

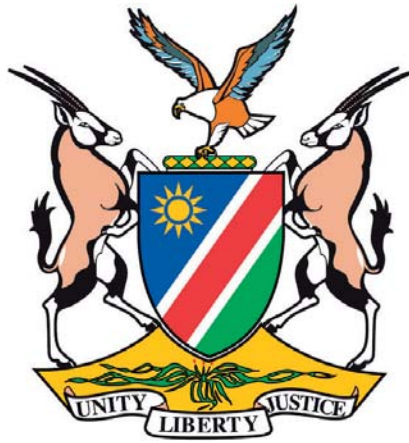


Republic of Namibia
Ministry of Health and Social Services

Plan for National Multi-Sectoral Monitoring and Evaluation of HIV and AIDS 2010/11 to 2015/16



2010



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Ministry of Health and Social Services

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2010/11 – 2015/16

2010

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***“If you do not measure results, you can not tell success from failure
If you can not see success, you cannot reward it
If you can not reward success, you are probably rewarding failure
If you can not see success, you can not learn from it
If you can not recognize failure, you can not correct it
If you can demonstrate results, you can win public support”***

Adapted by Kusek and Rist (2004) from Osborne & Gaebler, 1992

PREFACE

The National Strategic Framework (NSF) for HIV and AIDS (2010/11- 2015/16) defines how all sectors of society at all levels are going to respond to HIV and AIDS. The NSF uses a result based frame work which focuses on the understanding of how the service delivery efforts lead to changes in the lives of the targeted audiences, and therefore impact on the epidemic.

Namibia adopted a multi-sectoral approach for the implementation of the national HIV and AIDS response. In addition, the country also adopted and institutionalized the 3-Ones principle. This thus requires coordinated M&E systems that will track the implementation of the NSF. The M&E plan is aligned to the National Strategic Framework (NSF) and is expected to ensure effective and efficient monitoring and evaluation of the NSF based on the agreed national priority impact, outcome and output results

The monitoring and evaluation plan will guide the response of the multi-sectoral approach with essential information on the core indicators that measure the effectiveness of the national response to HIV and AIDS. The plan will also be used to guide, track and monitor Namibia's performance towards achieving its international commitments including Millennium Development Goals (MDG), United Nations General Assembly Special Session (UNGASS), the Abuja and other Southern African Development Community (SADC) and African Union (AU) commitments.

The Ministry would like to acknowledge all the stakeholders who contributed to the drafting and finalization of this plan. Special thanks go to the Directorates of Special Programmes for the coordination and overseeing the successful completion of this plan. I trust that all relevant stakeholders involved in HIV and AIDS will use it to measure the achievement of the expected results of the Namibia's national HIV response.


.....
Mr. K.K. Kahuure
Permanent Secretary



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ACRONYMS

AIDS	Acquired Immuno-Deficiency Syndrome
AIS	AIDS Indicator Survey
AMICAALL	Alliance of Mayors Initiative for Community Action on AIDS at the Local Level
ANC	Antenatal Care
ART	Anti-Retroviral Therapy
ARV	Anti-Retroviral
BSS	Behavioral Surveillance Survey
CACOC	Constituency AIDS Coordinating Committee
CBS	Central Bureau of Statistics
CBO	Community-Based Organization
CCN	Council of Churches in Namibia
CDR	Crude Death Rate
CHBC	Community Home-Based Care
CHPA	Commonwealth Health Professions Alliance
CSO	Civil Society Organization
CTX	Cotrimoxazole
DACOC	District AIDS Coordinating Committee
DHS	Demographic and Health Survey
DMT	District Management Team
DR	Drug Resistance
DSP	Directorate of Special Programs
EDT	Electronic Dispensing Tool
EMIS	Education Management Information System
ePMS	Electronic Program Monitoring System
EPP	Estimation and Projection Package
ETR	Electronic TB Register
EWI	Early Warning Indicator
FBO	Faith Based Organization
FY	Fiscal Year
GDP	Gross Domestic Product
GF	Global Fund
GFATM	Global Fund to Fight AIDS, Tuberculosis and Malaria
GRN	Government of the Republic of Namibia
HCT	HIV Counselling and Testing
HIS	Health Information System
HIV	Human Immuno-Virus
IBBS	Integrated Biological and Behavioral Surveillance
IPT	Isoniazid Preventative Therapy
JAR	Joint Annual Review
M&E	Monitoring and Evaluation
MARP	Most at Risk Population
MC	Male Circumcision
MCP	Multiple Concurrent Partnerships
MDG	Millennium Development Goal
MGE CW	Ministry of Gender Equality and Child Welfare
MoE	Ministry of Education
MOF	Ministry of Finance
MoHSS	Ministry of Health and Social Services
MoT	Mode of Transmission
MRLGHRD	Ministry of Regional and Local Government, Housing and Rural Development
MSM	Men Who Have Sex with Men
MTEF	Medium-Term Expenditure Framework
MTP	Medium-Term Plan
MTR	Mid-Term Review
NABCOA	Namibia Business Coalition on AIDS
NAC	National AIDS Council
NAEC	National AIDS Executive Committee
NAMBTS	Blood Transfusion Service of Namibia

NANASO	Namibia Network of AIDS Service Organizations
NASA	National AIDS Spending Assessment
NDHS	Namibia Demographic and Health Survey
NDP	National Development Plan
NDP III	The Third National Development Plan
NGO	Non-Governmental Organization
NPC	National Planning Commission
NSF	National Strategic Framework
OMAs	Offices, Ministries and Agencies
OPM	Office of the Prime Minister
OVC	Orphans and Vulnerable Children
PCR	Polymerase Chain Reaction
PEP	Post Exposure Prophylaxis
PEPFAR	President's Emergency Plan For AIDS Relief
PHC	Primary Health Care
PLHIV	People Living with HIV and AIDS
PMTCT	Prevention of Mother to Child Transmission
PRS	Poverty Reduction Strategy
QUIMS	Quality of Impact Mitigation Services
RAC	Regional AIDS Coordinator
RACOC	Regional AIDS Coordinating Committee
RBM	Results Based Management
RCC	Rolling Continuing Channel
RM&E	Response Monitoring and Evaluation
SACU	Southern African Customs Union
SADC	Southern African Development Community
SHPA	Senior Health Program Administrators
SME	Small and Medium Enterprise
SOW	Statement of Work
SPA	Service Provision Assessment
SPM	System for Programme Monitoring
STI	Sexually Transmitted Infection
TAC	Technical Advisory Committee
TB	Tuberculosis
TOR	Terms of Reference
TWG	Technical Working Group
UA	Universal Access
UN	United Nations
UNAIDS	Joint United Nations Program on HIV and AIDS
UNGASS	United Nations General Assembly Special Session on HIV and AIDS
UNICEF	United Nations Children's Fund
URC	University Research Corporation
VCT	Voluntary Counselling and Testing
WHO	World Health Organization
WPP	Workplace Program

OVERVIEW OF THE MONITORING AND EVALUATION PLAN AND ITS STRUCTURE

This Monitoring and Evaluation (M&E) plan is designed as a recipe book for the HIV M&E system in Namibia – a system designed to measure the achievement of Namibia’s national HIV response goals (as documented in the HIV and AIDS National Strategic Framework for HIV and AIDS (fiscal year 2010/11 to 2015/16)). A comprehensive and efficient M&E plan is critical for any HIV and AIDS program that aims to reduce the transmission of the disease and mitigate its impact. This plan provides relevant information to program managers and policy makers so that they can make key decisions regarding their response to the AIDS epidemic in Namibia. The plan also contributes to a more efficient use of data and resources by encouraging the use of standardized indicators and data collection methodologies that can be compared over time and between different geographical areas.

This M&E plan is organized into the following four chapters:

- Background Information and Introduction to the M&E Plan
- General M&E Concepts, Approaches and Terminology
- How the National HIV Monitoring and Evaluation System in Namibia functions
- What the HIV M&E system measures: NSF Thematic Goals, National Targets, Key Program Areas, and Core Indicators for Measurement

CHAPTER 1: BACKGROUND INFORMATION & INTRODUCTION TO THE MONITORING AND EVALUATION PLAN

1.0 The Country Context

Namibia is situated in the south western part of Africa and has a surface area of 824,116 km². The country is divided into 13 administrative regions. The population of Namibia was estimated to be 1,830,330 in the 2001 census and is estimated to increase to 2,180,000 by 2011 (population projection by the Central Bureau of Statistics [CBS]). Forty three percent (43%) of the population is under the age of 15 years, and less than 4% of the population is over the age of 65 years¹. Between 1981 and 1991, Namibia experienced a high population growth rate of over 3%; however, the growth rate fell to 2.6% per annum between 1991 and 2001² as a result of a number of factors, including the negative impacts of HIV and AIDS on the health and longevity of the population.

Namibia is classified as an upper-middle income country, with a gross national income per capita of US\$4,200 in 2008³. The Namibian economy comprises two sub-economies: the more formal and modern economic sector that includes mining, livestock production and fishing; and the informal, subsistence sector that consists of agriculture and herding. The mining sector is a major contributor to the Namibian economy, contributing to 13% of the gross domestic product (GDP) in 2008⁴. In the same year, agriculture and fisheries contributed 6% and 4%, respectively, to the GDP. However, Namibia is highly dependent on the Southern African Customs Union (SACU) revenue pool, resulting in a surplus of balance of payments in recent years. These revenues are anticipated to decline in the near future because of the challenging financial situation that the global economies are currently facing.

Namibia has one of the highest income inequalities in the world, as evidenced by a Gini coefficient of 0.7⁵ and a 51.2%⁶ unemployment rate. The income disparity is associated with Namibia's colonial history and the continued unequal distribution of productive resources and capital since independence. In Namibia, 27.6% of the general population is considered to be poor, of whom 13.8%⁷ are considered to be extremely poor.

Namibia has a well established network of modern infrastructure such as roads, rail lines, telecommunication equipment, and port facilities. Subsistence agriculture plays a major role in household food security. While Namibia may be food secure at a macro level, many rural households are food insecure because agriculture production is affected by fluctuating weather conditions and a lack of adequate water. Livestock is the backbone of the agriculture sector, and in 2005 livestock contributed 67% to agriculture exports.⁸

Since independence, the government has pursued policies and programs to reduce poverty in the country, including the formulation of a Poverty Reduction Strategy (PRS) in 1998. These policies and programs are also reflected in Namibia Vision 2030, a document detailing the country's long-term goals and the programs and strategies required to achieve those goals. A majority of the population (more than 60%) live in rural areas, as do most of the poor. The effects of poverty manifest themselves in various forms, including income and consumption inequality, low human development, social exclusion, ill being, lack of legal resources, relative deprivation, as well as vulnerability, including uncertain livelihoods and a lack of means to meet basic needs. Appropriate policies,

¹ 2001 National Population and Housing Census

² Namibia Vision 2030

³ World Bank website: www.web.worldbank.org/wbsite/external/datastatistics

⁴ African Economic Outlook 2008, African Development Bank

⁵ 2009 Human Development Report

⁶ 2008 Namibia Labor Force Survey

⁷ Central Bureau of Statistics, National Planning Commission, *A review of poverty and inequality in Namibia, 2008*

⁸ NDP 3, (pg 98)

strategies, and plans have been designed, but additional resources are required to constructively and decisively reduce poverty⁹.

1.1 The HIV Epidemic in Namibia

1.1.1 Magnitude of HIV

Namibia has a generalized, mature HIV epidemic with the virus primarily transmitted through heterosexual means. The first case of HIV infection in the country was reported in 1986. During FY 2008/09, HIV prevalence among 15–49 year olds was 13.3%, resulting in around 6,130 AIDS-related deaths during that time (Namibia HIV Estimates 2009). This amounted to approximately 23% of all deaths in Namibia (crude death rate [CDR] from population projections for FY 2008/09). In the same time period, a total of approximately 5,830 people were infected with HIV, with around 16 new infections occurring each day (Namibia HIV Estimates 2009). This steady stream of new infections over a long period of time resulted in an estimated 174,000 adults and children living with HIV and AIDS (i.e. people living with HIV and AIDS [PLHIV]) in Namibia by the end of FY 2008/09. Approximately 250,000 children aged 18 years old or younger were orphans or vulnerable children (OVC) in Namibia in FY 2008/09; around 28% of these OVC (69,000) were orphaned by AIDS by the end of FY 2008/09 (Spectrum 2009 estimates, the Namibia Demographic and Health Survey [NDHS] 2007, and Namibia population projections 2001–2031).

1.1.2 Overall Trends

Available data from the National HIV Sentinel Surveys indicate that HIV prevalence among pregnant women attending antenatal care (ANC) rapidly increased from 4.2% in 1992 to a peak of 22.3% in 2002 (see Figure 1), before showing signs of stabilization and a statistically significant decline. In 2008, HIV prevalence among pregnant women had decreased to 17.8%.

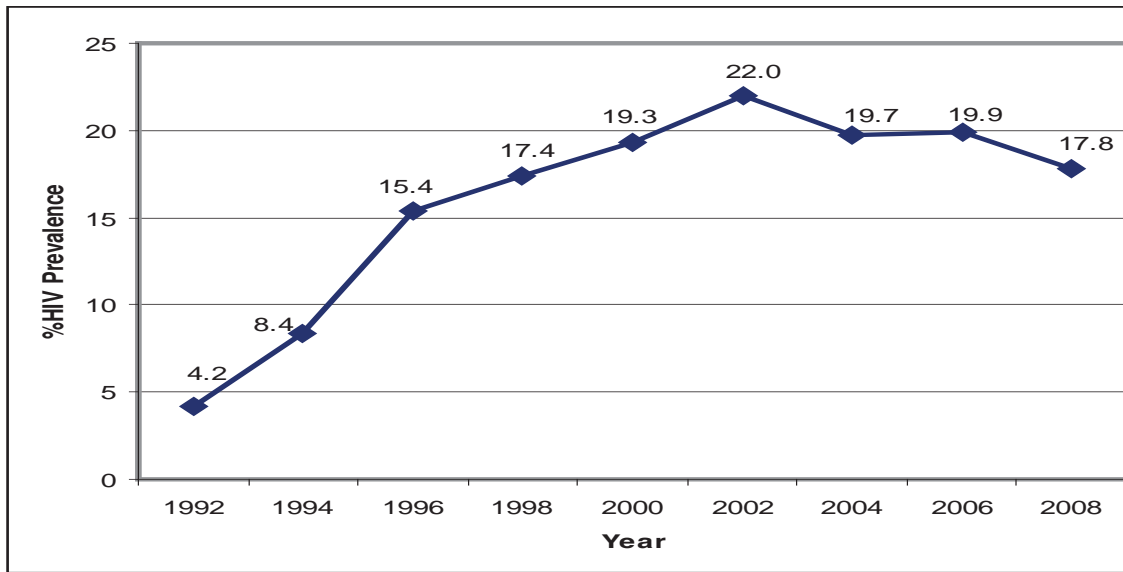
1.1.3 Geographic Homogeneity and Age-Related Heterogeneity

The 2008 ANC Sentinel Surveillance Report, which describes HIV prevalence trends among pregnant women, further found that HIV prevalence in this population was the same in rural areas as in urban areas. While HIV prevalence is highest among women aged 30–34 years (27% in 2008) and has increased in this group during the previous three rounds of sentinel surveillance, the prevalence declined from 12% in 2000 to 5% in 2008 among 15–19 year old women, and from 20% in 2000 to 14% in 2008 among 20–24 year old women (see Figure 2). This is indicative of a maturing epidemic and fewer new infections.

According to the Spectrum 2009 report, new infections in adults aged 15 years and above are projected to decline from 3,025 during FY 2010/11 to 2,877 by FY 2012/13. The prevalence rates for the same age group are projected to decline from 11.1% in FY 2010/11 to 10.0% by FY 2012/13.

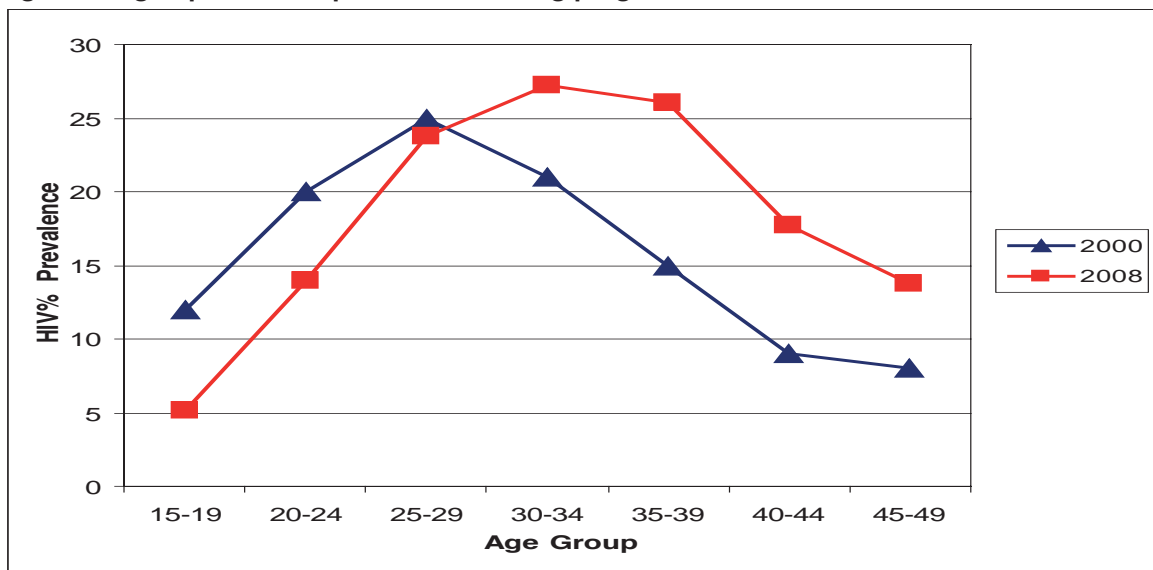
⁹ *An analysis of the Economic Challenges of Namibia and How the Donor Community should Assist - Country Paper for the International Conference on Development Cooperation with Middle Income Countries (MICs), Madrid, Spain, 2007 National Planning Commission*

Figure 1: HIV prevalence trends among pregnant women attending antenatal care between 1992 and 2008.



Source: MoHSS, ANC Sentinel Surveillance Report 2008.

Figure 2: Age-specific HIV prevalence among pregnant women in 2000 and 2008.



Source: MoHSS, ANC Sentinel Surveillance Report 2008.

1.1.4 Sources of new HIV Infections

Namibia has a generalized epidemic that has permeated throughout the society. As mentioned above, 16 new infections occur each day (25% among infants aged less than 1 year, 31% among youth aged 15–24 years, and 37% in adults aged 25 years or older)¹⁰. The main mode of HIV transmission is heterosexual, and the epidemic has sustained itself through specific sexual practices, community norms and practices, alcohol abuse that affects decisions on sexual behavior, low levels of male circumcision, and low HIV risk perceptions. The other major source of new infections is mother to child transmission (around 25% of new infections). Namibia has attained a 100% level of voluntary non-remunerated blood donation, and 100% of transfusions are screened for transmissible infections; therefore, transmission of HIV infection through blood transfusion is unlikely.

The ANC Sentinel Surveillance Report (Ministry of Health and Social Services [MoHSS] 2008) shows an overall decrease in HIV prevalence among the 15–24 age group, which corresponds to a reduction in new infections among youth from 39% of all new infections in 2002 to 31% of new infections in 2008, as estimated in the Namibia HIV Estimates 2009 report. This Estimates report further estimates that over 54% of new infections in 2008 were in women and 32% were in children under 15 years old. Early sexual debut may also fuel the epidemic. By age 18, the legal age for marriage, 36% and half of men (49%) have had sexual intercourse (Namibia Demographic and Health Survey [NDHS] 2006/07).

As part of the “know your epidemic” initiative, Namibia, in collaboration with other stakeholders, conducted a study on the behavioral and contextual factors driving the HIV epidemic and produced a report in 2009¹¹. This study highlighted the proximate and distal drivers that fuel new infections. These drivers are of a biological, behavioral, social, and structural nature and include the following: multiple and concurrent partnerships, condom use that is not universal and not consistent, low HIV risk perceptions, varying levels of male circumcision, alcohol use and abuse, intergenerational sex, transactional sex, mobility of populations, and the presence of most at risk populations (MARPs).

1.2 NATIONAL RESPONSE

Namibia integrated its national HIV and AIDS response within a long-term vision and planning framework by developing and adopting an AIDS policy in 2007. This policy provides a guide for a national multi-sectoral response to the HIV and AIDS epidemic and clearly defines and mandates the government to develop and maintain an operational monitoring and evaluation (M&E) plan for the purpose of tracking the national HIV and AIDS response. According to this policy, the Namibian government has a responsibility to track the progress of the national response as outlined in the Medium-Term Plan (MTP), and in the National Strategic Framework (NSF) for HIV and AIDS for FY 2010/11 to 2015/16.

The NSF for HIV and AIDS for FY 2010/11 to 2015/16 was developed through a participatory and consultative process and is a successor to the third MTP (MTP III) that came to an end in March 2010. The current NSF is specifically linked to the goals and strategies of a long-term development planning process called Namibia Vision 2030. This Vision outlines a broad framework for the country's 5-year National Development Plans (NDPs) until 2030 and provides direction to all levels of government, the private sector and civil society. The NDPs are vehicles for translating Namibia's Vision 2030 into action and realizing the goals enumerated in the Vision.

The Mid-Term Review (MTR) of the MTP III, conducted in June 2007, highlighted significant progress in the response to HIV and AIDS, particularly in the areas of ensuring availability of treatment, access and utilization of treatment and care services, and the mobilization of additional resources. However, the lack of a contingency plan to address the issue of long-term sustainability, the partial success of HIV prevention efforts, as well as the difficulties in coordinating and managing a multi-sectoral response remain a concern.

¹⁰ Estimates and Projections 2009

¹¹ HIV/AIDS in Namibia: Behavioral and Contextual Factors Driving the Epidemic, 2008, MoHSS

The current NSF for HIV and AIDS is structured around the following four strategic areas:

- Prevention
- Treatment, care and support
- Impact mitigation at individual, community and institutional levels
- Response management

These areas are anchored on issues and gaps identified in the MTP III. The NSF is the main national document used to guide annual action planning on the response to HIV and AIDS, and, as such, the document strengthens the harmonization and alignment of efforts and guides resource mobilization and management at various levels. Government offices, ministries and agencies (OMAs), as well as civil society organizations (CSOs) draw from the NSF to develop and implement programs and activities that address the epidemic in the short and medium terms.

1.3 INTERNATIONAL AND REGIONAL COMMITMENTS

The government of Namibia is signatory to a variety of international and regional declarations and commitments that guide and serve as a springboard for the national HIV and AIDS M&E system. To this end, the international community has mobilized significant resources to scale-up efforts to establish such an M&E system in Namibia. Some key commitments, such as the United Nations General Assembly Special Session on HIV and AIDS (UNGASS), the Millennium Development Goals (MDGs), the President's Emergency Plan For AIDS Relief (PEPFAR), the Global Fund to Fight AIDS, Tuberculosis and Malaria (GFATM), the WHO/UNICEF/UNAIDS Universal Access (UA) reports and Southern African Development Community (SADC) epidemic updates are associated with indicators required for national reporting. These indicators have been harmonized with the national list of indicators. A results-based framework for assessing the results of the NSF forms the foundation of this M&E plan and includes national and donor indicators to ensure that all national and international commitments are met.

