ZIMBABWE

Monitoring and Evaluation PLAN for the extended Zimbabwe HIV and AIDS National Strategic Plan (2015 – 2020)

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ACKNOWLEDGEMENTS:

ACRONYMS

ART	Antiretroviral therapy
AU	African Union
BCC	Behaviour Change and communication
CDC	Centre for Disease Control
C&HBC	Home-based care
CRIS	Country Response Information System
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
GFPF	Global Fund Performance Framework
HIV/AIDS	Human Immunodeficiency Virus/ Acquired Immunodeficiency Syndrome
HTC	HIV Testing and Counselling
ID	Identity Card
IP	Implementing Partners
LSU	Logistic Support Unit
M&E	Monitoring and Evaluation
MOHCC	Ministry of Health and Child Welfare
NAC	National AIDS Council
NARF	National Activity Reporting Form
NHIS	National Health Information System
NRMEAG	National Research, 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
UNPDC	United Nations 201 Declaration of Political Commitment on HIV and IDS
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
ZCTU	Zimbabwe Congress of Trade Union

ZIMA   Zimbabwe Medical Association
ZNASP   Zimbabwe National AIDS Strategic Plan

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PREFACE

In response to HIV and AIDS, the government of Zimbabwe has put together a multi-sectoral response articulated in the Zimbabwe National HIV and AIDS Strategic Plan (ZNASP 2015-2018). This strategy has now been extended from 2018 to 2020 and is now referred to as the extended ZNASP. The ZNASP provides both policy and strategic guidance to all HIV and AIDS interventions carried out by implementing partners (IPs) and stakeholders in Zimbabwe. The strategic plan for 2015-2018 was informed by the knowledge of the epidemic. The country has a generalized HIV epidemic with an estimated prevalence of 14.99% (CI 14.24-15.7) and an incidence of 0.98%[1]. Zimbabwe recorded a decline in adult HIV prevalence from 24.6% in 2004 to 14.99% in 2013. There is an estimated 1,390,211 people living with HIV and a total of 920,629 needed ART by December 2013. There is an estimated 63,853 annual AIDS deaths living about 889,339 AIDS orphans[1]. .

This extended Monitoring and Evaluation Plan takes into consideration more recent international recommendations such as the 90 90 90 Global Initiative and the UNAIDS FastTrack Strategy

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 Research, Monitoring and Evaluation Advisory Group (NRMEAG), developed the National Monitoring and Evaluation (M & E) plan. The M&E plan guides all stakeholders in effective measurement of inputs, outputs, outcomes, and impact of the ZNASP.

The production of the National M&E Plan was in accordance with the "THREE ONES" principle, which stipulates:
- 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.

In addition, this plan enables Zimbabwe to systematically monitor implementation of the strategic plan and measure progress towards the achievement of both national targets and international commitments in the national response to HIV and AIDS. The development of the M & E plan was followed by the development of the costed workplan. The implementation of the M & E workplan will be monitored by M & E taskforces at levels.

All national and international reporting is therefore to be done per the National M& E plan to maintain one agreed country level M & E system.

Dr T Magure
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CHAPTER 1:   BACKGROUND

1.1 HIV and AIDS Profile

Per the Zimbabwe Population based HIV Impact Assessment (ZIMPHIA) 2016 results estimate that approximately 1.2 million people age 15 to 64 years are living with HIV (PLHIV) in Zimbabwe. This number varies slightly with software models, where the HIV estimates software for the number of adults (15 years +) living with HIV was 1.35 million people (1,349,070). Zimbabwe is faced with a serious epidemic that is has a profound social and economic impact on the nation. Women and young girls constitute about 52% of those infected by HIV. An estimated, 29,000 people die of AIDS every year and about 800,000 children aged 17 years and below have lost one or both parents to AIDS (HIV Estimate report: 2015).

1.2 National response to HIV & AIDS

In response to the pandemic the government of Zimbabwe has put together a multi-sectoral response outlined in the Zimbabwe National HIV and AIDS Strategic Plan (ZNASP). The Zimbabwe National HIV and AIDS Strategic Plan 2015-2020 (ZNASP) consists of the following thematic areas: (i) HIV prevention, (ii) HIV and AIDS treatment, care and support   (iii) Enabling Environment (iv) Management and coordination, monitoring and evaluation. Each of the thematic areas consists of prioritized intervention areas. The ZNASP provides both policy and strategic guidance on all HIV and AIDS interventions carried out in Zimbabwe.
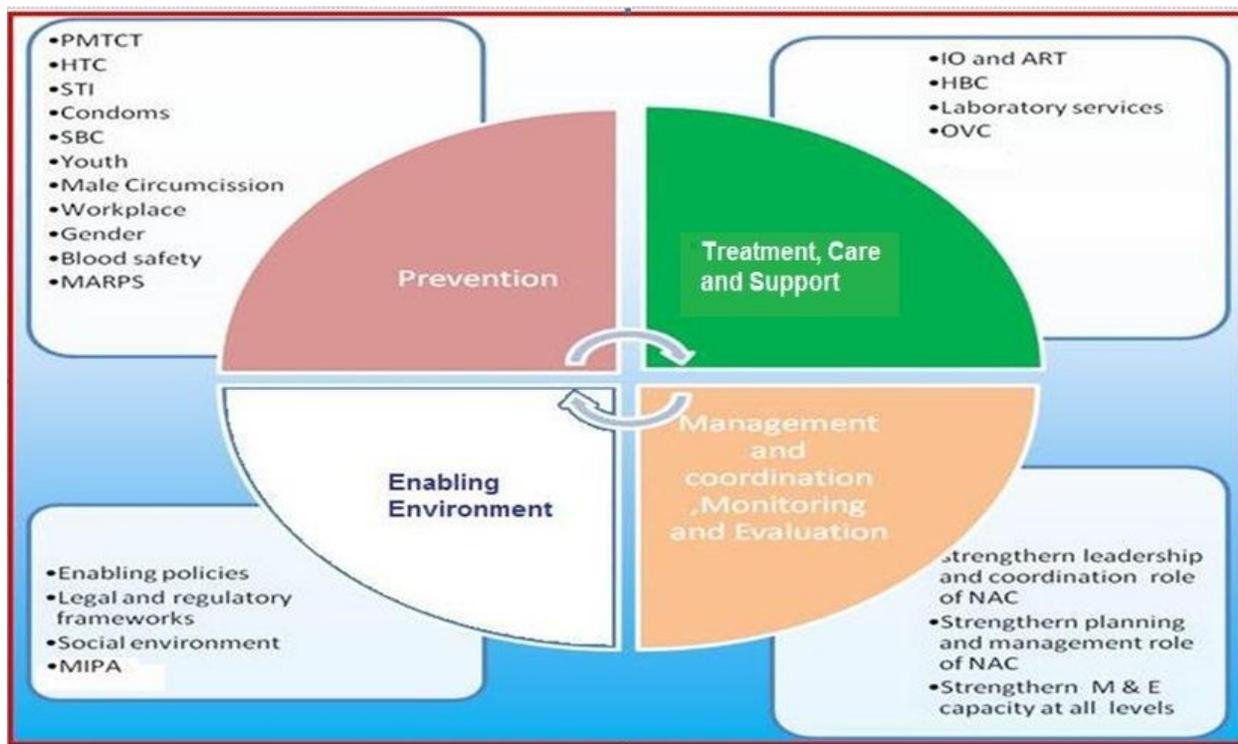
Figure 1: Strategic Components of ZNASP

1.3 The "THREE ONES" Principle

Zimbabwe subscribes to the "THREE ONES" principle which also guided the development of this M & E plan. The three ones principle 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 development of the M&E plan completes the three ones, the National Strategic Plan 2015 – 2018 is in place and the National AIDS Coordinating Authority (NAC) are in place. The plan is informed by the ZNASP and it enables Zimbabwe to systematically monitor implementation of the strategic plan and measure progress towards the achievement of national targets and international commitments in the fight against HIV and AIDS.

1.4 Global and Regional Commitments

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), Universal Access, Southern Africa Development Committee (SADC), African Union (AU), and the 2011 UN Political Declaration on

HIV/AIDS. The indicators selected in this plan cater for reporting to these global and regional commitments, in addition to national monitoring and evaluation requirements.

Zimbabwe subscribes to the 90 90 90 global initiative. This initiative states that by 2020, 90% of all people living with HIV will know their HIV status. By 2020, 90% of all people with diagnosed HIV infection will receive sustained antiretroviral therapy. By 2020, 90% of all people receiving antiretroviral therapy will have viral suppression.

This initiative is further strengthened by the Fast Track initiative to end HIV by 2030. This strategy builds upon proposed success factors of 2020, such that by 2030, 95% of all people living with HIV will know their HIV status. By 2030, 95% of all people with diagnosed HIV infection will receive sustained antiretroviral therapy. By 2030, 95% of all people receiving antiretroviral therapy will have viral suppression.

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 results based ZNASP 2015 - 2020. 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 spells out by programme areas, details of what information is needed including: indicators data sources, collection methods, flow, analysis, use and reporting, and feedback as well as the responsibilities of implementing partners and stakeholders. It outlines strategies for addressing each of the 12 components of a functional M & E system. It also includes a detailed costed M & E workplan.

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

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

- Monitor effectiveness of programs

- Facilitate data dissemination among implementing partners and stakeholders

- Guide Resource Mobilization

2.3 M&E Plan Development Process

Participatory and consultative approaches were used in developing this extended National M&E Plan. The development of the M&E plan was spearheaded by the NAC with support from NRMEAG and UN agencies. The plan builds upon and complements the ZNASP as well as implementation experiences of the previous M & E plan. Results from the M & E systems assessment also provided a platform for the development of this plan.

2.4 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:** A data source is a tangible set 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:** Information products are standard report/document that NAC or other stakeholders produce at regular intervals after receiving data and analysing these data.

(f) **M&E results chain:** There are four levels of indicators (inputs, outputs, outcomes and impact).

- o **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.
- o **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.
- o **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.
- o **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.

