

# Guidelines for National M&E Plan

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## HIV/AIDS NNRIMS' OPERATIONAL PLAN 2007-2010



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### ***Key HIV/AIDS National Response Targets***

-  Reduction of HIV prevalence by 25% by 2010
-  Prevention of 55% of new HIV infections by 2010
-  Placing of 550,000 HIV positive persons on treatment by 2010
-  Providing care and support services for 1.6 million HIV positive persons by 2010

**NACA 2007**

***Nigerian National Response information Management System Operational Plan***

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## **PREFACE**

The transformation of National Action Committee on AIDS to an Agency – National Agency for the Control of AIDS (NACA) in April, 2007 is a remarkable achievement in Nigeria's drive to lay a solid foundation based on the 'three ones' principle. Close on the heels of this is the development of the NNRIMS Operational Plan (2007 – 2010), an HIV/AIDS epidemic and response tracking and review guideline agreed to by all implementing partners and stakeholders.

The 'liberalization' of the National response under the rubric of a multi-sectoral platform, the strengthening of NACA and the application of the 'three ones' principle has led to better oversight, coordination, linkage, networking as well as increased access to and efficient utilization of resources. This has provided avenues for a multi-sectoral and multi-level fight against the scourge of HIV/AIDS. To do this, a well articulated monitoring and evaluation operational plan with the input of all stakeholders for Nigeria's response through the National Strategic Framework of Action became overwhelmingly necessary. This informed the development of the NNRIMS Operational Plan for 2007 – 2010. This document drew largely from the gaps and challenges recorded in the review of past efforts aimed at combating this pandemic examining the achievements, constraints, emerging issues, lessons learnt and recommendations. The outcomes provided the foundation on which this plan is built.

This document benefited largely from the contributions of all the stakeholders in Nigeria, other bilateral agencies, international non-government organizations and extensive consultations in the development process. The inclusiveness and consultations that resulted in the production of this NNRIMS Operational Plan (NOP) makes it unique. The contribution of all those that participated in the process is acknowledged.

I hereby urge all stakeholders in Nigeria to align their support in HIV/AIDS to our national objectives, strategies, policies, systems and cycles as contained in this document so that the goal of a 25% reduction in the incidence of HIV/AIDS within the next five years will be achieved.

The achievement of national response targets outlined in this NOP will assist us all greatly in the control of HIV/AIDS, both nationally and internationally and lead us to our desired goal.

Thank you.



Professor Babatunde Osotimehin  
Director General  
NACA  
June 2007

## **ACKNOWLEDGEMENT**

This NNRIMS Operational Plan 2007 to 2010 is the result of seven months rigorous work and the combined effort and support of various individuals and organizations. The process drew resources (technical, financial, moral and spiritual) from all stakeholders. The process commenced with the review of the National response monitoring and evaluation system which provided the basis for the development of the NNRIMS Operational Plan (2007 – 2010).

NACA acknowledges the important role played by the members of the M&E Technical Team for the vision in driving the process, providing oversight and linkages, mobilizing resources and facilitating the entire process. Special thanks go to the members of the Technical Team, for ensuring that this document was finalized. The Team includes: Akin Atobatele of USAID; Toyin Jagha of World Bank; Kola Oyediran of MEASURE Evaluation; Henry Damisoni of UNAIDS; Mrs. Oby Okwuonu of Fed. Min. of Women Affairs and Social Development; Mrs. Z.U. Momodu of Fed. Min. of Education; Mike Merrigan of FHI/GHAIN; Wole Fajemisin of NASCP/PATHS; Mukhtar Mohammed of CDC; Peter Edafiogho of IHVN; Prosper Okonkwo of APIN; Greg Ashefor, Wale Adeogun and Uchenna Onyebuchi from NACA; Godspower Omoregie of SFH; Chidozie Ezechukwu of NEPWHAN, Roni Babangida Lawal of CiSHAN, Segilola Araoye and Rose Iwueze of NASCP/UNAIDS;

NACA also appreciates the technical facilitation role of GAMET in producing the zero draft of the plan. The several visits by Rosalia Rodriguez-Garcia and Marcelo Castrillo and their technical inputs have in no small measure enriched the document.

The review of national response monitoring and evaluation system for HIV and AIDS in Nigeria was based to a large extent on documents and reports submitted to NACA from a broad range of stakeholders, in government, civil society and support groups and development partners. NACA appreciates their invaluable contributions. The entire National M&E Technical Working Group who reviewed and analyzed the national response must be commended. This document would not have been possible without their dedication and teamwork.

The Government of Nigeria and NACA acknowledge the financial, technical and logistical support provided by the following institutions: United Nations Systems in Nigeria, World Bank, USAID, DFID and CIDA.

All the staff of NACA provided valuable insights, helpful suggestions and support. I hope this document will be useful to all stakeholders in monitoring, evaluating and reporting our efforts in fighting HIV and AIDS in Nigeria



Dr Kayode Ogungbemi  
Director,  
Research, Monitoring and Evaluation  
NACA.  
June 2007

## **STAKEHOLDERS' COMMITMENT**

### **DECLARATION OF COMMITMENT TOWARDS THE IMPLEMENTATION OF THE NNRIMS OPERATIONAL PLAN IN NIGERIA**

#### **1. CONTEXT**

**“We the stakeholders involved in Nigeria’s response to AIDS:**

- 1.1. Realizing that the AIDS epidemic constitutes a national and global health crisis of unprecedented magnitude, that impact on economic and social development worldwide and poses a security threat to nations.
- 1.2. Affirming the need to respond to this global and national emergency, through the coordination principles of ‘Three Ones’ namely:
  - One National AIDS Coordinating Authority, (NACA) with a broad based multi-sector mandate
  - One National Strategic Framework (NSF) for AIDS Action that provides the basis for the work of all partners
  - One National Monitoring and Evaluation Framework (NOP), to track, monitor and evaluate the national AIDS response; within the national socio-legal framework.
- 1.3. Recognize the National Agency for the Control of AIDS (NACA), which has a broad based mandate as the One National coordination Authority.
- 1.4. Recognize the Nigeria National Response Information Management System Operational Plan (NOP) as the one monitoring and Evaluation Tool to track, monitor and evaluate the national AIDS response.

#### **2. PRINCIPLES**

*We, on this 28th.day of June 2007 declare our commitment to the following principles:*

- 2.1. National ownership and leadership of the AIDS response monitoring and evaluation at all levels.
- 2.2. Active involvement of all stakeholders in the planning, execution, tracking and reviewing of the HIV/AIDS trends and response at all levels.
- 2.3. Provide voluntary and timely information to feed into the nationally agreed Nigeria National Response Information Management System Operational Plan (NOP) of the AIDS response.

#### **3. UNDERTAKINGS**

Bearing in mind the above and that Nigeria is experiencing a generalized epidemic, we commit ourselves to make immediate and relevant decisions to address the complexities and challenges presented by the epidemic through information provided by the Nigeria National

Response Information Management System Operational Plan (NOP); by building on the June 2001 UNGASS Declaration of Commitment on AIDS and other international, regional, and national agreements, and interventions of the National Strategic Framework.

**We resolve to undertake the following:**

- 3.1. Promote *use of the NOP as the central system for data gathering, decision making, planning and programming* of all AIDS activities implemented by the Stakeholders and partners.
- 3.2. Under the national leadership of NACA, engage with other stakeholders to *update* programmes and projects to promote compatibility with the NSF.
- 3.3. Strive towards synchronized *planning and review cycles* in line with the NACA led annual review and planning in order to maximize the use of national capacities and competencies.
- 3.4. Promote data collection, harmonized reporting procedures and timelines regarding the HIV epidemic within the context of the *NNRIMS Operational Plan*.
- 3.5. Review *individual agency M&E requirements* to minimize additional and unnecessary management and reporting burden on national and state capacity.
- 3.6. Ensure adequate *representation, feedback and accountability mechanisms* of constituency views in the coordination mechanisms at all levels and within all sectors.
- 3.7. Ensure constituency representation in the *various sub-committees* of the National AIDS Partnership Committee on M&E, information and knowledge management among others to facilitate NACA's task in effectively fulfilling its coordinating role.
- 3.8. Continue to strengthen *information sharing and knowledge management mechanisms* within the constituency, availing information to NACA, partners and other various constituencies.
- 3.9. Promote and encourage the implementation of the principles of the 'Three Ones' at all levels.
- 3.10. Create a conducive environment for the advancement of science and research in Nigeria whilst adhering to highest ethical and scientific standards.
- 3.11. Promote documentation and dissemination of best practices and lessons learnt both inside and outside of Nigeria, and foster regional cooperation in information sharing using the NOP as a guiding document.
- 3.12. Ensure that all data to be reported on HIV/AIDS response are reconciled and cleared with NACA M&E Unit.
- 3.13. Ensuring that the key national targets are achieved through effective implementation of the NOP. They are:-

- Reduction of HIV prevalence by 25% by 2010
- Prevention of 55% of estimated new HIV infections by 2010
- Placing 550,000 HIV positive persons on treatment by 2010
- Providing care and support services for 1.6 million HIV positive persons by 2010

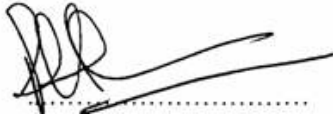
IN WITNESS WHEREOF the undersigned, being duly authorized representatives of the parties hereto, have signed this Declaration of Commitment on the day and year first above written.

**NATIONAL AGENCY FOR THE CONTROL OF AIDS**



.....  
 Babatunde Osotimehin  
 DIRECTOR GENERAL  
 NACA

**FOR THE DEVELOPMENT PARTNERS**

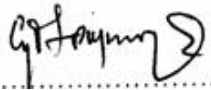


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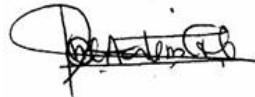


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 National Secretary  
 CiSHAN



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 Pat Matemilola  
 President  
 NEPHWAN

## LIST OF ACRONYMS

AAIN	ActionAid International Nigeria
AFPAC	Armed Forces Programme on AIDS Control
AIDS	Acquired Immuno-deficiency Syndrome
ANC	Ante-Natal Clinics
APIN	AIDS Prevention Initiative in Nigeria
ALGON	All Local Government of Nigeria
ARFH	Association for Reproductive and Family Health
ARH	Adolescent Reproductive Health
ART	Anti-Retroviral Therapy
ARV	Anti-Retroviral
BCC	Behavior Change Communication
CBOs	Community-Based Organizations
CCE	Consultative Constituent Entity
CCM	Country Coordination Mechanism
CDA	Community Development Association
CDC	Centre for Disease Control and Prevention (US)
CEDAW	Convention on the Elimination of Discrimination Against Women
CHAN	Christian Health Association of Nigeria
CHBC	Community and Home-Based Care
CIDA	Canadian International Development Agency
CiSNAN	Civil Society Network on HIV/AIDS in Nigeria
CJ	Chief Judge
CJN	Chief Justice of Nigeria
CRA	Child Rights Act
CSOs	Civil Society Organizations
CSW	Commercial Sex Worker
DfID	Department for International Development (UK)
ETG	Expanded Thematic Group
FBOs	Faith-Based Organizations
FCT	Federal Capital Territory
FEC	Federal Executive Council
FGN	Federal Government of Nigeria
FHI	Family Health International
FLE	Family Life Education
FMOH	Federal Ministry of Health
FMOL	Federal Ministry of Labour
FMOWA	Federal Ministry of Women Affairs
FMIGA	Federal Ministry of Inter-governmental Affairs, Youth Development & Special Duties
GFATM	Global Fund to fight AIDS, Tuberculosis and Malaria
GHAIN	Global HIV/AIDS Initiative Nigeria
GIPA	Greater Involvement of People Living With HIV/AIDS
HAF	HIV/AIDS Fund
HBC	Home-Base Care
HCT	HIV/AIDS Counselling and Testing
HEAP	HIV/AIDS Emergency Action Plan
HIV	Human Immuno-deficiency Virus
HSSP	Health Sector Strategic Plan
IAP	Interim Action Plan
IDPs	Internally Displaced Persons
IDU	Intravenous Drug User
IEC	Information, Education and Communication
ILO	International Labour Organization

INGO	International Non-Governmental Organization
IHVN	Institute of Human Virology Nigeria
LACA	Local Government Action Committee on AIDS
LDDs	Long Distance Drivers
LGA	Local Government Area
MAP	Multi-country AIDS Program
MARPs	Most At Risk Persons
MDGs	Millennium Development Goals
MoU	Memorandum of Understanding
MSM	Men who have Sex with Men
M&E	Monitoring and Evaluation
NACA	National Agency for the Control of AIDS
NDE	National Directorate of Employment
NAFDAC	National Agency for Food and Drug Administration and Control
NAPEP	National Poverty Eradication Programme
NARHS	National Adolescent and Reproductive Health Survey
NASCP	National HIV/AIDS/STI Control Programme
NASSRA	National Assembly Response to AIDS
NBCC	National HIV and AIDS Behavior Change Communication Strategy
NDHS	National Demographic and Health Survey
NEEDS	National Economic Empowerment and Development Strategy
NEPAD	New Economic Partnership for Africa Development
NEPWHAN	Network of People living With HIV and AIDS in Nigeria
NERB	National Ethical Review Board
NGO	Non-Governmental Organization
NHIS	National Health Insurance Scheme
NHVMAG	Nigeria, HIV Vaccine and Microbicide Advocacy Group
NiBUCAA	Nigerian Business Coalition Against AIDS
NIMR	Nigerian Institute of Medical Research
NIPRD	National Institute for Pharmaceutical Research and Development
NISER	Nigerian Institute for Social and Economic Research
NNRIMS	Nigeria National Response Information Management System for HIV/AIDS
NOP	NNRIMS Operational Plan
NPC	National Planning Commission
NRCS	Nigerian Red Cross Society
NRR	National Response Review
NSF	National Strategic Framework
NURTW	Nigerian Union of Road Transport Workers
NYNetHA	Nigerian Youth Network on HIV/AIDS
OIs	Opportunistic Infections
OPS	Organized Private Sector
OVC	Orphans and Vulnerable Children
PABA	People Affected By AIDS
PAC	Presidential AIDS Council
PEP	Post Exposure Prophylaxis
PEPFAR	President's Emergency Plan For AIDS Relief
PESSP	Persons Engaged in Same Sex Practice
PLWAs	People Living With AIDS
PMAN	Performing Musicians Association of Nigeria
PMM	Patient Management and Monitoring
PMTCT	Prevention of Mother-To-Child Transmission
PSC	Partnership Steering Committee
PSI	Population Services International
PTC	Partnership Technical Committee
PSRHH	Promoting Sexual and Reproductive Health for HIV/AIDS reduction
PWG	Partnership Working Group
R&D	Research and Development
SACA	State Action Committee on AIDS

SEEDS	State Economic Empowerment and Development Strategy
SFH	Society for Family Health
SGF	Secretary to the Government of the Federation
SIPAA	Support to International Partnership against AIDS in Africa
SSG	Secretary to the State Government
SNR	Strengthening National Response
SOP	Standard Operating Procedure
SPC	State Planning Commission
STIs	Sexually Transmitted Infections
SW	Sex Worker
TB-DOTS	Tuberculosis Direct Observation Treatment Scheme
UN	United Nations
UBE	Universal Basic Education
UNAIDS	Joint United Nations Programme on AIDS
UNDP	United Nations Development Programme
UNESCO	United Nations Educational, Scientific and Cultural Organization
UNFPA	United Nations Population Fund
UNGASS	United Nations General Assembly
UNICEF	United Nations Children Fund
UNIFEM	United Nations Development Fund for Women
UNODC	United Nations Office on Drugs and Crimes
USAID	United States Agency for International Development
USDOL	United States Department of Labour
VCT	Voluntary Counseling and Testing
WB	World Bank
WHO	World Health Organization

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# Chapter 1.0

## INTRODUCTION

### 1.1 BACKGROUND

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**A. Nigeria the Country:** Nigeria is located in West Africa within 3° and 14° longitudes, and 4° and 14° latitudes. It has a landmass of 923,968 square kilometers. The country shares international borders with the Republics of Cameroon, Chad, Niger and Benin (Chart 1). Nigeria is the most populous country in Africa, and the tenth in the world with over 373 ethnic groups. Preliminary results of the most recent census put Nigeria's population at 140 million (NPC 2006) <sup>1</sup>.

Figure 1: Map of Nigeria



<sup>1</sup> NPC 2006

Administratively, the country is divided into 36 states and a Federal Capital Territory (FCT). The states are semi-autonomous under the country's constitution with each having independent administrative, legislative and judicial system built to fit into the central system. The states and the FCT are further divided into smaller administrative units called local government areas or councils totaling 774. For political, population and economic analysis the states are grouped into six geopolitical zones; South-West (SW), South-South (SS), South-East (SE), North-East (NE), North-Central (NC) and North-West (NW).

**B. HIV/AIDS Epidemiology and Response Co-ordination:** Nigeria recorded her first case of AIDS in 1986. Since then, the epidemic has steadily increased from 1.8% in 1991, to 5.8% in 2001 to 5% in 2003 and finally retrogressing to 4.4% in 2005. The low literacy level, high poverty level and poor health-seeking behavior of most Nigerians, as well as the limited access to health services and low status of women in society, have significantly contributed to the spread of HIV in the country. During the military era when the first case of AIDS was confirmed and reported, the attitude of government and the general population to the epidemic was denial. However, the advent of democratic rule in 1999 brought about a significant change in the attitude of the Government to the epidemic as well as their responses to it.

The attitude of denial gave way to admission and refocusing of the response from being health sector-led to a truly multi-sectoral one, coordinated at the federal level by the National Governing Board and the National Action Committee on AIDS (NACA) established in 2001 and transformed into an Agency through an Act of the National Assembly in 2007. The Agency is now called the National Agency for the Control of AIDS and has a Governing Board. At the state levels, coordination is led by State Action Committee's on AIDS (SACA's), which are transforming into Agencies for effective performance and sustainability, while the Local Government Action Committee's on AIDS (LACA's) hold forth at the Local Government level. Coordinating structures were put in place and an Interim Action Plan (IAP) was developed to combat the epidemic in 2000. This strategy was named the HIV/AIDS Emergency Action Plan (HEAP 2001-2003). In 2004, a review of the national HIV and AIDS response was carried out, which pointed to the need for a new plan, the National Strategic Framework (NSF 2005 – 2009)<sup>2</sup> that was developed through a widely consultative and participatory process.

**C. Monitoring and Evaluation:** As in most African countries, monitoring of the HIV epidemic in Nigeria was primarily through sentinel surveillance, targeting pregnant women attending antenatal care services in line with the global guidelines from the World Health Organization (WHO). From 1999, when the country embraced a multi-sectoral response approach, it became quite apparent that the HIV sentinel surveillance was grossly inadequate to monitor the epidemic and related responses. Against this background, Nigeria identified the need for a

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<sup>2</sup> National Strategic Framework for Action, 2005 - 2009

robust, standardized and unified monitoring and evaluation framework in 2002. The initiative resulted in the Nigeria National Response Information Management System (NNRIMS) framework,<sup>3</sup> that was to guide monitoring and evaluation of interventions implemented under the HEAP. The NNRIMS framework was officially launched in April, 2004. The adoption of the 'Three Ones' principles provided an additional push for the NNRIMS framework.

The current HIV/AIDS epidemic characteristics and the rapid scale up of the national response has made it appropriate to revise the NNRIMS framework, to align with issues articulated in the NSF, as well as Nigeria's roadmap for moving towards Universal Access (UA) for prevention, treatment, care and support. The revision process will also provide an opportunity to address some of the weaknesses particularly an adequately costed operational plan to provide the basis for resource mobilization for monitoring and evaluation.

## **1.2 GOAL AND OBJECTIVES OF THE NNRIMS OPERATIONAL PLAN (2007-2010)**

**A. Goal:** The primary goal of the NNRIMS Operational Plan is to provide a simple and robust monitoring and evaluation system that will facilitate: -

1. Tracking of progress in the implementation of the National HIV/AIDS response
2. Using information to improve programs, policies and service delivery as a part of the multi-sectoral HIV and AIDS response in Nigeria based on the National Strategic Framework (2005-2009)

### **B. Specific Objectives**

1. To develop the requisite infrastructure for monitoring and evaluation in Nigeria
2. To develop the required human resource capacity across levels of the national response.
3. To harmonize indicators and standardize data tools and collection systems.
4. To coordinate and strengthen second generation surveillance and HIV/AIDS operational research.
5. To develop a database or clearing house for all strategic information on the national response.
6. To define clear roles and responsibilities in monitoring and evaluation across different levels and sectors of the system
7. To facilitate efficient data transmission and feedback flow
8. To outline how data collected by NNRIMS should be used
9. To mobilize adequate financial and material resources to support full operationalization of the monitoring and evaluation plan (2007- 2010)

### **C. The National Strategic Framework (2005 - 2009)**

The National Strategic Framework (NSF) seeks to reduce HIV incidence and prevalence by at least 25% and provide equitable prevention, treatment, care and

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<sup>3</sup> -Nigeria National Response Information Management System

support while mitigating its impact among women, children and other vulnerable groups and the general population in Nigeria by 2009. To realize this goal, a set of 8 objectives have been articulated and these are:

1. To increase the program implementation rate by 50% from 2005-09 through improved coordination mechanisms and effective mobilization and utilization of resources.
2. 95% of the general population making the appropriate behavioral changes (safe sex, abstinence, etc) through social mobilization by 2009.
3. To increase access to comprehensive, gender sensitive, prevention, care, treatment and support services for the general population, PLWAs, orphans and vulnerable children to 50% by 2009 and mitigate the impact on the health sector.
4. To increase gender-sensitive non-health sector responses for the mitigation of HIV/AIDS by 50%.
5. To have 95% of specific groups make the appropriate behavior changes (safe sex, abstinence etc) through social mobilization by 2009.
6. To strengthen national capacity for monitoring and evaluation of the response; such that the national monitoring and evaluation plan is 100% implemented by 2009.
7. To build national capacity for research, knowledge sharing and the acquisition and utilization of new HIV and AIDS technologies.
8. To improve the policy environment (policies, guidelines, legislation) that supports safe sex practices, reduces stigma, promotes positive living and rights of women and the general population, particularly PLWAs.

