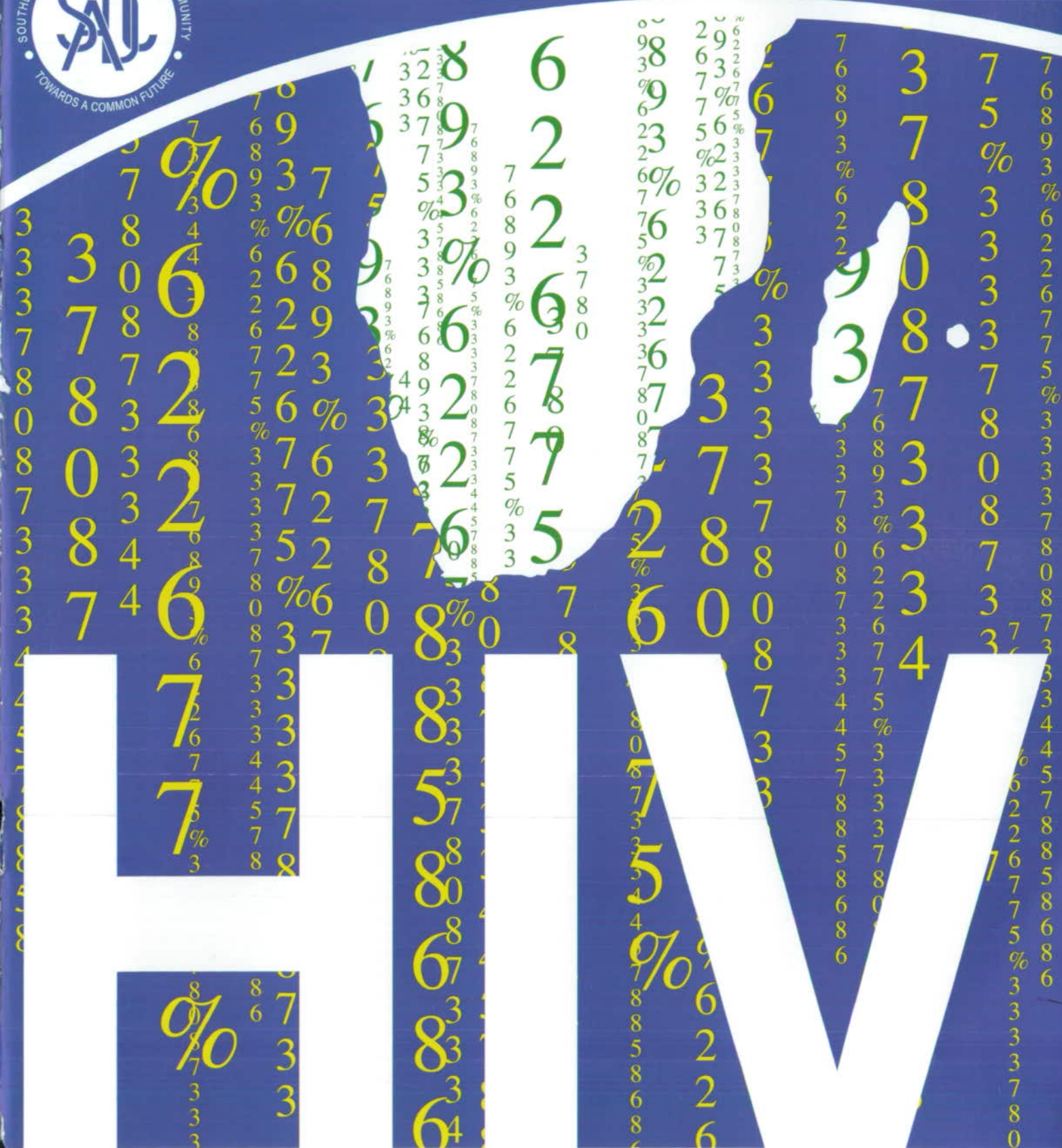


Southern Africa Development Community (SADC) Monitoring and Evaluation Framework for HIV and AIDS



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Acronyms

AIDS	Acquired Immune Deficiency Syndrome
ANC	Antenatal clinic
ART	Anti-retroviral Therapy
ARV	Anti-retroviral
BSS	Behavioural Surveillance Survey
CBO	Community-Based Organisation
CHBC	Community Home Based Care
CRIS	Country Response Information System
CSOs	Civil Society Organisations
DHIS	District Health Information System
DHS	Demographic and Health Survey
FHI	Family Health International
GFATM	Global Fund to Fight AIDS, Tuberculosis and Malaria
HIV	Human Immunodeficiency Virus
HMIS	Health Management Information System
IEC	Information, Education and Communication
M&E	Monitoring and Evaluation
MICS	Multiple Indicator Cluster Survey
NAC	National AIDS Commission
NCPI	National Composite Policy Index
NGO	Non-Governmental Organisation
OVC	Orphans and Vulnerable Children
PHC	Primary Health Care
PLWHIV	People Living with HIV
PMTCT	Prevention of Mother to Child Transmission
SADC	Southern African Development Community
STD	Sexually Transmitted Disease
STI	Sexually Transmitted Infection
TB	Tuberculosis
UN	United Nations
UNAIDS	Joint United Nations Programme on HIV and AIDS
UNDP	United Nations Development Programme
UNGASS	United Nations General Assembly Special Session on HIV and AIDS
USAID	United States Agency for International Development
VCT	Voluntary Counselling and Testing
WHO	World Health Organisation

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1. INTRODUCTION

There is an increasing level of commitment in SADC to the management of the HIV epidemic with policies and national strategic plans having been developed in most countries and multi-sectoral structures established to co-ordinate the implementation of plans and activities. Various mechanisms exist to channel resources for the implementation of HIV and AIDS related activities. Successful actions have been demonstrated in the area of Prevention of Mother-To-Child Transmission (PMTCT) of HIV, Voluntary Counselling and Testing (VCT) services and youth friendly health services. Condom access has improved; home-based care activities and community based orphan care are being supported to mitigate the impact of HIV and AIDS on households and communities.

Concerted efforts are being made to roll out treatment and access to anti-retrovirals (ARVs) for people living with HIV and AIDS. However, the coverage of interventions and their reach remains very low. This is evident in the estimate of coverage of services in sub-Saharan Africa where only 15% of people living with HIV that require treatment have access to ARVs. In several SADC Member States less than 5% of pregnant women living with HIV have access to PMTCT services and a small proportion of children orphaned and made vulnerable are reached by external interventions. As a result, HIV and AIDS continues to threaten development, social and political stability, food security and life expectancy. Coping capacities of communities and households are being severely compromised with the burden falling disproportionately on women and girls. Another challenge has been the ability of SADC to effectively monitor Member States fulfilment of various regional and global commitments to HIV and AIDS.

In order to address this problem, SADC Heads of States and Government adopted the Maseru Declaration on HIV and AIDS at a meeting in Maseru, Lesotho on 4th July 2003. In this Declaration, SADC Member States committed themselves to combating HIV. In response to the Declaration, the SADC Secretariat coordinated the development of a five-year HIV and AIDS Strategic Framework guided by the Business Plan on HIV and AIDS covering the period 2005 -2009. The Business Plan focuses on 5 major outputs, namely:

1. Policy development and harmonisation
2. Capacity building and mainstreaming HIV and AIDS into all SADC policies and plans
3. Facilitation of technical responses, resource networks, collaboration and coordination
4. Resource mobilisation for regional multi-sectoral response and
5. Monitoring and evaluation of the regional multi-sectoral response.

This framework presents a list of indicators, data management and reporting processes that could assist in the monitoring and reporting against the priority areas and key issues.

2. CONTEXT

With an increased global response to the HIV and AIDS epidemic, there is a corresponding interest in tracking the progress of the interventions in terms of coverage and their impact on individuals infected and communities affected by the epidemic. A number of countries have developed M&E frameworks to harmonise national M&E systems. In some countries these frameworks are operational while in others they are still at the planning/piloting stages. There are a number of challenges at the country level, which have constrained the expected progress of monitoring and evaluating the response. These include; little appreciation of M&E within the national plans; limited capacity at all levels; different systems/indicators from agencies with strong mandates and different reporting lines; and uncoordinated data collection strategies with little or no input from CSOs which are involved in service delivery. To address these challenges, there is considerable effort in supporting a harmonised M&E system at the country level by key stakeholders. A key step in this direction is the support to standardised reporting through a database (CRIS) supported by UNAIDS. The database harmonises national information systems and will help stakeholders to provide standardised data on selected key indicators that are comparable across time and countries. However, due to the slow progress in M&E in general, the CRIS roll out has been slow.

Given the level of progress, SADC, UNAIDS and partners are exploring ways to strengthen M&E in the region. To this end, SADC provided support for an assessment of the status of monitoring and evaluation in the region. The

results of this assessment provide a context for monitoring and evaluation in the region.

2.1 Status of Monitoring and Evaluation Systems in SADC Member States

(i) Coordination of National M&E Systems

The cornerstone of operationalising “the three ones” principle is strong coordination, collaboration and integration. In principle, all countries have a recognised coordinating authority which is well placed to push “the three ones” agenda.

Within the context of multi-sectoral response, HIV and AIDS is coordinated by the National AIDS Committees/Councils in all the countries, with the exception of South Africa and Namibia where coordination of the HIV and AIDS response resides in Health Ministries. In all countries, the coordinating authority has the mandate of collating data from stakeholders, and providing feedback.

(ii) Availability of M&E Frameworks

Harmonisation of a national M&E system needs a clear framework with stakeholder buy-in that defines M&E coordination mechanisms which include; a strategy on data collection, reporting, analysis and information feed back; well defined indicators (core and alternate); and guidelines on tools for data collection and a data management plan.

It is not only important to develop a framework as a working document, but its ultimate value lies in the stakeholders' use of the document as a road map to strengthen and harmonise M&E. The majority of the countries in the region had finalised a national M&E framework, of those only five had distributed/disseminated the framework to stakeholders.

(iii) Indicator Harmonisation and Development of Guidelines

There are many uncoordinated M&E systems collecting specific project information, leading to fragmented and unstandardised information. At a global level, key agencies have harmonised their indicators and key guidelines are available. However, these global agreements and collaboration are not

reflected at the country level in all the countries in the region.

In as much as there are country specific frameworks, there is need for a better understanding of data collection tools for specified indicators, levels of accountability and quality control mechanisms.

