



# THE NIGERIA NATIONAL RESPONSE INFORMATION MANAGEMENT SYSTEM OPERATIONAL PLAN III (2021 - 2025)



**National Agency for the Control of AIDS  
(NACA)**

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The Nigeria National Response Information Management System Operational Plan (**NOP III**) was developed to provide guidance on how to monitor and evaluate all HIV and AIDS programs in Nigeria country as well as tracking progress made with the National Strategic Framework (**NSF**) 2021-2025.

The states were provided with guidance to develop their various State M&E Plans, which were then aggregated upwards to develop the National M&E Plan.

I hope stakeholders find the NOP3 both informative and useful in guiding the country to having a robust and sensitive M&E plan that takes into account the current trend in the HIV and AIDS epidemic; the rapid scale-up of the National response and the changing dynamics of the HIV response globally, including the 90-90-90 strategy.

— Dr. Gambo Aliyu Gumel  
Director General, National Agency for the Control of AIDS

December 2020

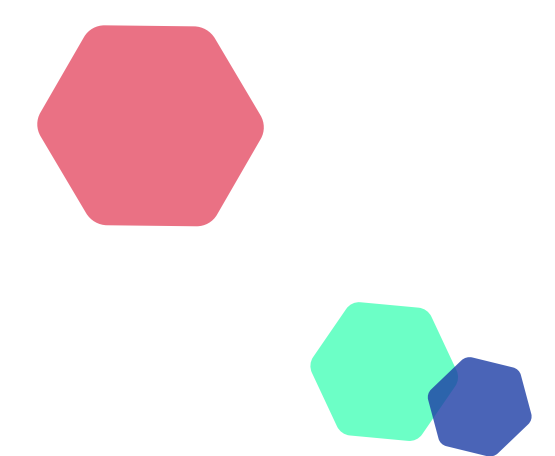
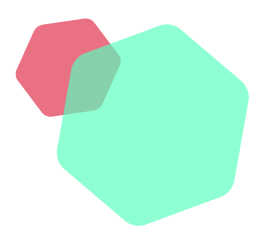
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— Dr. Greg Ashefor  
Director, Research, Monitoring and Evaluation

National Agency for the Control of AIDS

# List of Acronyms

AIDS	Acquired Immune Deficiency Syndrome
ANC	Ante-natal care
ART	Antiretroviral Therapy
ARV	Antiretrovirals
CBOs	Community-Based Organizations
CiSHAN	Civil Society for HIV and AIDS in Nigeria
CSOs	Civil Society Organizations
CTX	Co-trimoxazole
DHIS	District Health Information System
eMTCT	Elimination of Mother-to-Child Transmission of HIV
EID	Early Infant Diagnosis of HIV
FCT	Federal Capital Territory
FMoH	Federal Ministry of Health
FMWA & SD	Federal Ministry of Women Affairs and Social Development
HIV	Human Immunodeficiency Virus
HSS	Health Systems Strengthening
HTS	HIV Testing Services
IBBSS	Integrated Biological and Behavioral Sentinel Surveys
IDU	Injecting Drug Users
IPs	Implementing Partners
M&E	Monitoring and Evaluation
MSM	Men who have Sex with Men
NACA	National Agency for the Control of AIDS
NARHS	National AIDS and Reproductive Health Survey
NASA	National AIDS Spending Assessment
NASCP	National AIDS/STI Control Programme
NDHS	Nigeria Demographic and Health Survey
NGOs	Non-Governmental Organizations
NHSSS	National HIV Sero-prevalence Sentinel Survey
NSF	National Strategic Framework
NSP	National Strategic Plan
PEP	Post-exposure Prophylaxis
PEPFAR	President's Emergency Plan for AIDS Relief
PHDP	Positive Health, Dignity and Prevention
PLHIV	People Living with HIV
PMTCT	Prevention of Mother to Child Transmission of HIV
PrEP	Pre-exposure Prophylaxis
PWID	People Who Inject Drugs
SACAs	State Agency for the Control of AIDS
SDPs	Service Delivery Points
R, M & E	Research, Monitoring and Evaluation
SMoH	State Ministry of Health
STIs	Sexually Transmitted Infections
TB	Tuberculosis
TOR	Terms of Reference
TWG	Technical Working Group
UNAIDS	United Nations Joint Program on HIV and AIDS
UNGASS	United Nations General Assembly Special Session
UNICEF	United Nations Children's Fund
WHO	World Health Organization

# CHAPTER ONE: INTRODUCTION

## Background

Nigeria is the most populous black nation in the world. The country's 2020 population is estimated at 206,139,589 people at mid-year according to National Bureau of Statistics data. Nigeria occupies approximately 923,768 square kilometers of land stretching from the Gulf of Guinea on the Atlantic coast in the south to the fringes of the Sahara Desert in the north.

Despite significant national economic growth that spanned decades and the large revenue from oil, poverty level, and unemployment has remained high with youth unemployment estimated at 36.5% in 2018.

