Ministry of Health

Department of Policy, Planning and HRD

Monitoring and Evaluation Division

Second National
Integrated Monitoring and Evaluation Framework

2012 -2016

Eritrea

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Abbreviations and Acronyms

AIDS:	Acquired Immune Deficiency Syndrome
ART:	Antiretroviral Therapy
ANC	Antenatal Care
BHCP:	Basic Health Care Package
CBHS:	Community –Based Health Services
DoD:	Department of Defense
EPI:	Expanded Programme on Immunization
HCT:	HIV Testing and Counselling Services
VCT:	Voluntary Counselling & Testing
HIV:	Human Immunodeficiency Virus
HPC:	Health Promotion Centre
HSS:	Heath Systems Strengthening
HSSDP:	Health Sector Strategic Development Plan
IDA:	Iron Deficiency Anaemia
IDD:	Iodine Deficiency Disorders
LQAS:	Lot Quality Assurance Sampling
M&E:	Monitoring and Evaluation
MOE:	Ministry of Education
M&E TWG:	Monitoring and Evaluation Technical Working Group
MLHW:	Ministry of Labour and Human Welfare
MOH:	Ministry of Health
NATCoD:	National HIV/AIDS/STI and Tuberculosis Control Division
NBTC:	National Blood Bank & Transfusion Centre
NSO:	National Statistics Office
PLHAs:	People Living with HIV /AIDS
PMTCT:	Prevention of Mother to Child Transmission
RH:	Reproductive Health
STI:	Sexually Transmitted Infections
TB	Tuberculosis
VAD:	Vitamin A Deficiency
ZRH:	Zoba Referral Hospital

Foreword

The first edition of an M&E Framework covering four programs was developed in May, 2005 with the second edition covering Six programs developed in August 2008. The six priority health programs identified by the National Monitoring and Evaluation Advisory Committee (M&E Committee) during the initial phase of M&E system development are HIV/AIDS/STI, TB, Malaria, Reproductive Health, Child and Adolescent Health and Nutrition.

This was initially organized according to the "11 components of an M&E system"[i] adopted as a framework for M&E systems by the Monitoring and Evaluation Reference Group in Geneva and updated to 12 components in August, 2008 using the updated April 2008 international framework.

The 1stedition of an M&E Framework "National Framework for an Integrated M&E System" was completed in March, 2010 and consists of additional health systems strengthening indicators.

The need for the development of 2nd Integrated Monitoring and Evaluation (M&E) Framework (2012-2016) for the Eritrean health system was initiated by the Global Fund, though the Ministry of health had a plan to align the M&E framework with Health Sector Strategic Development Plan (2012-2016). Hence, the NATCoD takes the lead to the development process jointly with M&E Division.

In the development process, a task force formed to facilitate the process, contribute and/or guide programs inputs in to the M&E framework. The task force was comprised of different stakeholders, representatives from all programs in the ministry, information systems, and UN agencies. This task force has conducted a series of meeting till the finalization of the documents.

Finally, the 2nd M&E Framework is structured into four parts:

Part 1: Introduction and Background

Part 2: Conceptual Framework for MOH Integrated Monitoring and Evaluation (M&E) System

Part 3: Results Framework for the MOH Integrated Monitoring and Evaluation System

Part 4: Institutional Arrangements for M&E Coordination, Management and Implementation

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M&E Division

Department of Policy, Planning and HRD

Part 1 Introduction and Back ground

1.1 Introduction and purpose of the Monitoring and Evaluation Frame Work

Since 2008, the Ministry of Health in Eritrea has been implementing the comprehensive integrated monitoring and evaluation framework (2008-2012) for HIV/ AIDS and TB, Malaria, Reproductive Health, Nutrition, Child and Adolescent Health / EPI and the Health Systems Strengthening. These programmes that constituted the integrated M&E framework have been implemented by the health sector as part of the Health Sector Strategic Development Plan (HSSDP). The M&E framework has guided the collection and analysis data to measure the progress and performance of the health sector with respect to the above programmes.

In 2010, the Ministry of Health developed a national health policy to provide direction for the development of the health sector in Eritrea. Consequently the MOH also developed the HSSDP 2012-2016 to implement the new national health policy. The development of the 2nd comprehensive M&E framework covering a five year time frame from 2012 to 2016 is aimed at aligning it with the Health Sector Strategic Development Plan (HSSDP) 2012-2016. The 2nd M&E frame work will support and facilitate the MOH to monitor and evaluate sector's performance for key health sector programme in the HSSDP. Its development has been based on the assessment of the 1st Integrated M&E Framework. The programmes covered in this document are HIV/AIDS/STI, TB, Malaria, RH, Child and Adolescent Health, Nutrition and HSS.

The M&E Framework will primarily enable the generation and availability of strategic information for effective management of the seven programmes mentioned above. The frame work will also facilitate tracking and assessment of performance towards the attainment of the set HSSDP goals, strategic objectives, outcomes and outputs.

In general, this 2nd M&E framework is aimed at the following:

- Harmonize the mechanisms through which data and information is collected, analysed, verified, and transformed into useful information, to promote evidence based planning and management decisions.
- Institutionalize the use of data for evidence based decision-making.
- Ensure the availability of appropriate human resources, partnerships and planning necessary to support data collection and data use for improving and sustaining M&E system performance
- Provide up to date data and information on the performance of the health sector with emphasis on the programmes covered in this document.

1.2 Structure of the Monitoring and Evaluation Framework

The M&E Framework is structured into the following four parts:

Part 1 Introduction and Background

Part 2: Conceptual Framework for MOH Integrated Monitoring and Evaluation (M&E) System

Part 3: Results Framework for the MOH Integrated Monitoring and Evaluation System

Part 4: Institutional Arrangements for M&E Coordination, Management and Implementation

1.3 Background: Health Policy and Status

1.3.1 Institutional Set up and Governance

The MOH is accountable for health status of all Eritrean People. It is mandated to provide leadership for the health sector policy, Planning, Coordination and Implementation as well as to the national Multi-Sectoral Response to the HIV/AIDS Epidemic in Eritrea.

The Health Policy has defined three levels of health service delivery system in Eritrea namely primary, secondary and tertiary levels.

Primary Service Level: This is the first level of health services delivery and is constituted by Community –Based Health Services (CBHS), Health Stations and Community Hospitals.

The CBHS level has a catchment population of 2000-3000 people. At this level the community health workers are service providers charged with the community mobilisation and empowerment for the Basic Health Care Package (BHCP) programmes in the community, which are under the leadership of the Kebabi Health Committee.

Health Stations offer facility-based primary health care services to a catchment population of approximately 5,000-10,000.

The Community Hospital supervises the health stations and CHW. This is the next level for provision of promotive and preventive and basic curative services of the BHCP.

The Community Hospital *Service level* is charged with provision and supervision of BHCP services at the sub –zoba level. The sub –zoba has a catchment population of 50,000- 100,000 people. At this level, outpatient and inpatient services are provided, and it is the referral for lower level facilities in the sub-zoba. The community hospital services have a Hospital Management team which operates under the leadership of the sub –zoba local authority

Secondary Level Services: This is the second level of health services delivery which provides the Zoba Referral Hospital Services. It is the highest referral level in the Zoba and it operates under the Zoba Medical Officer. It is mandated to carry out the following functions:

- Provision of all services offered at sub-zoba level but at a higher level of expertise
- Referral centre for primary level facilities in the zoba;
- Teaching and training of middle and operational level health cadres
- Conducts health research programmes including operational research of health systems in the zoba
- Provision of technical support to lower health facilities in the zoba
- Provision of defined specialised services

There can be more than one hospital that provides secondary level services in a zoba depending on geographical and other reasons. In such a situation one of hospitals will be designated as the ZRH for administrative, strategic management and resource allocation.

Tertiary Level Services: This is the highest level of provision of health care in Eritrea. This level comprises of all national level hospitals that offer specialized services which are not offered by the Zoba referral hospitals. At this level, the development of needs-based centres of excellence that can meet the challenges the health sector in Eritrea takes place. This level also undertakes research and training in Eritrea.

Eritrea has a decentralised system of Governance. At the national level, the Ministry of Health provides policy direction, planning, monitoring and evaluation, regulations and setting of standards for the health sector.

At the Zoba level, the Zoba Health Management provides the leadership and supervises all health services in the Zoba, including those provided by the Zobal Referral Hospital. The Sub Zoba Health Management provides the leadership for CBHS, lower level primary health facilities and services as per the sub-Zoba Health Management Committee and the Heath Management team guidelines.

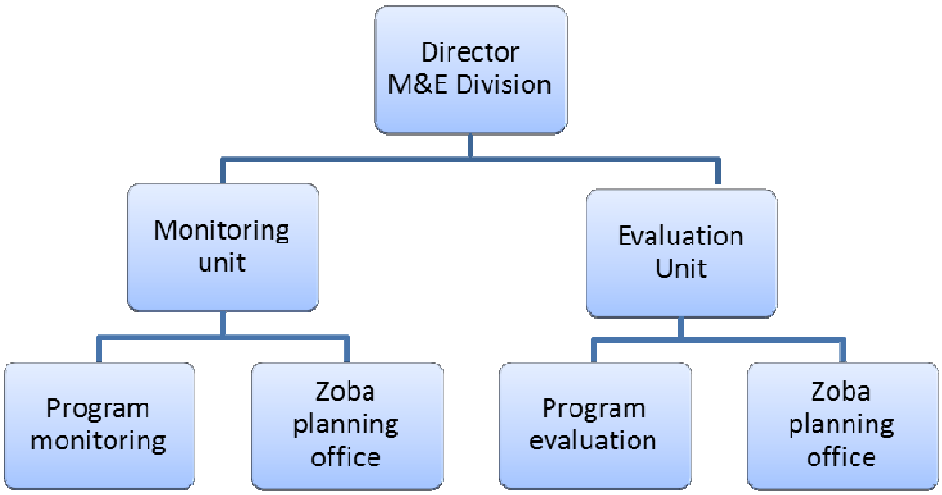
It is within the above institutional and governance set up that the 2nd Integrated Monitoring and Evaluation will be implemented.

1.3.2 Overview of the Health Status / Situation

I. Monitoring and Evaluation Division

The Ministry of Health established an M&E Division to provide leadership for the monitoring and evaluation activities in the health sector. The M&E Division was established under the Department of Policy, Planning and HRD.

Organogram of the M&E Division



The following are the functions of the M&E Division:

- To provide policy and planning direction for monitoring and evaluation activities for the health sector
- Coordination and technical support to all programmes and departments in the MOH
- Coordinate with the National Statistics Office (NSO), Ministry of National Development, to collect health information and vital statistics required for national development.

The capacity of the M&E Division requires strengthening. Currently the division has only one professional personnel with limited logistical support.

In addition the M&E Division has no national database that is linked to all the programmes for reporting purposes. The data base available is for HMIS, which is outside the M&E Division.

All the above capacity problems and constraints, present serious challenges for the M&E Division to be able to provide the required leadership, coordination and management of M&E activities of the health sector

II. HIV/AIDS /STI

HIV/AIDS in Eritrea is categorised as generalised epidemic, with few population groups that are most at risk. In 2009, overall the HIV prevalence among pregnant women attending ANC was 1.31% reducing from 2.41%, 2.38% and 1.33% in 2003, 2005 and 2007 respectively[1].

According to the same survey, the HIV prevalence is higher in urban populations being 1.72% compared to 0.38% in rural areas. The prevalence is also higher among single

i. Ministry of Health, Eritrea, HIV& Syphilis Sentinel Surveillance Survey in ANC Attendee Women In Eritrea, Report of the 2009 Round, March 2010

women being 5.1% as compared to 1% in married women which reflects a higher degree of faithfulness among married couples. The sentinel surveillance survey of 2009 estimated the prevalence of 0.73% in the age group 15-24 which can be a proxy indicator of new HIV infection (incidence rate) in the general population.

Results from the 2010 EPHS indicate that 0.93 percent of Eritrean adults age 15-49 are infected with HIV. Women are more than two times as likely to be infected with HIV as men (1.13 percent and 0.5 percent respectively). The female-to-male infection ratio of 2.26 is consistent with female-to-male infection ratios observed in a number of other countries in sub-Saharan Africa. Gender differences in infection levels reflect the fact that biological factors make women more susceptible to the risk of infection. They also relate to the fact that women both initiate sexual activity and marry at a much younger age than men.

For last ten years the Eritrean Ministry of Health has led the implementation of the multi-sectoral response to HIV/AIDS, guide by a series of National HIV/AIDS strategic plan, including the current one of 2008-2012. The multi sectoral response is constituted by the following programme in the table below.

Table1: National HIV/AIDS/STI Response Framework

Thematic Area	Key Strategic Interventions /Responses
Thematic Area 1: Prevention of new HIV infection	• Counselling and testing (VCT) • Condom promotion and distribution • Diagnosis and treatment of Sexually Transmitted Infections and Linkage to HIV Programs • Prevention of Mother to Child Transmission of HIV (PMTCT) • Behavioural Change Communications (BCC) and Information, Education & Communication (IEC) mechanisms • Life skills based HIV education in schools, • Promotion of blood safety, universal precautions and administration of Post- Exposure Prophylaxis (PEP) • Workplace based HIV/AIDS preventive interventions
Thematic Area 2: Improvement of Quality of Life for those Infected and Affected by AIDS	• Antiretroviral Treatment and monitoring • Prophylaxis and treatment of opportunistic infections • Care and support for the chronically ill.
Thematic Area 3: Mitigation of Social and Economic Impact of HIV/AIDS	• Support for orphans and vulnerable children
Complementary Area 4: Strengthening the support environment	• Strengthening multi-sectoral capacity • Community empowerment • Reduction of Stigma and discrimination in all settings • Issues of gender and gender violence • Enhancing new technology to addressing multi-dimensional HIV/AIDS response • Policy development including workplace policy, emergency and humanitarian issues
Complementary Area 5: Health system management	• Enhancing the health system management, • Infrastructure support, • Human resource capacity, • Monitoring and evaluation, • Procurement and supply management system, • Research and surveillance system

By the end of 2011, Eritrea has at total 239 health facilities (83.6%) that provide HIV Testing and Counselling Services (HCT), distributed through the country. In 2011, a total of 87,079 clients accessed HCT services. With regard to PMTCT, there are 198 health facilities (69.2%) that provide the services that prevent the transmission of HIV from mother to a child. Condom promotion and distribution is another major prevention intervention and in 2011, a total of 6,383,856 condoms were distributed, which was nearly 2 condoms for every individual in Eritrea.

The National HIV/AID response also covers the HIV/AIDS care and support programme. ART was introduced in 2005 and by 31st December 2011, a total of 7,282 eligible HIV/AIDS patients had accessed antiretroviral drugs. In addition to the ART service, home based care and support was also provided to 2,156 PLWHA and their families in 2011.

The M&E of the HIV/AIDS response in Eritrea is being speared by the Epidemiology & Monitoring unit of NATCoD. The unit has built capacity to carry out HIV surveillance and research, undertake collection of routine and non-routine data, analysis and management, as well as production and dissemination of a national report on the HIV/AIDS response in Eritrea

III. TB Control

TB is among the top 10 leading causes of mortality in adults in Eritrea. People Living with HIV are particularly vulnerable to developing active TB. In 2005 the TB prevalence in the age group 15 and above was estimated to be 50/100,000 while the incidence was reported to be 25/100,000. The TB/HIV co-infection in Eritrea is estimated to be 11.2%.

The TB detection rate in 2011 was 46.6%, down from 47% in 2008. The TB cure rate in 2011 was 79%, declining from 85% in 2009[2]. Pulmonary TB constituted 68% of the TB cases in 2010. The OPD morbidity has decreased from 0.9% in 1999 to 0.2% 2010, while the morbidity went down from2.4% to 0.9% during the same period. The decreasing trend of TB incidence is attributed to the improved diagnosis and increased expansion in the number of facilities providing TB services.

The health policy strategic direction is to reduce the incidence and prevalence of TB to a level where it will no longer be public health problem using evidence based interventions including MDR surveillance and early management. The HSSDP 2012-2016 has set the following targets for the planned TB strategic interventions:

- TB case detection increased from current 40% to at least 70%,
- TB cure rate increased from current 81% to 90% and reduce death rate to <4% by 2013 (TB)
- Ensure Lab AFB quality assurance and quality control to 85% DOTS implementing centres by the year 2013.
- Incidence, prevalence and death rates associated with tuberculosis measured and decreased.

[2] Eretria Ministry of Health, Health Management Information System Annual Health Activity Report of the Year 2010, May 201

IV Malaria

Malaria is among the top 10 disease burden in Eritrea. The most common and widely spread malaria parasite is Plasmodium *falciparum* which accounts for more than 80% of all malaria cases. Malaria morbidity accounted for 0.95% of the OPD cases and 2.2% of the inpatients in 2010. Mortality due to malaria accounts for 0.5% among children under 5 years, and 1.6% among inpatients five years and above. Between 1999 and 2010 the incidence of malaria among children under 5 and over 5 years reduced by 82.9% and 71.9% respectively.

Overall available data indicates that the disease burden due to malaria in Eritrea is decreasing from year to year. The National Malaria Control Programme attributed this success to the following interventions and factor:

Percent of pregnant women registered for ANC at different trimester (2007-2010)				
First	18.8	18.3	20.4	20.4
Second	60.6	60.4	58.7	61.3
Third	20.7	21	21	18.3
MOH Annual health report 2010				

- Coverage, re-impregnation and utilization of 1TNs.
- Introduction of combination therapy of CQ+SP as first line drugs.
- Early diagnosis and timely case management.
- High levels of community awareness and participation for environmental vector control.
- Effective and functional partnership of country and outside RBM partners
- Commitment and dedication of the Government, MOH, and malaria control staff and general health workers.
- Technical and financial support received through RBM initiative.
- Effective planning and implementation of program activities in the country.

Key Malaria Strategic Programme Interventions Include the following

- Mass promotion, distribution and use of insecticide treated nets (ITNs) in high malarious areas;
- Indoor residual spraying (IRS).
- Strengthening case management and diagnostic capacity. This was mainly through the introduction and scaling up of combination therapy drugs (artesunate + amodiaquine (AS+AQ)) and RDTs to as low as the health station level.
- Strengthen the supply and management of anti-malarial drugs and supply
- Eritrea has also been able to benefit from the World Bank HAMSET Project and from the GFATM Round 2 and 6. This funding has been very instrumental in scaling up of malaria control interventions.
- Strengthening of community capacity for treating malaria and improve participation in prevention and control of malaria

V. Reproductive Health

All health facilities in Eretria except the specialized referral hospitals are required to provide antenatal care services. In 2010, out of the 335 health facilities (public and

private) in the country, 248 (74.1) provided ANC services. The coverage of ANC services for at least one visit has been fluctuating over the years being 61.1% in 2007 increasing to 65.7% in 2009 before declining to 58.1% in 2010 (MOH Annual Health Report, 2010). The dropout rate of ANC visits (% of pregnant women failing to go for the 4th ANC visit) has worsened, increasing from 29% in 2007 to 43.1% in 2010. High risk rate has remained the same being 16.2% in 2007 and 2010. The percentage of pregnant women who go for ANC during the 1st trimester slightly improved from 18.8% in 2007 to 20.4% in 2010 as indicated in the box above

Health facilities providing delivery services have significantly increased to 65.4% in 2010 from 47.8% in 2005. Coverage of deliveries attended to at health facilities has slightly increased from 26.2% in 2004 to 29.5 % in 2010. The number for maternal death has ranged from 66 in 2006 to 74 in 2010 and overall the national mortality rate is estimated to be 365/100000[3]. This is a remarkable improvement compared to the situation in 1990 when maternal mortality was 1400/100,000, and later declining to 450/100,000 in 2005 (HSSDP:2012-2016).

Family planning services are a major component of reproductive health programme, that contribute to fertility decline as well as reducing unintended pregnancy. The availability and quality of family planning services increases the coverage of contraceptive use and declining fertility rates. In Eritrea of the 335 heath facilities in the country, 213 (63.6%) provided family planning services in 2010. The coverage of family planning services was 5.3% of the targeted population in 2010

The HSSDP has prioritised the following to be delivered under the Reproductive Health Programme, to improve the delivery of maternal health situation in the country:

- Expansion of the health facilities to the rural areas;
- Training of skilled health personnel and deploying them to all levels of health care services;
- Ensuring availability of essential drugs and supplies;
- Strengthening the blood transfusion services;
- Expanding the capacity of emergency surgery to save pregnant women,
- Developing policies and guidelines;
- Developing communication strategies in health promotion to increase awareness and bring behavioural changes and empowering the communities;
- Establishing maternity waiting homes to increase accessibility;
- Implementing IMNCI and therapeutic feeding strategies;
- Expanding VCT and PMTCT centres
- Further strengthening the malaria control program to elimination level;
- Strengthening the disease surveillance program

VI. Child and Adolescent Health

The Child Health programme is focused on reducing the morbidity and mortality of neonates, infants and children under-five. It tackles key diseases that include acute respiratory infection, malaria, diarrhoea, vaccine preventable diseases, and malnutrition.

[3] Eretria Ministry of Health, Health Management Information System Annual Health Activity Report of the Year 2010, May 2011

According to UNICEF, the infant mortality rate in Eritrea has reduced from 88/1000 in 1990 to 46/1000 in 2007, while the under five mortality has gone down from 147/1000 in 1990 to 70/1000 in 2007.

The Expanded Program on Immunization (EPI) is one of the priority interventions for MOH Child Health Programmes. In 2010 EPI services were provided in 74.33% of the health facilities in Eritrea. Based on BCG, the EPI coverage in 2010 was estimated to be 91%. Fully immunisation coverage in 2010 was reported to 58.1% in the 2010 MOH annual report.

Immunization programs have led to the eradication of vaccine preventable disease, and substantial reductions in the morbidity and mortality attributed to measles, pertussis, and polio, Tetanus, Diphtheria and TB. The morbidity due to immunizable diseases has reduced from 0.16 to 0.03 between 2000 and 2010 while mortality has reduced from 0.6 to 0.02 over the same period of time.

Given the above success **the strategic focus and direction for infant and child health** for the MOH for next five years will be:

- Improving the quality of care provided to children under-five years of age at health facility and household levels using Integrated Management of Neonatal and Childhood Illnesses (IMNCI) strategy and other child survival strategies including interventions targeting the health of the new born.
- Implementation of strategies to improve and sustain maximum immunisation coverage;

With regards to **Adolescent Health,** the MOH focus is on the health and safety that faces adolescents and young adults including reproductive health, substance abuse including tobacco use, and the prevention of communicable and non-communicable disease. The policy direction for the adolescent health programme will be:

- Elevate national focus on the health safety and well being of adolescents and young adults in schools;
- Promotion of user friendly approaches in the provision of health services,
- Provision of health and healthy life-styles information targeting adolescents and youth;
- Foster cooperation among different partners concerned with the youth such as the Ministry of Education, the youth and women associations.

VII. Nutrition

Anaemia and malnutrition are two of the top causes of morbidity and mortality both in children U5 and adults. In 2010, malnutrition was ranked the 6th cause of outpatient morbidity, and the 4th cause of inpatient morbidity. Malnutrition is the first cause of mortality in children U5. A total of 10,524 outpatient department cases and 3,845 inpatient malnutrition cases and 183 deaths were reported in hospitals and health centres in 2010.[4]

[4] Eretria Ministry of Health, Health Management Information System Annual Health Activity Report of the Year 2010, May 2011

According to the annual health service report, anaemia was ranked 14th cause of morbidity among OPD and IPD cases in 2010. It was the 10th cause of mortality in all age categories in hospitals and health centres. Children under 5 accounted for 14.9% of all morbidity cases due to anaemia and 19.7% of anaemia related deaths

The health policy aim is to ensure that the nutritional status (including balanced, under and over nutrition) of the population especially children, pregnant women and lactating mothers is monitored and improved. The prevalence of protein energy and micronutrient deficiencies will be reduced through various nutrition interventions and nutrition and growth promotion activities.

