obtained by counting the number that were provided with education assistance from the organisations' assistance registers
Denominator	Estimated number of OVC in the country from national estimates or population based surveys. The denominator will be used on the assumption that all OVC require educational support.
Interpretation	Education assistance is an integral intervention for OVC. It enables school attendance and quality of education. Access to education assistance may however vary by gender and age. The data can thus be disaggregated by gender and age (6-12, 13-18) to monitor trends in access by each age group. Because of the assumption of generalized need among all OVC, the indicator should be interpreted against national targets which would be based on timely needs assessments.

Programme Area 3: Gender

Indicator	3.3.1 Percent of women and girls who report being able to access and consistently use female and male condoms
Purpose	To monitor access and availability of condoms to women and girls for their protection against HIV infection and reproductive health needs.
Source	Population Based Survey
Numerator	Number of women and girls who report being able to access and consistently use the male and the female condom in the survey
Denominator	Number of women who responses to the questions on access to male and female condoms and on correct and consistent use of the condoms
Interpretation	Access and correct and consistent use of condoms by women and girls empowers them to protect themselves from HIV infection. Access and correct use of both male and female condoms is important. There are cultural barriers to condom use which programming has to deal with and monitoring access and use knowledge is a proxy indicator of progress towards breaking of access and use barriers. Women and girls face different kinds of barriers from men and boys. Women may also face different challenges from girls. The indicator should be disaggregated by women's age (<15, 15-24, 25-49) to differently monitor trends in the different age groups.

Indicator	3.3.2 Number of sexually abused women and girls provided with post-exposure prophylaxis (PEP)
Purpose	To monitor coverage and access to post exposure prophylaxis by sexually abused women and girls.
Source	Population Based Survey
Numerator	Number of women and girls who report having been sexually abused and

	received post exposure prophylaxis in the past 12 months in the survey
Denominator	Not Applicable
Interpretation	HIV-PEP must be part of comprehensive HIV prevention, occupational health, and post-rape care service policies. Availability of PEP addresses concerns in multiple program areas. The data collected through this indicator provides information relevant to prevention, program quality, gender. The indicator does not intend to capture the type and quality of PEP services provided. PEP services may include first AID, counselling, testing, provision of ARVs, medical care, trauma counselling, linkages with police, and other follow-up and support. Simple monitoring of PEP availability through program records does not ensure that all PEP-related services are adequately provided to those who need them. Access to PEP for sexual violence victims is anticipated to remain low due to presence of barriers to access and low reporting of sexual violence. Challenges may also be faced in reporting of this data in the absence of strategies to mobilize the relevant sources for this data to capture and report the data.

Programme Area 4: Water and Sanitation

Indicator	3.4.1 Percent of PLWHIV that have access to safe water and sanitation
Purpose	To measure how well community-based programs are reaching PLHIV with a water and sanitation services to protect the health of the infected persons and reduce the risk for PLHIV to contract water borne diseases and other diseases transmitted through unsafe sanitary conditions.
Source	National Survey
Numerator	Number of PLHIV with access to safe water and sanitation
Denominator	Number of PLHIV. The denominator will be obtained from national HIV and AIDS estimates or population based survey for PLHIV.
Interpretation	The indicator identifies gaps that may exist in access to water and sanitation by PLHIV. The information can be used to plan and make decisions on how PLHIV can be reached or provided with water and sanitation services. If a small percentage of the PLHIV is being reached, then it would be recommended that activities be scaled up to improve reach. If a large percentage is being reached, then programmers would want to take the lessons learned and replicate the strategy elsewhere. The data will not reflect the quality of the program unless the survey specifically collects this data.

STRATEGIC AREA 4: MONITORING AND EVALUATION, RESEARCH AND SURVEILLANCE

Programme Area 1: Monitoring and Evaluation

Indicator	4.1.1 National M&E calendar developed and implemented
Purpose	To monitor the development of a calendar for M&E activities which should be used to guide planning and implementation of monitoring and

	evaluation activities
Source	National Reports
Numerator	National M&E calendar has been developed, is available and is in use
Denominator	Not Applicable
Interpretation	The development of an M&E calendar facilitates planning and implementation of M&E activities. The indicator is based on assumption that once a calendar is developed it will be followed and all planned activities will be implemented. The indicator does not report on the accomplishment of each planned activity.

Indicator	4.1.2 Percent of implementers with a designated and functioning M&E focal person
Purpose	To assess progress in development of M&E capacity among implementers of all categories including health sector, civil society and business sector.
Source	Special Survey
Numerator	Number of implementers with a designated and functional M&E focal point. The numerator can be disaggregated by category of implementers since not all implementers will be expected to progress in designation of M&E focal points at the same pace.
Denominator	Number of implementers identified in each category.
Interpretation	The presence of focal points strengthens capacity of implementers to collect and report on data and also to analyze and utilize the data that they collect. These are critical requirements of monitoring and evaluation. The indicator does not measure availability of M&E resources to support the focal points or skill levels and technical capacity of focal points. It assumes once present focal points have capacity and support for functionality and productivity

Indicator	4.1.3 Percent of implementers regularly reporting to the national M&E system
Purpose	To monitor reporting rate so as to validate representativeness and comprehensiveness of the data collected in the national M&E system
Source	NAC Programme Data
Numerator	Number of implementers reporting at each reporting period
Denominator	Number of implementers registered with the National AIDS Council and expected to report at the reporting period
Interpretation	Reporting rate is important to assess completeness of data. Late and non-reporting by implementers is a data quality weakness in monitoring and evaluation. With low reporting rates, the data cannot present national picture. Programmers would also go without information about the state of the programmes and achievements in the missing geographical areas. The indicator does not measure other aspects of data quality like accuracy, integrity and precision.

