FINAL REPORT

ON THE

STAKEHOLDERS MEETING

FOR THE

FINALIZATION OF THE DRAFT NATIONAL MONITORING &EVALUATION (M&E) PLAN 2007 -2010

HELD AT

CONFLUENCE BEACH HOTEL, LOKOJA, KOGI STATE, 5TH -7TH FEBRUARY 2007

NATIONAL ACTION COMMITTEE ON AIDS

CONTENT

1.0 INTRODUCTION

The monitoring of the HIV/AIDS epidemic in Nigeria began in 1991 to determine the magnitude and trends of the HIV epidemic in the country by the Federal Ministry of Health. When the country adopted a multi-sectoral and multi-disciplinary approach in responding to the epidemic, HIV prevalence assessment became grossly inadequate as a tool for monitoring the national response. Other systems available for collecting data were uncoordinated and unsystematic. In addition, the systems did not have standardised indicators and data collection methods.

Recognising the need for a robust country monitoring and evaluation system, the National Committee on AIDS (NACA) with support from donors and other stakeholders initiated the development of a National HIV and AIDS monitoring and evaluation framework to guide the national response and provide key indicators for the evaluation of the impact of the various interventions in 2002. The system, coined Nigeria National Response Information Management System (NNRIMS) was officially launched in April 2004. The NNRIMS was developed with the full participation of stakeholders, partners and donor agencies. The NNRIMS consists of outputs, outcome and impact indicators. The framework provides for a system for data flow, sharing and feedback. A key achievement of NNRIMS is the harmonisation and standardisation of key indicators for use by all stakeholders.

NNRIMS also collates and reports on data from important data sources such as: HIV and Behavioural Sentinel surveys, population based surveys (examples are Demographic and Health Surveys, National AIDS and Reproductive Health Surveys), research work, special surveys, program and project reports. Four special surveys are conducted in Nigeria for assessing the impacts and outcome of the national response and to monitor the prevalence of HIV in the country. These are the National AIDS and Reproductive Health Survey (NARHS), the Behavioural Surveillance Survey (BSS), the National Demographic and Health Survey (NDHS) and the HIV Sero-prevalence Survey.

The Nigeria National Response Information Management System was developed to monitor HEAP 2001-2004 which has since expired. From the time NNRIMS was initiated to date, changes have taken place and new policies, programme initiatives and declarations that were not

envisaged at the time have been introduced and scaled up. Moreover additional public and private sector organizations, bilateral and multilateral organizations, CBOs and IPS have joined the national response and are providing services.

Every Funding partner demands strong Monitoring and Evaluation, yet each bilateral and multilateral funding partner has its own M &E system (tools, database, training curriculum, information flow and reporting guidelines) directed towards the projects it supports. Most of the systems do not talk to each other and the national systems and are not sustainable making it difficult to have a nationally harmonized functional M&E system.

Although the NNRIMS document identified a number of indicators to be reported on at national levels, these indicators need to be updated, defined in line with Global guidelines, categorized and selected for each level and sectors. Also NNRIMS does not include an operational plan that links selected indicators with data sources, frequency of reporting, responsibility and capacity for reporting and clearly defined roles and responsibility on information flow at all levels and sectors.

Monitoring and Evaluation is under-funded at all levels and sectors. Even the bilateral funding agencies with better funding for M&E still fall short of the 10% stipulated programme fund allocation to M&E. Most Public, Private and Civil society organizations spend less than 1% of programme fund on Monitoring and Evaluation. The immediate consequence of under-funding of M&E is inadequate human and material resources and skills for high quality M&E at all levels and sectors in Nigeria but if greater harmonization and synergies occurs and resources a re pooled towards developing the National System, as part of the NSF priorities, then much could be achieved within resources currently devoted to M & E.

Given the above context and the current momentum and resources to scale up various HIV/AIDS programmes in Nigeria including prevention, it was imperative for Nigeria to update NNRIMS and develop national M&E plan covering the period of 2007 to 2010. The new plan was developed with wide participation of and through the concession of major stakeholders. This will enable programme implementers to provide various levels of accountability for their activities to their constituencies.

It will also enable NACA, NASCP and other public and private sectors and implementing partners to be able to report accurately, timely and comparable data to national authorities and donors in order to secure continued funding for expanding HIV/AIDS programmes. It will facilitate access to quality strategic information needed to make adjustment and programmatic and technical decisions by programme managers and implementers. It will, finally, improve the services provided to the Nigerian population in all service delivery points in the country

NACA in 2006 produced a draft TOR for updating NNRIMS and drafted the National M&E Plan 2007-2010. The draft was shared with a wide range of stakeholders for inputs and support, and after useful contributions from stakeholders it was approved. A committee comprising UNAIDS, CDC, FMOH, FMOE, USAID, DFID, WB, NACA and Measure Evaluation was constituted to drive the process.

GAMET, WHO and Measure Evaluation provided Technical Assistance in compiling and defining HIV/AIDS indicators to be included in the plan. Apart from the initial visit by GAMET members, a GAMET consultant worked with NACA, NASCP and other stakeholders to produce the first draft of the plan. The M&E Plan development process included the following stages:

National M&E indicators were compiled, harmonized and presented to stakeholders for discussion, and agreed on by stakeholders.

Following consensus on the list of core indicators to be included in the plan, M&E indicator matrix that links selected indicators with data source(s), frequency of data reporting, organizations/sectors responsible for collecting data on the indicators, baseline value for 2005, yearly targets for 2007 to 2009 and data collection tools.

Development of national guidelines that explain how to operationalize the National M & E Plan (2007 – 2010).

As part of the process towards the finalization of the national M&E plan a national stakeholders forum took place in Lokoja, Kogi State from the 5th -9th February 2007. The national M&E stakeholders' forum consisted of 2 segments; the National M&E forum and the Global Fund (GF) forum. The GF segment had in attendance the 3 principal recipients (PRs) and their sub

recipients (SRs) while the national forum was attended by all major M&E stakeholders, policy makers and decision makers. This report documents the activities of the national M&E forum.

1.1 Goals of the National M&E stakeholders' forum

1. To provide a forum for Policy makers, Donors, Implementers and M&E experts to discuss National M&E programmes
2. Make inputs into the National M&E plan 2007-2010
3. Set National M&E priority for 2007
4. Advocate for increased funds for M&E.

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1.2 Objectives of the M&E stakeholders Forum

- Complete the Monitoring and Evaluation Systems Strengthening Tools
- Finalize the National M & E plan (2007-2010)
- Finalize the Revised M & E plan for Global fund Round 5.
- Set National Response M & E priority for 2007
- Produce calendar of key M & E activities for 2007
- Develop capacity building plan to strengthen National M&E System.

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Expected Outcomes from the forum

1. Production of the first draft of the National M&E plan for 2007-2010
2. Production of the first draft of Global Fund Round 5 M&E Plan
3. Report of the assessment of capacity of the National M&E systems
4. Agreed National M&E priority for 2007 with assignment of roles and responsibilities and calendar of key M&E activities.

2.0 INTRODUCTION/OPENING CEREMONY

2.1 WORKSHOP INTRODUCTION

The workshop introduction was by Dr kayode Ogungbemi who presented the workshop goals and objectives and the process of the development of the present draft for review and finalization

2.2 OPENING CEREMONY

The opening ceremony was facilitated by Alti Zwandor (UNAIDS) and she began by inviting the special guests to the high table. Dignitaries present at the occasion were as follows.

- Prof Babatunde Osotimehin, NACA Chairman
- Dr Klint Nyamuryekunge(WHO)
- Kharen Khasan(USAID)
- Roni Babangida Lawal (CiSHAN)
- Chidozie Ezechukwu(NEPWHAN)
- Dr Anette Akinsete(NASCP)
- Emmanuel Emedo (CIDA).

In his opening speech Prof Babatunde Osotimehin acknowledged the partners present at the forum and all members. He stated that the high level participation of numerous stakeholders at the meeting underscores the integrity of the national response in the country. Furthermore he emphasized that this collaboration between partners should be sustained and improved upon. He said the response has to be one with NACA working with NASCP, SACA and other partners. He thanked the development partners, CSOs, participating States for their active participation at this meeting and the funding/technical support given by GF and WHO.