### **1.3 METHODOLOGY: *The Development Process of the NNRIMS Operational Plan***

In 2006, NACA produced a concept note to guide review of the NNRIMS framework, development of an operational plan and harmonization of indicators. A committee was constituted to drive the process and included participants from:

- The National Agency for the Control of HIV & AIDS in Nigeria (NACA)
- Federal Line Ministries and Parastatals
- SACAs
- Development Partners
- Civil Society Organizations

The Global AIDS Monitoring and Evaluation Team (GAMET) of the World Bank was approached and kindly accepted to provide technical assistance for the development of the operational plan while WHO, MEASURE Evaluation and NASCP provided technical assistance in harmonizing indicators to be included in the plan. The GAMET support was a direct response to the M&E needs of Nigeria identified by a World Bank mission to Nigeria in early 2006<sup>4</sup>. A GAMET consultant worked with NACA, NASCP and other

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<sup>4</sup> Trip Report. Review of M&E Activities in HIV/AIDS, Abuja, Nigeria, March 12-18, 2006. Dr. Rosalía Rodríguez-García, GAMET, Global AIDS Program, World Bank and Dr. Marcelo Castrillo, GAMET Consultant

stakeholders to produce the zero draft of the plan that provided the basis for technical inputs from stakeholders.

The development process of the plan was led by NACA, the first draft of which was produced in February 2007 and jointly reviewed at a Stakeholders' Forum in Lokoja, Kogi State<sup>5</sup>. Following this, a core group of reviewers drawn from a cross-section of participants at the Forum who were also members of the National Monitoring and Evaluation Technical Working Group synchronized the comments and input from various stakeholders, and also made significant contributions to the finalization of the document. In May 2007, a target setting meeting was organized in Kaduna with support from UNAIDS and facilitation by CDC, USAID, NACA, NASCP and the Development Partners to set realistic targets and established baselines for all indicators in the plan<sup>6</sup>. The final draft was circulated amongst stakeholders in June 2007 for final comments and the comments were incorporated into the final document.

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<sup>5</sup> –Report of Stakeholder's Forum. Lokoja March 2007

<sup>6</sup> –Report of Target Setting meeting. Kaduna May 2007

## Chapter 2.0

### MONITORING & EVALUATION CONCEPTUAL FRAMEWORK

#### 2.1 BACKGROUND

Monitoring and evaluation is an essential process and tool to make *informed decisions* about operations management and service delivery, including efficient use of resources, determining the extent to which a *program is on track*, making any needed corrections accordingly and evaluating the extent to which the program/project is having or has had the *desired impact*. Monitoring and Evaluation is of vital importance to the successful implementation of programs since it is the only way of establishing what is being done and if the interventions being undertaken are making a difference. Establishment of an M&E system in the area of HIV/AIDS is very critical. Since the epidemic is relatively new and very dynamic and since no one is sure of its future course it poses challenges different from many other issues in development. Continuous assessment is necessary, given that new interventions are constantly being proposed. Efforts must be made to identify interventions that are more effective to make them more central in the national response. To effectively fulfill its mandate of coordinating the national response to HIV/AIDS, the National Agency for the Control of AIDS (NACA) and stakeholders need to understand the scope and effect of HIV interventions in Nigeria. In order to do this a functional and effective Monitoring and Evaluation (M&E) system needs to be in place. This section of the National M&E Plan provides:

- an overview of National Response M&E system on a conceptual level and
- defines the denominators and numerators for each of the indicators highlighted in the indicators' matrix.

The M&E strategy as given in this section will highlight the following:

- Objectives of the Monitoring and Evaluation strategy adopted by the plan.
- Program /reporting levels.
- Levels of indicators to be generated.
- M&E activities (assumed formats).
- Institutional framework and structures for monitoring and evaluation of the national response.
- Reporting channels and linkages between the various actors in the M&E strategy.
- Coordination of the monitoring and evaluation activities at the National, sectoral and State levels.
- Data collection, analysis and dissemination.

## 2.2 NATIONAL HIV/AIDS MONITORING & EVALUATION SYSTEM

On a generic level, a monitoring and evaluation (M&E) system can be defined as a system designed to guide the process of collecting, analyzing and presenting specific data, based on pre-defined indicators, with the purpose of *quantifying* achievements (or levels of success) of a defined strategy and *guiding* future strategies and interventions. Based on this generic definition, the Nigeria National Response M&E system for HIV/AIDS consists of the following elements:

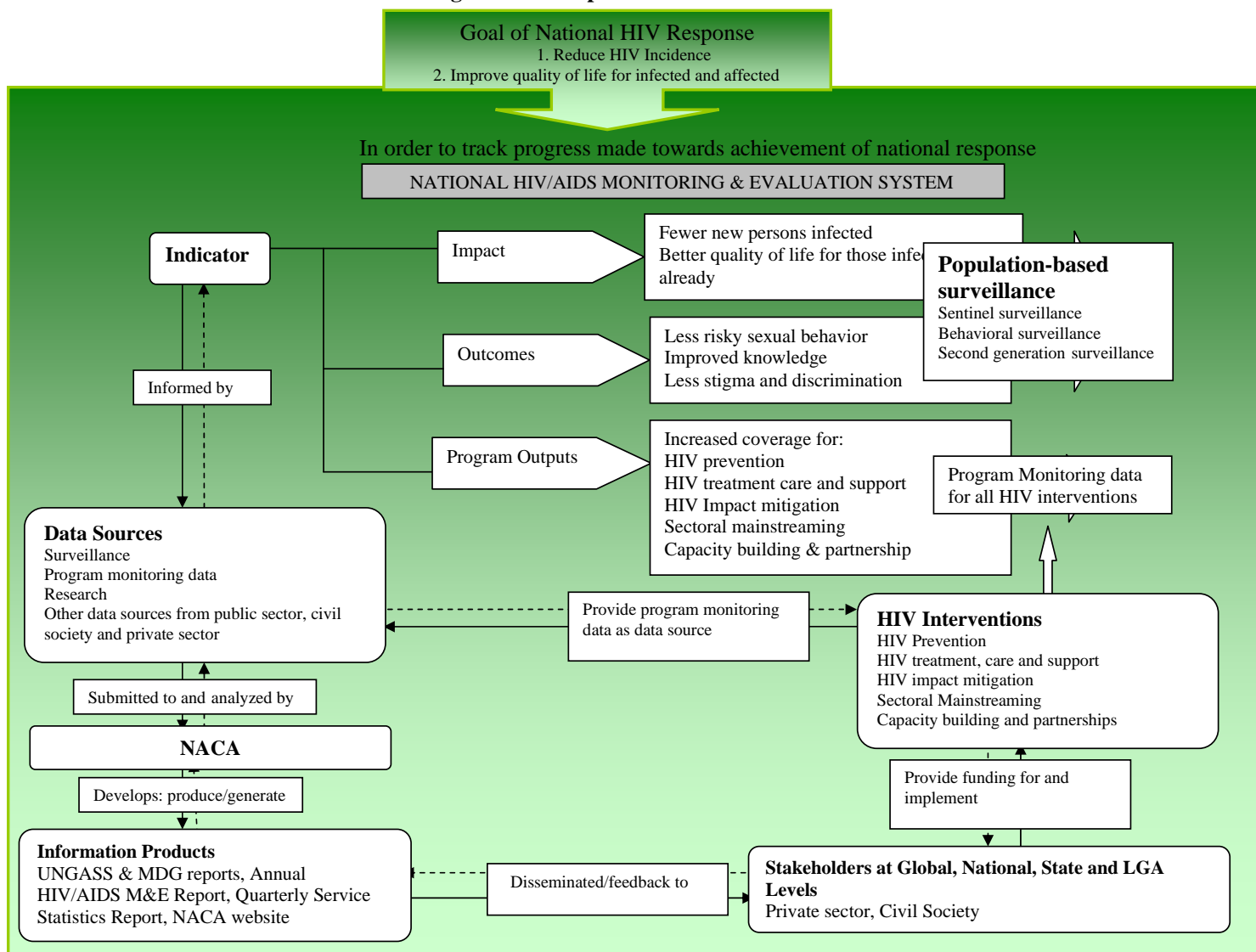
1. Understanding the *overall goal/s* of country's national response
2. Setting the quality standard (i.e. defining how we will know when we have achieved the overall goal/s). This is done by defining specific *indicators*, which would provide guidance as to whether the interventions have been successful in achieving the goal.
3. Further to the definition of a set of indicators, *each indicator is also described in detail*, including what the indicator measures, how the denominator and numerator are calculated, how often the indicator will be measured and the strengths and limitations of the indicator.
4. Definition of the *data sources* from where information will be obtained for the measurement of the indicators.
5. A detailed description of the *information products* that will be produced by the National Agency for the Control of HIV & AIDS on a periodic basis, using the data sources and plans for enhancing the use of this data and information for program and policy decisions.
6. The goal/s, indicators and data sources needed to form the backbone of the M&E system, and it is clearly linked using a *conceptual framework* such as a logical framework<sup>7</sup>.
7. A *process flowchart* that details the activities involved in the data collection, analysis and presentation cycles, the sequencing of these activities as well as the responsibilities internal and external (to NACA) stakeholders responsible for the execution of these activities.
8. Description of the *responsibilities* of the members of NACA's M&E unit.
9. *Annual work plan* for the execution of the M&E system, including the annual responsibilities of NACA's internal and external stakeholders.
10. *Annual operational budget* to execute the M&E work plan.

For key elements of NACA's HIV/AIDS M&E system, as well as the relationships between the elements (see Figure 2).

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<sup>7</sup> This logical framework should not be separated from the M&E system itself, but the system should be based on the framework and its elements should flow from it.

**Figure 2: Conceptual Framework**



### 2.3 RELATIONSHIP BETWEEN NATIONAL M&E SYSTEM AND PROGRAM-LEVEL M&E SYSTEM

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

Thus, a program-level M&E system *should* provide some of the data that it collects to the national level, whilst the additional information that has been collected will be used at program level. This implies the need for the information that is collected at local level to be useful to the sector or partner that collects it – the principle of “*collect it, only if it is useful to use*”.

The other link between the national M&E system and program-level M&E systems is that reporting to the national M&E system should be defined in the HIV program area’s set of implementation guidelines. This will ensure implementers of programmes are clear on their responsibilities in terms of data collection for their own management purpose and for the purpose of providing data to the national M&E system.

Please refer to sectoral M&E plan (to be developed) by key sectors for a more detailed description of the status of program-level M&E systems for each of the HIV program areas.

### 2.4 MONITORING & EVALUATION REPORTING LEVELS

With the assumption that all implementers are operating in well-defined geographical areas (e.g. Facility, Community, LGAs and States), there will be three levels of reporting. While two levels of reporting will consider information generated as a result of service delivery, the third will take care of information from special studies and research. At the lowest level, which is the implementation level, each organization will have indicators to monitor the various activities of their programs. A standard format will be supplied to the organizations to summarize only that information required for facility level reporting. At the second level, LGAs will use a standardized form to summarize the information from the different implementers within the respective LGAs and forward it to their respective State AIDS Coordinating Agencies (SACAs). The third level of reporting will be the national level from special studies conducted by NGOs, development partners, HIV/AIDS networks and research institutions. NACA will then be responsible for national and international level dissemination of the information.

### 2.5 DATA COLLECTION FOR NATIONAL MONITORING & EVALUATION

The monitoring and evaluation of the national response will be guided by NACA based on the M&E plan for the expanded national HIV/AIDS response. The M&E plan addresses the three main areas of HIV/AIDS intervention (prevention, capacity building and impact mitigation) as given in the National Strategic Framework (NSF). The plan matrix highlights the envisaged M&E activities, the indicators for the specific HIV/AIDS interventions, sources of data to generate the indicators, the frequency of data collection

for the specific indicators, the responsible units for collection, processing, analysis and aggregation of data required for the monitoring and evaluation of the national response at different levels. The plan also elaborates the methodology for calculating the indicator (definition) to ease application by various actors.

The National Agency for Control of AIDS (NACA) will work with relevant stakeholders and partners to collect data for generating reports on the national response and for dissemination among the stakeholders and to the international forums. Care has been taken to explore the possibility of utilizing all available data sources before suggestions are made to use survey methods that are oftentimes expensive. Baseline data for the NSF is available from the NDHS, NARHS, ANC sentinel surveillance program records while data for some indicators will be available on annual basis and others will be available periodically. Survey based indicators will again be available during the final year of the NSF – 2008/9 from the NDHS and NARHS surveys.

Data for National M&E indicators will be obtained from four main sources:

- a) Program service data records at facility level, e.g. care and support for PLWHAs records
- b) Program service data records at national level, e.g. NNRIMS
- c) Periodic national level survey like the NARHS and Sentinel Surveillance
- d) Special studies, e.g. facility based surveys for STI services, survey of establishments

For all the sources implementing partners will endeavor to improve the quality of the data collected. The sentinel surveillance data is based on antenatal clinics including women of child bearing age (15-49 years). It is the plan of the FMoH to continue tracking prevalence and to also monitor incidence by sampling young women in the 15-24 age group. The sentinel sites will also be expanded to target more regions of the country and different population groups to help generate estimates of HIV prevalence that are more representative nationally.

The different surveillance reports will also consistently include information on behavioral changes over time in regard to the sexual and social transmission factors. The levels of infections in different population sub groups together with the behavioral surveillance data will guide the specific interventions to address the identified risk factors. The surveillance reports will, to the extent possible, disaggregate the prevalence and infection rates by sex, age groups and other social economic categories that would be of importance depending on the predisposing risk factors.

To ensure complete and timely reporting, it will be necessary to have a deliberate program for capacity building for monitoring and evaluation at the State, LGA and small CSOs levels.

## **2.6 COORDINATION OF M&E ACTIVITIES**

Coordination of the national response to HIV/AIDS is the core function of NACA. This role would ideally involve bringing together all actors who are involved in responding to the epidemic for the harmonious implementation of HIV/AIDS activities. Equally, as a sub-activity of the agency, efficient implementation of the M&E Plan will require well-established coordination mechanisms at all levels of monitoring and evaluation. It is

noteworthy that effective implementation of the plan will go a long way in enhancing the overall coordinating role of the agency. The following sections describe the coordination mechanisms at different levels. The National M&E Coordination meeting will take as a priority the issues of developing and making available standardized national tools, SOP, for data quality and production of nationally agreed information products.

#### **A. National Coordination of the M&E Plan**

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

#### **B. State Coordination for M&E**

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

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

#### **C. Development Partners Coordination for M&E**

Donor support will be very important to ensure effective and efficient implementation of the M&E Plan. Most donors often require more information than is necessary for national level monitoring. However, a compromise needs to be reached between the three parties, donors, NACA and the implementers on an optimal set of data to be collected so that organizations are not overburdened. NACA will establish an M&E forum with the key donors and development partners involved in the HIV/AIDS National response to regularly update them on the requirements of the M&E plan and to solicit for their support in its implementation.

The forum will give an opportunity for the implementing partners to have an input in the implementation of the M&E plan by way of reviewing the program areas and indicators.

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

#### **D. Coordination of Data Dissemination on HIV/AIDS**

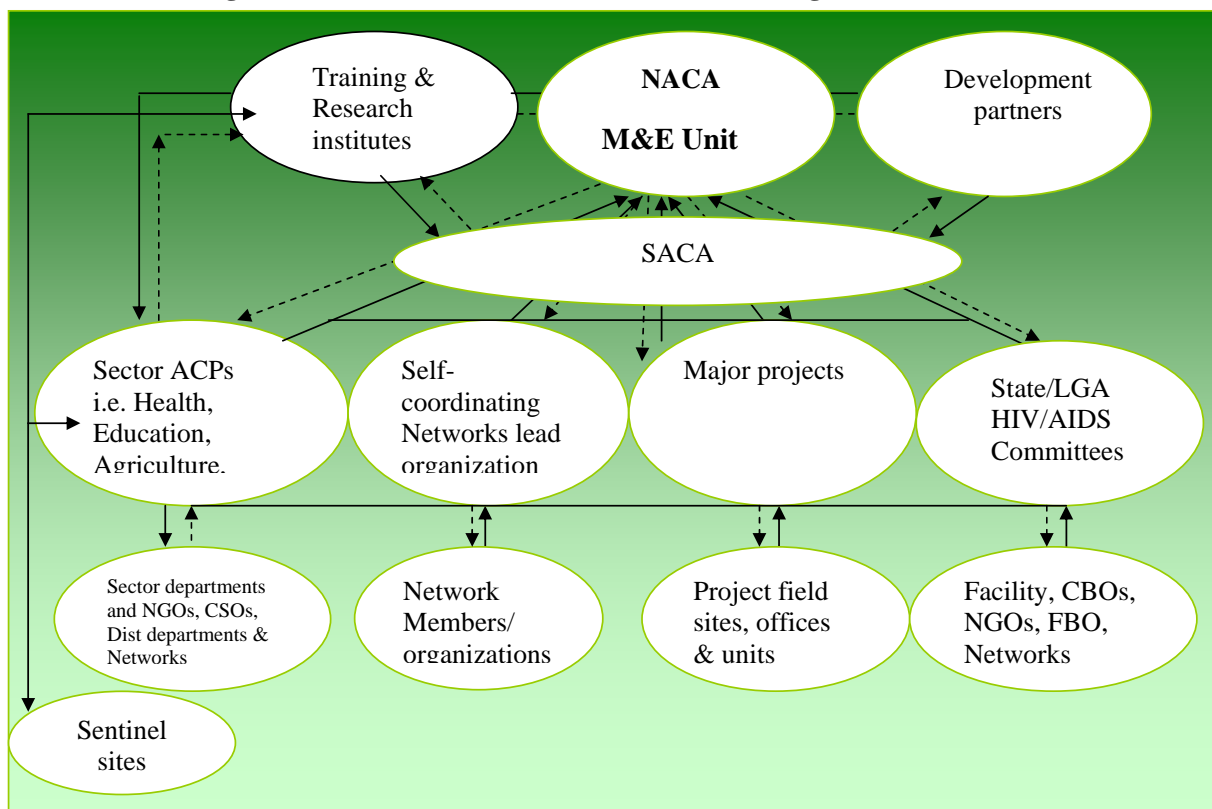
NACA will annually compile reports, which contain the indicators that would give the status of implementation of the National Strategic Framework. The purpose of this dissemination to the monitoring and evaluation strategy will be to:

- Share the data and information on HIV/AIDS for planning and the program development process, and to inform implementation and service delivery.
- Give feedback on the efforts and resources committed to the national response and highlight issues that still require intervention.
- Increase public commitment to the national response.

The dissemination will be done through the circulation of the annual status of HIV/AIDS national report, surveillance reports, HIV/AIDS fact sheets and brochures, print and electronic media reports, supplements, panel discussions as well as public lectures, debates and discussions.

The State and LGAs will also undertake to disseminate HIV/AIDS information to compliment NACA's efforts at their respective levels.

**Figure 3: M&E Institutional Framework and Linkages**



The above structure highlights the functional linkages that will enable the effective monitoring and evaluation of the national HIV/AIDS response. The following linkages, as illustrated in the above structure, highlight the data flow (as depicted), and information flow which follows the same path.

- Summarized report using the standard format to be submitted by the State to NACA. The sector and the National level Civil Society Organizations (CSOs)

receive detailed reports that are necessary for program implementation monitoring.

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

### **E. Indicators**

The Program areas for monitoring and evaluation of the National Strategic Framework are divided into the following broad areas of prevention, treatment, impact mitigation and Capacity Building. Prevention of HIV transmission remains the key strategy in the response to HIV/AIDS but as the epidemic has matured, treatment and mitigation of the personal and community impact had to be addressed as another key strategy in the national response. The successful implementation of these strategies, needless to say, is dependent upon the capacity that exists at both the national and local levels.

At the program level, input, process and output indicators will be used to monitor progress. At this level there are many indicators that individually contribute towards overall monitoring of different interventions. In order to facilitate monitoring NSF implementation at national level, an attempt has been made to identify a few indicators that can act as proxy or direct measures for the achievement of the NSF objectives. More detailed monitoring of program performance will remain within the domain of the lead actors from the program itself.

The selection of national indicators put the following criteria into consideration:

- Relevance to national HIV/AIDS program focus/interventions (NSF)
- Sensitivity of the indicators – ability of the indicator to detect change in the outcome
- Affordability – putting into consideration data that is currently collected by other agencies
- Usefulness
- Ethics
- Repeatability - comparability across levels of monitoring over time
- Measurability (mainly quantitative but consideration for qualitative)
- Validity
- Global commitment and declaration

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

The sections that follow outline the different program areas under the eight NSF objectives, strategies and indicators. An indicator matrix table has been included in chapter 7. A summary indicator reference sheet page is given as annex 1, to provide precise definitions of the indicators and the way they are calculated.

## Chapter 3.0

### DATA COLLECTION PLAN

The Nigerian National Response Information Management System (NNRIMS) is a management information system designed to facilitate the systematic collection, storage, retrieval and dissemination of information on Nigeria's response to the HIV/AIDS epidemic in a manner that meets the needs of the country, its stakeholders and partners. The system was designed in alignment with global monitoring and evaluation needs, and has been agreed upon by major stakeholders as the core monitoring and evaluation system for the country, to track as well as review the national HIV/AIDS response.

NNRIMS tracks the response through an Activity Report System – a generation of aggregate data on essential output indicators from a list of service delivery points using standardized forms (Appendix-NNRIMS Activity Report Form). On a monthly basis, NACA receives reports of validated data on the output of services implemented from all Implementing Partners, Line Ministries, States and CSOs. The form summarizes coverage achieved by organizations implementing HIV/AIDS intervention in the areas of prevention, treatment, and impact mitigation<sup>8</sup>.

NNRIMS also reviews the national HIV/AIDS response by utilizing research findings, routine and periodic data collection systems such as sentinel surveillance and special population based studies to determine the prevalence, level of progress and impact of the national response.

This chapter discusses the different routine and non-routine data collection methodologies currently being utilized in the country; the agreed national core indicators and standardized data collection tools; frequency of data collection; responsible organization for collecting the data; and data flow.

#### 3.1 NATIONAL INDICATORS

The national indicators are a set of nationally agreed indicators that will be utilized in tracking the progress made in the national response by all partners and provide relevant information that will inform future HIV/AIDS intervention plans, strategies and implementation. A listing of these indicators is contained here by the different categories. An indicator matrix is found in Chapter 7, which details the data source, frequency of reporting, baseline information as well as yearly targets from 2007 to 2010.