The strategic objective of MOH for improving the nutritional status of the people is to promote breastfeeding and growth monitoring activities. The MOH will also strengthen provision of routine supplements that will cover vitamin A, iron and zinc during ANC, postnatal care of mothers and to children under five years. The implementation of the HSSDP 2012-2016 will focus on the following strategic interventions:

- Household Food Security
- Protection, Promotion & Support to Infant and Young Child Feeding and Care
- Empowering communities to assess analyses and manage their nutrition problems through the establishment of Community-based and school health and nutrition programs.
- Prevention and control of Specific Micronutrient Deficiencies (VAD, IDA, IDD and Zinc deficiency)
- Special Programs: Supplementary Feeding and Therapeutic Feeding
- Development of Nutrition Information System

1.4 National Health Policy and Strategic Programming Framework

In 2010, the MOH developed a national health policy and a health sector strategic development plan. The two policy documents provide the direction of the health sector programming and management for the period 2012 -2016.

The ***vision*** of the sector as spelled in the national health policy is:

Improved health status, well being, productivity and quality of life of the Eritrean people with an enabling and empowering environment for the provision of sustainable quality health care that is effective, efficient, acceptable, affordable and accessible to all citizens.

The national health policy also spelled out the **Mission** as follows:

To promote and provide high quality promotive, preventive, curative and rehabilitative health care services to the Eritrean people

The policy has the following strategic objectives

i. Significantly reduce the burden of early childhood illnesses and improve maternal and child health development;

ii. Control communicable diseases with the aim of reducing them to a non-public health problem;
iii. Strengthen Health education (IEC) and health promotion to enhance health awareness, discourage harmful practices and promote healthy life style;
iv. Strengthen and periodically review health information management system;
v. Strengthen and promote applied health research on major health problems;
vi. Strengthen inter-sectoral collaboration with all relevant government and nongovernment bodies to implement multi-sectoral components of the national health strategies;
vii. Strengthen sector planning and monitoring capability

To implement the policy the MOH formulated a HSSDP whose thematic area and strategic interventions are described in the table below

Table 3: HSSDP Strategic Framework

Strategic Plan Thematic Area	Strategic Interventions
Basic Health Care Package	• Maternal and, Child Health Care and Nutrition • Prevention, Control and Management of Communicable Diseases • Prevention, Control and Management of Communicable Diseases • Prevention, Control and Management of Communicable Diseases • Cross-Cutting Health Interventions ▪ Environmental Health Services ▪ Health Promotion and Education ▪ Quality of Care ▪ Support Supervision. Rehabilitative Health Care ▪ Disaster Preparedness and Response ▪ Occupational Health
Hospital, Emergency and Integrated Essential Care	• Hospital Services. • Emergency Medical Care and Referral Network • Integrated Essential Medical Care
BHCP Essential Systems	• Human Resource for Health Development and Management • Pharmaceuticals Procurement, Supply & Logistics Management • Biomedical Engineering • National Medicines Administration/ Regulation • Procurement and Supplies Management System • Transportation and Communication • Infrastructure Engineering • Laboratory and diagnostic services Medical imaging services • Blood Transfusion Services • Legal affairs
Sector Planning, Monitoring & Evaluation	• Planning and Budgeting • Health Management Information System • Sector Monitoring and Evaluation • Health Research

1.4 Status of Integrated Health Sector M&E Framework

The assessment of the 1st Integrated M&E Frame work is summary has revealed the following:

I) The M&E Framework was compressively designed with the result framework that had clear targets and also a costed operational plan for its implementation

II) The established M&E structures for health sector have human resource challenges. They do not have qualified and skilled M&E personnel. The structures therefore have no capacity to execute their respective M&E functions.

III) Leadership for M&E in the sector remains a challenge. The M&E Division that is required to provide the leadership is grossly understaffed with only one person. Programme M&E units do not exists with the exception of NATCoD, which also has one individual. All these limit the capacity to implement M&E activities

IV) Programmes, with the exception of NATCoD, did not have M&E Framework and operational plans to guide the implementation of their respective M&E interventions

V) The Surveillance system for HIV/AIDS is functional and reports are being produced every two years. The task is to ensure that the results are used for policy and programme improvement

VI) Routine monitoring through HMIS is functional and a health service activity report is produced every year. The challenge remains dissemination and utilization of the results for programme improvement.

VII) Major surveys like EDHS and Malaria indicator survey have been carried out. The challenge is the delayed finalization and publication of the reports, which takes more than a year

VIII) Data collection for the indicators in the results framework (other than HMIS and selected surveys) remains a challenge. There is limited initiative by programmes to collect data to assess programme performance

Overall the structures established for M&E functions in the health sector have very limited capacity and are not fully functional. Data collection, reporting and utilization remain a major problem, which should tackled during the 2nd integrated M&E Framework

Part 2: Conceptual Framework for the 2nd MOH Integrated Monitoring and Evaluation (M&E) Framework

2.1 Introduction

Effective management and implementation of the HSSDP; and the delivery of the Basic Health Care Package (BHCP) requires timely generation; and utilization of accurate and reliable information that is critical for the sector's performance. It is important that timely mobilization of inputs is done to facilitate adherence to the implementation schedule specified in the HSSDP. Effective health sector management will require monitoring of the implementation process of the HSSDP as well as documentation of its progress and performance. Documentation should also include the deviations that occur from the planned course of action. Equally important is the need to provide financial, technical and social accountability to society and other relevant stakeholders. All this requires robust tracking of data and information. The 2nd Integrated M&E Framework has been designed to generate data and information for assessing the performance of HSSDP. The M&E frame will also promote the utilization of monitoring and evaluation data to improve programme performance.

2.2 Goal and Objectives and Outputs of the 2nd Integrated Monitoring and Evaluation Framework

2.2.1 Goal of the 2nd Integrate M&E Framework

The 2nd Integrated M&E Frame is part and parcel of the HSSDP and will assume its strategic goal. The Framework will therefore contribute to the attainment of the strategic policy goals for the health sector, already spelled out 1.4, but repeated below for emphasis:

- Reducing the burden of early childhood illness and improve maternal and child health/development
- Control communicable diseases to levels of non-public health problem.
- Prevent, control and manage non-communicable diseases.
- Strengthen cross cutting health interventions
- Enhance efficiency, equity and quality of service delivery
- Improve effectiveness of governance of the health system
- Introduce more effective and efficient health-financing scheme, as economic and purchasing capacity of the population improves.
- Strengthen sector planning, monitoring and evaluation capability

2.2.2 Objective, Strategic Actions and Key Outputs of the 2nd Integrated M&E Framework

The 2nd M&E Frame builds on the 1st1st M&E integrated frame work and has four objectives as follows:

A: Objective 1: To harmonize mechanisms through which data and information are collected, analysed, verified, and transformed into useful information, to promote evidence based planning and management decisions.

Data collection for the health sector is done by different programmes and actors. Routine clinical monitoring data is reported on monthly basis by health facilities through the Zobas to the MOH/ HMIS unit. At the same time, programmes like ART, VCT, PMTCT, have additional data collection demands, for which implementing health facilities have to report to NATCoD. The same also applies to other programmes like Malaria and TB. Health facilities therefore have multiple reporting tools, with different reporting time lines and data collection guidelines. Programmes also analyse and manage the data and information differently. The priority action and focus of the 2nd M&E Framework will be to put in place mechanisms through which data and information collection and management can be harmonised and used to improve programme performance. The following are planned strategic actions and key outputs for the five years:

Strategic Action 1: **Strengthening M&E Division to provide leadership and coordination for M&E.** The M&E Division will be supported to recruit staff and equipping of offices to be able to perform the M&E functions of the sector as well as coordination of the multiples data and information interests.

Strategic Action 2: Reviewing and harmonisation of available data and information collection arrangements. The M&E Division, with technical support, will review current mechanisms for data and information collection and management to ensure that:

- Data collection tools /instruments are standardised and harmonised.
- Reporting timelines are standardised and harmonised
- Data quality and audit systems are unified
- Population based surveys cover data and information needs of programmes

Strategic Action 3: Strengthen partnership to improve coordination of data and information collection and management. The M&E Division will review the existing Advisory M&E Committee, and the M&E TWG, and reconstitute them into one M&E Committee, for effectiveness, efficiency and practicability of executing M&E functions. The Committee should be chaired by the Departmental Head of Policy, Planning and HRD, who should be accountable for the functionality of the M&E System. Financial support should be provided to ensure that the Committee meets at least once every quarter, to bring together the different programmes and partners to harmonise their M&E needs, products and operating arrangements. Key functions for this Committee should include among others:

- Meeting at least once in a quarter
- Consensus on approaches for harmonisation data and information collection and management
- Reviewing and approving annual Programme M&E action /operational plans and budgets with a view of harmonising data and information collection activities
- Reviewing and recommending /acting on the findings of quarterly support supervision and data quality audits
- Ensuring that resources for M&E action plans are mobilised and that implementation is executed according to the planned schedules.

Key Outputs for Objective 1 and Strategic Actions:	
i.	M&E staff for the M&E Division recruited by end of 2012
ii.	M&E Advisory Committee & M&E TWG reconstituted into one M&E Committee by July 2012
iii.	Mechanisms for standardisation and harmonization of data and information collection and management developed and approved by the MOH, by end of March 2013.
iv.	At least 4 M&E quarterly coordination meetings held every year
v.	Joint supervision, data quality and audit guidelines developed
vi.	Annual Joint review for HSSDP & M&E held every year

B: Objective 2 for the 2nd M&E Framework: Institutionalize the use of data for evidence based decision-making.

It serves no purpose to collect data and information when it is not used for programmes decision making. More importantly the use of information products should mainly be at the point of collection. Aggregated findings should then be basis for policy and programming decision at national and decentralised level. Currently the HMIS unit clinical data and information, and produced a well detailed and analytical report with information that should be the basis for health sector decision making. It is more useful to go beyond production of report, to ensure that its findings inform decision making. During the 2nd M&E Framework, the following strategic actions are planned to promote use of data for evidence based decision making:

Strategic Action 1: **Annual synthesis of all routine monitoring, research survey findings to generate policy and planning actions**.

Annually the M&E Division will commission an undertaking of a synthesis of all the findings from monitoring, research and survey activities carried out. The synthesis should generate policy and planning actions that will bring about health sector programme improvement. Policy papers will be prepared to highlight the changes required for the health sector to be able to move to the next level of development.

Strategic Action 2: Organise an annual stakeholder's Forum to disseminate and communicate the required policy and planning actions.

The M&E Division will organise an annual stakeholders meeting, during which Government will announce and communicate its decisions, policy and planning actions on the findings of the monitoring, research and surveys carried out during the year. During this meeting, all actors in the health sector will be informed of the agreed policy and planning changes that should be implemented at the different levels of the health system.

Key output for Objective 2
Government decisions, policy and planning actions emanating from surveys, research and M&E finings, documented and communicated for implementation at different levels of the health care system.

C: Objective 3: Ensure the availability of appropriate human resources, partnerships and planning necessary to support data collection and data use for improving and sustaining M&E system performance.

During the implementation of the 1st1st integrated M&E Framework, human resources in terms staffing and skills has been a major constraint. The M&E Division had no staff, which created a leadership vacuum. All programmes had no M&E officers recruited to support M&E functions for their programmes. Therefore having a right mix of skilled staff in place for all the M&E structures in the health sector will be a priority focus of the 2nd Integrated M&E framework. The following strategic actions will be undertaken:

Strategic Action 1: Recruitment of M&E Staff at Programme and Zoba Level
At least three programme (HIV/AIDS/STI, TB & Malaria inclusive), will collaborate with the M&E Division, to develop job specification and accountabilities for M&E positions, and recruit the M&E officers to carry out the M&E functions at programme level. The M&E Division will also collaborate with the Zoba local administration leadership, to appoint staff who will be responsible for the M&E functions at the decentralised level.

Strategic Action 2: M&E human capacity and skills needs assessment
The M&E Division will soon after the recruitment of M&E staff at all levels, commission an M&E human resource capacity and skills needs assessment. The assessment should establish the skills gaps and trainings needs for the recruited staff that should inform the M&E capacity building programme.

Strategic Action 3: Designing an M&E capacity building programme, customized to the 2nd MOH Integrated M&E Framework.
As part of the M&E human capacity and needs assessment, an M&E capacity building programme will be designed, customised to the 2nd Integrated M&E Framework. The capacity building programme will be tailored to meeting the implementation needs of the 2nd Integrated M&E Framework. Its implementation will be done in a phased and cascading approach at all levels.

Key Outputs for Objective 3	
i.	M&E staff for all at least three programme and Zobas recruited by end of 2012
ii.	M&E human resource capacity needs assessment report produced by March 2013
iii.	M&E capacity building programme designed by April 2013
iv.	Implementation of the M&E capacity building programme completed by end 2013

D Objective 4: Provide up to date data and information on the performance of the health sector with emphasis on HIV/AIDS/STI, TB, Malaria, RH, Nutrition, Child and Adolescent Health and HSS.

Data and information collection will be the mainstream for the 2nd M&E Framework. To ensure provision of update data and information, the following strategic actions will be undertaken:

Strategic Action 1: Support to routine programme monitoring

The HMIS will be the main approach for routine monitoring for all the programmes. Data will be collected and reported on a monthly basis using existing HMIS reporting tools. Extra data required by programmes, which is not part of HMIS, will also be collected and reported on a monthly basis using tools developed by the respective programmes. The M&E Division will coordinate all programmes, to ensure that routine monitoring is harmonized to avoid duplication and overloading of health facilities with multiple data collection and reporting demands.

Strategic Action 2: Implementation of surveys and surveillance activities to assess performance of HSSDP

During the 2nd integrated M&E Framework, a number of surveys and surveillance activities will be carried out as indicated below:

Health Sector-Overall	▪ Demographic Health Survey ▪ LQAS Survey – Biennially ▪ Health Facility Survey
HIV/AIDS	▪ Antenatal Clinic (ANC) HIV and syphilis prevalence surveillance biennially ▪ HIV and syphilis surveillance survey in commercial sex ▪ HIV and syphilis surveillance survey in truck drivers commercial sex ▪ HIV surveillance survey in TB patients biennially ▪ Modes of HIV Transmission
TB Programme	▪ TB prevalence surveillance-Once during the 2nd M&E Framework ▪ National baseline MDR surveillance survey
Malaria Programme	▪ Malaria Indicator Survey –Once during the 2nd M&E Framework ▪ Malaria prevalence survey in 4 zones ▪ Entomological survey ▪ Anti-malarial drug's efficacy study in 4 sentinel sites
Nutrition Programme	▪ Micronutrient Survey among children
RH Programme	▪ Quality of care study on community hospitals and health centers providing EMNOC

Child Health	▪ Survey on proper preparation of ORS at home

Key outputs for Objective 4:

i) Routine programme monitoring

Health Sector (Overall)	▪ HMIS data collection and reporting tools printed and distributed to all health facilities ▪ Timely and accurate monthly HMIS reporting done by at least 90% of health facilities ▪ Annual Health Services Activity report produced and disseminated by end of March of every subsequent year
HIV/AIDS	▪ Routine data on HIV/AIDS death, ART, HCT/VCT, PMTCT, Condom distribution which is not captured by HMIS, reported by all implementing units every month. ▪ Routine data collection tools printed and distributed annually
TB Programme	▪ Monthly routine data collected and reported to the national TB programme by all TB treatment centres
Malaria Programme	▪ Routine data on malaria which is not captured by HMIS, reported by all implementing units every month

II) Data collected and reported on indicators in the result framework as below

Programme	Impact Indicators	Outcome Indictors	Output Indictors	Input Indicators	Total
HIV/AIDS	8	23	8	0	39
TB	3	7	5	0	15
Malaria	3	5	10	0	18
RH	4	5	2	0	11
Child & Adult Health	3	5	7	0	15
Nutrition	7	10	1	0	18
HSS	0	9	11	0	20
Total	28	64	44	0	136

Part 3 Results Framework for the MOH Integrated Monitoring and Evaluation System

3.1 Introduction

The 2nd integrated M&E framework will be the main guide in determining the extent to which the goals and objectives of the HSSDP have been attained. To realize this, a set of core indicators have been developed and have been aligned to the HSSDP objectives.

The core indicators in the result framework below respond to key levels of measurement of the M&E results chain (Impact, Outcome, and Output) for the priority programmes of the HSSDP 2012- 2016. The indicators shall also be able to meet the international reporting requirements for which Eritrea is mandated to report on, such as the MDG, Global Fund and UNGASS. The indicators in the result framework cover HSSDP priority programmes of HIV/AIDS/STI, TB, Malaria, RH, Nutrition, Child Health and HSS.

3.2 Result Framework

3.2.2 HIV /AIDS /STI Results Framework 2012-2016

Indicator	Baseline	Targets					Data Collection		
		2012	2013	2014	2015	2016	Frequency	Data Collection Instruments	Data Collection Responsibility
HSSDP Objectives: **I)** HIV-AIDS halted below 1% prevalence by 2016 and continue to reverse the spread of HIV/AIDS **II)** Achieve, by 2016, universal access to treatment for HIV/AIDS for all those who need it.									
Impact Indicators									
1. Prevalence of HIV/AIDS in the general population.	1.31% (2009)	1.2%	1.1%	1.0%	0.9%	0.8%	ANC 2 yrs;	ANC, EPHS +	NATCoD
2. HIV prevalence among young people age group 15-24 years	0.73% (2009)	0.5%	0.4%	0.3%	0.25%	0.2%	Every 2 yrs	ANC SSS	NATCoD
3. Syphilis sero-prevalence rate among ANC attendees aged 15-24 years	0.41% (2009)	0.3%	0.2%	0.10%	0.08%	0.05%	Every 2 yrs	ANC SSS	NATCoD
4. Syphilis sero-prevalence rate among pregnant women aged 15-49	0.62% (2009)	0.5%	0.4%	0.30%	0.2%	0.1%	Every 2 yrs	ANC SSS	NATCoD
5. Percentage of most-at-risk population(s) (female sex workers,) who are HIV infected	7.75% (2008)	7%	6.5%	6%	5.5%	5%	Every 2 yrs	Special studies on MARPs	NATCoD
6. Percentage of infants born to HIV infected mothers who are HIV infected at six weeks	9% (2011)	6%	3%	3%	3%	2%	Annual	Spectrum Modeling	NATCoD
7. Percentage of adults and children with HIV still alive 12 months after initiation of anti-retroviral therapy	85.0% (2009)	87%	88%	90%.	92%	95%	Annual	Annual report	NATCoD
Outcome Indicators for HIV/AIDS/STI									
Promotion of Condom Use									
1. Percentage of female sex workers using condoms with the most recent client (at capital city)	47.4% (2008)	85%	90%	95%	98%	99%	Every 2 years	Special studies on MARPs	NATCoD
2. Percentage of high risk groups (Truck drivers) who used condom properly during their last sex practice in the last 12 months.	93 (2006)	95%		95%		95%	Every 2 years	Special studies on MARPs	NATCoD
3. Proportion of sexually active males/females who report condom use during last high-risk sexual encounter within the last 12 months	70.5% (2007)	75%		85%		90%	Every 5 years	EPHS+	NSO
Behavioral Change Communication									
4. Percentage of young women and men who have had sex	TBE	TBD	TBD	TBD	TBD	TBD	Every 2 or 5	EPHS+	NATCoD/NSO

before the age of 15 years							years		
5. Percentage of never married young men and women aged 15-24 who have never had sex	TBE	TBD	TBD	TBD	TBD	TBD	Every 2 or 5 years	EPHS+	NATCoD/NSO
6. Percentage of women & men aged 15-49 who have had sexual intercourse with more than one partner in the last 12 months	TBE	TBD	TBD	TBD	TBD	TBD	Every 2 or 5 years	EPHS+	NATCoD/NSO
7. Percentage of never married young men and women aged 15-24 who have never had sex	TBE	TBD	TBD	TBD	TBD	TBD	Every 5 yrs	EPHS+	NATCoD/NSO
8. Percentage of women and men aged 15-49 who have had sexual intercourse with more than one partner in the last 12 months	TBE	TBD	TBD	TBD	TBD	TBD	Every 5 yrs	EPHS+	NATCoD/NSO
HIV Counselling and Testing									
9. Percentage of all adults 15-49 years old who were tested and received their HIV results in the last 12 months	TBE	TBD	TBD	TBD	TBD	TBD	Every 2 or 5 years	Special studies/ EPHS+	NATCoD/NSO
10. Percentage of infants born to HIV-positive women who received a virological test for HIV within 2 months of birth	NA	50%	65%	85%	95%	95%	Quarterly	Quarterly Report	NATCoD
11. Percentage of sex workers who have received an HIV test in the past 12 months and know their results	NA	TBD	TBD	TBD	TBD	TBD	Every 2 years	Special studies	NATCoD
12. Number of people (including pregnant women) who received testing and counseling services for HIV and received their test result	142,786 (2011)	170,000	170,000	170,000	170,000	170,000	Monthly	Monthly Report	NATCoD
ART, Care and Support Programme									
13. Number of adults and children with advanced HIV infection receiving anti-retroviral combined therapy	6431 (2011}	7718	8704	9469	10,368	11,324	Annually	Annual report	NATCoD
14. Number and percentage of adults and children with advanced HIV infection currently receiving ART	6431 (63%) (2011)	7718/10 720 (72%)	8704/10 880 (80%)	9469/11 140 (85%)	10,368/1 1,520 (90%)	11,324/1 1920 (95%)	Annually	Annual Report & Spectrum Modelling	NATCoD
Safe Blood Transfusion Programme									
HSSDP Objective: To provide safe and adequate quantities of blood and blood products for treatment of all patients who are medically in need.									
15. Number and % of transfused blood units screened for HIV and Hepatitis B&C, according to national guidelines	11,336 94%	11457 (95%)	11578 (96%)	11699 (97%)	11699 (98%)	11699 (99%)	Monthly	Monthly Report	NBTS
STI Prevention and Management									
16. Number of patients receiving diagnosis and treatment for STIs	4336 (2010)	6,000	6,000	6,000	6,000	6,000	Annually	Annual report	NATCoD
PMTCT Programme									

17. Number of HIV infected women receiving a complete course of antiretroviral prophylaxis to reduce the risk of Mother to Child transmission.	540 (2011)	590	640	690	740	790	Annually	Annual report	NATCoD
Output Indicators									
ART, Care and Support									
1. Number of health facilities providing ART	19 (2011)	21	23	25	27	30	Annually	Annual report	NATCoD
2. Number of health facilities providing PEP	19 (2011)	45	55	60	60	60	Annually	Annual report	NATCoD
Condom Promotion									
3. Number of male condoms distributed to general population	5,766,936 (2009)	8,000,000	8,000,000	8,000,000	8,000,000	8,000,000	Annually	Annual report	NATCoD
Behavioral Change Communication									
PMTCT									
4. Number of PMTCT sites established/supported	186 (2011)	190	193	196	199	202	Annually	Annual report	NATCoD
HIV Counseling and Testing									
5. Number of VCT sites established	238 (2011)	240	245	250	253	260	Annually	Annual report	NATCoD