Fig 2: M & E results chain
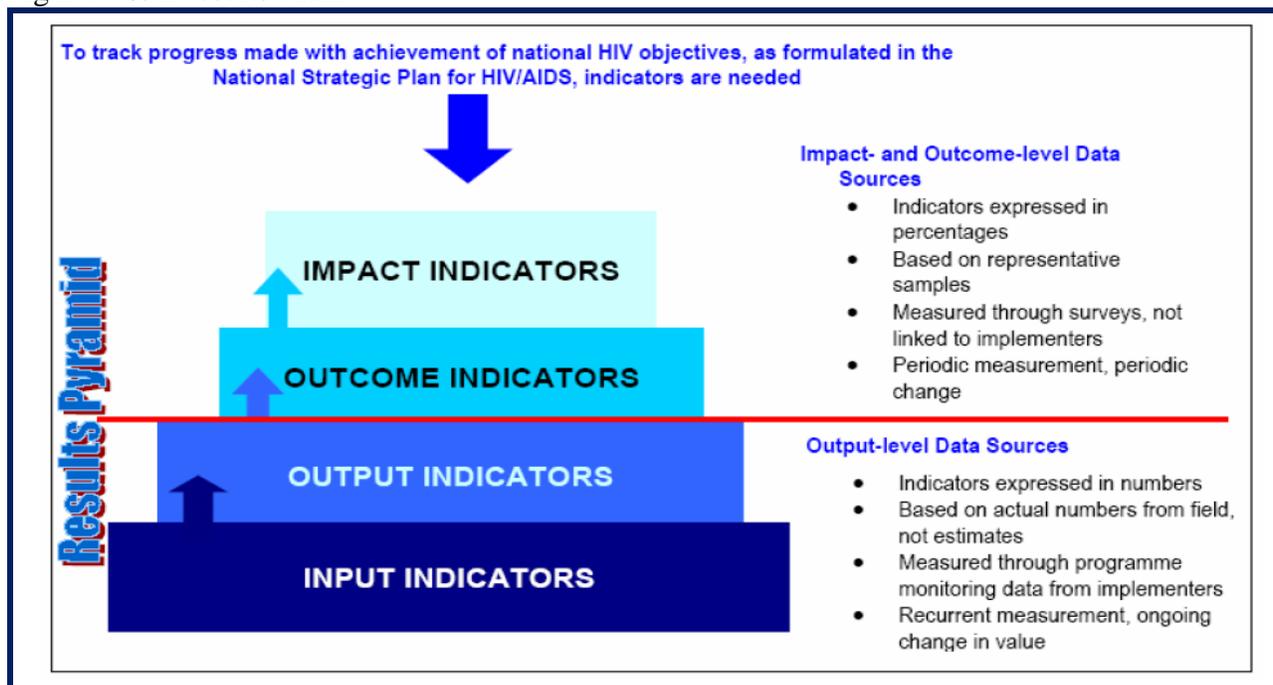
2.5 Components of the M&E system

- The UNAIDS developed, "*12 Component Framework for Developing a Functional National M&E System",* was used as a guide in developing the Zimbabwe national M&E Plan.

- The outer ring represents the human resources, partnerships and planning required to support data collection and data use. It includes individuals, organizations, functions/actions, and the organizational culture that are fundamental to improving and sustaining M&E system performance.

- The middle ring focuses on the mechanisms through which data are collected, verified and analysed.

- The centre of the diagram represents the primary purpose of the M&E system: using data for decision-making.
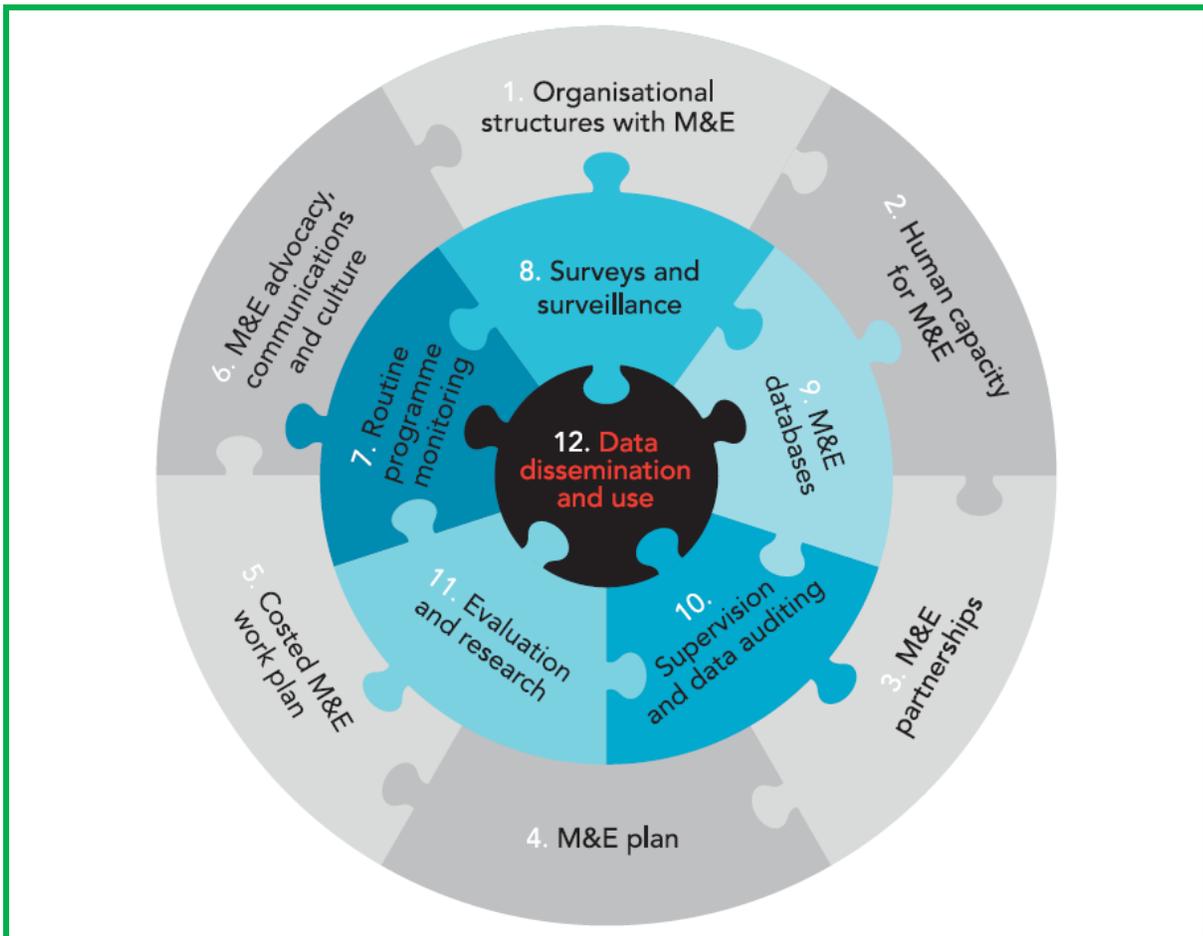
Figure 2:Organizing Framework for a functional National HIV M & E system.

Strategies in addressing each of the twelve components are also outlined below:

People, Partnership and Planning

2.5.1 Organizational structure with M & E function

For the national HIV M&E system to function effectively, a variety of organizations need to work together at different levels. Under the three ones principle NAC is responsible for coordinating the country level M & E system. NAC has a dedicated M&E unit with the mandate and authority to coordinate M&E activities and to request data from all relevant partners. Additional M&E staff is required at the national level, including HIV M&E focal points at the Ministry of Health (MOH) and other line ministries, as well as at sub-national governmental levels and in organizations or facilities providing HIV services. Although MOH undertakes M & E activities through the AIDS and TB unit, it does not have a dedicated M & E unit. Deliberate efforts should be made within the MOH to align the AIDS and TB M & E system with National Health Information System (NHIS).

Through strategies recommended in the 2015-2018 M&E Plan, the M&E Sector coordination mechanisms have been established through the multi-sectoral National Research, Monitoring and Evaluation Advisory Group (NRMEAG)
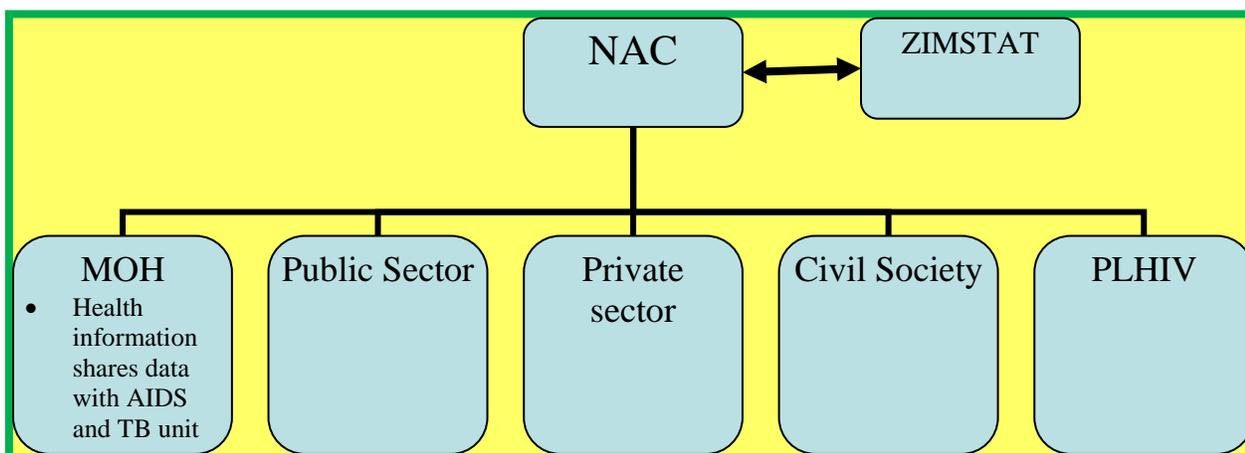
Figure 3: National Monitoring and Evaluation Coordination structures

Strategies
- Development of Statutory Instruments to enforce routine reporting
- Capacity building of sector coordination structures.
- Mainstream M & E into Health Information System.
- Support ZIMSTAT in collection of data for programme evaluation.

2.5.2 Human Capacity for M & E

It is necessary to have dedicated, adequate and well trained M&E staff. Human capacity building should focus on all levels; have measurable performance objectives; include a capacity building plan with clearly defined outputs; and include ways to track progress over time. M&E human capacity building requires a wide range of activities, including formal training, in-service training, mentorship, coaching and internships. M&E capacity building should focus not only on the technical aspects of M&E, but also address skills in leadership, financial management, facilitation, supervision, advocacy and communication.

M&E Staffing
Implementation of the M&E plan requires the establishment of an appropriate staff complement at NAC and across implementers at all levels. The number of M&E staff positions has significantly improved since 2015, with most posts being filled in at district and provincial levels. However, core competencies of the staff remain a point of concern.
Although most supporting organizations have achieved stability there is still a shortage of M&E staff.
Mechanisms to improve knowledge and skills in M&E
- Conduct M&E training for national health information and implementing partners
- Conduct ongoing refresher training courses using the adopted UNAIDS training curriculum.

- Advocate with implementing partners to recruit adequate M&E personnel
- Continuously review on the job education and mentoring tools for use by M&E staff

Strategies
- Capacitate M&E people in public, private sector, civil society and PLHIV
- Mainstream M&E in the training and duties of the nurses at site level as well as Health Information Officers.
- Ongoing professional training of M & E personnel.

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

It is important that all stakeholders in HIV M & E work together. The country has been successful in establishing and maintaining M&E partnerships through the National Research, M & E Advisory Group that meets regularly and includes all relevant stakeholders. Other examples of M & E partnerships include conducting joint planning with key M&E stakeholders at all levels. To avoid duplication of effort, NAC has established communication mechanisms with various organizations that provide regular technical support in M & E both in-country and internationally.

Strategies
- Strengthen national and sub-national M & E taskforces. At sub-national levels these taskforces are still to be established.
- Strengthen community involvement in provision of ART services.