In her opening remarks Karen Khasan (USAID) affirmed that the US Government is a strong support of the '3 ones' principle. She said the US Government is proud to contribute to the planning and development of the national M&E plan 2007-2010 for the country and is willing to continue to support surveillance and surveys especially the new VOXIVA platform.

Chidozie Ezechukwu (NEPWHAN) on behalf of the civil society organization acknowledged the good work of NACA in partnering particularly NEPWHAN both as a body and as individuals. NACA he continued has helped to enhance the capacity of CSOs for program planning &implementation as well as M&E. CSOS he said have often been involved in several decision making bodies on the national response. This he said has helped to foster transparency and accountability.

Dr Klint Nyamurekhenge (WHO) on behalf of the UN system pledged the continued support of the UN system to the national response. He also stated that the UN system willing to collaborate with other partners to ensure even greater success.

3.0 TRAINING METHODOLOGY

The training methods adopted include:

- Short lectures
- Interactive sessions
- Brain storming
- Plenary sessions
- Power point presentation
- Group discussion and presentation

Participants' registration for the workshop commenced on Monday 5th February 2007 on arrival in Lokoja. Facilitators held an orientation/planning meeting at the workshop venue on the same day. Participants at the workshop were drawn from all the states including the 12 Global fund supported states of the country; donor agencies and implementing partners, Global Fund PRs and SRs and other key stakeholders on M&E.

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4.0 WORKSHOP TECHNICAL SESSIONS

4.1 DAY 1 (Tuesday February 6th 2007)

4.1.1 Update of Prevention M&E Activities.

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This was a joint presentation of Federal Ministry of Education (Mrs Z.U. Momodu) and CiSHAN (Mr. Roni Lawal). Highlights of the presentation were as follows.

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-CiSHAN has responsibilities

- for the coordination of all Constituency Coordinating Entities (CCEs) working on HIV&AIDS
- to strengthen the role of the community, CSOs, & networks of PLWHAs in providing and supporting HIV&AIDS treatment & care

-FME has Developed FLHE curriculum, printed and distributed copies to all the states and FCT.

- Trained over 5000 teachers on FLHE curriculum implementation
- Developed an implementation guideline for FLHE
- Conducted Base line survey on HIV&AIDS KABPS among primary and JSS students, teachers and school administrators nationwide
- Put in place a National Education Sector HIV&AIDS Strategic Plan
- Has also put in place National Policy on HIV&AIDS in the Education Sector

Recommendations

- Need for systematic and coordinated involvement of all stakeholders in the implementation of education sector response
- Need for greater strengthening of national, zonal and state coordinating units to improve the CiSHAN's coordinating responsibility.

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4.1.2 Update of OVC Sector M&E Activities

Another joint presentation by FMOWA-OVC unit (Mrs Oby Okwuonu) and USAID (Dr. Ochi Ibe). Key points of this presentation were:

- OVC unit in the FMOWA was established in September 2004 and M&E and data base officers appointed.
- National OVC stakeholders' forum inaugurated in September 2005 and this has facilitated the development of the National Action Plan for OVC and accompanying M&E plan.
- M&E framework & draft tools developed in November 2005.
- Draft National Guidelines and Standard of Practice (SOP) for field level implementation including M&E already adopted.
- Due to almost non-existent M&E capabilities at the community level most programs are guided by anecdotal data rather that evidence based.
- Non existent data on number and location of the OVC
- Inadequate Data Base

- Poor funding for M&E.

4.1.3 National Surveys and Surveillance

This presentation was made by Dr. Issa Kawu (FMOH/NASCP). Highlights of the presentation were as follows:

- The HIV and AIDS epidemic in Nigeria is monitored through the regular conduct of relevant National surveys
- These surveys include general population surveys (e.g.HIV/Syphilis sentinel survey; NARHS) and special surveys (e.g. BSS; IBBS).
- The coordination of these surveys is undertaken by the FMOH in collaboration with partners
- NARHS surveys so far conducted (2003 &2005); 2 BSS Surveys conducted so far (2002 & 2005).
- IBBS intended to replace BSS.
- New surveys, 2 new challenges; need for experience sharing with countries that have conducted these surveys, provision of TA and capacity building of NASCP.
- Estimated Cost to conduct ANC = N246.9m

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4.1.4 Health Sector M&E Update

This was a presentation of NASCP (Dr. Anette Akinsete). The presentation highlighted the following:

- The health sector is broad comprising: Public (Govts: Federal, State, LGA), Private – not – for – profit, Private – for – profit.
- Before 2004, health sector M & E data came only from the biennial ANC Sentinel, NARHS & BSS surveys as well as AIDS case-reporting.
- Situation analysis conducted in 2004 identified M&E as a major challenge in health sector response to HIV & AIDS in Nigeria.
- Health Sector Strategic Plan for HIV & AIDS developed (2005 – 2009).

- "M & E" major priority in the plan with the GOAL: "To establish an M & E system for effective tracking of the HIV & AIDS epidemic and the health sector response"
- Harmonization of the plethora of indicators, tools and processes with the aim of having ONE national M & E system
- Development of a Health Sector M & E Framework/plan that will fit into the National Multisectoral M & E Framework
- Of the 3 health sector programmes identified for immediate M & E, PMTCT M & E most advanced.
- Conducted TOT workshop for 53 core trainers on the use of harmonised PMM forms and ART register (Dec 2006).
- Developed Roadmap for roll out of revised PMM/PME system (Dec 2006).
- PMM tools reviewed and harmonised from an initial 12 and scaled down to 8 which are:

1. ART Patient Card(Adult)

2. Clinical Evaluation Form

3. Pediatric Clinical Evaluation Form

4. Pharmacy order form

5. Laboratory order form (Immunology/Virology order form; Haematology order and result form; Chemistry order and result form; Microbiology order and result form)

6. Adherence Strategy Work plan Form

7. Termination form

8. Registers

- On MMIS, Lab/Blood safety development of tools, indicators have been selected and Development of tools commenced – to be completed 1st Qtr 2007.

Challenges

- Capacity for M&E in NASCP, states, sites remains inadequate.
- NASCP still operates within a bureaucratic system – delays.

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- Manual collation & analysis in NASCP tedious & slow.
- Current drive to recruit & deploy skilled personnel to NASCP (including M&E).

4.1.5 National Multi-Sectoral M&E System (NNRIMS) Update

Dr Kayode Ogungbemi (NACA) gave this presentation on NNRIMS update. The major points of his presentation were:

- NNRIMS contains national core indicators (UNAIDS/UNGASS &Nigeria Specific Indicators) – Impact, Outcome and Output level Indicators.
- NNRIMS contains guidelines for coordinating National M&E activities & reporting.
- Available M&E focal persons in all sectors, states and IPs.
- Improved M&E skills at all sectors
- 35 states have structure and skills to monitor and report on state level M&E programmes.
- CISHNAN at state and national levels have capacity to monitor and evaluate CSO Sect oral programmes
- National M&E TWG established to coordinate and harmonized M&E system.
- Sectoral and state level M&E TWG exists to coordinate monitoring of sector and state specific Programme.
- Platform for Joint Review of national programme established.
- NNRIMS Database developed and installed in NACA and 15 states.
- Training on the use of CRIS conducted for national and state M&E focal persons.
- 18 States produce and share quarterly NNRIMS updates.

Challenges

- Production of NNRIMS Updates commenced in 2005 but irregular.
- Weak capacity for M&E at state and sectoral levels.
- Poor funding of national M&E System
- Proliferation of M&E systems

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- Limitations in indicators.
- Lack of clearly defined roles of stakeholders
- No costed operational plan

4.2 Logistics and Health Program Management Information Platform (LHPMIP)

This presentation was made by Supo Oyedepo (VOXIVA). Key issues of the presentation included the following:

- The purpose of LHPMIP is
    - Timely collection and analysis of data from and communication with the field,
    - Provide HIV/AIDS program managers with the key data necessary to plan effectively monitor and supervise programs,
    - Provide key data for quantification, forecasting and supply chain management.
- The PMT will be responsible for:
    - Participation in development of project work plan.
    - Establishing an effective process to engage key stakeholders throughout the project life cycle.
    - Review and prioritization of system requirements.
    - Review and acceptance of project deliverables.
    - Establishment of enabling environment to maximize the use of ICT to achieve the desired results from this information system.