##### 3.1.1. Impact Level Indicators

###### A. *Reduction in HIV incidence/Prevalence*

- HIV Prevalence among young people aged 15-24
- HIV prevalence among general population aged 15-49
- Percentage of HIV positive infants born to HIV-infected mothers

###### B. *Improvement in Life Expectancy of PLWHAs*

- Percentage of adults and children with HIV still alive at 6, 12 and 24 months after initiation of anti-retroviral therapy

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<sup>8</sup> NNRIMS Monthly Summary Form

### 3.1.2 Outcome and Output Level Indicators by Program Area

#### A. *Prevention – Knowledge and Behaviors*

##### *Key Outcomes*

- 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
- Percentage of young people aged 15-24 who both correctly identify ways of preventing sexual transmission of HIV and who reject major misconceptions about HIV transmission
- Percentage of never-married young men and women aged 15-24 who have never had sex.
- 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.
- 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.
- Percentage of young women and men aged 15-49 who have had sex with a non-marital, non-cohabiting sexual partner in the last 12 months
- Percentage of women and men (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
- Percentage of high-risk groups reporting the use of condom the last time they had sex (with a non-marital, non-cohabiting sexual partner)
- Percent of sex workers who in the past 12 months who used a condom consistently during sexual intercourse with clients

##### *Key Outputs*

- Number of people trained to provide HIV/AIDS peer education
- Number of people in the general population reached with HIV/AIDS prevention programs
- Number of people in high risk groups reached with HIV/AIDS prevention programs.
- Total number of condoms (male) distributed by social marketing outlets in the country.

#### B. *PMTCT*

##### *Key Outcomes*

- 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
- Percentage of LGAs with at least one PMTCT centre offering the complete package of PMTCT services

##### *Key Outputs*

- Number of pregnant women who received HIV counseling and testing for PMTCT and received their test result
- Number of women receiving a complete course of antiretroviral prophylaxis to reduce the risk of mother to child transmission within a calendar year

- Number of health facilities providing a complete PMTCT package

**C. *Blood Safety/Nosocomial/Medical Injection Transmission***

***Key Outcomes***

- 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
- Percentage of blood units transfused in the last 12 months that have been screened for HIV

**D. *Sexually Transmitted Infections***

***Key Outcomes***

- Percentage of health facilities with capacity to appropriately diagnose, treat and counsel patients with STI

**E. *Counseling and Testing***

***Key Outcomes***

- Percentage of individuals who ever received counseling and testing for HIV and received their test result
- Percentage of high risk groups who received HIV counseling and testing services and received their test results in the last twelve months.
- Percentage of LGAs with specified number of service outlets providing HCT

***Key Outputs***

- Number of people provided with counseling and testing for HIV and received their test results. (cumulative)
- Number of HIV counseling and testing service outlets

**F. *Treatment***

***Key Outcomes***

- Percentage of people with advance HIV-infection receiving (current) antiretroviral combination therapy
- Percentage of Local Government Areas with at least one health facility providing ART services and care and treatment for people in-line with national standards

***Key Outputs***

- Number enrolled in HIV care: (a) new, (b) current and (c) cumulative ever at the facility by age and sex
- Number on ART: (a) new, (b) current and (c) cumulative ever started in the country
- Number of service delivery points providing antiretroviral combination therapy
- Number of HIV-positive people receiving home based care
- Number of patients currently on care who are receiving INH prophylaxis on care who are receiving TB preventive therapy)
- Number of HIV patients currently in care who are receiving TB Rx treatment
- Number of people with HIV receiving cotrimoxazole prophylaxis

### **G. Orphans and Vulnerable Children**

#### **Key Outcomes**

- Percentage of orphans and vulnerable children whose households received free basic external support in caring for the child according to national guideline.
- Ratio of current school attendance rate among orphans to that among non-orphans, aged 10-14

#### **Key Outputs**

- Number of orphans and vulnerable children whose households received free basic external support in caring for the child

### **H. Stigma and Discrimination**

#### **Key Outcomes**

- Percentage of the general population with accepting attitude toward PLWHAs

### **I. Monitoring and Evaluation**

#### **Key Outcomes**

- Percent of health facilities

#### **Key Outputs**

- Number of SACAs and LACAs disseminating updated HIV information to stakeholders quarterly
- Number of organizations provided with formal training in M&E

### **J. Policy and Coordination**

#### **Key Outcomes**

- Percentage of line ministries and large enterprises/companies that have HIV/AIDS workplace policy and programs
- 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
- National AIDS Program Effort Index (National Composite Police Index)
- Percentage and amount of national funds disbursed by governments on HIV/AIDS

#### **Key Outputs**

- Amount of fund budgeted for HIV/AIDS by Donors
- Number of small and medium enterprises with workplace policy and programs

### 3.2 DATA SOURCES

The following data sources have been identified as key sources for providing information on the national and other indicators required to track trends in the epidemic and progress in the national response.

**Table 1: Data Collection Timeline:–**

	2005	2006	2007	2008	2009	2010
<b>HMIS &amp; MIS System</b>	<b>Health Management Information System</b>					
	[Dark Blue Bar]					
	<b>Logistic Management Information System</b>					
	[Green Bar]					
<b>Population based Surveys, Surveillance and Special Studies</b>	<b>National HIV/AIDS and RH Behavioural Survey</b>					
	[Dark Red Bar]					
	<b>HIV Surveillance at ANC Clinics</b>					
	[Orange Bar]					
	<b>Health Facility Assessment</b>					
	[Red Bar]					
	<b>Nigeria DHS</b>					
	[Green Bar]					
	<b>BSS/IBSS</b>					
	[Purple Bar]					
	<b>HIV/AIDS Education Survey</b>					
	[Olive Bar]					
	<b>OVC National Survey</b>					
	[Purple Bar]					
<b>HIV/AIDS Workplace Survey</b>						
[Pink Bar]						
<b>National AIDS Spending Assessment</b>						
[Blue Bar]						
<b>Socio-Economic Impact Assessment</b>						
[Grey Bar]						

Data sources for HIV/AIDS in Nigeria are obtained through routine and non-routine data collection methodologies.

### 3.2.1 Non-routine Data Sources

#### A. Second Generation Surveillance System

Traditional HIV surveillance systems track HIV infection or other biological markers of risk such as STIs. Since HIV infection among adults must be preceded by one of a limited number of behaviors, such as unprotected sex with an infected partner or injection with contaminated needles, if these behaviors change, there will be a change in the spread of HIV. Second generation surveillance systems monitor risky behaviors, using them as early warning signs and to explain dynamics of the epidemic. changes in levels of infection. Thus, second generation surveillance uses data from behavioral surveillance to interpret data gathered from sero-surveillance efforts (UNAIDS 2000). Nigeria's second generation surveillance system needs to be tailored to the dynamics of the epidemic. There are a number of second generation surveys currently in place to provide decision makers with data on the trajectory of the epidemic and indications about the effectiveness of the overall response.

#### B. HIV Sentinel Surveillance

HIV sero-prevalence surveys among pregnant women attending antenatal clinics in Nigeria have been carried out since 1991; from 1999 data have been consistently collected every 2 years. It is designed to generate prevalence estimates that can be extrapolated in the general population. It is coordinated by the FMOH through NASCP and enables the Ministry of Health to monitor trends of HIV prevalence and make general population estimates and projections of the HIV/AIDS epidemic and its impact in the country.

#### C. National AIDS and Reproductive Health Behavioral Survey (NARHS)

The National HIV/AIDS and Reproductive Health Survey is a nationally representative survey aimed at providing information on key HIV & AIDS and reproductive health knowledge, attitudes and practices. The NARHS is conducted by NASCP and carried out every two years since 2003. From 2007 the NARHS has incorporated biological-markers on syphilis and HIV, and has been called NARHS Plus.

Indicators collected from the NARHS include:

- Percentage of people aged 15 – 49 years who know two or more symptoms of STIs (disaggregated by age, sex, target population, zone, state, and urban/rural).
- Percentage of young women and men aged 15 – 24 who both correctly identify ways of preventing the sexual transmission of HIV and who reject major misconceptions about HIV transmission. (Target: 90% by 2005; 95% by 2010).
- Percentage of young women and men who commenced sexual activity before the age of 15
- 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 months.
- Percentage of young women and men aged 15–24 reporting the use of a condom the last time they had sex with a non-marital, non-cohabiting sexual partner.

- Percentage of people aged 15 – 49 years reporting the use of a condom during last sexual intercourse with a non-regular sexual partner (disaggregated by age, sex, target population, region and urban/rural).
- Percentage of people aged 15 – 49 years (male and female) who in the last 12 months voluntarily requested for an HIV test and received their test results.
- Percentage of people aged 15 – 49 years (male and female) who in the last 12 months had an HIV test and received their test results.
- Median age at first sex: the age by which one half of young men and women aged 15-24 initiate penetrative sexual intercourse of all young people surveyed.

#### **D. Behavioral Surveillance Survey (BSS) and Integrated Biological and Behavioral Surveillance Survey (IBBSS)**

The Behavioral Surveillance Surveys (BSS) are designed to systematically monitor trends in HIV risk behaviors over time in key population sub-groups thought to be at higher risk of HIV infection. The BSS is coordinated by NASCP. The first was conducted in 2002 and focused on youths only. The second was conducted in 2005 and focused on several additional population sub-groups including female sex workers, uniformed services personnel, long distance truck and bus drivers and university students.

In 2007, NACA with the support of the US government and technical assistance from various national government departments, NGOs, international and multi-lateral agencies is conducting Nigeria's first integrated biological and behavioral surveillance survey (IBBSS) in 6 states (Edo, FCT, Kano, Lagos, Cross River and Anambra). The IBBSS will sample an additional two high risk groups about whom little is known in Nigeria, namely men who have sex with men (MSM) and injecting drug users (IDU). Results will provide valuable input into the future design of the national second generation surveillance system.

Key indicators generated through the BSS and IBBSS

- HIV prevalence among groups surveyed (IBBSS only)
- Syphilis prevalence among groups surveyed (IBBSS only)
- Percentage of persons within each group who both correctly identify ways of preventing the sexual transmission of HIV and who reject major misconceptions about HIV transmission. (Target: 90% by 2005; 95% by 2010).
- Percentage of persons within each group who have had sex with different types of partners including spouses/live-in partners, boyfriend/girlfriends, commercial and casual partners in the last 12 months.
- Percentage of persons within special groups reporting the use of a condom the last time they had sex with different types of partners including spouses/live-in partners, boyfriend/girlfriends, commercial and casual partners in the last 12 months.

### **3.2.2 Other Non-routine Special Studies**

#### **A. Health Facility Assessment**

To understand the effectiveness of HIV/AIDS services provided at health facilities, specific information about quality of services at health facilities are needed. This will be collated through two sources – Health Management Information System (HMIS or HIV/AIDS MIS) or a specific health facility survey. Currently, the HMIS and the HIV/AIDS MIS do not provide adequate information about the capacity utilization and effectiveness of HIV related services at health facilities. Due to this, a health facility survey through which additional information can be collected is presently required.

## **Responsibilities**

The Health facility assessment is to be conducted by the Federal Ministry of Health through its State and Local Government organs.

### **3.2.3 Routine Data Sources**

#### **Health Management Information System (HMIS)**

This data source is commissioned and funded by FMoH and the responsibility for data collection, analysis and reporting rests with NASCP. A Quarterly Service Coverage Report based on data filled out on the HMIS Monthly Summary Forms, from health facility level will be produced. The summary HMIS Form will feed into the NNRIMS Monthly Summary Form for treatment, care and support components.

This monitoring form is the core of the national program monitoring system (collection of “coverage data” about the extent and coverage of HIV interventions). It will be distributed to all health facilities, which will complete the form on a monthly basis.

This information will then be sent through the LGAs to the States and finally to the National level where such information will be analyzed and a service coverage report written and disseminated.

#### **A. Prevention of Mother to Child Transmission (PMTCT)**

Between 2002 and 2004, FMoH with support from partners identified a number of indicators required to facilitate tracking of the status of the PMTCT program. In addition, several data collection instruments including registers and summary forms along with the instruction manual have been produced. Furthermore a computerized Management Information System (MIS) and a comprehensive training curriculum for PMTCT data collection and reporting were developed in 2004 in collaboration with CDC and IHV-UMD.

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

A systematic plan for periodic external data quality checks will be conducted by FMoH and other stakeholders. These checks will include a review of site registers and reporting forms for completeness and accuracy, as well as to verify that previously submitted summary forms represent accurate tallies of the registered information.

#### **Tools**

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

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

The first three registers collect pre-delivery data, the labour and delivery register collects information pertaining to delivery related PMTCT services and the last 2 provide post delivery information. Most of the information captured in the summary forms are however, collected from the HCT and Labour/Delivery Register.

The system also includes a number of summary forms for monthly collection of data and transmission back to the FMOH for collation and analysis. The PMTCT Form will supply data needed to complete the PMTCT component of the NNRIMS Monthly Summary Form.

#### **B. Anti-Retroviral Treatment (ART)**

The ART program began in 2002 with a plan to provide ART for 15, 000 persons. At that time no M&E system was developed. In 2004 with support from partners FMOH developed a Patient Management and Monitoring System for ART program monitoring and evaluation.

##### **Tools**

The HIV/ART Card

PMM forms including: Initial clinical evaluation form; Pediatric clinical evaluation form; Laboratory request and result forms; Pharmacy forms; and Adherence form

Pre-ART register

ART register

ART monthly summary forms

Cohort analysis forms

Data from the registers are used to compile the National Monthly Summary Forms, which are transmitted through LGAs to State and National levels, which have been designed to be compatible with NNRIMS Monthly Summary Form.

#### **C. HIV COUNSELLING AND TESTING (HCT)**

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

##### **Tools**

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

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

##### **Combined Report-Requisition and Issue Form - HIV Test Kits**

- HIV Testing Worksheet
- HCT Monthly Summary Forms

#### **D. ORPHANS AND VULNERABLE CHILDREN (OVC)**

Orphans and vulnerable children activities are coordinated by the Federal Ministry of Women Affairs and Social Development.

Examples of programs in this area include:

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

- Women empowerment programs targeted at bettering their lives and the sexual choices they have at their disposal.

The Federal Ministry of Women Affairs and Social Development is responsible for coordinating all orphan and vulnerable children program of the national response.

#### **Tools**

OVC Register

Initial OVC Assessment forms

OVC Enrolment form

Household Assessment form

OVC Termination form

MIS forms – which is the same as the NNRIMS Monthly Summary Form

#### **3.2.4 Other Routine Data Sources**

Other routine data tools for programs such as Behavior Change Communication, Home Based Care, HIV/TB Collaboration, Laboratory Services, HIV Workplace Response Implementation and Family Life HIV/AIDS Education have been developed and are undergoing review and harmonization. Currently data on most of these are collected through NNRIMS Monthly Summary Forms.

### **3.3 EVALUATION OF NATIONAL RESPONSE**

In most Monitoring and Evaluation Plans considerable attention and resources are devoted to the monitoring component with almost total neglect of the evaluation component. This plan will maintain a balance between monitoring and evaluation/review of the national response. To operationalize this, a sub-committee of the National Technical Working Group will be constituted to identify priority review issues. The sub-committee will work on the platform for Joint Reviews of priority programs that are in existence.

The Joint Evaluation/Review priorities for the national response will include among others:-

1. Mid-term and end-term review of NSF
2. Periodic Evaluation and Review of National treatment program
3. Periodic Evaluation and Review of National prevention program
4. Periodic Evaluation and Review of Public sector response
5. Periodic Evaluation and Review of CSO response
6. National AIDS Spending Assessment
7. Impact Studies and Assessments.

In addition, all donors and partners will be encouraged to evaluate the effectiveness and impact of their programs periodically and submit the reports to NACA.

### **3.4 DATA FLOW**

Health facilities collect data on a daily basis with forms and registers specially designed for each program intervention. The LGA M&E HIV/AIDS Focal Person collects data on a monthly basis from the facilities. The LGA Focal Persons collate the information from all LGA health facilities and sends summary tables to the SMoH (SASCP), also on a monthly basis. The SMoH (SASCP) collates the information from all LGAs and on a quarterly basis, sends the summary data to NASCP and copies SACA. NASCP then collates the information from all States and sends the information to NACA and department of Health Planning and Research (DHPR) within FMOH on a quarterly basis.

It is the responsibility of NACA to collate information on the core indicators of the multi-sectoral national response on HIV/AIDS – (FMOE, FMOWA and other federal line ministries).

### **3.5 M&E REPORTING LEVELS AND INFORMATION FLOW**

Stakeholders implementing HIV/AIDS projects/programs are expected to regularly report on program indicators (see indicators matrix in Chapter 7) that are relevant to the type of intervention program they are undertaking. For all program indicators, the data collection formats at all levels (from lowest to national level) will be developed and distributed to all stakeholders. The proposed information flow between the different stakeholders and NACA is summarized in figure 4. Standard reporting formats that summarize the program indicators will be supplied to LGAs and States.

Facilities are expected to summarize their activities data on a monthly basis from various registers e.g. Pre-ART, ART, PMTCT, OVC, BCC and Advocacy among others into NNRIMS monthly summary format. LGA Officials will go round the various facilities within the LGA and collect completed forms.

Local Government Areas will gather data relevant to program indicators in the National M&E framework from all service providers e.g. health facilities, local CBOs, Non-governmental Organizations working in the LGAs on HIV/AIDS. A copy of the report should be submitted monthly to the State Action Committee on AIDS.

State Action Committee on AIDS (SACAs) will produce quarterly reports by compiling and analyzing data/reports received from LGAs. The state level information would include sector activities during the reporting quarter.

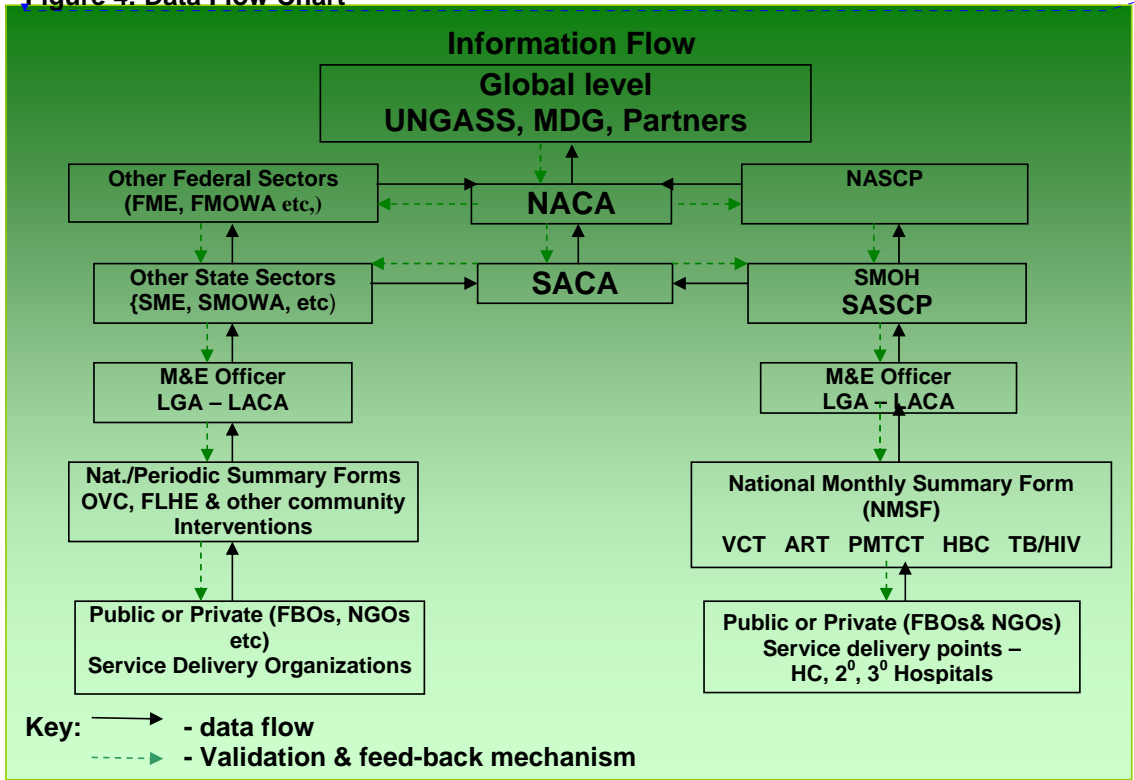
NACA will produce quarterly and annual reports by compiling and analyzing data/reports received from States, Federal Sector Offices (including MoH), Research Institutions, and other implementing partners.

Research institutions, associations, Universities and individual scholars are expected to send a copy of HIV/AIDS related study reports and papers to the National Agency for the Control of AIDS. NACA will make all research results centrally available for reference to users. The process of data collection and reporting from research studies and reports will be articulated in the National HIV/AIDS research plan to be developed.

National M&E systems typically focus on data collection and reporting from SDPs up to national and international stakeholders. This can lead to missed opportunities for feedback to State and local programs. Often, local data are reported up to the national level, but are not used locally. Higher level information may not be reported back to the local level, and local data are not assessed in a broader context. These missed opportunities may prevent local programs from making evidence based programming corrections that could positively impact the health of their communities. Additionally, if information is not presented back in a manner that can be used by local programs, there is little incentive to report quality data in a timely manner. This plan is designed to encourage data ownership and utilization at all levels. NACA will serve as a clearing house for all HIV/AIDS data in the country. It is therefore mandatory for all sectors and partners to reconcile and validate data with NACA's M&E unit. All data report within or outside the country without reconciliation and confirmation from NACA shall be considered not valid or representing national response data.

Figure 4: Data Flow Chart

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### 3.6 DATA QUALITY ISSUES

Data quality needs to be monitored and maintained throughout the data collection process. Obviously data are most useful when they are of the highest quality; however, data quality often requires a trade off between what is feasible and that which is obtainable. Potential biases should be considered, identified and addressed before data collection begins, and closely monitored throughout. To ensure the highest quality of data the following strategies will be utilized :

- Data cleaning at all levels of data reception
- Regular supportive supervision and data verification using standardized checklist<sup>9</sup>
- Periodic update and capacity building of data personnel
- Establishment of a good data and information feedback mechanism
- Periodic review of data quality issues by all stakeholders

<sup>9</sup> National Standard Operating Procedure and Checklist for Data Quality Assurance

### DISSEMINATION AND USE OF DATA

#### 4.1 INFORMATION PRODUCTS

The National Agency for the Control of AIDS is responsible for the compilation, management and dissemination of all data collected through the national HIV/AIDS M&E sub-systems. NACA will provide the following periodic information products and maintain functional reporting relationships with the National Bureau of Statistics, National Planning Commission and global HIV/AIDS organizations:

- Service Coverage Report
- Annual HIV/AIDS M&E Report
- Biennial UNGASS Report
- Biennial Triangulated Analysis Report
- NACA Quarterly Newsletter
- Directory of SDPs on HIV/AIDS
- Evaluation/Review Reports

The following is a brief description of each periodic information product.

