MINISTRY OF HEALTH & SOCIAL WELFARE

M & E Framework
for the
Health Sector Response
to HIV and AIDS

2006~2008

KINGDOM OF SWAZILAND
Swaziland

Government

Ministry of Health & Social Welfare

M&E Framework for the Health Sector Response to HIV and AIDS

2006 ~ 2008
Foreword

The pandemic continues to severely affect and threaten the survival of the Swazi population. It has proved not only to be a health or social problem, but even a threat to the national development as whole. In the absence of coordinated efforts to curb the epidemic, the underlying high prevalence of the disease attributed to unsafe sexual behavior, high frequency of sexually transmitted diseases (STDs) and poverty may further propel the epidemic in the country. Swaziland is one of the most affected countries in the World where the national adult HIV prevalence among pregnant women attending ANC was estimated at 42.6 percent in 2004.

Swaziland is one of the signatories of the Declaration of Commitments and initiatives such as the United Nations General Assembly Special Session (UNGASS) on HIV/AIDS in June 2001, whereby countries adopted the establishment of time-bound targets to which governments and the United Nations are held accountable. The main mandate of the Swaziland National HIV and AIDS Control Program of the Ministry of Health is to coordinate and direct the implementation of the health sector response. The establishment of an effective monitoring and evaluation system is therefore essential in order to assess progress made towards minimizing the spread of the epidemic and its impact on individuals, families and the societies at large.

The Ministry of Health and Social Welfare, together with stakeholders, has been working for the establishment and implementation of a functional M&E system to ensure trend tracking on the epidemic, monitoring of the progress made in health sector in combating HIV and AIDS. In this regard, an M&E framework is considered as an important tool to guide the operationalization of the monitoring and evaluation system and the definition of national indicators to be used in assessing health programmes in reaching national and international targets.

Though establishing an M&E system is not an easy task, translating the system into action is much harder and always a challenge. In this regard, I would like to appeal to all stakeholders to continue to support M&E, not only through financial contribution, but also by enhancing the capacity through relevant training and experience sharing. Finally, I would like to take this opportunity to thank partners and individuals that supported the development and finalization of this Health Sector M&E Framework.

[Signature]

MP Njabulo Mabuza
The Honorable Minister for Health & Social Welfare

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Acronyms

AIDS - Acquired Immuno Deficiency Syndrome
ANC - Ante Natal Care
ART - Anti Retroviral Therapy
HIV - Human Immunodeficiency Virus
HIVDR - HIV Drug Resistance
HMIS - Health Management Information System
HSRP - Health Sector Response Plan
HTC - HIV Testing and Counselling
M&E - Monitoring and Evaluation
MOHSW - Ministry of Health and Social Welfare
NGOs - Non Governmental Organizations
NSP - National Strategic Plan
PEP - Post Exposure Prophylaxis
PLWHAs - People Living With HIV and AIDS
PMTCT - Prevention of Mother to Child Transmission
SDHS - Swaziland Demographic and Health Survey
SNAP - Swaziland National AIDS Programme
STDs - Sexually Transmitted Diseases
STI - Sexually Transmitted Infections
TB - Tuberculosis
UNDP - United Nations Development Programme
UNGASS - United Nations General Assembly Special Session on HIV and AIDS
VCT - Voluntary Counselling and Testing
WHO - World Health Organization

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1. Introduction

The Review of the National Response to HIV and AIDS conducted in 2005, focused on key intervention areas among which are Monitoring, Evaluation and Research. One of the findings of the review was that the Monitoring and Evaluation aspects were not receiving all attention required. Indeed, the National Strategic Plan 2001-2005 had no specific monitoring and evaluation strategies, targets on expected outputs and outcomes and no action plan to guide implementing stakeholders.

In addition, there were weak linkages between M&E institutions and little consultations on M&E tools used at different levels for data collection. Mechanisms of information sharing were not clear and the reporting lines were influenced by funding mechanisms.

Following the review, it was recommended that the National Strategic Plan should have a monitoring and evaluation system plan with:

- Indicators to monitor progress in every thematic area
- Coordination mechanisms including definition of responsibilities of different institutions in charge of M&E of the national response to HIV and AIDS.
- Structures and mechanisms for data collection, reporting and dissemination.

As one of the main sector contributing to the national response to HIV and AIDS, it is essential for the Ministry of Health and Social Welfare together with other NGO's providing similar services to have proper tools that will allow monitoring and evaluation of all interventions carried out in the sector.

The aim of M&E Framework for the health sector is to serve as a foundation on which a comprehensive and proper coordinated M&E system will build on.

2. Background

2.1 HIV/AIDS Situation in Swaziland

2.1.1 Epidemiological Situation in Swaziland

According to the sentinel surveillance conducted in 2004 among pregnant women attending ANC clinics, the HIV prevalence was 42.6% whereas it was 3.9% in 1992 (Figure 1). The most affected age group was 25 to 29 with 56.6%, followed by the age group of 20 to 24 with 46.6% of HIV prevalence.

At present, it is estimated that about 210,000 to 230,000 people in Swaziland are living with HIV and AIDS of whom about 60% are women. It has been estimated that about 34,000 PLWHAs with full blown AIDS are in urgent need of antiretroviral treatment.

At the end of 2006, whereas the total number of AIDS patients enrolled in the programme were 23,371, only 17,160 PLWHAs were on treatment which implies that about 6,211 patients (26.6%) have died, lost or defaulted from the programme.

2.1.2 Health Impact

The health sector, which was already facing a certain number of challenges before the hit of HIV and AIDS, has been seriously weakened by this epidemic in terms of Health Care delivery. Indeed, a large increase in patient loads has been reported due to HIV and AIDS. The burden affects almost all services in hospital including laboratories, allied medical staff and catering.

In addition, the number of patients coming to outpatient departments with chronic diseases and complex situations mostly HIV and AIDS related has been dramatic.

The increase of TB patients has been reported as well. In fact, between 1990 and 2004, the number of TB cases has increased from 210 to 820 per 100,000 population because of HIV and AIDS. Consequently, the rate of TB admission in hospitals has been
increased and around 20% hospital deaths are attributed to TB. In overall, it has been estimated that about 80% of TB patients are HIV positive.

2.1.3. Socio Economic Impact

According to the UNDP report of 2005, Human Development Index (HDI) declined from 0.583 to 0.498. The observed decline is attributed to the deteriorating social and economic indicators, mostly as results of HIV and AIDS.

The total population of Swaziland is projected to increase to 1.58 million by 2015, which will be 41% below the expected number in absence of HIV and AIDS.

Indeed, in 2005 alone, it has been estimated that about 16,000 adults and children died from AIDS. If the situation continues to deteriorate, the death rate will increase from 22.7 per 1000 in 2002 to 30.2 per 1000 by 2010 indicating that the AIDS-deaths will be 10 times the non-AIDS related deaths. Life expectancy will decline from 59.7 years in 2001 to 38.3 years in 2015 with loss of 32% of the of highly trained and educated human resources, including health workers in 20 years.

In terms of human resources, a study of the three central ministries of Finance, Economic planning and Development, and Public Services and Information, shows that 32% of the staff will be lost due to the epidemic in 20 years time, requiring an annual replacement of 1.6% to maintain the staffing level.

2.2 National Response to HIV and AIDS

The Government of Swaziland has demonstrated a high level of political commitment to fight HIV/AIDS since the start of the epidemic. The Swaziland National AIDS Programme was established in 1987. A Short-Term Plan (1986-1988) and a Medium-Term Plan (1989-1992) for preventing and controlling HIV/AIDS in Swaziland were implemented, with a focus on providing information, education and communication, promoting and distributing condoms, managing sexually transmitted diseases and ensuring safe blood transfusion.


