National
HIV/AIDS/STI Monitoring and Evaluation Framework

Document Version Control
Document Number 2.0
24 Nov 2005
Final draft, discussed with Eritrea stakeholders

Author: UNAIDS RST
For more information, contact Emmanuel Baingana on bainganae@unaids.org
# TABLE OF CONTENTS

LIST OF TABLES.................................................................................................................. III
LIST OF FIGURES................................................................................................................... III
LIST OF ACRONYMS............................................................................................................. IV

TARGET AUDIENCES FOR THIS DOCUMENT................................................................. 1
PURPOSE AND STRUCTURE OF THIS DOCUMENT ....................................................... 1

1 INTRODUCTION ............................................................................................................... 2
1.1 HIV PREVALENCE IN ERITREA.................................................................................. 2
1.2 RISK FACTORS FOR HIV TRANSMISSION ............................................................... 2
1.3 THE DEVELOPMENT OF THE RESPONSE TO HIV/AIDS/STIs............................... 2
   1.3.2 National Strategic Plan for HIV/AIDS/STIs 2003 - 2007 .......................................... 3
   1.3.3 Government Structures to Manage and Coordinate the Response to HIV/AIDS/STIs . 4
   1.3.4 HIV Coordination Bodies ...................................................................................... 4

2 ANALYSIS OF EXISTING HIV/AIDS/STI MONITORING AND EVALUATION
   SYSTEMS AND DATA..................................................................................................... 5
2.1 SITUATIONAL OVERVIEW ......................................................................................... 5
2.2 ASSESSMENT OF EXTENT OF EXISTING HIV/AIDS/STI DATA .............................. 7
   2.2.1 Monitoring the Spread of the Epidemic ................................................................. 7
   2.2.2 Monitoring Risk Behaviours associated with HIV transmission .......................... 7
   2.2.3 Monitoring and Evaluating the Response to HIV/AIDS/STI ..................................... 7
2.3 HIV/AIDS/STI M&E STRATEGIC AREAS ............................................................... 8
2.4 GOAL AND OBJECTIVES OF NATIONAL HIV/AIDS/STI M&E SYSTEM ............... 8

3 INDICATORS FOR THE HIV/AIDS/STI RESPONSE .................................................. 9

4 DATA SOURCES FOR NATIONAL INDICATORS ......................................................... 22
4.1 ANC SENTINEL SURVEILLANCE REPORT ............................................................ 23
4.2 NATIONALLY REPRESENTATIVE BEHAVIOURAL OR OTHER SURVEYS ............ 24
4.3 HEALTH FACILITY SURVEY .................................................................................... 25
4.4 CONDOM AVAILABILITY SURVEY ............................................................................ 28
4.5 SCHOOL DATA FROM EXISTING SURVEYS ........................................................... 29
4.6 WORKPLACE SURVEY ............................................................................................... 30
4.7 HIV/AIDS/STI PROGRAMME MONITORING DATA ............................................... 32
4.8 GOVERNMENT FINANCIAL DATA ............................................................................. 35
4.9 DATA FROM MINISTRY OF HEALTH ......................................................................... 35
4.10 DATA FROM THE NATIONAL BLOOD TRANSFUSION SERVICE ............................... 37

5 INFORMATION PRODUCTS ............................................................................................ 38
5.1 QUARTERLY SERVICE COVERAGE REPORT (QSCR) ............................................. 38
   5.1.1 Purpose of Report ................................................................................................. 38
   5.1.2 Data Sources for Report ....................................................................................... 38
   5.1.3 Data Analysis ....................................................................................................... 38
   5.1.4 Report Format ..................................................................................................... 38
   5.1.5 Report Compilation .............................................................................................. 39
   5.1.6 Report Approval .................................................................................................. 39
5.2 ANNUAL HIV/AIDS/STI M&E REPORT .................................................................... 39
   5.2.1 Purpose of Report ............................................................................................... 39
National HIV/AIDS/STI Monitoring and Evaluation Plan

5.2.2 Data Sources for Report ................................................................. 39
5.2.3 Data Analysis ........................................................................... 39
5.2.4 Report Format ........................................................................ 40
5.2.5 Report Compilation ................................................................. 40
5.2.6 Report Approval .................................................................... 40

5.3 ANNUAL NATCoD NEWSLETTER .............................................. 41
5.3.1 Purpose of Newsletter .............................................................. 41
5.3.2 Data Sources for Newsletter .................................................. 41
5.3.3 Data Analysis ........................................................................ 42
5.3.4 Newsletter Format ................................................................. 42
5.3.5 Newsletter Compilation ......................................................... 42
5.3.6 Newsletter Approval .............................................................. 42

5.4 UNGASS REPORT ................................................................. 42
5.4.1 Purpose of Report ................................................................. 42
5.4.2 Data Sources for Report ........................................................ 42
5.4.3 Data Analysis ........................................................................ 43
5.4.4 Report Format ...................................................................... 43
5.4.5 Report Compilation .............................................................. 43
5.4.6 Report Approval ................................................................. 43

5.5 REGULAR INFORMATION SYSTEM UPDATES ............................. 44
5.6 AD-HOC INFORMATION NEEDS ................................................ 44

6 DISSEMINATION TO STAKEHOLDERS ........................................ 46
6.1 EMAILING OF REPORTS ............................................................. 46
6.2 ANNUAL HIV/AIDS/STI M&E DISSEMINATION CONFERENCE .... 46
6.3 QUARTERLY FEEDBACK WORKSHOPS AT ZOBAS ....................... 46
6.4 FEEDBACK WORKSHOPS BY HIV COORDINATION BODIES .... 46
6.5 USE OF OTHER FEEDBACK MECHANISMS ................................. 46
6.6 DISSEMINATION THROUGH THE MEDIA .................................. 46
6.7 NATIONAL INFORMATION AND DOCUMENTATION CENTRE .... 47
6.8 WEBSITE ................................................................................. 47
6.9 SUMMARY OF DISSEMINATION CHANNELS TO STAKEHOLDERS ... 47

7 MANAGEMENT OF THE NATIONAL HIV/AIDS/STI M&E SYSTEM ... 49
7.1 ROLES OF STAKEHOLDERS IN THE HIV/AIDS/STI M&E SYSTEM ... 49
7.1.1 NATCoD ................................................................................. 49
7.1.2 Other Units in MoH ............................................................... 49
7.1.3 Other Ministries ..................................................................... 50
7.1.4 The National M&E TWG ..................................................... 50
7.1.5 Survey Committees .............................................................. 50
7.1.6 Civil Society Organisations .................................................. 50
7.1.7 The Private Sector .............................................................. 51
7.1.8 Donor/UN Agencies ............................................................ 51
7.2 WORK PLANS AND BUDGETS FOR M&E ................................. 51
7.3 M&E SOFTWARE ....................................................................... 52
7.4 TECHNICAL SUPPORT FOR M&E .......................................... 52
7.5 NEED FOR CAPACITY BUILDING ............................................ 52
7.6 ADVOCACY AND COMMUNICATIONS FOR HIV/AIDS/STI M&E ... 53
7.7 REVIEW OF THIS HIV/AIDS/STI M&E FRAMEWORK ................. 53

ANNEXURE A .................................................................................. 55
ANNEXURE B .................................................................................. 67
ANNEXURE C .................................................................................. 70
ANNEXURE D .................................................................................. 72
List of Tables

TABLE 1: COMPOSITION OF HIV COORDINATION BODIES IN ERITREA................................. 4
TABLE 2: SITUATIONAL OVERVIEW OF HIV/AIDS/STI M&E IN ERITREA.......................... 6
TABLE 3: MINIMUM SET OF DATA SOURCES FOR ERITREA'S M&E SYSTEM...................... 22
TABLE 4: UNGASS REPORTING SCHEDULE...................................................................... 43
TABLE 5: DISSEMINATION CHANNELS FOR STAKEHOLDERS .............................................. 48

List of Figures

FIGURE 1: STRUCTURE IN MINISTRY OF HEALTH RESPONSIBLE FOR COORDINATION OF THE HIV RESPONSE IN ERITREA........................................................................................................ 4
FIGURE 2: SYNCHRONISATION OF M&E CYCLE WITH PLANNING CYCLE ...................... 40
FIGURE 3: NATCoD ORGANISATIONAL STRUCTURE .......................................................... 49
## List of Acronyms

<table>
<thead>
<tr>
<th>Acronym</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>AIDS</td>
<td>Acquired Immune-Deficiency Syndrome</td>
</tr>
<tr>
<td>ANC</td>
<td>Antenatal clinic</td>
</tr>
<tr>
<td>ART</td>
<td>Anti-retroviral Therapy</td>
</tr>
<tr>
<td>ARV</td>
<td>Anti-retrovirals</td>
</tr>
<tr>
<td>BCC</td>
<td>Behavioural Change Communication</td>
</tr>
<tr>
<td>BSS</td>
<td>Behavioural Surveillance Surveys</td>
</tr>
<tr>
<td>CBO</td>
<td>Community-Based Organisation</td>
</tr>
<tr>
<td>CRIS</td>
<td>Country Response Information System</td>
</tr>
<tr>
<td>CSO</td>
<td>Central Statistics Office</td>
</tr>
<tr>
<td>DFID</td>
<td>Department for International Development</td>
</tr>
<tr>
<td>DHS</td>
<td>Demographic and Health Survey</td>
</tr>
<tr>
<td>FBO</td>
<td>Faith-Based organisation</td>
</tr>
<tr>
<td>FHI</td>
<td>Family Health International</td>
</tr>
<tr>
<td>GDP</td>
<td>Gross Domestic Product</td>
</tr>
<tr>
<td>GNP</td>
<td>Gross National Product</td>
</tr>
<tr>
<td>GoE</td>
<td>Government of Eritrea</td>
</tr>
<tr>
<td>HIV</td>
<td>Human Immune-deficiency Virus</td>
</tr>
<tr>
<td>HMIS</td>
<td>Health Management Information System</td>
</tr>
<tr>
<td>IEC</td>
<td>Information, Education and Communication</td>
</tr>
<tr>
<td>M&amp;E</td>
<td>Monitoring and Evaluation</td>
</tr>
<tr>
<td>M&amp;E TWG</td>
<td>M&amp;E technical working group</td>
</tr>
<tr>
<td>MICS</td>
<td>Multi Indicator Cluster Survey</td>
</tr>
<tr>
<td>MoE</td>
<td>Ministry of Education</td>
</tr>
<tr>
<td>MoH</td>
<td>Ministry of Health</td>
</tr>
<tr>
<td>NATCoD</td>
<td>National AIDS and TB Control Division</td>
</tr>
<tr>
<td>NATC</td>
<td>National AIDS Technical Committee</td>
</tr>
<tr>
<td>NGO</td>
<td>Non-Governmental Organisation</td>
</tr>
<tr>
<td>NSP</td>
<td>HIV/AIDS/STI National Strategic Plan</td>
</tr>
<tr>
<td>OI</td>
<td>Opportunistic Infections</td>
</tr>
<tr>
<td>OVC</td>
<td>Orphans and Vulnerable Children</td>
</tr>
<tr>
<td>PEP</td>
<td>Post Exposure Prophylaxis</td>
</tr>
<tr>
<td>PLWA</td>
<td>People Living With HIV and AIDS</td>
</tr>
<tr>
<td>PMTCT</td>
<td>Prevention of Mother to Child Transmission</td>
</tr>
<tr>
<td>QSCR</td>
<td>Quarterly Service Coverage Report</td>
</tr>
<tr>
<td>STI</td>
<td>Sexually Transmitted Infection</td>
</tr>
<tr>
<td>TB</td>
<td>Tuberculosis</td>
</tr>
<tr>
<td>UN</td>
<td>United Nations</td>
</tr>
<tr>
<td>UNAIDS</td>
<td>United Nations Programme on HIV and AIDS</td>
</tr>
<tr>
<td>UNDP</td>
<td>United Nations Development Programme</td>
</tr>
<tr>
<td>UNFPA</td>
<td>United Nations Population Fund</td>
</tr>
<tr>
<td>UNGASS</td>
<td>United Nations General Assembly Special Session on HIV and AIDS</td>
</tr>
<tr>
<td>UNICEF</td>
<td>United Nations Children’s Fund</td>
</tr>
<tr>
<td>USAID</td>
<td>United States Agency for International Development</td>
</tr>
<tr>
<td>VCT</td>
<td>Voluntary Counselling and Testing</td>
</tr>
<tr>
<td>WHO</td>
<td>World Health Organisation</td>
</tr>
</tbody>
</table>
Target Audiences for This Document

This National HIV/AIDS/STI M&E Framework has been formulated for all stakeholders involved in the HIV/AIDS/STI response in Eritrea. This includes all government Ministries, development agencies, non-governmental organisations and the private sector that are funding, implementing, or benefiting from HIV/AIDS/STI services.

The National HIV/AIDS/STI M&E Framework will also include research agencies that are interested in undertaking HIV/AIDS/STI research in Eritrea, as well as potential new stakeholders that are interested in being involved in future.

Purpose and Structure of This Document

a) Give an overview of the HIV response in Eritrea, so as to understand the operational environment within which the national HIV/AIDS/STI M&E Framework will be operationalised (see Chapter 1)
b) Provide a situational overview of the HIV/AIDS/STI M&E situation in Eritrea, so as to define the priority areas of focus for the national HIV/AIDS/STI M&E Framework (Chapter 2)
c) Define all components (indicators, data sources, information products and dissemination to stakeholders) of the national HIV/AIDS/STI M&E System (Chapters 3, 4, 5, and 6)
d) Outline what management structures and processes are needed for the national HIV/AIDS/STI M&E system to be fully functional, and describe the way in which the national HIV/AIDS/STI M&E system will be operationalised (Chapter 7)
1 Introduction

1.1 HIV PREVALENCE IN ERITREA

The HIV/AIDS epidemic in Eritrea is stabilizing even in the midst of a post-conflict situation, with thousands still internally displaced, a large proportion of the young and productive force mobilized into the military, and a severe drought threatening the lives of over a million people. These factors contribute to the spread of HIV/AIDS as well as challenge the nation's capacity to mount an effective and expanded response to prevent and control the spread of the epidemic (State of Eritrea, 2003).

According to the 2003 assessment, the unweighted national prevalence rate is 2.4%. The highest prevalence rates are in Southern Red Sea (7.2%) and Maekel (3.6%). Women in the age groups 20-24 and 25-29 years have higher than average prevalence rates (2.7% and 3.6%) respectively (MoH, 2003). Prior to the 2003 assessment, there were a number of studies were carried out in the country to establish the status of the epidemic. The first HIV sentinel surveillance conducted among 2,244 ANC attendees, Commercial Sex Works and patients attending STI clinics established a prevalence rate of 4.2%. However, it should be noted that this study was only limited to the urban areas of; Maekel, Debub, Anseba, and Northern Red Sea zones

1.2 RISK FACTORS FOR HIV TRANSMISSION

The Eritrean HIV/AIDS National Strategic Plan (2003 - 2007) and AIDS case data confirm that risk factors that could contribute to the potential spread of HIV infection in Eritrea include:

- High number of population in armed forces
- High number of displaced communities
- Low literacy levels
- A history of travel outside the country
- A lifetime history of any STI
- Unsafe injection
- Blood transfusion

1.3 THE DEVELOPMENT OF THE RESPONSE TO HIV / AIDS/ STIs

Since M&E does not operate in isolation, it is important to understand the environment within which the M&E processes will be executed. Therefore, this section provides information about the development of the response to HIV, AIDS and STIs over the last ten years. Important milestones in the Government's response to the HIV/AIDS epidemic in the past 10 years include:

- The establishment of the National AIDS Control Program (NACP) in 1992
- The adoption in 1997 of a 5-Year Strategic Plan, which emphasized a multisectoral approach and decentralization of HIV/AIDS prevention and control program
- The ratification in 1998 of the HIV/AIDS and STIs policy and policy guidelines
- The launching of the HAMSET Control Project in 2001
- The adoption of a set of HIV testing guidelines in 2002, which governs voluntary counseling and testing, testing for diagnostic purposes, testing of donated blood, and compulsory testing of army recruits prior to admission to the Army
• The adoption of a national BCC strategy in 2002 entitled “Winning through Caring: A BCC Strategy for Prevention of HIV and Control of AIDS in Eritrea”

• The restructuring of the Ministry of Health in 2003, and the creation of the National HIV/AIDS/STI and TB Control Division (NATCoD) within the Ministry of Health replacing the National HIV/AIDS control Program (NAP)

• Establishment of different HIV coordination bodies over time

• Joint UN and Partners Implementation Support Plan to the National Strategic Plan, developed for 2003, 2004 and 2005

• The adoption of key guidelines e.g., Home based care (2003), VCT (1996), PMTCT (2003), ART (2005)

The most prominent of these milestones are discussed hereunder:


The HIV/AIDS and STIs policy and policy guidelines, adopted in 1998, provide direction for the implementation of interventions such as:

• Promotion of safer sex behaviours;
• Early diagnosis and treatment of STIs;
• Provision of condoms;
• Use of aseptic techniques to prevent infections in health facilities;
• Counseling health care and social support for PLHAs;
• Community empowerment; and
• Home-based care and mobilization of the international community.

The policy document is under revision to include areas PMTCT activities ARV treatment as well as address issues related to consent and confidentiality.

1.3.2 National Strategic Plan for HIV/ AIDS/ STIs 2003 - 2007

This NSP is based on the following nine main objectives:

Objective 1: To strengthen the multisectoral response to the HIV/AIDS epidemic

Objective 2: To strengthen the prevention of sexual transmission of HIV

Objective 3: To increase availability and capacity of human resources in the health sector to combat the HIV/AIDS epidemic & STIs

Objective 4: To reduce the incidence of HIV infection through early diagnosis and treatment of STIs

Objective 5: To promote the early diagnosis of HIV infection through increased access to VCT and PMTCT

Objective 6: To ensure the safe transfusion of blood and adhere to universal infection prevention precautions in the health care settings and in the traditional practices

Objective 7: To increase the provision and improve the quality of comprehensive health care, including antiretroviral therapy, for PLHAS

Objective 8: To expand the availability and quality of psychosocial and economic support for people infected with and affected by HIV/AIDS

Objective 9: To promote research and improve surveillance, monitoring and evaluation of the HIV/AIDS epidemic and STI in all sectors, including the military
1.3.3 Government Structures to Manage and Coordinate the Response to HIV/AIDS/STIs

In 2003, a new National HIV/AIDS/STI and Tuberculosis Control Division (NATCoD) was established in the Ministry of Health. This Division reports directly to the Director General of Health Services. NATCoD is responsible for the overall programme planning, implementation, management, monitoring and evaluation for HIV/AIDS/STI and tuberculosis by the Ministry of Health and partners. The Division is also responsible for coordination of activities and collaboration with partners within and outside of the Ministry of Health. The strategic plans for HIV/AIDS/STI and tuberculosis guide the implementation of activities carried out by the NATCoD (see Figure 1 hereunder).

Figure 1: Structure in Ministry of Health responsible for Coordination of the HIV response in Eritrea

1.3.4 HIV Coordination Bodies

Table 1 hereunder summarises all the main HIV coordination bodies in Eritrea, as well as their membership, chairperson, and the frequency with which they meet.