The absolute poverty incidence is 62.6%, and about 70% of the population live below the poverty line (CIA, 2019). Social and infrastructural development has also been poor including health services contributing to behavior promoting the HIV epidemic. The economic situation has remarkable implications for the HIV and AIDS response as poverty increases the vulnerability to HIV and impacts negatively on the ability of people living with HIV to appropriately seek for or adhere optimally to treatment. Furthermore, universal health coverage remains a challenge in the country with only 5.1% of the population (Augusto & Co, 2018) insured for health. The majority of the poor and vulnerable population have no access to health insurance

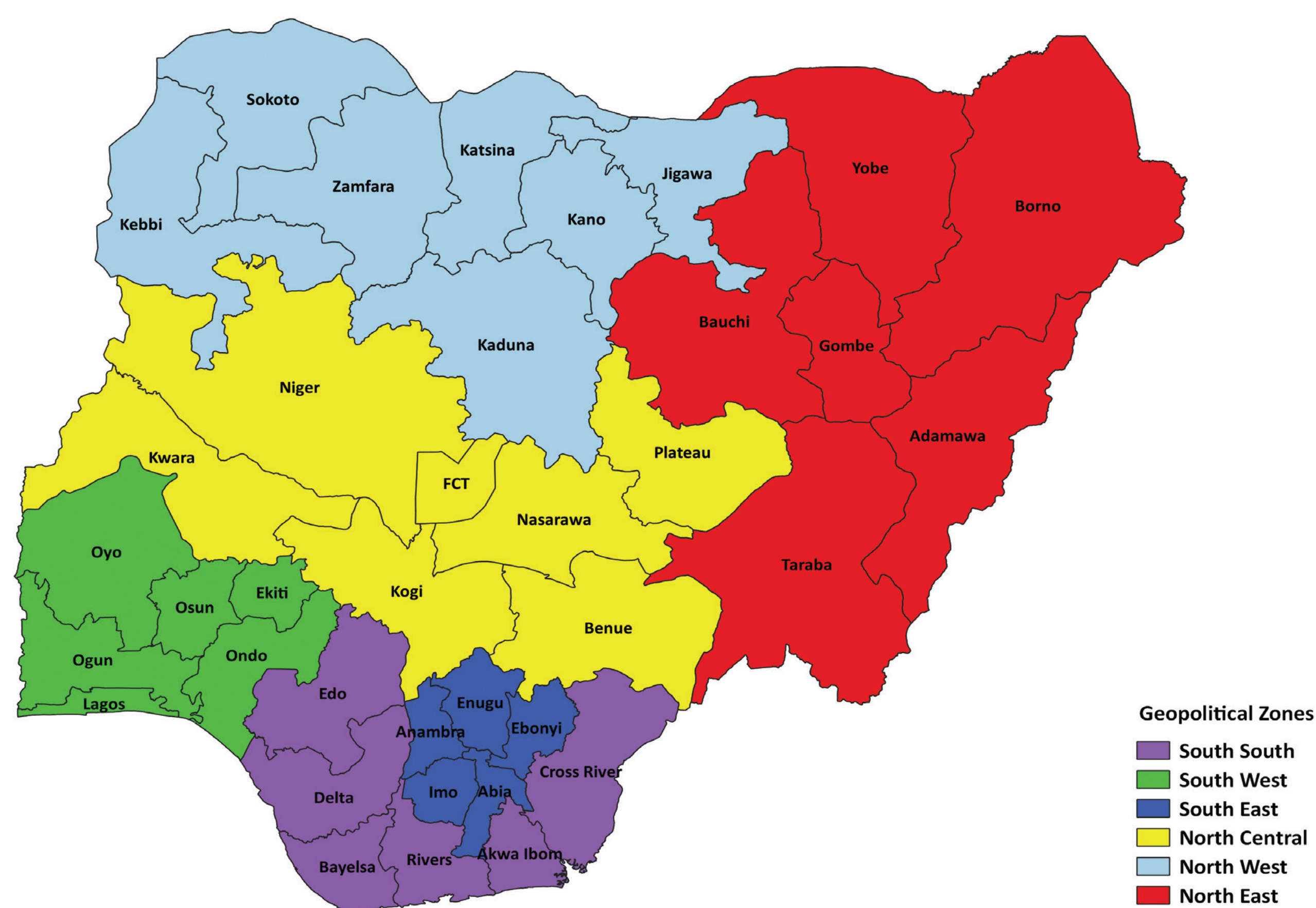


Figure 1: Map of Nigeria showing the different geopolitical zones

## Overview of National HIV and AIDS Response

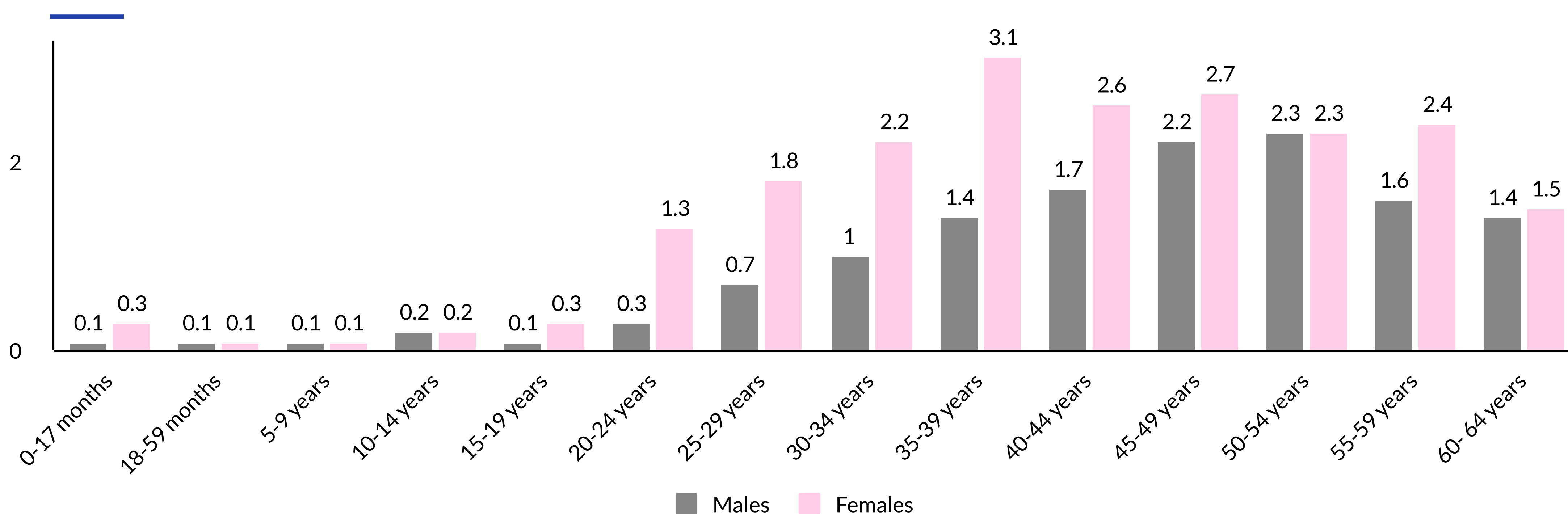
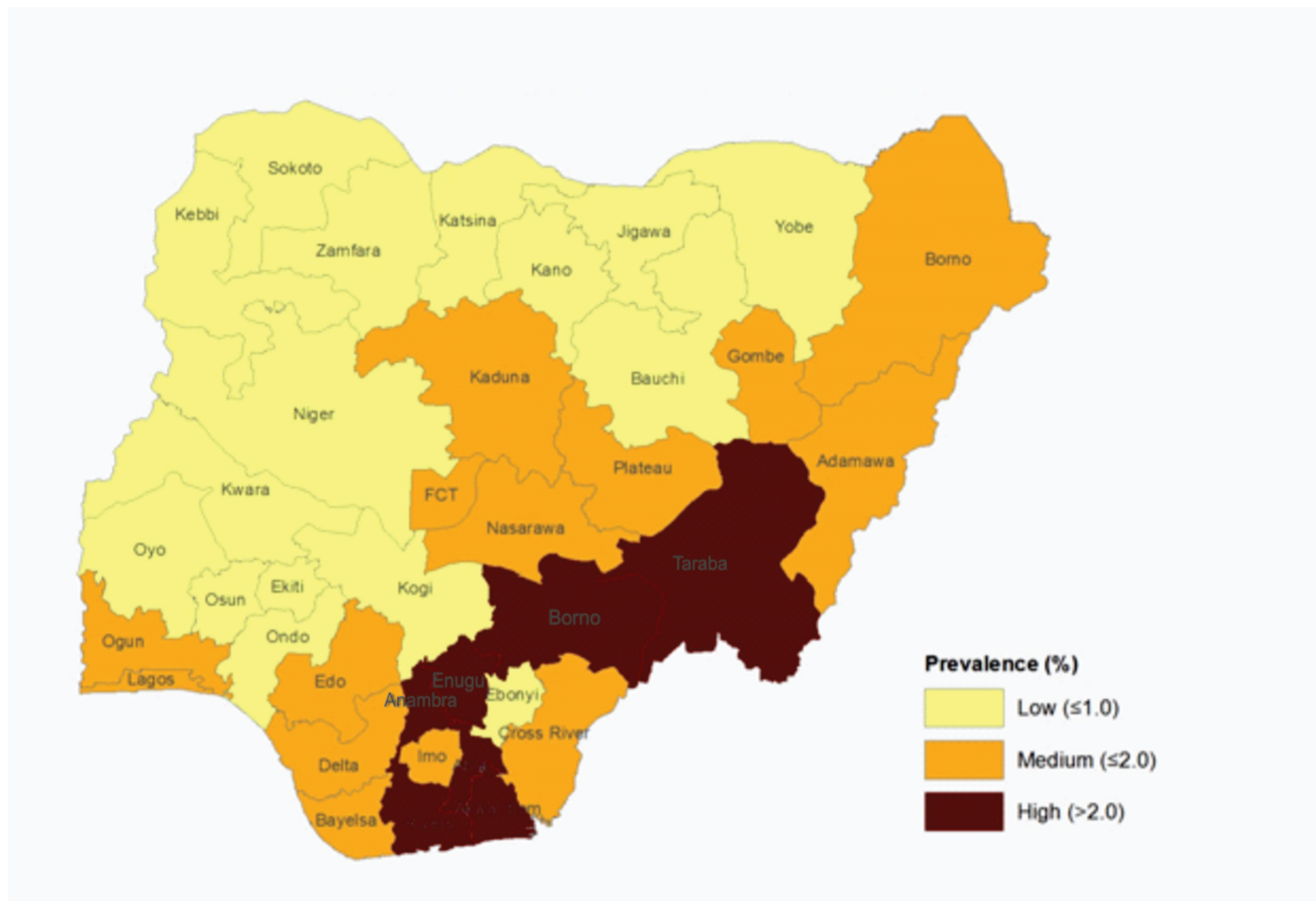


Figure 1: National HIV prevalence by sex and age band



One of the major findings from the Nigeria HIV and AIDS Indicator and Impact Survey (NAIIS) shows that Nigeria has fewer people living with HIV than previously estimated. The survey was conducted in 2018 to estimate HIV prevalence and related health indicators at National and subnational levels.