(iv) Monitoring and Evaluation Plans

One shortcoming at the country level has been lack of a clear road map to implement M&E. Indeed, in most of (if not all) the National Strategic Plans, the section on M&E is not comprehensive and there is no clear linkage between the objectives and activities outlined in the framework.

(v) Development of National Databases and Implementation of CRIS

There are few countries which have developed national databases to collate data from stakeholders. However, in some countries information is collected through different systems.

(vi) Country Targets

In addition to having harmonised programme indicators to measure progress, indicators should be linked to the National Strategic Plan objective targets. In many cases, the objectives are not measurable, baseline information is lacking and targets not clearly defined.

(vii) Capacity Building

Currently, capacity building in terms of skills development is weak in all the countries in the region. Few countries are carrying out training and other related capacity building activities. Those who have conducted training do not have standardised protocols for training in M&E. This poses a big risk to quality control of the training contents and skills provided for M&E.

(viii) Major Sources of Financial Support

Increased global commitment to fight the HIV epidemic has been matched with an increased commitment in resources from key partners. The challenge is the coordination/tracking of resource

commitments and access at the country level within the framework of "the three ones" principle to support one M&E framework and plan.

2.2 Challenges to the Development of a National M&E Framework

The challenges experienced by the countries within the region include:

- Limited capacity (human and institutional) at decentralised and community levels. A number of countries are depending on consultants.
- Many systems with different demands/indicators and mandates which are difficult to coordinate.
- Many stakeholders with different M&E requirements and reporting obligations and timelines.
- Lack of consensus on the strategy for data collection and regular reporting. In addition there is limited capacity to conduct quality assurance of the data collected.
- Incomplete national framework operationalisation plans upon which the M&E frameworks can be developed. This is also related to weak linkages between National Strategic Framework and the M&E frameworks. Many objectives in the National HIV and AIDS Strategic Framework are not SMART enough and are difficult to assign indicator(s) to. In addition, most of the National Strategic Plans are nearing the end of their lifetime; hence M&E frameworks developed will need to be revised in view of the expected changes in the National Strategic Plans.
- Inadequate understanding of the concept of M&E and its role in programme management by implementing partners.
- Disjointed technical assistance in supporting M&E in general and the framework in particular.

3. PURPOSE

A coherent monitoring and evaluation (M&E) framework contributes to more efficient use of data and resources. Where indicators and sampling methodologies are comparable over time, duplication of efforts is reduced and implementation strategies can be more effectively evaluated. Data generated by a comprehensive M&E system ought to serve the needs of many constituents. This includes programme managers, researchers, donors and the international community, eliminating the need

for repeated baseline surveys or evaluation studies. A comprehensive M&E system will cover many of the programme or thematic areas listed in the National HIV and AIDS Policy for 2001. As knowledge on HIV and AIDS is developing continuously, the M&E framework has to have sufficient flexibility to adjust to these new developments. It also needs to be sufficiently stable to gather information and allow for comparisons over time. A number of challenges exist in creating a coherent and harmonised M&E System. These include harmonising:

- A wide range of existing information sources
- The broad-spread and diverse activities across many role players and sectors
- A multiple number of HIV and AIDS (and other) programme areas
- Various data bases or information storage components;
- Newly developed programme areas and
- Different reporting requirements at a national and international level.

In order to strengthen the monitoring and evaluation of the implementation of the Maseru Declaration, the SADC Secretariat coordinated the development of this HIV and AIDS M&E framework. This framework is primarily intended to guide SADC Member States to objectively track and report on the core indicators for addressing the implementation of the Maseru Declaration. It provides a basis for harmonised national and regional review and reporting of progress made towards responding to the Declaration. Further, it provides guidance and defines core indicators for monitoring and evaluating progress in the implementation of key areas identified in the Declaration, mainly;

- Prevention and Social Mobilisation
- Improving Care, Access to Counselling and Testing Services and Treatment and Support
- Accelerating development and mitigating the impact of HIV and AIDS
- Resource mobilisation for regional multi-sectoral response and
- Strengthening institutional Monitoring and Evaluation Mechanisms.

Member States are being supported to integrate these core indicators in their national systems. Ultimately it is intended that the periodic reports produced by Member States on these core indicators will be sufficient to

respond to reporting requirements of various local and international bodies.

4. PRIORITY AREAS AND KEY ISSUES

The Maseru Declaration sets out the commitment of SADC Member States to combat HIV and AIDS. It outlines five key priority areas for action - these have been detailed below with the key issues and performance indicators of each.

4.1 Prevention and Social Mobilisation

Prevention of HIV and social mobilisation will be achieved by reinforcing multi-sectoral prevention programmes that promote responsible sexual behaviour and intensifying the provision of user-friendly reproductive health services. In addition, programmes designed to increase capacities of women and girls to protect themselves from the risk of HIV infection, and programmes to improve education and employment opportunities for youth will be promoted. Prevention of Mother to Child transmission (PMTCT) programmes will also be increased as well as HIV and AIDS education for all stakeholders. Finally, strategies to prevent the spread of HIV among the national uniformed services will be implemented. The key issues identified in respect of prevention and social mobilisation are:

- Promoting responsible sexual behaviour
- Providing user-friendly reproductive health services
- Building the capacity of women and girls to protect themselves from the risk of HIV infection
- Improving education and employment opportunities
- Prevention of Mother to Child Transmission (PMTCT)
- HIV and AIDS Education and
- Prevention of HIV among national uniformed forces.

4.2 Improving Care, Access to Counselling and Testing Services, Treatment and Support

In order to improve care, treatment and support, national health care systems as well as family and community based care structures will be strengthened to ensure that the capacity of caregivers is developed. Workplace and VCT programmes will be expanded and supported by efforts to remove stigma and discrimination of people living with HIV and AIDS. Through regional initiatives, essential medicines, including ARVs, will be supplied at

affordable prices. Nutrition programmes will be invested in, and a regulatory framework for the utilisation of traditional medicines will be developed. The key issues identified in respect of improving care, access to counselling and testing services, treatment and support are:

- Building the capacity of care givers
- Implementing workplace and VCT programmes
- Reducing stigma and discrimination
- Providing essential medicines including ART through regional initiatives
- Promoting nutrition programmes and
- Establishing a regulatory framework for utilisation of traditional medicine.

4.3 Accelerating Development and Mitigating the Impact of HIV and AIDS

Accelerating development and mitigating the impact of HIV and AIDS will take place by creating an enabling environment to address the underlying factors that lead to HIV infection. Policies and strategies as well as regional initiatives will be harmonised and enhanced, with best practices shared between Member States. HIV and AIDS will be mainstreamed into the regional integration process and focal intervention areas. In addition, the economic and social impact of HIV and AIDS will be evaluated and mechanisms to mitigate these impacts will be established. The key issues identified in respect of accelerating development and mitigating the impact of HIV and AIDS are:

- Harmonizing and enhancing policies
- Sharing best practices between Member States
- Mainstreaming HIV and AIDS into regional integration processes and focal intervention areas and
- Evaluating the social and economic impacts of the epidemic and measures established to mitigate these impacts.

4.4 Resource Mobilisation for Regional Multi-Sectoral Response

In order to achieve the above goals, SADC Member States pledge to mobilise sufficient resources, involve all stakeholders and ensure that funds are rapidly disbursed. A Regional Fund for the implementation of the HIV and AIDS Strategic Framework is to be

established. The Maseru Declaration also reaffirms the commitment of the Abuja Declaration of Member States to allocate at least 15% of their budgets for improving the health sector and urges International Cooperating Partners to increase their financial and technical support. The key issues identified in respect of resource mobilisation for regional multi-sectoral response are:

- A regional fund for the implementation of the HIV and AIDS framework
- Increase the level of national resource allocation to the health sector and
- Resource disbursement.

4.5 Strengthening Institutional, Monitoring and Evaluation Mechanisms

Institutional mechanisms for HIV surveillance, sharing of experiences and exchange of information on key interventions will be established. Training will be intensified to strengthen Member States' capacities to manage the epidemic. Monitoring and evaluation will take place to ensure the efficacy of the implementation of the Maseru Declaration, other continental and global commitments, and the SADC HIV and AIDS Strategic Framework and Programme of Action (2003-2007). The key issues identified in respect of strengthening institutional monitoring and evaluation mechanism are:

- Strengthening mechanisms for surveillance
- Sharing of experience and exchange of information on key intervention areas and
- Training/capacity building in M&E among Member States.

5. EXISTING DATA SOURCES

The development of the SADC M&E Framework is not starting from scratch. There are many components and information sources that can be drawn upon which will feed into the National Frameworks. These information sources may need to be further coordinated to give meaningful HIV and AIDS information. Some of the existing surveys conducted may need adjustments to represent the population more accurately. Others may need further analysis such as weighting to improve data validity (such as compensating for under or over-representation of urban/rural residence and socioeconomic variables from

the different surveillance sites). Two major data sources can be identified: (a) data sources for indicators that will be measured by surveys (outcome and impact indicators and outcome/impact data sources); and (b) data sources for indicators that will be measured using continuously monitored programme outputs (output indicators and output data sources). Some examples of existing systems include:

- Surveillance systems
- Surveys, studies and operations research
- Existing routine information systems
- Financial management information and
- Programme management information.

The data sources that are used provide indicator values. The sources are clearly defined in terms of responsibility for provision and frequency. There is at least one data source for each indicator. However, a data source may provide information for more than one indicator.

5.1 Surveillance

Biological HIV surveillance comprises anonymous testing for the presence of HIV infection in blood samples from target groups at sentinel sites, with over-sampling of young women in the age group 15-24 years. Five separate types of HIV sentinel surveillance are included: the ongoing biennial HIV sentinel surveillance amongst antenatal care clients; biennial STI sentinel surveillance for syphilis amongst antenatal care clients; HIV surveillance amongst TB clients; HIV sentinel surveillance amongst STI clients; and HIV surveillance amongst blood donors.