1.4 THE M&E PLAN: BACKGROUND, GOALS AND OBJECTIVES

1.4.1 Strategic Focus

The NSF for HIV and AIDS for FY 2010/11 to 2015/16 is a strategy that requires a coherent system of operation and a complementary M&E system to ensure accountability. To this end, the M&E plan described here was developed, with the measurement of results as its central focus. The current document outlines how the government of the Republic of Namibia plans to track the performance of the NSF for HIV and AIDS activities during FY 2010/11–2015/16 and provides an overview of the national HIV and AIDS M&E system.

A functional M&E system is a key factor in the internationally accepted concept of the 'Three Ones' principal, which provides an overarching framework to improve coordination of a national HIV and AIDS response. The principles of the 'Three Ones' are:

- One agreed national coordinating authority to steer the multi-sectoral response
- One agreed national strategic framework
- One agreed national monitoring and evaluation framework

The DSP at the MoHSS is mandated to coordinate the national response to the HIV and AIDS epidemic using the NSF as its framework for coordination. This is the 'first One'. The 'second One' is the NSF for HIV and AIDS FY 2010/11 to 2015/16 and the 'third One' is the National Plan for M&E of HIV and AIDS FY 2010/11 to 2015/16.

In recognition of the 'Three Ones' principle, the M&E plan advocates a harmonized M&E framework, system and reporting process. The goal of the plan is to create and strengthen a unified and coherent M&E system in Namibia that will ensure relevant, timely and accurate data collection and distribution from all stakeholders (health-facility- and non-health-facility-based).

1.4.2 Core Values

The following core values provide the foundation and guiding principles for the M&E plan:

- Quality service
- Visionary and strategic management
- Responsive
- Teamwork
- Coverage of all program areas outlined in the NSF for HIV and AIDS for FY 2010/11 to 2015/16 with particular emphasis on the identified emerging priority areas
- Results orientation
- The principle of the 'Three Ones' Transparency and accountability
- Simplicity of data collection
- Decentralization, mainstreaming and integration
- Building on existing national and international indicators and minimizing the number of indicators to be collected
- Coordinating national and donor M&E needs as well as harmonizing with other international commitments such as UA, UNGASS, MDGs and PEPFAR

1.4.3 Goal and Objectives of the M&E Plan

The goal of this M&E plan is to ensure collection and reporting of all national-level HIV and AIDS indicators, as it will guide a coordinated and efficient collection, collation, analysis, interpretation, and dissemination of information for HIV and AIDS programs. The M&E plan will be used to measure progress made in the national response to HIV and AIDS and enhance informed decision making and policy for multi-sectoral, decentralized HIV and AIDS programs.

The specific objectives of the M&E plan are:

- To direct gathering and reporting of information that is useful in monitoring and evaluating implementation of the NSF for HIV and AIDS for FY 2010/11 to 2015/16.
- To guide the development and strengthening of stakeholders' M&E systems.
- To assist all HIV and AIDS stakeholders in conceptualizing and harmonizing a coordinated M&E system for the national HIV and AIDS response.
- To increase the understanding of trends and changes in HIV and AIDS prevalence over time.
- To promote utilization of M&E data in planning and program management.
- To generate an information base for Namibia's timely reporting on its UNGASS commitment and MDG targets.
- To coordinate operational and basic research.
- To determine the resource needs and strategies for resource mobilization.

Expected outputs of implementing the M&E plan are:

- Quality and timely reporting by MoHSS and all program implementers.
- Strengthened M&E systems.
- An up-to-date documentation and information center.
- An M&E communication and advocacy strategy.
- Data availability for all HIV and AIDS national indicators.

1.4.4 Process for Developing the M&E Plan

In developing the national M&E plan, a desk review to assess the needs and capacities of the existing M&E system took place as did consultative and consensus building meetings. This process involved key stakeholders, both national and international, to secure consensus, commitment and ownership, ensure effective implementation, and achieve accountability. To this end, a technical working group (TWG) was formed to play a lead role in the development of the plan.

Specifically, the following methods were used:

- Consultative meetings with the M&E TAC (TAC) members. This committee was the TWG that supported the development of the results framework of the NSF.
- Reviews of relevant documents including national-level survey reports such as the Demographic and Health Survey (DHS), the UA Report, national HIV and tuberculosis targets reports, HIV Estimation and Projection Packages (EPPs), ANC sentinel surveillance reports, national MTP III progress reports and UNGASS reports.
- Interviews with key informants in line ministries, regions, CSOs, umbrella organizations, donors and partners to assess existing mechanisms in their constituencies.
- Consultative meetings with various stakeholders and participants through TWGs.

This plan incorporates useful indicators on the prevention, care and treatment, support, coordination and management from the previous HIV and AIDS M&E plan (FY 2006/07 to FY 2008/09). At the same time, the current plan recognizes the important evolving focus areas of the new NSF for FY 2010/11 to 2015/16.

1.4.5 Implementation of the M&E Plan

Implementation of this M&E plan is intended to be a participatory process and was designed to build on existing skills while developing additional M&E capacity at all levels. This plan describes the mechanisms that will capture data for national and regional reporting in conformity with the NSF and for reporting on international requirements (UNGASS, UA, MDGs).

The National AIDS Executive Committee (NAEC) will provide oversight for implementation of the M&E plan. Coordination of implementation of the M&E plan will be the responsibility of the National AIDS Council (NAC), with secretarial support from the Directorate of Special Program/Response, Monitoring and Evaluation Unit (DSP/RM&E).

Coordination activities will include convening meetings with key stakeholders on an annual basis, potentially linked to the Joint Annual Review (JAR), to obtain updates on progress towards program results, share and discuss data and data-related issues, support collaborative problem solving and plan for the following year. During these annual meetings, stakeholders will assess the M&E plan and make recommendations for any updates or revisions. This annual meeting will also provide a mechanism for the collation of data from multiple sources by the NAC and DSP/RM&E.

A mid-term review of the NSF and the M&E plan will also be conducted. During this review the NAC will support the coordination of data reporting and synthesis to assess progress toward achieving the goals of the NSF. This review will also provide an opportunity for stakeholders to revise targets as necessary.

Finally, an end-term review of the NSF and the M&E plan will be conducted. Again, NAC will support the coordination of data reporting and synthesis to assess the end-term progress toward achieving the goals of the NSF.

Following each of the convened meetings (annual, mid term and end term), the NAC will oversee feedback to all national, regional and district level bodies and development partners, and provide guidance and support for the use of data for program strengthening.

1.4.6 Critical Assumptions

The following assumptions have been taken into account to ensure successful implementation of the national M&E plan:

- All key stakeholders, government OMAs in particular, will cooperate in collecting and forwarding all the required HIV and AIDS data to the MoHSS in a timely manner and without information gaps.
- The quality assurance functions of the government ministries will ensure that the data collected are of high quality.
- HIV and AIDS partnership arrangements will establish incentives for establishing and maintaining functional M&E systems by making such systems a prerequisite for future support.
- The MoHSS will continuously clarify its coordination role and increase its capacity to coordinate, not implement, the M&E system.
- HIV and AIDS programs and projects will be approved only if they have satisfactory M&E implementation plans and budgets.
- The MoHSS and stakeholders will engage in an intensive participatory process to build ownership and buy-in, particularly for the overall M&E system and program monitoring.
- Each national-level implementing partner will agree on its key targets with the MoHSS.
- Each implementing partner will ensure that its M&E systems are capturing the intended data in a timely, accurate and complete way.
- Data will be checked and verified at appropriate intervals by specialized monitoring entities.
- The MoHSS will assess progress towards targets every year and rate the progress of the national response.
- Each national-level implementer will collate, analyze and submit annual reports to the MoHSS using a simple progress report form.
- The Namibia National HIV M&E TAC will meet regularly to review M&E reports, ensure utilization of data by all stakeholders, identify key lessons learned and make strategic recommendations and decisions.
- The MoHSS and key stakeholders will update their M&E manuals and procedures on the basis of lessons learned.

1.4.7 Assessment of M&E Systems

As part of the development of the NSF for HIV and AIDS FY 2010/11 to 2015/16 and the drafting of the Rolling Continuing Channel Global Fund (RCC GF) proposal for HIV and AIDS and health systems strengthening (HSS), a gap analysis was conducted that assessed the M&E systems that

support the HIV and AIDS response. The recommendations of this analysis, made in 2009, provided a key source of input into this M&E plan and are outlined below:

- The national M&E function needs to be restructured to ensure that sufficient permanent staff is available to monitor the national HIV and AIDS response.
- A priority M&E research agenda needs to be developed.
- The MoHSS and the Office of the Prime Minister (OPM) need to undertake an annual joint AIDS review.
- The MoHSS needs to complete the Health Facility Survey and undertake an AIDS Indicator Survey (AIS), a Demographic and Health Survey (DHS), a National AIDS Spending Assessment (NASA) and Behavioral Surveillance Surveys (BSSs) before conducting an HIV Modes of Transmission (MoT) study.
- HIV databases, including those in the MoHSS, need to be harmonized, and a national multi-sectoral database for HIV and AIDS needs to be created.
- Implementers collecting non-health-facility-based data should use standard data collection tools from the government of the Republic of Namibia.
- Joint data quality assurance involving all key partners needs to be improved as does timeliness and completeness of reporting.
- Mechanisms to ensure reporting to regional authorities need to be put in place and communicated to regional M&E coordinators for use by implementers working in their region.

1.4.8 Link of the M&E Plan to the NSF

The NSF was developed using a results-based management approach. Indicators for the measurement of each result were identified to ensure that the results are measurable. Baselines were obtained for most of the indicators, and targets were set for the end of the NSF period in FY 2015/16 for all indicators, and for the mid-term time point (FY 2012/13) for the output/input indicators. Protocols for each of the indicators are outlined in volume two of the M&E plan to facilitate utilization of the M&E plan by all stakeholders.

The NSF calls for a functional, national M&E system that provides values for 70% of the NSF results indicators by FY 2012/13 and 90% by FY 2015/16. The timely availability of the indicator values will be a gauge of the functional capacity of the M&E system to collect, collate, analyze and report data.

In the NSF, the output requirements for tracking the functionality of the national HIV M&E system are the following:

- Joint AIDS annual reviews of the NSF should be held annually, with a mid-term review in 2012/13 and a final NSF evaluation in 2015/16.
- The national M&E plan and HIV targets should be revised in FY 2012/13 and FY 2015/16.
- A total of 80% of implementers should use standardised M&E tools by FY 2012/13, increasing to 95% by FY 2015/16.
- By FY 2012/13, DHS+ (the DHS plus an HIV testing and counselling component), Behaviour Surveillance Survey BSSs and Quality of Impact Mitigation Services (QUIMS) surveys for understanding the epidemic should be completed, and an AIDS Indicator Survey (AIS) should be conducted and used to inform the evaluation of the current NSF and planning for the next NSF by FY 2015/16.
- The HIV research agenda should be updated at least once every 24 months.

CHAPTER 2: GENERAL M&E CONCEPTS, APPROACHES AND TERMINOLOGY

This chapter provides a broad overview of key concepts and approaches to M&E to provide a context for measurement of NSF results. Additional terminologies can be found in the glossary in Annex 1.

2.1 WHAT IS M&E?

Both monitoring and evaluation are fundamental aspects of good program management at the community, district, provincial, national and global levels. M&E involves examining program components to track and assess the program's progress and value. Though monitoring and evaluation usually go hand in hand, distinguishing between and understanding the different activities they encompass is important.

The three uses of M&E are:

- Reporting and accountability
- Sharing data with stakeholders
- Program improvement (see Figure 3)

Figure 3: The Purpose of Monitoring



Source: CDC 2003

2.1.1 Monitoring

Monitoring is the ongoing process of collecting quantitative and qualitative data about a program to determine the progress that has been made toward previously agreed-upon objectives. Monitoring involves routinely tracking the activities being conducted, the resources being used to support those activities, and the outputs and outcomes resulting from those activities. Effective monitoring relies primarily on good recordkeeping and regular reporting. Monitoring is also important at the national level as it tracks information relevant to national program planning and determines the achievement of intended outputs, outcomes and impacts.

2.1.2 Evaluation

Evaluation is the essential counterpart to monitoring. In general, evaluation is a systematic approach to analysing information to determine, as fairly as possible, the relevance, effectiveness, and impact of program activities in light of the objectives. Evaluation uses applied research methods to systematically investigate a program's effectiveness and make judgments about how a program is performing with respect to expectations. This process involves interpreting qualitative and quantitative measures that offer an independent and impartial assessment of what actions actually took place and the extent to which agreed-upon outcomes were achieved. Evaluation is a critical mechanism for improving existing HIV and AIDS programs and informing the development of new ones. More broadly, the evaluation process should also contribute to the ongoing, program-wide process of resource mobilization and allocation.

2.2 THE INPUT-PROCESS-OUTPUT-OUTCOME-IMPACT FRAMEWORK

When designing an M&E system for a health program, M&E experts use the input-process-output-outcome-impact framework, which incorporates both the monitoring and evaluation processes. This framework provides a logical foundation for identifying various indicators to be monitored by program staff, which, in turn, enables the program directors to determine if the implementation of activities is on track and whether the objectives have been met. The five concepts of the input-process-output-outcome-impact framework are defined as follows:

- 1) **Inputs:** the resources invested into a program. This typically includes money, staff time, and supplies and commodities.
- 2) **Processes:** the activities that are implemented in a program based on the inputs. These include training, workshops, development, provision of services, and dissemination of information materials and/or technical guidance documents.
- 3) **Outputs:** the program's achievements as direct results of the processes. For example, having trained staff, people receiving services such as counselling, testing and treatment, and creating a community that is more aware of stigma and discrimination issues. Outputs can also be represented as percentages when documenting coverage.
- 4) **Outcomes:** behavioral or societal changes that occur as a result of the achieved outputs. For example, youth changing their sexual behavior, as reflected in condom use and delay of first sexual contact, because their knowledge of HIV and AIDS transmission and prevention methods has improved.
- 5) **Impact:** the long-term societal change that emerges as a result of short-term changes or outcomes. Impacts are usually observed as reductions in HIV and AIDS cases and deaths; improved quality of life for those affected by the disease, and mitigated economic impact.

The first three factors — inputs, processes, and outputs are part of the **program monitoring** process and should be measured for every project on a routine basis in order to determine if program implementation is on track.

The final two factors — outcomes and impact are part of the **program evaluation** process. Evaluation requires considerable investment and skill because attributing short-term or long-term societal changes to an individual program is difficult and requires the use of detailed research methodologies. In contrast to program monitoring, program evaluation is, therefore, not performed routinely but at various intervals during the life of the program, typically at mid-term and at the end of the program. While not all HIV and AIDS programs can evaluate their effectiveness because of limited resources, a national HIV and AIDS program is required to do so to some extent in order to

demonstrate that resources have been well spent and that the HIV and AIDS epidemic in the country is being brought under control.

CHAPTER 3: THE NATIONAL HIV MONITORING AND EVALUATION SYSTEM IN NAMIBIA

3.1 GENERAL PRINCIPLES OF A NATIONAL HIV AND AIDS M&E SYSTEM

A harmonized M&E system guides the process of collecting, analyzing and presenting specific data on the basis of pre-defined indicators, with the purpose of quantifying achievements (or levels of success) of a defined strategy and guiding future strategy and interventions. See Chapter 2 for M&E concepts and Annex 1 for a glossary of M&E terms.

The need for and importance of a unified national M&E system are to:

- Strengthen the multi-sectoral response and national commitment towards HIV and AIDS prevention, care and treatment services by understanding the overall goals of the country's national response under the NSF for FY 2010/11 to 2015/16.
- Provide an organizing principle for creating an operational M&E system.
- Have a joint costed work plan which enables prioritization of activities.
- Link all aspects of the program, such as assessments, capacity strengthening plans, reviews, documentation and technical support, to the same framework.
- Harmonize M&E systems of different institutions at all levels through the use of common and internationally accepted indicators, such as the UNGASS core indicators, thus enabling information to be interpreted with a common understanding. Reporting should be released in a timely manner, while the data are still relevant, and should be synchronized to allow a broad analysis of progress. These activities have to be guided by a national M&E plan that incorporates standard output, outcome and impact indicators.
- Ensure ownership and stakeholder involvement, which implies that people understand and commit to scheduled M&E activities, and that they appreciate the value of the information they generate. The higher the participation levels, the more valid the generated 'evidence' is. The involvement of stakeholders and, more importantly, their use and application of the M&E systems and processes are what ultimately lead to the validation and delivery of results.
- Track progress toward achieving the objectives of the strategic framework.
- Monitor the effectiveness of interventions and the use of resources, which has become a national priority. Ensure financial accountability. Efforts should be made to link programmatic progress with financial expenditure patterns. This is important for accountability, as well as to identify where funds have either been over-allocated or under-allocated.

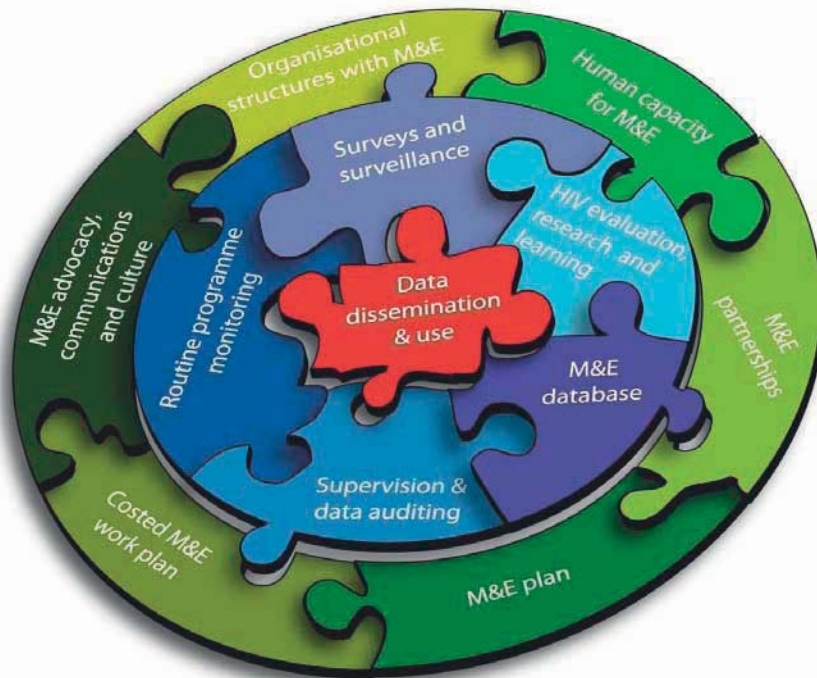
Broadly, the M&E plan will provide a road map for operationalising this system which will provide data for decision making:

3.2 OVERVIEW OF THE MAIN COMPONENTS OF A FUNCTIONAL HIV AND AIDS M&E SYSTEM

This section provides an overview of the main components of a national HIV and AIDS M&E system. This framework was developed by international partners and national governments and represents a standardized strategy for organizing M&E systems. These components serve to operate the M&E plan and ensure collection, reporting and quality of data for assessing the NSF as outlined in the previous chapter. In Figure 4, the outer ring represents planning, human resources and partnership components that support data collection and data use. This ring includes individuals, organizations, functions/actions and the organizational culture that are fundamental to improving and sustaining M&E system performance. The middle ring focuses on the functions of the system through which data are collected, captured, verified and transformed into useful information. The center represents the central purpose of the system, which is to use data for decision-making.

Ultimately this M&E plan is to have all the components of the M&E system functional at all levels; however, this process will take time. Consequently, the country needs to focus on a few components at the outset and then phase in M&E investments over time to eventually establish and operate all components.

Figure 4: The 12 Components of a Functional M&E System.



Source: UNAIDS 2008 Organizing Framework for a Functional National HIV M&E system

3.3 COMPONENTS OF THE NATIONAL M&E SYSTEM IN NAMIBIA

The following sections describe the various components of a functional, unified M&E system in Namibia, including proposals for future enhancements. These components are essential for operating an M&E system that can measure results of the NSF as outlined in the next chapter. For each component, performance goals and results are included, as well as a description of how each component is operated in Namibia.

3.3.1 Component 1—Organizational Structures with HIV M&E Functions

Component 1 outlines the key organizational structures and their roles and responsibilities in implementing the M&E plan.

Performance Goal: To establish and maintain a network of organizations responsible for HIV and AIDS M&E at the national, regional, district and service-delivery levels.

Performance Results: To ensure that the following elements are in place:

- Leadership—effective leadership for M&E in key organizations.
- Human resources—job descriptions for M&E staff, adequate number of skilled M&E staff, and defined career paths in M&E.
- Organizational culture—a national commitment to ensure M&E system performance.

- Organizational roles and functions—a well-defined organizational structure, including a national HIV M&E unit as well as M&E units or M&E focal points in other public, private and CSOs, written mandates for planning, coordinating and managing the M&E system, and well-defined M&E roles and responsibilities for key individuals and organizations at all levels.
- Organizational mechanisms—routine mechanisms for M&E planning and management, for stakeholder coordination and consensus building and for monitoring the performance of the M&E system, as well as establishing incentives for M&E system performance.
- Organizational performance—key organizations achieve their annual work plan objectives for M&E.

Description: The national HIV and AIDS M&E system will work well because a variety of coordination mechanisms and organizations at different levels will be working together toward achieving one goal through coordination by one national organization, the NAC. These are described below.

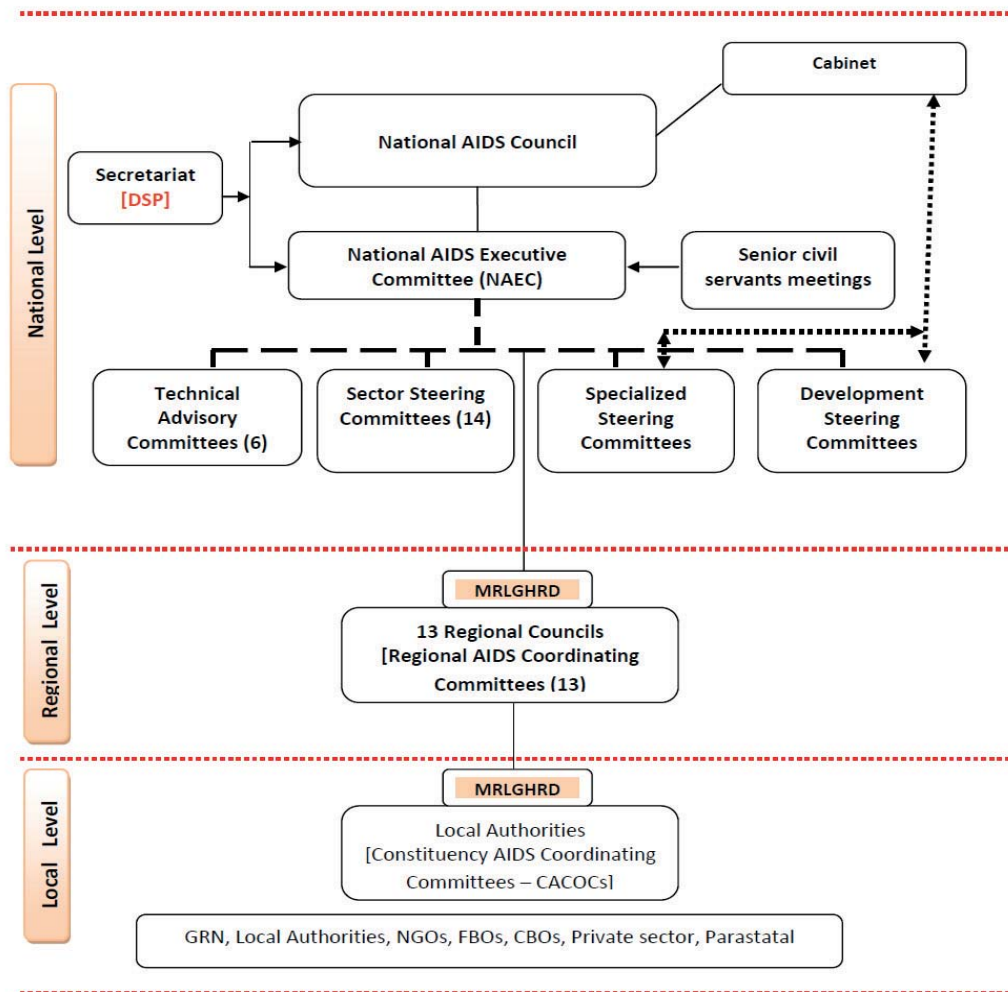
Organizational Structures: The MoHSS RM&E unit, which is the NAC multisectoral unit, has the mandate and authority to coordinate the implementation of a national and multi-sectoral M&E system in collaboration with other sectors and development partners. The RM&E unit collates HIV data from various data sources such as the Health Information System (HIS), the System for Programme Monitoring (SPM) which is Namibia's system for managing the sourcing, collection, collation, analysis, reporting and use of routine, program monitoring data on non-health-facility-based HIV and AIDS services. Other data sources include surveys, surveillance and operational research. The RM&E unit is also the secretariat of the National M&E Technical Advisory Committee (TAC).

