The National HIV and AIDS Monitoring and Evaluation Plan

2011-2016

The Nigeria National Response Information Management System (NNRIMS) Operational Plan II

Third Edition, 2011

Foreword

National Agency for the Control of AIDS is pleased to develop the NNRIMS Operational Plan II. The transformation of National Action Committee on AIDS to an Agency – National Agency for the Control of AIDS (NACA) in April 2007 is a remarkable achievement in Nigeria's commitment to the principle of the 'three ones'; which is one HIV/AIDS governing body, one strategic framework, and one monitoring and evaluation system. This led to the development of the first version of the NNRIMS Operational Plan (2007 – 2010) in 2007 to monitor the National Strategic Framework (2005-2009).

NACA has exemplified high level commitment to fight the pandemic through its multi-sectoral approach in collaboration with the United Nations, Donor Agencies, Implementing Partners, Civil Society groups and other stakeholders. These stakeholders have all invested resources in HIV interventions and it is important to track the progress and impact of these interventions by updating the existing plan to reflect the current situation. This will provide a framework for a functional, robust and effective M & E system that will address the gaps observed in the NOP 1(2007-2010).

Furthermore, this document will assist in ascertaining progress made towards mitigating the impact of HIV/AIDS and in recording key achievements as well as constraints.

The development of this second edition of the document has benefited largely from the contributions of stakeholders in Nigeria to ensure the huge amount of resources invested in HIV/AIDS achieve the expected results. It is therefore expected that all players in HIV/AIDS intervention will buy into this document. This will ensure that all our inputs, processes and outputs are monitored as well as evaluated for the outcomes and impacts of the programs.

Lastly, NACA will intensify her coordination efforts and continue to collaborate with all stakeholders for effective HIV and AIDS response.

Preface

Nigeria has the second largest population of People Living with HIV/AIDS (PLWHA) after South Africa. HIV epidemic has remained a major challenge and obstacle to the attainment of national development goals including the MDGs and the vision 20/2020.

Nigeria has a generalized epidemic with over three million Nigerians living with the virus. HIV/AIDS poses a serious threat to development in Nigeria, through the reduction in life expectancy, destabilization of the local and national economy, and increased burden on the health and welfare of the populace. The updated NNRIMS Operational Plan (NOP) is a renewed opportunity to monitor and evaluate efforts to combat the HIV/AIDS challenge.

The strategies that are highlighted in this NOPII are intended to provide a monitoring platform for the National HIV/AIDS Strategic Framework towards achieving its set goals. The first edition of the NNRIMS operational plan 2007-2010 came about as a result of a need to have a robust, standardized and unified monitoring and evaluation framework as well as the harmonization of various stakeholders M&E systems, so as to feed into the national M&E System.

Indicators collected from surveys, special studies and routine data collection were aligned with the national M&E system allowing streamlined reporting for international commitments such as UNGASS, Universal Access, PEPFAR and Global Funds as well as for national reporting requirements.

The goal of the NOPII 2011-2016 is to provide a simple and robust monitoring and evaluation system that will facilitate tracking of progress of the National HIV/AIDS response and the use of information to improve programs, policies and service delivery. This second edition of the M&E plan is therefore aimed at providing and improving the means for NACA to monitor the national response and provide effective leadership in the fight against the epidemic. Likewise, this M&E plan is aimed at strengthening the implementation of the NSP as well as strengthening the sub-national level M&E capacity to coordinate and monitor the activities under the various HIV/AIDS interventions.

In addition, this revised M&E plan will provide an opportunity to address some of the weaknesses and gaps noticed in the implementation of the first NOP particularly the issue of costing so as to provide the basis for resource mobilization for monitoring and evaluation. Thus, this document drew largely from the gaps and challenges recorded in the review of past efforts aimed at combating this pandemic examining the achievements, constraints, emerging issues,

lessons learnt and recommendations. The outcomes provided the foundation on which this new plan is built.

There are 70 national indicators (46 routine indicators and 24 non-routine indicators). The process of this indicator harmonization and development of this M&E plan was stakeholder-driven. This document benefited largely from the contributions of stakeholders in Nigeria, public sector organizations (MDAs), bilateral agencies, international non-government organizations and extensive consultations in the development process. The inclusiveness and consultations that resulted in the production of this NOPII makes it unique as a robust and technically sound document to provide useful guide to HIV programming in Nigeria.

I hereby urge all stakeholders in Nigeria to align their support in HIV/AIDS to our national objectives, strategies, policies and system. The achievement of national response targets outlined in this NOPII will assist us all greatly in the control of HIV/AIDS, both nationally and internationally, and lead us to our desired goal.

Professor John Idoko,
Director General,
National Agency for the Control of AIDS,

Acknowledgement

This document was produced by Nigeria's National Agency for the Control of AIDS (NACA) with funding from the UNAIDS, United States Agency for International Development (USAID) through MEASURE Evaluation, and the Global Fund. The document benefited from the contributions of numerous individuals and organizations. We would like to recognize, in particular, MEASURE Evaluation, UNAIDS and FMOH for their technical support in the design and development of this plan. NACA wishes to acknowledge the contributions of MEASURE Evaluation Washington, Global Fund Geneva, UNAIDS New York in reviewing the final draft of this document.

We extend our appreciation to the consultancy team and Steering Committee who worked closely to gather and weave the stakeholders' views into this M&E plan. Their untiring effort is a landmark contribution to Nigeria's national response.

Our commendation also goes to the National M&E Technical Working Group, HIV and AIDS thematic technical working groups and National/International Reviewers for their contributions. NACA wishes to thank the various sectors; Federal Ministry of Education, Federal Ministry of Women Affairs and Social Development, and especially the HIV/AIDS Division of the Federal Ministry of Health for their partnership and collaboration. Similarly, we wish to acknowledge the contributions of the staff of the Strategic Knowledge Management of NACA, for their tireless and unflinching technical support throughout the process. In addition, we cannot fail to acknowledge the important contributions of DFID, World Bank, USG (USAID, CDC, DoD), UN agencies, Global Fund M&E team and implementing partners who took part in the various consensus building workshops/meetings.

Abuja, August 2011

Kayode Michael Ogungbemi, PhD
Director, Strategic Knowledge Management
National Agency for the Control of AIDS

CONTENT OF THE PLAN

Annexes:

DECLARATION OF COMMITMENT TOWARDS THE IMPLEMENTATION OF THE NNRIMS OPERATIONAL PLAN (2011-2016) IN NIGERIA

1. CONTEXT

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

1.1. Recognising that HIV/AIDS is still a devastating health issue in the nation and globally and has impacted on economic and social development worldwide for more than two decades.

1.2. Affirm the need to continue in our response to this epidemic, through the coordination principles of 'Three Ones' namely:

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

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

1.4. Recognize the Nigeria National Response Information Management System Operational Plan (NOP) as the one monitoring and Evaluation guide used by all stakeholders for tracking, monitoring and evaluating the national AIDS response.

2. PRINCIPLES

"We on this 30th day of November, 2011 declare our commitment to the following principles:

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

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

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

3. UNDERTAKINGS

Bearing in mind the above and that Nigeria is experiencing a mixed epidemic, we commit ourselves to make immediate and relevant decisions to address the complexities and challenges presented by the epidemic through information provided by the Nigeria National Response Information Management System Operational Plan (2010-2015), other international, regional, and national agreements and interventions of the National Strategic Framework 2010-2015.

We resolve to undertake the following:

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

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

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

3.4. Promote data collection, harmonized reporting procedures and timelines regarding the HIV epidemic within the context of the **NNRIMS Operational Plan 2010-2015.**

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

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

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

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

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

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

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

3.12. Ensure that all data reported on the HIV/AIDS response are reconciled and cleared with NACA Monitoring and Evaluation Division before official publication.

3.13 Ensuring that the key national goals for each thematic area in the NSP (2010-2015) are achieved through effective implementation of the NOP (2011-2016). They are:

- Reduce the incidence of HIV/AIDS
- Ensuring that all eligible PLWHIV receive quality treatment services for HIV/AIDS and opportunistic infections (OIs), and PLWHIV co-infected with TB receive TB treatment services.
- Promote the survival and improve the quality of life of PLWHIV and people affected by HIV/AIDS (PABA), especially OVC.
- Protect the rights of PLHIV and PABA and empower them to reduce their cultural, legal, and socioeconomic vulnerabilities and ensure their full participation in the National response and other development initiatives.
- Strengthen structures and systems for the coordination of a sustainable and gender sensitive multi-sectoral HIV/AIDS response.
- Strengthen and institute a sustainable, systems-based approach to delivering a cost-effective, multidimensional and gender sensitive monitoring and evaluation system that supports the continuous improvement of the national response.

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

NATIONAL AGENCY FOR THE CONTROL OF AIDS

Professor John Idoko
DIRECTOR GENERAL
NACA

FEDERAL MINISTRY OF HEALTH

Dr Evelyn Ngige
National Coordinator, HIV Division

FOR OTHER FEDERAL MINISTRIES

Dr Ezinwa Uzuegbunan
National Coordinator,
Federal Ministry of Education

Mrs Oby Okwonu
National Coordinator,
OVC Programme, FMWASD

FOR THE DEVELOPMENT PARTNERS

Dr Michael O'dwyer
Chairman, Partner's Group
HIV Development

Dr Kwame Anpomah
UN Country Coordinator Development

FOR THE CSO AND NETWORKS

Mrs Ugo Uduma
National Chairman
CiSHAN

Edward Ogenyi
NEPHWAN Coordination

List of Acronyms

AFPAC	Arm Forces Programmes on AIDS Control
AIDS	Acquired Immune Deficiency Syndrome
ANC	Antenatal Care
ART	Antiretroviral Therapy
ARV	Antiretroviral
CBOs	Community Based Organization
CSI	Child Status Index
CSOs	Civil Society Organizations
CSW	Commercial Sex Workers
CTX	Cotrimoxazole
DG	Director-General
DBS	Dried Blood Spots
DHPR	Department of Health Planning and Research
DoD	Department of Defence
DHS	Demographic Health Survey
DQA	Data Quality Assessment
ETG	Expanded Theme Group
EAs	Enumeration Areas
FBOs	Faith Based Organization
FLHE	Family Life and HIV Education
FMR	Facility Monthly Report
FMWASD	Federal Ministry of Woman Affairs and Social Development
FCT	Federal Capital Territory
FME	Federal Ministry of Education
FMoH	Federal Ministry of Health
FSW	Female Sex Workers
GoN	Government of Nigeria
GF	Global Funds
HFA	Health Facility Assessment
HMIS	Health Management Information System
HRIS	Human Resource Information System
HIV	Human Immuno-deficiency Virus
HCT	HIV Counselling and Testing
HEAP	HIV/AIDS Emergency Action Plan
IBBSS	Integrated Biological and Behavioural Surveillance Survey
IDU	Injecting Drug Users

IPs	Implementing Partners
JAPR	Joint Annual Performance Review
LACA	local Action Committee on AIDS
L&D	Labour and Delivery
LGA	Local Government Agency
MAP	Multi-Sectoral AIDS Project
MARPs	Most at Risk Population
MD	Millennium Declaration
MDAs	Ministries Departments and Agencies
MDGs	Millennium Development Goals
M&E	Monitoring and Evaluation
MSM	Men having Sex with Men
MPP	Minimum Prevention Package
NACA	National Agency for the Control of HIV/AIDS
NASA	National Aids Spending Assessment
NASCP	National HIV/AIDS/STI Control Programme
NARHS	National Adolescent and Reproductive Health Survey
NDHS	National Demographic and Health Survey
NEPWAN	Network of People Living with HIV/AIDs
NGO	Non-Governmental Organisation
NHRC	National HIV/AIDS Resource Centre
MAP	Multi-Sectoral Aids Project
NNRIMS	Nigeria National Response Information Management System
NOP	National Operational Plan
NSF	National Strategic Framework
NSP	National Strategic Plan
OVC	Orphan Voluntary Care
PABA	People Affected by AIDS
PEPFAR	President's Emergency Plan for AIDS Relief
PME	patient Monitoring and Evaluation
PLWHA	People Living with HIV/AIDs
PMM	Patient Management Monitoring
PMTCT	Prevention of Mother to Child Transmission
PPM	Plan Preventive Maintenance
SACA	State Agency for the Control of AIDS
SASCP	State HIV/AIDS/STI Control Programme
SCR	Service Coverage Report
SKM	Strategic Knowledge Management
SSP	State Strategic Plan
STI	Sexually Transmission Infection
TB	Tuberculosis

TOR	Term of References
TWG	Technical Working Group
UA	Universal Access
USG	United State Government
USAID	United States Agency for International Development
UN	United Nation
UNAIDS	Joint United Nations Programme on AIDS
UNGASS	United Nations General Assembly
WB	World Bank

LIST OF STEERING COMMITTEE

Dr Kola Oyediran, MEASURE Evaluation, Abuja
Mr.Akin Atobatele, USAID, Abuja
Dr Kayode Ogungbemi, NACA Abuja
Dr Greg Ashefor, NACA Abuja
Dr AderemiAzeez, NASCP Abuja
Dr Job Sagbohan, UNAIDS Abuja
Mr.Godspower Omoregie, SFH Abuja

LIST OF TECHNICAL COMMITTEE

Dr Kola Oyediran, MEASURE Evaluation Abuja
Dr AdedayoAdeyemi, MEASURE Evaluation Abuja
Dr Kayode Ogungbemi, NACA Abuja
Dr GregAshefor, NACA Abuja
Dr AderemiAzeez, NASCP Abuja
Dr Job Sagbohan, UNAIDS Abuja
Dr Samson Adebayo, SFH Abuja
Mr Louis Edema, NACA, Abuja
Dr Adaoha Anosike, NACA Abuja
Mrs IdoteyinEzirim, NACA Abuja
Mr Kenneth Alau, NACA Abuja

LIST OF CONSULTANTS

Mr. Cyril Ojeonu
Mr IkechukwuUkeje
Miss Faith Okoeki

LIST OF REVIEWERS

Nibretie Gobezie (Global Fund, Geneva)
Upama Khatri (Measure Evaluation, USAID)

CHAPTER ONE

INTRODUCTION

1.0 Background

Nigeria is located on the West Coast of Africa between latitude 4°16′ and 13°53′N, and between longitude 2°40′ and 14°41′E. Nigeria has a land mass of 923,768 square kilometres and is bordered by Niger Republic (north), Chad (north-east), Cameroon (east), Benin Republic (west) and Atlantic Ocean (south). The country is the most populous country in Africa with a population of 140million from the 2006 National Census Figure[1]; a population of 158.3 million in mid-2010 from the estimate of Population Reference Bureau (PRB),[2] and over 373 ethnic groups. This makes Nigeria one of the ten most populous countries in the world.[2] Administratively, the country has 36 states and a Federal Capital Territory (FCT). The states are semi-autonomous with independent administrative, legislative and judicial systems built to fit into the central government. The states and the FCT are further divided into administrative units called Local Government Areas (LGAs) with a total of 774 LGAs in the country. In addition, the states are grouped into six geopolitical zones namely: North-West (NW), North-Central (NC), North-East (NE), South-West (SW), South-South (SS) and South-East (SE).

Figure 1: Map of Nigeria

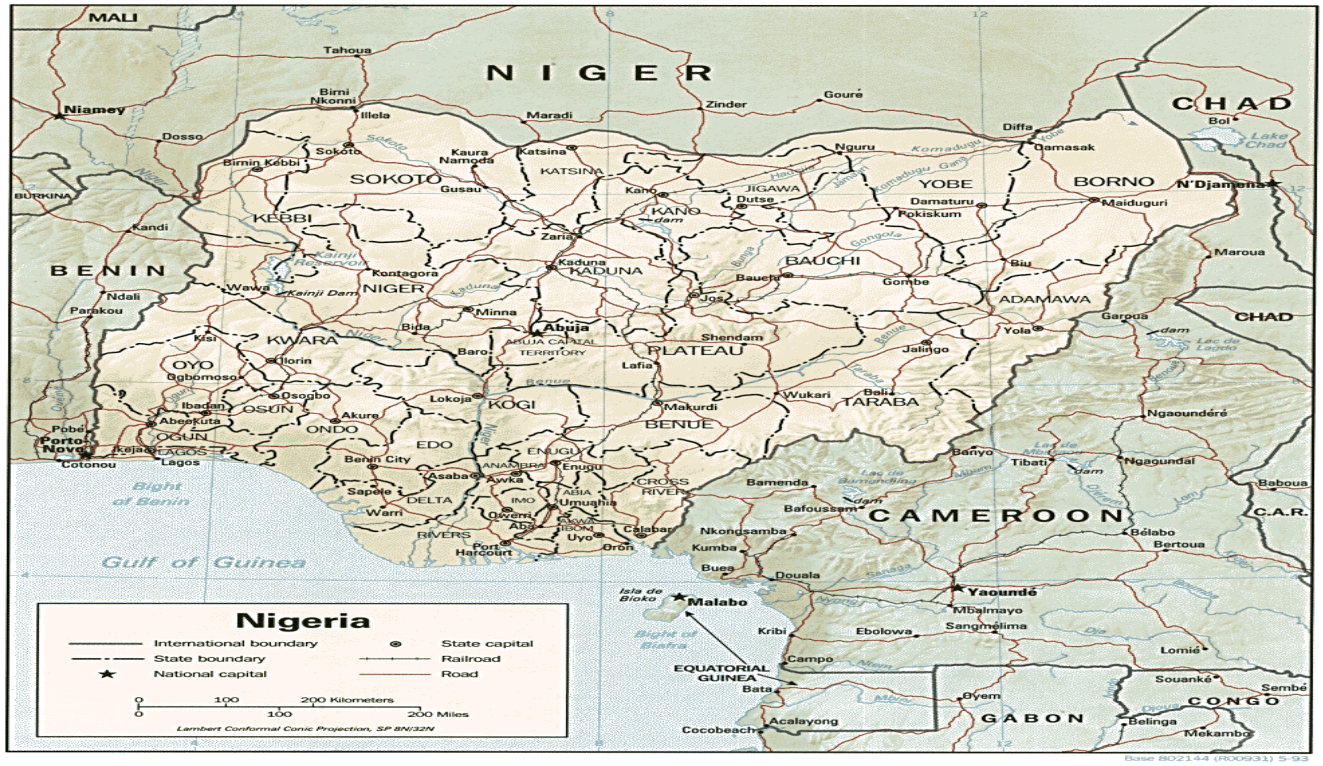


Table 1 below shows HIV/AIDS related data in Nigeria at the end of 2010.

Table 1: Epidemiology of HIV/AIDS in Nigeria

National Median HIV prevalence (ANC)	4.1%
Estimated number of people living with HIV/AIDS	Total: 3.14million
Cumulative AIDS death	Total: 2.1million (male 970,000; 1.13million)
Annual AIDS Death	Total: 215,130 (male 96,740; female 118,390)
Number in need of Antiretroviral Therapy	Total 1,512,720 (adults 1,300,000 and children 212,720)
New HIV infection	Total 281,180 (adult 126,260 and children 154,920)
Total AIDS orphans	2,229,883

Source: FMOH (2011) ANC 2010 Survey Report HIV estimates and projection

Figure 2: State Distribution of HIV prevalence

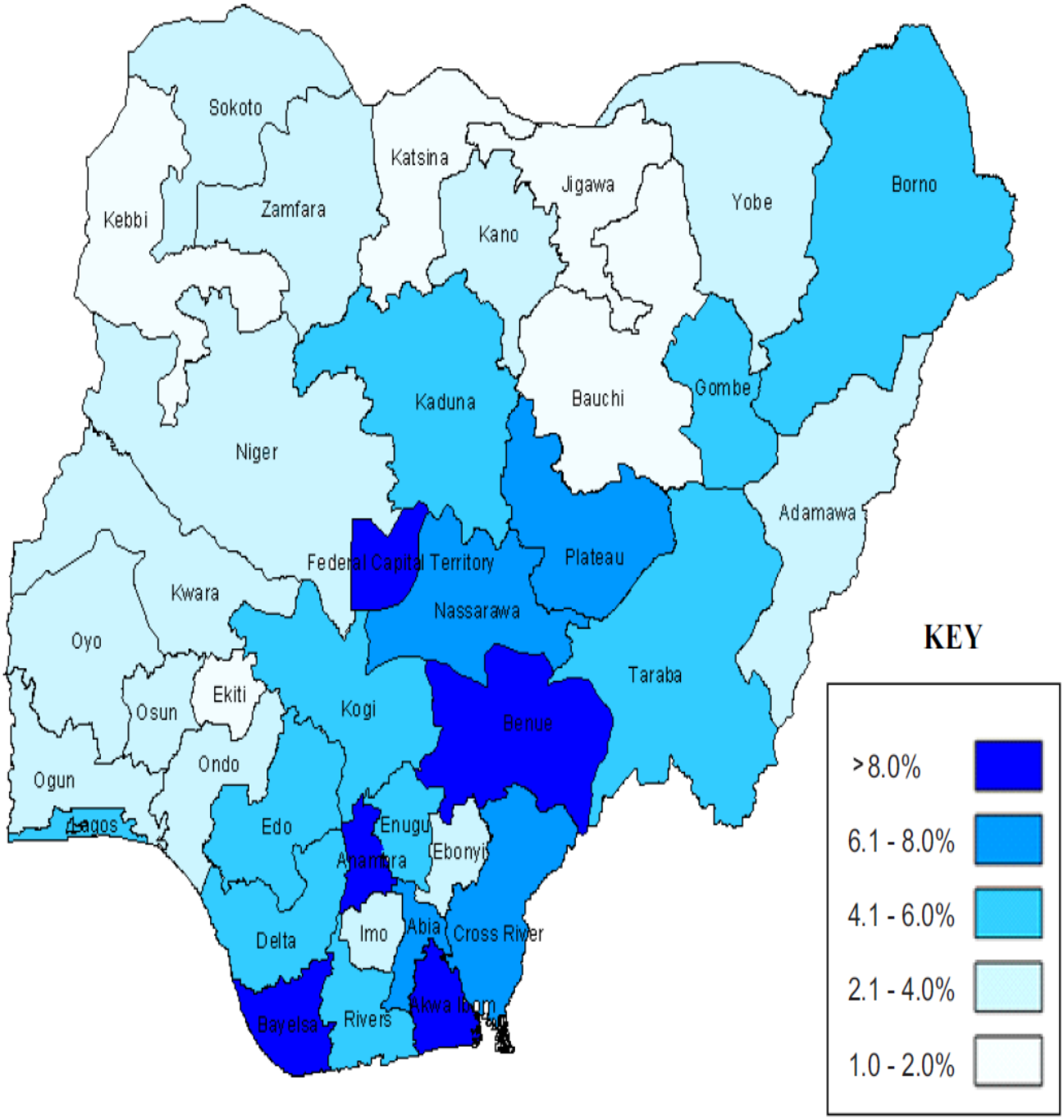


Figure 2 illustrates the distribution of HIV infections in 2010 by State. The map shows that AkwaIbom, Anambra, Bayelsa, Benue and FCT have the highest prevalence in Nigeria.

Figure 3: HIV Prevalence trend in Nigeria (1991-2010)

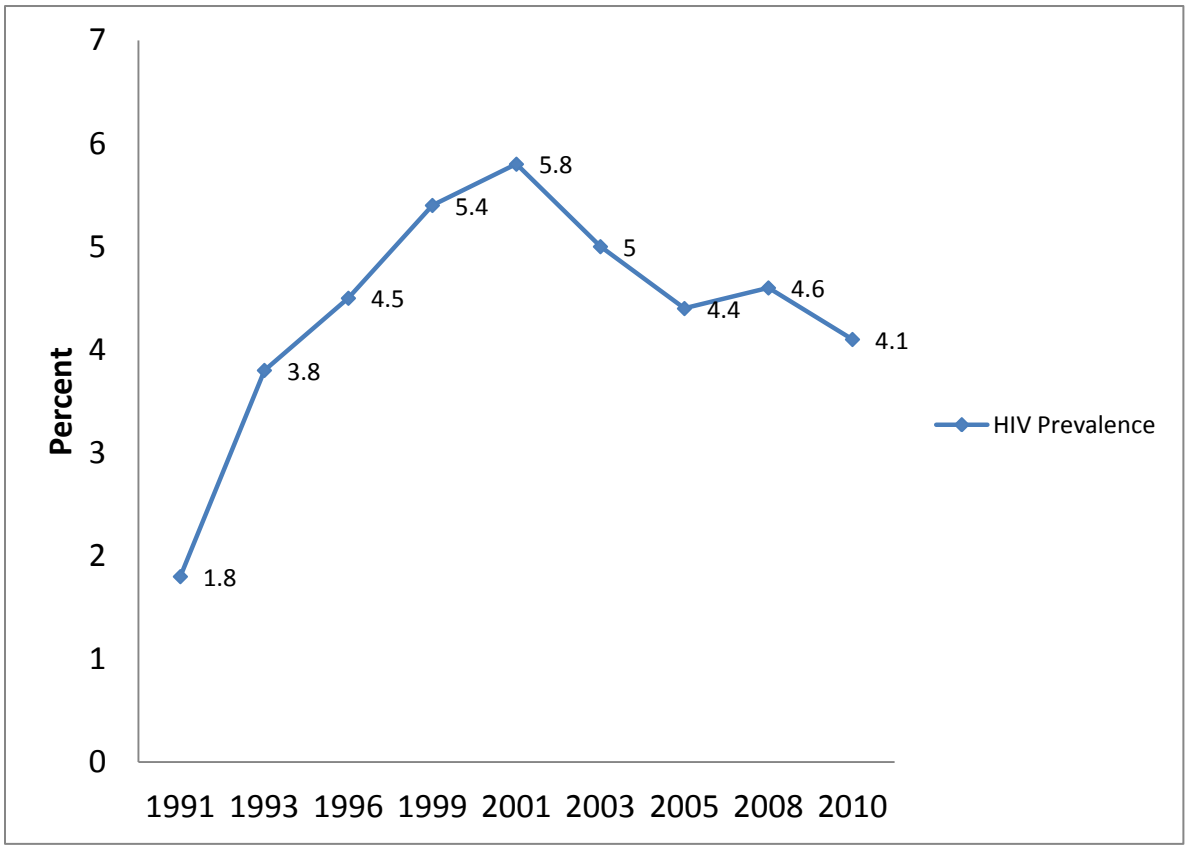


Figure 3 illustrates the trend in HIV prevalence from 1991 to 2010. HIV prevalence rose from 1.8% in 1991 and peaked in 2001 at 5.8% before declining to 4.1% in 2010.

1.1 The Overview of National HIV/AIDS Response

The health sector response commenced after the first case of AIDS was reported in Nigeria in 1986, however with the advent of democratic rule in 1999, there was strengthening of the national response to curb the increasing spread of HIV epidemic and move the response from a health-centred response to a development-oriented multi-sectoral response.

Similarly, the adoption of a national multi-sectoral response led to the creation of the Presidential Council on AIDS (PCA) and the National Action Committee on AIDS (NACA) in 2001 to coordinate the activities at the Federal level. NACA promotes a multi-sectoral approach to the national HIV/AIDS response. Membership includes representatives from Ministries, the private sector, non-governmental organizations (NGOs) and networks of People Living with HIV/AIDS.

At the state and local government levels, the State Action Committee on AIDS (SACA) and the Local Government Action Committee on AIDS (LACA) were created to spearhead the state and local multisectoral responses to HIV/AIDS respectively.
Around the same time in 2001, HIV/AIDS Emergency Action Plan (HEAP) was developed with the collaboration of relevant stakeholders. The HEAP, which served as an interim action plan, focused on three major areas: creation of an enabling environment through the removal of socio-cultural, informational and systematic barriers to community-based responses; prevention; and care and support.

Likewise, NACA developed a National HIV/AIDS Policy to create an enabling policy environment to drive the response against HIV/AIDS and developed guidelines for ART, PMTCT and HCT. The demand for a more comprehensive response led to the development of the first National Strategic Framework (NSF) in 2005.[3]The NSF framework set a goal to reduce HIV incidence and prevalence by at least 25%, and to provide equitable prevention, care, treatment, and support while mitigating the impact of HIV/AIDS among women, children and other vulnerable groups, and the general population by 2009.

The NSF goal and objectives served as a target and a guide for the national response strategic plan and action. The NSF was reviewed in 2009 and updated to cover a six year period from 2010-2016 and further strengthen the national response.[4]

The NSF 2010-2016 follows a strict multi-sectoral approach which involves active involvement and participation of stakeholders such as civil society organizations, Network of People Living with HIV/AIDS (NEPWAN), faith based organizations, line ministries, non-governmental organizations, development partners and the private sector. Over the years, there has been improved participation of the private sector, civil society organizations and international partners in the national response.

The multi-sectoral response has led to better resource mobilization and coordination among stakeholders (public, private and civil society groups) riding on the "*Three Ones Model"* (one national structure, one strategic plan, and one monitoring and evaluation framework).[5]

The goals, objectives and interventions of the NSF are detailed in the NSP.[6] However, the overarching goal is to assist towards achieving universal access in five priority areas by 2015. The priority areas are;

- Prevention;
- Treatment and other health related issues
- Care & Support;
- Policy, Advocacy, Human Rights and Legal Issues
- Institutional Architecture, Systems, Coordination, and Resourcing

- Monitoring and Evaluation, Research, and Knowledge Management

Figure 4: Conceptual Model of the National Response

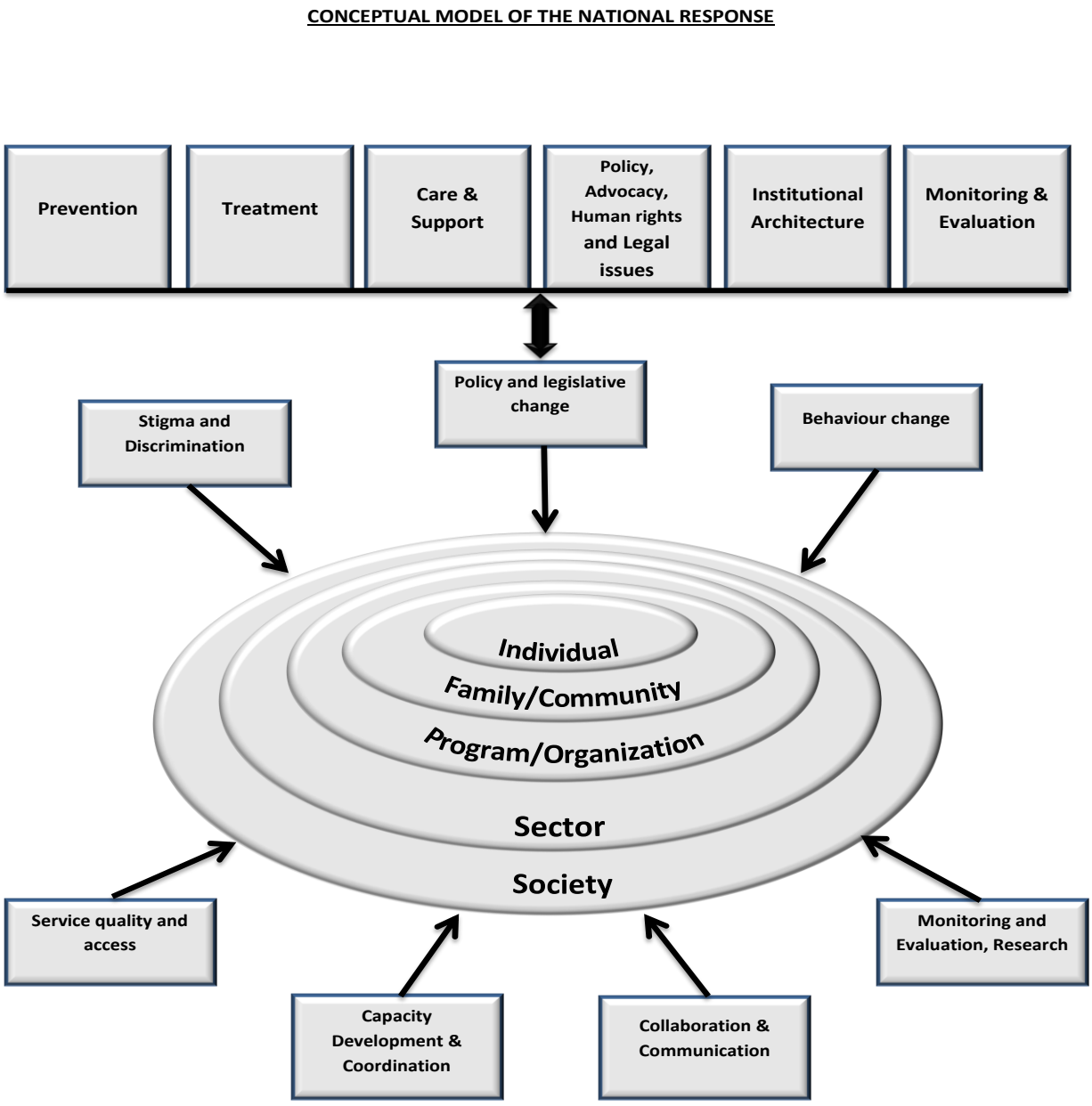


Figure 4 illustrates the conceptual model of the national HIV strategic plan with the four key thematic areas of prevention, treatment, care and support, and policy, and the linkages and inter-relationships between these areas.

CHAPTER TWO

DEVELOPMENT OF THE NATIONAL HIV/AIDS MONITORING AND EVALUATION PLAN

2.0 Overview of Monitoring and Evaluation

Monitoring and Evaluation (M&E) is a key component of the multi-sectoral response to HIV/AIDS in Nigeria**.** Initially it was done through HIV sentinel surveillenceof pregnant women accessing antenatal services in hospitals and clinics in line with global health standards from the World Health Organization. Currently, Nigeria combines routine data collection with periodic surveys to monitor the HIV epidemic and national response.

The push for a multi-sectoral response to the HIV epidemic led to the development of the Nigeria National Response Information Management System (NNRIMS) in 2004. NNRIMS currently provides a robust, standardized and unified monitoring and evaluation framework. The purpose of NNRIMS is to track progress in the implementation of the national HIV/AIDS response and use feedback information to improve policies, programs and service delivery in line with the principle of 'three ones'.

NACA initiated the formation of the National M & E Technical Working Group to provide technical support on monitoring & evaluation in the areas of prevention, treatment, care and support, research, surveillance, and capacity building in 2004. Additionally, the country's first HIV M&E Plan known as the NNRIMS Operational plan (NOP) was developed in 2007 as a guide to data collection, management, analysis and reporting, decision making, program planning and implementation.

Monitoring and Evaluation is of vital importance to the successful implementation of programs since systematic M&E tracks what is being done and if the interventions being undertaken are making a difference. Establishment of an M&E system for HIV/AIDS was critical. Continuous assessment is necessary, given that new interventions are constantly being proposed. Efforts must be made to identify interventions that are more effective to make them more central in the national response. To effectively fulfil its mandate of coordinating the national response to HIV/AIDS, NACA and stakeholders need to understand the scope and effect of HIV interventions in Nigeria.

2.1 Utilization and implementation of NOP1

NOP1 has been utilized by program managers, M&E managers, policy makers and academics. NOP1 was implemented to collect routine and survey data to monitor progress in HIV prevention, treatment, care and support in Nigeria. Data is collected from both governmental institutions and non-governmental institutions to improve programs, for decision making and assess program impact.

2.2 Rationale for the review of National M &E Plan

The first NNRIMS Operational Plan (NOP1) extended from 2007 through 2009. In 2010, the country developed a new National HIV/AIDS Strategic Plan for 2010through 2015, which also required a revision of the NNRIMS Operational Plan (NOP).
Likewise, the current characteristics of the HIV/AIDS epidemic and the rapid scale-up of the national response has made it appropriate to revise the NNRIMS operational plan, to align with strategies articulated in the new NSF, as well as Nigeria's roadmap for achieving Universal Access (UA) for prevention, treatment, care and support by 2015. In addition, the results of series of routine data quality assessments (DQA) and assessments of the national HIV/AIDS M&E system have revealed the continued existence of vertical systems, despite the participatory process that was used in the development of NOP-1, which need to be addressed and better linked to the national system.

The National HIV M&E system was assessed using the 12 Components System Strengthening Tool in 2009. The results of the assessment have informed the revision of NOP-I. The primary findings include:

a) The M&E system is relatively strong at the national level but much weaker at the state and local government levels, and across other sectors (public, private, and civil society).
b) Although there is a national system, vertical systems continue to exist and these systems are poorly harmonized with the national system in terms of the indicators, data collection tools, and reporting tools that are being used across partners and service delivery areas.
c) There is poor data use.

The gaps and weaknesses identified by the DQA and M&E assessment provided further justification for reviewing the National M&E plan. The revision process has provided an opportunity to address some of the weaknesses and gaps in operationalization of an effective M&E system in Nigeria.

Every program needs a monitoring and evaluation (M&E) plan. This is a fundamental document that details program's objectives, the interventions developed to achieve these objectives, and describes the procedures that will be implemented to determine whether or not the objectives are met. M&E plans show how the expected results of a program relate to its goals and objectives, describes the data needed and how these data will be collected and analysed, how the

information will be used, the resources needed, and how the program will be accountable to the stakeholders.

Likewise, an M&E plan is important because it states how a program will measure its achievements and provide accountability. It provides transparency, guides the implementation of M&E activities in a standardized manner and preserves institutional memory.

2.3 Goal of NOP II

- To provide a simple, comprehensive and results-based monitoring and evaluation system that will facilitate tracking of progress of the National HIV/AIDS response and produce information that can be used for evidence-based decision-making to improve programs, policies and service delivery.

2.3.1 Objectives of NOP II:

- To build upon the requisite infrastructure for monitoring and evaluation in Nigeria;
- To strengthen the required human resource capacity across all levels;
- To harmonize indicators and standardize data collection tools and systems;
- To coordinate and strengthen second generation surveillance and HIV/AIDS operations research;
- To define clear roles and responsibilities in monitoring and evaluation across different levels and sectors of the system;
- To facilitate efficient data transmission and feedback flow;
- To promote the use of information by outlining how data collected by NNRIMS should be used; and
- To mobilize adequate financial and material resources to support full operationalization of the monitoring and evaluation plan (2010-2015).

This M&E Plan is a companion document to the 2010 – 2015 National Strategic Framework (NSF) and National Strategic Plan (NSP). It is therefore expedient to refer to the NSF and NSP for detailed information on the program's objectives and interventions.

2.4 Target Users:

This M&E Plan targets all stakeholders involved in coordinating, implementing, and evaluating HIV related programs for people infected and affected by HIV/AIDS, in the general population, as well as the most at risk population.

2.5 Development Process:

The M&E plan was developed through a highly participatory approach that engaged all major stakeholders. The participatory, qualitative approaches that were used have enhanced ownership and should result in accountability, transparency and sustainability.

As the initial step, NACA developed a concept paper for the NOPII and a steering committee was set up. The mandate for this committee was to plan the process and activities for the development of the NOPII so as to align the document with the new NSF.

The specific activities that were carried out in the development of the plan include:

- **Assessment of the National M&E System**: The National M&E system was assessed using the 12 Components Systems Strengthening Tool, a tool designed around the Organizing Framework for a Functional National HIV Monitoring & Evaluation System , to determine strengths and weaknesses of the system as well as to document lessons learned. To conduct the assessment, NACA collaborated with stakeholders from the public and private sectors, development and implementing partners, facilities and civil society organizations to thoroughly review the status of NNRIMS Operational Plan developed to track the performance of NSF 2005-2009..
- **Review of Strategic Documents**: Several strategic M&E documents were reviewed during the development phase including UNGASS, Universal Access, NSP, PEPFAR, Global Fund and other related reports and guidelines for monitoring National HIV/AIDS programs in regard to priority program areas, targets indicators and monitoring and reporting mechanisms and compared the findings with the National Strategic Framework.
- **Review of National Survey Reports**: National level survey reports, such as NDHS, NARHS, IBBSS and ANC sentinel survey, with population based indicators relevant to the monitoring and evaluation of the National response on HIV/AIDS were reviewed.
- **Data Needs Assessment:** A template was developed and sent to Implementing Partners, government agencies and bilateral and multi-lateral agencies to collect information on which indicators are being used by different programs. . As part of the assessment process, discussions were held with NACA, technical working groups and implementing partners to seek clarifications on the national HIV/AIDS priority program areas and the roles that implementing partners play in program implementation and monitoring and evaluation. Consultative meetings were held with Federal Ministries of Health, Education and Women Affairs respectively including focal persons from public and private health facilities, community-based non-governmental organizations to:

- Have a better understanding of their program activities and achievements.
- Have a better understanding of how service providers have been reporting data to NACA.
- Clarify the expected data collection and reporting responsibilities of service providers under the new M&E system. Seek inputs on ways to improve the data reporting system.

The reports of the data assessment and consultative meetings were shared with the steering committee. A draft M&E plan was developed and presented to stakeholders for their comments and input.

A stakeholders' meeting was held to discuss the draft M&E plan and partners' data collection roles and responsibilities as well as seek inputs toward the finalization of the plan.

2.6 Core Components of the M&E Plan:

The national HIV/AIDS M&E Plan can be divided into two parts:

- **Part A**, ***the Conceptual Framework***, lays the conceptual foundation for the M&E system, by providing a logical framework for organizing and prioritizing national efforts. It provides a description of the goals, illustrative activities, and measurable core indicators by program area and defines the data sources that will be used to generate the indicators that are in the logical framework.