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4.3 Scaling up towards Universal Access(UA)

This presentation was delivered by Hajiya Maimuna Mohammed (NACA). Components of the presentation include:

The goal of UA is 50% increase in programme and implementation rate and access to a gender sensitive, comprehensive prevention treatment, care and support services for the population without discrimination.

- Scale up at the rate of 10% per annum

- 2007-20%
- 2008-30%
- 2009-40%
- 2010-50%

- End 2006 – Review of Human Resource Management Plan.
- 2007 – Establishment of Staff Motivation Scheme.
- 2007 – 2009 Implement the human resource management plan.
- 2008 – 2010 Full implementation of management plan and motivation scheme.

4.4 Strategic Information Plan

This was a presentation made by Christina Chapell (USAID). Major points of the presentation were:

- Strategic Objectives of this plan are
  - To provide sound monitoring of program services provided by PEPFAR implementing partners
  - To support and strengthen national evaluation systems to help determine, measure and monitor the effect of program activities
  - Provide timely reporting
  - Provide support to the GoN and develop national capacity in strategic information
  - Support the 3 'ones' principle
- Epidemiology and Surveillance activities for 2007 include
  - HIV Sero-prevalence sentinel survey among ANC attendees
  - Integrated bio-behavioral survey
  - NARHS +
  - Facility survey (SPA)
  - Other studies

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- PHE activities
- Epidemiologic reports.

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4.5 National M&E Plan

Dr Greg Ashefor (NACA) delivered this presentation and the highlights of the presentation included the following:

- NNRIMS limitations: Absence of some indicators, No operational plan that links selected indicators with data sources, frequency of reporting, Ill defined responsibilities on information flow at all levels and sectors.
- The goal of the national M&E plan is to track progress in the implementation of the National HIV/AIDS Strategic Framework (NSF).
- Key strategies aimed at achieving the goal of this plan include
    - Strengthen HIV/AIDS electronic information systems at NACA and key institutions.
    - Enhance the capacity of SACAs and LACAs to create and maintain HIV/AIDS databases
- An overview of the sections in the plan includes
- section i: introduction and background
- *section ii:* M&E conceptual framework
- section iii: data collection methodologies
- section iv: resources for national M&E
- section iv: information products
- section v: management of the national HIV/AIDS M&E framework & plan
- section iv: resources for national M&E
- section vii: information products
- section viii: management of the national HIV/AIDS M&E framework & plan
- section ix: budget

- section x: operational work plan

4.6 Group Work on National M&E plan

Participants were assigned to groups to do a group work exercise on the National M&E Plan. The groups were expected to address the issues appropriate to their groups as contained in the National M&E Plan before looking at other M&E issues. The groups along with the task assigned to each of them were:

GROUP 1: Introduction & Conceptual framework

GROUP 2: Core indicators, baseline &setting of targets

GROUP 3: Data collection methodologies & information products

GROUP 4: Resources and Management of national M&E plan

GROUP 5: Health Sector M&E system

GROUP 6 OVC/FLHE data management

GROUP 7: Other prevention M&E

GROUP 8: Other prevention M&E

GROUP 9: Annexes.

5.0 Day 2 (Wednesday 7th February 2007)

Proceedings on day 2 started at 8.30a.m with an opening prayer after which the groups made presentations of the previous day's group exercises

5.1 Group Work Presentation

Group 1: This group's assignment was

- To look at the sections on introduction and conceptual framework in terms of technical correctness and flow
- To check and edit for grammar

Observations by Group 1 include:

- Renumbering of the introduction and the background information
- General editing of the portion assigned to the Group

- Most of the captions on the introductory aspect of the document were restructured, to reflect active verbs
- They provided a brief introduction to the HIV/AIDS situation in the country, as is contained in the National Strategic Framework (NSF), but taking into account the 2005 Sero-prevalence survey
- On page 20, the following amendments were made

  Information products – rather than being left to read as was presented on the document, an amendment was made for it to read thus: "are standard report dissemination documents that **are produced…"**

  M&E Results Chain – ***Process indicator*** was introduced between input and output indicator, as contained in the NNRIMS document

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Group 2: The terms of reference for this group were to:

- Ensure that all outcome and impact indicator targets are in line with NSF targets. Where targets are unrealistic, make a recommendation
- Develop indicator definitions for all indicators using Annex 1
- Provide baseline for all indicators in the draft national M&E plan
- Set realistic targets for each of the indicators for 2007, 2008 and 2009
- Provide assumption of setting the targets and risk assumption for not meeting the target
- Provide information on level of desegregation for each indicator
- The group is expected to do a preliminary work before the stakeholders' forum

Key aspects of Group 2 presentation were that:

- the percentage of age group 15-24 convention on HIV/AID source should be rejected
- Stigma and Discrimination should be deleted as there is no reliable indicator.
- It was mentioned that indicator baseline and target setting needs to be clearly defined
- There is the need to include NBS to the plan of statistics in order to get other information needed which is not captured.

(Group 1) exercise on Indicator reference sheet

	Stigma and Discrimination
Rationale/What It Measures:	This is an indicator based on answers to a series of hypothetical questions about men and women with HIV. It reflects what people are prepared to say they feel or would do when confronted with various situations involving people living with HIV.
Definition:	Percent of women and men aged 15–49 expressing accepting attitudes toward people with HIV, of all women and men aged 15–49 surveyed who have heard of HIV
Measurement Tool:	Population-based survey such as the NDHS, NARHS
Numerator:	Number of women and men who report an accepting attitude on all four of these questions
Denominator:	Number of all women and men aged 15–49 surveyed who have heard of HIV
How To Measure It:	Respondents in a general population survey who have heard of HIV are asked a series of questions about people with HIV, as follows: • If a member of your family became sick with the AIDS virus, would you be willing to care for him or her in your household? • If you knew that a shopkeeper or food seller had the AIDS virus, would you buy fresh vegetables from him/her? • If a female teacher has the AIDS virus but is not sick, should she be allowed to continue teaching in school? • If a member of your family became infected with the AIDS virus, would you want it to remain a secret? The indicator should be reported separately for men and women.
Frequency:	Baseline, then every 2-3 years

Interpretation/ Strengths and Weaknesses:	Methodologically, this is a relatively easy way to construct an indicator of attitudes toward people with HIV. A low score on the indicator is a fairly sound indication of high levels of stigma, and for that reason alone it is worth measuring. There are, however, difficulties in interpreting indicators based on hypothetical questions, and a high score on the indicator is harder to understand. It could mean there is little real stigma attached to HIV. Or it could mean that people know they should not discriminate, and therefore report accepting attitudes. This may not change their behavior, which may continue to be discriminatory toward people with HIV. Changes in the indicator could therefore reflect a reduction in stigma or simply a growing awareness that it is not nice to own up to one's prejudices. That in itself may, however, constitute the first step in program success. High scores may also reflect the respondent's limited personal experience with someone who is HIV-infected. The proposed indicator is similar to an earlier measure developed by WHO, but questions have been changed following field testing to better reflect situations in which people with HIV actually suffer from stigma. Field tests revealed that responses are greatly affected by the exact wording of the indicator. When the gender of the teacher was not specified, for example, one country registered very high levels of "discriminatory" attitudes on that question, for example. Further investigation

Knowledge

Percent of young people aged 15–24 who both correctly identify ways of preventing the sexual transmission of HIV and reject major misconceptions about HIV transmission