##### **A. Service Coverage Report (SCR)**

NACA will produce a routine quarterly service coverage report on key HIV/AIDS program areas. This report will provide information on key service coverage statistics based on information received from states through NASCP, other sectors and implementing partners (grantees and non-grantees). Data sources will be presented in a structured format agreed amongst stakeholders and is expected to contain cumulative data for the year-to-date and also include the results of previous and current periods to enable trend analysis of individual indicators. Once data are captured, NACA will compile a periodic Service Coverage Report (SCR), using a standard analysis methodology to make conclusions and recommendations, before it is disseminated to stakeholders. It will be compiled on a quarterly basis within one month after the end of the period under review. The report will serve to better inform implementing partners and donor organizations of current scale of intervention, gaps in service access and coverage, and how to maximize resource utilization.

In summary the following channels will be followed for submission, compilation and approval:

- NASCP, SACAs, other sectors and IPs submit data to NACA M&E Unit quarterly.
- NACA M&E unit collates and analyses the data.
- NACA presents a draft report to the M&E TWG for comments and inputs. NACA M&E thereafter finalizes the report and disseminates at the national, state and LGA levels.

##### **B. Annual HIV/AIDS M&E Report**

The annual HIV/AIDS M&E report is intended to provide a comprehensive overview of the response to HIV/AIDS in Nigeria. This will involve reporting on all indicators contained in the national HIV/AIDS M&E Framework, and by providing key observations and guidance for future implementation. All data will focus on the previous calendar year (January – December), which will be the de facto reporting period for the report. The report format will be based on information needs for the National response; NACA will maintain this standard format to enable trend analyses of the epidemic. The report compilation will be done on an

annual basis by the NACA M&E Unit, with support from technical partners. It will be compiled in January of each year, and will be ready by the end of the first quarter; NACA may also supplement this report with additional data sources as they become available.

This report will be procedurally linked to the national response annual work planning and budgeting process to ensure that the information is used for strategic planning purposes. The report will also serve as an annual review of NSF implementation.

### **C. Biennial UNGASS Report**

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

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

- UNAIDS Survey on financial resource flows.
- National Composite Policy Index (NCPI) questionnaire.
- School-based survey and education program review.
- Workplace survey.
- Health facility survey.
- PMTCT and ARV program monitoring and estimates from NASCP.
- Population-based surveys.
- HIV sentinel surveillance at antenatal clinics.

For each of the indicators, data entry and analysis will be completed and disaggregated according to the UNAIDS requirements. The report will consist of a statistical overview of the data for each indicator, as well as a narrative description to add quality and texture to the overview. The compilation of the UNGASS report is the responsibility of NACA, with technical support from the in-country UNAIDS office and other stakeholders. The following approval process will be followed: collection of data from relevant sources; preparation of the report by NACA’s M&E Unit using the UNAIDS format; submission of the report to the M&E Technical Working Group for review and validation; and finalization of desired changes by NACA’s M&E Director, who will then send the report for reproduction and dissemination to relevant stakeholders at Federal and State levels.

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

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

explanations for sub epidemics and their major drivers. It will also include data on size estimation of the major drivers and the response targeted at them.

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

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

It is anticipated that analytical syntheses of the Nigerian National Response to the HIV/AIDS Epidemic will be carried out every two years. The report of the triangulated analysis will be forwarded to the M&E TWG for further review and inferences. Following this review, NACA will commence the reproduction and dissemination of the triangulated report. It will be disseminated to all relevant stakeholders including policy and decision makers at National and State levels.

#### **E. NACA Quarterly Newsletter**

NACA will develop and maintain a quarterly newsletter that summarizes all relevant information on HIV/AIDS from the past reporting period. The content may include:

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

The target of the newsletter will be different partners and stakeholders in response to HIV/AIDS. To maximize its impact, the newsletter will be written and presented in a manner that can be easily understood by all stakeholders including non-professional audiences. It will form part of the documents that are disseminated every quarter at the HIV/AIDS feedback workshops, organized at Federal and State levels. This product will be produced by NACA's Communication/Documentation Unit in collaboration with the M&E Unit.

#### **4.2 FORA FOR DATA USE AND DISSEMINATION**

In addition to the aforementioned information products, a number of fora have been established to review progress in implementing the national HIV/AIDS response. These fora have a strong focus on the use and dissemination of data collected for the national HIV/AIDS M&E plan and provide an opportunity to disseminate progress, lessons learned to various

stakeholders and enhance evidence-based decision-making by policy makers and program managers. Opportunities for data use and dissemination include the following:

- Nigerian HIV/AIDS Summit
- International Conferences on HIV and AIDS
- NACA Governing Board meeting
- Development Partners' Group meeting
- National AIDS Council
- State level HIV/AIDS feedback workshops
- Expanded Team Group Meetings
- M&E Technical Working Group Meeting
- NACA's website

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

#### **A. Nigerian HIV/AIDS Summit**

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

#### **B. International Conferences on HIV and AIDS**

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

#### **C. NACA Board Meeting**

NACA Board Meetings are chaired by the Board Chair and bring together Board members once every quarter to review evidence detailing the trajectory of the HIV epidemic in Nigeria, the combined response and current priorities and provide oversight and guidance to the national response.

#### **D. National AIDS Council Meeting**

Once a quarter, NACA and SACA's management and program staff meet to review program implementation progress within each state based on available input, output and outcome data. During the meeting, data is used to highlight recent successes and current challenges, and discussions are held to identify actions, resources and key stakeholders to overcome them. The meeting for the second and last quarters of each year should have in attendance Implementing Partners and major stakeholders to participate in the technical sessions.

#### **E. State level HIV/AIDS Feedback Workshops**

Once a quarter, SACA and LACA stakeholders within the States meet to review various program implementations within their State against its HIV/AIDS targets. This meeting is designed to improve the way HIV/AIDS policies/programs are planned and implemented; enable those working in the field to meet the needs of those affected by and living with HIV/AIDS; expand public awareness of the continued impact of and State response to HIV/AIDS.

#### **F. Development Partners' Group Meetings**

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

#### **G. Expanded Team Group Meetings**

Expanded Team Group Meetings bring together heads of donor and implementing agencies, NACA staff and selected SACA Project Members approximately every two months. Data from routine management information systems is used to discuss progress, identify opportunities and improve coordination of the response.

#### **H. M&E Technical Working Group Meetings**

The national HIV/AIDS M&E Technical Working Group is made up of focal persons from governmental departments, non-governmental organizations, the private sector, donor agencies, UN agencies, and coordinating bodies involved in HIV/AIDS prevention, treatment, care, and support programs. It is convened by NACA on a quarterly basis where topical M&E issues are discussed, presentations delivered on research and other initiatives and technical input is received for national M&E design and implementation issues. Once a year, members of the Technical Working Group will participate in an expanded annual HIV/AIDS M&E dissemination meeting, where the annual HIV/AIDS M&E report will be disseminated to relevant stakeholders during the first quarter of every year. All stakeholders including the Government, development partners, the private sector, NEPWHAN and civil society groups will be invited to attend. In addition to the National Dissemination meeting for the HIV/AIDS M&E results, there may also be a need to organize similar dissemination meetings in States and Local Government Areas.

#### **I. NACA's website**

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

### **4.3 REVIEW OF THE NATIONAL MONITORING & EVALUATION PLAN**

It has been acknowledged that due to the changing nature of the epidemic in Nigeria and due to new research and technologies, the monitoring and evaluation of HIV/AIDS responses is a dynamic field. To keep abreast of these developments and compare progress versus plans, periodic reviews of the appropriateness of this M&E plan for tracking the national HIV/AIDS response are required.

Revising the plan needs to be balanced with the need to maintain a solid core set of data to enable trend analyses over time.

To strike a balance between these 2 competing priorities, the following conditions have been agreed for the review of the National HIV/AIDS M&E plan:

1. The overall M&E Operations Plan, including the actual indicators, should be reviewed within 60 days of the annual review of the National HIV/AIDS Strategic framework, or within 90 days of the development of a NEW National HIV/AIDS Strategic Framework;
2. The data sources for the indicators, as defined in the conceptual framework, may be revised if they can be updated with improved (more accurate or more timely) data sources;
3. Should new information products be required, these may be added to the current list of information products. However, the basic format and content of all information products should remain the same for as long as this M&E plan exists in its current format;
4. The M&E work plan and operational budget may be adjusted annually when the NACA work plan and budget for the next fiscal year is prepared; and/or
5. Should the NSF not be reviewed within the next 2 years, this M&E plan should be reviewed in 2009.

### RESOURCES REQUIRED TO IMPLEMENT THE NNRIMS OPERATIONAL PLAN

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

While NACA has an effective HIV/AIDS management information system, the multi-sectoral response to HIV in Nigeria dictates that the implementation of HIV program level M&E is a contribution of the different sectors, e.g. health, education, labor, CSOs, etc. This coordinating role of the national AIDS program and its affiliates is one whose importance cannot be stressed strongly enough.

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

#### 5.1 FUNDING TO IMPLEMENT THE NNRIMS OPERATIONAL PLAN

There are wide variations in funding for HIV/AIDS programmes from country to country but if spending on the program is minimal, the amount dedicated to M&E systems for HIV will also be minimal. However, in some countries with relatively good resources for drugs and treatment, monitoring of the epidemic is either neglected, or funds for monitoring are allocated inefficiently. Donors wanting to see if their money is well spent often push for better monitoring and evaluation. In consequence, they also fund a disproportionate share of M&E activities. This has created anxieties for recipient countries, as the end of donor funding has in practice led to the collapse of many M&E systems.

In 2006, it was estimated that most HIV/AIDS programming activities in Nigeria spent only 1.0 % of the entire program cost on Monitoring and Evaluation. Since a good M&E system is crucial to ensuring resources are well used, it is recommended that about 10 percent of the National HIV/AIDS budget be used for monitoring and evaluation activities, excluding the routine surveillance of HIV and high risk behavior. NACA will also continue to advocate for Stakeholders at the different levels of implementation to allocate a minimum of 10% of the HIV/AIDS budget to M&E. In order to ensure sustainability, it is advised that (at all levels of the national response), no M&E activity should be entirely donor-dependent. Therefore the NNRIMS Operational Plan will be costed to estimate resources needed for full implementation of the national M&E system. This document will be costed and produced as an addendum.

To achieve effective resource mobilization for the national M&E a clear identification of resource maps and funding requirements is essential. This would enable accurate identification of what the funding gaps are and thus additional funding required.

Subsequently, NACA will identify and mobilize financial resources internally and externally to support the implementation of the NOP, from the private sector as well as the public. Annually, the M&E unit in NACA will prepare a joint M&E Priority Plan in collaboration with major Stakeholders in the Sector. This will be used as a consolidated tool to mobilize resources for national M&E from development partners and civil society, as well as the public and private sectors. NACA will also strengthen systems to track expenditure in order to re-allocate resources as necessary, as well as producing financial audits required by law.

## **5.2 HUMAN RESOURCES CAPACITY & SKILLS DEVELOPMENT**

The Nigerian National response is large and includes the Federal government, 36 States and the Federal Capital Territory as well as other stakeholders whose capacity need to be strengthened in Monitoring and Evaluation. Human capacity and skills development is key to enhancing national capacity for monitoring and evaluation. The Capacity building plan for M&E will be developed annually and implemented to achieve full utilization of the national monitoring and evaluation plan by 2010.

**Human capacity:** Staffing is a major constraint to M&E in many countries. While M&E units or committees do exist in many national programs, they are generally dramatically understaffed and their work is often limited to managing sero-surveillance systems. Human capacity will be considered in terms of numbers, salaries, capacities and qualities of performance. This relates to determining and organizing the appropriate number of staff that are needed, ensuring that their salaries are provided, and their capacities are relevant and updated. Processes to assess staff performance are critical and should focus on the productivity of staff and partners, but more attention should be paid to the quality of their work.

**Capacity building:** Is vital if M&E systems are to be strengthened. If capacity cannot be maintained within the national program, networks can be created to access outside skills as necessary. At a minimum, M&E units should have access to or consist of an epidemiologist, a statistician, a demographer, a social scientist, a data manager and a professional communications/documentation specialist, since available data are often poorly packaged and communicated.

The National Technical Working Group will provide the technical support required for M&E. The NTWG will complement the technical capacity of the central M&E unit. The NTWG will include representatives of academic institutions, NGOs and others in order to assure that data generated by these bodies are integrated into the NNRIMS. Furthermore, the credibility of information generated by the M&E unit will improve through the support of the NTWG.

On an annual basis, NACA and its stakeholders will assess the capacity of their M&E units in order to identify the M&E gaps/requirements of various entities in the national response. This will provide an opportunity for planning and providing M&E capacity building and skills development on a regular basis. To facilitate this provision, a comprehensive capacity development plan will be developed by NACA in collaboration with other stakeholders and will be reviewed on an annual basis.

**Infrastructure:** This refers to equipment, goods, office space, etc. in terms of amounts and qualities of each material per location, plus processes in place and resources allocated for maintenance.

Vehicles and various office equipments (including computers and software) will be needed to facilitate the implementation of the plan. NACA will ensure that enough operating input is provided at the headquarters and in partner institutions and that processes and procedures are in place for their maintenance.

**Leadership and Coordination of Monitoring & Evaluation:** Another major challenge is the M&E program coordination and harmonization of reporting systems. This task becomes even more complicated with the decentralized nature of implementing agencies and coordination mechanisms with inadequate technical capacity to manage the M&E at the State and Local government levels.

NACA will provide the leadership required to ensure that effective operations are established with practical and operational conditions for carrying out project activities effectively. At the State, line ministry, CSO, development partner and private sector levels, focal persons for monitoring and evaluation work should be selected to provide support to the national response.

**Organizational Culture:** This is the dynamic entity that is expected to evolve from operationalizing the M&E system and people working together as well as specific policies, procedures, written goals, and objectives that created the system in the first place. Stakeholders in the national response will work together to determine the skills and structures needed to achieve the national M&E mandate.

NACA will provide the coordination required to maintain a management style that focuses on goals and objectives through the guiding principles of the NSF. These values will be reflected in the objectives and actively supported by the team's leadership. The organizational culture that promotes ethical standards in the choice and implementation of HIV/AIDS intervention activities fosters recognition of the relationship between what needs to be done and those who are responsible for doing it.

**Work planning:** Internally, the National, State and LGA coordinating and implementing entities will produce and monitor the monthly, half-yearly and annual work plans for individual staff members, implementing teams and the project as a whole. NACA, on behalf of the national response will determine the roles and responsibilities of the external partners and ensure that coordination with other organizations is evident through internal reporting mechanisms and regular reviews of NNRIMS data for routine planning.

## Chapter 6.0

### ROLES AND RESPONSIBILITIES IN IMPLEMENTING THE NNRIMS OPERATIONAL PLAN

The achievement of the goals and objectives of the NNRIMS Operational Plan will require the collaborative effort of all stakeholders and their working with a clear understanding of their roles and responsibilities

An attempt has been made in this chapter to delineate the specific roles and responsibilities of the under listed offices in table 2

**Table 2: Responsibilities of Stakeholders in NOP HIV/AIDS M&E Plan**

STAKEHOLDER	OUTLINES OF RESPONSIBILITIES
NACA Board	<p>The board members of NACA have been mandated to provide overall guidance and oversight of the national response. In terms of monitoring and evaluation, the Board members will be responsible for:</p> <ul style="list-style-type: none"><li>• Overall guidance and strategic direction to the NSF and providing appropriate responses</li><li>• Advocating for allocation of adequate resources for M&amp;E in the national response.</li><li>• Promoting a culture of using information for decision-making</li></ul>
NACA DG	<p>The DG of NACA should be responsible for:</p> <ul style="list-style-type: none"><li>• Promoting the HIV/AIDS M&amp;E system within the public and private sectors, civil society and where possible</li><li>• Using information from the M&amp;E system to inform the national response</li><li>• Ensuring that sufficient resources (financial and human) are available to implement the national HIV/AIDS M&amp;E system</li><li>• Encouraging bilateral donors to make reporting to the NOP compulsory for the implementers they support.</li><li>• Facilitating development of the National HIV/AIDS Research Plan.</li><li>• Ensuring that no data on HIV/AIDS is reported to the Global community without clearance from NACA.</li></ul>
NACA's Director of Research, Monitoring and Evaluation	<p>M&amp;E Director of NACA will be responsible for:</p> <ul style="list-style-type: none"><li>• Providing overall leadership for M&amp;E team at NACA</li><li>• Supervision of work done by M&amp;E team</li><li>• First approval of all information products, before they are submitted to the DG for approval</li><li>• Giving guidance and attending meetings with NACA partners on M&amp;E issues</li><li>• Chairing the platform for review and evaluation of National Response Priority Issues.</li><li>• Approving monthly work plans of M&amp;E divisions</li><li>• Initiating and approving the procurement cycles for NACA-commissioned data sources</li></ul>

STAKEHOLDER	OUTLINES OF RESPONSIBILITIES
	<ul style="list-style-type: none"> <li>• Clearing, reconciling and confirming all HIV/AIDS data reported to stakeholders</li> <li>• Approving the annual M&amp;E budgets</li> <li>• Interpreting the M&amp;E report in terms of planning implications</li> <li>• Ensuring that the NACA annual work plan takes cognizance of the M&amp;E results</li> </ul>
Other NACA M&E team members	<p>The M&amp;E team at NACA is the pivot around which the M&amp;E system will be functioning. The team will be responsible for:</p> <ul style="list-style-type: none"> <li>• Implementation of the national HIV/AIDS M&amp;E plan</li> <li>• Coordinating and managing the NNRIMS Report System</li> <li>• Coordinating and Chairing the National M&amp;E TWG</li> <li>• Facilitating the development of the National HIV/AIDS research plan</li> <li>• Developing monthly work plans for M&amp;E activities</li> <li>• Attending the national M&amp;E technical working group and other sectoral unit's M&amp;E Steering Committee meetings</li> <li>• Liaising with all institutions that provide data sources for the NNRIMS system</li> <li>• Providing periodic information products, as requested by NACA</li> <li>• Representing M&amp;E interests of NACA at meetings, and investigating better ways of coordinating data gathering within Nigeria</li> <li>• Supporting HIV/AIDS M&amp;E Dissemination Seminar efforts</li> <li>• Supporting the dissemination of all information products, as defined in this document</li> <li>• Preparing annual M&amp;E work plan and operational budgets</li> <li>• Ensuring that all data is received for the annual HIV/AIDS M&amp;E report – sending reminders and requests for information to all persons/agencies responsible for data sources (as defined in this document)</li> <li>• Compiling and managing approval of the annual HIV/AIDS M&amp;E Report</li> <li>• Arranging funding for NACA-commissioned data sources</li> </ul>
State Action Committee on AIDS	<p>SACA's are responsible for:</p> <ul style="list-style-type: none"> <li>• Compiling and updating directories of facilities, NGOs and CBOs involved in HIV activities in their states and submit to NACA</li> <li>• Ensuring timely &amp; accurate completion, analysis and submission of NNRIMS summary forms</li> <li>• Dissemination of the Quarterly Service Coverage Report form and other National Operational Plan Information products to state stakeholders</li> <li>• Reconciling, validating and clearing all national data to be reported to the Global Community with NACA M&amp;E Director</li> </ul>
Chairman of State Action Committee on AIDS	<p>Chairman of SACA is responsible for:</p> <ul style="list-style-type: none"> <li>• Submitting names of service providers (health and non-health) NGOs and CBOs involved in HIV activities to NACA</li> <li>• Liaising and promoting the completion and submission of NNRIMS forms</li> </ul>

STAKEHOLDER	OUTLINES OF RESPONSIBILITIES
	<ul style="list-style-type: none"> <li>• Dissemination of the Quarterly Service Coverage Report and other NACA Information products to stakeholders</li> <li>• Using NACA information products where appropriate for planning</li> <li>• Completing the NNRIMS Form for all HIV interventions implemented by the State</li> <li>• Promoting completion of the NNRIMS monthly summary Form in other ministries represented at State level</li> <li>• Ensuring that the State House of Assembly and other arms of Government are informed of latest developments in terms of the progress with HIV interventions</li> </ul>
Local Action Committee on AIDS	<p>LACA's are responsible for:</p> <ul style="list-style-type: none"> <li>• Submitting names of facilities, NGOs and CBOs involved in HIV activities to SACA</li> <li>• Liaising and promoting the completion and submission of these forms</li> <li>• Dissemination of the Quarterly Service Coverage Report form and other NOP Information products to LGA stakeholders</li> </ul>
Local Government Action Manager	<p>LG Action Manager is responsible for:</p> <ul style="list-style-type: none"> <li>• Submitting names of service providers (health and non-health) NGOs and CBOs involved in HIV activities to NACA through SACA</li> <li>• Liaising and promoting the completion and submission of NNRIMS forms</li> <li>• Ensuring accurate and timely data collection from SDPs in the LGA</li> <li>• Dissemination of the Quarterly Service Coverage Report form and other SACA/NACA Information products to stakeholders</li> <li>• Using NOP information products where appropriate for planning</li> <li>• Promoting completion of the NNRIMS monthly summary Form in service delivery points (health and non-health) at LGA level</li> </ul>
Civil Society Organizations (including NEPWHAN;	<p>CSO's are responsible for:</p> <ul style="list-style-type: none"> <li>• Facilitating capacity building on M&amp;E for its networks, NGOs etc</li> <li>• Facilitating completion and submission of NNRIMS forms</li> <li>• Clearing all data on HIV/AIDS with NACA</li> </ul>
Institutions responsible for data sources NOT commissioned by NACA	<p>Different agencies are responsible for data sources. These agencies have the responsibility to:</p> <ul style="list-style-type: none"> <li>• Read through NOP and NACA's M&amp;E system to ensure that they are familiar with its content</li> <li>• Ensure that they understand their responsibilities in terms of data submission to NACA</li> <li>• Submit the necessary data, disaggregated as per request</li> <li>• Wherever possible, use the information generated by the NOP system for decision making and improving interventions</li> </ul>
Institutions responsible for data sources commissioned by NACA	<p>These agencies' responsibilities will be clearly defined in the agreement between NACA and the agency. However, in general terms these agencies will be responsible for providing good quality data sources that are based on international best practice, that are relevant to the M&amp;E system, as defined in this document.</p>

STAKEHOLDER	OUTLINES OF RESPONSIBILITIES
Implementers of HIV Interventions	<p>The Implementers of HIV interventions will be responsible for:</p> <ul style="list-style-type: none"> <li>• Completing the NNRIMS Form on a monthly basis and submitting it to the LACA/SACA</li> <li>• Utilizing the information products from NACA for decision making</li> </ul>
Funding Agencies	<p>These agencies provide the fuel that is needed for the HIV engine to run. In terms of M&amp;E, they will be responsible for:</p> <ul style="list-style-type: none"> <li>• <b>All New Contracts:</b> Ensuring that the contracts that they sign with implementers include reference to NACA's M&amp;E system and that reporting to this system is clearly defined. In particular, ensuring that the NNRIMS monthly summary Form is one of the reporting formats that is required</li> <li>• <b>All Existing Contracts:</b> Ensuring that service delivery points assisted by these implementers are requested to submit the NNRIMS Form to LACA/SACA on a monthly basis</li> <li>• Reconciling, validating and clearing of all national data to be reported to Global Community with M&amp;E Director of NACA</li> <li>• Supporting NACA through Technical and financial resources in building capacity &amp; skills required to implement the NOP</li> <li>• Providing technical and financial resources to support full implementation of NOP in states assigned to stakeholder</li> <li>• Provide technical assistance for implementation of NOP</li> </ul>
Researchers and Research Institutions	<p>The roles and responsibilities of researchers and research institutions will be to:</p> <ul style="list-style-type: none"> <li>• Work with NACA to develop the National HIV/AIDS Research plan</li> <li>• Conduct research that is of a high standard – both in terms of substance and in terms of research protocols</li> <li>• Submit research proposals to the relevant ethical review committee before research is commenced</li> <li>• Familiarize themselves with NACA's research strategy (once it is developed) and ensure that, where possible, research is in line with the research strategy</li> <li>• Once research has been completed, disseminate research results and submit a copy to NACA</li> <li>• Facilitate compilation of annotated bibliography of research studies conducted in Nigeria</li> </ul>
National M&E Technical Working Group (NTWG)	<p>This group consists of all stakeholders and will advise on all issues associated with M&amp;E. Please refer to Annexure 7 for a proposed Terms of Reference for the NTWG.</p>

## Chapter 7.0

### NNRIMS OPERATIONAL PLAN INDICATOR MATRIX (2007 – 2010)

#### A. REDUCTION IN HIV INCIDENCE/PREVALENCE IMPACT-LEVEL INDICATORS

INDICATORS	DATA SOURCE	FREQUENCY OF COLLECTION	RESPONSIBLE ORGANIZATION	BASELINE (2005)	TARGET 2007	TARGET 2008	TARGET 2009	TARGET 2010	Remarks/Comments
1. Percentage of young people aged 15-24 who are infected	ANC/General Population Survey	Biennial	FMOH/NASCP	4.3%	3.9%	3.7%	3.4%	3.2%	Target is based on the NSF target of reducing prevalence by 25% every 5 years.
2. HIV prevalence rate in the general population	ANC/General Population Survey	Biennial	FMOH/NASCP	4.4%	4.0%	3.7%	3.5%	3.3%	Target based on the NSF target of reducing prevalence by 25% by every 5 years.
3. Percentage of HIV positive infants born to HIV-infected Mothers	PMTCT MIS	Annual	FMOH/NASCP	45.0%	35.0%	30.0%	25.0%	22.5%	Baseline was estimated from international standards. Targets assume that: 1. HIV prevalence is static or reducing. 2. PMTCT scale-up takes off according to plan. 3. HAART is the therapy of choice.