Table 1: Composition of HIV Coordination Bodies in Eritrea

<table>
<thead>
<tr>
<th>NAME OF STRUCTURE</th>
<th>MEMBERSHIP</th>
<th>CHAIRED BY</th>
<th>MEETING FREQUENCY</th>
</tr>
</thead>
<tbody>
<tr>
<td>The National AIDS Technical Committee</td>
<td>• NATCoD staff</td>
<td>Director of NATCoD</td>
<td>Every 2 weeks</td>
</tr>
<tr>
<td>(NATC)</td>
<td>• Director of the Blood Bank</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Director of the Central Laboratory</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Chief of the IEC Unit of the MOH</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Representative from EDF Health Service</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>• UNAIDS CPA</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>• FHI Resident Adviser</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>• PSI Country Representative</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
### Analysis of Existing HIV/AIDS/STI Monitoring and Evaluation Systems and Data

#### 2.1 Situational Overview

HIV/AIDS and STI monitoring and evaluation (M&E) originated in the health sector, as epidemiologists originally set up biological surveillance systems as “tripwires” to inform health
authorities about trends in the spread of the virus. As the response to HIV became not only multisectoral but also decentralised, it was evident that a health sector-driven approach to monitoring and evaluation would not suffice. A national, multisectoral HIV/AIDS/STI M&E system was required to track the progress with the HIV/AIDS/STI response, as formulated in the latest NSP, in all sectors of Eritrean society.

The need for such a multi-sectoral HIV/AIDS/STI M&E system is also enshrined in the internationally-recognised Three Ones principles. This internationally-agreed set of three principles, announced by UNAIDS and its co-sponsors in 2003, compels governments to focus on having one HIV and AIDS coordinating body, one national action plan, and one agree country level monitoring and evaluation system for HIV and AIDS. The current situation in Eritrea in terms of HIV/AIDS/STI M&E has been assessed using each of the M&E principle of the Three Ones Principles – see Table 2 below:

Table 2: Situational Overview of HIV/AIDS/STI M&E in Eritrea

<table>
<thead>
<tr>
<th>CHARACTERISTICS OF THE 3rd PRINCIPLE – ONE NATIONAL HIV/AIDS M&amp;E SYSTEM</th>
<th>STATUS IN ERITREA BEFORE THE IMPLEMENTATION OF THE M&amp;E FRAMEWORK</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. One monitoring and evaluation unit coordinating M&amp;E activities implemented by various partners</td>
<td>MoH coordinates the national response to HIV/AIDS. STIs and TB in Eritrea – the responsible Division is NATCoD. The NATCoD Division in MoH has an Epidemiology and Monitoring Unit, who is responsible for all monitoring and evaluation associated with HIV/AIDS/STI.</td>
</tr>
<tr>
<td>2. National multi-sectoral M&amp;E plan with clear goals and targets included/derived from in the national strategic plan</td>
<td>Indicators have been developed, but there is not yet one comprehensive M&amp;E framework.</td>
</tr>
<tr>
<td>2.1: The M&amp;E plan should include data collection, dissemination and use strategies</td>
<td>There is not yet an M&amp;E Framework with these strategies contained in it</td>
</tr>
<tr>
<td>2.2: The plan should have secured funding (the recommended M&amp;E budget is 10% of the national HIV/AIDS/STI budget)</td>
<td>Since an M&amp;E framework and Road Map have not yet been developed, funding has not yet been secured for it</td>
</tr>
<tr>
<td>3. One national set of standardized indicators comparable over time</td>
<td>A draft set of indicators were included in the NSP 2003 - 2007</td>
</tr>
<tr>
<td>3.1: A sub-set comparable across countries, including the core DoC indicators, endorsed by all stakeholders, and reflecting the country needs and existing data collection and analysis capacities</td>
<td>The UNGASS indicators were included in the draft set of indicators that were in the NSP</td>
</tr>
<tr>
<td>4. One national level information system containing key data on:</td>
<td>A central computer system for information regarding HIV/AIDS/STIs does not exist.</td>
</tr>
<tr>
<td>4.1: Serological surveillance</td>
<td>Serological surveillance was done in 1999, 2001, 2003, and 2005</td>
</tr>
<tr>
<td>4.2: Behavioural surveillance</td>
<td>Behavioural Surveillance was conducted in 2001, A Demographic and Health Survey was carried out in 2002, and follow up survey on CSWs was conducted in 2004</td>
</tr>
<tr>
<td>4.3: Coverage of essential services</td>
<td>HIV/AIDS/STI health services have been included in the HMIS, but non-health related services have not been included</td>
</tr>
<tr>
<td>4.4: Financial tracking</td>
<td>Financial tracking does not take place by the MoH</td>
</tr>
<tr>
<td>4.5: Socio-economic impact of the epidemic, and its impact on a number of sectors including health and education</td>
<td>This information is not routinely captured</td>
</tr>
<tr>
<td>5. Strategic information flow from sub-national to national level and among different national level actors feeding into the national information system for effective use</td>
<td>Information flow is fragmented and consists primarily of health sector data. Non-health sector data is not routine captured. There is also limited interaction on M&amp;E issues with role players, as no Technical Working Group for</td>
</tr>
</tbody>
</table>
2.2 ASSESSMENT OF EXTENT OF EXISTING HIV/ AIDS/ STI DATA

A number of surveys, research and/or routine data collection have or are being conducted to assess the spread of HIV, AIDS and STIs, to assess risk behaviours associated with an increased risk of HIV transmission, and to determine factors that would influence the implementation of activities under the HIV response.

2.2.1 Monitoring the Spread of the Epidemic

There are a number of ways in which the spread of the epidemic has been monitored, including:

- Routine HIV and AIDS case reporting by health facilities in MOH
- HIV prevalence of VCT patients – this is done through the NATCoD
- HIV prevalence of blood donors – this is done through the HMIS or Annual report of the national blood transfusion centre
- PMTCT service reports

The HIV prevalence of STI patients is not currently determined. The extent to which STI prevalence and client service statistics is monitored, is not known.

2.2.2 Monitoring Risk Behaviours associated with HIV transmission

The following studies have been carried out to assess the extent of risk behaviours that could contribute to the spread of HIV in Eritrea:

- Eritrea Demographic and Health Survey (DHS) in 2002
- Report on 2004 BSS on Sex workers and HIV, by the State of Eritrea, ESMG, FHI, USAID
- Staying Safe in the Streets: A Situational Analysis of Commercial Sex Work in Eritrea, by the National HIV/AIDS/STI and Tuberculosis Division of the Government of Eritrea, UNFPA and UNAIDS

2.2.3 Monitoring and Evaluating the Response to HIV/ AIDS/ STI

Extensive data on the extent of HIV service delivery efforts were not available when this M&E Framework was prepared. However, some studies have been carried out prior to the implementation of HIV interventions. These studies include:
2.3 HIV/AIDS/STI M&E STRATEGIC AREAS

Based on the situational overview data, and the assessment of existing data collection processes, the following strategic areas need to be addressed in this M&E Framework:

a) Development of an integrated M&E conceptual framework.
b) Establishment of a set of national standardized indicators that adhere to national and international guidelines.
c) Standardisation of a minimum set of data sources that will be collected on a periodic basis to provide indicator values – this includes integration of VCT and PMTCT reporting systems as well as standardize AIDS case reporting from all the sectors to NATCoD.
d) Definition of a standard set of information products to communicate the results of M&E efforts and lead to improved planning of future HIV/AIDS/STI interventions.
e) Identification and definition of dissemination processes and channels through which data will be disseminated to stakeholders involved in HIV/AIDS/STIs.
g) Creation of a monitoring and evaluation Technical Working Group (M&E TWG).
h) Development of a costed work plan for HIV/AIDS/STI monitoring and evaluation.
i) Development of technical specifications for a central management information system for all HIV/AIDS/STI data collection.

2.4 GOAL AND OBJECTIVES OF NATIONAL HIV/AIDS/STI M&E SYSTEM

Within the above context and strategic areas, the goal of Eritrea’s national HIV/AIDS/STI M&E System is to track progress in the fight against HIV/AIDS/STI, by checking whether programme results meet the predetermined objectives, and by assessing whether HIV interventions in Eritrea are yielding the required results. The aim is that these would result in informed decision-making when planning and implementing HIV interventions in Eritrea.

Specific objectives are:

a) To define a list of core indicators that will enable tracking of progress in the most critical areas of the fight against HIV/AIDS/STI in Eritrea, based on those indicators defined in the latest NSP.
b) To develop a data collection strategy that will enable the measurement of the core indicators.
c) To provide a standardised tool for the monitoring of all HIV/AIDS/STI interventions.
d) To establish clear data flow channels between the different stakeholders in the fight against HIV/AIDS/STI.
e) To develop a strategy and mechanisms to ensure a correct dissemination of all critical information among all stakeholders, among implementing agencies, and among the beneficiaries and the general public.
f) To clearly describe the role of each of the stakeholders in the monitoring and evaluation of HIV/AIDS/STI programmes.
g) To develop a plan for strengthening the capacity of all partners involved in the monitoring and evaluation of HIV/AIDS/STI programmes.
3 Indicators for the HIV/AIDS/STI Response

This chapter lists the indicators for the monitoring and evaluation of the national response to the HIV and AIDS epidemic. Indicators were selected to be:

- In line with the main objectives and specific objectives formulated in the National Strategic Plan;
- In line with internationally recommended core indicators in UNGASS;
- In line with international HIV/AIDS/STI M&E guidelines produced by UNAIDS and its partners; and
- Realistically measurable at a reasonable cost.

The guidelines that were consulted in developing the attached indicator list, include:

- Indicators associated with the Declaration of Commitment to HIV and AIDS at a United Nations General Assembly Special Session on HIV and AIDS (“UNGASS indicators”)
- UNAIDS National Guide To Monitoring And Evaluating Programmes For The Prevention Of HIV In Infants And Young Children
- UNAIDS National AIDS Programmes: A Guide To Indicators For Monitoring And Evaluating National HIV/AIDS Prevention Programmes For Young People
- WHO M&E Guidelines For HIV, Malaria and TB
- UNAIDS National AIDS Programmes: A Guide To Indicators For Monitoring And Evaluating National Antiretroviral Programmes
- UNAIDS Guide To Monitoring And Evaluation Of The National Response For Children Orphaned And Made Vulnerable By HIV/AIDS
- UNAIDS National AIDS Programmes: A Guide To Monitoring And Evaluating HIV/AIDS Care And Support
- United States Government’s Presidential Emergency Plan for AIDS Relief (PEPFAR) indicators
- The Global Fund to Fight AIDS, TB and Malaria (GFATM) indicators
- Multi-Country HIV/AIDS Programme (MAP) indicators

The standard categories for how indicator scores should be disaggregated are: age, sex, and location. Unless otherwise stated, these standard categories mean:

**Age**: 15 – 19; 20 – 24; 25 – 49

**Sex**: Male; Female

**Location**: Urban; Rural

**Zoba**: Name of the six zobas where indicator data should be disaggregated

---

1 These are the standard age categories that are used in international guidelines. They are also provide a proxy indicator for HIV incidence (HIV prevalence in the 15 – 19 age group)
### Specific Objectives

<table>
<thead>
<tr>
<th>Main Objective I: To strengthen the multisectoral response to the HIV/AIDS epidemic</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>SpeObj-I.1</strong> To facilitate multi-sectoral coordination at the national and zoba levels.</td>
</tr>
<tr>
<td><strong>SpeObj-I.2</strong> To integrate prevention, care, support and impact mitigation priorities into the mainstream of development planning, including in poverty eradication strategies and sectoral development plans.</td>
</tr>
<tr>
<td><strong>SpeObj-I.3</strong> To establish public and private sector policies and programs that address HIV/AIDS in the workplace.</td>
</tr>
<tr>
<td><strong>SpeObj-I.4</strong> To improve the collection and dissemination of key socio-economic impact information capable of facilitating evidence-based decision-making.</td>
</tr>
</tbody>
</table>

### Core Indicators

<table>
<thead>
<tr>
<th>Indicator</th>
<th>Type</th>
<th>International M&amp;E Guide</th>
<th>Data Source(s)</th>
</tr>
</thead>
<tbody>
<tr>
<td>I.1: Existence of an annual HIV/AIDS/STI implementation support plan for the GoE and all its partners</td>
<td>Input</td>
<td>National indicator</td>
<td>Ministry of Health data</td>
</tr>
<tr>
<td>I.2: Number of zobas with functional multi-sectoral HIV/AIDS task forces</td>
<td>Output</td>
<td>National indicator</td>
<td>HIV/AIDS/STI Programme Monitoring Form, collected by Ministry of Health</td>
</tr>
<tr>
<td>I.3: Amount and proportion of national funds spent by governments on HIV/AIDS/STI interventions (UNGASS), by government sector</td>
<td>Input</td>
<td>a) UNAIDS UNGASS Indicator Guide (Indicator NCA 2)</td>
<td>Government budget data</td>
</tr>
<tr>
<td>I.4: Number of government ministries with an HIV/AIDS/STI work plans and budgets in the current financial year, by government sector</td>
<td>Input</td>
<td>National indicator</td>
<td>HIV/AIDS/STI Programme Monitoring Form, collected by Ministry of Health</td>
</tr>
<tr>
<td>I.5: Percentage of large enterprises/companies that have HIV/AIDS workplace policies and programmes (UNGASS), by type of organisation (public sector/private sector)</td>
<td>Outcome</td>
<td>a) UNAIDS UNGASS Indicator Guide (Indicator NPBI 2)</td>
<td>Workplace Survey</td>
</tr>
<tr>
<td>I.6: Number of employees that have participated in or benefited from HIV/AIDS workplace programmes in the last 12 months</td>
<td>Output</td>
<td>National indicator</td>
<td>HIV/AIDS/STI Programme Monitoring Form, collected by Ministry of Health</td>
</tr>
</tbody>
</table>

**An indicator for data use is included under Main Objective IX**
# National HIV/ AIDS/ STI Monitoring and Evaluation Plan

## Specific Objectives

### Main Objective II: To strengthen the prevention of sexual transmission of HIV

#### SpeObj-II.1 To maintain non-risk behaviours by promoting delayed onset of sexual activity, and avoiding, casual unprotected sexual intercourse with one or more individuals of unknown STI status.

<table>
<thead>
<tr>
<th>Core Indicator</th>
<th>Indicator Type</th>
<th>International M&amp;E Guide</th>
<th>Data Source/s</th>
</tr>
</thead>
<tbody>
<tr>
<td>II.1: Number of trained and active peer and community educators in the last 12 months, by zoba</td>
<td>Output</td>
<td>a) WHO M&amp;E Toolkit for HIV/AIDS, TB and Malaria (Only in summary sheet, p24)</td>
<td>HIV/AIDS/STI Programme Monitoring Form, collected by Ministry of Health</td>
</tr>
<tr>
<td>II.2: Number of IEC materials printed and distributed in the last 12 months, by type of material</td>
<td>Output</td>
<td>National indicator</td>
<td>HIV/AIDS/STI Programme Monitoring Form, collected by Ministry of Health</td>
</tr>
<tr>
<td>II.3: Percentage of young people who have had sex before the age of 15, by age, sex and location</td>
<td>Outcome</td>
<td>a) UNAIDS M&amp;E Guideline for programmes for young people (Behavioural Core Indicator 1)</td>
<td>Nationally representative behavioural or other survey</td>
</tr>
<tr>
<td>II.4: A composite of safe sexual behaviour among young people², by age, sex and location</td>
<td>Outcome</td>
<td>a) UNAIDS M&amp;E Guideline for programmes for young people (Behavioural Core Indicator 3)</td>
<td>Nationally representative behavioural or other survey</td>
</tr>
<tr>
<td>II.5: Percentage of schools with at least one teacher who have been trained in life-skills-based HIV/AIDS education and who taught it during the last academic year (UNGASS), by location of school (rural/urban) and by level of school (primary/secondary)</td>
<td>Outcome</td>
<td>a) UNAIDS M&amp;E Guideline for programmes for young people (Programmatic Core Indicator 3)</td>
<td>School survey, undertaken by Ministry of Education</td>
</tr>
<tr>
<td>II.6: Percentage of pregnant women testing positive for HIV during sentinel surveillance at selected antenatal clinics, by age, zoba and location</td>
<td>Impact</td>
<td>a) UNAIDS M&amp;E Guideline for programmes for young people (Impact Core Indicator 1)</td>
<td>ANC Sentinel Surveillance Report</td>
</tr>
</tbody>
</table>

² This indicator is a composite. It represents a departure from the usual focus on discrete behaviours. Sexual behaviours are interdependent and so it is difficult to interpret any single aspect in isolation. This composite indicator consist of 6 parts: Part 1 - Number of respondents who have never had sex; Part 2 - Number of respondents who have had sex but not in the preceding 12 months; Part 3 - Number of respondents who had sex with only one partner in the preceding 12 months and who used a condom the last time; Part 4 - Number of respondents who had sex with only one partner in the preceding 12 months and who did not use a condom the last time; Part 5 - Number of respondents who had sex with more than one partner in the preceding 12 months and who used a condom the last time; Part 6 - Number of respondents who had sex with more than one partner in the preceding 12 months and who did not use a condom the last time.
<table>
<thead>
<tr>
<th>Specific Objectives</th>
<th>Core Indicators</th>
<th>Indicator Type</th>
<th>International M&amp;E Guide</th>
<th>Data Source/s</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Main Objective II: To strengthen the prevention of sexual transmission of HIV</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>SpeObj-II.2 To promote the adoption of safe sexual practices among in and out-of-school youth.</td>
<td>II.7: Number of in-school youth and out-of-school youth that have participated in an HIV/AIDS/STI prevention programme in the last 12 months, by in-school or out-of-school youth and by zoba</td>
<td>Output</td>
<td>Not applicable</td>
<td>HIV/AIDS/STI Programme Monitoring Form, collected by Ministry of Health</td>
</tr>
<tr>
<td></td>
<td>II.8: Percentage of adults who are in favour of young people being educated about the use of condoms in order to prevent HIV/AIDS/STIs</td>
<td>Outcome</td>
<td>a) UNAIDS M&amp;E Guideline for programmes for young people (Protective Core Indicator 7)</td>
<td>Nationally representative behavioural or other survey</td>
</tr>
<tr>
<td></td>
<td>II.9: Percentage of young people aged 15 to 24 reporting the use of a condom at last sex with a non-marital, non-cohabitating sexual partner in the last 12 months, by sex and location (UNGASS)</td>
<td>Outcome</td>
<td>a) UNAIDS UNGASS Indicator Guide (Indicator NPBI 7)</td>
<td>Nationally representative behavioural or other survey</td>
</tr>
<tr>
<td></td>
<td>II.10: Percentage of young people aged 15 to 24 who both correctly identify ways of preventing the sexual transmission of HIV and who reject major misconceptions about HIV transmission, by sex and location (UNGASS)</td>
<td>Outcome</td>
<td>a) UNAIDS M&amp;E Guideline for programmes for young people (Protective Core Indicator 1)</td>
<td>Nationally representative behavioural or other survey</td>
</tr>
<tr>
<td>SpeObj-II.3 To promote the use of male and female condoms.</td>
<td>II.11: Proportion of randomly selected retail outlets and service delivery points that have condoms in stock at the time of a survey, of all retail outlets and service delivery points selected for survey, by type of outlet</td>
<td>Outcome</td>
<td>a) WHO M&amp;E Toolkit for HIV/AIDS, TB and Malaria (Indicator HIV-P13)</td>
<td>Condom Availability Survey</td>
</tr>
<tr>
<td>SpeObj-II.4 To expand/strengthen youth or adolescents reproductive health services.</td>
<td>II.12: Number of young people that have accessed reproductive health services (family planning, STI diagnosis, and HIV testing) in the last 12 months, by type of service and by zoba</td>
<td>Output</td>
<td>a) UNAIDS M&amp;E Guideline for programmes for young people (Programmatic Indicator 5)</td>
<td>HIV/AIDS/STI Programme Monitoring Form, collected by Ministry of Health</td>
</tr>
<tr>
<td>SpeObj-II.5 To improve access to services &amp; adapt safe sex practices among CSWs.</td>
<td>II.13: Number of sex workers and military personnel participating in HIV/AIDS/STI prevention programmes in the last 12 months, by type of participant and by zoba</td>
<td>Output</td>
<td>Not applicable</td>
<td>HIV/AIDS/STI Programme Monitoring Form, collected by Ministry of Health</td>
</tr>
<tr>
<td>SpeObj-II.6 To prevent HIV transmission among Uniformed services, through the promotion of safer sexual behaviours.</td>
<td>See Indicator II.12</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>SpeObj-II.7 To improve access to HIV/AIDS prevention programs for mobile populations.</td>
<td>II.14: Number of HIV/AIDS/STI prevention programmes aimed specifically at mobile populations and the estimated number of persons reached in the last 12 months, by zoba</td>
<td>Output</td>
<td>Not applicable</td>
<td>HIV/AIDS/STI Programme Monitoring Form, collected by Ministry of Health</td>
</tr>
</tbody>
</table>
### Specific Objectives