The RM&E unit at the NAC secretariat will be staffed with an M&E manager, a Surveillance and Research Officer, an epidemiologist, a statistician, M&E officers, a data manager, a system analyst and data clerks. At the regional level, there will be an M&E officer and data clerks. The scope of work of these officers is outlined in Annex 2. Each umbrella organization will also be staffed with an M&E officer and a data entry clerk.

Currently, M&E focal point persons have been appointed at some ministries, umbrella organizations and all the regional councils with the responsibility of collecting, collating, analyzing and producing a quarterly regional/sectoral report, forwarding these to DSP/RM&E. In the anti-retroviral therapy (ART) program, data clerks have been appointed at most of the anti-retroviral (ARV) clinics whose main responsibility is to capture patient information electronically and prepare monthly/quarterly facility reports to be submitted to the DSP/RM&E through the regional and district levels. Regional AIDS Coordinators (RACs) are located at each Regional Council.

Figure 5 illustrates the levels and lines of coordination for the national HIV and AIDS response as described in the NSF 2010/11 to 2015/16.

Figure 5: Organogram of HIV and AIDS coordination in Namibia



CBO = community-based organization, DSP = Directorate of Special Programs, GRN = Government of the Republic of Namibia, MRLGHRD = Ministry of Regional and Local Government, Housing and Rural Development, NGO = non-governmental organization, FBO = faith-based organization.

M&E Roles and Responsibilities of Different Stakeholders: The roles and responsibilities of key stakeholders are described below.

The National AIDS Council (NAC) is the highest body in the cabinet to make policy decisions on matters related to HIV and AIDS. It provides leadership for multi-sectoral and regional implementation of the NSF. All M&E reports from multi-sectoral and regional structures will be submitted to the council for endorsement, and the council will review progress made by these organizations and make recommendations.

The National AIDS Executive Committee (NAEC) This committee provides the technical leadership, management oversight and in particular coordinates the planning, development, implementation, monitoring and evaluation for the NAC. One of the subcommittees of the NAEC is the national M&E TAC and it provides oversight for this TAC.

The National M&E TAC provides leadership for multi-sectoral and regional implementation of all M&E activities related to HIV and AIDS (see Annex 3 for their terms of reference [TOR]). The committee ensures a platform for partnership, networking and collaboration between national and local level stakeholders in monitoring and evaluating various components of the NSF.

The Response Monitoring and Evaluation (RM&E) unit within the DSP is responsible for coordination of all multi-sectoral M&E activities and for the overall coordination of the HIV M&E system.

Development partners play an important role in the M&E of HIV and AIDS in Namibia, and are members of the National M&E TAC. Development partners are responsible for encouraging their members to submit their reports through the national system and providing them with the capacity and resources to do so.

The Ministry of Health and Social Services (MoHSS) generates health sector data from health facilities and forwards these data to districts and regions before submitting them to the Epidemiology and RM&E units at the national level. Under the M&E plan the relevant indicators and information management will be mainstreamed into existing M&E systems. Health surveillance, service delivery and health system M&E will become better institutionalized and linked to the national M&E systems.

The Office of the Prime Minister (OPM) HIV and AIDS Unit is responsible for coordination of workplace programs (WPPs) and coordinating M&E in the public sector.

The Ministry of Regional and Local Government, Housing and Rural Development (MRLGHRD) The MRLGHRD is the mother organization of the regional councils, through which all implementers are expected to report. An M&E officer for HIV and AIDS is at the MRLGHRD. This sector M&E officer collects data on internal and external HIV programs which is required for planning, monitoring and budget allocation. The MRLGHRD reports HIV workplace program data to the OPM. M&E officers are recruited at all regional council offices. Regional M&E officers are responsible for the coordination of HIV M&E activities in their regions. They are responsible for aggregation of HIV data in the regions and sharing HIV information with the RACOC as well as making quarterly reports to the RM&E and the MRLGHRD at the national level.

The Ministry of Gender Equality and Child Welfare (MGECW) plays a leading role in women's and children's welfare, especially for OVC and households affected by HIV and AIDS. MGECW is responsible for the M&E of OVCs and ensuring that gender is mainstreamed into M&E activities.

The National Planning Commission (NPC) and Central Bureau of Statistics (CBS) are responsible for coordinating HIV and AIDS activities in the public sector. These departments also provide the framework for data collection and data management of national statistics and financial information.

The Ministry of Education (MoE) is responsible for the education sector, including the introduction of HIV and AIDS life skills programs for children in schools. The Education Management Information System (EMIS) is managed by the MoE.

The Namibia Network of AIDS Service Organizations (NANASO) is the umbrella organization for CSOs, which play a crucial role in the response to HIV and AIDS in Namibia as these organizations implement several HIV and AIDS programs at the national, regional, district and local levels. CSOs are responsible for the M&E of the activities they implement. NANASO is responsible for encouraging all its implementers to submit their reports through the regional councils in their respective regions.

The National Business Coalition on AIDS (NABCOA) is an umbrella body that mobilises the private sector on HIV and AIDS and encourages the scaling up of WPPs on HIV and AIDS. The organization was founded on the principle of coordinating and implementing strategies and programs that would maximize the impact of businesses' involvement in HIV and AIDS, both in the workplace and in the community at large. NABCOA aims to be the lead agency to facilitate best practice HIV and AIDS WPPs within corporate enterprises in Namibia through:

- Coordinating and facilitating private sector activities to pool resources and skills to best address HIV and AIDS.
- Devising a strategy for small and medium enterprises (SMEs) to combat HIV and AIDS.
- Acting as a national clearing house on information and best practice among businesses on HIV and AIDS.
- Providing a forum for advocacy and lobbying to other businesses, and to government and civil societies.
- Facilitating the collection of accurate data to inform program development.

The Council of Churches in Namibia (CCN) is the umbrella organization for faith-based organizations in Namibia. The CCN is responsible for encouraging all its implementers to submit their reports to the regional councils in their respective regions.

The Alliance of Mayors Initiative for Community Action on AIDS at the Local Level (AMICAALL) is the umbrella organization for all municipalities in Namibia (one level below the regional local government). AMICAALL is responsible for encouraging all its implementers to submit their reports to the regional councils in their respective regions.

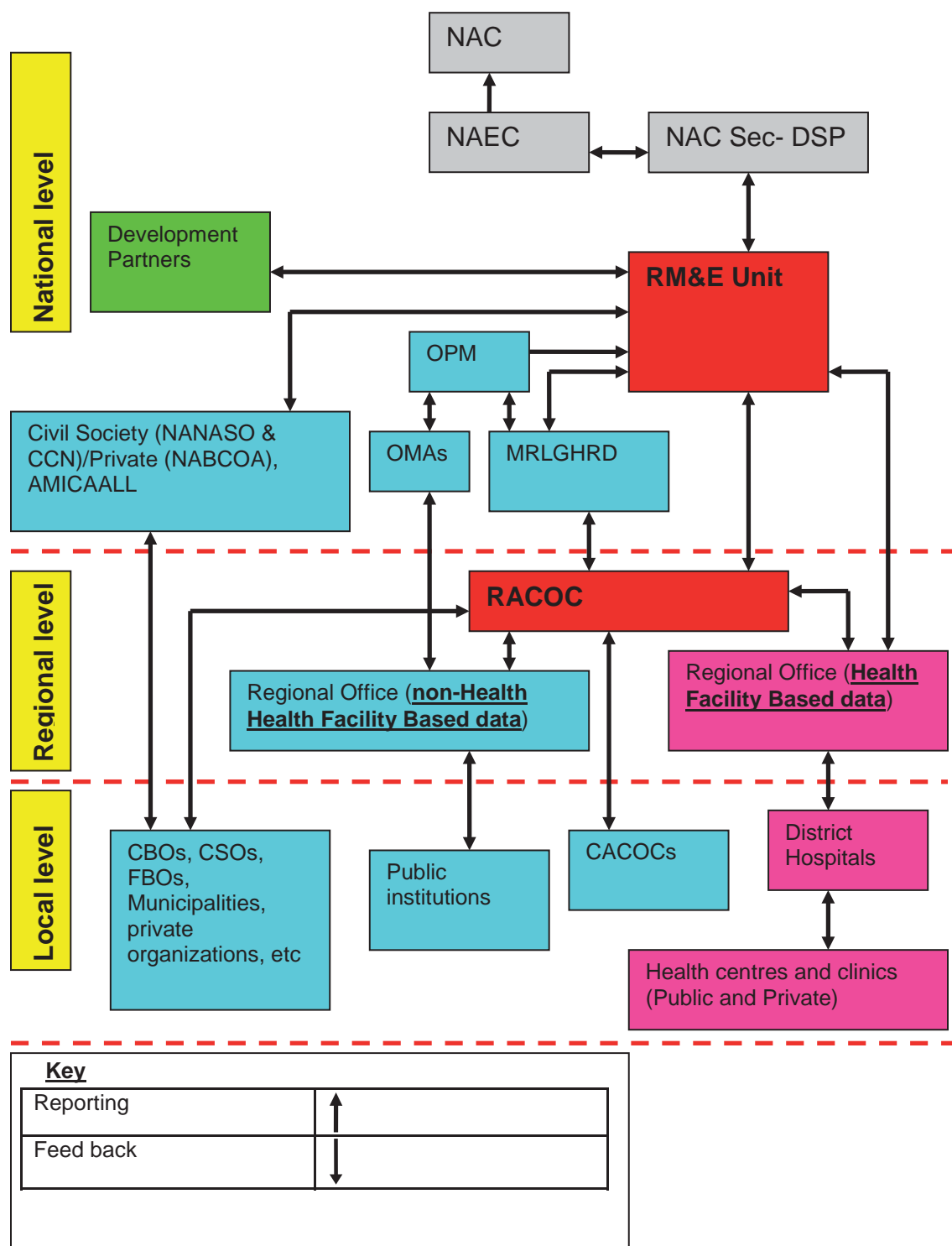
National-Level Coordination and Reporting Authority: The RM&E unit in the DSP within the MoHSS is the coordinating unit for the monitoring and evaluation of the multisectoral national response for HIV and AIDS (NSF 2010/11 to 2015/16) and the secretariat to the national M&E TAC and subsequent sub-committees and working groups. The RM&E unit convenes regular M&E TAC meetings to bring together key implementers of HIV and AIDS programs as well as regions/districts to discuss issues relevant to the implementation of the national M&E plan. Partnership Forum meetings are also used to update stakeholders on the requirements for the national M&E framework and to solicit their support for implementation.

Coordination and Reporting among Regional, District, Constituency and Other Levels:

The indicators included in the national M&E plan are primarily to measure progress made at the national level. However, regions districts and constituencies can measure their progress once programmatic indicators have been disaggregated at their levels. These data will be useful for planning and decision making at each of these levels, and the regions, districts and constituencies can use additional indicators based on their local needs. The DSP staff from the MoHSS and MGLGHRD will be responsible for coordinating the regional RM&E for HIV and AIDS. This staff will be responsible for compiling and disseminating information to the RACOC, CACOC, District AIDS Coordinating Committee (DACOC) and District Management Team (DMT). The RM&E unit provides support to the staff at regional, district and constituency levels. To harmonize data collection for indicators required at the national and local levels, it is essential that regional, district, and constituency committees hold regular meetings with all their partners.

Reporting and Feed back channels: The reporting and feed back channels (Figure 6) are based on the coordination framework for HIV and AIDS response in Namibia (Figure 5).

Figure 6: Reporting and feedback lines for the national multisectoral HIV response.



3.3.2 Component 2—Human Capacity for HIV M&E

The following section provides an overview of the goals and plans for developing human capacity for M&E in Namibia.

Performance Goal: To ensure adequate skilled human resources at all levels of the M&E system in order to complete all tasks defined in the annual costed national HIV M&E work plan.

Performance Results: To ensure that the following elements are in place:

- Defined skill sets for individuals and organizations at national, regional, district and service-delivery levels
- Work force development plans, including career paths for M&E
- Costed human capacity building plans
- Standard curricula for organizational and technical capacity building
- Local and/or regional training capacity, including links to training institutions
- Supervision, in-service training and mentoring

Description: Not only are dedicated and adequate numbers of M&E staff necessary to implement the M&E system, the staff need to have the right skills for the work. Human capacity building should focus on all levels, have measurable performance objectives, include a capacity building plan with clearly defined outputs, and include ways to track progress over time. Human capacity building for M&E requires a wide range of activities, including formal training, in-service training, mentorship, coaching and internships. M&E capacity building should focus not only on the technical aspects of M&E, but also address skills in leadership, financial management, facilitation, supervision, advocacy and communication.

In order to ensure adequate human capacity at all organizational levels, several key steps are needed. First a capacity assessment should be conducted to establish the needs in terms of human resources, technical capacity, infrastructure and financial and material resources. This assessment will be used for the development of a capacity building plan that will include training and mentorship for enhancing the skills of M&E staff and the overall function of the M&E system. To implement the plan, frequent supportive supervision should be utilized, with respective supervisors providing the necessary technical support to their respective supervisees. Guidelines will need to be developed with standard checklists related to key areas of performance to reinforce supportive supervision at all levels.

As a step toward development of M&E capacity, a 1 week M&E curriculum has been developed and used to build the capacity of M&E officers at different levels, i.e. the training of, for example, civil society implementers, regional managers and data clerks. In addition, the University of Namibia is in the process of developing a 1 year M&E curriculum and is involved in the professional development of lecturers in M&E.

In addition to human resources, there is a need for financial resources, as well as basic infrastructure, equipment and supplies. At a decentralized level, the NAC/DSP should help support existing RACOC and CACOC structures by strengthening their human and financial capacities. Support at this level institutionalizes the 'Three Ones' concept at regional and constituency levels.

To ensure that human resources with major M&E responsibilities at all levels are adequately skilled to perform the specific tasks as defined above, the following capacity building activities and competencies identification will be implemented:

- Development of a strategic plan for and implementation of capacity building at national, regional and local levels. This plan, based on the assessment described above, will include

activities for assessing, restructuring and implementing capacity building activities, including those listed below.

- Identifying a defined set of required technical and analytical skills and competencies, including adequate knowledge and educational qualifications, while recruiting people on a competitive basis.
- Pre-service and in-service training at the national and regional level in the areas of epidemiology, surveillance, programmatic M&E, information system operation, data entry and validation, data storage and data transfer.
- On-the-job training and mentorship for GFATM-grant programmatic M&E integrated into overall program management.
- Provision of international technical assistance to support the capacity building of national surveillance and M&E staff and to support surveillance data analysis and preparation of annual surveillance reports.
- Integrated modules within specific training programs and regular supervision to ensure the quality of data collection and verification.
- Opportunities to attend international conferences and meetings to maintain and improve qualifications and exchange experiences with persons involved in M&E in other countries and programs.

3.3.3 Component 3—Partnerships to Plan, Coordinate and Manage the HIV and AIDS M&E System

The following section outlines key activities to be implemented to ensure that functional partnerships are in place to plan, coordinate and manage the HIV and AIDS M&E system.

Performance Goal: Establish and maintain partnerships among in-country and international stakeholders who are involved in planning and managing the national HIV and AIDS M&E system.

Performance Results: To ensure that the following elements are in place:

- A national M&E TAC
- Coordination mechanisms for all stakeholders
- Local leadership and capacity for stakeholder coordination
- Routine communication channels to facilitate exchange of information among stakeholders

Description: HIV and AIDS is a multi-sectoral activity; therefore, it is important that all stakeholders in HIV and AIDS M&E work that are involved in the national response work together. The government, civil society, private sector and development partners are guided by the provisions contained in the NSF. To organize this cooperation, an M&E TAC that meets regularly and includes relevant stakeholders has been established at the national level. For detailed purposes, mandate and TOR of the M&E TAC see Annex 3. The committee consists of M&E focal points and technical experts from line ministries, non-governmental organizations (NGOs), CSOs, development partners and tertiary institutions. The DSP/RM&E unit is the secretariat to the committee. M&E TACs and TWGs will also be established at the regional level. These may be sub-committees of the RACOC and will consist of M&E focal persons at the regional, district and constituency level. To avoid duplication of effort, it is also important to establish communication mechanisms with those organizations that provide regular technical support in M&E, both in-country and internationally. The process for selection of members to the M&E TAC will be reviewed to ensure full representation of the stakeholders.

Coordinating Mechanisms: The purpose of the M&E systems in Namibia is to provide continuous and timely information on the results of the implementation of the NSF. The following provides a broad overview of the current M&E systems in place that support this purpose. See Annex 3 for a detailed list of the M&E TACs and Sub-Committees in Namibia.

Sector M&E

Coordinating bodies play a key role in sectoral coordination. In particular, these bodies facilitate liaison and coordination activities between their constituencies and the NAC, and with the decentralized coordinating structures at regional and community levels. Sector coordinating bodies are responsible for collation and analysis of all data from their implementing partners. They also provide feedback to their implementing partners and report to the NAC Secretariat M&E Division.

Decentralized Regional Coordination

Decentralized regional coordinating structures include regional AIDS coordinating committees (RACOCs) and constituency AIDS coordinating committees (CACOCs) that operate under the Ministry of Regional and Local Government, Housing and Rural Development (MRLGHRD). These institutions provide multi-sectoral coordination at their respective levels of operation. Their role is to facilitate the implementation of the regional operational plans that have been developed as part of the NSF. Key coordination roles include resource mobilization and facilitation of the M&E process. RACOCs, through their HIV M&E coordinators' offices, collate and analyze all reports from the HIV implementing partners in their regions, provide feedback to implementing partners and provide national level reports.

Development Partner Coordination

To support development partner coordination, the NAC facilitates and operates the National HIV and AIDS Partnership Forum, which collaborates with development partners under the National Planning Commission (NPC); existing fora and partnership structures align with the National HIV and AIDS Partnership Forum. Development partners undergo an assessment of their country operational plans to ensure accountability as well as alignment and harmonization with the national government through existing systems for HIV program management in Namibia. These include systems for HIV M&E, fiduciary and procurement processes and supply chain management.

3.3.4 Component 4—National Monitoring and Evaluation Plan

The M&E plan is the overall document that will be used to measure the NSF. It will provide guidance in the development of sub-national and sectoral M&E, plans. The national M&E plan will be reviewed at mid-term as part of the mid-term review. Targets will be reviewed annually after the preparation and dissemination of progress reports of the implementation of the NSF. The annual costed National HIV M&E plan is derived from the national M&E plan.

3.3.5 Component 5—Annual Costed National HIV M&E Work Plan (Integrated Action Plan)

Performance Goal: Develop an annual costed national M&E work plan, also referred to as an Integrated Action Plan (IAP) , including the specific and costed HIV M&E activities of all relevant stakeholders and identified sources of funding. Use this plan for coordination and assessment of progress of M&E implementation throughout the year.

Performance Results: To ensure that:

- The M&E work plan contains activities, responsible implementers, timeframes, activity costs and identified funding.
- The M&E work plan explicitly links to the government medium-term expenditure framework (MTEF) budgets.
- Resources (human, physical, financial) are committed to implementing the M&E work plan.
- All relevant stakeholders endorse the national M&E work plan.

- The M&E work plan is updated annually on the basis of performance.

Description: The costed national M&E work plan should reflect agreement on who will implement and finance each activity. The costed national M&E work plan is not the DSP work plan for M&E; rather, it is a joint work plan that integrates the HIV and AIDS M&E activities of all relevant stakeholders. The plan allows all stakeholders to plan and work together in a harmonized way, and for this reason it must be developed with input and agreement from all key stakeholders. M&E work plans may also be developed at the regional and service-delivery levels to guide M&E implementation linked to the national HIV and AIDS M&E system. The annual M&E work planning cycle will be closely linked to the overall government budgeting cycle, by ensuring that planning and costing activities for the years ahead take place during the second quarter. The work plan will be reviewed annually on the basis of continuous monitoring of the financial situation and implementation of activities. Contributions of development partners and other stakeholders to M&E of the national response will be aligned to the annual work plan

The summary of the costed annual M&E work plan (IAP) for three years is presented in the Table 1. The detailed costed annualized M&E work plan is contained in a separate document. All stakeholders including development partners will be expected to align their support and activities to the costed M&E workplan

Table 1: **Summary by component of the costed annual M&E workplan (IAP) for three years**

SUMMARY	Resource needs (US\$)		
	2010-2011	2011-2012	2012-2013
Organizational Structures for HIV M&E Systems	2,423,726	3,605,128	3,574,865
Human Capacity for HIV M&E	235,485	800,445	808,191
Partnerships to plan, coordinate, and manage the HIV M&E system	5,200	5,512	5,843
National, Multi-sectoral HIV M&E Plan	206,000	21,518	2,584
Annual, costed, national HIV M&E work plan	34,600	2,438	20,899
Advocacy, communication and culture for HIV M&E	42,300	2,438	2,584
Surveys and Surveillance	2,982,975	8,933,862	5,884,343
Routine HIV programme monitoring	215,683	444,148	299,390
National and sub-national HIV databases	1,577,171	3,150,648	3,655,820
Supportive supervision and data auditing	542,450	515,107	593,060
HIV Evaluation and Research Agenda	3,454,520	2,459,081	1,566,300
Data dissemination and use	234,636	5,283,523	492,802
Grand Total	11,954,746	25,223,848	16,906,680

3.3.6 Component 6— Advocacy, Culture and Communication for HIV M&E

Performance Goal: Ensure knowledge of and commitment to HIV and AIDS M&E and the HIV and AIDS M&E system among policymakers, program managers, program staff and other stakeholders.