Rationale/What It Measures:	HIV epidemics are perpetuated through primarily sexual transmission of infection to successive generations of young people. Sound knowledge about HIV/AIDS is an essential prerequisite—although often an insufficient condition—for adoption of behaviors that reduce the risk of HIV transmission. This indicator allows assessment of progress in achieving universal knowledge of the essential facts about HIV transmission.
Definition:	Percentage of young women and men aged 15–24 who, in response to prompted questions, say that people can protect themselves from contracting HIV by having sex with only one faithful, uninfected partner, and using condoms, who know that a healthy-looking person can have the AIDS virus, and who correctly reject the two most common local misconceptions about AIDS transmission.
Measurement Tool:	Population-based survey such as NARHS, NDHS, BSS (youth)
Numerator:	Number of young women and men aged 15–24 who, in response to prompted questions, say that people can protect themselves from contracting HIV by having sex with only one faithful, uninfected partner, and using condoms and know that a healthy-looking person can have the AIDS virus, and who correctly reject the two

	most common local misconceptions about AIDS transmission.
Denominator:	Number of young women and men aged 15–24 surveyed
How To Measure It:	This indicator is constructed from responses to the following set of prompted questions: 1. Can the risk of HIV transmission be reduced by having sex with only one faithful, uninfected partner? 2. Can the risk of HIV transmission be reduced by using condoms? 3. Can a healthy-looking person have HIV? 4. *Can a person get HIV from mosquito bites?*(this is an example, local misconceptions should be questioned here) 5. *Can a person get HIV by sharing a meal with someone who is infected?*(this is an example, local misconceptions should be questioned here) Those who have never heard of HIV/AIDS should be excluded from the numerator but included in the denominator. Indicator scores are required for all respondents aged 15–24 years and should be reported separately for males and females, according to urban/rural residence. Scores for each of the individual questions (based on the same denominator) are required in addition to the score for the composite indicator.
Frequency:	Baseline, then every 2-3 years

Life-skills-based HIV/AIDS education in schools

Percentage of schools with teachers who have been trained in life-skills-based HIV/AIDS education and who taught it during the last academic year

PURPOSETo assess progress towards implementation of life-skills based HIV/AIDS education in all schools

APPLICABILITY All countries

FREQUENCY Biennial

MEASUREMENT TOOL School survey or education programme review

METHOD OF MEASUREMENT Principals/heads of a nationally-representative sample of schools (to include both private and public schools) are briefed on the meaning of life-skills based HIV/AIDS education and then are asked the following questions:

Does your school have at least one qualified teacher who has

1. 3. received training in participatory
2. life-skills based HIV/AIDS
4. education in the last 5 years?

2.*If the answer to question 1. is "yes":* Did this person teach life-skills based HIV/AIDS education on a regular basis to each grade in your school throughout the last academic year?

The teacher training must have included time dedicated to mastering facilitation of participatory learning experiences that aim to develop knowledge, positive attitudes, and skills (e.g., interpersonal communication, negotiation, decision-making, critical thinking and coping strategies) that assist young people in

maintaining safe lifestyles. Wherever possible, the teacher training
should have been done in accordance with the latest UNICEF guidelines, which can be found at
http://www.unicef.org/lifeskills/index_documents.html.

For the purposes of calculating this indicator, at least 30 hours of
tuition per year per grade of pupil is recommended if life-skills
based HIV/AIDS education is to qualify as standard tuition. However, countries may adjust this number according to local
contexts.

Numerator: Number of schools with staff members trained in and regularly teaching life-skills-based HIV/AIDS education

Denominator: Number of schools surveyed

Indicator scores are required for all schools combined and for primary and secondary schools separately each by private/public status and by urban/rural setting. Church schools should be treated as private schools for this purpose. If school provides both primary and secondary education, information should be collected and reported separately for both levels of education

INTERPRETATION

- It is important that life-skills-based HIV/AIDS education is initiated in the early grades of primary school and then continued throughout schooling with contents and methods being adapted to the age and experience of the students. Where schools provide both primary and secondary education, at least one teacher should have been trained to teach life-skills-based HIV/AIDS education at each of these levels.
- **The indicator provides useful information on trends in the coverage of life-skills-based HIV/AIDS education within schools. However, the substantial variations in the levels of school enrolment must be taken into account when interpreting (or making cross-country comparisons of) this indicator. Consequently, primary and secondary school enrolment rates for the most recent academic year should be included in the supporting information provided for this indicator.**
- Complementary strategies that address the needs of out-of-school youth will be particularly important in countries

where school enrolment rates are low.

- The indicator is a measure of coverage. The quality of education provided may differ by country and over time

PMTCT

Percent of HIV-infected pregnant women receiving a complete course of antiretroviral prophylaxis to reduce the risk of MTCT	
Rationale/What It Measures:	In high-income countries, strategies such as antiretroviral treatment during pregnancy and following birth and use of breastfeeding substitutes have greatly reduced the rate of mother-to-child HIV transmission. In developing countries, significant difficulties exist in implementing these strategies due to constraints in accessing, affording and using VCT and reproductive health and maternal- and child-health services that offer MTCT prevention support. Nevertheless, substantial reductions in MTCT can be achieved in these settings through approaches such as short-course antiretroviral prophylaxis. This indicator allows assessment of progress in preventing mother-to-child HIV transmission.
Definition:	Percent of HIV-infected pregnant women receiving a complete course of antiretroviral prophylaxis to reduce the risk of MTCT
Measurement Tool:	Program monitoring (HMIS) and estimates (modeling)
Numerator:	Number of HIV-infected pregnant women provided with a full course of antiretroviral prophylaxis to reduce MTCT according to the nationally approved treatment protocol (or WHO/UNAIDS standards) in the last 12 months (program reports or HMIS)
Denominator:	Estimated number of HIV-infected pregnant women (modeled)
How To Measure It:	The number of HIV-infected pregnant women provided with antiretroviral prophylaxis to reduce the risk of MTCT in the last 12 months is obtained from program monitoring records. Only those women who completed the full course should be included. The definition of a 'full course' of antiretroviral prophylaxis will depend on the country's policy on antiretroviral prophylaxis to reduce the risk of MTCT and may or may not include a dose for newborns. Details of the definition used should be provided. The number of HIV-infected pregnant women to whom antiretroviral prophylaxis to reduce the risk of MTCT *could potentially have been given* is estimated by multiplying the total number of women who gave birth in the last 12 months (Central Statistics Office estimates of births) by the most recent national estimate of HIV prevalence in pregnant women (HIV sentinel surveillance antenatal clinic estimates). The decision as to whether or not to include women who receive treatment from private-sector and NGO clinics in the calculation of the indicator is left to the discretion of the country concerned. However, the decision taken should be noted and applied consistently in calculating both the numerator and the denominator. Private-sector and NGO clinics that provide prescriptions for antiretrovirals but assume that the drugs will be acquired by the individuals elsewhere are not included in this indicator, even though such clinics may be major providers of MTCT-reduction services. Separate estimates of the numbers of pregnant women provided with antiretroviral prophylaxis at public- and private-sector clinics should be given.

MTCT 2: PMTCT Service Availability – Only NASCP	
Definition	**Percentage of LGAs with at least one health facility providing a complete package of PMTCT services (disaggregated by State and zone)**
Purpose	**To measures PMTCT services coverage in the Country**
Measurement tool	**Mapping, Program reports**
Frequency	**Annual**
Responsible body	**NASCP, FMOH**
Method of measurement	**A list/database is constructed of all centers (private, public or NGO) offering PMTCT services in each of the LGA. The list will also include all PMTCT services provision type including complete package of services and "satellite" PMTCT centres offering only HCT to ANC clients** **Numerator: Number of LGA with at least one PMTCT offering complete package of PMTCT services in the last 12 months** **Denominator: Number of all LGA in the Country** **Note: It is useful if the number of PMTCT centers per 100,000 population is indicated**
Remark	**Method of measurement adapted from UNAIDS and WHO**

MMIS
Proportion of women and men age 15-49 reporting that the last health care injection was given with a syringe and needle set from a new, unopened package

Rationale/What It Measures:	Reuse of injection equipment in health care setting is a potential vector of HIV/AIDS. Thus, the proportion of injections given with reused injection equipment is an important prevention indicator in an initiative to prevent and control HIV AIDS.
Definition:	Proportion of women and men age 15-49 reporting that the last health care injection was given with a syringe and needle set from a new, unopened package
Measurement Tool:	Population survey such as DHS/AIS
Numerator	Number of those men and women from the denominator who mention that the last injection received was given with a syringe and needle set from a new, freshly opened package
Denominator	Number of men and women aged 15-49 who can recall receiving an injection in the last six months
How to measure it:	In a population survey men and women aged 15-49 are asked: • if they have had any injections for any reason in the last six months; • if yes, how many; • among those injections, how many were administered be a doctor, nurse, pharmacist, dentist, or any other health worker; • where the last injection was given; and • for the last injection, did the person who gave the injection take the syringe and

	needle from a new, unopened package.
Frequency:	Baseline, then every 2-3 years
Interpretation/ Strengths and Weaknesses:	Population-based surveys provide a good surrogate measure of the proportion of reuse of injection equipment. Results of combined assessments of injection practices that have used both observational and population-based survey approaches indicate that there is a good correlation between the results obtained with the two methods. Persons interviewed who recall receiving an injection in the last six months but who do not remember the circumstances of it should not be included in the numerator and should not be excluded from the denominator. This lack of recall is an indication of an absence of consumer demand.
Reference(s):	*WHO Injection practices: Rapid assessment and response guide*(2002); WHO Injection Safety CD ROM: *His life and her trust are in your hands*. WHO/HTP/EHT

Comments/issues arising

1. A comment was made that given the terms of reference the number of indicators needed should be taken if not meeting the target might be difficult.