<table>
<thead>
<tr>
<th>Specific Objectives</th>
<th>Core Indicators</th>
<th>Indicator Type</th>
<th>International M&amp;E Guide</th>
<th>Data Source/s</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Main Objective III: To increase availability and capacity of human resources in the health sector to combat the HIV/AIDS epidemic &amp; STIs</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
| SpecObj-III.1 To increase the presence of quality health staff in health facilities offering HIV/AIDS/STI prevention, care and support services. | III.1: Percentage of health facilities that have the capacity and conditions to provide basic HIV counseling and testing and to manage HIV/AIDS clinical services. | Outcome       | a) UNAIDS M&E guidelines for care and support (Core Indicator CS6)  
  b) WHO M&E Toolkit for HIV/AIDS, TB and Malaria (Indicator HIV-T13) | Health Facility Survey                                                                 |
| SpecObj-III.2 To improve the human resource planning capacity of the MoH.            | III.2: Number of person-days of training that project staff and employees have undergone to manage and implement HIV/AIDS/STI services in the last 12 months, by type of personnel | Output        | UNAIDS M&E guidelines for HIV prevention in infants and young children (Core Indicator 2, adapted for all HIV/AIDS/STI services) | HIV/AIDS/STI Programme Monitoring Form, collected by Ministry of Health |
| SpecObj-III.3 To improve the management of existing human resources.                | No indicator                                                                    |                |                                                                                          |                                                                                                |

---

3 Capacity to provide basic HIV counselling and testing and HIV/AIDS clinical services are defined as: (a) a system for testing and providing results for HIV infection; (b) systems and qualified staff for pre- and post-test counseling (trained counsellors, privacy for counselling, mechanisms for maintaining confidentiality, directory of services for referral, quality-control measures for specimen collection); (c) specific health services relevant to HIV/AIDS, including resources and supplies for providing these services; (d) elements for preventing nosocomial infections; and (e) trained staff and resources providing basic interventions for prevention and treatment for people living with HIV/AIDS.
<table>
<thead>
<tr>
<th>Specific Objectives</th>
<th>Core Indicators</th>
<th>Indicator Type</th>
<th>International M&amp;E Guide</th>
<th>Data Source/s</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Main Objective IV:</strong> To reduce the incidence of HIV infection through early diagnosis and treatment of STIs</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>SpeObj-IV.1</strong> To increase the knowledge of MoH decision makers on STI aetiology and drug sensitivity.</td>
<td>No indicator</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>SpeObj-IV.2</strong> To ensure the availability of appropriate STI drugs for the rational management of STIs.</td>
<td>IV.1: Percentage of STI service delivery points that have recorded at least one stock-out in the preceding six months.</td>
<td>Output</td>
<td>a) UNAIDS M&amp;E guideline for ARVs (Core Indicator 3, adapted)</td>
<td>Health Facility Survey</td>
</tr>
<tr>
<td><strong>SpeObj-IV.3</strong> To improve capacity in STI diagnosis and management in all six zobas.</td>
<td>Indicator on training included in Main Objective III</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>SpeObj-IV.4</strong> To improve the quality of STI diagnosis and case management.</td>
<td>IV.2: Percentage of patients with STIs at health care facilities, who are appropriately diagnosed, treated and counseled, by age (20 and younger, older than 20) and by sex. (UNGASS)</td>
<td>Outcome</td>
<td>a) WHO M&amp;E Toolkit for HIV/AIDS, TB and Malaria (Indicator HIV-PI1) b) UNAIDS UNGASS Indicator Guide (Indicator NPBI 3)</td>
<td>Health Facility Survey</td>
</tr>
<tr>
<td><strong>SpeObj-IV.5</strong> To increase the detection and treatment of syphilis.</td>
<td>IV.3: Syphilis prevalence amongst pregnant women at antenatal clinics</td>
<td>Impact</td>
<td>Not applicable</td>
<td>ANC Sentinel Surveillance Report</td>
</tr>
<tr>
<td><strong>SpeObj-IV.6</strong> To increase the early and appropriate treatment seeking behaviour for persons with STI symptoms.</td>
<td>IV.4: Number and percentage of persons reporting symptoms of STIs in the last 12 months who sought care at a service provider with personnel trained in STI care, by zoba and by sex</td>
<td>Output</td>
<td>a) UNAIDS M&amp;E Guidelines for National AIDS Commissions, (STI Service Indicator 3, adapted)</td>
<td>Nationally representative behavioural or other survey HIV/AIDS/STI Programme Monitoring Form, collected by Ministry of Health</td>
</tr>
<tr>
<td>Specific Objectives</td>
<td>Core Indicators</td>
<td>Indicator Type</td>
<td>International M&amp;E Guide</td>
<td>Data Source/s</td>
</tr>
<tr>
<td>------------------------------------------------------------------------------------</td>
<td>---------------------------------------------------------------------------------</td>
<td>----------------</td>
<td>------------------------------------------------------------------------------------------</td>
<td>---------------------------------------------------------------------------------------------------------------</td>
</tr>
<tr>
<td><strong>Main Objective V: To promote the early diagnosis of HIV infection through increased access to VCT and PMTCT</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>SpeObj-V.1 To increase access to early diagnosis of HIV infection for the general population and the military.</td>
<td>V.1: Number and percentage of the general population receiving an HIV test, the results, and post-test counselling in the last 12 months, by zoba and by sex</td>
<td>Outcome</td>
<td>a) UNAIDS M&amp;E guidelines for NACs (VCT indicator 1)</td>
<td>Nationally representative behavioural or other survey HIV/AIDS/STI Programme Monitoring Form, collected by Ministry of Health</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>b) WHO M&amp;E Toolkit for HIV/AIDS, TB and Malaria (Indicator HIV-PI8)</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>V.2: Percentage of zobas with at least one operational counselling and testing site</td>
<td>Output</td>
<td>a) WHO M&amp;E Toolkit for HIV/AIDS, TB and Malaria (Indicator HIV-PI7)</td>
<td>Health Facility Survey</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>V.3: Number of persons who are active members of VCT post-test clubs in the last 12 months, by zoba and by sex</td>
<td>Output</td>
<td>Not applicable</td>
<td>HIV/AIDS/STI Programme Monitoring Form, collected by Ministry of Health</td>
</tr>
<tr>
<td>SpeObj-V.2 To increase knowledge of HWs on testing and counseling, including in the military.</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>SpeObj-V.3 To design a national procurement and distribution system for HIV test kits. Specific and well-designed stock control system.</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>SpeObj-V.4 To ensure high quality of counseling and testing.</td>
<td>V.4: Percentage of VCT sites that have functional referral systems and referral registers in place, by zoba</td>
<td>Output</td>
<td>Not applicable</td>
<td>Health Facility Survey</td>
</tr>
<tr>
<td>SpeObj-V.5 To improve VCT data monitoring.</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**November 2005 15**
<table>
<thead>
<tr>
<th>Specific Objectives</th>
<th>Core Indicators</th>
<th>Indicator Type</th>
<th>International M&amp;E Guide</th>
<th>Data Source/s</th>
</tr>
</thead>
<tbody>
<tr>
<td>Main Objective V: To promote the early diagnosis of HIV infection through increased access to VCT and PMTCT</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>SpeObj-V.6 To increase pregnant women's access to high-quality services aimed at preventing MTCT.</td>
<td>V.5: Percentage of public, missionary, and workplace venues (family planning and primary health care clinics, ANC/MCH, and maternity hospitals) offering the minimum package of services to prevent HIV infection in infants and young children in the past 12 months, by zoba</td>
<td>Outcome</td>
<td>a) WHO M&amp;E Toolkit for HIV/AIDS, TB and Malaria (Indicator HIV-PI9)</td>
<td>Health Facility Survey</td>
</tr>
<tr>
<td></td>
<td>V.6: Percentage of HIV-infected pregnant women who are provided with a complete course of ARV prophylaxis to reduce the risk of MTCT(^4) in the last 12 months, by type of facility (UNGASS)</td>
<td>Outcome</td>
<td>a) UNAIDS UNGASS guidelines (Impact Indicator 1) b) WHO M&amp;E Toolkit for HIV/AIDS, TB and Malaria (Indicator HIV-PI10)</td>
<td>Birth data from Central Statistics Office Data on number of women who received ARV prophylaxis from HIV/AIDS/STI Programme Monitoring Form</td>
</tr>
<tr>
<td></td>
<td>V.7: Percentage of HIV-infected infants born to HIV-infected mothers (UNGASS)</td>
<td>Impact</td>
<td>a) UNAIDS UNGASS guidelines (Impact Indicator 1)</td>
<td>Formula-based estimate(^5)</td>
</tr>
<tr>
<td>SpeObj-V.7 To develop the capacity of health facilities to implement the PMTCT strategy.</td>
<td><em>Indicator on training and capacity of health sector to provide HIV/AIDS/STI services included in Main Objective III</em></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

\(^4\) Indicator score = \(\frac{C}{A\times B}\), where:
- \(A\): Total number of births (Statistics Office)
- \(B\): HIV prevalence estimate (ANC Sentinel Surveillance Report)
- \(C\): Number of pregnant women who received ARV prophylaxis

\(^5\) Indicator score = \(\{T\times\{1-e\} + (1-T)\} \times v\), where:
- \(T\): proportion of HIV-infected pregnant women provided with antiretroviral treatment
- \(v\): MTCT rate in the absence of any treatment
- \(e\): efficacy of treatment provided
### Specific Objectives

**Main Objective VI: To ensure the safe transfusion of blood and adhere to universal infection prevention precautions in the health care settings and in the traditional practices**

<table>
<thead>
<tr>
<th>Specific Objectives</th>
<th>Core Indicators</th>
<th>Indicator Type</th>
<th>International M&amp;E Guide</th>
<th>Data Source/s</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>SpeObj-VI.1</strong> To ensure that blood units included in the national blood supply, at central and zoba levels, are not infected with HIV.</td>
<td>VI.1: Percentage of blood units transfused in the last 12 months that have been adequately screened for HIV according to national or WHO guidelines, by blood screening facility</td>
<td>Output</td>
<td>a) WHO M&amp;E Toolkit for HIV/AIDS, TB and Malaria (Indicator HIV-PI13)</td>
<td>Data from National Blood Transfusion Service</td>
</tr>
<tr>
<td><strong>SpeObj-VI.2</strong> To prevent HIV transmission due to accidental exposure to blood and blood products in health-care settings.</td>
<td>VI.2: Percentage of health care facilities in a facility survey that have guidelines to prevent nosocomial transmission of HIV, adequate sterilization procedures, and surgical gloves in stock, by zoba</td>
<td>Output</td>
<td>a) UNAIDS M&amp;E guidelines for NACs. p118 Blood Safety Indicator 1</td>
<td>Health Facility Survey</td>
</tr>
<tr>
<td><strong>SpeObj-VI.3</strong> To minimize risk of getting infections from injections, disposal of potentially contaminated items including sharp instruments and harmful traditional practices.</td>
<td>No indicator</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Specific Objectives</td>
<td>Core Indicators</td>
<td>International M&amp;E Guide</td>
<td>Data Source/s</td>
<td></td>
</tr>
<tr>
<td>---------------------</td>
<td>----------------</td>
<td>-------------------------</td>
<td>---------------</td>
<td></td>
</tr>
<tr>
<td><strong>Main Objective VII: To increase the provision and improve the quality of comprehensive health care, including antiretroviral therapy, for PLHAS</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>SpeObj-VII.1 To increase specific biological diagnosis capacity for OI at centre &amp; zonal level.</td>
<td>See indicator VII.5</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>SpeObj-VII.2 To increase knowledge of health workers from all referral hospitals on chemoprophylaxis &amp; early diagnosis of &amp; treatment of OI of adults &amp; children.</td>
<td>Indicators on training and capacity building of the health sector included in Main Objective III</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>SpeObj-VII.3 To ensure the availability of drugs for OI management.</td>
<td>VII.1: Percentage of drug storage and delivery points experiencing stock-outs of ARVs, OI drugs, and drugs for palliative care(^6) in the preceding six months</td>
<td>Output</td>
<td>UNAIDS M&amp;E guideline for ARV programmes (Core Indicator 3, adapted)</td>
<td></td>
</tr>
<tr>
<td>SpeObj-VII.4 To improve counselling capacity of HW in health facilities including children counselling.</td>
<td>Indicators on training and capacity building of the health sector included in Main Objective III</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>SpeObj-VII.5 To build up continuum of care &amp; support for HIV+ and AIDS patients and their families.</td>
<td>VII.2: Number of registered TB patients who are tested for HIV, after giving consent in the last 12 months, by sex</td>
<td>Output</td>
<td>WHO M&amp;E Toolkit for HIV/AIDS, TB and Malaria (Indicator TB/HIV-TI 2)</td>
<td></td>
</tr>
<tr>
<td></td>
<td>VII.3: Number of newly diagnosed HIV positive clients who are given treatment of latent TB infection (TB preventive therapy) in the last 12 months, by sex</td>
<td>Output</td>
<td>WHO M&amp;E Toolkit for HIV/AIDS, TB and Malaria (Indicator TB/HIV-PI 2)</td>
<td></td>
</tr>
<tr>
<td></td>
<td>VII.4: Percentage of facilities that provide comprehensive case referrals for HIV/AIDS care and support services (where these services are not available on site)</td>
<td>Output</td>
<td>UNAIDS M&amp;E guidelines for care and support programmes (Core Indicator CS5)</td>
<td></td>
</tr>
<tr>
<td>SpeObj-VII.6 To increase response capacity from HW, TBAs, relatives and support organization members, for home Based care including nursing care.</td>
<td>Home-based care indicators included under SpeObj VIII.2</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

---

\(^6\) Drugs for stock-outs to be defined using Eritrea's Essential Drug List
### Specific Objectives

**Main Objective VII:** To increase the provision and improve the quality of comprehensive health care, including antiretroviral therapy, for PLHAS

**SpeObj-VII.7** To ensure access to ARV treatment in selected hospitals.

<table>
<thead>
<tr>
<th>Core Indicators</th>
<th>Indicator Type</th>
<th>International M&amp;E Guide</th>
<th>Data Source/s</th>
</tr>
</thead>
<tbody>
<tr>
<td>VII.5: Percentage of health care facilities that have the capacity and conditions to provide advanced-level HIV/AIDS care and support services, including provision of ART(^7)</td>
<td>Output</td>
<td>a) PEPFAR July 2005 Indicator Guidelines (Care and Support Indicator 3)</td>
<td>Health Facility Survey</td>
</tr>
<tr>
<td></td>
<td></td>
<td>b) WHO M&amp;E Toolkit for HIV/AIDS, TB and Malaria (Indicator HIV-T12)</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>c) UNAIDS M&amp;E guidelines for care and support programmes (Core Indicator CS7)</td>
<td></td>
</tr>
<tr>
<td>VII.6: Percentage of persons with advanced HIV infection receiving ARV combination therapy in the last 12 months, by age (UNGASS)</td>
<td>Outcome</td>
<td>a) UNAIDS M&amp;E guideline for ARV programmes (Core Indicator 7)</td>
<td>HIV/AIDS/STI Programme Monitoring Form, collected by Ministry of Health</td>
</tr>
<tr>
<td>VII.7: Percentage of people still alive at 6, 12, and 24 months after initiation of ARV combination therapy</td>
<td>Impact</td>
<td>a) PEPFAR July 2005 Indicator Guidelines (Care and Support Indicator 5)</td>
<td>HIV/AIDS/STI Programme Monitoring Form, collected by Ministry of Health</td>
</tr>
</tbody>
</table>

\(^7\) Capacity to provide advanced HIV/AIDS care is defined as: (a) systems and items to support the management of opportunistic infections and the provision of palliative care (symptomatic treatment) for the advanced care of people living with HIV/AIDS; (b) systems and items to support advanced services for the care of people living with HIV/AIDS; (c) systems and items to support antiretroviral combination therapy (including security measures for the ARVs); (d) conditions to provide advanced inpatient care for people living with HIV/AIDS; (e) conditions to support home-care services; and (f) post-exposure prophylaxis.
<table>
<thead>
<tr>
<th>Specific Objectives</th>
<th>Core Indicators</th>
<th>International M&amp;E Guide</th>
<th>Data Source/s</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Main Objective VIII: To expand the availability and quality of psychosocial and economic support for people infected with and affected by HIV/AIDS</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>SpeObj-VIII.1 To improve access of people infected and affected by HIV to voluntary testing and counselling services, and social and economic support.</td>
<td>VIII.1: Number of adults aged 18 – 59 who have been chronically ill for 3 or more months in the past 12 months whose households received, free of user charges, basic external support(^8) in caring for chronically ill adults</td>
<td>Output</td>
<td>UNAIDS M&amp;E guidelines for care and support programmes (Core Indicator CS9 - adapted)</td>
</tr>
<tr>
<td></td>
<td>VIII.2: Number of vulnerable groups that have received basic external support(^7) (free of user charges) in the last 12 months, by zoba and by type of vulnerable group</td>
<td>Output</td>
<td>Not applicable</td>
</tr>
<tr>
<td>SpeObj-VIII.2 To strengthen and expand facilities for providing home-based care for PLHAs.</td>
<td>VIII.3: Cumulative number of organisations(^9) that have been registered in the last 12 months to provide basic external support(^7) (free of user charges) for PLHAs and their families, by type of organisation</td>
<td>Output</td>
<td>Not applicable</td>
</tr>
<tr>
<td>SpeObj-VIII.3 To improve opportunities for people living with and affected by HIV/AIDS to continue being productive citizens able to support themselves and their families as long as possible.</td>
<td>VIII.4: Percentage of the general population that express positive attitudes towards persons living with HIV/AIDS and their families, by age, sex and location</td>
<td>Outcome</td>
<td>a) UNAIDS M&amp;E guidelines for NACs, p45, adapted</td>
</tr>
<tr>
<td>SpeObj-VIII.4 To ensure that PLHAs and their families who are in need of nutritional support have access to food aid.</td>
<td>See indicator VIII.1 – food aid is included with this indicator</td>
<td></td>
<td></td>
</tr>
<tr>
<td>SpeObj-VIII.5 To improve the delivery of psychosocial support for AIDS orphans.</td>
<td>VIII.5: Number of orphans and vulnerable children whose households received, free of user charges, basic external support in caring for the child, by zoba</td>
<td>Output</td>
<td>a) UNAIDS M&amp;E guidelines for care and support programmes (Core Indicator CS10)</td>
</tr>
<tr>
<td></td>
<td>VIII.6: Ration of school attendance among orphans to that among non-orphans, by sex (UNGASS)</td>
<td>Impact</td>
<td>a) WHO M&amp;E Toolkit for HIV/AIDS, TB and Malaria (Indicator HIV-CS 2)</td>
</tr>
</tbody>
</table>