In 2001, the National Emergency Response Committee on HIV/AIDS was established to replace the Crisis Management and Technical Committee, in coordinating the multisectoral response to the epidemic.

In terms of policy, national policy and strategic plan 2001-2005 on HIV and AIDS prevention and control were developed in 2001. These documents were reviewed in 2004 and new national policy and strategic plan for the period 2006-2008 were developed in 2005.

Regarding Monitoring and Evaluation, a road map along with National Multisectoral HIV and AIDS Monitoring and Evaluation covering 2006-2008 were developed in 2005.

During the past three years, the Ministry of Health and Social Welfare scaled up the key HIV and AIDS related programmes particularly ART, PMTCT, PEP and HTC. With the WHO/Italian Initiative, laboratory services have been strengthened to respond to service and delivery needs.

2.3. Health Sector Response (HSRP) 2003-2005

The MOHSW through SNAP developed the Health Sector Response Plan (2003-2005) to guide the implementation of all health sector based interventions for the three years 2003-2005. The objectives of the plan were to scale up programs, facilitate the integration of HIV/AIDS services, develop partnerships and improve the organisation and management of the programs. At the end of the Health Sector Response Plan (2003-2005) the MOHSW requested technical assistance from WHO to work with a local team to conduct a review of the progress over the 2003-2005 period, and in developing the Health Sector Response Plan for 2006-2008.

The review focused on elements within four broad areas which are management and coordination, prevention, care and support, and the area of monitoring and evaluation. The main findings were:

Management and Coordination

Although many recommended posts have been filled, the management and coordination within the MOHSW and with major partners has not been significantly strengthened. Similarly the co-ordination of funding activities remains loose and fragmented. Recommendations were made on activities that could begin the process of improving the management and co-ordination of the Health Sector Response.

Prevention/Care and support

There have been many significant achievements in these areas. The provision of services has been scaled up through decentralizing and involvement of the private sector and community organizations. However, further integration and packaging of the services offered by the SNAP programs is required, as well as, scaling up of regionally based prevention/care and support activities.
Monitoring and Evaluation

The need for a strong monitoring and evaluation system has been recognized and cannot be overemphasized, and the establishment and staffing of the M&E unit for SNAP demonstrates the national commitment and determination to improve the M&E system. All programs identified monitoring and evaluation as an urgent need and a necessity.


2.4 Health Sector Response Plan (HSRP) 2006-2008

The vision of the health sector is that by 2015, the people of The Kingdom of Swaziland shall have reversed the AIDS epidemic resulting in improved quality of life which will be characterized by reduced HIV and AIDS related morbidity, mortality and socio-economic impact.

Based on the review of the HSRP 2003-2005 and other developments in the fight against the epidemic, key intervention areas with strategic objectives were identified. These are:

- **PMTCT**
  
  **Objective:**
  To reduce the proportion of children (0-4 years) who are HIV positive by 30% by 2008. (NSP Objective 7)

  **Strategies:**
  - Create enabling environment and strengthen national capacity to provide PMTCT services (all four prongs)
  - Build capacity of health care workers to provide quality PMTCT services
  - Strengthen capacity of health facilities to provide quality PMTCT services
  - Facilitate provision and uptake of PMTCT services including primary HIV prevention among men and child bearing women at all levels

- **PRE-ART**
  
  **Objective:**
  Increase to an average of 7 years by 2008, the survival of PLWHAs after HIV testing and before ART. (NSP Objective 25)

  **Strategies:**
  - Develop and introduce a comprehensive national pre-ART care package, including the use of prophylaxis medication and food packages
  - Improve literacy on pre-ART services among the members of the public

- **ART**

  **Objective 1:**
  To increase the number of eligible PLWHAs receiving ART by 75% by 2008 (NSP Objective 22)

  **Strategy**
  Development of national capacity, including capacity of laboratory services to scale-up and provide quality and affordable ART services that address the needs of both the adult and children

  **Objective 2:**
  To increase to 100% by 2008, the proportion of PLWHAs who receive food packages as part of HIV and AIDS clinical management (HAART) (NSP Objective 23).

  **Strategy**
  Introduction of nutritional support as part of a comprehensive ART package

  **Objective 3:**
  To increase to 100% by 2008, the proportion of PLWHAs who receive food packages as part of HIV and AIDS clinical management (HAART) (NSP Objective 23).

  **Strategy**
  Improvement on the quality of nutrition support services to ensure adherence to ART

- **TB/HIV Co-infection**

  **Objective 1:**
  To increase the proportion of persons diagnosed with TB who are tested for HIV from below 50% in 2005 to 100% in 2008. (NSP Objective 26)

  **Objective 2:**
  To establish mechanisms for collaboration of TB/HIV activities at all levels. (NSP Objective 29)

  **Objective 3:**
  To decrease the burden of TB in people living with HIV and AIDS from 50% to 35% in 2008. (NSP Objective 30)

  **Objective 4:**
  To decrease the burden of HIV in TB patients from 78% to 45% in 2008. (NSP Objective 31)
Objective:
Increase the number of PLWHA accessing prevention services and commodities through the health sector to 90% by 2008.

Strategies:
- Build the national capacity to provide positive prevention within the health sector
- Strengthen the capacity of health facilities to provide positive prevention counseling and commodities for PLWHAs
- Use evidence on prevention practices of PLWHA to inform positive prevention activities
- Promote positive prevention for PLWHAs through educational material
- Expand provision of positive prevention services and commodities beyond health facilities

HIV Testing and Counseling

Objective:
To increase the proportion of people who have been tested and know their HIV status from 10% to 40% by 2008. (NSP Objectives 27 & 28).

Strategies:
- Strengthen national capacity to provide HIV testing and counseling at all levels.
- Integrate provider-initiated HIV testing and counseling in clinical care at all levels.
- Strengthen expansion of HTC services beyond health facilities.
- Increase public awareness and uptake of HTC services.

Basic prevention

Objective:
To increase the number of people accessing basic HIV prevention services and commodities through the health sector to 80% of the sexually active population. (NSP Objective 10, 11 & 12)

Strategies:
- Build national capacity to roll out HIV prevention in the health sector
- Strengthen the capacity of health facilities to provide basic HIV prevention services and commodities.
- Expand the provision of basic HIV prevention services and commodities beyond the health facilities through community organization, NGO, and other key partners such as TASC/PSI/FLAS.
- Promote the uptake of core prevention packages provided through the health sector.
- Develop a package for positive prevention and promote uptake

Sexually Transmitted Infections (STI)

Objective:
To reduce the prevalence of sexually transmitted infections by 20% by 2008. (NSP Objective 14).

Strategies:
- Expand the capacity of health facilities at all levels in the public and private sector.
- Integrate STI case management guidelines in pre-service curricula
- Develop and operationalize a national STI surveillance system
- Provide quality STI service at all levels of care

Blood Safety

Objective:
To increase the availability of 100% safe blood and blood products for transfusion in the country by 2008. (NSP Objective 4&5)

Strategies:
- Operationalize the NBTS policy and act
- Expand blood collection programme to 10000 units/year
- Establish a functioning QA system
Community and Home Based Care

Objective:
To increase by 70% the number of people receiving quality HBC services by 2008. (NSP Objective 29 & 30).