**B. IMPROVEMENT IN LIFE EXPECTANCY OF PLWHAs**  
**IMPACT-LEVEL INDICATORS**

INDICATORS	DATA SOURCE	FREQUENCY OF COLLECTION	RESPONSIBLE ORGANIZATION	BASELINE (2005)	TARGET 2007	TARGET 2008	TARGET 2009	TARGET 2010	Remarks/Comments
4a. Percentage of adults and children with HIV still alive 6 months after initiation of anti-retroviral therapy.	PMM/Cohort Analysis	Semi-annual	FMOH/NASCP	98.0%	98.0%	98.0%	98.0%	98.0%	Targets assume 80-90% adherence rate. Reference: WHO 3 <sup>rd</sup> by 5 <sup>th</sup> progress report 2004 of 7000 cohorts followed up over time in 24 different African countries.
4b. Percentage of adults and children with HIV still alive 12 months after initiation of anti-retroviral therapy	PMM/Cohort Analysis	Semi-annual	FMOH/NASCP	90.0%	91.0%	92.0%	93.0%	95.0%	Same as above
4c. Percentage of adults and children still alive 24 months after initiation of anti-retroviral therapy.	PMM/Cohort Analysis	Semi-annual	FMOH/NASCP	85.0%	86.0%	87.0%	88.0%	90.0%	Same as above

**PREVENTION: KNOWLEDGE**  
**OUTCOME INDICATORS**

<b>INDICATORS</b>	5. 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	6. Percentage of young people aged 15-24 who both correctly identify ways of preventing the sexual transmission of HIV and who rejected major misconceptions about HIV transmission
<b>Data Source</b>	Annual School Survey, 3- year Baseline School Survey, Annual Report submitted by FMOE Desk Officers	Population-based survey (e.g. NARHS, NDHS)
<b>Frequency of collection</b>	Annual	Biennial
<b>Responsible Organization</b>	FMOE	FMOH, National Population Commission
<b>Baseline (2005)</b>	19%	25.9%
<b>Target 2007</b>	30%	37.7%
<b>Target 2008</b>	40%	43.7%
<b>Target 2009</b>	60%	49.6%
<b>Target 2010</b>	80%	55.5%
<b>Remarks/Comments</b>	<p><b>Assumptions</b></p> <ul style="list-style-type: none"> <li>To certain level, capacity has been built</li> <li>Most trained teachers would be employed in schools.</li> </ul> <p><b>Justification</b></p> <ul style="list-style-type: none"> <li>100% not realistic because of the difficulty in covering all schools (1°, 2°, 3°, Public and Private) in the country.</li> </ul>	<p><b>Assumption:</b> 40% increase in knowledge due to emphasis on mass education &amp; awareness</p> <p><b>Justification:</b> As specified in the National HIV/AIDS Policy through available programs i.e. Peer Education and Life-skill Education.</p>

**SEXUAL BEHAVIOR  
OUTCOME INDICATORS**

<b>INDICATORS</b>	7. Percentage of never – married young men and women aged 15-24 who have never had sex.	8. 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	9. 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.	10. Percentage of young women and men aged 15-49 who have had sex with a non-marital, non-cohabiting sexual partner in the last 12 month
<b>Data Source</b>	Population-based survey (e.g. NARHS, NDHS)	Population-based survey (e.g. NARHS, NDHS)	Population-based survey (e.g. NARHS, NDHS)	Population-based survey (e.g. NARHS, NDHS)
<b>Frequency of collection</b>	Biennial	Biennial	Biennial	Biennial
<b>Responsible Organization</b>	FMOH, National Population Commission	FMOH, National Population Commission	FMOH, National Population Commission	FMOH, National Population Commission
<b>Baseline (2005)</b>	Male 62.7% Female 37.3%	Male 65.60% Female 34.40%	Male 20.1% Female 17.4%	Male 20.7% Female 10.7%
<b>Target 2007</b>	Male 68.6% Female 47.3%	Male 49.90% Female 26.10%	Male 20.3% Female 17.6%	Male 17.6% Female 9.10%
<b>Target 2008</b>	Male 71.6% Female 52.4%	Male 42.10% Female 22.00%	Male 20.4% Female 17.7%	Male 15.9% Female 8.2%
<b>Target 2009</b>	Male 74.5% Female 57.4%	Male 34.20% Female 17.80%	Male 20.5% Female 17.9%	Male 12.4% Female 6.4%
<b>Target 2010</b>	Male 77.6% Female 62.4%	Male 26.40% Female 13.70%	Male 20.6% Female 18%	Male 7% Female 3.6%
<b>Remarks/Comments</b>	<i>Assumption:</i> 40% increase in KAPB amongst special group including youth <i>Justification:</i> As specified in the National HIV/AIDS Policy through available programs i.e. Peer Education, Life-skill Education, HCT and Mass media/Community mobilization	<i>Assumption:</i> 40% increase in KAPB amongst special group including youth <i>Justification:</i> As specified in the National HIV/AIDS Policy through available programs i.e. Peer Education, Life-skill Education, HCT and Mass media/Community mobilization.	Sensitive indicator, no real target set however efforts must be made to ensure that it does not reduce by 0.1 annually.	<i>Assumption</i> 40% increase in KAPB <i>Justification:</i> As specified in the National HIV/AIDS Policy through available programs i.e. Peer Education, Life-skill Education, HCT and Mass media/Community mobilization

**CONDOMS**  
**OUTCOME INDICATORS**

<b>INDICATORS</b>	11. Percentage of women and men (disaggregate by young people and adults) reporting the use of condoms the last time they had sex with a non-marital, non-cohabiting sexual partner	12. Percentage of high-risk groups reporting the use of condoms the last time they had sex (with a non-marital, non-cohabiting sexual partner)	13. Percentage of sex workers who in the past 12 months used a condom consistently during sexual intercourse with clients
<b>Data Source</b>	Population-based survey (e.g. NARHS, NDHS)	High Risk Survey (BSS), NARHS	High Risk Survey (BSS), NARHS
<b>Frequency of collection</b>	Biennial	Biennial	Biennial
<b>Responsible Organization</b>	FMOH National Population Commission	FMOH/NASCP/SFH	FMOH/NASCP/SFH
<b>Baseline (2005)</b>	Male 61.3% Female 43.8%	BSS Not yet released/Approved	BSS Not yet released/Approved
<b>Target 2007</b>	Male 67.5% Female 47.5%	90%	90%
<b>Target 2008</b>	Male 70.6% Female 52.6%	92%	92%
<b>Target 2009</b>	Male 61.3% Female 63.4%	95%	95%
<b>Target 2010</b>	Male 76.8% Female 69.8%	98%	98%
<b>Remarks/Comments</b>	<i>Assumption</i> 40% increase in condom use amongst special group including youth <i>Justification</i> As specified in the National HIV/AIDS Policy through available programmes i.e. Peer Education, Life-skill Education, HCT and Mass media/Community mobilization.	Baseline to be obtained from 2005 BSS	Baseline to be obtained from 2005 BSS

**PMTCT  
OUTCOME INDICATORS**

<b>INDICATORS</b>	14. 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	15. Percentage of LGA's with at least one PMTCT centre offering the complete package of PMTCT services
<b>Data Source</b>	PMTCT/MIS	PMTCT facility mapping
<b>Frequency of collection</b>	Quarterly	Semi-annual
<b>Responsible Organization</b>	NASCP	NASCP
<b>Baseline (2005)</b>	0.81% (2005)	10% (based on the fact that at least 100 sites exist in the country presently)
<b>Target 2007</b>	10%	17%
<b>Target 2008</b>	20%	30%
<b>Target 2009</b>	40%	50%
<b>Target 2010</b>	50%	76%
<b>Remarks/Comments</b>		This target is based on the NSF target of increasing implementation by 50% and using yearly agreed Universal Access Targets.

**BLOOD SAFETY/NOSOCOMIAL/MEDICAL INJECTION TRANSMISSION  
OUTCOME INDICATORS**

<b>INDICATORS</b>	16. 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	17. Percentage of blood units transfused in the last 12 months that have been screened for HIV
<b>Data Source</b>	Population-based survey (e.g. NARHS, NDHS)	Special survey
<b>Frequency of collection</b>	Biennial	Biennial
<b>Responsible Organization</b>	FMOH, National Population Commission	FMOH/NBTS
<b>Baseline (2005)</b>	Not available	Not available
<b>Target 2007</b>	70%	85%
<b>Target 2008</b>	75%	90%
<b>Target 2009</b>	80%	95%
<b>Target 2010</b>	95%	98%
<b>Remarks/Comments</b>	This is based on fact that issues of shared needles are already seldom practiced in most urban centers and information to Health care workers is major intervention which should be feasible. Availability of commodities should be the main constraint	Obtain from NBTS. with a target of 100% by 2010 and using agreed yearly Universal Access Targets.

**SEXUALLY TRANSMITTED INFECTIONS  
OUTCOME INDICATORS**

<b>INDICATORS</b>	18. Percentage of health facilities with capacity to appropriately diagnose, treat and counsel patients with STI's.
<b>Data Source</b>	Health facility survey
<b>Frequency of collection</b>	Biennial
<b>Responsible Organization</b>	FMOH/NASCP
<b>Baseline (2005)</b>	Not Available
<b>Target 2007</b>	
<b>Target 2008</b>	
<b>Target 2009</b>	
<b>Target 2010</b>	
<b>Remarks/Comments</b>	This is an UNGASS indicator that Nigeria has had difficulty in responding to. Nigeria does not presently have a survey that captures the data and does not have funds to conduct the study separately. Any study done to generate this figure will have to be sourced outside the FMOH. For Nigeria to prevent 55% of new infections by 2010, a minimum of 75% of health facilities must have required capacity.

**HIV COUNSELLING & TESTING  
OUTCOME INDICATORS**

<b>INDICATORS</b>	19. Percentage of individuals who ever received counseling and testing for HIV and received their test result	20. Percentage of high risk groups who received HIV counseling and testing services in the last 12 months	21. Percentage of LGAs with specified no. of service outlets providing HCT
<b>Data Source</b>	Population-based survey (e.g. NARHS, NDHS)	High Risk Survey (BSS)	High Risk Survey (BSS)
<b>Frequency of collection</b>	Biennial	Biennial	Annual
<b>Responsible Organization</b>	FMOH, National Population Commission	FMOH/NASCP/SFH	FMOH/NASCP
<b>Baseline (2005)</b>	8.3%	21% (BSS Not yet released/Approved)	Estimated at 15%
<b>Target 2007</b>	15%	29%	23%
<b>Target 2008</b>	20%	33%	40%
<b>Target 2009</b>	26%	37%	66%
<b>Target 2010</b>	31%	41%	98%
<b>Remarks/Comments</b>	These targets were based on the data from Implementing Partners	<i>Assumption:</i> 21% in Baseline represents number of people who received result after testing.	The comprehensive care package aims at having at least 3 HCT sites within a cluster located mainly within a local government area

**TREATMENT  
OUTCOME INDICATORS**

<b>INDICATORS</b>	22. Percentage of people with advance HIV-infection receiving (current) antiretroviral combination therapy	23. Percentage of Local Government Areas with at least one health facility providing ART services and care and treatment for people in-line with national standards
<b>Data Source</b>	PMM	Health facility survey
<b>Frequency of collection</b>	Semi-annual	Annual
<b>Responsible Organization</b>	FMOH/NASCP	FMOH/NASCP
<b>Baseline (2005)</b>	18% (2006)	Not available
<b>Target 2007</b>	25%	17%
<b>Target 2008</b>	40%	30%
<b>Target 2009</b>	60%	50%
<b>Target 2010</b>	85%	76%
<b>Remarks/Comments</b>	This is based on the Universal Access projection of HIV/AIDS services. This is considered feasible based on the scale-up plan for ART and the programmes available including PEPFAR and the GFATM grants	Based on the NSF with a scale-up access of HIV/AIDS services to 50% of the citizens and projecting using agreed yearly Universal Access Targets.

**OVC**  
**OUTCOME INDICATORS**

<b>INDICATORS</b>	24. Percentage of orphans and vulnerable children whose households received free basic external support in caring for the child	25. Ratio of current school attendance rate among orphans to that among non-orphans, aged 10-14
<b>Data Source</b>	Population-based survey (e.g. NARHS, NDHS)	Population-based survey (NHDS)
<b>Frequency of collection</b>	Biennial	5-years
<b>Responsible Organization</b>	FMWA, National Population Commission	FME, National Population Commission
<b>Baseline (2005)</b>	22000/1300000	.64 (NDHS, 2003)
<b>Target 2007</b>	8%	0.65%
<b>Target 2008</b>	10%	0.07%
<b>Target 2009</b>	15%	0.075%
<b>Target 2010</b>	20%	0.8%
<b>Remarks/Comments</b>	The OVC targeted through this program constitute only a fraction of the OVC's in the country. This program therefore aims at meeting the needs of only about 15% of orphans that are a result of HIV and AIDS	Population based survey

**POLICY AND COORDINATION  
OUTCOME INDICATORS**

<b>INDICATORS</b>	26. Percentage of Line Ministries and Large Enterprises/Companies that have HIV/AIDS workplace policy and programs	27. National AIDS program effort index (National Composite Policy Index)	28. Percentage and amount of national funds disbursed by governments on HIV/AIDS
<b>Data Source</b>	HIV/AIDS Work-place survey	National Composite Index Survey	Special Survey
<b>Frequency of collection</b>	Biennial	Biennial	Biennial
<b>Responsible Organization</b>	FMOL&P/NiBUCA	NACA	NACA
<b>Baseline (2005)</b>	46.9%	62%	2,000,000,000
<b>Target 2007</b>	53%	72%	7,000,000,000
<b>Target 2008</b>	60%	80%	9,000,000,000
<b>Target 2009</b>	71%	84%	12,000,000,000
<b>Target 2010</b>	80%	95%	15,000,000,000
<b>Remarks/Comments</b>	These will be percentages of all the large enterprises in the country	Increase by 50%	1. Amount of national budget that goes to HIV 2. There is a need to calculate percentage of total budget that comes to HIV from all sources, including development partners and other donors

**STIGMA AND DISCRIMINATION**  
**OUTCOME INDICATORS**

<b>INDICATORS</b>	29. Percentage of the general population with <b>accepting attitude</b> toward PLWHAs
<b>Data Source</b>	Population-based survey (e.g. NARHS, NDHS)
<b>Frequency of collection</b>	Biennial
<b>Responsible Organization</b>	FMOH, National Population Commission
<b>Baseline (2005)</b>	65.2%
<b>Target 2007</b>	70%
<b>Target 2008</b>	85%
<b>Target 2009</b>	90%
<b>Target 2010</b>	95%
<b>Remarks/Comments</b>	

**STIGMA AND DISCRIMINATION  
OUTPUT INDICATORS**

<b>INDICATORS</b>	30. Number of people trained to provide HIV/AIDS peer education	31a. Number of high risk groups (female sex workers) reached with HIV/AIDS prevention programs.	31b. Number of high risk groups (armed forces) reached with HIV/AIDS prevention programs.	31c. Number of high risk groups (transport workers) reached with HIV/AIDS prevention programs.
<b>Data Source</b>	Program Report/Service Report	Program Report/Service Report	Program Report/Service Report	Program Report/Service Report
<b>Frequency of collection</b>	Semi-annual	Semi-annual	Semi-annual	Semi-annual
<b>Responsible Organization</b>	FBOs/Red Cross, CSOs, ARFH, UNICEF, FME and relevant line ministries	CSOs/Line Ministries	CSOs/Line Ministries	CSOs/Line Ministries
<b>Baseline (2005)</b>	43,000	58.2%	80.5%	64.2%
<b>Target 2007</b>	150,000	72%	90%	80%
<b>Target 2008</b>	310,000	81%	95%	85%
<b>Target 2009</b>	380,000	97%	95%	90%
<b>Target 2010</b>	440,000	97%	98%	95%
<b>Remarks/Comments</b>	Int Conf AIDS. 2004 Jul 11-16; 15: abstract no. E10635. Director General - National Youth Service Corps, Abuja, Nigeria	Baseline from BSS	Baseline from BSS	Baseline from BSS

**CONDOM  
OUTPUT INDICATORS**

<b>INDICATORS</b>	32. Total number of condoms (male) distributed by social marketing outlets in the country
<b>Data Source</b>	Program Report
<b>Frequency of collection</b>	Annual
<b>Responsible Organization</b>	Implementing partners - SFH
<b>Baseline (2005)</b>	159,333,336 (2005)
<b>Target 2007</b>	192,793,337
<b>Target 2008</b>	212,072,670
<b>Target 2009</b>	233,279,937
<b>Target 2010</b>	256,607,931
<b>Remarks/Comments</b>	10% exponential rate was used to compute the condom distribution per year. This was based on the SFH figures only (which forms the bulk) and did not take into consideration other social marketing factors. However, we think this is justifiable as the condom use rate in the average condom use in the general population is 6%. The baseline figure is therefore a very rough estimate of the true picture, but at least we can assume that the projections are realistic.

**PMTCT  
OUTPUT INDICATORS**

<b>INDICATORS</b>	33. Number of pregnant women who received HIV counseling and testing for PMTCT and received their test result	34. Number of women receiving a complete course of antiretroviral prophylaxis to reduce the risk of mother to child transmission within a calendar year	35. Number of health facilities providing a complete PMTCT package
<b>Data Source</b>	PMTCT/MIS	PMTCT/MIS	Health-facility survey
<b>Frequency of collection</b>	Quarterly	Quarterly	2-year
<b>Responsible Organization</b>	NASCP	NASCP	NASCP
<b>Baseline (2005)</b>	<150,000		194
<b>Target 2007</b>	230,000	12,000	297
<b>Target 2008</b>	640,000	34,250	517
<b>Target 2009</b>	900,000	48,500	854
<b>Target 2010</b>	1,040,000	55,800	1,293
<b>Remarks/Comments</b>	Based on data from Implementing Partners	Based on data from Implementing Partners	Projections made using agreed yearly Universal Access Targets.

**COUNSELING & TESTING  
OUTPUT INDICATORS**

<b>INDICATORS</b>	36. Number of people provided with Counseling and testing for HIV and received their test results. (cumulative)	37. Number of HIV counseling and testing service outlets
<b>Data Source</b>	Program Report	Program Report
<b>Frequency of collection</b>	Semi-annual	Semi-annual
<b>Responsible Organization</b>	FMOH/NASCP (SDPs)	FMOH/NASCP (SDPs)
<b>Baseline (2005)</b>		594
<b>Target 2007</b>	350,000	911
<b>Target 2008</b>	1,000,000	1,584
<b>Target 2009</b>	1,400,000	2,614
<b>Target 2010</b>	1,600,000	3,960
<b>Remarks/Comments</b>	Based on projections on need to achieve Universal access to ART and the HCT scale up plan. This target does not include CT in PMTCT figures	Projections made using agreed Annual Universal Access

**TREATMENT  
OUTPUT INDICATORS**

<b>INDICATORS</b>	38. Number enrolled in HIV care: (a)new and (b) current (c) cumulative ever at the facility by age and sex	(a) New	(b) Current	(c) Cumulative
<b>Target 2007</b>		97,000	254,000	280,000
<b>Target 2008</b>		240,000	450,000	500,000
<b>Target 2009</b>		350,000	221,000	800,000
<b>Target 2010</b>		422,000	1,032,000	1,140,000
<b>Remarks/Comments</b>		Figures presented are for new cases only. All HIV+ population in the year less 10% attrition= new Rx +new BC&S	All HIV + population (old and new including treatment) =PC previous year – those convert to Rx+ new PC for the year	BC&S –new entry to Rx + new PC including attrition+ current Rx.
<b>INDICATORS</b>	39. Number on ART: (a)new (b)current and (c)cumulative ever started in the country	(a) All HIV+ new (within the year)	(b) Current (at end of reporting period)	(c) Cumulative (at end of reporting period)
<b>Data Source</b>	Program Report (PMM)	Program Report (PMM)	Program Report (PMM)	Program Report (PMM)
<b>Frequency of collection</b>	Semi-annual	Semi-annual	Semi-annual	Semi-annual
<b>Responsible Organization</b>	FMOH/NASCP	FMOH/NASCP	FMOH/NASCP	FMOH/NASCP
<b>Target 2007</b>		46,500	107,500	126,500
<b>Target 2008</b>		93,500	187,000	220,000
<b>Target 2009</b>		143,000	308,600	363,000
<b>Target 2010</b>		187,000	467,500	550,000
<b>Remarks/Comments</b>				

**TREATMENT  
OUTPUT INDICATORS**

<b>INDICATORS</b>	40. Number of service delivery points providing anti retroviral combination therapy
<b>Data Source</b>	Program Report (PMM)
<b>Frequency of collection</b>	Semi-annual
<b>Responsible Organization</b>	FMOH/NASCP
<b>Baseline (2005)</b>	56
<b>Target 2007</b>	160
<b>Target 2008</b>	250
<b>Target 2009</b>	300
<b>Target 2010</b>	387
<b>Remarks/Comments</b>	Based on need to ensure that 50% of LGA (387) have at least one ART service delivery point by 2010 and using yearly agreed Universal Access Targets.