2.5.4 National Multi-Sectoral HIV M&E Plan

The M & E mandate is clearly defined in the ZNASP. The objectives of the national M&E plan are explicitly linked to the HIV National Strategic Plan priority areas to ensure that relevant data are collected to measure the progress in the country's HIV response. The national M&E plan, and specifically the national indicators adhere to global and national technical standards and agreed best practices. In addition to the national multi-sectoral M&E plan, different sectors, development partners and sub-national entities involved in the HIV response may develop their own M & E plans that detail how each will collect and report HIV data to contribute to the one national HIV M&E System. The national M&E plan shall be reviewed and updated at midline and final stages of the ZNASP to make adjustments in data collection needs associated with revisions of the National Strategic Plan, and to strengthen M&E system performance based on periodic M & E assessments.

Strategies
- Maintain M & E plan always aligned to National HIV and AIDS Strategic Plan.
- Adherence of the M & E Plan to national, regional and international standards for HIV M&E.
- Regular review and update of the M & E plan in line with ZNASP reviews.

2.5.5 Annual costed national HIV M&E work plan

For the national HIV M&E plan to be operationalised, an annual costed national M&E work plan was developed that describes the priority M & E activities for the strategic period with defined responsibilities for implementation, costs for each activity, identified funding, and a clear timeline for delivery of outputs. This work plan enables the NAC and the national M & E taskforces to ensure

that financial and human resources are mobilized and allows for monitoring progress towards implementation of one national HIV M&E system. The costed national M&E work plan also possible sources of funding for each activity. M & E work plans shall also be developed at the sub-national and service delivery levels to guide M&E implementation linked to the national HIV M&E system. The costed national M&E plan needs to be revised to incorporate the extension period.

Strategies

- Stakeholder involvement in development and finalization of costed M&E workplan, incorporating updates of the extended M&E Plan.
- Improve resource mobilization for M&E
- Constant review of the annual workplan.

2.5.6 Advocacy, communications and culture for HIV M&E

NAC currently has a draft Communication and Advocacy strategies and the M&E will be part of the strategies. Availability of a communication and advocacy strategy for M&E in NAC is essential for the creation of a supportive M&E culture. Equally important is political support to ensure transparency and accountability related to the HIV response. One way to gain political support is to identify an 'M&E champion', a high-level official who can promote M&E among his/her peers, to help foster an understanding about the importance of investing in quality data for policy formulation and programme decision-making. Currently NAC has a director responsible for M&E.

Strategies

- Updating the national communication and advocacy strategy to incorporate updates in the extended M&E Plan.

Collecting, verifying and analysing data

2.5.7 Routine HIV programme monitoring

NAC and MOH have routine systems to track the demand for and supply of HIV services. Standardized data from all providers, including facility and community-based HIV service providers are collected on a routine basis. To guide decision-making at all levels, the data needs of different stakeholders should be determined and routine data made available in a timely fashion. The national M&E unit at NAC and MOH ensures that data from health facilities are captured in the national M&E system on a timely basis to allow for their inclusion in routine reports and other information products. This is not withstanding the fact that there are various challenges in the provision of information to coordinate HIV service delivery and monitor the HIV response comprehensively.

The infrastructure to setup networking services for reporting purposes from health service facilities has been strengthened from district level to national level. These services will allow ease of transfer of reporting information from district level facilities to national level reporting structures.

Data should be obtained from all implementing partners providing HIV services such as those funded directly by the government as well as those funded through other sources (e.g., by

development partners). Sectoral databases currently exist that include data relevant to HIV programmes (e.g., social service information for orphans and vulnerable children).

The reporting requirements for the National AIDS Strategy have been spelt out and the reporting tools are in place. It is most appropriate to ensure these reporting tools are standardised across the key stakeholders who participate in the response.

An electronic patient monitoring system has been developed and deployed in 634 facilities. This facility offers the capacity to track patients at points of care. However, it is limited in tracking patients across different service facilities. There is need to allow for information captured in the electronic patient tracking system to be shareable across different service facilities. There are efforts towards the development of an HIV/AIDS macro database that will allow for patient transfer across the service points.

The patient level information systems must also interface with the national health data repository which is the District Health Information System.

Strategies

- Development of Statutory Instruments to enforce routine reporting
- Identification of all existing data sources and establishment of well documented appropriate links.
- Updating the electronic patient tacking system to all for patient transfer across service domains.
- Standardization of data collection processes and tools.
- Mainstreaming M & E in the functions of community cadres.
- Capacity building on data analysis.

2.5.8 Surveys and surveillance

Surveillance and surveys are essential to determine the drivers and the spread of the HIV epidemic in each country. HIV surveillance and HIV surveys may focus on the general population, most-at-risk populations or both. The need for surveys, as well as, the specific focus and content of each survey are considered within the context of the country's epidemic. Protocols and data collection tools are also based on international standards for surveys, such as the Demographic and Health Survey, the AIDS Indicator Survey, and the Multiple Cluster Indicator Survey. Where appropriate, surveillance and survey protocols include data collection to support the construction of the standardized national indicators defined in the national M&E plan. This can help prevent the need for additional data collection efforts and additional costs.

A few key surveys/surveillances have not been carried out on time. These strategies include:

- ANC Sentinel Surveillance
- Surveys on key populations
- Surveys for behavioural change
- National survey on condom availability

Strategies

- Finalising outstanding surveys and surveillances
- Development of a national database for survey and surveillance
- Strengthening the multi-sectoral coordination of survey and surveillance

2.5.9 National and sub-national HIV databases

Clear roles and responsibilities are going to be strengthened and maintained at national, sub-national, and service-delivery levels to ensure an appropriate and timely data flow between the different levels. Currently there are several existing databases where data is stored and processed and reports are produced. These databases include the MOH HIV reporting database, TB reporting database, HIS database, LSU database and NAC databases. In addition, implementing partners have programme level databases. Different departments within the Ministry are implementing different information systems that serve the same purpose. The main ones being electronic patient

management system and electronic health record. These systems are creating room for duplication of effort and compromising the quality of care as information gets split across information systems.

The implementation of various none coordinated information system emanates from the absence of a clearly well-defined and implementable e-Health Strategy/Policy. This policy should guide NAC, the Ministry and other partners to follow clear guidelines in the implementation of electronic information systems. These guidelines must be supported by a multi-sectoral governance structure that will guide with documentation and implementation of the various information systems involved in the multi-sectoral response.

Strategies

- Develop an e-Health Strategy/Policy to guide in the implementation of electronic databases
- Develop an e-Health Governance Structure and associated Technical Working Groups.
- Develop linkages between databases so that they feed into one national database, the District Health Information System
- Development of an electronic laboratory database
- Development of National IT policy
- Establishment of e-health systems compliant with national and international standards.

2.5.10 Supportive supervision and data auditing

Regular data quality checks and provision of feedback are important mechanisms to improve or sustain data quality. Guidelines for supportive supervision are useful to communicate expectations and standardize procedures. Supportive supervision has been routinely carried out. Standard Operating Procedures have been implemented for on the job support, supervision and data auditing. There is need to continue with supportive supervision and strengthening data use at the point of care, this will further enhance the quality of data with persistent use.

Strategies

- Assess the effectiveness of the existing SOPs for support and supervision and data auditing
- Strengthen support supervision and data auditing system focusing on data use for decision support.

- Establishment of a data audit system for the private sector, civil society and PLHIV

2.2.11 HIV Evaluation and Research

Evaluation and research are essential but often neglected components of a comprehensive HIV M&E system. Appropriate use of evaluation/research data ensures that the planning of the HIV response is based on the best available evidence and guides ongoing programme improvement. The evaluation and research must be supported by clear guidelines on the themes and expectations towards strengthening the multi-sectoral response. There must be clear strategies on how to disseminate and operationalise the research and evaluation findings.

Strategies
- Development of guidelines for research and evaluation
- Capacity building on evaluation and research
- Institutionalize mechanism for the dissemination of researches and evaluation findings.
- Resources mobilization for research and evaluation
- Promote implementation of operational research at all levels

Using data for decision making

2.5.12 Data dissemination and use

The most important reason for conducting M&E is to provide the data needed for guiding policy formulation and programme operations. A functional M&E system collates and presents the data in a way that facilitates data use at all levels, including the public and beneficiaries of HIV services. Data use has remained weak over time. There is need to train all structures towards data use at point of service delivery. This has been further weakened by the absence of a clear data dissemination plan that serves as a guide towards ensuring all key stakeholders have access to the data they should have access to. Though there are skills in basic monitoring and evaluation, skills in basic data use and analysis are still limited.

Strategies
- Development and implementation of data dissemination plan
- Capacity building of management on data usage for decision making.
- Reconstitute and capacitate M & E Taskforce on data analysis and use.

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 and provincial levels, NAC has M&E staff and at district and ward level, the organization is represented by a DAC and Ward Focal Person (WFP) respectively who coordinate partners' activities and facilitate implementer registration and reporting. All implementers register annually at district level through the Organizational Details Form (ODF) 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.

In support of this structure, should be a robust information system. There is need for NAC to implement an Information System that integrates seamlessly with the recommended national repository, the District Health Information System.

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

NAC is supported at national level by a multi-sectoral and multi-disciplinary National Research Monitoring and Advisory Group (RMEAG). The NRMEAG 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 NRMEAG.

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:

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 currently 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	EMCOZ, Zimbabwe Business Council on AIDS (ZBCA), ZCTU and ZIMA.	There are four key coordinating bodies in the private sector but for purposes of monitoring and evaluation of HIV/AIDS interventions, a coordinating body for the private sector shall be set up. The body shall require capacity strengthening for the function.
Public sector	Ministry of Public Service	The Ministry of Public Service is currently coordinating all other government ministries except for Ministry of Health. There is need for data to flow from this sector to the national M & E system.
PLHIV	ZNNP+	Currently ZNNP+ is coordinating network of PLHIV activities. The networks are in the process of identifying a permanent coordinator.

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:

Tool	Custodian	Purpose
Organizational Details Form (ODF)	NAC	Registration of implementers. The registration is done annually.
National Activity Report Form (NARF)	NAC	Completed by implementers on monthly basis for submission of core output indicators to the national M&E system.
ART and PMTCT Registers	MOHCC	For ART and PMTCT data capture from clients by health workers at facility level, from which data is extracted onto reporting forms.
T-series	MOHCC (NHIS)	For data flow within the NHIS from health facilities through district to national office.
Primary data collection tools	Implementing Partners	To be developed by every implementer of non-health interventions for data collection at activity level from which they will abstract data onto national reporting forms (NARF). Private medical implementers are expected to adopt the MoH data collection tools.

3.2.2 Reporting Timelines for Implementers

At the district level, the deadline for implementers to submit data to the DAC is the 10th of the following month and the deadline for the DAC to submit data to the PAC is the 15th of the month. The PAC then sends the data to the NAC HQ by the 20th of the month. Written protocols and guidelines describing the data collection process shall be made explicit to all implementers in both health and non-health facilities.

3.2.3 Mechanisms to improve data collection, tools and methods

- Register all implementing partners in all districts including renewal of organizational registration annually.
- Review and revise existing NARF data collection tools, clarify cut-off dates and reporting timeframes.
- Formal linkages between NAC and MoHCC put in place to establish clear roles and responsibilities and strengthen role of NHIS in data collection.
- Develop a data dictionary to harmonize AIDS and TB, NHIS and NAC indicators
- 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
- 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
- Develop an online data collection system that interfaces with the national data repository.