Performance Results: To ensure that:

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

Description: It is important to demystify M&E, create a supportive M&E culture and reduce any negative connotations of M&E. A communication and advocacy strategy for M&E will help to achieve these objectives. M&E fosters transparency, but it also requires a transparent environment to function effectively. Obtaining political support for transparency and accountability related to the HIV response is an important component of the communication and advocacy strategy. In addition, communication

and advocacy for HIV and AIDS M&E should be part of the country's national HIV and AIDS communication strategy to ensure that M&E is being mainstreamed into all DSP functions. The strategy should include mechanisms that would support the following:

- Create national M&E awareness by embarking upon communication and advocacy activities.
- Identify 'M&E champions' who can promote M&E in the country and foster understanding about the importance of using data for policy formulation and decision making.
- Develop key messages extracted from M&E activities reports, surveys, studies and communicated to stakeholders.
- Create platforms for advocacy by working with the media so that the media are well informed and report data correctly and appropriately.
- Promote data use among the stakeholders by producing and disseminating key reports and summary reports (e.g. bulletins) as well as create a website or use existing websites with key data products and description of M&E activities in the country.

3.3.7 Component 7—Surveys, Surveillance, Estimates and Projections

While routine program monitoring of systems ensures collection of output indicators (immediate results), the collection of outcome and impact indicators essential for measuring the mid-term and long-term results of the NSF rely on surveillance and surveys. The following section outlines these mechanisms.

Performance Goal: Produce timely and high quality data from surveys and surveillance.

Performance Results: To ensure that the following elements are in place:

- Protocols for all surveys and surveillance are based on international standards.
- Specified schedules for data collection are linked to stakeholders' needs, including identification of resources for implementation.
- An inventory of HIV-related surveys is maintained.
- A well-functioning biological surveillance system.
- A well-functioning behavioral surveillance system, including on cultural practices.

Description: Surveillance and surveys are essential in determining the drivers and the spread of the HIV epidemic in Namibia. Protocols and data collection tools are based on the international standards for surveys.

The MoHSS is mandated to oversee all surveys and surveillance related to HIV and AIDS, and survey and surveillance activities should meet the requirements of the HIV and AIDS, Research and Surveillance subcommittee. For a detailed TOR of the subcommittee see Annex 3.

Survey and surveillance data will be collected from community and regional levels and collated and aggregated at the national level. The reports are produced and disseminated to all relevant stakeholders for action/use.

The types of surveys and surveillance activities that are part of Namibia's M&E system are outlined below.

The Demographic and Health Survey (DHS): The DHS is a robust instrument for tracking changes in knowledge and behaviors at a national level and is a responsibility of the MoHSS. The DHS is a population-based health survey conducted every 5 years among a target population that is determined from a nationally representative sample of adults. The core DHS questionnaire emphasizes basic indicators and flexibility. The survey allows for the addition of special modules, such as the AIS. Namibia has not yet conducted a population-based DHS with respect to HIV testing, therefore, the plan is to conduct a DHS+ every 4–5 years and the AIS on a biennial basis. After the

DHS+ or AIS is conducted, the MoT modeling project (which uses data from DHS and AIS) will also be conducted to determine the drivers of the epidemic in the country.

The Behavioral Surveillance Survey (BSS): BSSs are designed to collect information on MARPs, such as commercial sex workers, men who have sex with men (MSM) and truck drivers and other MARPs. MoHSS will implement BSSs among these populations on a regular basis. These studies can also include a testing component that provides estimates of prevalence among these populations. In addition to implementing a number of BSSs, Namibia is in the process of conducting size estimations for MARPs, which will provide denominator information on the size of MARPs in Namibia, critical information for programming and reporting core indicator results for the NSF.

Antenatal Care (ANC) Sentinel Surveillance: Biological surveillance of HIV has been primarily tracked through surveillance of sentinel populations. Namibia began sentinel surveillance for HIV among pregnant women in 1992, and this is done biannually by MoHSS. ANC surveillance is currently the key data source for all HIV prevalence estimates in the country. ANC surveillance data provide inputs for the models that estimate and project national HIV prevalence, HIV incidence, estimated number of people living with HIV, ART estimated needs, and estimates of pregnant women who are living with HIV. Namibia has been conducting ANC surveillance since 1992 starting with eight health facilities. This surveillance has been conducted every 2 years since, and the last survey included 35 participating main sites. Surveillance sites are chosen on the basis of regional coverage, geographic location (rural/urban) and the volume of ANC clients at each site.

The Health Facility Survey (HFS): Specific information about services at health facilities is needed in order to understand the health services provided as part of the HIV and AIDS response. This can be collected through two sources—a health information system (HIS) survey or a specific health facility survey. The HIS collects aggregate health information from facilities; for HIV, this primarily involves PMTCT data. Currently, the HIS does not provide other programmatic information about HIV-related services at health facilities; thus, facility surveys are conducted to acquire relevant information. Should the HIS be updated to include the periodic collection of some of this information (the preferred option), this data source will be amended. The first HFS was implemented in 2009 to establish the baseline of all existing health facilities in the country. The MoHSS plans to implement an HFS every 5 years.

Workplace Surveys: UNGASS has developed an indicator on workplace policies and WPPs to track the extent to which policy development efforts are mainstreamed in workplaces. The data are derived from workplace surveys. Private sector employers are selected on the basis of the size of the labor force. The recommended public sector employers to conduct these surveys are the ministries of transport, labor, tourism, education and health. Employers are asked to state whether they are currently implementing personnel policies and procedures that cover, as a minimum, all of the following aspects:

- Prevention of stigmatization and discrimination on the basis of HIV infection status in staff recruitment and promotion and employment, sickness, and termination benefits.
- Workplace-based HIV and AIDS prevention, control and care programs that cover the basic facts on HIV and AIDS, specific work-related HIV transmission hazards and safeguards, condom promotion, voluntary counselling and testing (VCT), sexually transmitted infection (STI) diagnosis and treatment, and provision of HIV and AIDS-related drugs.

Copies of written personnel policies and regulations should be obtained and assessed wherever possible. Indicator scores are required for all employers combined and for the private and public sectors separately. Estimates of the size of the male and female formal sector workforce should also be provided, on the basis of the latest available census data.

This survey was undertaken in 2006 for the first time, and will be conducted again in 2011 and 2015.

HIV drug resistance, prevention, surveillance and monitoring: HIV drug resistance (DR) prevention will be carried out by program monitoring of 'early warning indicators' (EWIs) to evaluate if ART programs are functioning to minimize the emergence of HIV drug resistance. The EWIs to be tracked and their targets can be found in Annex 4. ART adherence cross sectional surveys will be done by carrying out pill counts to ascertain the number of days during which drugs were not taken.

The HIV DR **threshold survey** will be used to estimate frequency of HIV drug resistance in untreated persons recently infected with HIV in specific geographic settings using standard surveillance protocols. Blood samples for DR surveillance will be collected during ANC HIV sentinel surveillance surveys.

HIV DR **monitoring** will be used to evaluate patterns of drug resistance mutations emerging with first-line regimens in sentinel centers using HIV DR monitoring protocols.

National AIDS Spending Assessment (NASA). Determination of HIV and AIDS expenditure by AIDS Spending categories (Prevention, care and treatment, OVC, program management and administration strengthening, human resources, social protection and services, enabling environment and community development, research) will be carried out every two years. Financing sources will be grouped as domestic (public), international and domestic (private)

Quality of Impact Mitigation Services (QUIMS) surveys. The quality of Impact Mitigation services such as OVC and PLWHIV care and support will be assessed using the QUIMS.

HIV Estimates and Projections: The Estimates and Projection Package (EPP) and Spectrum modeling tools are utilized to develop estimates and projections on national HIV prevalence on the basis of ANC surveillance and other programmatic information. These models are also used to estimate the number of PLHIV, deaths due to AIDS, number of OVC and pregnant women in need of prevention of mother to child transmission (PMTCT). An EPP is carried out every 2 years. Data are entered into the EPP software, which uses a simple epidemiological model to find the best fitting curve that describes adult prevalence over time. The estimates generated are critical for planning purposes as they provide a representative estimate of HIV prevalence for Namibia in the absence of a population-based survey.

3.3.8 Component 8—Routine HIV Program Monitoring

The routine program monitoring system provides the mechanism for collecting, managing and reporting on the inputs, activities and outputs (as described in the previous chapter) for measuring the national response. The routine monitoring system and how it is operated are described below.

Performance Goal: Produce timely and high quality routine program monitoring data.

Performance Results: To ensure that the following elements are in place:

- A data collection strategy that is explicitly linked to data use.
- Clearly defined data collection, transfer and reporting mechanisms, including collaboration and coordination among the different stakeholders.
- Essential tools and equipment for data management (e.g. collection, transfer, storage, analysis).
- Routine procedures for data transfer from sub-national to national levels.
- Well-defined and managed national HIV database to capture, verify, analyze and present program monitoring data from all levels and sectors, including data on prevention, treatment, care and support, and finances.

Description: The purpose of the routine HIV monitoring system in Namibia is to manage the sourcing, collection, collation, analysis, reporting and use of routine program monitoring data about HIV services. The data managed with the routine HIV data system are collected on a daily basis as HIV interventions are being implemented (e.g. every time a new VCT client arrives, the VCT register is updated—similar to the mileage counter on a car); these data provide information about the inputs used (e.g. financing for HIV services) and outputs achieved (e.g. number of VCT clients served) during the implementation of HIV programs and are used for monitoring the progress with implementing programs.

Namibia's routine program monitoring systems are organized according to health sector services and community-based HIV services as follows:

Health sector services: The MoHSS has developed a routine system to track HIV services in Namibia through standardized data collection tools and reporting procedures from all health-care facilities in the country. Routine health sector data include data on VCT, polymerase chain reaction (PCR), ART, tuberculosis (TB) and PMTCT. Standardized facility level registers, patient intake forms and monthly summary sheets are used to capture and report facility-level data. These are submitted from the facility to the district level, then to the regional and national levels, where data are aggregated and quality checked at both junctures. Data are compiled annually and presented through a national review meeting to reflect on accomplishments, discuss challenges and make decisions.

Community-based HIV services: The SPM was developed to capture and report on non-health-facility based HIV services and activities. Regional M&E officers based at the Regional Council, who report to the RACOCs, use SPM to capture HIV-related data from CSOs as well as the public and private sectors in their respective regions.

Standardized data from all providers including non-health-facility- and health-facility-based HIV services are collected on a routine basis. This is the one data source that will not be commissioned and funded by only the DSP, as these responsibilities will lie with all stakeholders, while the responsibility for data collection, analysis and reporting will rest with the DSP/RM&E.

The four types of data that are collected through the routine HIV data system are:

- Data about HIV services provided in the community. Such data are sourced routinely by implementers, regional council offices and umbrella organizations, after which the data are collected, collated, analyzed, reported and used once every 3 months (quarterly).
- Data about HIV services provided by regional councils and umbrella organizations. Such data are sourced routinely by these two stakeholders and then collected, collated, analyzed, reported and used once every 3 months (quarterly).
- Data about HIV services provided at health facilities. Such data are sourced routinely by implementers of health-facility-located HIV services (MoHSS and private health facilities) and then collected, collated, analyzed, reported and used once every 3 months (quarterly).
- Data about the financing of HIV services. Data that are sourced routinely by implementers, regional council, and umbrella organizations, after which the data are collected, collated, analyzed, reported and used once a year.

The list of program indicators to be collected by the routine health information systems and the non-health information systems are included in Annexes 5 and 6. Quarterly program monitoring forms based on data to be collected with the routine HIV data system will be filled out by public sector OMAs, the private sector, CSOs and development partners.

Data collection, flow and quarterly reports: Data collection is the responsibility of the DSP/RM&E, using the SPM/health sector forms (one for the health sector and one for the non-health sector), which **ALL** implementers of HIV interventions in Namibia are required to complete, and other data collection tools. The forms are distributed to all implementers of HIV and AIDS programs, whether or not they receive grants from the DSP/RM&E, who then complete the form on a monthly/quarterly basis and use it to record information about HIV services provided. Depending on the type of implementer (i.e. health or non-health sector) and services provided (non-health-facility- and health-facility based) different data flow procedures are followed, as described below.

The flow and management of routine data on HIV services provided at non-health-facility-based locations (collected quarterly) is as follows (see Figure 6):

Implementers of HIV services record data are required to routinely record data about the services they provide onto a daily record keeping tool of some kind (for example, a register), and then collate (tally) the data every quarter onto the SPM summary form. The routine HIV data form is then submitted to the regional council of the region where the activity took place, as well as to the umbrella organizations for the sector within which the organization falls.

A designated officer at the regional council, usually the RAC or the M&E officer, sources and collects data from the SPM summary forms and captures the data onto a computer (using software designed for the purpose) or files the actual paper forms. The designated officer then collates the data from the summary SPM forms by using either a summary report function on the computer (using software designed for the purpose) or manually tallying the data.

In addition, the designated officer sources and collects data about services that the regional office has implemented (e.g. capacity building or WPPs) over the 3 month period of reporting and collates the data by completing a regional SPM summary form (Form RS).

The designated officer then reports both data sets—the tallied SPM data from implementers and the regional RS Form—to the RM&E. The officer also reports the data to the RACOCs, which analyze and use the data that they receive from implementers for coordinating HIV and AIDS, TB and malaria programs in their regions.

M&E officers at the umbrella organizations source, collect and collate data they receive on SPM summary forms from implementers of HIV and AIDS services in their sector. In addition, they source and collect data about services that the umbrella organization has implemented (e.g. capacity building or WPPs) over the 3 month period of reporting, and they collate the data by completing a sectoral SPM summary form (Form RS). The M&E officers then submit the Form RS to the RM&E. The umbrella organizations analyze the SPM data from themselves and from implementers, report the data to stakeholders in their sector, and use the data to inform decisions about HIV and AIDS programs in their sectors.

M&E officers at development partners (funders) also source and collect data about services that the development partner has implemented (e.g. capacity building or WPPs) over the 3 month period of reporting, and they collate the data by completing a sectoral SPM summary form (Form PS or CS). These M&E officers then submit the appropriate form to the RM&E. The development partners analyze the SPM data from implementers, report the data to their stakeholders, and use the data to inform decisions about funding for future HIV and AIDS programs.

DSP/RM&E staff source and collect SPM data from four sources:

- SPM data from implementers of HIV and AIDS services (Forms CS, PR and PB) sourced through the regional M&E officers
- Regional SPM Summary Forms (Form RS) received from regional local government offices
- Sectoral SPM Summary Forms (Form RS) received from umbrella organizations
- Development partners

The RM&E then collates and analyzes all the SPM data—together with data about health-facility-based HIV and AIDS services—to produce information products such as regional and national HIV and AIDS reports and the Quarterly Bulletin. These information products are used to report SPM data to stakeholders by disseminating them on a regular basis through electronic means and via regional-level feedback and planning workshops, thereby providing a data dividend to stakeholders who have reported SPM data and health-facility-based data. Combining the SPM feedback sessions with planning workshops maximizes opportunities for the data to be used during decision making.

The flow and management of routine data on HIV services provided at health-facility-based locations (collected quarterly) is as follows (see Figure 6):

Five stakeholder groups are involved in managing routine HIV data from health facilities:

- Health facility data staff/data clerks
- HIS officers at the district level
- Program managers at the regional level
- The national level M&E unit

Health facilities record data on an ongoing basis (routinely) onto registers, and data are collated (tallied) on a quarterly basis. Tallied data are captured onto the necessary HIS report forms as well as an electronic system where applicable.

The HIS officer or a data clerk captures the data onto a computer (using the File Maker Pro/Epi-Info database), analyzes the data to develop district-level quarterly reports, uses the data for their district planning purposes, and forwards the data to the regional level.

The regional manager then works in collaboration with the HIS officer and data clerk to prepare a regional quarterly report that includes all data from the private health facilities. A copy of the regional report is sent to the DSP/RM&E. Data from the regional level is also reported to the national level through the HIS and the RM&E/M&E unit.

By the end of this reporting process, the RM&E/M&E unit has verified data about HIV service provision at health facilities from the regional level. The RM&E/M&E unit then collects, collates, analyzes, reports and uses the routine HIV data to produce information products such as quarterly bulletins. These information products are disseminated on a regular basis through electronic means and via regional level workshops, thereby providing a 'data dividend' (a return on their effort to collate and report the data) to stakeholders who have reported data. Combining these feedback sessions with planning workshops maximizes opportunities for the data to be used during decision making.

Timelines for Reporting Data Using the Routine HIV Data System: Reporting forms are completed on a monthly basis by all health-facility-based implementers and on a quarterly basis by non-health-facility-based services in Namibia. However a report is produced on a quarterly basis for both the non-health-facility- as well as the health-facility-based services.

Timelines for Quarterly Routine HIV Data System Reporting (Service Data):

- SPM summary forms (Forms CS, PR and PB) are to be sent to the region and umbrella organizations within 5 days after the end of the quarter.
- National-level summary data from individual SPM summary forms from implementers, the regional SPM summary form (Form RS) and the sectoral SPM summary form (Form RS) from the umbrella organization should be reported to the RM&E within 20 days after the end of the quarter.
- Routine HIV data from MoHSS as well as private health facilities/private medical aid providers is due within 5 days after the end of the quarter to the district, within 10 days to the regional level and within 20 days to DSP/RM&E.
- Provided that the initial deadlines have been met, RM&E shall produce the Quarterly Bulletin within 45 days after the end of the quarter.

Timelines for Annual Routine HIV Data System Reporting (Financial Data):

- Annual HIV resource tracking forms (Form RT) should be submitted by the end of the government's financial year.
- Implementers should submit their RT forms to the regions in which their head offices are based within 10 days after the end of the financial year.
- Regional-level summary data from the implementers' RT forms and from regional routine RT forms, and sectoral-level data from the umbrella organizations' RT forms should be reported to RM&E/M&E unit within 30 days after the end of the financial year.
- Provided that the initial deadlines have been met, RM&E shall include the financial data in the annual HIV and AIDS report, which is due within 45 days after the end of the financial year.

3.3.9 Component 9— National and Sub-National HIV Databases

Performance Goal: Develop and maintain national and sub-national HIV databases that enable stakeholders to access relevant data for policy formulation and program management and improvement.

Performance Results: To ensure the following elements are in place:

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

Description: Namibia's M&E systems should generate accurate information in a timely fashion for response planning and management. The information system should be accessible to all stakeholders at all levels. The data quality check and quality assurance processes should take place at all levels before the final product is released. During the period of the NSF, a national indicator data base to which all other program data bases feed into will be developed.

The Ministry of Health and Social Services (MoHSS) has an electronic data management system that allows for information to be captured in a way that facilitates data verification, data collection, data analysis, data transfer, data sharing and data use. The national database for HIV care and treatment is called Electronic Program Monitoring System (ePMS). Data stored in the ePMS are shared at the national level, and recommendations for improvement and decisions on planning are made based on these data.

The Health Information System (HIS) is a public health planning and information system. It tracks a number of national health indicators at all health facilities in Namibia. HIS data are collected by each health facility in the country on a monthly basis. The data are sent through the district to the region, and then to the national HIS unit where results are aggregated. The PMTCT, ART, HIV counseling and testing (HCT) and PCR systems currently run as parallel systems, which are not yet fully integrated into the overall HIS. Plans are underway to integrate these systems into the overall HIS.

The Electronic TB Register (ETR) is a user-friendly system in which individual records from the TB registry are entered into a computer program that provides interactive support. The software provides several patient management and supervision functions, such as lists of defaulters. Finally, it generates standard quarterly and annual reports on case-finding, sputum conversion and cohort analysis, and provides graphs of trends and maps of TB indicators. The ETR software has been successfully implemented in Namibia. Factors critical for success of the ETR include a functioning, paper-based system, involvement of staff from the TB program, health information systems in health facilities, ongoing training and backup support.

Many different stakeholders that implement HIV and AIDS programs in Namibia may have their own sub-national HIV database, but these databases should link to a national system to promote a harmonized M&E system with improved coordination. Stakeholders may rely on their own databases for M&E of their own programs and for reporting purposes, but database development should follow the national and international standard and guidelines.

The following programs use different HIV technology platforms that are currently used by the RM&E unit for the management of HIV and AIDS data:

- ART—Paper-based patient cards and registers with ePMS, an electronic system. Data from the ePMS will be compared with that of the Electronic Dispensing Tool (EDT) that monitors pill pick up and is managed by the Pharmaceutical Division of MoHSS.

- VCT—Paper-based monthly summary forms with electronic entry in Excel (community counsellors) and DBase (health workers).
- PMTCT—Paper based monthly summary forms with an electronic system developed on DHIS (Access DBase).
- PCR—Paper-based patient forms with an electronic system developed in Epi Data (Access DBase).
- TB—A paper-based patient register with an electronic system developed in ETR.Net (Access DBase on .NET framework).
- Research—A database of relevant research activities conducted in the country.

The OVC database is managed by the Directorate of Child Welfare of the MGECW. The Education Management Information System (EMIS) is managed in the Ministry of Education.

3.3.10 Component 10—Data Quality Assurance Processes and Supportive Supervision

The quality of the data generated by the HIV and AIDS M&E system is crucial to the success of the system. Namibia's M&E system has a number of data quality assurance methods as well as procedures for supportive supervision. Many of these are also required by the GFATM. The approaches outlined below are primarily focused on external data quality processes; however, organizations that implement HIV and AIDS programs are encouraged to use the same processes to support and ensure internal data quality.

Performance Goal: To monitor data quality periodically and address any obstacles to producing high-quality data (i.e. data that are valid, reliable, comprehensive and timely).

Performance Results: To ensure that the following elements are in place:

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

Description: All M&E stakeholders will conduct joint support visits and data auditing for their respective programs on a quarterly basis and have a comprehensive data quality audit once a year. Regional M&E officers will conduct supportive supervision with a sample of implementers in their region on a quarterly basis. Chief health program and senior health program administrators will also conduct quarterly data verifications in their respective regions. In addition, supportive supervision and data quality audits within organizations should be a routine part of program service delivery and results reporting.

Supportive Supervision: MoHSS/DSP (RM&E) conducts quarterly supportive supervision visits in order to oversee performance and to transfer knowledge and skills. This enables the division to assess and provide feedback to the health-care workers and facilities and provide specific recommendations for improvement. Supportive supervision will also be conducted within organizations on a routine basis, with senior program staff providing supportive supervision meetings with program implementers. Supportive supervision will be followed by feedback to the organization's staff.

Data audits: Data auditing is the process of verifying for completeness and accuracy of reported aggregated HIV program data. This is done by:

- Field visits to the organizations that submitted the forms.

- Checking the quality of raw data kept by the reporting organization by examining the daily records used to complete the output monitoring form for a specific reporting period.
- Comparing the output monitoring form data against the raw data. Data auditing and verification offer an opportunity to give feedback to staff and to provide guidance to make improvements.

Data auditing requires field visits of the RM&E staff to the regional council as well as regional implementers on a quarterly basis. In addition, facilities and district hospitals are visited on a quarterly basis in order to check the reported data against the individual records. These field visits help to assess and verify the quality and accuracy of service provision data and are conducted by the RM&E, umbrella and sectoral organizations, as well as regional implementers. Chief health program and senior health program administrators also conduct quarterly data verifications in their respective regions.

Internally, organizations should implement data auditing processes on a routine basis to ensure the quality of reported data. Feedback on the results of data quality audits should always be provided to staff within the organization to enhance performance, service delivery, and reporting functions.

Support supervisory visits are conducted by national-level staff on a quarterly basis in order to assess data, provide feedback to local staff and, where necessary, provide guidance for improvement. Each quarter, senior data clerks in each region conduct data quality visits using standard data verification tools to ensure that data are valid, reliable, comprehensive and timely. Written reports should be shared at the national level for recommendations and decision making purposes. In order to make informed decisions on how to implement the national response to HIV, it is imperative that the data are reliable, valid and of satisfactory integrity. In order to ensure that data are of sufficient quality, data audit and supervision tools will be revised and strengthened for both health- and non-health-sector-related HIV data.