- **Part B**, ***the Operations Plan***, provides detailed indicator descriptions; describes the collection, flow, analysis, reporting, and dissemination of information; outlines the role of organizations and individuals responsible for specific tasks; and describes the data systems necessary to accommodate this information.

2.7 Description and overview of core national indicators

It is very important for stakeholders to be involved in the selection and definition of the core national indicators for several reasons. *First*, many of the indicators are derived from the stakeholder M&E systems and therefore they are the primary source of the data. *Second*, stakeholders are responsible for establishing baseline data, keeping track of indicator trends, and using the indicator for their own monitoring and evaluation activities. *Lastly*, the indicators that are collected by stakeholders at the service level feed up and are ultimately aggregated into the indicators that are reported internationally for MDG, UNGASS and poverty monitoring.

This section describes factors that were considered in the selection of the core national indicators:

1. **Indicator characteristics and details**: The precise definition of the indicator including the units that are used to measure the indicator and the level of disaggregation required.

   Plan for data collection and acquisition: The tools and methods that are used to collect data, the form in which data will be received, the frequency and timing of data collection, and the responsible sector/institution/organization that will collect the data. It is important that NACA and stakeholders reach consensus on the responsible sector/institution/organization that will collect the data required for each indicator.

3. **Plans for data analysis and review**: A description of how and when data analysis will be carried out.

2.8 Data quality issues

The importance of collecting good quality data cannot be overemphasized. Data validity is a facet of data quality that means that, data that are collected clearly and adequately represent the result that it is intended to measure. Data sources should clearly report how measurement errors, sampling procedures and transcription errors have been minimized or avoided. Not only should data be valid, they should also be reliable in repeatable measures. This involves consistent data collection and analysis processes over time of both the numerator and denominator. This will allow tracking of the response to the epidemic and analysis of trends.

NACA and sectors/agencies/institutions will jointly develop means and ways of ensuring that data sources that contribute to the core indicators of the monitoring and evaluation framework adhere to minimum data quality requirements. NACA will ensure that the stakeholders who collect data for the core indicators follow good statistical and methodological procedures that are incorporated in the tools used. Likewise, periodic reviews will be made to assess data quality issues and steps will be taken to improve the quality of data. Data quality should be assessed initially when indicators are established and baseline data are collected and reassessed annually or every two years.

2.9 Baseline and targets

1. For each core national indicator, baseline data and targets were established .National and international commitments were taken into account when setting targets and all assumptions have been documented. It is important to note that targets can potentially be revised in the future depending on the direction of the epidemic or if review of NSP or Annual Program Review is carried out

CHAPTER THREE

NATIONAL HIV/AIDS M&E SYSTEM

3.0 The Conceptual M&E Framework

The goal of the national response to HIV/AIDS is to reduce new HIV infections, and improve the quality of life for the infected and affected.

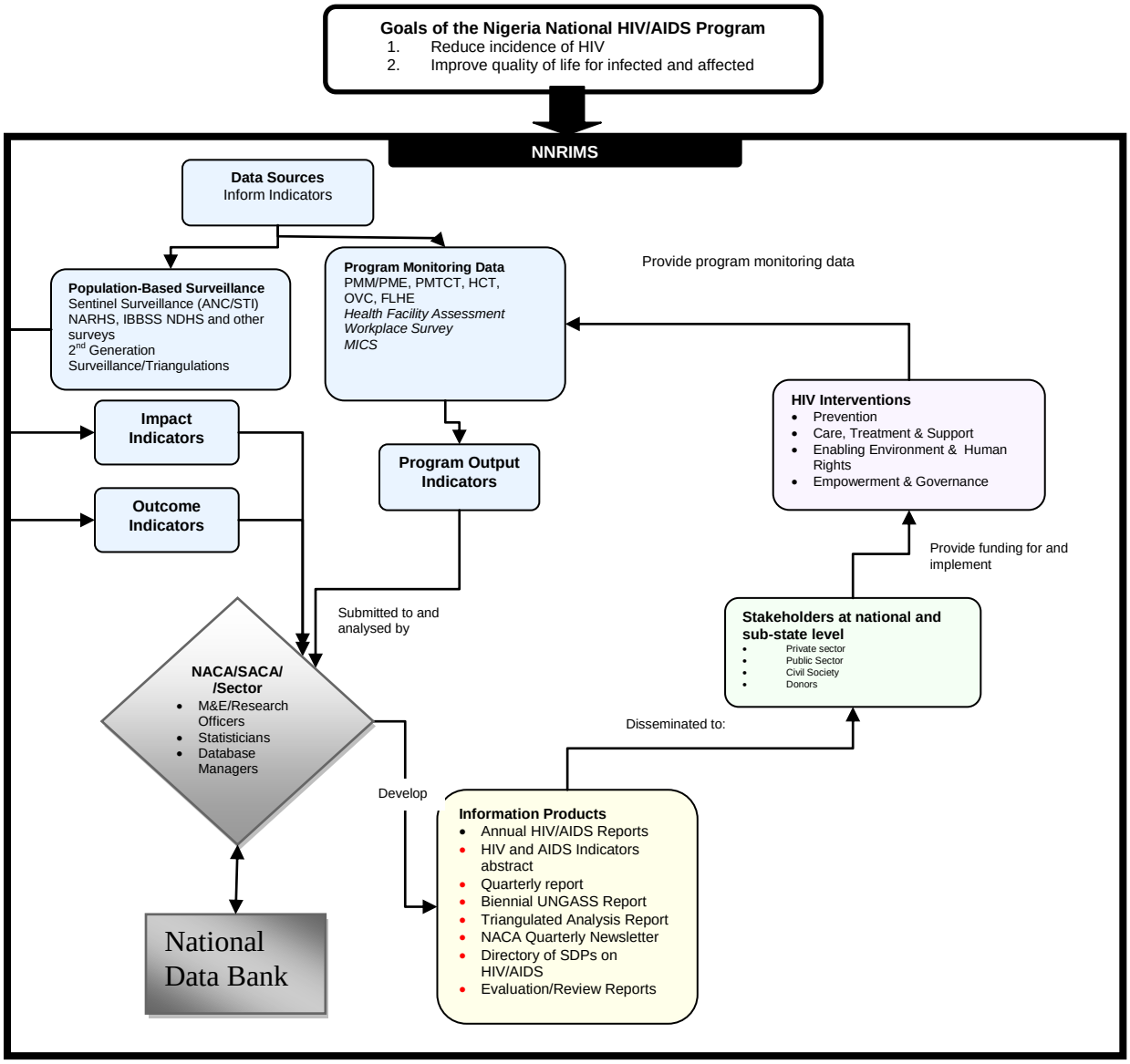


Figure 5: Overview of M&E framework

Figure 5 is the conceptual M&E framework that illustrates the linkages between the different components of the national HIV response.

3.1 Relationship between National M&E System and Program-level M&E System

A strong link exists between a national HIV/AIDS M&E system and the M&E systems for specific programmatic areas (such as PMTCT, HIV Care and Treatment, PMM system, HCT and OVC). A national M&E system provides a national overview to enable decision-making and track progress from a national perspective while the program-level M&E system feeds into the national M&E system, but collects more detailed data for use by the implementers of the various HIV programs. Thus, a program-level M&E system will collect more data on more indicators than is required by the national M&E system. But, as a minimum requirement, it should collect ***ALL*** of the information that is needed to measure the national indicators for the program.

How and when data is reported to the national M&E system should be defined in each program area's implementation guidelines. This will ensure that implementers of the various programs are clear on their responsibilities in terms of data collection for their own management purposes and for reporting data to the national M&E system.

3.2 Linkage of the National M&E Framework to National and International Goals

The M&E processes and systems in Nigeria were established to link national and international goals. NACA, working in collaboration with other sectors, ensures that M&E systems are increasingly aligned with one another and that the best possible data sets are collected and shared across government and with other stakeholders.

3.3 Linkage of the National M&E framework to Millennium Development Goals and National targets

The Millennium Development Goals (MDGs) represent a merging of the goals chartered in the Millennium Declaration (MD) by the United Nation General Assembly and longer standing international/development goals. Eight goals have been set by the MDG that relate to poverty, education, gender equality, child and maternal mortality, combating HIV/AIDS & malaria, environment sustainability and global partnership and development. Although MDG 6 (HIV/AIDS) is the goal that is most directly relevant to the National HIV/AIDS Response monitoring and evaluation framework, the achievement of all eight goals is intricately linked to the framework.

Therefore, the response to the HIV/AIDS epidemic should seize the opportunities within the context of MDG and build awareness of its reciprocal relationship between the National commitments, the response to the HIV/AIDS epidemic and the MDG. For example the

HIV/AIDS epidemic continues to deepen poverty, disrupt schooling, and worsen the child and maternal mortality picture. Additionally, it is affected by gender inequality.

It is clear that the HIV/AIDS epidemic has the potential to disrupt the achievement of the MDGs and conversely, if the MDGs are achieved, they would contribute to reducing the burden and impact of the epidemic. The relationship between HIV/AIDS and economic development is complex. The HIV/AIDS epidemic has negatively affected economic growth and it is difficult for weakened economies to respond effectively to the epidemic. What HIV/AIDS does to the human body has been likened to what it does to the nation. In both cases, it weakens the system to respond to developmental challenges.

3.4 Linkage to the United Nations Declaration of Commitment on HIV/AIDS

In the year 2001 the United Nations General Assembly Special Session (UNGASS) on HIV/AIDS made a commitment for a comprehensive programme of international and national action to fight the HIV/AIDS pandemic by adopting the Declaration of Commitment on HIV/AIDS. The Declaration provides a framework for an expanded response to the global HIV/AIDS epidemic. Its goals and targets are designed to address all dimensions of the epidemic. It represents an agenda for change and a benchmark for global action. Some of the more innovative aspects highlight the challenges facing women, people living with HIV/AIDS, human rights and interaction between prevention and care. It calls for a new type of leadership in response to HIV/AIDS. Such leadership should have governments at its centre, with the full involvement of civil society, the private sector and people living with HIV/AIDS. The emphasis is on a multi-sectoral response, with specific commitments in the following areas: leadership; prevention; care; support and treatment; HIV/AIDS and human rights; reducing vulnerability; children orphaned and made vulnerable by HIV/AIDS; alleviating the social and economic impact; HIV/AIDS in conflict zones and disaster-affected regions; resources; and follow-up.

Indicators for implementation of the Declaration of Commitment are divided into two subgroups: global indicators and national indicators. The global indicators comprise of five indicators that provide information on levels and trends in international commitment to mediate the impact of HIV/AIDS. The national indicators are subdivided into three categories: Indicators of national commitment and action, indicators of national program, knowledge and behaviour indicators and indicators of national-level program impact.

3.5 Linkage to Nigeria Multi-Country AIDS Project (MAP)

Through the World Bank, the Nigeria Multi-Country AIDS Project MAP) has been designed to support the Government of Nigeria's National Program on HIV/AIDS. MAP aims to reduce the

spread of HIV in the general population through multisectoral action involving government, Non-Government, civil society and community organizations. The monitoring and evaluation component of MAP is fully integrated with the national M&E framework and MAP supports NACA in the development and implementation of the national framework .

Therefore, instead of developing a separate parallel system, MAP will use the national M&E framework and the selected national core indicators. In addition, MAP will partner with NACA to conduct joint reviews so that as much as possible, M&E activities are streamlined and not duplicative.

3.6 M&E Framework

Establishing an effective monitoring and evaluation framework is a central role of NACA. This section of the framework sets out roles and responsibilities on M&E at different levels; flows of information; systems development requirements; and approach to capacity building for the effective monitoring and evaluation of the national HIV/AIDS response. The linkages within the M&E framework include:

- Summarized report using the standard format to be submitted by the State to NACA. The sector and the National level Civil Society Organizations (CSOs) receive detailed reports that are necessary for program implementation monitoring.
- All implementing organizations including the facility, CSOs and networks will also give a summary report using standard forms developed by NACA to the LGA.
- Sectors will offer supportive supervision and technical back-up in monitoring and evaluation to States/LGAs, networks and major projects.
- Development Partners will offer support supervision and technical back-up in monitoring and evaluation to the States/LGAs, networks and field project units.
- Bi-annual coordination meetings convened by NACA to monitor the implementation of the national M&E plan.
- National NGOs and Research Institutions will report directly to NACA any specialized studies and research activities. Studies and researches initiated at other levels shall pass through the HIV/AIDS Coordinating Authority at that level along the appropriate channel to NACA. This will be fully operational when the National HIV/AIDS Research Plan is finalized.

3.7 Coordination role of NACA

Coordination of the national response to HIV/AIDS is the core function of NACA. NACA plays the role of bringing together all actors who are involved in responding to the epidemic

for the harmonious implementation of HIV/AIDS activities. Similarly, as a sub-activity of the agency, efficient implementation of the M&E Plan will require well-established coordination mechanisms at all levels of monitoring and evaluation.

Effective coordination poses a major challenge and requires careful planning and skills development. Coordination of M&E activities will be a major task of the NACA Strategic Knowledge Management (SKM) Division. In line with the mandate of NACA the Director of SKM will provide a strategic oversight of M&E needs, activities, gaps and new initiatives across the various sectors.

Improved coordination between Ministries, institutions, special projects and surveys and other stakeholders will be essential to:

- Provide good quality, comprehensive and timely information on the state of the epidemic in Nigeria;
- Effectively track and monitor the implementation of the response
- Create a constructive environment and willingness among all partners to work together on a common goal;
- Provide the organizational, institutional settings and mechanism for effective coordination and management; and
- Learn how to cooperate, gain experiences and build trust among all partners.

NACA will convene and coordinate two activities that will promote better collaboration between the different stakeholders in the National HIV/AIDS Response:

1. A quarterly M&E TWG meeting will serve as a platform for the exchange of information and experiences between stakeholders.
2. A Joint Annual Performance Review (JAPR) is an important process that needs to be put in place to enable systematic review of progress in the response. TORs for this review process have been drafted as part of the M&E Framework document. These TORs outline the review process, which consists of an initial technical review on key issues concerning implementation of the National HIV/AIDS Response. The results of the Technical Review feed into the main review involving GoN and all key stakeholders. The main review will bring together all the main stakeholders to discuss progress and the way forward, make recommendations and agree on annual milestones for implementation.

3.8 Levels of coordination for the national M&E plan

There are various levels of coordination for the national M&E plan which include:

3.8.1 National Coordination of the M&E Plan by NACA

NACA will convene bi-annual M&E coordination meetings to bring together key implementers of HIV/AIDS programs and the States to discuss the progress made in implementing the national M&E plan and to address whatever challenges that may have arisen during the implementation process.

3.8.2 State Coordination for M&E

State HIV/AIDS Coordinating Authorities are expected to develop their state specific M&E Plan and based on it hold quarterly coordination meetings for all implementing partners to harmonize and analyse the data collected, and discuss the progress made in implementing the national M&E plan and to address whatever challenges that may have arisen during the implementation process.

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

3.8.3 Development Partners Coordination for M&E

Donor support will be very important to ensure effective and efficient implementation of the M&E Plan. Most donors often require more information than is necessary for national level monitoring. However, a compromise needs to be reached between the three parties, donors, NACA and the implementers on an optimal set of data to be collected so that organizations are not overburdened

For effective implementation of this plan, specific States will be assigned to donors and implementing partners who will provide technical and financial support to the State to ensure full implementation of the NNRIMS Operational Plan in the States. The support, amongst other things will include capacity building, data collection, supervision, verification, analysis, reporting and submission to the National System.

3.8.4 Coordination across Sectors

NACA will facilitate wide stakeholder consultation across sectors. It will ensure complementarily and consistency with other M&E frameworks especially the Vision 2020 strategic Monitoring Action Plan, Health Sector plan, OVC Plan of Action and the Education Sector framework. It will utilize, as appropriate, internationally agreed indicators at the national level (such as the UNGASS indicator set) to facilitate contribution to regional and global statistics.

Each of the national level core indicators are assigned to a specific sector. For example, the Ministry of Health will have a prime responsibility for the indicators that relate to sero-surveillance and health facility based surveys, the Federal Ministry of Women Affairs and Social Development and its partners will have primary responsibility for the indicators that relate to OVC and the Ministry of Education and its partners will have primary responsibility for the indicators that relate to primary and secondary schools.

All these sectoral or thematic area plans need to be elaborated in detail, including specific indicators and targets, assessment of human and financial resources, training and equipment needs. Interventions and activities must be costed, and monitoring, supervision and quality assurance measures must be identified.

3.9 Coordination and Responsibilities at Sub National Levels

3.9.1 State Level

At State level the State Coordinating Authority will play a primary role in the planning of, implementation, and monitoring of activities. They will provide technical assistance to LGAs and communities in developing their responses and plans. They will be responsible for monitoring LGA HIV/AIDS Operational Plans and compile routine reports and forward them to NACA for further analysis and compilation. The SACA will be responsible for tracking and discussing progress and other issues related to the multi-sector HIV/AIDS responses at the sub-national level.

3.9.2 LGA and Community Level

Each Local Government Council will coordinate all actors working on HIV/AIDS in their respective local government areas. Local Action Committee on AIDS (LACA), the multi-sectoral HIV/AIDS committee at the LGA level, will consist of representatives from the major government sectors, civil society and the private sector. The LACA will be responsible for providing technical assistance to local level actors following guidelines developed by the state

and national levels on local level planning, implementing and monitoring of the HIV/ AIDS response.

CHAPTER FOUR

HIV/AIDS INDICATORS

4.0 HIV/AIDS Indicators

An indicator is a variable that measures one aspect of a program/project and is related to the program's goal and objectives. Indicators provide M&E information crucial for decision-making at every stage of program implementation. NACA, in collaboration with its stakeholders, has selected a set of 70 core national indicators to inform management of the national HIV/AIDS program. The breakdown of these core indicators consists of 46 routine indicators and 24 non-routine indicators. In addition, there are several donors that contribute both financially and technically to the national HIV/AIDS programs. These donors may require reporting of additional indicators that are not included in the core set.

Section 4.1 provides a comprehensive list of all of the core national indicators. In addition, refer to Appendix1 for a detailed matrix of indicators that includes information on the data source, frequency of collection and reporting, person/institution responsible for collection and reporting and baseline values.

Each level of the health system has different data needs. NNRIMS collects indicators that are relevant at the global, national, and sub-national levels.

A global indicator provides a measure of the current situation of the epidemic at the global level. In order for global indicators to be meaningful, all countries must agree on the exact indicator definition. They must also all measure the indicator in the same way so that the values are comparable across countries.

At the national level, the National HIV/AIDS Program has a set of indicators that are used to help track HIV response to the epidemic. These indicators are developed through national consensus and will track the progress made in the national response by partners. The indicators will provide relevant information that will inform future HIV/AIDS intervention plans, strategies and implementation. Many of these indicators overlap with the global ones.

However, sub-national/ program level indicators provide more detailed information so that planners can make decisions on how best to target the program or facility's scarce resources and to meet their clients' needs. They provide information on whether or not the target population is being reached, how well services are being provided, and whether or not sufficient resources exist to be able to provide adequate services.

4.0.1 Uses of Indicators:

Information is only good when it is used. Data that are not useful or that cannot be used should not be collected. Often, it is not that the data itself are useless, but more training is needed on how to use it effectively.

Global indicators can be used to:

- Set aspirational but realistic international health agendas
- Monitor the progress that is made towards reaching international long term targets
- Determine the optimal allocation of funds and other resources
- Comparative monitoring of country performance in HIV programming

National indicators can be used to inform decisions on:

- How well the national system is functioning, and where additional support is needed
- The progress and impact that is made by various HIV programs
- The impact of HIV and AIDS on development
- The level of donor commitment, and when high-level negotiations and changes are necessary

At the local level, indicators can provide information for managers and planners that will help to determine:
Identify priority target groups

- Effective and fairly determine the allocation of limited funds Determine the right types of targeted interventions and activities for a particular community
- Determine the barriers to accessing services

4.0.2 Selection of Indicators:

The focal programmatic areas in the National Strategic Framework can be categorized into - Care, Support and Treatment; HIV/AIDS prevention; HIV/AIDS mitigation; Monitoring, Evaluation and Research; and National Capacity Building. HIV/AIDS prevention and HIV/AIDS mitigation are discussed separately, reflecting the fact that as the HIV/AIDS epidemic matures, identifying strategies for mitigating individual and community impact of the disease becomes more and more critical.

At the programme level, each activity that is implemented by the different partners and stakeholders will have input, process and outcome indicators that can be used to monitor progress. Consequently, at this level there are very many indicators that individually contribute towards overall monitoring of different interventions. In order to facilitate monitoring at the national level by NACA, an attempt has been made to identify core indicators that can act as

proxy or direct measures for the achievement of the over arching NSF objectives. More detailed monitoring of programme performance will remain within the domain of the lead actors at the program level.

The selection of the national core indicators were made taking into consideration the following criteria:

- Measureable- the indicator is measureable
- Relevance of the indicator to priority national HIV/AIDS interventions according to the NSF 2010 – 2015
- Sensitivity of the indicator – ability of the indicator to detect change in the outcome
- Affordability – the indicator can be obtain from data that is already being collected and will not require input of substantial additional financial resources
- Usefulness – the indicator generates data that are useful for policy, program, resource and planning decisions.
- Ethics – the indicator can be obtained ethically, without harming individuals or institutions, and is free of bias.
- Repeatability – the indicator can be measured repeatedly across levels and over time and will generate results that are comparable.

- Validity-the indicator actually measures what is intended to be measured
- The indicator is representative of national and international commitments

The current availability of an indicator was not used as a selection criteria because at the present moment, there are no national level indicators already in place for care and mitigation and capacity building, and furthermore, other than the Federal Ministries of Health, Education and Women Affairs, no other national institution is currently engaged in national level monitoring. The indicators that are already available tend to be specific to projects and programmes, designed to monitor progress of programme implementation and reporting to donors. For example, the Multi-country AIDS Project (MAP), which is a World Bank funded project, indicators are specific to the project and much as it is a big project, it contributes also to the funds budgeted for the NSF. The PEPFAR project target for PMTCT is to increase availability of services to 80% of pregnant women by 2015 while the national target is to increase availability of services to all hospitals by 2015. There are other equally important players who have their own indicators and their interests have to be taken into consideration if the national response is to be monitored realistically.

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

The sections that follow outline the different programme areas under the four NSF objectives, the strategies and indicators. In the annex section, indicator reference pages are given which provide the precise definition of the indicator, the way the indicator is calculated, the frequency of generating the indicator, the responsible institution and the data limitations. A summary of the list of indicators is given at the end of this Chapter and in Appendix1.

4.1 Summary of National Indicators

The indicators listed below are used to monitor and evaluate the National Strategic Framework (NSF)

Table 2: Summary of the national indicators

Indicator No.	Type	Data Source	Indicators
PM1	Impact	Routine program	Percentage of infants born to HIV-infected mothers who are infected with HIV
PM2	Output	Routine Program	Percentage of HIV positive pregnant women who receive antiretroviral medicines to reduce the risk of mother-to-child transmission (according to the national guidelines) during the reporting period
PM3	Output	Routine Program	Percentage of pregnant women who received HIV counseling and testing, and received their test results during pregnancy, labour, delivery and the post-partum
PM4	Output	Routine Program	Percentage of infants born to HIV-infected women (HIV-exposed infants) receiving antiretroviral prophylaxis to reduce the risk for mother-to-child transmission
PM5	Output	Routine Program	Number of infants born to HIV-infected women, who were started on cotrimoxazole (CTX) prophylaxis
PM6	Output	Routine Program	Percentage of infants born to HIV-infected women, who received virological test for HIV within 2 months of birth
PM7	Output	Routine Program	Percentage of HIV infected pregnant women assessed for ART eligibility through either clinical staging or CD4 testing during the reporting period

INFECTION CONTROL MANAGEMENT			
ICM1	Output	Routine Program	Percentage of exposed persons provided with post-exposure prophylaxis (PEP)
HUMAN RESOURCES FOR HEALTH			
HRH1	Output	Routine Program	Number of health care workers who successfully completed an in-service training program within the reporting period according to national guideline
TREATMENT			
T1	Output	Routine Program	Percentage of HIV positive adults and children who are eligible and currently receiving ART
T2	Output	Routine Program	Percentage of adults and children enrolled in HIV care currently receiving CTX prophylaxis
T3	Output	Routine Program	Percentage of HIV-infected pregnant women receiving ART for their own health during the reporting period
T4	Output	Routine Program	Number of adults and children on ART a) newly enrolled b) ever started
T5	Outcome	Routine Program	Percentage of adults and children with HIV known to be on treatment 12, 24, 36, 48, 60 months after initiation of antiretroviral therapy

LAB (SYSTEM STRENGHTENING)			
LAB1	Output	Routine Program	Percentage of HIV reference laboratories that are accredited according to national standards
LAB2	Output	Routine Program	Number of health facilities that provide virological testing services (e.g. PCR) for infant diagnosis on site or through dried blood spots (DBS)
LAB3	Output	Routine Program	Number of facilities providing ART that use CD4 monitoring in line with national guidelines/policies, on site or through referral
HEALTH SYSTEM LEADERSHIP/GOVERNANCE			
HSG1	Output	Routine Program	Number of States with costed annual workplan derived from State Strategic Plan
HSG2	Output	Routine Program	Number of LGAs with costed annual workplan derived from State Strategic Plan
HEALTH SYSTEM STRENGTHENING SUB AREA 6 - HEALTH FINANCING			
HSF1	Output	Special Study	Total domestic and international AIDS spending by categories and financing sources out of total AIDS spending
HSF2	Output	Special Study	Percentage of total public expenditure (health, communication, education, defence)dedicated to HIV/AIDS
HEALTH SYSTEM STRENGTHENING SUB AREA 6 –MEDICAL PRODUCTS, VACCINES AND TECHNOLOGY			
HSM1	Output	Routine Program	Percentage of health facilities dispensing ARVs that experienced a stock-out of at least one required ARV in each quarter
HEALTH SYSTEM STRENGTHENING SUB AREA 6 –HEALTH SERVICE DELIVERY			
HSD1	Output	Routine Survey	Percentage of pregnant women MAKING AT LEAST 4 ANC visits according to the national protocol

HCT			
HCT1	Output	Routine Program	Percentage of women and men who received HIV C&T and received their results through HCT sites in the reporting period
HCT2	Output	Routine Program	Percentage of women and men with Sexually Transmitted Infection (STI) who received HCT and received their results in the reporting period
HCT3	Output	Population Based survey	Percentage of women and men aged 15 and above who received an HIV Counseling and testing in the last 12 months and who know their results
HCT4	Output	Survey	Percentage of most-at-risk populations (IDU, MSM, FSW) who received an HCT in the last 12 months and who know their results
HCT5	Output	Routine Program	Percentage of women and men who tested positive for HIV during the reporting period
HCT6	Output	Routine Program	Number of facility that experienced a stock-out of any test kits during the reporting period
HCT7	Impact	Population Based survey	HIV Prevalence in the general population
HCT8	Impact	Population based survey	Percentage of young women and men aged 15-24 who are HIV infected

ORPHANS AND VULNERABLE CHILDREN(OVC)			
OVC1	Outcome	Routine Program	Percentage (number) of vulnerable children with improved wellbeing per a standardized instrument (Child Status Index-CSI) as related to the service areas
OVC2	Output	Routine Program	Number of vulnerable children provided with social services
OVC3	Impact	National Household survey	Ratio of school attendance of orphans to school attendance of non-orphans aged 10-14 years
OVC4	Output	National household survey	Percentage of orphans and vulnerable children whose households received free basic external support in caring for the child
OVC5	Output	Routine Program	Number of organizations and agencies that provide services to OVC demonstrating at least one score improvement in at least one area of capacity building, as measured by a OVC national tool

TB/HIV			
TB/HIV1	Output	Routine Program	Percentage of estimated HIV-positive incident TB cases that received treatment for TB and HIV
TB/HIV2	Output	Routine Program	Percentage of HIV-positive patients who were screened for TB in HIV care or treatment settings
TB/HIV3	Output	Routine Program	Percentage of TB patients Screened for HIV in TB care or treatment settings.
TB/HIV4	Output	Routine Program	Number of HIV patients currently in care who commenced TB Treatment
TB/HIV5	Output	Routine Program	Number of patients newly enrolled into HIV care and are given treatment for latent TB infection (isoniazid preventive therapy)

SEXUAL BEHAVIOUR CHANGE			
SBC1	Outcome	National Household survey	Percentage of young women and men who have had sexual intercourse before the age of 15
SBC2	Output	Routine Program	Percentage of schools that provided life skills-based HIV education within the last academic year (yearly)
SBC3	Output	Routine Program	Percentage of schools implementing FLHE curriculum
SBC4	Output	Routine Program	Percentage of People Living with HIV/AIDS (PLWHA) reached with individual and/or small group level minimum prevention package (MPP) interventions
SBC5	Output	Routine Program	Percentage of MARPs reached with individual and/or small group level MPP interventions
SBC6	Outcome	National Household survey	Percentage of people aged 15-24 who correctly identify ways of preventing the sexual transmission of HIV and who reject major misconceptions about HIV transmission

SBC7	Outcome	National House hold survey	Percentage of women and men aged 15–49 who have had more than one sexual partner in the last 12 months reporting the use of a condom during their last sexual intercourse
SBC8	Outcome	National House hold survey	Percentage of respondents aged 15–49 who have had sexual intercourse with more than one partner in the last 12 months
SBC9	Outcome	Survey	Percentage of males reporting the use of a condom the last time they had anal sex with a male partner
SBC10	Outcome	Survey	Percentage of female sex workers reporting the use of a condom with their last client
SBC11	Outcome	Survey	Percentage of injecting drug users reporting the use of a condom the last time they had sexual intercourse
SBC12	Outcome	Population based survey	Percentage of men aged 15-64 reporting sex with a sex worker in the last 12 months who used a condom during last sexual intercourse
SBC13	Outcome	Survey	Percentage of most-at-risk populations who both correctly identify ways of preventing the sexual transmission of HIV and who reject major misconceptions about HIV transmission
SBC14	Outcome	National Household survey	Percentage of women and men aged 15-49 who have had sex with a non-marital, non-cohabiting sexual partner in the last 12 month
SBC15	Outcome	Survey	Percentage of most-at-risk populations (IDU, MSM, FSW) who received an HIV test in the last 12 months and who know their results
SBC16	Impact	Survey	Percentage of most-at-risk populations (IDU, MSM, FSW) who are HIV positive
SBC17	Output	Routine Program	Number of high risk groups (female sex workers) reached with HIV/AIDS prevention programs.
SBC18	Output	Routine Program	Number of states with anti-stigma and discrimination law

WORKPLACE			
WP1	Outcome	National workplace survey	Percentage of enterprises with an HIV/AIDS workplace policy and implementing programs according to the minimum prevention package
WP2	Outcome	National workplace survey	Percentage of MDAs with HIV/AIDS workplace policy and implementing an HIV/AIDS workplace program (prevention/care and support/treatment)

INJECTION SAFETY			
IS1	Outcome	Survey	Percentage of injecting drug users reporting the use of sterile injecting equipment the last time they injected

BLOOD SAFETY			
BS1	Outcome	Routine Program	Percentage of donated blood units screened for HIV according to National guidelines

CARE AND SUPPORT			
CS1	Output	Routine program	Number of people living with HIV and people affected with HIV/AIDS provided with a minimum of one clinical care service (PLWH, PABA)
CS2	Output	Routine program	Number of adult and children enrolled in HIV care: (a) new and (b) current (c) ever enrolled in the facility.
CS3	Output	Routine program	Number of People Living with HIV/AIDS (PLHIV) receiving home based care
CS4	output	Routine program	Number of People Living with HIV/AIDS (PLHIV) receiving Adherence Support

GENDER			
G1	Output	Routine program	Number of male and female reached by an individual, small-group, or community-level intervention or service that explicitly addresses the legal rights and protection of women and girls impacted by HIV/AIDS

OTHER			
OT1	Outcome	Special study	National Composite Policy Index

CHAPTER FIVE

DATA COLLECTION PLAN

5.0 Data Collection Plan

Data for National indicators will be obtained from two main sources:

5.1 Routine Data Sources

Routine data sources provide data that are collected on a continuous basis, such as information that clinics collect on the patients utilizing their services. Although these data are collected continuously with patient encounters, processing, aggregation and reporting on the data usually takes place on a monthly or quarterly basis.

- Data collection from routine sources is useful because it provides information on a timely basis compared to non-routine sources. Since it is available more frequently, routine data can be used effectively to detect and correct problems in service delivery.
- However, it can be difficult to obtain accurate estimates of catchment areas or target populations through this method, and the quality of the data may be poor because of inaccurate record keeping or incomplete reporting.

5.1.1 Health Information System

Currently, healthcare delivery in Nigeria is a three-tier system with Federal and State Government owned tertiary hospitals and Specialist centres providing patients' management, teaching and carrying out research. Other levels of service delivery are General Hospital and Primary Health Centres. Data from these service delivery levels are aggregated on paper-based forms and sent directly to the implementing partners and sub-national levels e.g. L.GA and States. HIV/AIDS thematic areas (ART, PMTCT and HCT) has its own MIS housed in Federal Ministry of Health that collects data that is fed into the NNRIMS.

5.1.2 Prevention of Mother to Child Transmission (PMTCT)

Between 2002 and 2004, FMoH with support from partners identified a number of indicators required to facilitate tracking of the status of the PMTCT program. Several data collection tools including registers and summary forms along with the instruction manual were produced. Furthermore, a computerized Management Information System (MIS) and a comprehensive training curriculum for PMTCT data collection and reporting were developed in 2004.

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

5.1.2.1 PMTCT Data collection and reporting tools

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

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

The first three registers highlighted above, collect pre-delivery data, the labor and delivery register collects information pertaining to delivery related PMTCT services and the last two provide post-delivery information.
The system also includes a number of summary forms for monthly collection of data that is sent to Ministry of Health for collation and analysis. The PMTCT facility tools will supply data needed to complete the PMTCT component of the NNRIMS Monthly Summary Form.

5.1.3 Anti-Retroviral Treatment (ART)

The ART program began in 2002 with a plan to provide ART for 15, 000 persons. At that time no M&E system was in place. In 2004 with support from partners, FMoH developed a Patient Management and Monitoring System for ART program monitoring and evaluation.
Patient management and monitoring tools (PMM)contains information such as patient demographic and services obtained such as information on diagnostic procedures, discharge diagnoses; admission, antenatal, postnatal, child health, drug given, adverse effects, family planning and workload information within the hospital system.

Frequency of Data Collection and Reporting:
The facility data are collected on daily basis and aggregated into the monthly summary form and sent to the state Ministry of Health who complete the State HIV/AIDS Summary Report. It is sent on quarterly basis to the SKM Directorate of NACA and Strategic Information Division of NASCP, FMoH.

5.1.3.1 ART Data collection and reporting tools

These include:

- HIV/AIDS Care Card
- PMM forms including: Adult initial clinical evaluation form; Pediatric initial clinical evaluation form; Laboratory request and result forms; Pharmacy tools (daily worksheet and monthly worksheets); and Adherence support tools
- Pre-ART register
- ART register
- ART monthly summary forms
- Cohort analysis forms

Data from the registers are aggregated on a monthly basis into the ART Monthly Summary Forms, which are transmitted through LGAs to State and National levels.

5.1.4 HIV Counselling and Testing (HCT)

Data on HCT service provision is captured through the HCT MIS. The HCT program has developed registers for capturing relevant data on service provision.

5.1.4.1 HCT Data Collection and Reporting tools

The following tools are used to monitor and report on HCT:-

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

5.1.4.2 Combined Report-Requisition and Issue Form - HIV Test Kits

- HIV Testing Worksheet
- HCT Monthly Summary Forms

5.1.5 Orphans and Vulnerable children (OVC)

Activities targeting orphans and vulnerable children are coordinated by the Federal Ministry of Women Affairs and Social Development. Examples of programs in this area include:

- HIV/AIDS awareness creation targeted at women and girl children awareness of socio-cultural issues that put females at risk and its mainstreaming into all facets of the country's HIV response

- Women empowerment programs targeted at improving their lives and the sexual choices they have at their disposal Care and support for OVC through the provision of comprehensive services according to the national guidelines

5.1.5.1 OVC data collection and reporting tools

- OVC Register
- Initial OVC Assessment forms
- OVC Enrolment form
- Household Assessment form
- OVC Termination form

5.2 Non-routine Data Sources

Non-routine data sources provide data that are collected on a periodic basis, usually annually or biennially.

- Using non-routine data avoids the problem of incorrectly estimating the target population when calculating coverage indicators
- Non-routine data have two main limitations: collecting them is often expensive, and this collection is done on an irregular basis. In order to make informed program decisions, program managers usually need to receive data at more frequent intervals than non-routine data can accommodate.

5.2.1 Sentinel Surveillance of ANC and STI Clinic Attendees

Sentinel surveillance data is based on antenatal clinics attendees who are women of child bearing age (15-49 years). The sentinel sites will be expanded to target more regions of the country and different population groups to help generate estimates of HIV prevalence that are nationally representative.

The overall purpose of the HIV sentinel surveillance system is to monitor the trends in HIV prevalence in the country.
At the level of the health centre, a rapid test is applied or in some cases, the blood sample is sent to a testing site. Positive rapid tests are then confirmed with ELISA method at a reference or state laboratory, if there is no referral laboratory in the state or zone, positive rapid test are confirmed at the National Public Health Laboratory.

What does the National M&E System need from this data source?

- HIV prevalence among ANC attendees aged 15-24 years
- HIV prevalence among 15-49 year olds

Frequency of Data Collection and Reporting:

Sentinel surveillance involves testing women who attend ANC typically between April and September of that year. This information is collected every 2-3 years.

5.2.2 Periodic Surveys (NARHS, NDHS and MICS)

The National HIV/AIDS and Reproductive Health Survey (NARHS) and other periodic surveys (NDHS and MICS) are population-based surveys conducted every 5 years. The last NARHS was conducted in 2007 and the next one is scheduled to be conducted in 2012. The target groups in NARHS are women of reproductive age (15-49 years) and men aged 15-64 years. The survey obtains information on the knowledge, behaviour and practices related to the prevention and transmission of HIV and other STIs. Serological testing to estimate HIV prevalence has been incorporated into the NARHS since 2007.

These surveys provide national level measures of outcome indicators and focus on partner reduction, consistent use of condoms in regular and non-regular partnerships, delay of sexual activity among young persons, myths, stigma and discrimination and appropriate practices regarding STI/HIV/AIDS, knowledge and awareness of STI, and condom accessibility.

What does the National M&E System need from this data source?

- Percentage of sexually active youth (15-24 years) reporting using a condom at last sex act
- Percentage of people aged 15-49 years who reported using a condom at last sex with a non-regular partner
- Percentage of people that use condoms during intercourse with non-regular partner (disaggregated by sex and age) in the past 12 months.
- Percentage of young women and men aged 15-24 who had sex with a non-marital, non-cohabiting sexual partner in the last 12 months
- Percentage aged 15-49 years who reported having sex with multiple partners in the last 12 months
- Female and male median age at first sex
- Percentage of young women and men aged 15-24 who both correctly identify ways of preventing the sexual transmission of HIV and who reject major misconceptions about HIV transmission

- Percentage of people aged 15-49 years expressing accepting attitudes towards people with HIV/AIDS
- Prevalence of HIV in the general population

5.2.3 Integrated Biological and Behavioural Surveillance Survey (IBBSS)

These surveys provide national level measures of outcome indicators and prevalence in high risk groups such as IDUs, MSMs and CSWs. They focus on use of condoms with regular and non-regular partners, myths and appropriate practices with regards to STI/HIV/AIDS, exposure to interventions, and other high risk behaviours such as substance abuse. It also includes collection of serological samples for HIV testing to determine the prevalence amongst MARPS. The last round of IBBSS was conducted in 2010. The results are planned to be released in 2011. This survey is conducted every 2 – 3 years.

What does the National M&E System need from this data source?

MSM:

- Percentage of MSM who are HIV infected
- Percentage of MSM reporting using a condom at last sex act

FSW:

- Percentage of FSWs who are HIV infected
- Percentage of FSWs reporting using a condom at last sex act with client (paying partner)
- Percentage of FSWs reporting using a condom at last sex act with non-paying partner

IDUs

- Percentage of IDUs who are HIV infected
- Percentage of injecting drug users reporting the use of a condom the last time they had sexual intercourse
- Percentage of injecting drug users reporting the use of sterile injecting equipment the last time they injected other key populations (Transport workers, Armed forces, police)
- Percentage of MARPs reached with individual and/or small group level MPP interventions

5.2.4 Second Generation Surveillance System

HIV surveillance systems track HIV infection or other biological markers of risk such as STIs. Since HIV infection among adults must be preceded by one of a limited number of behaviours, such as unprotected sex with an infected partner or injection with contaminated needles, if these behaviours change, there will be a change in the spread of HIV. Second generation surveillance

systems monitor risky behaviours, using them as early warning signs and to explain dynamics of the epidemic. Thus, second generation surveillance uses data from behavioural surveillance to interpret data gathered from sero-surveillance efforts (UNAIDS 2000) and generate hypotheses. Nigeria's second generation surveillance system needs to be tailored to the dynamics of the epidemic. There are some second generation surveillance opportunities in the country such as HIV data triangulation conducted in 2009 on sexual transmission prevention of HIV to provide decision makers with data on the trend and magnitude of the epidemic, and indications about the effectiveness of national response. Other second generation surveillance analyses conducted in Nigeria recently include Epidemiology, Response and Policy Synthesis (ERPS) at national and state levels, and Mode of Transmission (MOT) analysis.