3.2.3 TB Results Framework 2012-2016

Indicator	Baseline	Targets					Data Collection		
		2012	2013	2014	2015	2016	Frequency	Data Collection Instruments	Data Collection Responsibility
HSSDP Objectives for the TB Programme: • TB case detection increased from current 40% to at least 70%, • TB cure rate increased from current 81% to 90% and reduce death rate to <4% by 2013 (TB) • Ensure Lab AFB quality assurance and quality control to 85% DOTS implementing centres by the year 2013. • Incidence, prevalence and death rates associated with tuberculosis measured and decreased.									
Impact Indicators									
1. Prevalence rate of TB per 100,000	50 (2005)	25/100,000	24/100,000	23/100,000	22/100,000	20/100,000	Every 7 years	TB prevalence survey	NTCP
2. TB mortality rate	6.00% (2010)	5%	4%	<4%	<4%	<4%	Quarterly	NTCP Prog report	NTCP
3. Prevalence of MDR- TB among new and re-treatment cases (Facility based)	NA TBE	TBD	TBD	TBD	TBD	TBD	Every five years	Facility based Survey	NTCP
Outcome Indicators									
1. Percentage of new smear positive TB cases detected among the total estimated number of new smear positive TB case per year	46% (2010)	50%	60%	70%	>70	>70	Quarterly	Annual report	NTCP
2. Percent of new smear positive pulmonary TB cases that are cured	83.0% (2010)	82%	85%	<90%	<90%	<90%	Quarterly	Annual report	NTCP
3. Percent of new smear positive pulmonary TB cases that are successfully treated	85% (2010)	88%	<90%	<90%	<90%	<90%	Quarterly	Annual report	NTCP
4. Percentage of All TB Cases detected (all TB cases) during the year	67% (2011)	68%	69%	70%	70%	72%	Quarterly	Annual report	NTCP
5. Number of HIV positive patients screened for TB	143 (2010)	2000	2500	3000	3000	3000	Quarterly	Annual report	NTCP
6. Number of TB patients screened for HIV	1019 (2010)	2500	3000	3200	3500	3500	Quarterly	Annual report	NTCP
7. Number of MDR-TB cases detected in new and re-treatment cases	33 (2011)	50	70	80	90	100	Quarterly	Annual report	NTCP
Output Indicators									
1. Percentage of functional AFB microscopy center	64% (2010)	70%	76%	78%	80%	82%	Quarterly	Annual report	NTCP

Indicator	Baseline	Targets					Data Collection		
		2012	2013	2014	2015	2016	Frequency	Data Collection Instruments	Data Collection Responsibility
2. Percentage of health facilities with adequate stock of TB medicines in the last 3 months	80% (2011)	100%	100%	100%	100%	100%	Bi-annually	Semi/Annual report	NTCP
3. Number of peripheral health facilities (health stations) functioning as sputum collection and fixing centers and providing DOTS	114 (2011)	120	125	130	140	15	Quarterly	Annual report	NTCP
4. Number of Health facilities supervised once every two quarters	77 (2011)	77	77	77	77	77	Quarterly	Annual report	NTCP
5. Number of TB suspects who are referred by the TB promoters.	286 (2011)	336	386	436	486	536	Quarterly	Annual report	NTCP

3.2.4 Malaria Results Framework, 2012-2016

HSSDP Objective for Malaria : Have halted by 2014 and continue to reverse the incidence of malaria and other major diseases									
		Targets					Data Collection		
Indicator	**Baseline**	**2012**	**2013**	**2014**	**2015**	**2016**	**Frequency**	**Data Collection Instruments**	**Data Collection Responsibility**
Impact Indicators									
1. Malaria inpatient deaths per 1000 people at risk per year	1.02 (2010)	0.83	0.74	0.67	0.60	0.54	Monthly	HMIS	NHMIS/NMCP
2. Incidence of malaria cases (per 1000 people at risk) per year	23.97 (2010)	19.42	17.47	15.73	14.15	12.73	Monthly	HMIS	NHMIS/NMCP
3. Case fatality rate in children under five at health facilities	0.55% (2010)	0.11	0.099	0.079	0.071	0.064	Monthly	HMIS	NHMIS/NMCP
Outcome Indicators									
1.Percentage of pregnant women sleeping under ITN the previous night	50.4% (2004)	95%	NA	100%	NA	100%	Every 5-7 years	EPHS+	NMCP/M&E Division /NSO
2.Percentage of children under five sleeping under ITN the previous night	48.9% (2008)	95%	NA	100%	NA	100%	Every 2-3 years	Malaria Indicator Survey	NMCP
3.Percent of under five children with malaria/fever receiving appropriate treatment within 24 hours (community/health facility)	16.20% (2008)	70%	NA	100%	NA	100%	Every 2-3 years	Malaria Indicator Survey	NMCP
4.Percentage of households in malarious areas owning at least 1 ITN	70.90% (2008)	100%	100%	100%	100%	100%	Every 2-3 years	Malaria Indicator Survey	NMCP
5.Percentage of households in malarious areas owning at least 2 ITNs	40.0% (2008)	96%	100%	100%	100%	100%	Every 2-3 years	Malaria Indicator Survey	NMCP
Output Indicators									
1.Average number of LLINs per household	0.5 (2008)	2.5	NA	2.5	NA	2.5	Every 2-3 years	Malaria Indicator Survey	NMCP
2.Percentage of People (or target groups) who know the cause of, symptoms of, treatment for or preventive measures for malaria	75.3% (2008)	92%	NA	100%	NA	100%	Every 2-3 years	Malaria Indicator Survey	NMCP
3.Percent of health facilities with no reported stock-outs lasting >1 week of nationally recommended anti-malarial drugs at any time during the past 3 months	82% (2008)	100%	100%	100%	100%	100%	Quarterly	LMIS	LMIS/NMCP
4.Number of LLITNs distributed	2,940,286 (2011)	11,7500	104,112	1,829,926	122,725	127,634	Monthly	NMCP Excel database	NMCP
5.Number of patients receiving ACT treatment	67,933 (2011)	67,932	61,139	55,025	49,525	44,575	Monthly	HMIS	NHMIS

HSSDP Objective for Malaria : Have halted by 2014 and continue to reverse the incidence of malaria and other major diseases									
		Targets					Data Collection		
Indicator	**Baseline**	**2012**	**2013**	**2014**	**2015**	**2016**	**Frequency**	**Data Collection Instruments**	**Data Collection Responsibility**
6. Number of malaria cases (clinical and confirmed) treated at community level.	30,367 (2011)	27,330	24,597	22,137	19,901	17,920	Monthly	NMCP Excel database	NMCP
7. Number of RDTs distributed to public, private & military health facilities	353,730 (2011)	345,630	393,178	376046	378,244	360,723	Quarterly	NMCP program reports	NMCP
8. Number of <5 children reached through home based management	3,566 (2011)	2,841	2,557	2,301	2,071	1,864	Quarterly	NMCP program reports	NMCP
9. Percent of houses in target communities in high and moderate incidence sub-zobas covered by a timely application of indoor residual spraying (IRS)	90.3% (2008)	95%	95%	95%	95%	95%	Annually	NMCP program reports	NMCP
10. Number of sentinel sites collecting epidemiological information	32 (2011)	32	32	32	32	32	Quarterly	NMCP program reports	NMCP

3.2.5 Reproductive Health Results Framework 2012-2016

HSSDP Objective for Reproductive Health:

1. Improve maternal health
   - Reduce Maternal Mortality Ratio to 300 or lower per 100,000 live births by 2016.
   - Achieve, by 2015, universal access to reproductive health by 2014
   - Reduce incidence of anaemia in pregnancy by 50%
2. Reduce perinatal, neonatal, infant and child mortality by 75% from the baseline by the end of 2014

		Targets					Data Collection		
Indicator	**Baseline**	**20012**	**2013**	**2014**	**2015**	**2016**	**Frequency**	**Data Collection Instruments**	**Data Collection Responsibility**
Impact Indicators									
1. Maternal Mortality Ratio per 100,000	486 (2010)	450	400	350	325	300	Every 5 yrs	EPHS+	RH Program
2. Prevalence of Obstetric Fistula	0.30% (2010)	0.2%	0.15%	0.12%	0.11%	0.10%	Every 5 yrs	EPHS+	RH/M&E Division /NSO
3. Prevalence of Female Genital Mutilation (FGM) among girls child under 15 Years	33% (2010)	25%	20%	16%	14%	10%	Every 5 yrs	EPHS+	RH/M&E Division /NSO
4. Prevalence of teenage pregnancy	14% (2010)	13%	12%	10%	9%	8%	Every 5 yrs	EPHS+	RH/M&E Division /NSO
Outcome Indicators									
1. Percentage of mothers visiting ANC at least once	88.5% (2010)	90%	92%	94%	95%	95%	Every 5 years	EPHS+	M&E Unit, RH Unit/NSO
2. Percentage of mothers making at least four ANC visits	18.7% (2011)	25%	35%	50%	55%	60%	Annual report	HMIS	M&E Unit, RH Unit
3. Percentage delivered in health facility	33.7% (2010)	40%	45%	50%	55%	60%	Annual report	HMIS	RH Unit
4. Percentage of mothers delivered by caesarian section	2% (2011)	4%	6%	8%	10%	14%	Annually	HFA	RH/M&E Division /NSO
5. Contraceptive Prevalence Rate (modern method)	8.40% (2010)	9%	10%	11%	12%	13%	Every 5 yrs	EPHS+	RH/M&E Division /NSO
6. Met need for contraception									
7. Antiretroviral prophilaxis among HIV positive pregnant women to prevent vertical transmission of HIV, and antiretroviral therapy for women who are treatment eligible									
Output Indicators									

1. Number of community hospitals and health centers providing Basic EMNOC	25 (2011)	37	42	47	52	59	Annually	HFA	RH Unit
2. Number of community hospitals and health centers providing Comprehensive EMNOC	13 (2011)	16	19	22	25	28	Annually	HFA	RH Unit
3. Percentage of mothers and babies who received postnatal care visit within two days of childbirth									

3.2.6 Child and Adolescent Health / EPI Results Framework 2012 - 2016

HSSDP Objective: **Reduce child mortality:**
- Reduce Infant mortality rate to 29 or lower per 1,000 live births by 2016
- **Reduce Under-five mortality rate 42 or lower per 1,000 live births by 2016**

		Targets					Data Collection		
Indicator	**Baseline (Year)**	**20012**	**20013**	**2014**	**2015**	**2016**	**Frequency**	**Data Collection Methodology**	**Data Collection Responsibility**
Impact Indicators									
1. Under 5 mortality rate:	63/1000 (2010)	58/1000	54/1000	49/1000	45/1000	42/1000	Every 5 years	EPHS+	CH/M&E Division/ NSO
2. Infants mortality rate-	42/1000 (2010)	38/1000	33/1000	29/1000	27/1000	25/1000	Every 5 years	EPHS+	CH/M&E Division/ NSO
3. Neonates mortality rate	23/1000 (2010)	21/1000	19/1000	17/1000	16/1000	15/1000	Every 5 years	EPHS+	CH/M&E Division/ NSO
Outcome Indicators									
1. Child under five who are stunted(percentage of children under five years of age whose height for age is below minus two standard deviations from the median of the WHO child growth standards)									
1. Percentage of children under one year old immunized with Pentavalent 3 vaccine	93.7% (2010)	95.7%	97%	98%	99%	99%	Every 5 years	EPHS+	CH/M&E Division/ NSO
2. Percentage of children under one year old immunized with Measles vaccine	95.2% (2010)	96%	97%	98%	99%	99%	Every 5 years	EPHS+	CH/M&E Division/ NSO
3. Percentage of new born protected at birth from Maternal Neonatal Tetanus (MNT)	93% (2009)	94%	95%	96%	98%	99%	Every 3 years	EPI coverage survey	CH/M&E Division/ NSO
4. Percentage of children aged 0-59 months with suspected ARI taken to Health Facilities	44.8% (2010)	52%	57%	62%	67%	72%	Every 5 years	EPHS+/HFA	CH/M&E Division/ NSO
5. Percentage of children aged 0-59 months with diarrhea receiving any oral dehydration therapy	70% (2010)	71.4%	75%	78.5%	82.4%	86.6%	Every 5 years	EPHS+	CH/M&E Division/ NSO
6. Three doses of the combined diphtheria, pertussis and tetanus vaccine (percentage of infants aged 12-23 months who received three doses of diphtheria/perussis/tetanus vaccine									
7. Antibiotic treatment for pneumonia (Percentage of children aged 0-59 months with suspected pneumonia receiving antibiotics)									
Output Indicators									
1. Proportion of health facilities without stock outs of ORS in the last month	83% (2010)	100%	100%	100%	100%	100%	Every 3 yrs	LMIS, HFA	CH/M&E Division

2. Proportion of health facilities with at least one trained health workers in IMCI	61% (2010)	63%	66%	69%	72%	75%	Every 3 yrs	Health facility assessment	CH/M&E Division
3. Proportion of health facilities without stock outs of co-trimoxazole in the last month	92% (2010)	100%	100%	100%	100%	100%	Every 3 yrs	LMIS, HFA	CH/M&E Division
4. Proportion of households having at least ONE long-lasting net or ITN retreated within the last 12 months with insecticide	70.90% (2008)	80%	85%	90%	100%	100%	Every 2.5yrs	Malaria pop survey	CH/M&E Division/ NSO
5. Percentage of health facilities with None-Obsolete, Standard,& functioning CC Equipment	71% (2010)	76	81	86	91	96	Every 5 years	Cold chain assessment	CH/M&E Division/ NSO
1. Percentage of HF with availability of at least one HW with upgraded skill on vaccine and CC Managements	80% (2010)	82	84	86	88	90	Every 3 years	Health facility assessment	CH/M&E Division/ NSO
2. Proportion of mothers who properly demonstrate on how to prepare ORS	XX	XX	XX	XX	XX	XX	Every 5 years	Health facility assessment	CH/M&E Division/ NSO

3.2.7 Nutrition Results Framework 2012 -2016

HSSDP Objective: Reduce acute malnutrition rate in children U5 from 15.3% in 2010 to 5.5% in 2016									
		Targets					**Data Collection**		
Indicator	**Baseline**	**2012**	**2013**	**2014**	**2015**	**2016**	**Frequency**	**Data Collection Instruments**	**Data Collection Responsibility**
Impact Indicators									
1.Prevalence of underweight in under 5 children	38.8% (2010)	36%	34%	34%	32%	30%	Every 5 years	EPHS+	Nutrition Unit, NSO
2.Prevalence of wasting in under 5 children	15.3% (2010)	13.5%	11.5%	9.5%	7.5%	5.5%	Every 5 years	EPHS+	Nutrition Unit, NSO
3.Prevalence of Iron Deficiency Anemia in children 6-59 months	45% (2002)	43%	42%	41%	40%	39%	Every 5 years	Micronutrient Survey	Nutrition Unit
4.Prevalence of Night Blindness in children	0.6% (2002)	0.5%	0.4%	0.3%	0.2%	0.1%	Every 5 years	Micronutrient Survey	Nutrition Unit
5.Prevalence of Vitamin A Deficiency in preschool children 6-59 months	42% (2002)	40%	38%	35%	33%	30%	Every 5 years	Micronutrient Survey	Nutrition Unit
6.Prevalence of Maternal under nutrition 15-49 years	37.3% (2002)	36%	35%	34%	33%	32%	Every 5 years	EPHS+	Nutrition Unit, NSO
7. Prevalence of Iron Deficiency Anemia in Pregnant Women	11.8% (2002)	10.5%	9.0%	8.0%	7.0%	6.0%	Every 5 years	Micronutrient Survey	Nutrition Unit
Outcome Indicators									
1. Percentage of mothers initiating BF with **1** hour after delivery	79.0% (2002)	90%	92%	94%	96%	98%	Every 5 years	EPHS+	Nutrition Unit
2. Percent of children breastfed exclusively in the first 6 months of age	50.3% (2010)	54%	56%	58%	59%	60%	Every 5 years	EPHS+	Nutrition Unit, NSO
3. Percent of infants initiating complementary food 6 months of age	33% (2002)	45%	50%	57%	62%	72%	Every 5 years	EPHS+	Nutrition Unit, NSO
4. Percent of severely wasted children cured in Therapeutic Feeding Centers	90% (2011)	91%	92%	93%	94%	95%	Yearly	Monthly TFC reports	Nutrition Unit
5. Percent of severely wasted children cured in Community based Therapeutic Feeding Centers	70% (2011)	72%	74%	76%	78%	80%	Yearly	Monthly TFC reports	Nutrition Unit
6. Moderately wasted under 5 children discharged from supplementary feeding program	78% (2011)	79%	80%	81%	82%	83%	Yearly	Monthly TFC reports	Nutrition Unit
7. Percent of households consuming Iodized Salt	68% (2002)	73%	78%	80%	85%	90%	Every 5 years	EPHS+	Nutrition Unit, NSO
8. Percent of under 5 supplemented VA every 6 months	81% (2011)	82%	83%	84%	85%	86%	Every 6 months	National Vit A Supplementation Campaigns, Annual	Nutrition Unit

								Nutritional Report	
9. Percentage of complementary feeding at 6 months of age	56% (2010)	70%	71%	72%	73%	74%	Every 5 years	EPHS+	Nutrition Unit
10.Percent of Pregnant women provided with iron folic acid tablets at ANC	38% (2002)	45%	50%	60%	70%	80%	Yearly	Annual Nutritional Report	Nutrition Unit
Output Indicators									
1. Number of Health Workers trained on management of acute malnutrition	120	120	120	120	120	120	Yearly	Annual Nutritional Report	Nutrition Unit

3.2.8 Health Systems Strengthening Results Framework 2012-2016

		Targets					Data Collection		
Indicator	**Baseline**	**2012**	**2013**	**2014**	**2015**	**2016**	**Frequency**	**Data Collection Instruments**	**Data Collection Responsibility**
Human Resource for Health Development and Management		**2012**	**2013**	**2014**	**2015**	**2016**	**Frequency**	**Data Collection Instruments**	**Data Collection Responsibility**
HSSDP Objective: I. To increase availability of skilled human resources at all levels by 2016 as per the set norms and improve their management II. To improve the ratio of Doctor to Nurses to 1: 4 by 2016 III. To reduce attrition rate of health workers									
1.Proportion of health facilities with at least 70% of the position filled as per the established staffing norms i	60 2011	62	64%	66%	68%	70%	Annual	Annual HRH Report	HRH Division
2.The ratio of Doctor to Nurses	1:6 (2011)	1:6	1:5	1:5	1:5	1:4	Annual	HRH Database	HRH Division
3.Average attrition rate of health workers	6.4% (2011)	6.2%	6%	5.5%	5%	4%	Annual	Annual HRH Report	HRH Division
4.Number and Proportion of staff trained on infection control and medical waste management in health facilities (GF indicator)	(6) 20% (2011)	(10) 33%	(15) 50%	(20) 66%	(25) 83%	(30) 100%	Annual	Annual MSD Report	Nursing & QA Unit
Pharmaceuticals Procurement, Supply and Logistics Management	**Baseline**	**2012**	**2013**	**2014**	**2015**	**2016**	**Frequency**	**Data Collection Instruments**	**Data Collection Responsibility**
HSSDP Objectives: I. Ensure the availability and accessibility to safe, effective and quality pharmaceuticals and medical equipments and supplies in line with the national & international standards. II. Ensure an uninterrupted and adequate supply of quality pharmaceuticals III. To ensure that the medicines, medical supplies, and logistics are of standard quality and managed properly at all levels;									
1. At least 85% of essential medicines available in stock all the time in the country.	80%	85%	90%	95%	95%	95%	Annual	LMIS	Drug Management Division
2. Proportion of health facilities with no stock out of key essential medicines	80%	85%	90%	95%	95%	95%	Annual	LMIS	M&E Division / Pharmacy
3. Proportion of public hospital pharmacies with fully computerized inventory control system(OPD, Inpatient, Main pharmacy store)	35%	60%	70%	80%	95%	95%	Annual	LMIS	M&E Division / Pharmacy

4. Number and percentage of targeted health facilities that reported on adverse drug reactions (GF indicator)	NA	16(5%)	33(10%	43(13%)	50(50%	67(20%)	Annual	Pharmacovigilance center report	Medicines Control Division
Laboratory	**Baseline**	**2012**	**2013**	**2014**	**2015**	**2016**	**Frequency**	**Data Collection Instruments**	**Data Collection Responsibility**
HSSDP Objective: To enhance laboratory and diagnostic capacity and/or strengthen laboratory and diagnostic networking system for early diagnosis of communicable and non-communicable diseases at all levels by 2016.									
1. Number and proportion of health facilities with established laboratory infrastructure that meet the national standards	TBE	TBD	TBD	TBD	TBD	TBD	TBD	TBE	TBE
2. Number and proportion of health facilities that have without basic laboratory supply stock out	TBE	TBD	TBD	TBD	TBD	TBD	TBD	TBE	TBE
3. Proportion of health facilities with laboratories that have the required technical staff, according to the MOH staffing norms	TBE	TBD	TBD	TBD	TBD	TBD	TBD	TBE	TBE
Health Management Information System	**Baseline**	**2012**	**2013**	**2014**	**2015**	**2016**	**Frequency**	**Data Collection Instruments**	**Data Collection Responsibility**
HSSDP Objective: To provide accurate, relevant, complete, and timely health information for decision makers, implementers and other HMIS data users.									
1. Percentage of Zones submitting complete reports to national level	98.7% (2010)	99%	100%	100%	100%	100%	Annual	Annual Health Service Activity Report	HMIS
2. Percentage of Zones submitting timely reports to national level	83% (2010)	84%	86%	88%	<90%	<90%	Annual	Annual Health Service Activity Report	HMIS
3. Annual Health Service Activity Report Produced by end of May of every subsequent year	May 2011 (for 2010)	Report for 2011 Produced by May 2012	Report for 2012 Produced by May 2013	Report for 2013 Produced by May 2014	Report for 2014 produced by May 2015	Report for 2015 Produced by May 2016	Annual	Annual Health Service Activity Report	HMIS
4. Health Information Systems Performance Index (HISPIX)-GF indicator)	TBE	TBD	TBD	TBD	TBD	TBD	TBD	TBE	HMIS
Monitoring and Evaluation System	**Baseline**	**2012**	**2013**	**2014**	**2015**	**2016**	**Frequency**	**Data Collection Instruments**	**Data Collection Responsibility**
HSSDP Objective: To provide decision makers at all levels evidence-based data for planning and program management.									
• Number of MOH Programmes that have M&E Units with at least one M&E Officer	2(2011)	4	6	7	7	7	Annual	M&E Implementation Status Report	M&E Division
• Number of Zobas that have M&E units with at least one M&E Officer	0 (2011)	1	3	5	6	6	Annual	M&E Implementation Status Report	M&E Division
• Number of Programmes producing reports on the implementation of the M&E activities and M&E Indicators	0 (2011)	3	4	5	6	7	Annual	M&E Implementation Status Report	M&E Division

for which they are mandated for, by end of January of each subsequent year									
• Number of and Proportion of M&E Officers trained in the implementation of the 2nd Integrated M&E Framework and the national M&E data base	NA	60	60	60	60	60	Annual	M&E Implementation Status Report	M&E Division
• Annual M&E Implementation Status Report Produced by end March every year	No report on M&E implementation being produced (2011)	M&E implementation report for 2011 produced by end March 2012	M&E implementation report for 2012 produced by end March 2013	M&E implementation report for 2013 produced by end March 2014	M&E implementation report for 2014produced by end March 2015	M&E implementation report for 2015produced by end March 2016	Annual	M&E Implementation Status Report	M&E Division

3.3 National Integrated Monitoring & Evaluation Action Plan (NIMEAP) 2012-2016

National Integrated Monitoring & Evaluation Action Plan (NIMEAP) 2012- 2016										
	Activity	**Responsible agency**	**Cost Description**	**2012**	**2013**	**2014**	**2015**	**2016**	**Total 2012-2016**	**Source of Funding**
Component 1: Organization Structures for M&E Functions										
Objective 1: *To strengthen M&E organizational structures at national and decentralized levels and provision of support to ensure their functionality*.										
1.1.1	Develop Job Profiles, functions, and mandates of M&E Units for Depts., Divisions and Prog, at MOH, and for Zobas	M&E Division and Programmes	Refreshment for task force meetings	160	160	160	160	160	**800**	Gov't
1.1.2	Equip and furnish all M&E units at Division, Programme and Zoba level	M&E Division & Programmes	Office equipment and furniture		8,339.20	8,339.20	8,339.20	8,339.20	**33356.8**	Global Fund
1.1.3	Review and reconstitute the Advisory M&E Committee, and the M&E Technical Working Group (M&E TWG), into one M&E Committee	M&E Division	Quarterly meetings for M&E Committee (Refreshments, & Stationery)	120	120	120	120	120	**600**	Global Fund (RD10 *)
1.1.4	Annually review the functionality of the established M&E structures improve their performance	M&E Division	Holding review meetings with each M&E units	140	140	140	140	140	**700**	Global Fund
1.1.5	Email-internet connection	M&E Division	Procure Internet connectivity	10,000.00	10,000.00	10,000.00	10,000.00	10,000.00	**50000**	Global Fund (RD 10 *)
Component 2: Human and Operational Capacities for M&E										
Objective 2: *To develop and implement a customized M&E human resources training programme for the implementation of the 4th Integrated M&E Framework*										