5.2 Surveys, Studies and Operations Research

There are several national population-based surveys that provide information which specifically addresses the monitoring and evaluation needs of HIV and AIDS programmes. Nation wide population-based surveys measure indicators relating to behaviour and knowledge, the extent of the use of VCT services, community-home based care and support for OVC. Each survey needs to ensure that it captures the relevant data for the national set of HIV and AIDS indicators. Surveys of this kind that are already planned for in the coming years include, among others:

- The Demographic and Health Survey undertaken every 4 – 5 years
- Behavioural Surveillance Surveys amongst youth and selected high-risk populations, planned to be conducted biennially
- The population census
- UNICEF's Multiple Indicator Cluster Survey (MICS) and
- Young People Policy Index - this measures progress in the development of HIV and AIDS policies and strategies at the national level in the following six key areas relating to young people.
 - Identification of HIV prevention among young people as a priority in the national strategic plan on HIV and AIDS
 - Application of a multi-sectoral approach to HIV prevention among young people
 - Existence of a policy or strategy to promote HIV information, education and communication (IEC) for young people
 - Existence of a policy promoting life-skills-based education in schools
 - Existence of a policy providing youth-friendly health services and
 - Existence of a policy promoting young people's access to condoms.

5.3 Routine Information Systems

The Health Management Information System (HMIS) in Ministries of Health collects epidemiological data from health facilities. Due to the preponderance of HIV-related health services provided at health facilities, information relating to the quality of HIV-related services at health facilities is needed. Such information cannot only be collected through routine HMIS information, as the HMIS relies on self-reporting information by health facilities themselves, hence consideration should be given to data verification processes.

5.4 Programme Management Information

Ensuring good Programme Management Information will be a major challenge due to the very large numbers of actions that will be undertaken by different stakeholders and funded through various financing mechanisms. It is the least developed of all the components of a good M&E System. This component may require considerable

development by the SADC Secretariat and the Member States to develop guidelines and standard formats for reporting on progress and achievements in a way that will allow synthesis. In addition, broad consultation on these common reporting arrangements will be needed to ensure ownership and acceptance by as wide a range of stakeholders as possible. The flow of information is not a simple process and there will in some cases need to be progress reports distributed to more than one stakeholder from projects. As far as possible, the administrative burden should be reduced by agreement on use of standard formats.

6. DATA MANAGEMENT

6.1 Stakeholders

An M&E system involves a large number of role players. These include those who are directly involved with HIV and AIDS activities and those who could contribute to the M&E system. Examples of direct role players include:

- Ministries, Departments and Agencies - these may be located at national or regional levels and include a wide cross section of sectors whose mandates cover multiple areas
- NACs
- Policy Makers (Ministers of Health and Heads of States)
- UN and Bilaterals' supporting national responses within the SADC region
- Civil Society Organisations – including international NGOs and Faith Based Organisations that have a regional focus
- Informal and private sectors – businesses and business organisations and
- Academic and research institutions.

6.2 Data Flow Processes

The data flow processes will vary across the Member States. The critical issues detailed in the Framework with respect to the data flow process are as follows:

- The most efficient data flow processes between the Member States and the SADC Secretariat
- Mechanisms are, or need to be put in place for the management, coordination and verification of data

- At country level the responsible entity within the Member State to collate the data and report on it in a consistent manner to the SADC Secretariat and
- The format of the report against the performance of the respective indicators. It is proposed that a synthesised report be provided, however for verification purposes countries are to provide the raw data to the SADC Secretariat.

6.3 Harmonising Reporting Processes

Many of the major initiatives currently underway in the SADC Member States include reporting on the HIV and AIDS epidemic within the respective countries. As part of these initiatives, there are often monitoring and evaluation processes established. The need for coordination and consistency between these information collection and analysis activities is necessary to avoid duplication and additional workloads. For this framework SADC will obtain information from the coordinating authorities in the Member States. The contact focal point within the respective Member States will be the National Coordinating Body (NAC). It is envisioned that the SADC Member States will develop and harmonise road maps for information collection, collation and reporting. The harmonised reports will be produced annually (no later than September). The Member States will submit synthesised reports and where possible, raw data to the SADC Secretariat. The information contained in the first synthesised report will include all UNGASS indicators and some indicators tracking implementation of the Maseru Declaration on HIV and AIDS and the Business Plan. At the Monitoring and Evaluation Technical meetings decisions regarding reporting on the additional indicators will be made. The SADC Secretariat will be responsible for collating information from Member States and annually produce a regional SADC report in terms of the indicators contained in the framework. The regional report will be shared with Member States and other partners. It is anticipated that this report will form the basis for a peer-review mechanism to assess performance and provide feedback to key strategic policy makers and SADC partners within the respective Member States. For purposes of capturing and reporting against the indicators detailed in this framework, SADC will consult and agree with Member States on a single system of data and information management to be utilised by the

Member States.

6.4 Roles and Responsibilities

For an effective monitoring and evaluation system to be established there needs to be clarity about the roles and responsibilities at different levels. The roles and responsibilities of the respective stakeholders are as follows:

• NAC

- The NAC will bring together and coordinate all actors working on HIV and AIDS data in the country
- The coordinator identified at the NAC will ensure that the synthesised report is generated and signed off by the relevant NAC person at the Country level and
- NAC Coordinator will submit the signed off report to the SADC Secretariat.

• SADC

- The SADC Secretariat will receive the report and collate the information across all the Member States. If there are any queries, the SADC Secretariat will raise these with the person responsible at the NAC offices within the respective countries
- The SADC Secretariat will include the collated report and submit to the respective stakeholder meetings including the Council of Ministers, the Heads of State, Health Ministers and the Monitoring and Evaluation Technical Meeting and
- The SADC Secretariat will provide feedback on the synthesised report to all the Member States.

6.5 Information Products

The products that will be submitted to report on the performance of the Maseru Declaration are:

- Country Reports Collated and Synthesised by the NAC

Purpose: The purpose of this report is to provide a comprehensive response on the performance of the Member State in relation to the Maseru Declaration and the SADC Business Plan. This will be done by

reporting on core indicators contained in the SADC Framework. This report will be linked to the road map that is developed within the respective Member States.

Data Analysis: Data analysis will be carried out as per the data analysis plan for the respective countries.

Report Format: The SADC Steering Committee will determine the reporting format.

- Synthesised Report drafted by the SADC Secretariat

Purpose: The purpose of this report is to provide an overview on the regional performance of the Maseru Declaration and the SADC Business Plan on HIV and AIDS by all Member States. This will be done by reporting on the core indicators contained in the SADC Framework.

Data Analysis: Data analysis will be carried out annually by the SADC Secretariat utilising data and reports from the Member States.

Report Format: The SADC Steering Committee will determine the reporting format.

7. INDICATORS TO TRACK THE HIV AND AIDS RESPONSE IN SADC COUNTRIES

This section provides a definition of the core indicators for reporting on progress being made by Member States and the SADC Secretariat towards implementation of the Maseru Declaration and SADC Business Plan on HIV and AIDS. The section is divided in two sub-sections.

Part A comprises a description of indicators specific to Member States tracking and reporting. Part B describes indicators that will facilitate the harmonization of policies and guidelines, and implementation of regional frameworks and orientations. It should be noted however that in Part B, only indicators tracked by Member States are defined.

7.1 PART A - Indicators for Tracking Implementation of the Maseru Declaration 2005 – 2009

7.2 Summary of Indicators for tracking implementation of the Maseru Declaration

Prevention and Social Mobilisation		
Key Issue	UNGASS Indicator	Other Indicators
1. Reinforcing multi-sectoral prevention programmes aimed at strengthening family units and upholding appropriate cultural values.	1.1 Percentage of young people aged 15-24 who are HIV infected.	1.3 Proportion of young people aged (10-24) who cite a member of the family as a source of HIV and AIDS related information.
	1.2 Percentage of men and women aged 15-49 who had sex with more than one partner in the last 12 months.	
2. Strengthening initiatives that would increase the capacities of women and adolescent girls to protect themselves from the risk of HIV infection, principally through the provision of health care and health services, including for sexual reproductive health and through prevention education that promotes gender equality within a culturally and gender sensitive framework.	2.1 Percentage of schools with teachers who have been trained in life-skills based HIV education and who taught it during the last academic year.	
	2.2 Percentage of women and men aged 15-24 who both correctly identify ways of preventing the sexual transmission of HIV and who reject major misconceptions about HIV transmissions.	
3. Promoting and strengthening programmes for the youth aimed at creating opportunities for their education, employment and self expression and reinforcing programmes to reduce their vulnerability to alcohol and drug abuse.	3.1 Percentage of schools with teachers who have been trained in life-skills based HIV education and who taught it during the last academic year.	3.2 Percentage of enterprises/ organisations that have affirmative policies in respect of job creation for youth.
		3.3 Number of job creation programmes targeting youth.
4. Rapidly scaling up the programmes for the Prevention of Transmission of HIV and ensuring that levels of uptake are sufficient to achieve the desired public health impact.	4.1 Percentage of women and men with sexually transmitted infections at health care facilities that are appropriately diagnosed, treated and counselled.	

Prevention and Social Mobilisation		
Key Issue	UNGASS Indicator	Other Indicators
	4.2 Percentage of HIV-positive pregnant women receiving a complete course of anti-retroviral prophylaxis to reduce the risk of mother to child transmission.	Number of condoms distributed.
	Percentage of transfused blood units screened for HIV.	
5. Evaluation of the impact of HIV and AIDS programmes.	5.1 Percentage of young people aged 15-24 who are HIV infected (see indicator 1.1).	
	5.2 Percentage of infants born to HIV infected mothers who are infected.	

Improving Care, Access to Counselling and Testing Services and Support		
Key Issue	UNGASS Indicator	Other Indicators
6. Strengthening health care systems, especially public health.	6.1 National composite policy index	6.2 Percentage of health care facilities that have the capacity and conditions to provide advanced HIV and AIDS psychosocial support services.
		6.2 Percentage of health care facilities that have the capacity and conditions to provide monitoring of ART combination therapy.
		6.3 Percentage of facilities that provide comprehensive care referrals for HIV and AIDS care and support services (when these services are not available).
7. Strengthening family and community based care as well as support to orphans and other vulnerable children.	7.1 Percentage of orphans and vulnerable children whose households received free basic external support in caring for the child.	7.3 % of children aged less than 18 years who are orphans (single, double orphans).
	7.2 Ratio of current school attendance among orphans to that among non-orphans, aged 10-14.	7.4 Percentage of individuals reached by community-based care programmes in the last 12 months.
8. Workplace programmes	8.1 Percentage of large enterprises/companies which have HIV and AIDS workplace policies and programmes.	
9. Development of service and caring capacity among all people caring for the HIV and AIDS infected persons including the home based care providers as well as upgrading of diagnostic and related technologies.		9.1 Percentage of chronically ill people that are receiving Home Based Care from trained care providers.
		9.2 Number of providers trained in Home Based Care.