Strategies:
- Build the capacity of HBC service providers at all levels (health workers, community care workers and family carers) to provide quality HBC.
- Strengthen the co-ordination of HBC services at all levels
- Improve HBC supply system
- Strengthen the quality of HBC services and referral in the context of the continuum of care for HBC patients
- Build the capacity of service providers at all levels (health workers, community care workers and family carers) to provide quality palliative care.

Workplace Programme

Objective 1:
To establish and strengthen workplace infection prevention and control programmes in all health facilities by 2008. (NSP Objective 15, 16 & 17).

Objective 2:
To provide psychological care and support to 10% facility based health care workers by 2008

Strategies:
- Strengthen national capacity to provide psychological care & support at all levels
- Integrate psychological care & support in clinical care at all levels
- Expand tailored service to health care workers taking account their special needs.
- Build capacity for health facilities to integrate HIV/AIDS workplace programme
- Expand training in IPC to all health workers
- Integrate IPC in health care delivery
- Promote IPC through development and distribution of educational material

Monitoring and Evaluation

Objective:
To establish functional monitoring and evaluation, research and surveillance systems by the end of 2008. (NSP Objective 62, 63 & 64).

Strategies:
- Develop, implement and oversee the health sector HIV/AIDS national monitoring and evaluation system
- Use research findings for strategic planning of HIV/AIDS interventions
- Develop and implement a national HIV drug resistance (HIVDR) surveillance system.
- Build and strengthen M&E capacity at regional and facility level

Management, Coordination, and Partnerships

Objective:
To strengthen management, coordination, and partnership development of the Health Sector Response by 2008.

Strategies:
- Strengthen management and co-ordination at all levels
- Conduct progress reviews
- Develop and adopt the required HR policies and procedures
- Mobilize adequate local and international resources for the health sector response

3.0 Health Sector Monitoring and Evaluation

Monitoring and Evaluation is a critical component of the HIV and AIDS Health Sector Plan. The Ministry of Health and Social Welfare, with support from NERCHA and partners, established an M&E unit in July 2005, which aims at monitoring the activities implemented, services delivered as well as evaluate outcomes achieved and long-term impact made. This framework therefore is anchored on the key strategic objectives of the health sector response.

The Monitoring and Evaluation (M&E) Framework, is designed to measure progress towards the achievement of the HIV/AIDS Health Sector specific goals and targets and at the same time, to contribute to the measuring of the National HIV/AIDS response. In this regard, the present M & E framework has to focus on the following aspects:
- **Coordination**
  To avoid duplication and to allow proper information sharing, it is essential that M&E related activities be coordinated not only between different development partners, but also between different levels of the health system.

- **Management of the information**
  The management of information has been always critical within the health sector. The M&E framework provides opportunities for definition of better information flow and dissemination so that it can be used for decision making at all levels and by all interested parties.

- **Data collection and analysis**
  Data collection constitutes a very important step in generating information needed to assess program performance. In this regard, it is necessary to collect only information considered as essential in decision making. In this context, health workers involved in data collection need to be clearly identified and their tasks well defined. The reporting timeframe also needs to be clearly identified to allow timely analysis.

- **Data collection tools**
  There is a need to define data collection tools for different programs in line with data to be collected in accordance to defined needs. A large concentration between programmes is necessary to avoid duplication in data collection. If required, data collection tools have to be regularly reviewed to meet rising needs and new developments.

- **Feedback**
  After data analysis, a feedback to institutions involved in data collection constitutes a very important component of the information sharing process. It is also considered an appropriate way of motivating those involved in data collection at different levels.

- **Equipment**
  To be able to respond to all requirements in terms of data collection and analysis, all involved entities have to be properly equipped in terms of logistics (computers and all necessary accessories) and communication (telephone, internet etc.).

- **Capacity building**
  M&E is a dynamic process which changes over time, it is therefore necessary to capacitate people involved in data management at all levels in order to meet new requirements and challenges.

### 3.1 M&E concepts

M&E conceptual overview refers to HIV and AIDS Monitoring and Evaluation System Operational Plan, the National Strategic Plan as well as to the Health Sector Response Plan. Core indicators listed in the national M&E framework have been in fact updated in line with the HIV and AIDS Monitoring and Evaluation System Operational Plan, Health Sector Response as well as with international standards.

### 3.2 Justification

The purpose of this M&E Framework is to have a strategy to monitor HIV and AIDS interventions in Health Sector and to assess their impact on the epidemic specifically, this framework aims at strengthening the health sector response to the epidemic by systematically tracking progress made and evaluating its impact. The M&E Framework will also allow Swaziland to meet the national and international reporting requirements.

### 3.3 Goals and Objectives of the M&E framework

The goal of the framework is to provide information that will be used in assessing progress and enhance decision making at all levels in the implementation of the interventions under the health sector response to HIV/AIDS.

The specific objectives are:

i. To promote importance of M&E, the need for systematic data collection and utilization of monitoring and evaluation results in further planning of HIV/AIDS interventions under the health sector response

ii. To strengthen the M&E capacity of the health sector and implementing partners

iii. To increase the understanding of trends and explaining the changes in the levels of HIV/AIDS prevalence overtime

iv. To give guidance to the health sector in order to meet national and international reporting requirements

### 3.4 Key Programmatic Areas of the Health Sector Plan

The Health Sector Plan is guided by the following programmatic areas:

#### 3.4.1 Quality of Care

The plan envisions significant investments to ensure that the highest available quality of care is provided to the people of Swaziland in line with international and local norms and standards. Treating AIDS patients with antiretroviral drugs has been shown in many instances to prolong the lives of people who would have progressed to stage 3 and 4 of AIDS. The care and treatment protocols are based on international best
practice. Accreditation/ initiation procedures help to ensure that the facilities that are approved for the provision of comprehensive care, management and treatment are of good quality and observe the highest standards of care.

The Health Sector Plan also provides for extensive investments in monitoring and research to allow for continual evaluation and improvement in the quality of care. All these efforts will ensure that the best information is available for the benefit of Swazis undergoing care and treatment.

3.4.2 Universal Care and Equitable Implementation
The program is founded upon the principle of universal access to care, management and treatment for all, irrespective of race, color, gender and economic status. This program attempts to address the challenge of providing services in rural and urban settings equitably without compromising the quality of care. The operational plan aims to achieve a balance between areas that can readily implement the program and those that need additional resources and investments to upgrade their general health capacity.

3.4.3 Strengthening the National Health System
The strengthening of the national health system as a whole in order to ensure the effective delivery of comprehensive HIV and AIDS care and treatment is a fundamental principle of the plan. The plan calls for significant additional investments to improve the capacity and capabilities of the national health care system, in particular the strengthening of human resource capacity, and providing incentives to recruit and retain health professionals in even underserved areas and populations. The plan is reinforcing efforts to upgrade health care management information system, to improve patient tracking and referral mechanisms, and to continue with the upgrading and/or refurbishing of public hospitals, health centers and clinics, and to improve efficiency of laboratory services.

3.4.4 Reinforcing the Key Prevention Strategies
In the absence of a cure for AIDS, prevention remains the cornerstone of the country's response to HIV and AIDS. The current range of prevention strategies includes provision of counseling and HIV testing, prevention of mother-to-child transmission (PMTCT), post-exposure prophylaxis (PEP), syndromic management of STIs, TB management, and a large and sustained information, education and communication campaign. Some of these strategies are critical entry points for care and treatment interventions.