5.3 Other Data Sources

There are other routine data sources that are at various stages of development. Many of these data sources are managed outside of the Ministry of Health and may even be outside of the health sector, but provide valuable information for the overall HIV/AIDS M&E system. Such data sources include routine data tools for programs such as Behavior Change Communication, Home Based Care, HIV/TB Collaboration, Laboratory Services, HIV Workplace Response, and Family Life HIV/AIDS Education.

Table 3: Other data sources outside the health sector

Data Source	Development Status	Frequency of Reporting	Responsible Organization
Military HIV/AIDS data base (Ministry of Defence)	completed	Quarterly	DoD, AFPAC
OVC Database	Ongoing	Quarterly	FMWASD
National Blood Transmission Service & Public Health Lab	completed	Quarterly report of number of HIV tests by group: • Risk category • ANC • STI • Outreach • Hospital • Region • Sex • Age	NBTS/FMoH

TB Records	completed	*Quarterly*	*NTBLCP/FMoH*
Prevention Intervention Tracking Tool (PITT)	completed	Information comes from NGOs/CSOs to the appropriate Line Ministry Coordinator and to SKM Division of NACA	NACA

In addition to the specific instruments and methodologies listed above, the NACA SKM will access additional data sources and implement other data collection activities over the next few years to obtain data that are not covered by any of the above tools.

Some of these data sources include the following:

5.3.1 Health Facility Assessment

The objective of Health Facility Assessment (HFA) is to determine whether the health centres and hospitals are capable of providing quality HIV/AIDS and STI services, and if not, what materials, equipment and training will be needed to fulfil this goal.

The specific objectives of the HFA are:

- Establish whether the health facilities have the necessary infrastructure and equipment to deliver quality services; such as counselling materials and protocols, testing kits, IEC and job-aids;
- Establish the clinical and management skills of health care personnel;
- Coordinate efforts with other health services and private practitioners

The HFA will provide information on the following indicators:

- Percentage of health care facilities currently stocked with ARV according to national protocol and reporting no stock-outs in the last 3 months
- Percentage of women and men with STIs at health care facilities who are appropriately diagnosed, treated and counselled.
- Percentage of public sector clinicians managing OIs in adult AIDS patients according to national guidelines
- Percentage of health facilities surveyed that practice proper waste management and ways to reduce occupational exposures

5.3.2 Workplace survey

Workplace surveys are conducted to collect data on workplace HIV/AIDS programs, knowledge and behaviours of workers concerning HIV/AIDS, employees' participation in HIV/AIDS

activities and small medium enterprises (SME)/Ministries' participation in workplace policy on HIV/AIDS.

5.3.3 Data triangulation and secondary data analysis

There was a national data triangulation project in 2009 which focused on sexual transmission of HIV and prevention efforts. The study used available multiple data sources in the country to generate evidence capable of informing new programs, policy and research. In addition, there have been several secondary data analyses in the country using the NARHS, ANC and IBBSS data to assist in the reporting of UNGASS, Universal Access, and in having deeper understanding of national or state level indicators that were not contained in the primary survey report.

5.4 National HIV/AIDS Data Flow

Health facilities collect data on a daily basis with forms and registers specially designed for each program intervention. The LGA M&E HIV/AIDS focal person collects data on a monthly basis from the facilities. The LGA focal persons collate the information from all LGA health facilities and sends summary tables to the SMoH (SASCP), also on a monthly basis. The SMoH (SASCP) collates the information from all the LGAs and on a quarterly basis, sends the summary data to NASCP and gives a copy to SACA who forwards a copy to NACA. NASCP then collates the health sector data from all States and shares the information with NACA and Department of Health Planning and Research (DPRS) of the FMoH, on a quarterly basis.

The information collected will be used at LGA, State and National levels to plan strategies and activities for improving various HIV/AIDS programs. It is the responsibility of NACA to collate information on the core indicators of the multi-sectoral national response on HIV/AIDS. The data flow for other non health sector indicators coordinated by FMOE and FMWASD follow a similar structure.

National M&E systems typically focus on data collection and reporting to national leaders and international donors. This can lead to missed opportunities for feedback to states and local programs. Similarly, local data are reported up to the national program, but are not used locally. Higher level information may not be reported back to the local level, and local data are not assessed in a broader context. These missed opportunities may prevent local programs from making simple mid-course corrections that could positively impact the health of their communities. Additionally, if information is not presented back in a manner that can be used by local programs, there is little incentive to report quality data in a timely manner.

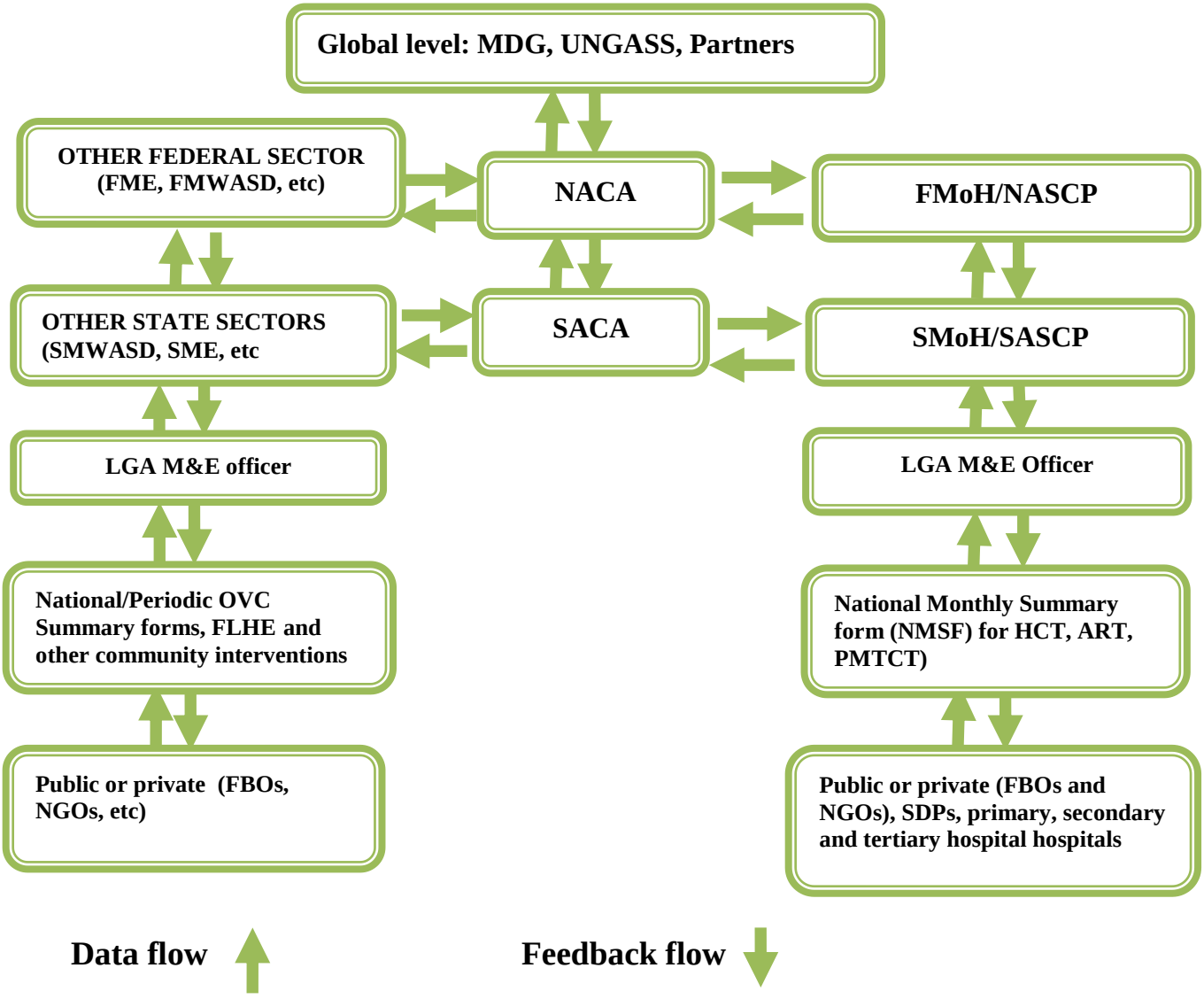
Below is a diagram of the data flow of the National M&E system that was developed for the 2011 - 2016 NNRIMS-II. In the past year, the strengthening of the M&E TWG, and additional technological advances, such as efficient management of the NACA website have improved the

ability to provide information back to the local level, although more work need to be done in the future.

5.5 Data Flow Chart

The figure 6 below shows the flow of data from facility, NGOs and Line Ministries to NACA. This is eventually made available to the NACA board for decision making. Similarly, there is a feedback from NACA to the Line Ministries.

Figure 6: National data flow chart for health and non-health sector



5.6 Data Quality Issues

Data are most useful when they are of high quality. Therefore data quality needs to be monitored and maintained throughout the data collection process. However, obtaining data of the highest

quality has cost implications and often times may not be feasible in which case decisions have to be made to determine what level of quality is adequate.

To ensure high quality data the following strategies will be utilized:

- Data cleaning at all levels of data entry
- Regular supportive supervision and data verification using standardized checklists
- Periodic update and capacity building of data managers and personnel with data management roles
- Establishment of an information feedback mechanism
- Periodic review of data quality issues by all stakeholders.

For each data set, the following data quality issues should be considered:

- ***Completeness:*** Are data complete? If not, what is missing? Could missing data be easily obtained? What changes could be made to the system to solve this problem?
- ***Accuracy****:* Do the data collection instruments that are being used result in valid and reliable data?
- ***Duplication****:* Is there a threat of duplication or double counting when services, beneficiaries, etc. are counted? What mechanism is in place to control for this?
- ***Frequency:*** Is the frequency of data collection appropriate?? For example, while the national program may only need data annually, how often do state and LGA programs need data?
- ***Reporting Schedule:*** Do the available data reflect the time periods of interest? How are data needs for different reporting schedules reconciled (for example, data needs for the Nigerian Government Calendar Year, US Federal Fiscal Year etc.)
- ***Accessibility:*** Are data easily accessible and retrievable? If not, what are the barriers?
- ***Power:*** Is the sample size large enough to provide a reasonable estimate or detect change?

5.7 Interoperability of the database

The M&E framework requires the capture and storage of a wide range of data that are needed to monitor the results of the initiatives undertaken as part of the national response. Because of the breadth and volume of data that are being collected, a database is required to enter, verify, store and analyze service coverage M&E data from service delivery points. Without a database, data collection, verification and analysis is unlikely to happen since ministries and other public agencies are rarely equipped to manage such a process. The monitoring and evaluation framework will include a national database that will collect all that data that are required to be reported for national and international purposes. Furthermore, since there are existing databases for various HIV/AIDS programs, the framework will outline protocols to ensure that the various

databases currently in use as well as future databases are interoperable with the national database in order to reduce redundancy, and at the same time, leverage resources.

CHAPTER SIX

DATA DISSEMINATION AND INFORMATION USE

6.0 Information Products

The National Agency for the Control of AIDS is responsible for the compilation, management and dissemination of all data collected through the national HIV/AIDS M&E system and sub-systems. NACA will serve as the clearing agency for all national multi-sectoral HIV/AIDS data and maintain functional reporting relationships with the National Bureau of Statistics, National Planning Commission and global HIV/AIDS organizations.

NACA is responsible for the following periodic information products:

- Bi-annual Service Coverage Report and fact sheets
- Annual HIV/AIDS M&E Report
- Biennial UNGASS Report
- Biennial Triangulated Analysis Report
- NACA Quarterly Report and Newsletter
- Directory of SDPs on HIV/AIDS
- Evaluation/Review Reports
- Updated Bibliography of HIV/AIDS Research

The following section provides a brief description of each periodic information product:

A. Service Coverage Report (SCR)

The SKM Directorate in NACA is responsible for producing a routine quarterly Service Coverage Report (SCR) that contains information on the key HIV/AIDS program areas. The reports are prepared by the SKM unit based on information that is submitted to NACA by states, NASCP, other sectors and implementing partners. The report presents service coverage statistics including up-to-date cumulative data and results from previous periods to enable trend analysis of indicators. In addition to an analysis of the data, the report also contains key conclusions and recommendations. The report is compiled on a quarterly basis within the month after the end of the period under review. Prior to releasing the final report, NACA first submits a draft to the M&E TWG for their comments and inputs. NACA SKM thereafter finalizes the report and disseminates at the national, state and LGA levels. The report is designed to provide government stakeholders, implementing partners and donor organizations with up-to-date information on the outputs of key interventions and the gaps that may exist in service access or coverage so stakeholders have the information they need to optimize resource allocation and utilization decisions.

B. Annual HIV/AIDS M&E Report

The annual HIV/AIDS M&E report contains data for all indicators in the national HIV/AIDS M&E Framework and provides a comprehensive overview of the response to HIV/AIDS in Nigeria. The format of the report was developed to meet the information needs of stakeholders. The NACA SKM Department is responsible for compiling the report annually and may ask for support from partners as needed. The report is prepared during the first quarter of each year, and is available for dissemination by the end of April. The report will be used to inform the national response annual work planning and budgeting process. The report will also serve as an annual review of the implementation of the NSF.

C. Biennial UNGASS Report

Nigeria is a signatory to the 2001 Declaration of Commitment on HIV/AIDS from the United Nations General Assembly Special Session on HIV/AIDS (UNGASS). This Declaration of Commitment includes a set of indicators that all signatory countries, including Nigeria, have agreed to report on to UNAIDS on a biennial basis. All UNGASS indicators are included in the national HIV/AIDS M&E Indicator matrix.

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

- National AIDS Spending Assessment
- National Composite Policy Index (NCPI) questionnaire.
- School-based survey and education program review.
- Workplace survey.
- PMTCT and ARV program monitoring and estimates from NASCP.
- Population-based surveys.
- HIV sentinel surveillance from antenatal clinics.

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

validation; and finalization of desired changes by NACA's SKM Director, who will then send the report for publication and dissemination to relevant stakeholders at Federal and State levels.

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

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

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

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

It is anticipated that analytical syntheses of the Nigerian National Response to the HIV/AIDS epidemic will be carried out every two years. The report of the triangulated analysis will be forwarded to the M&E TWG for further review and inferences. Following this review, NACA will commence the publication, communication and

dissemination of the triangulated report. It will be disseminated to all relevant stakeholders including policy and decision makers at National and State levels.

E. NACA Quarterly newsletter

The NACA Newsletter shall be a quarterly publication in both hard and electronic copies (posted on NACA website) containing summaries of national program implementation, updates on key indicators and relevant information on HIV/AIDS issues within the reporting period. The newsletter shall provide information to all stakeholders in the national response to HIV/AIDS in Nigeria as well as the general public. To maximize its relevance, the newsletter will be written and presented in a manner that can be easily understood by all stakeholders including non-professional audiences.

The content may include:

- Key results and conclusions from relevant surveys
- Successes and lessons learned from on-going projects and activities
- Case studies, personal testimonies and opinions

The target of the newsletter will be different partners and stakeholders. It will form part of the documents that are disseminated every quarter at the HIV/AIDS feedback workshops, organized at Federal and State levels. This product will be produced by NACA's Communication/Documentation Unit in collaboration with the SKM Department.

The Strategic Knowledge Management Department will also produce a Quarterly PowerPoint presentation highlighting the content of this newsletter in presentation form to aid its use during meetings, workshops and other events.

6.1 Fora for Data Use and Dissemination

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

- Nigerian HIV/AIDS Conference
- International Conferences on HIV and AIDS
- NACA Governing Board meeting
- Development Partners' Group meeting
- National AIDS Council
- State level HIV/AIDS feedback meetings

- Expanded Theme Group Meetings
- M&E Technical Working Group Meeting

Following is a brief overview of these fora for data use and dissemination.

1) Nigerian HIV/AIDS Conference

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

2) International Conferences on HIV and AIDS

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

3) NACA Board Meeting

NACA Board Meetings are chaired by the Board Chair and bring together Board members once every quarter to review evidence detailing the trajectory of the HIV epidemic in Nigeria, the combined response, current priorities and provide oversight and guidance to the national response. The board is the highest decision making body for NACA. Its functions include among others; to provide leadership and advocacy for the prevention and control of HIV/AIDS scourge in Nigeria. To effectively carryout this function, the board requires evidenced based information.

4) National AIDS Council Meeting

At least once a year, NACA and SACA management and program staff meet to review program implementation progress within each state based on available input, output and outcome data. During the meeting, data are used to highlight recent successes, current challenges, and discussions are held to identify actions, resources and key

stakeholders. Implementing Partners and other major stakeholders participate in the technical sessions at these meetings.

5) State level HIV/AIDS Biannual Review Meeting

Once every six months, SACA and LACA stakeholders within each state shall meet to review progress made within their state towards the attainment of HIV/AIDS targets contained in their strategic plans. This meeting is designed to improve the way HIV/AIDS policies/programs are planned and implemented at the state level; ensuring that the response provided meets the needs of those affected by and/or living with the virus; expand public awareness and support for the state response; provide feedback on the programmatic efforts, resultant progress and challenges.

In addition, the meeting is to provide feedback on resource utilization in the state response to enhance better program coordination. It promotes interaction among stakeholders to assess and disseminate M&E outcomes; maximize the opportunity to advocate for the use of M&E results for decision making.

6) Development Partners' Group Meetings

The Development Partners' Group meets quarterly. The meeting serves as an opportunity for high-level representatives from major donor agencies to review progress in combating HIV/AIDS, to coordinate planning and the efficient allocation of resources. Data from the national M&E system is used at these meetings to facilitate evidence-based decision making and increase commitment. The secretariat of the group is in the UN and the meeting is rotated amongst the members.

The development partner group is a forum that brings together bilateral and multilateral organizations involved with HIV/AIDS activities in the country. In this meeting, the different organizations give an update of their various activities. This helps to avoid duplication of efforts, improve efficient allocation of resources in joint response efforts and contribute towards the achievement of the HIV Strategic Plan objectives at national and state levels.

7) Expanded Theme Group Meetings

The national Expanded Theme Group (ETG) is a structure charged with the provision of technical and policy guidance to NACA. The group was also set up to improve coordination of HIV/AIDS activities in the country. It is chaired by NACA and co-chaired by the UN Theme Group. The ETG meets quarterly and consists of technical stakeholders which include the UN system, Donors, Civil Society, PLHWA, private and public sectors, the Country Coordinating Mechanism for the Global Fund, professional bodies, research institutions and the academia. During the meeting data

from routine management information systems are used to discuss progress, identify opportunities and improve coordination of the response.

The meeting also functions as a stakeholders' forum for technical discussions, decision making and review of progress on alignment and harmonization. The ETG plays a major role in monitoring and evaluation of the national response, and the discussions and decisions made during the meeting lead to financial and technical commitments for the implementation of future M&E activities.

8) M&E Technical Working Group Meetings

The national HIV/AIDS M&E Technical Working Group is made up of focal persons from government departments, non-governmental organizations, the private sector, donor agencies, UN agencies, and coordinating bodies involved in HIV/AIDS prevention, treatment, care, and support programs. It is convened by NACA on a quarterly basis where topical M&E issues are discussed, presentations delivered on research and other initiatives, and technical input is received for national M&E design and implementation.

The overall objectives of the M&E technical working group are to:

- Assist in the development of a multi-year and multi-sectoral costed annual work plans;
- Coordinate M&E activities of stakeholders and implementing partners;
- Assist in the harmonization of tools;
- Provide opportunities for sharing of information and lessons learned among stakeholders;
- Establish closer working relationships with the Government of Nigeria (GON) and other donor agencies; and
- Provide support for the "Three Ones".

9) Mechanism for Data Dissemination

The following will provide opportunity to disseminate progress, lessons learned to various stakeholders and enhance evidence base decision making by policy makers and program managers. It will also inform the general public on HIV response activities.

10) National HIV/AIDS Resource Centre

The National HIV/AIDS Resource Centre (NHRC) is a platform to generate, share and use strategic information by all stakeholders within the HIV/AIDS National Response. It will provide evidence to the governance responsibility of NACA and SACA, and contribute to strengthening their stewardship role. Likewise, it will serve as a one point source of authentic, appropriate and viable information in different

contents and categories for all HIV/AIDS topics. It would build a comprehensive data base of information generated in Nigeria in the area of HIV/AIDS and allied areas to facilitate its easy online access and use by the administrators, policy makers, research scholars, health care professionals, programme personnel and the general public. The center will run as an online virtual network with search engines housing research outcome, reports and training manual as well as tools.

The NHRC will provide a new, efficient and cost-effective channel for generating, accessing, sharing and disseminating research, best practices, methodologies and innovative ideas by all stakeholders in HIV/AIDS prevention, treatment, care and support.

The NHRC will serve two main functions: first act as a clearinghouse and repository of national and state level information on HIV/AIDS; and second to serve as a virtual focal point and channel for best practices and resources on conducting effective M&E and operations research.

The central clearinghouse and virtual network will support an online, searchable database of information including research outcomes; inventory of tools developed by researchers; a compendium of bilateral organizations, funders and implementing partners; training manuals and resources; operational plans; and reports that can be accessed by all stakeholders.

The virtual NHRC will be a key tool for strengthening NACA's ability to manage information as well as create a community of practice around M&E and operations research. This latter function will build capacity of state-level practitioners and program managers while providing information on cost-effective approaches and programme impact.

11) NACA's website

All M&E reports produced by NACA (including the Annual HIV/AIDS M&E report, Service Coverage Report and the UNGASS report) will be available on the NACA's web portal for electronic download (in PDF and/or MS Word format). This will ensure that HIV/AIDS stakeholders and concerned members of the general public have access to up-to-date information and statistics. All HIV/AIDS indicator data will be updated in the NACA database when new data becomes available. The website will also be used to disseminate the following:

News and Events – Events are always organised with the objective of reducing the impact of HIV/AIDS in Nigeria. These are packaged into event news for publication on the NACA website

Research – HIV/AIDS research in the local and international arena becomes available from time-to-time. Members of the academia, HIV/AIDS researchers, media people and interested members of the public could access these resources on the website.

Reports – Activity reports are published on the NACA web platform. Report types that get published include:

- Meetings
- Lectures, symposia, colloquiums
- Local and international conferences
- Visits
- Funding and financial reports
- Partners' activities

HIV/AIDS Data – HIV and AIDS statistics of general interest (including prevalence and incidence rate disaggregated by age, gender and geographic spread) are accessible through the Agency's website.

HIV/AIDS Services – HIV and AIDS services information such as facilities and types of services offered are put on display via the website for public consumption.

6.2 Guidelines for the Review and Update of the National M&E Plan

It has been acknowledged that due to the changing nature of the epidemic in Nigeria and due to new research and technologies, the monitoring and evaluation of HIV/AIDS response is a dynamic field. To keep abreast of these developments, the National M&E Plan will be formally reviewed on a biennial basis by the Monitoring and Evaluation Technical Working Group (TWG). However, on-going assessments and suggestions for modifications may become evident during the course of a strategic planning year, requiring more immediate attention and adjustments of the framework.

1. The overall M&E Operational Plan, including the actual indicators, should be reviewed within 60 days of the annual review of the National HIV/AIDS Strategic Framework or within 90 days of the development of a New National HIV/AIDS Strategic Framework;

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

3. Should new information products be required, these may be added to the current list of information products The NACA work plan and operational budget may be adjusted annually when the work plan and budget for the next fiscal year is prepared; and/or

4. If the NSF is not reviewed within the next two years, this M&E plan should be reviewed in 2014.

CHAPTER SEVEN

OPERATIONALIZATION OF THE NNRIMS OPERATIONAL PLAN

This operationalization of the NOP11 will be based on the experience and lessons learned from the NOP 1. The requirement for effective operationalizaion of the NOP11 will include the following:

7.0 Resource mobilization and funding

The National Strategic Framework (NSF) identified strengthening of the Monitoring and Evaluation system as one of the priority areas for focus and funding. Resource mobilization is necessary for effective national monitoring and evaluation. The national HIV/AIDS response has in the last couple of years attracted resources from a wide range of stakeholders such as the Federal and State Governments, Development Partners, the private sector, PEPFAR, the Global Fund, United Nations Systems and a host of others. The coordination of monitoring and evaluation of HIV/AIDS programs generally rests with the National Agency for the Control of HIV/AIDS at the national level and with SACAs, LACAs, line ministries and CSOs at various levels and sectors. M&E units have already been established in most of these levels and sectors of implementation and coordination.

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

In 2006, it was estimated that most HIV/AIDS programming activities in Nigeria spent only 1.0 per cent of the entire program cost on Monitoring and Evaluation. Since a good M&E system is crucial to ensuring resources are well used, it is recommended that about 10 per cent of the National HIV/AIDS budget be used for monitoring and evaluation activities, not including the cost of periodic surveillance of HIV and high risk behavioral surveys which should be budgeted separately. NACA will continue to advocate for stakeholders at different levels of implementation to allocate a minimum of 10% of their HIV/AIDS budget to M&E. In order to ensure sustainability, it is advised that at all levels of the national response, no M&E activity should be entirely donor-dependent. Therefore, the NNRIMS Operational Plan will be costed to estimate resources needed for full implementation of the national M&E system.

To achieve effective resource mobilization for the national HIV M&E system, a clear identification of resource gaps and funding requirements is essential. As part of this document

the M&E activities will be costed to estimate the total M&E envelope for the period. This would enable accurate identification of what the funding gaps are and the additional funding that is required.

Subsequently, NACA will identify and mobilize financial resources internally and externally to support the implementation of the NOP2, from the private sector as well as the public. Annually, NACA SKM will prepare a joint M&E Priority Plan in collaboration with major stakeholders. This will be used as a consolidated tool to mobilize resources from Development Partners and Civil Society, as well as the public and private sectors. Additionally, NACA will strengthen systems to track expenditure in order to re-allocate resources as necessary, as well as producing financial audits required by law.

7.1 Human capacity

Staffing is a major constraint to M&E in many countries. While M&E units do exist in many national programs, they are generally understaffed and their work is often limited to managing sero-surveillance systems. Human capacity needs to be considered broadly in terms of the adequacy of the number of staff with respect to the work that is required, remuneration of staff, competencies and the quality of work. This relates to determining and organizing the appropriate number of staff that are needed, ensuring that their salaries are competitive, and their capacities are relevant and updated. Processes to assess staff performance are critical and should focus on the productivity as well as the quality of work.

7.2 Institutional Capacity Development

Recently, a lot of effort has been made to strengthen the institutional set-up of NACA in order to build the capacity necessary to fulfil its functions. The institutional strengthening of NACA will facilitate better coordination among MDAs, LGA institutions, special projects, surveys and other stakeholders to provide good quality, comprehensive and timely information on the state of the epidemic in Nigeria.

7.3 Building capacity in M&E across the sectors and stakeholders

A training and development needs assessment of capacity in monitoring and evaluation is needed at different levels and among different stakeholders, with a focus on sub-national levels. The sub-national level coordinating agencies will need to be trained in M & E and in turn should provide training to key people involved in M & E at LGA, District and Ward as well as community level such as the community-based organizations. There is a need to link information systems development to standardized progress reporting at LGA level. Hence, simple information report formats, feedback reporting formats and related manuals would be developed.

One aspect that is linked to the provision of synthesized information for planning is feedback to those involved in data collection. Another is the provision of useful data from other sources such

as the surveillance and population-based surveys. Feedback and provision of useful information will provide incentives that will enhance good quality data and timely reporting.

7.4 Roles and Responsibilities in implementing the NNRIMS Operational Plan

For an effective monitoring and evaluation system to be established, there is a need to clarify the roles and responsibilities at different levels, and who requires what information and for what purpose. Importantly, our response is multi-sectoral and has multiple funding sources with different levels of responsibilities and stakeholders. The national HIV/AIDS M&E system will require a coherent information flow system that is developed through regular consultations. The table below gives a broad outline of roles and responsibilities, and is intended as a basis for further development as the national response evolves and is scaled-up.

In addition, the achievement of the goals and objectives of the NNRIMS Operational Plan will require the collaborative efforts of all stakeholders, and their working with a clear understanding of their roles and responsibilities

Table 4: Responsibilities of Stakeholders in NOPII

STAKEHOLDER	RESPONSIBILITIES
NACA Board	The board members of NACA have been mandated to provide overall guidance and oversight of the national response. In terms of monitoring and evaluation, the Board members are responsible for: • Overall guidance and strategic alignment of M&E to the NSF • Advocacy for allocation of adequate level of resources for M&E in the national response. • Promoting a culture of using information for decision-making at the highest level to serve as an example for the sub-national levels
NACA Director General	The Director General of NACA is responsible for: • Promoting the HIV/AIDS M&E system within the public and private sectors, and civil society. • Using information from the national M&E system to shape the national response. • Ensuring that sufficient resources (financial and human) are available to implement the national HIV/AIDS M&E system. • Negotiating with bilateral donors to make it compulsory for call implementers to report to the NOP. Facilitating development of the National HIV/AIDS Research Agenda/ Plan. • Enforcing procedural requirements for all HIV/AIDS data to be officially cleared by NACA before it is shared with the international

	community.
NACA's Director of Strategic Knowledge Management (SKM)	NACA Director of SKM is responsible for: • Providing overall leadership to the M&E team at NACA. • Supervising the day to day work of the M&E team. • Preliminary review and approval of all information products before they are submitted to the NACA DG for clearance. • Representing NACA and providing guidance and leadership during meetings addressing M&E issues. • Chairing the platform for review and evaluation of National Response Priority Issues. • Approving monthly work plans of the SKM department • Reconciling, confirming and clearing all HIV/AIDS data reported to stakeholders • Developing annual M&E budgets • Interpreting M&E reports in terms of planning implications • Ensuring that data and M&E results inform the NACA annual work plan
Ministry of Health	• Coordinates and implements the health sector response to HIV • Develop and review national health sector M&E tools • Facilitate collection of data, collate, analyze and report data on the health sector response • Training, supervision and mentoring of service providers at the facility • Coordinate periodic national surveys (e.g NARHS, IBBSS, NDHS, ANC sentinel survey) • Map and update directory of health facilities providing HIV services
Ministries outside of the Health Sector	• Coordinates and implements the non-health sector response to HIV • Develop and review national non-health sector M&E tools • Facilitate collection of data, collate, analyze and report data on the non-health sector response • Training, supervision and mentoring of service providers at the facility • Coordinate periodic national non-health sector surveys
NACA SKM Staff	The SKM team at NACA is the pivot around which the M&E system functions. The team is responsible for: • Implementation of the national HIV/AIDS M&E plan • Coordinating and managing the NNRIMS Reporting System • Coordinating and chairing the National M&E TWG • Facilitating the development of the National HIV/AIDS research agenda/ plan

	• Developing monthly work plans of M&E activities • Attending the national M&E TWG and other sectoral M&E Steering Committee meetings • Liaising with all institutions that provide data sources for the NNRIMS system • Providing periodic information products, as requested by NACA leadership • Representing M&E interests of NACA at meetings, and actively working to improve the coordination of data gathering processes within Nigeria • compilation of an annotated bibliography of research studies conducted in Nigeria • Supporting the dissemination of all information products as defined in the NOP. • Contributing to the development of annual M&E work plans and operational budgets • Ensuring that all data required for the annual HIV/AIDS M&E report is received in a timely manner • Compiling the annual HIV/AIDS M&E Report and managing the NACA institutional approval process •
State Agency for the Control of AIDS (SACA)	SACA's are responsible for: • Compiling and updating directories of facilities, NGOs and CBOs involved in HIV activities in the state and submitting this information to NACA • Ensuring timely & accurate completion and submission of NNRIMS summary forms from the LGAs and SMoH • Compiling and analysing the State's NNRIMS Monthly Summary Form, including gathering data from non-health sector stakeholders and other ministries. • Dissemination of the Quarterly Service Coverage Report form and other National Operational Plan Information products to state stakeholders • Reconciling, validating and clearing all state level data that will be reported to the international community Funding, chairing and facilitating of State monthly M&E meetings. • Using data and information products to inform state level planning. • Ensuring that the State House of Assembly and other arms of Government have the most up-to-date information regarding the progress of the HIV/AIDS response.

	•
Local Action Committee on AIDS (LACA)	LACA's are responsible for: • Promoting and ensuring the timely completion and submission of NNRIMS forms • Ensuring timely & accurate completion and submission of NNRIMS forms from the health facilities and non-health sector stakeholders in the LGA • Dissemination of the quarterly service coverage report and other NOP information products to LGA stakeholders LG Action Manager is responsible for: • Submitting names of facilities, NGOs and CBOs(health sector and non-health sector) involved in HIV activities to SACA • Liaising and promoting the completion and submission of NNRIMS forms • Ensuring accurate and timely data collection from SDPs in the LGA • Dissemination of the quarterly service coverage report and other SACA/NACA Information products to stakeholders • Using NOP information products where appropriate for planning • Promoting completion of the NNRIMS Monthly Summary Form in service delivery points (health and non-health) at LGA level
Civil Society Organizations including NEPWHAN	CSO's are responsible for: • Facilitating capacity building on M&E for its networks, NGOs • Facilitating completion and submission of NNRIMS forms • Clearing all data on HIV/AIDS with NACA
Institutions responsible for data sources NOT commissioned by NACA	Different agencies are responsible for data sources. These agencies have the responsibility to: • Read through NOP and NACA's M&E system to ensure that they are familiar with its content • Ensure that they understand their responsibilities in terms of data submission to NACA • Submit the necessary data, disaggregated as per request • Wherever possible, use the information generated by the NOP system for decision making and improving interventions
Institutions responsible for data sources commissioned by NACA	These agencies' responsibilities will be clearly defined in the agreement between NACA and the agency. However, in general terms these agencies will be responsible for providing good quality data sources that are based on international best practice, that are relevant to the M&E system, as defined in this document.
Implementers of	The Implementers of HIV interventions are responsible for:

HIV Interventions	• Ensuring that program/organization level M&E plans are aligned with the national HIV/AIDS M&E plan • Ensuring that programs are generating and reporting high quality data • Completing the NNRIMS Form on a monthly basis and submitting it to the LACA/SACA • Utilizing the information products from NACA for decision making
Funding Agencies	In terms of M&E, these agencies are responsible for: • Ensuring that all new contracts that are signed with implementer stresses a need for alignment with the national HIV and AIDS M&E system. . In particular, funding agencies should ensure that implementers understand the reporting requirements to the GoN, specifically, the completion of the NNRIMS Monthly Summary Form. • Ensuring that existing implementers routinely submit NNRIMS Monthly Summary Form to the appropriate level • Reconciling, validating and clearing all national HIV data with Director SKM of NACA before it is reported to the global community • Supporting NACA with technical and financial resources to build capacity & skills required to implement the NOP • Providing technical and financial resources to support the implementation of NOP in assigned states
Researchers and Research Institutions	The roles and responsibilities of researchers and research institutions are: • Work with NACA to develop and implement the National HIV/AIDS Research plan/agenda • Conduct research that is of a high standard – in terms of both research design and choice of topics that are of national interest • Submit research proposals to the relevant ethical review committee before research is commenced • Once research has been completed liaise with NACA to disseminate research results • Assist NACA with the
National M&E Technical Working Group (NTWG)	This group consists of all relevant M&E stakeholders and will advise on all issues associated with M&E. • Assist in the development of a multi-year and multi-sectoral costed annual work plans; • Coordinate M&E activities of stakeholders and implementing partners; • Assist in the harmonization of tools;

CHAPTER EIGHT

ASSESSMENT OF AN EFFECTIVE M&E SYSTEM

8.0 Assessment of an effective M&E System

In line with the "Three Ones" principles, the initial M&E plan was developed. However, this revised plan will support an effective and robust monitoring and evaluation system; facilitate tracking of progress in the implementation of the national HIV/AIDS response and guide programs, policies, and service delivery. Thus, NNRIMS is committed to effective operationalization. This will include development of costed national HIV/AIDS M&E plan, implementation of an M&E plan, assessment of M&E system capacity, production of high quality timely data, and communication of HIV/AIDS Information to relevant stakeholders.

M&E System Performance Objective 1: Develop a Costed National HIV/AIDS M&E Plan

- HIV/AIDS M&E plan is linked to National Strategic Plan and addresses its objectives
- HIV/AIDS M&E plan is reviewed annually
- HIV/AIDS M&E plan is revised based on annual review
- HIV/AIDS M&E plan meets the needs of stakeholders
- HIV/AIDS M&E plan includes agreed standards, indicators and timeframe for data collection, reporting and use

***M&E System Performance Objective 2*:** Implementation of an M&E Plan

- Milestones in national HIV/AIDS M&E plan reached
- Percentage of reports with accurate data
- Percentage of reports received in a timely manner
- Reports are disseminated to stakeholders
- Evidence that data from M&E system feeds into program planning
- Increased research for activities in M&E plan
- Weaknesses in data collection and data use are reduced or eliminated
- Capacity of M&E system increases at state and national levels

M&E System Performance Objective 3: Assessing and upgrading of M&E system capacity

- Appropriate staffing levels maintained to effectively support M&E system
- Percentage of data systems that meet established standards
- National reporting is standardized

- Percentage of stakeholders integrated into national M&E system
- Data quality monitored and maintained
  - Percentage of data quality audits completed
- Information shared with all relevant stakeholders
- Reliable data storage and retrieval
- External stakeholders are formal part of system (TWG)

M&E System Performance Objective 4: Produce High Quality Data on a Timely Basis

- Data collection systems are appropriate, useful, accurate and use standardized formats
  - Data should be produced with the "users" in mind
- Standards are communicated to stakeholders
- Consistent use of standard indicators and practices
  - Percentage monthly reports arrive on time
  - Percentage monthly reports that meet quality standards (through audit)
- Consistent use of data analysis approaches
- Periodic assessment of data quality conducted (to ensure accuracy, completeness and timeliness)
- Reports submitted from one level to the next are of high quality (i.e., complete, accurate and timely)
- Appropriate technology to support data production (user friendly technology)

Ratio of manual versus electronic databases

M&E System Performance Objective 5: Communicate HIV/AIDS Information to Relevant Stakeholders and Facilitate the Use of Information among Stakeholders

- Inter-agency and intra-agency units share reports, review progress and communicate information to decision makers
- Stakeholders reflect greater understanding of HIV/AIDS M&E information
- Ready and reliable access to monitoring data among stakeholders
- Evidence that information is guiding intervention strategies
- Trend analysis and global comparisons using local data
- Data is used for benchmarking
- Data is used to identify best practices
- Number of programs implemented based on evidence based information
- Number of requests for information from stakeholders is met
- Data use guidelines are produced and communicated

Annex 1: NNRIMS OPERATIONAL PLAN INDICATORS AND TARGETS

	INDICATORS	Baselines						TARGETS						% increase	Comments
		Value	Source	Value	Source	% Increase by	Target Source	2010	2011	2012	2013	2014	2015		
	Prevention of Mother to Child Transmission (PMTCT)														
1	PM1. % of infants born to HIV infected mothers who are infected with HIV			29.1 (Spectrum Modeling)	UNGASS, 2010		**NSP**								
							Historical trend								
							NOP11	**29.1%**	**24.1%**	**19.1%**	**14.1%**	**9.1%**	**4.1%**		-Universal Access is total elimination of HIV transmission from mother to child -Assumption is a 5% decrease per year.
2	PM2. % of pregnant women who received HIV counselling and testing and received their test results during pregnancy, labour, delivery and the post-partum.	9.3%	(Universal Access 2007)	14%	(Universal Access 2010)	51%	**NSP**	14%			46%		80%	471%	Assumption 1: In order to reach the UA coverage for PMTCT , we need to ensure we do not lose the 62% attending ANC at least once – (PMTCT Scale up plan)
							PMTCT Scale up Plan	14%			60%		90%	543%	Assumption 2: 62% pregnant women attending ANC by 2015 has been estimated as 4290400 (EPP spectrum estimation)
							NOP11	**14%**	**21%**	**28%**	**35%**	**42%**	**50%**	254%	Assumption 3: 80% of pregnant women attending ANC will receive HCT by 2015. This is estimated at 3,432,320 which is about 50% of pregnant women in the country.