The response to this was that the impact was based on the NSF Target. For ART, universal target was used; looking at what 80% will be in year 2009 will be 240. Based on GF Target, scale up of HCT.

2. On sexual behavior data it was mentioned that we need to be careful in including this indicator in the national data as it can bring about discrimination.

3.On definition of targets there is need to look at the indicators carefully, as some may be used to get information over the allocated timeframe while some could be used for a short time frame

4. On target setting it was mentioned that we need to set realistic targets, there may be need to extrapolate a bit but these needs to be well managed.

5. For C&T, there is need to improve the quality of counseling so that we can get people to come back for their results.

6. It was also mentioned that there is the need to look at the indicators as they are more of the UNGASS indicators.

7. On the issue of evaluation plan we need to look at other studies to include other than the BSS, NARHS and others that we presently have

INDICATORS	Data Source	Frequency of collection	Responsible Organization	Baseline	Target 2009
IMPACT-LEVEL INDICATORS					
A. REDUCTION IN HIV INCIDENCE/PREVALENCE					
Percentage of young people aged 15-24 who are HIV-infected	ANC/General Population Survey	Biennial	FMoH/NASCP	4.3% (2005)	3.2%
HIV prevalence rate in the general population	ANC/General Population Survey	Biennial	FMoH/NASCP	4.4%	3.3%
Percentage of HIV positive infants born to HIV-infected mothers.	PMM/Cohort Analysis	Semi-annual	FMoH/NASCP	not available	not availbale
B. IMPROVEMENT IN LIFE EXPECTANCY OF PLWHA					
Percentage of adults and children with HIV still alive at 6,12 and 24 months after initiation of anti-retroviral therapy	PMM/Cohort Analysis	Semi-annual	FMoH/NASCP	not available	not available
At 6 months					
At 12 months					
At 24 months					
OUTCOME INDICATORS					
Prevention: Knowledge					
Percentage of young people aged 15-24 who both correctly identify ways of preventing the sexual transmission of HIV and who reject major misconceptions about HIV transmission	Population-based survey (e.g. NARHS, NDHS)	Biennial	FMoH, National Population Commission	25.9% (2005)	52.0%

Stigma and Discrimination					
Percentage of the general population with **accepting attitude** toward PLWHA	Population-based survey (e.g. NARHS, NDHS)	Biennial	FMoH, National Population Commission	to be calculated	to be calculated
Percent of people reached with HIV prevention messages dissagregated by media channels	Population-based survey (e.g. NARHS, NDHS)	Biennial	FMoH, National Population Commission		Not required. To be removed
Prevention: Sexual Behaviour					
Percentage of never–married young men and women aged 15-24 who have never had sex.	Population-based survey (e.g. NARHS, NDHS)	Biennial	FMoH, National Population Commission	available	available
Percentage of never married women and men 15-24 who had sex in the last 12 months, of all (never married men and women) respondents.	Population-based survey (e.g. NARHS, NDHS)	Biennial	FMoH, National Population Commission	79.2% (2005)	
Median age at first sex: The age by which one half of young men and women aged 15-24 have had penetrative sex (median age) of all young people surveyed.	Population-based survey (e.g. NARHS, NDHS)	Biennial	FMoH, National Population Commission	M=20.1 F=17.4	
Male				20.10	
Female				17.40	
Percentage of young women and men aged 15-24 who have had sex with a non-marital, non-cohabiting sexual partner in the last 12 month	Population-based survey (e.g. NARHS, NDHS)	Biennial	FMoH, National Population Commission	6.00%	to decrease by 100% by 2009
Prevention: Condom					

Percentage of women and men age (disaggregate by young people and adults) reporting the use of condom the last time they had sex with a non-marital, non-cohabiting sexual partner	Population-based survey (e.g. NARHS, NDHS)	Biennial	FMoH, National Population Commission	55.90%	78.0%
Percentage of high-risk groups reporting the use of condom the last time they had sex (with a non-marital, non-cohabiting sexual partner)	High Risk Survey (BSS)	Biennial	FMoH/NASCP/SFH	Not available	
Percent of sex workers who in the past 12 months did not use a condom consistently during sexual intercourse with a client	High Risk Survey (BSS)	Biennial	FMoH/NASCP/SFH	Not available	
INDICATORS	**Data Source**	**Frequency of collection**	**Responsible Organization**	**Baseline**	**Target 2009**
Prevention: PMTCT					
Percentage of HIV positive pregnant women receiving a complete course of ARV prophylaxis to reduce the risk of PMTCT in accordance with nationally approved treatment	PMTCT/MIS	Quarterly	NASCP		
Percentage of LG with specified no. of service outlets providing PMTCT	PMTCT facility mapping	Semi-annual	NASCP		10PMTCT sites/LG
Prevention: Blood safety/nosocomial/Medical Injection transmission					
Proportion of women and men aged 15-49 reporting that the last health care injection was given with a syringe and needle set from a new , unopened package	Population-based survey (e.g. NARHS, NDHS)	Biennial	FMoH, National Population Commission	not available	

Average number of injections per year	Population-based survey (e.g. NARHS, NDHS)	Biennial	FMoH, National Population Commission		
Percentage of blood units transfused in the last 12 months that have been screened for HIV	Special survey	Biennial	FMoH/NBTS		
Prevention: Sexual Transmitted Infections					
Percentage of health facilities with capacity to appropriately diagnosed, treat and counsel patients with STI	Health facility survey	Biennial	FMoH/NASCP	Not Available	
HIV Counselling and Testing					
Percentage of individuals who ever received counseling and testing for HIV and received their test result	Population-based survey (e.g. NARHS, NDHS)	Biennial	FMoH, National Population Commission	8.30%	20.0%
Percentage of high risk groups who received HIV counseling and testing services in the last six months.	High Risk Survey (BSS)	Biennial	FMoH/NASCP/SFH		
Percentage of LG with specified no. of service outlets providing CT	Health facility survey	annual	FMoH/NASCP	not available	50.0%
Treatment					
Percentage of people with advance HIV-infection receiving (current) antiretroviral combination therapy	PMM	Semi-annual	FMoH/NASCP	18.00%	80.0%
Percentage of LG with specified no. of service outlets providing care and treatment	Health facility survey	annual	FMoH/NASCP	not available	50.0%
Percentage of designated laboratories with the capacity to monitor antiretroviral combination therapy according to national and international guidelines	Health facility survey	annual	FMoH/NASCP		Deleted

OVC					
Percentage of orphans and vulnerable children whose house holds received free basic external support in caring for the child	Population-based survey (e.g. NARHS, NDHS)	Biennial	FMoH, National Population Commission	not available	
Ratio of current school attendance rate among orphans to that among non-orphans, aged 10-14	Population-based survey (NHDS)	5-years	NPC	Not available	
Monitoring and Evaluation					
Percentage of service delivery points submitting timely and complete reports.	Program	Semi-annual	Line Ministries/NACA/SACAs	not available	100.0%
Percentage of orgnizations with functional M&E systems	Program	Semi-annual	Line Ministries/NACA/SACAs	not available	100.0%
Policy and Coordination					
Percentage of Line Ministries and Large Enterprises/Companies that have HIV/AIDS workplace policy and programs	Work-palce survey	Biennial	FMoL&P/NiBUCA	47%	70.0%
National AIDS program effort index	Special Survey	Biennial	NACA	67.0% (2005)	84.0%
Percentage and amount of national funds disbursed by governments on HIV/AIDS	Special Survey	Biennial	NACA	not available	
INDICATORS	**Data Source**	**Frequency of collection**	**Responsible Organization**	**Baseline**	**Target 2009**
OUTPUT INDICATORS					
Prevention: Knowledge					