Guidelines: Supportive supervision and data auditing are guided by standard guidelines for supervising routine data collection at health facilities and community-based HIV services. The guidelines will be put in place in order to communicate expectations and standardize procedures to local staff. The guidelines will be adapted by organizations to guide internal data quality assurance. Data auditing and supervisory guidelines will be developed for each system i.e SPM, Facility based etc.

Managing data quality will be an ongoing process; therefore, data quality assurance measures should be embedded within the steps that an organization follows for managing routine HIV data.

3.3.11 Component 11—HIV Evaluation and Research

Namibia advocates for a coordinated research agenda that can answer the following key public health question: are the interventions and services being implemented resulting in the intended outcomes and impacts? Studies that answer these questions tend to serve as a springboard for resource mobilization and are conducted primarily with high priority interventions. An exercise to prioritize a strategic evaluation and research agenda to guide evaluation and research activities was recently conducted.

Performance Goal: Identify key evaluation and research questions, coordinate studies to meet the identified needs, and enhance the use of evaluation and research findings.

Performance Results: To ensure that the following elements are in place:

- Inventory of completed and ongoing country-specific HIV evaluation and research studies.
- Inventory of local HIV evaluation and research capacity, including major research institutions and their focus of work.
- National HIV evaluation and research agenda.
- Ethical approval procedures and standards.

- Guidance on evaluation and research standards and appropriate methods.
- National conference or forum for dissemination and discussion of HIV research and evaluation findings.
- Evidence of use of evaluation and research findings (e.g. referenced in planning documents).

Description: Evaluation and research are essential components of an M&E system.

Accordingly, the MoHSS will put in place a database that contains the following:

- An inventory of completed and ongoing country-specific HIV evaluation and research studies.
- An inventory of local HIV evaluation and research capacity, including major research institutions and their focus of work.
- A national HIV evaluation and research agenda.

Representatives from stakeholders from public, private, civil society, academic and development organizations were convened and developed an evaluation and research agenda. These stakeholders will meet annually to review the agenda. During this platform, participants will share evaluation and research study findings, identify evaluation and research gaps relevant to the NSF, and develop a plan for implementing future research and evaluation projects. Research protocols and results will be submitted to the MoHSS research committee for review and approval.

DSP has a national mandate for coordinating HIV and AIDS activities and therefore in over seeing the implementation of the Research Agenda. Formulation and implementation of research programs, projects and activities will, however, be the responsibility of research institutions or institutions with mandate for undertaking HIV and AIDS research. DSP will provide leadership in the dissemination of HIV and AIDS research findings in the country, principally through:

- A Biennial Scientific Conference
- A National Research Website backed by a research database

Based on the agenda setting process, planned evaluation and research projects are listed according to NSF thematic areas in Annex 7.

3.3.12 Component 12—Data Analysis, Interpretation, Dissemination and Use

At the heart of the M&E system in Namibia is the use of data for program improvement. This involves a strategic and operational plan for data use that includes opportunities for data analysis and interpretation. The following section outlines the key elements of this system in Namibia.

Performance Goal: Disseminate and use data from the M&E system to guide policy formulation and program planning and improvement.

Performance Results: To ensure that the following elements are in place:

- Inclusion of a data use plan in the NSF and the national M&E plan.
- Analysis of data needs and data users.
- A data use calendar to guide the timetable for major data collection efforts and reporting requirements.
- A timetable for national reporting and feedback to national, regional and district level stakeholders.
- A standard format for reporting and data tabulation.
- Information products tailored to different audiences and a dissemination schedule. Evidence of information use (e.g. data referenced in funding proposals and planning documents).

- Mechanisms for providing feedback to and sharing data with regional, district and community level stakeholders as well as implementing and development partners, and providing guidance on understanding data and the use of data for program improvement.

Description: Health sector services have a standardized system of not only collecting and analyzing data, but also of disseminating and using it for program planning and decision making. Results from routine M&E, surveys, special studies, and other research are released to relevant stakeholders through a variety of means as prescribed in information product and dissemination matrices. The matrices give guidance on the timing and scope of national, regional, sectoral and specialist dissemination.

Information Products: On the basis of these information needs, the DSP/RM&E HIV and AIDS M&E system will produce the following periodic information products:

- A quarterly program monitoring report
- An annual HIV and AIDS NSF progress report
- A biennial UNGASS Report
- A DSP Quarterly Bulletin
- Other research/survey reports

In addition to these periodic information products, the DSP/RM&E will also respond to specific and ad hoc information needs of its stakeholders. Each of the periodic information products, and the process for accessing ad hoc information, is described below.

Quarterly Program Monitoring Reports: The DSP/NAC are planning to implement a process for generating and disseminating a quarterly program monitoring report. This report will provide information on coverage statistics per HIV program area and will be based on the information provided by all stakeholders in the quarterly program monitoring format. The production of this report will also ensure that the DSP/NAC meets requirements in terms of minimum reporting standards, as well as reporting to its other basket donors.

The purpose of the quarterly program monitoring report is to provide a quick overview of service coverage in the previous quarter to better inform implementers and development partners of the status of interventions, where the gaps are, and how to maximize resource utilization. The only data source for this report is the quarterly program monitoring report form. Once the DSP/NAC has collected and captured the data on a monthly/quarterly basis, it will compile a quarterly program monitoring report, using a standard analysis methodology (descriptive statistics). This statistical analysis will be prepared for the approval process and dissemination to stakeholders.

The DSP/RM&E will disseminate the quarterly program monitoring report directly to stakeholders (all organizations that submitted data). The format of this report will be based on the framework taken from the MTP III on HIV and AIDS in Namibia. This quarterly report will be compiled within 1 month of the end of the quarter and will be approved by the director of the DSP, and the deputy permanent secretary and permanent secretary of the MoHSS.

Annual HIV and AIDS NSF Progress Report: The purpose of this report is to provide a comprehensive overview of Namibia's response to HIV and AIDS. This is done by reporting on all indicators contained in the DSP/NAC's national HIV and AIDS M&E plan and by providing key observations and guidance for future implementation. This report is procedurally linked to the government's annual work planning and budgeting process to ensure that the phrase "using information for decision-making" is taken seriously.

Notably, all indicators should be reported with "the last 12 months" as a timeframe. All data should focus on the previous fiscal year (April–March), the de facto reporting period for the report. This timeframe should allow sufficient time for the report information to be used as a guide for work planning and budget making for the following financial year (1 April–31 March).

The format of the annual HIV and AIDS NSF Progress report is based on the information needs of the DSP/NAC and its stakeholders, and is compiled on an annual basis by the DSP/NAC. The RM&E is responsible for drafting this report, with key support from the DSP. The report is approved by the director of the DSP, and the deputy permanent secretary and permanent secretary of the MoHSS.

The report is compiled during April/May of each year, and is then ready by 1 June so that the information can be disseminated to stakeholders at the annual HIV and AIDS NSF Progress report dissemination seminar and Joint AIDS Review that is held in August. All stakeholders from the public sector, private sector and civil society are invited to attend. In addition to the national dissemination seminar for M&E results, there will be regional dissemination seminars to ensure distribution of results to the regional level.

Biennial UNGASS Report: Namibia is a signatory to the 2001 Declaration of Commitment on HIV and AIDS at the UNGASS. Part of this declaration of commitment includes a set of indicators that the government of Namibia has agreed to report on to UNAIDS on a periodic basis. A total of 24 UNGASS indicators have been included in the list of Namibia HIV and AIDS national core indicators. This ensures that data collection and analysis for the UNGASS indicators form part of the M&E processes within DSP/NAC and that it is not treated as a report “outside the scope of DSP/NAC’s M&E mandate”. The purpose of the UNGASS report is to report to the UNAIDS on a periodic basis regarding Namibia’s progress in the fight against AIDS, by reporting on the 24 specific indicators in a manner defined in the UNAIDS Guidelines for the Construction of Core Indicators.

Data analysis is carried out as per the UNAIDS Guidelines for the Construction of Core Indicators, and the datasheets for each of the 24 indicators will be completed and disaggregated as is required. This report is based on the format provided by UNAIDS and consists of a statistical overview of the data for each indicator, as well as a narrative description to add quality and texture to the statistical overview.

This report is compiled on a biennial basis and is the responsibility of the DSP, with technical support from the in-country UNAIDS office. The report is approved by the director of the DSP, and the deputy permanent secretary and permanent secretary of the MoHSS.

Regular Information System Updates: All M&E reports produced by DSP/NAC (The Annual HIV and AIDS NSF progress report, The Quarterly Program Monitoring Report and the UNGASS report) are available on DSP/NAC’s website for electronic download (in PDF or MS Word format). This ensures that DSP/NAC stakeholders are able to access up-to-date information. All HIV indicator data are updated when new data becomes available in the DSP/NAC database.

Ad Hoc Information Needs: In addition to the information products listed above, some stakeholders might have specific information needs at some stage. Although DSP/NAC encourages the use of existing information products, it will assist if there are any specific and ad hoc information needs that are not covered in one of the above information products. Such a request should be made in writing to the DSP/NAC and will then be considered. If possible, the request will be accommodated within the budget limitations of the RM&E unit of the DSP. If it is not possible, the person/institution will be informed of the cost implications. Whether or not there are costs implications for DSP/NAC to provide the ad hoc information need, DSP/NAC will respond in writing to the request for ad hoc information within 5 working days of receiving such a request.

Quarterly Bulletin: DSP/NAC will develop a quarterly bulletin that summarizes all relevant information on HIV and AIDS, TB and malaria. The bulletin is targeted at all audiences including those who are not in the health profession, and, therefore, it will be written in a manner that is easily understood. The bulletin will form part of the documents that are disseminated every quarter. To ensure that the bulletin’s content is widely understood, it will be translated into the local languages before dissemination. The development of the bulletin will be done by the Liaison Officers of the Directorate in collaboration with RM&E unit.

Data Triangulation: Every 2 years, data triangulation exercises will be conducted to validate data from various sources. Hypotheses will be generated from the data triangulation which will form the basis of subsequent research.

Modes of Transmission (MoT) study: An MoT study will be conducted every 4–5 years following the release of reports of the population based HIV second generation surveillance. MoT studies will review the epidemiological evidence available for the transmission of the disease in Namibia and apply the UNAIDS incidence model using data from the AIS or DHS+, BSS and NASA. As part of the MoT, a review of the prevention efforts will also be conducted, as will be a synthesis of where the new infections are occurring, where prevention efforts are being emphasized and where resources are being directed.

Methods of Dissemination of Information Products: In terms of implementation, this M&E plan is linked to the annual work planning and budgeting process of the government which commences in July/Aug every year. This can only be practically achieved if the M&E information products are available prior to the work plan being developed, which will ensure that M&E results are used to inform decision making.

Various information products will be disseminated using a combination of various methods:

- Annual regional meetings
- Annual regional support visits
- Emailing the reports
- The annual M&E dissemination workshop
- Joint Annual Review (JAR)
- Sectoral feedback workshop/meetings
- Use of other feedback mechanisms already in place (e.g. regional and sector meetings).
- Dissemination through media
- The MoHSS website
- The DSP/NAC/Documentation Centre, MoHSS Documentation Centre and Regional Resource Centre

All information/reports produced will be disseminated to all relevant stakeholders, including the private and public sectors and CSOs, and at national, regional and district levels. The reports/data will help program officers use evidence for programmatic decision-making.

The Joint Annual Review for HIV/AIDS

Each year in August, Namibia will take stock of the progress of the National Strategic Framework for HIV/AIDS through a Joint Annual Review during which stakeholders from all sectors and development partners will participate and deliberate over their contributions to the national response. During the JAR, a national priority action plan for the next year will be developed as well as a list of key undertakings for the next year. The first day of the JAR will be used to share the progress in the past year and the next two days will be used to plan for the next year.

CHAPTER 4: NSF THEMATIC GOALS AND NATIONAL TARGET, KEY PROGRAM AREAS AND CORE INDICATORS FOR MEASUREMENT WITH DATA SOURCES

4.1 OVERVIEW

The following section provides a brief overview of the national response to HIV and AIDS in Namibia for the next 6 years from FY 2010/11 to 2015/16 and the corresponding core set of indicators (impact, outcomes and outputs) that will be used to measure the response. The response revolves around the NSF thematic areas of prevention, treatment, care and support, impact mitigation, and response management and coordination. The NSF will be operated through the national, regional (13), sector (14) operational plans and development partners' plans. This section begins with an overview of the overarching and additional impact level results, and is followed by a section that details the output and outcome indicators according to thematic areas, goals and programs that will be used to measure the impact results.

4.2 OVER-ARCHING IMPACT RESULT

The overarching impact result of the NSF is to improve human development as measured by the human development index (HDI). Details of this indicator are provided in Table 2

Table 2: National Impact as Measured by the Human Development Index

No.	INDICATOR DESCRIPTION	NUMERATOR	DENOMINATOR	DISAGGREGATION	FREQ. / TIMING	BASELINE (YEAR)	MID-TERM TARGET (FY 2012/13)	END-TERM TARGET (FY 2015/16)	DATA SOURCE	RESP. INSTITUT.	COMMENT
NATIONAL IMPACT LEVEL INDICATOR: Level of Human Development Improved											
	Human Development Index (HDI)	Life expectancy, adult literacy, gross school enrollment, standard of living			Annual	0.542 (2008)	0.55		Human Development Report	NPC	Core Indicator

4.2 OVERVIEW OF IMPACT LEVEL RESULTS

Stakeholders identified thematic priority impact level results (Table 3) that contribute to the achievement of the overarching national level impact result of human development articulated in the national development plan (NDP III). By FY 2015/16, implementation of the NSF is anticipated to contribute to the achievement of the following impact level results. Impact results include codes that link to the corresponding NSF impact results. Details of measuring impact through a core set of outcome and output measures are included in the following section.

Table 3: **Overview of Impact Level Results**

Level	Description of impact level result
National	Namibian Human Development Index (HDI) is improved from 0.542 in 2008 to 0.55 by FY2015 /16 (overarching)
Prevention	Annual number of new infections has reduced by 50% between FY 2010/11 and FY 2015/16 (IR-1)
	% of pregnant women attending ANC aged 15-24 who are HIV infected reduced from 11% in 2008 to 5% by FY 2015/16 (IR-2)
	% of infected infants born to HIV positive mothers is reduced from 12% in 2007 to 4% by FY 2015/16 (IR-4)
Treatment, Care and Support	Life expectancy has increased from 51.6 years in 2008 to 55 years in FY 2015/16 (IR-6)
	% of people reported dying from AIDS has decreased from 23% in 2008/09 to 18% in FY 2015/16 (IR-7)
Impact Mitigation	% poor households has decreased from 28% in 2008 to 20% in FY 2015/16 (IR-8)
	% of households with vulnerable individuals that are able to cope with the impact of HIV has increased to 50% by FY 2015/16 (IR-9)
Response management	% of NSF service coverage targets (output level results) that have been met in the areas of HIV prevention, treatment care and support and impact mitigation has increased from 0% in 2009 to 60% by 2013 and to 75% by FY 2015/16 (IR-10)
	% of stakeholders that have expressed satisfaction with the level and type of services provided by MoHSS has increased from 60% in 2009 to 80% in FY 2015/16 (IR-11)

4.3 OVERVIEW OF THEMATIC AREAS, RESULT (TARGETS) AND INDICATORS FOR MEASUREMENT

This section presents a core set of indicators that will be used to measure the impact results of the NSF. A result is a measurable change that is derived from a causal relationship, while an indicator is a unit of the measurable change used to demonstrate progress in a program.

4.3.1 Core Indicators

The indicator codes are as follows:

- IR=Impact Result
- OC=Outcome
- OP=Output

These codes link to the NSF and are presented in a framework that corresponds to the overarching impact level results of human development and the individual NSF focus areas within the four themes:

- Prevention
- Treatment Care and Support
- Impact Mitigation
- Response Management

This core set of indicators will be required for national reporting of progress in the NSF implementation.

Other recommended indicators that may be used to provide detail in addition to the core indicators can be found in Annex 8. Recommended indicators may be useful at the program level, and program managers should use them to ensure that their programs are contributing to the NSF results.

The following framework outlines the core indicators, expected coverage of services to achieve the desired changes in behavior, systems and ultimately reduced morbidity, mortality, improved quality of life and human development. The system takes into account the expected efficacy of the interventions and assumes efficient delivery. These core indicators cover all 26 NSF areas of focus (10 in prevention, 4 in treatment, care and support, 4 in impact mitigation, and 8 in response management). All impact level indicators have been included for reporting in the national NSF Annual Progress Report. All indicators that are part of the NDP reporting and those that have an international requirement to be reported have also been included in the list of indicators. These include MDG, UN Human Development Report, UNGASS, SADC, UA, required PEPFAR and HIV indicators among the top ten GFATM indicators. The additional indicators are coded as AI (additional indicators) with sequential numbering.

For each core indicator, the frameworks provide the result it will measure, its description, numerator and denominator where applicable, baseline where available, targets, sources, frequency of reporting and the institution responsible. Please note that results may or may not be cumulative, depending on program area. The targets were set during the stakeholder meetings as an integral part of the development of the NSF. The resulting framework developed during the process was reviewed by the M&E TAC at a national workshop in Roof of Africa as well as during numerous meetings and consultations. The levels of the targets are set to achieve the linked higher level results and, therefore, a change in one or more of the targets affects others. The targets will be reviewed on an annual basis and during the mid-term review. However, it is important to emphasize the need to obtain baseline data where it does not exist through setting up and strengthening existing systems, including conducting a population-based AIDS indicator survey and behavioral surveillance surveys

during the first 2 years of the NSF. Data sources for indicators should typically be retained for 3 years.

Detailed definitions and descriptions of all core indicators and their elements are included in Volume 2 of the national M&E plan and have been harmonized with international standards.

4.4: PREVENTION CORE INDICATORS

Indicator Number	Indicator Description	Numerator	Denominator	Disaggregation	Freq./ Timing	Baseline (Year)	Mid-Term Target (FY 2012/13)	End-Term Target (FY 2015/16)	Data Source	Resp. Institute	Harmonized Indicator/Additional Information
Result: Fewer adults become infected with HIV											
IR 1	Annual number of new infections	Number of new infections in one year		Age, Sex, Region	Annual	5,800 (2008/09)	Reduced by 20%	Reduced by 50%	EPP: HIV Estimates and Projections Report	MoHSS	NDP III goal 14, SADC goal
Result: Fewer young people are HIV positive											
IR 2	% of young women and men aged 15–24 years who are HIV infected	Number of young women and men aged 15–24 years who are HIV infected	Total number of young women and men aged 15–24 years	Age, Region	Every 2 years	11% (ANC survey 2008)	7%	5%	ANC Sentinel Surveys	MoHSS, NPC	UNGASS, MDG
Result: Fewer infants become infected with HIV											
IR 4	% of HIV infected infants born to HIV positive mothers	Number of HIV infected infants born to HIV positive mothers	Total number of infants born to HIV positive mothers	Region	Annual	12% (2007)	8%	4%	Routine program data/PMTCT/SPA /reports/HIS	MoHSS, NPC	UNGASS
Result: Fewer most at risk populations are HIV positive											
IR 3	% of Most at risk populations who are HIV infected (MSM, CSWs, Prisoners)	Number of most at risk populations who are HIV infected	Total number of most at risk populations surveyed	Age, sex, region, type of MARP	Every 2–3 years	70% (CSWs) Katutura 2007	55% (CSWs)	40% (CSWs)	BSS	MoHSS, NPC, Ministry of safety, Security and correctional services.	UNGASS

4.4.1: Social and Behavioral Change

Result: Reduced Risky Sexual Behavior											
Outcome Indicators											
Indicator Number	Indicator Description	Numerator	Denominator	Disaggregation	Freq./ Timing	Baseline (Year)	Mid-Term Target (FY 2012/13)	End-Term Target (FY 2015/16)	Data Source	Resp. Institute	Harmonized Indicator/Additional Information
OC 1	% of women and men aged 15–49 years in the general population who had concurrent partnerships in the last six months	Number of women and men aged 15–49 years in the general population who had concurrent partnerships in the last six months	Total number of women and men aged 15–49 years surveyed	Age, Sex, Region	Every 4–5 years	Baseline values not available	M&F: 10%	M&F: 5%	DHS or AIS	MoHSS, NPC	
OC 2	% women and men aged 15–49 years who had sexual intercourse who had multiple partners in the last 12 months	Number of women and men who had multiple partners in the last 12 months	Total number of women and men aged 15–49 years who had sexual intercourse in the last 12 months	Age, Sex, Region	Every 4–5 years	F: 3% (2007) M: 16% (2007) 5%	F: 2% M: 10%	F: 1% M: 5%	DHS or AIS	MoHSS, NPC	UNGASS
OC 3	% of women and men aged 15–24 years who had sexual intercourse before age 15	Number of respondents aged 15–24 years who report the age at which they first had sexual intercourse as under 15 years	Total number of respondents aged 15–24 years	Sex, Region	Every 4–5 years	F: 7% (2007) M: 18% (2007)	F: 6% M: 14%	F: 4% M: 10%	DHS or AIS	MoHSS, NPC	UNGASS

OC 6	% of persons 15–24 years with comprehensive knowledge of HIV and AIDS	Number of persons 15–24 years with comprehensive knowledge of HIV and AIDS	Total number of persons aged 15–24 years	Sex, Region	Every year	F: 65% (2007) M: 62%	F: 78% M: 765	F: 90% M: 90%	DHS or AIS	MoHSS, NPC, MoE	UNGASS, UA
Output Indicators											
OP 4	% of schools that provided life skills-based HIV education within the past academic year	Number of schools that provided life skills-based HIV education within the past academic year	Total number of schools surveyed	Region, Level: Primary, Secondary,	Every 2 years	Primary: 85% (2008/09) Secondary: 50% (2008/09)	Primary: 95% Secondary: 90%	Primary: 100% Secondary: 100%	School survey or program review	MoE	UNGASS
OP 3, OP 5, OP 7, OP 8	% of persons reached with small group or individual social and behavior change programs	Number of persons reached with small group or individual social and behavior change programs	Total number of persons in the country	Sex, Age: (10–14, 15–24, 25+ years)	Annual	Baseline values not available	F: 20% M: 20%	F: 45% M: 45%	Routine program data/SPA	MoHSS	PEPFAR

4.4.2: HIV Counseling and Testing (HCT)

Result: Increased HIV Counselling and Testing (HCT PROGRAM)											
Outcome Indicators											
Indicator Number	Indicator Description	Numerator	Denominator	Disaggregation	Freq./ Timing	Baseline (Year)	Mid-Term Target (FY 2012/13)	End-Term Target (FY 2015/16)	Data Source	Resp. Institute	Harmonized Indicator/Additional Information
OC 8	% of women and men aged 15–49 years ever tested for HIV and received their results	Number of women and men aged 15–49 years ever tested for HIV and received results	Total number of women and men interviewed in survey	Age, Sex, Region	Every 4–5 years	F: 51% M: 32%	F: 80% M: 40%	F: 90% M: 75%	DHS or AIS	MoHSS, NPC	
Output Indicators											
OP 13, OP 14	% of women and men aged 15–49 years who received an HIV test in the last 12 months and who know their results	Number of women and men aged 15–49 years who received an HIV test in the last 12 months and who know their results	Total number of women and men aged 15–49 years surveyed	Age, Sex, Result Type, MC	4–5 years	F: 29% (2007) M: 18% (2008)	F: 41% M: 28%	F: 50% M: 50%	Routine program data/SPA	MoHSS	
OP 15	% of children aged 10–14 years tested for HIV in the last 12 months and received their results	Number of children aged 10–14 years tested for HIV in the last 12 months and received their results	Total Number of children aged 10–14 years	Sex, Region	Annual	Baseline values not available	30%	55%	DHS or AIS	MoHSS, NPC	
OP 16	Number of couples who were counselled and tested in the last 12 months	NA	NA	Region	Annual	7129 - 2009	15,000	35,000	Routine program data/SPA	MoHSS, NPC	