**PALLIATIVE CARE  
OUTPUT INDICATORS**

<b>INDICATORS</b>	41. Number of HIV/Positive people receiving Home based care	42. Number of HIV patients currently in care who commenced TB Rx	43. Number of people with HIV receiving cotrimoxazole prophylaxis
<b>Data Source</b>	Program Report	Program Report(PMM)	Program Report(PMM)
<b>Frequency of collection</b>	Semi-annual	Semi-annual	Semi-annual
<b>Responsible Organization</b>	NGOs	FMOH/NASCP	FMOH/NASCP
<b>Baseline (2005)</b>	N/A	N/A	N/A
<b>Target 2007</b>	4,500	6,750	76,200
<b>Target 2008</b>	7,500	19,300	134,500
<b>Target 2009</b>	10,500	27,300	216,200
<b>Target 2010</b>	13,500	31,500	309,500
<b>Remarks/Comments</b>	A PR in GF has a target of 150 for yr1 & 300 for yr2. <i>Assumption:</i> A progressive scale up of 10 of such Organizations yearly and an exponential increase of 2.5	Based on available data from IPs.	The assumption is that 30% (10% paed, 10% adults, and 10% due to involvement of lower HF) of all HIV+ on care and Treatment are placed on CTX.

**OVC; MONITORING & EVALUATION**  
**OUTPUT INDICATORS**

<b>INDICATORS</b>	44. Number of orphans and vulnerable children whose house holds received free basic external support in caring for the child	45. Percentage of Service Delivery Points submitting timely and complete reports
<b>Data Source</b>	Program Report	Program Report
<b>Frequency of collection</b>	Semi-annual	Annual
<b>Responsible Organization</b>	FMOW/UNICEF/NGOs	Line Ministries/NACA/SACAs
<b>Baseline (2005)</b>	22,000	40%
<b>Target 2007</b>	60,000	70%
<b>Target 2008</b>	70,000	80%
<b>Target 2009</b>	80,000	90%
<b>Target 2010</b>	100,000	90%
<b>Remarks/Comments</b>	Actual number per year includes GF and other sources	Analysis of report from Zonal M&E Officers from NASCP

## ANNEX 1: Indicator Reference Table

### A. REDUCTION IN HIV INCIDENCE/PREVALENCE IMPACT-LEVEL INDICATOR

INDICATORS	DATA SOURCE	DEFINITION	PERCENTAGE		Value/Comments
			Numerator	Denominator	
1. Percentage of young people aged 15-24 who are HIV-infected	ANC/General Population Survey	Percentage of pregnant women aged 15-24 years attending ANC clinics who are HIV-infected (disaggregated by age, region and urban/rural)	Number of ANC attendees (aged 15-24) tested whose HIV test results are positive	Number of ANC attendees (aged 15-24) tested for their HIV infection status	This indicator is calculated using data from pregnant women attending ANCs in HIV Sentinel Surveillance sites.
2. HIV prevalence rate in the general population	ANC/General Population Survey	Percentage of pregnant women aged 15-49 years attending ANC clinics who are HIV-infected (disaggregated by age (15-24), region and urban/rural)	Number of ANC attendees (aged 15-49) tested whose HIV test results are positive	Number of ANC attendees (aged 15-49) tested for their HIV infection status	This indicator is calculated using data from pregnant women attending ANCs in HIV Sentinel Surveillance sites.
3. Percentage of HIV positive infants born to HIV-infected mothers	PMTCT MIS	Percent of HIV-infected infants born to HIV-infected mothers	n/a	n/a	Expressed as a simple mathematical formula: Indicator score = $\{T*(1-e) + (1-T)\} * v$ where: T = proportion of HIV-infected pregnant women provided with antiretroviral treatment v = MTCT rate in the absence of any treatment e = efficacy of treatment provided

**B. IMPROVEMENT IN LIFE EXPECTANCY OF PLWHA**  
**IMPACT-LEVEL INDICATORS**

INDICATORS	DATA SOURCE	DEFINITION	PERCENTAGE		Value/Comments
			Numerator	Denominator	
4a. Percentage of adults and children with HIV still alive after 6 months after initiation of anti-retroviral therapy	PMM/Cohort analysis	Percentage of people alive and known to be on treatment at 6, 12, 24, 36, etc. months after initiation of treatment. The indicator can be constructed as a minimum and maximum estimate of survival; depending on the inclusion criteria for the denominator (see options (a) and (b) below). Survival at 6, 12, 24, 36, etc. months after initiation of treatment The percentage of patients who at the various times are still on first line regimens A first line regimen is a A second line regimen is a Reasons for switching patients to second line regimens include: Continuation of first-line regimens at 6, 12 and 24 months after initiation	Number of people continuously on ART at 6, 12, 24, 36, etc. months after initiation of treatment.	: a) Minimum survival: Total number of individuals who initiated ART in the ART start-up group in the previous 6, 12, 24, 36, etc. months, including those who have stopped ART, those who have transferred out and people lost to follow-up. b) Maximum survival: Total number of individuals who initiated ART in the ART start-up group in the previous 6, 12, 24, 36, etc. months, excluding those who have stopped ART, those who have transferred out and people lost to follow up.	Method of measurement UNAIDS and WHO. The strengths of this indicator of data collection, as a should monitor patient determine the number survive beyond specific Patient's records may vary populations (e.g. refugees) duration of their therapy This indicator may only limited number of advanced facilities and/or design while HMISs are scaled become institutionalized data can be expected to comprehensive.
4b. Percentage of adults and children with HIV still alive after 12 months after initiation of anti-retroviral therapy					
4c. Percentage of adults and children with HIV still alive after 24 months after initiation of anti-retroviral therapy					

**KNOWLEDGE  
OUTCOME INDICATORS**

<b>INDICATORS</b>		5. 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	6. 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
<b>DATA SOURCE</b>		Annual School Survey, 3- year Baseline School Survey, Annual Report submitted by FMOE Desk Officers	Population-based survey (e.g. NARHS, NDHS)
<b>DEFINITION</b>			Percentage of young women and men aged 15–24 who, in response to prompted questions, say that (1) people can protect themselves from contracting HIV by having sex with only one faithful, uninfected partner, and (2) using condoms, (3) who know that a healthy-looking person can have the AIDS virus, and (4 & %) who correctly reject the two most common local misconceptions about AIDS transmission
<b>PERCENTAGE</b>	<b>Numerator</b>	Number of schools with staff members trained in and regularly teaching life-skills-based HIV/AIDS education	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
	<b>Denominator</b>	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	Number of young women and men aged 15–24 surveyed

**SEXUAL BEHAVIOUR  
OUTCOME INDICATORS**

INDICATORS	DATA SOURCE	DEFINITION	PERCENTAGE	
			Numerator	Denominator
7. Percentage of never-married young men and women aged 15-24 who have never had sex.	Population-based survey (e.g. NARHS, NDHS)	Percent of never married young women and men aged 15–24 who have never had sex	Number of never married young women and men who have never had sex	Number of never married young women and men aged 15–24 surveyed
8. Percentage of never married women and men 15-24 who had sex in the last 12 months.	Population-based survey (e.g. NARHS, NDHS)	Percent of never married young women and men aged 15–24 who have not had sex in the last 12 months preceding the survey	Number of never married young women and men who have not had sex in the past twelve months	Number of never married young women and men who have not had sex in the past twelve months aged 15–24 surveyed
9. 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)	Same as indicator	Method of measurement (see M&E health sector framework)	
10. Percentage of young women and men aged 15-49 who have had sex with a non-marital, non-cohabiting sexual partner in the last 12 month	Population-based survey (e.g.	Same as indicator	Number of women and men who reported sexual activity with non-marital, non-cohabiting partners in the last 12 months.	Number of Women and men surveyed.

**CONDOM  
OUTCOME INDICATORS**

<b>INDICATORS</b>		11. 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	12. Percentage of high-risk groups reporting the use of condom the last time they had sex (with a non-marital, non-cohabiting sexual partner)	13. Percent of sex workers who in the past 12 months used a condom consistently during sexual intercourse with a client
<b>DATA SOURCE</b>		Population-based survey (e.g. NARHS, NDHS)	High Risk Survey (BSS), NARHS	High Risk Survey (BSS)
<b>DEFINITION</b>		Percentage of people aged 15-49 years reporting the use of a condom during last sexual intercourse with a non-regular sexual partner (disaggregated by age (15-24), sex, target population, region and urban/rural) , none cohabiting	Percentage of people within high risk groups reporting the use of a condom during last sexual intercourse with a non-regular sexual partner (disaggregated by age (15-24), sex, target population, region and urban/rural) , none cohabiting)	Percentage of people within high risk groups reporting the use of a condom during last sexual intercourse with a non-regular sexual partner (disaggregated by age (15-24), sex, target population, region and urban/rural) , none cohabiting)
<b>PERCENTAGE</b>	<b>Numerator</b>	Number of respondents 15-49 who reported having non regular (ie non marital,non-cohabiting) sexual partner in the last 12 months who also reported that a condom was used the last time they had sex with this partner.	Number of respondents (15-49) who reported having had a non-regular (i.e., non-marital and non-cohabitating) sexual partner in the last 12 months who also reported that a condom was used the last time they had sex with this partner	Number of respondents (15-49) who reported having had a non-regular (i.e., non-marital and non-cohabitating) sexual partner in the last 12 months who also reported that a condom was used the last time they had sex with this partner
	<b>Denominator</b>	Number of respondents 15-49, who reported they had a non regular sexual partner in the last 12 months.	Number of respondents (15-49) who reported having had a non-regular sexual partner in the last 12 months	Number of respondents (15-49) who reported having had a non-regular sexual partner in the last 12 months

**PMTCT  
OUTCOME INDICATORS**

INDICATORS	DATA SOURCE	DEFINITION	PERCENTAGE		Value/Comments
			Numerator	Denominator	
14. 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 and statistical modelling	Percent of HIV-infected pregnant women receiving a complete course of antiretroviral prophylaxis to reduce the risk of MTCT	Number of HIV-infected pregnant women provided with a full course of antiretroviral prophylaxis to reduce MTCT according to the nationally approved treatment protocol in the last 12 months (PMTCT MIS)	Estimated number of HIV-infected pregnant women (modeled)	
15. Percentage of LGA with at least one PMTCT centre offering the complete package of PMTCT services	PMTCT facility mapping/listing	Percentage of LGAs with at least one health facility providing a complete package of PMTCT services (disaggregated by State and zone)	Number of LGA with at least one PMTCT offering complete package of PMTCT services in the last 12 months	Number of all LGAs in the Country	This target is based on the NSF target of increasing implementation by 50% and using yearly agreed Universal Access Targets.

**BLOOD SAFETY/NOSOCOMIAL/MEDICAL INJECTION TRANSMISSION  
OUTCOME INDICATORS**

INDICATORS	DATA SOURCE	DEFINITION	PERCENTAGE		Value/Comments
			Numerator	Denominator	
16. 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)	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			
17. Percentage of blood units transfused in the last 12 months that have been screened for HIV	Special survey	Percent of blood units transfused in the last 12 months that have been adequately screened for HIV according to national or WHO guidelines	The number of blood units screened for HIV in the previous 12 months according to national guidelines	The number of blood units transfused in the previous 12 months;	

**SEXUALLY TRANSMITTED INFECTIONS  
OUTCOME INDICATORS**

INDICATORS	DATA SOURCE	DEFINITION	PERCENTAGE		Value/Comments
			Numerator	Denominator	
18. Percentage of health facilities with capacity to appropriately diagnosed, treat and counsel patients with STI	Health facility survey	Percentage of health-care facilities who are appropriately diagnosing, treating and counseling for STIs	Number of health facilities that follow national protocols for STI management	Number of health facilities surveyed for STI patients	Score for each component of the indicator (i.e., history-taking, examination, diagnosis and treatment, and counseling) should be reported, in addition to the overall indicator score

**HIV COUNSELING & TESTING  
OUTCOME INDICATORS**

<b>INDICATORS</b>		19. Percentage of individuals who ever received counseling and testing for HIV and received their test result	20. Percentage of high risk groups who received HIV counseling and testing services in the last 12 months.	21. Percentage of LG with specified no. of servi outlets providing HCT
<b>DATA SOURCE</b>		Population-based survey (e.g. NARHS, NDHS)	High Risk Survey (BSS)	Mapping/Listing
<b>DEFINITION</b>		Proportion of persons aged 15 – 49 years (male and female) who have ever received HIV counseling and testing and their result.	Proportion of persons aged 15 – 49 years (male and female) amongst the special groups who in the last 6 months had an HIV test and received their test results	Number & Percentage of Local Government Ar with at least one health facility providing HCT services in-line with national standards
<b>PERCENTAGE</b>	<b>Numerator</b>	Number of respondents (15-49yrs) who answered YES to the first question; and Yes to the 4th question i.e. received their results	Number of respondents (15-49yrs) who answer YES to the first question; ; less than 12 months to the second question; and Yes to the 4th question i.e. received their results	Number of LGA surveyed with accredited HCT centres (i.e. HCT centres that meet all the criteri
	<b>Denominator</b>	Total number of respondents (15-49) who gave answers (including "don't know") to question 1	Total number of respondents (15-49) who gave answers (including "don't know") to question 1	Total number of LGA surveyed
<b>Value/Comments</b>		The indicator was derived from responses to the following set of prompted questions 1. Have you ever been tested for HIV/AIDS before? 2. If Yes, When was the last time you ever tested? a. Less than six months ago b. 6-12 months ago c. 12-23 months ago d. 24 months or more 3. Why was the test done? a. I asked for the test b. I was offered and accepted c. I was required to have it 4. Did you receive your results? a. Yes b. No	1. Have you ever been tested for HIV/AIDS before? 2. If Yes, When was the last time you were tested? a. Less than six months ago b. 6-12 months ago c. 12-23 months ago d. 24 months or more 3. Why was the test done? a. I asked for the test b. I was offered and accepted c. I was required to have it 4. Did you receive your results? a. Yes b. No	Standard for HCT - 1. Provic initiated HCT (ANC, STI, TB, FP/RH etc) 2. Client initiated HCT 3. Pre test counseling (risk reduction, basic HIV education, ) 4. HCT testing using a nationally approved testi algorithm 5. Post test counseling 6. Care and Support Linkages 7. TB linkages 8. PMTCT linkages 9. Condom availability

**TREATMENT  
OUTCOME INDICATORS**

<b>INDICATORS</b>		22. Percentage of people with advanced HIV-infection receiving (current) antiretroviral combination therapy	23. Percentage of Local Government Areas with at least one health facility providing ART services and care and treatment for people in-line with national standards
<b>DATA SOURCE</b>		ART MIS	Mapping/Listing
<b>DEFINITION</b>		Percentage of people with advanced HIV infection receiving ARV combination therapy (disaggregated by age, sex )	Percentage of Local Government Areas with at least one health facility providing ART services in-line with national standards (disaggregated by State and zone)
<b>PERCENTAGE</b>	<b>Numerator</b>	Number of people (i.e., adults and children) with advanced HIV infection who receive antiretroviral combination therapy according to the nationally approved treatment protocol (Aa) Number of people with advanced HIV infection receiving treatment at startthe beginning of the year Plus (Bb) Number of people with advanced HIV infection who commenced treatment in the last 12 months Minus Cc: Number of people with advanced HIV infection for whom treatment was terminated in the last 12 months (including those who died)	Number of LGA with at least one ART site offering complete package of ART services in the last 12 months
	<b>Denominator</b>	Number of people with advanced HIV infection The denominator is estimated to be 15% of the total number of people currently infected (based on the most recent national Sentinel Surveillance data). Note: • Private sector antiretroviral provision should be included in the calculation of the indicator wherever possible and the extent of such provision should be recorded separately	Number of all LGA in the Country
<b>Value/Comments</b>		This is based on the Universal Access projection of HIV/AIDS services. This is considered feasible based on the scale-up plan for ART and the programmes available including PEPFAR and the GFATM grants	Based on the NSF with a scale-up access of HIV/AIDS services to 50% of the citizens and projecting using agreed yearly Universal Access Targets

**OVC**  
**OUTCOME INDICATOR**

<b>INDICATORS</b>		24. Percentage of orphans and vulnerable children whose households received free basic external support in caring for the child	25. Ratio of current school attendance among orphans to that among non-orphans aged 10-14
<b>DATA SOURCE</b>		Household-based survey (e.g. NDHS)	Household-based survey (NHDS)
<b>DEFINITION</b>		Percent of orphans and vulnerable children under 18 living in a household whose households have received, free of user charges, basic external support in caring for the child  <b>ORPHANS:</b> All children under 18 who have at least one dead parent (mother or father) <b>AND VULNERABLE CHILDREN:</b> All children under 18 who have a chronically ill parent (mother or father) defined as a parent who has been very sick for 3 or more months during the last 12 months, regardless of whether or not the ill parent lives in the household	
<b>PERCENTAGE</b>	<b>Numerator</b>	Number of orphans and vulnerable children residing in households that received: a. health care support within the past 12 months; b. emotional support within the past 3 months; c. school-related assistance within the past 12 months; d. other social support, including material support, within the past 3 months; and e. all four types of support.	Percentage of orphans aged 10-14 who are attending school.
	<b>Denominator</b>	All Orphans and vulnerable children identified in the survey.	Percentage of non-orphans of non-orphans aged 10-14 who are attending school.
<b>Value/Comments</b>			

**POLICY AND COORDINATION**  
**OUTCOME INDICATORS**

<b>INDICATORS</b>		26. Percentage of Line Ministries and Large Enterprises/Companies that have HIV/AIDS workplace policy and programs	27. National AIDS program effort index (National Composite Policy Index)	28. Percentage and amount of national funds disbursed by governments on HIV/AIDS
<b>DATA SOURCE</b>		HIV/AIDS Work-place survey	National Composite Index Survey	Special Survey
<b>DEFINITION</b>			The average score given to a national program by a defined group of knowledgeable individuals asked about progress in over 90 individual areas of programming, grouped into 10 major components	
<b>PERCENTAGE</b>	<b>Numerator</b>	Number of employers with HIV/AIDS policies and programmes that meet all of the above criteria	n/a	
	<b>Denominator</b>	Number of employers surveyed	n/a	
<b>Value/Comments</b>				<ol style="list-style-type: none"> <li>1. Allows for cross country, regional and international comparison of data</li> <li>2. Identifies how resources are being mobilized within a country: <ol style="list-style-type: none"> <li>a) Who pays?</li> <li>b) Who finances?</li> <li>c) Under what schemes?</li> </ol> </li> <li>3. Identifies how resources are being managed within a country</li> <li>4. Identifies who provides HIV/AIDS services and who benefits from these services</li> <li>5. Measures additionally</li> <li>6. Provides possibility to conduct beneficiary analysis</li> </ol>

**STIGMA AND DISCRIMINATION  
OUTCOME INDICATORS**

INDICATORS	DATA SOURCE	DEFINITION	PERCENTAGE	
			Numerator	Denominator
29. Percentage of the general population with <i>accepting attitude</i> toward PLWHA	Population-based survey (e.g. NARHS, NDHS)	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	Number of women and men who report an accepting attitude on all four of these questions	Number of all women and men aged 15–49 surveyed who have heard of HIV

**KNOWLEDGE  
OUTPUT INDICATORS**

INDICATORS	DATA SOURCE	DEFINITION	PERCENTAGE		Value/Comments
			Numerator	Denominator	
30. Number of people trained to provide HIV/AIDS peer education	Program Report/Service Report		n/a	n/a	Total number of people trained to provide HIV/AIDS peer education
31a. Number of high risk groups (female sex workers) reached with HIV/AIDS prevention programs.	Program Report/Service Report		n/a	n/a	Total number of high risk groups (female sex workers) reached with HIV/AIDS prevention programs.
31b. Number of high risk groups (armed forces) reached with HIV/AIDS prevention programs	Program Report/Service Report		n/a	n/a	Total number of high risk groups (armed forces) reached with HIV/AIDS prevention programs.
31c. Number of high risk groups (transport workers) reached with HIV/AIDS prevention programs.	Program Report/Service Report		n/a	n/a	Total number of high risk groups (transport workers) reached with HIV/AIDS prevention programs.