3.3 Data Storage

Data storage and management vary across implementers. Some implementers store their data manually while others use electronic systems. In other cases, there is a combination of manual and electronic storage. These databases include the MOH HIV reporting database, TB reporting database, HIS database, such as LSU database and NAC database. In addition, implementing partners have programme level databases. By 2016, it had been established to have one national repository for programme reporting, the District Health Information System (DHIS). Harmonisation of reporting has been established through multi-sectoral access to DHIS.

3.3.1 Mechanisms to improve data storage

- Standardise the approach towards the implementation of electronic information systems so that systems meet minimum criteria that will allow for multi-sectoral information exchange where necessary. This is achieved through a well-documented e-Health Strategy.
-
- Standardize the existing manual data storage system and move toward an electronic database in all districts to manage NARF data. This system should be a web based application that makes use of the existing networking infrastructure that is established from district level to national level.
- Develop a mechanism for sharing data from different HIV and AIDS related databases and provide programme managers access to complete disease surveillance and service coverage information online. This is achieved through the adoption of national health information exchange standards that will facilitate information flow to and from other data repositories.
- 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 ZIMSTAT. This documentation will be supporting the earlier recommended e-Health Strategy.

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. Implementing partners must use the most efficient and effective transmission means available in their district. All the districts to date have Internet resources as supported by partners. Mobile applications can also interface with data repositories. Hence it is recommended that data flow be strengthened primarily through these existing Internet based technologies.

The following figure illustrates the proposed data flow & feedback loop needed to implement the M&E plan.
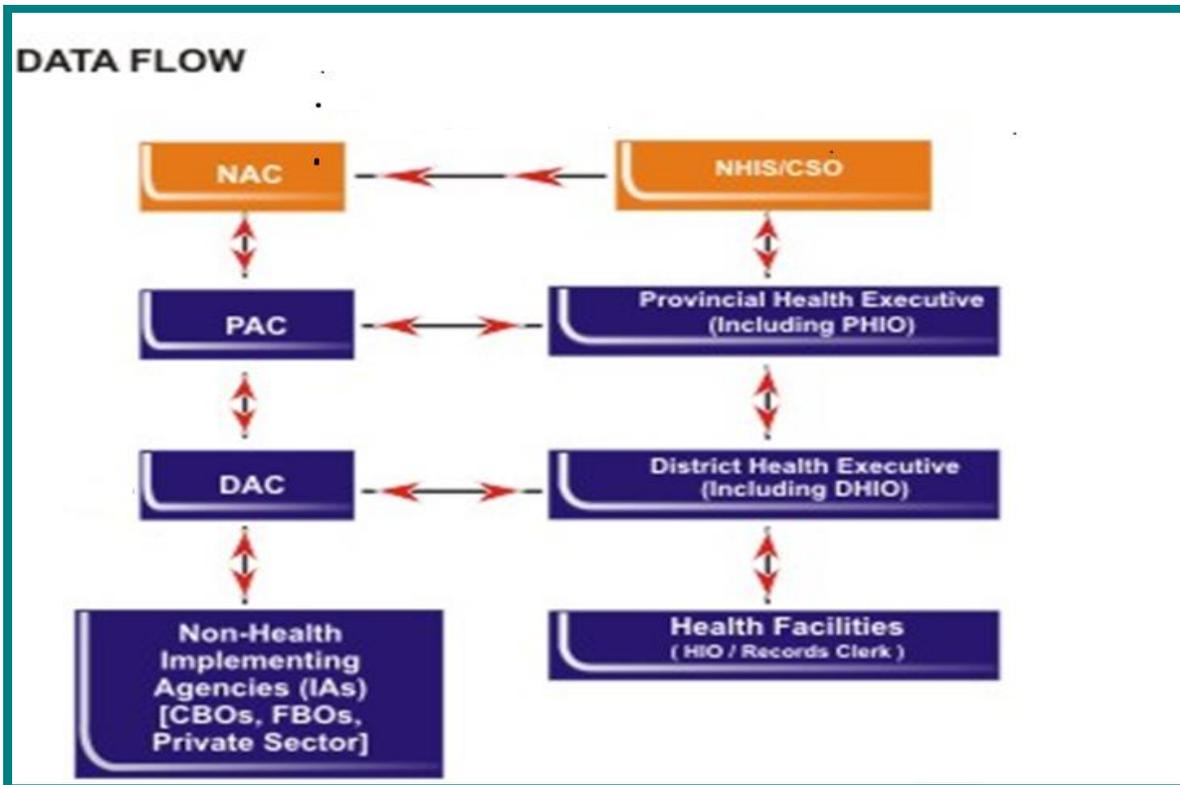
Figure 4: Current Data Flow

3.4.1 Mechanism to improve data flow and transmission

- In each district the DAAC or DRMEAG will update their data transmission systems to incorporate electronic flow of data from implementers to the DAC.

- Facilitate improvements in Internet 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

- Maintain electronic connectivity at every DAC office with the PAC office and NAC HQ to enable all districts to send reports by email.

- **NAC & NHIS/CSO teams will provide the continuous technical support**

3.5 Data Quality Assurance

Implementing partners will be supported to put in place data verification strategies at the district, province and national level.

3.5.1 Mechanisms 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

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- Provide ongoing training, supervision and mentoring to all staff involved in data verification
- Institutionalize **regular** data quality assessment using the MEASURE EVALUATION RDQA tool
- Implement the district M & E toolkit

3.6 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.

3.6.1 Mechanisms 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
- NAC/NHIS/CSO/NMEARG will provide guidance on standard priority indicators for selection of key indicators by (strategic area, baseline, implementer, health facility and by district and province) to facilitate regular (as needed) comparisons at those levels;

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 Mechanisms 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.
- Enhance implementing partners, stakeholders and DACs, and M&E officers' skills on report writing, presentation of data and the role of dissemination in planning.
- Provide ongoing 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

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

Report	Responsible	Key recipients
DAC District and PAC Provincial Quarterly, Statistical Reports	M&E Officer, DAC	WAAC, VAAC, DA, DMO, PMD, NAC, PAC & District level implementers
District and Provincial Health Information Quarterly Report	Health Information Officer/DMO/PMD	DAC, District implementers, AIDS/TB unit (Director)
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)	MOHCC 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

4.2.2 Dissemination

- Develop a data dissemination plan. This plan must follow recognised standards on data dissemination.
- Strengthen mechanisms for stakeholders to give and receive feedback at all levels
- Ensure sufficient resources are budgeted annually for dissemination

The following will be utilized for information dissemination: NAC website, MOH&CW website, ZIMDAT website, Printed copies to all key stakeholders, District Stakeholders Coordination meetings, Provincial Stakeholders Coordination meetings, National Partnership Forum and Newsletters. Mobile applications and solutions should also be explored as options.

CHAPTER 5: EVALUATION, SURVEILLANCE & RESEARCH

5.1 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 must 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. *ANC sentinel surveillance*	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 ANC sentinel sites around the country as an anonymous, unlinked sero-survey. It is done every two years and coordinated by the Ministry of Health and Child Welfare with support from partners.
2. *Zimbabwe Demographic Health Survey (ZDHS)*	The ZDHS is a national population based survey conducted every five years. It is conducted by the Zimbabwe Statistical Agency (ZIMSTAT). 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
3. *Young Adult Reproductive Health and HIV and AIDS Survey (YAS)*	The 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.

Survey Surveillance Evaluation Study	Description
4. *Early Warning Indicator (EWI) survey*	The goal of this study is to assess the quality of Zimbabwe ART program and to generate recommendations on how ART program design might be strengthened so that the survival and quality of life of HIV-infected adults receiving ART can be improved. Ideally all sites offering ART services should report on the selected indicators during a specified survey period on an annual basis. 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%), percentage of patients picking up all prescribed drugs on time(Acceptable >90%), percentage of patients who attended all clinical consultations on time (Acceptable > 80%) and % months with no drug stock-outs (Drug supply continuity) (Target 100%).
5. *HIV DR Threshold survey*	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) per 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.
6. *HIV drug resistance monitoring*	HIVDR prevention surveys support and builds upon EWI collection and includes viral load and HIVDR testing. This is a survey being 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.
7. *Midterm and Terminal Evaluation of ZNASP*	The Zimbabwe National HIV/AIDS Strategic Plan (ZNASP) is a 5 year (2011-2015) national strategic plan developed to coordinate, monitor and strengthen implementation of the multi-sectoral response to HIV and AIDS. The National AIDS Council with support from partners must conduct terminal evaluations (2020) of the ZNASP.
8. *National AIDS Spending Assessment (NASA)*	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 conducted its first NASA in 2009 for the years 2006 and 2007. The country is currently

conducting NASA for 2009 and 2010. This has since been institutionalized 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.	
Survey Surveillance Evaluation Study	**Description**
9. *Multi-indicator monitoring survey*	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 about women, children and other vulnerable groups in the country. Zimbabwe conducted the MIMS in 2009, which provided an update on key developmental indicators, including the MDGs on women and children. The ZIMSTAT coordinates this survey with support from UNICEF and other partners. The MIMS is supposed to be conducted every 3 to 5 years' subject to availability of funding from partners.
10. *Behavioural Surveillance Survey (BSS+)*	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 behaviours. It also assesses services provided to each sub-group and their access to prevention and treatment (including HIV testing, counselling and ARV treatment). Zimbabwe conducted the BSS in 2010 and is expected to be conducted every 2-3 years.
11. *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 conducted 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.
12. *Tracking Surveys / Project TRAC*	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 behaviours, 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 behaviours in HIV prevention.

CHAPTER 6: IMPLEMENTATION OF THE M&E PLAN

6.1 Linkages, Integration and Partnerships

The National M&E Plan for HIV and AIDS is linked to the ZNASP, 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.

6.2 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 5 summarizes the institutional framework and roles and responsibilities for operationalising the M&E plan.

Table 5: 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.	• Facilitate debate on HIV and AIDS policy issues.
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 NRMEAG.
NRMEAG	• Provide technical oversight in 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.

Institution/Person	Responsibility
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.

Institution/Person	Responsibility
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.
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
DRMEAG/PRMEAG (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 per plan.

6.3 Communication and Dissemination of the M&E 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.

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.

6.4 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 NRMEAG will provide necessary technical advice to the department. 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. There is also 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.

CHAPTER 7: NATIONAL PERFORMANCE MEASUREMENT FRAMEWORK

7.1 National Performance Measurement Framework

This section provides the list of indicators that satisfies national, regional (SADC, AU), and global (Universal Access, UNGASS, MDGs, PEPFAR, Global Fund, UNHLMPDC, incorporated 90 90 90 initiative and Fast Track indicators) 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.

The list of indicators tracks output, outcome and impact indicators. 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.