\(^8\) Basic external support can be in the areas of health, psychosocial, emotional, or other social and material support  
\(^9\) This includes faith based organisations, community-based organisations, and non-governmental organisations
<table>
<thead>
<tr>
<th>Specific Objectives</th>
<th>Core Indicators</th>
<th>Indicator Type</th>
<th>International M&amp;E Guide</th>
<th>Data Source/s</th>
</tr>
</thead>
<tbody>
<tr>
<td>SpeObj-VIII.6</td>
<td>To strengthen the coordination of care and support activities between and among the health and non-health sectors and improve quality assurance mechanisms.</td>
<td>See indicator VII.5 – continuum of care indicator has already been included</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Main Objective IX:</strong> To promote research and improve surveillance, monitoring and evaluation of the HIV/AIDS epidemic and STI in all sectors, including the military</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>SpeObj-IX.1</td>
<td>To promote medical/clinical operational research for decision making on HIV/AIDS and STI programs.</td>
<td>IX.1: The existence of an HIV/AIDS/STI research regulatory framework</td>
<td>Input</td>
<td>Not applicable</td>
</tr>
<tr>
<td>SpeObj-IX.2</td>
<td>To strengthen the surveillance system of HIV/AIDS and STIs.</td>
<td>IX.2: The existence of annual sentinel surveillance report</td>
<td>Input</td>
<td>Not applicable</td>
</tr>
<tr>
<td>SpeObj-IX.3</td>
<td>To strengthen ethics in research.</td>
<td>See indicator IX.1</td>
<td></td>
<td></td>
</tr>
<tr>
<td>SpeObj-IX.4</td>
<td>To build data management capacity for decision making processes and purposes on HIV/AIDS and STIs.</td>
<td>IX.3: Number of information products that are produced by the Ministry of Health's NATCoD Division</td>
<td>Input</td>
<td>Not applicable</td>
</tr>
<tr>
<td></td>
<td></td>
<td>IX.4: The Country Response Information System has been installed and is populated with serological data, HIV intervention data, financial tracking data, and data on socio economic impact studies</td>
<td>Input</td>
<td>Not applicable</td>
</tr>
<tr>
<td></td>
<td></td>
<td>IX.5: Percentage of implementers of HIV/AIDS interventions that have submitted HIV/AIDS/STI Programme Monitoring Forms that are correctly and comprehensively completed on time in the last 12 months, by type of implementer and by zoba</td>
<td>Output</td>
<td>Not applicable</td>
</tr>
<tr>
<td></td>
<td></td>
<td>IX.6: Percentage of implementers of HIV/AIDS interventions who report that they have participated in at least two zoba-level HIV/AIDS/STI data dissemination workshops in the last 12 months, by type of implementer and by zoba</td>
<td>Output</td>
<td>Not applicable</td>
</tr>
</tbody>
</table>
### 4 Data Sources For National Indicators

Two major data sources can be differentiated: (a) data sources for indicators that will be measured by surveys (outcome and impact indicators and outcome-level and impact-level data sources); and (b) data sources for indicators that will be measured using continuously monitored programme outputs (input and output indicators and input-level and output-level data sources). Table defines the minimum set of data sources will need to be prepared and/or coordinated by NATCoD in order to collect all indicator data:

<table>
<thead>
<tr>
<th>OUTCOME-LEVEL AND IMPACT-LEVEL DATA SOURCES</th>
<th>INPUT-LEVEL AND OUTPUT-LEVEL DATA SOURCES</th>
</tr>
</thead>
<tbody>
<tr>
<td>• ANC Sentinel Surveillance Report (see 5.1)</td>
<td>• HIV/AIDS/STI Programme Monitoring Form (see 5.7)</td>
</tr>
<tr>
<td>• Nationally representative behavioural or other Survey (see 5.2)</td>
<td>• Government financial data (see 5.8)</td>
</tr>
<tr>
<td>• Multi-cluster Indicator (MICS) Survey (see 5.2)</td>
<td>• Ministry of Health data (see 5.9)</td>
</tr>
<tr>
<td>• National Orphan Survey (see 5.2)</td>
<td>• Data from National Blood Transfusion Service (see 5.10)</td>
</tr>
<tr>
<td>• Health Facility Survey (see 5.3)</td>
<td>•</td>
</tr>
<tr>
<td>• Condom Availability Survey (see 5.4)</td>
<td>•</td>
</tr>
<tr>
<td>• Data from existing School Surveys (see 5.5)</td>
<td>•</td>
</tr>
<tr>
<td>• Workplace Survey (see 5.6)</td>
<td>•</td>
</tr>
</tbody>
</table>

All the data sources in Table 3 have been described in this section, by providing a description of it, what NATCoD needs from it, the frequency of collection, the responsibility for collecting it and the data flow diagram that describes how the data will flow from the organisation responsible for preparing it to NATCoD. Annexure C contains details on the nomenclature associated with the data flow diagrams that have been provided.

Each of the data flow diagrams illustrated in this Chapter has three standard tasks associated with it: first, inclusion of indicator scores in the annual HIV/AIDS/STI M&E report, second, inclusion of the indicator scores in the Country Response Information System (see Chapter 8.3), and third, sending a copy of the indicator scores to Eritrea’s Central Statistics Office (so that this office may continue to be the governor of data in Eritrea). Outcome/impact-level data sources are presented first, then input/output-level data sources.
4.1 ANC SENTINEL SURVEILLANCE REPORT

Description

Antenatal clinic surveillance is a form of routine sentinel surveillance, using the WHO guidelines for sentinel surveillance. Broadly, it comprises of anonymous HIV testing of blood samples of pregnant women who attend antenatal clinics (pre-selected sentinel sites), with over-sampling of young women in the age group 15-24. When HIV testing is done, syphilis testing is carried out at the same time. HIV testing of blood donors is also carried out on a routine basis, as every blood donation is tested for HIV prior to release to health facilities. Further, HIV testing of TB patients will also be recommended on a routine basis.

What data NATCoD needs from this survey

- The HIV prevalence among pregnant women, disaggregated by age (15 – 19; 20 – 24; 25 – 34; 35 - 49) and location (rural, urban)
- The syphilis prevalence among pregnant women, disaggregated by age (15 – 19; 20 – 24; 25 – 34; 35 - 49) and location (rural, urban)
- The HIV prevalence amongst blood donors, disaggregated by sex (male; female), and age (15 – 19; 20 – 24; 25 – 34; 35 - 49)

Frequency

Antenatal clinic surveillance for HIV and syphilis will be undertaken every two years.

Responsibility

The MoH’s Epidemiology and Monitoring Unit will be responsible for these surveys; in particular the Depts of Research, Human Resources Development, Regulatory Services will collaborate as technical review panel and coordinate the annual sentinel surveillance.

Data Flow Diagram
4.2 Nationally Representative Behavioural or Other Surveys

**Description**

Behavioural and knowledge outcome indicators in terms of HIV/AIDS/STIs, as well as indicators on the extent of the use of VCT services, of community-home based care and of support for OVC, will be measured by nationwide population-based surveys. Surveys of this kind include:

- Demographic and Health Survey
- Behavioural Surveillance Surveys among youth and selected high-risk populations
- A Population Census
- National Orphan Survey
- Other Household Survey
- Multiple Indicator Cluster Survey (MICS)

Each survey needs to ensure that it captures the relevant data for the national set of HIV/AIDS/STI indicators. NATCoD and the Survey Committee set up for this purpose will have to develop a schedule of such surveys to ensure that new data (see data requirements hereunder) are available at least every two years.

**What data NATCoD needs from this survey**

- Percentage of young people who have had sex before the age of 15, by age, sex and location
- A composite of safe sexual behaviour among young people, by age, sex and location
- Percentage of adults who are in favour of young people being educated about the use of condoms in order to prevent HIV/AIDS/STIs
- Percentage of young people aged 15 to 24 reporting the use of a condom at last sex with a non-marital, non-cohabitating sexual partner in the last 12 months, by sex and location (UNGASS)
- Percentage of young people aged 15 to 24 who both correctly identify ways of preventing the sexual transmission of HIV and who reject major misconceptions about HIV transmission, by sex and location (UNGASS)
- Number of men and women reporting symptoms of STIs in the last 12 months who sought care at a service provider with personnel trained in STI care
- Percentage of the general population receiving an HIV test, the results, and post-test counselling in the last 12 months, by zoba and by sex

---

10 All these behavioural surveys may not be undertaken in the time period of this current M&E plan
11 This indicator is a composite. It represents a departure from the usual focus on discrete behaviours. Sexual behaviours are interdependent and so it is difficult to interpret any single aspect in isolation. This composite indicator consist of 6 parts: Part 1 - Number of respondents who have never had sex; Part 2 - Number of respondents who have had sex but not in the preceding 12 months; Part 3 - Number of respondents who had sex with only one partner in the preceding 12 months and who used a condom the last time; Part 4 - Number of respondents who had sex with only one partner in the preceding 12 months and who did not use a condom the last time; Part 5 - Number of respondents who had sex with more than one partner in the preceding 12 months and who used a condom the last time; Part 6 - Number of respondents who had sex with more than one partner in the preceding 12 months and who did not use a condom the last time
• Percentage of the general population that express positive attitudes towards persons living with HIV/AIDS and their families, by age, sex and location
• Percentage of young people who have had sex before the age of 15, by age, sex and location
• Ratio of school attendance among orphans to that among non-orphans, by sex (UNGASS)

Frequency
Surveys will be undertaken at least once every two years, or at the least once every 4 years.

Responsibility
The National Statistics Office will be responsible for coordinating the population-based surveys. The role of NATCoD is to ensure that an HIV/AIDS module is included in the population-based surveys. It will be responsibility of the national statistics office to coordinate the over-all survey.

Data Flow Diagram

4.3 Health Facility Survey

Description
Some of the core indicators on STI care, PMTCT and clinical care are indicators on the quality or extent of health-related HIV/AIDS/STI services. Such information cannot be collected
through routine HMIS information, as the HMIS relies on self-reporting of information by health facilities themselves. Instead, a survey is needed whereby an external and independent team, appointed for such a purpose, examines health facility information and services objectively.

The Health Facility Survey will be undertaken by using a number of protocols, including those identified in the UNAIDS M&E guidelines, the MEASURE Service Provision Assessment; (SPA facility survey), and the MEASURE Evaluation blood safety protocol.

What data NATCoD needs from this survey

- Percentage of health facilities that have the capacity and conditions to provide basic HIV counseling and testing and to manage HIV/AIDS clinical services

  Capacity to provide basic HIV counselling and testing and HIV/AIDS clinical services is defined as: (a) a system for testing and providing results for HIV infection; (b) systems and qualified staff for pre- and post-test counseling (trained counsellors, privacy for counselling, mechanisms for maintaining confidentiality, directory of services for referral, quality-control measures for specimen collection); (c) specific health services relevant to HIV/AIDS, including resources and supplies for providing these services; (d) elements for preventing nosocomial infections; and (e) trained staff and resources providing basic interventions for prevention and treatment for people living with HIV/AIDS.

- Percentage of STI service delivery points that have recorded at least one stock-out in the preceding six months.

- Percentage of zobas with at least one operational counselling and testing site

- Percentage of patients with STIs at health care facilities, who are appropriately diagnosed, treated and counselled, by age (20 and younger, older than 20) and by sex. (UNGASS)

- Percentage of VCT sites that have functional referral systems and referral registers in place, by zoba

- Percentage of public, missionary, and workplace venues (family planning and primary health care clinics, ANC/MCH, and maternity hospitals) offering the minimum package of services to prevent HIV infection in infants and young children in the past 12 months, by zoba

- Percentage of health care facilities in a facility survey that have guidelines to prevent nosocomial transmission of HIV, adequate sterilization procedures, and surgical gloves in stock, by zoba

- Number of health facilities with items and systems to provide ART services in line with national standards, by zoba

- Percentage of facilities that provide comprehensive case referrals for HIV/AIDS care and support services (where these services are not available on site)

- Percentage of health care facilities that have the capacity and conditions to provide advanced-level HIV/AIDS care and support services, including provision of ART

  Capacity to provide advanced HIV/AIDS care is defined as: (a) systems and items to support the management of opportunistic infections and the provision of palliative care (symptomatic treatment) for the advanced care of people living with HIV/AIDS; (b) systems and items to support advanced services for the care of people living with HIV/AIDS; (c) systems and items to support antiretroviral combination therapy (including security measures for the ARVs); (d) conditions to provide advanced inpatient care for people living with HIV/AIDS; (e) conditions to support home-care services; and (f) post-exposure prophylaxis.
• Percentage of drug storage and delivery points experiencing stock-outs of ARVs, OI drugs, and drugs for palliative care\(^{12}\) in the preceding six months

**Frequency**

The Health Facility Survey will be undertaken on an annual basis, between June and September. The report should be available in January of the following year in time for inclusion in HIV/AIDS/STI M&E report.

**Responsibility**

NATCoD will ensure that HIV/AIDS, STI related data are included in the Health Facility survey. The responsible body may be the medical services in collaboration with NATCoD and the Depts of Regulatory services and the Research and Human Resource Development

A Health Facility Survey committee, presided over by the MoH, will be responsible for the preparation and coordination of all aspects of these surveys.

**Data Flow Diagram**

---

\(^{12}\) Drugs for stock-outs to be defined using Eritrea’s Essential Drug List
4.4 CONDOM AVAILABILITY SURVEY

Description
This survey measures condom availability at retail outlets and service delivery points and the quality of a random sample of condoms that were found during the survey. The quality of condoms at their time of use determines their effectiveness in preventing HIV, STIs and pregnancy. The MEASURE Evaluation/WHO/PSI Compiled Condom Availability and Quality Protocol will be used as a basis for developing a protocol for this survey.

What NATCoD needs from this survey
- Percentage of randomly selected retail outlets and service delivery points that have condoms in stock at the time of a survey (by zoba)

Frequency
This survey will be undertaken every two years, with the first one being undertaken in 2006.

Responsibility
The HIV Surveillance Committee in MoH, who is responsible for all HIV surveillance, will be the technical review panel and responsible for coordinating the annual sentinel surveillance.

Data Flow Diagram
4.5 **SCHOOL DATA FROM EXISTING SURVEYS**

**Description**

Some of the youth education indicators require data that is collected at the school level. These data will be collected through a school survey, or alternatively through an annual assessment by distributing forms to be filled out by each school. Since there are existing school-level data collection processes, NATCoD will collect this survey by adding some questions to an existing routine school survey or other school-level data collection process, which will be identified at an opportune time.

**What data NATCoD needs from this survey**

- Percentage of schools with at least one teacher who has been trained in participatory life-skills based HIV/AIDS/STI education and who taught it during the last academic year. (UNGASS) (by location, and by school type (primary and secondary))

**Responsibility**

The Ministry of Education will be responsible for data collection and analysis.

**Frequency**

Data collection will occur on a biennial basis.

**Data Flow Diagram**

Ministry of Education

- Ensures that additional questions is added to school survey
- Conduct school-level survey
- Prepare report
- Send copy of report to NERCHA

NATCoD

- Include relevant information in the annual HIV/AIDS M&E report
- Capture indicator scores in CRIS database
- Send an electronic copy of indicator scores to CSO
4.6 Workplace Survey

To track the extent to which policy development efforts are mainstreamed in workplaces, UNGASS has developed an indicator on workplace policies and programmes. The data is derived from a Workplace Survey, which is being undertaken using the protocol specified in the UNAIDS UNGASS indicator guidelines.

Private sector employers are selected on the basis of the size of the labour force. Public sector employers recommended in the UNAIDS guidelines for the collection of UNGASS indicators are the ministries of transport, labour, tourism, education, and health. (note that NATCoD may wish to broaden the sampling of ministries and businesses for its own evaluation of multisectoral response.)

Employers are asked to state whether they are currently implementing personnel policies and procedures that cover, as a minimum, all of the following aspects:

- Prevention of stigmatisation and discrimination on the basis of HIV infection status in staff recruitment and promotion and employment, sickness, and termination benefits.

- Workplace-based HIV/AIDS/STI prevention, control, and care programmes that cover: (a) the basic facts on HIV/AIDS/STI, specific work-related HIV transmission hazards and safeguards, condom promotion, VCT, STI diagnosis and treatment, and provision of HIV/AIDS-related drugs.

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

What does NATCOD need from this survey?

- Percentage of large enterprises/companies which have HIV/AIDS/STI workplace policies and programmes (UNGASS) (by type of enterprise (public sector / private sector))

Frequency

This survey will be undertaken in 2006 for the first time, and thereafter every 2 years.

Responsibility

The responsibility for carrying out the survey will rest with the Eritrea Central Statistics Office, who will closely involve the Ministry of Labour.
Prepares TOR for Workplace Survey in collaboration with Ministry of Labour

Identify 5 public sector and 25 private sector employers

Submit names of employers to NACToD for approval

Conduct survey

Prepares report

Disseminate report to stakeholders

Inform Statistics Office to select alternative employers

Are the employers selected in order?

NO

YES

Inform Statistics Office to proceed

Include relevant information in the annual HIV/AIDS/STI M&E report

Capture indicator scores in CRIS database
4.7 HIV/ AIDS/ STI PROGRAMME MONITORING DATA

Description

For indicators that will be measured using routine programme outputs, all entities implementing activities within that programme will carefully monitor their outputs. The extent of activities that have been implemented will then be recorded by these implementers on a quarterly basis and sent to NATCoD using the HIV/AIDS/STI Programme Monitoring Form.

The HIV/AIDS/STI Programme Monitoring Form is used by all stakeholders – those in the health sector and those outside the health sector – to record specific HIV/AIDS/STI information. The principle of reporting is that every IMPLEMENTER of HIV/AIDS/STI interventions should complete one HIV/AIDS/STI Programme Monitoring Form every quarter for every zoba where they have worked in that quarter. Annexure A contains the HIV/AIDS/STI Programme Monitoring Form template.