2.1	M&E Human Resource			2012	2013	2014	2015	2016	Total 2012-2016	Funding Source
2.1.1	Recruit a National M&E Coordinator in the M&E Division to provide M&E leadership for the MOH	M&E Division	TOR Devpt Advertisement, Interviews, and Salary support		150,000		150,000		**300,000**	Gobal Fund
2.1.2	Implement the Zoba level M&E system	M&E Division	Office supplies		30,000		30,000		**60,000**	TBI
2.2	**Training on M&E System**									
2.2.1	Zoba M&E training on data management, analysis, decision making, and report writing	M&E Division	6 five-day workshop of 30 participants	40,500		40,500		40,500	**121,500**	Global Fund
2.2.2	Conduct training for M&E officers on Epi Info data analysis and data interpretation	M&E Division	International TA for 20 days plus return ticket & 5 day workshop of 30 people		25,750		25,750		**51,500**	Global Fund
2.2.3	Identification of M&E training needs for all M&E staff in the ministry	M&E Division	Short term TA Commission an M&E skills & training needs assessment	27,000		27,000		27,000	**81,000**	UNDP *
2.2.4	Build the capacity of M&E Division, programs and PMU's staff by 4 weeks training abroad	M&E Division	Training abroad	20,000	20,000	20,000	20,000	20,000	**100,000**	Global Fund
2.2.5	Conduct refresher course for M&E officers	M&E Division	refresher M&E course	9,450	9,450	9,450	9,450	9,450	**47,250**	Global Fund (RD 8, 9, 10) *
2.2.6	Attend long term training (epidemiology/ Statistics/ Demography, M&E etc)		2 year long-term training course		50,000		50,000		**100,000**	Global Fund (RD 10) *
Component 3: National M&E Partnerships										

Objective 3: To Strengthen the National M&E Advisory Committee and the M&E Technical Working Groups to Promote Partnership for M&E Implementation										
3.1	**National M&E Advisory Committee**									
3.1.1	Conduct regular M&E Committee meetings	M&E Committee	Refreshment for every qrt	120	120	120	120	120	**600**	Global Fund (RD 10) *
3.1.2	Hold the annual health sector joint review of the HSSDP implementation	M&E Division	3 day joint review meetings of 50 pple every 2 yrs	6,750.00		6,750.00		6,750.00	**20,250**	Global Fund
Component 4: National Integrated M&E Framework										
Objective 4: *To Strengthen Implementation of the National Integrated M&E Plan for the Health Sector for the Seven Priority Programmes*										
4.1	**National Integrated M&E Framework**									
4.1.1	Technical support supervision and mentoring of M&E units at programme and Zoba level	M&E Division	One day visit to each M&E units per quarter	372	372	372	372	372	**1,860.00**	Global Fund RD-10 *
4.2	**Programme Specific M&E Frameworks**									
4.2.1	Support the development of Programme Specific M&E frameworks for six priority areas	M&E Division & Programmes	TA, Meeting Costs and staff time	9,600	0	0	0	0	**9,600.00**	Global Fund
4.2.3	Printing and dissemination M&E frameworks to relevant stakeholders	Respective M&E Units	Printing & dissemination	5,000	5,000	5,000	5,000	5,000	**25,000.00**	Global Fund
Component 5: National Integrated Costed M&E Work plan (Roadmap)										
Objective: *To support the costing and mobilization of resources for annual roll out of a National M&E Work plan*										
5.1	**National M&E Integrated Action Plan (NIMEAP)**									
5.1.1	Annual planning & budgeting for integrated M&E frame work implementation based on the five-year action plan	M&E Division	Meeting costs(3o people for 4 days	5,400	5,400	5,400	5,400	5,400	**27,000.00**	Global Fund

Component 6: Advocacy, communication and the culture of M&E										
Objective 6: To ensure knowledge of and commitment to M&E among policymakers, program managers, program staff and other stakeholders										
6.1	**Develop an advocacy plan to promote M&E**									
6.1.1	Develop M&E Advocacy and Communication strategy for all programmes	M&E Division	Short term TA to develop M&E advocacy & communication, printing cost		27,000.00				**27,000.00**	Global Fund
6.1.2	Support implementation of the M&E advocacy and communication strategy for all programmes	M&E Division& HPC	Lump sum (printing & dissemination)		5,000.00	5,000.00	5,000.00	5,000.00	**20,000.00**	Global Fund
Component 7: Surveys and Surveillance										
Objective: To Support implementation of cost effective and short term surveys and surveillance to assess the performance of HSSD										
7.1	**Protocol for Surveys and Surveillance**									
7.1.1	Establish and maintain quality control and assurance mechanisms and system for surveys and surveillances conducted by all programmes	M&E Division and Programmes	TA for 20 days	19,000	19,000	19,000	19,000	19,000	**95,000.00**	UNDP
7.2	**Biological surveillance**									
7.2.1	Captured at program level M&E plan								**0**	
7.3	**Conduct Lot Quality Assurance Sampling (LQAS) Survey**									
7.3.1	Design protocols and conduct integrated LQAS survey for key health sector indictors	M&E Division and Programmes	TA to design & conduct the LQAS protocol & tools	27,000		27,000		27,000	**81,000.00**	Global Fund RD 9

7.3	**Eritrean Demographic and Health and other Population Surveys**									
7.3.1	Contribute to Eritrea Population and Health Survey (EPHS+) every 5 years	NSO/M&E Division						100,000	**100,000.00**	Global Fund
7.3.2	Design plan & undertake survey on proper preparation of ORS at household level	Child Health	Lump sum cost	150,000					**150,000.00**	UNICEF
7.3.3	Design protocol plan and conduct a Micronutrient survey among children	Nutrition	Lump sum cost	150,000					**150,000.00**	UNICEF
7.4	**Health Facility Survey**									
7.4.1	Design protocol, plan and undertake Health Facility Assessment	M&E Division	medium sample survey	45,000	45,000	45,000	45,000	45,000	**225,000.00**	Global Fund
7.4.7	Design protocol plan and undertake quality of care study on community hospitals and health centers providing EMNOC	RH	Study Costs	45,000	45,000	45,000	45,000	45,000	**225,000.00**	UNFPA
Component 8: Routine Programme Monitoring										
Objective: To Sustain the Functionality of the Health Management Information										
8.1	**National Health Management Information System (NHMIS)**									
8.1.1	Production/Printing of HMIS Tools	NHMIS	Printing	30,000	30,000	30,000	30,000	30,000	**150,000.00**	Global Fund
8.1.2	Conduct HMIS trainings at different levels	NHMIS	Workshop	70,000	70,000	70,000	70,000	70,000	**350,000.00**	Global Fund
8.1.3	Support to monthly HMIS reporting from health facilities to zobas for all diseases	NHMIS	Staff time & operational expenses	50,000	50,000	50,000	50,000	50,000	**250,000.00**	Global Fund

8.1.4	Monthly collation of HMIS data at Zoba level and reporting to MOH HMIS	NHMIS	Staff time & operational costs	20,000	20,000	20,000	20,000	20,000	**100,000.00**	Global Fund
8.1.5	Establish a supervision team from programmes to conduct joint HMIS supervision on quarterly basis	NHMIS	Supervision visits	20,000	20,000	20,000	20,000	20,000	**100,000.00**	Global Fund
8.1.6	Write annually HMIS reports arising from supervision and disseminate findings	NHMIS		10,000	10,000	10,000	10,000	10,000	**50,000.00**	Global Fund
8.2	**Logistics Management Information System (LMIS)**									
8.2.1	Train/refresh additional LMIS (SCS) database operators	LMIS	5 days training for 30 persons every yr	6,750.00	6,750.00	6,750.00	6,750.00	6,750.00	**33,750.00**	Global Fund
8.2.2	Create a connectivity (network) link with ALL SCS database workstations	LMIS		50,000	50,000	50,000	50,000	50,000	**250,000**	UNFPA
8.2.3	Advanced IT maintenance support training for the LMIS database administers (Diploma IT Course) (Scaling-up Computer training programmer for 2 senior computer operators to a level of competent system administrator level, network administrator, and web- design and develop	LMIS			50,000		50,000		**100,000**	UNFPA

8.2.4	Replace old computers and network accessories (dedicated server) and expand down to all new Health	LMIS	50 computer sets with accessories	126,050.00	126,050.00	126,050.00	126,050.00	126,050.00	**630,250.00**	UNFPA
8.2.5	Training and facilitation on how to use and implement the newly developed stock catalogue	LMIS	3 days workshop for 30 persons	4,050.00	4,050.00	4,050.00	4,050.00	4,050.00	**20,250.00**	UNFPA
8.2.6	Conduct an assessment of quality pharmaceutical logistics information in 18 hospitals	LMIS	Small size survey	15,000.00	15,000.00	15,000.00	15,000.00	15,000.00	**75,000.00**	UNFPA
8.2.7	Conduct regular supervision	LMIS	6 ten days supervisory visits of 5 pple	372	372	372	372	372	**1,860.00**	UNFPA
8.2.8	Strengthen OPD computerized Database services and advocate for increased budget, hospital pharmacy resources and investment	LMIS			50,000				**50,000**	UNFPA
Component 9. National Data Bases										
Objectives : To strengthen health sector and programme data bases for HIV/AIDS/STI, TB, Malaria, Nutrition, RH, Child and Adolescent health and HSSDP										
9.1	**Develop a National M&E Database= Relevant – Where these activies implemented during 1stM&E framework**									
9.1.1	Establish and support national database linked to all reporting entities	M&E Division	30 days TA for software dept	7,500	7,500	7,500	7,500	7,500	**37,500.00**	Global Fund

9.1.2	Develop and support implementation of an M&E analysis module at national, programmatic and zoba levels	M&E Division	10 days international TA	11,000	11,000	11,000	11,000	11,000	**55,000.00**	Global Fund
9.1.3	Maintain a national database linked to all reporting entities	M&E Division	Local consultant for 30 days	7,500	7,500	7,500	7,500	7,500	**37,500.00**	Global Fund
Component 10: Support Supervision, Data Quality Assurance and Audit										
Objective: To ensure that support supervision, data quality assurance and audit are all implemented as part of the M&E										
10.1	**Develop supervision checklists and procedures**									
10.1.1	Update mentoring, support supervision, data quality and auditing guidelines and checklists	SQ & QA Division	Workshop	6,750	6,750	6,750	6,750	6,750	**33,750.00**	Global Fund
10.1.2	Conduct regular supportive supervision, data quality and audit and mentoring to health facilities and providers every Qrt	M&E Division& all Programmes	6 10-day supervisions of 8 person	3720	3720	3720	3720	3,720	**18,600.00**	Global Fund
10.1.3	Hold meetings with stakeholder to review and take action on the outcome of the technical support supervision, data quality and data audit visits	M&E Division, HMIS, IDSR & Programmes	Meeting Costs	2,700	2,700	2,700	2,700	2,700	**13,500.00**	Global Fund
Component 11: Evaluation and Research										
Objective: Strengthen capacity and support implementation of evaluation and research studies relevant to HSSDP										
11.1.1	Develop an evaluation and research agenda	M&E Division	Staff costs of lumpsum	666.7	666.7	666.7	666.7	666.7	3333.5	**Gov't**

11.1.2	Establish and support a national research and evaluation committee to guide and ensure the quality of evaluation and research	M&E Division	Staff and meeting costs	5400	5,400	5,400	5,400	5,400	27000	Global Fund
11.1.3	Finance /commission research / evaluation undertakings	Research Unit	commissioning Lump sum	16,750	16,750	16,750	16,750	16,750	83750	Global Fund
1.1.4	Undertake the midterm and final evaluation of the HSSDP	M&E Division	International TA f0r 30 days	0		27,000		27,000	54000	Global Fund
Component 12: Information dissemination and use										
Objective: To support mechanisms for information dissemination and use M&E results for decision making and programme improvement										
12.1	**Plan for dissemination**									
12.1.1	Annually compile and print reports of surveys, evaluation and research work done	M&E Division & Programmes	Print integrated M&E report	1,000	1,000	1,000	1,000	1,000	**5,000.00**	Global Fund
12.1.2	Annually produce policy papers on the implications for policy and planning of each of the study, survey and evaluation carried out.	M&E Division & Programmes		5,000	5,000	5,000	5,000	5,000	**25,000.00**	Global Fund
12.1.3	Organise annual stakeholders information dissemination Forum, to disseminate available data	M&E Division & Programmes	One /two day forum on yearly bases	3,600	3,600	3,600	3,600	3,600	**18,000.00**	Global Fund
12.1.4	Establish &maintain the M&E resource center in M&E Division	M&E Division	Furniture	3,650	3,650	3,650	3,650	3,650	**18,250.00**	Global Fund
	Grand Total			**979,070.70**	**864,309.90**	**709,809.90**	**837,309.90**	**809,809.90**	**4,200,310.30**	

Part 4: Institutional Arrangements for M&E Coordination, Management and Implementation

4.1 Monitoring and Evaluation Coordination

4.1.1 Ministry of Health– Department of Policy, Planning and Evaluation

The Ministry of Health will provide the leadership, oversight, policy development and regulation and advocate for the implementation of the 2nd integrated M&E Framework. This will be provided through the Department of Policy, Planning and HRD that will ensure that the 2nd integrated M&E Framework and operational plan is rolled out in conformity with the national policies and institutional set up of the sector. The department will also ensure that implementation of the M&E Plan is in harmony with other health sector programmes. The department will further ensure that the framework effectively provides the data and information required on the performance of the Health Sector Strategic Development Plan.

4.1.2 Monitoring and Evaluation Division

The M&E Division will champion the coordination, planning and implementation of the 2nd integrated M&E Frame for HSSDP. The M&E Division will coordinate all M&E structures of programmes, and stakeholders that are involved in the implementation of the M&E framework at all levels. The Division will have the following functions:

i) Provide leadership for mobilization of the strategic human, logistical, financial and material resources required for the implementation of the 2nd National Integrated National Monitoring and Evaluation Framework for HSSDP, at all levels.
ii) With the support of the Department of Policy, Planning and HRD, promote and popularize the M&E frame work, among all programmes in the MOH, Development Partners and decentralized structures.
iii) Coordinate the development of standard and harmonized data collection and reporting tools and instruments.
iv) Coordinate and lead the development, establishment and maintenance of the national health and HIV/AIDS database.
v) Coordinate undertaking of surveys and research studies that involve more than one health sector programme.
vi) Ensure and coordinate the development of information products and dissemination as well as promoting the utilization of the M&E and information products.
vii) Cause programmes to account for the implementation of the Programme specific M&E interventions.
viii) Report to the MOH structures on a quarterly basis about the implementation of the M&E Framework.

4.1.3 The Monitoring and Evaluation Committee

The current M&E Advisory Committee and the M&E- TWG will be restructured into one M&E Committee. The M&E Committee shall provide the overall technical guidance and back up support to the implementation of the 2nd MOH Integrated M&E Framework. The M&E Division will be the Secretariat to the M&E Committee. The Committee will have the following roles and responsibilities:

- Promote partnership for M&E activities and bring together the different MOH Programmes, partners and stakeholders of the different M&E functions.

- Ensure that the implementation of the M&E framework meets the technical and stakeholders' expectations.
- Lead the annual operational planning for M&E, mobilization of resources and support for M&E, and monitor the adherence to the provisions of the M&E Framework by different stakeholders.
- Champion the advocacy for M&E support, and utilization of the M&E products.
- Review and make recommendations for the coordination and harmonization of
  - ✓ Indictors, surveys national level research studies
  - ✓ Data collection tools and instruments
  - ✓ Integration of database management systems
  - ✓ Review of the national, programmatic and zoba M&E plans
- Review and recommend actions to improve development and implementation of the national integrated M&E framework and annual operational plan
- Review and make recommendations on national surveys and research findings before production of final reports
- Review and recommend action on annual routine data collection reports like the HMIS
- Champion the use of M&E products to promoted evidence based planning and decision making

4.1.4 Programme Level (NATCoD, NMCP, RH, Child and Adolescent Health, & HSS)

The M&E Units established under the Programmes (NATCoD, NMCP, RH, Child and Adolescent Health, & HSS) will be responsible for the overall planning, management coordination and implementation of all M&E interventions under their respective Programmes. The M&E Units, with the support of the Programme Directors will carry out the following functions:

i) Provide leadership for mobilization of the strategic human, logistical, financial and material resources required for the implementation of the Programme specific M&E Framework at all levels of the health sector structures.
ii) Promotion and popularization of the Programme M&E frame work, among all staff, Development Partners, decentralized structures and stakeholder relevant to the Programme.
iii) Coordinate with M&E Division during the development of standard and harmonized data collection and reporting tools and instruments for their Programmes
iv) Coordinate with the M&E Division during the development, establishment and maintenance of the programme specific database
v) Coordinate with M&E Division when undertaking of surveys and research studies planned by their programme,
vi) Work with the M&E Division, to advocacy for support and implementation of the Programme M&E Framework
vii) Coordinate with the M&E Division during the development of information products and dissemination of the M&E findings and information products
viii) Prepare quarterly progress reports on the implementation of the Programmes M&E frameworks, report and share with the M&E Division and other programmes.

4.1.6 Ministry of National Development- National Statistics Office (NSO)

The National Statistics Office (NSO) is the mandated to lead and guide the collection, compilation, analysis, validation and dissemination of all official and other statistical information in the country. NSO will provide technical support to MOH M&E structures. NSO will ensure that methodologies used in collecting data, generation of scientific representative samples and management of data during research, comply with the national and international standards and specifications and protocols. NSO will play a leading role in protocol and questionnaire designs for national population surveys, and other routine data collection activities.

NSO will work with MOH M&E structures during the planning and implementation of the Eritrean Health and Demographic Survey and other population surveys. This will ensure that the survey content has adequate provisions for the generation of information and data on indictors in the M&E Framework.

4.1.11 Data Quality Assurance (DQA)

The M&E Division will develop National Data Quality Assurance (DQA) Protocols that will be used to assess the quality of data collected as part of the 2nd Integrated M&E Framework. The protocols will be reviewed by the M&E Committee, before approval by the MOH. The primarily objective Data Quality Assessment will be to verify the quality of reported data and assessing the underlying data management and reporting systems for the indicators at output level. DQAs will enable MOH to strengthen data management and reporting systems for all programmes. Each of the data sources will have the DQA measures specified in the protocols. The M&E Division will compile a report of the DQA findings and report to the M&E Committee, to agree on required action for performance improvement before approval by MOH.

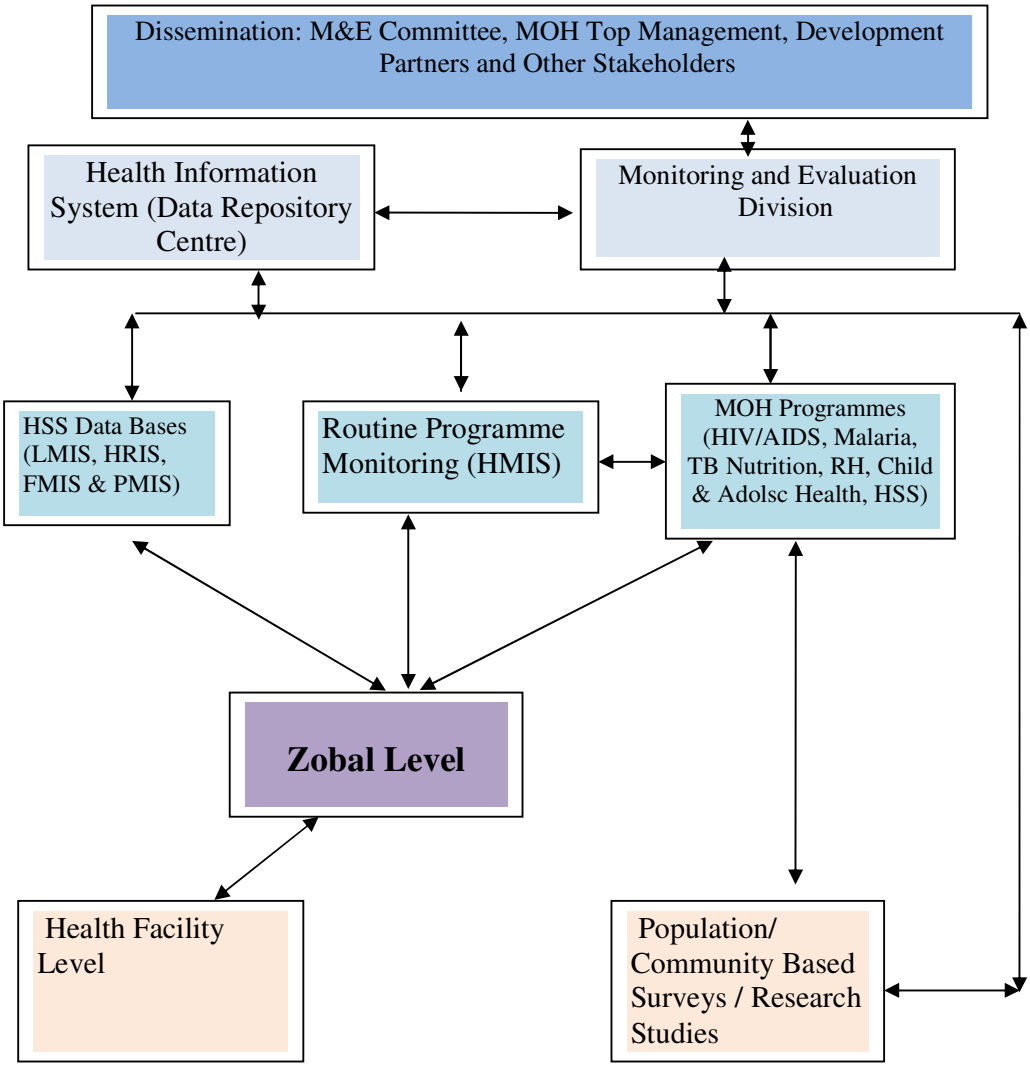
4.2 Data and Information Flow

The health facility level and the population /community surveys and research studies will be the main sources of primary data and information. Health facilities will report both the HMIS data and the programme specific information (which is not captured by HMIS) to the Zoba level. The Zobas will then report the data and information to the HSS data bases, HMIS, and MOH Programmes, for more analysis, dissemination and use. Programmes shall be required to provide feedback to the Zobas and the health facilities, in order to bring about programme improvement.

Programmes will then submit their data and information to the M&E Division and the HIS Division. The M&E Division will utilize the data and information from the programmes, to report on the health sector performance and to organize its dissemination to health sector stakeholders and partners. The HIS division (the national health repository centre) shall use the data and information from the programmes to update the national health data base.

Data from population/community surveys and research studies shall and be reported through the Programmes, or directly to the M&E Division, as indicated in the data and information flow chart below.

Data and Information Flow Chart



4.3 National, Programme and Other Data Base

Currently the data bases include the following: HMIS, HIV/AIDS, Malaria, LMIS, HRIS, FMIS, PAMIS and other data bases. These shall be enhanced to enable easy access and linkage to promote the sharing of information and data on health sector programme.

The health policy requires establishment a National Heath Information System that shall be the national health database. It will serve as the main national health sector repository for data from routine programme monitoring; population based surveys, surveillance, research, financial monitoring and other relevant sources data and information. Data bases shall as much as possible be harmonized and shall adopt user friendly database management protocols and procedures. All data bases to ensure that it's data are updated regularly, consistently and on time and easily accessible.

4.4 Logistical and Technical Support for M&E Planning and Coordination

All M&E Units and implementation structures will need logistical support to be able to execute their respective core M&E functions. On annual basis, the M&E Division will ensure that every M&E units and structure has adequately planned and made budgetary provisions for logistical and technical support for the M&E activities. The core functions include planning, coordination, monitoring, evaluation and technical support for their respective constituencies.