7.1.1 Mechanisms to Improve National Performance Measurement Framework

- Periodic review of the national M&E indicators
- Develop, simplify and distribute to all response participants a data dictionary to ensure standardization of indicator definitions for collection and reporting
- Commission a compilation of annual M&E Report on progress of implementation of the plan

Monitoring and Evaluation Plan Performance Measurement Framework

PROGRAM ME AREA	INDICATOR	INDICATOR TYPE	(N/R/G) INDICATOR	FREQ	SOURCES OF DATA	BASE-LINE 2015	2016	2017	2018	2019	2020	COMMENT
	1.1.1 AIDS related deaths per 100 000 population	Impact	National	Annual	HIV Estimates EPP Spectum	199					119	
	1.1.2 Under-five AIDS related mortality	Impact	National	Annual	Special study, HIV Estimates	21% (2009)			10%		6%	
	1.1.3 HIV Prevalence among adult men and women (15-49 yrs.)	Impact	National	Annual	DHS, HIV Estimates	13.8% (ZDHS 2015)					13.5%	
	1.1.4 HIV prevalence among key populations	Impact	GARPR	5/2 years	BSS	SW – 56.4% Prisoners- PLWD- MSM- TG-					SW –55% Prisoners- PLWD- MSM- TG-	
	1.1.5 HIV Prevalence among women aged 15-24 attending ANC	Impact	National	2 yrs.	ANC Survey [MOHCW]/National Estimates	15.9% [2012]		15.5%				

Indicator	Type	Level	Frequency	Source	Baseline						
1.1.6 HIV incidence among adult men and women (15-49 yrs.)	Impact	National	Annual	HIV Estimates	0.88 (2015 HIV Estimates)	0.48				0.24	
1.1.7 HIV incidence among key populations	Impact	GARPR	2/5yrs	BSS, Programme data	SW – 10% Prisoners- PLWD- MSM- TG-					SW – 5% Prisoners- PLWD- MSM- TG-	
1.1.8 Percentage of young women and men aged 15-24 who are HIV infected	Outcome	GARPR	Annual	HIV Estimates and DHS	F-6.7% M-2.9% ZDHS 2015					F-6.1% M-2.2%	
1.1.9 TB/HIV mortality rate per 100,000 population	Impact	National	Annual	Global TB report	40 Global TB Report 2016	40	39	37	34	29	
1.1.10 Percentage of infants born to HIV infected mothers (in the last 12 months) who are infected	Outcome	GARPR	Annual	HIV Estimates	7.24% HIV Estimates 2015					<5%	

1.1.11 Percentage of adults and children with HIV known to be on treatment 12 months after initiation of ARVs	Outcome	GARPR	Annual	Program Data, [MOHCC]	87.7% (A-87.8 C-91.9%)	87.7% (A-87.8 C-91.9%)	A-85% C-85%	A-85% C-85%	A-85% C-85%	A-85% C-85%	
1.1.12 Percentage of adults and children with HIV known to be on treatment 24 months after initiation of ARVs	Outcome	GARPR	Annual	Program Data, [MOHCC]	83% (A-82.8 C-84.9%)	83% (A-82.8 C-84.9%)	A-80% C-80%	A-80% C-80%	A-80% C-80%	A-80% C-80%	
1.1.13 Percentage of adults and children with HIV known to be on treatment 60 months after initiation of ARVs	Outcome	GARPR	Annual	Program Data, [MOHCC]		75%	75%	75%	75%	75%	
1.1.14 Prevalence of syphilis among antenatal care attendees	Outcome	GARPR	2 yrs.	ANC Survey	1.8% (2012)						

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PROGRAMME AREA	INDICATOR	INDICATOR TYPE	(N/R/G) INDICATOR	FREQ	SOURCES OF DATA	BASE-LINE (2015)	2016	2017	2018	2019	2020	COMMENT
PMTCT	1.2.1 Proportion of health facilities that provide ANC services with both HIV testing and ARVs for PMTCT on site	Output	National/G ARPR	Annual	Program Data [MOHCW]	100%	100%	100%	100%	100%	100%	
	1.2.2 Percentage of infants born to HIV-positive women receiving a Virological (DNA PCR) test for HIV within 2 months of birth	Output	GARPR	Annual	Program Data [MOHCW]	54% (Prog Report 2015)	69%	70%	72%	75%	75%	
	1.2.3 Percentage of infants born to HIV-infected women (HIV-exposed infants) who received antiretroviral prophylaxis to reduce the risk of early mother-to-child- transmission	Output	GARPR	Annual	Program Data [MOHCC] + ANC and ZIMSTAT Infant dispensing register	76% (Prog Report 2015)	75%	77%	78%	79%	80%	

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	1.2.4 Percentage of HIV infected pregnant women who receive anti-retroviral to reduce the risk of Mother to Child Transmission	Output	GARPR	Annual	Program Data [MOHCC – PMTCT register] numerator + Pop data denominator from HIV Estimates	82% (Prog Report 2015)	87%	88%	90%	93%	95%	.
	1.2.5 Percentage of HIV infected pregnant and lactating women who receive anti-retroviral to reduce the risk of Mother to Child Transmission	Output	National	Annual	Program Data [MOHCC]	84% (Prog Report 2015)	89%	90%	92%	95%	97%	
	1.2.6 Percentage of infants born to HIV infected women started on cotrimoxazole prophylaxis within two months of birth.	Output	GARPR	Annual	Program Data [MOHCC] + Pop based data.	60% (Prog Report 2015)	61%	63%	65%	67%	70%	
	1.2.7 Percentage of pregnant women attending ANC	Output	GARPR	Annual	Program Data [MOHCC]	93% (DHS 2015)	93%	94%	95%	96%	97%	

1.2.8 Percentage of pregnant women who were tested for HIV and received their results - during pregnancy, during labour and delivery, and during the post-partum period (<72 hours), including those with previously known HIV status	Output	GARPR	Monthly	Program Data [MOHCC]	99% (Prog Report 2015)	99%	99%	99%	99%	99%	
1.2.9 Percentage of pregnant women attending antenatal care whose male partner was tested for HIV in the last 12 months	Output	GARPR	Annual	Program Data [MOHCC]	23% (Prog Report 2015)	23%	25%	27%	30%	35%	

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	1.2.10 Distribution of feeding practices (exclusive breastfeeding, replacement feeding, mixed feeding/other) for infants born to HIV-infected women at DTP3 visit	Output	GARPR	Annual	Program Data [MOHCC]/							MOHCC to develop a system to collect the indicator
	1.2.11 Contraception use among women	Output	National	Annual	ZDHS	67% for CPR (ZDHS 2015)					68%	

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PROGRAMME AREA	INDICATOR	INDICATOR TYPE	(N/R/G) INDICATOR	FREQ	SOURCES OF DATA	BASE-LINE	2016	2017	2018	2019	2020	COMMENT
Counselling and Testing	1.3.1 Percentage of women and men aged 15-49 who received an HIV test in the last 12 months and who know their results (by age and gender)	Output	GARPR 1.5	5 yrs.	ZDHS	Women 48.8% Men: 35.9% ZDHS 2015					W=90% M=90%	
	1.3.2 Percent of key affected populations that are counselled and tested for HIV in the past 12 months who know their results (by type of KAP, age group and gender)	Output	National	2 yrs.	Special Study [UNAIDS]	SW – 72% Prisoners-PLWD-MSM-TG-	SW – 73% Prisoners-PLWD-MSM-TG-	SW – 74% Prisoners-PLWD-MSM-TG-	SW – 75% Prisoners-PLWD-MSM-TG-	SW – 80% Prisoners-PLWD-MSM-TG-	SW –85% Prisoners-PLWD-MSM-TG-	

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Condoms		Output	PEPFAR, GF	Annual	Program Data [PSI/MOHCW]/ ZNASP	2,210,246	2664844					
	1.3.3 Number of people tested and counselled for HIV who received results							2,777,0 00	2,448, 058	2,658,2 86	3,135,798	
Condoms	1.4.1 Percent of adults – women and men (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	Outcom e	GARPR	5 yrs.	ZDHS	M-37.1% F-49.6% (ZDHS 2015)					M - 50% F - 60%	
	1.4.2 Percentage of Key populations reporting the use of a condom with their most recent client	Outcom e	GARPR	Annual	BSS	SW– 66.8% MSM - TG – PLWD- Prisoners-					SW– 80% MSM - TG – PLWD- Prisoners-	

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	1.4.3 Percent of women and men in sero-discordant relationships who reported using condoms consistently in the last sexual intercourse in the last 12 months	Output	National	5 yrs.	ZDHS	25%	60%	70%	80%	**80%**	**80%**	
	1.4.4 Number of male/female condoms distributed	Output	National	Annual	Program Data [MOHCW/PSI]	109.4 mill 5.6m fem	110m-male 6m-Female	123m-male 4.7m-Female	128m male 6.4m-Female	132m Male 6.4m Female	137m Male 6.5m Female	
KAPs	1.5.1 Condom use in paid sex among 15 - 49 years	Outcome	GARPR	5 yrs.	ZDHS	89.8% ZDHS 2015					100%	
	1.6.1 Percentage of people with comprehensive correct knowledge of HIV&AIDS.	Output	National	2 yrs.	DHS/Trac Survey (PSI)	F-54.6% M-55.7% DHS 2015	F – 80% M – 78%				F – 90% M – 90%	
BC	1.6.2 Percentage of young women and men aged 15-24 who have had sexual intercourse before the age of 15	Output	GARPR	5 yrs.	ZDHS	5 % [2015]						

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	1.6.3 Percent of women and men aged 15 – 49 who have had sexual intercourse with more than one sexual partner in the past 12 months	Output	GARPR	5 yrs.	ZDHS/ Trac Survey (PSI)	F-1% M-9% ZDHS 2015							.
Youth	1.7.1 Number/ percentage of youth in school (girls and boys) reached through HIV and AIDS life-skills education	Output	National	Annual	Program Data [NAC]	26.9% Number-1129074							
	1.7.2 Number of youth out-of-school exposed to HIV&AIDS education	Output	National	Annual	Program Data [NAC]	135,902 MOESAC (2015)							
	1.7.3 Number of youth in tertiary institutions exposed to HIV&AIDS education	**OUTPUT**	**NATIONAL**	**ANNUAL**	**PROGRAM DATA** [NAC]/School Based Surveys	104,134 NAC Report 2015	120000						

	1.7.4 Percentage of vulnerable girls reached with comprehensive HIV prevention packages	**OUTPUT**	**NATIONAL**	**ANNUAL**	**PROGRAM DATA [NAC]**	TBA	30%	30%	30%	**30%**	**30%**	26,825 girls are estimated to be vulnerable in the 20 Districts according to the 2012 Census. The sister to sister clubs targets to reach 30% of these vulnerable girls on a yearly basis. Target is to reach 10 000 girls each year through 200 sister to sister mentors.
	1.7.5 Percentage of vulnerable girls referred by sister to sister mentors for HIV prevention services (HTC)	**OUTPUT**	**NATIONAL**	**ANNUAL**	**PROGRAM DATA [NAC]**	TBA	51%	50%	50%	**50%**	**50%**	**OF THE 30% VULNERABLE GIRLS REACHED BY THE SISTER TO SISTER CLUBS 50% ARE EXPECTED TO BE REFERRED FOR HIV SERVICES.**
VMMC	1.8.1 Percentage of men circumcised (15-49) as part of the minimum package of male circumcision for HIV prevention services	Outcome	GARPR	5/2yrs	DHS/ MICS	14% ZDHS 2015					80%	
	1.8.2 Number of men circumcised (10-29) as part of the minimum package of male circumcision for HIV prevention services	Output	GARPR	annual	MOHCC DATA Client Intake Form/VMMC Register	223,313 (2015)	Ann- 203797	Ann - 322436	Ann- 353706	Ann- 315543	Ann – 248258	

