HIV & AIDS

2019 – 2023 National Monitoring & Evaluation Framework for HIV, AIDS and Viral Hepatitis

SEYCHELLES

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2019 - 2023
NATIONAL
MONITORING & EVALUATION FRAMEWORK
FOR HIV, AIDS AND HEPATITIS

SEYCHELLES

GLOSSARY OF KEY TERMS

Baseline Information	:	Information – usually consisting of facts and figures collected at the initial stages of a project – that provides a basis for measuring progress in achieving project outcomes. Historical performance.
Behaviour change communication (BCC)	:	Behaviour change communication promotes tailored messages, personal risk assessment, greater dialogue, and an increased sense of ownership. Behaviour change communication is developed through an interactive process, with its messages and approaches using a mix of communication channels in order to encourage and sustain positive, healthy behaviours.
Combination HIV prevention	:	The combination prevention approach seeks to achieve maximum impact on HIV prevention by combining behavioural, biomedical and structural strategies that are human rights-based and evidence-informed, in the context of a well-researched and understood local epidemic.
Comprehensive HIV Prevention, Treatment, Care, And Support	:	Comprehensive HIV prevention, treatment, care, and support includes tailored HIV prevention strategies, clinical care, adequate nutrition, psychological support, social and daily living support, involvement of people living with HIV and their families, and respect for human rights and legal needs.
Efficiency	:	Assesses the outputs in relation to inputs, looking at costs, implementing time, and economic and financial results.
Effectiveness	:	Measures the extent to which an objective has been achieved or how likely it is to be achieved.
Evaluation	:	Systematic and independent assessments of ongoing or completed projects or programs, their design, implementation, and results with the aim of determining the relevance of objectives, development efficiency, effectiveness, impact, and sustainability.
Human Immunodeficiency Virus (HIV)	:	HIV is the virus that weakens the immune system, ultimately leading to AIDS. Since HIV means human immunodeficiency virus, it is redundant to refer to the 'HIV virus'.
Impacts	:	The positive and negative, and foreseen and unforeseen, changes to and effects caused by the projects or programs under evaluation.
Indicators	:	A measure used to gauge the extent to which an output has been achieved (policy developed, presentation delivered, service rendered). Quantitative or qualitative statements that can be used to describe situations which exist and measure changes or trends over a period of time. (In the context of the logical framework approach, an indicator defines the performance standard to be reached in order to achieve an objective.) Cost, Quality, Quantity, Time or Compliance.
Inputs	:	The funds, personnel, materials, etc., necessary to produce the intended outputs.
Monitoring	:	The continuous or periodic process of collecting and analysing data to measure the performance of a program, project, or activity. (As an integral and continuing part of project/program management, it provides managers and stakeholders with regular feedback on implementation and progress towards the attainment of global environmental objectives).
Monitoring and Evaluation (M&E)	:	The combination of monitoring and evaluation which together provide the knowledge required for: a) adaptive project management, b) reporting and accountability responsibilities, c) learning and d) empower the primary stakeholders.
M&E System	:	The set of planning, information gathering and synthesis, and reflection and reporting processes, along with the necessary supporting conditions and capacities required for the M&E outputs to make a valuable contribution to project decision making and learning.
Strategic Objectives / Goals	:	The ultimate and long-term development impact that is expected to be attained after the project purpose is achieved. (Objectives or goals define a project's success).
Output	:	The planned results that can be guaranteed with high probability as a consequence of project activities. An output is used synonymously with the terms outcome at more senior levels and result of an activity at the lower levels of an organisation.
People Living With HIV	:	People living with HIV' (PLHIV), since this reflects the fact that an infected person may continue to live well and productively for many years.
Post-exposure prophylaxis (PEP)	:	PEP refers to antiretroviral medicines that are taken after exposure or possible exposure to HIV. The exposure may be occupational, as in a needle stick injury, or non-occupational, as in unprotected sex with a person living with HIV.
Performance	:	Human performance involves (1) people's behaviour or actions, and (2) the outcomes or effects of those actions. Performance is a process in which resources are used in an effective, efficient and productive way to produce results that satisfy requirements of time, quality and quantity, and which are the effect or outcome of the actions or behaviour of a performer in the work process.
Programmes	:	A group of related projects or services directed toward the attainment of specific (usually similar or related) objectives, as per Treasury definition.
Seroprevalence	:	As related to HIV infection, seroprevalence is the percentage of persons who have serologic evidence of HIV infection, i.e. antibodies to HIV, at any given time.
Sexually transmitted infection (STI)	:	STIs are spread by the transfer of organisms from person to person during sexual contact. In addition to the traditional STIs (syphilis and gonorrhoea), the spectrum of STIs also includes: HIV, which causes AIDS; Chlamydia Trachomatis; Human Papilloma Virus (HPV), which can cause cervical, penile or anal cancer; genital herpes; and Chancroid. More than 20 disease-causing organisms and syndromes are now recognised as belonging in this category.

GLOSSARY OF KEY TERMS

Stakeholders	:	People, groups, organisations, or other bodies with a "stake" or interest in the area or field where interventions and assistance are directed.
Stigma and Discrimination	:	'Stigma' is derived from the Greek meaning a mark or a stain. Stigma can be described as a dynamic process of devaluation that significantly discredits an individual in the eyes of others. When stigma is acted upon, the result is discrimination that may take the form of actions or omissions. Discrimination refers to any form of arbitrary distinction, exclusion, or restriction affecting a person, usually but not only by virtue of an inherent personal characteristic or perceived belonging to a particular group—in the case of AIDS, a person's confirmed or suspected HIV-positive status—irrespective of whether or not there is any justification for these measures.
Tuberculosis (TB)	:	Tuberculosis (TB) is the leading HIV-associated opportunistic infection in low- and middle income countries and is a leading cause of death among people living with HIV globally.
Validity	:	The extent to which the information measures what it is intended to measure.

TABLE OF CONTENTS

ABBREVIATIONS AND ACRONYMS

AIDS	Acquired Immune Deficiency Syndrome
ANC	Antenatal Care
APDAR	Agency for the Prevention of Drug Abuse and Rehabilitation
ART	Anti-Retroviral Treatment
ARV	Anti-Retroviral (medicines)
BCC	Behaviour Change Communication
BSS	Behavioural Surveillance Survey
CD4	Cluster Differentiation 4
CSO	Civil Society Organisation
DALYs	Disability Adjusted Life Years
DQA	Data Quality Assessment
DURNS	Drug Users' Rehabilitation Network (Seychelles)
EMTCT	Elimination Mother-to-child Transmission of HIV
FBO	Faith-Based Organisation
FP	Family Planning
FSW	Female Sex Workers
GAM	Global AIDS Monitoring
GARPR	Global AIDS Response Progress Report
GBV	Gender-Based Violence
HAART	Highly Active Antiretroviral Therapy
HASO	HIV and AIDS Support Organisation
HBV	Hepatitis B Virus
HCA	Health Care Agency
HCT	HIV Counselling and Testing
HCV	Hepatitis C Virus
HF	Health Facility
HIV	Human Immunodeficiency Virus
IBBS	Integrated Biological Behavioural Survey
ICTC	Integrated Counselling and Testing Centre
IDU	Injecting Drug Users/Intravenous Drug Users
IEC	Information, Education, Communication
JAR	Joint Annual Review
KAPB	Knowledge, Attitudes, Practices and Behaviour (Survey)
KP	Key Population
LEA	Legal Environment Assessment
MC	Male Circumcision
MDGs	Millennium Development Goals
M&E	Monitoring and Evaluation
MOH	Ministry of Health
MSM	Men who have Sex with Men

MSW	Male Sex Workers
MTR	Mid-Term Review
NAC	National AIDS Council
NGO	Non-Government Organization
NSB	National Statistics Bureau
NSEP	Needle and Syringe Exchange Programme
NSP	National Strategic Plan
OI	Opportunistic Infection
OST	Opiate Substitution Therapy
PCR	Polymerase Chain Reaction test
PEP	Post-Exposure Prophylaxis
PHA	Public Health Authority
PICT	Provider-Initiated Counselling and Testing
PLHIV	People Living with HIV
PMTCT	Prevention of Mother-to-Child Transmission of HIV
PrEP	Pre-Exposure Prophylaxis
PWID	People Who Inject Drugs
QI	Quality Improvement
RBM	Results Based Management
SCR	Service Coverage Report
SDG	Sustainable Development Goal
SRH	Sexual and Reproductive Health
STI	Sexual Transmitted Infection
TWG	Technical Working Group
TB	Tuberculosis
UNAIDS	Joint United Nations Program on AIDS
UNGASS	United Nations General Assembly Special Session on HIV and AIDS
UN	United Nations
WHO	World Health Organization

List of Figures

List of Tables

“Not everything that can be counted counts, and

Not everything that counts can be counted."

Albert Einstein (1879-1955)

SECTION ONE: OVERVIEW

1.1 INTRODUCTION

The Seychelles is a small island state with a population of 94600 inhabitants. In 2017, life expectancy at birth is 74,8 years (80,8 years for women and 69,5 years for men)[1]. The right to health is enshrined in the constitution and all health services are available free of charge at the point of delivery in government facilities. Geographic access to health services is good and the population to doctor ratio was 591:1 in 2016.[2] Seychelles response to the Acquired Immune Deficiency Syndrome (AIDS) began 30 years ago. The first Human Immunodeficiency Virus (HIV) infection was detected in 1987 while the first case of AIDS was reported in 1993. The government has put in place and incrementally strengthened the national response to HIV through the implementation of the short and medium-term plans.

The overarching health sector vision is 'the attainment, by all people in Seychelles, of the highest level of physical, social, mental **and spiritual health and living in harmony with nature'.** In line with this vision, the health sector has defined its mission as "*to relentlessly promote, protect and restore health and quality of life and dignity of all people in Seychelles with the active participation of all stakeholders, through the creation of an enabling environment for citizens to make informed decisions about their health'*.[3]

The National Health Strategy includes indicators and targets to be achieved by 2020, including free antiretroviral medicines as essential treatment and free HIV testing services. Other sector ministries indicate their commitment to address HIV in their strategies and programmes. The National AIDS Council has a mandate and commits to coordinating the multi-sector HIV and AIDS response. The commitment by Seychelles to the global Joint United Nations Programme on HIV and AIDS (UNAIDS) Strategy 2016-2021 and the Sustainable Development Goals (SDGs) adopted by the United Nations General Assembly includes a commitment to Fast-Tracking the HIV response towards ending the AIDS epidemic as a public health threat by 2030.

While extensive efforts have been made to create an enabling environment, work still needs to continue in addressing stigma and discrimination; continuing and expanding the implementation of human rights for key populations and PLHIV; decreasing gender inequality and violence against women, young boys and adolescent boys and girls as well as harmful norms of 'masculinity' and 'femininity'; and to change social attitudes and the criminalisation of sex work (SW), men who have sex with men (MSM) and people who use drugs (PWUD).

[1] Seychelles in figures, 2017 edition. National Bureau of Statistics, Seychelles

[2] Seychelles in figures, 2017 edition. National Bureau of Statistics, Seychelles

[3] Seychelles, National Health Strategic Plan 2016-2020

1.2 2019-2023 NSP AT A GLANCE

An estimated 676 people were living with HIV in Seychelles by December 2017. In the same year 75 people were newly infected with HIV and cumulatively there were 332 new AIDS cases and 177 AIDS-related deaths. Despite steady improvements, the global target to reach 90% treatment coverage is far from being accomplished, as about 83% of people living with HIV in Seychelles were enrolled in treatment. With the National Strategic Plan for HIV, AIDS and Viral Hepatitis, Seychelles has accepted the challenges of being effective in ending the AIDS epidemic as a public health threat by 2030, through achieving the 90.90.90 treatment targets by 2020.

The National Strategic Plan for HIV, AIDS and Viral Hepatitis for the period 2019-2023 is a set of evidence-informed strategies focused on building one consolidated, unified, rights-based and decentralized HIV programme with services that are integrated in the general health services of the country. It builds on lessons learned from implementation of the National Strategic Plan for HIV 2012-2016, its end-term review, the National Health Strategic Plan 2016–2020, the IBBS for Heroin Users, consultation on the key strategic priorities and other strategic information from studies, surveys and assessments.

Key populations remain the main focus of the National Strategic Plan for HIV, AIDS and Hepatitis. In Seychelles, these populations include male and female sex workers, clients of sex workers, men who have sex with men, people who inject drugs and people in prisons. In addition, all pregnant women are the focus of the National HIV Strategic Plan for elimination of vertical transmission.

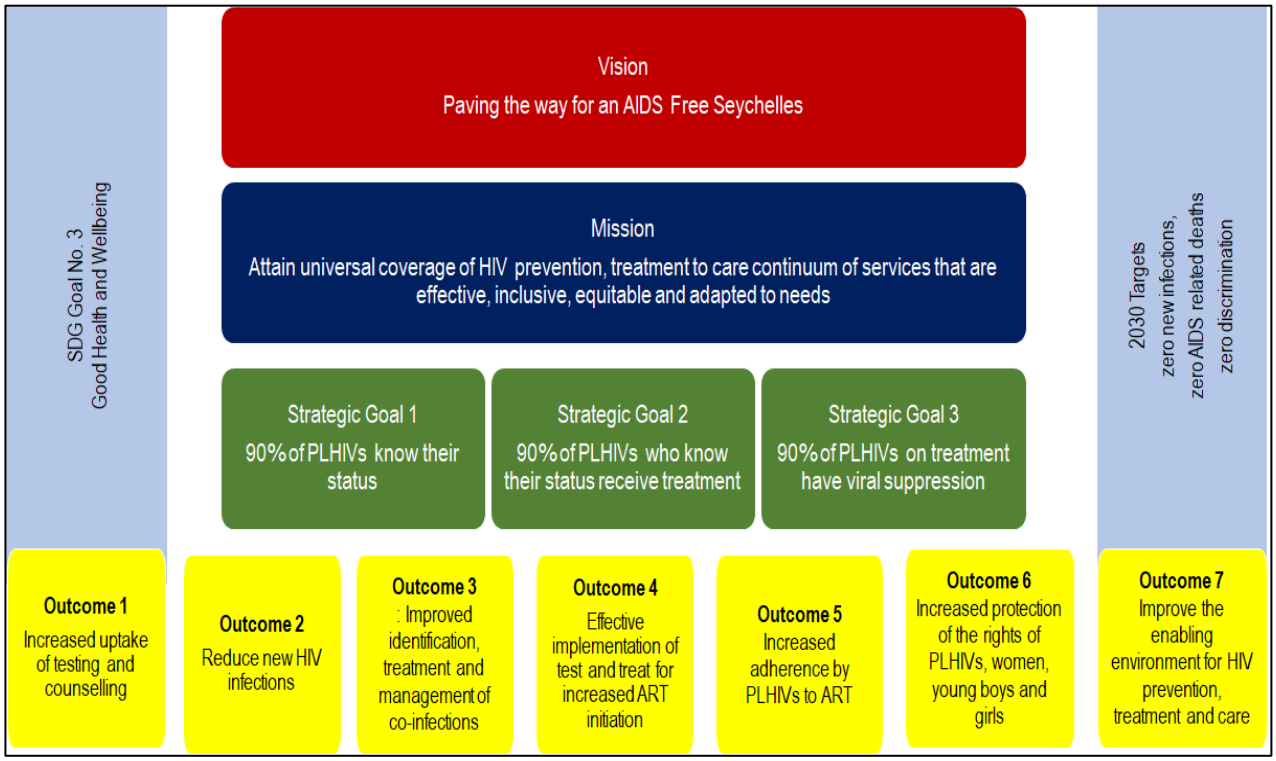
Innovative service delivery approaches include intensified testing to reach key populations through facility-based outreach and community-led in-reach; linking testing to treatment and retention with smart and innovative referral systems, and introducing test for triage, initiated through community-led HIV screening. Task-sharing to identify, reach, recommend, test, treat and retain is essential, central and fundamental in the National Strategic Plan for HIV, AIDS and Hepatitis. In order for this forward-looking prevention-treatment continuum to be successful within a case-finding/case management approach, the capacity and competence of health service providers and trained community laypeople will be updated and made fit for purpose. By investing in this National Strategic Plan for HIV, AIDS and Viral Hepatitis in a combination of focused and innovative services, activities and strategies to prevent new HIV infections, Seychelles will close the prevention gap.

With HIV Vision 2030, the prospect of zero new HIV infections has never been so real. Time-proven approaches, combined with new tools and discoveries, will provide people with a real chance of protecting themselves and preventing HIV transmission, leaving no one behind.

The 2019-2023 National Strategic Plan for HIV, AIDS and Viral Hepatitis is designed around a results-based framework that reflects the commitments and 90-90-90 targets by 2023. The framework is based on a causal relationship between the vision, mission, goal and the strategic outcomes. To maximize the impact of the response, the country will invest adequately and strategically, prioritising where, for which people and what to invest in to generate best returns. The priorities are based on what has been identified to work in local context. Furthermore, these strategic outcomes will be articulated in terms of inputs, outputs and costs in the implementation plan. While there are several external and internal risks that may positively or adversely affect results, the

combination of strategies adopted will be calibrated according to the epidemiological, health priorities and available resources.
The overview of the results framework is detailed in Figure 1.