4.4.3: Condom Social Marketing and Distribution Program

Result: Risk of infection reduced by using condoms (CONDOM PROGRAM)											
Outcome Indicators											
Indicator Number	Indicator Description	Numerator	Denominator	Disaggregation	Freq./ Timing	Baseline (Year)	Mid-Term Target (FY 2012/13)	End-Term Target (FY 2015/16)	Data Source	Resp. Institute	Harmonized Indicator/Additional Information
OC 9	% of women and men aged 15–49 years who had higher-risk sex in the last 12 months who reported consistent use of a condom with the last higher-risk sex partner	Number of women and men aged 15–49 years who had higher-risk sex in the last 12 months who reported consistent use of a condom with the last higher-risk sex partner	Total number of women and men aged 15–49 years who had higher-risk sex in the last 12 months	Sex, Age, Region	Every 4–5 years	F: 51% (2007) M: 66% (2007)	F: 68% M: 78%	F: 85% M: 90%	DHS or AIS	MoHSS, NPC	MDG Higher risk sex defined in Volume 2
OC 12	% women and men aged 15–49 years who had multiple partners in the last 12 months who reported using a condom the last time they had sex	Number of women and men aged 15–49 years who had multiple partners in the last 12 months who reported using a condom the last time they had sex	Number of men and women who had multiple partners in the last 12 months	Sex, Age, Region	Every 4–5 years	F: 66% (2007) M: 74% (2007)	F: 80% M: 85%	F: 85% M: 90%	DHS or AIS	MoHSS, NPC	UNGASS, GFATM

Output Indicators										
OP 17, OP 18	Number of condoms distributed free per year and by social marketing	N/A	N/A	Condom type: F, M, Social marketing, Region	Annual	F: Condoms: 1.16 million (2008/09) M: Condoms: 30.3 million (2008/09) By social marketing:	F: Condoms: 2 million M: Condoms: 45 million By social marketing:	F: Condoms: 3 million M: Condoms: 52 million By social marketing:	Routine condom program data	MoHSS
						F: 157,940 (2007/08) M: 1.6 million (2007/08)	F: 300,000 M: 1.6 million	F: 400,000 M: 3.0 million		
Additional Indicator										
AI 1	Number of targeted condom service outlets	N/A	N/A	Region	Annual	N/A	N/A	N/A	Routine condom program data	PEPFAR

4.4.4: Prevention of HIV among MARPs

Result: Reduced risk for infection among Most at Risk Population (MARP) Programs											
Impact Indicators											
Indicator Number	Indicator Description	Numerator	Denominator	Disaggregation	Freq./ Timing	Baseline (Year)	Mid-Term Target (FY 2012/13)	End-Term Target (FY 2015/16)	Data Source	Resp. Institute	Harmonized Indicator/Additional Information
IR 3	% of prevalence among sex workers	Number of sex workers that are HIV infected	Total population of sex workers	Age, Region	Every 2-3 years	70%	55%	40%	IBBS, MARP size estimates	MoHSS	UNGASS
Outcome Indicators											
OC 13	% of female sex workers reporting the use of a condom with their most recent client	Number of female sex workers reporting use of a condom with their most recent client	Total number of female sex workers who reported having commercial sex in the last 12 months	Age, Region	Every 2-3 years	Baseline values not available	Increased by 20% between 2010/11 & 2012/13	Increased by 50% between 2010/11 & 2015/16	BSS	MoHSS, NPC	UNGASS
OC 15	% of men reporting the use of a condom the last time they had anal sex with a male partner	Number of men reporting the use of a condom the last time they had anal sex with a male partner	Total number of men who reported having anal sex with a male partner in the last 12 months	Age, Region	Every 2-3 years	Baseline values not available	Increased by 20% between 2010/11 & 2012/13	Increased by 50% between 2010/11 & 2015/16	BSS	MoHSS, NPC	UNGASS

OC 16	% of MARPs who both correctly identify ways of preventing the sexual transmission of HIV and who reject major misconceptions about HIV transmission	Number of MARPs who both correctly identify ways of preventing the sexual transmission of HIV and who reject major misconceptions about HIV transmission	Total number of MARPs surveyed	MARP type, Region	Every 2-3 years	Baseline values not available	Increased by 20% between 2010/11 & 2012/13	Increased by 50% between 2010/11 & 2012/13	BSS	MoHSS	UNGASS
Output indicators											
OP 25	% of MARPs who have received an HIV test in the last 12 months and who know their HIV results	Number of MARPs who have received an HIV test in the last 12 months and who know their HIV results	Total number of MARPs populations	MARP type, Region	Annual, Every 2-3 years	Baseline values not available	Increased by 25% between 2010/11 & 2012/13	Increased by 40% between 2010/11 & 2015/16	Routine program data, BSS	MoHSS	UNGASS
OP 24, OP 26, OP 27	Number of sex workers, prisoners, MSM & OVP who have been reached with individual or small group HIV prevention interventions that address the drivers of the epidemic.	N/A	N/A	MARP type, Region	Annual, Every 2-3 years	Baseline values not available	SW: Increased to 50% Prisoners Increased to 80% MSM: Increased to 50%	SW: Increased to 80% Prisoners Increased to 100% MSM: Increased to 80%	Routine program data, BSS	MoHSS	PEPFAR

4.4.5: Involvement of PLHIV in Prevention

Output Indicators											
Indicator Number	Indicator Description	Numerator	Denominator	Disaggregation	Freq./ Timing	Baseline (Year)	Mid-Term Target (FY 2012/13)	End-Term Target (FY 2015/16)	Data Source	Resp. Institute	Harmonized Indicator/Additional Information
OP 28, OP 29	Number of PLHIV aged 15–49 years reached with HIV prevention interventions (minimum package)	NA	N/A	Site Type: Facility or Community; Age, Sex, Region	Annual	Baseline values not available	Increased to 50%	Increased to 80%	Routine program data	MoHSS	PEPFAR Minimum package is defined in Volume 2

4.4.6: Male Circumcision

Outcome Indicators											
Indicator Number	Indicator Description	Numerator	Denominator	Disaggregation	Freq./ Timing	Baseline (Year)	Mid-Term Target (FY 2012/13)	End-Term Target (FY 2015/16)	Data Source	Resp. Institute	Harmonized Indicator/Additional Information
OC 19	% of men aged 15–49 years who reported being circumcised by a health professional	Number of men aged 15–49 years who reported being circumcised by a health professional	Total number of men aged 15–49 years who reported being circumcised	Age, Region	Every 4–5 years	15% (2007)	30%	40%	DHS or AIS	MoHSS, NPC	
OC 20	% of newborn male infants circumcised in a health facility in the first week of life	Number of newborn male infants circumcised in a health facility within the first week of life	Total number of newborn male infants circumcised	Region	Annual	Baseline values not available	Increased to 40%	Increased to 80%	Routine program data	MoHSS, NPC	
Output Indicators											
OP 30	Number of men aged 1 year and older circumcised as part of the minimum package of MC for HIV prevention services in the past 12 months	N/A	N/A	Age: (1–14, 15+ years), Region	Annual	Baseline values not available	Mid-term values not set	Between 2010/11 & 2015/16: 450,000 men (approx. 50% of UC men 1 year and older)	Routine program data (MC client register or client medical records)	MoHSS	

OP 31	% of public hospitals that provide male circumcision (MC) surgery as part of the minimum package of MC for HIV prevention services in the last 12 months	Number of public hospitals that provide MC surgery as part of the minimum package of MC for HIV prevention services in the last 12 months	Total number of public hospitals	Region	Annual	5% (2008)	60%	90%	Routine program data (health facility survey)	MoHSS
OP 32	Number of male newborns circumcised within the first week of life	N/A	N/A	Region	Annual	Baseline values not available	Mid-term values not set	Between 2010/11 & 2015/16: 167,900 male newborns (approx. 80% of newborns)	Routine program data (MC client register or client medical records)	MoHSS
Additional Indicator										
AI 2	Number of clients circumcised who experienced one or more moderate or severe adverse event(s) within the reporting period	N/A	NA	Severity: Moderate/Severe	Annual	Baseline values not available	Mid-term values not set	End-term values not set	Routine program data (MC client register or client medical records)	MoHSS

4.4.7: PMTCT

Result: Reduced Mother to Child Transmission (PMTCT Program)											
Outcome Indicators											
Indicator Number	Indicator Description	Numerator	Denominator	Disaggregation	Freq./ Timing	Baseline (Year)	Mid-Term Target (FY 2012/13)	End-Term Target (FY 2015/16)	Data Source	Resp. Institute	Harmonized Indicator/Additional Information
OC 24	% of HIV infected pregnant women who received ARVs to reduce the risk of mother to child transmission of HIV	Number of HIV infected pregnant women who received ARVs to reduce the risk of mother-to-child transmission in the last 12 months	Estimated number of HIV infected pregnant women in the last 12 months	Age, Region, Prophylactic regimens: ART; Prophylactic Regimens using a combination of 2 ARVs	Annual	70% (2007)	80%	95%	Routine program data for Surveillance and modeling for denominator	MoHSS, NPC	
OC 25	% infants born to HIV infected women receiving antiretroviral prophylaxis to reduce the risk of MTCT in the first week of life	Number of infants born to HIV infected women receiving antiretroviral prophylaxis to reduce the risk of MTCT in the first week of life.	Number of infants born to HIV infected women	Region, Sex	Annual	67% (2007)	82%	95%	Routine program data for Surveillance and modeling for denominator	MoHSS	

Output Indicators										
OP 35	% of pregnant women who were tested for HIV and know their results	Number of pregnant women who were tested for HIV and know their results	Total number of pregnant women	Result: known status at entry/tested positive, Region	Annual	71% (2008)	80%	95%	Routine program data PMTCT/HIS	MoHSS
OP 36	% of HIV exposed infants receiving HIV DNA/PCR test	Number of infants who received an DNA/PCR test during the reporting period	Number of HIV positive pregnant women identified within the reporting period (include known HIV positive at entry)	Region, age at which tested (within 2 months, 9 months, 18 months)	Quarterly, Annual	20% within 2 months (2009)	50%	80%	PMTCT/EID records	
OP 39	% of health facilities providing ANC services that offer both HIV testing and ART for PMTCT on site	Number of health facilities providing ANC services that offer both HIV testing and ART for PMTCT on site	Total number of health facilities providing ANC services	Level of health facility, Region	Annual	56% (2008)	90%	98%	Routine Program data PMTCT/HIS (Health facility census)	MoHSS
Additional Indicator										
AI 3	Number of HIV-positive pregnant women assessed for ART eligibility through either clinical staging (using WHO clinical staging criteria) or CD4 testing	N/A	NA	Region, Age	Annual				PMTCT client records	

4.4.8: Post Exposure Prophylaxis

Result: Reduced risk of HIV transmission through PEP (PEP Program)											
Output Indicator											
Indicator Number	Indicator Description	Numerator	Denominator	Disaggregation	Freq./ Timing	Baseline (Year)	Mid-Term Target (FY 2012/13)	End-Term Target (FY 2015/16)	Data Source	Resp. Institute	Harmonized Indicator/Additional Information
OP 40	% of health facilities with PEP services available on site and being provided according to the national guidelines	Number of health facilities with PEP services available on site	Total number of health facilities	Exposure (occupational, non-occupational Sector (public, private)	Annual	18% (2007)	50%	75%	National program data, health facility survey/ census	MoHSS	UNGASS, UA
Outcome Indicator											
OC 27	% of people reporting to be in need of PEP in the last 12 months and who have received PEP services as per national guidelines	Number of people reporting to be in need of PEP in the last 12 months and who have received PEP services as per national guidelines	Total number of people reporting to be in need of PEP	Exposure type: occupational, rape/sexual assault victims, other non-occupational	Annual	Baseline values not available	Increased to 80%	Increased to 95%	Routine program data	MoHSS	PEPFAR

4.4.9: Sexually Transmitted Infections

Output Indicators											
Indicator Number	Indicator Description	Numerator	Denominator	Disaggregation	Freq./ Timing	Baseline (Year)	Mid-Term Target (FY 2012/13)	End-Term Target (FY 2015/16)	Data Source	Resp. Institute	Harmonized Indicator/Additional Information
OP 44	Number of clients treated for urethra discharge syndrome in public sector hospitals	Number of clients treated for urethra discharge syndrome in public sector hospitals	N/A	Sex, Age, Region	Annual	17,000 (2007)	9,750	7,000	Routine program data (Client records, clinic registers)	MoHSS	

4.4.10: Blood Safety

Result: Blood units are safe for usage (BLOOD SAFETY Program)											
Outcome Indicator											
Indicator Number	Indicator Description	Numerator	Denominator	Disaggregation	Freq./ Timing	Baseline (Year)	Mid-Term Target (FY 2012/13)	End-Term Target (FY 2015/16)	Data Source	Resp. Institute	Harmonized Indicator/Additional Information
OC 29	% of donated blood units that have been screened for HIV through national testing guidelines	Number of donated blood units that have been screened for HIV through national testing guidelines	Number of blood units donated in the last 12 months	N/A	Annual	100%	100%	100%	NAMBTS	MoHSS	PEPFAR
Output Indicator											
OP 45	% of safe blood units supplied in the last 12 months	Number of safe blood units supplied in the last 12 months	Number of blood units	N/A	Annual	100%	100%	100%	NAMBTS	MoHSS	PEPFAR
Additional Indicators											
AI 4	Number of units of whole blood collected by the NBTS network and screened for transfusion-transmissible infections per 1,000 population per year	N/A	NA	N/A	Annual	Baseline values not set	Mid-term values not set	End-term values not set	NAMBTS	MoHSS	PEPFAR

AI 5	% of blood units collected and screened by the NBTS network which are identified as reactive for HIV by an NBTS network laboratory.	Number of blood units collected and screened by the NBTS network which are identified as reactive for HIV by an NBTS network laboratory.	Number of blood units collected and screened by the NBTS network.	N/A	Annual	Baseline values not available	Mid-term values not set	End-term values not set	NAMBTS	MoHSS	PEPFAR
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4.4.11: Universal Precautions

Outcome Indicator Number	Indicator Description	Numerator	Denominator	Disaggregation	Freq./Timing	Baseline (Year)	Mid-Term Target (FY 2012/13)	End-Term Target (FY 2015/16)	Data Source	Resp. Institute	Harmonized Indicator/Additional Information
OC 30	% of men and women receiving medical injection in the last 12 months who said that the last injection the syringe and needle were taken from a new/unopened package	Number of men and women receiving medical injection in the last 12 months who said that the last injection the syringe and needle were taken from a new/unopened package	Number of men and women receiving medical injection in the last 12 months	Region	Annual	F: 97% - 2009 M: 95% (2009)	F: 100% M: 100%	F: 100% M: 100%	Routine program data (Facility records)	MoHSS	PEPFAR

Output Indicator											
OP 46	% of health facilities with observed guidelines for infection prevention and control, and waste management guideline at site	Number of health facilities with observed guidelines for infection prevention and control, and waste management guideline at site	Number of health facilities	Region	Annual	Baseline values not set	Increased to 20%	Increased to 50%	Routine program data (Facility records)	MoHSS	PEPFAR
Additional Indicator											
AI 6	% of health facilities with no stock outs of new sterile syringes (standard or safety) in the prior 6 months	Number of health facilities with no stock outs of new sterile syringes (standard or safety) in the prior 6 months	Number of health facilities	Region	Annual	Baseline values not set	Mid-term values not set	End-term values not set	Routine program data (Facility records)	MoHSS	PEPFAR
AI 7	% of health facilities with no stock outs of safety boxes in the prior 6 months	Number of health facilities with no stock outs of safety boxes in the prior 6 months	Number of health facilities	Region	Annual	Baseline values not set	Mid-term values not set	End-term values not set	Routine program data (Facility records)	MoHSS, URC	PEPFAR
AI 8	Average number of medical injections per person per year	N/A	N/A	N/A	Annual	Baseline values not set	Mid-term values not set	End-term values not set	Routine program data (Facility records, HIS)	MoHSS	

4.4.12: Gender

Additional Indicators											
Indicator Number	Indicator Description	Numerator	Denominator	Disaggregation	Freq./ Timing	Baseline (Year)	Mid-Term Target (FY 2012/13)	End-Term Target (FY 2015/16)	Data Source	Resp. Institute	Harmonized Indicator/Additional Information
AI 9	Male Norms and Behaviors: Number of people reached by an individual, or small-group, or community-level intervention or service that explicitly addresses norms about masculinity related to HIV and AIDS.	N/A	N/A	Age: (0-15; 15-24; 25+ years), Sex	Annual	Baseline values not set	Mid-term values not set	End-term values not set	Routine program data	PEPFAR	
AI 10	Gender Based Violence and Coercion: 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 and AIDS.	N/A	N/A	Age: (0-15; 15-24; 25+ years), Sex	Annual	Baseline values not set	Mid-term values not set	End-term values not set	Routine program data	PEPFAR	

AI 11	Number of people reached by an individual, or 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 and AIDS.	N/A	N/A	Age: (0-15; 15-24; 25+ years), Sex	Annual	Baseline values not set	Mid-term values not set	End-term values not set	Routine program data	PEPFAR	
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OC 31	% of PLHIV enrolled in a pre-ART program who are retained until they graduate ART	The number of PLHIV enrolled in a pre-ART program who are retained until they graduate ART	The number of PLHIV enrolled on pre-ART program	Sex, Age: (0-14; 15-19; 20-24; 25-29; 30-49; 50+ years), Region	Annual	Baseline values not available	Increased to 80%	Increased to 90%	Routine program monitoring (Facility registers, client medical reports)	MoHSS	
Output Indicators -											
OP 48, OP 49	% of PLHIV not on ART who were enrolled in a pre-ART program in the past 12 months	Number of PLHIV not on ART who were enrolled in a pre-ART program in the past 12 months	Total number of PLHIV enrolled in a pre-ART program not on ART in the past 12 months	Sex, Age (PEPFAR: <18; >18 years), Region	Annual	F: 60% M: 38% (2009)	F: 80% M: 55%	F: 95% M: 80%	Routine program data, EPP: HIV Estimates and Projections	MoHSS, PEPFAR	
OP 50, OP 51	% adults and children enrolled in HIV care and eligible for Cotrimoxazole (CTX) prophylaxis (according to national guidelines) who are currently receiving CTX prophylaxis	Number of adults and children enrolled in HIV care and eligible for CTX prophylaxis (according to national guidelines) who are currently receiving CTX	Total number of adults and children enrolled in HIV care and eligible for CTX prophylaxis (according to national guidelines)	Sex, Age: (<15; >15 years), Region	Annual	100%	100%	100%	Routine program data	MoHSS, PEPFAR	

4.5.2: TB/HIV Co-Infection

Result: More PLHIV with TB co-infection are successfully treated (TB/HIV COLLABORATION PROGRAM)											
Outcome Indicator											
Indicator Number	Indicator Description	Numerator	Denominator	Disaggregation	Freq./ Timing	Baseline (Year)	Mid-Term Target (FY 2012/13)	End-Term Target (FY 2015/16)	Data Source	Resp. Institute	Harmonized Indicator/Additional Information
OC 32	% of PLHIV with new smear-positive TB who have been successfully treated (in accordance with national TB program guidelines)	Number of PLHIV with new smear-positive TB who were successfully treated for (in accordance with national TB Program guidelines)	Estimated number of incident TB cases in people living with HIV	Sex; Age: (>15; <15 years), Region.	Annual.	73% in 2007	80%	85%	Routine program data, TB register	MoHSS	UNGASS
Output Indicators											
OP 52	% of estimated HIV positive incident TB cases that received treatment for TB and HIV	Number of estimated HIV positive incident TB cases that received treatment for TB and HIV	Total number of estimated HIV positive incident TB cases	Sex, Age, Region	Annual	74% (2008)	85%	95%	Routine program data	UNGASS	PEPFAR
OP 53	% of adults and children enrolled in HIV care who had TB status assessed and recorded during their last visit to a public health facility	Number of adults and children enrolled in HIV care who had TB status assessed and recorded during their last visit to a public health facility	Total number of adults and children enrolled in HIV care	Age, Sex, Region	Annual		80%	95%	Routine program data	MoHSS	PEPFAR

OP 55	Number of adults and children newly-enrolled in HIV care in the past 12 months who start (given at least one dose) treatment of latent TB infection (IPT)	N/A	N/A	Age, Sex, Region	Annual	1495 (2007)	1800	2800	Routine program data (TB/HIV)	MoHSS	
OP 56	% of HIV-positive TB patients who are started on ART	# of HIV-positive TB patients who are started on ART	Total number of HIV-positive TB patients	Age, Sex, Region	Annual		50%	75%	Routine program data (TB/HIV)	MoHSS	
Additional Indicator											
AI 12	Number of TB patients who had an HIV test result recorded in the TB register	N/A	N/A	Age, Sex, Region	Annual	54% (2007)	70%	95%	Routine program data/TB Register		PEPFAR

4.5.3: Anti Retroviral Therapy (ART)

Result: More PLHIV survive longer on ART (ART PROGRAM)											
Outcome Indicator											
Indicator Number	Indicator Description	Numerator	Denominator	Disaggregation	Freq./ Timing	Baseline (Year)	Mid-Term Target (FY 2012/13)	End-Term Target (FY 2015/16)	Data Source	Resp. Institute	Harmonized Indicator/Additional Information
OC 33	% of adults and children (aged 0–14 years) with HIV still alive at 12 months after the initiation of ART	Number of adults and children who are still alive and on antiretroviral therapy at 12 months after initiating treatment	Total number of adults and children who initiated antiretroviral therapy who were expected to achieve 12-month outcomes within the reporting period	Sex, Age, Region	Timing	Adults: 69% (2007) Children: 82% (2007)	Adults: 86% Children: 93%	Adults: 90% Children: 95%	Routine program data (Monthly cohort data, ART registers)	MoHSS, UNGASS, PEPFAR	
Output Indicators											
OP 57, OP 58	% of adults (15+ years old) eligible for ART who receive ART (current)	Number of adults (15+ years old) eligible for ART receiving ART	Total number of adults (15+) eligible for ART	Age, Sex, Region	Annual	F: 73% M: 55% (2009)	F: 87% M: 83%	F: 95% M: 95%	Routine program data (ART)	MoHSS, UNGASS, MDG, PEPFAR	
OP 59	% of children (aged 0–14 years) eligible for ART receiving ART (current)	Number of children (aged 0–14 years) eligible for ART that are receiving ART	Total number of children (age 0-14) eligible for ART	Sex, Age: (<15; >15), Region	Annual	100% (2009)	100%	100%	Routine program data (ART)	MoHSS, UNGASS, MDG, PEPFAR	