In addition to receiving data from HIV/AIDS/STI implementers, NATCoD also needs to ensure the validity of HIV/AIDS/STI data. Such validation will be done through an annual Data Reliability Survey, to be commissioned by NATCoD.

What does NATCoD need from this survey?

- Number of zobas with multi-sectoral HIV/AIDS task forces that have a work plan and budget for HIV/AIDS/STIs and that have met at least four times during the past year with a minimum attendance of 70%, in the last 12 months
- Number of government ministries with HIV/AIDS/STI work plans and budgets in the last 12 months, by government sector
- Number of employees that have participated in or benefited from HIV/AIDS workplace programmes in the last 12 months
- Number of trained and active peer and community educators in the last 12 months, by zoba
- Number of IEC materials printed and distributed in the last 12 months, by type of material
- Number of in-school youth and out-of-school youth that have participated in an HIV/AIDS/STI prevention programme in the last 12 months, by in-school or out-of-school youth and by zoba
- Number of young people that have accessed reproductive health services (family planning, STI diagnosis, and HIV testing) in the last 12 months, by type of service and by zoba
- Number of sex workers and military personnel participating in HIV/AIDS/STI prevention programmes in the last 12 months, by type of participant and by zoba
- Number of person-days of training that project staff and employees have undergone to manage and implement HIV/AIDS/STI services in the last 12 months, by type of personnel
- Number of persons reporting symptoms of STIs in the last 12 months who sought care at a service provider with personnel trained in STI care, by zoba and by sex
- Number of the general population receiving an HIV test, the results, and post-test counselling in the last 12 months, by zoba and by sex
National HIV/AIDS/STI Monitoring and Evaluation Plan

- Number of persons who are active members of VCT post-test clubs in the last 12 months, by zoba and by sex
- Number of orphans and vulnerable children whose households received, free of user charges, basic external support in caring for the child, by zoba
- Number of adults aged 18 – 59 who have been chronically ill for 3 or more months in the past 12 months whose households received, free of user charges, basic external support (Basic external support can be in the areas of health, psychosocial, emotional, or other social and material support) in caring for chronically ill adults
- Number of persons who are active members of VCT post-test clubs in the last 12 months, by zoba and by sex
- Percentage of HIV-infected pregnant women who are provided with a complete course of ARV prophylaxis to reduce the risk of MTCT\(^{13}\) in the last 12 months, by type of facility
- Number of registered TB patients who are tested for HIV, after giving consent in the last 12 months, by sex
- Number of newly diagnosed HIV positive clients who are given treatment of latent TB infection (TB preventive therapy) in the last 12 months, by sex
- Percentage of persons with advanced HIV infection receiving ARV combination therapy in the last 12 months, by age (UNGASS)
- Percentage of people still alive at 6, 12, and 24 months after initiation of ARV combination therapy
- Number of vulnerable groups that have received basic external support\(^7\) (free of user charges) in the last 12 months, by zoba and by type of vulnerable group
- Cumulative number of organisations\(^{14}\) that have been registered in the last 12 months to provide basic external support\(^7\) (free of user charges) for PLHAs and their families, by type of organisation
- Percentage of implementers of HIV/AIDS interventions that have submitted HIV/AIDS/STI Programme Monitoring Forms that are correctly and comprehensively completed on time in the last 12 months, by type of implementer and by zoba
- Percentage of implementers of HIV/AIDS interventions who report that they have participated in at least two zoba-level HIV/AIDS/STI data dissemination workshops in the last 12 months, by type of implementer and by zoba

**Frequency**

The HIV/AIDS/STI Programme Monitoring forms need to be completed once a quarter and sent to the NATCoD.

**Responsibility**

Implementers of HIV interventions are responsible for completing the forms and sending them on time and correctly completed to the NATCoD.

\(^{13}\) Indicator score = \(\frac{C}{(A*B)}\), where:

\(A\) = Total number of births (Statistics Office)

\(B\) = HIV prevalence estimate (ANC Sentinel Surveillance Report)

\(C\) = Number of pregnant women who received ARV prophylaxis

\(^{14}\) This includes faith based organisations, community-based organisations, and non-governmental organisations
Appoint/nominate a person to be responsible for completing the HIV/AIDS/STI programme monitoring form

Prepares HIV/AIDS/STI Programme Monitoring Form

Send the HIV/AIDS/STI Programme Monitoring Form to NACToD, with a copy to the funder of the implementer

HIV IMPLEMENTERS

Records the names of HIV implementers that have submitted HIV/AIDS/STI Programme Monitoring Forms

Verify completeness of HIV/AIDS/STI Programme Monitoring Forms

Capture data on CRIS software

Prepares Quarterly Service Coverage Report

Disseminates Quarterly Service Coverage Report

Sends QSCR back to zoba for dissemination

Organises quarterly HIV and AIDS feedback workshop in zoba

Capture indicator scores in CRIS database

Send an electronic copy of indicator scores to CSO

NACToD

Data flow diagram
4.8 GOVERNMENT FINANCIAL DATA

Description

Information regarding expenditure on HIV/AIDS/STI is required from the Government of Eritrea, so that UNGASS reporting purposes may be met. The data should be supplied by the Treasury Department, and should detail all government expenditure (not budgets) on HIV, AIDS, and STIs by all government Ministries. In order to report this data, the government’s annual accounting and budgeting process needs to have separate line items for HIV/AIDS expenditure, to enable resource tracking.

What does NATCoD need from this survey?

- Amount and proportion of national funds spent by governments on HIV/AIDS/STI interventions (UNGASS), by government sector

Frequency

This data is required on an annual basis.

Responsibility

The Ministry of Finance will be responsible for collecting this data from all government ministries, and for supplying it to NATCoD in the required format when it is needed.

Data flow diagram

Data flow will simply consist of NATCoD contacting the Ministry of Finance (Treasury Department), requesting the data, and then the Ministry of Finance supplying the data in the necessary format.

4.9 DATA FROM MINISTRY OF HEALTH

Description

In addition to the quantitative data that needs to be reported using the HIV/AIDS/STI Programme Monitoring Form,

What does NATCoD need from this survey?

- Amount and proportion of national funds spent by governments on HIV/AIDS/STI interventions (UNGASS), by government sector

Frequency

This data is required on an annual basis, before the annual HIV/AIDS/STI report is prepared.

Responsibility

The Ministry of Finance will be responsible for collecting this data from all government ministries, and for supplying it to NATCoD in the required format when it is needed.
4.10 DATA FROM THE NATIONAL BLOOD TRANSFUSION SERVICE

Description

HIV is not only transmitted sexually, but can also be transmitted through blood-to-blood contact. For this reason, it is paramount that the country’s blood transfusion service tests all blood that is donated for transfusion, before it is used. For this reason, an indicator on the percentage of blood units that are screened for HIV prior to transfusion has been included in the national set of HIV/AIDS indicators.

What does NATCoD need from this survey?

- Percentage of blood units transfused in the last 12 months that have been adequately screened for HIV according to national or WHO guidelines, by blood screening facility

Frequency

This data is required on an annual basis.

Responsibility

The National Blood Transfusion Service will be responsible for keeping data on blood transfusions on an ongoing basis, and for

Data flow diagram

Data flow will simply consist of NATCoD’s Director contacting the National Blood Transfusion Service, requesting the data, and then the National Blood Transfusion Service supplying the data in the necessary format.
5 INFORMATION PRODUCTS

NATCoD is responsible for the compilation, management and dissemination of all data collected through the national HIV/AIDS/STI M&E system. NATCoD will use the data that it collects through the various data sources defined in Chapter 5 to produce a number of information products. An information product is a regular and routine report that communicates the progress made with the achievement of the objectives of the National HIV/AIDS Strategic Plan. Information products may report on the national output indicators only, or it may report on all the indicators in the national HIV/AIDS M&E Framework. This Chapter will describe the processes involved in producing the following information products:

- Quarterly Service Coverage Report
- Annual HIV/AIDS/STI M&E Report
- Annual Newsletter
- UNGASS Report
- Periodic Information Systems Updates
- Ad hoc Information Requests

5.1 QUARTERLY SERVICE COVERAGE REPORT (QSCR)

NATCoD will produce a Quarterly Service Coverage Report (QSCR). This report will provide information on HIV service coverage in selected areas, and will be based on the information provided by implementers of HIV interventions.

5.1.1 Purpose of Report

The purpose of this report is to provide a quick overview of service coverage in the last quarter to better inform implementers and funders of interventions of where gaps are and how to maximise resource utilisation.

5.1.2 Data Sources for Report

The main and only data source for this report is the data collected through the HIV/AIDS/STI Programme Monitoring Form.

5.1.3 Data Analysis

Once NATCoD has captured the data, it will compile a Quarterly Service Coverage Report, using descriptive statistics. The Quarterly Service Coverage Report will be primarily in tabular format, and will contain indicator scores for the previous year, the cumulative total to date for the current year, and the scores for the quarter that is being reported on. Trend analyses will also be carried out, where applicable.

5.1.4 Report Format

The format of this report will be based on the structure of the HIV/AIDS.STI Programme Monitoring Form. It will contain an introduction by the Head of NATCoD, all indicator scores, and end with observations and conclusions from the research statistics.
5.1.5 Report Compilation