3.4.5 Providing a Comprehensive Continuum of Care and Treatment
The comprehensive HIV and AIDS care, management and treatment program embodied in this plan builds on the existing programs as outlined in the Health Sector Response Plan. Prevention of HIV/TB/STIs infections remains the mainstay.

3.4.6 A Sustainable Program
There is currently no cure for AIDS. The best that an AIDS management program can achieve is to prolong the lives of people living with HIV and AIDS, so that they can remain productive members of society. Once people enter into a comprehensive treatment and care program, treatment must be sustained for the rest of their lives. Within the overall stewardship role of government, it is recommended that in order to ensure the sustainability of the programs, a reasonable slice of the budget for the care and treatment program should be considered.

3.4.7 Promotion of Healthy Lifestyles
Any health care program must begin with the promotion of healthy lifestyles, which includes physical exercise, and non smoking, good nutrition, the practice of safe sex, prevention of alcohol and substance abuse and effective prophylactic medical care are fundamental to good health. This remains true for all people - both to prevent the spread of HIV to those uninfected, and to sustain the immune systems of HIV-positive people for as long as possible. This program is integrated with existing health education efforts and other interventions to promote healthy lifestyles among the Swazi nation.

3.4.8 Ensuring the Safe Use of Medicines
If not administered and monitored properly, antiretroviral drugs can become less effective and cause serious side effects as drug-resistant strains of the virus develop. For these reasons, the plan goes to great lengths to monitor patient safety and educate or emphatically counsel on the safe use of medicines and the importance of adherence to treatment.

3.4.9 Drug Resistance
As with TB, poor management and poor compliance with antiretroviral therapy results in multi-drug resistant HIV, which could impact negatively on both diseases. To optimize care for HIV and AIDS patients who also have tuberculosis it is important to develop and sustain joint management programs. Key elements in a containment strategy include the prudent use of antimicrobial agents, educational intervention, good surveillance and monitoring systems in all areas as well as good infection control practice.
4.0 Guiding Principles of the Framework

4.1 The Three Ones principle

The Swaziland HIV and AIDS program is committed to the implementation of the "Three Ones" principles agreed upon by implementing partners during the 2003 ICASA meeting in Nairobi, as a basis for country level action to improve coordination and harmonization of efforts to scale up AIDS response.

The “Three Ones” are:

- One agreed AIDS Action Plan framework that provides the basis for coordinating the work of all partners;
- One National AIDS Coordinating Authority with broad based multisectoral mandate;
- One agreed country level Monitoring and Evaluation (M&E) System.

This framework is a sub component of the national M&E framework and therefore fulfills the "Three ones" principle in Swaziland.

Further to the above, the framework follows the following principles:

4.2 Integration:
The framework advocates for the integration of both routine data with that from sentinel surveillance, behavioural surveys and other qualitative programmatic data. Both clinical and non-clinical data will be analysed and integrated at a central data warehouse, which will be situated at NERCHA and will then be used for the drafting of trend and coverage reports. Integration and harmony will also be maintained with the HMIS unit.

4.3 Centralization and coordination:
Data generated at the health facilities and other service providers will be forwarded to the SNAP M&E Unit for compilation of national aggregates and for use in shaping programs and policies at the national level.

4.4 Decentralization:
Despite emphasis for data flow to the national level, it is however critical that data analysis and use takes place where it is collected before filtering it to the higher administrative levels. The framework advocates for use of this data at all levels to improve coverage and address challenges regarding service utilization, etc.

4.5 Definition of roles and responsibilities:
Data collection and analysis does not take place on its own. Clear roles and responsibilities will be defined at every level.

4.6 Timeliness and reliability:
Emphasis will be on both the reliability of data generated including its submission on agreed upon time frames.

4.7 Compliance:
This framework has to a large extent been informed by existing regional frameworks, while maintaining its simplicity of local context.

4.8 Collaboration:
The implementation of the framework will only be realized through collaboration with all partners implementing HIV and AIDS programs in the clinical setting.

4.9 Simplicity:
The framework advocates for use of simple data collection tools and procedures that do not overburden the program implementers. The system should be simple enough to be used by all relevant stakeholders involved in the HIV response. Even in the absence of computers or electricity shortages, data collection should be maintained and reporting procedures adhered. With time, it is expected that the systems will benefit from modern technology to ease data entry, analysis and transmission.

5.0 OPERATIONALIZING THE M&E FRAMEWORK

5.1 Review and select national level indicators

Building on the national M&E framework, the health sector M&E framework clearly defines all health sector related indicators for specific health interventions, the sources of data for generating each specific indicator and the roles and responsibilities of all partners and stakeholders in actualizing the system.

SNAP will work closely with the Health Management Information System to collect the necessary data for generating reports to assess the status of the national response at a glance. As much as possible the indicators have been selected based on ease of collection putting emphasis on routine data collection systems and resorting to surveys only as a last option. The emphasis will be on the collection of good quality and minimum number of indicators that can demonstrate that we are making a difference and taking cognizant of the Universal Access indicators and targets. With the completion of the 2006 Sentinel Surveillance survey, the ongoing SDHS and the forthcoming 2007 Census, it is believed that most baseline data will be generated for national as well as for the UNGASS and Universal Access. So far the indicators have undergone scrutiny to ensure they are disaggregated by gender and age, and harmonized to the health sector response plan, the National Multisectoral HIV and AIDS strategic plan and the M&E plan.
5.2 Data sources
The main data sources for measuring the indicators include:
1. Routine data from health facilities and other service providers (private and NGOs).
2. Behavioral surveillance surveys
3. Swaziland Demographic and Health surveys
4. The sentinel surveillance Survey.
5. Service availability mapping and quality of services assessment.
6. Health Information Systems database
7. STI surveillance

In line with the three ones principle outlined earlier on in this report, NERCHA is charged with the responsibility of coordinating the national HIV and AIDS response. At NERCHA, there is an M&E Unit whose task it is to coordinate all HIV and AIDS M&E undertakings countrywide. This Unit is expected to liaise closely with the SNAP M&E Unit, which supplies over 80 percent of HIV and AIDS data. The M&E Unit at SNAP is expected to supply aggregated information on a quarterly basis to NERCHA and partners for monitoring the status of activities and impact of the interventions.

5.3 Data Flow arrangement

Note: RHMT consists of Regional health manager, clinic supervisors, PHD sisters, HIV/AIDS coordinators, regional matrons, sisters in charge of programmes, heads of NGO's and hospital administrators

* The RHMT will be assisted by the data management team in capturing regional data from facilities and compiling regional reports