Indicator	4.1.4 Number of functional district and provincial M&E task forces
Purpose	To monitor the existence and functionality of M&E task forces at sub-

	national levels in Zimbabwe.
Source	NAC Programme Reports
Numerator	Number of M&E task forces that held at least one monitoring and evaluation task force meeting per quarter and has evidence of minutes of the meeting.
Denominator	Not Applicable
Interpretation	A defined oversight structure in the form of an M&E task force is recommended in a multi-sectoral response like the one being implemented in Zimbabwe. It assists in collective monitoring of the national response programme, in peer-reviewing of individual implementers and in the enforcement of policies and strategies. The indicator will monitor functionality of M&E task forces but will not measure quality of discussions and deliverables from task forces. It will also not measure overall capacity of task forces.

Indicator	4.1.5 Number of research projects, special studies and impact evaluations completed
Purpose	To check whether research is going on in the field of HIV and AIDS as planned on the monitoring and evaluation calendar and M&E action plan
Source	NAC programme Reports
Numerator	Number of research studies, special studies and evaluations commissioned in the country which have been completed and have results. The numerator is obtained by counting the researches that have been completed.
Denominator	Not Applicable
Interpretation	Research is important. It forms the evaluation component of monitoring and evaluation. Outcome and impact indicators are collected through researches and evaluations. The indicator will monitor the implementation of all research studies, surveillances and evaluations planned for in the M&E plan. It will measure those that have been completed and not those that are underway to avoid double counting. The indicator will not measure the quality of findings and dissemination of the studies. It assumes that once completed, all studies will be disseminated.

Indicator	4.1.6 Number of M&E feed-back reports disseminated at district, provincial and national levels
Purpose	To assess whether the M&E data being collected is analysed and disseminated at national and sub-national levels
Source	Programme Report
Numerator	Number of monitoring and evaluation feedback reports produced and disseminated at district, provincial and national level. These will be reports produced by the National AIDS Council on the data collected in the national M&E system.
Denominator	Not Applicable
Interpretation	Dissemination of M&E information and reporting back to implementers from which data is collected is a pre-requisite for M&E. implementers are able so see the progress made in the response through feedback from M&E.

	Implementation gaps can also be identified which will inform planning. Feedback reports should be available to all stakeholders. Facilities such as website may be used for dissemination in addition to hard copies.
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Indicator	4.1.7 Number of implementers with HIV and AIDS policies in place
Purpose	To assess progress in the development and implementation of national-level HIV/AIDS policies and strategies
Source	Special Survey
Numerator	Number of implementers with existing HIV policy or strategy documents and evidence of implementing the policy or strategy
Denominator	Not Applicable
Interpretation	It is important for all organisations; public, non-governmental and business sector to have HIV and AIDS policies or strategic plans which guides their programmes including workplace programmes. Policies and strategies spell out the targets to be achieved which monitoring and evaluation will assess. In counting organisations with policies in place, enumerators must confirm implementation. However, the indicator will not measure degree of implementation and quality of programmes deriving from the strategy or policy.

Indicator	4.1.8 Number of implementers provided with technical support in monitoring and evaluation
Purpose	The intention of the indicator is to monitor extent to which technical capacity is being built among local organizations to collect, analyze, disseminate and use HIV and AIDS data.
Source	NAC Programme Reports
Numerator	Number of implementers provided with technical support at the end of the reporting period
Denominator	Not Applicable
Interpretation	Technical support is intended to assist in capacity development for monitoring and evaluation among implementers. It should include involve regular through a combination of strategic approaches including individualized on-site training and support and training workshops on standardized curricula. The support may be for data verification and validation and training on M&E system development, methods and tools for data collection, data analysis and dissemination and data utilization. The indicator does not capture the quality of the technical support provided, nor does it capture changes in the capacity of the organization/agency in collecting, analyzing, disseminating and using HIV and AIDS data.

Indicator	4.1.9 Percent of funds allocated to M&E in national HIV and AIDS programmes (ESP, GF, NATF, NAP for OVC, AIDS & TB)
Purpose	To collect data on amounts of funds that are allocated and spent of HIV and AIDS monitoring and evaluation in the country.

Source	NASA Survey
Numerator	Total amount of funds allocated to M&E in different organisations. This will be obtained by summing the amounts reported by different organisations.
Denominator	Total amount of funds received or deployed to HIV and AIDS in the country including what is spend I other programme areas like prevention, treatment and care, mitigation and coordination or programme management
Interpretation	The data must be actual expenditures, not budgets or commitments. They must include M&E expenditures that were made as part of broader systems development. For example, expenditures of trainings attended, equipment donations and capacity building support and supervisory visits. Some expenditure will require detailed estimation to calculate actual expenditures, which is provided in NASA. The M&E expenditure might occur outside the M&E function given the nature of organisational structures. Assessing M&E expenditure will provide a more detailed picture of the situation at country level, which is useful for both national and global decision-making.

Annex II: Work Plan and Budget (attached)