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

5.1.6 Report Approval

To ensure a fast turnaround time, the following approval channels will be followed:

```
NACToD compiles QSCR

<table>
<thead>
<tr>
<th>Submits to DG: Health Services for approval</th>
</tr>
</thead>
<tbody>
<tr>
<td>NACToD makes changes to the report</td>
</tr>
</tbody>
</table>

DG Health Services: Is the report in order?

<table>
<thead>
<tr>
<th>YES</th>
</tr>
</thead>
<tbody>
<tr>
<td>NACToD sends report for reproduction</td>
</tr>
<tr>
<td>NACToD disseminates QSCR</td>
</tr>
</tbody>
</table>

| NO |

November 2005

5.2 ANNUAL HIV/ AIDS/ STI M&E REPORT

5.2.1 Purpose of Report

The purpose of this report is to provide a comprehensive overview of Eritrea's response to HIV. The report will contain data on the entire set of HIV/AIDS/STI indicators; it will also provide observations, conclusions and recommendations for future implementation. This report will be procedurally linked to NATCoD’s annual work planning and budgeting process to ensure that it provides a platform for the data contained in it to be used for decision-making.

5.2.2 Data Sources for Report

The data sources for this report are all data sources mentioned in Chapter 5 of this Framework. Should new and improved data sources become available, NATCoD may also wish to supplement this report with additional data sources.

5.2.3 Data Analysis

Data analysis will be carried out by determining the correct denominator and numerator values for each indicator – as defined in the indicator set accompanying this Framework. All output-level data should be for the last calendar year (January – December), as this is the report’s reporting period. This also implies that data for all the output-level indicators should
cover the time period - “the last 12 months”. The reporting period covered in the report will facilitate the report results being used for decision-making. This is because the report will be available at the time when planning and budgeting for the following financial year (April to March, as per Government of Eritrea’s fiscal year) is done. The synchronisation of the M&E reporting period with the national work plan and budgeting cycle is visualised in Figure 7 below:

Figure 2: Synchronisation of M&E Cycle with Planning Cycle

This diagram implies that the M&E reporting year will be from January to December of Year 1. This will be the M&E report that will be used to plan for the fiscal year that starts from April of Year 2 to March of Year 3. Similarly, the M&E report for the period January to December of Year 2 will be used for the fiscal year planning from April of Year 3 to March of Year 4.

5.2.4 Report Format

The format of this report will be based on the information needs of NATCoD and its stakeholders. NATCoD will maintain this standard format to enable trend analyses. It should be noted that this report would report on the indicator scores for the entire set of national HIV indicators, irrespective of whether the indicator scores have changed for that particular year.

5.2.5 Report Compilation

This report will be compiled on an annual basis by NATCoD. The person in NATCoD who will be responsible for this report is NATCoD M&E Officer, with key support from the Data Manager and SHAPMoS Manager. The report will be compiled during January and each year, and will be ready by the first of February every year. This will be in time for the HIV/AIDS/STI M&E Report Dissemination Conference in February of the same year, and before annual work planning for the next year is concluded.

5.2.6 Report Approval

The following approval process will be followed prior to publication of the report:
5.3 **ANNUAL NATCoD NEWSLETTER**

**5.3.1 Purpose of Newsletter**

The annual HIV/AIDS/STI report will be technical and not easily understood by grassroots level stakeholders. To ensure the widest possible dissemination and use of data contained in the report, NATCoD will develop an annual newsletter that summarises all relevant information on HIV/AIDS/STI report of that year. The target audience of the newsletter is, in the first place, the different partners and stakeholders in the fight against HIV/AIDS/STI. The newsletter will be written and presented in a manner that it is easily understood by a non-technical audience, and pleasant to read.

**5.3.2 Data Sources for Newsletter**

The only data source for the annual newsletter will be the annual HIV/AIDS/STI M&E report
5.3.3 Data Analysis

Since the newsletter will be a summary of the annual HIV/AIDS/STI M&E report, data analysis is not required.

5.3.4 Newsletter Format

It will be brief and ideally should not exceed 8 pages, and the content may range from the presentation of key results and conclusions from relevant surveys, all presented in an understandable and accessible way. To ensure its widest possible use, it will be translated into the vernacular.

5.3.5 Newsletter Compilation

The newsletter will be compiled after the annual HIV/AIDS/STI report has been approved, and the NATCoD team will prepare it.

5.3.6 Newsletter Approval

Since the newsletter will be based on the approved version of the annual HIV/AIDS/STI report, extensive approval processes are not required. The same approval process as that which is followed for the QSCR – see section 6.1.6.

5.4 UNGASS Report

Eritrea is a signatory to the 2001 Declaration of Commitment on HIV/AIDS/STI at the United Nations Special Session on HIV/AIDS/STI (UNGASS). Part of this Declaration of Commitment includes a set of indicators that the Government of Eritrea has agreed to report to UNAIDS on a periodic basis. All 12 UNGASS indicators have been included in the national HIV/AIDS/STI set of indicators (see Chapter 4, pages 14 to 25). This was done to ensure that the data collection and analysis for the UNGASS indicators form and integral part of the country's national HIV/AIDS/STI M&E processes.

5.4.1 Purpose of Report

The purpose of this report is to report to the UNAIDS on a periodic basis in terms of Eritrea's progress in the fight against AIDS, by reporting on 12 specific indicators in a manner defined in the UNAIDS Guidelines for the Construction of Core Indicators. Its purpose is also to report to the country as to the progress made in terms of these important indicators.

5.4.2 Data Sources for Report

The data sources for the 12 UNGASS indicators, as per the indicator table in chapter 4 and the UNAIDS Guidelines for the Construction of Core Indicators, are:

- Government of Eritrea data on expenditure on HIV/AIDS/STIs by the government
- National Composite Policy Index questionnaire
- School-based survey and education programme review
- Workplace survey
- Health facility survey
- PMTCT and ARV programme monitoring and estimates from MoH
- Population-based survey (Nationally representative behavioural or other survey)
- HIV sentinel surveillance at antenatal clinics
5.4.3 Data Analysis

Data analysis will be carried out as per the *UNAIDS Guidelines for the Construction of Core Indicators*. These guidelines provide the exact way in which the indicator data should be reported.

5.4.4 Report Format

UNAIDS UNGASS reporting guidelines will be followed in terms of the format of the report.

5.4.5 Report Compilation

This report will be compiled as per the schedule defined in Table 4:

<table>
<thead>
<tr>
<th>Year</th>
<th>National commitment and action</th>
<th>National programme and behaviour</th>
<th>Impact</th>
</tr>
</thead>
<tbody>
<tr>
<td>2006</td>
<td>UNGASS Indicators # 1 – 2</td>
<td>UNGASS Indicators # 1 – 8</td>
<td>UNGASS Indicators # 1 -2</td>
</tr>
<tr>
<td>2009</td>
<td>UNGASS Indicators # 1 – 2</td>
<td>UNGASS Indicators # 1 – 6</td>
<td>UNGASS Indicators # 1 -2</td>
</tr>
<tr>
<td>2012</td>
<td>UNGASS Indicators # 1 – 2</td>
<td>UNGASS Indicators # 1 – 6</td>
<td>UNGASS Indicators # 1 -2</td>
</tr>
</tbody>
</table>

NATCoD is responsible for compiling the UNGASS report, with technical support from the UN Theme Group on HIV/AIDS.

5.4.6 Report Approval

The following approval process will be followed prior to publication of the report:
5.5 REGULAR INFORMATION SYSTEM UPDATES

All information products produced by NATCoD will be available on NATCoD’s website for electronic download (in PDF or MS Word format). This will ensure that HIV/AIDS/STI stakeholders will be able to access up-to-date information. All HIV indicator data will be updated as and when new data becomes available in NATCoD database.

5.6 AD-HOC INFORMATION NEEDS

In addition to the specific information products listed above, some stakeholders might have specific information needs at some stage. Although NATCoD encourages the use of existing information
products, it will assist if there are any specific and ad hoc information needs that are not covered in one of the above information products.

Such a request should be made in writing to NATCoD, who will consider it. If possible, the request will be accommodated within the budget limitations of NATCoD. If it is not possible, the person/institution will be informed of the cost implications before the request is processed.

Whether or not there are cost implications for NATCoD to provide the ad hoc information need, NATCoD will respond in writing to the request for ad hoc information within 5 working days of receiving such a request. The response from NATCoD will include:

1. An acknowledgement that the request has been received
2. Confirmation of whether NATCoD has the data/skills to provide the information that has been requested
3. A statement of whether NATCoD is able to provide the information that is requested, the time frame involved for preparing the information
4. The name of the contact person at NATCoD who will handle this information request and submit the necessary information
6 Dissemination to Stakeholders

NATCoD will ensure proper dissemination of the critical information to all stakeholders and to the general public. This will be done by using a combination of methods, including:

6.1 Emailing of Reports

Reports will be emailed in PDF format and will be sent out to stakeholders that have access to email. NATCoD will fund the emails through its office operating costs;

6.2 Annual HIV/AIDS/STI M&E Dissemination Conference

On an annual basis, NATCoD M&E Unit will fund organise a national HIV/AIDS/STI M&E Dissemination Workshop where progress in the national fight against HIV/AIDS/STI will be discussed with all stakeholders. All stakeholders from the public sector, private sector and civil society will be invited to attend. NATCoD will present the values for the national set of HIV/AIDS/STI indicators. The results of any operational research relevant to the fight against HIV/AIDS/STI that was conducted during the year will be presented as well. The annual meeting will form a basis for refining the national response and reviewing strategies and programmes.

6.3 Quarterly Feedback Workshops at Zobas

On a quarterly basis, NATCoD will fund and organise six zoba-level workshops with all HIV/AIDS/STI stakeholders and beneficiary groups in the zoba. The purpose of this workshop will be to disseminate results of the previous quarter and plan for the next quarter. The NATCoD Newsletter and QSCR will be disseminated at and used as a basis for discussion during these workshops.

6.4 Feedback Workshops by HIV Coordination Bodies

HIV Coordination Bodies (see Table 1) may choose to host their own workshops to communicate the results of efforts. These would be funded and initiated by the different HIV coordination bodies in Eritrea. NATCoD may be involved in, informed of, and invited to these workshops.

6.5 Use of Other Feedback Mechanisms

NATCoD may also make use of other, less-known dissemination techniques, such as feature stories in the newspapers or community drama to communicate the progress made in responding to HIV/AIDS/STIs.

6.6 Dissemination through the Media

NATCoD will also ensure that critical information is disseminated to the general public through the media. Such information will be disseminated through press coverage, but also through paid airtime/copy-space such as newspaper spreads and advertisements on radio. They have to be clear and simple and reserved to news items that are relevant enough for the entire community.
6.7 NATIONAL INFORMATION AND DOCUMENTATION CENTRE

It is of utmost importance that the results and conclusions of the evaluations, surveys and operational research conducted remain available for all stakeholders and interested partners. For this reason, NATCoD will create in its premises a national HIV/AIDS/STI information and documentation centre.

The documents to be collected in this centre include:

- Copies of progress reports by NATCoD, and copies of any relevant progress or evaluation reports of HIV/AIDS/STI projects by other donor agencies, NGO or others in Eritrea.
- Copies of reports of all the surveys and research conducted in the domain of HIV/AIDS/STI, or related areas such as reproductive health, in Eritrea.
- Copies of the periodic newsletter and other newsletters and printed media relevant to the national HIV/AIDS/STI programme.
- Copies of relevant HIV/AIDS/STI materials and tools developed in Eritrea, such as educational materials, training manuals, guidelines, etc.
- Relevant background information on HIV/AIDS/STI.

NATCoD will be responsible for the collection, presentation and renewal of the documents.

6.8 WEBSITE

In addition to paper copies being available at the information and documentation centre, NATCoD will create a database of electronic copies of all relevant documents and datasets. Electronic copies will be accessible through the NATCoD website.

6.9 SUMMARY OF DISSEMINATION CHANNELS TO STAKEHOLDERS

Table 5 overleaf summarises the dissemination channels for different stakeholders:
### Table 5: Dissemination Channels for Stakeholders

<table>
<thead>
<tr>
<th>HIV stakeholder</th>
<th>INFORMATION PRODUCTS</th>
<th>DATA SOURCES</th>
</tr>
</thead>
<tbody>
<tr>
<td>CBOs, FBOs and NGOs</td>
<td>Quarterly HIV/AIDS/STI feedback workshop Email</td>
<td>Paper copies</td>
</tr>
<tr>
<td></td>
<td>Annual M&amp;E Dissemination Workshop Email</td>
<td>Quarterly HIV/AIDS/STI feedback workshop Media</td>
</tr>
<tr>
<td></td>
<td>Paper copies</td>
<td>Paper Copies</td>
</tr>
<tr>
<td></td>
<td>Quarterly HIV/AIDS/STI feedback workshop Posted copies</td>
<td>Paper Copies</td>
</tr>
<tr>
<td></td>
<td>Quarterly HIV/AIDS/STI feedback workshop Media</td>
<td>Paper Copies</td>
</tr>
<tr>
<td>Public Sector</td>
<td>Email</td>
<td>Paper copies</td>
</tr>
<tr>
<td>(all government ministries)</td>
<td>Annual M&amp;E Dissemination Workshop Email</td>
<td>Quarterly HIV/AIDS/STI feedback workshop Media</td>
</tr>
<tr>
<td></td>
<td>Email</td>
<td>Paper Copies</td>
</tr>
<tr>
<td></td>
<td>Quarterly HIV/AIDS/STI feedback workshop Posted copies</td>
<td>Paper Copies</td>
</tr>
<tr>
<td>Private sector</td>
<td>Email</td>
<td>Paper copies</td>
</tr>
<tr>
<td></td>
<td>Quarterly HIV/AIDS/STI feedback workshop Email</td>
<td>Quarterly HIV/AIDS/STI feedback workshop Media</td>
</tr>
<tr>
<td></td>
<td>Email</td>
<td>Paper Copies</td>
</tr>
<tr>
<td></td>
<td>Quarterly HIV/AIDS/STI feedback workshop Posted copies</td>
<td>Paper Copies</td>
</tr>
<tr>
<td></td>
<td>Quarterly HIV/AIDS/STI feedback workshop Media</td>
<td>Paper Copies</td>
</tr>
<tr>
<td>HIV/AIDS Coordinating Bodies</td>
<td>Email</td>
<td>Paper copies</td>
</tr>
<tr>
<td></td>
<td>Quarterly HIV/AIDS/STI feedback workshop Email</td>
<td>Quarterly HIV/AIDS/STI feedback workshop Media</td>
</tr>
<tr>
<td></td>
<td>Email</td>
<td>Paper Copies</td>
</tr>
<tr>
<td></td>
<td>Quarterly HIV/AIDS/STI feedback workshop Posted copies</td>
<td>Paper Copies</td>
</tr>
<tr>
<td></td>
<td>Quarterly HIV/AIDS/STI feedback workshop Media</td>
<td>Paper Copies</td>
</tr>
<tr>
<td>Zoba governors</td>
<td>Quarterly HIV/AIDS/STI feedback workshop Email</td>
<td>Quarterly HIV/AIDS/STI feedback workshop Media</td>
</tr>
<tr>
<td></td>
<td>Email</td>
<td>Paper Copies</td>
</tr>
<tr>
<td></td>
<td>Quarterly HIV/AIDS/STI feedback workshop Posted copies</td>
<td>Paper Copies</td>
</tr>
<tr>
<td></td>
<td>Quarterly HIV/AIDS/STI feedback workshop Media</td>
<td>Paper Copies</td>
</tr>
</tbody>
</table>
7 MANAGEMENT OF THE NATIONAL HIV/ AIDS/ STI M&E SYSTEM

7.1 ROLES OF STAKEHOLDERS IN THE HIV/ AIDS/ STI M&E SYSTEM

7.1.1 NATCoD

It is in the mandate of NATCoD to coordinate the monitoring and evaluation of all HIV/AIDS/STI interventions in the country. As such, NATCoD plays a leading role in developing the national HIV/AIDS/STI M&E Framework and in ensuring proper data collection, management and dissemination. NATCoD also compiles all the data that have been collected by its partners, analyse it and disseminate the critical results as described in Chapter 7. NATCoD will primarily coordinate the data collection efforts of others, by providing them with assistance to develop their own M&E strategies, systems and tools, and with capacity building where needed. Within NATCoD, the responsibility of coordinating M&E has been delegated to {insert name of post}.

Figure 3: NATCoD Organisational Structure

7.1.2 Other Units in MoH

Other units in NATCoD also have a role to play in implementing the national response to HIV and AIDS. The Research and Human Resources Development Directorate would need to support all capacity building efforts in the health sector, and support HIV/AIDS/STI research. On the other hand, the Regulatory Services Directorate should need to play a leading role in any HIV/AIDS/STI
regulatory matters. These Directorates would also be responsible for implementing their own workplace programmes, along with all other government departments.

### 7.1.3 Other Ministries

No ministries other than the MoH are currently playing a major role in the monitoring and evaluation of HIV/AIDS/STI activities. However, in the multi-sectoral approach some of the ministries will play a larger role in the future.

- The *Ministry of Education* (MOE) will play a major role in the monitoring and evaluating all school-based programmes.

- The *Ministry of Labour* will coordinate the public sector response and all HIV/AIDS/STI workplace programmes in the public sector. It will therefore play a leading role in the M&E of these programmes.

- The *Ministry of Agriculture* will play a leading role in food security programmes for OVC and households affected by HIV/AIDS/STI.

- All other Ministries have a role to play in terms of monitoring the workplace programmes that they implement, and reporting these results to NATCoD.

### 7.1.4 The National M&E TWG

The National M&E TWG’s task is to assist in the coordination of all HIV/AIDS/STI M&E activities in the country. The M&E TWG is multisectoral and includes representatives from governmental departments, non-governmental organisations, the private sector, donor agencies, UN agencies, academic institutions and HIV coordinating bodies.

It consists of M&E specialists and/or representatives from relevant government departments, research institutions, donor agencies, NGOs, and representatives from all national coordinating bodies. The committee is chaired by one of its members on a rotation basis and meets quarterly. It plays a leading role in assisting NATCoD with the development of national M&E strategies, systems and tools, with developing M&E capacity among partners, and with the dissemination of results. Please refer to [Annexure B](#) for the M&E TWG’s Terms of Reference.

### 7.1.5 Survey Committees

Chapter 5 identified those survey committees will be created to coordinate the major surveys that will be undertaken. There will be an HIV Surveillance Survey Committee (chaired by NATCoD’s Epidemiology and Monitoring Unit), a Population-based Survey Committee (chaired by the Eritrea Central Statistics Office), and a Health Facility Survey Committee (chaired by NATCoD).

Broadly, the role of these Survey Committees will be to develop Terms of Reference for the surveys, to approve the survey protocol, to oversee the appointment of a survey team, to refer the surveys for ethical approval, to coordinate the survey, and to manage the dissemination of survey results.

### 7.1.6 Civil Society Organisations

The civil society organisations play a crucial role in the response to the HIV/AIDS epidemic and STIs in Eritrea. They are not only important programme implementers, but also play a role in the coordination of several HIV/AIDS/STI programmes at the national level. These organisations will therefore play an important role in the monitoring and evaluation of the national HIV/AIDS/STI response by correctly monitoring and evaluating the activities they implement, through their participation in the M&E committee, by providing technical assistance in some areas and by conducting part of the necessary surveys.
7.1.7 The Private Sector

The private sector is another important player in the national response against the epidemic. It provides a large part of the clinical care for HIV/AIDS/STIs, and it has a responsibility in the provision of adequate HIV prevention and care services for their workforce through the implementation of HIV/AIDS/STI workplace programmes. The role of the private sector in the national M&E framework lies mainly in a correct monitoring and reporting of their activities, but can also include assistance in the development of monitoring systems for specific programme areas, such as clinical care.

7.1.8 Donor/UN Agencies

Many of the international agencies that are present in Eritrea play an important role in the monitoring and evaluation of HIV/AIDS/STI interventions. They comprise, among others, UNAIDS that has a mandate to coordinate all HIV/AIDS/STI activities supported by the UN agencies and that is a direct partner of NATCoD; UNICEF and UNFPA that play a leading role in HIV/AIDS/STI activities with children, youth and women; UNDP; USAID; UNAIDS; and the Italian Cooperation that are all funding and/or implementing HIV/AIDS/STI activities in the country and that are important sources of expertise and funding for M&E.

7.2 WORK PLANS AND BUDGETS FOR M&E

NATCoD is responsible for coordinating the implementation of the national HIV/AIDS/STI M&E Framework. To do this, NATCoD and the M&E TWG will develop a national HIV/AIDS/STI M&E Road Map every year.

This Road Map is a national, integrated action plan for the operationalisation of Eritrea’s HIV/AIDS/STI M&E Framework. The National HIV/AIDS/STI Road Map is not NATCoD’s M&E work plan. It is a unified work plan and unified budget\(^\text{15}\) and its development involves firstly an assessment of where the national HIV/AIDS/STI M&E system is at a specific point in time, then determining a clear vision of where it needs to be in order to be fully functional, and finally, a list of activities that need to be implemented by NATCoD and all its partners to ensure that the vision is realised.

The benefit of such a unified work plan and budget is that it allows NATCoD, the Ministry of Health, development partners providing M&E support and technical assistance, other public sector institutions, the private sector companies, NGOs, CBOs and the faith based sector to all align their M&E processes (i.e. not just align M&E indicators, as is usually the case), and to collectively develop the national HIV/AIDS/STI M&E system in a way that is synchronized, integrated, and comprehensive.

NATCoD’s M&E unit will use the national HIV/AIDS/STI M&E Road Map to guide their activities and improve coordination of HIV/AIDS/STI M&E amongst HIV/AIDS/STI stakeholders in Eritrea. The M&E Road Map for the period October 2005 to December 2006 may be found in Annexure D.

NATCoD’s M&E team will prepare an annual M&E work plan when all the other units are preparing their work plans – the work plan will correspond to the relevant activities in the national HIV/AIDS/STI M&E Road Map. The team will also develop an annual M&E budget, which will include (but not be limited to) the following items:

- Communication
- Staff costs
- Supervision
- Quarterly Review meetings
- Workshops

\(^{15}\) Similar to the way in which UNAIDS and its co-sponsors prepare a Unified Budget and Work plan every year to guide the activities and expenditure of all co-sponsors and ensure unified, synchronised and integrated action
7.3 M&E SOFTWARE

The data collected on the national core indicators will be captured into UNAIDS software, referred to as Country Response Information System (CRIS). An information management protocol will be developed for CRIS, to ensure that its data are updated regularly, consistently and timeously. This protocol will define when CRIS will be updated, what it will be updated with, who will update it, who will have access to the data on it, who will be able to make changes to the data, and how the changes will be made. An appropriate version of CRIS should be used, to ensure that all HIV/AIDS/STI data are captured individually, and that report formats can be used centrally.

Implementers of HIV interventions will develop their own appropriate M&E software, based on their own data needs and software skills. All data can be submitted to NATCoD in either paper or electronic format, thereby not making it compulsory to have advanced software skills to report to NATCoD.

In future years, NATCoD may consider installing the CRIS software at sub-national level, as this will automate data capture and relieve the NATCoD’s data capture burden.

7.4 TECHNICAL SUPPORT FOR M&E

Although M&E for NATCoD will be managed internally, technical support may be required from time to time. Technical support in M&E may be provided through NATCoD funds, or externally through funds or support from other development partners. Should such support be required or offered, it will:

a) Be accompanied by a clear scope of work/terms of reference
b) Be in line with requirements set out in the national HIV/AIDS/STI M&E Road Map
c) Be combined with a local consultant, where possible, so that mentorship and capacity building takes place
d) Carry the approval of NATCoD Director
e) Ensure that a detailed report with recommendations and progress made with achievement of scope of work / terms of reference is provided to a technical review group, appointed by NATCoD and consisting of at least one NATCoD representative, one M&E TWG representative and a development partner representative (this last person could “attend” via email-based discussions, if the person is not in the country when such review is required)

7.5 NEED FOR CAPACITY BUILDING

The National M&E Framework for HIV/AIDS/STI relies on the existence of proper M&E strategies, systems and tools for each of the HIV/AIDS/STI programme areas and on the capacity of the implementing entities to correctly monitor and evaluate their activities. An M&E capacity assessment is needed, so that the need for M&E capacity may be assessed. Once the assessment is completed, M&E capacity needs may include (but not be limited to):