5.4 The roles of SNAP M&E Unit
Working closely with NERCHA, SNAP M&E are expected to play the lead role in coordinating the management of data collection systems for HIV and AIDS at all levels of program implementation. Where there is need to provide analysis and meaning to the health related data, it will be the role of SNAP to partake that task, and compile together with NERCHA non health data to form a joint report of progress, trends and challenges, etc. In addition to the above, the SNAP M&E unit working with the HMIS is tasked with the responsibilities of:
1. Monitoring the implementation of the Health Sector Strategic Plan.
2. Reviewing and evaluating the health Sector Strategic Plan.
3. Disseminating M&E framework to all relevant partners and stakeholders.
4. Building capacity of data gatherers and programme implementers on M&E.
5. Strengthening M&E at regional levels
6. Strengthening weak data collection systems, including data flow and develop non-existent ones such as for HBC, condom logistics and blood safety.
7. Coordinating research on health related HIV and Health issues including bio-medical surveillance, sero-prevalence surveys, facility surveys and population based surveys.
8. Streamlining and developing a reporting relationship with the HMIS for regular reporting of defined indicators, i.e. STI, reproductive health and TB data.
9. Ensuring timely and accurate analysis and drafting of national and regional M&E reports as well as dissemination of the reports to all relevant stakeholders and development partners.
11. Ensure reports from program and research on HIV and AIDS are utilized for policy formulation and programme implementation.
12. Development of the roadmap for the strengthening of the health sector M&E systems.
13. Sharing of local, regional and international experiences.
14. Feedback to program implementers and partners.
15. Bi-annual audit of data collection, quality and data management systems
16. Evaluation of information utilization for policy and programme development
17. Mid and end term review of the data management systems at SNAP.
5.5 The role of Decentralized Levels
Swaziland has adopted a decentralization policy and with it comes the added tasks of reporting based on the implementation of activities at that level. At the facility level, implementers are not only required to complete the necessary reporting tools for submission to the regional health management team, they are also expected to review data as it emerges and analyze trends and progress and use this to resolve any emerging bottlenecks. It is at this level that the data is utilized to improve service delivery. Monthly reports are prepared by implementing health personnel and handed over to the nursing sister in charge, who will then submit reports for all program interventions to the health management information system office. The data should then be forwarded at an agreed upon time frame to the regional health management information system office.

Within the regions, the Regional health management teams' role will be:
- Coordination of data collection, collation and flow in the regions
- Supervision and coordination for data management.
- Ensure HIV and AIDS data is used for programming, planning and advocacy.
- Ensure that data is collated to produce regional aggregates.
- Submit copies of the regional reports to the SNAP M&E unit on a monthly basis.

5.6 Role of development partners
NERCHA in collaboration with development partners will be expected to mobilize resources to implement all M&E initiatives. Donor support is particularly crucial for ensuring that all the planned initiatives are implemented. Besides funding, development partners are required to harmonize their efforts and activities by rallying interventions and support around the third one, and subsequently reducing the burden of having to customize reports to suit various donor agencies. Lastly, in supporting the implementation of the national strategic plans development partners should make it mandatory that 15 percent of funds to programmes is allocated to M&E for them to realize and see results in the key intervention areas.

5.7 Plan for implementation of the M&E framework
In a nutshell this implies that the execution of the framework requires teamwork and coordination in order to fulfill the human, financial and physical resources required to operationalize it. The activities necessary for the operationalization of the framework will include the following:

The specific operationalization of the framework will be planned as follows:

**Phase I (March 2007-April 2008)**
1. Hiring of the SNAP national epidemiologist and M&E coordinator
2. Review of tools to ensure that the necessary elements for selected indicators are captured in the tools
3. Match indicators to data sources and identify gaps for baseline studies.
4. Undertake training needs assessment for regional data support teams.
5. Mapping out of indicators with data sources, data elements and reporting mechanisms and defining timelines for reporting.
6. Development and training on new tools and systems such as the patient and drug management system as well as the home based care system.
7. Dissemination of tools
8. Supervisory visits to check data quality.
9. Definition of roles and responsibilities of reporting entities.
10. Strengthening supervision and coordination of data management at regional levels.
11. Development of a capacity building plan following a capacity assessment.
12. Contributing to the drafting of MoHSW Quarterly Service Coverage Report (QSCR) and the annual report on HIV and AIDS.
13. Assessing and determine infrastructural requirements at regional and national levels.
14. Undertake HIV drugs resistance monitoring survey
15. Completion of service availability mapping report.
16. Provision of data for the UNGASS and Universal Access reports.
17. Developing and costing a roadmap for Health sector M&E initiatives not currently in the national M&E roadmap.

**Phase II (April 2008-May 2009)**
- Continuous routine monitoring.
- Mid term review of the health sector response plan.
- Provision of data for UNGASS and Universal Access.
- Capacity strengthening of regions on data collection, analysis and use.
- Bi-annual audit of data quality, collection and management systems.
- Drafting of quarterly report and AIDS updates.
- Continuous supervisory visits to assess data collection challenges.
- Sentinel surveillance and in ANC, TB and STI.
5.8 Use of Monitoring and Evaluation data
As evidenced in the indicator section, the health sector M&E system will not only collect data for collection sake, but will also ensure that it is of good quality, accurate and available when needed. In the future it will be mandatory for all program implementers to show how they have utilized program data for work planning processes as well as in any issues where strategic decisions need to be made including but not limited to budgeting, progress reviews, quarterly and annual meetings, conferences and symposiums.

5.9 Capacity Building at Facility, Regional and National Level

6. Core Set of Indicators

6.1 Core national indicators by Strategic Objectives
Based on the strategic objectives for HSRP 2006-2008, the following indicators should be collected by the health sector at the national level. Indicators have been listed for the strategic directions falling under the thematic areas of prevention, care & support.

6.1.1 Prevention of mother to child transmission (PMTCT)

Objective:
- To reduce the proportion of children 0–4 years who are HIV positive by 50% by 2008 (NSP Objective 7)

<table>
<thead>
<tr>
<th>Indicators</th>
<th>Data Source</th>
<th>Disaggregation</th>
<th>Reference</th>
</tr>
</thead>
<tbody>
<tr>
<td>Percentage of pregnant women testing positive for HIV during routine PMTCT counseling and testing</td>
<td>PMTCT monthly report forms</td>
<td>Age, Region</td>
<td>UNGASS, NERCHA 1</td>
</tr>
<tr>
<td>Percentage of HIV-positive pregnant women receiving a complete course of antiretroviral prophylaxis to reduce the risk of mother-to-child-transmission</td>
<td>PMTCT monthly report forms</td>
<td>Age, Region</td>
<td>NERCHA19, UNGASS</td>
</tr>
<tr>
<td>Number and percentage of HIV-exposed infants and children seen within 6 weeks of birth and started on cotrimoxazole prophylaxis</td>
<td>PMTCT monthly report forms</td>
<td>Region</td>
<td></td>
</tr>
<tr>
<td>Percentage of facilities offering the minimum package for preventing HIV in infants and young children</td>
<td>SAM Type of health facility</td>
<td></td>
<td>NERCHA 18</td>
</tr>
<tr>
<td>Number of facilities with accessible guidelines on PMTCT</td>
<td>SAM Type of health facility</td>
<td></td>
<td>NERCHA 11</td>
</tr>
<tr>
<td>Percentage of pregnant women making at least one ANC visit who have received an HIV test result and post test counseling</td>
<td>PMTCT monthly report forms</td>
<td>Age, Region</td>
<td>NERCHA 20</td>
</tr>
<tr>
<td>Proportion of children born from HIV+ mothers who received prophylactic dose and test negative at 18 months</td>
<td>PMTCT monthly report forms</td>
<td>Age, Region</td>
<td></td>
</tr>
</tbody>
</table>

6.1.2 Pre-ART

Objective:
Increase to an average of 7 years by 2008 the survival of PLWHAs after HIV testing and before ART (NSP Objective 25)

<table>
<thead>
<tr>
<th>Indicators</th>
<th>Data Source</th>
<th>Disaggregation</th>
<th>Reference</th>
</tr>
</thead>
<tbody>
<tr>
<td>Number of diagnosed AIDS cases in the last 12 months</td>
<td>HIS database</td>
<td>Region</td>
<td>NERCHA 45</td>
</tr>
<tr>
<td>Number of PLWHAs who have enrolled in the pre-ART program</td>
<td>Monthly report forms</td>
<td>Age, Sex</td>
<td>NERCHA 47</td>
</tr>
</tbody>
</table>