The M&E Division shall mobilize and ensure that resources for logistical support are secured. For activities that require technical support, M&E Division shall work with the respective programmes, to mobilize and secure the technical support from development partners and any possible source of funding.

4.5 Advocacy for Research, Monitoring and Evaluation

To ensure that M&E and research activities become of the top priorities of the health sector, the Policy, Planning and HRD Department shall undertake the needed high level advocacy to enhance the M&E culture in the health sector. The advocacy for M&E shall also be part of the health sector national advocacy and communications strategy. The Department will also lead the advocacy for the allocation of the resources for M&E functions, including recruitment of staff for all M&E structures at the different levels of the health system

4.6 Performance Assessment of the M&E Framework

The 2nd M&E Framework is part of the HSSDP. Its implementation will be assessed, as part of the HSSDP joint reviews (annual, mid-term and end of term review of the implementation of all of the programmes.

Annually the M&E Division shall conduct an M&E Systems Strengthening Assessment (MESS) using the UNAIDS MESST approach. The assessments provide opportunities for addressing challenges, gaps and constraints that may be affecting effective implementation of the 2nd Integrated M&E Framework.

Annexes

Annex 1 Detailed Indicator Definitions

Annex 1.1 HIV/AIDS/STIs Results Indicator Definitions 2012

	Indicator Definitions		
Impact Indicators	**Numerator or value**	**Denominator**	**Notes on method**
Prevalence of HIV/AIDS in the general population.	Number of ANC sentinel surveillance survey participant pregnant women whose blood samples tested positive for HIV [Number of blood samples of EDHS+ survey tested positive for HIV]	Total number of ANC sentinel surveillance survey participant [Total number of blood samples included in EDHS+ survey]	Anonymous unlinked national ANC sentinel surveillance survey in pregnant women- every 2 years [EDHS+ plus – a population based survey every 5 years]
HIV prevalence among young people age group 15-24 years	Number of ANC sentinel surveillance survey participant pregnant women aged 15 – 24 years whose blood samples tested positive for HIV	Total number of ANC sentinel surveillance survey participant 15 – 24 years	Anonymous unlinked national ANC sentinel surveillance survey in pregnant women- every 2 years
Syphilis sero-prevalence rate among ANC attendees aged 15-24 years	Number of ANC sentinel surveillance survey participant pregnant women aged 15 – 24 years whose blood samples tested positive for syphilis	Total number of ANC sentinel surveillance survey participant 15 – 24 years	Anonymous unlinked national ANC sentinel surveillance survey in pregnant women- every 2 years
Syphils sero-prevalence rate among pregnant women aged 15-49	Number of ANC sentinel surveillance survey participant pregnant women aged 15-49 whose blood samples tested positive for syphilis	Total number of ANC sentinel surveillance survey participants aged 15-49	Anonymous unlinked national ANC sentinel surveillance survey in pregnant women- every 2 years
% of most-at-risk population(s) (female sex workers,) who are HIV infected	Number of most-at-risk population(s) (female sex workers,)who participated in the study who are HIV infected	Number of most-at-risk population(s) (female sex workers,)who participated in the study	Anonymous unlinked survey in sex workers every 2 years
Percentage of infants born to HIV infected mothers who are HIV infected	Percentage of infants born to HIV infected mothers who are HIV infected	Number of infants born from HIV positive mothers	Annual facility report
Percentage of adults and children with HIV still alive 12 months after initiation of anti-retroviral therapy	Number of adults and children with HIV still alive 12 months after initiation of anti-retroviral therapy	Number of adults and children with HIV initiated for anti-retroviral therapy for the past 12 months (cohorts)	Annual facility report
Percentage of children under age 18 years who are orphans	Total number of children under the age of 18 years who are orphans	Total number of children who are under the age of 18 years	

Outcome Indicators	Numerator or value	Denominator	Notes on method
Percentage of female sex workers using condoms with the most recent client (at capital city)	Number of high risk groups (CSW) who used condom properly with their most recent client..	Total number of high risk groups (CSW) who participated in high risk groups special study	High risk groups special study on HIV and syphilis – every 2 years
% of high risk groups (Truck drivers) who used condom properly during their last sex practice in the last 12 months.	Number of high risk groups (Truck drivers) who used condom properly during their last sex practice in the last 12 months.	Total number of high risk groups (Truck drivers) who participated in the special study	High risk groups special study on HIV and syphilis – every 2 years
Proportion of sexually active males/females who report condom use during last high-risk sexual encounter within the last 12 months	Number of sexually active males/females who report condom use during last high-risk sexual encounter within the last 12 months	Number of sexually active males/females who had high-risk sexual encounter within the last 12 months	HS or other population-based studies
Percentage of young women and men who have had sex before the age of 15 years	Number of young women and men who have had sex before the age of 15 years	Total number of young women and men who participated in the study	
Percentage of never married young men and women aged 15-24 who have never had sex	Number of never married young men and women aged 15-24 who have never had sex	Total number of never married young men and women aged 15-24 who participated in the study	
Percentage of women and men aged 15-49 who have had sexual intercourse with more than one partner in the last 12 months	Number of women and men aged 15-49 who have had sexual intercourse with more than one partner in the last 12 months	Total number of women and men aged 15-49 who participated in the study	
Percentage of all adults 15-49 years old who were tested and received their HIV results	Number of all adults 15-49 years old who was tested and received an HIV result	Total number of all adults 15-49 years old who participated in a survey	population based study
Proportion of HIV positive infants who are born to HIV positive mothers	Number of HIV positive infants who are born to HIV positive mothers	Total number of infants who are born to HIV positive mothers tested for HIV at 18 months	NATCoD and HMIS PMTCT services annual report
Percentage of sex workers who have received an HIV test in the past 12 months and know their results	Number of sex workers who have received an HIV test in the past 12 months and know their results	Total number of sex workers who participated in the study	
Number of people (including pregnant women) who received testing and counseling services for HIV and received their test result	Number of people (including pregnant women) who received testing and counseling services for HIV and received their test result		
Number of adults and children with advanced HIV infection receiving anti-retroviral combined therapy	Number of adults and children with advanced HIV infection receiving anti-retroviral therapy	Total estimated number of adults and children with advanced HIV infection who are eligible for anti-retroviral therapy	NATCoD and HMIS ART annual report
Number and percentage of adults and children with advanced HIV infection currently receiving ART	Number and percentage of adults and children with advanced HIV infection currently receiving ART		
7. Number of adult and children receiving prophylaxis for OIs (including the military)	Number of adult and children receiving prophylaxis for OIs (including the military)		
8.Number of chronically ill PLWHA receiving home based care and psychosocial support	Number of chronically ill PLWHA receiving home based care and psychosocial support		
9. Number of orphans and vulnerable children (OVCs) receiving financial support	Number of orphans and vulnerable children (OVCs) receiving financial support		

10. Number of women headed households in 6 zoba assisted through income generating activities/ microcredit loan	Number of women headed households in 6 zoba assisted through income generating activities/ microcredit loan		
11. Number of beneficiaries supported by community-based income-generating schemes established for PLWHA within their areas of residence	Number of beneficiaries supported by community-based income-generating schemes established for PLWHA within their areas of residence		
Number and % of transfused blood units screened for HIV and Hepatitis B&C, according to national guidelines	Number and % of transfused blood units screened for HIV and Hepatitis B&C, according to national guidelines		
Number of patients receiving diagnosis and treatment for STIs	Number of patients receiving diagnosis and treatment for STIs		
Number of HIV infected women receiving a complete course of antiretroviral prophylaxis to reduce the risk of Mother to Child transmission.	Number of HIV infected women receiving a complete course of antiretroviral prophylaxis to reduce the risk of Mother to Child transmission.		
Number of women referred for PMTCT services by CBOs	Number of women referred for PMTCT services by CBOs		
Output Indicators	**Numerator or value**	**Denominator**	**Notes on method**
Number of health facilities providing ART	Total number of health facilities providing ART services	NA	NATCoD ART services annual report
Number of health facilities providing PEP	Number of health facilities providing PEP		
Number of male condoms distributed to general population	Number of male condoms distributed to general population		
Number of female condoms distributed to the female sex workers	Number of female condoms distributed to the female sex workers		
Number of youth in secondary school receiving life skill education	Number of youth in secondary school receiving life skill education		
Number of high risk groups (female sex workers) reached with BCC activities	Number of high risk groups (female sex workers) reached with BCC activities		
Number of high risk groups (women) reached with BCC activities	Number of high risk groups (women) reached with BCC activities		
Number of high risk groups (truck drivers) reached with BCC activities	Number of high risk groups (truck drivers) reached with BCC activities		
Number of PMTCT sites established/supported	Number of PMTCT sites established/supported		
Number of free-standing and facility based VCT sites supported	Total number of VCT sites established	NATCoD VCT services annual report	
Input Indicators	**Numerator or value**	**Denominator**	**Notes on method**

Amount of fund allocated for HIV/AIDS prevention, treatment and care	Total fund allocated for HIV/AIDS prevention, treatment and care	MOH finance unit and PMU annual financial report	
Number of trained counselors and other health workers available in HIV/AIDS prevention, treatment and care service provision.	Total number of trained counselors and other health workers working in HIV/AIDS prevention, treatment and care service provision.	HRD and NATCoD man power annual report	

Annex 1.2 TB Indicator Definitions 2012

	Indicator Definitions		
Impact Indicators	**Numerator or value**	**Denominator**	**Notes on method**
Prevalence rate of TB per 100,000	Number of TB suspects found to be smear positive during a specified period	Number of TB suspects identified clinically during the same period	Prevalence survey conducted nationally that will produce national and zonal level prevalence
TB mortality rate	Number of TB cases died during the year	Total Noof TB cases identified during the year	Annual facility report
Prevalence of MDR- TB among new and re-treatment cases (Facility based)			
Outcome Indicators	**Numerator or value**	**Denominator**	**Notes on method**
Case detection rate: new smear positive TB cases	Annual number of new smear-positive TB cases detected	Total annual number of estimated new smear-positive TB cases (incidence)	Quarterly report that will be gathered from registers, disaggregated by age, sex, zone, national
Percent cure rate of new smear positive cases	Number of new smear-positive pulmonary TB cases registered under DOTS in a specified period that subsequently were successfully treated (sum of WHO outcome categories 'cured' plus 'treatment completed')	Total number of new smear-positive pulmonary TB cases registered under DOTS in the same period	Quarterly report that will be gathered from registers, disaggregated by age, sex, zone, national
Treatment success rate: new smear positive TB cases	Number of new smear-positive pulmonary TB cases registered under DOTS in a specified period that subsequently were treated	Total number of new smear-positive pulmonary TB cases registered under DOTS in the same period	Quarterly report that will be gathered from registers, disaggregated by age, sex, zone, national
Number of TB Cases detected (all TB cases) during the year	Number of TB Cases detected (all TB cases) during the year		
No of HIV positive patients screened for TB	No of HIV positive patients screened for TB		
Number of TB patients screened for HIV	Number of TB patients screened for HIV		

Number of MDR-TB cases detected in new and re-treatment cases	Number of MDR-TB cases detected in new and re-treatment cases		
Percent of adults and children living with HIV/AIDS receiving appropriate TB treatment during the last year	Number of HIV positive TB patients, registered over a given time period, who are referred to HIV care and support services during their treatments	Total number of HIV positive TB patients positive registered over the same given time period.	Quarterly report that will be gathered from registers, disaggregated by age, sex, zone, national
Output Indicators	**Numerator or value**	**Denominator**	**Notes on method**
Percentage of functional AFB microscopy center	Number of health centers and hospitals with functional AFP microscopy center	Total number of health centers and hospitals	
Percentage of health facilities with adequate stock of TB medicines in the last 3 months	Number of health facilities with adequate anti-TB drugs	Total number of health facilities in all sub-zones	Annual report compiled from facility reports
Number of peripheral health facilities (health stations) functioning as sputum collection and fixing centers and providing DOTS	Number of peripheral health facilities (health stations) functioning as sputum collection and fixing centers and providing DOTS		
Number of Health facilities supervised once every two quarters	Number of Health facilities supervised once every two quarters		
No of TB suspects who are referred by the TB promoters	No of TB suspects who are referred by the TB promoters		
Input Indicators	**Numerator or value**	**Denominator**	**Notes on method**
Number of microscopes procured and distributed to DOTS sites	Number of microscopes procured and distributed to DOTS sites		Annual report compiled from facility reports
Anti-TB medicines procured	Number of Anti-TB medicines procured		Annual report compiled from facility reports

Annex 1.3 Malaria Results Framework 2012:

	Indicator Definitions		
Impact Indicators	**Numerator or value**	**Denominator**	**Notes on method**
Malaria specific mortality (Rate per 100,000)	Number of clinical and confirmed deaths due to malaria	Not applicable	
Incidence of malaria cases (per 1000 people) per year	Number of malaria cases seen at health facilities x 1000	Population living at risk of malaria	
Case fatality rate in children under five at health facilities	Number of malaria deaths among children under-five	Number of children under-five admitted due to malaria	
Outcome Indicators	**Numerator or value**	**Denominator**	**Notes on method**
Percentage of pregnant women sleeping under ITN the previous night	Number of pregnant women surveyed who are at risk for malaria in areas of stable endemic malaria transmission who slept under a mosquito net the previous night, which has been treated within the last 12 months or is a Long lasting Insecticidal Net (LLIN)	Total number of pregnant women who reside within surveyed households within malaria-endemic areas	
Percentage of children under five sleeping under ITN the previous night	Number of children under five years old surveyed in malaria endemic areas who slept under a mosquito net the previous night, which has been treated within the last 12 months or is a Long-lasting Insecticidal Net (LLIN)	Total number of children under five years old who slept the previous night in surveyed households within malaria endemic areas	
Percent of under five children (and other target groups) with malaria/fever receiving appropriate treatment within 24 hours (community/health facility)	Number of children <5 years old with fever/malaria who were treated with a locally effective anti-malarial medicine according to the national malaria treatment policy, within 24 hours from onset of the fever during the previous two weeks	Total number of children <5 years old with fever/malaria out of surveyed number of children during the previous two weeks	
Output Indicators	**Numerator or value**	**Denominator**	**Notes on method**
Percentage of households in malarious areas owning at least 1 ITN	Number of households having 1 or more ITNs	Total number of sampled households	
Percentage of households in malarious areas owning at least 2 ITNs	Number of households having 2 or more ITNs	Number of sampled households	
Average number of LLINs per household	Total number of LLINs reported from within surveyed households	Total number of households surveyed	
Proportion of households aware of at least 1 environmental management preventive method	Number of HH aware of at least ONE Malaria EM method (Household denotes the member /respondent targeted for the survey)	Total number of households surveyed within malaria-endemic areas	

Number and percent of health facilities with no reported stock-outs lasting >1 week of nationally recommended anti-malarial drugs at any time during the past 3 months	Number of health facilities with nationally recommended anti-malarial medicines available and with no stock outs lasting one week or longer at any time in the last three months	Total number of health facilities captured under Logistic Management Information System	
Number of LLITNs distributed	Number of long lasting bed nets distributed to targets such as pregnant women, among others, and the general population.	Not applicable	
Number of patients receiving ACT treatment	Number of malaria patients seen at community and health facility level, and treated with ACTs	Not applicable	
Number of malaria cases (clinical and confirmed) treated at community level.	Number of malaria patients seen at community level, and treated with ACTs	Not applicable	
Number of RDTs distributed to public, private & military health facilities	Number of RDTs distributed to health facilities from zonal MoH branches and number dispatched to Military Health Services from MoH/HQs	Not applicable	
Number of <5 children reached through home based management	Number of children <5 reached and treated for malaria at community level	Not applicable	
Number and percent of houses in target communities in high and moderate incidence sub-zobas covered by a timely application of indoor residual spraying (IRS)	Number of houses whose indoors sprayed with insecticide	Number of houses targeted to be sprayed with insecticide	
Number of sentinel sites collecting epidemiological information	Numer of sentinel sites collecting epidemiological information in all th six zones	Not applicable	
Input Indicators	**Numerator or value**	**Denominator**	**Notes on method**

Annex 1.4 Reproductive Health Indicator Definitions 2012

	Indicator Definitions		
Impact Indicators	**Numerator or value**	**Denominator**	**Notes on method**
Maternal Mortality Ratio	Total number of maternal death	100,00 live births	
Prevalence of Obstetric Fistula	Total number of women with Obstetric Fistula cases	100,00 live births	
Perinatal Mortality Rate	Total number of perinatal death	1000 live births	
Prevalence of Female Genital Mutilation (FGM) among girls child under 10 Years	Number girl child under 10 yrs who are circumcised	Total number of girl child under 10 yrs old	
Prevalence of teenage pregnancy	Total number of teenage pregnancies	Total number of pregnancies	
Outcome Indicators	**Numerator or value**	**Denominator**	**Notes on method**
Percentage of mothers Visiting ANC at least once			
Percentage of mothers making four ANC visits	Women who received four ANC services	Total No. of women who had 1st visit	
Percentage of institutional deliveries	Number of institutional deliveries in a specified time	Total number of expected deliveries in that specified time	
Percentage of mothers delivered by caesarian section	Number of mothers delivered by cesearian section in a specified time	Total number of expected deliveries in that specified time	
Met need for cesarean section	Number of Cesarean section	Total number of expected deliveries	
Percentage of mothers who receive at least 2 post partum visits in the first week	Number of post natal visits	Total number of expected deliveries	
Contraceptive Prevalence Rate (modern method)	The number of women ages 15–49 in marital or consensual unions who report that they are practicing (or whose sexual partners are practicing) contraception	Total number of women ages 15–49 (and same Marital status, if applicable) in the survey.	
Number of hospitals, HC, HS with family planning services with at least 3 methods			
Hospitals			
Health Centers			
Health Stations			
Proportion of children between the ages of 1-2 who have growth monitoring data recorded twice	Number of children ages 1-2 who had growth monitoring data recorded twice per year	Total number of children ages 1-2	
Output Indicators	**Numerator or value**	**Denominator**	**Notes on method**

Percentage of facilities providing Basic EmOC			
Hospitals	No of Hospitals providing basic EmOC services	Total number of Hospitals	
Health Centers	No of Health Centers providing basic EmOC services	Total number of Health Centers	
Health Stations	No of Health Stations providing basic EmOC services	Total number of Health Stations	
Percentage of facilities providing Comprehensive EmOC	No of facilities providing basic EmOC services	Total number of hospitals	
Met need for Emergency Obstetric Care	Number of obstetric emergencies managed	Total number of expected obstetric emergencies	
Percentage of basic EmOC facilities offering post abortion care	No. of basic EmOC facilities offering PAC	Total No. of EmOC facilities offering PAC	
Percentage ofomprehensive EmOC facilities offering post abortion care	No. of comprehensive EmOC facilities offering PAC	Total No. of EmOC facilities offering PAC	
Input Indicators	**Numerator or value**	**Denominator**	**Notes on method**
Percentage of Facilities with at least 90% of the essential RH commodities	No. of facilities with at least 90% of the essential RH commodities	Total Number of health facilities	

Annex 1.5 Child Health/EPI Indicator Definitions 2012

	Indicator Definitions		
Impact Indicators	**Numerator or value**	**Denominator**	**Notes on method**
Under 5 mortality rate	Number of all less than 5 deaths before reaching their fifth birth day	Total number of surviving children U5	
Infants mortality rate	Number of all less than 1 year infant deaths before reaching their first birth day	Total number of surviving children less than one year	
Neonates mortality rate	Number of all deaths less than 28 days	Total number of surviving neonates	
Outcome Indicators	**Numerator or value**	**Denominator**	**Notes on method**
Percent of children 12-23 months immunized for DPTHP3 before 12 months	Number of children age 12-23months immunized for DPTHP3 before 12 months according to child vaccination card	Total number of children aged 12-23 months who have a vaccination card	
Percentage of children aged 0-35 months with suspected ARI taken to Health Facilities	Number of children aged 0-35 months with suspected ARI taken to H/Facilities	Total number of children age 0-35 months suspected with ARI	
Percentage of children aged 0-59 months with diarrhea receiving oral dehydration and continuing feeding.	Number of children aged 0-59 months with diarrhea receiving oral dehydration and continuing feeding.	Total number of children aged 0-59 months with diarrhea	
Output Indicators	**Numerator or value**	**Denominator**	**Notes on method**
Proportion of health facilities without stock outs of ORS in the last month	Number of health facilities with adequate ORS in the last two weeks prior to survey.	Total number of health facilities	
Proportion of health facilities with at least one trained health workers in IMCI	Number of health facilities with at least one trained health workers in IMCI.	Total number of health facilities	
Proportion of health facilities without stock outs of co-trimoxazole in the last month	Number of health facilities with adequate Bacterium in the last two weeks prior to survey.	Total number of health facilities	
Proportion of households having at least ONE long-lasting net or ITN retreated within the last 12 months with insecticide	Number of households with at least one ITN treated within the last one year.	Total number of households visited within the last year	
Proportion of health facilities with all vaccines available and stored under appropriate condition on the day of the survey.	Number of health facilities with all vaccines available and stored under appropriate condition on the day of the survey.	Total number of health facilities	
Proportion of mothers who properly demonstrate on how to prepare ORS			

Annex 1.6 Nutrition Indicator Definitions 2012

	Indicator Definitions		
Impact Indicators	**Numerator or value**	**Denominator**	**Notes on method**
Prevalence of underweight in under 5 children	Number of children with weight for age z-score <-2SD	Total number of under five children	
Prevalence of Iron Deficiency Anemia in children 6-59 months	Number of anemic children in 6-59 months	Total number children 6-59 months	
Prevalence of Vitamin A Deficiency in pre-school children 6-59 months	6-59 months children with Serum retinol level below 0.70 □mol/L	Total number children 6-59 months	
Prevalence of Iodine Deficiency in pre-school children 6-59 months	Urine iodine level below 100 □mol/L	Total number children 6-59 months	
Prevalence of Maternal under nutrition 15-49 yrs	Women 15-49 years with Body Mass Index (BMI) >18.5	Total number of women 15-49 years	
Prevalence of Iron Deficiency Anemia in Pregnant Women	Anemic pregnant women 15-49 years	Total number of pregnant women 15-49 years	
Outcome Indicators	**Numerator or value**	**Denominator**	**Notes on method**
Percent of children breastfed exclusively in the first 6 months of age	Exclusively breastfed Children 0-6 months	Total number children of 0-6 months	
Percent of infants initiating complementary food 6 months of age	Infants initiating complementary food at 6 months	Total number of children age 6 months	
Percent of severely wasted children cured in Therapeutic Feeding Centers	Number of severely wasted under 5 children cured	Total number of severely wasted under 5 children admitted in Therapeutic feeding center	
Moderately wasted under 5 children discharged from supplementary feeding program	Number of moderately under 5 children discharged	Number of moderately under 5 children admitted	
Percent of households consuming Iodized Salt	Number of households consuming iodized salt	Total number of households	
Percent of under 5 supplemented VA every 6 months	No of children 6-59 months supplemented vitamin A every 6 months	Total number of children 6-59 months	
Percent of Pregnant women provided with iron folic acid tablets at ANC	Number of pregnant women provided iron folic acid tablets	Total number of pregnant women 15-49 years	
Output Indicators	**Numerator or value**	**Denominator**	**Notes on method**
Number of sites with CB-GMP Service	Number of sites with community based growth monitoring and promotion service	None	
Number of Health Workers trained on management of acute malnutrition	Number of HWs trained on management of acute malnutrition		
Number of Community Based Therapeutic Feeding (CBTF)sites established	Number of community based therapeutic feeding	None	
Number of Facility Based Therapeutic Feeding Centers (FBTFC) established	Number of Facility based therapeutic feeding	None	
Input Indicators	**Numerator or value**	**Denominator**	**Notes on method**