Figure 1. Seychelles 2019-2023 National Strategic Plan for HIV, AIDS and Hepatitis Results Matrix



The Government of Seychelles, civil society and the private sector are committed to meeting the 90-90-90 targets. The country has realised that in order to ensure that the targets committed to are met a robust monitoring and evaluation system is required. In addition, the country is committed to implementing the principle of 'Three Ones':

- One agreed HIV and AIDS action framework that provides the basis for coordinating the work of all partners.
- One national AIDS coordinating authority, with a broad based multi-sector mandate.
- One agreed HIV country-level monitoring and evaluation system

Undoubtedly, an appropriate and efficient M&E system is the cornerstone of the country's HIV response: it provides the data needed to make evidence-based decisions for programme management and improvement, policy formulation, and advocacy, and is necessary to satisfy accountability requirements. Such information is useful to understand the scale and outcome of implementation and can be used to secure continued funding for the expansion of HIV and AIDS programmes. More importantly, it can be used locally to enhance community and health-facility-based programs. The National M&E Framework HIV, AIDS and Viral Hepatitis provides stakeholders with a tool for well-coordinated, harmonized and functional HIV, AIDS and Viral Hepatitis M&E systems that allow them to efficiently assess how well programme interventions are contributing to achieving the national program goals.

The following reasons justify the necessity of having National M&E Framework for HIV, AIDS and Viral Hepatitis:

a) It provides opportunities to develop integrated national and sector specific M&E systems to guide a national response to HIV, AIDS and Viral Hepatitis;
b) It assists in responding to the international commitments and reporting requirements;
c) It provides the platform for partnership, networking, and collaboration between national-level and local-level stakeholders in monitoring and evaluating the responses to HIV, AIDS and Viral Hepatitis.

1.3 SUMMARY OF THE M&E STATUS

Table 1: Summary of the M&E Status based on the 12 Components of the M&E System

M&E System Component	Strengths, enabling factors* & achievements	Weaknesses & disabling factors and gaps	Priority Actions for M&E System Improvement
1. Organizational structures responsible for M&E	Currently the CDCU in the Ministry of Health is responsible for collecting health data related to the HIV and AIDS epidemic.	• Weak organizational and M&E structures in the MOH • Lack of a central or decentralised M&E system • Inadequate numbers of staff to undertake the M&E functions • Limited disciplinary scope of the M&E staff towards inclusion of statisticians, economists, sociologists, epidemiologists, demographers, IT specialists and database managers in key agencies • The M&E function is very limited in the civil society organisations implementing the HIV response.	• The MOH needs to establish M&E system that is functioning and meets the requirements of monitoring and evaluating the epidemic • Employ personnel with the requisite skills to – Strengthen the M&E function at umbrella organizations – Expand disciplinary scope of the M&E staff to include statisticians, economists, sociologists, epidemiologists, demographers, IT specialists and database managers in lead agencies – Set up terms of reference for all M&E focal persons.
2. Human Capacity building for HIV M&E		• Lack of a comprehensive and coordinated M&E Capacity Building • Lack of a data base of up to date directory on HIV M&E capacity building resources • Limited M&E Capacity in MOH and across NGOs implementing the HIV response • Some M&E personnel in the CSO and CBOs not matching reporting capacity requirements	• Widen the support supervision scope • Regular M&E Capacity building workshops • Establish a directory or data base for HIV M&E Resources: curriculum, courses, trainers, funding • Plan training interventions involving the M&E focal persons and NGOs
3. Partnerships for HIV M&E		• Absence of a functional national multi-sectoral HIV M&E technical working group (the MEIS TWG) coordinated by NAC • Absence of a functional national M&E/HIS technical working group under the Ministry of Health. • Absence of operational mechanisms for feedback on to partners and key stakeholders about reports, HIV M&E activities and decisions	• Establish a functional national multi-sectoral HIV M&E technical working group (the MEIS TWG) coordinated by NAC • Establish a functional national M&E/HIS technical working group under the Ministry of Health • Establish functional linkages & feedback with all stakeholders implementing the HIV response • Undertake a stakeholder mapping
4. National HIV M&E Plan	Existence of a national HIV M&E plan to monitor and evaluate the National response.	• The previous M&E Plan is too generic • Plan not promoted adequately for stakeholder buy in • The M&E plan is not widely known and has not been implemented in the 2012-2016 NSP period	• Have an NSP plan that is operationalised • NAC and the partners should be committed to supporting the implementation the M&E plan at all programme levels • Advocate the use and implementation of the M&E plan

M&E System Component	Strengths, enabling factors* & achievements	Weaknesses & disabling factors and gaps	Priority Actions for M&E System Improvement
5. Costing and annual roll out of a National HIV M&E Work-plan		• There is no costed National Integrated Annual Work Plan for the implementation of the M&E framework • Major HIV M&E Projects such as the DHS, NASA and IBSS have not been planned for or costed • There is no functional inter-sectoral linkages with the other lead sector actors in relation to M&E funding: the Ministry of Finance; the National Statistics Bureau (NSB)	• M&E TWG should lead in developing an integrated and multi-sectoral master HIV M&E plan • Plan and budget for HIV M&E projects to ensure that these projects are implemented • Collaborate with other key agencies responsible for collecting national level data • Mainstreaming M&E in plans and budgets for MOH and other ministries supporting the HIV response
6. Advocacy, communication and the culture of HIV M&E	• Performance based budgeting has been introduced by the World Bank, and is currently being implemented for the National Health Strategy.	• Evidence collected is currently only generated by MOH evidence from other implementers is not provided which necessitate use of M&E information products and involvement of M&E personnel • Limited appreciation of HIV M&E at by CSOs and other line ministries and agencies • Inadequate advocacy for M&E	• Promote evidence based planning and performance based budgeting to make use of M&E data a necessity • NAC should sustain a strong M&E advocacy • Apply performance based budgeting during the costing of the 2019-2023 NSP
7. Routine programme monitoring	• Good performance of routine programme reporting undertaken by CDCU • Observing/meeting of the international reporting requirements like GARPR report annually	• There is an absence of guidelines to guide collection, collation, analysis, reporting, data quality assurance and audit • There are limited standard reporting forms • Except for CDCU and MOH there is no regular production of routine programme coverage and progress reports by NAC, line ministries and implementing partners. • Routine monitoring more biased in favour of/ tied to funding and thus not covering all response who's funding not through NAC • Limited use of the sectors and NGOs with HIV, AIDS and Viral Hepatitis for monitoring and reporting • Lack of reporting forms beyond MOH • Lack of recent stakeholder and service mapping and progress report tracking tools	• NAC needs to make adequate provision for NGO monitoring/ reporting • Provide minimum funding for core coordination of the M&E functions the coordinating M&E meetings, sectors and NGOs to improve M&E of the HIV response • Build capacity for NGOs and line ministries to facilitate the collation, reporting and utilization of the data/ information for decision making • Enhance the standardization and harmonization of reporting forms • Enhance feedback and interaction between all implementing partners submitting and receiving reports • Review and amend data collection tools to make it more user friendly and cost effective for all HIV implementers • Develop and implement an automated system for data capturing • Institutionalize routine reporting on the HIV information

M&E System Component	Strengths, enabling factors* & achievements	Weaknesses & disabling factors and gaps	Priority Actions for M&E System Improvement
8. Surveys and Surveillance	• The Ante-Natal Clinic (ANC) based surveillance reports have been produced • A series of Behavioural Surveillance Surveys (BSS) in 2011, 2015 and 2017 was undertaken	• Workplace and facility based surveys not undertaken as regularly as required • No recent survey on condom access as required • The IBBS study for MSM (2011) and Sex Workers (2015) is dated • A mode of transmission study (MOT) has not been done hence the assumption is that the sources of the new infections, patterns of transmission etc is by PWIDs • Impact studies on effectiveness of mainstreaming of HIV, AIDS and Viral Hepatitis, non-bio-medical interventions and data triangulation exercises has not been undertaken	• Develop a national surveillance system to steer the planning and guiding of surveillance. • Conduct IBBS studies for MSM and Sex Workers • Undertake an exercise to establish the population estimates for HIV amongst the general and key populations • With the increased participation of NGOs in the HIV response, it would be important to conduct impact studies on the effectiveness of mainstreaming of HIV, AIDS and Viral Hepatitis, non-bio-medical interventions and data triangulation exercises has not been undertaken
9. HIV data bases		• There is no centrally developed data base • Limited internet connectivity • Limited reporting to populate data bases • Little utilization of information from data bases and thus reduced commitment to get the systems up and running. • Prohibitive costs for reliable internet. • Insufficient desegregation of data in some data bases	• Design and set up of user-friendly data bases with disaggregation of the resultant information products. • Build the capacity of the users at national, sectoral and NGO levels • Enhance the inter-operability of the different existing data bases • Promote and popularize the use of the data bases
10. Support supervision, data quality assurance and audit		• There are no supportive supervision and DQA guidelines in place • NAC and other implementing partners do not have technical personnel to carry out the supportive supervision and DQA function • No time is given to the supportive supervision and DQA function either due to low prioritization of human and logistical capacity. • There is limited interaction between NAC and the implementing partners. • Verbal feedback is the main format and written ones are not adhered to. • Inadequate technical capacity building and facilitation for the decentralized staff (i.e. in health sector) to undertake support supervision and DQA	• Simplify data collection tools • Extend supportive supervision and DQA to all HIV implementers • Increase interaction between NAC MOH and implementing partners. • Provide systematic written feed back to the implementing partners. • Build adequate human technical capacity and facilitate supportive supervision and DQA. This will free time for the national level personnel to be more focused on more response strategic issues. • Ensure that the community based interventions also have well guided processes for support supervision and DQA

M&E System Component	Strengths, enabling factors* & achievements	Weaknesses & disabling factors and gaps	Priority Actions for M&E System Improvement
11. Evaluation and Research	• Review of the 2012-2016 NSP	• Lack of a current HIV research and evaluation agenda • Lack of a comprehensive and regularly updated research and evaluation inventory • No evaluation of the HIV program	• Develop research and evaluation agenda • Develop and strengthen the coordination for HIV, AIDS and Viral Hepatitis research and evaluation • Conduct evaluations as per the research and evaluation agenda • Enhance the documentation, sharing and utilization of research results for policy development and programming
12. HIV and AIDS information dissemination and use		• Limited and not timely circulation information • Limited utilization of available information service delivery points and decentralized levels. • Lack of systematic dissemination guidelines with well-defined audiences, appropriate channels, appropriate information packaging & schedule.	• Assessment of information needs; • Develop comprehensive and systematic dissemination guidelines. • Establish, strengthen and make access all HIV related information

1.4 OBJECTIVES OF THE M&E FRAMEWORK

The M&E Framework will facilitate integration of information from various programmes and stakeholders involved with the delivery of the 2019-2023 National Strategic Plan for HIV, AIDS and Viral Hepatitis. The goal of the M&E Framework is to enable the process and generation of data addressing information requirements for:

- enabling planning, learning and effective decision making at various levels using evidence
- addressing accountability and improving performance
- meeting various national and international reporting needs

The objective of the M&E Framework is to:

"Enhance utilization of reliable and timely available strategic information for National HIV, AIDS and Viral Hepatitis Response management, response performance and epidemic assessments"

The more specific objectives are:

a) Strengthened Leadership and Coordination of HIV, AIDS and Viral Hepatitis Monitoring and Evaluation;
b) Enhanced Strategic, Human Resource and Logistical capacity for Monitoring and Evaluation (M&E) of the National Response;
c) Improved routine HIV, AIDS and Viral Hepatitis data collection, management and quality;
d) Strengthened systems to undertake HIV and AIDS and related biological and behavioural Surveillance, Surveys and Research;
e) Enhanced HIV, AIDS and Viral Hepatitis Information & Knowledge Management; and
f) Strengthened HIV, AIDS and Viral Hepatitis Financial monitoring, budget and expenditure analysis.

Through the M&E Framework, the programme results at all levels (impact, outcome, output) will be measured to provide the basis for accountability and informed decision-making at both programme and policy levels. The framework also provides the background information for the indicators included in the 2019-2023 National Strategic Plan for HIV, AIDS and Viral Hepatitis. The M&E Framework will allow for data to be collected, processed and transformed into strategic information (SI), to allow for informed decision-making at all levels: country, regional and global level.

1.5 IMPORTANCE OF THE M&E PLAN

Implementation of a 2019-2023 National Strategic Plan for HIV, AIDS and Viral Hepatitis in the multi-sectoral response entails so many actions and activities; by many actors/players; with varying specific objectives and responsibilities; capacities, mandates, acting at different levels and with different approaches; generating a lot of results and information and measuring their inputs and results in varied ways. To effectively manage a national response therefore requires the adoption and the roll out of a robust coordination framework and a matching

Monitoring and Evaluation (M&E) Framework. The M&E Framework will be vital to guide the collection, collation, analysis, management and dissemination of strategic information on the HIV, AIDS and Viral Hepatitis epidemic and the performance of the responses to the epidemic.

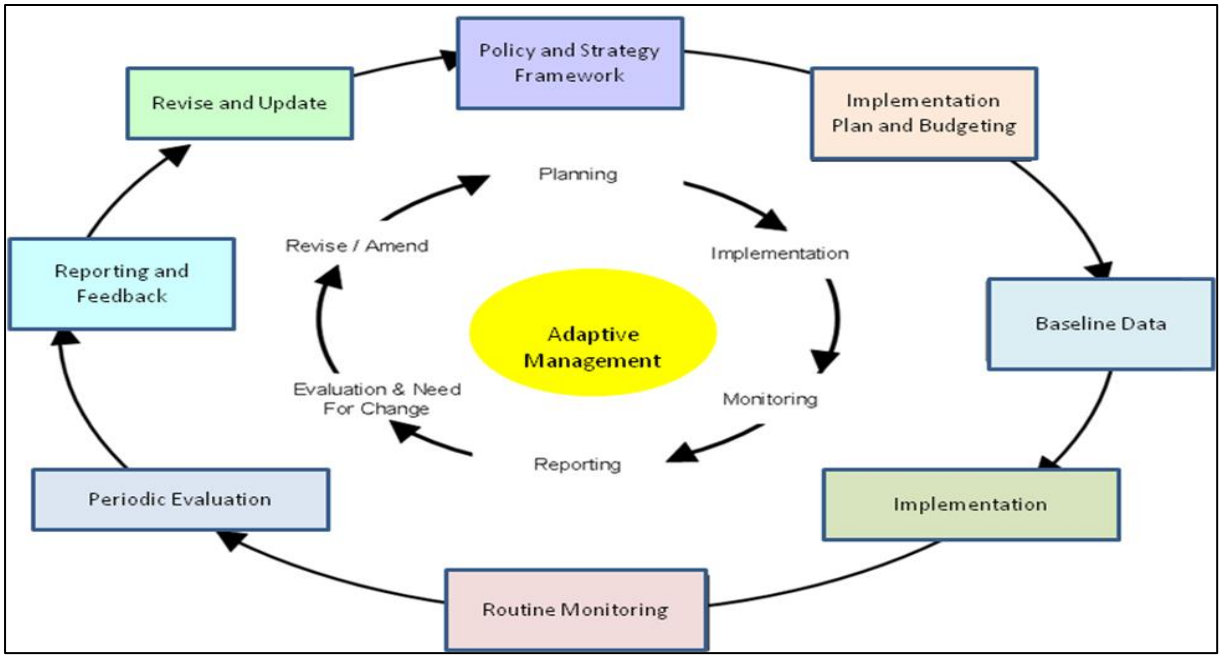
SECTION TWO: METHODOLOGY

2.1 CONCEPTUAL FRAMEWORK FOR RESULTS-BASED MANAGEMENT

Results-based management (RBM) is a lifecycle approach to management that integrates strategy, people, resources, processes, and measurements to improve decision making, transparency, and accountability. The approach focuses on achieving outcomes, implementing performance measurement, learning, and adapting, as well as reporting performance.

RBM is a management philosophy and approach that emphasizes development results in planning, implementation, learning and reporting. As reflected in the figure below, the development of the logic model and the M&E is dependent upon sound planning (including budgeting) and implementation as its base. Planning and M&E are viewed as two sides of the same coin – one can only be as good as the other.

Figure 2: Conceptual Framework



The above conceptual framework also answers the critical question: “what do we seek to measure through the Monitoring and Evaluation system?”

In short, we measure:

- **Outcomes:** Incrementally in 5-year chunks within the 2019-2023 National Strategic Plan for HIV, AIDS and Viral Hepatitis
- **Outputs:** Mostly quarterly and annually as defined in the implementation plan

On the basis of the above, Seychelles adopted the Results-based management (RBM) for monitoring, evaluation and reporting across 2019-2023 National Strategic Plan for HIV, AIDS and Viral Hepatitis. RBM is a life-cycle approach to management that integrates strategy, people, resources, processes, and measurements to improve decision making, transparency, and accountability. The approach focuses on achieving outcomes, implementing performance measurement, learning, and adapting, as well as reporting performance.