Number of teachers who have been trained in life-skills based HIV/AIDS education and who taught it during the last academic year.	Program Review/data	annual	FMoE		
Number of people trained to provide HIV/AIDS peer education	Program Report/Service Report	Semi-annual	FBOs/Red Cross, CSOs, ARFH, UNICEF		
Number of high risk groups reached with HIV/AIDS prevention programs.	Program Report/Service Report	Semi-annual	CSOs/Line Min istries		
Prevention: Condom					
Total number of condoms distributed by social marketing outlets in the country.	Program Report	annual	Social Marketing Agency (UNFPA, SFH, PPFN)		
PMTCT					
Number of pregnant women who received HIV counseling and testing for PMTCT and received their test result	PMTCT/MIS	Quarterly	NASCP		1,720,192
Number of women receiving a complete course of antiretroviral prophylaxis to reduce the risk of mother to child transmission	PMTCT/MIS	Quarterly	NASCP		130,735
Number of health facilities providing a minimum PMTCT package	Health-facility survey	2-year	NASCP		
CT					
Number of people provided with Counseling and testing for HIV and received their test results.	Program Report	Semi-annual	FMoH/NASCP (SDPs)		5,045,898

Number of HIV counseling and testing service outlets	Program Report	Semi-annual	FMoH/NASCP (SDPs)		
TREATMENT					
Number enrolled in HIV care: (a)new and (b) current (c) cumulative ever at the facility by age and sex	Program Report (PMM)	Semi-annual	FMoH/NASCP		1,226,564
Number started on ART: (a)new (b)current and (c)cumulative ever started at the facility	Program Report (PMM)	Semi-annual	FMoH/NASCP	80,000 (2006)	550,000
Number currently on ART at the facility (at the end of reporting period)	Program Report (PMM)	Semi-annual	FMoH/NASCP		
Number of service delivery points providing anti retroviral combination therapy	Program Report (PMM)	Semi-annual	FMoH/NASCP		
PALLIATIVE CARE					
Home Based Care					
Number of HIV/Positive people receiving Home based care	Program Report	Semi-annual	NGOs		
TB/HIV Collaboration					
Number of patients currently on care who are receiving INH prophylaxis (No of HIV Client on care who are receiving TB preventive therapy)	Program Report (PMM)	Semi-annual	FMoH/NASCP		
Number of HIV patients currently in care who are receiving TB Rx	Program Report (PMM)	Semi-annual	FMoH/NASCP		130,735
Opportunitinic Infections					
Number of people with HIV receiving cotrimoxazole prophylaxis	Program Report (PMM)	Semi-annual	FMoH/NASCP		806,564
OVC					

Number of orphans and vulnerable children whose house holds received free basic external support in caring for the child	Program Report	Semi-annual	FMoW/UNICEF/NGOs		
Number of OVCs receiving support by OVC programs	Program Report	Semi-annual	FMoW/UNICEF/NGOs		
Monitoring & Evaluation					
Number of SACAs and LACAs disseminating updated HIV information to stakeholders quarterly	Program	Semi-annual	Line Ministries/NACA/SACAs		
Number of Organizations provided with a formal training in M&E	Program	Semi-annual	Line Ministries/NACA/SACAs		

Group 3 Presentation

The group's assignment was to take a critical look at sections III and IV of the National M&E plan with a view to reaching a consensus, finalizing and editing the following topic areas. The summary of their presentation was as shown below

Group 3

Summary of Comments

General Comments:

- The flow of the Text:. It was noted that the flow of the text was not well presented; the technical group needs to work on this.
- Data should be analyzed at point of collection to encourage utilization at all level
- All tools should be harmonized by all technical group concerned
- Data Flow chart: Where the data flow chart appears is not relevant, where it is relevant there is no feedback.

Specifics Comment:

A. Logistics Management Information System should include:

- RTKs and Lab reagents
- OIs and PMTCT commodities

Should be harmonized by technical groups

B. Comment: The document should include list of tools, roles and responsibilities, data flow and programmes within Line ministries e.g. FMoE, FMoW. There should be deliberate effort by NACA to institutionalized M&E in all ministries.

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C**.** The committee also noted that we share results in most Cases but not Processes and Best practice

Group 4 Presentation

The group's assignment was to look at sections V and VI of the National M&E plan in terms of reaching a consensus, editing and finalizing the following topics

- Human capacity to implement National M&E plan.
- Skill development for implementation of National M&E plan.
- Management and monitoring the implementation of the National M&E plan.
- National M&E TWG and decentralized M&E TWG.
- Programme Evaluation.
- Quality assurance of data and services

The group edited the sections assigned to them and made additions/changes which are expected to be reflected in the final draft M&E plan.

Group 5 presentation

The group looked at the available national tools, their status and was to decide on the full operationalization of the following programmes. Key observations by the group include

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On Blood safety, HBC & STI:

- Tools are unavailable.

On ART

- Indicators are not arranged by programme areas
- Data source, frequency of collection (Pg 69 row 5) should read cohort analysis and annually respectively
- The word advanced should be removed/ struck out (Pg 74 row 8)
- On the same page and row we seek clarification what the data source should be; PMM-system or ART-MIS.
- Still on the same page row 9; clarifications is sort on what the specified number should be.
- Page 75; row 10; the word current should be removed from the indicator column

On PMTCT

- 6 out of 8 Tools were not physically available but a team member guided us having a prior knowledge of the content.
- Page 69, row 5; replace data source and frequency of collection with PMTCT MIS and annually respectively.

- Substitute MTCT for PMTCT and also clarification is sort on what the specified no. Should be on page 73 of rows 3and 4 respectively.
- Page 74,4th row; is a repetition and needs to be removed.

On HCT

- Page 74, clarification is sort for the specified number.
- Data source on page 75, row 6; should be the HCT register.
- The phrase on page 20, 3rd row of the Health sector M&E plan should be transferred to National M&E draft document.
- All tools should be made available electronically.

The following are the gaps identified:

- Unavailability of HBC, Universal precaution (Blood safety, PEP, MMIS) & STI tools.
- Inadequate manpower at all levels
- Inadequate resources for M&E
- No timeline for reporting
- The National M& E system is not integrated into the National Health Management Information System.

Group 5 Recommendations

Intervention	Responsible	Time
Unavailable tools should be developed and made available	NASCAP, relevant partners/ agencies	March, 2007
PMTCT register to be made available	NASCP	Immediately
Recruit and deploy appropriate manpower	FMoH/SMoH	31st March,2007
Regular training and re-training	Government and Stakeholders	Start training by Feb,2007
There should be a budget line in FMoH & SMoH for M&E. 15% of the budget (of FMoH & SMoH) should be earmarked for M&E		
Agencies and partners with requisite M&E skills should transfer their skills to desk officers at the National, State and L.G.A levels	Agencies	On-going

Group 6 Presentations

The group looked at the available national tools, their status and was to decide on the full operationalization of the following programmes.

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- OVC
- FLHE

Some of the group's observations were as follows:

- Adequate tools for data collection are available
- There is the need for capacity development for collation, analysis and reporting
- The national indicators need to be modified to accommodate some of the Core indicators of the draft M&E Plan for the National Plan of Action for OVC
- The 3 indicators in the National M & E Plan should be split into 4 (2 on outcome and 2 on output)
- There should be distinct focus on the OVC and households for outcomes and outputs, e.g.