							NSP	11%			50%		80%	627%	Assumption 1: By 2015 3,432,320 pregnant women are targeted to be counseled, tested and received results (CTR)
	PM3. % of HIV infected pregnant women who receive ARV to reduce the risk of mother-to-child transmission (according to the national guidelines)	5.25%	(Universal Access 2007)	11%	(Universal Access 2010)	11%	**PMTCT Scale up Plan**	11%			50%		80%	627%	Assumption 2: Prevalence of 4.1% for 3,432,320 pregnant women targeted for CTR is 140725
3							**NOP11**	**11%**	**17%**	**23%**	**29%**	**35%**	**41%**	274%	Assumption3: 80% of the estimated positive pregnant women (140,725) will receive prophylaxis. (112,580)
							NSP	Not available	Not available	Not available	Not available	Not available	Not available		
	PM4. % of HIV-infected pregnant women who assessed for ART eligibility through either clinical staging or CD4 testing during the period.			(19572) 9%	(Universal Access 2010)		**PMTCT Scale up Plan**	Not available	Not available	Not available	Not available	Not available	Not available		
4							**NOP11**	**(9%) 19572**	**(17%) 41099**	**(23%) 57232**	**(29%) 74002**	**(35%) 91439**	**(41%) 109834**		All positive pregnant women targeted for prophylaxis will be assessed for eligibility. 80% of positive pregnant will be assessed for eligibility in line with UA.
							NSP	Not available	Not available	Not available	Not available	Not available	Not available		
	PM5. % of infants born to HIV - infected women who were started on contrimoxazole (CTX) prophylaxis (within two months of birth).			2%	(Universal Access 2010)		**PMTCT Scale up Plan**	2%			25%		90%	4400%	Assumption 1: All positive pregnant women have at least one baby.
5							**NOP11**	**2%**	**10%**	**18%**	**25%**	**33%**	**41%**	1950%	Assumption 2: 80% of exposed infants will receive a virological test for HIV within 2 months of birth by 2015

	PM6. % of infants born to HIV - infected women (HIV-exposed infants receiving antiretroviral prophlaxis to reduce the risk of mother-to-child transmission.			6%	(Universal Access 2010)		**NSP**	2%			40%		80%	3900%	
							PMTCT Scale up Plan	6%			25%		90%	1400%	
6							**NOP11**	**6%**	**17%**	**23%**	**29%**	**35%**	**41%**	585%	All positive pregnant women have at least one baby and 80% of exposed infants will receive prophylaxis in line with UA
	PM7. % of infants born to HIV-infected women, who received an virological test for HIV within 2 months of birth			19446 (8%)	Universal Access, 2010		**NSP**	8%			50%		80%		
							PMTCT Scale up Plan	8%			25%		90%		Assumption 1: All positive pregnant women have at least one baby.
7							**Revised**	**8%**	**17%**	**23%**	**29%**	**35%**	**41%**	414%	Assumption 2: 80% of exposed infants will receive a virological test for HIV within 2 months of birth by 2015
	Infection Control Management															
	ICM1. Percentage of exposed persons provided with post-exposure prophylaxis (PEP)			NA			**NSP**	TBD			50%		80%		
							Scale up Plan								
8							**NOP11**								
	Human Resource for Health															
	% of health care workers who successfully completed an in-service training program within the reporting period according to national guideline			NA			**NSP**								
							Scale up Plan								
9							**NOP11**								

	TREATMENT														
10	T1. Percentage of HIV positive adults and children who are eligible and currently receiving ART (disaggregated by first-line, second-line and third-line)	16.7%	UNGASS 2007	34.2%	UNGASS 2010	104.8 %	**NSP**	34.2%		56%			80%		Moving from 16.7% in 2007of the number of HIV positive adult and children who are eligible and currently receiving antiretroviral therapy to 35% 2009, 110% effort is required. To achieve universal access target of 80% by 2015, 129% effort will be required.
							Historical trend	34.2%	46%	58%	70%	82%	94%	175%	Following Historical trends, the country will achieve 94% by 2015
							NOP11	**34.2%**	**43%**	**53%**	**62%**	**71%**	**80%**	134%	It took 4yrs to achieve 110% increase from 16.7% to 34.2%. Reaching 80% in 5 years from where we are now will amount to 133% leap. . To achieve universal access target of 80% by 2015, 129% effort will be required which will be feasible if the following assumptions hold: 1. Funding sources for treatment experienced between 2006 - 2009 (PEPFAR, GF, CDC, DOD etc will be replicated or/or improved upon; 2. Sustain activated treatment sites and scale up more treatment sites as projected under existing ART scale up plan 3. Decentralization of ARV to PHCs
11	T2. % of adults and children enrolled in HIV care currently receiving CTX prophylaxis			76%	UA report 2011		**NSP**			67%			80%		No historical data for 2007 & difficult to estimate number enrolled in care who will receive ART prophylaxis during their last visit in a particular year; 7hieve6% achieved by 2010 indicates that 80% universal access is achievable yearly in the next five years
							Historical trend								We believe there is an underreporting for CTX in the UA report. However, it was agreed that to achieve UA target from 2011 and maintain on this till 2015.
							NOP11	**76%**	**80%**	**80%**	**80%**	**80%**	**80%**		

12	T3. % of HIV-infected pregnant women receiving ART for their own health during the reporting period	Not Available	Not Available	Not Available	Not Available	Not Available	**EPP Projection 1 (%)**	2.8	5.75	8.06	11.57	13.92	18.52		
							Historical trend	N/A	N/A	N/A	N/A	N/A	N/A		
							NOP11	**25%**	**34%**	**35%**	**40%**	**40%**	**44%**		Based on the PMTCT scale up plan which says that 40% of pregnant women on ARVs will be placed on ART for their own health
13	T4. Number of adults and children on ART a) newly enrolled	Not Available	Not Available	109226	UA report 2011		**NSP**	109226	152402	146006	165221	185090	70314		This is based on differences between persons currently on ART as projected in the NSP every year.
							Historical trend	N/A	N/A	N/A	N/A	N/A	N/A		Could not get data to establish trends
							NOP11	**109226**	**141993**	**184591**	**239969**	**311960**	**405548**		For this indicator the team observed a trend on newly enrolled both from reported data and estimated projections in the NSP. We agreed that a 30% enrolment would be reasonable for this indicator and have calculated the number based on a 30% increase
14	T5. Percentage of adults and children with HIV known to be on treatment 12, 24, 36, 48, 60 months after initiation of antiretroviral therapy	70%	FMoH 2009 (Program Data)	73.4%	FMoH 2009 (Program Data)	5%	**NSP**								
							Historical trend								
							NOP11	**73.45**	**74.72%**	**76.04%**	**77.36%**	**78.68%**	**80%**		Between 2009 – 20011 (3 yrs), 5% increase was required. To achieve universal access of 80% by 2015 a 9% effort of increase is required
15	T6. Number of adults and children on ART b) ever started			496462	National Program data 2010		**NSP**	N/A	N/A	N/A	N/A	N/A	N/A		
							Historical trend								
							NOP11	**496462**	**40%**	**50%**	**60%**	**70%**	**80%**		

	TB/HIV														
16	TBHIV1. % of estimated HIV + incident TB cases that received treatment for TB and HIV	55.95 %	NTBLCP-Program data	69.1%	FMoH, 2009	24 %	**NSP**				60%		80%		
							Historical trend	10%							
							Actual Figure	12068							
							NOP11	**69.1%**	**73.28%**	**77.46%**	**81.64%**	**85.82%**	**90%**	**30%**	To achieve UA 0f 80% by 2015, a 30% increase will be required
							stop TB partnership Target								
17	TBHIV2. % of HIV + patients who were screened for TB in HIV care or treatment settings	NA					**NSP**								
							Historical trend								
							NOP11								
							stop TB partnership Target								
18	TBHIV3. % of TB patients Screened for HIV in TB care or treatment settings	55.95 %	2007 NTBCP Data	66.80%	2009 NTBCP Data	19.39 %	**NSP**	N/A	N/A	N/A	N/A	N/A	N/A		
							Historical trend	66.80 %	76.30 %	79.80 %	89.30 %	95.40 %	104.90 %	114%	Following historical trend there has been a 19.4% increase over two years as highlighted in the base line section. Following this trend, the country would have overshot a 100% achievement by 2015.
							NOP11	**66.80 %**	**73.40 %**	**80%**	**86.70 %**	**93.40 %**	**100%**		The target has been set based on the stop TB partnership target which is a global target which Nigeria TB and leprosy control programme is currently working towards this. This is reasonable as following historical trend, the country could have still reached this target all things being equal
							stop TB partnership Target	66.8%					100%		As highlighted in the stop TB global partnership document to which Nigeria is a signatory, the target to reach by 2015 for this indicator is 100%

							NSP								
							Historical trend								
							NOP11								
19	TBHIV4. Number of HIV patients currently in care who commenced TB Treatment						**stop TB partnership Target**								
							NSP	N/A	N/A	N/A	N/A	N/A	N/A	N/A	
							Historical trend	N/A	N/A	N/A	N/A	N/A	N/A	N/A	
							NOP11	**1%**	**16.8%**	**32.6%**	**48.4%**	**64.2%**	**80%**		The criteria for the use of IPT among PLWHA is explicity described in the ART guidelines. Provided the ART guideline on IPT implementation is widely disseminated and used at all SDPs, Funds for the regular procurement and supply of INH to ART sites is increased, this is a realistic target (80% of positives on care will be on IPT). Currently GF is supplying IPT through the NTBCP.
								1750	29400	57050	84700	112350	140000		
20	TBHIV5. Number of HIV patients newly enrolled into HIV care and are given treatment for latent TB infection (isoniazid preventive therapy)	NA	NA	1% (1750)	UA report 2011		**stop TB partnership Target**	1%	20.8%	40.6%	60.4%	80.2%	100%		Not realistic for now due to certain constraints like dissemination of guidelines on IPT, IPT PSM
	LAB (System Strengthening)														
							NSP								
	LAB1. Percentage of HIV reference laboratories that are accredited according to national standards						**Scale up Plan**								
21							**NOP11**								

22	LAB2. Number of health facilities that provide virological testing services (e.g. PCR) for infant diagnosis on site or through dried blood spots (DBS) (e.g. PCR) fir infant diagnosis on site or through dried blood sample (DBS)						**NSP**									
							Scale up Plan									
							NOP11									
23	LAB3. Number of facilities providing ART that use CD4 monitoring in line with national guidelines/policies, on site or through referral						**NSP**									
							Scale up Plan									
							NOP11									
	Health System Leadership/Governance															
24	HSG1. Number of States with costed annual workplan derived from State Strategic Plan						**NSP**									
							Scale up Plan									
							NOP11									
25	HSG2. Number of LGAs with costed annual workplan derived from State Strategic Plan						**NSP**									
							Scale up Plan									
							NOP11									
	Health System Strengthening Sub Area 6 - Health Financing															
26	HSF1. Total domestic and international AIDS spending by categories and financing sources out of total AIDS spending and financing sources out of total AIDS spending	US$394,963,881	NASA, 2008	US$497,817,471	NASA, 2010		**NSP**									
							Scale up Plan									
							NOP11	US$394,963,881	**US$497,817,471**	**US$600,671,061**	**US$703,524,651**	**US$806,378,241**	**US$909,231,831**			

27	HSF2. Percentage of total public expenditure (health, communication, education, defence)dedicated to HIV/AIDS						**NSP**									
							Scale up Plan									
							NOP11									
	Health System Strengthening Sub Area 6 - Medical Products, Vaccines and Technology															
28	HSM1. Percentage of health facilities dispensing ARVs that experienced a stock-out of at least one required ARV in each quarter						**NSP**									
							Scale up Plan									
							NOP11									
	Health system strengthening-Service delivery															
29	HSD1. Percentage of pregnant women MAKING ATLEAST 4 ANC visits according to the national protocol						**NSP**									
							Scale up Plan									
							NOP11									
	SEXUAL BEHAVIOUR CHANGE															
30	SBC1. % of people aged 15-24 who both correctly identify ways of preventing the sexual transmission of HIV and who reject major misconceptions about HIV transmission	22.5%	UNGASS 2007	24.2%	UNGASS 2010	9%	**NSP**	N/A	N/A	N/A	N/A	N/A	N/A			
							Scale up Plan				67%					
							NOP11	**24.2%**	**32%**	**39%**	**46%**	**53%**	**60%**	148%	This source of this indicator is a survey and the denominator is the respondents during the survey. The target is aligned with the National prevention plan operational framework to have at least 60% of persons 15-24 have comprehensive knowledge on HIV/AIDS. Based on expected contributions from GF, WB, etc. and effective implementation of programs	

	SBC2. % of women and men aged 15-49 who have had more than one sexual partner in the last 12 months reporting the use of a condom during their last sexual intercourse			52.5%	UNGASS '10 & NARHS '07		**NSP**	**32.0%**			**60%**		**80%**		
							2010-2012 NPP			**67%**					
31							**NOP11**	**52.5%**	**58%**	**64%**	**69%**	**74.5%**	**80%**		The 80% target is realistic because as at 2010 we are at 52.5%. Based on assumption that expected contributions from GF, WB, etc. and effective implementation of programs
	SBC3. % of schools that provided life skills-based HIV education within the last academic year (FLHE)			22.8%	UNGASS '10 & NARHS '07		**NSP**	N/A	N/A	N/A	N/A	N/A	N/A		
							2010-2012 NPP	N/A	N/A	N/A	N/A	N/A	N/A		
32							**NOP11**	**51.0%**	**57%**	**63%**	**68%**	**74%**	**80%**		This represents 80% reduction of adults 15-49 involved in multiple sexual intercourse. Based on assumption that expected contributions from GF, WB, etc. and effective implementation of programs.
	SBC4. % of adults aged 15-49 who have had sexual intercourse with more than one partner in the last 12 months			11.0%			**NSP**								
							2010-2012 NPP								
33		10.4%	UNGASS 2007		UNGASS '10 & NARHS '07	6%	**NOP11**	**11.4%**	**9.58%**	**7.76%**	**5.94%**	**4.12%**	**2.30%**		The 80% target is realistic because as at 2010 we are at 52.5%. Agreed on 80% reduction in multiple sexual partnership
	SBC5. % of young women and men who have had sexual intercourse before the age of 15						**NSP**								
							2010-2012 NPP								
34		9.8%	UNGASS 2007	11.9%	UNGASS '10 & NARHS '07	21%	**NOP11**	**11.9%**	**11.06 %**	**10.22 %**	**9.38%**	**8.54**	**7.70%**		Target represents 35% reduction from base year. Attainment would depend on success with indicators 31 (increase in comprehensive knowledge about HIV/AIDS) and 33 (increase in provision of life skills-based HIV education in schools)
	SBC6. % of PLWHA reached with individual and/or small group level minimum prevention package (MPP) interventions						**NSP**								
							2010-2012 NPP								
35							**NOP11**	**23%**	**28%**	**33%**	**38%**	**43%**	**48%**		48% was adopted because the prevention plan targets 60% of those that on ART

36	SBC7. % of MARPs reached with individual and/or small group level MPP intervention						**NSP**								
							Scale up Plan				60%				
							NOP11	**10%**	**20%**	**30%**	**40%**	**50%**	**60%**		Target based on NPP to reach 60%
37	SBC8. % of most-at-risk populations (IDU, MSM, SW) who are HIV +	11.6%	IBBSS 2007	FSW 24%, MSM 17% IDU 4%;	IBBSS 2010/ UA 2010		**NSP**								
							2010-2012 NPP								
							NOP11	**FSW 24% MSM 17% IDU 4%**	**FSW 21.6% MSM 15.3% IDU 3.6%**	**FSW 19.2% MSM 13.6% IDU 3.2%**	**FSW 16.8% MSM 11.9% IDU 2.8%**	**FSW 14.4% MSM 10.2% IDU 2.4%**	**FSW 12% MSM 8.5% IDU 2%**		50% Target is determined by trend in reduction from 2007-2010
38	SBC9. % of males reporting the use of a condom the last time they had anal sex with a male partner in the last six month						**NSP**								
							2010-2012 NPP								
							NOP11	**52.80 %**	**57.80 %**	**62.80 %**	**67.80 %**	**72.80 %**	**80%**		
39	SBC10. % of males reporting the use of a condom the last time they had anal sex with a male partner in the last six month			52.8%	UNGASS 2010		**NSP**								
							2010-2012 NPP								
							NOP11	**52.8%**	**57.80 %**	**62.80 %**	**67.80 %**	**72.80 %**	**80%**		
40	SBC11. % of FSW reporting the use of a condom with their last client			Brothel FSW 98.7% Non-brothel FSW 97.1%	UNGASS 2010		**NSP**	64.80 %			78%		90%		
							Scale up Plan				67%				
							NOP11 Target: Brothel FSW Non Brothel FSW	**98.7% 97.1%**	**99% 99%**	**99% 99%**	**99% 99%**	**99% 99%**	**99% 99%**		UNGASS 2010 reports 90% achievement on this indicator. The assumption for the revised target is to maintain this achievement. UNGASS 2010 reports 90% achievement on this indicator. The assumption for the revised target is to maintain this achievement
41	SBC13. Number of states with anti stigma and discrimination law			4	2010		**NSP**	N/A	N/A	N/A	N/A	N/A	N/A		Target based on an increment of 7 states per year till 2015
							2010-2012 NPP								
							NOP11	**4%**	**11%**	**17%**	**24%**	**31%**	**37%**		Target based on an increment of 7 states per year till 2015

							NSP								
							2010-2012 NPP								
42	SBC14. % of most-at-risk populations who both correctly identify ways of preventing the sexual transmission of HIV and who reject major misconceptions about HIV transmission	FSW 32.9%, MSM 44%, IDU 34%	IBBSS '07	FSW 35%, IDU 30.7%, MSM 33.1%	IBBSS '10		**NOP11**	**FSW 35%, IDU 30.7%, MSM 33.1%**	**FSW 37.2% IDU 33.7% MSM 36.1%**	**FSW 39.6 IDU 36.7% MSM 39.1%**	**FSW 42.1% IDU 39.7 MSM 42.1**	**FSW 45.5% IDU 42.7% MSM 45.1%**	**FSW 49.1% IDU 45.7% MSM 48.1%**		FSW-Increase between 2010 & 2013 was based on percent increase between 2007 & 2010 (6.4%), while percent increase between 2013-2015 was slightly increased to 8%. IDU & MSM-since these are harder to reach, a 3% (about half of that of FSW between 2010 & 2013) increase per year was adopted from 2010-2015.
							NSP								
	SBC15. % of women and men aged 15-49 who have had sex with non-marital, non-cohabiting sexual partner in the last 12 month						**2010-2012 NPP**								
43		11.4 %	(NARHS '07)				**NOP11**	**11.4%**	**10.80 %**	**10.24 %**	**9.66%**	**9%**	**8.60%**		Used 11.4% NARHS '07 as baseline in 2010 and assumed a 25% reduction by 2015.
							NSP								
	SBC16. Number of schools implementing FLHE curriculum						**2010-2012 NPP**								
44							**NOP11**	**22,980**	**25, 278**	**27, 576**	**29, 874**	**32, 172**	**34, 470**		Target based on 50% increase by 2015 from the baseline figure of 22, 980
	SBC17. % of men aged 15-64 reporting sex with a sex worker in the last 12 months who used a condom during last sexual intercourse						**NSP**								
							2010-2012 NPP								
45							**NOP11**								
							NSP								
	SBC18. Number of high risk group (female sex workers) reached with HIV/AIDS prevention programs (disaggregated by FSW, armed forces and transport workers)						**2010-2012 NPP**								
46		34.3 %	IBBSS, 2007	18.2%	IBBSS, 2010		**NOP11**	**18.2%**	**24.6%**	**30.9%**	**37.3%**	**43.6%**	**50%**		

	HCT														
47	HCT1. % of individuals who received an HIV counseling and testing in the last 12 months and who know the results (disaggregated by sex)	8.60%	NARHS 2005	11.7%	UNGASS 2010	36%	**NSP**	11.7%			**60%** (14,848,228)		**80%** (10,434,572)		
							Scale up Plan	N/A	N/A	N/A	N/A	N/A	N/A		
							NOP11	**11.7%**	**17%**	**23%**	**29%** (4,305,986)	35%	**40%** (4,173,829)		Aligning with the national prevention plan operational framework to have at least 40% of adult accessing HCT services in an equitable and sustainable manner
48	HCT2. Percentage of men and women who received HIV C&T and received their results through HCT sites in the reporting period				73%	UA, 2010	**NSP**								
							Scale up Plan	N/A	N/A	N/A	N/A	N/A	N/A		
							NOP11	**73%**	**74.4%**	**75.8%**	**77.2%**	**78.6%**	**80%**		Assumption 1: As at 2010, 73% of persons C&T at health facility received their result. Aligning with UA, the target for this indicator by 2015 is 80%.
49	HCT3. % of people aged 15 and above with Sexually Transmitted Infection (STI) who received HCT and received their results in the past 12 months						**NSP**								
							Historical trend								
							NOP11								
50	HCT4. % of individuals who tested positive for HIV during the reporting period						**NSP**								
							Historical trend								
							Revised								
51	HCT5. % of facility that experienced stockout of any test kits during the reporting period						**NSP**								
							Historical trend								
							NOP11								

52	HCT6. % of most-at-risk population (IDU, MSM, SW) who received an HIV test in the last 12 months and who know the results			ArmedForce 70.5%, brothel FSW 46.2% Transport W 20.3% MSM 30.2 %, IDU 23.2%	UNGASS, 2010		**NSP**	Armed Force 70.5%, brothel FSW 46.2% Transport W 20.3% MSM 30.2 %, IDU 23.2%					Armed Force 80%, brothel FSW 80% Transport W 80% MSM 80 %, IDU 80%		
							Scale up Plan	Armed Force 70.5%, brothel FSW 46.2% Transport W 20.3% MSM 30.2 %, IDU 23.2%					Armed Force 50%, brothel FSW 50% Transport W 50% MSM 50 %, IDU 50%		Assumption 1: transport workers, MSM and IDU aligned with National Prevention Plan
							NOP11	**Armed Force 70.5%, brothel FSW 46.2% Transport W 20.3% MSM 30.2 %, IDU 23.2%**					**Armed Force 80%, brothel FSW 80% Transport W 50% MSM 50 %, IDU 50%**		Assumption 2: Armed forces and brothel based FSW are aligned with NSP
53	HCT7. HIV Prevalence in the general population						**NSP**								
							Historical trend								
							NOP11								

							NSP								
54	HCT8. Percentage of young women and men aged 15-24 who are HIV infected						**Historical trend**								
							NOP11								
	OVC/ Care and Support														
	OVC1. % (number) of vulnerable children with improved well being per a standardized instrument(Child Status Index- CSI) as related to the service areas e.g. one score improvement on Child Status Index (CSI)						**NSP**	N/A	N/A	N/A	N/A	N/A	N/A		The target here represent the 50% of the total OVC population that will be provided with services, using the new NPA on Vulnerable children and the CSI tool. It is expected that a child provided with services should have at least 1 score improvement in the service areas.
							Historical trend								
55							**NOP11**	**341,337**	**975,275**	**3,009,505**	**5,159,295**	**8,490,961**	**10,917,253**		
	OVC2. Number of vulnerable children (OVC) provided with social services (health, nutrition, shelter, education, care, protection, psychosocial support, household and economic strengthening)						**NSP**	N/A	N/A	N/A	N/A	N/A	N/A		
56				1.80%	USAID/ GF SRs programmatic reports for 2010		**Historical trend**								

							NOP11	**341,337**	**975,275**	**3,009,505**	**5,159,295**	**8,490,961**	**10,917,253**		24.5% of the children population are said to be OVC (SAA 2008), using strategy in the new NPA on Vulnerable Children, 50% of the total OVC population will be targeted by 2015, currently (2010), 1.8% are been provided with services, 5% by 2011, 15% 2012, 25% 2013, 40% 2014 and 50% 2015. The % increase is based on the assumption that the coordination role of OVC activities will be improved, and more IPs will be reporting their data to the National coordinating body through the new M&E plan for the response.
57	OVC3. Percentage of orphans and vulnerable children whose households received free basic external support in caring for the child			N/A			**NSP**								
							Historical trend								
							NOP11	TBD	TBD	TBD	TBD	TBD	TBD		The number of household with OVC is currently not known. This indicator is an UNGASS indicator to be tracked by NDHS. It is hoped that the NDHS 2013 will provide data that can be used in setting later target. Programme data based on the new M&E plan for vulnerable children response will also provide useful basis for target in future.
58	OVC4. Number of organizations and agencies demonstrating at least one score improvement in at least one areas of capacity building, as measured by a standardized tool			N/A			**NSP**								
							Historical trend								
							NOP11	**259**	**518**	**777**	**1036**	**1295**	**1870**		Currently 1870 organization are registered and providing OVC services in the country, with an average of 37/state. The NOP will be targeting organization from 7 states per year and expect to reach all the 36+FCT States by 2015
59	OVC5. Ratio of school attendance of orphans to school attendance of non-orphans aged 10-14 years			83.80%	NDHS 2008		**NSP**								
							Historical trend								
							NOP11	**83.9%**	**87.1%**	**90.3%**	**93.5%**	**96.7%**	**100%**		Using the DHS 2008 that reported 83.9%, the short fall to achieve 100% stand at 16.1% and this was spread accordingly through the years at the end of which 100% will be achieve by 2015

	PLHIV														
60	PLHIV1. Number of people living with HIV and people affected with HIV/AIDS provided with a minimum of one clinical care service (PLWH, PABA, sex and age:<15 and >15						**NSP**								
							Historical trend								
							NOP11								
61	PLHIV2. Number of PLHIV receiving Adherence Support						**NSP**								
							Historical trend								
							NOP11								
62	PLHIV3. Number of PLHIV receiving HBC			35293	Non health sector validation report, 2010		**NSP**								
							Historical trend								
							NOP11	**152358**	**304717**	**457070**	**609429**	**761787**	**761767**		
	Blood Safety														
63	BS1. % of donated blood units screened for HIV according to national guidelines						**NSP**								
							2010-2012 NPP								
							NOP11								
	Injection and Injection Drug - Use														
64	IDU1. % of IDUs reporting the use of a condom the last time they had sexual intercourse						**NSP**								
							2010-2012 NPP								
							NOP11								
65	IDU2. % of IDUs reporting the use of sterile injecting equipment the last time they injected						**NSP**								
							2010-2012 NPP								
							NOP11								

	Care and Support														
66	CS1. Number of people living with HIV and people affected with HIV/AIDS provided with a minimum of one clinical care service (PLWH, PABA)						**NSP**								
							2010-2012 NPP								
							NOP11								
67	CS2. Number of children and adult enrolled in HIV care: (a)new and (b) current (c) ever enrolled in the facility.						**NSP**								
							2010-2012 NPP								
							NOP11								
	WORKPLACE														
68	% of enterprises with an HIV/AIDS workplace policy and implementing programs according to minimum prevention package						**NSP**								
							2010-2012 NPP								
							NOP11								
69	% of MDAs with HIV/AIDS workplace policy and implementing an HIV/AIDS workplace program (prevention/care and support/treatment) according to the minimum prevention package						**NSP**								
							2010-2012 NPP								
							NOP11								
	GENDER														
70	Number of male and female reached by an individual, small-group, or community-level intervention or service that explicitly addresses the legal rights and protection of women and girls impacted by HIV/AIDS						**NSP**								
							2010-2012 NPP								
							NOP11								
	OTHERS														
71	National Composite Policy Index						**NSP**								
							2010-2012 NPP								
							NOP11								

ANNEX II: PROGRAM INDICATORS

Apart from national indicators listed in Chapter 4, there are several other indicators that are useful for monitoring of various programs in the country. A few of them are listed below.

PROGRAM INDICATORS:

Routine Indicators

1) Number of health worker trained on injection safety and waste management (APR)
2) Number/Percentage of laboratories with satisfactory performance in external quality assurance/proficiency testing (EQA/PT) program (a) for CD4 (patient monitoring), (b) for HIV rapid test (HIV diagnostics), (c.) for AFB smear microscopy (TB Diagnostics) (output)-Routine (APR)
3) Ratio between the median price paid by the country for each ARV in the last 12 months to the median international price (output-routine) (bi – or – annual from procurement and logistics report) (APR)
4) Proportion of generic to branded drugs procured. (output-routine) (bi – or – annual from procurement and logistics report) (APR)
5) Number/Percentage of facilities providing ART that use CD4 monitoring in line with national guidelines/policies, on site or through referral (output-routine) (APR)
6) Percentage of health care facilities (Private-not for-profit) that have the capacity and conditions to provide basic -level HIV testing and HIV/AIDS clinical management (output-routine) (APR)
7) Percentage of health facilities that offer paediatric ART (i.e. prescribe and/or provide clinical follow-up (output-routine) (APR)
8) Number of LGAs that have a Planned Preventive Maintenance(PPM) program established (output-routine) (APR)
9) Number of Service outlets providing HCT according to National Guidelines (output)-Routine (APR)
10) Number/Percentage of people aged 15 and above with Sexually Transmitted Infection (STI) who received HCT and received their results through provider -initiated services in the past 12 months; disaggregated by sex. (output-routine) (APR)
11) Number/Percentage of HCT clients accessing STI services (output-routine)-tool
12) Number/Percentage of HCT clients accessing FP services (output-routine)-tool
13) Number/Percentage of HCT clients accessing RH services (output-routine)-tool
14) Number of people reached by an individual, small-group, or community-level intervention or service that explicitly addresses norms about masculinity related to HIV/AIDS (output)-Routine-NARHS survey

15) Number of people reached by an individual, small group or community-level intervention or service that explicitly addresses gender-based violence and coercion related to HIV/AIDS (output)-Routine-NARHS survey
16) Number of people reached by an individual, small group, or community-level intervention or service that explicitly aims to increase access to income and productive resources of women and girls impacted by HIV/AIDS (output)-Routine-NARHS survey

Non-Routine Indicators

17) Median age of sexual debut among young people aged 15-24 years (outcome level)-NARHS survey
18) Percentage MARPs (IDU, FSW, MSM) who sought treatment for STI, of those reporting symptoms (output)-IBBSS survey
19) Percentage of never-married people aged 15-24 who have never had sex (output)-NDHS/NARHS survey
20) Percentage of never married women and men aged 15-24 who used a condom at last sex (output)- NDHS/NARHS survey
21) Percentage of women and men with accepting attitudes toward PLHIV (output)-NDHS/NARHS survey
22) Cross-generational sex: Percentage of women and men respondents aged 15-24 who have had non-marital sex with a man 10 years or more older than themselves in the last 12 months, of all those who have had non-marital sex in the last 12 months (output)-NDHS/NARHS
23) Condom use at last premarital sex, last sex: Percentage of young never married people (aged 15-24) who used a condom at last sex, of all young single sexually active people surveyed (output)- NARHS
24) Number of states/LGAs implementing the MPPI (as contained in the national prevention plan) (output-routine) (APR)
25) Number of NGO/CBO/FBO/CSO implementing the MPPI (output-routine) (APR)
26) Percentage
27) of total health expenditure dedicated to HIV/AIDS (output-routine)-(APR)

Indicator No	Indicator	Indicator Definition and Unit of Measurement	Data Source	Method/Approach of Data Collection or Calculation(how it will be collected)	Data Acquisition Analysis & Reporting		Baseline (as at 2010)	Comment
					Schedule/ Frequency	Responsible Organizations/sector		
IMPACT/OUTCOME LEVEL INDICATORS								
1	Percentage of infants born to HIV-infected mothers who are infected with HIV. (Routine /Outcome)	**Definition:** Percentage of HIV-infected infants born to HIV-infected mothers **Numerator:** Number of infants born to HIV-infected mothers who are infected with HIV **Denominator:** Total number of infants born to HIV- infected mothers	Delivery register for HIV+ women/child follow-up	Monthly summary form	Quarterly/ Annually	FMoH/ NASCP	29.1%	UNGASS Indicator 25 Pg 75
2	Percentage of adults and children with HIV known to be on treatment 12, 24, 36, 48 months after initiation of antiretroviral therapy	**Definition:-** Percentage of adults and children with HIV known to be on treatment 12 months after initiation of antiretroviral therapy **Numerator:**-Number of adults and children with HIV known to be on treatment 12 months after initiation of antiretroviral therapy **Denominator:-** Estimated number of adults and children with advanced HIV infection	PMM/Cohort Analysis	Monthly summary form	Quarterly/ Annually	NASCP	73.4%	FMoH
3	HIV Prevalence in the general population	**Definition:**-HIV Prevalence in the general population/percentage of pregnant women aged 15-49years attending ANC clinics who are HIV-	NARHS/ANC surveys	Survey	2-5years	NASCP	3.6%(NARHS 2007)/4.1% (ANC 2010)	This indicator is calculated using data

	(Non-Routine/Outcome)	infected **Numerator:-**Number of respondents who are infected with HIV/number of ANC attendees aged 15-49years who tested positive **Denominator:-**Total number of respondents in the survey/total number of ANC attendees (aged 15-49) tested for their HIV infection status						from pregnant attending ANCs in HIV sentinel surveillance sites
4	Percentage of young women and men aged 15-24 who are infected	**Definition:-** Percentage of young women and men aged 15-24 who are infected/percentage of pregnant women aged 15-24years attending ANC clinics who are HIV-infected **Numerator:-** Number of young women and men aged 15-24 who are infected with HIV/number of ANC attendees aged 15-24years who tested positive **Denominator:-** Total number of young women and men aged 15-24 in the survey/ total number of ANC attendees (aged 15-24) tested for their HIV infection status	NARHS/ANC surveys	Survey	2-5years	NASCP	4.2%	ANC, 2010

5	% of infants born to HIV infected mothers who are infected with HIV	**Definition:** Out of the total number of infants born to HIV-infected mothers how many of them are infected with HIV **Numerator:** Number of infants born to HIV-infected mothers who are infected with HIV **Denominator**: Total number of infants born to HIV- infected mothers	Programme monitoring tool /DELIVERY register for HIV +women/child follow up , Spectrum, or other statistical modelling that uses programme coverage and efficacy studies		Quarterly/ Annually			
PREVENTION OF MOTHER TO CHILD TRANSMISSION								
6	% of pregnant women who received HIV counselling and testing and received their test results during pregnancy, labour, delivery and the post-partum.	**Definition:** - Percentage of pregnant women who received HIV counselling and testing including the provision of test results at ANC/ PMTCT service outlets. **Numerator:** - Number of pregnant women who received HIV counselling and testing including the provision of test results at ANC/ PMTCT service outlets. **Denominator:**- Total number of pregnant women attending the ANC	Facility registers (General ANC and ANC/HCT register)	Monthly summary form	Quarterly/Annually	NASCP	16.9%	GARPR, 2012

7	Percentage of HIV positive pregnant women who receive antiretroviral medicines to reduce the risk of mother-to-child transmission (according to the national guidelines) during the reporting period	**Definition:** Percentage of HIV-infected pregnant women receiving a complete course of antiretroviral prophylaxis to reduce the risk of MTCT **Numerator:** Number of HIV-infected pregnant women provided with a full course of antiretroviral prophylaxis to reduce MTCT according to the nationally approved treatment protocol in the last 12 months **Denominator:** Total number of HIV-infected pregnant women	PMTCT/MIS	Monthly summary form/modelling	Monthly (Quarterly)	NASCP	15.9%	FMoH, 2011
8	%/Number of HIV-infected pregnant women who assessed for ART eligibility through either clinical staging or CD4 testing during the period(Routine)	**Definition:** Number of HIV-infected pregnant women who assessed for ART eligibility through either clinical staging or CD4 testing during the period **Numerator:** Number of HIV infected pregnant women who assessed for ART eligibility through either clinical staging or CD4 testing during the reporting period on site or by referral **Denominator:** Estimated number of HIV-infected pregnant women in the last 12 months	PMTCT Register	Monthly Summary form	Monthly/Annually	FMOH/NASCP	10.38%	GARPR, 2012
9	% of infants born to HIV -infected women who were started on contrimoxazole (CTX) prophylaxis	Definition:- Percentage of infants born to HIV infected women started on CTX Numerator:-Number of infants born to HIV-infected women started on co-	EID Register/Delivery register/ Pharmacy register	Monthly Summary form	Monthly/Annually	FMOH/NASCP	2%	Universal Access, 2011

	(within two months of birth).(Routine/Output)	trimoxazole prophylaxis Denominator:- Estimated number of HIV-infected pregnant women who gave birth in the past 12 months						
10	Percentage/Number of infants born to HIV-infected women(HIV-exposed infants receiving antiretroviral prophylaxis to reduce the risk for mother-to-child transmission(disaggregated by treatment regimen)(Routine)	Definition: Percentage of infants born to HIV-infected women(HIV-exposed infants receiving antiretroviral prophylaxis to reduce the risk for mother-to-child transmission Numerator: Number of infants born to HIV-infected women(HIV-exposed infants receiving antiretroviral prophylaxis to reduce the risk for mother-to-child transmission Denominator: Total number of infants born to HIV-infected women	EID Register/Delivery register/ Pharmacy register	Monthly Summary form	Monthly/Annually	FMOH/NASCP	6%	Universal Access, 2011
11	%/Number of infants born to HIV-infected women, who received an HIV test within 12 months of birth	**Definition**- Out of the total number of HIV positive pregnant giving birth in the last 12 month how many of their infants received an HIV test within 2 months of birth **Numerator:** Number of infants born to HIV-infected women who received an HIV test within 12 months of birth **Denominator:** Number of HIV-positive pregnant women giving birth in the last 12 months	EID Register/Delivery register/ Pharmacy register	Monthly Summary form	Monthly/Annually	FMOH/NASCP	4.0%	FMoH, 2011
12	Number of infants born to HIV-infected women	Definition: Number of infants born to HIV-infected women during the reporting period	EID Register/Delivery register/	Monthly Summary form	Monthly/Annually	FMOH/NASCP		

	during the reporting period(Routine)		Pharmacy register					
INFECTION CONTROL MANAGEMENT								
13	Percentage of persons provided with post-exposure prophylaxis (PEP) (Output/Routine)	Definition: Percentage of persons provided with post-exposure prophylaxis (PEP)(Disaggregated by age 0-5,6-12,13-17, 18 & above, sex. and circumstance of exposure Numerator: Number of persons provided with post-exposure prophylaxis (PEP) to reduce the risk of HIV infection through occupational and/or non-occupational. Exposure. Denominator: Total number of persons on post-exposure prophylaxis	Survey(NDHS) /Facility survey	Survey/Program monitoring tools	5 years	FMOH/NASCP		
HUMAN RESOURCE FOR HEALTH								
14	Number of health care workers who successfully completed an in-service training program within the reporting period (all trainings across all thematic areas and by sex	**Definition:** Number of health care workers who successfully completed an in-service training program within the reporting period (all trainings across all thematic areas and by sex **Numerator:** Number of health care workers who successfully completed an in-service training program	Program reports, Human Resource Information Systems, educational institutions, professional associations, Ministry of Education, Labor or Health	Program monitoring tools	Annually	FMOH		
TREATMENT								
15	Percentage of HIV positive adults and children who are	Definition: Proportion of people (adult and children) with HIV-infection currently receiving	ART register	Program monitoring tools	Monthly/ Quarterly	FMOH/NASCP	29.8%	FMoH, 2011

	eligible and currently receiving ART(disaggregated by first-line, second- line and third-line) (Routine)	antiretroviral therapy Numerator: Number of HIV infected (adults and children) who are currently receiving antiretroviral therapy in accordance with the nationally approved treatment protocol (or WHO/UNAIDS standards) at the end of the reporting period Denominator: Estimated number of adults and children with HIV infection						
16	Percentage of adults and children enrolled in HIV care currently receiving CTX prophylaxis (Routine)	Definition: The reporting period is defined as any continuous 12-month period that has ended within a pre-defined number of months from the submission of the report. Numerator: Number of adults and children enrolled in HIV care currently receiving CTX prophylaxis Denominator: Total number of adults and children in HIV care 12-month within the reporting period	ART register	Program monitoring tools	Monthly/ Quarterly	FMOH	76%	Universal Access, 2011
17	Percentage of HIV-infected pregnant women receiving ART for their own health during the reporting period(Routine)	Definition: Proportion of HIV+ pregnant women receiving ART for their own health Numerator: Number of HIV-infected pregnant women receiving ART for their own health during the reporting period Denominator: Total number of HIV-infected pregnant women.	ART register	Program monitoring tools	Monthly/ Quarterly	FMOH		

		This indicator is for pregnant women receiving treatment for their own health and not for PMTCT.						
18	Number of adults and children on ART .a)newly enrolled b)ever started (Routine)	Definition: Number of adults and children on ART	ART register	Program monitoring tools	Monthly/Annually	FMOH/ NASCP		
TB/HIV								
19	Percentage of estimated HIV-positive incident TB cases that received treatment for TB and HIV (Routine)	Definition: proportion of adults with HIV infection who received antiretroviral therapy in accordance with the nationally approved treatment protocol and who were started on TB treatment (in accordance with national TB programme guidelines), within the reporting year **Numerator:** Number of adults with HIV infection who received antiretroviral therapy in accordance with the nationally approved treatment protocol and who were started on TB treatment (in accordance with national TB programme guidelines), within the reporting year **Denominator:** Estimated number of incident TB cases in people living with HIV	Facility ART registers and reports; programme monitoring tool	Program monitoring tool	Annually	FMOH/ NASCP)	69.1%	FMoH, 2009
20	Percentage of HIV-positive patients who were screened for TB in HIV care or	**Definition:** proportion of HIV positive patients who were screened for TB enrolment in HIV care or treatment settings	Facility PRE-ART registers and reports; programme monitoring tool	Program monitoring tools	Monthly	FMOH/ NASCP)		

	treatment settings (Routine)	**Numerator**: Number of HIV positive patients who were screened for TB at enrolment in HIV care or treatment settings **Denominator:** Total Number of HIV-positive patients that were enrolled during the reporting period						
21	Percentage of TB patients Screened for HIV in TB care or treatment settings. (Routine)	**Definition:** Number of TB patients who were screened for HIV in TB care or treatment setting **Numerator:** Number of TB patients who were screened for HIV in TB care or treatment setting **Denominator:** Total Number of TB patients registered during the reporting period	TB treatment monitoring tools	TB treatment monitoring tools	Monthly	FMOH		
22	Number of HIV patients currently in care who commenced TB Treatment (Routine)	**Definition:** Total number of HIV patients currently in care who are commenced TB treatment	Program Report (PMM)and PRE-ART Registers and TB treatment monitoring tools	TB treatment monitoring tools	Monthly	FMOH		
23	Number of patients newly enrolled into HIV care and are given treatment for latent TB infection (isoniazid preventive therapy)(Routine)	**Definition:** Number of patients newly enrolled into HIV care and are given treatment for latent TB infection	Program Report (PMM)and PRE-ART Registers and TB treatment monitoring tools	TB treatment monitoring tools	Monthly	FMOH	1%	Universal Access, 2011