The NAIIS has the goal of examining the distribution of HIV, assessing the coverage and impact of HIV services, and measuring HIV-related risk behaviors. Persons aged 0-64 years were used as Nationally-representative sample for the survey. The Primary objectives of NAIIS were to provide estimates of the National HIV incidence, the prevalence of suppressed HIV viral load (VL) at state and National levels and National and state HIV prevalence among the 15-64 years age group.



**Figure 2:** Prevalence of HIV/AIDS in Nigeria by (NAIIS 2018)

HIV prevalence from NAIIS stood at 1.3% among 15–49 years which was an improvement from the last population-based survey National HIV and AIDS Reproductive Health and Survey 2012 with HIV prevalence of 3.4%. Nigeria currently ranks fourth in the world with regards to HIV burden. While there has been a remarkable gain in rolling back the epidemic, the total number of people living with and affected by the epidemic remains high.

Since its first diagnosis in 1986 (Nasidi & Harry, 2006), HIV and AIDS has impacted millions, resulting in high mortality and morbidity rates. Since then, there was a significant expansion in the country’s HIV response. The number of sites providing treatment has increased, prevention of mother-to-child sites increased several times and HIV Testing Services sites increased considerably.

Available data from NAIIS shows that the prevalence estimates by state may be categorized as follows: a. High prevalence 2.0% and above - Seven states: Abia, Taraba, Benue, Enugu, Anambra, Akwa Ibom and Rivers; b. medium prevalence between 1.0% and 1.9% - thirteen states and FCT, Borno, Gombe, Adamawa, Kaduna, Plateau, Nasarawa, Cross River, Imo, Edo, Delta, Bayelsa, Lagos, and Ogun; c. low prevalence, below 1.0% - sixteen states.

All the states in the North-West and South-West, except for Kaduna, Lagos and Ogun have low HIV prevalence. North-Central zone has a mix of low, medium and high prevalence. (80%) of all persons living with HIV are estimated to be residing in nineteen (19) states plus FCT and only seven states account for 50% of the overall estimated number of persons living with HIV in Nigeria.

As at 2019, Nigeria has a total of 1,803,831 living with HIV and 107,112 new infections. From 2017, the percentage increase in people living with HIV and new infections were 5.7% and 2.0% respectively. A total of 1,146,643 living with HIV were on antiretroviral therapy with a treatment coverage of 63.6% and 42,203 pregnant women were on treatment prophylaxis for prevention of mother to child transmission of HIV (PMTCT) with a coverage of 44.4%. The number of AIDS-related deaths was 44,698 in 2019 which is 10.6% increase from 2017.

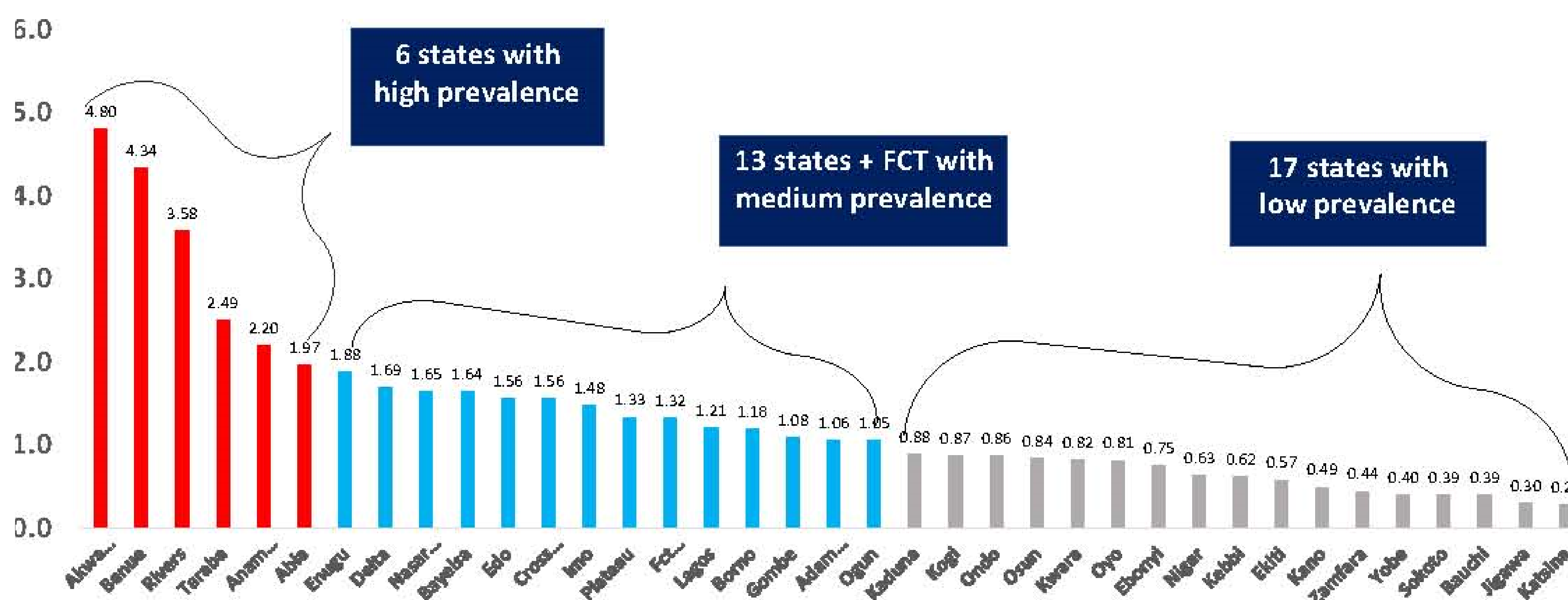


Figure 3: HIV prevalence by state (NAIIS 2018)