Improving Care, Access to Counselling and Testing Services and Support		
Key Issue	UNGASS Indicator	Other Indicators
10. Expanding access to VCT	10.1 Percentage who undertook an HIV test in the last 12 months and who know the results.	10.2 Percentage of facilities where VCT services are provided.
11. Preventing and removing stigma, silence, discrimination and denial which continue to hamper and undermine HIV control efforts particularly towards the people living with HIV and AIDS.	11.1 National composite policy index.	11.2 Percentage of population expressing accepting attitudes towards PLHIV.
12. Increasing access to affordable essential medicines, including ARVs and related technologies through regional initiatives for joint purchasing of drugs, with the view to ensuring the availability of drugs through sustainable mechanisms using funds from national budgets.	12.1 Percentage of people with advanced HIV infection receiving antiretroviral combination therapy.	12.2 Percentage of districts or local administration units with at least one health facility providing anti-retroviral combination therapy.

Intensifying Resource Mobilisation		
Key Issue	UNGASS Indicator	Other Indicators
13. The commitment to implementing the Abuja Declaration on allocating 15% of the annual budget for the improvement of the health sector.		13.1 Percentage of the national budget committed to the health sector.

Strengthening institutional monitoring and evaluation mechanisms		
Key Issue	UNGASS Indicator	Other Indicators
14. Intensifying training and research initiatives or programmes to strengthen Member States capacities to manage the epidemic.	14.1 Amount of public funds for research and development of a preventive HIV vaccine and microbicide.	
15. Developing and strengthening appropriate mechanisms for monitoring and evaluating the implementation of this Declaration and other continental and global commitments and establishing targets and timeframes to be included in the SADC HIV and AIDS Strategic Framework and Programme of Action (2003-2007).	15.1 National Composite Policy Index.	15.2 Number of countries tracking all core indicators outlined in the SADC M&E Framework.

Indicator Definitions

Prevention and Social Mobilisation

Key Issue 1: Reinforcing multi-sectoral prevention programmes aimed at strengthening family units and upholding appropriate cultural values, positive behavioural change and promoting responsible sexual behaviour.

Indicator 1.1: Percentage of young people aged 15-24 who are HIV infected.

Rationale: To assess progress towards reducing HIV infection.

Tools: UNAIDS/WHO Guidelines for Second Generation HIV Surveillance, and Guidelines for Conducting HIV serosurveys among pregnant women and other groups.

Frequency: Annual

Method of Measurement: This indicator is calculated using data from pregnant women attending antenatal clinics in HIV sentinel surveillance sites in the capital city, other urban areas and rural areas.

Numerator: Number of antenatal clinic attendees (aged 15–24) tested whose HIV test results are positive.

Denominator: Number of antenatal clinic attendees (15–24) tested for their HIV infection status. Median figures should be used for other urban and rural areas. Indicator scores should be given for the whole age range (15–24 years) and disaggregated by 5-year age-group (i.e., 15–19 years and 20–24 years). The proportion of the total female population aged 15–24 living in the capital city, in other urban areas and in rural areas should be provided so that national estimates can be calculated, where possible.

Reference: UNGASS

Indicator 1.2: Percent of men and women aged 15-49 who had sex with more than one partner in the last 12 months.

Rationale: To assess progress in reducing the percentage of young people age 15–49 who have higher risk sex.

Tools: Population-based survey such as DHS, MICS, BSS (youth section).

Frequency: 4 – 5 years

Method of Measurement: Respondents are asked about their marital status and the last three sexual partners within the last 12 months. For each partner, details are taken of cohabiting status as well as duration of the relationship, condom use and other factors.

Numerator: Number of respondents aged 15–49 who have had sex with a non-marital, non-cohabiting partner in the last 12 months.

Denominator: Number of respondents aged 15–49 who report sexual activity in the last 12 months.

Reference: UNGASS

Indicator 1.3: Proportion of young people aged 10-24 who cite a member of the family as a source of HIV and AIDS related information.

Rationale: To assess progress in the proportion of families who provide information to young people.

Tools: Population-based survey such as DHS, MICS, BSS.

Frequency: 4 – 5 years

Method of Measurement: Respondents (families – parents/guardians) are asked about what information in respect of HIV and AIDS they provide to the custodian. Youth are asked what HIV and AIDS information they receive from the parents/guardians.

Numerator: Number of respondents aged 10–24 who cite a member of the family as a source of HIV and AIDS related information.

Denominator: Number of respondents aged 10–24 who respond to the question on access to information.

Reference: New Indicator

Key Issue 2: Strengthening initiatives that would increase the capacities of women and adolescent girls to protect themselves from the risk of HIV infection, principally through the provision of health care and health services, including for sexual reproductive health and through prevention education that promotes gender equality within a culturally and gender sensitive framework.

Indicator 2.1: Percentage of schools with teachers who have been trained in life-skills-based HIV education and who taught it during the last academic year.

Rationale: To assess progress towards implementation of life-skills based HIV education in all schools.

Tools: School surveys or education programme reviews.

Frequency: Biennial

Method of Measurement: Principals/heads of nationally-representative sample of schools (including both private and public schools) are briefed on the meaning of life-skills based HIV education and asked the following questions.

1. Does your school have at least one qualified teacher who has received training in participatory life-skills based HIV education in the last 5 years?
2. If the answer to question 1. Is "yes": Did this person teach life skills based HIV education on a regular basis to each grade in your school throughout the last academic year?

The teacher training must have included time dedicated to mastering facilitation of participatory learning experiences that aim to develop knowledge, positive attitudes, and skills (e.g., interpersonal communication, negotiation, decision-making, critical thinking and coping strategies) that assist young people in maintaining safe lifestyles. Wherever possible, the teacher training should have been done in accordance with the latest UNICEF guidelines. The purposes of calculating this indicator, at least 30 hours of tuition per year per grade of pupil is recommended if life-skills-based HIV education is to qualify as standard tuition. However, countries may adjust this number according to local contexts.

Reference: UNGASS

Numerator: Number of schools with staff members trained in and regularly teaching life-skills-based HIV prevention.

Denominator: Number of schools surveyed

Indicator 2.2: Percentage of women and men aged 15–24 who both correctly identify ways of preventing the sexual transmission of HIV and who reject major misconceptions about HIV transmission.

Rationale: To assess progress towards universal knowledge of the essential facts about HIV transmission.

Tools: Population-based surveys such as DHS, MICS, BSS (youth section).

Frequency: Biennial

Method of Measurement: This indicator is constructed from responses to the following set of prompted questions.

1. Can the risk of HIV transmission be reduced by having sex with only one faithful, uninfected partner?
2. Can the risk of HIV transmission be reduced by using condoms?
3. Can a healthy-looking person have HIV?
4. Can a person get HIV from mosquito bites?
5. Can a person get HIV by sharing a meal with someone who is infected?

Numerator: Number of respondents (aged 15–24 years) who gave the correct answers to all five questions.

Denominator: Number of respondents (15–24) who gave answers (i.e., including "don't know") to all five questions. Those who have never heard of HIV and AIDS should be excluded from the numerator but included in the denominator. Indicator scores are required for all respondents aged 15–24 years and for males and females, separately, by urban/rural residence. Scores for each of the individual questions (based on the same denominator) are required as well as the score for the composite indicator.

Reference: UNGASS

Key Issue 3: Promoting and strengthening programmes for the youth aimed at creating opportunities for their education, employment and self expression and reinforcing programmes to reduce their vulnerability to alcohol and drug abuse.

Indicator 3.1: Percentage of schools with teachers who have been trained in life-skills based HIV education and who taught it during the last academic year (see indicator 2.1).

Indicator 3.2: Percentage of organisations/enterprises that have affirmative policies in respect of job creation for youth.

Rationale: To assess progress made by organisations in

respect of job creation policies to empower youth to reduce vulnerability to alcohol and drug abuse.

Tools: Special surveys

Frequency: Biennial

Reference: New Indicator

Measurement: This is measured through regular surveys of organisations to explore among other things whether organisations and/or enterprises have affirmative policies in respect to job creation.

Numerator: The number of organisations that report having affirmative policies in respect of job creation for youth.

Denominator: Number of organisations surveyed

Indicator 3.3: Number of job creation programmes targeting youth

Rationale: To assess progress towards number of jobs created to reduce vulnerability related to poverty among young people.

Tools: Population based survey such as DHS, MICS, BSS (youth).

Frequency: Annual

Reference: New Indicator

Key Issue 4: Rapidly scaling up the programmes for the prevention of transmission of HIV and ensuring that levels of uptake are sufficient to achieve the desired public health impact.

Indicator 4.1: Percentage of women and men with sexually transmitted infections at health-care facilities who are appropriately diagnosed, treated and counselled.

Rationale: To assess progress in implementing universally effective sexually transmitted infection diagnosis, treatment and counselling.

Tools: Health facility survey—based on the UNAIDS/MEASURE (2000) National AIDS Programme: A guide to monitoring and evaluation.

Frequency: Biennial

Method of Measurement: Data collected by observing provider-client interaction at a sample of health care facilities offering sexually transmitted infection services. See reference on: *Evaluation of a national AIDS programme: A methods package UNAIDS/WHO (1994)* for details on how to select this sample. Providers are assessed on history taking, examination, proper diagnosis and treatment of patients, and effective counselling including counselling on partner notification, condom use and HIV testing. “Appropriate” diagnosis, treatment and counselling procedures in any given country, are those specified in national sexually transmitted infection service guidelines. A “health-care” facility is defined as any setting (i.e., including public, private, and church sectors) where health-care services are provided by one or more medically qualified personnel.

Numerator: Number of sexually transmitted infection patients for whom the correct procedures were followed on: (a) history-taking; (b) examination; (c) diagnosis and treatment; and (d) effective counselling on partner notification, condom use and HIV testing.

Denominator: Number of sexually transmitted infection patients for whom provider-client interactions were observed. Disaggregated indicator scores should be reported for men and women and for patients under and over 20 years of age. Scores for each component of the indicator (i.e., history-taking, examination, diagnosis and treatment, and counselling) must be reported as well as the overall indicator score.

Reference: UNGASS

Indicator 4.2: Percentage of HIV-positive pregnant women receiving a complete course of anti-retroviral prophylaxis to reduce the risk of mother-to-child transmission.

Rationale: To assess progress in preventing vertical transmission of HIV.

Tools: Programme monitoring and estimates.