LAB (SYSTEM STRENGHTENING)								
24	Percentage of HIV reference laboratories that are accredited according to national standards (Routine)	**Definition:** Percentage of HIV reference laboratories that are accredited according to national standards **Numerator:** Number of HIV reference laboratories that are accredited according to national or international standards **Denominator:** Number of HIV reference laboratories with capacity to perform clinical laboratory tests	Program Reports	Program Monitoring tools	Monthly/ Annually	FMOH/ NASCP		
25	Percentage of health facilities that provide virological testing services (e.g. PCR) for infant diagnosis on site or through dried blood spots (DBS) (Routine)	**Definition:** Percentage of health facilities that provide virological testing services **Numerator:** Number of health facilities that provide virological testing services (e.g. PCR) for infant diagnosis on site or through dried blood spots (DBS) **Denominator:** Total number of health facilities that provide virological testing services	Program Reports	Program Monitoring tools	Monthly/ Annually	FMOH/NA SCP		
26	Percentage of facilities providing ART that use CD4 monitoring in line with national guidelines/policies, on site or through referral (Routine)	**Definition:** Percentage of facilities providing ART that use CD4 monitoring in line with national guidelines **Numerator:** Number of facilities providing ART that use CD4 monitoring in line with national guidelines/policies, on site or through	Program Reports	Program Monitoring tools	Monthly/Ann ually	FMOH/NA SCP		

		referral **Denominator:** Total number of facilities providing ART						
HEALTH SYSTEM LEADERSHIP/GOVERNANCE								
27	Number of States with costed annual workplan derived from State Strategic Plan (Output and Routine)	**Definition:** Number of States with costed annual workplan derived from State Strategic Plan for a comprehensive HIV response **Numerator:** Number of States with costed annual workplan derived from State Strategic Plan	Annual priority costed Plan	Program Monitoring tools	Annually	NACA		
28	Number of LGAs with costed annual workplan derived from State Strategic Plan (Output and Routine)	**Definition:** Number of LGAs with costed annual workplan derived from State Strategic Plan for a comprehensive HIV response **Numerator:** Number of LGAs with costed annual workplan derived from State Strategic Plan	Implementation Framework	Program Monitoring tools	Annually	NACA		
HEALTH SYSTEM STRENGTHENING SUB AREA 6 - HEALTH FINANCING								
29	Total domestic and international AIDS spending by categories and financing sources out of total AIDS spending and financing sources out of total AIDS	**Definition:** Total number of domestic and international AIDS spending by categories and financing sources	NASA Report	Survey	Annually	NACA/NASCP	US $497,817,417	NASA, 2010

	spending							
30	Percentage of total health expenditure dedicated to HIV/AIDS (Non-Routine)	**Definition:** Percentage of total health expenditure dedicated to HIV/AIDS **Numerator:-** Amount of health expenditure dedicated to HIV/AIDS **Denominator:** Total amount of health expenditure	NASA	NASA	Annual	NACA		
HEALTH SYSTEM STRENGTHENING SUB AREA 6 – MEDICAL PRODUCTS,VACCINES AND TECHNOLOGY								
31	Percentage of health facilities dispensing ARVs that experienced a stock-out of at least one required ARV in each quarter (Routine)	**Definition:** Percentage of health facilities dispensing ARVs that experienced a stock-out **Numerator:** Number of health facilities dispensing ARVs that experienced one or more stock-outs of required ARV drug in each quarter **Denominator:** Total number of health facilities dispensing ARVs.	Logistics management information systems or health facility surveys	Program Monitoring tools	Quarterly	FMOH/ NASCP		
HEALTH SYSTEM STRENGTHENING SUB AREA 6 –HEALTH SERVICE DELIVERY								
32	Percentage of pregnant women MAKING ATLEAST 4 ANC visits according to standards (Routine)	**Definition:** Percentage of pregnant women MAKING ATLEAST 4 ANC visits according to standards **Numerator**: Number of pregnant women MAKING ATLEAST 4 ANC visits according to standards **Denominator:** Total number of pregnant women	ANC Register	Program Monitoring tool	Monthly/ Annually	FMOH/ MCH		

SEXUAL BEHAVIOR CHANGE								
33	Percentage of people aged 15-24 who both correctly identify ways of preventing the sexual transmission of HIV and who reject major misconceptions about HIV transmission (Non-Routine)	**Definition:** Percentage of people aged 15-24 with knowledge about preventing the sexual transmission of HIV **Numerator:** Number of most-at-risk population respondents who gave the correct answers to all five questions **Denominator:** Total number of most-at-risk population respondents who gave answers, including "don't know", to all five questions	Behavioural surveys (NDHS/ NARHS)	Sampling/Behavioural survey reports.	Every 2 years	FMOH/ NASCP	24.2%	NARHS, 2007
34	Percent of women and men aged 15–49 who have had more than one sexual partner in the last 12 months reporting the use of a condom during their last sexual intercourse. (Non-Routine)	**Definition:** Percent of women and men aged 15–49 who have had more than one sexual partner **Numerator:** Number of respondents (aged 15–49) who reported having had more than one sexual partner in the last 12 months who also reported that a condom was used the last time they had sex **Denominator:** Total number of respondents (15–49) who reported having had more than one sexual partner in the last 12 months	Population-based surveys (Demographic Health Survey, AIDS Indicator Survey, Multiple Indicator Cluster Survey or NARHS)	Sampling/Survey report.	Every 4 to 5 years	FMOH	52.5%	NARHS, 2007

35	% of schools that provided life skills-based HIV education within the last academic year (FLHE) (Routine)	**Definition:** Percentage of schools that provided life skills-based HIV education within the last academic year **Numerator:** Number of schools that provided life-skills based HIV education in the last academic year **Denominator:** Number of Schools Surveyed	School Survey or Education program record	School Survey	Annually	FMOE		
36	Percentage of respondents aged 15–49 who have had sexual intercourse with more than one partner in the last 12 months (Non-Routine)	**Definition:** Percentage of respondents aged 15–49 who have had sexual intercourse with more than one partner in the last 12 months **Numerator:** Number of respondents aged 15–49 who have had sexual intercourse with more than one partner in the last 12 months **Denominator:** Total number of all respondents aged 15–49	Population-based Survey	Population-based Survey report.(NARHS)	Every 4 to 5 years	FMOH	11.4%	NARHS, 2007
37	Percentage of young women and men who have had sexual intercourse before the age of 15 (Non-Routine)	**Definition:** Percentage of young women and men who have had sexual intercourse before the age of 15 **Numerator:** Number of respondents (aged 15–24 years) who report the age at which they first had sexual intercourse as under 15 years **Denominator:** Total number of all respondents aged 15–24 years	Population-based Survey	Population-based Survey report	Every 4 to 5 years	FMOH	11.9%	NARHS, 2007
38	Percentage of People Living with	**Definition:** Percentage of People Living with HIV/AIDS (PLWHA)	HBC register	Program monitoring tool	Quarterly/Annually	FMOH		

	HIV/AIDS (PLWHA) reached with individual and/or small group level minimum prevention package (MPP) interventions (Routine)	reached **Numerator:** Number of People Living with HIV/AIDS (PLWHA) reached with individual and/or small group level minimum prevention package (MPP) interventions **Denominator:** Number of people living with HIV/AIDS						
39	Percentage of MARPs reached with individual and/or small group level MPP interventions (Routine)	**Definition:** Percentage of MARPs reached with individual and/or small group level MPP interventions (Routine) **Numerator**: Number of MARPs reached with individual and/or small group level MPP interventions	HBC register	Program monitoring tool	Quarterly/Annually	FMOH		
40	Percentage of most-at-risk populations (IDU, MSM, SW) who received an HIV test in the last 12 months and who know the results (disaggregated by age group) (Non-Routine)	**Definition**: **Numerator**: Number of most-at-risk population respondents who have received an HIV test in the last 12 months and who know the results **Denominator**: Number of most-at-risk population included in the sample	Behavioral Surveys	Survey	2 to 3 years	FMOH		
41	Percentage of most-at-risk populations (IDU, MSM, SW) who are HIV positive (Non-Routine)	**Definition:** Percentage of most-at-risk populations (IDU, MSM, SW) who are HIV positive **Numerator**: Number of members of the most-at-risk population who test positive for HIV	IBBSS	Survey	2 to 3 years	FMOH		

		Denominator: Number of members of the most-at-risk population tested for HIV						
42	Percentage of males reporting the use of a condom the last time they had anal sex with a male partner in the last six month (Non-Routine)	**Definition:** Percentage of males reporting the use of a condom the last time they had anal sex with a male partner **Numerator:** Number of respondents who reported that a condom was used the last time they had anal sex. **Denominator:** Total number of respondents who reported having had anal sex with a male partner10 in the last six months.	IBBSS	IBBSS report	2 to 3 years	FMOH	50.97%	IBBSS, 2010
43	Percentage of female sex workers reporting the use of a condom with their last client (Non-Routine)	**Definition:** Percentage of female sex workers reporting the use of a condom with their last client **Numerator:** Number of respondents who reported that a condom was used with their last client. **Denominator:** Total number of respondents who reported having commercial sex in the last 12 months.	IBBSS	IBBSS report	2 to 3 years	FMOH	92.9%	IBBSS, 2010
44	Percentage of men aged 15-64 reporting sex with a sex worker in the last 12 months who used a condom during last sexual intercourse (Non-Routine)	**Definition:** Percentage of men aged 15-64 reporting sex with a sex worker **Numerator:** Number of men aged 15-64 reporting sex with a sex worker in the last 12 months who used a condom during last sexual intercourse **Denominator:** Total number of men aged 15-64 reporting sex with a sex	NARHS	NARHS report/database	2 to 3 years	FMOH		Global fund Indicator

		worker in the last 12 months						
45	Number of states with anti stigma and discrimination law (routine)	**Definition**: Number of states with anti stigma and discrimination law	Annual Progress Report	Program Report	Annually	NACA		
46	Percentage of most-at-risk populations who both correctly identify ways of preventing the sexual transmission of HIV and who reject major misconceptions about HIV transmission (Non-Routine)	**Definition:** Percentage of most-at-risk populations with correct knowledge about sexual prevention of HIV **Numerator:** Number of most-at-risk population respondents who gave the correct answers to all five questions **Denominator:** Total number of most-at-risk population respondents who gave answers, including "don't know", to all five questions	IBBSS	IBBSS report	2 to 3 years	FMOH,		UNGASS Indicator 14 Page 54
47	Percentage of women and men aged 15-49 who have had sex with a non-marital, non-cohabiting sexual partner in the last 12 month (Non-Routine)	**Definition:** Percentage of women and men aged 15-49 who have had sex with a non-marital, non-cohabiting sexual partner in the last 12 month **Numerator:** Number of women and men who reported sexual activity with non-marital, non- cohabiting partners in the last 12 months **Denominator:** Total number of Women and men surveyed.	Population-based survey (e.g. NARHS, NDHS)	Population-based survey (e.g. NARHS, NDHS) report	2 to 5 years	FMOH/ NPC		NOP page 42
48	Number of schools implementing FLHE curriculum (non-routine)	**Definition:** Number of schools implementing FLHE curriculum **Numerator:** Number of schools implementing FLHE curriculum Denominator: Total number of schools	Program reports	Reports	Annually	FMOE		

49	Number of high risk group(female sex workers) reached with HIV/AIDS prevention programs.(Disaggregated by FSW, armed forces and transport workers)(non-routine)	**Definition:** Number of high risk group(female sex workers) reached with HIV/AIDS prevention programs	Survey	Survey	Biannually	FMOH/ NASCP		
TESTING AND COUNSELLING								
50	% of individuals who received an HIV counseling and testing in the last 12 months and who know the results (disaggregated by sex) (Non-Routine)	**Definition:** Percentage of individuals who received an HIV counselling and testing **Numerator:** Number of respondents who have been tested for HIV during the last 12 months and who know their results **Denominator:** Number of all respondents surveyed	Population-based surveys (Demographic Health Survey, AIDS Indicator Survey, Multiple Indicator Cluster Survey or NARHS)	Population-based surveys report.	Every 2 to 5 years	FMOH/ NPC/NBS		
51	Percentage of women and men who received HIV C&T and received their results through HCT sites in the reporting period	**Definition:** Percentage of client population aged 15 and above who received HIV C&T **Numerator:** Number of client population aged 15 and above who received HIV C&T and received their results through HCT sites in the past 12 months (routine)	Program data	HCT register	Every 2 to 5 years	FMOH/ NASCP		

	(Routine)	**Denominator:** Number of the patient population aged 15 and above who received HIV C&T and received their results						
52	Percentage of women and men aged 15 and above with Sexually Transmitted Infection (STI) who received HCT and received their results in the past 12 months (Routine)	**Definition:** Percentage of people aged 15 and above with Sexually Transmitted Infection (STI) **Numerator:** Percentage of women and men aged 15 and above with Sexually Transmitted Infection (STI) who received HCT and received their results in the past 12 months (routine) **Denominator:** Total number of people with a sexually transmitted infection (STI) aged 15 and older.	Program, survey, special study	Program, survey, special study report	2 to 5 years	FMOH/ NASCP		
53	Percentage of most-at-risk populations (IDU, MSM, SW) who received an HIV test in the last 12 months and who know the results (Non-Routine)	**Definition:** Proportion of persons aged 15 – 49 years (male and female) amongst the special groups who in the last 6 months had an HIV test and received their test results **Numerator:** Number of respondents (15-49yrs) who answer YES to the first question; ; less than 12 months to the second question; and Yes to the 4th question i.e. received their results **Denominator:** Total number of respondents (15-49) who gave answers (including "don't know") to question 1	High Risk Survey (IBBSS)	(IBBSS) report	Every two years	FMOH/ NASCP	60%	Universal Access, 2011
54	% of individuals who tested positive for HIV during the	**Definition:** Number of individuals who tested positive for HIV during the reporting period	HCT Register	Program Monitoring Tool	Monthly/ Quarterly	FMOH/ NASCP		

	reporting period (Routine)	**Numerator:** Number of individuals who tested positive for HIV during the reporting period **Denominator:** Total number of individuals that were tested during the reporting period						
55	Number of facility that experience stock out of any test kits during the reporting period(Routine)	**Definition:** Number of facility that experience stock out of any test kits during the reporting period	Lab Register	Monthly Summary Form	Monthly/ Quarterly	FMOH/ NASCP		
OVC								
56	Percentage (number) of vulnerable children with improved wellbeing per a standardized instrument (Child Status Index-CSI) as related to the service areas	**Definition:** This is the percentage of enrolled OVC with improved quality of life measured by a standard nationally approved instrument e.g. CSI tool. **Numerator:** Number of vulnerable children that showed a minimum of one score improvement in any service areas since last assessment. **Denominator:** Number of vulnerable children receiving services	OVC Register	Program monitoring tool	Annually	FMWASD		
57	Number of vulnerable children (OVC) provided with social services (health, nutrition, shelter, education, care, protection, psychosocial	**Definition:** Number of vulnerable children (OVC) provided with social services (health, nutrition, shelter, education, care, protection, psychosocial support, household and economic strengthening)	OVC Register	Program monitoring tools	Monthly, Quarterly, Annually	FMWASD		

	support, household and economic strengthening)							
58	Percentage of orphans and vulnerable children whose households received free basic external support in caring for the child	**Definition:** An ophan is defined as a child younger than 18 years who has lost both parents. A child made vulnerable by HIV is younger than 18 years and fulfills any of the following: 1. Has lost one or both parents; 2. Has a chronically ill parents (regardless of whether the parent lives in the same house as the child); 3. Lives in a household where, in the last 12 months, at least one adult died and was sick for three or four months before he or she died; 4. Lives in a household where at least one adult was seriously ill for atleast three of the last 12 months; 5. Lives with a guidiant who is 65 years or older; or 6. Lives with guidian(s) who are physically impaired **Numerator:** Percentage of orphans and vulnerable children whose households received free basic external support in caring for the child **Denominator:** Total number of orphaned and vulnerable children aged 0-17	Population-based survey	Population-based survey	Every 3-5 years	FMWASD		
59	Number of organizations and	**Definition:** Number of organizations and agencies demonstrating at least	Program data	OVC register	Every 3-5 years	FMWASD		

	agencies demonstrating at least one score improvement in at least one areas of capacity building, as measured by a standardized tool	one score improvement in at least one areas of capacity building, as measured by a standardized tool Number of grantees who show at least one score improvement in at least one areas of capacity building, since last assessment Targeted aspects: 1. Financial Management 2. Management and Human Resources 3. Technical Capacity 4. Monitoring and Evaluation 5. Oversight and Governance 6. External Resources						
60	Ratio of school attendance of orphans to school attendance of non-orphans aged 10-14 years (Non-Routine)	**Definition:** This is the proportion of orphans (children who have lost one or both parents) aged 10-14 years currently attending school to non-orphans of the same age group that are currently attending school. **Numerator**: Number of children whose parents are alive, who are living with at least one parent and who attend school **Denominator**: Number of children whose parents are alive who are living with at least one parent	Population-based survey (Demographic Health Survey, AIDS Indicator Survey, Multiple Indicator Cluster Survey or other representative survey)	Survey	Preferred: Every two years Minimum: every 4 to 5 years	FMWASD		
PLHIV								
61	Number of people	**Definition:** Number of people living	Routine program	Program Monitoring	Monthly	FMWASD		

	living with HIV and people affected with HIV/AIDS provided with a minimum of one clinical care service (PLWH, PABA, sex and age: <15 and above 15years) (Routine)	with HIV and people affected with HIV/AIDS provided with a minimum of one clinical care service (PLWH, PABA, sex and age: <15 and above 15years) (routine	Registers/ databases, client records and registers, or other program monitoring tools	Tool				
62	Number of People Living with HIV/AIDS receiving Adherence Support(Routine)	**Definition:** Number of People Living with HIV/AIDS receiving Adherence Support	Program Report(PMM)	Program monitoring tool (PITT)	Quarterly	FMOH/ NASCP		
63	Number of People Living with HIV/AIDS receiving Home Based Care(Routine)	**Definition:** Number of People Living with HIV/AIDS receiving Home Based Care	Program Report(PMM)	Program monitoring tool (PITT)	Quarterly	FMOH/ NASCP		
BLOOD SAFETY								
64	Percentage of donated blood units screened for HIV according to national guidelines (Routine)	**Definition:** Percentage of donated blood units screened for HIV **Numerator:** Number of donated blood units screened for HIV According to national guidelines. **Denominator**: Total number of blood units donated	Program data	Blood transfusion register	Biennial	FMOH/ NASCP		NOP Page 45

INJECTION SAFETY AND INJECTION DRUG USE								
65	Percentage of injecting drug users reporting the use of a condom the last time they had sexual intercourse (Non- Routine)	**Definition:** Percentage of injecting drug users reporting the use of a condom **Numerator:** Number of respondents who reported that a condom was used the last time they had sex **Denominator:** Total number of respondents who report having injected drugs and having had sexual intercourse in the last month	IBBSS	IBBSS report	2 to 3 years	FMOH/ NASCP	52.5%	IBBSS, 2010
66	Percentage of injecting drug users reporting the use of sterile injecting equipment the last time they injected (Non- Routine)	**Definition:** Percentage of injecting drug users reporting the use of sterile injecting equipment **Numerator**: Number of injecting drug users reporting the use of sterile injecting equipment the last time they injected **Denominator:** Number of respondents who report injecting drugs in the last month	Behavioral Surveys for injecting drug users	IBBSS	2 to 3 years	FMOH/ NASCP	70.89%	IBBSS, 2010
CARE AND SUPPORT								
67	Number of children and adult enrolled in HIV	**Numerator:** Number of children and adult enrolled in HIV care: (a)new and (b) current (c) ever enrolled in the	Program monitoring tool		Annually			

	care: (a)new and (b) current (c) ever enrolled in the facility	facility by sex and age: <1 yr, 1-17yrs, 18 and above						
WORK PLACE PROGRAMS								
68	Percentage of enterprises with an HIV/AIDS workplace policy and implementing programs according to minimum prevention package (Non-Routine)	**Definition:** Percentage of enterprises with an HIV/AIDS workplace policy and implementing programs according to minimum prevention package **Numerator:** Number of enterprises implementing an HIV/AIDS workplace program, (prevention/care and support/treatment) according to minimum package **Denominator:** Number of registered enterprises	Workplace Survey	Survey	Annually	FMOLP		
69	Percentage of MDAs with HIV/AIDS workplace policy and implementing an HIV/AIDS workplace program (prevention/care and support/treatment) according to the minimum prevention package (Non-Routine)	**Definition:** Percentage of MDAs with HIV/AIDS workplace policy and implementing an HIV/AIDS workplace program (prevention/care and support/treatment) according to the minimum prevention package **Numerator:** Number of MDAs that have HIV/AIDS workplace policy and programs. **Denominator:** Total number of MDAs	Workplace Survey	Survey	Annually	FMOLP		

GENDER								
70	Number of male and female reached by an individual, small-group, or community-level intervention or service that explicitly addresses the legal rights and protection of women and girls impacted by HIV/AIDS (Routine)	**Definition:** Number of male and female reached by an individual, small-group, or community-level intervention or service that explicitly addresses the legal rights and protection of women and girls impacted by HIV/AIDS	HBC Register	Program Monitoring Tool	Annually	FMWASD		
OTHERS								
71	National Composite Policy Index (Non-Routine)	**Definition:** Assessment of progress in the development and implementation of national level HIV and AIDS policies, strategies and laws	**Ref UNGASS Reporting guidelines** (Areas covered: prevention, treatment, care and support, human rights, civil society involvement, gender, workplace programmes, stigma and discrimination and monitoring and evaluation).	UNGASS online reporting tool	Annual	NACA		

Annex lll: National Indicators: Reference Sheet

NATIONAL INDICATORS: REFERENCE SHEET

IMPACT/OUTCOME LEVEL INDICATORS

Percentage of infants born to HIV-infected mothers who are infected with HIV	
Type of Indicator	National
Numerator	Number of infants born to HIV-infected mothers who are infected with HIV
Denominator	Total number of infants born to HIV- infected mothers.
Disaggregation	Age
Purpose	To assess progress towards eliminating mother-to-child HIV transmission
Data collection frequency	Quarterly/Annually
Measurement tool	Programme monitoring tool /DELIVERY register for HIV +women/child follow up , Spectrum, or other statistical modelling that uses programme coverage and efficacy studies
Method of measurement	The indicator will be calculated by taking the weighted average of the probabilities of mother-to-child transmission for pregnant women receiving and not receiving HIV prophylaxis, the weights being the proportions of women receiving and not receiving various prophylactic regimes.
Interpretation	This indicator focuses on prevention of mother-to-child transmission of HIV through increased provision of antiretroviral medicines. The Spectrum HIV estimation modelling software takes into consideration the type of antiretroviral regimen as well as additional factors that influence HIV transmission rates such as infant feeding practices. For further information on Spectrum please consult the webpage of the UNAIDS/WHO Estimates and Projections Reference Group listed below.
Additional Information	For further information, please consult the following website: • http://www.unaids.org/en/HIV_data/Methodology/default.asp

Percentage of adults and children with HIV known to be on treatment 12, 24, 36 and 48 months after initiation of antiretroviral therapy	
Type of Indicator	National
Numerator	Number of adults and children who are still alive and on antiretroviral therapy at 12, 24, 36 and 48 months after initiating treatment
Denominator	Total number of adults and children who initiated antiretroviral therapy who were expected to achieve 12, 24, 36 and 48 -month outcomes within the reporting period, including those who have died since starting therapy, those who have stopped therapy, and those recorded as lost to follow-up at month 12, 24, 36 and 48.
Disaggregation	sex: Male and Female Disaggregate by age groups: ≤ 18 months, 19months-5years, 6-9 years, 10-14 years, 15 years and above. Disaggregate by location: Health facility level, LGA, state.
Purpose	To assess progress in increasing survival among infected adults and children by maintaining them on antiretroviral therapy
Data collection frequency	Quarterly/Annually
Measurement tool	Programme monitoring tools; cohort/group analysis forms
Method of Measurement	Antiretroviral therapy registers and antiretroviral therapy cohort analysis report form
Interpretation:	Using this denominator may underestimate true "survival", since a proportion of those lost to follow-up are alive. The number of people alive and on antiretroviral therapy (i.e. retention on antiretroviral therapy) in a treatment cohort is captured here. Priority reporting is for aggregate survival reporting. If comprehensive cohort patient registries are available then it is encouraged for countries to track retention on treatment at 24, 36, and 48 months and yearly thereafter. This will enable comparison over time of survival on antiretroviral therapy. As it Stands, it is possible to identify whether survival at 12 months increases or decreases over time. However, it is not possible to attribute cause to these changes. For example, if survival at 12 months increases overtime, this may reflect an improvement in care and treatment practices or earlier initiation of antiretroviral therapy. The retention on antiretroviral therapy at 12 months therefore needs to be interpreted in view of the baseline characteristics of the cohort of patients at the start of antiretroviral therapy: mortality will be higher in sites where patients accessed antiretroviral therapy at a later stage of infection. Therefore, collection and reporting of survival over longer durations of treatment outcomes may provide a better picture of the long-term

	effectiveness of antiretroviral therapy
Additional Information	Explanations of Numerator and Denominator Numerator:- The numerator requires that adult and child patients must be alive and on antiretroviral therapy at 12 months after their initiation of treatment. For a comprehensive understanding of survival, the following data must be collected: • Number of adults and children in the antiretroviral therapy start-up groups initiating therapy at least 12 months prior to the end of the reporting period; • Number of adults and children still alive and on antiretroviral therapy at 12 months after initiating treatment. The numerator does not require patients to have been on antiretroviral therapy continuously for the 12-month period. Patients who may have missed one or two appointments or drug pick-ups, and temporarily stopped treatment during the 12 months since initiating treatment but are recorded as still being on treatment at month 12 are included in the numerator. On the contrary, those patients who have died, stopped treatment or been lost to follow-up at 12 months since starting treatment are not included in the numerator. For example, for those patients who started antiretroviral therapy in May 2005, if at any point during the period May 2005 to May 2006 these patients die, are lost to follow-up (and do not return), or stop treatment (and do not restart), then at month 12 (May 2006), they are not on antiretroviral therapy, and not included in the numerator. Conversely, a patient who started antiretroviral therapy in May 2005 and who missed an appointment in June 2005, but is recorded as on antiretroviral therapy in May 2006 (at month 12) is on antiretroviral therapy and will be included in the numerator. What is important is that the patient who has started antiretroviral therapy in May 2005 is recorded as being alive and on therapy after 12 months, regardless of what happens from May 2005 to May 2006. Denominator:- The denominator is the total number of adults and children in the antiretroviral therapy start-up groups who initiated therapy at any point during the 12 months prior to the beginning of the reporting period, regardless of their 12-month outcome. For example, for the reporting period 1 January to 31 December 2007, this will include all patients who started antiretroviral therapy during the 12-month period from 1 January to 31 December 2006. This includes all patients, both those on antiretroviral therapy as well as those who are dead, have stopped treatment or are lost to follow-up at month 12.
	At the facility level, the number of adults and children on antiretroviral therapy at 12 months includes patients who have transferred in at any point from initiation of treatment to the end of the 12-month period and excludes patients who have transferred out during this same period to reflect the net current cohort at each facility. In other words, at the facility level, patients who have transferred out will not be counted either in the numerator or the denominator. Similarly, patients who have transferred in will be counted in both the numerator and denominator. At the national level, the number of

	transferred-in patients should match the number of transferred-out patients. Therefore, the net current cohort (the patients whose outcomes the facility is currently responsible for recording—the number of patients in the start-up group plus any transfers in, minus any transfers out) at 12 months should equal the number in the start-up cohort group 12 months prior.

HIV Prevalence in the general population	
Type of indicator	National
Numerator	Number of respondents who are infected with HIV/ Number of ANC attendees aged 15 – 49 years who test positive for HIV
Denominator:	Total number of respondents in the survey/ Total number of ANC attendees (aged 15 – 49) tested for HIV infection status
Disaggregation:	Sex: male and female Age: 15 – 49
Purpose:	Population-based surveys are potentially the best source of data on HIV prevalence in the general population. It is less sustainable to collect data for this indicator than it is to obtain ANC surveillance data. Such surveys are costly and complex and should only be considered in situations where the quality of the surveys can be assured. In order to provide robust estimates of prevalence trends they must be repeated at regular intervals in a comparable manner. If such surveys can only be conducted at infrequent intervals the findings can be compared with the results of ANC surveillance.
Data collection frequency:	2-5 years
Measurement tool:	Nationally representative population-based surveys, including the collection of suitable biological specimens.
Method of measurement:	This indicator should be reported as percentages for males and females and the age groups 15–24 and 25 years and above. Any data available on young people aged 10–14 years can also be given. The sample sizes should be given for each category and the HIV testing protocol should be given. It may be appropriate to give estimates disaggregated by the duration of the high-risk behaviour. In surveys conducted among groups with high-risk behaviour, sampling should not be restricted to young people. Instead, this indicator should be based on data from a subset of respondents. It is important that surveys among these groups cover a sufficiently large sample to provide reliable estimates for young people. If sample sizes are small and, as a consequence, such subdivisions would prejudice anonymity, or if information is not available on HIV status, it is not necessary to provide the prevalence data subdivided by

	age or duration of the high-risk behaviour. Instead, the age distribution of whole groups should be reported, regardless of HIV status. The groups can be described in the age groups <15, 15–24 and 25 years and above. If available, the median duration of the high-risk behaviour should be reported for each age group. Tracking HIV in subpopulations can be logistically and ethically difficult, especially if the groups are marginalized or their activities are illegal. The sampling and estimation of total population sizes are key issues. An understanding of how the sampled population relates to any larger population sharing similar risk behaviour is critical for the interpretation of the indicator. For some groups, population based sampling strategies are necessary. In other cases, sentinel sites are available. Sentinel sites for these populations tend to be linked to the provision of health services, e.g. a men's health clinic in an area with a high concentration of gay sex bars, or a drug rehabilitation center.
Interpretation:	HIV prevalence at any given age is the difference between the cumulative number of people that have become infected with HIV up to this age minus the number who have died, expressed as a percentage of the total number alive at this age. At older ages, changes in HIV prevalence are slow to reflect changes in the rate of new infections (HIV incidence) because the average duration of infection is long. Furthermore, declines in HIV prevalence can reflect saturation of infection among those individuals who are most vulnerable and rising mortality rather than behaviour changes. At young ages, trends in HIV prevalence are a better indication of recent trends in HIV incidence and risk behaviour.
Additional Information:	http://www.unaids.org/en/HIV_data/methodology/default.asp

Percentage of young women and men aged 15-24 who are HIV infected	
Type of Indicator:	National
Numerator:	Number of young women and men aged 15-24 who are infected with HIV/number of ANC attendees aged 15-24years who tested positive
Denominator:	Total number of young women and men aged 15-24 in the survey/ total number of ANC attendees (aged 15-24) tested for their HIV infection status
Purpose	To assess progress towards reducing HIV infection
Disaggregation:	By Age:15-24 By Sex: male and female
Data collection frequency:	2-5 years
Measurement tool:	WHO guidelines for HIV sentinel surveillance
Method of Measurement	This indicator is calculated using data from pregnant women attending antenatal clinics in HIV sentinel surveillance sites in the capital city, other urban areas and rural areas.
Interpretation:	HIV prevalence at any given age is the difference between the cumulative numbers of people that have become infected with HIV up to this age minus the number who have died, expressed as a percentage of the total number alive at this age. At older ages, changes in HIV prevalence are slow to reflect changes in the rate of new infections (HIV incidence) because the average duration of infection is long. Furthermore, declines in HIV prevalence can reflect saturation of infection among those individuals who are most vulnerable and rising mortality rather than behaviour change. At young ages, trends in HIV prevalence are a better indication of recent trends in HIV incidence and risk behaviour. Thus, reductions in HIV incidence associated with genuine behaviour change should first become detectable in HIV prevalence figures for 15–19-year-olds. Where available, parallel behavioural surveillance survey data should be used to aid interpretation of trends in HIV prevalence. In countries where the age at which young people first have sexual intercourse is late and/or levels of contraception use are high, HIV prevalence among pregnant women of 15–24 years of age will differ from that among all

	women in the age group. 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. It is less reliable as an indicator of HIV-epidemic trends in locations where most infections remain temporarily confined to most-at-risk populations. 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. If available, survey based estimates should be disaggregated by sex. The addition of new sentinel sites will increase the samples representativeness and will therefore give a more robust point estimate of HIV prevalence. However, the addition of new sentinel sites reduces the comparability of values. As such it is important to exclude new sites from the calculation of this indicator when undertaking trend analyses
Additional Information	http://www.unaids.org/en/HIV_data/Methodology/default.asp

Prevention of Mother to Child Transmission (PMTCT)

Percentage of pregnant women who received HIV counselling and testing , and received their test results during pregnancy, labour delivery and post-partum	
Type of Indicator:	National
Numerator:	Number of pregnant women who received HIV counselling and testing , and received their test results during pregnancy, labour, delivery and post-partum
Denominator:	Total number of pregnant women attending the ANC(new) and L&D clients
Disaggregation:	By: Known positives at entry Number of new positives identified
Purpose:	This indicator reflects one goal of PMTCT, which is to increase the number of pregnant women who know their HIV status. Identification of a pregnant woman's HIV status is the key entry point into PMTCT services and other HIV care and treatment services. These data will be important to PEPFAR Headquarters, TWGs and USG country-level managers in order to: • Identify progress toward the USG goal to reach 80% of pregnant women with HIV testing and counselling • Determine PEPFAR and PEPFAR-funded partners' performance in providing HIV testing to pregnant women • Identify countries/ partners needing assistance with program implementation
Data collection frequency:	Quarterly
Measurement tool:	General ANC and ANC/HCT register
Method of Measurement	The numerator is a composite of the following two data components: The number of women with known (positive) HIV infection attending ANC for a new pregnancy over the last reporting period The number of women attending ANC, L&D who were tested for HIV and received results (These should also be counted in indicator

	#P11.1.D) The numerator can be summed from categories a-d below: a) Number of pregnant women who received an HIV test and result during ANC b) Number of pregnant women attending L&D with unknown HIV status who were tested in the L&D and received results c) Women with unknown HIV status attending postpartum services within 72 hours of delivery who were tested and received results d) Pregnant women with known HIV infection attending ANC for a new pregnancy. Explanation of Numerator: The numerator is calculated using national and/or PEPFAR program records aggregated from facility registers in the ANC and L&D. In countries with high L&D attendance rates (>90%), data can be collected from L&D registers only. Health facility registers should reflect known HIV infection among HIV-positive pregnant women coming to the ANC for a new pregnancy, such as through a code, circle, or other method, in order for them to receive subsequent PMTCT interventions. Pregnant women with unknown status: women who were not tested during ANC or at L&D for this pregnancy or did not have documented proof of having been tested during ANC or at L&D for this pregnancy. Pregnant women with known HIV-infection: women who were tested and confirmed HIV-positive at any point prior to the current pregnancy, who are attending ANC for a new pregnancy. Pregnant women with known HIV infection attending ANC for a new pregnancy do not need retesting if that is in line with the national guidelines on testing pregnant women and/or, as long as they bring documented proof of their positive status with them. However, these women do need subsequent PMTCT services, and so should be counted in the numerator. In this case, documented proof may include (but is not limited to), a health card with HIV status noted in it, test results from another testing centre, or any other document that denotes that the bearer of the document is HIV positive. Denominator: The total number of new clients attending ANC and L&D services at USG-supported sites should be used as the denominator. This total will include the number of new clients who attend PMTCT services at USG-supported ANC sites and the number of women who present at L&D sites supported by USG with unknown status (as a proxy for those who have not attended ANC with

	PMTCT services). USG country team is to identify the best source of data for unduplicated individuals. If the country has high facility delivery rates (>90%), the L&D data may be used as the denominator, otherwise ANC data should be used. Note: This indicator is meant to measure the number of pregnant women who know their HIV status and is not meant to provide programmatic guidance around the types of services that should accompany HIV testing (i.e. counselling). All HIV testing programs should be adhere to national or international standards.
Interpretation:	This indicator enables the Nigeria government to monitor trends in HIV testing among pregnant women and uptake of testing in the country
Additional Information:	- #7, Guidance and Specifications for Additional Recommended Indicators, Addendum to: UNGASS. Monitoring the Declaration of Commitment on HIV/AIDS. Guidelines on Construction of Core Indicators. 2008 Reporting. April 2008. http://data.unaids.org/pub/BaseDocument/2009/20090305_additionalrecommendedindicators_finalprintversio_en.pdf - Partially harmonized with Prevention indicator (HIV-P11), The Global Fund to Fight AIDS, Tuberculosis and Malaria Monitoring and Evaluation Toolkit: HIV, Tuberculosis and Malaria and Health Systems Strengthening, Part 2: Tools for monitoring programs for HIV, tuberculosis, malaria and health systems strengthening, Third Edition, February 2009 http://www.theglobalfund.org/documents/me/M_E_Toolkit_P2-HIV_en.pdf - IATT PMTCT M&E Guidance
Limitation	The points at which drop-outs occur during the testing and counselling process and the reasons why they occur are not captured by this indicator. This indicator does not measure the quality of the testing or counselling. It also does not capture the number of women who received pre- or post- test counselling. - There is a risk of double counting with this indicator, as a pregnant woman could be tested multiple times during ANC, L&D, or postpartum. This is particularly true where women get re-tested in different facilities, or where they come to the L&D without documentation of their test. While not feasible to avoid double counting entirely, countries should ensure a data collection and reporting system is in place to minimize it, such as using patient held and facility held ANC records to document that testing took place.

Percentage of HIV-infected pregnant women who received antiretroviral to reduce risk of mother-to-child-transmission(according to national guidelines during the reporting period)	
Type of Indicator	Program
Numerator:	Number of HIV-infected pregnant women who received antiretroviral to reduce risk of mother-to-child-transmission
Denominator:	Total number of HIV- infected pregnant women identified in the reporting period (including known HIV- positive at entry)
Disaggregation:	By regimen type: 1. Single-dose Nevirapine only 2. Prophylactic regimens using a combination of 2 ARVs 3. Prophylactic regimens using a combination of 3 ARVs 4. ART for HIV-positive pregnant women eligible for treatment
Purpose:	This indicator measures the delivery and uptake of antiretroviral prophylaxis, by regimen type, for the prevention of mother-to-child-transmission (PMTCT). The risk of MTCT can be significantly reduced with the use of antiretrovirals for the mother, with or without prophylaxis to the infant. • The disaggregation by regimen type provides data used by SPECTRUM and other models and applications to determine the impact of PMTCT programs, by country.
Data collection frequency:	Monthly/ Quarterly
Measurement tool:	PMTCT/MIS/GEN ANC register, Pharmacy summary form
Method of measurement:	Monthly summary form/modelling Explanation of Numerator: The number of HIV-positive pregnant women who received antiretroviral to reduce MTCT is obtained from program monitoring records compiled from patient records and facility registers. ARVs can be provided to HIV-positive women during pregnancy, at labor, and shortly after delivery (i.e. within 72 hours or according to national/international standards) across a number of sites to prevent mother to child transmission of HIV, including at ANC, L&D, and care and treatment. Numerator data will be stratified by maternal regimen: 1. Single-dose Nevirapine only 2. Prophylactic regimens using a combination of 2 ARVs 3. Prophylactic regimens using a combination of 3 ARVs

4. ART for HIV-positive pregnant women eligible for treatment[1]

Each ARV regimen category is mutually exclusive. ARVs can be provided to HIV-positive women at many sites including ANC, L&D and care & treatment. If a woman switches regimens within one reporting period, she should be counted only once. Count the most recent regimen provided to her in the reporting period. If Neverapine is given after AZT this will be counted as two-drug. HIV-positive women receiving any of the above regimen categories meet the definition of the numerator.