In 2016, after an extensive review of evidence of both the clinical and population level benefits of expanding ART, WHO changed its recommendation to support a policy of “Treatment for All,” regardless of CD4 count.<sup>1,2</sup> In Nigeria, the “test and treat” policy was adopted in December 2016.

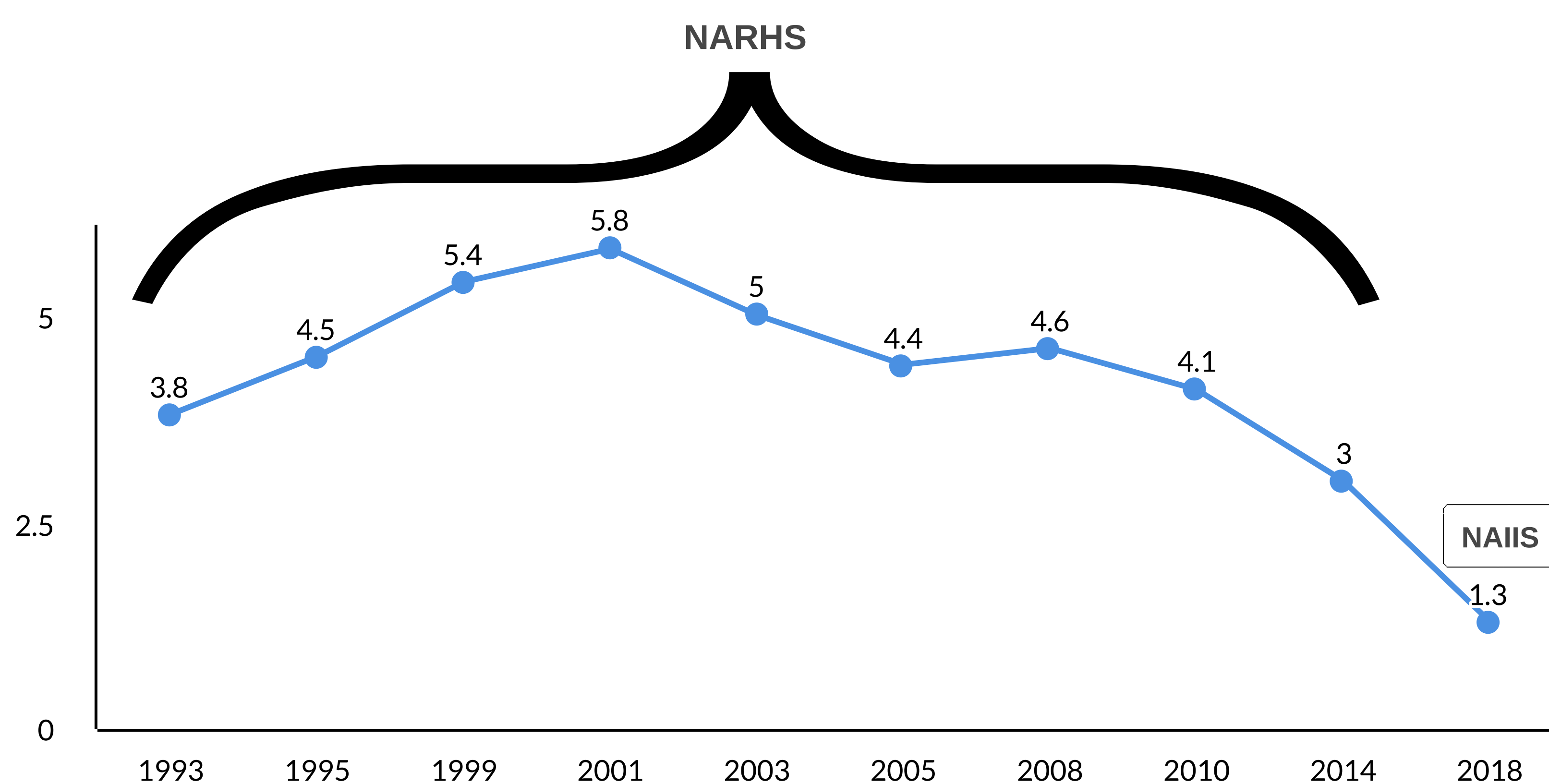
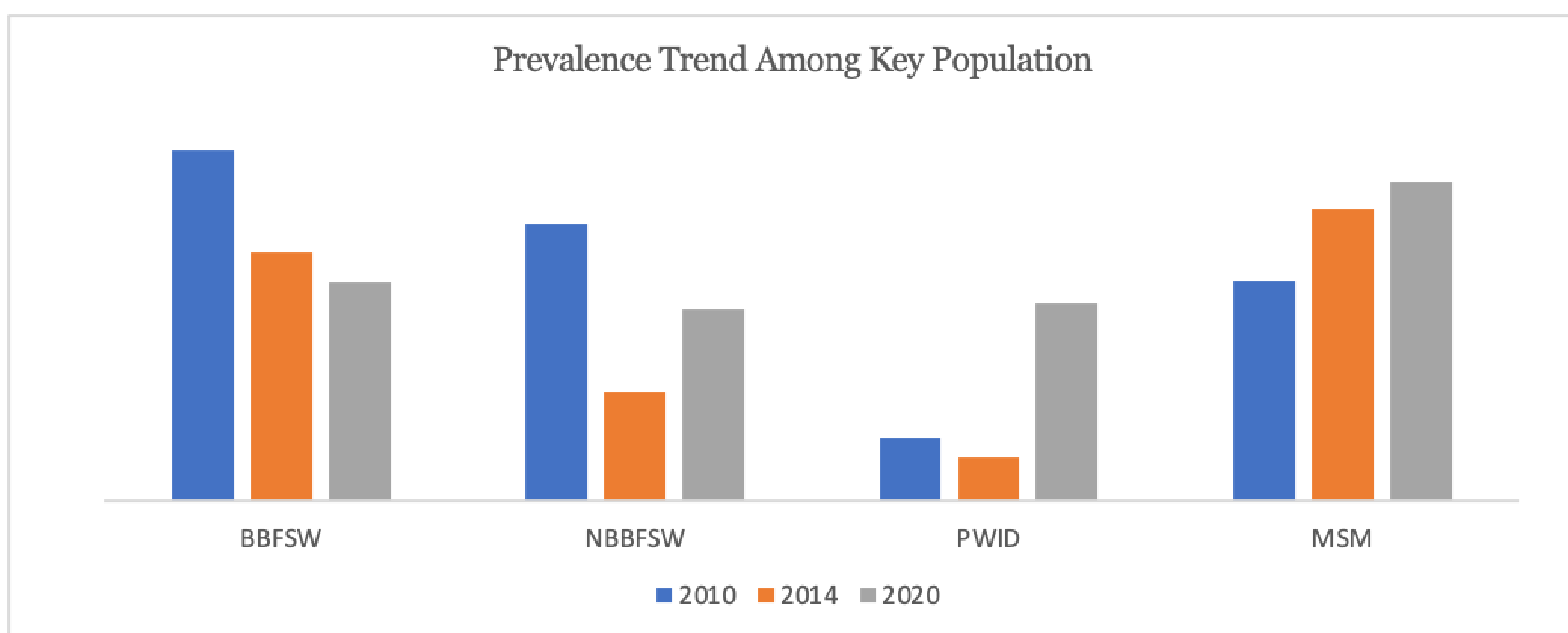