• The further development of the capacity at NATCoD to coordinate the M&E of all HIV/AIDS/STI capacities at a national and zoba level
• The further development of M&E capacity among national and regional programme coordinators
• Development of M&E capacity among implementing partners such as government ministries, NGOs, CBOs, FBOs and the private sector

Capacity building should include (1) training of programme management staff in basic concepts around M&E, (2) technical assistance for the development of M&E strategies, systems and tools, (3) financial support for M&E, and (4) practical focus to M&E – how to develop data registers, how to use basic software, and all the other “mechanical aspects’.

7.6 ADVOCACY AND COMMUNICATIONS FOR HIV/AIDS/STI M&E

Communication and advocacy for HIV/AIDS/STI M&E will keep the nation informed of developments and promote data use. For this reason, a Communications Plan for the national HIV/AIDS/STI M&E Framework needs to be developed, costed and included in the M&E Road Map. Such a communications plan should focus on how the NATCoD plans to advocate for HIV/AIDS/STI reporting to NATCoD, and communicate general information about the national HIV/AIDS/STI M&E system.

7.7 REVIEW OF THIS HIV/AIDS/STI M&E FRAMEWORK

HIV/AIDS is dynamic: the epidemic itself and the response to it. This implies that reviews of this M&E Framework may be required from time to time. However, this need for revision of the Framework needs to be balanced with the need to maintain a solid core set of data to enable trend analyses over time. To strike a balance between these two competing priorities, the National HIV/AIDS/STI M&E Framework will be reviewed as follows:

a) The overall M&E Framework, including the actual indicators, should be reviewed within 15 days of the annual review of the HIV/AIDS/STI National Strategic Plan, or within 30 days of the development of a new HIV/AIDS/STI National Strategic Plan;

b) The data sources for the indicators, as defined in Chapter 5, may be revised, if improved data sources (i.e. more accurate or more timely data sources) become available;

c) Should new information products be required, these may be added to the current list of information products. However, the information products defined in this Framework should remain NATCoD’s minimum commitment for communicating the results of HIV/AIDS/STI M&E efforts to stakeholders;

d) The M&E work plan and operational budget (i.e. M&E Road Map) maybe adjusted annually when the NATCoD work plan and budget for the next fiscal year is prepared; and

e) Should the NSP not be reviewed within the next 2 years, this M&E Framework should be reviewed in 2008.
Bibliography


Annexure A

HIV/ AIDS/ STI PROGRAMME MONITORING FORM
INSTRUCTIONS FOR FILLING OUT THE PROGRAMME MONITORING FORM

1. The purpose of this form is to record information about HIV/AIDS/STI activities that your organisation has undertaken in a specific 3-month period.

2. Activities should be reported on a quarterly basis. The latest submission date is the 15th of the quarter following the end of the quarter. The ends of the quarters are March 31, June 30, September 30 and December 31 so reports are due on these dates:
   - Report for Quarter 1, due on 15 April
   - Report for Quarter 2, due on 15 July
   - Report for Quarter 3, due on 15 October
   - Report for Quarter 4, due on 15 January of the following year

3. Please report only on those activities that your organisation are conducting or coordinating, irrespective of the funding source.

4. You may complete this form by hand, and then fax it to its appropriate destination, or you may request an electronic copy of this form, and then complete the form electronically, print it out and fax it, or email it to its appropriate destination.

5. For each of the activities that your organisation has conducted, fill out the total number of outputs realised in the appropriate column.

6. Disaggregate the data as indicated in the form. If disaggregated data is NOT available, simply fill out the TOTAL column. Unless otherwise specified, the following standard categories have been used for disaggregating data:
   - **Age:** 15 – 19 years; 20 – 24 years; 25 – 49 years
   - **Sex:** Male; Female
   - **Location:** Urban; Rural

7. The definition for rural and urban: The definition of the Central Statistics Office (NSO) of Eritrea is used to define what is meant by RURAL and URBAN.
   - URBAN is defined as any geographic area (or persons or households within that geographic area) that fall within the boundaries of the towns that are under the auspices of AMICAALL.
   - RURAL is defined as any geographic area (or person or households with that geographic area) that falls under the management of the regional councils.

8. Once you have completed the form, please make a copy of the form to keep at your organisation. Sign it, and send the original to NATCoD.

9. In case of doubt where to report your activities or any queries about the completion of this form, please contact the following person:

<table>
<thead>
<tr>
<th>Name and Designation of Person</th>
<th>Author note: to be completed by NATCoD</th>
</tr>
</thead>
<tbody>
<tr>
<td>Telephone and Fax Numbers</td>
<td>Author note: to be completed by NATCoD</td>
</tr>
<tr>
<td>Postal Address</td>
<td>Author note: to be completed by NATCoD</td>
</tr>
<tr>
<td>Email Address</td>
<td>Author note: to be completed by NATCoD</td>
</tr>
</tbody>
</table>
### 1. Extent of HIV Activities in Government

This section should be completed only by each of the ZOBAs and each GOVERNMENT MINISTRY

**Report on Activities for this Quarter Only**

<table>
<thead>
<tr>
<th>Ques.</th>
<th>Yes</th>
<th>No</th>
<th>ZB</th>
</tr>
</thead>
<tbody>
<tr>
<td>1A: Does your zoba/government ministry have a multi-sectoral HIV/AIDS task force?</td>
<td></td>
<td></td>
<td>ZB1</td>
</tr>
<tr>
<td>1B: Does your zoba/government ministry have a work plan for the current financial year?</td>
<td></td>
<td></td>
<td>ZB2</td>
</tr>
<tr>
<td>1C: Is the work plan costed?</td>
<td></td>
<td></td>
<td>ZB3</td>
</tr>
<tr>
<td>1D: Has a budget been approved for the work plan?</td>
<td></td>
<td></td>
<td>ZB4</td>
</tr>
<tr>
<td>1E: Have funds been available this quarter to implement and coordinate HIV and AIDS activities?</td>
<td></td>
<td></td>
<td>ZB5</td>
</tr>
<tr>
<td>1F: How many times has the multi-sectoral HIV/AIDS task force met this quarter?</td>
<td></td>
<td></td>
<td>ZB6</td>
</tr>
</tbody>
</table>

#### What was the attendance at the meeting? Tick the appropriate option.
- Less than 50% of members attended
- Between 50 and 70% of members attended
- More than 70% of members attended

<table>
<thead>
<tr>
<th>Ques.</th>
<th>Attendance</th>
</tr>
</thead>
<tbody>
<tr>
<td>1G:</td>
<td></td>
</tr>
</tbody>
</table>

### 2. HIV/AIDS Workplace Programmes

This section should be completed by ALL implementers of HIV/AIDS interventions

**Report on Activities for this Quarter Only**

<table>
<thead>
<tr>
<th>Ques.</th>
<th>Yes</th>
<th>No</th>
<th>WP</th>
</tr>
</thead>
<tbody>
<tr>
<td>2A: Does your organisation have an HIV/AIDS workplace policy and/or programme?</td>
<td></td>
<td></td>
<td>WP1</td>
</tr>
<tr>
<td>2B: In the last 3 months, how many employees in your organisation has participated in or benefited from the workplace programme?</td>
<td></td>
<td></td>
<td>WP2</td>
</tr>
</tbody>
</table>
3. HIV/AIDS/STI PREVENTION PROGRAMMES

This section should be completed by ALL implementers of HIV/AIDS interventions

REPORT ON ACTIVITIES FOR THIS QUARTER ONLY

<table>
<thead>
<tr>
<th>Types of IEC materials</th>
<th>Number newly printed</th>
<th>Total number distributed</th>
</tr>
</thead>
<tbody>
<tr>
<td>Brochures &amp; booklets</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Posters</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Other (specify)</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

PLEASE NOTE THAT THE ORGANISATION THAT WAS RESPONSIBLE FOR THE DISTRIBUTION TO END USERS SHOULD REPORT ON DISTRIBUTION FIGURES

<table>
<thead>
<tr>
<th>IN-SCHOOL YOUTH (15 – 24)</th>
<th>OUT-OF-SCHOOL YOUTH (15 – 24)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Male</td>
<td>Female</td>
</tr>
</tbody>
</table>

3B: Number of young people who attended HIV/AIDS/STI prevention programmes (excluding reproductive health services) this quarter

3C: Number of sex workers, and military personnel that have participated in HIV/AIDS/STI prevention programmes this quarter

<table>
<thead>
<tr>
<th>Male</th>
<th>Female</th>
<th>TOTAL</th>
</tr>
</thead>
</table>

Other target groups, specify

3D: Number of trained peer/community educators active in your organisation this quarter

<table>
<thead>
<tr>
<th>Male</th>
<th>Female</th>
<th>TOTAL</th>
</tr>
</thead>
</table>

3E: Number of young people aged 15 – 24 who have accessed reproductive health services in this quarter

<table>
<thead>
<tr>
<th>Male</th>
<th>Female</th>
<th>TOTAL</th>
</tr>
</thead>
</table>

3F: The number of STI cases seen in this quarter

3G: Has your organisation implemented HIV/AIDS/STI prevention programme/s specifically for mobile populations this quarter?

YES | NO

3H: If YES to 3F, what has been the coverage this quarter (i.e. what is the estimated number of persons from mobile populations that have participated in such programmes this quarter)?

4. HIV/AIDS/STI TRAINING AND CAPACITY BUILDING

This section should be completed by ALL implementers of HIV/AIDS interventions

REPORT ON ACTIVITIES FOR THIS QUARTER ONLY

<table>
<thead>
<tr>
<th>TRAINING OF HEALTH PERSONNEL</th>
</tr>
</thead>
<tbody>
<tr>
<td>Male</td>
</tr>
</tbody>
</table>

AUTHOR NOTE: INSERT THE DIFFERENT TYPES OF HEALTH PERSONNEL in TC1 to TC5. TC 6 is for all non-health services training
5. HIV/AIDS/STI TREATMENT, CARE AND SUPPORT SERVICES
This section should be completed by ALL implementers of HIV/AIDS interventions
REPORT ON ACTIVITIES FOR THIS QUARTER ONLY

### TB PREVENTATIVE THERAPY

<table>
<thead>
<tr>
<th></th>
<th>Male</th>
<th>Female</th>
<th>TOTAL</th>
<th>CS1</th>
</tr>
</thead>
<tbody>
<tr>
<td>5A: Number of newly diagnosed HIV positive persons who have been given treatment for latent TB infection (TB preventative therapy) this quarter</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

### ARV THERAPY

<table>
<thead>
<tr>
<th></th>
<th>Aged younger than 20</th>
<th>Aged 20 and older</th>
<th>TOTAL</th>
<th>CS2</th>
<th>CS3</th>
<th>CS4</th>
</tr>
</thead>
<tbody>
<tr>
<td>5B: Cumulative number of persons with advanced HIV infection receiving ARV combination therapy (since the start of the ARV programme)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>5C: Number of persons receiving ARV combination therapy that have stopped with treatment this quarter</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>5D: Number of NEW persons that start on ARV combination therapy for the first time this quarter</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th></th>
<th>Alive after 6 months</th>
<th>Alive after 12 months</th>
<th>Alive after 24 months</th>
<th>CS5</th>
</tr>
</thead>
<tbody>
<tr>
<td>5E: Cumulative number of persons still alive at 6 months, 12 months and 24 months after starting ARV combination therapy</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th></th>
<th>YES</th>
<th>NO</th>
<th>CS6</th>
</tr>
</thead>
<tbody>
<tr>
<td>5F: Has your organisation registered with NATCoD to provide basic external support (free of user charges) to households with chronically ill persons or to OVC?</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

### PROVISION OF BASIC EXTERNAL SUPPORT

<table>
<thead>
<tr>
<th>TYPE OF BASIC EXTERNAL SUPPORT</th>
<th>OVC</th>
<th>ELDERLY</th>
<th>WIDOWS/ WIDOWERS</th>
<th>VULNERABLE HOUSEHOLDS</th>
<th>OTHER VULNERABLE GROUPS</th>
<th>CS7</th>
</tr>
</thead>
<tbody>
<tr>
<td>Health care and supplies</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Emotional and psychological support</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Other social support</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>School fees and school-related assistance</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

6. HIV/AIDS/STI MONITORING AND EVALUATION
This section should be completed by ALL implementers of HIV/AIDS interventions
REPORT ON ACTIVITIES FOR THIS QUARTER ONLY

| 6A: Did your organisation attend an HIV/AIDS/STI feedback or data dissemination workshop at zoba-level this quarter? | YES | NO | ME1 |

I verify that this information is complete and correct and that I have not misrepresented any information in this report.

Signed: __________________ Name: __________________ Position in Organisation: __________________ Date: ________________

FOR OFFICE USE

<table>
<thead>
<tr>
<th>Date form received</th>
<th>Verified by</th>
<th>Date captured</th>
<th>Date verified</th>
<th>Captured by</th>
<th>Date filed</th>
</tr>
</thead>
</table>

November 2005 59
<table>
<thead>
<tr>
<th>DATA ELEMENT</th>
<th>DEFINITION/S</th>
</tr>
</thead>
<tbody>
<tr>
<td>RD1</td>
<td>This is the 6 zobas, or administrative districts, into which Eritrea has been divided</td>
</tr>
<tr>
<td>RD2</td>
<td>This is the date that the HIV/AIDS/STI Programme Monitoring Form was completed (i.e. all relevant data on it have been filled in)</td>
</tr>
<tr>
<td>RD3</td>
<td>This is the quarter that is being reported on. A quarter is a 3 month consecutive period, and is defined in the form by specifying the month that the quarter started and the month that the quarter ended. (e.g. FROM January 2005 TO March 2005)</td>
</tr>
<tr>
<td>RD4</td>
<td>This is the name of the organisation that is completing the form (i.e. the implementer of the HIV/AIDS interventions that are being reported on in this HIV/AIDS/STI Programme Monitoring Form). It is NOT the name of the funder, or the name of the umbrella organisations. Organisation names should be written out, with the acronym after the name (e.g. Family Health International (FHI))</td>
</tr>
</tbody>
</table>
| RD5          | This is the type of organisation – there are three options:  
Civil society are all non governmental organisations, faith based organisations, and community based organisations  
Private sector are all listed or commercial business enterprises  
Government are all government ministries, parastatals and government trusts |
| RD6          | This is the registration code that the organisation would have been given (a unique identification number) had it registered with NATCoD. This is NOT the organisation’s business registration number, or any other number. If the organisation is not registered with NATCoD, please leave this line blank. |
| RD7          | This line requires information about who is funding the organisation. More than one option may be completed, as more than one funder can fund an organisation. The different funding categories mean:  
GoE – This is when the funding for the HIV/AIDS intervention comes from NATCoD or the Ministry of Health. All health facilities, for example, that implement HIV/AIDS/STI interventions receive funding from NATCoD, through the GoE’s annual budget  
Faith-based – This is when funding for the HIV/aids interventions comes from a local church, or an international church association. An example of this type of funding source, is the local Catholic church, or the Norwegian Church Aid  
Private sector – This is when funding for the activity comes from one or more private sector organisations. This funding may be given by a private sector organisation to another organisation to implementer HIV/AIDS interventions, or it may use such funding itself to fund workplace programmes.  
International – This is when the funding source is not from an in-country source, but from an international development agency or the like (e.g. UN, World Bank, USAID, etc.)  
Other – This is any other type of funding source, that do not form part of any of the first 4 categories that have already been described |
| RD8          | This is the first name and last name of the person that was responsible for completing the HIV/AIDS/STI Programme Monitoring Form. This may be the M&E officer or the person responsible for data collection in the organisation. |
| RD9          | This may be different to the name in RD8, or it may be the same. If NATCoD has a query about any of the contents of the report, they will contact the person listed here to find out more information. This person needs to be able to answer technical queries about the report itself. |
| ZB1          | This question should be completed by zobas and government ministries only  
This question asks the organisation to reflect on whether the zoba has a multi-sectoral HIV/AIDS task force. The existence of such a committee will be characterised by (a) a list of members; (b) an identified chairperson; (c) minutes of previous meetings that have been undertaken in the past year. It may also have a terms of reference or constitution, although this is not essential to acknowledge the existence of such a committee. |
| ZB2          | This question should be completed by zobas and government ministries only  
This question asks the organisation to report on whether they have a work plan for the current financial year. The existence of a work plan will be characterised by a written/typed document with a list of activities, time frames and assigned responsibilities in terms of HIV/AIDS/STIs for the current financial year. Such a document should be known to members of the multi-sectoral HIV/AIDS task force, and should be produced on request. |
| ZB3          | This question should be completed by zobas and government ministries only  
This question asks the organisation to reflect on whether the work plan is costed. A costed work plan would be one where the costs of each activity in the work plan has been calculated and documented with the work plan, irrespective of whether or not the costs were approved. |
<table>
<thead>
<tr>
<th>DATA ELEMENT</th>
<th>DEFINITION/S</th>
</tr>
</thead>
</table>
| ZB4          | This question should be completed by zobas and government ministries only  
This question asks the organisation to reflect on whether the costs associated with the work plan have been approved and included in the budget of the organisation. |
| ZB5          | This question should be completed by zobas and government ministries only  
This question asks the organisation to reflect on whether the allocated funds (i.e. funds committed in the budget) were available and were used to implement those activities defined in the work plan, in the quarter being reported on. |
| ZB6          | This question should be completed by zobas and government ministries only  
This question should be answered by counting the number of times that the zoba's multisectoral HIV/AIDS task force held a meeting in the quarter being reported on. A meeting is defined as an organised gathering of members of the multi-sectoral HIV/AIDS task force, where members of the task force were invited to the meeting, where an attendance register and minutes were taken, and where the chairperson (of his/her designated representative) managed all meeting procedures in an appropriate and professional manner. A meeting is not an impromptu, informal or unplanned gathering of some members of the multi-sectoral HIV/AIDS task force. |
| ZB7          | This question should be completed by zobas and government ministries only  
This requires the zoba to calculate the percentage of members of the multisectoral HIV/AIDS task force that attended meeting/s during the quarter.  
The numerator for the calculation of the percentage is the number of persons that attended the meeting. This data can be obtained from the meeting attendance register.  
The denominator of the calculation is the number of members of the multisectoral HIV/AIDS task force. This data can be obtained by counting the number of persons on the task force's membership list.  
The percentage is calculated by dividing the number of persons who attended the meeting (numerator), by the number of persons who are members of the task force (denominator), and multiplying the result by 100.  
After calculating the percentage of members that attended the meeting, tick the appropriate box, depending on what the calculated percentage is. Do not guess the percentage – leave this line blank if you do not have the data to calculate the percentage that have attended. |
| WP1          | This question asks an organisation to reflect on whether they have a workplace policy or programme. Such a policy or programme would be a written document, available on request, in which the organisation has defined how it plans to protect its employees against HIV transmission, and how it plans to care for those who are already infected. Such a document would be known in the organisation, and would involve the human resource department. |
| WP2          | Determining the number of employees that have benefited from or participated in the organisation's workplace programme during the quarter being reported on, requires that a record be kept of all HIV/AIDS/STI workplace programme activities. The date of the event, the nature of the event, the venue of the event, the number of employees who attended, the person organising it, and the main focus areas would need to be recorded after every event (or on an ongoing basis if the organisation, for example, offers free VCT at its premises).  
The total number of employees is then calculated by adding up all the employees who attended each event. If employees’ spouses were also invite to the event, they should also be added to the calculation. Please note that this should EXCLUDE all military personnel, as their involvement are counted in HP3. |
| HP1          | Data should be disaggregated by type of IEC material, and by whether it was newly printed material, or materials that were distributed.  
The number of new IEC materials printed is the total number of new brochures, pamphlets, posters, or other mass communication materials that were printed during the quarter reported on. This is NOT the number of old or existing IEC materials that have been distributed, or that are left over from a previous quarter.  
The total number of IEC materials distributed during the quarter being reported on, is the total number of materials that have been distributed to end users during the period being reported on. This total should ONLY reflect ALL of the existing or new IEC materials that were distributed to END USERS (i.e. it excludes all IEC materials that were distributed to other organisations – this distinction is necessary to avoid double counting) during the report period. This total should include ALL IEC materials that were distributed in the quarter, irrespective of whether they were old or new materials.  
Please note that the organisation that distributes the materials may not be the same as the organisation that printed them.  
1. So, an organisation may have the value of “0” in the column “new materials printed”, and a value of “2000” in the column “total materials distributed”.  
2. The reverse is also possible: an organisation may have the value of “2000” in the column “new materials printed”, and a value of “0” in the column “total materials distributed”.  
3. Finally, an organisation that prints its own materials, may have a value of “2000” in the column “new materials printed”, and a value of “1000” in the column “total materials distributed”.  
4. If an organisation prints and distributes its own materials, but did not print any new materials in a particular quarter, it may have the value of “0” in the column “new materials printed”, and a value of “2000” in the column “total materials distributed”. |
<table>
<thead>
<tr>
<th>DATA ELEMENT</th>
<th>DEFINITION/S</th>
</tr>
</thead>
</table>
| HP2          | This indicator requires a calculation of the total number of young people who have participated in HIV/AIDS/STI prevention programmes in this quarter. As such, it requires that the organisation implementing the prevention programme keep records on the date of the event, the nature of the event, the venue of the event, the number of young persons who attended, the person organising it, and the main focus areas.  
‘Young people’ is defined as tho persons aged 15 to 24. This is in line with international indicator standards. The data that needs to be calculated, is the number of persons of this age group that attended HIV prevention programmes in the quarter being reported on.  
Data should be disaggregated by ‘in-school youth’ and ‘out-of-school youth’. The reason for disaggregating the data in this way is that very diverse strategies are needed to reach these two sub-groups. Since in-school youth are physically in one location (the classroom) for a substantial part of the day, it is much easier to reach them than out-of-school youth. Typically, programmes that want to target out-of-school youth need to create an ‘organisational mechanism’, such as a youth club, to bring out-of-school youth together in one place so as to reach them.  
HIV/AIDS/STI prevention programmes – This term covers a broad spectrum of programmes: from peer education, to mass media campaigns, to youth clubs, to anti-AIDS clubs in schools. It does, however, exclude these persons accessing reproductive health services, as this is counted in HP5  
In-school youth – Given the age definition of a ‘young person’, in-school youth is defined as persons who are enrolled in secondary school, college, or university.  
Out-of-school youth – This term refers to any person aged 15 to 24 that are not enrolled in school, university, or college and that are part of an HIV/AIDS/STI prevention programme |
| HP3          | This indicator requires a calculation of the total number of sex workers and total number of military personnel who have participated in HIV/AIDS/STI prevention programmes in this quarter. As such, it requires that the organisation implementing the prevention programme keep records on the date of the event, the nature of the event, the venue of the event, the number of sex workers and military personnel who attended, the person organising it, and the main focus areas.  
Sex workers - Persons who engage in commercial or transactional sex.  
Military personnel – Persons who are employees of the military on a full time or part time basis: this may include soldiers or other administrative personnel. Reservists are also included in this calculation.  
HIV/AIDS/STI prevention programmes – This term covers a broad spectrum of programmes: from peer education, to mass media campaigns, to anti-AIDS clubs, to reproductive health services. |