Frequency: Biennial

Method of Measurement: The number of HIV-infected pregnant women provided with anti-retroviral prophylaxis to reduce the risk of mother-to-child transmission in the last 12 months is obtained from programme monitoring records. Only those women who completed the full course should be included. The number of HIV-infected pregnant

women to whom anti-retroviral prophylaxis to reduce the risk of mother-to-child transmission could potentially have been given is estimated by multiplying the total number of women who gave birth in the last 12 months (Central Statistics Office estimates of births) by the most recent national estimate of HIV prevalence in pregnant women (HIV sentinel surveillance antenatal clinic estimates).

Numerator: Number of HIV-infected pregnant women provided with anti-retroviral to reduce mother-to-child transmission according to the nationally approved treatment protocol (or WHO/UNAIDS standards) in the last 12 months.

Denominator: Estimated number of HIV-infected pregnant women. The decision as to whether or not to include women who receive treatment from private sector and non governmental organisation clinics in the calculation of the indicator is left to the discretion of the country concerned. However, the decision taken should be noted and applied consistently in calculating both the numerator and the denominator. Private sector and non governmental organisation clinics that provide prescriptions for anti-retrovirals, but assume that the drugs will be acquired by the individuals elsewhere are not included in this indicator, even though such clinics may be major providers of prevention of mother-to-child transmission services.

Reference: UNGASS

Indicator 4.3: Percentage of transfused blood units screened for HIV.

Rationale: To assess progress in screening transfused blood units for HIV.

Tools: MEASURE Evaluation blood safety protocol.

Frequency: Biennial

Method of Measurement: Three pieces of information are needed for this indicator: the number of blood units transfused in the previous 12 months, the number of blood units screened for HIV in the previous 12 months, and among the units screened, the number screened up to WHO or national standards. The number of blood units transfused and the number screened for HIV should be available from national health information systems. Quality of screening may be determined from a special study that retests a sample of blood previously screened. In situations where this approach is not feasible, data on the percentage

of facilities with good screening and transfusion records and no stock outs of test kits may be used to estimate adequately screened blood for this indicator.

Numerator: Number of blood units screened for HIV in the last 12 months up to WHO or national standards.

Denominator: Number of blood units transfused in the last 12 months.

Reference: UNGASS

Indicator 4.4: Number of condoms distributed

Rationale: To assess the extent to which the general population is protecting themselves from infection with HIV.

Tools: Condom distribution logistics system.

Frequency: Annual

Method of Measurement: This indicator is calculated from the condom logistics data that show the number of condoms that have been distributed throughout the country

Reference: New

Key Issue 5: Evaluation of the impact of HIV AND AIDS programmes

Indicator 5.1: Percentage of young people aged 15-24 who are HIV infected (see indicator 1.1).

Indicator 5.2: Percentage of infants born to HIV-infected mothers who are not infected with HIV.

Rationale: To assess progress towards eliminating mother-to-child HIV transmission.

Tools: Estimates based on programme coverage.

Frequency: Biennial

Method of Measurement: The indicator can be calculated by taking the weighted average of the probabilities of mother-to-child transmission for pregnant women receiving and not receiving anti-retrovirals; the weights being the proportions of women receiving and not receiving anti-

retrovirals, respectively, expressed as a simple mathematical formula:

Indicator score = $\{ T*(1-e) + (1-T) \} * v$ where:

T = proportion of HIV-positive pregnant women provided with anti-retroviral treatment

v = mother-to-child transmission rate in the absence of any treatment

e = efficacy of treatment provided

T is simply national indicator #6. Default values of 25% and 50%, respectively, can be used for v and e. However, where scientific estimates of the efficacy of the specific forms of anti-retroviral treatment (e.g., nevirapine) used in the country are available, these can be used in applying the formula. When this is done, the values of these estimates should be recorded.

Reference: UNGASS

Numerator: Number of infants born to mothers who are HIV-positive and are not infected with HIV

Denominator: All infants born to mothers who are infected with HIV

Improving Care, Access to Counselling and Testing Services and Support

Key Issue 6: Strengthening health care systems, especially public health

Indicator 6.1: National composite policy index

Rationale: To assess progress in the development and implementation of national-level HIV and AIDS policies and strategies.

Frequency: Biennial

Method of Measurement: The composite index covers the following broad areas of policy

Part A

1. Strategic plan
2. Political support
3. Prevention
4. Care and support and
5. Monitoring and evaluation.

Part B

1. Human rights
2. Civil Society involvement
3. Prevention and
4. Care and Support.

A number of specific policy indicators have been identified for each of these policy areas

Reference: UNGASS

Indicator 6.2: Percentage of health care facilities that have the capacity and conditions to provide HIV and AIDS psychosocial support services

Rationale: This indicator measures the availability of advanced service specific to people living with HIV. It is assumed that the services and items measured in this indicator require substantial input and personnel training beyond what are routine for most health systems. In some settings facilities will not have all items for each component and countries may have different strategies for providing select advanced services at only certain levels of the health care system.

Tools: Health facility survey with observation in all relevant service areas. Like care, treatment and or support, interviews with HIV and AIDS service providers would also be needed.

Frequency: Annual

Reference: UNAIDS Care and Support Guide (2004)

Numerator: Number of health care facilities that provide psychosocial support services

Denominator: Number of health care facilities surveyed

Indicator 6.3 Percentage of health care facilities that have the capacity and conditions to provide monitoring of ART combination therapy

Rationale: This indicator measures the availability of advanced service specific to people living with HIV. It is assumed that the services and items measured in this indicator require substantial input and personnel training beyond what are routine for most health systems. In some settings facilities will not have all items for each component and countries may have different strategies for providing select advanced services at only certain levels of the health care system.

Tools: Health facility survey with observation in all relevant service areas. Like care, treatment and or support, interviews with HIV and AIDS service providers would also be needed.

Frequency: Annual

Reference: UNAIDS Care and Support Guide (2004)

Numerator: Number of health care facilities that provide monitoring ART combination therapy

Denominator: Number of health care facilities surveyed

Indicator 6.4: Percentage of facilities that provide comprehensive care referrals for HIV and AIDS care and support services (when these services are not available).

Rationale: This indicator measures the availability of advanced service specific to people living with HIV. It is assumed that the services and items measured in this indicator require substantial input and personnel training beyond what are routine for most health systems. In some settings facilities will not have all items for each component and countries may have different strategies for providing select advanced services at only certain levels of the health care system.

Tools: Health facility survey

Frequency: 2 – 4 years

Reference: UNAIDS (2004) National AIDS Programmes. A guide to monitoring and evaluating HIV and AIDS care and support.

Numerator: Number of health care facilities that do not provide HIV and AIDS services but provide comprehensive referrals for HIV and AIDS services

Denominator: Number of health care facilities surveyed.

Key Issue 7: Strengthening family and community based care as well as support to orphans and other vulnerable children

Indicator 7.1: Percentage of orphans and vulnerable children whose households received free basic external support in caring for the child.

Rationale: To monitor the proportion of children who are orphaned by HIV and AIDS or other circumstances.

Monitoring and evaluation of a national response in this area has particular challenges. The challenges relate to the lack of experience with data collection on OVC, measurable indicators and representative sampling frames of orphans.

Tools: Population based surveys (DHS and MICS)

Frequency: 4 – 5 years

Method of Measurement: Household heads are asked the following four questions about the types and frequency of support received, and the primary source of the help for each orphan and vulnerable child:

1. Has this household received medical support, including medical care and/or medical care supplies, within the last 12 months?
2. Has this household received school-related assistance, including school fees, within the last 12 months?
3. Has this household received emotional/psychological support, including counselling from a trained counselor and/or emotional/spiritual support/companionship, within the last three months?
4. Has this household received other social support, including socio-economic support (e.g., clothing, extra food, financial support, shelter) and/or instrumental support (e.g., help with household work, training for caregiver, childcare, legal services) within the last three months?

Numerator: Number of orphaned and vulnerable children who live in households that answered YES to at least one of questions 1, 2, 3 and 4.

Denominator: Total number of orphaned and vulnerable children.

Reference: UNGASS

Indicator 7.2: % of children aged less than 18 years who are orphans.

Rationale: To monitor the proportion of children who are orphaned by HIV and AIDS or other circumstances. Monitoring and evaluation of a national response in this area has particular challenges. The challenges relate to the lack of experience with data collection on OVC,

measurable indicators and representative sampling frames of orphans.

Tools: Population based survey (UNAIDS/Measure (2000), National AIDS Programmes: A Guide to Monitoring and Evaluation

Frequency: 4 – 5 years

Numerator: Number of children aged less than 18 years who report that they are either single or double orphans.

Denominator: Number of orphans surveyed.

Reference: UNGASS

Indicator 7.3: Ratio of current school attendance among orphans to that among non-orphans, aged 10-14.

Frequency: Preferred: biennial
Minimum: every 4-5 years

Method of Measurement: Ratio of the current school attendance rate of children aged 10-14 both of whose biological parents have died to the current school attendance rate of children aged 10-14 both of whose parents are still alive and who currently live with at least one biological parent.

Orphan school attendance (1):

Numerator: Number of children who have lost both parents and are still in school

Denominator: Number of children who have lost both parents

Non-orphan school attendance (2):

Numerator: Number of children, both of whose parents are still alive, who live with at least one parent and who are still in school

Denominator: Number of children both of whose parents are still alive and who live with at least one parent

Calculate the ratio of (1) to (2): Indicator scores are required for all children aged 10-14 years, and for boys and girls, separately. Where possible, the indicator should also be calculated by single year of age. The minimum number of orphans required to calculate this indicator is 50.

Indicator 7.4: Percentage of individuals reached by

community-based care programmes in the last 12 months.

Rationale: To assess progress in respect of the number of individuals reached by community and family-based care programmes.

Tools: Programme Monitoring and Evaluation

Frequency: Annual

Reference: New

Numerator: Number of survey respondents who reported that they have been reached by community-based care programmes

Denominator: Number of people interviewed

Key Issue 8: Facilitating the expression of workplace programmes on HIV and AIDS prevention and management of all levels of the workforce, supported by appropriate policy and legal frameworks.

Indicator 8.1: Percentage of large companies/enterprises which have HIV and AIDS workplace policies and programmes.

Rationale: To assess progress in implementing workplace policies and programmes to combat HIV and AIDS.