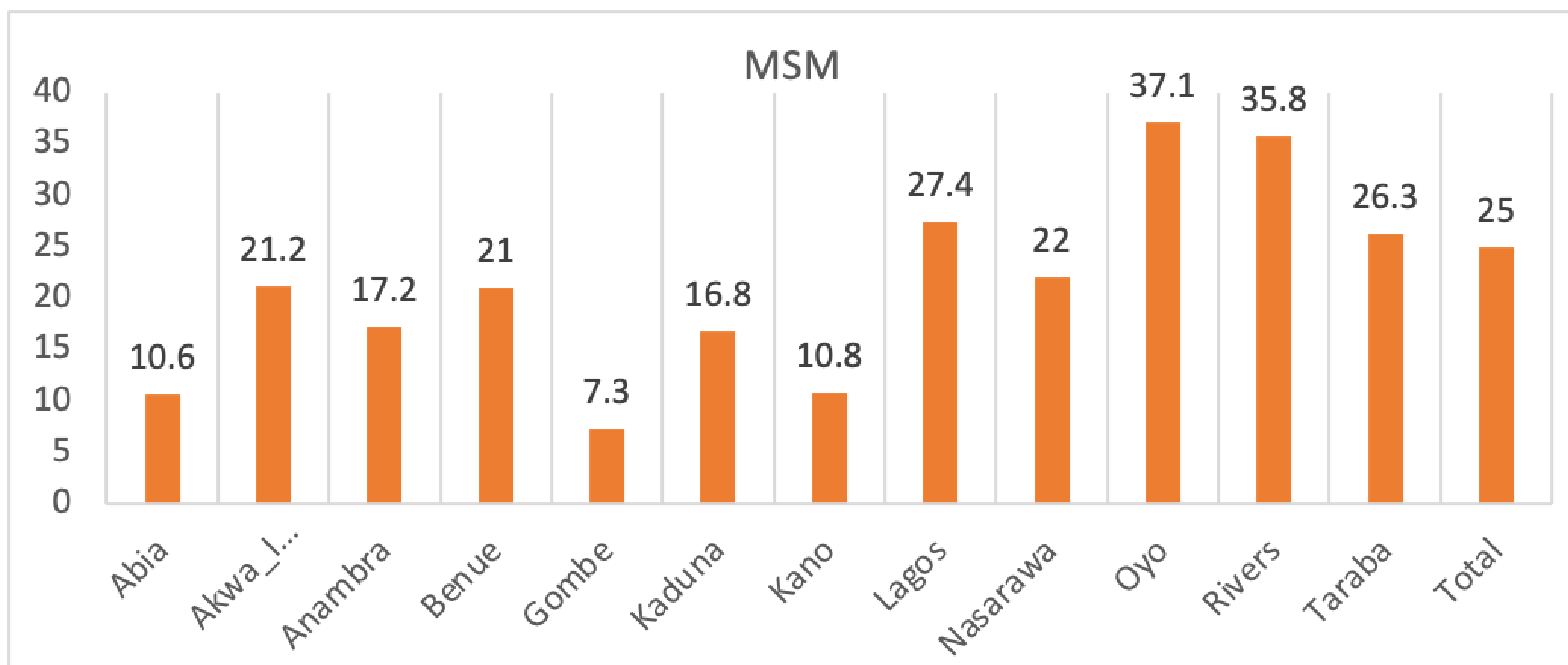
Figure 4: Trend of HIV/AIDS from 1993 to 2018