| HP4          | Calculating the number of active trained peer educators and community educators this quarter requires that records on all full time, part time and volunteer educators be kept by the organisation.  
Records should include the peer/community educator’s names, their education backgrounds, the date that they commenced working, their status (full time, part time, volunteer), reports on peer education sessions that they have submitted, the training in peer education that they have received, their target audiences, when they have worked (dates and times), the areas where they work, the number of persons that they have reached, whether they attend meetings held by the organisation, whether they have been evaluated, and the methodology that they have used.  
Active – This refers to the fact that the educator should have worked at least 80 hours (10 days) in the last 3 months  
Trained – The peer or community educator should be trained in how to conduct peer education sessions and community education sessions. Training should consist of at least 16 hours of contact time in a training venue, should cover all the basic information about HIV and STI prevention, and should include at least one role-play session where peer education skills are practised. A person that is experienced and skilled in HIV prevention, peer education and community education techniques and methodologies should conduct the training.  
Peer educators – This is a person who is approximately the same age as the target group, and who engages with the target group either in a small group or on a one-to-one basis, discussing issues around HIV and STI prevention. Discussions may be started informally at, for example, taxi ranks, or may be more structured sessions at health facilities. They may be full time, part time or volunteer staff.  
Community educators – This is a person who goes into the community to conduct HIV and STI prevention training sessions with community leaders and other community groups. They may be full time, part time or volunteer staff. |
<table>
<thead>
<tr>
<th>DATA ELEMENT</th>
<th>DEFINITION/S</th>
</tr>
</thead>
</table>
| HP5          | Calculating the number of young people aged 15 – 24 who have accessed reproductive health services during this quarter requires that the health facility records (patient registers, etc.) include the age and sex of the person who have accessed these services, so that data may be disaggregated in this way.  
**Family planning services** – These are services relating to condom use, contraception, pregnancy prevention, and other advice relating to family planning  
**STI diagnosis services** – This is a clinical service that involves clinicians that are skilled in diagnosing clients that present with suspected STI symptoms, and managing those symptoms in a syndromic manner  
**HIV testing services** – This involves a venue (at a health facility or separate from it) where HIV testing services are offered. Such services should include a facility for pre-test counselling, testing, and post test counselling. Other aspects in terms of sites that offer such services, include: trained counsellors, privacy for counselling, mechanisms for maintaining confidentiality, directory of services for referral, quality-control measures for specimen collection  
Accessing any health service is a confidential matter. In accessing health facility records to calculate this data, the confidentiality of such records should be respected and not compromised in any way. |
| HP6          | Calculating this indicator on the number of STI cases requires STI registers, based on international standards, to be kept at health facilities. |
| HP7          | This question asks the organisation to reflect on whether it has implemented an HIV/AIDS/STI prevention programme that focus specifically on mobile populations this quarter.  
**HIV/AIDS/STI prevention programmes** – This term covers a broad spectrum of programmes: from peer education, to mass media campaigns, to anti-AIDS clubs, to accessing reproductive health services.  
**Mobile populations** – This refers to persons who have been displaced, for whatever reasons (war, draught, conflict, natural disaster, temporary employment migration). Persons who have been displaced voluntarily for, for example, work reasons, may include truck drivers. Involuntarily displacement can also occur. Such displacement may have been either outside the borders of the country (in which case these persons are referred to as refugees), or within the borders of the country (in which case the persons are referred to as internally displaced persons) – see the illustration below: |
| HP8          | Estimating the number of persons from mobile populations that have participated in HIV/AIDS/STI prevention programmes this quarter requires that data about such programmes be kept by the organisation implementing it. Such data include: date of the event, the nature of the event, the venue of the event, the number of sex workers and military personnel who attended, the person organising it, and the main focus areas. If the exact numbers were not recorded or if a person’s origin (i.e. whether or not he/she is from a mobile population group), the estimated number of persons that have been reached, should be estimated. Please refer to HP6 for a definition of “HIV/AIDS.STI prevention programmes” and “mobile populations”. |
| HP9          | Calculating the number of persons (disaggregated by sex) that have received an HIV test, that have received their test results and that have been for post-test counselling this quarter requires that appropriate data be kept at the health facility. Such data should be kept in the form of a VCT register, and should include: date of visit, client code (not name), client sex, client age, whether the client attended pre test counselling, who carried out pre test counselling, whether the client consented to an HIV test, who took the blood sample, whether the patient remained at the site to receive his/her test results, what the test result was, whether the person went for post test counselling, whether the person’s test result was given to him/her. Only persons that were tested, received their test results, and went for post test counselling should be counted. When calculating the total, please note that it should exclude TB patients who are tested for HIV, this is because such persons are counted in HP9. |
Calculating the number of TB patients (disaggregated by sex) that have consented to an HIV test, that have received their test results and that have been for post-test counselling this quarter requires that appropriate data be kept at the TB treatment site. Such data should be kept in the form of a VCT register, and should include: date of visit, client code (not name), client sex, client age, whether the client attended pre test counselling, who carried out pre test counselling, whether the client consented to an HIV test, who took the blood sample, whether the patient remained at the site to receive his/her test results, what the test result was, whether the person went for post test counselling, whether the person's test result was given to him/her. When calculating the total for the quarter being reported on, only persons that were tested, received their test results, and went for post-test counselling should be counted.

When calculating the total, please note that it should only include TB patients who are tested for HIV; this is because all other persons who undergo VCT are counted in HP8.

Counting the number of persons (disaggregated by sex) who are active members of VCT post-test clubs this quarter, requires that organisations who arrange these clubs, keep appropriate data, Such data should include: the name of the club, its membership, the dates, venues and times that it meets, the meeting facilitators, the meeting discussion points, the number of persons who attended each meeting. When calculating the total, keep these definitions in mind:

VCT post-test clubs – These are informal, social groupings of persons who have been for VCT, and who have, despite their status, decided to become a member of a club that supports them: if their HIV status is negative, the club helps them with strategies to remain negative, and if their status is positive, the clubs will assist them with aspects of positive living, referral to other health facilities and support services for PLHAs, etc.

Persons active members of VCT post-test clubs – A person who is an active member of a club is one that has attended at least one meeting in the past 3 months.

When calculating the total number of persons in the quarter being reported on, only count those persons that have attended at least one meeting in the past 3 months. This can be done by adding up the attendance registers of club meetings, whilst being careful to avoid double counting (i.e. counting the same person twice, if he/she has attended more than one meeting in the quarter).

Counting the number of HIV positive pregnant women who are provided with a complete course of ARV prophylaxis to reduce the risk of mother-to-child transmission of HIV this quarter, requires that appropriate registers be kept at PMTCT sites. Such registers should include data on:

HIV positive pregnant women – This refers to pregnant women who presented at antenatal clinics, who consented to an HIV test after PMTCT counselling, and whose HIV status is positive.

Complete course of ARV prophylaxis – This refers to whatever is defined in the country's PMTCT guidelines as what constitutes a "complete course": In some countries, this constitutes a single dose of neverapine just before labour, whilst standards are different in other countries.

When calculating the total number of pregnant women, please keep in mind that data from the different types of facilities should be kept separate (private sector facilities and public sector facilities).

Calculating the number of person-days for the training of …… this quarter

Author note – to be defined after health personnel categories have been inserted

Calculating the number of person-days for the training of …… this quarter

Author note – to be defined after health personnel categories have been inserted

Calculating the number of person-days for the training of …… this quarter

Author note – to be defined after health personnel categories have been inserted

Calculating the number of person-days for the training of …… this quarter

Author note – to be defined after health personnel categories have been inserted

Calculating the number of person-days for the training of …… this quarter

Author note – to be defined after health personnel categories have been inserted

Calculating the number days that non-health sector project staff spent in training in the quarter being reported on, requires: (a) that the organisations conducting the training and the organisations whose staff were trained keep accurate records; and (b) that the person completing the HIV/AIDS/STI Programme Monitoring Form has a very good understanding of the different concepts involved in this indicator. Data that need to be kept, are: names and organisations of trainees, title of training session, name of facilitator, name of organisation conducting the training, training logistics (date, venue and times), training materials used, evaluations carried out, and learning outcomes of training sessions.

First, the organisation whose staff were trained will report data on training, and NOT the organisation who conducted the training.

Second, the unit for counting is “person-days”. One person-day is equal to one person attending one 8-hour training session. So, if one person attended two days of training, the value of that training in person-days, is 2 (1 person x 2 days/person = 2 person-days). If 3 persons each attended 4 days of training, the value of that training in person-days, is 12 (3 persons x 4 days/person = 12 person-days).

Third, the concept of training refers to a structured session where knowledge and skills are transferred. Training is conducted by a skilled facilitator, has written training materials, and includes a form of assessment at the end of the training session.
<table>
<thead>
<tr>
<th>DATA ELEMENT</th>
<th>DEFINITION/S</th>
</tr>
</thead>
<tbody>
<tr>
<td>CS1</td>
<td>Calculating the number of newly diagnosed HIV positive persons (disaggregated by sex) who have been given treatment for latent TB infection (TB preventative therapy) in the quarter being reported on, requires that accurate data be kept at VCT sites. The data needed for this indicator can be collected in all situations where counselling and testing for HIV is conducted e.g. VCT centres, PMTCT sites, inpatient medical services or at HIV care services, depending on where TB preventive therapy (TBPT) is to be administered. In all these situations HIV positive clients should be screened for TB. Those clients found NOT to have evidence of active TB will be offered treatment according to nationally determined guidelines. All those accepting IPT and receiving at least the first dose of treatment should be recorded. This information could be recorded in an extra column in the HIV care register. To accurately predict drug requirements for supply management more detailed information will need to be collected. For this purpose a TBPT register is required where client attendance to collect further drug supplies (usually monthly) is recorded. From this facilities would be able to report the number of new cases, continuing cases and completed cases on a quarterly basis.</td>
</tr>
<tr>
<td>CS2</td>
<td>Calculating the cumulative number of persons (disaggregated by age group – younger than 20, and 20 and older) with advanced HIV infection receiving ARV combination therapy (since the start of the ARV programme) involves checking data in the ARV registers kept at ARV sites. Additional information that may be useful: 1. The age group breakdown for this indicator is not the standard breakdown used for all other sites. This is because it is the age breakdown that is required by the UNGASS indicator guidelines. 2. This data will help to calculate the total number of people with advanced HIV infection who receive antiretroviral combination treatment according to the nationally approved treatment protocol. The total number of persons is equal to the number of people receiving treatment at start of the quarter (CS2) plus the number of people who commenced treatment in the last 3 months (CS3) minus the number of people for whom treatment was terminated in the last 3 months (including those who died) (CS4).</td>
</tr>
<tr>
<td>CS3</td>
<td>Calculating the number of persons (disaggregated by age group – younger than 20, and 20 and older) receiving ARV combination therapy that have stopped with treatment this quarter involves checking data in the ARV registers kept at ARV sites. Additional information that may be useful: 1. The age group breakdown for this indicator is not the standard breakdown used for all other sites. This is because it is the age breakdown that is required by the UNGASS indicator guidelines. 2. This data will help to calculate the total number of people with advanced HIV infection who receive antiretroviral combination treatment according to the nationally approved treatment protocol. The total number of persons is equal to the number of people receiving treatment at start of the quarter (CS2) plus the number of people who commenced treatment in the last 3 months (CS3) minus the number of people for whom treatment was terminated in the last 3 months (including those who died) (CS4).</td>
</tr>
<tr>
<td>CS4</td>
<td>Calculating the number of NEW persons (disaggregated by age group – younger than 20, and 20 and older) that start on ARV combination therapy for the first time this quarter involves checking data in the ARV registers kept at ARV sites. Additional information that may be useful: 1. The age group breakdown for this indicator is not the standard breakdown used for all other sites. This is because it is the age breakdown that is required by the UNGASS indicator guidelines. 2. This data will help to calculate the total number of people with advanced HIV infection who receive antiretroviral combination treatment according to the nationally approved treatment protocol. The total number of persons is equal to the number of people receiving treatment at start of the quarter (CS2) plus the number of people who commenced treatment in the last 3 months (CS3) minus the number of people for whom treatment was terminated in the last 3 months (including those who died) (CS4).</td>
</tr>
<tr>
<td>CS5</td>
<td>Calculating the number of people continuously on ART at 6, 12, 24, 36, etc. months after initiating treatment (numerator). Information on survival can be obtained from patient registers (HMIS) by tallying results for several monthly cohorts, each tabulated when on ART for 6 months, 12 months and yearly thereafter. For a comprehensive understanding of survival the following components have to be measured. a) Number of people initiating ART and the start date. b) Number of people continuously on ART at 6, 12 , 24, 36, etc. months after initiating treatment. c) Number of people who have stopped ART, those who have transferred out, people lost to follow-up, and those who have died. A proportion of people who have stopped treatment or were lost to follow up may still be alive. As they are not continuously on treatment, however, they should not be included in the numerator. People who transfer between ART programmes and for whom a start date of treatment exists should be counted as continuously on treatment. These data should be presented for each specified period. It is recommended that, if feasible, programmes should follow patients throughout their time on treatment, as AIDS is a lifelong disease. Six-monthly tallies of new patients are necessary in order to measure this indicator. Data are collected continuously and aggregated in accordance with the required reporting period.</td>
</tr>
<tr>
<td>CS6</td>
<td>This question asks organisations to reflect on whether they have registered with NATCoD to provide basic external support (free of charge) to ART start-up teams. The rationale is that a clear statement is made about WHO/HIV treatment guidelines.</td>
</tr>
</tbody>
</table>

November 2005
### DATA ELEMENT | DEFINITION/S
---|---
**user charges** to households with chronically ill persons or to OVC.  
**Registered with NATCoD** – This is the process through which organisations involved in care and support register with NATCoD, after NATCoD has set up a registration process specifically dealing with this.  
**Basic external support to households with chronically ill patients** – This is defined as:  
- Health care and supplies;  
- Emotional and psychological: counselling from a trained counsellor, companionship and emotional or spiritual support; and  
- Other social support, including socioeconomic (clothing, extra food or financial support) or instrumental (help with household work, training for a caregiver or legal services).

External support is defined here as help free of user charges coming from a source other than friends, family or neighbours unless they are working for a community-based group or organization.  
The definition of chronically ill varies from setting to setting. Developing and noting a commonly agreed upon definition prior to initiating work is therefore important.

**Basic external support for OVC** – This is defined as  
- Health care and supplies;  
- Emotional and psychological: counselling from a trained counsellor, companionship and emotional or spiritual support;  
- School fees and school-related assistance; and  
- Other social support, including socioeconomic (clothing, extra food or financial support) or instrumental (help with household work, training for a caregiver or legal services).

External support is defined here as help free of user charges coming from a source other than friends, family or neighbours unless they are working for a community-based group or organization.  
Again, the definition of OVC varies from setting to setting, and developing and noting a commonly agreed upon definition prior to initiating work is therefore important.

**CS7**  
Calculating the number of vulnerable groups that have received support, requires an understanding of the definitions of the different vulnerable groups, and of the different types of support:

**Different vulnerable groups (column headings of HIV/AIDS/STI Programme Monitoring Form)**

**Orphans and/or vulnerable children (OVC)** - Children (under 18 years) who have at least one dead parent (mother or father) or a chronically ill parent (mother or father), defined as a parent who was very sick for 3 or more months during the past 12 months.  
**Elderly** – These are persons 60 years and older  
**Widows/ Widowers** – These are women or men who have lost husbands or wives, respectively  
**Vulnerable Households** – These are households with chronically ill persons, as well as households with an extended family, households in poverty, and others  

**Types of support**  
- Health care and supplies;  
- Emotional and psychological: counselling from a trained counsellor, companionship and emotional or spiritual support;  
- School fees and school-related assistance; and  
- Other social support, including socioeconomic (clothing, extra food or financial support) or instrumental (help with household work, training for a caregiver or legal services).

**ME1**  
This question asks an organisation to reflect on whether a person who represent the organisation attended an HIV/AIDS/STI feedback or data dissemination workshop at zoba-level this quarter. In answering this question, the organisation should consider the definition of an HIV/AIDS/STI feedback or data dissemination workshop:  
**HIV/AIDS/STI feedback or data dissemination workshop** – This is a pre-arranged event at zoba-level for which invitations were sent out, and an agenda was prepared. Its duration will typically be 2 hours or longer. During the workshop, issues relating to HIV/AIDS/STI service delivery in the zoba will be discussed. The purpose of the workshop is NOT to discuss HIV preventions or to train persons, but to discuss, plan and improve the response to HIV/AIDS/STIs in the zoba.
The Monitoring & Evaluation TWG in Eritrea is a multisectoral consultative group that is intended to advise on activities concerning Monitoring, Evaluation and Information Systems for HIV and AIDS in Eritrea.

a) Management of M&E TWG

The M&E TWG will be chaired by a representative who is skilled in M&E from civil society, or a person designated by the M&E TWG for this purpose. The Deputy chairperson of the M&E TWG will be a nominated representative of MoH. A person may remain chairperson for 3 years, provided that the person is still a mandated representative of the civil society group that he/she represented when he/she first joined. The chairperson and deputy chairperson will be rotated after 3 years.

Secretariat services for the committee will be provided by NATCoD.

b) Composition of M&E TWG

The membership of the M&E TWG will be comprised of coordinating bodies from the Government (at least NATCoD and MoH), international groups, NGOs, and CBOs. The following specific officers will be invited to attend M&E TWG meetings:

<table>
<thead>
<tr>
<th>Officer 1</th>
<th>Officer 2</th>
<th>Officer 3</th>
<th>Officer 4</th>
<th>Officer 5</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Author Note: Table with membership to be completed during the next mission to Eritrea

c) Mandate

The M&E TWG will advise on the implementation of the national M&E system and will review progress made with the implementation of the NATCoD integrated annual work plan for monitoring and evaluation. Specifically the M&E TWG will conduct the following activities to fulfil its mandate:

- Monitoring and Evaluation
  - Review progress made with implementation of NATCoD annual integrated work plan for M&E
  - Facilitate the provision of and provide guidance in terms of collection of data from all data sources
- Provide input into the format and contents of M&E system information products
- Review the dissemination channels and stakeholders for NATCoD information products
- Advise on the implementation of and suggest improvements to the NATCoD activity reporting system
- Advise on the progress with reporting using the HIV/AIDS/STI Programme Monitoring Form
- Provide M&E-related input into the NAS/NSF Joint Annual Review process
- Provide guidance on ongoing M&E training needs within the private sector, public sector and civil society (including faith-based society)
- Provide ongoing information about latest M&E developments and trends – including new M&E systems within Eritrea that could impact on the national HIV/AIDS M&E system
- Drive the development of the UNGASS report

**Information Systems**
- Ensure that the CRIS database is supported, functioning and appropriate
- Advise NATCoD on the maintenance of data, the website and a data update strategy
- Define linkages with new database efforts that are established within Eritrea and that could be harmonised with NATCoD databases
- Provide ongoing information about latest information system trends and developments

d) **Meeting times**

The M&E TWG will meet on a monthly basis. The venue of the meeting will rotate as best fits the membership. In addition to monthly meetings, the chairperson may call ad hoc meetings after consultation with the deputy chairperson, as the need arises.

M&E TWG members will receive a seating allowance for attendance of meetings.

e) **Review of Terms of Reference**

These TORs will be reviewed annually and changes made as deemed necessary by the M&E TWG.
DATA FLOW CHARTS - INTRODUCTION
INTRODUCTION TO DATA FLOW CHARTS

A flow chart is a schematic representation of a process. For each of the data flow diagrams in Chapter 4, the following nomenclature apply:

- **Start/End**: The terminator symbol marks the starting or ending point of the system. It usually contains the word "Start" or "End."

- **Action or Process**: A box can represent a single step ("add two cups of flour"), or an entire sub-process ("make bread") within a larger process.

- **Document**: A printed document or report.

- **Decision**: A decision or branching point. Lines representing different decisions emerge from different points of the diamond.

- **Flow**: Lines indicate the sequence of steps and the direction of flow.
Annexure D

NATIONAL M&E ROAD MAP:
OCTOBER 2005 TO DECEMBER 2006
M&E Road Map to be inserted from MS Excel file once it has been approved by Eritrea M&E stakeholders