Annex 1.7 Health Systems Indicator Definitions 2012

	Indicator Definitions		
Impact Indicators	**Numerator or value**	**Denominator**	**Notes on method**
Human Resource for Health Development and Management			
Proportion of health facilities with at least 70% of the position filled as per the established staffing norms	Number of government health facilities whose staffing conform with the establishes staffing norm	Total number of Government Health Facilities	Conformity to staffing norms means that all established positions are filled with health worker
The ratio of Doctor to Nurses	Total number doctors practicing in government health facilities	Total number of Nurses practicing in Government health facilities	The doctors and nurses must be practicing health workers
Average attrition rate of health workers	Total number of practicing health workers who have left serving in government health facilities and have been removed from the government pay roll during the year	Total number of practicing health workers who have been on the government pay roll and have been practicing in government health facilities during the year	
Number and Proportion of staff trained on infection control and medical waste management in health facilities (GF indicator)	Number of health workers who have been trained in infection control as per the approved training curriculum	Total number of all health workers practicing and serving in government health facilities (on government pay roll)	Emphasis is on practicing health workers
Pharmaceuticals Procurement, Supply and Logistics Management			
At least 85% of essential medicines available in stock all the time in the country.	List of medicines on the essential package that are missing from the national medicines store at any time of the year	Total number of medicines that are on the essential medicines list /package approved by MOH	
Proportion of health facilities with no stock out of key essential medicines	Number of government health facilities that have no stock out of any medicine on the essential medicines list during the last one week	Total number of all government health facilities	
Proportion of public hospital pharmacies with fully computerized inventory control system(OPD, Inpatient, Main pharmacy store)	Total number of public hospital pharmacies with fully computerized inventory control system(OPD, Inpatient, Main pharmacy store	Total number of all hospital pharmacies in the country	
Number and percentage of targeted health facilities that reported on adverse drug reactions (GF indicator	Number of health facilities that are reporting on adverse drug	Total number of health facilities targeted to report on adverse drug	A list of health facilities targeted to report on adverse drugs will be provided at the beginning of every year
Laboratory			
Number and proportion of health facilities with established laboratory infrastructure that meet the national standards	Number of government health facilities that have laboratory infrastructure that meets the national standards	Total number of government health facilities that are required to have laboratory services	
Number and proportion of health facilities without basic laboratory supply stock out	Number of health facilities that have no stock out the MOH defined basic laboratory supplies in the last one	Total number of health facilities that provide laboratory services	The laboratory units will every year provide a list of basic

	week		laboratory supplies
Proportion of health facilities with laboratories that have the required technical staff, according to the MOH staffing norms	Total number of health facilities with laboratories that have the required technical staff, according to the MOH staffing norms	Total number of health facilities that provide laboratory services	
Health Information System (HIS)	**Numerator or value**	**Denominator**	**Notes on method**
Percentage of Zones submitting complete reports to national level	Total number of Zones submitting complete reports to national level	Total number of Zones in the Country	HIS will provide definition for a complete report
Percentage of Zones submitting timely reports to national level	Total number of Zones submitting timely reports to national level	Total number of Zones in the Country	HIS will provide deadlines for submitting reports by Zones every year
Annual Health Service Activity Report Produced by end of May of every subsequent year	Number of annual health service report		
Health Information Systems Performance Index (HISPIX)- GF indicator)			
Monitoring and Evaluation	**Numerator or value**	**Denominator**	**Notes on method**
Number of Programmes in the MOH that M&E Units with at least one M&E Officer	Number of Programmes in the MOH that M&E Units with at least one M&E Officer		
Number of Zobas that have M&E units with at least one M&E Officer	Number of Zobas that have M&E units with at least one M&E Officer		
Number of Programmes producing reports on the implementation of the M&E activities and M&E Indicators for which they are mandated for, by end of January of each subsequent year	Number of Programmes producing reports on the implementation of the M&E activities and M&E Indicators for which they are mandated for, by end of January of each subsequent year		
Number of and Proportion of M&E Officers trained in the implementation of the 4th Integrated M&E Framework and the national M&E data base	Number of and Proportion of M&E Officers trained in the implementation of the 4th Integrated M&E Framework and the national M&E data base		
Annual M&E Implementation Status Report Produced by end March every year	Number of Annual M&E Implementation Status Report Produced by end March every year		

Annex 2 Summary of the Findings for the Assessment of the 1st M&E Framework

1: Status of organizational structures responsible for M&E

Status Before 1st Integrated M&E Framework (Best on the 2007 MESSA Report)	Progress/ Achievements / Made by the 1st M&E Framework / Current Strength/ Enabling Factor	Current Weakness/ Challenges	Way forward /Recommended Actions
HIV/AIDS /STI & TB			
No assessment made prior to 2007	Leadership for the HIV and AIDS response is under the National HIV and AIDS /STI and TB Division (NATCoD). The Division has an M&E section that coordinates implementation of all HIV and AIDS /STI & TB M&E activities. The M&E Division provides overall health sector M&E leadership and direction	The M&E section of the National HIV/AIDS /STI & TB Division has limited capacity for M&E of the HIV/AIDS response and TB. Except for few surveys, the M&E unit at NATCoD is engaged in routine data collection and report writing. Major parts of M&E activities are being coordinated by the National HIV and AIDS care unit of the Division	Strengthen human resources and logistical capacity for implementation the HIV and AIDS M&E Framework activities
Malaria			
No clear division of responsibilities among different MOH sections in relation to M&E activities	Currently there is no clearly defined leadership responsible for Malaria M&E activities. There are a number of entities involved in the Malaria M&E activities. These include: The M&E Division of MOH, NMCP, and NHIMS & IDSR. Their role and responsibilities are not documented.	• There is a leadership vacuum for Malaria M&E activities. The malaria strategic plan does not provide direction on M&E leadership for malaria • There is no defined structure of the Malaria M&E activities • No clearly defined roles & responsibilities for entities involved in Malaria M&E activities	• Establish M&E leadership and implementation structures for NMCP • Support recruitment of M&E staff for the NMCP
Reproductive Health , Nutrition & Child Health			
No clear division of responsibilities among different MOH sections in relation to M&E activities	• The M&E Division was created to provide overall health sector M&E leadership, direction and coordination • There is no defined roles and responsibility for RH , Nutrition and Child Health M&E activities at Programme level	• There is no defined structure for coordination & implementation RH, Nutrition & Child Health M&E activities • Leadership vacuum exists for RH, Nutrition & Child Health M&E activities	• Establish M&E leadership and implementation structures for the RH, Nutrition and Child Health
Health Systems Strengthening			
No clear division of responsibilities among different	• The M&E Division provides overall health sector M&E leadership and direction	Apart from HMIS, there is no defined structure for the coordination of and	Strengthen and harmonize structures and systems for M&E

Status Before 1st Integrated M&E Framework (Best on the 2007 MESSA Report)	Progress/ Achievements / Made by the 1st M&E Framework / Current Strength/ Enabling Factor	Current Weakness/ Challenges	Way forward /Recommended Actions
MOH sections in relation to M&E activities		implementation of the M&E activities for the HSS	activities of HSS Programmes

2: Status of Human Capacity Building for M&E

Status Before 1stIntegrated M&E Framework (Based on the 1st Integrated M&E Framework)	Progress/ Achievements / Made by the 1stM&E Framework / Current Strength/ Enabling Factor	Current Weakness/ Challenges	Way forward /Recommended Actions
For all the seven Programmes			
MOH had human resource capacity gaps which included: • Lack of M&E skilled personal in 6 priority programmes • Lack of M&E coordinators in all the 6 Zobas • Inadequate M&E skills in data management, analysis, decision making and report writing at national and decentralized level • Absence of tailored M&E training packages for the different levels	M&E Division developed a general M&E training manual on Results-Based Monitoring and Evaluation System for conducting M&E training courses for key MoH persons and other stakeholders.	• The M&E Training Programme was not customized to the implementation of the 1stIntegrated M&E Framework • M&E skilled personnel have not been recruited for the M&E units in the six programmes	Establish M&E training and capacity needs for the 2nd M&E frame work and develop a training programme customized to its implementation
3: Status of the National M&E Partnerships			
• A National M&E Advisory Committee was in Place to promote M&E partnerships • In addition there were also joint meetings and reviews between MOH, Development Partners, CSOs, and FBOs, also aimed at promoting M&E partnerships	• The National M&E Advisory Committee is in place and its TORS were revised and updated in 2010. In addition, the M&E Technical Working Group (M&E-TWG), representing various information systems, programs and zobas was established in 2008, to handle technical M&E issues and advise the National M&E Committee. Joint planning and review meetings have continued to be carried out and all these have promoted the M&E partnership.	The established structures are not regularly meeting to performing their expected roles and responsibilities	Restructure the two existing partnership structures to establish one functional M&E Committee.

4: Status of the Development of an Integrated M&E Framework

Status Before 1st Integrated M&E Framework (Best on the 2007 MESSA Report)	Progress/ Achievements / Made by the 1stM&E Framework / Current Strength/ Enabling Factor	Current Weakness/ Challenges	Way forward /Recommended Actions
HIV and AIDS			

Status Before 1st Integrated M&E Framework (Best on the 2007 MESSA Report)	Progress/ Achievements / Made by the 1stM&E Framework / Current Strength/ Enabling Factor	Current Weakness/ Challenges	Way forward /Recommended Actions
Strength • Programme had a national strategic plan and draft M&E plan. • The M&E plan had key indicators that conformed to international standards & linked to the national strategic Plan. **Weakness** • Indicators in the M&E Plan did not have targets & were not time-limited • Indicators lacked clear definition. • Only the HAMSET & GF project had budgets for the M&E Plan. • Data for survey-based indicators had not been collected • Many indicators were not disaggregated by age, sex or socio-economic status • The M&E Plan was not widely disseminated and was not in general use • Shortage of qualified human resources, at decentralized level.	• The programme has a national HIV and AIDS/ STI strategic plan (2008-2012) aligned to the Health Sector Strategic Development Plan • A 1stIntegrated M&E System 2008-2012 was developed and aligned to the national HIV and AIDS/STI strategic plan • The 1stM&E Framework had well defined HIV and AIDS/STI result framework, with indicators, baseline and targets for each year of implementation, and defined data collection methodology. Indictors were defined and costing of the M&E plan was done, and funding source indentified. • The HIV& Syphilis Sentinel Surveillance is functional and the 2009 report was produced in March 2010 • Data was collected at least once for 7 of 8 impact indicators in the result framework. 5 of the 8 impact indicators are in the HMIS matrix reflecting a measure of integration & sustainability • Data was collected at least for 6 of the 17 outcome indicators. 8 of 17 indicators are in HMIS matrix • Data was collected for 5 of the 12 output indicators. 3 of the 12 indictors are in the HMIS matrix	• Data collection was only made for less than 50% of the indictors in the result framework • There is no report produced on the implementation of the M&E plan.	• Strengthen supervision and mentoring of M&E structures to ensure implementation of planned M&E interventions • Undertake annual operational planning and budgeting to implement M&E activities for HIV/AIDS • Revise and harmonize the data collection tools • Develop guidelines and formats for monitoring the quality of services.; • Annual reports should be made available at all operational levels and be shared with stakeholders by 2012.
TB			
Strengths • The programme had a national TB strategy with indictors linked to the integrated national M&E plan • The NTCP data is easily available to all stakeholders including the zones • Programme had a budget for M&E activities. **Weakness** • There was no strong coordination between the NTCP and other data collection systems such as DHS, HMIS and National M&E	• The 1st integrated M&E plan has TB indictors with baseline and targets and data collection methods defined. Indictor definition and costing of TB M&E activities were done and source of funding identified • Data collection was done and reported for 1 of the 3 impact indicators. Data was also collected and reported on all the 8 and 11 outcome and output indicators respectively.	• There was no data collection for input indicators • Data collection for TB is still parallel to other methods of data collection. • Data collection for TB is yet to be integrated in HMIS and other systems. This challenge was also reported in 2007	• Develop annual operational plans and mobilize resources for its implementation • Undertake regular review of the implementation the operational M&E plans • Harmonize TB data collections with HMIS

Status Before 1st Integrated M&E Framework (Best on the 2007 MESSA Report)	Progress/ Achievements / Made by the 1stM&E Framework / Current Strength/ Enabling Factor	Current Weakness/ Challenges	Way forward /Recommended Actions
• Information on the disease trends (prevalence, incidence, mortality rates) was not regular • There was missing data on quality of services, client satisfaction, adherence to treatment			
Malaria			
Strength • Programme had a national malaria strategy with measurable indicators and targets, aligned to the 2nd integrated the national M&E plan • Data was being collected from various sources such as the NHMIS, IDSR, health facility surveys, community survey, desk review, DHS, and routine program activity monitoring. • Data was being disseminated to all levels via annual assessment meetings, newsletters, distribution of annual reports and survey reports to MOH staff and stake holders. **Weakness** • There was no separate M&E Plan for the National Malaria Control Program. • The programme had limited capacity for data analysis and interpretation. • NMCP had no indicators definitions • Budget allocation for M&E activities was below 7% of the malaria budget	• The Programme has five year strategic plan 2012-2016, aligned to the Health Sector Strategic Development Plan. The strategic plan has indictor with baseline values and targets which were aligned to the 1stintegrated M&E plan. The 1stintegrated M&E plan has indictor definitions for all the malaria indicators. The costing of the M&E plan was done and funding source indentified. • Data has been collected for 4 of the 5 impact indictors all through HMIS, which makes data collection more sustainable. • Data for 4 of the 5 outcome indicators was collected once in 2008 • Data for 12 of the 16 output indicators was collected and reported through the regular NMCP reports	• There is no NMCP M&E plan, a challenge that has persisted since 2007. • No data collected and reported on input indicators	• Support development of the NMCP M&E Framework and operational plan • Regularly review the implementation the of the National Malaria M&E Framework and annual operational plan • Mobilization of resources to support implementation of the NMCP M&E framework
Reproductive Health			
There was no nutrition specific monitoring and evaluation plan to	• The Health Sector Strategic Development Plan has at least 12 indictors on reproductive health	• RH has no strategic plan. Its interventions are only spelt out in the Health Sector	• Ensure integration of RH data collections into exiting data

Status Before 1st Integrated M&E Framework (Best on the 2007 MESSA Report)	Progress/ Achievements / Made by the 1stM&E Framework / Current Strength/ Enabling Factor	Current Weakness/ Challenges	Way forward /Recommended Actions
support monitoring of nutrition activities and indicator	• Reproductive health is part of the 1st integrated M&E plan. Indicators and targets were defined. Indicator definition was done . • Data has been collected for all the five indictors defined in the result framework for reproductive health in 1st integrated M&E plan. Data has also been collected for 7 of the 11 outcome indictors for reproductive health	Strategic Development Plan. There is also no RH M&E plan. • Data collected was mainly a result of EDHS. It was not a deliberate effort of the RH programme • No data collected for all output and input indictors	collection systems and mechanisms • Regularly review implementation of RH M&E activities
Nutrition			
There was no Nutrition Specific Monitoring and evaluation plan to support monitoring of Nutrition activities and indicator	• The Health Sector Strategic Development Plan has at least 15 indictors on nutrition that will be regularly monitored. • Nutrition was part of the 1stintegrated M&E plan. Indicators and targets were defined. Indicator definition was also done. • Data was collected for 4 of the 8 outcome indicators and for 2 of the 4 output indictors in the 1stintegrated M&E plan.	• The Nutrition programme has no strategic plan. Its interventions are only outlined in the Health Sector Strategic Development Plan. Nutrition also has no M&E plan. • No effort made to collect data for the impact indictors • There is no evidence to show that Nutrition has programme for implementation of its M&E activities	• Ensure integration of nutrition data into existing data collection systems and mechanisms
Child health			
There was no Child Health Specific Monitoring and Evaluation Plan	• The Health Sector Strategic Development Plan has at least 5 indictors on child health for regular monitoring • Child health was part of the 1stintegrated M&E plan. Indicators and targets were defined. Indicator definition was also done • EDHS collected data and reported on all the 3 impact indictors, and for 1 of the 3 outcome indicators. Data was also collected and reported on the 3 of the 6 output indicator.	• Child health has no strategic plan. Its interventions are only outlined in the Health Sector Strategic Development Plan. Child health also has no M&E plan for its programme activities. • There is no evidence to show that Child health has a programme for implementation of M&E activities for its programme	• Support development of an operation plan to facilitates M&E activities for Child Health activities • Regularly review implementation of M&E activities for Child Health Programme
Health Systems Strengthening			
• HSS has not been focused during the health sector strategic planning • There was no specific budget and resources allocated for HSS • There were multiple databases without common data dictionary • No defined indictors for HSS	• The HSSDP has a focus on HSS and there are indictors that were formulated • HSS was part of the 1stintegrated M&E plan. Indicators for HSS were formulated • Data collection was done for one impact indictor and only two indictors on human resource • Strategic plan has been developed for strengthening HMIS	There was no baseline and target for the indicators that were formulated. The result framework did not identify data collection methods for the HSS indictors. As a result data collection was not done for 20 of the 23 indictors in the 1stintegrated M&E plan	Support development annual operational plan for the M&E activities of the HSS programme
5: Costing and annual roll out of the 1stIntegrated M&E Framework			
Status Before 1stIntegrated M&E Framework	**Progress/ Achievements / Made by the 1stM&E Framework / Current Strength/ Enabling Factor**	**Current Weakness/ Challenges**	**Way forward /Recommended Actions**
At the zobal level , there was no	The 1stNational Integrated M&E Action Plan (NIMEAP) (2008-	There was limited effort to mobilize	• Annually plan and budget for

support for developing costed zoba action plans for their M&E responsibilities	2012) was costed for all M&E activities. It contained activities, responsible implementers, timeframe, cost and source of funding both Government and Development Partners. In addition, disease specific M&E action plans were developed for the three programme (HIV/AIDS/STI, TB and Malaria) were also costed. For the rest of the programmes (RH, Nutrition, Child Health, &HSS) their M&E activities were costed under the M&E plan for the M&E Division. The costing included major M&E .interventions like EDHS, NASA & HIV/AIDS social economic impact studies	resources for the implementation of the M&E operational plan. Some of the source of funding that had been indentified were projects which had ended.	M&E activities as part of the overall plan and budget under each of the programmes • Resource mobilization efforts for the Health Sector Strategic Development Plan should include funding for the 2ndIntegrated M&E Frame work
6: Status of Advocacy, Communication for the Culture of M&E			
Status Before 1stIntegrated M&E Framework	**Progress/ Achievements / Made by the 1stM&E Framework / Current Strength/ Enabling Factor**	**Current Weakness/ Challenges**	**Way forward /Recommended Actions**
Programmes had no advocacy and communication strategies for M&E	• Increasing demand for evidence based planning, increases emphasis on M&E • Increasing demand for programme accountability nationally and by Development Partners	The 3th integrated M&E Framework did not have an advocacy strategy for mobilizing support for M&E activities of the sector	Support development and implementation of an advocacy strategy to promote the importance of M&E and the use of M&E products
7: Status of Routine Programme Monitoring			
Status Before 1stIntegrated M&E Framework	**Progress/ Achievements / Made by the 1stM&E Framework / Current Strength/ Enabling Factor**	**Current Weakness/ Challenges**	**Way forward /Recommended Actions**
Strength • Programmes had standard tools, source documents and guidelines (e.g., medical record, register) and reporting forms for use by all reporting levels • There was an M&E Unit at national level that identifies the data management responsibilities • Programmes were collecting information on performance by all Sub-reporting entities of sub-national and national level • Periodic supportive supervision was being conducted at all levels support to the functionality of HMIS **Weakness** • There were no periodic revision and updating of the source documents and guidelines	• The HMIS is Functional able to analysis data and produce reports • Routine data collection, entry analysis & dissemination of HIV/ AIDS/ STI & TB is conducted by collecting AIDS/STI/TB cases report, VCT report, PMTCT report, blood transfusion donors HIV screening report, condom distribution report and other relevant reports from partners • Good performance of routine programme reporting in the healthy facility based services • Decentralized responsibility to districts • Existence of guidelines to guide collection, collation, analysis, reporting, data quality assurance and audit • Availability of standard reporting forms • Meeting international reporting requirements like UNGASS • The development of the HMIS Strategic Plan to focus on strengthen and improving the functionality of HMIS • The accuracy from the health facility to Zoba level is reported to be 80.6% while completeness is above 90%. The data and information reported can be relied upon for decision making • The timeliness from Zoba to National level in 2010 was 83% • Routine data is available and includes:	• Lack of policy and legal framework for HMIS • Lack of coordination in the collection of routine data and information • Inadequate IT infrastructure at decentralized levels • Reporting is mainly done to the development patterns. There is limited sharing of report with other Government partners	• Support harmonization and standardization of routine data and information collection and reporting • Support establishment of a policy framework for the Health Management Information System

• The M&E unit at NATCoD was a one man unit • M&E units for HIV and other diseases did not exist at sub-national level. At zoba level TB and HIV programs are coordinated by one person. • There was lack of clearly written instructions to each Sub-reporting Entity on what to collect, how to report, to whom and when to send data and verify data quality. • There was a delay in reporting, inadequacy in completeness and sometimes need of validation. • Supportive supervision was not coordinated and integrated and there was no regular feedback • There was limited data analysis, utilization and dissemination of reports at all levels. Absence of one data base at national level.	▪ Population data ▪ Antenatal, delivery & family planning services ▪ PMTCT and VCT services ▪ Growth monitoring, immunisation, health promotion and education services ▪ IDSR diseases ▪ OPD & Inpatient services that includes: Morbidity and mortality data from heath facilities		
8: Status of Surveys and Surveillance			
Status Before 1stIntegrated M&E Framework	**Progress/ Achievements / Made by the 1stM&E Framework / Current Strength/ Enabling Factor**	**Current Weakness/ Challenges**	**Way forward /Recommended Actions**
Lack of quality control and quality assurance mechanisms for surveys and surveillances conducted by programmes	• Antenatal Clinic (ANC) HIV and syphilis prevalence surveillance has been regular and reports produced to determine the trends and levels of HIV prevalence • Undertaking of the EDHS in 2010	• High cost and technical demands for conducting national population surveys • The EDHS 2010 report has not been produced and disseminated	Undertake advance planning and mobilization of resources for the surveys
9: Status of Health & HIV/AID Data Bases			
Status Before 1stIntegrated M&E Framework	**Progress/ Achievements / Made by the 1stM&E Framework / Current Strength/ Enabling Factor**	**Current Weakness/ Challenges**	**Way forward /Recommended Actions**
• There was no national database linking all reporting entities • There was no single national HIV/AIDS/STI database housing all relevant data for the M&E system within NATCoD. • There was no national malaria database housing all relevant data for the M&E system within NMCP	• The HMIS which constitutes part of the M&E database, produces relevant strategic information for decision-making at all levels of health services National Health Information System (HIS), which • There is a defined set of national core health indicators to be measured at different levels • The new structure of MOH has created an HIS Division to coordinate and establish a national health data base	• Technical and logistical capacity for managing the health sector data base requires strengthening.	• Establish and support national database linked to all reporting entities • Mobilization of technical and financial support for establishing and maintaining a functional national level health sector data base