  -% of orphan and vulnerable children who received free basic external support";

  -% of households with orphan and vulnerable children that received free basic external support

  -Consider deleting "by OVC program" from the third indicator "the number of OVC receiving support by OVC programs
- The following were noted as limitations in the tools:
  - Other vulnerability grouping should be included as described in the NPOA for OVC
  - Number of trained OVC caregivers is not captured in the indicators
  - Capacity building for care givers and service providers (CSO) was not reflected in the national indicators
- Collected data will capture indicators that will be reported on and in line with the NSF
- Technical Assistance Plan would need to focus on human and institutional capacity building for data management at all levels

On FLHE the group observed that

- Adequate tools for data collection are available: assessment questionnaire, checklist
- One of the 4 indicators in the National M & E Plan captures OVC issues

- The tools may not capture all in-school extra-curricula activities on HIV prevention among young people, e.g. the NYSC and other CSO interventions
- The group drew attention to some editorial mistakes in the National M & E Plan
- Although Section C in the National M & E Plan makes provision for other Line Ministries (p.40), perhaps there is the need to reflect national responses from the other organs of government such as the NYSC and other key CSOs that may feed into the Non Health Sector Response Management Information System
- All sectoral responses to create distinct links in their data flow chart to the NNRIMS

Group 7 presentation

The group was assigned to look at available national tools/protocol for the following programmes, their status and decide on their full operationalization

- NARHS
- BSS
- ANC Sentinel survey
- Health Facility assessment
- Education facility assessment
- Socioeconomic impact study
- OVC Survey
- Workplace intervention

Some of the group's observations were as follows

On NARHS

Roles and responsibilities of partners

- SFH implements
- WHO, UNAIDS, UNFPA, UNICEF provided Technical Assistance
- DFID and USAID provided funds
- FMoH owns it

Estimate response for financial resources

- About two hundred million Naira

TA Plan for NARHS

- Set up technical working group
- Organise meetings
- Development of research instruments

- Pre testing of instruments
- Selection of research agencies
- Training of research agencies
- Implementation of plans

Issues to be addressed (on NARHS)

- For some target sets, how realistic are those they?
- Indicator reference sheet should be provided for these indicators
- Data flow on page 41 seems not appropriate
- There should be feedback on survey findings

On BSS

Estimate response for financial resources not known

TA Plan (BSS)

- Set up technical working group
- Organize meetings
- Development of research instruments
- Pre testing of instruments.
- Selection of research agencies.
- Training of research agencies.
- Implementation of the plans.

Deleted: Organise

Dissemination plan

- Who funds the national dissemination workshop and who are the participants?
- Specify the relevant stakeholders

Issues to be addressed

- Specify the target groups rather than using the phrase "special groups"
- How realistic are the targets?
- Mention all the stakeholders involved and clarify roles & responsibilities.

ANC Sentinel Survey

- M&E plan does not have indicator(s) to be tracked in ANC sentinel survey.
- Tools not available for review

It was recommended that OVC and socioeconomic study be part of other major surveys.

Group 8 Presentation

The group looked at the available national tools, their status and was to decide on the full operationalization of the following programmes.

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- BCC by types of media
- Peer education
- Advocacy
- Stigma and discrimination, Human rights.
- Condom Distribution.

The findings of this group were as shown in the table below:

PROGRAMME AREA	CORE OUTPUT INDICATORS	AVAILABLE NATIONAL TOOLS	DATA COLLECTION METHODS	REPORTING AND DISEMINATION	TA PLAN
BCC BY TYPES OF MEDIA	Percentage of people reached with HIV prevention messages disaggregated by media channels. -HIV knowledge &misconception	NARHS, DHS, NNRIMS,HMIS	Forms, Questinnaires, ledgers, Registers	Population-based survey,National level Analysis, State level Analysis, Dissemination workshops, publications, Communication materials – posters, handbills, fliers, TV, Radio, jingles, etc	Capacity **Needs Assessment** at all levels, List of training Institutions –Local, International, Training Mode – Training Workshops, correspondence Courses, off-site training
PEER EDUCATION	% of never married young men and women aged 15-24 who have never had sex orhad never had sex in the last 12 Months, % young women aged 15-24 with strong negotiating Skills.	Population Based surveys, eg NARHS, NNRIMS, PEP model MIS Forms, NYSC PET M/E forms, State in-school peer Education MIS,etc.	Forms, Questionnaires, ledgers, Registers	Population based surveys,National level Analysis, State level Analysis, Dissemination workshops, publications, Communication materials – posters, handbills, fliers, TV, Radio, jingles, etc	Capacity needs assessment at all levels, List of training Institutions –Local, International, Training Mode – Training Workshops, correspondence Courses, off-site training
ADVOCACY	Reduction of Religious and cultural barriers to HIV prevention	AIDS Programme Index (API)	Forms, Questinnaires, ledgers, Registers	National level Analysis, State level Analysis, Dissemination workshops,	Capacity needs assessment at all levels, List of training Institutions –Local,

	Improve the policy environment for HIV prev. care & treatment			publications, Communication materials – posters, handbills, fliers, TV, Radio, jingles, etc	International, Training Mode – Training Workshops, correspondence Courses, off-site training
STIGMA AND DISCRIMINATION, HUMAN RIGHTS	% of general population with accepting attitude towards PLWHAs Reduction of stigma and discrimination on PLWHAs in the Workplace, medical/health service providers, the media and among general population	NARHS, NNRIMS, NDHS	Forms, Questinnaires, ledgers, Registers	National level Analysis, State level Analysis, Dissemination workshops, publications, Communication materials – posters, handbills, fliers, TV, Radio, jingles, etc	Capacity needs assessment at all levels, List of training Institutions –Local, International, Training Mode – Training Workshops, correspondence Courses, off-site training
CONDOM DISTRIBUTION	% men and women reporting the use of condom the last time they had sex with a non-marital and non-cohabiting partner Availability within 10 mins. walking distance to buyers	NARHS, NNRIMS	Forms, Questinnaires, ledgers, Registers	National level Pop. Based survey, Analysis, State level Analysis, Dissemination workshops, publications, Communication materials – posters, handbills, fliers, TV, Radio, jingles, etc	Capacity needs assessment at all levels, List of training Institutions –Local, International,
	Affordability: reduced proportion of people using high price as a reason for non-condom use.				Training Mode – Training Workshops, correspondence Courses, off-site training
	Increase in number of organizations trained in condom logistics.				

Group 9 Presentation

The terms of reference for this group were as follows

- To look at the relevance, completeness and appropriateness of the annexes.
- To complete the template in the annexes as necessary

The key points of the group's findings were as follows:

Proposed Content of the Annexure

- **Annex 1:** Harmonized National M&E Indicator Matrix based on NSF goals and objectives (small changes)
- **Annex 2:** Harmonized National M&E Indicator Matrix based on Program Areas (as completed by Group 2)
- **Annex 3:** National M&E Indicator Reference Sheet (definitions …) (as completed by Group 2)
- **Annex 4:** Implementing Partners: National M&E system development and Implementation
- **Annex 5:** National M&E Priority Activities List (2007-2010)
- **Annex 6:** National M&E Calendar (2007)
- **Annex 7:** National M&E Data Collection Tools and Data Summary Forms (By Program Areas)
- **Annex 8:** Terms of Reference for the National Technical Working Group on M&E
- **Annex 9:** NNRIMS Indicator Reporting Template
- **Annex 10:** National M&E Operational/ Implementation Action Plan (Based on the result of the M&E Strengthening Tools)

On the waiting list (To be done)

- MDG Indicators (on HIV/AIDS)
- UNGASS Indicators
- WHO Indicators (on HIV/AIDS)
- Global Fund Indicators
- PEPFAR Indicators
- Health Sector M&E Indicators
- Multi-sectoral M&E/NNRIM Indicators
- Other Indicators
- Decision Calendar

5.2 Key M&E Priority Areas

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Dr Greg Ashefor (NACA) facilitated this session. He made the following observations in this presentation:

- NACA generated and sent out request to stakeholders for M&E activities for 2007
- Very few partners responded to the request for 2007 Priority Activities.
- Some key activities have timelines drawn and activities have commenced
- Key National surveys and reports are due and planned for 2007
- Key instruments are to be worked on in 2007
- Scaling-up of programs and systems in 2007
- Capacity building for institutions

On the way forward the following were suggested:

- A group could then be given the responsibility to:
  -Work on time sequencing
  -Explore joint/collaborative implementation of activities

5.3 Calendar of M&E activities

Dr Greg Ashefor (NACA) mentioned that the importance of the M&E calendar of activities is to list out and organize all the M&E activities of partners including NACA and NASCP for them to have an organized activity plan and this will be collated.

The calendar will help promote information sharing and also allow participants plan appropriately for those activities. However since a comprehensive submission was not received from partners before the stakeholders forum, it was agreed that partners forward a list of their M&E activities for 2007 to NACA for collation and dissemination.

5.4 Next Steps

The following were proposed and agreed upon as the next steps:

NACA to prepare and circulate the TWG calendar of meetings for 2007.