Tools: Survey a representative sample of major employers in both the public and private sectors. Public sector employers should include the ministries of transport, labour, tourism, education and health at minimum. Private sector employers should be selected on the basis of the size of their labour force

Frequency: Biennial

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

1. Prevention of stigmatisation and discrimination on the basis of HIV infection status in: (a) staff recruitment and promotion; and (b) employment, sickness and termination benefits.
2. Workplace-based HIV and AIDS prevention activities that cover:

- (a) the basic facts on HIV and AIDS
- (b) specific work-related HIV-transmission hazards and safeguards
- (c) condom promotion
- (d) voluntary counselling and testing
- (e) sexually transmitted infection diagnosis and treatment and
- (f) provisions for HIV and AIDS related treatment.

Numerator: Number of employers with HIV and AIDS policies and programmes that meet all of the above criteria.

Denominator: Number of employers surveyed. Copies of written personnel policies and regulations should be obtained and assessed wherever possible. Indicator scores are required for all employers combined and for the public and private sectors separately. Estimates of the total number of men and women in formal sector workforce should also be provided in the supporting information provided for this indicator.

Reference: UNGASS

Key Issue 9: Development of service and caring capacity among all people caring for persons living with HIV including the home based care providers as well as upgrading of diagnostic and related technologies.

Indicator 9.1: Proportion of chronically ill people that are receiving home based care from trained care providers.

Rationale: For the purpose of planning it is important to assess the resources available to address health needs. Before the implementation or expansion of services it is vital to know not only what facilities and equipment are available, but also the extent of training and human resources that exist. This indicator tracks the number of personnel trained. However, no conclusion should be drawn regarding the quality, because this is affected by the practices employed rather than the existence of trained personnel.

Tools: Programme Evaluation

Frequency: Annual

Reference: New Indicator

Numerator: Number of chronically ill people who reported

that they are receiving home based care from trained care providers

Denominator: Number of chronically ill people who reported that they are receiving home based care

Indicator 9.2: Number of providers trained in Home Based Care

Rationale: For the purpose of planning it is important to assess the resources available to address health needs. Before the implementation or expansion of services it is vital to know not only what facilities and equipment are available, but also the extent of training and human resources that exist. This indicator tracks the number of personnel trained. However, no conclusion should be drawn regarding the quality, because this is affected by the practices employed rather than the existence of trained personnel.

Tools: Programme Evaluation

Frequency: Annual

Reference: New Indicator

Rationale: For the purpose of planning it is important to assess the resources available to address health needs. Before the implementation or expansion of services it is vital to know not only what facilities and equipment are available, but also the extent of training and human resources that exist. This indicator tracks the number of personnel trained. However, no conclusion should be drawn regarding the quality, because this is affected by the practices employed rather than the existence of trained personnel.

Tools: Programme Evaluation

Frequency: Annual

Reference: New Indicator

Key Issue 10: Expanding access to VCT

Indicator 10.1: Percentage (most at risk populations) who received an HIV test in the last 12 months and who know the result

Rationale: To assess progress in implementing HIV testing and counselling among most-at-risk populations.

Tools: A. Special surveys such as the FHI BSS
B. Programme monitoring

Frequency: Biennial

Method of Measurement:

A. Surveys: respondents are asked the following questions:

1. Have you been tested for HIV in the last 12 months?
2. If the answer to question 1 is "yes:" Do you know the results of that test?

B. Programme monitoring: the proportion of the population accessing HIV testing and counselling services is calculated from data collected by service providers.

Numerator: Number of [most-at-risk population] respondents who have been tested for HIV during the last 12 months and who know the results of their test.

Denominator: Number of [most-at-risk population] included in the sample (A) or prevalence estimation methods for the size of the most-at-risk population for the denominator (B).

Reference: UNGASS

Indicator 10.2: Percentage of public health facilities where VCT services are provided.

Rationale: HIV testing and counselling are important entry points for prevention and care. Measuring the people who access these services is therefore important to indicate the number of people who could potentially benefit from prevention and care. In addition, this indicator provides information on the number of people newly tested over time. This indicator is designed to show how many people have been tested and received post test counselling services. This indicator can be used as a proxy for counselling and testing services. Because testing and counselling are not performed within discrete units or departments, reports can be duplicated for the same individual being tested in multiple units or those being tested multiple times during a 12 month period. Double reporting may occur in cases where preventing MTCT of HIV and other HIV testing and counselling services are performed in the same place.

Tools: Health management information systems, Health facility surveys and Household surveys.

Frequency: Annual

Reference: UNAIDS/Measure (2000) National AIDS

Programme: A guide to monitoring and evaluation

Numerator: Number of public health facilities that provide VCT services

Denominator: Number of all public health facilities

Key Issue 11: Preventing and removing stigma, silence, discrimination and denial which continue to hamper and undermine HIV control efforts particularly towards the people living with HIV and AIDS.

Indicator 11.1: National composite policy index (For details see Indicator 6.1).

Indicator 11.2: Percentage of population expressing accepting attitudes towards those living with HIV.

Rationale: To assess the level of stigma and discrimination in society towards people living with HIV and AIDS. While some stigmatising attitudes and discriminatory practices are all too obvious, other remain largely hidden. There is no clear relationship between attitudes and behaviours in this context. It is difficult to collect information about behaviours towards people living with HIV, partly because of stigma itself and because the HIV status of people living with HIV is rarely openly acknowledged. This is an indicator based on answers to a series of hypothetical questions about men and woman with HIV. It reflects what people are prepared to say they feel or would do when confronted with various situations involving people living with HIV.

Tools: Population based surveys

Frequency: Biennial

Method of measurement: Respondents in a general population survey are asked a series of questions about people with HIV, as follows:

- If a member of your family became sick with the AIDS virus, would you be willing to care for him or her in your household?
- If you knew that a shopkeeper or food seller had the AIDS virus, would you buy fresh vegetables from them?
- If a female teacher has the AIDS virus but is not sick, should she be allowed to continue teaching in school?
- If a member of your family became infected with the AIDS virus, would you want it to remain a secret?

Reference: UNAIDS (2004) National AIDS programmes: A guide to monitoring and evaluating HIV and AIDS care and support

Numerator: Respondents who reports an accepting or supportive attitude on all four of these questions.

Denominator: All people surveyed

Key Issue 12: Increasing access to affordable essential medicines, including ARVs and related technologies through regional initiatives for joint purchasing of drugs, with the view to ensuring the availability of drugs through sustainable mechanisms using funds from national budgets.

Indicator 12.1: Percentage of people with advanced HIV infection receiving anti-retroviral combination therapy.

Rationale: To assess progress towards providing anti-retroviral combination therapy to all people with advanced HIV infection. As the HIV pandemic matures, increasing numbers of people are reaching advanced stages of HIV infection. The ART has been shown to reduce mortality among those infected and efforts are being made to make it more affordable even in less developed countries. Although the indicator allows trends to be monitored over time, it does not attempt to distinguish between the different types of therapy available nor does it measure costs, quality or effectiveness of such treatment.

Tools: Programme monitoring

Frequency: Biennial

Method of Measurement: The number of people with advanced HIV infection who are currently receiving anti-retroviral combination therapy is obtained from programme monitoring records.

Numerator: Number of people with advanced HIV infection who receive anti-retroviral combination therapy in accordance with the nationally approved treatment protocol (or WHO/UNAIDS standards); it is calculated as follows: number of people receiving treatment at the start of the year, plus number of people who commenced treatment in the preceding 12 months, minus number of people for whom treatment was terminated in the preceding 12 months (including those who died).

Denominator: Number of people with known advanced HIV infection (i.e. those in need of anti-retroviral combination therapy). The number of adults in need of anti-retroviral combination therapy is calculated by adding the number

of adults newly in need of therapy to the number who were on treatment in the previous year and survived to the current year. The number of adults newly in need of anti-retroviral combination therapy is estimated as the number developing advanced HIV disease that are not yet on treatment. Since some of the adults projected to develop advanced HIV disease may already have started treatment in the previous year, the number newly in need of anti-retroviral combination therapy is adjusted by subtracting people in this category. It is currently assumed that between 80% and 90% of adults on treatment will survive to the following year, depending on patients' adherence to treatment, resistance patterns, the quality of clinical management and other factors.

Reference: UNGASS

Indicator 12.2: Percentage of districts or local administration units with at least one health facility providing anti-retroviral combination therapy.

Rationale: This indicator is important to measure coverage of anti-retroviral combination therapy within a country by looking at the number of districts in which treatment is available. The method of measuring this indicator depends strongly on the ability of the national and or district levels to collect and provide this information.

Tools: Record reviews of the district medical office or district AIDS office which may have a list of all facilities providing ART. Record reviews of the national AIDS programme or national drug management system of the Ministry of Health - Health facility survey.

Frequency: Biennial

Reference: New Indicator

Numerator: Number of districts or local administration units with at least one health facility providing ART in line with national standards

Denominator: Total number of districts or local administration units

Intensifying Resource Mobilisation

Key Issue 13: The commitment to implementing the Abuja Declaration on allocating at least 15% of the annual national budget for the improvement of the health sector.

Indicator 13.1: Percentage of the national annual budget committed to the health sector

Rationale: To assess progress made in respect of the Abuja Declaration.

Tools: Questionnaire to all countries that signed the Abuja Declaration.

Frequency: Annual

Reference: New Indicator - SADC Business Plan

Numerator: Annual health sector budget

Denominator: Total annual budget

Strengthening Institutional monitoring and Evaluation Mechanisms

Key Issue 14: Intensifying training and research initiatives or programmes to strengthen Member States capacities to manage the epidemic.

Indicator 14.1: Amount of public funds for research and development of a preventive HIV vaccine and microbicide.

Rationale: To track public sector funding for research and development for preventive HIV vaccine and microbicide.

Tools: Survey of financial resource flow to relevant governments (government research bodies, development assistance governments, multilateral organisations) funding preventive HIV vaccine and microbicide research and development.

Frequency: Annual

Method of Measurement: Information on annual investment levels are collected from the national/federal departments and multilateral organisations identified who provide funding for preventive HIV vaccine and microbicide research and development. Information is collected on funds disbursed each year on a range of activities including: vaccine related basic science; pre-clinical research; clinical trials; support for clinical trial preparation; advocacy and policy efforts directed at accelerating the development of these technologies and their eventual use. The estimates, however, do not include:

- Research and development expenditures/investments for vaccines with primarily therapeutic applications
- Research not directed primarily at preventive HIV vaccines and/or microbicides but that may have benefits or links to either of these products (e.g., platform technologies).