The key elements of the RBM methodology used were:

- Defining **realistic expected results** based on **appropriate analysis;**
- **Clearly identifying programme beneficiaries** and designing programmes to meet their needs;
- **Monitoring progress toward results and resources consumed** with the use of appropriate indicators;
- **Identifying and managing risk** while bearing in mind the expected results and necessary resources;
- Increasing knowledge by **learning lessons and integrating them into decisions**; and
- **Reporting** on the results achieved and resources involved.

2.2 THE LOGIC MODEL

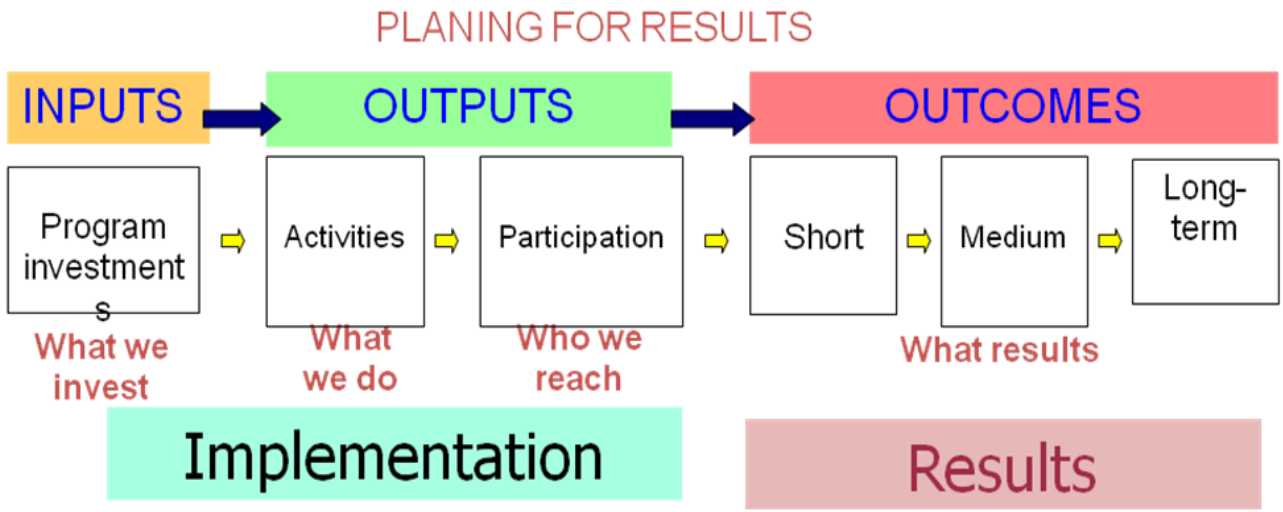
The logic model provides the basic framework for monitoring and evaluation. Figure 3 is a graphic representation that describes logical linkages across the different levels of results. It illustrates a program's theory of change, showing how day-to-day activities connect to the results or outcomes the programme is trying to achieve. Similar to a flowchart, it lays out programme activities and outcomes using boxes, and using arrows to connect the boxes, shows how the activities and outcomes connect with one another.

The logic model is simply a schematic representation of the logical sequence and causal relationships among:

- The results and the changes to achieve;
- The activities plan to do; and
- The resources to operate programme.

The Logic Model is divided into six levels: **inputs**, **activities**, **outputs**, direct **outcomes**, **intermediate outcomes,** and **ultimate outcome.** Each of these represents a distinct step in the causal logic of a policy, strategy, program, or project. The bottom three levels (inputs, activities, and outputs) address the ***how*** of a plan, whereas the top three levels (the various outcomes) constitute the actual ***changes*** that take place: the ***development results***.

Figure 3: Results-Based Management Cycle[4]



2.3 INDICATORS

Core to the development of an M&E Framework is the development of the indicators to measure the performance of the results. An indicator seeks to measure a result, to provide evidence that a result has been achieved or to provide a signal that progress is being made towards the achievement of a result. An indicator is a means of measuring actual results against planned or expected results in terms of quality, quantity and timeliness. Indicators must be directly related to the result they are measuring. Suitable indicators need to be specified to measure performance in relation to outputs, outcomes and impacts. The challenge is to specify indicators that measure things that are useful from a management and accountability perspective. Defining a good performance indicator requires careful analysis of what is to be measured and why. One needs to have a thorough understanding of the nature of the output, the desired outcomes and impacts, and all relevant definitions and standards used in the field.

This M&E Framework details the level of indicators. These are:

- ***Impact indicators*** - indicators that show to what extent the project has contributed towards its goals
- ***Outcome indicators*** - indicators that show to what extent the project has achieved its planned outcomes
- ***Output indicators*** - indicators that show the specific outputs that have been delivered as a result of the activities

The criteria used in the selection of indicators were as follows:

- ***Reliable:*** the indicator should be accurate enough for its intended use and respond to changes in the level of performance.
- ***Well-defined*****:** the indicator needs to have a clear, unambiguous definition so that data will be collected consistently, and be easy to understand and use.

[4]Moodley, JM and Beryl MOHr: Step-by-Step Guide to Monitoring and Evaluation, 2003. Bristol-Myers Squibb Foundation

- ***Verifiable*:** it must be possible to validate the processes and systems that produce the indicator.
- ***Appropriate*:** the indicator must avoid unintended consequences and encourage service delivery improvements, and not give managers incentives to carry out activities simply to meet a particular target.
- ***Relevant:*** the indicator must relate logically and directly to an aspect of the institution's mandate, and the realisation of strategic goals and objectives.

2.4 GUIDING PRINCIPLES IN THE DEVELOPMENT OF M&E FRAMEWORK

The M&E Framework outlined in this document has been developed and will be implemented within the context of the "Three Ones" principle. The M&E Framework is explicitly linked to the 2019-2023 National Strategic Plan for HIV, AIDS and Viral Hepatitis and equip the country and coordinating mechanisms at national level with effective tools aimed at informed decision-making and improved planning of evidence based interventions. The principles that guided the development of this M&E Framework are as follows:

a) **Strong consensus on "Three Ones" principles** applicable to all stakeholders in the country level HIV and AIDS response. One of the critical principles is "One agreed country level Monitoring and Evaluation System". The harmonised M&E Framework has facilitated efforts to increase capacity for quality assurance, national oversight and adequate use of M&E for policy adaptation. The common M&E framework ensured alignment of core national M&E system with 2019-2023 National Strategic Plan for HIV, AIDS and Viral Hepatitis

b) **Using the 12 Components** – Developing an M&E system that can produce trustworthy, timely, and relevant information on the performance of government, civil society or private sector projects, programmes, and policies requires that one overcomes many M&E system challenges and approaches the implementation of such a system with experience, skill, and real institutional capacity. The 12 Components of a Functional M&E System offer a framework for what a strong M&E system that works.[5]

c) **Developing M&E systems**: To improve the quality, access and availability of data for planning, decision making and implementation, clear data flow mechanisms that provide a base for building a comprehensive M&E system is required. The approach of developing this M&E Framework will be to identify means of information collection and processing improve these and identify new mechanisms to improve the quality, reliability and integrity of data.

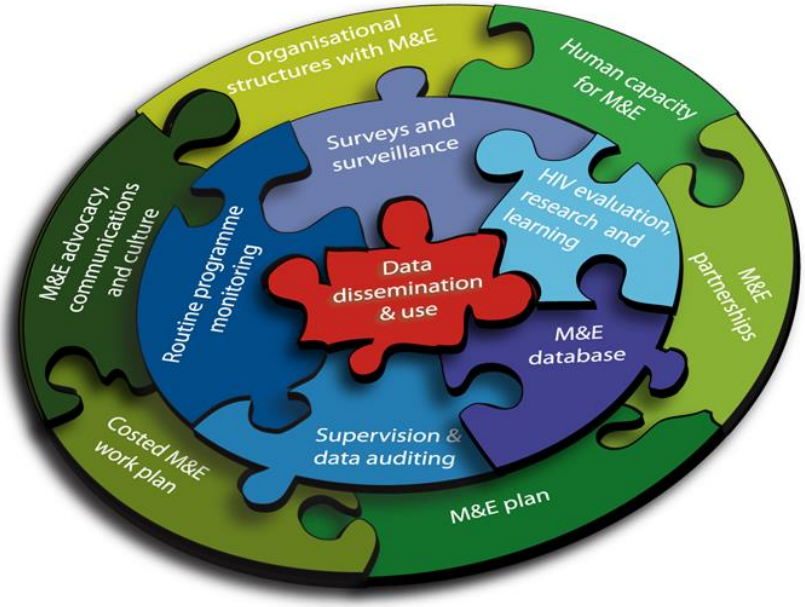
d) **Evidence- and Results-based**: The system is oriented towards generating and using information related to programme results so as to create opportunities for results- and evidence-based learning and planning at various levels. The system focuses on measuring /describing progress toward achievement of project outputs and purpose at regular intervals along with timely and accurate analysis, for timely corrective action for maintaining strategic direction.

[5]Marelize Görgens and Jody Zall, Making monitoring and evaluation systems work: a capacity development tool kit. 2009

e) **Simplicity:** The M&E Framework will ensure a simple and effective M&E system is made operational which will provide the needed data inputs at all levels and will facilitate use of the data for programmatic and policy level decision making. In order to facilitate simple to operate system of data management, it will continue to use automated system for data entry and analysis.
f) **Key Information Needs:** System meeting needs and demands of information of various stakeholders at different levels. Data collected will be addressing the needs of various stakeholders. There will be direct link between data collection, analysis, reporting and decision making at all levels.
g) **Mechanisms:** Include both Independent, impartial assessments along with internal self-assessments
h) **Harmonization of tools and formats**: Standard set of tools to collect and analyse information
i) **Feedback loops operate:** System works in circular fashion of action-analysis-reporting feedback-action; not just one way.

2.5 ORGANISING STRUCTURE OF THE M&E FRAMEWORK

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



The following is a brief description of the 12 components.[6]

- **Component 1: Organisational Structures for HIV M&E Systems -** This aspect – is therefore about the *people* involved in the M&E system.
- **Component 2: Human Capacity for the M&E System -** Both capacity and capacity development focus on three levels: individual, organisational, and systems. This component focuses on the level of an individual when building human resource skills in the HIV M&E system, including individuals at the national level, sub-national level, and

[6]The 12 components of a functional HIV M&E system. Global AIDS Monitoring and Evaluation Team (GAMET).

HIV service delivery level (project level) involved in executing HIV M&E functions, or managing employees with HIV M&E functions.

- **Component 3: M&E Partnerships -** M&E partnerships are part of the "people, planning and partnerships" ring of the 12 components of a functional HIV M&E system. Establishing and maintaining strong partnerships provide a mechanism for a group of diverse people from different organisations to work together around the same set of objectives. This is especially important for an HIV M&E system, given that many of the people involved do not work in the same institutions or come from the same sector.
- **Component 4: National M&E Framework -** A national HIV M&E plan, is at the heart of HIV M&E systems as it describes the purpose of the system, the data the system will collect, and details of how the system will operate.
- **Component 5: Costed M&E Work Plan -** For a national HIV M&E system at country level to become, and remain, operational, it is essential to co-ordinate the efforts of all stakeholders involved in the HIV M&E system. A costed, M&E work plan is therefore a very useful tool for prioritising, planning and co-ordinating activities relating to the HIV M&E system.
- **Component 6: HIV Advocacy, Communications and Culture –** this element advocates for, HIV *monitoring and evaluation*.
- **Component 7: Surveys and HIV Surveillance -** Data for the national HIV response can be collected through a range of methods, from observation, through to structured methods (such as surveys and surveillance). More structured methods are preferred for national HIV M&E systems, as this approach means that data can be compared year-on-year.
- **Component 8: Routine Monitoring -** For HIV results at all levels to be measured, the entire spectrum of input, output, outcome and impact data are needed. Input and output monitoring data are important, as these answer questions about the resources and interventions needed and provided, and whether planned programmes have been implemented. Input and output monitoring data are *collected through routine monitoring systems*.
- **Component 9: Supportive Supervision and Data Auditing - Supportive supervision** is defined as directing and overseeing the performance of others, whilst transmitting skills, knowledge and attitudes that are essential for successful monitoring of HIV activities. **Data auditing** is the process of verifying the completeness and accuracy of a selection of HIV output/programme monitoring.
- **Component 10: Sub-National and National Databases -** A **Database** is a collection of data which has been organised so that a computer programme can quickly select desired items. The database management system is the computer programme used to manage data.
- **Component 11: Operational Research and Evaluation - Research** refers to a systematic investigation, including research development, testing and evaluation, designed to develop or contribute to generalizable knowledge.
- **Component 12: Data analysis, Information Dissemination and Use -** This component is about using data to create information for decision-making, and is the primary and overriding purpose of M&E systems. If data are used to create valuable information that informs decision-making, these decisions can be improved and then inform and improve subsequent actions.

SECTION THREE: COMPONENTS OF THE MONITORING AND EVALUATION FRAMEWORK

3.1 COMPONENT 1: STRUCTURE AND ORGANIZATIONAL ALIGNMENT FOR M&E SYSTEMS

Organizational structure describes the hierarchy, reporting lines, and systematic arrangement of work in an organization. It is depicted in an organizational chart or organogram, showing how the various parts of the organization relate to each other.

The M&E system is one component of the "Three Ones", and a crucial tool for an effective, efficient, and accountable response to the HIV epidemic. The goal of the M&E system is to provide timely and relevant support for an effective. For an effective and efficient M&E System to function, Government, Civil Society and implementers need to make an effort to develop and strengthen the M&E system.

3.1.1 NATIONAL AIDS COUNCIL (NAC)

The NAC, as the "one Coordinating Authority", and; the secretariat of the "one Strategic Plan", the NSP needs to champion the planning, monitoring and evaluation the National HIV and AIDS response in line with the "one M&E System" principle. NAC will be expected to support the development and the strengthening of coordination arrangements in both government and non-government sectors and with all the different categories of stakeholders in the national response at all programme levels.
The NAC will also be responsible for:

- leading and supporting the mobilization of the strategic, human, logistical and material resources for the implementation of the National Monitoring and Evaluation Framework of the HIV response at all programme levels and in all thematic areas;
- the development of the "one M&E system", and therefore, the promotion and popularization of the adopted M&E Framework and Operational Plan;
- development and supporting the partnerships needed for M&E, supporting the development of the standard and harmonized data collection and reporting tools;
- establishment and sustaining the functioning of a master national HIV and AIDS data base;
- guiding the undertaking of HIV and AIDS Research; and
- guiding the data management; data bases development and inter-operability; development of user friendly information products and dissemination and; promotion of utilization of the M&E and information products.

3.1.2 MINISTRY OF HEALTH (MOH)

The HIV and AIDS Control Unit within the Public Health Authority in the MOH is charged with the overall planning, management and coordination of all HIV, AIDS and Viral Hepatitis interventions under the health sector. The HIV and AIDS Control Unit needs to establish a

Monitoring and Evaluation sub-unit with the responsibility for the overall sector technical guidance for M&E and providing support to other sectors responsible for the execution of health-related HIV interventions.

The HIV and AIDS Control Unit being the historical response leader and as one of the key actors, will be expected to ensure that the data from the health sector is fed into the "One National M&E System" of the response. The HIV and AIDS Control Unit will also ensure that there is synchronization and inter-operability between their data base and the other non-health sector response data bases managed by NAC and other line ministries for completeness of response reporting. The MOH shall also establish a functioning health sector M&E TWG that brings together a wide range of actors across different sectors. This sector wide M&E TWG will also be responsible for M&E of HIV, AIDS and Viral Hepatitis as part of the sector programmes.

3.1.3 OTHER LINE MINISTRIES

To effectively monitor the multi sectoral HIV, AIDS and Viral Hepatitis Response, all the line ministries need to have a HIV and AIDS Focal Persons/ focal points to lead the planning, implementation, coordination and monitoring of all HIV, AIDS and Viral Hepatitis interventions targeting the sector/ministry employees and the population groups whose development and well-being is the mandate of the sector.

The respective Ministry HIV and AIDS Control units with the support of the planning units shall coordinate the development and implementation of M&E of HIV, AIDS and Viral Hepatitis activities in the sector implementing public and non-public departments and agencies. Key line ministries like those of Education; Ministry/Ministries responsible for the youth, Gender, Children and Community Affairs; and Ministry of Employment/Labour shall be key sources of information for the computation of output indicators from the routine reporting. The sector ministries will also be key in leading and coordinating population based assessments, surveys and research that will generate the data for the computation of outcome and impact indicators.

3.1.4 NATIONAL STATISTICS BUREAU (NSB)

The National Statistics Bureau (NSB) is the mandated national body responsible for leading and guiding the collection, compilation, analysis, validation and dissemination of all official and other statistical information in the country. NSB will technically support NAC, the M&E TWG and other stakeholders in ensuring that methodologies used in collecting data, generation of scientific representative samples, management of data during research, monitoring and evaluation of HIV, AIDS and Viral Hepatitis activities are complaint with the national and international standards and specifications or technical protocols. NSB will be playing a lead role in questionnaire designs, development of methodologies for surveys, censuses or routine data collection and has to ensure that NAC updates it on the values of the HIV indicators baselines and targets set in the NSP and this M&E Plan.