OP 60	% of health facilities that offer ART	Number of health facilities that offer ART	Total number of health facilities in the country	Public/Private	Annual	17% (2008)	30%	45%	National facility data, health facility census	MoHSS, PEPFAR
Additional Indicator										
AI 13	Number of adults and children with advanced HIV infection newly enrolled on ART	N/A	NA	Sex, age, pregnant women	Annual	Baseline values not set	Mid-term values not set	End-term values not set	Routine program data (ART)	MoHSS, PEPFAR

4.5.4: Care & Support

Result: More PLHIV are cared for in better ways in their communities (CHBC PROGRAM)											
Output Indicator											
Indicator Number	Indicator Description	Numerator	Denominator	Disaggregation	Freq./ Timing	Baseline (Year)	Mid-Term Target (FY 2012/13)	End-Term Target (FY 2015/16)	Data Source	Resp. Institute	Harmonized Indicator/Additional Information
OP 62	% of male and female adult PLHIV who are clinically malnourished and who received therapeutic or supplementary food during the last 12 months	Number of male and female adult PLHIV who are clinically malnourished and who received therapeutic or supplementary food during the last 12 months	Total number of male and female adult PLHIV who are clinically malnourished	Sex, Age	Annual	25% (2008)	40%	50%	ART program	MoHSS	PEPFAR
Additional Indicator											
AI 14	Number of eligible adults and children provided with psychological, social, or spiritual support			Sex, Age: (<18; >18)	Annual				Community-based care program records, SPM	MoHSS	PEPFAR
AI 15	Number of chronically ill people living with HIV who receive home based care, including PLWHA receiving care and support			Sex, Age (<18 and >18)	Quarterly, Annual				Community-based care program records, SPM	MoHSS	

4.6: IMPACT MITIGATION CORE INDICATORS

4.6.1: Care and Support for OVC

Result: More OVC receive free external basic support											
Outcome Indicator											
Indicator Number	Indicator Description	Numerator	Denominator	Disaggregation	Freq./ Timing	Baseline (Year)	Mid-Term Target (FY 2012/13)	End-Term Target (FY 2015/16)	Data Source	Resp. Institute	Harmonized Indicator/Additional Information
OC 36	% of OVC aged 0–17 years whose households received any free external support (medical, education, emotional, social and materials) in the past 12 months to care for the child	Number of OVC aged 0–17 years whose households received any free basic external support (medical, education, emotional, social and materials) in the past 12 months to care for the child	Total number of OVC aged 0–17 years surveyed	Sex, Region	Every 4–5 years	16% (2007)	30%	45%	DHS	MoHSS, MoE	UNGASS
Output Indicators											
OP 74	% of OVC aged 10–14 years attending school	Number of OVC aged 10–14 years attending school	Total number of OVC aged 10–14 years	Region	Every 4–5 years	94.6% (2007)	100%	100%	DHS or AIS	MoHSS, EMIS	MDG

4.6.2: Legal Rights and Protection Services for Vulnerable Persons

Indicator Number	Indicator Description	Numerator	Denominator	Disaggregation	Freq./ Timing	Baseline (Year)	Mid- Term Target (FY 2012/13)	End- Term Target (FY 2015/16)	Data Source	Resp. Institute	Harmonized Indicator/Additional Information
AI 16	Women's Legal Rights and Protection: Number of people 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 and AIDS.	N/A	N/A	Sex, Age, Region	Annual	Baseline values not available	Mid-term values not set	End-term values not set	Routine program data	PEPFAR	PEPFAR

4.7: RESPONSE MANAGEMENT CORE INDICATORS

Impact Indicators											
Indicator Number	Indicator Description	Numerator	Denominator	Disaggregation	Freq./ Timing	Baseline (Year)	Mid-Term Target (FY 2012/13)	End-Term Target (FY 2015/16)	Data Source	Resp. Institute	Harmonized Indicator/Additional Information
IR 10	% of NSF service coverage targets (output level results) that have been met in the areas of HIV prevention, care and support, resource management and impact mitigation	Number of output level results actually met	Total number of output level results intended to meet	Thematic Area	Every 2-3 years	0% (2009)	60%	90%	NSF implementation report	NAC,DSP (RM&E), Sectors, Partners, NPC, NAC	
IR 11	% of stakeholders that have expressed satisfaction with the level and type of services provided by HIV coordination structures	Number of stakeholders that have expressed satisfaction with the level and type of services provided by HIV coordination structures	Number of stakeholders	Level of services	Every 2-3 years	60% (2009)	70%	80%	Surveys, case studies	MoHSS at the national level, MRLGH at the regional level	Stakeholder and coordinating structures will be defined in Volume 2

4.7.1: Enabling Policy and Legal Environment

Result: Addressing stigma and discrimination											
Outcome Indicator											
Indicator Number	Indicator Description	Numerator	Denominator	Disaggregation	Freq./ Timing	Baseline (Year)	Mid-Term Target (FY 2012/13)	End-Term Target (FY 2015/16)	Data Source	Resp. Institute	Harmonized Indicator/Additional Information
OC 46	% of women and men aged 15–49 years expressing attitudes toward PLHIV	Number of women and men aged 15–49 years expressing attitudes toward PLHIV	Total population of women and men aged 15–49 years surveyed	Sex, Age, Region	Every 4–5 years	F: 39% M: 36% (2009)	F: 55% M: 50%	F: 70% M: 65%	DHS, AIS	MoHSS	

4.7.2: Capacity Development (Health Systems Strengthening)

Additional Indicators											
Indicator Number	Indicator Description	Numerator	Denominator	Disaggregation	Freq./ Timing	Baseline (Year)	Mid-Term Target (FY 2012/13)	End-Term Target (FY 2015/16)	Data Source	Resp. Institute	Harmonized Indicator/Additional Information
AI 17	Percentage of testing facilities (laboratories) with capacity to perform clinical laboratory tests	Number of testing facilities (laboratories) with capacity to perform clinical laboratory tests	Total number of testing facilities	Public, Private	Every 1–2 years	Baseline values not available	Mid-term values not set	End-term values not set	Special survey or case study	MoHSS	

AI 18	Percent of testing facilities (laboratories) that are accredited according to national or international standards	Number of testing facilities (laboratories) that are accredited according to national or international standards	Total number of testing facilities	Public, Private	Every 1–2 years	Baseline values not available	Mid-term values not set	End-term values not set	Special survey or case study	MoHSS
AI 19	Number of new health-care workers who graduated from a pre-service training institution	N/A	N/A	By specific types	Annual	Baseline values not available	Mid-term values not set	End-term values not set	Training records	MoHSS
AI 20	Number of community health and para-social workers who successfully completed a pre-service training program	N/A	N/A	Community health workers, Para-social workers	Annual	Baseline values not available	Mid-term values not set	End-term values not set	Training records	MoHSS
AI 21	Number of health-care workers who successfully completed an in-service training program	N/A	N/A	Program type	Annual	Baseline values not available	Mid-term values not set	End-term values not set	Training records	MoHSS
										PEPFAR Health-care workers are defined in Volume 2
										PEPFAR Program types are defined in Volume 2

4.7.3: Community Systems Strengthening

Community Systems Strengthening Services for CACOCs, DACOCs and RACOCs											
Output Indicators											
Indicator Number	Indicator Description	Numerator	Denominator	Disaggregation	Freq./ Timing	Baseline (Year)	Mid-Term Target (FY 2012/13)	End-Term Target (FY 2015/16)	Data Source	Resp. Institute	Harmonized Indicator/Additional Information
OP 95	Number of RACOCs that have actually conducted 3 meetings in the past 12 months	N/A	N/A	Region	Annual	Baseline values not available	13 regions	13 regions	Regional Councils HIV and AIDS Reports	MRLGHRD	
OP 96	Number of CACOCs that have actually conducted 3 meetings in the past 12 months	N/A	N/A	Communities	Annual	Baseline values not available	60	80	Community Councils HIV and AIDS Reports	MRLGHRD	
OP 98	Number of small, medium and large enterprises implementing a comprehensive HIV and AIDS WPP with a budget	N/A	N/A	Size of the enterprise	Every 2-3 years	50 (2007)	150	200	Workplace Survey	OPM, MOL, NABCOA	Size of enterprise: small, medium, large
Additional Indicator											
AI 22	Number of OMAs that have actually implemented a comprehensive HIV & AIDS workplace program with a budget	N/A	N/A	Type of entity	Annual	Baseline values not available	Mid-term values not set	End-term values not set	Workplace Surveys	MoHSS, SPM	Type of entity: Office, Ministry Agency

4.7.4: Resource Mobilization and Management

Output Indicators											
Indicator Number	Indicator Description	Numerator	Denominator	Disaggregation	Freq./ Timing	Baseline (Year)	Mid-Term Target (FY 2012/13)	End-Term Target (FY 2015/16)	Data Source	Resp. Institute	Harmonized Indicator/Additional Information
OP 101	% of government funding spent on health during the past fiscal year	Amount of government funding spent on health during the past fiscal year	Total government funding in the past fiscal year	N/A	Annual	11% (2003)	14%	15%	Financial and expenditure reports	MoF, MoHSS	
OP 102	Amount of domestic (government, private sector & other national sources) and international AIDS spending by categories and financing (% domestic)	Amount spent by category and financing source	Total Expenditure	Category, Financing source	Annual	Baseline values not available	80%	100%	Routine Program reports, NASA	MoHSS, UNGASS	

4.7.5: Monitoring and Evaluation, and HIV Research

Output Indicator											
Indicator Number	Indicator Description	Numerator	Denominator	Disaggregation	Freq./ Timing	Baseline (Year)	Mid-Term Target (FY 2012/13)	End-Term Target (FY 2015/16)	Data Source	Resp. Institute	Harmonized Indicator/Additional Information
OP 108	HIV research agenda has been updated at least once in the past 24 months.	List of priority research and evaluation topics in the past 24 months	N/A	N/A	Every 2 years	N/A	N/A	N/A	Routine program reports	MoHSS	

Annex 1: Glossary of Terms

Accountability—responsibility for the use of resources and the decisions made, as well as the obligation to demonstrate that work has been done in compliance with agreed-upon rules and standards and to report fairly and accurately on performance results vis-à-vis mandated roles and/or plans.

Activity—actions taken or work performed through which inputs such as funds, technical assistance, and other types of resources are mobilized to produce specific outputs.

Attribution—the ascription of a causal link between observed changes and a specific intervention.

Baseline—the status of services and outcome-related measures such as knowledge, attitudes, norms, behaviors, and conditions before an intervention, against which progress can be assessed or comparisons made.

Coverage—the extent to which a program/intervention is being implemented in the right places (geographic coverage) and is reaching its intended target population (individual coverage).

Data—specific quantitative and qualitative information or facts that are collected and analyzed.

Effectiveness—the extent to which a program/intervention has achieved its objectives under normal conditions in a real-life setting.

Efficacy—the extent to which an intervention produces the expected results under ideal conditions in a controlled environment.

Efficiency—a measure of how economically inputs (resources such as funds, expertise, and time) are converted into results.

Evaluation—the rigorous, scientifically-based collection of information about program/intervention activities, characteristics, and outcomes that determine the merit or worth of the program/intervention. Evaluation studies provide credible information for use in improving programs/interventions, identifying lessons learned, and informing decisions about future resource allocation.

Gini coefficient—an index of income inequality, with a range from 0 (lowest score of inequality) to 1 (highest score of inequality).

Goal—a broad statement of a desired, usually longer-term, outcome of a program/intervention. Goals express general program/intervention intentions and help guide the development of a program/intervention.

Impact—the long-term, cumulative effect of programs/interventions over time on what they ultimately aim to change, such as a change in HIV infection, AIDS-related morbidity and mortality. Note: Impacts at a population-level are rarely attributable to a single program/intervention, but a specific program/intervention may, together with other programs/interventions, contribute to impacts on a population.

Incidence—the number of new cases of a disease that occur in a specified population during a specified time period.

Indicator—a quantitative or qualitative variable that provides a valid and reliable way to measure achievement, assess performance, or reflect changes connected to an intervention.

Inputs—the financial, human, and material resources used in a program/intervention.

Intervention—a specific activity or set of activities intended to bring about change in some aspect(s) of the status of the target population (e.g., HIV risk reduction, improving the quality of service delivery).

Monitoring—routine tracking and reporting of priority information about a program / project, its inputs and intended outputs, outcomes and impacts.

M&E plan—a multi-year implementation strategy for the collection, analysis and use of data needed for program / project management and accountability purposes.

M&E work plan—an annual costed M&E plan that describes the priority M&E activities for the year and the roles and responsibilities of organizations / individuals for their implementation; the cost of each activity and the funding identified; a timeline for delivery of all products / outputs.

Outcome—short-term and medium-term effect of an intervention's outputs, such as change in knowledge, attitudes, beliefs, behaviors.

Outputs—the results of program/intervention activities; the direct products or deliverables of program/intervention activities, such as the number of HIV counselling sessions completed, the number of people served, the number of condoms distributed.

Performance—the degree to which an intervention or organization operates according to specific criteria/standards/guidelines or achieves results in accordance with stated goals or plans.

Population-based survey—a type of survey which is statistically representative of the target population, such as the AIDS Indicator Survey (AIS), the Demographic and Health Survey (DHS).

Prevalence—the total number of persons living with a specific disease or condition at a given time.

Quality assurance—planned and systematic processes concerned with assessing and improving the merit or worth of an intervention or its compliance with given standards.

Research—a study which intends to generate or contribute to generalizable knowledge to improve public health practice, i.e. the study intends to generate new information that has relevance beyond the population or program from which data are collected.

Results—the outputs, outcomes, or impacts (intended or unintended, positive and/or negative) of an intervention.

Results based management (RBM)—a management strategy focusing on performance and achievement of outputs, outcomes and impacts.

Surveillance—the ongoing, systematic collection, analysis, interpretation, and dissemination of data regarding a health-related event for use in public health action to reduce morbidity and mortality and to improve health. Surveillance data can help predict future trends and target needed prevention and treatment programs.

Target—the objective a program/intervention is working towards, expressed as a measurable value; the desired value for an indicator at a particular point in time.

Triangulation—the analysis of data from three or more sources obtained by different methods. Findings can be corroborated, and the weakness or bias of any of the methods or data sources can be compensated for by the strengths of another, thereby increasing the validity and reliability of the results.

Annex 2: CORE M&E Functions within M&E Units

I. The Monitoring and Evaluation Manager is responsible for:

- Design and review of the overall program monitoring and evaluation (M&E) system;
- Coordinate the development of program M&E framework with key indicators, expected results and periods of measurement and reporting in compliance with national needs and international standards;
- Coordination of the process of development of standard procedures, operational manual and unified reporting and data collection forms;
- Design and review of monthly, quarterly and annual reporting forms for Sub-recipients;
- Design and organization of the process of development of M&E database for primary data collection;
- Coordinate the provision of international consultancy in monitoring and evaluation, surveillance and other areas that directly support the activities of the Program M&E Unit;
- Analysis of data on overall programmatic progress in close collaboration with national consultants;
- Draft aggregate quarterly, annual and interim program progress reports in relation to reporting to the Global Fund to Fight AIDS, Tuberculosis and Malaria and other NTP stakeholders;
- Participation in the development and implementation of a National Tuberculosis M&E Plan;
- Coordination of Program M&E activities with other activities related to monitoring and evaluation of Tuberculosis situation and response in the country as well as with various regional and international initiatives.

II. The Surveillance and Research Officer is responsible for:

- Support to the construction of indicators for monitoring the disease trends and risk behaviors;
- Participation in the development of guidelines, protocols, training materials and data collection forms related to the monitoring of the diseases;
- Collection, processing and analysis of demographic, behavior and social data related to the spread to the spread and the risks of spread of the diseases;
- Preparation of periodic reports and analyzes on the epidemiology of the diseases in the country, the region and globally.
- Coordination of HIV operational research activities including review of the research and evaluation agenda.

III. The Monitoring and Evaluation Officers are responsible for:

- Design and maintenance of a filing system for collecting and storing hard copies and electronic versions of Sub-recipients reports, consultants' reports and other reports on results achieved under the Program;
- Participation in the development of standard procedures, operational manual and unified reporting and data collection forms;
- Review of Sub-recipients reports for conformity with reporting requirements, completeness and quality of data and forwarding SRs' reports for approval;
- Liaise effectively with Sub-recipients, Objective Managers, and consultants to ensure timeliness of report submission and approval;
- Support the Monitoring and Evaluation Manager in preparation of monthly, quarterly and interim program progress updates;
- Participation and coordination of the process of development of M&E database for primary data collection.

IV. The Systems Analyst is responsible for:

- Determination of computer systems and software needs and upgrading
- Maintenance of computer networking
- Ensure safety and confidentiality of information stored in computer system
- Provide continuous protection of the computer systems from viruses

V. The Data Manager is responsible for overseeing:

- Support the design, development, maintenance and improvement of web-based and computer-based electronic systems for data collection, storage and processing;
- Management and regular back-up of electronically stored data;
- Support the development of system for quality assurance of paper-based and electronically entered and stored data;
- Participation in the development of standard procedures, operational manual and unified reporting and data collection forms.
- Supervising the data clerks

VI. The Data Clerks are responsible for:

- Data entry
- Data cleaning
- Participate in data verification exercises
- Prepare summary reports

VII. Statistician

- Collect, analyze, interpret, process and present numerical information provided by the HIV programs
- Determine the sample group parameters
- Support field research

VIII. Epidemiologist

- Design surveys and experiments recommended by the HIV programs
- Create survey question forms
- Recommend appropriate strategic information studies
- Carry out regular reviews of the epidemic

Annex 3: M&E Technical Advisory Committees and Subcommittees

I. National Monitoring and Evaluation (M&E) Technical Advisory Committee Terms of Reference

Background

HIV and AIDS is a multi-sectoral activity and, therefore, many stakeholders are involved in the national response. The government and development partners are guided in this task by the provisions contained in the National Strategic Framework for HIV and AIDS 2010 to 2016. It is therefore, important that all stakeholders in HIV M&E work that are involved in the national response work together in harmony and with alignment to the NSF and the national plan for HIV and AIDS.. The government, civil society, private sector and development partners are guided by the provisions contained in the NSF and the national plan for HIV and AIDS. To operate this, an M&E TAC that meets regularly and includes relevant stakeholders has been established at the national level.

The MoHSS/DSP is tasked by the government to coordinate the monitoring and evaluation (M&E) of the national response to the HIV and AIDS epidemic. Together with all stakeholders it is responsible for the national M&E plan. The MoHSS/DSP needs to issue on a quarterly and annual basis an M&E report on HIV and AIDS to all stakeholders at national, regional and lower levels. The government also has reporting requirements to international and regional commitments, such as the UNGASS Declaration, MDGs, UA and SADC to which Namibia is signatory. As part of the NSF, the NAEC is tasked to monitor implementation of the plan, to regularly discuss progress and constraints, and to report to the National AIDS Council (NAC).

Goal

Establish and maintain partnerships among in-country and international stakeholders who are involved in planning and managing the national HIV M&E system.

Performance Results

To ensure that the following elements are in place:

- A national M&E TAC
- Coordination mechanisms for all stakeholders
- Local leadership and capacity for stakeholder coordination
- Routine communication channels to facilitate exchange of information among stakeholders

Objectives of the M&E TAC

The main objectives are:

- To guide the development of a national M&E framework for HIV and AIDS
- To provide technical advice for the coordination of the national M&E system and to the RM&E Subdivision in the MoHSS DSP
- To verify the quarterly and annual reports
- To share information and ensure alignment and harmonization of all M&E mechanisms, activities and capacity building in Namibia
- To provide advice to quality assurance, data validation and interpretation, and analysis.
- To ensure adequate reporting and dissemination
- To advise the HIV and AIDS RM&E unit on a key set of essential indicators required to monitor the national response
- To assist in mobilizing support for M&E
- To monitor the development of a sustainable national M&E system

Membership

The coordination mechanism for overseeing the M&E in Namibia is the M&E TAC. The M&E TAC is composed of M&E focal points and technical experts from:

Government:

- Ministry of Health & Social Services (Directorate of Primary Health Care [PHC], Division of Epidemiology, Directorate of Policy and Planning & Human Resource Development, Management Information Systems & Research subdivision, DSP, RM&E unit)
- Ministry of Education (MoE)
- National Planning Commission (NPC) Secretariat: Central Bureau of Statistics (CBS)
- Office of the Prime Minister (OPM)
- Ministry of Regional and Local Government, Housing and Rural Development (MRLGHRD)
- National Planning Commission (NPC)
- Ministry of Gender Equality and Child Welfare (MGECW)
- Ministry of Finance (MoF)

Other Stakeholders:

- Namibia Network of AIDS Service Organizations (NANASO)
- Namibia Business Coalition on AIDS (NABCOA)
- The Council of Churches in Namibia (CCN)
- Alliance of Mayors Initiative for Community Action on AIDS at the Local Level (AMICAALL)
- University of Namibia (Population/Research and Multi-disciplinary Research Centre)
- Polytechnic of Namibia
- 2-3 Research Institutions identified

Development Partners:

- The UN, USG and other development partners

Chair and Secretariat

The Chairperson of the committee will be a representative from civil society/private sector/development partner who is skilled in M&E or a person designated by the M&E TAC for this purpose. The Deputy Chairperson will be a nominated representative of the MoHSS from the HIV unit. A person may remain chairperson for 2 years, provided that the person is still a mandated representative of the relevant stakeholder he/she represented when he/she first joined. The chairperson and deputy chairperson will be rotated after 2 years of service.

Secretariat functions: The RM&E unit of the DSP will provide the secretariat functions.

Frequency of meetings

Meetings will occur on a monthly basis on predetermined dates to provide timely progress reporting of activities. Meetings may be called by the Chairperson as determined necessary or on an as-needed basis, according to the situation. The venue of the meeting will rotate as best suits the membership.

Review of Terms of Reference

The TORs will be reviewed annually and changes made as deemed necessary by the M&E TAC.

II. M&E Informatics Subcommittee Terms of Reference

The Monitoring, Evaluation Informatics subcommittee in Namibia is intended to advise on activities concerning Monitoring, Evaluation and Information Systems.

Mandate

The Informatics subcommittee will advise on the implementation of the national M&E system. Specifically this subcommittee will conduct the following activities to fulfill its mandate.

Monitoring and Evaluation

Advise and provide technical guidance in terms of piloting of the national M&E system
 Advise on the operationalization of the activity monitoring report system
 Provide strategic input into the annual review process

Information Systems

Provide a mechanism to evaluate the effectiveness of IS on a periodic basis
Development of system boundary documents and piloting of systems
Ensure that the annual data collection mechanism is supported, functioning and appropriate
Advise the DSP on the maintenance of data, standalone software and the website
Advise on ongoing support and training for the DSP and user agencies

Membership

The membership of this subcommittee will be comprised of appropriate personnel with technical expertise in information systems from the coordinating bodies of the government i.e office of the prime minister, MoHSS, international groups, NGOs and community-based organizations (CBOs). The group will be chaired by an officer appointed by the Director of DSP.

Meeting times

The group will meet on a quarterly basis and ad hoc when need arises. The venue of the meeting will rotate as best fits the membership. On a six-monthly basis the chair of the group will present its progress and key issues emerging to the Director of Special Programs.

Review of Terms of Reference

This TOR will be reviewed annually and changes made as deemed necessary by the M&E TAC.

III. HIV and AIDS, TB and Malaria Research and Surveillance Subcommittee Terms of Reference

This Research and Surveillance sub-committee is intended to provide inputs and technical expertise concerning Research and Surveillance in the field of HIV and AIDS, TB and Malaria to the Research Management Committee (RMC) and RM&E at the MoHSS.