A selected group was to meet, revise and finalize the national M&E plan.

NACA is expected to monitor the implementation of the national M&E plan

Stakeholders could submit further comments within 5days from Wednesday 7th February 2007 for possible inclusion into the final draft of the national M&E plan.

Deleted:

NACA should ensure that costing be part of the development process of the plan.

5.5 Closing

The meeting came to a close at 6.30p.m. Vote of thanks was given by Mrs. Victoria Ugor (Project Manager Benue state SACA).

APPENDIX 1: LIST OF REGISTERED PARTICIPANTS AT THE NATIONAL STAKEHOLDES FORUM ON M&E

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APPENDIX 2: AGENDA FOR STAKEHOLDERS FORUM ON M&E

ARRIVAL
Monday February 5th, 2007: 5 - 8 p. m.

There will be a Facilitators' Orientation/Planning meeting on Monday 5th, February, 2007 at the workshop venue in Lokoja at 5pm prompt.

2- DAYS STAKEHOLDERS'FORUM SCHEDULE

ARRIVAL MONDAY: FEBRUARY, 2007			
Activity	**Methodology**	**Time**	**Facilitator**
Registration		2:00pm	Dr Uche
Facilitators' meeting		4:00pm	Alti Zwandor
Day 1 TUESDAY: FEBRUARY 6, 2007			
Activity	**Methodology**	**Time**	**Facilitator**
▪ Registration		8: 30- 9: 00 am	Dr Uche
Introduction Introductions and Workshop Expectations	Plenary	9:00-9:30am	Alti Zwandor
M&E Systems Update ▪ Prevention activities • OVC Sector. • National Surveys and Surveillance. • Discussion/ Questions • Health Sector • National Multi sectoral M&E system(NNRIMS) • Discussion/Questions		9:40-9 :50am 9:50-10:00am 10:00-10:20am 10:20-10:40am 10:40-11:00am 11:00-11:30am 11:30_12:00pm	CISHNAN/Mrs Momodu Dr Oby Okwuonu/ Dr Ochi Ibe Dr Issa/Mukhtar Alti Zwandor Dr Akinsette Dr Ogungbemi Alti Zwandor
Completion of M&E systems strengthening tools/Feedback	Group session for selected participants	12:00-2:30 pm	Dr Catherine Bilger/Edema
LUNCH		2:30-3:30pm	
NATIONAL M&E PLAN • National M&E Plan 2007-2010		3:30-4:00pm	Dr Greg Ashefor
M& E systems strengthening tools feedback	Plenary	4:00 – 4:30pm	Catherine Bilger

Group work on National M&E plan ▪ Introduction/Conceptual framework ▪ Core indicators, baseline and setting of target ▪ Data collection methodologies &information products ▪ Resourcing and Management of National M&E Plan ▪ Health Sector M&E system -ART -PMTTCT -HCT -HBC -Blood safety ▪ OVC/FLHE data management ▪ Population Based Studies/Special Assessment ▪ Other Prevention M&E Activities - BCC - Condom distribution ▪ Annexes	Group Work	4:30-6:30pm	Uche/Tumala Dr Mukhtar/Fajemisin Henry/Omoregie Kola/Toyin Jagha Bilger/Christoph/Kola Prof. Adeokun/Ibe Ochi/Oyinloye Stanley /Samson Adebayo Zach/Kanada Green Funso Adebayo/Greg
TEA BREAK		6:30pm	
Facilitators meeting		6:30pm	Alti Zwandor

DAY 2 WED: FEBRUARY 7, 2007			
Activity	**Methodology**	**Time**	**Facilitator**
Group work on M&E Plan	Plenary	8:30-10:30am	Drs Catherine Bilger/ Zwandor/Dr Akinsette
TEA BREAK		10:30-11:00am	
Opening ▪ Welcome/Progress with Meeting ▪ Target Setting ▪ Systems Strengthening tools. ▪ Comments ▪ Address on M&E Priorities for the National Response. ▪ Message of Support for National M&E priorities by Partners (UN, USAID, DFID, WORLD BANK, CDC, CCM&DPCG		11:00-11:05am 11:05-11:15am 11.15 – 11.25a.m 11:25-11:35am 11.35- 12.05pm 12.05- 12.30pm	Dr Ogungbemi Dr. Mukhtar Dr. Catherine Bilger Professor Osotimehin Dr Pierre M'pele, Poly Dunford/ Peter Hawkins/Gerald/Jerome Mafeni/John Vertefuile/Kenna Owoh
Group Work Feedback		12.30-1.30pm	
LUNCH BREAK		**1.30-2.30PM**	
Group Work Feedback		2.30-4.30PM	
▪ Presentation of key M&E priority areas ▪ Calendar of M&E activities	Plenary	4:30-4:45pm 4:45-5:00pm	Dr Greg Ashefor Dr kola Oyediran
Group Work on: ▪ Calendar of M&E activities ▪ Key M&E priority areas	Group Work-partners/sectors	5:00pm-5:30pm	▪ Dr Mukhtar/ Dr Aminu ▪ Henry/Greg-
Presentation of group work report	Plenary	5:30-6:00pm	Alti Zwandor/Akinsette
Next Steps	Plenary	6:00-6:30pm	Dr Ogungbemi/Dr Akinsette
Closing prayer		6:30-6:35pm	Dr Greg
Facilitators Meeting		7:30pm	Alti Zwandor

APPENDIX 3: Comment on the Groups' Presentations on Aspects of Draft M&E Plan

Group. 1: Stakeholders noted that the concept of MMIS and Injection Safety on page 12 is different and so should be retained as distinct elements. The mention of condoms on the same page should be qualified i.e. condom distribution and or production. House suggested that documents be open to additional comments, preferably written comments as some participants probably did not have enough time to study the draft plan before the forum.

Group 2: Stakeholders argued that projections should be evidence based. House submitted that if we are constructing fresh indicators, we may not use baseline derived elsewhere. House further suggested that the National Bureau of Statistics may be added to the sources of information to fill some of the manifest gaps in the groups report.
Group responded that presentation was based on the NSF. The claim made on ARV according to the group was also based on the NARHS report. Group also asserted that believing that Global Fund and PEPFAR will be functional, the attempted projection was achievable.

Group 3: Stakeholders argued that there was need to

a) Define tools at a particular level before moving to another level.
b) Make clear distinction between tools of data reporting and data collection.

Group 4: It was suggested that the format in question should be adapted to the Nigerian situation, not retaining the original Swaziland label. House equally requested that a more user friendly calendar was needed.

Group 5: Stakeholders sought to know:

a) The role of SACA in the whole arrangement.

b) The volume of resources needed hinting that a needs assessment may have to be conducted.

c) The relationship between FMOH and SACAs

It was argued that the staff should be part of the whole process even as more attention should be accorded capacity strengthening at both the levels of the local government and the civil society. All stakeholders should also work towards the strengthening of NHMIS.

Stakeholders further stressed that M&E officers who work for Health Dept. at the Local Government level could also work on HIV/AIDS. The most important thing is the prompt delivery of data every month.

Stakeholders also reckoned that timeline for intervention is unrealistic and conflicting even as it noted that there was the needs to identify proper feedback mechanism to make data collectors appreciate the importance of their efforts.

Group 6: Stakeholders asked for the clarification of the following:

The concept of learners in the context in which it was used.

The flow of the arrows in the chart presented

It was later suggested that civil society groups should be captured in peer education training.

Group's response: Learners include students in tertiary institutions including those in the informal sector. The term peer coordinators refer to the teachers. The said arrows were also said to be pointing to both directions thus indicating feedback mechanism.

Group 7: It was recommended that the duo of the Fed Min of Women Affairs and SFH should come together to dialogue on the issue of OVC to avoid undue duplication of efforts. Representative of FMOWA agreed with this recommendation.

Group 8: Stakeholders noted that no mention was made of the consistency in the use of condoms. Members recommended further synthesis of the number of indicators to make for clarity.

Group 9: After the Group's presentation stakeholders observed that:

a) State Min. of Education does not have to be included.

b) Many acronyms are missing e.g. FLHE.

c) F.M.E is the proper acronym for Ministry of education not FMOE.

d) Distinguishing between indicators deriving from UNGASS, Global Fund etc may cause confusion.

e) There is need to study information or data flow channel.

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