NSB will involve NAC and the M&E TWG in planning for the HIV, AIDS and Viral Hepatitis, Reproductive Health and related Social Economic surveys so that the content makes enough

provisions for the generation of information needed by the National HIV, AIDS and Viral Hepatitis response for outcomes and impact level measurements only derived from the surveys and other studies.

3.1.5 CIVIL SOCIETY ORGANISATIONS, NGOs AND CSOs

The implementation of the M&E Framework will make use of the strategic positioning of NGOs, CSOs agencies and networks that coordinate the various constituencies of actors in the national response. These NGOs, CSOs agencies and networks need to play a key role in the monitoring of HIV, AIDS and Viral Hepatitis programmes at the national and community levels.

NGOs, CSOs agencies and networks are also required to, in addition to reporting; provide alternative assessment of the national response when preparing the Global AIDS Monitoring (GAM) report. The NGOs, CSOs agencies and networks' participation is also an important component in constructing an indicator on national programme Effort Index. The NGOs, CSOs agencies and networks shall be supported by NAC to assist and guide the collection of data required under the M&E Framework, compilation and submission of NAC M&E Forms, supervision visits, M&E capacity building; report production and; utilization of data to improve the way that they plan and manage the implementation of HIV, AIDS and Viral Hepatitis interventions in the country.

NGOs, CSOs agencies and networks shall also be represented by the relevant technical persons in the National HIV and AIDS M&E TWG; shall develop and keep inventories and data bases and be channels for dissemination of the HIV and AIDS information products.

3.2 COMPONENT 2: HUMAN CAPACITY FOR THE M&E SYSTEM

Monitoring and Evaluation Capacity Building, an approach for the development of monitoring and evaluation systems, is the integrated and planned development of skills, resources and infrastructure and the intentional shift towards an M&E culture. Nonetheless, getting to grips with the institutionalization of the discipline of monitoring and evaluation and the building of an ongoing capacity turns out to be extremely difficult.

Human resource capacity building for the stakeholders including NAC is vital for the successful implementation of the proposed M&E activities and development systems in this Framework. The priority capacity building needs are reflected in 1.3 of this framework.

In recognition of existing gaps in M&E skills and infrastructure the development and strengthening of the existing M&E system is critical for the realization of the goals and objectives of the M&E Framework. The M&E Framework would focus on institutional capacity building, developing and strengthening structures and systems, building linkages between ongoing systems, and enhancement of procedures and guidelines for implementation.

Sustainability measures instituted will include technical guidance, close supervision, periodic and continued capacity building through on-site mentoring and coaching. Infrastructure

development based on assessments and lessons learned during implementation may have to be phased based on resources available.

Institutional capacity building and infrastructure strengthening would be done through:

- Recruitment of requisite M&E skills (subject to availability of funds)
- Development of data management systems
- Training and Development (capacity building trainings to be conducted for key M&E)

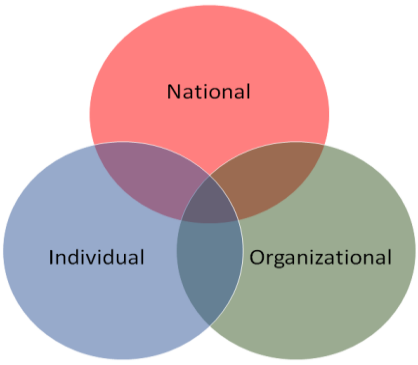
The NAC will develop and have a capacity building programme implemented covering the key offices responsible for coordination and M&E of the response at national levels. This programme should also enable stakeholders' access the data bases with information on the reference resources, M&E curricular, M&E trainers and available opportunities for building M&E Capacity.

The activities that will be focused on in the 2019-2023 M&E Framework will include:

- Development of M&E capacity building program
- Conducting capacity building workshops for all M&E focal persons within line ministries including the MOH, NGOs, CSOs and private sector
- Development of a trainer-of-trainer curriculum to assist in on-going skills building and training in areas including data collection, analysis, and utilisation of data planning and program implementation.
- Development of data collection tools and capacitation of M&E focal person on the application and used of these tools
- Development of reporting strategies which will facilitate the timely submission of data and the development of mechanisms for the return of data.
- Development of the assessment tools to improve data utilization at National level
- The M&E Unit within the NAC collecting and consolidating the data into a quarterly report to be submitted on a quarterly basis or as per indicator decision.

Capacity building or capacity development will be focused on three levels, including the individual, organizational and systems. This component focuses on the level of an individual; building the human resource skills in the M&E system. The capacity building is therefore focused on the individuals that are involved in monitoring and evaluation functions or the management of staff members with M&E functions.

Figure 5: Levels of Capacity Building



- **National** - illustrates the broader environment in which the M&E Framework should be implemented. This level is often referred to as the national level the "action environment" or simply the environment.
- **Organisational** - consists of structures responsible for functions associated with the M&E framework.
- **Individual** - comprises the individual(s) functioning within various organisations or at various levels of the system. This includes individuals within the Line Ministries, NAC, NGOs, CSOs, Networks and Communities.

The M&E units in the NAC and MOH will be responsible for monitoring and evaluation of the implementation of the 2019-2023 National Strategic Plan for HIV, AIDS and Viral Hepatitis.

The capacity building requirements for the implementation of the 2019-2023 National Strategic Plan for HIV, AIDS and Viral Hepatitis would focus on the providing technical assistance to individuals involved in monitoring and evaluation as part of the on-the-job training. The capacity building would focus on the building of institutional memory within the programme by ensuring that all individuals trained are in a position to train others in their respective organisations. The training strategy and plan should be relevant to the programme.

The Capacity building would focus on some of the following elements:

- Context of Monitoring and Evaluation
- Planning – Results Based Management
- Monitoring and Evaluation Models
- Developing Logic Models
- Developing Indicators
- Developing data collection tools
- Data management and analysis
- Reporting

3.3 COMPONENT 3: M&E PARTNERSHIPS

An M&E partnership refers to a cooperative relationship between people or groups of people who agree to share responsibility for achieving the requirements of the M&E Framework. Such partnerships are characterised by commitment to cooperation, shared responsibility and the achievement of common goal. Partnerships are both internal (units within NAC) and external (e.g. MOH, other government ministries, civil society organisation, private sector and development partners.

For the M&E partnerships component to operate effectively, a National HIV, AIDS and Viral Hepatitis M&E Technical Working Group (TWG) needs to be established.

This TWG will have multi-sectoral membership and will shall provide the overall technical guidance to the roll out and implementation of the M&E Framework and the operational plan. The TWG will ensure that the implementation of the M&E Framework and the operational plan meets the technical and stakeholders' expectations.

The NAC M&E focal person will provide the secretariat to the TWG which will lead the operational planning for M&E, develop of strategic resources for M&E, mobilize support to the M&E efforts by stakeholders and monitor the compliance to the provisions of the Plan by different stakeholders, including the critical role assigned to NAC under this framework. The M&E TWG will operate as independent technical forum based on the technical interpretation of the 2019-2023 National Strategic Plan for HIV, AIDS and Viral Hepatitis and M&E Framework and operational plan by the members, supported by NAC as a secretariat. The TWG will serve as the stakeholders' forum which will among other functions ensure that the NAC plays it's expected pivotal role in the execution of the M&E Framework. The TWG will also be expected to support the major national data collection and research related to HIV, AIDS and Viral Hepatitis and other thematic TWGs for quality assurance and promotion of coherence to the one M&E system.

Implementation of some specific specialized activities of the M&E Framework shall require implementation by the M&E TWG that will guide the conceptualization and crystallizing of technical view points on to guide implementation. Such activities may include definition of some new indicators in the context of the country, scope of some studies or surveys and the modelling, projections and target setting tasks.

The M&E-TWG will also be used to arrive at the best national estimates or informed guesses where specific data is not available for determination of a given indicator but must yet be reported upon through estimation informed by credible assumptions. The M&E-TWG will also be needed for related policy development, further indicator analysis and development and production of the National HIV, AIDS and Viral Hepatitis Status and thematic reports production. The M&E-TWG will preside over surveys and surveillance that will be made use of during the next 5 years of this Framework such as the IBBS, Social and Behavioural Surveys, the Workplace Survey and projections. The M&E-TWG will also be used to help develop Terms of Reference, approve the protocol documents; new or amended clinical guidelines and highly specialized M&E processes or activities.

3.4 COMPONENT 4: NATIONAL M&E FRAMEWORK

The National M&E plan is the main guide in determining the extent to which the aims of the response have been attained. To attain this, a selected set of core Indicators shall, to extent possible, be aligned to the results of the 2019-2023 National Strategic Plan for HIV, AIDS and Viral Hepatitis. The core indicators being proposed in this section will respond to all levels of measurement or the entire length of the M&E results chain (Long term Impact, Intermediated Outcome, Short-term Outcome and Output). The indicators shall also be able to meet the regional and international reporting requirements to which Seychelles is a participating stakeholder such as for SADC and UNAIDS' Global AIDS Monitoring (GAM).

The table below gives estimates for key populations based on performed IBBS and facility records.

Table 2: Estimates of key population sizes

Population	Estimated Number	Source of Data
MSM	1,084	IBBS 2011
PWID	1,671	IBBS 2011
SW	586	IBBS 2015
Heroin Users	4,761	IBBS 2017
Injecting Heroin Users (IDU)	2,560	IBBS 2017
Prisoners	441	Prison Records 2017

Table 3: Summary of 2019-2023 M&E Framework Impact and Outcome Indicators in line with Global Targets

Global target to end AIDS by 2030	Fast Track Commitment by 2020	NSP Goal	M&E Impact Indicator	M&E Outcome Indicator
Zero New Infections	Reduce the number of people newly infected with HIV to fewer than 500 000 globally	**1: 90% of all PLHIVs know their status**	**1. Reduced new HIV infections**	1.1 Increased universal and targeted HIV testing and counselling 1.2 Reduced sexual transmission of HIV 1.3 Reduced HIV transmission through injecting drug use 1.4 Eliminated mother-to-child transmission of HIV and syphilis 1.5 Improved identification, treatment and management of co-infections
Zero AIDS-related Deaths	Reduce the number of people dying from AIDS-related causes to fewer than 500 000 globally	**2: 90% of all PLHIVs who know their status receive ART**	**2. Reduced HIV mortality for adults and children**	2.1 Increased ART initiation, care and support for 90% of PLHIV
		3: 90% of all PLHIVs on ART will have viral suppression		2.2 Increased adherence by PLHIVs to ART
Zero Stigma & Discrimination	Eliminate HIV-related stigma and discrimination	**4: Zero stigma and discrimination**	**3. Reduced stigma and discrimination**	3.1 Improved social and legal protection for PLHIVs and key populations
		5: Facilitate a sustainable national response to HIV, AIDS and Viral Hepatitis (national control program to meet the 90-90-90 targets)	**4. Improved enabling environment to meet the 90-90-90 targets**	4.1 Strengthened delivery of HIV prevention, treatment and care services

The overall goal, thematic goals, objectives and strategies are as represented in NSP results framework in the Table 3 below.

Table 4: National M&E Framework as per NSP Goals and Targets

Indicator	Baseline Data	Target 2021	Target 2023	Disaggregation Variables	Data Collection Tool	Reporting Frequency
NSP GOAL 1: 90% of all PLHIVs know their status						
Impact 1	**Reduced new HIV infections**					
Outcome 1.1	**Increased universal and targeted HIV testing and counselling**					
Number and % of people receiving an HIV test in the last 12 months and who know their results	72 % KAPB 2012	90%	95%	▪ Sex ▪ Age ▪ Region	HCT Register/ Program data Survey data	Quarterly, Annually & Every 2-5 years
Number and % of new HIV infections	112 Annual Health Report 2017	80 (30% reduction) NHSP Mid-term target	40 (65% reduction) NSP Target	▪ Sex ▪ Age ▪ Region	HCT Register/ Program data	Quarterly and Annually
% of PLHIV who know their status	73% MOH 2017	90%	95%	▪ Sex ▪ Age ▪ Region	ART Register	Quarterly and Annually
Number and % of people living with HIV	676 CDCU Report 2017	<1%	<1%	▪ Sex ▪ Age ▪ Region	ART Register/ (Spectrum Estimates)	Quarterly and Annually
Number and % of PWIDs who received an HIV test in the last 12 months and who know the results	29.4% IBBS Heroin Users 2017	75%	90%	▪ Sex ▪ Age ▪ Region	HCT Register/ Program Report Survey data	Every 2-5 years
Number and % of SWs who received an HIV test in the last 12 months and who know the results	53.8% IBBS FSW 2015	80%	90%	▪ Sex ▪ Age ▪ Region	HCT Register/ Program Report/ Survey data	Every 2-5 years
Number and % of MSMs who received an HIV test in the last 12 months and who know the results	59.1% (IBBS 2011)	100%	100%	▪ Age ▪ Region	HCT Register/ Program Report/ Survey data	Every 2-5 years
Number and % of transgender persons who received an HIV test in the last 12 months and who know the results	N/A	90%	90%	▪ Age ▪ Region	HCT Register/ Program Report/ Survey data	Every 2-5 years
Number and % of prison inmates who received an HIV test in the last 12 months and who know the results	246 GARPR 2016	90%	90%	▪ Sex ▪ Age	Prison Records	Quarterly and Annually
HIV prevalence amongst PWIDs	8% IBBS Heroin Users 2017	5,5%	3,3%	▪ Sex ▪ Age ▪ Region	IBBS, PWIDs	Every 2-5 years
HIV prevalence amongst SWs	4.6% IBBS FSW 2015	3%	2%	▪ Age ▪ Region	IBBS, SWs	Every 2-5 years
HIV prevalence amongst MSMs	13.2% IBBS MSM 2011	10%	7%	▪ Age ▪ Region	IBBS, MSMs	Every 2-5 years

Indicator	Baseline Data	Target 2021	Target 2023	Disaggregation Variables	Data Collection Tool	Reporting Frequency
HIV prevalence amongst transgender persons	N / A	TBD	TBD	▪ Age ▪ Region	IBBS, Transgender Persons	Every 2-5 years
HIV prevalence amongst prison inmates	4.1% GARPR 2016	3%	2%	▪ Sex ▪ Age ▪ Region	IBBS, Prison Inmates, Program data	Annually
Number and % of health facilities providing HIV testing services	10%	30%	50%	Region	MOH Asset Register of HCT sites	Annually
Number and % of rapid HIV tests conducted	997 MOH 2014 9%	10%	20%	▪ Sex ▪ Age ▪ Region	HCT Register	Quarterly
% of people who have tested for HIV using a self-test kit	0%	2%	10%	▪ Sex ▪ Age ▪ Region	Pharmacy Stock Register	Quarterly
Number of male circumcisions performed	70 MOH 2017	500	1000	▪ Region ▪ Age	Ministry of Health Report	Annually
Outcome 1.2	**Reduced sexual transmission of HIV**					
Number of female and male condoms distributed	523,004 Male condoms MOH 2016	600,000 Male condoms	700,000 Male condoms	Region	Condom distribution schedule/ Program data	Quarterly and annually
Number of condoms distributed to prisoners	2000 Prison record 2016	3,000	4,000	Site	Program data	Quarterly and annually
% of adults aged 15-49 who had sexual intercourse with more than one partner in the past 12 months and used a condom	51.3% KAPB 2012	80%	90%	▪ Sex ▪ Age ▪ Region	Social and Behavioural Surveillance Survey	Every 2-5 years
% of female sex workers reporting condom use with most recent client	81.3% IBBS FSW 2015	90%	95%	Region	IBBS for Sex Workers	Every 2-5 years
% of people who inject drugs, reporting condom use at last sex	44.1% IBBS Heroin Users 2017	70%	90%	Region	IBBS for PWIDs	Every 2-5 years
% men who have sex with men reporting condom use at last anal sex with a male partner	54.5%[7]	70%	90%	Region	IBBS for MSM	Every 2-5 years
% transgender persons reporting condom use at last sex	0 New Indicator	TBD	TBD	Region	IBBS for transgender	Every 2-5 years
% of youth and adolescents (15-24) reached with HIV prevention programmes (define package of services)	88% IBBS 2013	90%	95%	▪ Sex ▪ Age ▪ Region	Program progress reports	Quarterly