Reference: UNGASS

Key Issue 15: Developing and strengthening appropriate mechanisms for monitoring and evaluating the implementation of this Declaration and other continental and global commitments and establishing targets and time frames to be included in the SADC HIV and AIDS Strategic Framework and Programme of Action (2003-2007).

Indicator 15.1: National composite policy index (For details see Indicator 6.1)

Indicator 15.2: Number of countries tracking the indicators outlined in the SADC M&E framework.

Rationale: This is a critical indicator of national capacity for M&E HIV and AIDS, care, support, treatment programmes - all the data from the HMIS contained rely on the integrity of the system.

Tools: Indicator Reports

Frequency: Annual

Reference: New Indicator

7.3 PART B – SADC DECLARATION AND THE BUSINESS PLAN INDICATORS

Summary of Indicators to track implementation of the SADC Business Plan on HIV and AIDS

Prevention and Social Mobilisation		
Key Issue	Indicator	Regional/National
1. Putting in place national strategies to address the spread of HIV among national uniformed services, including the armed forces, and consider ways of using personnel from these services to strengthen awareness and prevention initiatives.	1.1 National Strategies for uniformed forces in place	National
	1.2 Availability of regional guidelines for harmonizing national strategies for the prevention of HIV and social mobilization	Regional
2. Facilitating the expression of the workplace programmes on HIV and AIDS prevention and management among all levels of the workforce, supported by appropriate policy and legal frameworks.	2.1 Number of countries with workplace guidelines for HIV and AIDS	National
	2.2 Regional workplace guidelines for HIV and AIDS programmes for all sectors in place	Regional
3. Investing in nutrition programmes and promoting the use of nutritional supplements, production and consumption of locally available foods.	3.1 Number of countries with policies on HIV and AIDS for agriculture and food security	National
	3.2 Regional policy on HIV and AIDS for agriculture and food security in place	Regional
4. Developing a regulatory framework and institutional capacity for the testing and utilization of traditional medicines.	4.1 National guidelines for use of indigenous knowledge in care and treatment and the relevant knowledge and practicing centres established	National
	4.2 Regional guidelines for collaborating in the use of indigenous knowledge systems in medical research and development of drugs and medicines	Regional
Accelerating Development and Mitigating the Impact of HIV and AIDS		
5. Putting in place national legislation and regional legal regimes to ensure the availability of technologies and drugs at affordable prices for treatment, including bulk purchasing of drugs and manufacturing of generic medicines in the SADC region.	5.1 Availability of regional framework for bulk purchasing	National
	5.2 Number of SADC Member States with national drug policies for purchasing medicines aligned to the regional framework	Regional
Accelerating Development and Mitigating the Impact of HIV and AIDS		
Key Issue	Indicator	Regional/National
6. Enhancing the regional initiatives to facilitate access to HIV and AIDS prevention, treatment, care and support for people living along our national borders, including sharing best practices.	6.1 Number of SADC countries that have functional cross-border HIV and AIDS programmes	National
	6.2 Framework to harmonise regional cross-border interventions in place	Regional

7. Developing a regulatory framework and institutional capacity for the testing and utilization of traditional medicines.	7.1 Availability of regional guidelines for HIV testing and utilisation of traditional medicines for HIV and AIDS	Regional
	7.2 Number of countries with guidelines for HIV testing and utilisation of traditional medicines for HIV and AIDS	National
8. Mainstreaming and factoring HIV and AIDS in our regional integration process and focal intervention areas, particularly in the area of trade liberalization, infrastructure development, food security, social and human development.	8.1 Availability of regional policy on HIV and AIDS in SHD (Human and Social Development) sector, trade, infrastructure, Finance and Investment	Regional
	8.2 Number of SADC Countries using HIV and AIDS mainstream guidelines	National
Accelerating Development and Mitigating the Impact of HIV and AIDS		
Key Issue	Indicator	Regional/National
9. Developing and strengthening institutional mechanisms for HIV surveillance, sharing of experiences and exchange of information on key areas of intervention such as prevention, provision of care to and support of HIV and AIDS related conditions.	9.1 Regional HIV and AIDS Surveillance developed	Regional
	9.2 Number of SADC Member States reporting on HIV and AIDS indicators to the SADC Secretariat	National
10. Intensifying training and research initiatives or programmes to strengthen Member States capacities to manage the HIV epidemic.	10.1 Harmonised Regional Research priorities developed	Regional
	10.2 Number of SADC Countries conducting research in line with the SADC research priorities	National

Prevention and Social Mobilisation

Key Issue 1: Putting in place national strategies to address the spread of HIV among national uniformed services, including the armed forces, and consider ways if using personnel from these services to strengthen awareness and prevention initiatives.

Indicator 1.1: National Strategies for uniformed forces in place

Rationale: To assess progress in respect to institutionalising national strategies for uniformed forces made by the Member States

Frequency: Annual

Key Issue 2: Facilitating the expression of workplace programmes on HIV and AIDS prevention and management among all levels of the workforce, supported by appropriate policy and legal frameworks.

Indicator 2.1: Number of countries with workplace guidelines for HIV and AIDS

Rationale: This indicator is designed to measure progress made in respect of development and adaptation of workplace guidelines by Member States

Frequency: Annual

Improving Care, Access to Counselling and Testing Services and Support

Key Issue 3: Investing in nutrition programmes and promoting the use of nutritional supplements, production and consumption of locally available foods.

Indicator 3.1: Number of countries with policies on HIV and AIDS for agriculture and food security

Rationale: This indicator is designed to measure progress made in respect of development and adoption of HIV and AIDS policy in respect of agriculture by Member States.

Frequency: Annual

Key Issue 4: Developing a regulatory framework and institutional capacity for the testing and utilisation of traditional medicines.

Indicator 4.1: National guidelines for use of indigenous knowledge in care and treatment and the relevant knowledge and practicing centres established

Rationale: This indicator is designed to measure progress made in respect of the utilisation of indigenous knowledge in care and treatment by Member States.

Tools: National Composite Policy Index

Frequency: Annual

Reference: Adaptation from the SADC HIV and AIDS Business Plan

Accelerating Development and Mitigating the impact of HIV AND AIDS

Key Issue 5: Putting in place national legislation and regional legal regimes to ensure the availability of technologies and drugs at affordable prices for treatment, including bulk purchasing of drugs and manufacturing of generic medicines in the SADC region.

Indicator 5.1: Number of SADC Member States with national drug policies for purchasing medicines aligned to the regional framework

Rationale: This indicator measures the existence of a drug policy for the distribution of ARVs and drugs used in the treatment of HIV and AIDS and opportunistic infections.

Tools: National Composite Policy Index

Frequency: Once

Reference: SADC Business Plan

Key Issue 6: Enhancing the regional initiatives to facilitate access to HIV and AIDS prevention, treatment, care and support for people living along our national borders, including sharing best practices.

Indicator 6.1: Number of SADC countries that have functional cross-border HIV and AIDS programmes

Rationale: The indicator assess whether national programmes catering for cross-border populations are

being implemented in Member States.

Frequency: Biennial

Reference: Adapted UNAIDS: A Guide to Monitoring and Evaluating HIV and AIDS Care and Support (2004)

Key Issue 7: Developing a regulatory framework and institutional capacity for the testing and utilisation of traditional medicines.

Indicator 7.1: Number of countries with guidelines for HIV testing and utilisation of traditional medicines for HIV and AIDS

Rationale: The indicator assess whether national policies, strategies and guidelines have been developed.

Frequency: Annual

Reference: SADC Business Plan

Key Issue 8: Mainstreaming and factoring HIV and AIDS in our regional integration process and focal intervention areas, particularly in the areas of trade liberalisation, infrastructure development food security, social and human development.

Indicator 8.1: Number of SADC Countries using HIV and AIDS mainstream guidelines

Rationale: In order for the mainstreaming of HIV and AIDS in all sectors, at the national level there should be policies and strategies to promote mainstreaming in a comprehensive way, linking it with prevention and the strengthening of health care systems and including all groups, especially vulnerable populations.

National guidelines and policies are commonly based on existing international standards and on standards that are generally agreed upon but not yet formally presented as international guidance. Without guidelines, services of unknown quality and impact may be implemented on an ad hoc basis making it difficult to monitor and evaluate efforts.

Tools: A survey among key informants is used to determine whether suitable systems and strategies exist.

Frequency: Biennial

Reference: UNDP

Strengthening Institutional monitoring and Evaluation Mechanisms

Key Issue 9: Developing and strengthening institutional mechanisms for HIV surveillance, sharing of experiences and exchanges of information on key areas of interventions such as prevention, provision of care to and support of HIV and AIDS related conditions.

Indicator 9.1: Number of SADC Member States reporting on HIV indicators to the SADC secretariat.

Rationale: National guidelines and policies are commonly based on existing international standards and on standards that are generally agreed upon but not yet formally presented as international guidance. Without guidelines, services of unknown quality and impact may be implemented on an ad hoc basis making it difficult to monitor and evaluate efforts.

Tools: A survey among key informants is used to determine whether suitable systems and strategies exist.

Frequency: Annual

Reference: SADC Business Plan

Key Issue 10: Intensifying training and research initiatives or programmes to strengthen Member States capacities to manage the epidemic.