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					Data Source	Baseline (2015)	2016	2017	2018	2019	2020	
STI	1.9.1 Percent of adults (15-49years) who had an STI in the last 12 months (by age and gender)	Outcome	National	5 yrs.	ZDHS	W-2.2% M-2.5% ZDHS 2015	F- 2.8% M-3.0%					
Blood Safety	1.10.1 Percent of donated blood units screened for HIV	Output	UNGASS	Annual	Program Data [NBTS]	100%	100%	100%	100%	100%	100%	Blood screening has been at 100% for some years now.
Post Exposure Prophylaxis	1.11.1 Number of health facilities providing PEP services	Output	National	Annual	Program Data [MOHCW]	87.2% [2015]	100%	100%	100%	100%	100%	
	1.11.2 Percentage of sexually abused clients received PEP (HIV, STI, ECP) within 72 hrs	Output	National	Annual	Program Data [MOHCW]	18%	100%	100%	100%	100%	100%	

	Data Source	2015	2016	2017	2018	2019	2020	
Treatment Care and Support		**Baseline**	**Target**	**Target**	**Target**	**Target**	**Target**	

ART/OI	2.1.1 Number / Percent of adults and children on ART among all adults and children living with HIV	Output	GARPR	Annual	Program Data [MOHCC] and HIV Estimates	A- 60% C- 82%	A- 66% C-84%	A- 72% C-87%	A- 76% C-90%	A-79% C- 92%	A – 81% C – 95%	Denominator is based on the total number of PLHIV
	2.1.1a Percentage of the people living with HIV in a key population receiving antiretroviral therapy	Output	GARPR	Annual	Program Data [MOHCC] and HIV Estimates	SW - MSM - TG – PLWD- Prisoners-	SW - MSM - TG – PLWD- Prisoners-	SW - MSM - TG – PLWD- Prisoners-	SW - MSM - TG – PLWD- Prisoners-	SW - MSM - TG – PLWD- Prisoners-	SW – 85% MSM - TG – PLWD- Prisoners-	
	2.1.2 Proportion of Health facilities dispensing ART based on the national accreditation guidelines	Output	National	Annual	Program Data [MOHCC]	100% [2015]	100%	100%	100%	100%	100%	

	2.1.3 Percent of health facilities dispensing ARVs which have experienced a stock out of at least one required ARV in the last 12 months.	Output	GARPR	Annual	EWI / LMIS [MOHCC]	3.9%	0%	0%	0%	0%	0%	
	2.1.4 Percentage of people on ART tested for viral load	Output	National	Annual	Program Data [MOHCC]	5% (Prog Report 2015) ePMS	10%	30%	50%	75%	80%	
	2.1.5 Percentage of people on ART who have a suppressed viral load	Output	GARPR	Annual	EWI survey/ePMS		86.5%	87%	88%	89%	90%	

	2.1.6 Percentages of people living with HIV with the initial CD4 cell count <200 cells/mm3 and <350 cells/ mm3	Output	GARPR	Annual	Program Data [MOHCC]							
	2.1.7 Percentage of Children enrolled in HIV care and given CTX prophylaxis	Output	GARPR	Annual	Program Data [MOHCC]	59% (HIV Est Report 2015)	70%	75%	80%	85%	90%	
TB/HIV COLABORATION	2.2.1 Percentage TB patients who are HIV positive enrolled on ART	Output	National	Annually	Program Data [MOHCC]	83% (Prog Report 2015)	87%	91%	95%	98%	100%	

	2.2.2 Percentage of estimated HIV-positive incident tuberculosis (TB) cases that received treatment for both TB and HIV	Output	GARPR	Annually	Survey							
	2.2.3 Proportion of people living with HIV newly enrolled in HIV care started on TB preventive therapy	Output	GARPR	Annually	Program Data [MOHCC]							

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Category	Indicator	Type	Source	Frequency	Data Source							Comments
	2.2.4 Percentage of HIV-Positive patients who were screened for TB in HIV care or treatment settings in the last visit	Output	GF	quarterly	Program Data [MOHCC]		94%	95%	95%	95%	95%	
Laboratory Servicies.	2.3.1 Percentage of laboratories that are accredited according to national or international standards	Output	National	Annual	Lab information							
C&HBC	2.4.2 Number of clients served by HBC programme	Output	National	Monthly	Programme Data [NAC]	16.429	16.796	17.000	18.000	19.000	20.000	CHBC clients include working (mobile), ambulatory and Bedridden

PROGRAMME AREA	INDICATOR	INDICATOR TYPE	(N/R/G) INDICATOR	FREQ	SOURCES OF DATA	BASE-LINE 2015	2016	2017	2018	2019	2020	COMMENT
PLHHIV	3.1.1 Percentage of men and women expressing specific acceptance attitudes towards PLHIV	Output	National	Annual	ZDHS	M-80% **W-78% (ZDHS 2015)**					**M-80% W-75%**	
	3.1.2 Avoidance of HIV services because of stigma and discrimination among key populations	Output	National	5/2yrs	BSS	SW - MSM - TG – PLWD- Prisoners-					SW - MSM - TG – PLWD- Prisoners-	
OVC	3.2.1 Number/Percent of OVC (under 18 years of age) living in households that have received basic external support (by age and sex)	Output	National	Annual	MoLSS [programme data report]	83.4% MoLSS data	85%	87%	88%	89%	90%	
	3.2.2 Current school attendance rate of orphans aged 10-14 primary school age, secondary school age	Output	GARPR	5 yrs.	ZDHS	92% ZDHS 2015					95%	

	3.2.3 Percent of children aged less than 18 years who are orphans (single, double orphans)	Outcome	SADC	5 yrs.	ZDHS	16% (ZDHS 2015)					10%	
Enabling Environment	4.1.1 Percentage of ever-married or partnered women aged 15-49 who experienced physical or sexual violence from a male intimate partner in the past 12 months	Outcome	National – GAPRR	Survey	ZDHS	35.4% ZDHS 2015					20%	
	4.1.2 Number/ percentage of policies, strategies reviewed and implemented regularly to guide the multi-sectorial response	Output	National	Annual	Program Data [NAC]							

Monitoring and Evaluation	4.2.1 Percent of implementers with a designated and functioning M&E focal person	Output	National	Annual	Program Data [NAC]	70%	80%	85%	90%	95%	95%	
	4.2.2 Percent of registered implementers regularly reporting (quarterly) to the national M&E system	Output	National	Annual	Program Data [NAC]	80%	80%	85%	90%	95%	95%	
	4.2.5 Percentage of clients receiving HIV and AIDs satisfied with quality of service	Outcome	National	Annual	Survey Satisfaction Survey Data	78%	78%	80%	85%	90%	95%	To be collected through client satisfaction surveys
Coordinatio n	4.3.1 Number of functional sector coordination bodies	Output	National	Annual	Program Data [NAC]	4	5	5	5	5	5	
	4.3.1 Percentage of coordination meetings held at all structures	Output	National	Annual	Program Data [NAC]	100%	100%	100%	100%	100%	100%	
HIV Spending	4.4.1 Percentage of local funds mobilized to support the national HIV response	Output	GARPR	Annual	NSSA	25%	25% domestic and 75% donor	30% domestic and 70% donor	30% domestic and 70% donor	30% domestic and 70% donor	30% domestic and 70% donor	

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Impact Level Indicators

Indicator	**1.1.1 AIDS related deaths per 100 000 population**
Purpose	To assess the impact of HIV treatment in reducing HIV related mortality
Source	National HIV Estimates
Numerator	Number of adults and children who died on HIV related conditions
Denominator	Total population regardless of HIV status
Interpretation	The impact indicator gives a picture of HIV related deaths averted due to HIV prevention and treatment programme. HIV Estimates are used as data source to ensure that the country is kept abreast of the HIV related mortality rate.

Indicator	**1.1.2 Under five AIDS related mortality**
Purpose	To assess the impact of HIV treatment in reducing under 5 HIV related mortality
Source	National HIV Estimates/Special study
Numerator	Number of under-five who died on HIV related conditions
Denominator	Total number of under 5s who lived in a given time period
Interpretation	The impact indicator gives a picture of HIV related deaths averted due to HIV prevention and treatment programme. HIV Estimates are used as data source to ensure that the country is kept abreast of the HIV related mortality rate.

Indicator	**1.1.3 HIV Prevalence among adult men and women (15-49 yrs)**
Purpose	To assess the impact of HIV services in reducing HIV infection in the reproductive age group
Source	Demographic Health Survey, HIV & AIDS 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
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	**1.1.4 HIV prevalence among key populations**
Purpose	To assess progress towards reducing HIV infection in key populations
Source	Special Survey, BSS and RDS
Numerator	Number of the people in specific key populations who test positive for HIV
Denominator	Number of people in specific key population tested for HIV
Interpretation	This indicator gives a fairly good estimate of relatively recent trends in HIV infection among key populations. Special surveys, RDS and BSS are used as data source to ensure that the country is informed of the of the HIV prevalence

Indicator	**1.1.5 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	**1.1.6 HIV incidence among adult men and women (15-49 yrs)**
Purpose	To assess the impact of HIV prevention programmes
Source	National HIV Estimates, Incidence assays
Numerator	Number of new infections among 15-49 years
Denominator	Total number of uninfected population (or person-years exposed)
Interpretation	The impact indicator gives a picture of new HIV infections.

Indicator	**1.1.7 HIV incidence among key populations**
Purpose	To assess the impact of HIV prevention programmes
Source	Cohort studies
Numerator	Number of new infections
Denominator	Estimated population at risk
Interpretation	The impact indicator gives a picture of new HIV infections among key populations.

Indicator	**1.1.8 TB/HIV mortality rate per 100,000 population**
Purpose	To assess the disease burden of TB in HIV cases
Source	TB Registers
Numerator	Number of HIV positive people who died of HIV with TB as a contributory cause of death.
Denominator	Number of people in the population
Interpretation	The data on TB/HIV mortality are generated by the Spectrum programme used by HIV and now by TB programmes at country level. The level of estimated TB/HIV mortality is highly influenced by ART coverage. It is possible using Spectrum to generate what-if scenarios allowing to compare future TBHIV deaths based on the predicted coverage of specific interventions. TB/HIV mortality is estimated and not measured directly (e.g. from national vital registration systems), so particular care is needed when making interpretations as the estimated TBHIV mortality may change as a result of updates in the underlying model implemented in Spectrum

Indicator	**1.1.9 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, DHS, HIV Estimates

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	**1.1.10 Percentage of infants born to HIV infected mothers (in the last 12 months) who are infected**
Purpose	To assess progress towards eliminating mother-to-child HIV transmission
Source	HIV estimates (statistical modelling)
Numerator	Number of infants born to HIV infected mothers who are infected
Denominator	Estimated number of HIV infected pregnant women
Interpretation	This indicator focuses on PMTCT of HIV through increased provision of ART medicines. The Spectrum HIV estimation modelling software takes into consideration the type of ARV regimen as well as additional factors that influence HIV transmission rates such as infant feeding practices.