[7] IBBS, MSM 2011

Indicator	Baseline Data	Target 2021	Target 2023	Disaggregation Variables	Data Collection Tool	Reporting Frequency
% of PWID reached with HIV prevention programmes (define package of services)	64% IBBS 2017	70%	80%	▪ Sex ▪ Age ▪ Region	NGO/CSO/Network Program progress reports	Quarterly, Annually & Every 2-5 years
% of SWs reached with HIV prevention programmes (define package of services)	51% IBBS 2015	60%	80%	▪ Sex ▪ Age ▪ Region	NGO/CSO/Network Program progress reports	Quarterly, Annually & Every 2-5 years
% of MSMs reached with HIV prevention programmes (define package of services)	96% IBBS 2011	96%	96%	▪ Age ▪ Region	NGO/CSO/Network Program progress reports	Quarterly, Annually & Every 2-5 years
% of transgender reached with HIV prevention programmes (define package of services)	N / A	60%	80%	▪ Age ▪ Region	NGO/CSO/ Network Program progress reports	Quarterly, Annually & Every 2-5 years
% of people in prisons reached with HIV prevention programmes (define package of services)	N / A	60%	80%	▪ Sex ▪ Age ▪ Region	Program progress reports	Quarterly
Update school curriculum on Personal and Social Education (PSE) to include Prevention & Early Intervention (PEI), HIV prevention and SRH by target date	Existing PSE Curriculum	Update school curriculum on PSE to include PEI, HIV prevention & SRH	100%	N / A	PSE School Curriculum	Once
% of schools that provided life skills-based HIV education in the last academic year	100% Ministry of Education 2017	100%	100%	Region	Ministry of Education/ NGO/ CSO Program progress reports	Quarterly
Outcome 1.3	**Reduced HIV transmission through injection drug use**					
% of youth and adolescents using drugs	25% (various sources: Child Well-Being Study, Youth Study 1998 & 2010)	15% National Drug Control Master Plan	TBD	Region	Agency for Prevention of Drug Abuse & Rehabilitation Progress Report	Quarterly, Annually & Every 2-5 years
% of youth and adolescents who inject drugs	18.2% IBBS Heroin Users 2017	TBD	TBD	Region	Agency for Prevention of Drug Abuse & Rehabilitation progress report	Quarterly, Annually & Every 2-5 years
Number of facilities providing comprehensive NSP package	3	TBD	TBD	Region	Ministry of Health Report	Quarterly and Annually
Number of needles-syringes distributed in the past 12 months by needle-syringe programmes	21,550	TBD	TBD	Region	Ministry of Health Report	Quarterly and Annually

Indicator	Baseline Data	Target 2021	Target 2023	Disaggregation Variables	Data Collection Tool	Reporting Frequency
Number of needles and syringes distributed per person who injects drugs per year by needle and syringe programmes	5.7 GARPR 2016	TBD	TBD	Region	Ministry of Health Report	Quarterly and Annually
% of PWIDs reporting the use of sterile injecting equipment the last time they injected	74.8% IBBS Heroin Users 2017	80%	90%	Region	• Ministry of Health/ • IBBS in PWIDs • DURNs Progress reports	Quarterly, Annually & Every 2-5 years
Number of points of care managing the prevention of overdose (Naloxone, First aid training).	**3**	8	15	Region	Ministry of Health Report	Quarterly and Annually
Number and % of people who inject drugs on Methadone Substitution Therapy	26.6% GARPR 2016	75% National Drug Control Master Plan 2012	75%	Region	Agency for Prevention of Drug Abuse & Rehabilitation progress report	Quarterly and Annually
Number of MST facilities established	3 APDAR 2018	TBD	TBD	Region	Agency for Prevention of Drug Abuse & Rehabilitation progress report	Annually
Number of mothers-to-be who are drug dependent	27 National Drug Control Master Plan, 2012	14 (50% reduction) National Drug Control Master Plan 2012	7 (75% reduction)	Region	▪ Agency for Prevention of Drug Abuse & Rehabilitation progress report ▪ MOH Annual Report	Annually
Estimated number of PWIDs on the waiting list for MST	800 APDAR 2017	Reduce by 50%	Reduce by 80%	Region	▪ Agency for Prevention of Drug Abuse & Rehabilitation progress report ▪ MOH Annual Report	Quarterly and Annually
Outcome 1.4	**Eliminated mother to child transmission of HIV and Syphilis**					
Number and % of pregnant women who are HIV-positive	8 Local Situation Report 2017	1	1	Region	▪ PMTCT Register ▪ PMTCT Progress Report	Quarterly and Annually
% of infants born to HIV-infected mothers who are infected	1% Local Situation Report 2017	0%	0%	Region	▪ PMTCT Register ▪ PMTCT Progress Report	Quarterly and Annually
% of HIV-positive pregnant women who received antiretroviral therapy to reduce the risk of mother-to-child transmission	100% Annual Health Report 2017	100%	100%	Region	▪ PMTCT Register ▪ PMTCT Progress Report ▪ ARV Register	Quarterly

Indicator	Baseline Data	Target 2021	Target 2023	Disaggregation Variables	Data Collection Tool	Reporting Frequency
% of HIV positive pregnant women provided with adherence support to PMTCT	0% MOH 2017	100%	100%	Region	▪ PMTCT Register ▪ PMTCT Progress Report	Quarterly
% HIV-infected among HIV exposed infants born in the past 12 months	1% MOH 2017	0%	0%	Region	▪ PMTCT Register ▪ PMTCT Progress Report	Quarterly and Annually
% of HIV-exposed infants started on cotrimoxazole prophylaxis within 2 months of birth	100% MOH 2017	100%	100%	Region	▪ PMTCT Register ▪ PMTCT Progress Report	Quarterly and Annually
% of HIV exposed infants tested for HIV at 6 weeks	60% MOH 2017	90%	95%	Region	▪ PMTCT Register ▪ PMTCT Progress Report	Quarterly
% of pregnant women attending ANC whose male partners were tested for HIV during pregnancy	3.8% MOH 2014	90%	95%	Region	▪ PMTCT Register ▪ PMTCT Progress Report	Quarterly
% of infants born to women living with HIV receiving a virological test for HIV within two months of birth	91.7% GARPR 2016	100%	100%	▪ Sex ▪ Region	▪ PMTCT Register ▪ PMTCT Progress Report	Quarterly and Annually
Coverage of Syphilis testing in women attending antenatal care services at any visit	100%	100%	100%	▪ Age ▪ Region	Ministry of Health Report	Quarterly and Annually
Outcome 1.5	**Improved identification, treatment and management of co-infections**					
Estimated number and % of people living with HIV who have co-infections	190 (20%) Local Situation Reports 2002 -2017	10 %	5 %	▪ Sex ▪ Age ▪ Region	Ministry of Health Report	Annually
STI newly diagnosed cases	1518 Annual Health Report 2017	1000 (40% reduction) NHSP Mid-term target	300 (80% reduction) NSP Target	▪ Sex ▪ Age ▪ Region	Ministry of Health Report	Quarterly and Annually
% of men reporting an STI in the past 12 months	1% CDCU 2017	TBD	TBD	▪ Age ▪ Region	Social & Behavioural Surveillance Survey	Every 2-5 years
% of individuals seropositive for syphilis	0.02 MOH 2017	TBD	TBD	▪ Sex ▪ Age ▪ Region	Ministry of Health Report	Quarterly and Annually
% of the PWIDs screened for STIs	15.7% IBBS 2017	60%	80%	▪ Sex ▪ Age ▪ Region	IBBS	Every 2-5 years
% of SWs screened for STIs	26% IBBS 2015	60%	80%	▪ Sex ▪ Age ▪ Region	IBBS	Every 2-5 years

Indicator	Baseline Data	Target 2021	Target 2023	Disaggregation Variables	Data Collection Tool	Reporting Frequency
% of people in HIV care who were screened for hepatitis B	100%	100%	100%	▪ Sex ▪ Age ▪ Region	Ministry of Health Report	Quarterly and Annually
% of people who received treatment for hepatitis B	54 Local Situation Report 2017	100%	100%	▪ Sex ▪ Age ▪ Region	Ministry of Health Progress Report	Quarterly and Annually
% of people co-infected with HIV and HBV receiving combined treatment	66.7% MOH 2017	70%	90%	▪ Sex ▪ Age ▪ Region	Ministry of Health Progress Report	Quarterly and Annually
% of PWIDs co-infected with HIV and HBV receiving combined treatment	36.4% MOH 2017	70%	90%	▪ Sex ▪ Age ▪ Region	Ministry of Health Progress Report	Quarterly and Annually
Hepatitis C incidence (actually newly diagnosed cases)	186 Annual Health Report 2017	100%	100%	▪ Sex ▪ Age ▪ Region	Ministry of Health Progress Report	Quarterly and Annually
Number of people living with Hepatitis C	946 Local Situation Report 2017	Reduce by 50%	Reduce by 80%	▪ Sex ▪ Age ▪ Region	Ministry of Health Progress Report	Quarterly and Annually
Prevalence of hepatitis C and co-infection with HIV among key populations	57.8% GARPR 2016	Reduce by 50%	Reduce by 80%	▪ Sex ▪ Age ▪ Region	Ministry of Health Progress Report	Quarterly and Annually
% of people starting on antiretroviral therapy who were tested for Hepatitis C virus (HCV)	47.6% MOH 2017	70%	90%	▪ Sex ▪ Age ▪ Region	Ministry of Health Progress Report	Quarterly and Annually
% of PWIDs starting on antiretroviral therapy who were tested for Hepatitis C virus (HCV)	44.4% MOH 2017	70%	90%	▪ Sex ▪ Age ▪ Region	Ministry of Health Progress Report	Quarterly and Annually
HCV prevalence for PWIDS	46.5% Annual Health Report 2017	Reduce by 50%	Reduce by 80%	▪ Sex ▪ Age ▪ Region	▪ Ministry of Health Progress Report ▪ IBBS	Quarterly, Annually & Every 2-5 years
HCV prevalence for MSMs	41.9% Annual Health Report 2017	Reduce by 50%	Reduce by 80%	▪ Age ▪ Region	▪ Ministry of Health Progress Report ▪ IBBS	Quarterly, Annually & Every 2-5 years
HCV prevalence for FSWs	34.6% Annual Health Report 2017	Reduce by 50%	Reduce by 80%	▪ Age ▪ Region	▪ Ministry of Health Progress Report ▪ IBBS	Quarterly, Annually & Every 2-5 years
HCV prevalence for prison inmates	5.4% Prison records 2016	Reduce by 50%	Reduce by 80%	▪ Age ▪ Sex ▪ Site	▪ Ministry of Health Progress Report ▪ IBBS	Annually
Proportion of people in HIV care (including PMTCT) who were screened for TB in	60% MOH, 2017	80%	90%	▪ Age ▪ Region	Ministry of Health Progress Report	Quarterly and Annually

Indicator	Baseline Data	Target 2021	Target 2023	Disaggregation Variables	Data Collection Tool	Reporting Frequency
HIV care and treatment settings						
% of people living with HIV and newly enrolled in HIV care who have active TB disease	0 MOH 2017	0	0	▪ Age ▪ Region	Ministry of Health Progress Report	Quarterly and Annually
Number and % of people who were screened for cancer	189 Annual Health Report 2017	134 (30%) NHSP Mid-term target	75 (60% reduction) NSP Target	▪ Age ▪ Region	Ministry of Health Progress Report	Quarterly and Annually
% of women living with HIV 30-49 years old who report being screened for cervical cancer using visual inspection with acetic acid (VIA), Pap smear or human papilloma virus (HPV) test	84.6% MOH 2017	90%	95%	▪ Age ▪ Region	▪ Ministry of Health Progress Report ▪ ART register	Quarterly and Annually
NSP GOAL 2: 90% of all PLHIVs who know their status receive antiretroviral therapy						
Impact 2	**Reduced HIV mortality and morbidity for adults and children**					
Outcome 2.1	**Increased ART initiation, care and support for 90% of PLHIV**					
ART Coverage	62% Annual Health Report 2017	90%	95%	▪ Sex ▪ Age ▪ Region	▪ Ministry of Health Progress Report ▪ ART register	Quarterly and Annually
Number and % of people living with HIV who initiate ART in the last 12 months	907 MOH 2017 80%	85%	90%	▪ Sex ▪ Age ▪ Region	▪ Ministry of Health Progress Report ▪ ART register	Quarterly and Annually
Number and % of health care facilities providing ART	3 (10%) MOH 2017	6	10	Region	▪ Ministry of Health Progress Report	Quarterly and Annually
% of facilities with stock-outs of antiretroviral drugs	0%	0%	0%	Region	▪ Ministry of Health Progress Report ▪ Logistics & supply chain management register	Quarterly and Annually
Number and % of PLHIVs not on treatment identified	242 (63%) MOH 2017	80%	90%	▪ Sex ▪ Age ▪ Region	▪ Ministry of Health Progress Report ▪ Estimates	Quarterly and Annually
% of PWIDs living with HIV who are receiving ART	42% IBBS 2017	80%	90%	Region	▪ Ministry of Health Progress Report ▪ ART register ▪ DURNs Progress report	Quarterly and Annually
% of SWs living with HIV who are receiving ART	57% IBBS 2015	80%	90%	Region	▪ Ministry of Health Progress Report ▪ ART register	Quarterly and Annually
% of MSMs living with HIV who are receiving ART	N / A	80%	90%	Region	▪ Ministry of Health Progress Report ▪ ART register	Quarterly and Annually
% of transgender persons living with HIV who are receiving ART	N / A	80%	90%	Region	▪ Ministry of Health Progress Report ▪ ART register	Quarterly and Annually

Indicator	Baseline Data	Target 2021	Target 2023	Disaggregation Variables	Data Collection Tool	Reporting Frequency
% of prison inmates living with HIV who are receiving ART	69.4% GARPR 2016	80%	90%	Region	▪ Ministry of Health Progress Report ▪ ART register	Quarterly and Annually
Number and % of PLHIVs receiving psychosocial support	TBD	30%	60%	Region	Ministry of Health Progress Report	Quarterly and Annually
NSP GOAL 3: 90% of all PLHIVs on ART will be virally suppressed						
Outcome 2.2	**Increased adherence by PLHIVs to ART**					
Number and % of PLHIVs on ART who are retained on ART 12 months after initiation	98 or 95%	95%	98%	Region	Ministry of Health Progress Report	Quarterly and Annually
Establish standard operation procedures for referral and feedback by target date	0	2020	N/A	N/A	Standard operation procedures for referral	Once
% of all PLHIVs on ART who are virally suppressed.	62% Annual Health Report 2017	80% NHSP Mid-term target	90% NSP Target	▪ Sex ▪ Age ▪ Region	Ministry of Health Progress Report	Quarterly and Annually
% of people (children and adults) on ART with viral load test results at 12 months	100% MOH 2017	100%	100%	▪ Sex ▪ Age ▪ Region	Ministry of Health Progress Report	Quarterly and Annually
% of PLHIVs on ART who have virological suppression (<1000 copies/ml) at 12 months after initiating treatment	83% MOH 2017	85%	90%	▪ Sex ▪ Age ▪ Region	Ministry of Health Progress Report	Quarterly and Annually
Mortality due to AIDS	2% (16 deaths) Annual Health Report 2017	0.5% NHSP Mid-term target	0.5% NSP Target	▪ Sex ▪ Age ▪ Region	Ministry of Health Progress Report	Quarterly / Annually
NSP GOAL 4: Zero stigma and discrimination						
Impact 3	**Reduced stigma and discrimination**					
Outcome 3.1	**Improved social and legal protection for PLHIVs and key populations**					
% of population expressing accepting attitudes in relation to PLHIV	88% KAPB 2012	90%	90%	▪ Sex ▪ Age ▪ Region	Social and Behavioural Surveillance Survey	Every 2-5 years
% of population expressing accepting attitudes in relation to key populations	88% KAPB 2012	90%	90%	▪ Sex ▪ Age ▪ Region	Social and Behavioural Surveillance Survey	Every 2-5 years
Number and % using PrEP in key populations	2	TBD	TBD	Region	Ministry of Health Progress Report	Quarterly and Annually
% of health facilities where PrEP is available	1	3	TBD	Region	Ministry of Health Progress Report	Quarterly and Annually
% of health facilities where PEP is available	100% MOH 2017	100%	100%	Region	Ministry of Health Progress Report	Quarterly and Annually

Indicator	Baseline Data	Target 2021	Target 2023	Disaggregation Variables	Data Collection Tool	Reporting Frequency
% of SW who avoided seeking HIV testing because of fear of stigma	N / A	0%	0%	▪ Sex ▪ Age ▪ Region	Ministry of Health Progress Report	Every 2-5 years
% of MSM who avoided seeking HIV testing because of fear of stigma	14% IBBS 2011	5%	0%	▪ Sex ▪ Age ▪ Region	Ministry of Health Progress Report	Every 2-5 years
% of PWID who avoided seeking HIV testing because of fear of stigma	6% IBBS 2011	0%	0%	▪ Sex ▪ Age ▪ Region	Ministry of Health Progress Report	Every 2-5 years
Number and % people from key populations who have experienced discrimination by health workers	N / A	0%	0%	▪ Sex ▪ Age ▪ Region	Ministry of Health Progress Report	Quarterly, Annually & Every 2-5 years
Number of facilities providing clinical and social services to survivors to mitigate the harms associated with GBV	N / A	TBD	TBD	Region	▪ Ministry of Health Progress Report ▪ Ministry of Family Affairs Report	Quarterly and Annually
NSP GOAL 5: Facilitate a sustainable national response to HIV, AIDS and Viral Hepatitis (sustainable national HIV control program to meet the 90-90-90 targets)						
Impact 4	**Improved enabling environment to meet the 90-90-90 targets**					
Outcome 4.1	**Strengthened delivery of HIV prevention, treatment and care services**					
Development of the HIV Policy to support new international and regional obligations	2012	2020	N/A	N/A	HIV Policy	Once
Testing & counselling guidelines developed by target date	2015	2020	N/A	N/A	Testing and counselling guidelines	Once
Treatment management guideline developed by target date	2015	2020	N/A	N/A	Treatment management guideline	Once
Comprehensive Condom Distribution and Management strategy developed by target date	0	2020	N/A	N/A	Comprehensive Condom Distribution and Management strategy	Once
Clinical protocols for the management of the HIV response developed by target date	2015	2020	N/A	N/A	Clinical protocols for the management of the HIV response	Once
Level of functionality of the M&E system	0%	100%	100%	N/A	M&E Functionality Assessment Report	Every two years
% of M&E operational plan activities implemented	0%	100%	100%	N/A	M&E Operational Plan Progress Report	Annually

3.5 COMPONENT 5: COSTED M&E WORKPLAN

To be completed upon development of the operational M&E plan

3.6 COMPONENT 6: HIV ADVOCACY, COMMUNICATIONS AND CULTURE

It is critically important to develop advocacy and communication strategies to help communicate messages that will help popularise monitoring and evaluation as an effective tool for managing performance. The overarching objective is to obtain buy in and thereby help building the 2019-2023 National Strategic Plan for HIV, AIDS and Viral Hepatitis as a way of doing business. The performance goal is to ensure knowledge of, commitment to M&E among programme managers, programme staff and other stakeholders.