Indicator: Number of SADC Countries conducting research in line with the SADC research priorities

Rationale: To share best practices and lessons learnt across the Member States. This will also facilitate evidence-based planning in Member States

Tools: Interviews and Record reviews

Frequency: Annual

Reference: SADC Business Plan

Appendix A

Prevention and Social Mobilisation			
Key Issue	Indicators	Data Source/Tools	Frequency
1. Reinforcing multi-sectoral prevention programmes aimed at strengthening family units and upholding appropriate cultural values.	1.1 Percentage of young people aged 15-24 who are HIV infected.	UNAIDS/WHO Guidelines for Second Generation HIV Surveillance, and Guidelines for Conducting HIV serosurveys among pregnant women and other groups.	Annual
	1.2 Percentage of men and women aged 15-49 who had sex with more than one partner in the last 12 months.	Population-based survey such as DHS, MICS, BSS (youth section)	4 – 5 years
	1.3 Proportion of young people aged (10-24) who cite a member of the family as a source of HIV and AIDS related information.	Population-based survey such as DHS, MICS, BSS	4 – 5 years
2. Strengthening initiatives that would increase the capacities of women and adolescent girls to protect themselves from the risk of HIV infection, principally through the provision of health care and health services, including for sexual reproductive health and through prevention education that promotes gender equality within a culturally and gender sensitive framework.	2.1 Percentage of schools with teachers who have been trained in life-skills based HIV education and who taught it during the last academic year.	School surveys or education programme reviews	Biennial
	2.2 Percentage of women and men aged 15-24 who both correctly identify ways of preventing the sexual transmission of HIV and who reject major misconceptions about HIV transmissions.	Population-based survey such as DHS, MICS, BSS (youth section)	Biennial
3. Promoting and strengthening programmes for the youth aimed at creating opportunities for their education, employment and self expression and reinforcing programmes to reduce their vulnerability to alcohol and drug abuse.	3.1 Percentage of schools with teachers who have been trained in life-skills based HIV education and who taught it during the last academic year.	School surveys or education programme reviews	Biennial
	3.2 Percentage of enterprises/ organisations that have affirmative policies in respect of job creation for youth.	Special surveys	Biennial
	3.3 Number of job creation programmes targeting youth.	Population based survey such as DHS, MICS, BSS (youth)	Annual
4. Rapidly scaling up the programmes for the Prevention of Transmission of HIV and ensuring that levels of uptake are sufficient to achieve the desired public health impact.	4.1 Percentage of women and men with sexually transmitted infections at health care facilities who are appropriately diagnosed, treated and counselled.	Health facility survey—based on the UNAIDS/MEASURE (2000) National AIDS Programme: A guide to monitoring and evaluation	Biennial
	4.2 Percentage of HIV-positive pregnant women receiving a complete course of anti-retroviral prophylaxis to reduce the risk of mother to child transmission.	Programme monitoring and estimates	Biennial
	4.3 Number of condoms distributed		
	4.4 Percentage of transfused blood units screened for HIV.	MEASURE Evaluation blood safety protocol	Biennial
5. Evaluation of the impact of HIV and AIDS programmes.	5.1 Percentage of young people aged 15-24 who are HIV infected (see indicator 1.1).	UNAIDS/WHO Guidelines for Second Generation HIV Surveillance, and Guidelines for Conducting HIV serosurveys among pregnant women and other groups.	Annual
	5.2 Percentage of infants born to HIV infected mothers who are infected.	Estimates based on programme coverage.	Biennial

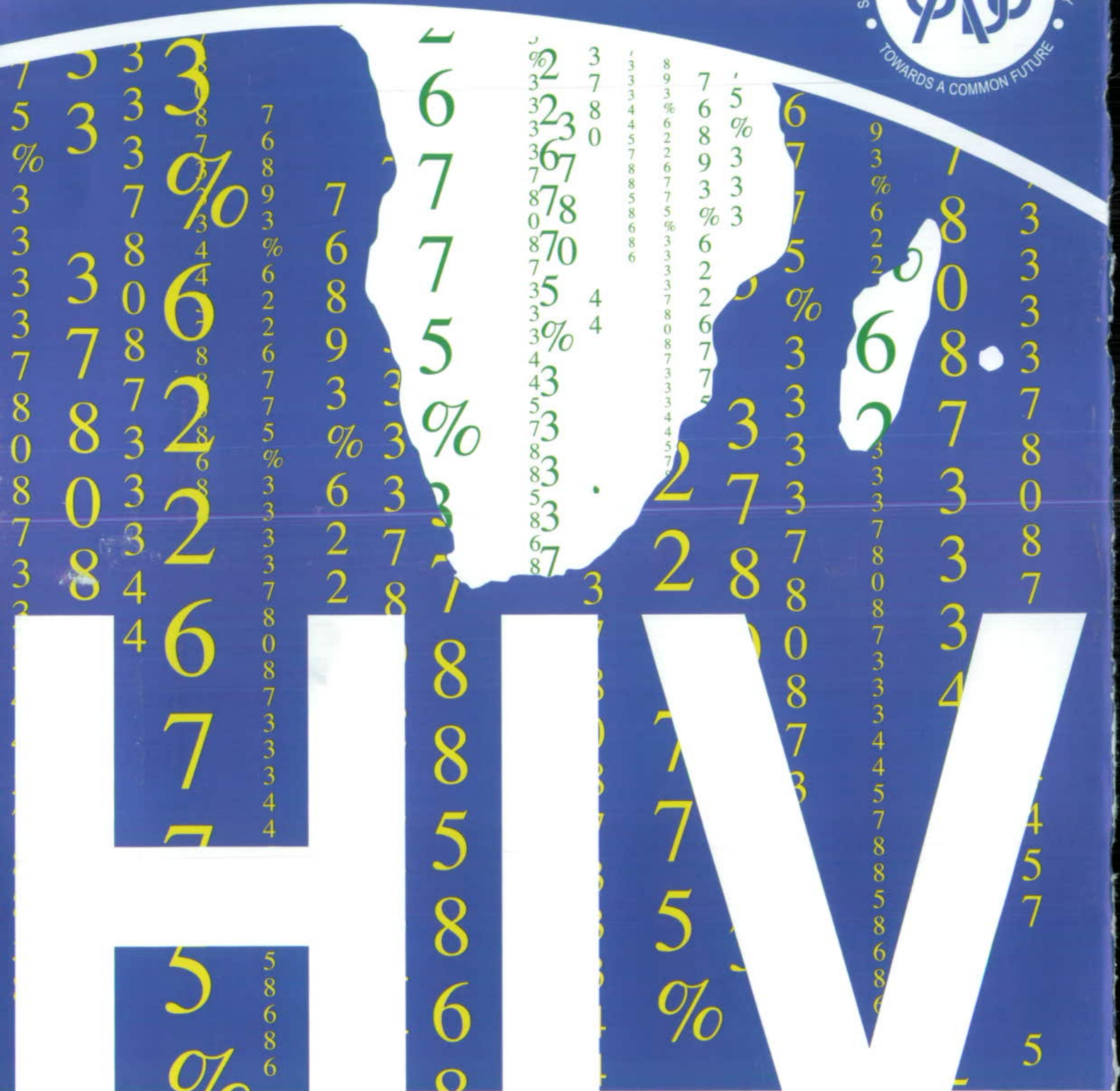
Improving Care, Access to Counselling and Testing Services and Support			
Key Issue	Indicators	Data Source/Tools	Frequency
6. Strengthening health care systems, especially public health.	6.1 National composite policy index	Country assessment questionnaire	Biennial
	6.2 Percentage of health care facilities that have the capacity and conditions to provide advanced HIV and AIDS psychosocial support services.	Health facility survey with observation in all relevant service areas. Like care, treatment and or support, interviews with HIV AND AIDS service providers would also be needed	Annual
	6.3 Percentage of health care facilities that have the capacity and conditions to provide monitoring of ART combination therapy	Health facility survey	2 – 4 years
	6.4 Percentage of facilities that provide comprehensive care referrals for HIV and AIDS care and support services (when these services are not available).	Health facility survey	2 – 4 years
7. Strengthening family and community based care as well as support to orphans and other vulnerable children.	7.1 Percentage of orphans and vulnerable children whose households received free basic external support in caring for the child.	Population based surveys (DHS and MICS)	4 – 5 years
	7.2 Ratio of current school attendance among orphans to that among non-orphans, aged 10–14.	Population-based survey such as DHS, MICS or other representative survey.	Preferred: biennial Minimum: every 4–5 years
	7.3 Percentage of individuals reached by communitybased care programmes in the last 12 months	Programme Monitoring and Evaluation	Annual
8. Workplace programmes	8.1 Percentage of large enterprises/companies which have HIV and AIDS workplace policies and programmes.	Survey a representative sample of major employers both the public and private sectors. Public sector employers should include the ministries of transport, labour, tourism, education and health at minimum. Private sector employers should be selected on the basis of the size of their labour force.	Biennial
9. Development of service and caring capacity among all people caring for the HIV and AIDS infected persons including the home based care providers as well as upgrading of diagnostic and related technologies.	9.1 Percentage of chronically ill people that are receiving Home Based Care from trained care providers.	Programme Evaluation	Annual
	9.2 Number of providers trained in Home Based Care.	Programme Evaluation	Annual
Improving Care, Access to Counselling and Testing Services and Support			
Key Issue	Indicators	Data Source/Tools	Frequency
10. Expanding access to VCT	10.1 Percentage who undertook an HIV test in the last 12 months and who know the results.	A. Special surveys such as the FHI BSS B. Programme monitoring	Biennial
	10.2 Percentage of facilities where VCT services are provided.	Health management information systems, Health facility surveys and Household surveys	Annual
11. Preventing and removing stigma, silence, discrimination and denial which continue to hamper and undermine HIV control efforts particularly towards the people living with HIV and AIDS.	11.1 National composite policy index	Country assessment questionnaire	Biennial
	11.2 Percentage of population expressing accepting attitudes towards PLHIV.	Population based surveys	Biennial

Improving Care, Access to Counselling and Testing Services and Support			
Key Issue	Indicators	Data Source/Tools	Frequency
12. Increasing access to affordable essential medicines, including ARVs and related technologies through regional initiatives for joint purchasing of drugs, with the view to ensuring the availability of drugs through sustainable mechanisms using funds from national budgets.	12.1 Percentage of people with advanced HIV infection receiving anti-retroviral combination therapy.	Programme monitoring	Biennial
	12.2 Percentage of districts or local administration units with at least one health facility providing anti-retroviral combination therapy.	Record reviews of the district medical office or district AIDS office which may have a list of all facilities providing ART Record reviews of the national AIDS programme or national drug management system of the Ministry of Health - Health facility survey.	Biennial
13. The commitment to implementing the Abuja Declaration on allocating 15% of the annual budget for the improvement of the health sector.	13.1 Percentage of the national budget committed to the health sector.	Survey of financial resource flow to relevant governments (government research bodies, development assistance governments, multilateral organisations).	Annual
14. Intensifying training and research initiatives or programmes to strengthen Member States capacities to manage the epidemic.	14.1 Amount of public funds for research and Development of preventive HIV vaccine and microbicide.	Survey of financial resource flow to relevant governments (government research bodies, development assistance governments, multilateral organisations) funding preventive HIV vaccine and microbicide research and development.	Annual
15. Developing and strengthening appropriate mechanisms for monitoring and evaluating the implementation of this Declaration and other continental and global commitments and establishing targets and timeframes to be included in the SADC HIV and AIDS Strategic Framework and Programme of Action (2003-2007).	15.1 National Composite Policy Index	Country assessment questionnaire	Biennial
	15.2 Number of countries tracking all core indicators outlined in the SADC M&E framework.	Indicator Reports	Annual









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