Indicator	**1.1.11 - 13 Percentage of HIV infected children and adults known to be on treatment 12, 24 and 60 months after initiation of ARVs.**
Purpose	To assess the survival rate of patients on antiretroviral combination therapy 12, 24 and 60 months after initiation on ART. This will be a proxy indicator for impact of antiretroviral therapy programme.
Source	ART outcome survey, 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, 24 and 60 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	**1.1.14 Prevalence of Syphilis among ANC attendees.**
Purpose	To assess progress in reducing high – risk sexual behaviour, and intervention efforts to control syphilis other than behavioral.
Source	ANC Surveillance
Numerator	Number of antenatal clinic attendees aged 15 years and over who tested positive for syphilis

Denominator	Number of antenatal clinic attendees aged 15 years and over who were tested for syphilis.
Interpretation	This indicator (using data from antenatal clinics) gives a fairly good estimate of relatively recent trends in syphilis.

STRATEGIC AREA 1:   **HIV PREVENTION**

Programme Area 1: Prevention of Mother to Child Transmission- PMTCT

Indicator	1.2.1 Proportion of health facilities that provide ANC services with both HIV testing and ARVs for PMTCT on site
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	Total number of health 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	1.2.2 Percentage of infants born to HIV-positive women receiving a Virological (DNA PCR) test for HIV within 2 months of birth
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 DNA PCR test
Denominator	Estimated number of pregnant women needing PMTCT
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	1.2.3 Percentage infants born to HIV infected women receiving ARV prophylaxis to reduce the risk of early mother to child transmission
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 ARV prophylaxis
Denominator	Estimated number of pregnant women needing PMTCT
Interpretation	The total number of infants born to HIV infected women who are receiving ARV 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	1.2.4 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: Infant dispensing registers & summary reporting forms Denominator: Antenatal clinic surveillance surveys in combination with demographic data or estimation models such as spectrum
Numerator	Number of infants born to HIV-infected women who are breastfeeding and provided an antiretroviral intervention (i.e. maternal or infant ARVs) to reduce mother-to-child transmission through breastfeeding.
Denominator	(Estimated) number of infants born to HIV-infected women who are breastfeeding
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 model based on the efficacy of corresponding regimens.

Indicator	**1.2.5 Percentage of HIV infected pregnant and lactating 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	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 and lactating 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 and lactating 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 model based on the efficacy of corresponding regimens.

Indicator	**1.2.6 Percentage of infants born to HIV infected women started on cotrimoxazole prophylaxis within two months of birth.**
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 infants born to HIV infected women started on cotrimoxazole prophylaxis within two months of birth.
Denominator	Estimated number of HIV infected pregnant and lactating 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.

Indicator	**1.2.7 Percentage of pregnant women attending ANC**
Purpose	To assess progress in uptake of ANC services

Source	PMTCT progress reports
Numerator	Number of pregnant women attending ANC
Denominator	Expected number of pregnancies
Interpretation	The indicator monitors ANC attendance. This is a proxy indicator to measure uptake of ANC services by pregnant women.

Indicator	**1.2.8 Percentage of pregnant women who were tested for HIV and received their results - during pregnancy, during labor and delivery, and during the post-partum period (<72 hours), including those with previously known HIV status**
Purpose	To measure the number of pregnant women who are tested for HIV during ANC and received their results
Source	PMTCT progress reports
Numerator	Number of pregnant women who were tested for HIV in the last 12 months and received their results - during pregnancy, during labour and delivery, and during the post-partum period (<72 hours), including those with previously known HIV status
Denominator	Estimated number of pregnant women
Interpretation	This indicator measures the uptake and extent to which pregnant women are accessing HIV testing services for PMTCT

Indicator	**1.2.10 Distribution of feeding practices (exclusive breastfeeding, replacement feeding, mixed feeding/other) for infants born to HIV-infected women at DTP3 visit**
Purpose	To measure infant feeding practices among HIV exposed infants
Source	DTP3 visit register
Numerator	Number of infants born to HIV-infected women assessed for and whose infant feeding practices were recorded at DTP3 visit
Denominator	NA
Interpretation	This indicator measures the extent to which infant feeding practices are contributing to mother to child transmission. These feeding practices ranges from exclusive breastfeeding, replacement feeding, mixed feeding to other methods

Indicator	**1.2.11 Contraception use among women**
Purpose	To measure contraception use among women
Source	DHS
Numerator	Number of women using contraception
Denominator	Number of women of child bearing age in the sample size.
Interpretation	This indicator measures the extent to which women are using contraception to prevent pregnancy. The forms of contraceptives are barrier, hormonal and natural methods

Programme Area 2:   Testing and Counselling- T&C

Indicator	**1.3.1 Percentage of women and men aged 15-49 who received an HIV test in the last 12 months and 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 key affected populations that are counselled and tested for HIV in the past 12 months who know their results (by type of KAP, age group and gender))
Purpose	To assess progress in implementing HIV testing and counselling among KAPs
Source	Behavioural surveillance or other special surveys
Numerator	Number of KAP respondents who have been tested for HIV during the last 12 months and who know the results
Denominator	Number of KAP included in the sample.
Interpretation	Accessing and/or surveying KAPs can be challenging. Consequently, data obtained may not be based on a representative sample of the national KAP 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 KAP 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	**1.3.3 Number of people counselled and tested for HIV and received their results (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 counselled and tested for HIV
Denominator	N/A
Interpretation	The indicator seeks to report on the total number of people counselled and tested in one year.

Programme Area 3:	**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 sexual partners regularly). The current indicator does not provide (estimation) of the level of consistent condom use.

Indicator	1.4.2 Percentage of Key populations reporting the use of a condom with their recent client
Purpose	To assess the progress in preventing exposure to HIV among sex workers through unprotected sex with clients.
Source	Programme Data
Numerator	Number of sex workers who reported using a condom with their last client
Denominator	Number of sex workers who reported having commercial sex in the past 12 months
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.

Indicator	1.4.3 Percent of women and men in sero-discordant relationships who reported using condoms consistently in the last sexual intercourse in the last 12 months
Purpose	To assess progress in preventing the sexual transmission of HIV among sero-discordant relationships
Source	Population Based Surveys
Numerator	Number of respondents reporting the consistent use of a condom in sero-discordant relationships
Denominator	Number of respondents who reported having sex in sero-discordant relationships
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 in sero-discordant relationships.

Indicator	1.4.4 Number of male and 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 4: Key Affected Populations (KAPs)

Indicator	1.5.1 Condom use in paid sex among 15 - 49 years
Purpose	To assess progress in preventing exposure to HIV among transactional sex
Source	Demographic Health Survey
Numerator	Number of respondents who reported that a condom was used with their paid sex.
Denominator	Number of respondents who reported having paid sex.
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.

Programme Area 5: Behaviour Change (BC)

Indicator	1.6.1 Percentage of people with comprehensive correct knowledge of HIV&AIDS.
Purpose	To assess progress in scaling up the BCC to the communities as prevention programme
Source	KAP Survey
Numerator	Number of people with comprehensive HIV and AIDS knowledge
Denominator	Number of people reached through the BCC programmes
Interpretation	BCC Media is defined as any effort to effect change through newspapers, magazines, radio, television etc

Indicator	1.6.2 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	1.6.3 Percent of women and men aged 15 – 49 who have had sexual intercourse with more than one sexual partner in the past 12 months
Purpose	To assess progress in reducing number of sexual partners.
Source	Population-based surveys (Demographic Health Survey, AIDS Indicator Survey, Multiple Indicator Monitoring Survey)
Numerator	Number of respondents 15 -49 who have had sexual intercourse with more than one sexual partner in the last 12 months
Denominator	Number of all respondents 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 6:   **YOUTH**

Indicator	**1.7.1 Number/ percentage of youth in school (boys and girls) reached through HIV and AIDS life-skills education**
Purpose	To assess progress in increasing knowledge among youth in school on HIV&AIDS
Source	Programme Data
Numerator	Number of youth in school reached through HIV and AIDS education
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 preciously 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	**1.7.2 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 to HIV and AIDS education
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	**1.7.3 Number of youth in tertiary institutions exposed to HIV and 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

Indicator	**1.7.4 Percentage of vulnerable girls reached with comprehensive HIV prevention packages**
Purpose	This indicator measures vulnerable young girls (school drop outs, orphans & teenage mothers) who receive comprehensive HIV prevention packages through sister-to-sister mentors. The comprehensive package include HTC, SRH, GBV, STI screening, ART, cervical cancer screening, HIV couple testing, PMTCT, YFS, psychological support, etc. A total of 10 sister-to-sister mentors will be recruited and trained in 20 districts (10 mentors/district) to provide education and counseling services to vulnerable girls in their communities. Each mentor is expected to reach a minimum of 50 vulnerable girls per year.

	Baseline is not available because the intervention is new. Data generated in 2016 will be used to establish the baseline.
Source	Sister to sister registers
Numerator	Actual number of girls reached through the sister to sister clubs
Denominator	Total census number of vulnerable girls in the districts
Interpretation	The indicator provides the percentage of the vulnerable girls reached with prevention messages
Indicator	**1.7.5 Percentage of vulnerable girls referred by sister to sister mentors for HIV prevention services (HTC)**
Purpose	This indicator measures vulnerable young girls (school drop outs, orphans & teenage mothers) who received comprehensive HIV prevention packages through sister-to-sister mentors and referred for HTC services. Of the 10 000 girls to be reached per year, it is expected that 50% will be referred for HIV services.
Source	Sister to sister registers and quarterly reports
Numerator	Numerator is the number of vulnerable children to be referred for services (5,000 per year).
Denominator	The Denominator is the total number of vulnerable children to be reached in the 20 districts (10,000 per year)
Interpretation	This indicator shows the extent at which the girls are seeking services after being given information

Programme Area 7: VOLUNTARY MEDICAL MALE CIRCUMCISION

Indicator	**1.8.1 Percentage of men circumcised (15-49) as part of the minimum package of male circumcision for HIV prevention services**
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 Number of men circumcised (10-29) as part of the minimum package of male circumcision for HIV prevention services**
Purpose	To assess progress in the prevention of HIV infections
Source	MOHCC DATA, Client Intake Form/VMMC Register
Numerator	HIV negative men circumcised (disaggregated by ages 10-14, 15-19,20-24, 25-29)
Denominator	NA
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 8: Sexually Transmitted Infections (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.

Programme Area 9: 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

Programme Area 10: POST EXPOSURE PROPHYLAXIS

Indicator	1.11.1 Number of health facilities providing PEP services
Purpose	To assess progress in the protection against infections
Source	MOHCW Programme Data
Numerator	Number of health facilities providing PEP services
Denominator	N/A
Interpretation	This indicator measures the availability of PEP in health facilities.

Indicator	1.11.2 Percentage of sexually abused clients received PEP (HIV, STI, ECP) within 72 hours
Purpose	To assess progress in the protection of sexually abused people against infections
Source	MOHCW Programme Data/MoLSS
Numerator	Number of sexually abused clients received PEP within 72 hours
Denominator	Number of people sexually abused reported
Interpretation	This indicator measures access to PEP among the sexually abused.

Programme are 11:   Workplace programme

Indicator	1.12.1 Number of organizations (private sector, public sector, civil society) with functional 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 organizations with existing HIV policy or strategy documents and evidence of implementing the policy or strategy
Denominator	N/A
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.