Advocacy to key audiences, such as policy makers, donors, program planners, and the general public is critical for ensuring effective national and localized responses to the epidemic. The appropriate selection of data can support the planning of multiple HIV programs. Estimating the extent of the epidemic can also help better decision making about allocating resources. It is important that the relevant information is communicated to the right audience and that data reports should address concerns using the appropriate language and length and be delivered in a timely manner to the appropriate audience.

The following will be the critical means of institutionalising M&E:

- **Advocacy –** the intention here is to educate, sensitise, influence and change opinion or motivate by creating and implementing favourable policy
- **Communication –** Good communication always has clear purpose, content, reliable source, effective transmission and is effectively delivered to intended recipients
- **M&E Culture –** shared set of values, conventions, or social practices associated with M&E

Action plan for implementing the performance goal

- Conduct change management/orientation workshop
- Develop communication and advocacy plan by target date
- Develop communication and advocacy M&E material
- Support development of M&E plans within respective chief directorates
- Build capacity for implementation of M&E Framework

To ensure that the Monitoring, Evaluation and Research activities remain priorities in the National HIV, AIDS and Viral Hepatitis response, the NAC, with support from MOH, NGOs, CSOs, Networks and development partners, will undertake the needed high-level advocacy to enhance the M&E culture in the National response. Advocacy for HIV, AIDS and Viral Hepatitis M&E shall also be part of the National Advocacy and Communications strategy. NAC will also guide the stakeholders on what proportion of resources that should be reserved for Monitoring

and Evaluation. NAC, MOH, Line ministries, NGOs, CSOs and Networks will also undertake advocacy for M&E at national, sectoral and decentralized levels.

3.7 COMPONENT 7: SURVEYS, HIV SURVEILLANCE

3.7.1 BIOLOGICAL HIV SURVEILLANCE

Biological HIV/Hepatitis surveillance along with the behavioural surveillance is an important component of this HIV, AIDS and Viral Hepatitis M&E plan to produce both bio-makers and social-behavioural indicators. This source is very important since it generates information that is used to monitor trends in the epidemic and effectiveness of the response which are key for designing interventions. Key data sources among the biological HIV surveillance in the National HIV, AIDS and Viral Hepatitis response will include HIV Sero-Prevalence Surveys and HIV surveillance at ANC Facilities, namely, sentinel surveillance for HIV and STIs at ANC clinics using the MOH protocols for sentinel surveillance.

3.7.2 BEHAVIOURAL SURVEILLANCE SURVEY (BSS)

A number or regular reproductive Health and HIV, AIDS and Viral Hepatitis related behavioural surveillance, which are usually undertaken alongside biological surveillance, need to be undertaken as an important component of the M&E plan for monitoring the epidemic and for evaluation of the effectiveness of the various BCC interventions. BSS will be used to monitor the proximate determinants underlying or driving the epidemic associated with social and sexual behaviours and practices relating to HIV, AIDS and Viral Hepatitis prevention, care and treatment and support.

The BSS will provide an understanding and explanation of HIV infection patterns and trends and provides critical information that serves as basis for priority interventions and program development. The BSS information will also serve as an early warning system, alerting policy makers and stakeholders to emerging risks or changes in existing risk behaviours. The behavioural surveillance focusing on key population will be undertaken every four years where possible. The data from these surveys will also be submitted by the respective responsible agencies to NAC for input into the single M&E System.

3.7.3 QUALITY OF HEALTH-RELATED HIV SERVICES SURVEY

The Health Sector response with a larger proportion of HIV, AIDS and Viral Hepatitis interventions in Health facilities need to conduct regular surveys of health services. It is therefore important to collect data on both the quantity and quality of these services provided at health facilities. The assessment of the quality of care or of HIV service provision required needs to be done in independent surveys. MOH will be responsible for the Quality of Health related HIV Services Survey every two to three years, resources permitting. The data from this source will also be submitted to NAC as part of the single M&E system.

3.7.4 SURVEYS

A number of key thematic assessments and evaluations need to be undertaken as part of M&E of the response to enhance the in-depth understanding of the performance of these key interventions. A specific evaluation or assessment of ART programme is likely to produce deeper analysis and understanding of the key sub theme compared to when ART is reported in routine reporting or assessed as part of overall National response strategic theme or assessment/ review track of treatment, care and support.

This need for deeper investigation, however, does not rule out the wider thematic component or wider response evaluation that examines the inter-relationships within a thematic area or even between different thematic areas (i.e. ART adherence and community and family level support structures that could fall in two components of Care: the ART provision at clinical setting and the community care and support). MOH and other thematic lead actors will be responsible for the Quality of service delivery Surveys and assessments every two years, resources permitting. The data from this source generated by the agencies commissioning the evaluations will also be submitted to NAC as part of one M&E system.

A) WORKPLACE HIV AND AIDS PROGRAMME SURVEY

Workplace surveys covering a sample of public and private sector work places will be undertaken to assess the adherence to the Workplace Policy and regularly track the extent to which HIV and AIDS prevention and care policy provisions have been mainstreamed in workplaces. Private sector establishments are selected on the basis of the size of the labour force and feed into the National M&E system steered by NAC and the indicators for the GARPR reporting.

The workplace survey will be undertaken every two years. The Employment Bureau and the ministry responsible for labour will oversee and implement the survey in accordance with the workplace survey protocol produced by UNAIDS and ILO.

B) INTEGRATED HOUSEHOLD SURVEYS

HIV impact and other social economic indicators will be generated through household surveys by the National Statistics Office (NSO) or sub contracted agencies. These will be the basis for generation of some of the NSP outcome and impact indicators. The NAC and the sector line ministries and Partners will ensure that questions on HIV, AIDS and Viral Hepatitis are part of tools for the integrated household surveys data collection modules.

C) ASSETS INVENTORY, PROCUREMENT AND LOGISTICS SUPPLY AND ADMINISTRATIVE RECORDS ANALYSIS

All stakeholders implementing the HIV and AIDS interventions, under the guidance of NAC, will be required to keep an asset inventory and Procurement and Supplies Management (PSM) records as a vital source of input indicators. The data is important for monitoring the volume, quality, durability, timely delivery and cost of the inputs and the efficient use of the different types of logistics. This data will be fed into the Logistics Information System or sub component of the National HIV, AIDS and Viral Hepatitis data base. Normally this information is reported/ submitted and aggregated annually.

D) RESOURCE TRACKING, HIV AND AIDS ACCOUNTS, BUDGET & EXPENDITURE ANALYSIS

National AIDS Council together with the Ministry of Finance will undertake National HIV and AIDS Spending Assessments (NASA) every two years. In addition, NAC will circulate a Resource Tracking Form at the end of every financial year that will require stakeholders to submit summaries of information on resources accessed and committed to HIV and AIDS interventions in the financial year.

Resource Tracking will also be undertaken through resource tracking studies, HIV, AIDS and Viral Hepatitis budget analysis, national accounts analysis and unit cost studies by other partners and independent researchers and advocacy groups. These will be targeted at major programmes and projects to determine the proportional expenditures between different thematic areas, beneficiary populations, production factors, unit costs, programme cost-effectiveness/ efficiency, by service delivery approaches, by categories of actors and by programme levels. These analyses will be useful for advocacy purposes, promotion of cost-effective approaches and will also help in prioritization of interventions that will have been regarded as more effective studies.

E) HIV OPERATIONAL RESEARCH AND SPECIAL STUDIES

Operational research and special studies will be undertaken to complement the data from the other data sources. Operational research and special studies will include both quantitative and qualitative research. The National HIV, AIDS and Viral Hepatitis M&E and Information Systems Technical Working Group (TWG) will spearhead the development of a national HIV and AIDS research and evaluation Agenda and Strategy. In the research strategy, formal reporting procedures will be formulated that will enable the NAC to capture findings arising from the research that different research/academic institutions undertake. The results of this research and special studies will also feed into the one National M&E system by responsible lead agencies.

Specific Socio-Economic Impact studies will be undertaken to help identify the effects and impacts of the epidemic on the various population groups and geographical areas. These can be commissioned by the M&E-TWG, in collaboration with the NAC.

F) INDEPENDENT ASSESSMENTS, JOINT ANNUAL, MID TERM AND END OF TERM REVIEWS

The M&E TWG will support NAC, funding, responsible line ministry or other supervising organizations or agencies to commission annual Independent Response Assessments, Joint Annual Reviews (JAR), Mid Term Review (MTR) and End of Term or Terminal Reviews for specific national programmes (i.e. Prevention, ART programme) or major projects and the National Strategic Plan of the entire multi-sectoral HIV, AIDS and Viral Hepatitis response. These assessments help to stake stock of the progress made along the Operational plan and action plans and NSP targets and provide information for more strategic response re-programming.

3.8 COMPONENT 8: ROUTINE MONITORING

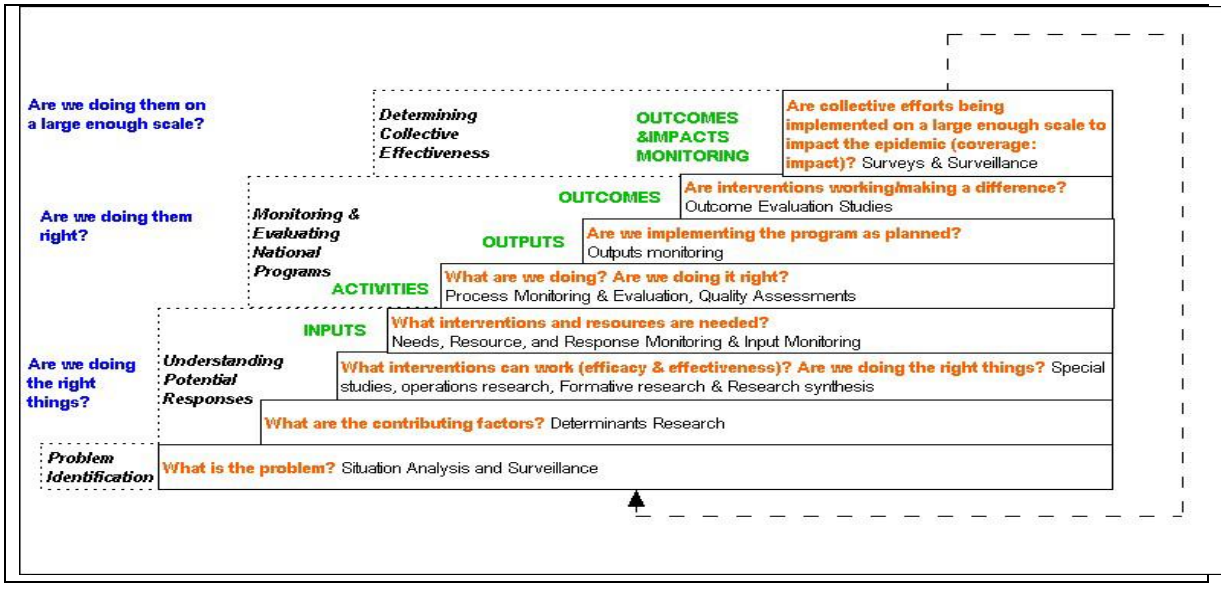
3.8.1 OVERVIEW

Not everything that can be counted counts, and not everything that counts can be counted."
Albert Einstein (1879-1955)

For HIV results at all levels to be measured, the entire spectrum of input, output, outcome and impact data are needed. Figure 6 illustrates the different types of data required. Input and output monitoring data are important, as these answer questions about the resources and interventions needed and provided, and whether planned programmes have been implemented. Input and output monitoring data are collected through routine monitoring systems. Routine monitoring refers to the frequency of data collection and the type of data collected.

Routine monitoring is the *routine* tracking of the key elements of program/project performance (usually inputs and outputs) through record-keeping, regular reporting and surveillance systems, as well as surveys. Monitoring helps program or project managers determine which areas require greater effort and identify areas which might contribute to an improved response. In a well-designed monitoring and evaluation system, monitoring contributes greatly towards evaluation. Indicators selected for monitoring will be different, depending on the reporting level within the system. Routine monitoring is used for measuring trends over time, thus the methods used need to be consistent and rigorous to ensure an appropriate comparison.

Figure 6: An approach to Monitoring and Evaluation of HIV and AIDS Programmes



There are two major sources of data for the core indicators – periodic and routine:
(a) data sources for indicators that will be measured by surveys (outcome and impact indicators and outcome/impact data sources) are periodic; and
(b) data sources for indicators that will be measured continuously – monitor programme outputs (output indicators and output data sources) are routine.

Input and output monitoring data are important, as these answer questions about the resources and interventions needed and provided, and whether planned programmes have been implemented. Input and output monitoring data are *collected through routine* monitoring *systems*, and are addressed by this Component

Two questions arise in respect of routine date:

1. Is it really necessary to collect data on issues other than whether or not interventions are making a difference and whether they are being implemented as planned?
2. Is it really necessary to use routine monitoring systems to collect data about available funding (input data) and whether programmes have been implemented as planned (output data)?

This framework purports that routine data is important for a number of reasons:

- Routine monitoring data provides data to explain the changes at the outcome and impact level. This project intervention is needed to bring about higher-order changes. Therefore, the implementation of such interventions and the inputs supplied to deliver these, need to be monitored, the data helps to interpret positive and negative changes (or lack thereof) at the higher order level.
- Routine monitoring provides real-time data that can be used for day-to-day monitoring, coordination and planning for the project, unlike surveys and evaluation which simply provide a snapshot in time.
- Routine monitoring data can be used to validate service coverage data generated through the baseline and the training needs assessment.

3.8.2 HEALTH SECTOR PROGRAMME ACTIVITY MONITORING DATA

The CDCU and HIV and AIDS Control Program Unit are responsible for monitoring the health facility based and other community health HIV services including HCT, ART, ANC, PMTCT, Sexually Transmitted Infection, STI, OI management, care, blood products safety, Post Exposure Prophylaxis (PEP), Pre-Exposure Prophylaxis (PrEP), prevention programmes for key populations, Universal precautions for infection control, and clinical care and condom distribution, the MST and NEP. The MOH has developed its own data collection tools for routine reporting of HIV information on each of these services. All health facilities in the country providing any of these services, are required to submit monthly routine reports and CDCU aggregates these reports quarterly.

3.8.3 NON-HEALTH SECTOR PROGRAMME ACTIVITY MONITORING DATA

NAC will develop and harmonize reporting tools and reporting formats with existing sector specific reporting tools and formats to enhance the capture data on all non-health sectors HIV services (i.e. all HIV services that are not provided by the Ministry of Health such as the Ministry of Education, ministry of Gender into the single M&E System. Furthermore, the NAC will work with the NGOs, CSOs, Networks and Faith-based organisations and develop data collection tools for the HIV prevention and care services provided by these organisations. The data collected includes HIV prevention, care and impact mitigation interventions. This is a

routine data source that requires strengthening and will not be limited to the ministries and organisations supported through NAC but will cover all Government Ministries, Departments and Agencies, government institutions implementing HIV, AIDS and Viral Hepatitis activities. This source will be vital in production of report routine data to for computation of non-health output level indicators in the national set of indicators.

A Service Coverage Reporting form needs to be developed and the Government Ministries, Departments and Agencies offering non-health HIV services will complete the routine Service Coverage Reporting (SCR) forms on a quarterly basis and submit directly to NAC. The NAC will aggregate data from the forms submitted by Government Ministries, Departments and Agencies and enter the data into the national data bases, undertake analysis of key parameters or output indicators and compile a national HIV summary report.

3.8.4 ROUTINE PROGRAMME MONITORING DATA FROM OTHER AGENCIES AND PROJECTS

The Non-Governmental / non-public sectors are key actors in the national response. Using the same National Level Service Coverage Report form (SCR) as for the Government Ministries, Departments and Agencies, NAC will also solicit quarterly reports from other NGOs, CSOs, Faith-based organisations and networks. These organisations and networks will be vital hubs and engines for M&E of the response by strengthening routine reporting in their respective constituencies into the “One M&E system”.