6.1.3 Anti retroviral therapy (ART)

Objectives:
- To increase by the average of 5 years the survival of people on ART (NSP Objective 22)
- To increase to 100% by 2008 the proportion of people living with HIV who receive food package as part of HIV clinical management (HAART) (NSP Objective 23)
- To increase the # of eligible PLWHAs receiving ART to 75% by 2008 (NSP Objective 24)

<table>
<thead>
<tr>
<th>Indicators</th>
<th>Data Source</th>
<th>Disaggregation</th>
<th>Reference</th>
</tr>
</thead>
<tbody>
<tr>
<td>Percentage of adults and children with HIV still alive and known to be on treatment 6, 12, 24, 36 months after initiation of ART</td>
<td>ART database</td>
<td>Age, Sex, Region</td>
<td>UNGASS</td>
</tr>
<tr>
<td>Number and percentage of persons on ART who are receiving nutritional support from health care facilities in the last 12 months</td>
<td>WFP records</td>
<td>Age, Sex, Region</td>
<td>NERCHA 44</td>
</tr>
<tr>
<td>Percentage of people with advanced HIV infection receiving antiretroviral combination therapy</td>
<td>ART monthly report forms</td>
<td>Age, Sex</td>
<td>NERCHA 42</td>
</tr>
<tr>
<td>Continuation of first-line regimen at 6, 12, and 24 months after initiating treatment</td>
<td>ART database</td>
<td>Age, Sex, Region</td>
<td>NERCHA 43</td>
</tr>
<tr>
<td>Percentage of health care facilities that have the capacity and conditions to provide advanced level HIV/AIDS care and support services, including provision of ART</td>
<td>SAM, health facility survey; annual</td>
<td>Type of health facility</td>
<td>NERCHA 44</td>
</tr>
<tr>
<td>Existence of national policies, strategies and guidelines for ART</td>
<td>N/A None</td>
<td></td>
<td>NERCHA 46</td>
</tr>
</tbody>
</table>
6.1.4 TB/HIV co-infection

Objective:
- To improve the management of TB/HIV co-infection
- To increase the proportion of persons diagnosed with TB who are tested for HIV from below 50% in 2005 to 100% in 2008 (NSP Objective 26)
- To establish the mechanisms for collaboration of TB/HIV activities at all levels (NSP Objective 29).
- To decrease the burden of TB in people living with HIV and AIDS from 50% to 35% in 2008 (NSP Objective 30)
- To decrease the burden of HIV in TB patients from 78% to 45% in 2008 (NSP Objective 31)

<table>
<thead>
<tr>
<th>Indicators</th>
<th>Data Source</th>
<th>Disaggregation</th>
<th>Reference</th>
</tr>
</thead>
<tbody>
<tr>
<td>16 Number and percentage of newly diagnosed HIV positive clients who are given treatment for latent TB infection (TB preventive therapy)</td>
<td>TB registers</td>
<td>Age, Sex, Region</td>
<td>NERICA 51</td>
</tr>
<tr>
<td>17 Number of all newly registered TB patients who are HIV positive</td>
<td>TB registers</td>
<td>Age, Sex, Region</td>
<td>NERICA 48</td>
</tr>
<tr>
<td>18 Number of registered TB patients who are tested for HIV</td>
<td>TB registers</td>
<td>Age, Sex, Region</td>
<td>NERICA 50</td>
</tr>
<tr>
<td>19 Percentage of smear positive pulmonary TB/HIV co-infected cases that are successfully treated for TB</td>
<td>TB registers</td>
<td>Age, Sex, Region</td>
<td>NERICA 49</td>
</tr>
<tr>
<td>20 Percentage of TB/HIV positive patients initiated on ART</td>
<td>ART database</td>
<td>Age, Sex</td>
<td></td>
</tr>
</tbody>
</table>

6.1.5 HIV Testing & Counselling (HTC)

Objective:
- Increase the proportion of people who have been tested and know their HIV status from 10% to 40% by 2008 (NSP Objectives 27 and 28)

<table>
<thead>
<tr>
<th>Indicators</th>
<th>Data Source</th>
<th>Disaggregation</th>
<th>Reference</th>
</tr>
</thead>
<tbody>
<tr>
<td>21 Percentage of persons who know their HIV status</td>
<td>DHS, HTC monthly report forms</td>
<td>Age, Sex, Region, Disaggregate testing entry point if possible, e.g. ANC</td>
<td>NERICA 35</td>
</tr>
<tr>
<td>22 Percentage of health facilities that offer free routine basic HIV counselling and testing</td>
<td>SAM</td>
<td>Region</td>
<td>NERICA 52</td>
</tr>
<tr>
<td>23 Percentage of in-patients who have received HIV test results and post test counselling in the last 12 months</td>
<td>HIS monthly summary sheets</td>
<td>Type of health facility</td>
<td>NERICA 53</td>
</tr>
<tr>
<td>24 Percentage of counsellors who have received support counselling in the last 12 months</td>
<td>SNAP Psycho-social support records</td>
<td>Sex, Region</td>
<td>NERICA 39</td>
</tr>
</tbody>
</table>

6.1.6 Basic prevention

Objective:
- To increase the number of people accessing basic HIV prevention services and commodities through the health sector to 80% of the sexually active population. (NSP Objectives 10, 11, 12)

<table>
<thead>
<tr>
<th>Indicators</th>
<th>Data Source</th>
<th>Disaggregation</th>
<th>Reference</th>
</tr>
</thead>
<tbody>
<tr>
<td>25 Percentage of health facilities that have achieved accreditation for HTC</td>
<td>HTC program records</td>
<td>Type of health facility</td>
<td></td>
</tr>
<tr>
<td>26 Number of health care workers trained on provider initiated HTC</td>
<td>HTC program records</td>
<td>Region</td>
<td></td>
</tr>
<tr>
<td>27 Percentage of most-at-risk-populations who received HIV testing in the last 12 months and who know the results</td>
<td>Special survey</td>
<td>Age, Sex</td>
<td>UNGASS</td>
</tr>
</tbody>
</table>

6.1.7 Positive prevention

Objectives:
- Reduce HIV transmission rates by empowering people living with HIV AIDS to adopt safer sexual behavior
- Reduce HIV infection risk among most-at-risk populations

<table>
<thead>
<tr>
<th>Indicators</th>
<th>Data Source</th>
<th>Disaggregation</th>
<th>Reference</th>
</tr>
</thead>
<tbody>
<tr>
<td>32 Percentage of facilities providing positive prevention</td>
<td>SAM</td>
<td>Type of facility</td>
<td></td>
</tr>
</tbody>
</table>
6.1.8 Sexually Transmitted Infections (STI)

**Objective:**
- Reduce prevalence and prevent transmission of sexually transmitted infections to reduce HIV transmission