**CONDOM  
OUTPUT INDICATORS**

INDICATORS	DATA SOURCE	DEFINITION	PERCENTAGE		Value/Comments
			Numerator	Denominator	
32. Total number of condoms (male) distributed by social marketing outlets in the country.	Program Report		n/a	n/a	TOTAL # of condoms distributed to end users

**PMTCT  
OUTPUT INDICATORS**

INDICATORS	DATA SOURCE	DEFINITION	PERCENTAGE		Value/Comments
			Numerator	Denominator	
33. Number of pregnant women who received HIV counseling and testing for PMTCT and received their test result	PMTCT/MIS		n/a	n/a	Total number of pregnant women who received HIV counseling and testing for PMTCT and received their test result
34. Number of women receiving a complete course of antiretroviral prophylaxis to reduce the risk of mother to child transmission within a calendar year	PMTCT/MIS		n/a	n/a	Total number of women receiving a complete course of antiretroviral prophylaxis to reduce the risk of mother to child transmission within a calendar year
35. Number of health facilities providing a complete PMTCT package	Mapping/Listing		n/a	n/a	Total number of communities/LGAs with facilities that are providing comprehensive PMTCT services

**PMTCT  
OUTPUT INDICATORS**

INDICATORS	DATA SOURCE	DEFINITION	PERCENTAGE		Value/Comments
			Numerator	Denominator	
36. Number of people provided with Counseling and testing for HIV and received their test results. (cumulative)	HCT MIS/HMIS		n/a	n/a	Number of the general population who received Counseling and testing for HIV and received their test results.
37. Number of HIV counseling and testing service outlets	Mapping/Listing		n/a	n/a	Total number of HIV counseling and testing service outlets

**TREATMENT  
OUTPUT INDICATORS**

INDICATORS	DATA SOURCE	DEFINITION	PERCENTAGE		Value/Comments
			Numerator	Denominator	
38. Number enrolled in HIV care: (a) new and (b) current (c) cumulative ever at the facility by age and sex	Program Report (PMM)				
(a) New			n/a	n/a	Figures presented are for new cases only.
			n/a	n/a	All HIV+ population in the year less 10% attrition= new Rx +new BC&S
(b) Current			n/a	n/a	All HIV + population (old and new including treatment) =PC previous year – those convert to Rx + new PC for the year
(c) Cumulative			n/a	n/a	BC&S –new entry to Rx + new PC including attrition + current Rx.
39. Number on ART: (a) new (b) current and (c) cumulative ever started in the country	Program Report (PMM)		n/a	n/a	
New (Within the year)	Program Report (PMM)		n/a	n/a	
Current (at end of reporting period)	Program Report (PMM)		n/a	n/a	
Cumulative (at end of reporting period)	Program Report (PMM)		n/a	n/a	
40. Number of service delivery points providing anti retroviral combination therapy	Program Report (PMM)		n/a	n/a	Total number of service delivery points providing anti retroviral combination therapy

**PALLIATIVE CARE – HOME BASED CARE  
OUTPUT INDICATORS**

INDICATORS	DATA SOURCE	DEFINITION	PERCENTAGE		Value/Comments
			Numerator	Denominator	
41. Number of HIV/Positive people receiving Home based care	Program Report		n/a	n/a	Total number of HIV/Positive people receiving Home based care

**TB/HIV COLLABORATION  
OUTPUT INDICATORS**

INDICATORS	DATA SOURCE	DEFINITION	PERCENTAGE		Value/Comments
			Numerator	Denominator	
42. Number of HIV patients currently in care who commenced TB Rx	Program Report (PMM)	Total number of HIV patients currently in care who are commenced TB Rx	n/a	n/a	

**OPPORTUNISTIC INFECTIONS  
OUTPUT INDICATORS**

INDICATORS	DATA SOURCE	DEFINITION	PERCENTAGE		Value/Comments
			Numerator	Denominator	
43. Number of people with HIV patients currently in care who are receiving cotrimoxazole prophylaxis	Program Report (PMM)		n/a	n/a	Number of persons newly enrolled for HIV care who were placed on CTX prophylaxis this month

**PREVENTION: OVC  
OUTPUT INDICATORS**

INDICATORS	DATA SOURCE	DEFINITION	PERCENTAGE		Value/Comments
			Numerator	Denominator	
44. Number of orphans and vulnerable children whose household received free basic external support in caring for the child	Program Report	Total number of orphans and vulnerable children whose household received free basic external support in caring for the child	n/a	n/a	Total number of orphans and vulnerable children whose household received free basic external support in caring for the child

**MONITORING AND EVALUATION  
OUTPUT INDICATORS**

INDICATORS	DATA SOURCE	DEFINITION	PERCENTAGE		Value/Comments
			Numerator	Denominator	
45. Percentage of Service Delivery Points submitting timely and complete reports	Program Report		n/a	n/a	Analysis of report from Zonal M&E Officers from NASCP

## ANNEX 2: Implementing Partners: National M&E System Development and Implementation

Program / Service Delivery Areas		Implementers (Public, CS, Private and IPs)	Data Collection Methodologies (HMIS, surveillance, etc.)	Responsible(s) for Data Collection	Data Flow, Collation and Reporting	Levels of Decision Making and Policy Formulation
Prevention	BCC: Mass Media	NACA, GHAIN, FHI, Society for Family Health, DFID, NGOs, FBOs	National HIV AIDS and RH Survey, NNRIMS	NARHS: FMOH/NASCP NNRIMS: SACAs and LACAs	NARHS: LGA → State → Fed	All Levels
	BCC: Community Outreach	NGOs, FBOs		SACAs, LACAs	LGA → State → Fed	All Levels
	Youth Education	FMoE, SMoE;	IS	Principals	LGA → State → Fed	National and State
		NGO/FBOs; MOS&SD				
	Condom Distribution	SFH, NACA	NARHS, NNRIMS	LACA, SACA	LGA → State → Fed	All Levels
		Line Ministries				
		Private sector				
	Program Specific Groups (CSW, Migrants, MSM)	NGOs (SWAAN, SFH)	Questionnaires, Survey Report			
	VCT	FMOHFMoH, SMoH, GHAIN, IHVN, ICAP, APIN, AIDSRELIEF, FBOs, Private	HMIS, NNRIMS, NARHS, NHSS		SDP → FMOHFMoH (NASCP), NACA	National
	PMTCT	FMOHFMoH, SMoH, GHAIN, IHVN, ICAP, APIN, AIDSRELIEF, FBOs, Private	NNRIMS, NARHS, NHSS		SDP → FMOHFMoH (NASCP), NACA	National
STI Diagnosis	FMOHFMoH, SMoH, FBOs, Private	HMIS, NARHS, NHSS		LGA → State → Fed		

Comment [U2]: Toyin pls use only the light part of the green so that the text in the upper part of the table will be legible

	Post Exposure Prophylaxis					
	Blood Safety	FMOHFMoH, Safe Blood Africa	Registers, HMIS		LGA → State → Fed	National
	Universal Precaution	ENHANCE	Guidelines,			
<b>Care and Support</b>	OVC	FMoWA, NGOs, FBOs	Action Plan, Guidelines		LGA → State → Fed	National
	TB	FMOHFMoH, FBOs	Summary Forms NNRIMS		LGA → State → Fed	National
	Support for Chronically Ill	FMOHFMoH, SMoH	Health Register		LGA → State → Fed	
<b>Treatment</b>	OI	FMOHFMoH, FBOs, Private	Summary Forms, NNRIMS		SDP → FMOHFMoH (NASCP), NACA	National
	ARV	FMOHFMoH, SMoH, FBOs, Private	Summary Forms, NNRIMS		SDP → FMOHFMoH (NASCP), NACA	National
	TB	FMOHFMoH, FBO	Summary Forms, NNRIMS			National
<b>Supportive Environments</b>	Workplace	FML&P	Questionnaires, Survey Report			National
	Adult Support: Sexual Health Education for the young population	FMoE, FMoWA, NGOs	Program Reports			
	Stigma and discrimination	NACA, NGOs	Program Reports			
	Partnerships: Civil society - public sector, private-public partnerships, among others	NACA, CiSHNAN, NEPWAN	Program Reports			
<b>Management Environment</b>	M&E System	NACA, Measure Evaluation, NASCP	NNRIMS		LGA → State → Fed	All Levels
	NACA					
	Procurement / Logistics	NACA, JSI Deliver, Crown Agent	PSM Doc		SDP → FMOHFMoH (NASCP), NACA, CMS	National
	Decentralization	SACA, LACA, State L/Min				

### ANNEX 3: NOP Implementation Plan

Activities and Tasks	Responsible	Period	Duration
Launching of NOP	NACA	August	1 day
Costing of NOP	NACA/ GAMET	September	2 weeks
Dissemination of NOP to Stakeholders	NACA	September	1 week
<b>Roll out of NOP in the states</b>			
Capacity building of six states on NOP	NACA	December	1 week
Commencement NOP implementation – data collation, analysis, information flow and decision making	NACA	January	4 months
Assessment of NOP piloting in six states	NACA	Jan 09	2 weeks

**Comment [U3]:** Toyin pls use only the light part of the green so that the text in the upper part of the table will be legible

## ANNEX 4: SWOT Analysis of NNRIMS Implementation 2004 – 2006

Below is a SWOT analysis of the implementation of NNRIMS:

<p><b>Strengths</b></p> <ul style="list-style-type: none"> <li>✚ Created awareness about monitoring and evaluation as a core function of the response among program managers and donor partners.</li> <li>✚ Capacity for monitoring and evaluation developed at federal, state, local government and service delivery levels.</li> <li>✚ Facilitated the development of national M&amp;E tools for major programmes in all sectors.</li> <li>✚ Mobilized increased financial and human resources for M&amp;E at all levels.</li> </ul>	<p><b>Weaknesses</b></p> <ul style="list-style-type: none"> <li>✚ Absence of an operational plan and budget to operationalize the NNRIMS framework</li> <li>✚ Inability to fully provide guidance for monitoring and evaluating all issues articulated in the NSF and the country roadmap for moving towards Universal Access (UA) for prevention, treatment, care and support that was developed in 2006.</li> <li>✚ Proliferation of tools and systems for strategic information in Nigeria.</li> <li>✚ The system is well developed at the central level (NACA). However a lot more needs to be done to decentralize its operationalization to the sectors, states, local governments and service delivery points</li> </ul>
<p><b>Opportunities</b></p> <ul style="list-style-type: none"> <li>✚ Development partners’ willingness to support monitoring and evaluation</li> <li>✚ General stakeholder interest in monitoring and evaluation</li> <li>✚ Interest and willingness to harmonize and align programmes and support</li> </ul>	<p><b>Threats</b></p> <ul style="list-style-type: none"> <li>✚ Limited funding for implementation of monitoring and evaluation activities (less than the 10% recommendation)</li> </ul>

**Comment [U4]:** Toyin pls use only the light part of the green so that the text in the upper part of the table will be legible

## ANNEX 5: NNRIMS Activity Report Form.

Formatted

Comment [U5]: Toyin Pls insert the NNRIMS Activity Report Form that I gave you through Louis that is in excel

NIGERIA NATIONAL FACILITY MONTHLY REPORTING SUMMARY FORM FOR ARV SITES									
1. Name of facility					2. State				
3. Month of Report					4. Year of Report				
Sources of Funding:		GON <input type="checkbox"/>		PEPFAR <input type="checkbox"/>		OTHERS <input type="checkbox"/>		Grand Total	
		Male	Female	Male	Female	Male	Female		
		0 - 14 yrs	15yrs & above	0 - 14 yrs	15yrs & above	0 - 14 yrs	15yrs & above		
Coverage and Usage									Source of information
ART 1	Number of Persons cumulatively enrolled into the ART program for <b>HIV care</b> before this reporting period (month)								Pre ART Register
ART 2	Number of persons newly enrolled into the ART program for <b>HIV care</b> during the last month								Pre ART Register
ART 3	Number of Persons cumulatively enrolled into the ART program for <b>HIV care</b> since the beginning of the program								Pre ART Register
ART 4	No of persons eligible for ART but yet to commence ART								Pre ART Register
ART 5	Number of Persons cumulatively started on ART before this reporting period (month)								ART register
ART 6	Number of persons newly started on <b>ART</b> during the last month								ART register
ART 7	Number of Persons cumulatively started on ART since the beginning of the program								ART register

NIGERIA NATIONAL FACILITY MONTHLY REPORTING SUMMARY FORM FOR ARV SITES								
1. Name of facility				2. State				
3. Month of Report				4. Year of Report				
Sources of Funding:		GON <input type="checkbox"/>		PEPFAR <input type="checkbox"/>		OTHERS <input type="checkbox"/>		Grand Total
		Male	Female	Male	Female	Male	Female	
		0 - 14 yrs	15yrs & above	0 - 14 yrs	15yrs & above	0 - 14 yrs	15yrs & above	
Coverage and Usage								Source of information
ART 8	Number of pregnant women who initiated ARV this month							ART register
ART 9	Number of persons cumulatively transferred in for ART from other health facilities							ART register
ART 10	Number of persons newly transferred into the ART program for ART from other facilities during the month							ART register
ART 11	Number of persons who restarted ART therapy after stopping therapy for more than 3 months							ART register

NIGERIA NATIONAL FACILITY MONTHLY REPORTING SUMMARY FORM FOR ARV SITES								
1. Name of facility				2. State				
3. Month of Report				4. Year of Report				
Sources of Funding:		GON <input type="checkbox"/>		PEPFAR <input type="checkbox"/>		OTHERS <input type="checkbox"/>		Grand Total
		Male	Female	Male	Female	Male	Female	
		0 - 14 yrs	15yrs & above	0 - 14 yrs	15yrs & above	0 - 14 yrs	15yrs & above	
Drug Adherence								Source of information
ART 12	Number of persons on due to receive ARVs who had <b>initial adherence counseling</b> this month							Adherence register
ART 13	Number of persons who did not pick up their ARV regimens in the month							ART Register
ART 14	Number of persons who did not pick up there medication in the past month who have been <b>MISSING</b> from the program							ART Register
ART 15	Number of persons who did not pick up there medication in the past month who have been <b>LOST TO FOLLOW UP</b> from the program							ART Register
ART 16	Number of persons who did not pick up there medication in the past month who have died ( <b>DEAD</b> )							ART Register
ART 17	Number of persons who did not pick up there medication in the past month who have <b>STOPPED</b> ART							ART Register
ART 18	Number of persons who did not pick up there medication in the past month who have <b>TRANSFERRED OUT</b>							ART Register

NIGERIA NATIONAL FACILITY MONTHLY REPORTING SUMMARY FORM FOR ARV SITES								
1. Name of facility				2. State				
3. Month of Report				4. Year of Report				
Sources of Funding:		GON <input type="checkbox"/>		PEPFAR <input type="checkbox"/>		OTHERS <input type="checkbox"/>		Grand Total
		Male	Female	Male	Female	Male	Female	
		0 - 14 yrs	15yrs & above	0 - 14 yrs	15yrs & above	0 - 14 yrs	15yrs & above	
								Source of information
ART 19	Number of baseline CD4+ counts for persons who enrolled for HIV care during the previous month (optional).							Pre ART Register
ART 20	Number of baseline CD4+ counts for persons who started ART during the previous month (optional).							ART Register
ART 21	Median baseline CD4+ count for persons who started ART during the previous quarter (optional).							ART Register
								Source of information
ART 22	Number of persons newly enrolled for HIV care who were screened for TB this month							Pre ART Register
ART 23	Number of persons newly enrolled for HIV care who were placed on INH prophylaxis this month							Pre ART Register
ART 24	Number of persons newly enrolled for HIV care who were placed on CTX prophylaxis this month							Pre ART Register

**NIGERIA NATIONAL FACILITY MONTHLY REPORTING SUMMARY FORM FOR ARV SITES**

<b>1. Name of facility</b>				<b>2. State</b>				
<b>3. Month of Report</b>				<b>4. Year of Report</b>				
<b>Sources of Funding:</b>		GON <input type="checkbox"/>		PEPFAR <input type="checkbox"/>		OTHERS <input type="checkbox"/>		Grand Total
	Male	Female	Male	Female	Male	Female		
	0 - 14 yrs	15yrs & above	0 - 14 yrs	15yrs & above	0 - 14 yrs	15yrs & above		
<b>ARV Drug Regimens</b>								<b>Source of information</b>
ART 25	Number of persons currently on 1st-line ART regimens this month							ART Register
ART 26	Number of persons currently on 2nd line ART regimens this month							ART Register
ART 27	Number of persons currently on 1st and 2nd line ART regimens this month							ART Register
ART 28	Number of persons on Salvage drug regimens this month							ART Register
ART 29	Total number of persons on 1st line, 2nd line and Salvage drug regimens this month							ART Register
ART 30	Did you experience a stock out of any 1st or 2nd line regimen drug during the month?		YES		NO			
ART 31	If you answered "yes" to question ART 30, which drug(s) and regimen(s) were stocked out? (list in space at right)							

NIGERIA NATIONAL FACILITY MONTHLY REPORTING SUMMARY FORM FOR ARV SITES									
1. Name of facility				2. State					
3. Month of Report				4. Year of Report					
Sources of Funding:			GON <input type="checkbox"/>		PEPFAR <input type="checkbox"/>		OTHERS <input type="checkbox"/>		Grand Total
			Male	Female	Male	Female	Male	Female	
			0 - 14 yrs	15yrs & above	0 - 14 yrs	15yrs & above	0 - 14 yrs	15yrs & above	
<b>HIV Counseling &amp; Testing</b>									
<b>Source of information</b>									
HCT 1	Number of Clients pre-test counseled this month								HCT register
HCT 2	Number of Clients counseled and tested for HIV this month								HCT register
HCT 3	Number of Clients post-test counseled this month								HCT register
HCT 4	Number of Clients who receive their results and were post-test counseled this month								HCT register
HCT 5	Number of clients who tested positive this month								HCT lab register
HCT 6	Number of clients who tested negative this month								HCT lab register
HCT 7	Number of clients referred to Support groups this month								HCT register
HCT 8	Number of clients referred for Home -Based Care this month								HCT register

NIGERIA NATIONAL FACILITY MONTHLY REPORTING SUMMARY FORM FOR ARV SITES										
1. Name of facility					2. State					
3. Month of Report					4. Year of Report					
<b>Sources of Funding:</b>			GON <input type="checkbox"/>		PEPFAR <input type="checkbox"/>		OTHERS <input type="checkbox"/>		Grand Total	
			Male	Female	Male	Female	Male	Female		
			0 - 14 yrs	15yrs & above	0 - 14 yrs	15yrs & above	0 - 14 yrs	15yrs & above		
<b>HIV Counseling &amp; Testing</b>									<b>Source of information</b>	
HCT 9	No of persons who tested for HIV who were also referred for TB screening								HCT register	
HCT10	Number of patients referred from STI clinics								HCT register	
HCT11	Number of patients referred from TB clinics								HCT register	
HCT12	Number of patients referred from ANC clinics								HCT register	
HCT13	Number of patients self referred								HCT register	
HCT14	Did you experience a stock out of any test kits during the month?		YES			NO				
HCT15	If you answered "yes" to question VCT15, which test kit(s) was stocked out? (list in space at right)									

**NIGERIA NATIONAL FACILITY MONTHLY REPORTING SUMMARY FORM FOR ARV SITES**

<b>1. Name of facility</b>		<b>2. State</b>					
<b>3. Month of Report</b>		<b>4. Year of Report</b>					
<b>Sources of Support/Funding:</b>		<b>FGN</b> <input type="checkbox"/>	<b>PEPFAR</b> <input type="checkbox"/>	<b>GLOBAL FUND</b> <input type="checkbox"/>	<b>OTHERS (specify)</b>	<b>Grand Total</b>	
		Female					
		<15 yrs	>=15 yrs				
<b>PMTCT Program</b>							
PMTCT 1	Number of pregnant women who were seen by a provider						
PMTCT 2	Number of pregnant women pre-test counseled						
PMTCT 3	Number of pregnant women tested for HIV						
PMTCT 4	Number of pregnant women who received their test results						
PMTCT 5	Number of pregnant women post-test counseled						
PMTCT 6	Number of pregnant women who tested positive						
PMTCT 7	Number of pregnant women who tested negative						
PMTCT 8	Number of HIV-positive pregnant women provided with ART prophylaxis						

NIGERIA NATIONAL FACILITY MONTHLY REPORTING SUMMARY FORM FOR ARV SITES										
1. Name of facility					2. State					
3. Month of Report					4. Year of Report					
Sources of Support/Funding:			FGN <input type="checkbox"/>		PEPFAR <input type="checkbox"/>		GLOBAL FUND <input type="checkbox"/>		OTHERS (specify)	Grand Total
			Female							
			<15 yrs		>=15 yrs					
<b>PMTCT Program</b>										
PMTCT 9	Number of HIV-positive pregnant women counseled on infant feeding									
PMTCT 10	Number of HIV-positive woman given a dose of nevirapine at antenatal and/or labor									
PMTCT 11	Number of babies born to HIV-positive woman given a dose of Nevirapine									
PMTCT 12	Did you experience a stock out of Nevirapine during the month?		YES		NO					
<b>ANC Sites without a PMTCT Program</b>										
PMTCT 13	Number of Antenatal patients pre-tested counseled									
PMTCT 14	Number of Antenatal patients tested for HIV									
PMTCT 15	Number of Antenatal patients who test positive for HIV									

**NIGERIA NATIONAL FACILITY MONTHLY REPORTING SUMMARY FORM FOR ARV SITES**

<b>1. Name of facility</b>		<b>2. State</b>							
<b>3. Month of Report</b>		<b>4. Year of Report</b>							
<b>Sources of Support/Funding:</b>		FGN <input type="checkbox"/>		PEPFAR <input type="checkbox"/>		GLOBAL FUND <input type="checkbox"/>		OTHERS (specify)	Grand Total
		Male		Female					
<b>ORPHANS AND VULNERABLE CHILDREN (OVC)</b>									
OVC1	Total number of OVCs served								
OVC2	Number of OVCs provided with financial support								
OVC3	Number of OVCs provided with clinical management support								
OVC4	Number of OVCs provided with nursing care at home support								
OVC5	Number of OVCs provided with food and nutrition support								
OVC6	Number of OVCs provided with psychosocial support								
OVC7	Number of OVCs provided with clothing support								
OVC8	Number of OVCs provided with education expenses support								
OVC9	Number of OVCs provided with legal aid support								
OVC10	Number of OVCs provided with vocational training support								
OVC12	Number of OVC provided with minimum package according to national guidelines								
OVC13	Number of widows provided with access to micro-credit support								
OVC14	Number of widows referred to support groups								
OVC15	Number of widows provided with food and nutrition support								
OVC16	Number of caregivers (excluding widows) provided with access to micro-credit support								

NIGERIA NATIONAL FACILITY MONTHLY REPORTING SUMMARY FORM FOR ARV SITES									
1. Name of facility					2. State				
3. Month of Report					4. Year of Report				
Sources of Support/Funding:		FGN <input type="checkbox"/>		PEPFAR <input type="checkbox"/>		GLOBAL FUND <input type="checkbox"/>		OTHERS (specify)	Grand Total
		Male		Female					
<b>ORPHANS AND VULNERABLE CHILDREN (OVC)</b>									
OVC17	Number of caregivers (excluding widows) referred to support groups								
OVC18	Number of caregivers (excluding widows) provided with food and nutrition support								
OVC19	Total number of orphans in school								

**NIGERIA NATIONAL FACILITY MONTHLY REPORTING SUMMARY FORM FOR ARV SITES**

<b>1. Name of facility</b>				<b>2. State</b>											
<b>3. Month of Report</b>				<b>4. Year of Report</b>											
<b>Sources of Support/Funding:</b>		FGN <input type="checkbox"/>		PEPFAR <input type="checkbox"/>		GLOBAL FUND <input type="checkbox"/>		OTHERS (specify)		<b>Grand Total</b>					
<b>HOME BASED AND COMMUNITY CARE</b>															
HBC1		Number of home based care service outlets (team) reported on: __													
		<b># Reach in past month</b>				<b>Total # reached</b>									
		<b>Rural</b>		<b>Urban</b>		<b>Rural</b>		<b>Urban</b>							
HBC2		Number of home based care visits by health care workers													
HBC3		Number of home based care visits by volunteers													
HBC4		Number of Households supported by your organization													
HBC5		Number of Households provided with nutritional support													
HBC6		Number of Households provided with psychosocial support													
HBC7		Number of Households provided with financial support													
HBC8		Number of Households provided with support for clinical care													
HBC9		Number of Households provided with legal aid													
HBC10		Number of Households provided with education support													
		<b>Male</b>		<b>Female</b>		<b>Total</b>									
		<b>&lt;15 yrs</b>		<b>&gt;=15yrs</b>		<b>&lt;15yrs</b>		<b>&gt;=15yrs</b>		<b>Male</b>		<b>Female</b>		<b>Grand Total</b>	
HBC11		Number of HIV positive persons enrolled in PLWHA support groups in the last month													
HBC12		Total number of HIV positive persons enrolled in PLWHA support groups to date													

NIGERIA NATIONAL FACILITY MONTHLY REPORTING SUMMARY FORM FOR ARV SITES										
1. Name of facility					2. State					
3. Month of Report					4. Year of Report					
<b>Sources of Support/Funding:</b>		FGN <input type="checkbox"/>	PEPFAR <input type="checkbox"/>	GLOBAL FUND <input type="checkbox"/>	OTHERS (specify)					
<b>BCC/PREVENTION ACTIVITIES</b>		<b>Number of activities conducted using the following strategies</b>					<b># people reached (estimate)</b>		<b># of people trained</b>	
		Abstinence and/or Be faithful (AB)	Abstinence Only (A)	Condom (C)	Others (Specify)		Male	Female	Male	Female
BCC1	Mass media									
BCC2	Community Outreach									
BCC3	Advocacy									
BCC4	Life Skills									
BCC5	Condom promotion									
BCC6	Peer Education									
BCC7	Counseling									
BCC8	Phone-in Program									
BCC9	Mass media									
<b>Source of Support/Funding</b>		FGN	PEPFAR	Global Fund	Others (Specify)					
<b>CONDOM DISTRIBUTION</b>										
			Number (of Cartons)							
CND1	Condom Distribution to Retail Outlets									
CND3	Condom Distribution to other Groups									

TRAINING	Source of information	Program reports	Program reports	Program reports	Program reports	Program reports	Program reports	Program reports
Doctors								
Pharmacists								
Nurses								
Nurse/ Midwives								
Lab Scientists								
Lab technicians								
Medical Records								
Social workers								
Counselors (not registered nurses)								
Records officers								
Data mangers								
Cashiers								
Community Health officers								
CHEWS/JCHEWS								

## ANNEX 6: Format of Annual National HIV/AIDS M&E Report

### 1. Foreword

This should be a statement by the Director General of the National Agency for the Control of AIDS.  
The report shall be approved by NACA Governing Board prior to its publication.