The CSOs, NGOs, Faith-based organisations and networks will collate the organisational level summary reports along with data from other sources and produce a Quarterly Service Coverage Report for the organisation. These CSOs, NGOs, Faith-based organisations and networks will then submit the reports to the NAC and the relevant Sector Ministries with whom they are partners in execution of the respective mandates. The CSOs, NGOs, Faith-based organisations and networks will also be expected to disseminate the Quarterly Service Coverage Report to stakeholders in their respective constituencies on quarterly and annual basis.

3.8.5 FIELD MONITORING AND SUPPORT SUPERVISION

Field support supervision reports by organizations responsible for the HIV, AIDS and Viral Hepatitis response coordination including: NAC, MOH, line ministries, departments and agencies, CSOs, NGOs, Faith-based organisations and networks; constitute another key source of data. These HIV projects will produce reports based on the field monitoring and support supervision undertaken.

The field monitoring and support supervision reports will complement the data from the regular reporting generated and other regular reports from the line ministries, departments and agencies, CSOs, NGOs, Faith-based organisations and networks in their respective sectors, constituencies and projects that have been entered in their respective organizational and project data bases and produce reports as part of the routine progress data reports. These reports will enrich the one M&E system to which they regularly submit reports.

3.9 COMPONENT 9: SUPPORTIVE SUPERVISION AND DATA AUDITING

Data quality refers to the "fitness for use" of the collected data and focuses on ensuring that the process of data collection, collation and analysis enable the data reported fit to be used and can withstand an internal and external data quality audit. If data management is flawed there is a risk that the data will be of poor value. As programme planners/implementers it is prudent to make plans to ensure that data collected will be of good quality.

Data quality reflects the value / accuracy of data and is a measure of how well an information system represents the real world - the real world in this instance, being HIV programme activities and their results. Data quality, therefore, is a measure of how well the data collection tools being used reflect or mirror the activities or services being implemented. Good data quality is when our information system accurately collects, processes and disseminates information on needs, interventions and the results of these activities.

Data Quality Assessment is the process of verifying the completeness and accuracy of a selection of HIV output/program monitoring forms through, a) field visits to the organisations that submitted the forms; b) checking the quality of raw data kept by the reporting organisation by examining the daily records used to complete the output monitoring form for a specific reporting period; c) comparing the output monitoring form data against the raw data; and d) checking for internal consistency.

Data assessment is useful because:

1. The data assessment processes help improve the credibility of the M&E data by improving HIV stakeholders' confidence that the data presented to them presents a true picture of the HIV services delivered.
2. These processes help builds capacity in routine data collection and capture, and the way in which they can use data to improve their own programmes.
3. These processes help to improve the use of information for decision making, as more HIV implementers collect and capture better quality data, and learn how to use this data.

Data quality assessment involves both verifying that appropriate data management systems are in place and the quality of reported data, for key indicators. This implies that data-quality processes need to assess the design of the data management and reporting systems; check system implementation for design compliance at selected service delivery and intermediary reporting sites; trace and verify historical reporting on a limited number of indicators at a few sites; and communicate the audit findings and suggested improvements in a formal audit report. The quality of data and information generated by the M&E system is central to its effectiveness. NAC, in collaboration with other National partners will spearhead the Data Quality Assessment (DQA) using the current National DQA Protocol.

The DQA will basically focus on verifying the quality of reported data and assessing the underlying data management and reporting systems for standard program-level output indicators. The Routine Data Quality Assessment facilitates programs and projects to

strengthen their data management and reporting systems. Each of the non-routine data sources will also have the DQA measures specified as part of the protocols. The M&E TWG will review the DQA protocol guidelines when need arises but at most every 2 years to ensure sustained relevance and appropriateness. Provision is also made for process and schedule for external data audits where need arises.

3.10 COMPONENT 10: SUB-NATIONAL AND NATIONAL DATABASES

National and sub national data bases, notable of which are: the CDCU database run by MOH, the databases managed by the different CSOs, NGOs, Faith-based organisations and networks. The data bases shall be enhanced to enable easy access, have inter-operability to enhance the sharing of information on HIV, AIDS and Viral Hepatitis. NAC will establish the National HIV, AIDS and Viral Hepatitis database to serve as the main national repository for data from routine programme monitoring; population based surveys, surveillance, research, financial monitoring and other relevant sources.

All the national data bases shall have user friendly procedures or database management protocols to ensure that it's data are updated regularly, consistently and on time and accessed with relative ease even in the largely resource constrained settings with poor connectivity. All data bases will be required to ensure data disaggregation, by thematic areas and target beneficiary population and service provider categories. NAC will encourage and work towards the creation of a single database. Once such database exists, relevant data will be used for reporting and for inclusion in M&E information products for enhanced strategic information management.

3.11 COMPONENT 11: OPERATIONAL RESEARCH AND EVALUATION

3.11.1 PERFORMANCE LOGIC CHAIN ASSESSMENT

The performance logic chain assessment evaluation strategy is used to determine the strength and logic of the causal model behind the policy, program, or project. The causal model addresses the deployment and sequencing of the activities, resources, or policy initiatives that can be used to bring about a desired change in an existing condition. The evaluation would address the plausibility of achieving that desired change, based on similar prior efforts and on the research literature.

The intention is to avoid failure from a weak design that would have little or no chance of success in achieving the intended outcomes. In attempting to assess the present effort in comparison to past efforts, the evaluator could focus on the level of resources, timing, capacity of the individuals and organizations involved, level of expected outcomes, and so forth, to determine if the present strategy can be supported from prior experience. Likewise, in examining the research literature, the evaluator can find out if the underlying premises of the proposed initiative can be supported. For example, that increased awareness, by citizens, of government corruption through a public information campaign will lead to increased pressure from civil society for the government to combat and control the corruption.

3.11.2 PRE-IMPLEMENTATION ASSESSMENT

The pre-implementation assessment evaluation strategy addresses **three standards** that should be clearly articulated before moving to the implementation phase. The standards are encompassed in the following questions:

1. Are the objectives well-defined so that outcomes can be stated in measurable terms?
2. Is there a coherent and credible implementation plan that provides clear evidence of how implementation is to proceed and how successful implementation can be distinguished from poor implementation?
3. Is the rationale for the deployment of resources clear and commensurate with the requirements for achieving the stated outcomes?

The intention of such an evaluation approach is to ensure that failure is not programmed in from the beginning of implementation.

3.11.3 PROCESS IMPLEMENTATION EVALUATION

The focus of process implementation evaluation is on implementation details. It asks questions such as:

- What did or did not get implemented that was planned?
- What congruence was there between what was intended to be implemented and what actually happened?
- How appropriate and close to plan were the costs, the time requirements, the staff capacity and capability, the availability of required financial resources, facilities, and staff, and political support?
- What unanticipated (and thus unintended) outputs or outcomes emerged from the implementation phase?

The implementation phase can be short or long. The emphasis throughout would be to study the implementation process. Managers can use this information to determine whether they will need to make any mid-course corrections to drive toward their stated outcomes. This evaluation strategy is similar to monitoring. The added value is that the implementation is not just documented (monitored). In evaluating the implementation, unanticipated outcomes can be studied.

Additionally, some of the more intangible aspects of implementation, such as political support, institutional readiness for change, and the trust in management to successfully lead a change effort, can be addressed.

Finally, having some understanding of why the implementation effort is or is not on track gives a firm basis for initiating countermeasures, if needed.

3.11.4 RAPID APPRAISAL

Because we view M&E as a ***continuous*** management tool, rapid appraisals deserve special consideration here. Rapid appraisals can be invaluable to development practitioners in a

results-based M&E system. They allow for quick, real-time assessment and reporting, providing decision-makers with immediate feedback on the progress of a given project, program, or policy. Rapid appraisal can be characterized as a multi-method evaluation approach that uses a number of data collection methods.

"Rapid appraisal methodology . . . [can be thought of] in the context of the goal of applied research; that is, to provide timely, relevant information to decision-makers on pressing issues they face in the project and program setting. The aim of applied research is to facilitate a more rational decision-making process in real-life circumstances." **(Kumar 1993, p. 9)**

There are five major rapid appraisal data collection methods:

1. Key informant interviews
2. Focus group interviews
3. Community interviews
4. Structured direct observation
5. Surveys

These methods are particularly useful in dealing with the following situations:

- When descriptive information is sufficient for decision-making
- When an understanding, is required, of the motivations and attitudes that may affect people's behaviour, in particular, the behaviour of target populations or stakeholders in an intervention
- When available quantitative data must be interpreted
- When the primary purpose of the study is to generate suggestions and recommendations
- When the need is to develop questions, hypotheses, and propositions for more elaborate, comprehensive formal studies **(Kumar 1993, pp. 21–22)**.

Rapid appraisals are highly relevant to the timely production of management-focused evaluation information. As with any evaluation method, there are some strengths and weaknesses of rapid appraisals that should be taken into account. Rapid appraisals produce needed information on a quick and timely basis and are relatively low cost, especially in comparison with more formal, structured evaluation methods. Such appraisals can provide a quick turnaround to see whether projects, programs, and policies are basically on track.

However, the reliability, credibility, and validity of rapid appraisals may be more open to question because of such factors as individual bias and preconceptions, and lack of quantitative data that can be easily replicated and verified. Likewise, it is difficult to aggregate the findings from multiple rapid appraisals, as each is relatively unique and the mix of methods varies from one application to another. On balance, though, rapid appraisals can make rapid reporting possible and help flag the need for continuous corrections.

3.11.5 CASE STUDY

The case study is the appropriate evaluation strategy to use when a manager needs in-depth information to understand more clearly what happened with a policy, program, or project. Case studies imply a trade-off between breadth and depth in favour of the latter.

There are six broad ways that managers can draw on case study information to inform themselves:

Case studies can

1. Illustrate a more general condition;
2. Be exploratory when little is known about an area or problem;
3. Focus on critical instances (high success or terrible failure of a program);
4. Examine select instances of implementation in depth;
5. Look at program effects that emerge from an initiative; and
6. Provide for broader understanding of a condition when, over time, the results of multiple case studies are summarized and a cumulative understanding emerges.

3.11.6 IMPACT EVALUATION

Governments and agencies regularly seek ideas and guidance to develop new programmes or to improve existing ones, but on time-frames and budgets that do not allow rigorous evidence to be developed. These institutions may do well in their normal data-collection and evaluation tasks related to monitoring inputs, improving operations, and assessing performance, but largely fail in building knowledge, which requires studies that fall outside normal budget and planning cycles for which incentives are sorely lacking.

One type of knowledge concerns the net impact of a programme or intervention on conditions that the programme sought to alter. Acquiring this knowledge typically demands studies that are different from programme monitoring or process evaluations. It requires impact studies.

An impact evaluation is the classic evaluation (though not only after the fact) that attempts to find out the changes that occurred, and to what they can be attributed. The evaluation tries to determine what portion of the documented impacts the intervention caused, and what might have come from other events or conditions. The aim is the attribution of documented change. This type of evaluation does not assume that the sum of the inputs, outputs and outcomes is the production of impact. Even though impact - or cause and effect -is determined by a host of variables, its focus is primarily to determine attribution after-the-fact, some of which may or may not lie within the parameters of the intervention (project, policy or programme). This type of evaluation addresses attribution; it also embodies the continuous analysis of programmes to assist managers to gain a better understanding of their work from design to implementation, and to completion of results, and subsequent consequences.

Impact evaluations generate knowledge that has wider benefits and may be more applicable to other settings and over time than the information generated by monitoring activities, process evaluations, or performance. Different kinds of data collection are required for impact evaluations. They most notably require attention to gathering information from appropriate comparison groups so that valid inferences can be made about the impact of a particular programme as compared with what would have happened without it or with a different programme. This type of data collection must be considered from the beginning, the design phase, rather than after the programme has been operating for many years, when stakeholders may ask, “So what is the programme really accomplishing?” Impact evaluations

are not required for all programmes and projects. They are best targeted to programmes that are new or expanding and for which effectiveness has not been established[8].

This type of evaluation is difficult, especially as it comes after the end of the intervention (so that if outcomes are to be evident, they will have had time to emerge). Obviously, the longer the time between the intervention and the attempt to attribute change, the more likely it is that other factors will interfere in either positive or negative ways to change the intended outcome, that the timeframe in which one was seeking to measure change is incorrect (too soon or too late), and that the outcome will become enveloped in other emerging conditions and be lost.

Another way of addressing the issue of attribution is to ask the counterfactual question, 'what would have happened if the intervention had not taken place?' Answering this question is difficult. But there are strategies for doing so, using both experimental and quasi-experimental designs. Use of random assignment and control or comparison groups are the basic means of addressing this question.

When possible, it is best to plan for impact evaluations before the intervention even begins. Determining which units will receive the intervention and which will not, and establishing baseline information on all units, are just two of the reasons for planning the impact evaluation prospectively.

Box 1: Impact Assessments

Impact assessment is essentially about change and therefore asks the following questions, some of which can be assessed in various combinations or individually:

- What are the impacts of government, project, policy and programmes?
- Whether, to what extent and how are goals achieved over time?
- What is the impact in monitoring programmes?
- What is the relevance of objectives, efficiency, effectiveness, impact, sustainability, in order to incorporate lessons learnt into decision-making processes?
- What are the impacts of resource allocations?
- What are the impacts of design?

Within a developmental framework, impact should show:

- How the lives of citizens have been bettered
- What change has occurred
- To what this change can be attributed
- Which of the changes documented can be attributed to the intervention and what has come of these changes and conditions?

This level of analysis and interrogation builds trust in citizens about how public money has been spent and what the impacts have been.
Finally, impact assessment asks what would have happened if the intervention did not occur and what changes are needed to enhance impact?

[8] Source: Centre for Global Development (2006). When will we ever learn? Improving lives through impact evaluation.

There are several methods and models of impact evaluation[9]:

- **Rapid assessment or review**, conducted ex-post. This method can encompass a range of approaches in the endeavour to assess impact, such as participatory methods, interviews, focus groups, case studies, an analysis of beneficiaries affected by the project, and available secondary data;
- **Ex-post comparison** of project beneficiaries with a control group. With this method, multivariate analysis may be used to control, statistically, for differences in attributes between the two groups. This is one way of estimating the counterfactual situation;
- **Quasi-experimental design**, involving the use of matched control and project (beneficiary) groups. This method involves the use of a "non-equivalent" control group to match, as closely as possible, the characteristics of the project population – either through propensity score matching or using a multivariate regression approach. This method often involves the use of large-scale sample surveys, and sophisticated statistical analysis; and
- **Randomized design.** This involves the random assignment of individuals or households either as project beneficiaries, or as a control group, which does not receive the service or good being provided by the project. This is also known as the experimental method, and is used in health research. For example, in areas such as evaluating the effectiveness of new drugs and medical procedures.

3.11.7 META-EVALUATION

If a number of evaluations have been conducted on one or similar initiatives, a meta-evaluation establishes the criteria and procedures for systematically looking across those existing evaluations to summarize trends and to generate confidence (or caution) in the cross study findings. Meta-evaluation can be a reasonably quick way of learning "what do we know at present on this issue and what is the level of confidence with which we know it?" (**Leeuw and Cooksy, 2003**).

It is envisaged that the following kinds of evaluation will be carried out:

1. Internal Informal Evaluation reviews / Periodic Self Assessments
2. Mid-Term Evaluations
3. Final Evaluations
4. External Evaluations

[9] Source: World Bank OED Impact Evaluation

Figure 7: Meta-Evaluation

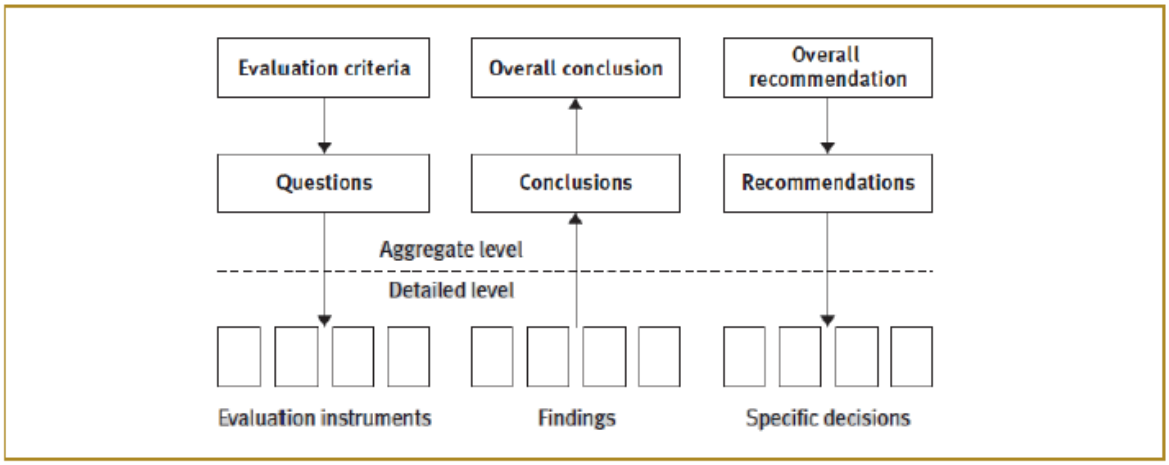
Internal Informal Evaluation reviews/ Periodic Self Assessments	Organizations need to conduct internal reviews of performance information at regular intervals during the year to assess progress toward achieving the results. This type of evaluation is often informal and can be done quarterly at staff meetings but needs to be based on performance data (results form indicator data collection) as well as staff observation of projects and programs. Internal evaluations provide the opportunity for organizations to review specific projects and their contribution towards larger program results and the outcomes of the evaluation should be used to make early adjustments or refinements in tactics or implementation strategies.
Mid-term evaluations	Mid term evaluations provide recommended actions to prompt mid-course adjustments in the last half of the program. To the degree possible mid-term evaluations should be participatory in nature and include stakeholder (customer) analysis of programs.
Final Evaluations	Final Evaluations may be required or planned for some projects but should also be considered as a way to review and update your business plan
External Evaluations	The department may require (and may be required by their own rules) an external evaluation. This means the department will hire a person or team to look at the activities, processes, outputs, outcomes, and impacts of your project or program. External evaluations can be very beneficial to an organization as they call for third party analysis (often thought to be less biased) and bring in fresh perspectives. Organizations still have a key role to play in external evaluations as you need to ensure that evaluators understand the objectives of your program, your approach (results framework) what you think is working well, and is not working well and how you are responding (fixing it). Make sure to request a copy of the results so you can use this information internally.