Mandate

The working group will advise on all aspects relating to research and surveillance with regard to HIV and AIDS, TB and Malaria. Specifically this group will conduct the following activities to fulfill its mandate:

Research

- Advise and agree to the National HIV and AIDS, TB and Malaria research strategy
- Participate in appraisal of all HIV and AIDS, TB and Malaria projects submitted for approval to the MoHSS
- May recommend for approval/non approval of all HIV and AIDS, TB and Malaria related research projects submitted for approval to the RMC
- Link collaborating institutions on research to ensure quality results and reporting
- Ensure and support dissemination of all research findings
- Protocol developments and implementation of studies

Surveillance

- Provide technical guidance on surveillance to be undertaken
- Co-ordinate all surveillance done by different agencies to prevent duplication of effort
- Link collaborating institutions on surveillance to ensure quality results and reporting
- Ensure and support dissemination of all surveillance findings
- Protocol developments and implementation of studies

Membership

The membership of this sub-committee will be comprised of appropriate personnel from the HIV and AIDS, TB and Malaria coordinating bodies of the Government (MoHSS), International groups, NGOs, CBOs, and representatives from the research community in Namibia. The group will be chaired by an officer appointed by the Director of Special Programs.

Meeting times

The group will meet on a quarterly basis or adhoc when needed. The venue of the meeting will rotate as best fits the membership. On a six-monthly basis the chair of the Research and Surveillance sub-committee will present its progress and key issues emerging to the Director of Special Programs for information and appropriate action.

Review of Terms of Reference

This TOR will be reviewed annually and changes made as deemed necessary by the M&E TAC.

Annex 4: Early Warning Indicators (EWIs)

Indicator Code	Indicator Description
EWI 1	Percentage of adult patients <i>initiating ART at the site*</i> who are initially prescribed, or who initially pick up from the pharmacy, an <i>appropriate first-line ART regimen</i> (cross-sectional). Target 100%
EWI 1-P	Percentage of paediatric patients <i>initiating ART at the site*</i> who are initially prescribed, or whose care-giver initially picks up from the pharmacy, an <i>appropriate first-line ART regimen</i> (cross-sectional). Target 100%.
EWI 2	Percentage of patients <i>initiating ART at the site*</i> who are <i>lost to follow-up</i> 12 months after ART initiation (cohort). Target <20%
EWI 3a	Percentage of adult patients <i>initiating ART at the site*</i> who are taking an <i>appropriate first-line ART regimen</i> 12 months later (cohort). Target >70%
EWI 3a-P	Percentage of paediatric patients <i>initiating ART at the site*</i> who are taking an <i>appropriate first-line ART regimen</i> 12 months later (cohort). Target >70%
EWI 3b	Percentage of patients <i>initiating ART at the site*</i> whose initial ART regimen was changed during the first 12 months to a regimen that includes a different drug class (cross-sectional). Target 0%
EWI 4a	Percentage of patients who picked up prescribed antiretroviral (ARV) drugs <i>on time</i> (cross-sectional). Target >90%
EWI 4b	Percentage of patients <i>initiating ART at the site*</i> who picked up all prescribed ARV drugs <i>on time</i> during their first 12 months of ART (cohort). Target >90%.
EWI 5a	Percentage of ART patients who attend clinical consultations <i>on time</i> (cross-sectional). Target >80%
EWI 5b	Percentage of patients <i>initiating ART at the site*</i> who attended all scheduled or expected clinical consultations <i>on time</i> during the first 12 months of ART (cohort). Target >80%
EWI 6a	Percentage of months in a designated year in which there were no ARV drug <i>stock-outs</i> (cross-sectional). Target 100%
EWI 6c1	Percentage of patients on ART whose regimen was <i>stopped*, switched, substituted, or incompletely dispensed</i> at the pharmacy due to ARV <i>stock-out</i> in a 12 month period (cross-sectional). Target 0%
EWI 6c2	Percentage of patients <i>initiating ART at the site*</i> whose regimen was <i>stopped, switched, substituted, or incompletely dispensed</i> at the pharmacy due to ARV <i>stock-out</i> during the first 12 months of ART (cohort). Target 0%
EWI 7a	Percentage of patients <i>initiating ART at the site*</i> who demonstrate 100% adherence by pill count (cross-sectional). Target >90%
EWI 8	Percentage of patients <i>initiating ART at the site*</i> whose viral load is <1000 copies/ml after 12 months of ART (cohort). Target >80%

Annex 5: Program Indicators Collected Through the Routine Health Information Systems

Ref. No.	Indicator	Disaggregated by
1	Number of male and female condoms distributed free to the general public	Male/Female, Public/Social marketing, region
2	Number/percent of pregnant women with known HIV status (includes women who were tested for HIV and received their results)	By age group, Known positives at entry; Number of new positives identified, region
3	Number/percent of pregnant women who received HIV counselling and testing for PMTCT and received their test results	By age group, region
4	Number /Percent of HIV-positive pregnant women who received antiretrovirals to reduce risk of mother-to-child-transmission	By age group, region
5	Number/percent of health facilities providing ANC services that provide both HIV testing and ARVs for PMTCT on site	By region, private/public/NGO Mission,; Hospital/health center/ clinic
6	Number/percent of HIV-positive pregnant women assessed for ART eligibility through either clinical staging (using WHO clinical staging criteria) or CD4 testing	By age group, region
7	Number/Percent of infants born to HIV-positive women who received an HIV test within 12 months of birth	By region
8	Number/Percent of infants born to HIV-positive pregnant women who are started on CTX prophylaxis within two months of birth	By age group, region
9	Number/Percent of health facilities that provide virological testing services for infant diagnosis for HIV exposed infants, on site or through Dried Blood Spots (DBS).	By region, private/public/NGO Mission,; Hospital/health center/ clinic
10	Number/Percentage of donated blood units screened for HIV in a quality assured manner	
11	Number of males circumcised as part of the minimum package of MC for HIV prevention services	By age group; region
12	Number of clients circumcised who experienced one or more moderate or severe adverse event(s) within the reporting period	By age group; region
13	Number of persons provided with post-exposure prophylaxis (PEP)	By sex, age group and region
14	Number of individuals who received Testing and Counselling (T&C) services for HIV and received their test results	By sex, age group and region
15	Number/ Percentage of the patient population aged 15 and older who received HIV T&C and received their results through provider-initiated services in the past 12 months	By sex, age group and region
16	Number of HIV-positive persons receiving cotrimoxazole prophylaxis	By sex, age group and region
17	Number of HIV-positive clinically malnourished clients who received therapeutic or supplementary food	By sex, age group and region
18	Number/Percent of HIV-positive patients who were screened for TB in HIV care or treatment settings	By sex, age group and region
19	Number/Percent of HIV-positive patients in HIV care or treatment (pre-ART or ART) who started TB treatment	By sex, age group and region
20	Number/percent of eligible HIV positive patients starting Isoniazid Preventive Therapy (IPT)	By sex, age group and region
21	Number/Percent of TB patients who had an HIV test result recorded in the TB register	By sex, age group and region
22	Number/Percent of estimated HIV-positive incident TB cases that received treatment for TB and HIV	By sex, age group and region

23	Number/ Percent of HIV-positive patients who were screened for TB in HIV care or treatment settings	By sex, age group and region
24	Number of adults and children with advanced HIV infection receiving antiretroviral therapy (ART) [CURRENT]	By sex, age group and region; first and second line
25	Percent of adults and children known to be alive and on treatment 12 months after initiation of antiretroviral therapy	By sex, age group and region
26	Number of health facilities that offer ART	By region, private/public/NGO Mission,; Hospital/health center/ clinic
27	Percentage of health facilities providing ART that experienced stock-outs of ARV in the last 12 months	By region, private/public/NGO Mission,; Hospital/health center/ clinic
28	Percent of filled staff establishments posts for Medical doctors, Nurses and Pharmacists in the public sector.	By type of post
29	Number/Percent of Health Districts submitting timely, complete and accurate HIS reports to the national level per semester	By District
30	Government spending on health as a percentage of total government spending	
31	Number/Percent of batches of HIV pharmaceuticals that have undergone a QA according to national standard procedures.	By type of HIV pharmaceutical

Annex 6: HIV Indicators Collected Through the Non-Health-Facility-Based Routine Data Collection (SPM) System

Ref. No.	Indicator	Disaggregated by
1	Number /percent of schools that have taught life skills based HIV and AIDS education during the last academic year	Primary / secondary schools, region
2	Number of people reached through HIV and AIDS radio and television	By type of media
3	Number of HIV and AIDS radio programs aired	Spots/programs
4	Number of people reached with comprehensive HIV & Sexual Reproductive Health services.	By type of target population
5	Number of People Living with HIV and AIDS (PLHIV) reached with a package of PWP interventions that meet the minimum standards required	By sex, age group and region
6	Number of the targeted population reached with individual, small group level or community preventive interventions that are based on evidence and/or meet the minimum standards required	By level of intervention, sex, age group and region
7	Number of MARP reached with individual and/or small group level interventions that are based on evidence and/or meet the minimum standards	By sex, age group and region
8	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 and AIDS.	By sex, age group and region
9	Number of enterprises (including (OMAs) implementing an HIV and AIDS workplace program, providing at least one of the 4 critical components	By region
10	Estimated number of people reached through work place programs	By age group and region, Public/Private
11	Number/Percent of large enterprises/companies (including OMAS) that have HIV and AIDS workplace policies and programs	By region, Public/Private
12	Number/Percent of SMEs that have HIV and AIDS workplace policies and programs	By region
13	Number of chronically ill people living with HIV who receive home based care, including PLWHA receiving care and support	By sex
14	Number of Home Based Care kits distributed	
15	Number of eligible clients who received food and/or other nutrition services	By region
16	Number of OVCs receiving social welfare grants	By region
17	Number of orphans and vulnerable children receiving comprehensive care and support including psychosocial support	
18	Number/percent of orphans completing school	By sex, Grade 10 &12
19	Number of eligible children provided with shelter and care-giving	By region
20	Number of eligible children provided with health-care referral	By region
21	Number of eligible children provided with Education and/or vocational training	By region
22	Number of eligible adults and children provided with Protection and Legal Aid services	By region
23	Number of eligible adults and children provided with psychological, social, or spiritual support	By region
24	Number of eligible adults and children provided with Economic Strengthening services	By region
25	Number of new health-care workers who graduated from a pre-service training institution	By region, By type of health worker
26	Number of community health and para-social workers who successfully completed a pre-service training program	By region, By type of training and type of health worker

27	Number of health-care workers who successfully completed an in-service training program	By region, By type of training
28	Budget for HIV and AIDS activities in past 12 months	By source, NSF thematic and program area
29	Actual expenditure on HIV and AIDS during the last 12 months	By NSF thematic and program area

Annex 7: Inventory of Prioritized Planned HIV and AIDS Research and Evaluation Studies and Surveys

Goal: To strengthen the capacity of stakeholders to generate data necessary for validating the NSF results	
PREVENTION	When
AIDS Indicator Survey (AIS)	2015
Prevention with Positives (PWP) study	2012/13
Mode of Transmission (MoT) study	2013/14
Namibia Demographic and Health Survey plus (NDHS+)	2012
Study on changing gender norms that support HIV risk behaviors among young men in Namibia	2012/13
Study on condom needs assessment including condom availability and quality assessment in Namibia	2011/12
STI etiological study to determine the etiologies of the three common syndromes	2012/13
Counselling intervention behavior change study (Men's Study)	2012/13
Counselling intervention trial to reduce alcohol-related HIV risks in Namibia	2011/12
Etiological survey for genital infections among HIV-infected adults entering HIV care	2011/12
Exploratory investigation of drinking and sex contexts among women (Women's Study)	2011/12
Exploratory study among vulnerable young women (Women's Study)	2011/12
Formative assessment with recently released inmates in Namibia	2011/12
HIV prevalence survey in Namibian corrections facilities	2011/12
HIV Sentinel Surveillance in ANC clinics	2010/11 2012/13; 2014/15
MSM Size Estimation and Integrated Bio-Behavioral Study (IBBS)	2011
CSW Size Estimation and Integrated Bio-Behavioral Study (IBBS)	2010/11
Shebeen demonstration project (study on alcohol consumption and HIV risk reduction)	2010/11
Study on reaching vulnerable target groups with SRH/STI services	2011/12
Study to strengthen the BCC outreach program	2011/12
Study on Infant and young child feeding in PMTCT	2011/12
Multiple and concurrent partnerships (MCP) evaluation study	2010/11
Process and outcome evaluation of the Windows of Hope Life Skills Prevention Program	2012/13
Study of Health Behaviors After Male Circumcision	2012/13
Effectiveness of a Community Level Intervention on Individual Behavior Change	2011/12
Evaluation of the Communication for Behavioral Impact (COMBI) project	2010/11
Evaluation of the PMTCT programme	2010/11
Evaluation of work place programmes	2010/11
CARE AND TREATMENT	
Study on compliance to guidelines and evaluation of medicines prescription including ARVs	2012/13
Impact of ART adherence interventions study	2012/13
Carry out Public Health evaluation for Palliative Care in Namibia	2012/13
Study on AZT/ANAEMIA	2010/11
Evaluation of an Intervention Toolkit for HIV Care and Treatment Settings	2012/13
Study on improving clinical outcomes through patient education (ART literacy)	2012/13
Nutrition study among people living with HIV	2010/11

TB MDR Survey	Every 2 years
ART Drug resistance Monitoring	Annual
IMPACT MITIGATION	
HIV and AIDS Stigma Instrument (HASI) Index determination	2012/13
Operational Research on Adolescent Girls	2011/12
Risks and Vulnerability to HIV of Adolescents	2011/12
Service coverage of PLHIV in support groups	Every 2 years
Quality of Impact Mitigation Services (QUIMS) survey including OVC policy index determination	2011/12
Study on understanding and reducing sexual vulnerability of adolescent OVC (multi-country PHE w/ Ethiopia & Namibia)	2011/12
RESPONSE MANAGEMENT	
Mid-term Review of NSF	2012/13
End Term review of the NSF	2015/16
Qualitative assessment of the extent to which national policies and legal instruments incorporate human and legal rights	2011/12
Survey of workplace programs in Namibia in the public sector	2011/12, 2013/14, 2015/16
Survey of workplace programs in Namibia in the private sector	2011/12, 2013/14, 2015/16
National Composite Policy Index (NCPI) determination	Every 2 years
National AIDS Spending Assessment (NASA)	Every 2 years
HIV and AIDS Data triangulation	Every 2 years

Annex 8: Recommended Indicators

THEMATIC AREA 5.1 Prevention

Indicator Code	Indicator Description
OC 4	% of women aged 15-24 who had higher-risk sex in the past 12 months with a man who was 10 or more years older
OC 7	% of women and men aged 15-24 & 25-49 who had sex when they were drunk or when their partner was drunk
OP 1	% of in-school youth aged 10-19 reached by skills based HIV prevention within the regular school curriculum in the last year
OP 2	% of in-school youth aged 15-24 reached by skills based HIV prevention within the regular school curriculum in the last year
OP 4	% of schools that provided life skills based HIV education within the last academic year
OP 6	% of CACOCs that reported MCP and other epidemic driver reduction programs that have been implemented in their community in the last 12 months.
OP 9	% of couples reached with small group or individual social and behavior change programs
OP 10	% of women and men aged 15-49 years reached with SB&C interventions on the risk of alcohol abuse
OP 11	% of community leaders & other popular opinion leaders who have been reached by programs to address multiple and concurrent partnerships
OP 12	Ratio of population aged 15-49 to the number of counselling and testing sites
OC 10	% of young women and men aged 15-24 who ever had sex and used a condom the first time they had sexual intercourse
OC 11	% of women and men aged 15-24 who had higher-risk sex in the past 12 months who reported using a condom at last higher-risk sex intercourse
OC 13	% of female sex workers reporting the use of a condom with their most recent client
OC 14	% of men who reported using a condom in their last paid sexual intercourse
OC 17	% of PLHIV aged 15-49 who reported having adopted and adhered to at least 2 key HIV prevention behaviors in the last 12 months
OC 18	% of PLHIV newly tested who reported having disclosed their status to their sexual partners in the last 12 months
OP 19	% of retail outlets and services that reported no condom stock out
OP 20	% of mobile populations who received an HIV test in the last 12 months and who know their results
OP 21	% of prisoners who received an HIV test in the last 12 months and who know their results
OP 22	% of female sex workers who received an HIV test in the last 12 months and who know their results
OP 23	% of MSMs who received an HIV test in the last 12 months and who know their results
OP 34	% primary caregivers reached with male circumcision communication interventions
OP 36	% of HIV exposed infants receiving HIV DNA/PCR test at 6 weeks of birth
OP 37	% of babies of HIV positive pregnant mothers receiving Cotrimoxazole
OP 38	% of male partners of pregnant women who know their HIV status
OP 41	% of people in need of PEP provided with PEP in accordance with national guidelines in the last 12
OP 42	% of rape cases reported at police stations in the last 12 months that have been referred to and screened at a health facility
OP 43	% of health facilities offering care and support services that have at least one medication for treating Herpes
OP 44	Number of clients treated for urethra discharge syndrome in public sector hospitals
OC 21	% of circumcised men aged 15-49 who had higher-risk sex in the past 12 months

	who used a condom with last non co-habiting partner
OC 22	% of circumcised men aged 15-49 years who had sexual intercourse with multiple partners in the last 12 months
OC 23	The total fertility rate
OC 26	% infants younger than 4 months who are exclusively breastfed
OC 28	% of women and men who reported having a genital sore/ulcer in the past 12 months

THEMATIC AREA 5.2: Treatment Care and Support

OC 34	% of households with terminally ill/life limiting (vulnerable persons) and their families, who have reported that they have received CHBC services in the past 12 months
OC 35	
OP 63	% men and women 18-59 yrs, who have been either very sick or who died within the past 12 months after being very sick, whose households received at least one type of free basic external support in the past 30 days
OP 64	% of PLHIV with known status enrolled in PLHIV support groups in the last 12 months.
OP 65	Ratio of number of vulnerable households to number of active HBC volunteers

THEMATIC AREA 5.3: Impact Mitigation

OC 35	% of persons living below the poverty datum line
OC 37	% of OVC aged 5-17 possessing three minimum basic material needs
OC 38	% of women who have made succession plans
OC 39	OVC Policy and Planning Efforts Index
OC 40	Number of vulnerable people (including OVC, PLHIV, women and girl child) who understand their human and legal rights and empowered to access services
OC 41	Number of social welfare and child protection systems strengthened to ensure provision of essential care, support and protection services
OC 42	% of children and OVC younger than 5 who are underweight
OC 43	% of the PLHV malnourished
OP 66	% of vulnerable households reached with sustained support programs in the past 12 months
OP67	% of vulnerable households trained in self sufficiency and livelihood techniques
OP68, OP 69	% of women and men aged 60 years and above who received an old age grant in the past 12 months
OP 70	% of health facilities offering birth and death registration services
OP 71	% of children under five who have a birth certificate
OP 72	Number of OVC receiving psychosocial support services, economic strengthening and shelter and care services
OP 73	Number of children receiving social welfare grants
OP 75	% of OVC completed grade 10 and grade 12 maintained at the rate of non-orphans
OP 76	Number of children attending ECD program
OP 77	% of planned activities in the NPA for OVC implemented and reports submitted
OP 78	Number of policies and bills drafted, promulgated, enacted, and implemented related to protection of OVS
OP 79	% of vulnerable households reached with messages on legal rights and protection services for vulnerable persons
OP 80	Number of service providers trained on referral system for existing legal rights and protection services
OP 81	% of OVC aged 0-17 who received food support in the last 12 months
OP 82	% of households with vulnerable adults aged 18 and older who receive food support
OP 83	% of facilities offering HIV and AIDS Care and Support Services that have fortified protein supplements
OP 84	% of vulnerable households trained in food production techniques

THEMATIC AREA 5.4: Response Management

OC 44	Number of regions, sectors, partner and communities who work together effectively and efficiently
OC 45	The extent to which national policies and legal instruments incorporate human and legal rights that prevent vulnerable people from all forms of discrimination and stigmatization at all levels of society
OC 47	% of self-identifying PLHIV that are formally-employed (in government and other sectors) that report stigma and discrimination as per the HASI index
OC 48	% of all HIV implementers at national, sectors and regions are able to implement the NSF
OC 49	% of communities led efforts to coordinate their local HIV responses?
OC 50	Number of regions and sectors who have mainstreamed HIV, plan and implement their HIV response every year in a collaborative process
OC 51	% of NSF financial resources mobilized and efficiently used
OC 52	% of country's functional M&E system provides indicator values of the NSF results framework indicators
OP 85	Number (and %) of HIV coordinating structures capacitated with clearly defined roles and responsibilities to provide leadership & governance
OP 86	Number of development partners whose coordination systems are harmonized and aligned with the NSF strategies
OP 87	% of strategic sectors that have reviewed their policies and programs and integrated HIV and AIDS activities in their development programs in line with NSF services
OP 88	Number of political and community leaders trained in providing sustained leadership in community planning and implementation of HIV and AIDS related activities
OP 89	% of individuals that have been reached with stigma and discrimination reduction messages
OP 90	% of OMAs that address stigma and discrimination in their workplace policies
OP 91	Number of support groups capacitated to address legal and basic human rights
OP 92	% of individuals that have been reached with human and legal rights education and information messages
OP 93	% of sectors, regions and communities for which HIV capacity assessments have been developed
OP 94	% of established posts of key professionals in the MoHSS in the last 12 months that have been filled
OP 97	% of strategic sectors that have reviewed their policies and programs and integrated HIV and AIDS activities in their development programs in line with the NSF services
OP 99	% of the public sector, civil society and private sector work force accessing quality and comprehensive HIV and AIDS services through workplace Programs
OP 100	% public sectors and regions with annual costed HIV action plans that are harmonized with the GRN financial year
OP 103	% of National HIV and AIDS expenditures that is domestic
OP 104	Number of joint annual review of the NSF that have held annually with a midterm review
OP 105	The national M&E plan and HIV targets have been revised
OP 106	Percent of implementers using standardized M&E tools
OP 107	DHS+, BSS and QUIMS surveys for understanding the epidemic and used to inform end evaluation of current NSF and planning for the next NSF

Proposed Additional and Forthcoming Recommended Indicators by Program Area

The following section includes additional recommended indicators as discussed during program meetings on the M&E plan.

Note: Several program areas are currently either developing new M&E systems or are revising existing systems. As ongoing M&E efforts proceed, additional indicators will be forthcoming: OVC & Gender from MGEW and UNICEF; Ministry of Education; Workplace; Testing and Counselling.

Testing & Counselling: The following indicators have been proposed by WHO to monitor quality of services. Once these are finalized, they will be added to the recommended set.

Indicator Code	Indicator Description
N/A	% trained (certified) providers conducting counselling
N/A	% trained (certified) providers conducting testing
N/A	Number of days/quarter when test kits are out of stock
N/A	Standardized lab register maintained daily
N/A	% clients where consent is obtained
N/A	% operators/sites using correct testing algorithm
N/A	% clients where confidentiality is assured
N/A	% operators/sites participating in EQA with concordant results
N/A	% clients where a risk reduction plan is discussed
N/A	% high risk negatives lost to follow-up
N/A	% individuals receiving same day results
N/A	% clients who take condoms away with them
N/A	% clients who know their status
N/A	% HIV+ve patients enrolled in treatment and care