<table>
<thead>
<tr>
<th>Indicators</th>
<th>Data Source</th>
<th>Disaggregation</th>
<th>Reference</th>
</tr>
</thead>
<tbody>
<tr>
<td>33 Percentage of patients with sexually transmitted infections at health care facilities who are appropriately diagnosed, treated, and counselled</td>
<td>Health facility survey, HIS database</td>
<td>Age (&lt;20 and 20 and older), sex</td>
<td>UNGASS, NERCHA 28</td>
</tr>
<tr>
<td>34 Number of STI cases diagnosed in the last 12 months</td>
<td>HIS database</td>
<td>(Age), sex</td>
<td>MoHSW</td>
</tr>
<tr>
<td>35 Percentage of people reporting symptoms of STIs in the last 12 months who sought care at a service provider with personnel trained in STI care</td>
<td>DHS, BSS.</td>
<td>Age, sex, region</td>
<td>MoHSW</td>
</tr>
<tr>
<td>36 Percentage of persons aged 15-49 years who know two or more symptoms of STIs</td>
<td>DHS</td>
<td>age, sex, region</td>
<td>NERCHA 27</td>
</tr>
<tr>
<td>37 Number of young people that have accessed reproductive health services (family planning, STI diagnosis, and HIV testing) in the last 12 months</td>
<td>SRHU</td>
<td>type of health facility, region</td>
<td>NERCHA 31</td>
</tr>
<tr>
<td>38 Percentage of STI service delivery points that have recorded at least one stock-out in the preceding six months</td>
<td>Health facility survey</td>
<td>type of facility</td>
<td>NERCHA 29</td>
</tr>
<tr>
<td>39 Percentage of STI clients who were HIV positive in the last 12 months</td>
<td>HIV STI Surveillance report</td>
<td>Age, sex, region</td>
<td>MoHSW</td>
</tr>
<tr>
<td>40 Number of health workers trained on syndromic management of sexually transmitted infections according to national guidelines in the last 12 months</td>
<td>STI program records</td>
<td>sex, region</td>
<td>NERCHA 30</td>
</tr>
<tr>
<td>41 Percentage of STI clients who receive HTC</td>
<td>STI program records</td>
<td>Region, Age, Sex</td>
<td>MOHSW</td>
</tr>
</tbody>
</table>

6.1.9 Workplace Program

**Objective:**
- To establish and Strengthen workplace infection prevention and control programmes in all health facilities by 2008 (NSP objective 15, 16 & 18)
- To provide psychological care and support to 10% facility based health care workers by 2008

<table>
<thead>
<tr>
<th>Indicators</th>
<th>Data Source</th>
<th>Disaggregation</th>
<th>Reference</th>
</tr>
</thead>
<tbody>
<tr>
<td>42 Percentage of health facilities meeting the minimum requirement for infection prevention control (IPC)</td>
<td>SAM, health facility survey</td>
<td>Region</td>
<td>MoHSW</td>
</tr>
<tr>
<td>43 Percentage of health facilities equipped for PEP</td>
<td>SAM, health facility survey</td>
<td>Type of health facility, region</td>
<td>MoHSW</td>
</tr>
<tr>
<td>44 Number of eligible persons that have undergone PEP treatment in the last 12 months</td>
<td>PEP monthly report forms</td>
<td>Age, Sex, Region</td>
<td>NERCHA 34</td>
</tr>
<tr>
<td>45 Number of emergency service personnel (such as health workers, police service personnel and fire brigade personnel) that have been trained on PEP in the last 12 months</td>
<td>PEP program records</td>
<td>Region, category</td>
<td>NERCHA 33</td>
</tr>
<tr>
<td>46 Number of health personnel that have benefited from psychological care support</td>
<td>HTC psychological quarterly reports</td>
<td>Region, sex, Category</td>
<td>MOHSW</td>
</tr>
</tbody>
</table>

6.1.10 Blood Safety

**Objective:**
- To increase the availability of 100% safe blood and blood products for transfusion in the country by 2008 (NSP Objective 4 & 5)

<table>
<thead>
<tr>
<th>Indicators</th>
<th>Data Source</th>
<th>Disaggregation</th>
<th>Reference</th>
</tr>
</thead>
<tbody>
<tr>
<td>47 Percentage of blood units transfused in the last 12 months that have been adequately screened for HIV according to national or WHO guidelines</td>
<td>NBTS records</td>
<td>None</td>
<td>NERCHA 17</td>
</tr>
<tr>
<td>48 Percentage of health facilities with access to blood transfusion services that adhere to national guidelines</td>
<td>SAM</td>
<td>Type of health facility</td>
<td>NERCHA 16</td>
</tr>
<tr>
<td>49 Percentage of donated blood units that were HIV positive in the last 12 months</td>
<td>Blood transfusion report</td>
<td>Region</td>
<td>NERCHA 3</td>
</tr>
</tbody>
</table>
6.1.11 Community Home Based Care (CHBC)

Objective:
- To increase by 70% the number of people receiving quality HBC services by 2008 (NSP Objective 29 & 30)

### Indicators

<table>
<thead>
<tr>
<th>Indicators</th>
<th>Data Source</th>
<th>Disaggregation</th>
<th>Reference</th>
</tr>
</thead>
<tbody>
<tr>
<td>Number of ART patients reached by community health workers</td>
<td>Program monitoring</td>
<td>Age, sex, region</td>
<td>MOHSW</td>
</tr>
<tr>
<td>Number of home-based care person-visits in the last 12 months</td>
<td>Program monitoring</td>
<td>Age, sex, region</td>
<td>NERCHA 54,</td>
</tr>
<tr>
<td>Number of terminally ill patients receiving palliative care</td>
<td>Community HBC reports</td>
<td>Region, age</td>
<td>NERCHA 56</td>
</tr>
</tbody>
</table>

6.1.12 Monitoring & Evaluation

Objective:
- To establish functional Monitoring and Evaluation, research and surveillance systems by 2008 (NSP 62, 63 & 64).

### Indicators

<table>
<thead>
<tr>
<th>Indicators</th>
<th>Data Source</th>
<th>Disaggregation</th>
<th>Reference</th>
</tr>
</thead>
<tbody>
<tr>
<td>Percentage of facilities submitting timely service reports in line with key reporting indicators</td>
<td>Facility reports</td>
<td>Program type, Region</td>
<td>MOHSW</td>
</tr>
<tr>
<td>Percentage of facilities monitored on data collection at least once a quarter</td>
<td>Supervision reports</td>
<td>Program type, Region</td>
<td>MOHSW</td>
</tr>
<tr>
<td>Number of quarterly monitoring feedback meetings at national and regional levels</td>
<td>M&amp;E Reports</td>
<td>Program type</td>
<td>MOHSW</td>
</tr>
<tr>
<td>Percentage of facilities providing HIV and AIDS services using standardized data collection systems</td>
<td>M&amp;E records</td>
<td>Program type</td>
<td>MOHSW</td>
</tr>
<tr>
<td>Number of information products produced and disseminated per year</td>
<td>Reports</td>
<td>Type of product</td>
<td>MOHSW</td>
</tr>
<tr>
<td>Existence of a comprehensive M&amp;E system in the MoHSW that consists of: an MoHSW HIV and AIDS M&amp;E strategy, an HIV and AIDS M&amp;E unit with full time skilled staff within MoHSW, an annual work plan and budget</td>
<td>M&amp;E records</td>
<td>None</td>
<td>NERCHA 85</td>
</tr>
</tbody>
</table>

6.1.13 Management and Coordination

Objective:
- To strengthen management, coordination and partnership development in the HSR to HIV and AIDS

### Indicators

<table>
<thead>
<tr>
<th>Indicators</th>
<th>Data Source</th>
<th>Disaggregation</th>
<th>Reference</th>
</tr>
</thead>
<tbody>
<tr>
<td>Percentage of partners that express satisfaction with the level and type of services and support provided by MoHSW</td>
<td>MoHSW client satisfaction survey</td>
<td>Type of partner</td>
<td>NERCHA 74</td>
</tr>
<tr>
<td>The existence of an improved organisational structure for coordinating the health sector response</td>
<td>MoHSW records</td>
<td>None</td>
<td>NERCHA 76</td>
</tr>
<tr>
<td>Amount and percentage of HIV funding allocated to MoHSW partners</td>
<td>MoHSW financial records</td>
<td>Type of partner</td>
<td>NERCHA 79</td>
</tr>
<tr>
<td>Average amount of funding allocated to NGOs and private health facilities on the MoHSW’s last financial year records</td>
<td>MoHSW financial records</td>
<td>None</td>
<td>NERCHA 81</td>
</tr>
</tbody>
</table>