[1]The categories can be clarified as follows:

Categories	Further clarification	Examples
a) Single-dose nevirapine only	One dose of nevirapine for mother given at or around birth	Single-dose (SD) NVP
b) Prophylactic regimens using a combination of two ARV;	A prophylactic regimen that uses more than one ARV drug for mothers to prevent HIV transmission and is started before labour and delivery	AZT + SD NVP AZT + SD NVP +7 day post-partum tail of AZT/3TC AZT + 3TC AZT + 3TC + SD NVP
c) Prophylactic regimens using a combination of three ARVs	Highly active regimen for MTCT prophylaxis designed to fully suppress viral replication prior to and during delivery and for a variable duration post partum	AZT + 3TC + NNRTI or AZT + 3TC +PI or AZT + 3TC + NRTI
d) ART for HIV-positive pregnant women eligible for treatment	ART for HIV-positive pregnant women eligible for treatment (estimate < 2% trans)	Standard national treatment regimen AZT + 3TC + NNRTI or AZT + 3TC +PI or AZT + 3TC + NRTI

Two methods for calculating the numerator can be used:

1) Low facility delivery settings:

Counting at point of ARV provision: In settings with low facility deliveries, data for the numerator should be compiled from patient registers based on where ARVs are dispensed and where the data is being recorded. For example, where ARV prophylaxis is provided in the ANC and ART is provided in the care and treatment unit, countries should aggregate data from the ANC/PMTCT register as well as the pre-ART or ART register. There is a risk of double counting in settings where ARVs are provided at different points in time and/or in different

	service units or health facilities (e.g. a woman received SD-NVP at post-test counselling and then received AZT at 28 weeks). Countries should ensure a data collection and reporting system is in place to minimize the potential for double counting. 2) High facility deliver settings: Counting at the end-point of labor and delivery: In settings with high facility delivery rates (>90%), countries can aggregate the numerator entirely from the L&D register by counting the number of HIV-positive pregnant women who had received a specific ARV regimen by the time of delivery (e.g., a woman received SD-NVP and AZT during her pregnancy; at the time of delivery she would be recorded in the L&D register as having received AZT+SD-NVP during pregnancy and included in category #2). This may be the most reliable and accurate method for calculating this indicator for settings with high facility deliveries, as the corresponding ARV regimen dispensed is counted at the end of a woman's pregnancy. PEPFAR denominator: This denominator will include a sum of categories a-d below, at USG-supported sites: a) number of pregnant women who received an HIV+ test and result during ANC b) pregnant women attending L&D with unknown HIV status who were tested HIV+ in the L&D and received their results c) pregnant women with known HIV infection attending ANC for a new pregnancy d) Women with unknown HIV status attending postpartum services within 72 hours of delivery who were tested HIV positive
Interpretation:	This indicator allows Nigeria to monitor: 1) the coverage of antiretroviral given to HIV-positive pregnant women to reduce the risk of HIV transmission to the child; and 2) increased access to more efficacious ARV regimens for PMTCT in countries that are scaling up newer regimen categories. One weakness of this indicator is the exclusion of mother-infant pairs who only received infant prophylaxis. Therefore, partial prophylaxis for the infant only is not measured. The indicator measures ARVs dispensed and not ARVs consumed, thus it is not possible to determine adherence to the ARV regimen.
Additional Information:	- #5, Monitoring the Declaration of Commitment on HIV/AIDS. Guidelines on Construction of Core Indicators 2010 Reporting, United Nations General Assembly Special Session [UNGASS]. - Prevention indicator (HIV-P12), The Global Fund to Fight AIDS, Tuberculosis and Malaria Monitoring and Evaluation Toolkit: HIV, Tuberculosis and Malaria and Health Systems Strengthening Part 2: Tools for monitoring programs for HIV, tuberculosis, malaria and health systems strengthening, Third Edition, February 2009 http://www.theglobalfund.org/documents/me/M_E_Toolkit_P2-HIV_en.pdf
Limitation	As the indicator measures antiretroviral drug dispensed and not those

	consumed, it is not possible to determine adherence to the regimen in most cases. This indicator does not capture the use of appropriate postpartum regimens ('tail') for the mother (to reduce transmission and viral resistance) and for the infant (to reduce peripatum transmission) which should accompany antiretroviral drug regiments to reduce peripatum mother-to-child transmission.
References:-	Http://www.who.int/hiv/pub/mtct/antiretroviral2010/en/index.html Http://www.who.int/hiv/pub/me/en/index.html

Percentage/Number of HIV infected pregnant women who assessed for ART eligibility through either clinical staging or CD4 testing during the reporting period	
Type of Indicator:	National
Numerator:	Number of HIV infected pregnant women who assessed for ART eligibility through either clinical staging or CD4 testing during the reporting period on site or by referral
Denominator:	Estimated number of HIV-infected pregnant women in the last 12 months
Purpose	Pregnant women with a known HIV positive status who are not already on ART should have their CD4 count measured to determine ART eligibility. Ideally these CD4 counts should be done on the same day as the client's HIV status is determined to be positive. If eligible for ART as per the Nigeria guidelines, the woman should be initiated as such. If her CD4 count determines that she is not eligible for ART, she should receive appropriate ARV prophylaxis (as per the Nigeria guidelines) to prevent HIV transmission to her baby.
Disaggregation:	This indicator should be disaggregated by the type of assessment (clinical staging or CD4 testing)
Data collection frequency:	Monthly
Measurement tool:	Monthly Summary form
Method of Measurement	Assessment can be conducted in antenatal care clinics and HIV care and treatment unit, onsite or by referral. Data should be aggregated from the appropriate register, with consideration of which registers capture the data, where the assessment actually took place, possible double counting or undercounting and the need to accurate data for the national level. All public/private and nongovernmental organizations-run health facilities that assess eligibility of HIV-infected pregnant women for anti-retroviral therapy, either on site or by referral, should be included. Two methods can be used to calculate the denominator: (a) A projection model such as that provided by spectrum software, use

	the output "number of pregnant women needing prevention of mother to child transmission of HIV/AIDS" or (b) Multiply the number of women who gave birth in the last 12 months (which can be obtained from estimate of the central statistics office or the United Nation Population Division or pregnancy registration system with complete data) by the most recent national estimate of HIV prevalence in pregnant women** (which can derived from HIV sentinel surveillance in antenatal care clinics), if spectrum projection are unavailable
Interpretation:	This indicator measures HIV positive pregnant (not currently on ART) who were given CD4 counts to assess ART eligibility. Count only once on the day the blood was drawn for CD4 testing. Although the woman should receive the CD4 test result to provide her with further HIV care and support, for reporting purposes count when the blood was actually drawn for CD4.
Additional Information	http://www.who.int/hiv/pub/me/en/index.html.
Limitation	The indicator help to monitor the extent to which HIV-infected pregnant women are receiving highest quality medical care that is critical for accessing antiretroviral therapy for their own health. It does not capture whether HIV-infected pregnant women who were eligible for antiretroviral therapy actually received it. Although each activity is mutually exclusive, there is a risk of double-counting when HIV – infected pregnant women have been assessed both clinically and immunologically or assessed in different units or in a different facility. ***This indicator does not capture women who have been identified as HIV-infected at labour and delivery and subsequently assessed for their eligibility for antiretroviral therapy. The value of this indicator could be underestimated when women are referred to another facility and their data are not aggregated.

Percentage of infants born to HIV-infected women who were started on CTX prophylaxis within 2 months of birth	
Type of Indicator:	National
Numerator:	Number of infants born to HIV-infected women started on co-trimoxazole prophylaxis within 2 months of birth
Denominator:	Estimated number of HIV-infected pregnant women who gave birth in the past 2 months in the past 12 months. This is a proxy measure for the number of infants born to HIV-infected women.
Disaggregation:	N/A
Purpose	Cotrimoxizole prophylaxis is a simple and cost-effective intervention to prevent Pneumocystis jirovecipneumonia (PCP) among HIV-exposed and -infected infants. PCP is the leading cause of serious respiratory disease among young HIV-infected infants in resource-limited countries and often occurs before HIV infection can be diagnosed. Because diagnosing HIV infection among young infants is difficult, all infants born to women living with HIV should receive Cotrimoxizole prophylaxis starting at 4–6 weeks after birth and continuing until HIV infection has been excluded and the infant is no longer at risk of acquiring HIV through breastfeeding.
Data collection frequency:	Numerator: Periodically Denominator: Annual**.**
Measurement tool:	Numerator: program or facility records; denominator: antenatal care surveillance, projection model, population estimates For more details on *calculation and interpretation* of the indicator, see Core indicators for national AIDS programs: guidance and specifications for additional recommended indicators.
Method of Measurement	Data for the numerator should be aggregated from the appropriate facility registers, which could include integrated maternal and child health registers, registers on the follow-up of HIV-exposed infants or pre–antiretroviral therapy registers. The register used may vary depending on the country context. For example, where HIV-exposed infants are followed up in the HIV care and treatment setting, countries may aggregate information either from a pre–antiretroviral therapy register adapted for follow-up of HIV exposed infants or from a separate register for HIV-exposed infants. The denominator is generated by estimating the number of HIV-infected women who were pregnant in the last 12 months. This is based on HIV surveillance data from antenatal clinics, and estimates can be generated by: *1) using a projection model, such as Spectrum; or* *2) multiplying: The total number of women who gave birth in the last 12*

	months × *The most recent national estimate of HIV prevalence among pregnant women* The total number of women who gave birth in the last 12 months can be obtained from estimates of births from central statistics offices or the estimates of the United Nations Population Division. The most recent national estimate of HIV prevalence among pregnant women can be derived from HIV sentinel surveillance data collected in antenatal clinics.
Interpretation:	This indicator allows countries to monitor progress in the early follow-up of exposed infants by measuring provision of Cotrimoxizole in line with international guidelines. It can also be used as a proxy indicator for early follow-up visits of exposed infants within the recommended first 4-6 weeks of life. The indicator captures only those infants who return for HIV-exposed infant follow-up services within two months of birth. It does not measure actual coverage of Cotrimoxizole prophylaxis for HIV-exposed infants as some infants may have been started on treatment after 2 months. A low value of the indicator could signal potential bottlenecks in the system, including poor management of CTX supplies in country, poor data collection, and inadequate distribution systems.
Additional Information	• #9, Guidance and Specifications for Additional Recommended Indicators, Addendum to: UNGASS. Monitoring the Declaration of Commitment on HIV/AIDS. Guidelines on Construction of Core Indicators. 2008 Reporting. April 2008. http://data.unaids.org/pub/BaseDocument/2009/20090305_additionalrecommendedindicators_finalprintversio_en.pdf • Prevention #HIV-P14, The Global Fund to Fight AIDS, Tuberculosis and Malaria Monitoring and Evaluation Toolkit: HIV, Tuberculosis and Malaria and Health Systems Strengthening, Part 2: Tools for monitoring programs for HIV, tuberculosis, malaria and health systems strengthening, Third Edition, February 2009 http://www.theglobalfund.org/documents/me/M_E_Toolkit_P2-HIV_en.pdf

Percentage of infants born to HIV-infected women (HIV-exposed infants) receiving antiretroviral prophylaxis to reduce the risk of mother-to-child transmission	
Type of Indicator:	National
Numerator:	Number of infants born to HIV-infected women(HIV-exposed infants receiving antiretroviral prophylaxis to reduce the risk for mother-to-child transmission
Denominator:	Total number of infants born to HIV-infected women
Purpose	To assess progress in the prevention of mother-to-child by the provision of antiretroviral drugs
Disaggregation:	Age, Sex
Data collection frequency:	Monthly
Measurement tool:	Program records
Method of Measurement	The numerator is calculated from national programme records aggregated from facility registers/forms while the numerator can be gotten from the following: - Counting at the time of labour and delivery: In settings where a high proportion of women give birth in health facilities - Counting at postnatal or child health sites: In setting where a high proportion of women and children attend post-natal and child health sites - Combining data from labour and delivery and post-natal/child health sites
Interpretation:	Antiretroviral drug interventions to reduce HIV transmission through breast feeding can be initiated shortly after delivery at the facility for labour and delivery if infants are burn at the facilities at outpatients, post-natal care or child clinic for infants burn at home and brought to the facility, or at HIV care and treatment or other sites.
Additional Information	UNAIDS Indicator Registry. UNAIDS Geneva. Available at: http://www.indicatorregistry.org Monitoring and evaluating the prevention of mother transmission of HIV: A guide for national programmes. Towards the elimination of mother-to-child-transmission, 2011. Available at: http://www.who.int/hiv/pub/me/en/index.html

Number and percentage of infants born to HIV-infected women who received an HIV test within 12 months of birth	
Type of Indicator:	National
Numerator:	Number of infants born to HIV-infected women who received an HIV test within 12 months of birth
Denominator:	Number of HIV-positive pregnant women giving birth in the last 12 months. This is a proxy measure for number of infants born to HIV positive women Two methods can be used to estimate this denominator: a) Using a projection model such as the one provided by Spectrum software use the output "Number of pregnant women needing PMTCT" as a proxy, or; b) Multiplying the total number of women who gave birth in the last 12 months, by the most recent national estimate of HIV prevalence in pregnant women (from HIV sentinel surveillance in ANC clinic and appropriate adjustments related to coverage of ANC surveys), if Spectrum projection are unavailable. To ensure comparability, the Spectrum output will be used for the denominator when global analyses are done.
Purpose	The reason for conducting the test at 12 months is that the infant no longer has maternal antibodies to HIV. In most cases, infants enrolled in the PMTCT program are weaned at 4-6 months. HIV transmission usually occurs within the first 12 months after birth. Therefore, testing at 12 months can accurately detect transmission rates. HIV testing is important to determine whether HIV transmission to the infant occurred. If the baby is identified as HIV-infected, further referral for care and support services is required.
Disaggregation:	HIV sero-status - Baby PCR test positive around 12 months
Data collection frequency:	Quarterly
Measurement tool:	Monthly Summary form
Method of Measurement	Early Infant Diagnosis (EID) testing laboratories for the numerator, and Spectrum estimates and sentinel surveillance for the denominator.
Interpretation:	The number of HIV-exposed infants (born to HIV-infected women) who were tested for HIV through an HIV antibody test at approximately 12 months after birth.

	Count only those infants born to HIV-infected mothers that received an ELISA or Rapid HIV antibody test. Also, only count those infants tested around the 12 month after birth timeframe as recommended in the Nigeria guidelines.
Additional Information	http://www.who.int/hiv/pub/me/en/index.html
Limitation	This indicator does not capture the number of children with a definitive diagnosis (i.e. of HIV infection) or measure weather appropriate follow up services were provided to child base on interpretation of test results. It also does not measure the quality of testing nor the system in place for testing.

Number of infants born to HIV-infected women during the reporting period	
Type of Indicator:	National
Numerator:	Number of infants born to HIV-infected women during the reporting period
Denominator:	Not applicable
Purpose	To assess progress towards eliminating mother-to-child HIV Transmission
Disaggregation:	Sex, Age, stillbirth, neonatal and live birth
Data collection frequency:	Monthly
Measurement tool:	Monthly Summary form
Method of Measurement	Program Data
Interpretation:	This indicator captures the number of infants born to HIV-infected women which will include stillbirth, neonatal and live birth
Additional Information	http://www.unaids.org

INFECTION CONTROL MANAGEMENT

Percentage of persons provided with post-exposure prophylaxis (PEP) (disaggregated by age, and circumstances of exposure)	
Type of Indicator:	National
Numerator:	Number of persons provided with post-exposure prophylaxis (PEP) to reduce the risk of HIV infection through occupational and/or non-occupational exposure to HIV.
Denominator:	Total number of persons on post-exposure prophylaxis
Disaggregation:	Disaggregated by age 0-5, 6-12,13-17, 18 & above, sex. and types of PEP . Number of persons provided with post-exposure prophylaxis (PEP) to reduce the risk of HIV infection through occupational and/or non-occupational. Exposure
Purpose:	A key consensus at the 2005 Joint International Labor Organization/World Health Organization Technical Meeting for the Development of Policy and Guidelines regarding occupational and non-occupational HIV-PEP was that HIV-PEP must be part of comprehensive HIV prevention, occupational health, and post-rape care service policies (UNAIDS). Nigeria considers availability of PEP to be a cross-cutting issue that addresses concerns in multiple program areas. The data that will be collected through this indicator provides information to answer questions around prevention, program quality, human resources for health, gender, and overall health system strengthening. Policy makers and program managers will use this data to report to the Presidency, National Assembly and international stakeholders to monitor coverage of PEP services and to track progress of PEP scale-up over time
Data collection frequency:	Monthly/ Annually
Measurement tool:	Program monitoring tool and reports

Method of Measurement	The indicator can be generated by counting the number of individuals receiving PEP for occupational and non-occupational purposes. Individuals should be counted only one (1) time, not incidence. This indicator should not include infants who receive neonatal prophylaxis. Explanation: The country should regularly update their program records on the availability PEP services in health facilities, and supplement these data with those obtain through a health facility survey or census every few years. PEP services for occupational exposure include: PEP services include a comprehensive package of services for occupationa exposed health care workers and patients. Individuals should be counted only they have received PEP drugs (in accordance with international or natior protocols). PEP services for non-occupational exposure include PEP service delivery for sexual violence or other non-occupational includes PEP services as part of a larger, comprehensive package of services for sexual violence victims. Individuals should be counted only if they have received PEP drugs (in accordance with international or national protocols).
Interpretation:	This indicator does not intend to capture the type and quality of PEP services provided. PEP services may include first AID, counselling, testing, provision of ARVs, medical care, trauma counselling, linkages with police, and other follow-up and support. Simple monitoring of PEP availability through program records does not ensure that all PEP-related services are adequately provided to those who need them. It is anticipated that access to PEP for sexual violence victims will be low initially. This number will remain low in countries where HIV prevalence is relatively low and incidence of sexual violence is low. However, in those countries where sexual violence and HIV are prevalent, percentages are expected to increase.
Additional Information	- Occupational and Non-occupational Post-exposure Prophylaxis for HIV Infection (HIV-PEP), Joint ILO/WHO Technical Meeting for the Development of Policy and Guidelines: Summary Report (2005) http://www.unaids.org/en/KnowledgeCentre/Resources/PolicyGuidance/Tech policies/HIV_post_Technical_policies.asp - Post-exposure prophylaxis to prevent HIV infection. Joint WHO/ILO guidelines on post-exposure prophylaxis (PEP) to prevent HIV infection (http://www.who.int/hiv/pub/guidelines/PEP/en/index.html
	- Refer to the PEPFAR Palliative Care Indicator TWG with further inquiries
Limitation	This indicator does not intend to capture the type and quality of PEP services provided. PEP services may include first aid, counseling, testing, provision of ARVs, medical care, trauma counseling, linkages with police, and other

	follow-up and support. Simple monitoring of PEP availability through program accords does not ensure that all PEP-related services are adequately provided to those who need them.

HUMAN RESOURCE FOR HEALTH

Number of health care workers who successfully completed an in-service training program within the reporting period	
Type of Indicator:	National
Numerator:	Number of health care workers who successfully completed an in-service training program
Denominator:	N/A
Disaggregation:	Training across all thematic areas Sex
Purpose:	It is widely acknowledged that the lack of trained health workers is a major barrier to scaling up HIV/AIDS services. The lack of a sufficient workforce in the Nigeria presents a serious challenge not only to HIV/AIDS programs but to every area of health. The data will tell us the number of health care workers who are available to support the mitigation of the HIV/AIDS epidemic each year in Nigeria either with support from GoN and partners. This indicator will not be collected at GoN by cadre of health care worker; however, if the data are available by cadre in Nigeria and reviewed along with survey or other human resources data, country teams could gain some understanding about whether the participants completing in-service training programs represent the correct ratio of health care worker cadres and whether the 'mix' of health care workers is the correct 'mix' to meet the human resource demands of the health system, according to each country's epidemiological profile and other factors. Based on this data, countries can determine how to prioritize investments in the education and on-going training of health care workers to maximize workforce expansion and capacity building within the cadres of professionals that are most needed.
Data collection frequency:	Annually
Measurement tool:	Program reports, Human Resource Information Systems, educational institutions, professional associations, Ministry of Education, Labor or Health
Method of Measurement	The number is the sum of health care workers who successfully completed an in-service training program within the reporting period . Individuals will not count as having successfully completed their training unless they meet the

	minimum requirements as defined by international or national standards. Any individual involved in safeguarding and contributing to the prevention, promotion, and protection of the health of the population may be counted in this in-service training indicator. Explanation: Training is a learning activity taking place within Nigeria or outside the shore of the country in a setting predominantly intended for teaching or facilitating the development of certain knowledge, skills or attitudes of the participants with formally designated instructors or lead persons, learning objectives, and outcomes, conducted full-time or intermittently. Training refers to training or retraining of individuals and must follow a curriculum with stated (documented) objectives and/or expected competencies. Training may include traditional, class-room type approaches to training as well as on the job or "hands-on" training such as clinical mentoring or structured supervision so long as the following three criteria are met: 1) Training objectives are clearly defined and documented 2) Participation in training is documented (e.g. through sign-in sheets or some other type of auditable training) 3) The program clearly defines what it means to complete training (e.g. attend at least four days of a five-day workshop, achieve stated key competencies, score XX% on post-test exam, etc.) The unit of measure is the number of persons trained or retrained. A person is counted as having been trained if he or she participates in a workshop or course, sponsored with GoN or partners support (in whole or in part), with a specific training subject, area, theme or topic. Some examples of training domains are: (1) Delivering home-based care to HIV infected persons; (2) New methods for ensuring financial accountability; (3) Treatment of resistant HIV Infection; (4) Provincial M&E training. If a person attended all four of the above courses, for example, that person should be counted four times. If a person repeats the same training course, he/she should not be counted twice. Please count the staff/volunteers of your organization who were trained, as well as any additional individuals (e.g. from a different organization) that you may have trained in a GoN or partners-supported training course that your organization implemented. Only participants who complete the full training course should be counted. An individual should only be counted once they have completed the training. Individuals that are mid-way through a training course should be counted in the next reporting period. Individuals attending more than one training in a particular program area during a reporting period should only be counted once. Individuals participating in training that covers more than one program

	area may be counted in each of the respective areas. If two partners are providing different aspects of training to the same individuals in the same program area (e.g. one partner provides classroom training, another provides clinical mentoring), each partner should report the number of persons uniquely trained by their respective organization, but should note which partner is providing the complementary training role and estimate the number of persons counted by both partners. In the specific case where GoN and/or partner conduct training events that include the staff of sub-grantees, then the prime partner should report all the persons trained, in order to avoid double counting. In-service training programs are for practicing providers to refresh skills and knowledge or add new material and examples of best practices needed to fulfill their current job responsibilities. In-service training may update existing knowledge and skills, or add new ones. Care should be taken to base trainee selection on content and skill needs. It requires a shorter, more focused period of time than pre-service education, and is often more "hands-on." It can be a workplace activity (led by staff, peers or guest lecturers) or an external event. In-service training can occur through structured learning and follow-up activities, or through less structured means, to solve problems or fill identified performance gaps. In-service training can consist of short non-degree technical courses in academic or in other settings, non-academic seminars, workshops, on-the-job learning experiences, observational study tours, or distance learning exercises or interventions. An in-service training program must meet national or international standards and have specific learning objectives, a course curriculum, expected knowledge, skills, and competencies to be gained by participants, as well as documented minimum requirements for course completion. The duration and intensity of training will vary by cadre; however, all training programs should have at a minimum the criteria listed above. This indicator is distinct and separate from the indicator for pre-service training and education – a health care worker may be counted under both indicators ONLY if that worker has completed pre-service training and education distinct and separate from their in-service training in the same reporting period. Types of In-service Training: 1. Continuing education: Education/training offered to current providers to either update or add new knowledge and skills. While in-service training is often limited to practitioners in the public sector and/or

	managed by the Ministry of Health (or similar entity), continuing education is often used to describe education/training that is provided by other sources, such as professional associations, that reaches private sector practitioners and which can be linked to re- licensure and/or certification. 2. On-the-job training: Instruction in a specific task or skill is provided via mentoring by a practitioner using explanations, demonstration, practice and feedback. On-the-job training may be combined with academic or technical training to provide a practical experience component. 3. Computer based training: An interactive learning experience in which the computer provides most of the stimuli, the learner responds, and the computer analyzes the responses and provides feedback to the learner. Components most often consist of drill-and practice, tutorial, or simulation activities offered alone or as supplements to traditional instruction. CBT is sometimes also used as a component of a pre-service education course. 4. Distance learning: Distance learning is characterized by a geographic separation of instructor and learner where learners work on their own. It uses a range of mechanisms such as self-guided lesson plans, mailings, radio, and computer based activities. Usually it is tied to an educational facility and uses sequential instructional material that is corrected by the instructor. Regardless of methodologies chosen, it requires motivation on the part of the learner and regular feedback on the part of the learning institution. It can also be used for pre-service education. Explanation of Subsets: MALE CIRCUMCISION TRAINING: Persons who receive in-service training in one or more of the following functions in the delivery of MC for HIV prevention services should be counted in this sub-set: 1) MC provider/surgeon (persons who surgically remove the foreskin, regardless of whether they are a physician, nurse, clinical officer, etc.); 2) surgical assistant; 3) counselor (persons who provide education and counselling of clients on MC); and/or 4) ancillary staff (persons who perform sterilization and preparation of surgical instruments/equipment). Training may be for infant or adolescent/adult MC surgical methods. Persons who receive training to perform multiple functions (i.e., as both counselor and surgical assistant), and persons trained in multiple methods (infant and adolescent/adult methods) should only be counted once. Programs should focus on compiling data on male circumcision training from Training Registers maintained by funded programs. MC for HIV prevention services are comprised of a minimum package of components that includes elective surgical male circumcision using local anesthesia provided after

	education and consent and delivered in the context of comprehensive pre-operative HIV counselling and testing (offer of), pre-operative STI assessment (and treatment when indicated), post-operative HIV risk reduction counselling and abstinence/healing instructions, and provision of condoms. PEDIATRIC TREATMENT TRAINING: Persons who receive in-service training to perform a key function in the pediatric treatment should be counted in this sub-set. Pediatric treatment in-service training will fall into the following categories for this indicator: - Nurse - Counselor - Clinical Officer - Physician - Health Surveillance Advisor (HSA) - Pharmacist In-service training for the purposes of this indicator includes the following modalities in addition to traditional classroom training and workshops: - Issues in pediatric treatment - Dosing for children - Adherence counselling for children - Appropriate clinical monitoring of therapy
Interpretation:	This indicator does not measure the quality of the training, nor does it measure the outcomes of the training in terms of the competencies of individuals trained, nor their job performance. This indicator does not measure the placement or retention in the health workforce of trained individuals. Although training is an essential component of human resources for health, programs should plan it in the context of effective human resources management and an overall HRH strategy.
Additional Information	The in-service training must have a standardized curriculum, there must be evidence of completion.

Number of new health care workers who graduated from a pre-service training institution	
Type of Indicator:	National
Numerator: Essential/Reported	A count of the number of new health care workers who graduated from a pre-service training institution or program
Disaggregation: Essential	By doctors, nurses, midwives; cadres; clinical/non-clinical
Purpose:	It is widely acknowledged that the lack of trained health workers is a major barrier to scaling up HIV/AIDS services. The lack of a sufficient workforce in the country presents a serious challenge not only to HIV/AIDS programs but to every area of health. The data will tell us the number of new health care workers who are available to enter the health work force each year to provide HIV/AIDS related services.
Data collection frequency:	Data should be collected and aggregated in time for PEPFAR reporting cycles.
Measurement tool:	Human Resource Information Systems, pre-service training institutions, professional associations, Ministry of Education or Health Public Service Database HRIS, MOH HRIS, Ministries of Social Welfare HRIS, Councils and other professional associations, Alumni Networks/Graduates Networks, HRH Plans, Implementing partners.
Method of measurement:	The number is the sum of new health care workers from the host country who graduated from a pre-service training institution within the reporting period either <u>with full or partial government of Nigeria or development/implementing partners.</u> Individuals may be in pre-service training over a number of years, but will not count as graduated until they have completed their program. Local pre-service institutions may support other host country nationals under their program but those graduates should not be included in a country's report on this indicator. <u>Explanation:</u> Training under this indicator is defined as "pre-service" training – the training of "new" health care workers (see definition below). All training must occur prior to the individual entering the health workforce in his or her new position. A health care worker who transitions to another position (e.g., nurse completes medical school to become a doctor) shall be counted as a "new" health care worker for the purposes of this indicator. However, the intent of government of Nigeria program is to expand the number of workers in the workforce. Pre-service training institutions are university-based or affiliated schools of

	medicine, nursing, public health, social work, laboratory science, pharmacy, and other health-related fields. Non-professional or paraprofessional training would be any accredited and nationally recognized pre-service program that is a requirement for this cadre's entry into the workforce. "In-service" and "continuing education" training should not be included in the count for this indicator, but continue to be encouraged by GoN. These types of training may be captured by other indicators. A pre-service training program must be nationally accredited, or at the minimum meet national and international standards. The program must also have specific learning objectives, a course curriculum, expected knowledge, skills, and competencies to be gained by participants, as well as documented minimum requirements for course completion. The duration and intensity of training will vary by cadre; however, all training programs should have at a minimum the criteria listed above. Individuals may be in training over many reporting periods; however, only participants who have successfully completed their training should be counted. Successful completion of training may be documented by diploma or certificate. Individuals not meeting these documented requirements should not be counted in this indicator. "Health workers" refers to individuals involved in safeguarding and contributing to the prevention, promotion and protection of the health of the population (both professional and auxiliary-professionals). The categories below describe the different types of health workers to be considered under this indicator. This not an exhaustive list of all health workers and position titles may vary from country to country. For the purposes of this indicator, health workers include the following: 1) Clinical health workers – Clinical health workers play clinical roles in direct service delivery and patient care: a) Clinical professionals, including doctors, nurses, midwives, laboratory scientists, pharmacists, social workers, medical technologists, and psychologists; They usually have a tertiary education and most countries have a formal method of certifying their qualifications. b) Clinical officers, medical and nursing assistants, lab and pharmacy technicians, auxiliary nurses, auxiliary midwives, T&C counsellors. They should have completed a diploma or certificate program according to a standardized or accredited curriculum and support or substitute for university-trained professionals.

	2) Non-clinical health workers - Non-clinical workers do not play clinical roles in a health care setting but rather include workers in a health ministry, hospital and facility administrators, managers, monitoring and evaluation advisors, epidemiologists and other professional staff critical to health service delivery and program support. Disaggregation of doctors and nurses; other cadres and clinical/non-clinical (as defined below).
Interpretation:	This indicator does not measure the quality of the pre-service training, nor does it measure the outcomes of the training in terms of the competencies of individuals trained, nor their job performance. This indicator does not measure the placement or retention in the health workforce of trained individuals from their host country. Pre-service training is an essential component of human resources for health that is planned as part of an overall HRH strategy, which links the production of new health workers with service delivery needs and health systems capacity to recruit and retain newly trained health workers. Data collected by this indicator at the national level can be combined with survey data, workforce vacancy rate data, or other human resources data looking at the number of health workers per 1000 population in order to gain an understanding of the overall impact of pre-service training programs on workforce expansion.

TREATMENT

Percentage/Number of HIV positive adult and children who are eligible and currently receiving antiretroviral therapy	
Type of Indicator:	National
Numerator:	Number of HIV infected (adults and children) who are currently receiving antiretroviral therapy in accordance with the nationally approved treatment protocol at the end of the reporting period
Denominator:	Estimated number of adults and children with advanced HIV infection
Disaggregation:	This indicator should be disaggregated by sex and age (<15, 15+)4 and percentages given for 2008 and 2009 to track annual trends in coverage
Purpose:	To assess progress towards providing antiretroviral combination therapy to all people with advanced HIV infection
Data collection frequency:	Monthly/Annually
Measurement tool:	For the numerator: facility-based antiretroviral therapy registers or drug supply management systems. For the denominator: HIV prevalence estimation models such as Spectrum.
Method of Measurement	Programme records, HMIS and HIV surveillance
Interpretation:	This indicator permits monitoring trends in coverage but does not attempt to distinguish between different forms of antiretroviral therapy or to measure the cost, quality or effectiveness of treatment provided. These will each vary within and between countries and are liable to change over time. The proportion of people needing antiretroviral therapy varies with the stage of the HIV epidemic and the cumulative coverage and effectiveness of antiretroviral combination therapy among adults and children. The degree of utilization of antiretroviral therapy will depend on factors such as cost relative to local incomes, service delivery infrastructure and quality, availability and uptake of voluntary counselling and testing services, and perceptions of effectiveness and possible side effects of treatment.
References:-	UNAIDS indicator registry; UNAIDS; Geneva

Percentage of adults and children enrolled in HIV care currently receiving CTX prophylaxis	
Type of Indicator:	National
Numerator:	Number of adults and children enrolled in HIV care currently receiving CTX
Denominator:	Program coverage: Number of HIV-positive adults and children receiving a minimum of one clinical service Population coverage: A. Number of HIV-positive adults and children who are eligible for CTX, (according to national guidelines) B. Estimated number of people living with HIV in the country
Disaggregation:	Disaggregate by Sex: male and female age groups: ≤ 18 months, 19months-5years, 6-9 years, 10-14 years, 15 years and above. Disaggregate by location: Health facility level, LGA, State
Purpose:	CTX prophylaxis is a simple and cost-effective intervention that reduces the risk of opportunistic infections (OIs) and mortality in HIV-positive children and adults. WHO recommends administration of CTX for the following groups: adults with HIV infection, including pregnant women, children with HIV infection, and infants exposed to HIV. The WHO guidelines offer countries a choice of whether to provide CTX broadly or according to disease stage. This indicator is important to program and national for several reasons including: • Assesses scale-up and coverage of CTX prophylaxis • Identifies gaps in services to improve scale-up and coverage • Provides data to assess quality of care • Focuses on a primary intervention for HIV-positive infants, children, and adults • Informs program planning and budget allocations to improve utilizations of resources to focus on this essential intervention
Data collection frequency:	Monthly/Annual Data should be collected continuously at the facility level (or community level). Data should be aggregated in time for the prescribed reporting cycles. In addition, State teams are encouraged to request periodic aggregation, i.e. quarterly, for the purposes of program management and review
Measurement tool:	Program monitoring tools, including Pre-Art and ART registers and electronic databases that routinely record provision of CTX, including pharmacy records
Method of Measurement	The numerator can be generated by counting the number of HIV-positive individuals receiving CTX prophylaxis at some point during the reporting

	period. Explanation of Numerator Individuals should be considered to be "receiving" CTX prophylaxis if CTX has been prescribed and obtained by the patient (provided by a program or procured by the patient). The indicator is not meant to account for short term lapses in adherence or short term stock outs. If individuals are served by more than one program that might provide CTX prophylaxis, the figure should be adjusted as needed so that the numerator represents only unique individuals receiving CTX within the reporting period. Countries should focus on compiling data for the numerator from patient registers at facilities. Where patient level data are not available, countries may develop program or facility level estimates of coverage with CTX and apply these estimates to the total number of individuals receiving care and support services through those programs or facilities. HIV-positive individuals receiving CTX in both the private sector and the public sector should be included in the numerator where data for both are available. Provision of Cotrimoxizole is one of the key services included under "clinical" services. [The information will be considered in the context of the national policy on CTX in the country, the total numbers of HIV-positive individuals in the country, WHO guidelines, and the numbers of HIV-positive individuals receiving HIV care services.]
Interpretation:	The figure of individuals served by more than one program should be adjusted as needed so that the numerator represents only unique individuals receiving CTX within the reporting period, which would be impossible without unique IDs and electronic monitoring systems. Although countries may not have a system in place yet to collect and report coverage of CTX among HIV-positive individuals, the goal should be to develop such a system. This indicator permits monitoring trends in the numbers and proportion of HIV-positive persons receiving CTX prophylaxis according to the guidelines on the provision of CTX to HIV-positive individuals in Nigeria. However comparisons of aggregate estimates overtime and proportions must be interpreted with caution and with reference to eligibility criteria. In addition to tracking the numbers of persons on prophylaxis, this indicator can be interpreted as a proportion, or measure of coverage, using various denominators as appropriate. Coverage can be considered using different denominators, for example the proportion of HIV-positive persons in care (receiving at least one clinical service) receiving CTX, the proportion of the estimated number of HIV-positive persons receiving CTX, or the proportion of HIV-positive individuals who are eligible for CTX, (according to national guidelines) who are receiving CTX.