10:Status of Support supervision, data quality assurance and audit			
Status Before 1stIntegrated M&E Framework	**Progress/ Achievements / Made by the 1stM&E Framework / Current Strength/ Enabling Factor**	**Current Weakness/ Challenges**	**Way forward /Recommended Actions**
• There was need to revise the mentoring, supervision, support and auditing guidelines and checklists • There was no quality control system for double data entry, post data entry verification and training on how to back up • There were no standard operational guidelines, supervision checklists and reporting forms for supportive supervision and data auditing for programmes	• The Health Management Information System (HMIS) has its own data auditing tool that is used as an in-house data quality assessment. • The Ministry of Health has a general integrated supportive supervision manual composed of several checklists to assess the entire service delivery, resources available, and data auditing. • Guidelines for integrated supportive supervision have been developed jointly by the Ministry of Health.	• Support supervision is not based on clear objectives for which it is being done • Findings from support supervision activities are never translated into actions and are not shared with all sections and units in MOH • Feedback is not given to the supervised units. • `There is no harmonized programme of support supervision for the different Programmes in MOH yet the units supervised are the same	• Development of a harmonized progrmme for support supervision for the sector, that focuses on technical back stopping mentoring, data quality and audit , • Establish a mechanism for sharing of the outcomes of the support supervision and implementation of agreed actions
11: Evaluation and Research.			
Status Before 1stIntegrated M&E Framework	**Progress/ Achievements / Made by the 1stM&E Framework / Current Strength/ Enabling Factor**	**Current Weakness/ Challenges**	**Way forward /Recommended Actions**
• There was no systematic mechanism to identify evaluation and research priorities for policy, programme and interventions • There was no stakeholders information needs assessment being done • There was no inventory of completed and ongoing evaluation and research studies in the country to avoid redundancy and duplication • Absence of a database of institutions capable of conducting evaluation and research; • Lack of a national evaluation & research agenda • Lack of national ethical procedures and standards for undertaking research and evaluation ; • Lack of guidelines and standards on evaluation and research;		• A number of evaluations planned to be carried out were not implemented • Resources were not mobilized to implement many of the planned evaluations and planned interventions	• Annually develop an evaluation and research agenda, plan, budget and mobilize resources for its implementation • Establish a mechanism for ensuring quality and ethical considerations of evaluation and research protocols and findings
12: Health & HIV/AIDS information dissemination and use			
Status Before 1stIntegrated M&E Framework	**Progress/ Achievements / Made by the 1stM&E Framework / Current Strength/ Enabling Factor**	**Current Weakness/ Challenges**	**Way forward /Recommended Actions**

• Lack of functional M&E resource centre for M&E Division and the Programmes		Lack of an effective mechanism for dissemination and use of M&E products to promoted evidence based decision making, planning and management. There is limited use of M&E products to promote programme, policy improvements	Establish a mechanism and system for annually synthesizing all M&E products to generate actions for policy, planning, management and programme improvements

Annex 3 Detailed Programme Specific M&E Operational Plans (Road Maps)

Annex 3.1 Five Year National HIV&AIDS M&E Operational Plan 2012-2016

	Activity	Responsible agency	Cost Description	2012	2013	2014	2015	Y 2016	Total 2012-2016	Source of Funding
COMPONENT 1: Organization Structures for the HIV/AIDS for M&E Functions										
Objective 1: To strengthen M&E organizational structures at national and decentralized levels and provision of support to ensure their functionality.										
1.1	Recruit the following staff for NATCoD M&E unit: (i) Data entry manager: (ii) Social researcher: (iii) M&E expert	HIV/AIDS Unit	• Recruitments process • Staff salaries	214,068	64,068	64,068	64,068	64,068	150,000.00 **320,338.50**	GFATM, To Be Identified (TBI)
1.2	Procure Technical Assistance to support implementation of the M&E framework	HIV/AIDS Unit	TA costs	25,000.00	-	-	-	-	25,000.00	UNAIDS
1.3	Furnish and equip HIV/AIDS Unit M&E Structures	HIV/AIDS Unit	Office Equipment & furniture	20,000.00	20,000.00	20,000.00	20,000.00	20,000.00	100,000.00	TBI
Component2: Human Resource Capacity for HIV M&E										
Objective 2:To equip the M&E Personnel at the M&E Unit and Zoba level with skills required for effective implementation of the HIV/AIDS M&E framework 2012-2016										
2.1	Undertake M&E skills assessment and design a training programme to enhance M&E skills and capacity for the M&E of the HIV/AIDS response	HIV/AIDS Unit & M&E Division	TA recrute in 1.2	0	0	0	0	0	0	To be carried out at no additional cost by the TA recruited in 1.2
2.2	Support implementation of the M&E skills and capacity building programme	M&E Div HIV/AIDS Unit & HMIS	Training Costs	13,500.00	13,500.00	13,500.00	13,500.00	13,500.00	**67,500.00**	TBI
Component 3: National M&E Partnerships										
Objective: 3 Strengthen partnerships with key stakeholders who are involved in planning and managing the National HIV M&E system										
3.1	Establish M&E TWG for the HIV/AIDS Response	HIV/AIDS Unit	TOR & Constituting the TWG	80.00	0.00	0.00	0.00	0.00	80.000	TBI
3.2	Support the Quarterly meetings of the M&E TWG for HIV/AIDS	HIV/AIDS Unit	Meetings	80.00	80.00	80.00	80.00	80.00	400.000	TBI
3.3	Hold annual joint review of the national HIV/AIDS response implementation	HIV/AIDS Unit M&E Division,	Two day annual review	2,700.00	2,700.00	2,700.00	2,700.00	2,700.00	**13,500.00**	TBI
Component4: National M&E Framework										
Objective 4: Develop and ensure implementation of the National HIV/AIDS M&E plan										

4.1	Review and develop the National HIV/AIDS M&E Framework and operational plan for the national response	HIV/AIDS Unit	TA	27,000.00	-	-	-	-	27,000.00	GFATM, JUNT
4.2	Standardize and harmonize all indicators, data collection tools, reporting formats, activity schedules for HIV/AIDS/STI	HIV/AIDS Unit, M&E Division, HMIS, IDSR	TA for 20days & 3 days workshop		23,050.00	-	-	-	23,050.00	GFATM, JUNT
Component 5: National Costed HIV M&E Work plan (Roadmap)										
Objective 5: Develop a Costed National M&E Operational Plan for the National HIV/AIDS M&E Framework										
5.1	Annually plan and budget for the HIV/AIDS M&E activities based on the five year operational plan, as part of the overall annual budget for the national HIV/AIDS response	HIV/AIDS Unit		27,000.00	27,000.00	27,000.00	27,000.00	27,000.00	**135,000.00**	TBI
Component 6: Advocacy and communication										
Objective 6: To Strengthen Advocacy and Communication to Promote the M&E Culture and Secure Commitment to support implementation of M&E interventions										
6.1	Advocate for support and commitment to implementation of HIV/AIDS M&E systems and functions targeted at MOH Depts, Partners & all stakeholders in the national response	HIV/AIDS Unit	Communication costs , Meetings, Posters	2,500.00	2,500.00	2,500.00	2,500.00	2,500.00-	12,500.00	JUNT, GFATM
Component 7: Surveys, Surveillances and special studies										
Objective: To Support implementation of cost effective and short term surveys and surveillance activities to generate data and information to assess the performance of HSSD and inform programme management										
7.1	**Biological surveillance**									
7.1.1	Plan and undertake Antenatal Clinic (ANC) HIV and syphilis prevalence surveillance biennially	HIV/AIDS Unit	Survey costs	15,000.00	-	15,000.00	-	15,000.00	45,000.00	GFATM, J
7.1.2	Plan and undertake national HIV and syphilis surveillance survey in commercial sex workers biennially	HIV/AIDS Unit	Survey costs	15,000.00	-	15,000.00	-	15,000.00	45,000.00	GFATM
7.1.3	Plan and undertake national HIV and syphilis surveillance survey in truck drivers biennially	HIV/AIDS Unit	Survey costs	15,000.00	-	15,000.00	-	15,000.00	45,000.00	GFATM

7.1.4	Plan and undertake national HIV surveillance survey in TB patients biennially	HIV/AIDS Unit	Survey costs	15,000.00	-	15,000.00	-	15,000.00	45,000.00	GFATM
7.2	**Population based surveys**									
7.2.2	Design protocol, plan and undertake a condom availability survey biennially	HIV/AIDS Unit LMIS, ESMG	Survey costs	0.00	15,000.00	0.00	15,000.00	0.00	30,000.00	GFATM
7.2.3	Design protocol, plan and undertake mode of transmission survey biennially	HIV/AIDS Unit	Survey costs	70,000.00	0.00	0.00	70,000.00	0.00	140,000.00	UNAIDS/GFATM
Component 8: Routine Programme Monitoring										
Objective : To Sustain the Functionality of Routine Programme Monitoring Systems										
8.1	**Health Management Information System (HMIS)**									
8.1.1	Monthly HMIS /HIV/AIDS data collection at health facility level and reporting to Zoba	HMIS	Staff time & HMIS Forms	0.00	0.00	0.00	0.00	0.00	0.00	Government (No additional cost)
8.1.2	Monthly HMIS /HIV/AIDS data reporting by Zobas to National Level	HMIS	Staff time & HMIS Forms	0.00	0.00	0.00	0.00	0.00	0.00	Government (No additional cost)
8.2	**NATCoD Information Collection System**									
8.2.2	Monthly data collection, analysis and reporting on HIV/AIDS death VCT, PMTCT, ART, HBC and TB-HIV to the HIV/AIDS UNITS	HIV/AIDS Unit	Staff time	0.00	0.00	0.00	0.00	0.00	0.00	Government (No additional cost)
8.2.3	Data from partners on multi-sectoral response are captured in HIV/AIDS Unit monthly	HIV/AIDS Unit	Staff time	0.00	0.00	0.00	0.00	0.00	0.00	Government (No additional cost)
8.3	**Multisectoral HIV/AIDS/STI Response Reporting System**									
8.3.1	Quarterly reporting by all implementers of multi-sectoral HIV/AIDS/STI to HIV/AIDS Unit	Implementers	Staff time& Reporting Instruments	0.00	0.00	0.00	0.00	0.00	0.00	Government (No additional cost)
8.3.2	Production of Quarterly report for the multi-sectoral HIV/AIDS response	HIV/AIDS Unit	Staff time& Reporting Instruments	0.00	0.00	0.00	0.00	0.00	0.00	Government (No additional cost)
8.4	National Blood Bank and Transfusion Centre (NBTC) Reporting System									
8.4.1	Monthly reporting by NBTC to HIV/AIDS Unit	NBTC	Staff time	0.00	0.00	0.00	0.00	0.00	0.00	Govt (No additional cost)

8.5	**Routine Data Collection Tools /Instruments**									
8.5.1	Printing of routine data collection tools for HIV/AIDS/STI: VCT, PMTCT, ART, HBC, TB-HIV registers and reporting formats	NATCoD, M&E Division, HMIS, PMU	Printing and distribution costs	20,000.00	20,000.00	20,000.00	20,000.00	20,000.00	100,000.00	TBI
Component 9: National and Local HIV Databases										
Objective: To strengthen the national and sub national data bases for HIV/AIDS/STI										
9.1	Maintain a single national HIV/AIDS/STI database housing all relevant data for the M&E system within NATCoD	NATCoD, M&E Division, HMIS, IDSR	Staff time, Routine data updating	10,000.00	10,000.00	10,000.00	10,000.00	10,000.00	50,000.00	TBI
	Component 10: Supportive Supervision and Data Auditing									
	Objective 10: To ensure that support supervision, data quality assurance and audit are all implemented as part of the M&E									
10.1	Undertake routinely integrated supportive supervision, data quality and auditing	NATCoD, M&E Division, HMIS, IDSR	Travel and communication costs	10,000.00	2,000.00	2,000.00	2,000.00	2,000.00	10,000.00	TBI
10.1	Hold meetings with stakeholder to review and take action on the outcome of the technical support supervision, data quality and data audit visits	NATCoD, M&E Division, HMIS, IDSR	Meeting Costs	160.00	160.00	160.00	160.00	160.00	**800.00**	TBI
Component 11: Evaluation, Research and Learning										
Objective: Strengthen capacity & support implementation of evaluation & research studies relevant to the National HIV/AIDS/STI response										
11.1	Develop research and Evaluation Agenda for the National HIV/AIDS response	HIV/AIDS Unit , M&E Div, HMIS, IDSR	Workshop & short term TA	28,350.00	28,350.00	28,350.00	28,350.00	28,350.00	**141,750.00**	TBI
11.2	Support processes and mechanism for reviewing and approving research and evaluation studies	HIV/AIDS Unit, M&E Division, HMIS, IDSR	Protocol &research/ evaluation review meetings	120.00	120.00	120.00	120.00	120.00	**600.00**	TBI
11.3	Undertake midterm review and final evaluation of ENASP implementation	HIV/AIDS Unit and partners	Meetings, communication & consultants	-	-	58,620.00	-	78,620.00	**137,240.00**	TBI
11.4	Writing and Producing of Biannual UNGASS and Universal Access Report	HIV/AIDS Unit		1,000.00	1,000.00	1,000.00	1,000.00	1,000.00	**5,000.00**	TBI

Component 12: Data Dissemination and Information Use										
Objective: To support mechanisms for information dissemination and use M&E results for decision making and programme improvement										
12.1	**Data dissemination and information use strategy**									
12.1.1	Preparation of policy papers on programme, planning and policy implication of surveys, studies and evaluations carried out	HIV/AIDS Unit , M&E Division, HMIS, IDSR, Research unit	Short term TA	27,000.00	27,000.00	27,000.00	27,000.00	27,000.00	**135,000.00**	TBI
12.1.2	Printing and distribution of the following: • Policy papers from studies, surveys and evaluations • Comprehensive multisectoral and health sector report • Reports of all special surveys, surveillance and studies undertaken • Biennial UNGASS report • Biannual Universal access report	HIV/AIDS Unit, M&E Division, HMIS, IDSR, Research unit	Printing and distribution costs	10,000.00	10,000.00	10,000.00	10,000.00	10,000.00	50,000.00	TBI
12.1.3	Organise stakeholder forum annually to disseminate data and information from surveys, evaluation and studies carried out during the year and implications for policy and planning	HIV/AIDS Unit M&E Division, HMIS, IDSR, Research unit	Stakeholders forum, printing of reports & presentation of reports	4,600.00	4,600.00	4,600.00	4,600.00	4,600.00	**23,000.00**	TBI
12.3.4	Annual M&E regional meetings	HIV/AIDS Unit M&E Div	Travel & communication costs	4,050.00	4,050.00	4,050.00	4,050.00	4,050.00	**20,250.00**	TBI
12.3.7	Establish and maintain the M&E resource centre in HIV/AIDS Unit	HIV/AIDS Unit	Establishment & running costs for RC	5,000.00	5,000.00	5,000.00	5,000.00	5,000.00	**25,000.00**	GFATM, JUNT
	GRAND TOTAL BUDGET			572,207.70	278,177.70	358,747.70	325,127.70	378,747.70	1,913,008.50	

Annex 3.2 Five Year Integrated National TB M&E Operational Plan 2012-2016

	Activity	Responsible agency	Cost Description	Yr 2012	Yr 2013	Yr 2014	Yr2015	Year2016	Total 2012-2016	Source of funding
1	**COMPONENT 1: Organisation Structures With TB M&E Functions**									
Objective: To strengthen TB M&E organizational structures at national and decentralized levels and provision of support to ensure their functionality										
1.1	Recruit the following staff for TB M&E unit:	TB Programme	Annual staff salaries	5,000.00	5,000.00	5,000.00	5,000.00	5,000.00	**25,000.00**	TBI
2	**COMPONENT 2: Human Capacity For TB M&E**									
	Objectives: To develop and implement a customized M&E human resources training programme for the implementation of the TB M&E Framework									
2.1	Training health facility staff key managers and zonal personnel in TB data collection, auditing and mgt	M&E Div, TB Programme HMIS, IDSR	Training workshop costs	98,000.00	9,800.00	9,800.00	9,800.00	9,800.00	**137,200.00**	GFATM, WHO
3	**Component 3: M&E Partnership for TB**									
	Objective: To strengthen the Partnership for TB M&E									
3.1	Establish an M& E TWG for HIV/AIDS & TB	TB Prog, M&E Div		80.00	0.00	0.00	0.00	0.00	80.00	WHO, GFATM
3.2	Organize quarterly coordination, feedback and information sharing meetings of M&E TWG and its sub committees at national level	TB Programme, M&E Div, HMIS, IDSR		160.00	160.00	160.00	160.00	160.00	**800.00**	WHO, GFATM
4	**Component 4: TB M&E Framework**									
	Objective: To Strengthen Implementation of the National TB M&E Plan									
4.1	Develop the National TB M&E Framework and operational plan for the TB Programme	TB Programme	TA	27,000.00	0.00	0.00	0.00	0.00	27,000.00	GFATM, WHO
4.2	Quarterly review of the implementation of the National TB M&E Framework	TB Programme	One day meeting	80.00	80.00	80.00	80.00	80.00	400.00	GFATM, WHO
4.3	Standardize and harmonize all indicators, data collection tools, reporting formats, activity schedules for TB	TB Programme M&E Div, HMIS, IDSR	TA & 3 days workshop	31,050.00	0.00	0.00	0.00	0.00	31,050.00	GFATM, WHO
5	**Component 5: Costing and Annual Roll Out of the National TB M&E Work plan**									
	Objective: To support the costing and mobilization of resources for annual roll out of the TB National M&E Work plan									
5.1	Annually plan and budget for the TB M&E activities based on the five year operational plan, as part of	TB Programme		9,786.00	9,786.00	9,786.00	9,786.00	9,786.00	48,930.00	WHO, GFATM

	the overall TB Programme annual budget									
6	**Component 6: Advocacy and Communication**									
	Objective 6: To Strengthen Advocacy and Communication to Promote the M&E Culture and Secure Commitment to Support Implementation of TB M&E interventions									
6.1	Advocate for support and commitment to TB M&E systems and functions targeted at MOH Depts, Partners & all stakeholders in the national response	TB Programme	Communication costs , Meetings, Posters	5,000.00	5,000.00	5,000.00	5,000.00	5,000.00	**25,000.00**	TBI
7	**Component 7:** Surveys, Surveillances and Special Studies									
Objective: To Support implementation of cost effective and short term surveys and surveillance activities to generate data and information to assess the performance of TB programme										
7.1	Design protocol, plan and undertake TB prevalence surveillance every five years	TB Programme	Survey costs		90,000.00		-		90,000.00	GFATM, WHO
7.2	Plan and undertake national baseline MDR surveillance survey	TB Programme	Survey costs	60,000.00	-	15,000.00	-	15,000.00	90,000.00	World Bank, GFATM
	Component 8: Routine TB Programme Monitoring									
	Objective : To Sustain the Functionality of Routine Programme Monitoring Systems									
8.1	**Health Management Information System (HMIS)**									
8.1.1	Monthly HIMIS collecting and reporting of TB data by health facilities to Zoba	HMIS	Staff time	0.00	0.00	0.00	0.00	0.00	0.00	Government
8.1.2	Monthly HMIS/TB data collation and reporting reports MOH to HMIS	HMIS	Staff time	0.00	0.00	0.00	0.00	0.00	0.00	Government
8.2	**NATCoD Information Collection System**									
8.2.1	Collect, analyse and report data on TB cases, deaths generated through HMIS	TB Programme	Staff time	0.00	0.00	0.00	0.00	0.00	0.00	Government
8.2.2	Printing of routine data collection and recording tools for TB, TB-HIV registers and reporting formats	TB Programme M&E Div. HMIS	Printing and distribution costs	1,000.00	1,000.00	1,000.00	1,000.00	1,000.00	5,000.00	GFATM, , WHO
	Component 9: National and Local IB Databases									
	Objective: To strengthen the national and sub national data bases for TB									
9.1	Maintain a single national TB database housing all relevant data for the M&E system.	TB Prog, M&E Div. HMIS	Routine updating of the data base	15,000.00	15,000.00	15,000.00	15,000.00	15,000.00	75,000.00	GFATM, WHO

10	**Component 10:** Supportive Supervision and Data Auditing									
	Objective 10: To ensure that support supervision, data quality assurance and audit for TB are all implemented									
10.1	Undertake routinely integrated supportive supervision, data quality and auditing	TB Programme M&E Div. HMIS, IDSR	Travel and communication costs –	5,000.00	5,000.00	5000.00	5,000.00	5000.00	25,000.00	???
10.2	Stakeholder's meetings to review and take action on the outcome of the technical support supervision, data quality and audit visits	TB Programme, M&E Division, HMIS, IDSR	Meeting Costs	2,700.00	2,700.00	2,700.00	2,700.00	2,700.00	13,500.00	???
11	**Component 11: Evaluation, Research and Learning**									
	Objective: Strengthen capacity and support implementation of evaluation and research studies relevant to TB									
11.1	Develop research and Evaluation Agenda for TB	TB Prog, IDSR		1,000.00	1,000.00	1,000.00	1,000.00	1,000.00	5,000.00	???
11.2	Support processes and mechanism for reviewing and approving research and evaluation studies	NATCoD, M&E Division, HMIS, IDSR		160.00	160.00	160.00	160.00	160.00	800.00	???
11.3	Undertake a review and evaluation of the TB programme	TB Programme	Meetings, communication and TA	160.00	160.00	160.00	160.00	160.00	800.00	???
12	**Component 12: Data Dissemination and Information Use**									
	Objective: To support mechanisms for information dissemination and use M&E results for decision making and programme improvement									
12.1	**Data dissemination and information use strategy**									
12.1.1	Annually compile and print reports of surveys, evaluation & research work done on TB	TB Programme, & M&E DIV	Printing costs	2,000.00	2,000.00	2,000.00	2,000.00	2,000.00	10,000.00	Global Fund
12.1.2	Organize annual TB stakeholder's information dissemination Forum.	TB Prog & M&E DIV	One /two day forum	27,000.00	27,000.00	27,000.00	27,000.00	27,000.00	13,500.00	???
12.1.3	Establish and maintain a TB resource centre	TB Prog & M&E DIV		5,000	-5,000	5,000	5,000	5,000	25,000.00-	???
	GRAND TOTAL BUDGET			271,876.00	155,546.00	80,546.00	65,546.00	80,546.00	654,060.00	

Annex 3.3 Five Year National Malaria M&E Operational Plan 2012-2016

	Roadmap Activity	Responsible Agency	Cost Description	2012	2013	2014	2015	2016	Total 2012-2016	Source of Funding
1	**COMPONENT 1: Organisational Structures for the Malaria M&E Functions**									
Objective: To strengthen the Malaria M&E organizational structures at national and decentralized levels and provision of support to ensure their functionality										
1.1	Recruitment of M&E Staff for the M&E unit of the NMCP	NMCP	Recruitment costs	6,000.00	6,000.00	6,000.00	6,000.00	6,000.00	6,000.00	GOV/WHO
1.3	Furnish and equip all Malaria M&E structures for	NMCP	Computers, office Equip and furniture		152,320.00				152,320.00	
2	**COMPONENT 2: Human Capacity for Malaria M&E**									
Objectives: To Develop and Implement a Customized Malaria M&E Human Resources Training Programme for the Malaria M&E Framework										
2.2	Training in data collection, analysis, management and reporting at health facility, zoba and national level	NMCP		0.00	0.00	9,801.00	9,801.00	9,801.00	29,403.00	Global Fund
3	**Component 3:** M&E Partnerships									
	Objective: 3 To strengthen the Partnership for Malaria M&E									
3.1	Participate in quarterly coordination, feedback and information sharing meetings of the National M&E Committee and Zoba Level	NMCP, M&E Division, HMIS, IDSR		0.00	0.00	0.00	0.00	0.00	0.00	
4	Component 4: National Malaria M&E Plan									
	Objective: To Strengthen Implementation of the National TB M&E Plan									
4.1	Develop Malaria M&E framework and operational plan	NMCP& M&E Div	Short term TA	8,400.00	0.00	0.00	0.00	0.00	8,400.00	GFATM
4.2	Quarterly review of the implementation of the National Malaria M&E Framework	NMCP& M&E Div	One day meetings every QTR.	160.00	160.00	160.00	160.00	160.00	800.00	GFATM
5	Component 5: Costing and Annual Roll Out of the National Malaria M&E Work plan									
	Objective: To Support the Costing and Mobilization of Resources for Annual Roll out of the Malaria National M&E Work plan									
5.1	Annually plan and budget for M&E activities as part of the NMCP Budget	NMCP	NMCP staff	0.00	0.00	0.00	0.00	0.00	0.00	
6	**Component 6: Advocacy and Communication**									
	Objective 6: To Strengthen Advocacy and Communication to Promote the M&E Culture and Secure Commitment to Support Implementation of Malaria M&E interventions									