6.2 Other areas to be monitored

6.2.1

### Indicators

<table>
<thead>
<tr>
<th>Data Source</th>
<th>Disaggregation</th>
<th>Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>ANC sentinel surveillance</td>
<td></td>
<td></td>
</tr>
<tr>
<td>% of pregnant women testing positive for HIV during sentinel surveillance at selected antenatal clinics</td>
<td>ANC sentinel surveillance; annual or biennial</td>
<td>Age, location</td>
</tr>
<tr>
<td>% of pregnant women testing positive for syphilis during sentinel surveillance at selected antenatal clinics</td>
<td>ANC sentinel surveillance; annual or biennial</td>
<td>Age, location</td>
</tr>
</tbody>
</table>

The above data could be triangulated with any population-based surveys with HIV testing planned.

For each intervention area or strategic objective, an expanded list of indicators could be monitored to track progress. Some common areas that each intervention area should monitor include the monitoring of:

1. Activities planned
2. Existence of appropriate national polices, strategies and guidelines (newly developed, adapted to the new context, or scaled up dissemination or use)
3. Human resources and training (central database to be kept in M&E Unit)
4. Quality of services (through accreditation of service points or other mechanism)

In addition, for each area, special studies and operational research topics should be identified. For example, a special study on issues surrounding ART adherence, whether "positive prevention" is working and how it can be improved, or on how successful STI contact tracing is and ways to improve it, may be of interest.

Although the priority is to ensure the routine monitoring system is functional, future plans to improve M&E can include working towards making links with the central medical store, and creating synergies by collaborating closer with the entire health sector response for purposes such as to identify, assess, communicate and implement new safety concern associated with the use of antiretrovirals and other HIV medicines.

7. INFORMATION PRODUCTS

Information collected and collated from routine data collection, surveys, program reviews, evaluations and other consultative exercises will be compiled as necessary to reports and other information products for sharing, dissemination and documentation by SNAP M&E unit. Information products that may be generated will include but not limited to:

- MoHSW Quarterly Service Coverage Report (QSCR)
- MoHSW Annual HIV and AIDS M&E Report
- Surveys, surveillance and operational research reports
- HIV/AIDS epidemiological updates

7.1 MoHSW Quarterly Service Coverage Report (QSCR)

SNAP M&E will produce a quarterly service coverage report. This report will provide information on coverage statistics per HIV and AIDS programme area, and will be based on the routine data from the Health Sector programme monitoring system. The production of this report will also ensure that MoHSW feeds back to the regions on progress made in service delivery by the health sector.

7.1.1 Purpose of the Report

The purpose of this report is to provide an overview of service coverage in the last quarter. This will inform service providers and funders of interventions, where gaps are and how to maximize resource utilization.

7.1.2 Data Sources for Report

The only data source for this report is the Health Sector Programme monitoring system.

7.1.3 Data Analysis

Following the routine health sector data flow, collection of data will be on a monthly basis from health facilities to the regional HMIS office and sent to the MOHSW HMIS and SNAP M&E office. The SNAP M&E office will then capture the data and compile the Quarterly Service Coverage Report. The QSCR will be made available to NERCHA for compilation of the National QSCR to be disseminated to stakeholders.

7.1.4 Report Format

Every QSCR will contain cumulative data for the year-to-date, the results of previous quarter and the results of the current quarter, to enable trend analysis of individual indicators.

7.1.5 Report Compilation

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

7.1.6 Report Approval

To ensure a fast turnaround time, the following approval channels will be followed:
1. SNAP M&E compiles report
2. Submit to SNAP Programme Manager and MOHSW Directorate
3. Then submit to NERCHA M&E for compilation of national QSCR

7.2 MoHSW - M&E Annual HIV and AIDS Report

7.2.1 Purpose of Report

The purpose of this report is to provide a comprehensive overview of MoHSW's response to HIV and AIDS. This will be done by reporting on all indicators contained in the SNAP M&E Framework. This will assist in informing programme implementation and guidance for future implementation. This report will be procedurally linked to the Government annual work planning and budgeting process to ensure that the information is actually used for decision-making.

7.2.2 Data Sources for Report

The data sources for this report are all the data sources from the SNAP M&E Framework. Should new and improved data sources become available, MoHSW may also wish to supplement this report with additional data sources.

7.2.3 Data Analysis

Following the routine health sector data flow, collection of data will be on a monthly basis from health facilities to the regional HMIS office and sent to the HMIS and SNAP M&E office. On an annual basis, SNAP M&E office will compile an annual
7.2.4 Report Format
The format of this report will be based on the information needs of MoHSW and its stakeholders.

7.2.5 Report Compilation
This report will be compiled on an annual basis by SNAP M&E Unit. The report will be compiled in synchrony with the National Annual M&E Report during January of each year, and will be ready by 1 February every year. This will be in time for the HIV and AIDS M&E Report Dissemination Seminar in March of the same year, and before annual work planning for the next year is concluded.

7.2.6 Report Approval
The following approval cycle has been agreed upon:
1. SNAP M&E compiles report
2. Submit to SNAP Programme Manager and Head Quarters Directorate
   If not approved, SNAP Programme Manager sends report to SNAP M&E for changes
   If approved, SNAP M&E sends report to stakeholders.

8.0 DISSEMINATION TO STAKEHOLDERS
The SNAP M&E Unit will ensure proper dissemination of the critical information to all stakeholders and to the general public. This will be done by using a combination of various methods, amongst which include the following:

1. Regional Quarterly feedback workshops by Regional HIV/AIDS Coordinators to Regional HIV and AIDS M&E Coordinators (REMSHACC).
   Inline with the decentralization of activities, Regional HIV/AIDS Coordinators will provide health related information to the REMSHACC on a quarterly basis and a dissemination workshop to all HIV and AIDS stakeholders held. The purpose of this workshop will be to disseminate results of the previous quarter and plan for the next quarter.

2. Annual HIV and AIDS M&E Dissemination Workshop
   The MoHSW - M&E Annual HIV and AIDS Report will be disseminated to the stakeholders at the annual HIV and AIDS M&E Dissemination Seminar, to be held at the end of March every year. All stakeholders from the public sector, private sector and civil society will be invited to attend. It is envisaged that 1 000 copies of the report will need to be printed in hard copy format to ensure effective dissemination of data to all stakeholders. In addition to the national Dissemination Seminar for the HIV and AIDS M&E results, there might be a need to organize regional dissemination seminars, as well, to ensure distribution to regional levels. The annual meeting will form a basis for refining the national response to HIV and AIDS and reviewing strategies and programmes.

3. A dissemination workshop will be convened with all relevant stakeholders to present the findings of various survey reports including the sentinel surveillance report, service availability mapping (SAM) report Review of this HSRP M&E Framework

The Health Sector Response Plan has a life span of three years 2006 - 2008. The HSRP will be reviewed according to the activities planned. However, this need for revision of this plan needs to be balanced with the need to maintain a solid core set of data to enable trend analysis and programme monitoring over time. An overall comprehensive evaluation of the HSRP 2006-2008 will be held at the end of its life span which is end of 2008.