	This indicator attempts to track progress in scale-up of CTX to HIV-positive individuals. The indicator does not attempt to capture interruptions in drug availability or patient adherence to prescribed therapy. The reports will need to be interpreted in the context of national policy and/or guideline.
Additional Information	Clinical services may be provided in facilities, the community, or in the home, and may include both *assessment* of the need for interventions (for example assessing pain, clinical staging, eligibility for Cotrimoxizole, or screening for tuberculosis) and *provision* of needed interventions: prevention and treatment of TB/HIV, prevention and treatment of other opportunistic infections (OIs), alleviation of HIV-related symptoms and pain, nutritional rehabilitation for malnourished PLWHA. While partners may be supported to provide services only in a single domain (for example only social support), individuals receiving that support should be linked to other providers who provide clinical services to meet the criteria to count an individual as receiving one clinical service. Please refer to the national guidelines for a list of clinical services. While a minimum of one clinical service is sufficient to count an HIV-positive individual for this indicator, programs should strive to provide comprehensive care to all HIV-positive individuals by providing other needed services (clinical and support services) either directly or through referral. Individuals who receive services from more than one partner or provider should be de-duplicated at the program summary level.
References:-	UNAIDS Indicator Registry. UNAIDS : Geneva. Available at:http://www.indicatorregistry.org/node/764

Percentage of HIV-infected pregnant women receiving ART for their own health during the reporting period	
Type of Indicator:	Program
Numerator:	Number of HIV-infected pregnant women receiving ART for their own health during the reporting period
Denominator:	Total number of HIV- infected pregnant women
Disaggregation:	Age
Purpose	To assess progress towards providing antiretroviral combination therapy to pregnant women with advanced HIV infection
Data collection frequency:	Monthly/Annually
Measurement tool:	Program record
Method of	The numerator can be generated by counting the number of infected pregnant

Measurement	women who received ART for their own health while the denominator is generated by estimating the number of infected pregnant women with advanced HIV infection requiring (in need of/ eligible for) ART.
Interpretation:	Antiretroviral therapy taken only for the purpose of prevention of mother-to-child transmission and post-exposed prophylaxis are not included in this indicator. HIV infected pregnant women who are eligible for ART and on ART for their treatment can be monitored using this indicator.
Additional Information	UNAIDS Indicator Registry. UNAIDS Geneva. Available at: http://www.indicatorregistry.org

Number of adults and children on ART (a) newly enrolled (b) ever started	
Type of Indicator:	National
Numerator:	Number of adults and children on ART (a) newly enrolled (b) ever started
Denominator:	
Purpose	There are three program indicators to count individuals receiving antiretroviral therapy at a service outlet directly providing ART-services NEW, and EVER. What it measures: NEW refers to individuals enrolled on antiretroviral therapy for the first time during a reporting period. EVER refers to all individuals that have been on antiretroviral therapy.
Disaggregation:	Sex: Refers to male or female Age: Age is divided into two categories: age <15 years or age>= 15 years. Pregnant: A new client is counted as pregnant if she is pregnant at the time she is initiated on antiretroviral therapy, regardless of the outcome of the pregnancy.
Data collection frequency:	Monthly
Measurement tool:	Program monitoring tool
Method of Measurement	This indicator includes two mutually exclusive sets of individuals on ART: those who receive antiretroviral therapy at a designated PMTCT+ site and those who receive antiretroviral therapy elsewhere. If an individual transfers in to the ART program with records from continuous ART at another facility or program, this person should NOT be counted as new. If an individual transfers in without records or has no documented evidence of previous antiretroviral therapy, this person may be counted as new (because programs have no choice but to enroll this person as a new client). If an individual previously on ART in the program restarts ART after an

	interruption in therapy, this person should NOT be counted as new. If an individual initiated treatment during the period but died, stopped ART, or transferred out before the end of the reporting period, this person should still be counted as new (since status at the end of the period does not affect the fact that the person was still new on therapy during the period). This indicators do not require reporting of transfers or restarts, but it is expected that programs will keep records of these persons and events. Clients who transfer in, transfer out, and/or who restart after interruption of therapy will be counted in the CURRENT client load, as long as they are on ART at the end of a reporting period. For the NEW indicator, age represents an individual's age at initiation of therapy. Disaggregation of pregnant women by age is NOT required. The number of pregnant women is to be shown as a subset of all women.
Interpretation:	As the health of ART clients improves and ART services become available at more locations, transferring patients may account for an increasing proportion of ART client load in the health care system and at any given facility. If treatment is not adequately documented or records are not transferred with a client, clients may be newly initiated at more than one program/facility over time. At the country level, these clients will be double counted in the NEW and EVER client indicators. Double counting of individuals within a program area is to be avoided among funded partners to the extent possible. Since age and pregnancy status change over time, the comparison of NEW, and EVER clients by age and pregnancy status is challenging. Because new and cumulative are states defined by beginning in a program, it is expected that the characteristics of new and cumulative clients are recorded at the time they newly initiate or transfer into a program. On the contrary, current is a state defined by vital/treatment status when last seen, so it is expected that characteristics of these clients would be updated each time they are seen by a program. Combining all children into one age group of < 15 yrs may not be satisfactory for program managers. For children of different ages, there are different criteria for starting treatment, as well as different disease burdens, care needs, and mortality patterns. Programs may wish to further disaggregate children by age to follow programmatically and clinically meaningful differences as follows: 0-18 months, 18 months-5 years, 6-14 years.
Additional Information	Antiretroviral therapy: Long-term combination antiretroviral therapy intended primarily to improve the health of the individual on treatment, not to prevent mother-to-child transmission. Newly initiated: Initiated antiretroviral therapy during the reporting period in

	a program directly supported by GoN and/or other funds. PMTCT+ site: A service outlet that provides a minimum package of services which includes HIV counseling and testing for pregnant women, ARV prophylaxis to prevent mother-to-child transmission, counseling for safe infant feeding practices, family planning counseling or referral, and ARV therapy for HIV+ women, their children, and their families.
References:-	http://www.indicatorregistry.org/sites/default/files

TB/HIV

Percentage of estimated HIV-positive incident TB cases that received treatment for TB and HIV	
Type of Indicator:	National
Numerator:	Number of adults with HIV infection who received antiretroviral therapy in accordance with the nationally approved treatment protocol and who were started on TB treatment (in accordance with national TB programme guidelines), within the reporting year
Denominator:	Estimated number of incident TB cases in people living with HIV
Disaggregation:	By Sex: Male and Female By Age:<15 and 15+
Purpose:	To assess progress in detecting and treating TB in people living with HIV
Data collection frequency:	Data should be collected continuously at the facility level. Data should be aggregated periodically, preferably monthly or quarterly, and reported annually. The most recent year for which data and estimates are available should be reported here.
Measurement tool:	Facility registers/Program Monitoring Tools
Method of measurement:	Program data and estimates of incident TB cases in people living with HIV
Interpretation:	Adequate detection and treatment of TB will prolong the lives of people living with HIV and reduce the community burden of TB. WHO provides annual estimates of the burden of TB among people living with HIV, based on the best available country estimates of HIV prevalence and TB incidence. All incident TB cases among people living with HIV should be started on TB treatment and depending on country specific eligibility criteria. Incident TB cases are defined as new cases that have occurred in that year, and specifically exclude latent cases. All or most people living

	with HIV who have TB should be on antiretroviral therapy, depending on local eligibility criteria. TB treatment should only be started in accordance with national TB program guidelines. This indicator provides a measure of the extent to which collaboration between the national TB and HIV program is ensuring that people with HIV and TB disease are able to access appropriate treatment for both diseases. However, this indicator will also be affected by low uptake of HIV testing, poor access to HIV care services and antiretroviral therapy, and poor access to TB diagnosis and treatment. Separate indicators exist for each of these factors and should be referred to when interpreting the results of this indicator. It is important that those providing HIV care and antiretroviral therapy record TB diagnosis and treatment, as this information have important implications for antiretroviral therapy eligibility and choice of antiretroviral regimen. It is therefore recommended that the date of starting TB treatment is recorded in the antiretroviral therapy register. If possible, the number of patients started on TB treatment among those in HIV care but not yet on antiretroviral therapy should also be reported. This would capture additional cases of TB that are detected and treated among people living with HIV.
Additional Information:	WHO (2009). *Global Tuberculosis Control: Surveillance, Planning, Financing.* Geneva: World Health Organization. http://www.who.int/tb/country/en

Percentage of HIV-positive patients who were screened for TB in HIV care or treatment settings	
Type of Indicator:	National
Numerator:	Number of HIV-positive patients who were screened for TB at enrollment in HIV care or treatment setting
Denominator:	Total number of HIV adults and children enrolled in HIV care during the reporting period
Disaggregation:	By Sex: Male and Female Age: <15 and >15+
Purpose:	This indicator captures assesses activity intended to reduce the impact of TB among people living with HIV. It demonstrates the level of implementation of the people living with HIV be screened for TB at diagnosis and at the follow-up visits in HIV clinics or centres.
Data collection frequency:	Monthly/ quarterly/annually
Measurement tool:	TB Treatment Monitoring Tools and ART and Pre-ART register

Method of measurement:	Number of HIV-positive patients who were screened for TB at enrolment in HIV care or treatment setting/ Total Number of HIV-positive patients
Interpretation:	A form/checklist is used to screen the clients by asking certain questions which will include key symptoms of TB disease such as; coughing lasting more than two weeks, persistent fever, night sweats, unexplained weight loss and lymphadenopathy. Any positive response would indicate that the individual may be having TB
Additional Information:	UNAIDS indicator registry. UNAIDS : Geneva. Available at:http://www.indicatorregistry.org/node/768

Percentage of TB patients Screened for HIV in TB care or treatment settings	
Type of Indicator:	National
Numerator:	Number of TB patients who were screened for HIV in TB care or treatment setting
Denominator:	Total number of HIV adults and children enrolled in HIV care during the reporting period
Disaggregation:	By Sex: Male and Female By Age: <15 and 15+
Purpose:	This indicator captures assesses activity intended to reduce the impact of TB among people living with HIV. It demonstrates the TB/HIV collaboration, were TB patients are screened for HIV in a TB clinic or centre.
Data collection frequency:	Monthly/ quarterly/annually
Measurement tool:	TB Treatment Monitoring Tools and ART and Pre-ART register
Method of measurement:	Dividing the number of TB patients who were screened for HIV in TB care or treatment setting by the total number of TB patients registered during the reporting period
Interpretation:	A form is used to screen TB clients by asking certain questions which will include risky behaviours that will expose the client to having HIV. Any positive response would indicate that the client may be likable to be infected.
Additional Information:	UNAIDS indicator registry. UNAIDS : Geneva. Available at:http://www.indicatorregistry.org

Number or percent of HIV patients currently in care who commenced TB Treatment	
Type of Indicator:	National
Numerator:	Number of HIV patients currently in care who are commenced TB treatment
Denominator:	Number of adults and children into HIV care* during the reporting period
Disaggregation:	The data for this indicator should be reported disaggregated by antiretroviral therapy and pre-antiretroviral therapy registers
Purpose:	TB is the major coinfection of people living with HIV. This indicator assesses trends in the detection and treatment of TB among people living with HIV who are registered in the HIC care. It may also be used in drug supply planning, as the treatment of people with HIV for TB may require temporary antiretroviral drug substitution.
Data collection frequency:	Monthly/Quarterly/Annually
Measurement tool:	PRE-ART Registers and TB treatment monitoring tools
Method of measurement:	The data for thenumerator come from the 'TB treatment' column of the pre-antiretroviral therapy and antiretroviraltherapy registers. Among those newly enrolled in the HIV care during the reporting period, those receiving TB treatment at time of enrollment and those starting TB treatment during the reporting period should both be included in the numerator.The data needed for this indicator are more difficult to collect if TB diagnosiusand treatment are not carried out on the same site as HIV testing or treatment and care. This situation will require establishing reliable two-way communication between the TB services and the HIV treatment and care services. The denominator data are obtained by adding those retained on treatment at the beginning of the reporting period to those newly enrolled in the program during the reporting period.
Interpretation:	This indicator captures clients who have been confirmed to be HIV positive and have been enrolled in the ART program but not on treatment and have been confirmed TB positive and have commenced TB treatment
Additional Information:	UNAIDS indicator registry. UNAIDS : Geneva. Available at:http://www.indicatorregistry.org/node/769
Limitations	This indicator does not capture if the client have completed TB treatment or not

Number or percent of patients newly enrolled into HIV care and are given treatment for latent TB infection (isoniazid preventive therapy)	
Type of Indicator:	National
Numerator:	Number of patients newly enrolled into HIV care and are given treatment for latent TB infection(isoniazid preventive therapy)
Denominator:	Number of adults and children into HIV care* during the reporting period
Purpose	To ensure that eligible people living with HIV are given treatment for latent TB infection and thus to reduce the incidence of TB among people living with HIV.
Disaggregation:	By Sex and Age
Data collection frequency:	Monthly/quarterly/annually
Measurement tool:	Program Report (PMM)and PRE-ART Registers and TB treatment monitoring tools
Method of Measurement	The data needed for this indicator are colected from pre-antiretroviral therapy and antiretroviral therapy register at the HIV care service sites, depending on where TB preventive therapy is to be administered. People living with HIV should have their TB status assessed. Those found not to have evidence of active TB will be offered TB preventive therapyaccording to the national determined guidelines/ All those accepting TB preventive and receiving at least the first dose of treatment should be recorded. This informationis being recorded through an extra columnin the HIV care registerand on the patient treatment card. Accurately predicting drug requirements for supply management requires collecting more detailed information e.g. number of new cases, continuing cases a nd completed cases on quartely basis. If such information is collected routinely, the indicator of choice would be the number of HIV-positive clients completing treatment of latent TB infection as a proportion of thetotal number of HIV-positive clients started on such treatment.
Interpretation:	This indicator captures clients who have been confirmed to be HIV positive and have been enrolled in the ART program but not on treatment and are given treatment for latent TB infection (isoniazid preventive therapy)
Additional Information	UNAIDS indicator registry. UNAIDS : Geneva. Available at:http://www.indicatorregistry.org/node/770

LAB (SYSTEM STRENGHTENING)

Percentage of HIV reference laboratories that are accredited according to national standards	
Type of Indicator:	National
Numerator:	Number of HIV reference laboratories that are accredited according to national standards
Denominator:	Number of HIV reference laboratories with capacity to perform clinical laboratory tests
Purpose	Laboratory services are an essential component in the diagnosis and treatment of persons infected with the human immunodeficiency virus (HIV), and other related diseases of public health significance, including malaria and TB. Presently, the laboratory infrastructure for HIV, malaria, and TB testing and quality assurance remains weak in most PEPFAR-supported countries. There is therefore an urgent need to strengthen the laboratory. The establishment of accreditation systems will help countries to improve and strengthen the capacity of their laboratories. Accreditation provides documentation that the laboratory has the capability and the capacity to detect, identify, and promptly report all diseases of public health significance that may be present in clinical and research specimens. The accreditation process further provides a learning opportunity, a pathway for continuous improvement, a mechanism for identifying resource and training needs, and a measure of progress. This indicator measures the progress and extent to which USG-support has built laboratory capacity, quality, and sustainability by determining the number of accredited clinical laboratories and the laboratories' ability to maintain accreditation over time.
Data collection frequency:	Monthly/ Annual
Measurement tool:	Monthly summary form/program data
Method of Measurement	Program Monitoring tool
Interpretation:	This indicator monitors the scale up of accreditation practices in testing facilities (laboratories). This indicator assesses the quality systems of a laboratory and the ability of a laboratory to maintain quality.

Percentage of health facilities that provide virological testing services (e.g. PCR) for infant diagnosis on site or through dried blood spots (DBS)	
Type of Indicator:	National
Numerator:	Number of health facilities that provide virological testing services (e.g. PCR) for infant diagnosis on site or through dried blood spots (DBS)
Denominator:	Denominator: Total number of health facilities that provide virological testing services
Disaggregation:	N/A
Purpose	This indicator reflects Government of Nigeria efforts to strengthen capacities of laboratories to perform HIV/AIDS related tests, diagnostics and monitoring tasks.
Data collection frequency:	Semi-annual/Annual
Measurement tool:	Program reports. To assess whether the laboratory sites have the capacity to perform the specified testing, special studies using observation techniques may be necessary. GoN and implementing partners should keep an inventory of the name and location of laboratory sites that are able to perform the specified testing. This information should be submitted to the HIV Division of the Federal Ministry of Health staff responsible for compiling the semiannual / annual reporting data as evidence for the reported number of laboratories with the capacity to perform the specified tests.
Method of Measurement	Counts the number of laboratory sites that have at minimum the capacity to perform the virological testing at the end of the specified reporting period (6 months for semi-annual report / 12 months for annual report). Count only those laboratory sites that are able to perform both HIV tests and [PCR tests]. The National HIV Division of the FMoH staff responsible for compiling the semi-annual / annual reporting data should use the laboratory sites list submitted by each partner reporting on this indicator in order to count the total number of laboratory sites that have the stated capacity, avoiding any double-counting of the same laboratory site supported by more than one partner.
Interpretation:	This indicator does not consider the quality of service provision, which would require more in-depth evaluation efforts like facility surveys. This is not a complete measure of coverage, as there is no denominator of total facilities.
Additional Information	Laboratory capacity is defined as the ability to perform (1) HIV tests and (2) PCR test. This refers to both the equipment and personnel necessary to carry out testing.

Percentage of facilities providing ART that use CD4 monitoring in line with national guidelines/policies, on site or through referral	
Type of Indicator:	National
Numerator:	Numerator: Number of facilities providing ART that use CD4 monitoring in line with national guidelines/policies, on site or through referral
Denominator:	Denominator: Total number of facilities providing ART
Disaggregation:	By sites: Private, Public, Primary, Secondary and Tertiary facilities
Purpose	This indicator measures the capacity of services specific to people living with HIV/AIDS. It is assumed that the systems and items measured in this indicator require substantial input and a personnel training beyond what is routine for most health systems.
Data collection frequency:	Annually
Measurement tool:	Program reports, health facility surveys
Method of Measurement	If there is a system that monitors this indicator, then the parameters can be extracted from the system. Alternatively, the information may need to be collected through a special survey or site visits.
Interpretation:	This indicator captures the quality of service rendered by the facility dispensing ART in line with the WHO standard of placing clients on ART.
Additional Information	UNAIDS indicator Registry unaids: Geneva. available at: http://www.indicatorregistry.org
Limitation	This indicator only provide information on facilities that uses or not CD4 monitoring in line with national guideline policies but does not provide information on why facilities are not using CD4 monitoring in line with national guideline policies

HEALTH SYSTEM LEADERSHIP/GOVERNANCE

Percentage of States with evidence-based implementation framework/annual priority Costed plan for a comprehensive HIV response that ensures UA by 2015	
Type of Indicator	Output
Numerator	Number of States with evidence-based implementation framework/annual priority costed plan for a comprehensive HIV response that ensures UA by 2015
Denominator:	Total number of states (including FCT)
Disaggregation	Disaggregate by LGA
Purpose	This indicator measures existence of a state HIV-specific implementation plan. The indicator has two parts. The first is the existence of a coordinated multi-year HIV -specific implementation framework/annual priority costed plan with a schedule for activities implementation and data analysis. The second part is whether the plan is being implemented as outlined.
Data collection frequency	Annual
Measurement tool	Administrative records
Method of Measurement	The indicator is generated by conducting a desk review of State specific Strategic plan framework and checking whether it is a multiyear plan, whether it has cost associated with each activity. The second part after the review of the plan is to monitor its implementation. An annual review is therefore conducted of whether the plan is being implemented according to what is outlined in the plan.
Interpretation	The development of a coordinated multi-year disease M&E plan is an important tool that could address program weaknesses in terms of timely, high-quality data that will enable evidence-based decision-making for decision-makers, including program managers, to facilitate improved health outcomes. A plan with a clearly identified schedule for surveys separate from routine information on diseases and program implementation is critical to strengthening the performance of health systems. This indicator therefore helps to monitor the existence of the plan and whether it is being implemented as outlined.
Additional Information	http://www.indicatorregistry.org

Number of LGAs with costed annual workplan derived from State Strategic Plan	
Type of Indicator	National
Numerator	Number of LGAs with costed annual workplan derived from State Strategic Plan
Denominator:	Not Applicable
Disaggregation	By ward
Purpose	This indicator measures existence of a LGA HIV-specific implementation plan that is derived from the State Strategic Plan.
Data collection frequency	Annual
Measurement tool	Administrative records
Method of Measurement	The indicator is generated by conducting a desk review of LGA HIV-specific implementation plan. The second part after the review of the plan is to monitor its implementation. An annual review is therefore conducted of whether the plan is being implemented according to what is outlined in the plan.
Interpretation	This indicator captures LGA that have a costed workplan which is derived from the State Strategic Plan
Limitation	This indicator does not measure the implementation of the workplan

HEALTH SYSTEM STRENGTHENING SUB AREA 6 - HEALTH FINANCING

Total domestic and international AIDS spending by categories and financing sources out of total AIDS spending	
Type of Indicator:	National
Numerator:	Total domestic and international AIDS spending by categories and financing sources out of total AIDS spending
Denominator:	Not applicable
Purpose:	To collect accurate and consistent data on how funds are spent at the national level and where those funds are sourced
Data collection frequency:	Annually
Measurement tool:	National AIDS Spending Assessment(NASA)/National Health Accounts/Resource Flow Survey
Method of Measurement	Actual expenditures classified by eight AIDS Spending Categories and by financing source, including public expenditure from its own sources (i.e. government revenues such as taxes) and from international sources: 1. Prevention 2. Care and treatment 3. Orphans and vulnerable children2 4. Programme management and administration strengthening 5. Incentives for human resources 6. Social protection and social services (excluding orphans and vulnerable children) 7. Enabling environment and community development 8. Research (excluding operations research included under programme management). (There are multiple subcategories in each AIDS Spending Category; see Appendix 3) Three main groups of financing sources: 1. Domestic public 2. International 3. Domestic private (optional for UNGASS reporting).
Interpretation:	The financial data entered in the National Funding Matrix must be actual expenditures, not budgets or commitments. They must also include AIDS expenditures that were made as part of broader systems of service provision. For example, the diagnosis and treatment of opportunistic infections would require a special costing estimate to track the specific resources allocated to AIDS-related diagnosis and treatment.

	Similarly, prevention activities in schools may benefit from a detailed estimation to calculate actual expenditures on AIDS activities. The AIDS expenditures might occur outside the health system given the nature of expanded responses to AIDS. Completing the National Funding Matrix will provide a more detailed picture of the situation at the country level, which is useful for both national and global decision-making.
Additional Information	UNAIDS (2009). National AIDS Spending Assessment (NASA): Classification taxonomy and definition. This is available at: http://www.unaids.org/en/knowledgeCentre/HIVData/Tracking/Nasa.asp

Percentage of total health expenditure dedicated to HIV/AIDS	
Type of Indicator:	National
Numerator: Essential/reporter	Total number of health expenditure dedicated to HIV/AIDS
Denominator:	Total health expenditure
Disaggregation:	None
Purpose:	To collect accurate and consistent data on how funds are spent on HIV related activities at the national; sub-national level and where those funds are sourced
Data collection frequency:	Annually
Measurement tool:	Primary tool/method: National AIDS Spending Assessment (NASA) Alternative tools/methods: 1) National Health Accounts—AIDS sub-accounts. There should not be any difference in the AIDS health spending measured by NASA or by the National Health Accounts sub-accounts. However, some activities performed outside the health system might not be included in National Health Accounts. 2) Resource Flows Survey. There has been an alignment process and countries that have been selected in the sample of this survey and have responded to the questionnaires may enter the information in the funding matrix at the aggregated level by main activities. Some activities performed outside the health system might not be included in this Resource Flows Survey. In addition, some population-related actions should be excluded from the total for AIDS. The outputs from any of these measurement tools are to be used to

	complete the National Funding Matrix, which is to be submitted as part of the Country Progress Report.
Method of measurement:	Actual expenditures classified by eight AIDS Spending Categories and by financing source, including public expenditure from its own sources (i.e. government revenues such as taxes) and from international sources: 1. Prevention 2. Care and treatment 3. Orphans and vulnerable children2 4. Programme management and administration strengthening 5. Incentives for human resources 6. Social protection and social services (excluding orphans and vulnerable children) 7. Enabling environment and community development 8. Research (excluding operations research included under programme management). Three main groups of financing sources: 1. Domestic public 2. International 3. Domestic private (optional for UNGASS reporting). The National Funding Matrix is available on the UNGASS 2010 reporting website: www.unaids.org/ UNGASS2010.
Interpretation:	The financial data entered in the National Funding Matrix must be actual expenditures, not budgets or commitments. They must also include AIDS expenditures that were made as part of broader systems of service provision. For example, the diagnosis and treatment of opportunistic infections would require a special costing estimate to track the specific resources allocated to AIDS-related diagnosis and treatment. Similarly, prevention activities in schools may benefit from a detailed estimation to calculate actual expenditures on AIDS activities. The AIDS expenditures might occur outside the health system given the nature of expanded responses to AIDS. Completing the National Funding Matrix will provide a more detailed picture of the situation at the country level, which is useful for both national and global decision-making.
Additional Information:	http://www.unaids.org

HEALTH SYSTEM STRENGTHENING SUB AREA 6 – MEDICAL PRODUCTS, VACCINES AND TECHNOLOGY

Percentage of health facilities dispensing ARVs that experienced a stock-out of at least one required ARV in the last quarter	
Type of Indicator:	National
Numerator:	Number of health facilities dispensing ARVs that experienced one or more stock-outs of required ARV drug in the last quarter
Denominator:	Total number of health facilities dispensing ARVs
Purpose	This indicator measures the current availability of ARV regimen at the facilities during the quarter. Physical availability is a basic measure of access to essential ARV regiment for the population. This indicator can also be used for monitoring the effectiveness of the distribution system.
Data collection frequency:	The situation status at facilities should be monitored annually at the subnational level as a management tool; sample facility surveys every 2–3 years or routine reporting systems can provide national statistics
Measurement tool:	Logistics management information systems or health facility surveys
Method of Measurement	Data collection methods: facility visits are required using a standardized checklist to assess the availability of non-expired ARV regimen and review the pharmacy card bin which details issues of stock. Go through the pharmacy record and identify which of the ARV regimens are not available at the facility at the time of the survey. Comparability issues: the quality of data generated by facility visits is likely to be better than those based on reporting systems. Complementary dimensions: data on the ARVs availability are used with data on other components of service capacity to assess the ability of facilities to provide specific services
Interpretation:	
Additional Information	List of required ARV regimen as prescribed in the national ART guidelines

HEALTH SYSTEM STRENGTHENING SUB AREA 6 –HEALTH SERVICE DELIVERY

Percentage of pregnant women MAKING ATLEAST 4 ANC visits according to national protocols	
Type of Indicator:	National
Numerator:	Number of pregnant women MAKING ATLEAST 4 ANC visits according to national protocols
Denominator:	Total number of pregnant women
Disaggregation:	Age
Purpose:	To monitor the extend of ANC attendance by pregnant women
Data collection frequency:	Annual
Measurement tool:	NDHS/MICS, program data
Method of Measurement	Counting the number of respondents or pregnant women that make at least 4 ANC visits and divide it by the total number of respondents or pregnant women
Interpretation:	This indicator captures the number of respondents or pregnant women that make at least 4 ANC visit who will eventually deliver in the hospital and given all the services as stated in the national protocol/guidelines

SEXUAL BEHAVIOR CHANGE

Percentage of people aged 15–24 who both correctly identify ways of preventing the sexual transmission of HIV and who reject major misconceptions about HIV transmission	
Type of Indicator:	National
Numerator: Essential/reporter	Number of respondents aged 15-24 years who gave the correct answer to all five questions
Denominator:	Total number of all respondents aged 15–24 who gave the correct answers to all five questions
Disaggregation:	By Sex: Male, Female By Age: 15-19, 20-24
Purpose:	To assess progress towards universal knowledge of the essential facts about HIV transmission
Data collection frequency:	Preferred: every two years; minimum: every 4–5 years
Measurement tool:	Population-based surveys (Demographic and Health Survey, AIDS Indicator Survey, Multiple Indicator Cluster Survey or other representative survey)
Method of measurement:	This indicator is constructed from responses to the following set of prompted questions: 1. Can the risk of HIV transmission be reduced by having sex with only one uninfected partner who has no other partners? 2. Can a person reduce the risk of getting HIV by using a condom every time they have sex? 3. Can a healthy-looking person have HIV? 4. Can a person get HIV from mosquito bites? 5. Can a person get HIV by sharing food with someone who is infected? The first three questions should not be altered. Questions 4 and 5 ask about local misconceptions and may be replaced by the most common misconceptions in your country. Examples include: “Can a person get HIV by hugging or shaking hands with a person who is infected?” and “Can a person get HIV through supernatural means?” Those who have never heard of HIV and AIDS should be excluded from the numerator but included in the denominator. An answer of “don’t know” should be recorded as an incorrect answer. The indicator should be presented as separate percentages for males and females and should be disaggregated by the age groups 15-19 and 20–24 years. Scores for each of the individual questions (based on the same denominator) are required as well as the score for the

	composite indicator.
Interpretation:	The belief that a healthy-looking person cannot be infected with HIV is a common misconception that can result in unprotected sexual intercourse with infected partners. Rejecting major misconceptions about modes of HIV transmission is as important as correct knowledge of true modes of transmission. For example, belief that HIV is transmitted through mosquito bites can weaken motivation to adopt safer sexual behavior, while belief that HIV can be transmitted through sharing food reinforces the stigma faced by people living with HIV/AIDS. This indicator is particularly useful in countries where knowledge about HIV and AIDS is poor because it permits easy measurement of incremental improvements over time. However, it is also important in other countries as it can be used to ensure that pre-existing high levels of knowledge are maintained.
Additional Information:	#14, Monitoring the Declaration of Commitment on HIV/AIDS. Guidelines on Construction of Core Indicators 2010 Reporting, United Nations General Assembly Special Session [UNGASS]. March 2009 http://data.unaids.org/pub/Manual/2009/JC1676_Core_Indicators_2009_en.pdf

Percent of women and men aged 15–49 who have had more than one sexual partner in the last 12 months reporting the use of a condom their last sexual intercourse	
Type of Indicator:	National
Numerator:	Number of respondents (aged 15–49) who reported having had more than one sexual partner in the last 12 months who also reported that a condom was used the last time they had sex
Denominator:	Total number of respondents (15–49) who reported having had more than one sexual partner in the last 12 months
Disaggregation:	By Sex: Male, Female By Age: 15-19, 20-24, 25-49
Purpose:	To assess progress towards preventing exposure to HIV through unprotected sex with non-regular partners
Data collection frequency:	Every 4-5 years
Measurement tool:	Population-based survey Population-based surveys (Demographic Health Survey, AIDS Indicator Survey, Multiple Indicator Cluster Survey or other representative survey)
Method of measurement:	Respondents are asked whether or not they have ever had sexual intercourse and, if yes, they are asked: 1. In the last 12 months, how many different people have you had sexual intercourse with?

	If more than one, the respondent is asked: 2. Did you or your partner use a condom the last time you had sexual intercourse?
Interpretation:	This indicator shows the extent to which condoms are used by people who are likely to have higher-risk sex (i.e. change partners regularly). However, the broader significance of any given indicator value will depend upon the extent to which people engage in such relationships. Thus, levels and trends should be interpreted carefully using the data obtained on the percentages of people that have had more than one sexual partner within the last year The maximum protective effect of condoms is achieved when their use is consistent rather than occasional. The current indicator does not provide the level of consistent condom use. However, the alternative method of asking whether condoms were always/sometimes/never used in sexual encounters with non regular partners in a specified period is subject to recall bias. Furthermore, the trend in condom use during the most recent sex act will generally reflect the trend in consistent condom use.
Additional Information:	#17, Guidance and Specifications for Additional Recommended Indicators, Addendum to: UNGASS. Monitoring the Declaration of Commitment on HIV/AIDS. Guidelines on Construction of Core Indicators. 2008 Reporting. April 2008. http://data.unaids.org/pub/BaseDocument/2009/20090305_additionalrecommendedindicators_finalprintversio_en.pdf

Percentage of schools that provided life skills-based HIV education within the last academic year (yearly)	
Type of Indicator:	National
Numerator:	Number of schools that provided life-skills based HIV education in the last academic year
Denominator:	Number of Schools Surveyed
Disaggregation:	
Purpose:	To assess progress towards implementation of life-skills based HIV education in all schools
Data collection frequency:	Annually
Measurement Tools	School survey or education program review
Method of measurement:	Principals/heads of a nationally-representative sample of schools (to include both private and public schools) are briefed on the meaning of life-skills based HIV education and then are asked the following question: Within the last academic year, did your school provide at least 30 hours

	of life-skills training to each grade?
Interpretation:	It is important that life-skills based HIV education is initiated in the early grades of primary school and then continued throughout schooling with contents and methods being adapted to the age and experience of the students. The indicator provides useful information on trends in the coverage of life-skills based HIV education within schools. However, the substantial variations in the levels of school enrolment must be taken into account when interpreting (or making cross-country comparisons of) this indicator. Consequently, primary and secondary school enrolment rates for the most recent academic year should be included in the supporting information provided for this indicator. Complementary strategies that address the needs of out-of-school youth will be particularly important in countries where school enrolment rates are low. The indicator is a measure of coverage. The quality of education provided may differ by country and overtime.
Additional Information:	For further information, please consult the following websites: • http://www.unicef.org/lifeskills/index_hiv_aids.html • http://www.unicef.org/aids/index_documents.html

Percentage of respondents aged 15–49 who have had sexual intercourse with more than one partner in the last 12 months	
Type of Indicator:	National
Numerator: Essential/reported	Number of respondents aged 15–49 who have had sexual intercourse with more than one partner in the last 12 months
Denominator:	Number of all respondents aged 15–49
Disaggregation:	By Sex: Male, Female By Age: 15–19, 20–24 and 25–49
Purpose:	Prevention messages should focus on abstinence and also on mutual monogamy. But because sexual relationships among young people are frequently unstable, relationships that were intended to be mutually monogamous may break up and be replaced by other relationships in which similar intentions prevail. Particularly in high HIV prevalence epidemics, serial monogamy is not greatly protective against HIV infection. This indicator measures the proportion of people that have been exposed to more than one partner in the last year.
Data collection frequency:	4–5 years
Measurement tool:	Population-based surveys (Demographic Health Survey, AIDS Indicator Survey, Multiple Indicator Cluster Survey or other representative survey)

Method of measurement:	Respondents are asked whether or not they have ever had sexual intercourse and, if yes, they are asked: In the last 12 months, how many different people have you had sexual intercourse with?
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 program success. Additional indicators may need to be selected to capture the reduction in multiple sexual partners in general.
Additional Information:	#16, Guidance and Specifications for Additional Recommended Indicators, Addendum to: UNGASS. Monitoring the Declaration of Commitment on HIV/AIDS. Guidelines on Construction of Core Indicators. 2008 Reporting. April 2008. http://data.unaids.org/pub/BaseDocument/2009/20090305_additionalrecommendedindicators_finalprintversio_en.pdf

Percentage of young men and women who have had sexual intercourse before the age of 15	
Type of Indicator:	National
Numerator:	Number of respondents (aged 15–24 years) who report the age at which they first had sexual intercourse as under 15 years
Denominator:	Total number of all respondents aged 15–24 years
Purpose	To assess progress in increasing the age at which young women and men aged 15–24 first have sex
Disaggregation:	By sex: male and female By Age: 15- 19 and 20 -24 years
Data collection frequency:	3 to 5 years
Measurement tool:	Population-based surveys (Demographic and Health Survey, Multiple Indicator Cluster Survey, National AIDS and Reproductive Health Survey or other representative survey)
Method of Measurement	Respondents are asked whether or not they have ever had sexual intercourse and, if yes, they are asked: How old were you when you first had sexual intercourse for the first time?
Interpretation:	If policy maker and programme manager especially at the sub-national level is interested in using this indicator and where very few young people have sex before the age of 15 might opt to use an alternative indicator: percentage of young women and men aged 20–24 who report their age at sexual initiation as under 18 years. The advantage of using the reported age at which young

	people first had sexual intercourse (as opposed to the median age) is that the calculation is simple and allows easy comparison over time. The denominator is easily defined because all members of the survey sample contribute to this measure. It is difficult to monitor change in this indicator over a short period because only individuals entering the group, i.e. those aged under 15 at the beginning of the period for which the trends are to be assessed, can influence the numerator. If the indicator is assessed every two to three years, it may be better to focus on changes in the levels for the 15–17 age group. If it is assessed every five years, the possibility exists of looking at the 15–19 age group. In states 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.
Additional Information	UNAIDS Indicator Registry. UNAIDS: Geneva Available at: http://www.indicatorregistry.org/node/660

Percentage of People Living with HIV/AIDS (PLWHA) reached with individual and/or small group level minimum prevention package (MPP) interventions	
Type of Indicator:	National
Numerator:	Number of People Living with HIV/AIDS (PLWHA) reached with individual and/or small group level minimum prevention package (MPP) interventions
Denominator:	Number of people living with HIV/AIDS
Disaggregation:	Sex, Age
Purpose:	It measures progress in reaching individuals and /or small group with ther minimum prevention package (MPP)
Data collection frequency:	Quarterly/Annually
Measurement tool	Program monitoring tools
Method of measurement:	Dividing number of People Living with HIV/AIDS (PLWHA) reached with individual and/or small group level minimum prevention package (MPP) interventions by number of people living with HIV/AIDS

Percentage of MARPs reached with individual and/or small group level MPP interventions	
Type of Indicator:	National
Numerator:	Number of MARPs reached with individual and/or small group level MPP interventions
Denominator:	Number of MARPs
Disaggregation:	Per key population group at risk
Purpose:	Individuals and small-group level prevention interventions have been shown to be effective in reducing HIV transmission risk behaviours. Delivering these interventions with fidelity to the appropriate populations is an important component of combination HIV prevention strategies. It is important to know how many people complete an intervention in order to monitor how well programs are reaching the intended target population with HIV prevention programming. This information can be used to plan and make decisions on how well a certain target population is being reached with individuals and/ or small group level interventions.
Applicability:	Countries with concentrated or low-level epidemics. Countries with generalized epidemics may also have a concentrated sub-epidemic among one or more key populations. If so, they should and report this indicator for those population groups.
Data collection frequency:	Quarterly/Annually
Measurement tool	Program monitoring tools
Method of measurement:	Dividing number of MARPs reached with individual and/or small group level MPP interventions by number of MARPs

Percentage of most-at-risk populations (IDU, MSM, SW) who received an HIV test in the last 12 months and who know the results	
Type of Indicator:	National
Numerator:	Number of most-at-risk population respondents who have received an HIV test in the last 12 months and who know the results
Denominator:	Number of most-at-risk population included in the sample
Disaggregation:	Age:15-24

Purpose:	To assess progress in implementing HIV testing and counselling among Most at Risk Population
Data collection frequency:	Every 2 years
Measurement tool:	Behavioural surveillance or other special surveys
Method of measurement:	Respondents are asked the following questions: 1. Have you been tested for HIV in the last 12 months? If yes: 2. I don't want to know the results, but did you receive the results of that test?
Interpretation:	Accessing and/or surveying most-at-risk populations can be challenging. Consequently, data obtained may not be based on a representative sample of the national, most-at-risk population being surveyed. If there are concerns that the data are not based on a representative sample, these concerns should be reflected in the interpretation of the survey data. Where different sources of data exist, the best available estimate should be used. Information on the sample size, the quality and reliability of the data, and any related issues should be included in the report submitted with this indicator. Tracking most-at-risk populations over time to measure progress may be difficult due to mobility and the hard-to-reach nature of these populations with many groups being hidden populations. Thus, information about the nature of the sample should be reported in the narrative to facilitate interpretation and analysis over time. To maximize the utility of these data, it is recommended that the same sample used for the calculation of this indicator be used for the calculation of the other indicators related to these populations
Additional Information:	WHO/UNODC/UNAIDS (2009). *Technical Guide for Countries to set Targets for Universal Access to* *HIV Prevention, Treatment and Care for Injecting Drug Users*. Geneva: WHO. • UNAIDS (2007). *A Framework for Monitoring and Evaluating HIV Prevention Programmes for Most-At-* *Risk Populations*. Geneva: UNAIDS. • UNAIDS (2007). *Practical Guidelines for Intensifying HIV Prevention: Towards Universal Access*. Geneva: UNAIDS.

Percentage of most-at-risk populations (IDU, MSM, SW) who are HIV positive	
Type of Indicator:	National
Numerator: Essential/reporter	Number of members of the most-at-risk population who test positive for HIV
Denominator:	Number of members of the most-at-risk population tested for HIV
Disaggregation:	Sex: male and female Age : <25/25+
Purpose:	To assess progress on reducing HIV prevalence among most-at-risk Populations
Measurement tools	UNAIDS/WHO *Second Generation Surveillance Guidelines*; Family Health International guidelines on sampling in population groups
Data collection frequency:	Annually
Method of measurement:	This indicator is calculated using data from HIV tests conducted among members of most-at-risk population groups in the primary sentinel site or sites
Interpretation:	Due to difficulties in accessing most-at-risk populations, biases in sero surveillance data are likely to be far more significant than in data from a more general population, such as women attending antenatal clinics. If there are concerns about the data, these concerns should be reflected in the interpretation. An understanding of how the sampled population(s) relate to any larger population(s) sharing similar risk behaviours is critical to the interpretation of this indicator. The period during which people belong to a most-at-risk population is more closely associated with the risk of acquiring HIV than age. Therefore, it is desirable not to restrict analysis to young people but to report on other age groups as well. Trends in HIV prevalence among most-at-risk populations in the capital city will provide a useful indication of HIV-prevention program performance in that city. However, it will not be representative of the situation in the country as a whole. The addition of new sentinel sites will increase the samples representativeness and will therefore give a more robust point estimate of HIV prevalence. However, the addition of new sentinel sites reduces the comparability of values. As such it is important to exclude new sites from the calculation of this indicator when undertaking trend analyses. Revised guidelines on HIV surveillance on most-at-risk populations are currently being prepared by theWHO/UNAIDS Global Working Group on

	STI/HIV Surveillance.
Additional Information:	For further information please refer to: http://www.unaids.org/en/KnowledgeCentre/HIVData/Epidemiology/default.asp

Percentage of males reporting the use of a condom the last time they had anal sex with a male partner in the last six months	
Type of Indicator:	National
Numerator:	Number of male respondents who reported that a condom was used the last time they had anal sex in the last six months.
Denominator:	Total number of male respondents who reported having had anal sex with a male partner in the last six months.
Disaggregation:	Age
Purpose:	To assess progress in preventing exposure to HIV among men who have unprotected anal sex with a male partner
Data collection frequency:	Every 2 years
Measurement tool:	Behavioral Survey including the Family Health International Behavioural Surveillance Survey for men who have sex with men
Method of measurement:	In behavioural survey of a sample of men who have sex with men, respondent are asked about sexual partnerships in the preceding six months, about anal sex within those partnerships and about condom use when they last had anal sex
Interpretation:	This indicator captures information on condom used at last anal sex men who have sex with men.
Additional Information:	UNAIDS (2007). A framework for M&E HIV Prevention Programmes for MARPS. Geneva. UNAIDS.
Limitations	This indicator does not give any idea of risk behaviour in sex with women among men who have sex with both men and women

Percentage of female sex workers reporting the use of a condom with their last client	
Type of Indicator	National

Numerator	Number of female sex workers who reported the use of a condom at their last sexual encounter
Denominator	Total number of FSW respondents
Purpose	To assess progress in preventing exposure to HIV among sex workers through unprotected sex with clients
Data collection frequency	Every 2 years
Measurement tool	Behavioral Survey, Family Health International Behaviour Surveillance Survey for sex workers
Method of measurement	Respondents are asked question such as; did you use condom with your most recent client?
Interpretation	Condoms are most effective when their use is consistent rather than occasional. The current indicator will provide an over estimate of the level of consistent condom use. However, the alternative method of asking whether condoms are always/sometimes/never used in sexual encounters with clients in a specified period is subject to recall bias. Furthermore, the trend in condom use in the most recent sexual act will generally reflect the trend in consistent condom use.
Additional Information	A framework for M&E HIV Prevention Programmes for MARPS. Geneva USAIDS

Percentage of men aged 15-64 reporting sex with a sex worker in the last 12 months who used a condom during last sexual intercourse	
Type of Indicator	National
Numerator	Number of men aged 15-64 reporting sex with a sex worker in the last 12 months who used a condom during last sexual encounter
Denominator	Total number of men aged 15-64 reporting sex with a sex worker in the last 12 months
Disaggregation	By Age : 15-64
Purpose	To assess progress in preventing exposure to HI among men who have unprotected sex with sex worker in the last 12 months.
Data collection frequency	Every 2 years
Measurement tool	Behavioral Survey, Family Health International Behaviour Surveillance Survey for sex workers
Method of measurement	Divide the numerator by the denominator
Interpretation	Condoms are most effective when their use is consistent rather than

	occasional. The current indicator will provide an over estimate of the level of consistent condom use.
Additional Information	UNAIDS (2007). A framework for M&E HIV prevention and programmes for MARPS. Geneva. UNAIDS

Number of states with anti-stigma and discrimination law	
Type of Indicator:	National
Numerator:	Number of states with anti stigma and discrimination law
Denominator:	Not Applicable
Purpose:	Monitor the states that have anti-stigma and discrimination law
Data collection frequency:	Annually
Measurement tool:	Administrative records
Method of measurement:	Count the states with anti-stigma and discrimination law
Interpretation:	All states are supposed to have anti-stigma and discrimination law but not all actually have. This indicator measure the states with anti-stigma and discrimination law
Limitation	The indicator does not measure the states that use the anti-stigma and discrimination law

Percentage of most-at-risk populations who both correctly identify ways of preventing the sexual transmission of HIV and who reject major misconceptions about HIV transmission	
Type of Indicator:	National
Numerator: Essential/reported	Number of most-at-risk population (SW's, MSM's, & IDU's) respondents who gave the correct answers to all five questions
Denominator:	Total number of most-at-risk population (SW's, MSM's, & IDU's) respondents

Disaggregation:	SW, MSM and IDU
Purpose:	It measures progress towards universal knowledge of the essential facts about HIV transmission among MARPs
Data collection frequency:	Every 2 years
Measurement tool:	Population Based Survey, Demographic and Health Survey (DHS)
Method of measurement:	A questionnaire is used with questions like; - Can the risk of HIV transmission be reduced by having sex with only one uninfected partner who has no partner? - Can a person reduce the risk of getting HIV by using a condom every time they have sex? - Can a healthy-looking person have HIV? - Can a person get HIV from mosquito bite? - Can a person get HIV by sharing food with someone who is infected?
Additional Information:	UNAIDS Indicator Registry. UNAIDS Geneva. Available at: http://www.indicatorregistry.org

Percentage of women and men aged 15-49 who have had sex with a non-marital, non-cohabiting sexual partner in the last 12 month	
Type of Indicator:	National
Numerator: Essential/reported	Number of women and men aged 15-49 who reported sexual activity with non-marital, non- cohabiting partners in the last 12 months
Denominator:	Total number of Women and men aged 15-49 surveyed.
Disaggregation:	By Sex : Male and Female By Age : 15-49
Purpose:	It measures the risk of exposure by sexual activity among women and men aged 15 – 49
Data collection frequency:	Every 2 years
Measurement tool:	Behavioral Survey
Method of measurement:	Design questionnaire that will be used to tract and measure the numerator and denominator
Interpretation:	It monitors people within the age limit of 15-24 who were exposed within the last 12 months
Additional Information:	UNAIDS Indicator Registry

Number of schools implementing FLHE curriculum	
Type of Indicator:	National
Numerator:	Number of schools implementing FLHE curriculum
Denominator:	Not Applicable
Purpose	To assess progress toward implementation of life-skills based HIV education in schools
Disaggregation:	Private, Public Schools
Data collection frequency:	Annually
Measurement tool:	Program reports
Method of Measurement	Counting the number of schools implementing FLHE curriculum
Interpretation:	It is important that life-skills based HIV education is initiated in the early grades of primary school and then continued throughout schooling using the FLHE curriculum. This indicator provide useful information on trends in the coverage of life-skills based HIV education within schools
Additional Information	http://www.unicef.org/lifeskills/index_hiv_aids.html http://www.unicef.org/aids/index_documents.html

Number/ % of high risk groups (female sex workers) reached with HIV/AIDS prevention programs	
Type of Indicator:	National
Numerator:	Number of high risk groups(female sex workers) reached with HIV/AIDS prevention programs
Denominator:	Total number of sex workers surveyed
Purpose	Measures progress in implementing basic elements of HIV prevention programmes for sex workers
Disaggregation:	By FSW, Armed forces, transport workers
Data collection frequency:	2 years (Biennial)

Measurement tool:	Behavioural Surveillance or other special surveys
Method of Measurement	Respondents are asked questions like; Do you know where you can go if you wish to receive an HIV test? In the last twelve months, have you been given condoms? Data for sex workers should be collected through civil society organizations that have worked closely with this population in the field. The indicator may over estimate the coverage of HIV prevention services of sex workers. While continued monitoring of this indicator is recommended in order to determine trends in coverage of minimum services, additional measures are required in order to accurately determine whether adequate HIV prevention services are being provided for those populations.
Interpretation:	Sex workers are often difficult to reach with HIV prevention programmes. However, in order to prevent the spread of HIV/AIDS among sex workers as well as into the general population, it is important that they access these services.
Additional Information	WHO/UNODC/UNAIDS (2009). Technical guide for countries to set targets for Universal Access to HIV Prevention, Treatment and Care for Injection Drug Users.