### 2. Executive Summary

This should be a two or three page summary of the overall report, with a focus on key statistics and changes in statistics, as well as a description of key trends and how these influence the implementation of HIV/AIDS interventions.

### 3. Annual M&E System Results

#### A. REDUCTION IN HIV INCIDENCE/PREVALENCE IMPACT-LEVEL INDICATORS

INDICATORS & REFERENCES	Data Source	Responsible Organization	Baseline (2005)	Previous year's Target	Previous year Result	Current Year Target	Current Year Result	Comments
1. Percentage of young people aged 15-24 who are HIV-infected			4.3% (2005)					
2. HIV prevalence rate in the general population			4.4% (2005)					
3. Percentage of HIV positive infants born to HIV-infected mothers			45.00%					

**B IMPROVEMENT IN LIFE EXPECTANCY OF PLWHA**  
**IMPACT-LEVEL INDICATORS**

INDICATORS & REFERENCES	Data Source	Responsible Organization	Baseline (2005)	Previous year's Target	Previous year Result	Current Year Target	Current Year Result	Comments
4a. Percentage of adults and children with HIV still alive after 6 months after initiation of anti-retroviral therapy				4a. Percentage of adults and children with HIV still alive after 6 months after initiation of anti-retroviral therapy				
4b. Percentage of adults and children with HIV still alive after 12 months after initiation of anti-retroviral therapy			90.00%	4b. Percentage of adults and children with HIV still alive after 12 months after initiation of anti-retroviral therapy			90.00%	
4c. Percentage of adults and children with HIV still alive after 24 months after initiation of anti-retroviral therapy			85.00%	4c. Percentage of adults and children with HIV still alive after 24 months after initiation of anti-retroviral therapy			85.00%	

**PREVENTION: KNOWLEDGE**  
**OUTCOME INDICATORS**

INDICATORS & REFERENCES	Data Source	Responsible Organization	Baseline (2005)	Previous year's Target	Previous year Result	Current Year Target	Current Year Result	Comments
5. 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			19%					
6. 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			25.90%					

**PREVENTION: SEXUAL BEHAVIOR**  
**OUTCOME INDICATORS**

INDICATORS & REFERENCES	Data Source	Responsible Organization	Baseline (2005)	Previous year's Target	Previous year Result	Current Year Target	Current Year Result	Comments
7. 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.			Male 65.6% Female 34.4%	7. 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.				
8. 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.			Female 17.4 Male 20.1	8. 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.				
9. Percentage of young women and men aged 15-49 who have had sex with a non-marital, non-cohabiting sexual partner in the last 12 month			Male 20.70% Female 10.70%	9. Percentage of young women and men aged 15-49 who have had sex with a non-marital, non-cohabiting sexual partner in the last 12 month				

**PREVENTION: CONDOM**  
**OUTCOME INDICATORS**

<b>INDICATORS &amp; REFERENCES</b>	<b>Data Source</b>	<b>Responsible Organization</b>	<b>Baseline (2005)</b>	<b>Previous year's Target</b>	<b>Previous year Result</b>	<b>Current Year Target</b>	<b>Current Year Result</b>	<b>Comments</b>
10. 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			Male 61.3% Female 43.8%					
11. Percentage of high-risk groups reporting the use of condom the last time they had sex (with a non-marital, non-cohabiting sexual partner)								
12. Percent of sex workers who in the past 12 months used a condom consistently during sexual intercourse with a client			85.10%					

**PREVENTION: PMTCT**  
**OUTCOME INDICATORS**

<b>INDICATORS &amp; REFERENCES</b>	<b>Data Source</b>	<b>Responsible Organization</b>	<b>Baseline (2005)</b>	<b>Previous year's Target</b>	<b>Previous year Result</b>	<b>Current Year Target</b>	<b>Current Year Result</b>	<b>Comments</b>
13. 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			3.0% (2005)					
14. Percentage of LGA with at least one PMTCT centre offering the complete package of PMTCT services			10%					

**PREVENTION: BLOOD SAFETY/NOSCOMIAL/MEDICAL INJECTION TRANSMISSION**

**OUTCOME INDICATORS**

<b>INDICATORS &amp; REFERENCES</b>	<b>Data Source</b>	<b>Responsible Organization</b>	<b>Baseline (2005)</b>	<b>Previous year's Target</b>	<b>Previous year Result</b>	<b>Current Year Target</b>	<b>Current Year Result</b>	<b>Comments</b>
15. 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								
16. Percentage of blood units transfused in the last 12 months that have been screened for HIV								

**PREVENTION: SEXUALLY TRANSMITTED INFECTIONS**

**OUTCOME INDICATORS**

<b>INDICATORS &amp; REFERENCES</b>	<b>Data Source</b>	<b>Responsible Organization</b>	<b>Baseline (2005)</b>	<b>Previous year's Target</b>	<b>Previous year Result</b>	<b>Current Year Target</b>	<b>Current Year Result</b>	<b>Comments</b>
17. Percentage of health facilities with capacity to appropriately diagnosed, treat and counsel patients with STI								

**PREVENTION: HIV COUNSELING & TESTING**  
**OUTCOME INDICATORS**

INDICATORS & REFERENCES	Data Source	Responsible Organization	Baseline (2005)	Previous year's Target	Previous year Result	Current Year Target	Current Year Result	Comments
18. Percentage of individuals who ever received counseling and testing for HIV and received their test result			8.30%					
19. Percentage of high risk groups who received HIV counseling and testing services in the last 12 months.			21%					
20. Percentage of LG with specified no. of service outlets providing HCT	Health facility survey		Estimated at 15%					

**PREVENTION: TREATMENT**  
**OUTCOME INDICATORS**

INDICATORS & REFERENCES	Data Source	Responsible Organization	Baseline (2005)	Previous year's Target	Previous year Result	Current Year Target	Current Year Result	Comments
21. Percentage of people with advance HIV-infection receiving (current) antiretroviral combination therapy			18% (2006)					
22. Percentage of Local Government Areas with at least one health facility providing ART services and care and treatment for people in-line with national standards								

**PREVENTION: OVC**  
**OUTCOME INDICATORS**

INDICATORS & REFERENCES	Data Source	Responsible Organization	Baseline (2005)	Previous year's Target	Previous year Result	Current Year Target	Current Year Result	Comments
23. Percentage of orphans and vulnerable children whose house holds received free basic external support in caring for the child			3%					
24. Ratio of current school attendance rate among orphans to that among non-orphans, aged 10-14			0.64 (NDHS, 2003)					

**PREVENTION: POLICY & COORDINATION**  
**OUTCOME INDICATORS**

INDICATORS & REFERENCES	Data Source	Responsible Organization	Baseline (2005)	Previous year's Target	Previous year Result	Current Year Target	Current Year Result	Comments
25. Percentage of Line Ministries and <i>Large Enterprises/Companies</i> that have HIV/AIDS workplace policy and programs			46.90%					
26. National AIDS program effort index (National Composite Policy Index)			62.0% (2005)					
27. Percentage and amount of national funds disbursed by governments on HIV/AIDS			#####					

**PREVENTION: STIGMA & DISCRIMINATION**  
**OUTCOME INDICATORS**

INDICATORS & REFERENCES	Data Source	Responsible Organization	Baseline (2005)	Previous year's Target	Previous year Result	Current Year Target	Current Year Result	Comments
28. Percentage of the general population with <b>accepting attitude</b> toward PLWHA			65.20%					

**PREVENTION: KNOWLEDGE**  
**OUTPUT INDICATORS**

INDICATORS & REFERENCES	Data Source	Responsible Organization	Baseline (2005)	Previous year's Target	Previous year Result	Current Year Target	Current Year Result	Comments
29. Number of people trained to provide HIV/AIDS peer education			43,000		29. Number of people trained to provide HIV/AIDS peer education			43,000
30a. Number of high risk groups (female sex workers) reached with HIV/AIDS prevention programs.			58.20%		30a. Number of high risk groups (female sex workers) reached with HIV/AIDS prevention programs.			58.20%
30b. Number of high risk groups (armed forces) reached with HIV/AIDS prevention programs.			80.50%		30b. Number of high risk groups (armed forces) reached with HIV/AIDS prevention programs.			80.50%
30c. Number of high risk groups (transport workers) reached with HIV/AIDS prevention programs.			64.20%		30c. Number of high risk groups (transport workers) reached with HIV/AIDS prevention programs.			64.20%

**PREVENTION: CONDOM**  
**OUTPUT INDICATORS**

INDICATORS & REFERENCES	Data Source	Responsible Organization	Baseline (2005)	Previous year's Target	Previous year Result	Current Year Target	Current Year Result	Comments
31. Total number of condoms (male) distributed by social marketing outlets in the country.			159,333,336 (2005)					

**PREVENTION: PMTCT**  
**OUTPUT INDICATORS**

INDICATORS & REFERENCES	Data Source	Responsible Organization	Baseline (2005)	Previous year's Target	Previous year Result	Current Year Target	Current Year Result	Comments
32. Number of pregnant women who received HIV counseling and testing for PMTCT and received their test result			<150,000	32. Number of pregnant women who received HIV counseling and testing for PMTCT and received their test result			<150,000	
33. Number of women receiving a complete course of antiretroviral prophylaxis to reduce the risk of mother to child transmission within a calendar year				33. Number of women receiving a complete course of antiretroviral prophylaxis to reduce the risk of mother to child transmission within a calendar year				
34. Number of health facilities providing a complete PMTCT package			194 (2006)	34. Number of health facilities providing a complete PMTCT package			194 (2006)	

**PREVENTION COUNSELLING & TESTING**  
**OUTPUT INDICATORS**

INDICATORS & REFERENCES	Data Source	Responsible Organization	Baseline (2005)	Previous year's Target	Previous year Result	Current Year Target	Current Year Result	Comments
35. Number of people provided with Counseling and testing for HIV and received their test results. (cumulative)								
36. Number of HIV counseling and testing service outlets			594 (2006)					

**PREVENTION: TREATMENT**  
**OUTPUT INDICATORS**

INDICATORS & REFERENCES	Data Source	Responsible Organization	Baseline (2005)	Previous year's Target	Previous year Result	Current Year Target	Current Year Result	Comments
37. Number enrolled in HIV care: (a)new and (b) current (c) cumulative ever at the facility by age and sex								
(a) New								
(b) Current								
(c) Cumulative								
38. Number on ART: (a)new (b)current and (c)cumulative ever started in the country								
New (Within the year)								
Current (at end of reporting period)								
Cumulative (at end of reporting period)								
39. Number of service delivery points providing anti retroviral combination therapy								

**PREVENTION: PALLIATIVE CARE – HOME BASED**  
**OUTPUT INDICATORS**

INDICATORS & REFERENCES	Data Source	Responsible Organization	Baseline (2005)	Previous year's Target	Previous year Result	Current Year Target	Current Year Result	Comments
40. Number of HIV/Positive people receiving Home based care								

**PREVENTION: TB/HIV COLLABORATION**  
**OUTPUT INDICATORS**

INDICATORS & REFERENCES	Data Source	Responsible Organization	Baseline (2005)	Previous year's Target	Previous year Result	Current Year Target	Current Year Result	Comments
41. Number of HIV patients currently in care who are receiving TB Rx								

**PREVENTION: OPPORTUNISTIC INFECTIONS**  
**OUTPUT INDICATORS**

INDICATORS & REFERENCES	Data Source	Responsible Organization	Baseline (2005)	Previous year's Target	Previous year Result	Current Year Target	Current Year Result	Comments
42. Number of people with HIV receiving cotrimoxazole prophylaxis								

**PREVENTION: OVC**  
**OUTPUT INDICATORS**

INDICATORS & REFERENCES	Data Source	Responsible Organization	Baseline (2005)	Previous year's Target	Previous year Result	Current Year Target	Current Year Result	Comments
48. Number of orphans and vulnerable children whose house holds received free basic external support in caring for the child			22,000					

**PREVENTION: MONITORING & EVALUATION**  
**OUTPUT INDICATORS**

INDICATORS & REFERENCES	Data Source	Responsible Organization	Baseline (2005)	Previous year's Target	Previous year Result	Current Year Target	Current Year Result	Comments
49. Percentage of Service Delivery Points submitting timely and complete reports			40.00%	49. Percentage of Service Delivery Points submitting timely and complete reports				

#### 4. Status of National M&E system

Due to its prominence, it is recommended that this section of the report should focus on the quality of data sources and the functioning of the national M&E system itself. This section should take the form of an objective assessment of the “health” of the M&E system, by means of the following headings:

- a) Reporting on M&E system indicators in National M&E plan
- b) Quality of data sources
- c) Status of data flow to and from stakeholders, identification of bottle necks and recommendations for improvement
- d) Status of NACA database and website, and recommendations for improvement
- e) Comments on the quality and frequency of dissemination requests – particularly in light of the ad-hoc information needs which might have been submitted to NACA

#### 5. Implementing Partners and Development Partners

This section should provide the following summative information about NACA’s implementing and development partners, in tabular format:

DATA SOURCE	STATEMENT ABOUT QUALITY
1.	
2.	
3.	
4.	
5.	
6.	
7.	
8.	
9.	
10.	
11.	

INFORMATION ABOUT NACA PARTNERS	TYPE OF PARTNER	
	Development Partner	Implementing Partner
Number of partners		
Location of Partners		
Number of Partners names on database		
Number of activities supported by partners		
Type of involvement		

### ***6. Conclusions and recommendations***

This report should focus on presenting information in a format that is useful and applicable to the information needs of its readers. Thus, this section of the report should focus on key recommendations and suggested focus areas for the following year. This should be an objective assessment based on the results of the various indicators, and should not be a narrative report based on what the person writing the report feels is important.

The following headings are suggested:

- a) Overall conclusions and recommendations
- b) Conclusions per program area:
  - Information, Education, and Communication
  - Promotion of Safer Sex Practices (ABCs)
  - Prevention of Mother-to-Child Transmission
  - STI Treatment and Prevention
  - Infection Prevention and Health Care Waste Management, including Blood Safety
  - HIV Counseling and Testing
  - Anti-Retroviral Therapy
  - TB Treatment
  - Community and Home-based Care and Support
  - Support for Orphans and Vulnerable Children (OVC)
  - Sectoral Mainstreaming
  - National management and commitment
- c) Policy implications of M&E data

### ***7. Monitoring and Evaluation & Work plan***

This section shall provide feedback on what has been achieved in terms of the work plan, identify gaps and suggest improvements for the next work plan. This section should summarize key M&E activities for the following 12 months. This should include major surveys to be undertaken, as well as anticipated research to be published.

### ***8. Bibliography / list of data sources consulted***

This section of the report shall list all of the data sources that have been consulted and used in developing this report. A checklist and recording sheet has been provided overleaf to allow for easy capture of data source references while the report is being compiled.



## **ANNEX 8: Terms of Reference for National M&E Technical Working Group (NTWG)**

The NTWG is purely an advisory body for the National response of HIV/AIDS with NACA as the coordinating body. It is intended to advice on activities concerning all Monitoring, Evaluation and Information Systems activities in Nigeria.

### **Membership**

Membership will be comprised of coordinating bodies from the Government (at least NACA and NASCP), International groups, NGOs, and CBOs. The group will be chaired by an officer appointed by NACA.

### **Meeting times**

The group will meet on a monthly basis. The venue of the meeting will rotate as best fits the membership. On a monthly basis the chair of each Subgroup will present its progress and key issues emerging to the National Technical Working Group (NTWG) on HIV/AIDS for information and appropriate action.

### **Review of Terms of Reference**

These TORs will be reviewed annually and changes made as deemed necessary by the NTWG Subgroup and passed by the National TWG.

### **General Mandate**

The activities of the NTWG will include, but not be limited to the following functions:

- Providing technical guidance on appropriate data collection methods, analytic strategies, dissemination of recommendations, selection and definition of indicators for national reporting
- Monitoring changing needs for M&E as country program and advise on prioritization of tasks and recommendations for outputs or products from working groups
- Support NACA in the review of the national HIV and AIDS M&E Framework (NNRIMS) and oversee its implementation and keep stakeholders in the national HIV/AIDS response informed of developments within other institutions and working groups.
- In conjunction with NACA, facilitate the development and adoption of a national integrated and costed M&E work plan in line with NSF and oversee its implementation and identify critical technical questions arising from M&E activities and organizing smaller working groups to address the questions and provide technical feedback on issues
- Developing and maintaining consensus around M&E strategies across partners and institutions and informally advocate for increased attention to and resources for M&E activities within the National response
- Advise on the development of country's multidisciplinary HIV and AIDS research agenda and review research proposals and refer them to the appropriate structure for approval
- Support NACA in the coordination, supervision and reporting on M&E activities at sub-national levels of M&E activities (data collection, analysis, dissemination) (*although the actual coordination will be conducted by NACA*)

- Identifying and recommending strategies for addressing the needs for capacity building at all levels thereby strengthening the states' M&E group along side national, sectoral and line ministries M&E units
- Perform other activities pertinent to M&E as may be requested by the Secretariat

## **ANNEX 9: List of Organizations that contributed to the NNRIMS Operational Plan**

S/N	ORGANIZATION
1.	Armed Forces Program on AIDS Control (AFPAC)
2.	AIDS Prevention Initiative Nigeria (APIN)
3.	Association for Reproductive and Family Health (ARFH)
4.	Canadian International Development Agency (CIDA)
5.	Centre for Disease Control (CDC)
6.	Civil Society Network on HIV/AIDS in Nigeria (CiSNAN)
7.	Global HIV/AIDS Initiative Nigeria (GHAIN)
8.	Institute of Human Virology Nigeria (IHVN)
9.	Joint United Nations Program on HIV/AIDS (UNAIDS)
10.	MEASURE Evaluation
11.	National Agency for the Control of AIDS (NACA)
12.	National AIDS and STIs Control program (NASCP)
13.	Network of People Living with HIV and AIDS in Nigeria (NEPWHAN)
14.	Society for Family Health (SFH)
15.	Supporting the Nigerian Response to HIV/AIDS (SNR)
16.	United States Agency for International Development (USAIDS)
17.	World Bank
18.	World Health Organization (WHO)

## ANNEX 10: References and Documents Used

1. NPC 2006: *National report on 2006 National Census*. Abuja. National Population Commission
2. NACA 2005: *HIV/AIDS National Strategic Framework 2005-2009*. Abuja: National Action Committee on HIV/AIDS.
3. NACA 2004: *Nigeria National Response Information Management System [NNRIMS for HIV/AIDS: Guidelines & Indicators]*. Abuja: National Action Committee on HIV/AIDS.
4. Trip Report. Review of M&E Activities in HIV/AIDS, Abuja, Nigeria, March 12-18, 2006. Dr. Rosalía Rodríguez-García, GAMET, Global AIDS Program, World Bank and Dr. Marcelo Castrillo, GAMET Consultant.
5. NACA 2007: *Report of Monitoring and Evaluation Stake holder's Forum. Lokoja, March 2007*. National Agency for the Control of AIDS
6. NACA: *Report of NOP Indicator Matrix Target Setting Meeting. Kaduna May 2007*. National Agency for the Control of AIDS
8. NACA 2004: *NNRIMS Monthly Summary Form*, Abuja (Reviewed in 2007). National Agency for the Control of AIDS
9. NACA 2007: *National Standard Operating Procedure and Checklist for Data Quality Assurance*, Abuja (2007). National Agency for the Control of AIDS