3.11.8 ANALYSIS OF INFORMATION

The objective of analysis is to "transform data into credible evidence about the …intervention and its performance. (Ministry of Foreign Affairs of Denmark, 2006, p.72).The task of data analysis is one that is applicable in respect of all aspects of M&E. Regular analysis of implementation data as part of a monitoring process may assist in improving performance during the delivery of outputs and associated activities. It may allow for the identification of trends, challenges, risks and areas of success. Data analysed as part of the monitoring cycle, however, is often not useful in providing information of why changes are occurring – with this being a function of evaluation. Regardless of whether data is to be collected and analysed in support of a monitoring or evaluation related activity, the following steps may apply:

- **Review the indicators** identified for the monitoring or evaluation process;
- Ensure **data is collected with these indicators in mind** (i.e. data is relevant);
- Establish a **structure for the analysis** – e.g. in terms of concerns, ideas or themes;
- **Organise the data** within the context of this structure, in preparation for analysis;
- **Focus on patterns**, varied **forms of interpretation or trends**; and
- **Document the findings**, and establish **conclusions and recommendations** (Shapiro, 2002).

Figure 8: The analysis process in the context of an evaluation (Ministry of Foreign Affairs of Denmark, 2006, p.74)



While analysis in the context of a monitoring exercise will take place in respect of the predefined indicators included in this Framework, an evaluation exercise may address different questions, as depicted in the figure above. The evaluation instruments, analyses and findings will ultimately be directly dependent on the nature of questions under review.

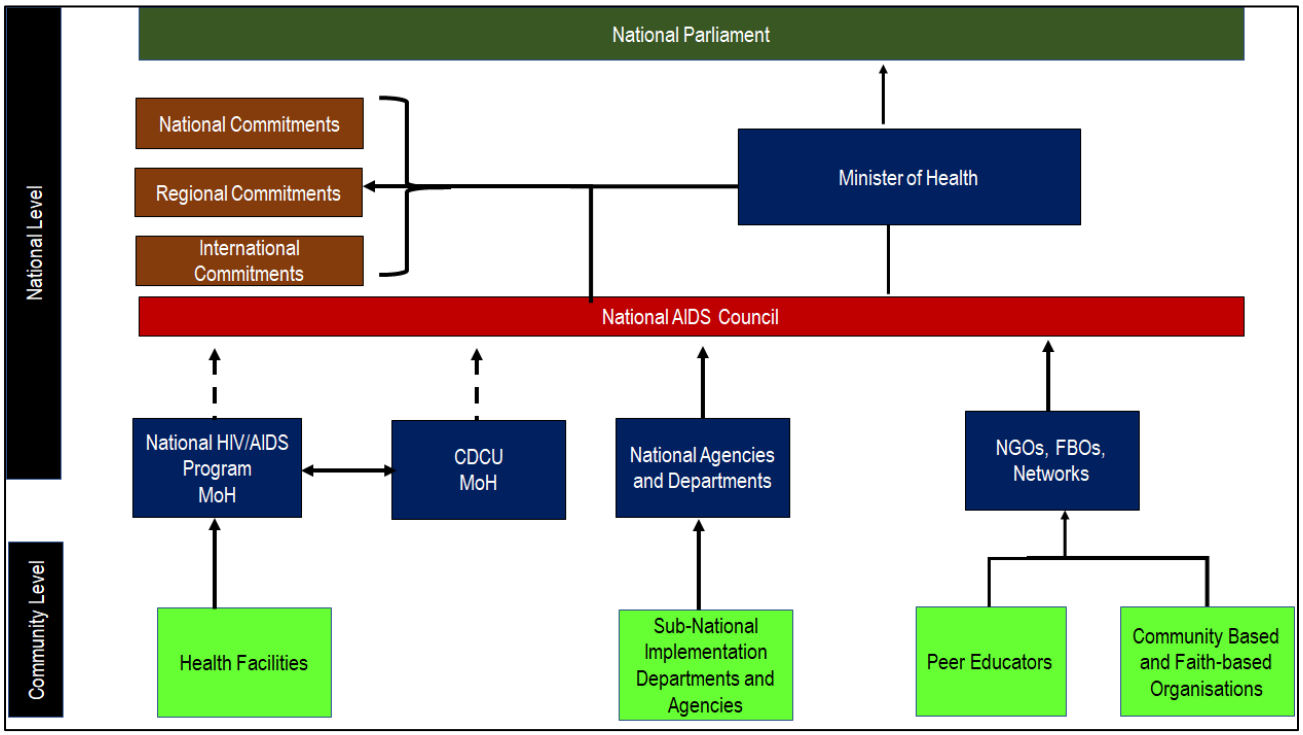
3.12 COMPONENT 12: DATA ANALYSIS, INFORMATION DISSEMINATION AND USE

3.12.1 DATA AND INFORMATION FLOW ARRANGEMENTS IN THE NATIONAL RESPONSE

The figure below illustrates the flow of data/ information right from the community level service delivery points to the national repository of the one M&E System at NAC. The structure also indicates the coordination, reporting and partnerships. The arrangements also provide for the continued reporting and other functional linkages expected between the individual agencies or offices in the field and their mother offices or sectors to which they are affiliated at national level. The information flow system also emphasizes the need for feedback at all levels between those who generate and submit the information and those who collate, analyse, store and disseminate the information.

The National AIDS Council will support the fast data and information flows in the response through the different structures.

Figure 9: Data Flow Process



3.12.2 INFORMATION PRODUCTS, DISSEMINATION AND UTILIZATION

In pursuit of the above information needs, the following key information products will be generated under the 2019-2023 National M&E Plan:

Table 5: Information Products and Responsible Entities under the 2019-2023 National M&E Plan

Information Product	Responsible Entity
Monthly, Quarterly and Annual progress /service coverage reports	NAC, Ministry of Health
Policy briefs	Ministry of Health
Annual programme thematic reports	NAC, Ministry of Health, Line Ministries, Departments, Agencies, NGOs, CSOs, FBOs, Networks
Field monitoring and support supervision specific reports	NAC, Ministry of Health
Monthly, quarterly and annual surveillance reports	NAC, Ministry of Health
GAM Report	NAC Coordinating with support from, Ministry of Health, Line Ministries, Departments, Agencies, NGOs, CSOs, FBOs, Networks
Survey reports	NAC, Ministry of Health
Evaluation and Assessment reports	NAC
NASA reports	NAC and Ministry of Finance
Budget and expenditure analysis reports	NAC, Ministry of Health, Line Ministries, Departments, Agencies, NGOs, CSOs, FBOs, Networks
Estimates and projections reports	NAC, Ministry of Health
Brochures, leaflets, fact sheets	NAC Coordinating with support from, Ministry of Health, Line Ministries, Departments, Agencies, NGOs, CSOs, FBOs, Networks
Assets registers and inventory, PSM reports	Ministry of Health

To the extent possible, all the information products above will contain information/data analysed by sex, age group, social status/ groups and location (district or other administrative units). This will be done to enhance the monitoring of the coverage of interventions, address gender issues, disparities in service utilization by sex and age, which also allows for targeting and re-directing of interventions.

3.12.3 ADDRESSING AD-HOC AND EMERGING INFORMATION NEEDS FOR THE NATIONAL RESPONSE

The M&E plan is anchored on to the 2019-2023 National Strategic Plan for HIV, AIDS and Viral Hepatitis but would also cater for M&E needs beyond the NSP results framework provided the information need is considered relevant. From time to time situations may arise where some stakeholders might have information needs that are not adequately covered by the information products in the National HIV, AIDS and Viral Hepatitis M&E Plan. Such requests should be made in writing to NAC which will in turn consider whether it can accommodate the requests within the available resources and technical appraisal by the M&E TWG.

Information needs may emerge that require re-analysis of the existing data or the collection of raw data beyond what is routinely collected. Depending on the information needs in question and their relevance to the management of the National response, the NAC will make an effort to commission an activity to generate such information with support from the relevant partners if resources are available or give the necessary technical guidance to the stakeholders in need of such information.

3.12.4 INFORMATION DISSEMINATION

The sustainability of the application and the buy-in into this Framework will to a large extent dependent on the user-friendly nature of the products for stakeholders to utilize the information products produced as part of the operational plan. There is no point at all in collecting data that cannot be used or will not be used. The ultimate use of data should serve to direct HIV control efforts at all levels: national, sectoral and community levels.

Data from the monitoring and evaluation of the national response will be disseminated widely to various stakeholders using different channels that will include the following:

a. The NAC to bring together stakeholders at national and community levels to share the information products generated and those sourced from elsewhere by NAC. The engagement at these levels will enable sharing of the HIV, AIDS and Viral Hepatitis status reports and other resources key for the strategic development and technical references for the national response interventions. It will also be the channel for sharing information on the national response in the preceding implementation period with key focus on the scope of service coverage, the best practices and management of challenging and emerging issues.

b. Quarterly coordination and planning meetings will be held with the HIV and AIDS Focal Persons in the Ministry of Health, Line Ministries, Departments, Agencies, NGOs, CSOs, FBOs, Networks at National levels.
c. Use of the print and electronic media by having airtime and newspaper space and pull outs in the widely circulated newspapers.
d. Websites and electronic platforms or common email addresses. This will require the NAC to:
    - Regularly uploading and updating the NAC and other linked websites
    - National, sectoral, district and other public and private Resource Centres
    - Stakeholder Mailing lists—electronic and manual
    - Stakeholder dissemination workshops
    - Coordination meetings of the Line Ministries, Departments, Agencies, NGOs, CSOs, FBOs, Networks
    - Training Workshops and Seminars
    - National and International Conference

SECTION 4: IMPLEMENTATION OF THE MONITORING AND EVALUATION FRAMEWORK

In line with the NAC mandate to coordinate the HIV, AIDS and Viral Hepatitis response and having coordinated M&E System, the execution of the M&E framework requires commitment and partnership guided by the principles articulated in Section one of this document.

The following will be necessary for the successful execution of the M&E system:

4.1 **Developing and building consensus on a M&E work plan** (operation plan) for data collection and reporting;

4.2 **Building and strengthening a functional M&E System**, with a database linked to NAC and other sub-systems;

4.3 **Strengthening the M&E units MOH, Line Ministries, Government Departments, Agencies, NGOs, CSOs, FBOs and Networks** through the capacity strengthening workshops to strengthen the capacity of these entities on data analysis, estimates and projections.

4.4 **The execution of this M&E Framework**, **which will require human, financial and physical resources**. There is need, therefore, to build consensus on the budgeting and financing of M&E.

4.5 **Institutional Strengthening** The intervention targets making the M&E system functional and effective.

Specific activities include:

- Creation of a functional database at NAC
- Supporting the **MOH, Line Ministries, Government Departments, Agencies, NGOs, CSOs, FBOs and Networks** to develop a data management system;
- Carrying out supervision and data audit;
- Establishing a functioning resource centre including virtual library;
- Organizing workshops / seminars to establish and enhance the culture of M&E, e.g. targeting advocacy and sensitization.

4.6 **Strengthening Data Collection, Analysis and Reporting** This component targets making data collection, analysis, and reporting more efficient and timely. Besides, it is to enhance the quality of data and make it available for decision making and programming for the HIV, AIDS and Viral Hepatitis activities.

The specific areas of interventions include:

- Developing a national HIV M&E operational guide (User's guide)
- Developing the M&E annual data collection plan – with clear activities and timeframe;

- Establishing a baseline for core HIV, AIDS and Viral Hepatitis indicators, where there are not available;
- Developing and building consensus on a standardized, user friendly data collection instrument(s) and reporting formats;
- Establishing Data Quality Assessment Protocols.

4.7 Strengthening coordination of HIV, AIDS and Viral Hepatitis Research and Surveys - This component aims at enhancing the coordination of the HIV and AIDS research.

Specific activities include the following:

- Development of the HIV, AIDS and Viral Hepatitis research protocol / norms;
- Finalizing the development of higher education HIV, AIDS and Viral Hepatitis research strategy;
- Identifying and coordinating the carrying out of strategic research
- Enhancing reporting and dissemination of research results to, national and regional forums including publication of research articles.

4.8 Co-ordinating Regional and National Consultative Meetings and Reviews of the M&E Plan - This component of intervention targets dissemination of information products by NAC to relevant stakeholders and implementers. The dissemination of information products has to be coordinated to reach various stakeholders in time and in an effective manner.

Specific activities in this component include the following:

- Organize the annual national stakeholders meeting on the HIV, AIDS and Viral Hepatitis response;
- Organize workshops for the dissemination and discussion of results with **MOH, Line Ministries, Government Departments, Agencies, NGOs, CSOs, FBOs and Networks; and**
- Organize dissemination workshops for sharing good practice and lessons learned in the HIV, AIDS and Viral Hepatitis programme activity monitoring.

SECTION 5: ANNEX

SUMMARY OF THE 2019-2023 NSP AND M&E FRAMEWORK FOR HIV, AIDS AND VIRAL HEPATITIS

NSP Goal	NSP Outcome	Strategic Priority		M&E Impact Indicator	M&E Outcome Indicator
1: 90% of all PLHIVs know their status	1. Increased uptake of counselling and testing services	1.1	Scaling up of HIV testing and counselling for all with a specific focus on key populations and at-risk populations (youth and adolescents)	**1. Reduced new HIV infections**	1.1 Increased universal and targeted HIV testing and counselling 1.2 Reduced sexual transmission of HIV 1.3 Reduced HIV transmission through injecting drug use 1.4 Eliminated mother-to-child transmission of HIV and syphilis 1.5 Improved identification, treatment and management of co-infections
	2. Reduced new HIV infections	2.1	Reduced new HIV infections amongst key populations through sexual transmission		
		2.2	Implementation of advocacy, communication and social mobilisation programs for the uptake of counselling, testing and treatment		
		2.3	Reduced new HIV infections amongst key populations through injecting drug use		
		2.4	Reduced new HIV infections amongst people in closed (prison) settings		
		2.5	Reduced new HIV infections amongst youth and adolescents		
		2.6	Elimination of mother-to-child transmission of HIV and syphilis		
2: 90% of all PLHIVs who know their status receive ART	3. Effective implementation of 'Test and Treat' for increased ART initiation	3.1	Increased uptake of ART by PLHIVs	**2. Reduced HIV mortality for adults and children**	2.1 Increased ART initiation, care and support for 90% of PLHIV
		3.2	Strengthened linkages to care and support services		
	4. Improved identification, treatment and management of co-infections	4.1	Diagnosis, treatment and management of PLHIVs with STIs		
		4.2	Diagnosis, treatment and management of PLHIVs with Hepatitis B and C		
		4.3	Screening for Cancers		
3: 90% of all PLHIVs on ART will be virally suppressed	5. Increased adherence of PLHIVs to ART	5.1	Increased retention on ART		2.2 Increased adherence by PLHIVs to ART
4: Zero stigma and discrimination	6. Increased protection of the rights of PLHIVs, women, young boys and girls	6.1	Responsiveness of the social and legal environment to the rights of PLHIVs	**3. Reduced stigma and discrimination**	3.1 Improved social and legal protection for PLHIVs and key populations
		6.2	Implementation of gender responsive HIV programming		
5: Facilitate a sustainable national response to HIV and AIDS	7. Improved enabling environment for HIV prevention, treatment and care	7.a	Improved enabling environment for HIV prevention, treatment and care – Policies and Guidelines	**4. Improved enabling environment to meet the 90-90-90 targets**	4.1 Strengthened delivery of HIV prevention, treatment and care services
		7.b	Improved enabling environment for HIV prevention, treatment and care – Health Systems		
		7.c	Improved enabling environment for HIV prevention, treatment and care – Community Systems		
		7.d	Improved enabling environment for HIV prevention, treatment and care – Coordination and Management of the National HIV Response		
		7.e	Improved enabling environment for HIV prevention, treatment and care – Monitoring and Evaluation		
		7.f	Improved enabling environment for HIV prevention, treatment and care – Costing and Financing the HIV Response		