Key findings from NAIIS indicate that among HIV- positive adults aged 15-64 years, 71.1% self-reported being unaware of their HIV status. 25.9% of the HIV- positive adults aged 15-64 years, reported being on ART. The percentage of HIV- positive adults aged 15-64 years unaware of their HIV status was higher in rural areas (74.0%) than urban areas (67.4%).

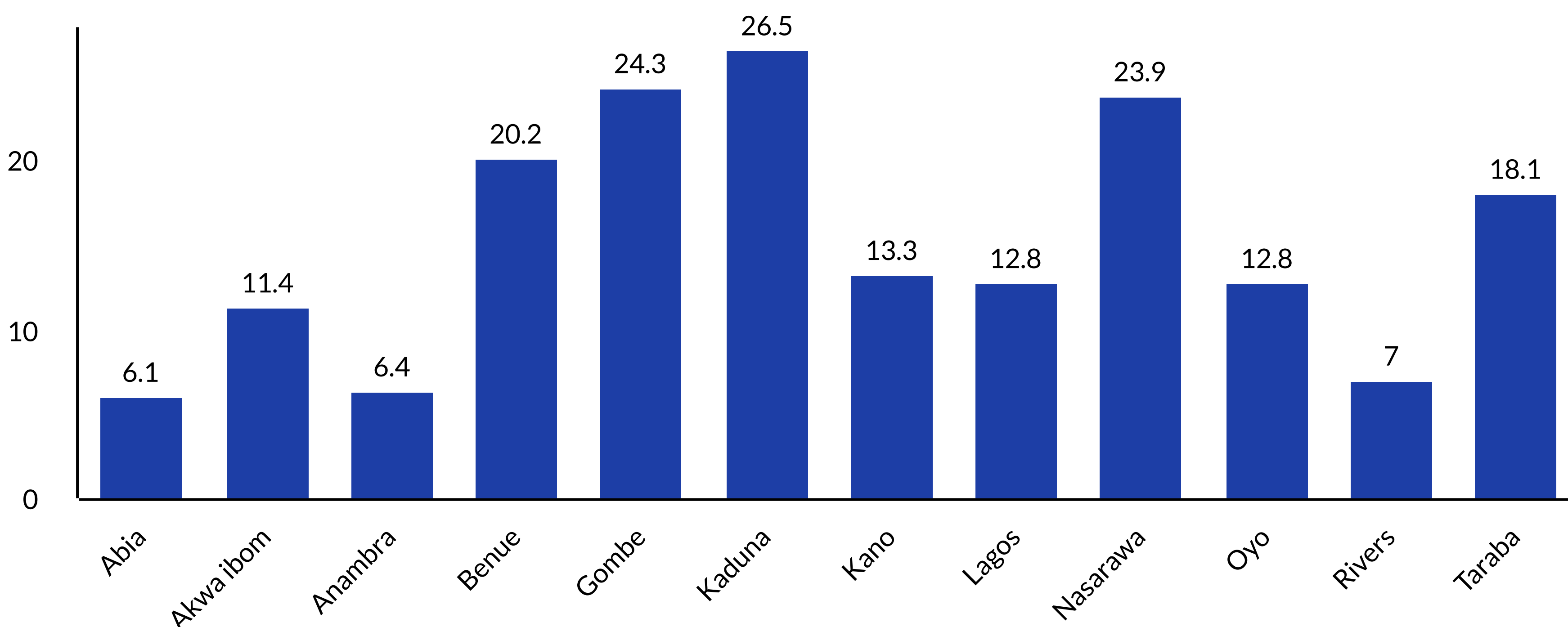
As seen in figure 7 below, the IBBSS report 2020 showed that among the 12 states sampled in the survey, the prevalence of HIV/AIDS among FSW is highest in Kaduna state with 26.5% while the state that recorded the lowest prevalence was Abia state with 6.1%.