6.1	Advocacy for implementation of the Malaria M&E Frame work at all levels	NMCP, M&E Division, HPC		5,000.00	5,000.00	5,000.00	5,000.00	5,000.00	25,000.00	TBI
	Component 7: Surveys, Surveillances and Special Studies									
Objective: To Support Implementation of Cost Effective and Short term Surveys and Surveillance Activities to Assess the Performance of NMCP										
7.1	Design Protocol, plan and undertake a Malaria Indicator Survey every 5 years			0.00	0.00	300,000.00	0.00	0.00	300,000.00	Global Fund
7.2	Conduct anti-malarial drug's efficacy study in 4 sentinel sites	NMCP, WHO & zones	Study costs	30,000.00	0.00	30,000.00	0.00	30,000.00	90,000.00	Global Fund
7.3	Conduct impact evaluation of malaria interventions	NMCP	Survey costs	0.00	0.00	400,000.00	0.00	0.00	400,000.00	Global Fund
7.4	Undertake entomological survey	NMCP	Survey costs	150,000.00	0.00	0.00	0.00	0.00	0.00	Global Fund
7.5	Conduct bioassay and susceptibility studies			3,000.00	3,000.00	3,000.00	3,000.00	3,000.00	15,000.00	Global Fund
8	**Component 8:** Routine Malaria Programme Monitoring									
	Objective : To Sustain the Functionality of Routine Programme Monitoring Systems									
8.1	**Routine Data Collection Tools**									
8.1.1	Printing of routine data collection tools	NMCP	Printing costs	5000.00	5000.00	5,000.00	0.00	0.00	15,000.00	TBI
8.2	**Health Management Information System (HMIS)**									
8.2.1	Monthly HMIS data collection, analyses and reporting on malaria from Health facility to Zoba	HMIS	Staff time	0.00	0.00	0.00	0.00	0.00	0.00	Gov't
8.2.2	Zoba HMIS collates data and sends to MOH/HMIS monthly	HMIS	Staff time	0.00	0.00	0.00	0.00	0.00	0.00	Gov't
8.2.3	Malaria HMIS data captured in national database monthly	HMIS	Staff time	0.00	0.00	0.00	0.00	0.00	0.00	Gov't
9	**Component 9:** National and Local Malaria Databases									
	Objective: To strengthen the national and sub national data bases for Malaria Programme									
9.1	Maintain a National malaria database housing all relevant data for the M&E system within NMCP	NMCP, M&E Division, HMIS, IDSR	Routine updating of the data base	0.00	0.00	0.00	0.00	0.00	0.00	Gov't
10	**Component 10:** Supportive Supervision and Data Auditing									
	Objective 10: To ensure that support supervision, data quality assurance and audit for Malaria are all implemented									
10.1	Undertake routinely integrated supportive supervision, data quality and auditing	NMCP M&E Division, & HMIS,	Travel and communication costs-	10,000.00	10,000.00	10,000.00	10,000.00	10,000.00	50.000.00	Global Fund

10.2	Hold meetings with stakeholder to review and take action on the outcome of the technical support supervision, data quality and data audit visits	NMCP M&E Division, & HMIS,	Meeting Costs – Part of M&E Div Costs	0.00	0.00	0.00	0.00	0.00	0.00	
11	Component 11: Evaluation and Research									
	Objective: Strengthen capacity and support implementation of evaluation and research studies relevant to Malaria									
11.1	Develop research and Evaluation Agenda for Malaria	NMCP M&E Div, HMIS, IDSR & Research	Short term national TA	0.00	7,001.00	0.00	0.00	0.00	7,001.00	Global Fund
11.2	Support processes and mechanism for reviewing and approving research and evaluation studies	NMCP M&E Div, HMIS, IDSR & Research	Review meeting costs	0.00	0.00	0.00	0.00	0.00	0.00	
11.4	Undertake a review and evaluation of the Malaria programme	NMCP, M&E Div	TA, Meetings costs	100,000.00	0.00	0.00	0.00	0.00	100,000.00	EARN/ Global Fund
11.5	Take part in the annual review & planning of health activities at Zoba level	MOH, Zobas	Part of HIV/AIDS costs	2,800.00	2,800.00	8,000.00	8,000.00	2,800.00	14,000.00	TBI
11.6	Take part in the MOH annual joint programme review process	MOH	Part of the HIV/AIDS costs	0.00	0.00	0.00	0.00	0.00	0.00	
12	**Component 12:** Data Dissemination and Information Use									
Objective: To support mechanisms for information dissemination and use of M&E results for decision making and programme improvement										
12.1	**Print and disseminate M&E information products**									
	Annually produce policy papers on the implications for policy and planning of each of the study, survey and evaluation carried out.									Gov't
12.1.1	Print & distribute reports of all special surveys, surveillance & studies undertaken	NMCP, M&E Division,	Printing costs	10,000.00	10,000.00	10,000.00	10,000.00	10,000.00	50,000.00	Global Fund
12.1.2	Print *Malaria Update* newsletter biannually	NMCP	Printing costs	16,000.00	16,000.00	16,000.00	16,000.00	16,000.00	80,000.00	Global Fund
	GRAND TOTAL BUDGET			**346,360**	**70,961**	**808,961**	**73,961**	**98,761**	**1,405,004**	

Annex 4 Global Fund related Indicators

Annex 4.1 HIV /AIDS /STI Indicators, 2012-2016

Indicator	Baseline	Targets					Data Collection		
		2012	2013	2014	2015	2016	Frequency	Data Collection Instruments	Data Collection Responsibility
Impact Indicators									
Percentage of children under age 18 years who are orphans	5.60% (2010)	5%	4.5%	4%	3.5%	3%	Every 5 yrs	EPHS +	NSO
Outcome Indicators for HIV/AIDS/STI									
ART, Care and Support Programme									
1. Number of adult and children receiving prophylaxis for OIs (including the military)	11670 2010	6,000	6,000	6,000	6,000	6,000	Annually	Annual report	NATCoD
2. Number of chronically ill PLWHA receiving home based care and psychosocial support	18327 2011	300	300	300	300	300	Annually	Annual report	NATCoD
3. Number of orphans and vulnerable children (OVCs) receiving financial support	5587 (2011)	4603	4703	4803	4903	5003	Annually	Monthly Report	MOLHW
4. Number of women headed households in 6 zoba assisted through income generating activities/ microcredit loan	1141 (2011)	1578	1720	2612	2100	2200	Monthly	Monthly Report	NUEW
5. Number of beneficiaries supported by community-based income-generating schemes established for PLWHA within their areas of residence	719 (2011)	1360	1360	1360	300	300	Annually	Monthly Report	Bidho
PMTCT Programme									
Number of women referred for PMTCT services by CBOs	NA	2,000	2,000	2,000	2,000	2,000	Annually	Annual report	HPC
Output Indicators									
Behavioral Change Communication									
6. Number of youth in secondary school receiving life skill education (Note –the target remains the same for 5 years)	30,000 (2011)	30,000	30,000	30,000	30,000	30,000	Quarterly	Annual report	MOE
7. Number of high risk groups (female sex workers) reached with BCC activities (Note –the target remains the same for 5 years)	800 (2010)	2,000	2,000	2,000	2,000	2,000	Quarterly	Quarterly Report	HPC
8. Number of high risk groups (truck drivers) reached with BCC activities (Note –the target remains the same for 5 years)	NA	2,000	2,000	2,000	2,000	2,000	Quarterly	Quarterly Report	HPC

Annex 4.2 Malaria Indicators, 2012-2016

		Targets					Data Collection		
Indicator	**Baseline**	**2012**	**2013**	**2014**	**2015**	**2016**	**Frequency**	**Data Collection Instruments**	**Data Collection Responsibility**
Output Indicators									
1.Number of studies conducted	7	2	1	4	3	3	Annually	Reports	NMCP
2.Number of new associate nurse trained	300 (2008)		300	300	300	300	Annually	Reports	HRD
3.Number of students enrolled at distance learning of Bachelors of Arts in Professional Development (BAPD), BN Program	50 (2008)		50	50	50	50	Annually	Reports	HRD
4.Number of associate nurses upgraded to nurses	100 (2006)	50	50	50	50	50	Annually	Reports	HRD
5.Number and percentage of health care facilities that received supervision in past 12 months	8.4 % 27/320 (2011)	145/320 45.3%	155/320 48.3%	165/320 51.6%	54.68	58.81	Annually	Reports	HRD
6.Number of community health agents trained on community based health information system	NA	200	300	300	300	300	Annually	Reports	HRD
7.Number and percentage of zones submitting timely reports to the national level	231/369 62.6% (2009)	6/6 100%	6/6 100%	6/6 100%	6/6 100%	6/6 100%	Annually	Reports	HRD
8.Number and percentage of zones submitting complete reports to the national level	363/369 98.4% (2009)	6/6 100%	6/6 100%	6/6 100%	6/6 100%	6/6 100%	Annually	Reports	HRD

Annex 5 Basic Terms and Concepts

OECD Glossary of M&E Concepts and Terms[5]

Term	Definition
Accountability	Obligation to demonstrate that work has been conducted in compliance with agreed rules and standards or to report fairly and accurately on performance results vis a vis mandated roles and/or plans. This may require a careful, even legally defensible, demonstration that the work is consistent with the contract terms. Note: Accountability in development may refer to the obligations of partners to act according to clearly defined responsibilities, roles and performance expectations, often with respect to the prudent use of resources. For evaluators, it connotes the responsibility to provide accurate, fair and credible monitoring reports and performance assessments. For public sector managers and policy-makers, accountability is to taxpayers/citizens.
Activity	Actions taken or work performed through which inputs, such as funds, technical assistance and other types of resources are mobilized to produce specific outputs. Related term: development intervention.
Analytical tools	Methods used to process and interpret information during an evaluation.
Appraisal	An overall assessment of the relevance, feasibility and potential sustainability of a development intervention prior to a decision of funding. Note: In development agencies, banks, etc., the purpose of appraisal is to enable decision-makers to decide whether the activity represents an appropriate use of corporate resources. Related term: ex-ante evaluation
Assumptions	Hypotheses about factors or risks which could affect the progress or success of a development intervention. Note: Assumptions can also be understood as hypothesized conditions that bear on the validity of the evaluation itself, e.g., about the characteristics of the population when designing a sampling procedure for a survey. Assumptions are made explicit in theory based evaluations where evaluation tracks systematically the anticipated results chain.
Attribution	The ascription of a causal link between observed (or expected to be observed) changes and a specific intervention. Note: Attribution refers to that which is to be credited for the observed changes or results achieved. It represents the extent to which observed development effects can be attributed To a specific intervention or to the performance of one or more partner taking account of other interventions, (anticipated or unanticipated) confounding factors, or external shocks.
Audit	An independent, objective assurance activity designed to add value and improve an organization's operations. It helps an organization accomplish its objectives by bringing a systematic, disciplined approach to assess and improve the effectiveness of risk management, control and governance processes. Note: a distinction is made between regularity (financial) auditing, which focuses on compliance with applicable statutes and regulations; and performance auditing, which is concerned with relevance, economy, efficiency and effectiveness. Internal auditing provides an assessment of internal controls undertaken by a unit reporting to management while external auditing is conducted by an independent organization.
Base-line study	An analysis describing the situation prior to a development intervention, against which progress can be assessed or comparisons made.
Benchmark	Reference point or standard against which performance or achievements can be assessed. Note: A benchmark refers to the performance that has been achieved in the recent past by other comparable organizations, or what can be reasonably inferred to have been

[5] OECD 2002, Glossary of Key Terms in Evaluation and Results, Based Management, Evaluation and Aid Effectiveness, Development Assistance Committee (DAC) Working Party on Aid Evaluation (WP-EV), 2002

Term	Definition
	achieved in the circumstances.
Beneficiaries	The individuals, groups, or organizations, whether targeted or not, that benefit, directly or indirectly, from the development intervention. Related terms: reach, target group.
Cluster evaluation	An evaluation of a set of related activities, projects and/or programs.
Conclusions	Conclusions point out the factors of success and failure of the evaluated intervention, with special attention paid to the intended and unintended results and impacts, and more generally to any other strength or weakness. A conclusion draws on data collection and analyses undertaken, through a transparent chain of arguments.
Counterfactual	The situation or condition which hypothetically may prevail for individuals, organizations, or groups were there no development intervention.
Country Programme Evaluation/ Country Assistance Evaluation	Evaluation of one or more donor's or agency's portfolio of development interventions, and the assistance strategy behind them, in a partner country.
Data Collection Tools	Methodologies used to identify information sources and collect information during an evaluation. Note: Examples are informal and formal surveys, direct and participatory observation, community interviews, focus groups, expert opinion, case studies, literature search.
Development Intervention	An instrument for partner (donor and non-donor) support aimed to promote development. Note: Examples are policy advice, projects, programs.
Development objective	Intended impact contributing to physical, financial, institutional, social, environmental, or other benefits to a society, community, or group of people via one or more development interventions.
Economy	Absence of waste for a given output. Note: An activity is economical when the costs of the scarce resources used approximate the minimum needed to achieve planned objectives.
Effect	Intended or unintended change due directly or indirectly to an intervention. Related terms: results, outcome.
Effectiveness	The extent to which the development intervention's objectives were achieved, or are expected to be achieved, taking into account their relative importance. Note: Also used as an aggregate measure of (or judgment about) the merit or worth of an activity, i.e. the extent to which an intervention has attained, or is expected to attain, its major relevant objectives efficiently in a sustainable fashion and with a positive institutional development impact. Related term: efficacy.
Efficiency	A measure of how economically resources/inputs (funds, expertise, time, etc.) are converted to results.
Evaluability	Extent to which an activity or a program can be evaluated in a reliable and credible fashion. Note: Evaluability assessment calls for the early review of a proposed activity in order to ascertain whether its objectives are adequately defined and its results verifiable.
Evaluation	The systematic and objective assessment of an on-going or completed project, programme or policy, its design, implementation and results. The aim is to determine the relevance and fulfillment of objectives, development efficiency, effectiveness, impact and sustainability. An evaluation should provide information that is credible and useful, enabling the incorporation of lessons learned into the decision– making process of both recipients and donors. Evaluation also refers to the process of determining the worth or significance of an activity, policy or program. An assessment, as systematic and objective as possible, of a planned, on-going, or completed development intervention. Note: Evaluation in some instances involves the definition of appropriate standards, the examination of performance against those standards, an assessment of actual and expected results and the identification of relevant lessons. Related term: review.
Ex-ante evaluation	An evaluation that is performed before implementation of a development intervention. Related terms: appraisal, quality at entry.

Term	Definition
Ex-post evaluation	Evaluation of a development intervention after it has been completed. Note: It may be undertaken directly after or long after completion. The intention is to identify the factors of success or failure, to assess the sustainability of results and impacts, and to draw conclusions that may inform other interventions.
External evaluation	The evaluation of a development intervention conducted by entities and/or individuals outside the donor and implementing organizations.
Feedback	The transmission of findings generated through the evaluation process to parties for whom it is relevant and useful so as to facilitate learning. This may involve the collection and dissemination of findings, conclusions, recommendations and lessons from experience.
Finding	A finding uses evidence from one or more evaluations to allow for a factual statement.
Formative evaluation	Evaluation intended to improve performance, most often conducted during the implementation phase of projects or programs. Note: Formative evaluations may also be conducted for other reasons such as compliance, legal requirements or as part of a larger evaluation initiative. Related term: process evaluation.
Goal	The higher-order objective to which a development intervention is intended to contribute. Related term: development objective.
Impacts	Positive and negative, primary and secondary long-term effects produced by a development intervention, directly or indirectly, intended or unintended.
Independent evaluation	An evaluation carried out by entities and persons free of the control of those responsible for the design and implementation of the development intervention. Note: The credibility of an evaluation depends in part on how independently it has been carried out. Independence implies freedom from political influence and organizational pressure. It is characterized by full access to information and by full autonomy in carrying out investigations and reporting findings.
Indicator	Quantitative or qualitative factor or variable that provides a simple and reliable means to measure achievement, to reflect the changes connected to an intervention, or to help assess the performance of a development actor.
Inputs	The financial, human, and material resources used for the development intervention.
Institutional Development Impact	The extent to which an intervention improves or weakens the ability of a country or region to make more efficient, equitable, and sustainable use of its human, financial, and natural resources, for example through: (a) better definition, stability, transparency, enforceability and predictability of institutional arrangements and/or (b) better alignment of the mission and capacity of an organization with its mandate, which derives from these institutional arrangements. Such impacts can include intended and unintended effects of an action.
Internal evaluation	Evaluation of a development intervention conducted by a unit and/or individuals reporting to the management of the donor, partner, or implementing organization. Related term: self-evaluation.
Joint evaluation	An evaluation to which different donor agencies and/or partners participate. Note: There are various degrees of "jointness" depending on the extent to which individual partners cooperate in the evaluation process, merge their evaluation resources and combine their evaluation reporting. Joint evaluations can help overcome attribution problems in assessing the effectiveness of programs and strategies, the complementarity of efforts supported by different partners, the quality of aid coordination, etc.
Lessons learned	Generalizations based on evaluation experiences with projects, programs, or policies that abstract from the specific circumstances to broader situations. Frequently, lessons highlight strengths or weaknesses in preparation, design, and implementation that affect performance, outcome, and impact.
Logical framework (Logframe)	Management tool used to improve the design of interventions, most often at the project level. It involves identifying strategic elements (inputs, outputs, outcomes, impact) and their causal relationships, indicators, and the assumptions or risks that may influence success and failure. It thus facilitates planning, execution and evaluation of a development intervention.

Term	Definition
	Related term: results based management.
Meta-evaluation	The term is used for evaluations designed to aggregate findings from a series of evaluations. It can also be used to denote the evaluation of an evaluation to judge its quality and/or assess the performance of the evaluators.
Mid-term evaluation.	Evaluation performed towards the middle of the period of implementation of the intervention Related term: formative evaluation.
Monitoring	A continuing function that uses systematic collection of data on specified indicators to provide management and the main stakeholders of an ongoing development intervention with indications of the extent of progress and achievement of objectives and progress in the use of allocated funds. Related term: performance monitoring, indicator.
Outcome	The likely or achieved short-term and medium-term effects of an intervention's outputs. Related terms: result, outputs, impacts, effect.
Outputs	The products, capital goods and services which result from a development intervention; may also include changes resulting from the intervention which are relevant to the achievement of outcomes.
Participatory evaluation	Evaluation method in which representatives of agencies and stakeholders (including beneficiaries) work together in designing, carrying out and interpreting an evaluation.
Partners	The individuals and/or organizations that collaborate to achieve mutually agreed upon objectives. Note: The concept of partnership connotes shared goals, common responsibility for outcomes, distinct accountabilities and reciprocal obligations. Partners may include governments, civil society, non-governmental organizations, universities, professional and business associations, multilateral organizations, private companies, etc.
Performance	The degree to which a development intervention or a development partner operates according to specific criteria/standards/ guidelines or achieves results in accordance with stated goals or plans.
Performance indicator	A variable that allows the verification of changes in the development intervention or shows results relative to what was planned. Related terms: performance monitoring, performance measurement.
Performance measurement	A system for assessing performance of development interventions against stated goals. Related terms: performance monitoring, indicator.
Performance monitoring	A continuous process of collecting and analyzing data to compare how well a project, program, or policy is being implemented against expected results.
Process evaluation	An evaluation of the internal dynamics of implementing organizations, their policy instruments, their service delivery mechanisms, their management practices, and the linkages among these. Related term: formative evaluation.
Program evaluation	Evaluation of a set of interventions, marshaled to attain specific global, regional, country, or sector development objectives. Note: a development program is a time bound intervention involving multiple activities that may cut across sectors, themes and/or geographic areas. Related term: Country program/strategy evaluation.
Project evaluation	Evaluation of an individual development intervention designed to achieve specific objectives within specified resources and implementation schedules, often within the framework of a broader program. Note: Cost benefit analysis is a major instrument of project evaluation for projects with measurable benefits. When benefits cannot be quantified, cost effectiveness is a suitable approach.
Project or program objective	The intended physical, financial, institutional, social, environmental, or other development results to which a project or program is expected to contribute.
Purpose	The publicly stated objectives of the development program or project.
Quality Assurance	Quality assurance encompasses any activity that is concerned with assessing and improving the merit or the worth of a development intervention or its compliance with given standards.

Term	Definition
	Note: examples of quality assurance activities include appraisal, RBM, reviews during implementation, evaluations, etc. Quality assurance may also refer to the assessment of the quality of a portfolio and its development effectiveness.
Reach	The beneficiaries and other stakeholders of a development intervention. Related term: beneficiaries.
Recommendations	Proposals aimed at enhancing the effectiveness, quality, or efficiency of a development intervention; at redesigning the objectives; and/or at the reallocation of resources. Recommendations should be linked to conclusions.
Relevance	The extent to which the objectives of a development intervention are consistent with beneficiaries' requirements, country needs, global priorities and partners' and donors' policies. Note: Retrospectively, the question of relevance often becomes a question as to whether the objectives of an intervention or its design are still appropriate given changed circumstances.
Reliability	Consistency or dependability of data and evaluation judgments, with reference to the quality of the instruments, procedures and analyses used to collect and interpret evaluation data. Note: evaluation information is reliable when repeated observations using similar instruments under similar conditions produce similar results.
Results	The output, outcome or impact (intended or unintended, positive and/or negative) of a development intervention. Related terms : outcome, effect, impacts.
Results Chain	The causal sequence for a development intervention that stipulates the necessary sequence to achieve desired objectives beginning with inputs, moving through activities and outputs, and culminating in outcomes, impacts, and feedback. In some agencies, reach is part of the results chain. Related terms: assumptions, results framework.
Results framework	The program logic that explains how the development objective is to be achieved, including causal relationships and underlying assumptions. Related terms: results chain, logical framework.
Results-Based Management (RBM)	A management strategy focusing on performance and achievement of outputs, outcomes and impacts. Related term: logical framework.
Review	An assessment of the performance of an intervention, periodically or on an ad hoc basis. Note: Frequently "evaluation" is used for a more comprehensive and/or more indepth assessment than "review". Reviews tend to emphasize operational aspects. Sometimes the terms "review" and "evaluation" are used as synonyms. Related term: evaluation.
Risk analysis	An analysis or an assessment of factors (called assumptions in the logframe) affect or are likely to affect the successful achievement of an intervention's objectives. A detailed examination of the potential unwanted and negative consequences to human life, health, property, or the environment posed by development interventions; a systematic process to provide information regarding such undesirable consequences; the process of quantification of the probabilities and expected impacts for identified risks.
Sector program evaluation	Evaluation of a cluster of development interventions in a sector within one country or across countries, all of which contribute to the achievement of a specific development goal. Note: a sector includes development activities commonly grouped together for the purpose of public action such as health, education, agriculture, transport etc.
Self-evaluation	An evaluation by those who are entrusted with the design and delivery of a development intervention.
Stakeholders	Agencies, organizations, groups or individuals who have a direct or indirect interest in the development intervention or its evaluation.
Summative evaluation	A study conducted at the end of an intervention (or a phase of that intervention) to determine the extent to which anticipated outcomes were produced. Summative

Term	Definition
	evaluation is intended to provide information about the worth of the program. Related term: impact evaluation.
Sustainability	The continuation of benefits from a development intervention after major development assistance has been completed. The probability of continued long-term benefits. The resilience to risk of the net benefit flows over time.
Target group	The specific individuals or organizations for whose benefit the development intervention is undertaken.
Terms of reference	Written document presenting the purpose and scope of the evaluation, the methods to be used, the standard against which performance is to be assessed or analyses are to be conducted, the resources and time allocated, and reporting requirements. Two other expressions sometimes used with the same meaning are "scope of work" and "evaluation mandate".
Thematic evaluation	Evaluation of a selection of development interventions, all of which address a specific development priority that cuts across countries, regions, and sectors.
Triangulation	The use of three or more theories, sources or types of information, or types of analysis to verify and substantiate an assessment. Note: by combining multiple data sources, methods, analyses or theories, evaluators seek to overcome the bias that comes from single informants, single methods, single observer or single theory studies.
Validity	The extent to which the data collection strategies and instruments measure what they purport to measure.

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