STRATEGIC AREA 2:   **TREATMENT AND CARE**

Programme Area 2:   **OI/ART**

Indicator	2.1.1 Number / Percent of adults and children on ART among all adults and children living with HIV
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 eligible 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 in need of ART. 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	2.1.1a Percentage of the people living with HIV in a key population receiving antiretroviral therapy

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	2.1.2 Proportion of health facilities dispensing ART based on the national accreditation guidelines
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	2.1.3 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, EWI
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.

Indicator	2.1.4 Percentage of people on ART tested for viral load
Purpose	To monitor viral load suppression among patients on ART.

Source	National ART Programme Data, EWI, ePMS
Numerator	Number of patients of patients with a diagnosis of HIV and AIDS with viral load below 200 copies/ml of quantification 1 at last test during the measurement year.
Denominator	Total number of patients with a diagnosis of HIV and AIDS who: 1. Had at least two medical visits during the measurement year with at least 60 days in between each visit. 2. Were prescribed ART for at least 6 months 3. Had a viral load test during the measurement year
Interpretation	This indicator measures inhibition of HIV replication as measured by consistent plasma HIV RNA (viral load) values below the level of detection using commercially available assays.

Indicator	2.1.5 Percentage of people on ART tested for viral load who have a suppressed viral load
Purpose	To monitor viral load suppression among patients on ART.
Source	National ART Programme Data, EWI, ePMS
Numerator	Number of patients of patients with a diagnosis of HIV and AIDS with viral load below 200 copies/ml of quantification 1 at last test during the measurement year.
Denominator	Total number of patients with a diagnosis of HIV and AIDS who: 4. Had at least two medical visits during the measurement year with at least 60 days in between each visit. 5. Were prescribed ART for at least 6 months 6. Had a viral load test during the measurement year
Interpretation	This indicator measures inhibition of HIV replication as measured by consistent plasma HIV RNA (viral load) values below the level of detection using commercially available assays.

Indicator	2.1.6 Percentages of people living with HIV with the initial CD4 cell count <200 cells/mm3 and <350 cells/mm3
Purpose	To monitor viral load suppression among patients on ART.
Source	National ART Programme Data, EWI, ePMS
Numerator	Number of patients of patients with a diagnosis of HIV and AIDS with viral load below 1000 copies/ml of quantification 1 at last test during the measurement year.
Denominator	Total number of patients of patients with a diagnosis of HIV and AIDS who: 7. Had at least two medical visits during the measurement year with at least 60 days in between each visit. 8. Were prescribed ART for at least 6 months 9. Had a viral load test during the measurement year
Interpretation	This indicator measures inhibition of HIV replication as measured by consistent plasma HIV RNA (viral load) values below the level of detection using commercially available assays.

Indicator	2.1.7 Percentage of Children enrolled in HIV care and given CTX prophylaxis
Purpose	To monitor viral load suppression among patients on ART.
Source	National ART Programme Data, EWI, ePMS
Numerator	Number of children enrolled in HIV and given CTX prophylaxis
Denominator	Total number of children tested for HIV
Interpretation	This indicator measures the trends of those children enrolled in HIV and given CTX prophylaxis

Programme Area 2:   **HIV/TB COLLABORATION**

Indicator	2.2.1 Percentage TB patients who are HIV positive enrolled on ART
Purpose	To assess progress towards providing antiretroviral combination therapy to TB patients LHIV.
Source	National ART Programme Data
Numerator	Number of TB patients LHIV who are initiated on ART.
Denominator	Number of TB patients LHIV (within the same period).
Interpretation	The indicator will monitor trends in ART coverage among TB patients who are LHIV.

Indicator	2.2.2 Percentage of estimated HIV-positive incident tuberculosis (TB) cases that received treatment for both TB and HIV
Purpose	To assess progress towards providing antiretroviral combination therapy to TB patients LHIV.
Source	National ART Programme Data
Numerator	Number of TB patients LHIV who are initiated on ART.
Denominator	Number of TB patients LHIV (within the same period).
Interpretation	The indicator will monitor trends in ART coverage among TB patients who are LHIV.

Indicator	2.2.3 Proportion of people living with HIV newly enrolled in HIV care started on TB preventive therapy
Purpose	To assess progress towards providing antiretroviral combination therapy to TB patients LHIV.
Source	National ART Programme Data
Numerator	Number of TB patients LHIV who are initiated on ART.
Denominator	Number of TB patients LHIV (within the same period).
Interpretation	The indicator will monitor trends in ART coverage among TB patients who are LHIV.

Indicator	2.2.4 Percentage of HIV positive patients who were screened for TB in HIV care or treatment settings in the last visit

Purpose	To assess progress towards screening of TB among PLHIV at initial and subsequent visits and link them to diagnosis and treatment.
Source	ART Programme Data
Numerator	Number of HIV positive adults and children in HIV care or treatment (pre ART or ART) who are screened for TB.
Denominator	Total number of adults and children enrolled in HIV care and seen for care in reporting period.
Interpretation	The indicator will monitor the diagnosis and treatment of TB among HIV positive patients to increase the chances of survival and reduce transmission of TB in the community. It emphasizes the importance of intensified TB case finding for people living with HIV at diagnosis and at every contact they have with HIV treatment and care services.

Programme Area 3:   **Laboratory Services**

Indicator	**2.3.1 Percent of laboratories that are 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	Lab Reports
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 4:   **Community and Home Based Care**

Indicator	**2.41 Number of clients served by home based care programme**
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 clients/patients)

STRATEGIC AREA 3:   ENABLING ENVIRONMENT

Programme Area 1:	PLWHIV
Indicator	**3.1.1 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.

Indicator	**3.1.2 Avoidance of HIV services because of stigma and discrimination among key populations**
Purpose	Progress towards reducing discriminatory attitudes and support for discriminatory policies
Source	Behavioural surveillance or other special surveys
Numerator	Number of respondents who answer yes to one of the following: Why did you not seek HIV testing/prevention/treatment services? 1. Fear of or concern about stigma by staff or neighbours.

	2. Fear of or concern about or experienced violence.
	3. Fear of or concern about or experienced police harassment or arrest.
Denominator	Number of respondents
Interpretation	Discrimination is a human rights violation and is prohibited by international human rights law and most national constitutions. Discrimination in the context of HIV refers to unfair or unjust treatment (an act or failing to act) of an individual based on his or her real or perceived HIV status. Discrimination exacerbates risks and deprives people of their rights and entitlements, fuelling the HIV epidemic. HIV-related stigma refers to negative beliefs, feelings and attitudes towards people living with HIV, groups associated with people living with HIV (e.g. the families of people living with HIV) and other key populations at higher risk of HIV infection, such as people who inject drugs, sex workers, men who have sex with men and transgender people. This indicator directly measures fear of or experienced stigma or discrimination. This indicator could provide further understanding and improve interventions in reducing HIV stigma and discrimination by: (1) showing change over time in the percentage of people perceiving or experiencing stigma, (2) enabling comparisons between national, provincial, state and more local administrations and (3) indicating priority areas for action.

Programme Area 2:   **OVC**

Indicator	**3.2.1 Number/Percent of OVC (under 18 years of age) living in households that have received basic external support (by age and sex)**
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 *each* 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 proxy indivcators 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.

Indicator	3.2.2 Current school attendance rate of orphans aged 10-14 years, primary school age, secondary school age.
Purpose	To assess progress towards preventing relative disadvantage in school attendance among orphans
Source	MICS/ZDHS
Numerator	Number of children who have lost one or both parents and who attend school
Denominator	Number of children who have lost one or both parents
Interpretation	The age-range 10–14 years is used because younger orphans are more likely to have lost their parents recently so any detrimental effect on their education will have had little time to materialize. This indicator does not distinguish children who lost their parents due to AIDS from those whose parents died of other causes.

Indicator	3.2.3 Percent of children aged less than 18 years who are orphans (single and double orphans)
Purpose	The indicator measures the percentage of children under the age of 18 years who are orphans. Orphans include those who have lost one parent and those who have lost both parents. It important to disaggregate this indicator according to gender.
Source	ZDHS/MICS
Numerator	Number of orphans, both single and double aged below 18 years
Denominator	Number of children aged below 18 years
Interpretation	The indicator helps to monitor the proportion of children who are orphaned by AIDS or other circumstances. Monitoring and evaluation of a national response in this area has particular challenges. The challenges relate to the

	lack of experience with data collection on OVC, measurable indicators and representative sampling frames for orphans.

STRATEGIC AREA 4:   MANAGEMENT AND COORDINATION, MONITORING AND EVALUATION

Programme Area 1:   Enabling Environment

Indicator	4.1.1 Percentage of ever-married or partnered women aged 15-49 who experienced physical or sexual violence from a male intimate partner in the past 12 months
Purpose	To assess the prevalence of gender based violence
Source	Survey
Numerator	Number of ever-married or partnered women aged 15-49 who experienced physical or sexual violence from a male intimate partner in the past 12 months
Denominator	Total number of ever-married or partnered women aged 15-49
Interpretation	This indicator seeks to measure the number of ever-married or partnered women aged 15-49 who experienced physical or sexual violence from a male intimate partner in the past 12 months

Indicator	4.1.2 Number/ percentage of policies, strategies reviewed and implemented regularly to guide the multi-sectorial response
Purpose	To establish the number of policies and strategies that are reviewed and implemented to guide the multi-sectorial response
Source	Not known
Numerator	Actual policies reviewed and implemented
Denominator	Number of policies identified for review
Interpretation	This indicator is meant to align policies and strategies with the ideals of the national strategic plan and ZIMASSET

Programme Area 2:   Monitoring and Evaluation

Indicator	4.2.1 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	4.2.2 Percent of registered implementers regularly reporting (quarterly) 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 none-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	4.2.3 Percentage of clients receiving HIV and AIDs satisfied with quality of service
Purpose	To monitor and improve quality of service.
Source	Special surveys
Numerator	Number of clients satisfied with services provided
Denominator	Total number of clients sampled receiving services.
Interpretation	The indicator measures level of client satisfaction with HIV and AIDS services provided.

Programme area 3:   **Coordination**

Indicator	4.3.1 Number of functional sector coordination bodies
Purpose	To assess whether there are sector coordination bodies in place.
Source	Programme Report
Numerator	Number of functional sector coordination bodies
Denominator	Not Applicable
Interpretation	This indicator intends to measure sectors with coordination bodies in place and executing their duties.

Indicator	4.3.2 Percentage of coordination meetings held at all structures
Purpose	To assess whether the coordination bodies are functional at all level

	structures.
Source	Programme Report
Numerator	Number of coordination meetings held with full quorum at all level structures.
Denominator	Number of expected coordination meetings.
Interpretation	This indicator is a proxy measure of the multisectoral response to HIV and AIDS. Its intend to measure sectoral response or participation in HIV and AIDS programmes.

Programme area 4:   **HIV Spending**

Indicator	**4.4.1 Percentage of local funds mobilized to support the national HIV response**
Purpose	To measure the amount of public and donor funds mobilized for the national response and spent
Source	NASA Survey
Numerator	Total national funds spent for HIV and AIDS
Denominator	Total national and international HIV and AIDS spending
Interpretation	The data must be actual expenditures, not budgets or commitments. They must include total income and expenditures that were made as part of broader national response.