TESTING AND COUNSELLING

Percentage of men and women who received an HIV Counselling and testing in the last 12 months and who know their results	
Type of Indicator:	National
Numerator:	Number of individuals who received an HIV counselling and testing in the last 12 months and who know their results
Denominator:	Total Number of individuals who know their results
Disaggregation:	By Sex :male and female By Age By test result: Positive and negative
Purpose:	This indicator is intended to monitor trends in the uptake of HIV T&C services over time within a country, regardless of the type of T&C service delivery method.
Data collection frequency:	2- 5 years
Measurement tool:	Population based Survey
Method of measurement:	Data will be generated by counting the number of individuals who receive HIV T&C from any service delivery point. Service delivery points could include fixed health care facilities such as; hospitals, public and private clinics, VCT, ANC, labour and Delivery, PMTCT, or TB sites, stand alone sites such as free standing sites in a specific location for a limited period of time, e.g. outreach, door-to-door service and workplace testing events. All individuals receiving T&C should be counted in this indicator regardless of where the service is provided.
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. The introductory statement "I don't want to know the results, but…" allows for better reporting and reduces the risk of underreporting of HIV testing among people who do not wish to disclose their
Additional Information:	For further information, please consult the following website: • http://www.measuredhs.com/aboutsurveys/ais/start.cfm http://www.indicatorregistry.org/node/537
Limitations	This indicator is intended to monitor individuals and the trends in the uptake of C&T over time. However, in some cases, data for this indicator might include repeat testers. If data on persons who retest are not available, this indicator will give information on the number of times HTC services

	were delivered, rather than the number of individuals who received HTC services. Repeat testing is common practice among most HIV T&C programs and it is important to recognize this and interpret the aggregated data with caution.

Percentage of client population aged 15 and above who received HIV C&T and received their results through HCT sites in the past 12 months	
Type of Indicator:	National
Numerator:	Number of the Clients population aged 15 and above who received HIV C&T and their results through HCT sites in the past 12 months.
Denominator:	Total number of the population aged 15 and above who received HIV C&T and their results through HCT sites in the past 12 months.
Disaggregation:	Sex:- Male and Female Age:- 15 – 24 and 25 years and above
Purpose:	Measures progress in implementing HIV counselling and testing
Data collection frequency:	2-5 years
Measurement tool:	Population based survey, Demographic and Health Survey (DHS)
Method of measurement:	Number of the Clients population aged 15 and above who received HIV C&T and their results through HCT sites in the past 12 months/ Total number of the population aged 15 and above who received HIV C&T and their results through HCT sites in the past 12 months.
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.
Additional Information:	UNAIDS Indicator Registry. UNAIDS: Geneva. Available at: www.indicatorregistry.org
Limitations	Knowledge of HIV test results for the last twelve months does not guarantee that a respondent knows their current HIV status. A respondent may have contracted HIV in the time since their last HIV test

Percentage of people aged 15 and above with Sexually Transmitted Infection (STI) who received HCT and received their results in the past 12 months	
Type of Indicator	National
Numerator	Number of people aged 15 and above with sexually transmitted infection (STI) who received HCT and received their results in the past 12 months;
Denominator	Total number of people aged 15 and above with sexually transmitted infection (STI)
Disaggregation	By Sex: male and female By Age : 15 and above
Purpose	Measures progress in the implementing HIV counselling and testing among people aged 15 and above that have STI
Data collection frequency	2-5 years
Measurement tool	Special Survey
Method of measurement	Number of people aged 15 and above with sexually transmitted infection (STI) who received HCT and received their results through provider - initiated services in the past 12 months/ Total number of people aged 15 and above with sexually transmitted infection (STI)
Interpretation	Captures information of men and women aged 15 and above who have been confirmed with STI and also known their HIV status
Additional Information	UNAIDS Indicator Registry. UNAIDS: Geneva. Available at: www.indicatorregistry.org
Limitations	Knowledge of HIV test results for the last twelve months does not guarantee that a respondent knows their current HIV status. A respondent may have contracted HIV in the time since their last HIV test

Percentage of most-at-risk populations (IDU, MSM, SW) who received HCT in the last 12 months and who know the results	
Type of Indicator:	National
Numerator: Essential/report	Number of most-at-risk population who received HCT in the last 12 months and who know their results

er	
Denominator:	Total number of most-at-risk population
Disaggregation:	By sex, age, IDU, FSW and MSM
Purpose:	To assess progress in implementing HIV testing and counselling among most-at-risk populations
Applicability:	
Data collection frequency:	2-5 years
Measurement tool:	Behavioral surveillance or other special surveys
Method of measurement:	Number of most-at-risk population who received an HCT in the last 12 months and who know their results/ Total number of most-at-risk population
Interpretation:	Accessing and/or surveying most-at-risk populations can be challenging. Consequently, data obtained may not be based on a representative sample of the national, most-at-risk population being surveyed. If there are concerns that the data are not based on a representative sample, these concerns should be reflected in the interpretation of the survey data. Where different sources of data exist, the best available estimate should be used. Information on the sample size, the quality and reliability of the data, and any related issues should be included in the report submitted with this indicator. Tracking most-at-risk populations over time to measure progress may be difficult due to mobility and the hard-to-reach nature of these populations with many groups being hidden populations. Thus, information about the nature of the sample should be reported in the narrative to facilitate interpretation and analysis over time. To maximize the utility of these data, it is recommended that the same sample used for the calculation of this indicator be used for the calculation of the other indicators related to these populations
Additional Information:	For further information, please consult the following references: • WHO/UNODC/UNAIDS (2009). *Technical Guide for Countries to set Targets for Universal Access to HIV Prevention, Treatment and Care for Injecting Drug Users*. Geneva: WHO. • UNAIDS (2007). *A Framework for Monitoring and Evaluating HIV Prevention Programmes for Most-At-Risk Populations*. Geneva: UNAIDS. • UNAIDS (2007). *Practical Guidelines for Intensifying HIV Prevention: Towards Universal Access*. Geneva: UNAIDS
Limitations	Knowledge of HIV test results for the last twelve months does not guarantee that a respondent knows their current HIV status. A respondent may have contracted HIV in the time since their last HIV test

Number/% of individuals who tested positive for HIV during the reporting period	
Type of Indicator:	National
Numerator:	Number of individuals who tested positive for HIV during the reporting period
Denominator:	Total number of individuals that were tested during the reporting period
Purpose	Measures the incidence rate among the general population
Disaggregation:	By: Age, sex, positive and negative
Data collection frequency:	Monthly/Quarterly
Measurement tool:	Program Monitoring Tool
Method of Measurement	Count and then divide the numerator by the denominator
Interpretation:	Captures information on both males and females that have been counselled, tested and confirmed positive according to the national algorithm for counselling and testing
Additional Information	For further information, please consult the following references: • WHO/UNODC/UNAIDS (2009). *Technical Guide for Countries to set Targets for Universal Access to HIV Prevention, Treatment and Care for Injecting Drug Users*. Geneva: WHO. • UNAIDS (2007). *A Framework for Monitoring and Evaluating HIV Prevention Programmes for Most-At-Risk Populations*. Geneva: UNAIDS. • UNAIDS (2007). *Practical Guidelines for Intensifying HIV Prevention: Towards Universal Access*. Geneva: UNAIDS
Limitation	Does not measure how many of the positive clients received any intervention or enrolled into the ART program

Number of facility that experienced a stock out of any test kits during the reporting period	
Type of Indicator:	National
Numerator:	Number of facility that experienced a stock out of any test kits during the reporting period
Denominator:	Not Applicable
Purpose	Counselling and testing is the entry point for the ART program, this indicator monitor the logistics management system in ensuring that all facilities offering counselling and testing services does not run out of test kits
Disaggregation:	Public, private, primary, secondary and tertiary hospitals
Data collection frequency:	Monthly/Annually
Measurement tool:	Program monitoring tool
Method of Measurement	Physical counting of the stock inventory
Interpretation:	Facilities offering counselling and testing services are suppose to have test kits all the time to avoid gaps in the delivery of services
Additional Information	UNAIDS Indicator Registry. UNAIDS: Geneva. Available at: www.indicatorregistry.org
Limitation	This indicator does not give information on the reason for the stock out, where the stock out occur, how long, which test kits and quality of the test kits?

OVC

Percentage (number) of vulnerable children with improved wellbeing per a standardized instrument (Child Status Index-CSI) as related to the service areas	
Type of Indicator:	National (Outcome)
Numerator	The total number of OVC that showed at least one score improvement in any OVC service area
Denominator	The total number of OVC receiving services.
Disaggregation:	By Sex : male and female Service areas: Health, education, food and nutrition, shelter and care, protection, psychosocial and household economic strengthening.
Purpose:	This indicator measures the outcome of various support services for OVC. It is to help track the changes (growth, development, well being etc) that have been achieved in the life of the OVC through provision of services in various service area. It will also inform need and strategy for scale up of service provision in all the service delivery areas. The indicator will be used to report the improvement in the well being of OVC receiving support services in Nigeria.
Applicability:	Reporting this indicator applies to all support services provided to OVC by all partners in Nigeria. It is reported at all levels (Community, LGA, State and Federal)
Data collection frequency:	Data is collected at the Community, LGA and State level biannually and collected at the national level annually.
Measurement tool:	OVC Enrolment Card that incorporates Child Status Index is used as baseline; it is repeated biannually and could incorporate any other tool to measure quality of life of OVC.
Method of measurement:	This is calculated by dividing the total number of OVC who showed at least one score improvement in any service area by the total number of OVC receiving supports and multiply by 100.
Interpretation:	It reports improvement in all areas of support services provided to OVC by all the partners of OVC response in Nigeria. This indicator does not correlate the result in the service areas. However, this can be calculated in other studies.
Additional Information:	It reports improvement in all areas of support services provided to OVC by all the partners of OVC response in Nigeria. This indicator does not correlate the result in the service areas. However, this can be calculated in other studies.

Number of vulnerable children (OVC) provided with social services (health, nutrition, shelter, education, care, protection, psychosocial support, household and economic strengthening)	
Type of Indicator:	National
Numerator:	Number of orphans and vulnerable children (OVC) receiving services (educational, , nutrition, shelter and care, protection, psychosocial support and household economic strengthening)
Denominator:	N/A
Disaggregation:	By Sex : Male and Female
Purpose:	Because there are causes of orphan hood other than HIV/AIDS, it can be difficult to differentiate between HIV/AIDS orphans and those orphaned or those who are vulnerable due to other causes (e.g. war, chronic disease). As OVCs may receive food and material support from more than one program, the number of OVCs receiving support may be overestimated due to double counting. This indicator only indicates whether or not assistance was received and does not provide information on the amount of assistance.
Data collection frequency:	Monthly, Quarterly, Annually
Measurement tool:	Program Monitoring Tools
Method of measurement:	Counting the number of orphans and vulnerable children (OVC) receiving services (educational, , nutrition, shelter and care, protection, psychosocial support and household economic strengthening) from the program data.
Interpretation:	Material assistance includes food, clothing, and shelter provided by HIV/AIDS service organizations dealing with children.

Number and percent of orphans and vulnerable children whose households received free basic external support in caring for the child according to the national guideline	
Type of Indicator:	National
Numerator:	Number of orphans and vulnerable children whose households received free basic external support in caring for the child
Denominator:	Total number of orphaned and vulnerable children aged 0-17 For the purpose of this indicaor, an ophan is defined as a child younger than 18 years who has lost both parents. A child made vulnerable by HIV is younger than 18 years and fulfills any of the following:

	7. Has lost one or both parents; 8. Has a chronically ill parents (regardless of whether the parent lives in the same house as the child); 9. Lives in a household where, in the last 12 months, at least one adult died and was sick for three or four months before he or she died; 10. Lives in a household where at least one adult was seriously ill for atleast three of the last 12 months; 11. Lives with a guidiant who is 65 years or older; or 12. Lives with guidian(s) who are physically impaired
Disaggregation:	
Purpose:	As the number of ophaned and vulnerable children continues a grow, adequate support to families and communities needs to be assured. In practice, care and support for ophaned children comes from families and communities. As a foundation for this support, it is important that households be connected to additional support from external sources. External support is defined as help free of charge from a source other than friends, family or neighbours unless they are working for a community-based group or organization. Identify, this support should be designed along the national guidelines for OVC support where this exist.
Applicability:	Countries with high level of HIV infection
Data collection frequency:	Every 3-5 years
Measurement tool:	Population-based survey
Method of measurement:	The data should be collected through program monitoring reports of implementing partners on a routine basis. These records are compiled and aggregated to obtain an overall measure of the reach of the care and support for orphans and vulnerable children. Implementers at the community level devise reliable tracking mechanisms that capture accurate data to avoid double counting. There is a need to ensure that clients served (as opposed to client visits) for the same service or across services are counted. Since the routine monitoring is self-reported by implementing entities. Compliance with national guidelines will only be measured periodically through supervision, assessments and the surveys
Interpretation:	
Additional Information:	Children and HIV/AIDS : technical and policy documents (website). New York, United Nations Children's Fund, 2008 (http://www.unicef.org/aids/index_documents.html).

Number of organizations and agencies demonstrating at least one score improvement in at least one areas of capacity building, as measured by a standardized tool	
Type of Indicator:	National
Numerator:	Number of organizations and agencies demonstrating at least one score improvement in at least one areas of capacity building, as measured by a standardized tool
Data collection frequency:	Every 3-5 years
Measurement tool:	Program data
Method of measurement:	Counting
Interpretation:	Number of organizations and agencies demonstrating at least one score improvement in at least one areas of capacity building, as measured by a standardized tool Number of grantees who show at least one score improvement in at least one areas of capacity building, since last assessment Targeted aspects: 1. Financial Management 2. Management and Human Resources 3. Technical Capacity 4. Monitoring and Evaluation 5. Oversight and Governance 6. External Resources

Percentage/ratio of school attendance of orphans to school attendance of non-orphans aged 10-14 years	
Type of Indicator:	National
Numerator:	**Orphans: School attendance rate** Number of children 10-14 years who have lost both natural parents and are still in school. *Non-orphans: school attendance rate:* Number of children 10-14 years both of whose natural parents are still alive, who are still in school, and who are living with at least one of these parents.

Denominator:	**Orphans: School attendance rate** Total number of children 10-14 who have lost both natural parents. *Non-orphans: school attendance rate:* Total number of children 10-14 both of whose natural parents are still alive and who are living with at least one of these parents. Number of children whose parents are alive who are living with at least one parent
Disaggregation:	Sex:- Male and Female; Urban vs. Rural
Purpose:	To assess progress towards preventing relative disadvantage in schoolattendance among orphans versus non-orphans
Data collection frequency:	Every 4-5 years
Measurement tool:	Population based Survey
Method of measurement:	Number of children whose parents are alive, who are living with at least one parent and who attend school/ Number of children whose parents are alive who are living with at least one parent
Interpretation:	The definitions of orphan/non-orphan used here—i.e., child aged 10–14 years as of the last birthday both of whose parents have died/are still alive—are chosen so that the maximum effect of disadvantage resulting from orphan hood can be identified and tracked over time. 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. However, orphaned children are typically older than non-orphaned children (because the parents of younger children have often been HIV-infected for less time) and older children are more likely to have left school. Typically, the data used to measure this indicator are taken from household-based surveys. Children not recorded in such surveys—e.g., those living in institutions or on the street—generally, are more disadvantaged and are more likely to be orphans. Thus, the indicator will tend to understate the relative disadvantage in educational attendance experienced by orphaned children. This indicator does not distinguish children who lost their parents due to AIDS from those whose parents died of other causes. In countries with smaller epidemics or in the early stages of epidemics, most orphans will have lost their parents due to non-HIV-related causes. Any differences in the treatment of orphans according to the known or suspected cause of death of their parents could influence trends in the indicator. However, to date there is little evidence that such differences in treatment are common. The indicator provides no information on actual numbers of orphaned children. The restrictions to double orphans and to 10–14 year-

	olds mean that estimates may be based on small numbers in countries with small or nascent epidemics.
Additional Information:	For further information, please consult the following website: • http://www.unicef.org/aids/index_documents.html

PLHIV

<table>
<tr><th colspan="2">Number of people living with HIV and people affected with HIV/AIDS provided with a minimum of one clinical care service (PLWH, PABA, sex and age: <15 and above 15years)</th></tr>
<tr><td>Type of Indicator:</td><td>Direct</td></tr>
<tr><td>Numerator: Essential/reported</td><td>Number of people living with HIV and people affected with HIV/AIDS provided with a minimum of one clinical care service (PLWH, PABA, sex and age: <15 and above 15years)</td></tr>
<tr><td>Denominator:</td><td>N/A</td></tr>
<tr><td>Disaggregation:</td><td>
<table>
<tr><td>Essential/reported</td><td>Males</td></tr>
<tr><td>Essential/reported</td><td>Females</td></tr>
<tr><td>Essential/reported</td><td><18 years of age</td></tr>
<tr><td>Essential/reported</td><td>18+ years of age</td></tr>
<tr><td>Recommended</td><td><1</td></tr>
<tr><td>Recommended</td><td><5</td></tr>
<tr><td>Recommended</td><td><15</td></tr>
</table>
Age represents an individual’s age at the end of the reporting period or when last provided with a support service.</td></tr>
<tr><td>Purpose:</td><td>PEPFAR has a legislative 5-year goal to care for 12 million individuals, including care services to 5 million children orphaned or made vulnerable by HIV.

PEPFAR recognizes that individuals, families, and communities are being affected by HIV in ways that may hinder the medical outcomes of HIV-positive persons as well as the emotional and physical development of children orphaned or made vulnerable by HIV. A variety of services are supported through PEPFAR to mitigate these effects in order to improve health outcomes for HIV positive, improve the developmental growth of children, and optimize the quality of life of adults and children living with and affected by HIV

This indicator measures the number of individuals receiving care services through PEPFAR. Data collected through this indicator will inform country programs and PEPFAR about the scale-up of services for individuals affected by HIV. Data collected from this indicator can inform</td></tr>
</table>

	program planning, budget allocations, and will be used to report against the legislative 5-year goal of 12 million individuals. The age disaggregation (<18) will be used to report on the goal of 5 million children who are orphaned or made vulnerable due to HIV.
Applicability:	All countries with PEPFAR-funded partners providing services that traditionally fell under the Care and Support or OVC technical program areas. (see appendix 2 for menu of support services and clinical services)
Data collection frequency:	Data should be collected continuously at facility and/or community/home-based sites. Data should be aggregated in time for PEPFAR reporting cycles. In addition, USG country teams may request periodic aggregation, i.e. quarterly, for the purposes of program management and review
Measurement tool:	Registers/databases, client records and registers, or other program monitoring tools. Programs may need to modify the revised WHO Pre-ART/ART registers to capture this data.
Method of measurement:	The numerator is generated by counting the number of eligible individuals who received at least one care service from facilities and/or community/home-based organizations. This is the number of unique individuals receiving care services. Definitions: PEPFAR CARE programs include <u>support</u>, <u>preventative</u>, and <u>clinical</u> services <u>Clinical Services</u> – Include a broad range of services related to the specific clinical needs of HIV-positive persons. Clinical services may be provided in facilities, the community, or in the home, and may include both *assessment* of the need for interventions (for example assessing pain, clinical staging, and eligibility for Cotrimoxizole, or screening for tuberculosis) or provision of needed interventions. These services are further defined under the CARE indicator for Clinical Services for HIV-positive. See appendix 2 for the full menu of clinical services. <u>Individuals eligible for clinical services:</u> People living with HIV/AIDS (PLWHA), including pregnant women <u>Preventive Services</u> - Include a range of services related to the prevention of the transmission or acquisition of HIV. Services may include both *assessment* of risk and need for interventions or provision of needed interventions. <u>Support Services</u> – Include a broad range of services, which provide social, psychological, or spiritual support and are appropriate for all persons who are affected by HIV, including people living with HIV/AIDS (PLWHA). Support services fall into these broad categories: Psychological, spiritual, preventive, food support*, shelter, protection, access to health care,

	education/vocational training, and economic strengthening. See appendix 2 for the full menu of support related services. <u>Individuals eligible for preventive and support services:</u>
	-Adults and children living with HIV (PLWHA), including pregnant women-Family members, caregivers, or other household members living with or caring for an HIV-positive individual or an OVC -Children made vulnerable due to HIV (<18 years old) including children who have lost one or both parents to AIDS, who live in households made increasingly vulnerable because of HIV/AIDS. In high prevalence communities, all children may be affected due to break down in community support, loss of teachers, or other social support as a result of HIV epidemic.-Infants born to HIV-positive mothers
	To count under this indicator, individuals must receive a minimum of one service. However, PEPFAR programs should seek to provide a comprehensive set of support and clinical services appropriately tailored to the status of the individual or family. This comprehensive set of services should include linkages to partners providing other types of services as indicated. For HIV-infected persons, programs should ensure that patients receive services through the full continuum of care, which extends specifically to clinical services and eventually to anti-retroviral therapy The aggregated total for this indicator is not simply the sum of the individuals served by all partners. Overlap of services provided by facility-based care and support and community/home-based care and support partners must be adjusted for so that individuals are counted only once in the aggregated total. Individuals who receive services from more than one partner or provider should be de-duplicated at the program summary reporting level. *For example: individuals may receive services from different partners and still be counted at the partner level (i.e. social service from partner A and psychological services from partner B), individuals should only be reported once at the summary program level.*
	*Food Support may also fall under clinical support when provided as therapy for clinically malnourished HIV-positive clients. See indicator
Interpretation:	This is a high-level indicator that provides the total number of all individuals receiving care services through PEPFAR from facilities and/or community/home-based organizations. While an individual must receive at least one care service to be counted, this indicator does not articulate what type of service was provided, or where it was provided. However, subsets of this high-level indicator provide more specificity regarding types of populations and services received (For example, see indicators
	This indicator does not currently provide measures of coverage, nor does it

	measure quality or effectiveness of services.
Additional Information:	• Partially harmonized with Care and support (HIV-CS2), The Global Fund to Fight AIDS, Tuberculosis and Malaria Monitoring and Evaluation Toolkit: HIV, Tuberculosis and Malaria and Health Systems Strengthening Part 2: Tools for monitoring programs for HIV, tuberculosis, malaria and health systems strengthening, Third Edition, February 2009

Number of People Living with HIV/AIDS(PLHIV) receiving Adherence Support	
Type of Indicator:	National
Numerator:	Number of People Living with HIV/AIDS(PLHIV) receiving Adherence Support
Denominator:	Not Applicable
Purpose	Measures the progress of adherence to ARV among People Living with HIV/AIDS(PLHIV)
Disaggregation:	By Sex and age, facilities or communities or in homes
Data collection frequency:	Quarterly
Measurement tool:	Program monitoring tool
Method of Measurement	Counting the number of People Living with HIV/AIDS(PLHIV) receiving Adherence Support
Interpretation:	People Living with HIV/AIDS(PLHIV) receiving Adherence Support either in the facilities or communities or in homes
Additional Information	UNAIDS Indicator Registry. UNAIDS: Geneva. Available at: www.indicatorregistry.org
Limitation	Does not indicate the level of adherence and the reasons for not adhering

Number of People Living with HIV/AIDS(PLHIV) receiving home based care	
Type of Indicator:	National
Numerator:	Number of People Living with HIV/AIDS(PLHIV) receiving home based care
Denominator:	Not applicable
Purpose	Monitor the extend of home based support by care providers for people living with HIV/AIDS
Disaggregation:	By age and sex
Data collection frequency:	Quarterly
Measurement tool:	Program monitoring tool
Method of Measurement	Counting the number of People Living with HIV/AIDS(PLHIV) receiving home based care
Additional Information	UNAIDS Indicator Registry. UNAIDS: Geneva. Available at: www.indicatorregistry.org

BLOOD SAFETY

Percentage of donated blood units screened for HIV according to national guidelines	
Type of Indicator:	National
Numerator:	Number of donated blood units screened for HIV According to national guidelines.
Denominator:	Total number of blood units donated
Disaggregation:	Positive, negative, age, sex
Purpose:	Blood safety program aim to ensure that all blood units are screened for transfusion-transmission infections, including HIV, and that only the units that do not react on screening tests are released for clinical use. In many countries, blood units are not screened for all the major transfusion-transmission infections. Even when screening does occur, inaccurate test results often compromise the safety of the blood due to the poor quality or incorrect storage of the test kits. Further, inadequate staff training or a lack of standard operating procedures may result in laboratory errors. This could lead to blood units being classified as safe even when they infectious, posing a serious risk of transmission of HIV through unsafe blood. Universal (100%) screening of donated blood for HIV and other transfusion-transmission infections cannot be achieved without mechanisms to ensure quality and continuity in screening. In some countries, interruption in supplies of test kits and reagents, or emergency situations, can result in the use of blood for transfusion without screening for transfusion-transmission infections. The development of systems that provide reliable and regular supplies of low-cost, high quality test kits and reagents and effective stock management is therefore essential to ensure universal quality screening of blood units. Thus, screening all donated blood units for HIV in a quality manner is crucial. Two key components of quality assurance in screening are: • The use of documented and standardized procedures (standard operating procedures) for the screening of every blood unit; and • Participation of the laboratories in an external quality assessment scheme for HIV screening in which external assessment of the laboratory's performance is conducted using samples of known, but undisclosed, content to assess its quality system and assist in providing standards of performance.
Data collection frequency:	Every 2 years

Measurement tool:	Special Survey
Method of measurement:	The information relates to data from the previous 12 months. The information should be available from the National Blood Transfusion Service or the office responsible for the National Blood Programme in the Ministry of Health.
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. If a blood screening performed is being assessed at regular intervals. It is important to view the percentage of screened blood units in relation to these two basic components of quality as both are required to ensure the quality of procedures. The following information is required to measure this indicator; - The total number of blood units that were donated in the country - For each blood centre and blood screening laboratory that screens donated blood for HIV; (the number of units of blood donated in each blood centre/blood screening laboratory and the number of donated units screened in the blood centre/blood screening laboratory)
Additional Information:	UNAIDS indicator registry, UNAIDS: Geneva. Available at: http://www.indicatorregistry.org/node/648

INJECTION SAFETY AND INJECTION DRUG USE

Percentage of injecting drug users reporting the use of a condom the last time they had sexual intercourse	
Type of Indicator:	National
Numerator:	Number of respondents who reported that a condom was used the last time they had sex
Denominator:	Number of respondents who report having injected drugs and having had sexual intercourse in the last month
Disaggregation:	Sex Age <25/25+
Purpose:	To assess progress in preventing sexual transmission of HIV
Data collection frequency:	Every 2 years
Measurement tools	Special surveys including the Family Health International Behavioural Surveillance Survey for injecting drug users
Method of measurement:	Respondents are asked the following sequence of questions. 1. Have you injected drugs at any time in the last month? 2. If yes: have you had sexual intercourse in the last month? 3. If yes in answer to both 1 and 2: did you use a condom when you last had sexual intercourse?
Interpretation:	Surveying injecting drug users can be challenging. Consequently, data obtained may not be based on a representative sample of the national injecting drug user population being surveyed. If there are concerns that the data are not based on a representative sample, these concerns should be reflected in the interpretation of the survey data. Where different sources of data exist, the best available estimate should be used. Information on the sample size, the quality and reliability of the data, and any related issues should be included in the report submitted with this indicator. The extent of injecting drug use-associated HIV transmission within a country depends on four factors: (i) the size, stage and pattern of dissemination of the national AIDS epidemic; (ii) the extent of injecting drug use; (iii) the degree to which injecting drug users use contaminated injecting equipment; and (iv) the patterns of sexual mixing and condom use among injecting drug users and between injecting drug users and the wider population. This indicator provides partial information on the fourth factor.

	To maximize the utility of these data, it is recommended that the same sample used for the calculation of this indicator be used for the calculation of the other indicators related to these populations.
Additional Information:	WHO/UNODC/UNAIDS (2009). *Technical Guide for Countries to set Targets for Universal Access toHIV Prevention, Treatment and Care for Injecting Drug Users*. Geneva: WHO. • UNAIDS (2007). *A Framework for Monitoring and Evaluating HIV Prevention Programmes for Most-At-Risk Populations.* Geneva: UNAIDS. • UNAIDS (2007). *Practical Guidelines for Intensifying HIV Prevention: Towards Universal Access*. Geneva: UNAIDS.

Percentage of injecting drug users reporting the use of sterile injecting equipment the last time they injected	
Type of Indicator:	National
Numerator:	Number of respondents who report using sterile injecting equipment the last time they injected drugs
Denominator:	Number of respondents who report injecting drugs in the last month
Disaggregation:	
Purpose:	To assess progress in preventing injecting drug use-associated HIV transmission
Data collection frequency:	Every 2years
Measurement tool:	Special surveys including the Family Health International Behaviour, Surveillance Survey for injecting drug users
Method of measurement:	Respondents are asked the following questions. 1. Have you injected drugs at any time in the last month? 2. If yes: The last time you injected drugs, did you use a sterile needle and syringe
Interpretation:	Surveying injecting drug users can be challenging. Consequently, data obtained may not be based on a representative sample of the national injecting drug user population being surveyed. If there are concerns that the data are not based on a representative sample, these concerns should be reflected in the interpretation of the survey data. Where different sources of data exist, the best available estimate should be used. Information on the sample size, the quality and reliability of the data, and any related issues should be included in the report submitted with this indicator. The extent of injecting drug use-associated HIV transmission within a country depends on four factors: (i) the size, stage and pattern of dissemination of the national AIDS epidemic; (ii) the extent of injecting drug use; (iii) the degree to which

	injecting drug users use contaminated injecting equipment; and (iv) the patterns of sexual mixing and condom use among injecting drug users and between injecting drug users and the wider population. This indicator provides information on the third factor. To maximize the utility of these data, it is recommended that the same sample used for the calculation of this indicator be used for the calculation of the other indicators related to these populations.
Additional Information:	WHO/UNODC/UNAIDS (2009). *Technical Guide for Countries to set Targets for Universal Access to HIV Prevention, Treatment and Care for Injecting Drug Users*. Geneva: WHO. • UNAIDS (2007). *A Framework for Monitoring and Evaluating HIV Prevention Programmes for Most-At-Risk Populations*. Geneva: UNAIDS. • UNAIDS (2007). *Practical Guidelines for Intensifying HIV Prevention: Towards Universal Access*. Geneva: UNAIDS.

CARE AND SUPPORT

Number of children and adult enrolled in HIV care: (a)new and (b) current (c) ever enrolled in the facility by sex and age: <1 yr, 1-17yrs, 18 and above	
Type of Indicator:	National
Numerator:	Number of children and adult enrolled in HIV care: (a)new and (b) current (c) ever enrolled in the facility by sex and age: <1 yr, 1-17yrs, 18 and above
Denominator:	Not applicable
Disaggregation:	Sex: male and female Age: <1 yr, 1-17yrs, 18 and above
Purpose:	To monitor the trends of children and adult that were confirmed positive and were enrolled into the ART program
Data collection frequency:	Monthly/Quarterly
Measurement tool	Program monitoring tool
Method of measurement:	Counting the number of children and adults

WORKPLACE PROGRAMS

Percentage of enterprises with an HIV/AIDS workplace policy and implementing programs according to the minimum prevention package.	
Type of Indicator:	National
Numerator:	Number of registered enterprises with an HIV/AIDS policy and implementing a program, (prevention/care and support/treatment) according to the 3 minimum prevention package detailed in the National prevention Plan.
Denominator:	Number of registered enterprises..
Data collection frequency:	Annually
Measurement tool:	Program reports; surveys FMoLP, NIBUCAA Database, CAC registration database, FMOLP, NANTs.(National Association of Nigerian Traders)
Method of measurement:	Number of registered enterprises with an HIV/AIDS policy and implementing a program, (prevention/care and support/treatment) according to the 3 minimum prevention package detailed in the National prevention Plan/ Number of registered enterprises

Percentage of MDAs with HIV/AIDS workplace policy and implementing an HIV/AIDS workplace program, (prevention/care and support/treatment) according to the minimum prevention package	
Type of Indicator:	National
Numerator: Essential/reported	Number of MDAs implementing an HIV/AIDS workplace program, (prevention/care and support/treatment) according to minimum package
Denominator:	Number of MDAs having an HIV/AIDS workplace Policy
Data collection frequency:	Annually
Measurement tool:	Assessment Forms/Program Monitoring Tools
Method of measurement:	Number of MDAs implementing an HIV/AIDS workplace program, (prevention/care and support/treatment) according to minimum package/ Number of MDAs having an HIV/AIDS workplace Policy

GENDER

Number of male and female reached by an individual, small group or community-level intervention or service that explicitly addresses gender-based violence and coercion related to HIV/AIDS	
Type of Indicator:	National
Numerator:	Number of people reached by an individual, small group or community-level intervention or service that explicitly addresses gender-based violence and coercion related to HIV/AIDS
Denominator:	N/A
Disaggregation:	By age: <15; 15 – 49
Purpose:	This indicator measures the number of adults and children reached by an intervention or service that explicitly addresses gender-based violence and coercion related to HIV and AIDS.
Applicability:	
Data collection frequency:	Monthly/Quarterly
Measurement tools	Program monitoring tools
Interpretation:	Gender-based violence is violence involving men and women in which the female is usually the victim and which is derived from unequal power relationships between men and women. It includes, but is not limited to, physical, sexual and psychological harm (including intimidation, suffering, coercion, and/or deprivation of liberty within the family, or within the general community). It includes violence which is perpetrated or condoned by the state. Sexual and other forms of abuse against women and girls fuel the spread of HIV. The practice or threat of sexual violence against women and girls puts them at increased risk of HIV infection by creating situations in which women are unable to voluntarily abstain from sex or negotiate condom use. **Includes:** • HIV post-exposure prophylaxis in clinical settings for survivors of violence; • The development of couple HIV counselling; • Partner notification strategies; • Health workers' awareness of and skills to address violence;

	• Links with community and social services that provide protection and care for victims of violence; and • The activities of community- and faith-based organizations to ▪ Change social norms that perpetuate male violence against women, ▪ Train couples in negotiation and conflict resolution, and ▪ Strengthen policy and legal frameworks that outlaw gender-based violence;

OTHERS

National Composite Policy Index	
Type of Indicator:	National
Numerator:	National Composite Policy Index
Denominator:	Not applicable
Purpose:	To assess progress in the development and implementation of national level HIV and AIDS policies, strategies and laws
Data collection frequency:	Every two years. The National Composite Policy Index is ideally completed in the last 6 months of the reporting period (i.e., between June and December 2009 for the 2010 reporting round). As a variety of stakeholders need to be consulted, it is important to allow adequate time for the data gathering and data consolidation process.
Measurement tools	National Composite Policy Index questionnaire
Method of measurement:	The National Composite Policy Index questionnaire is divided in two parts which cover the following areas: Part A - to be administered to government officials I. Strategic plan II. Political support III. Prevention IV. Treatment, care and support V. Monitoring and evaluation Part B - to be administered to representatives from civil society organizations, bilateral agencies, and UN organizations I. Human rights II. Civil society involvement III. Prevention IV. Treatment, care and support Some questions occur in both Part A and Part B to ensure that the views of both the national government and nongovernment respondents, whether in agreement or not, are obtained. Each section should be completed by (a) conducting a desk review of relevant documents and (b) interviewing key people most knowledgeable about the topic. It is important to submit a fully completed National Composite Policy Index: check the relevant standardized responses as well as provide further information in the open text boxes where requested. This will facilitate a better understanding of the current country situation, provide examples of good practice for others to learn from, and pin-point some issues for further improvement. National Composite Policy Index

	responses reflect the overall policy, strategy, legal and program implementation environment of the HIV response. The open text boxes provide an opportunity to comment on issues that are perceived as important but insufficiently captured in the questions as asked e.g. important sub-national variations; the level of implementation of strategies, policies, laws or regulations; explanatory notes; comments on the data sources etc. In general, *draft* strategies, policies, or laws are *not* considered 'in existence' (i.e. there is no opportunity yet to expect their influence on program implementation) so questions about whether such a document exists should be answered with 'no'. It would, however, be useful to state that such documents are in draft form in the relevant open text box. While the responsibility for submitting the consolidated National Composite Policy Index data lies with the national government, the assistance of technical coordinators for data gathering, data consolidation and data validation is strongly advised. Accurate completion of the National Composite Policy Index requires the involvement of a range of stakeholders which should include representatives of civil society organizations. It is strongly recommended to (a) organize an initial workshop with key stakeholders to agree on the National Composite Policy Index data gathering process (including relevant documents for desk review, organizational representatives to be interviewed, process to be used for determining final responses, timeline); and to (b) organize a final workshop with key stakeholders to present, discuss and validate the National Composite Policy Index findings before official submission as part of the UNGASS Country Progress Report. Agreement on the final National Composite Policy Index data does not require that discrepancies, if any, between overlapping questions in Part A and Part B be reconciled; it simply means that when there are different perspectives, that Part A respondents agree on their responses, Part B respondents agree on their responses, and that both are submitted. If not already the case, it is useful to collate all key documents (i.e. policies, strategies, laws, guidelines, reports etc) related to the HIV response in one place which allows easy access by all stakeholders (such as a website). This will not only facilitate validation of National Composite Policy Index responses but, even more importantly, increase awareness about and encourage use of these important documents in the implementation of the national HIV response going forward.
Interpretation:	The National Composite Policy Index is the most comprehensive standardized questionnaire available to assess the policy, strategy, legal and program implementation environment for the HIV response. Although the National Composite Policy Index is generally referred to as an 'indicator' or an 'index', it is not used in that sense. While it is possible to calculate an overall score by assigning a value to each response, the importance of the Index lies in the process of data collection and data reconciliation between different stakeholders,

	detailed analysis of the responses, and its use in strengthening the national HIV response. The National Composite Policy Index process provides a unique opportunity for the variety of stakeholders to take stock of progress made and to discuss what still needs to be done to support an effective and efficient HIV response. When completed in a truly collaborative manner, inviting appropriate representation and respecting different views, the National Composite Policy Index process can play an important role in strengthening in-country collaboration and increasing shared ownership of the HIV response. • It is important to analyse the data for each of the National Composite Policy Index sections and include a write-up in the narrative section of the Country Progress Report in terms of progress made in (a) policy, strategy and law development and (b) implementation of these in support of the country's HIV response. Comments on the agreements or discrepancies between overlapping questions in Parts A and B should also be included, as well as a trend analysis on the key National Composite Policy Index data since 2003, where available3.