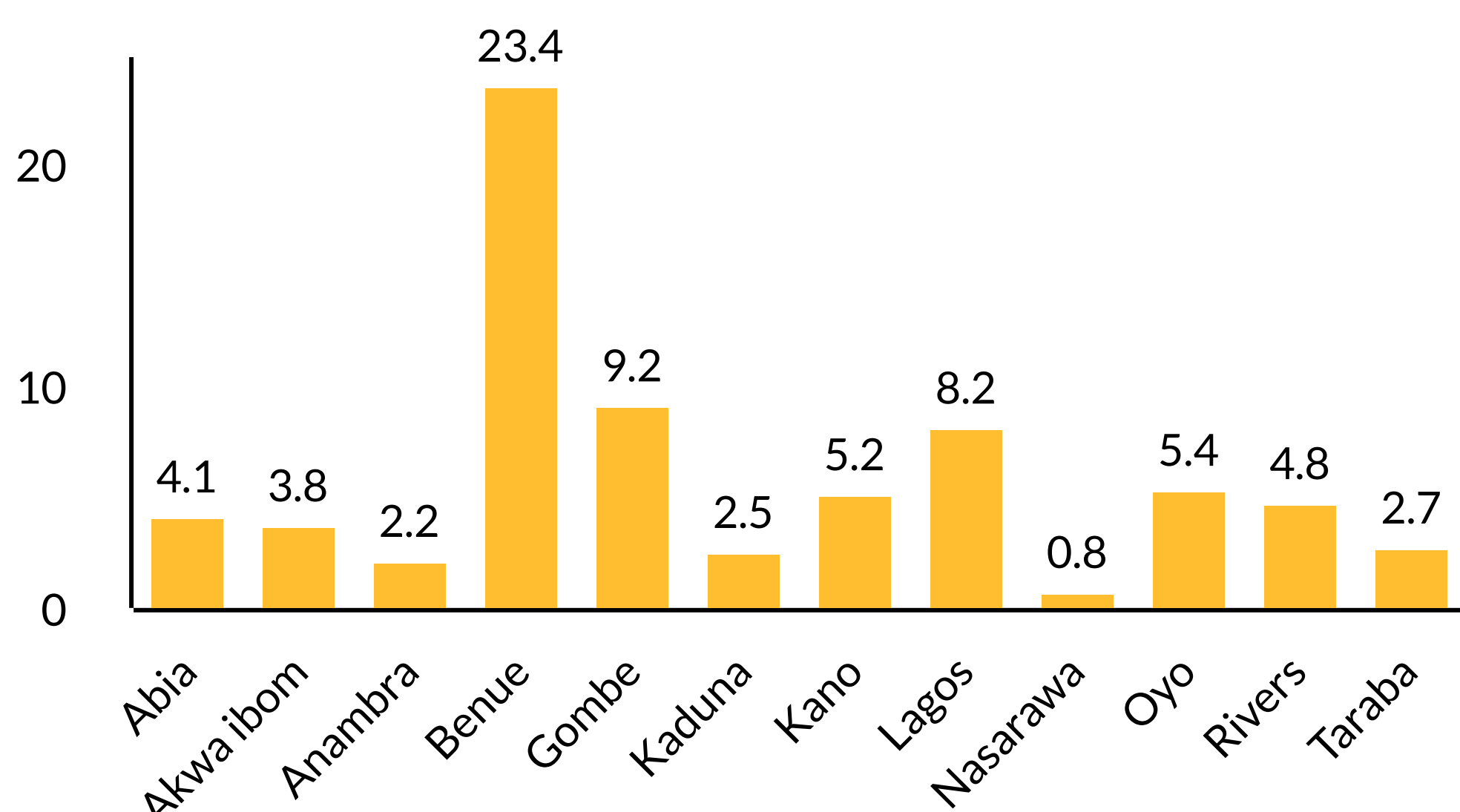
**Figure 5:** Prevalence Trend of Key Population (IBBSS 2010, 2014 and 2020)



**Figure 6:** Prevalence of HIV among MSM in Nigeria



**Figure 7:** Prevalence of HIV among FSWs in Nigeria (IBBSS 2020)



**Figure 8:** Prevalence of HIV among PWID in Nigeria (IBBSS 2020)

According to the report as seen in figure 8, the distribution of HIV among MSMs in the states surveyed showed that all the states had a prevalence above 10% with the exception of Gombe state with a prevalence of 7.3%. The state with the highest prevalence was Oyo with a prevalence of 37.1% followed closely by Rivers with a prevalence of 35.8%.

Figure 9 showcases a distribution of less than 10% of HIV prevalence among PWID in the 12 states surveyed except Benue state with a drastic high prevalence of 23.4%.

# CHAPTER TWO:

## Development of the NNRIMS Operational Plan 3

### — Rationale for the review of NOP 2

The last NNRIMS Operational Plan 2 (NOP 2) expired in 2016 making it imperative for the country to develop a National HIV M&E Operational plan to monitor the Revised National HIV and AIDS Strategic Framework 2021-2025 to reflect the findings from the NAIS.

The National level provided guidance to the states to develop their various State Strategic Plans (SSPs) which were then aggregated upwards to develop the National Strategic Framework (NSF). To monitor the progress of implementation of these plans (NSP and SSP), a robust and sensitive M&E Operational plan at the state and National level are required. This also provides another opportunity for the country's National HIV response stakeholders to review the National HIV and AIDS M&E system and develop a new M&E plan for the response known as the NNRIMS Operational Plan (NOP III) at federal level and State Operational Plan 3 (SOP3) at the state level.

### Guiding principles for the development of the NOP3

The development of the NOP III was guided by the following principles:

- Country ownership and leadership of the AIDS response monitoring and evaluation at all levels.
- Multisector strategy and engagement involving all relevant stakeholders
- Linkage to the 2021-2025 Nigeria National HIV and AIDS Strategic Framework and other relevant National plans- e.g., Sustainable Development goals (SDGs).
- Conformity and alignment with National, international standards and best practice for monitoring & evaluation of HIV and AIDS programs.

### Goal/objectives of the NOP3 development process

To review the National HIV M&E system & plan and develop a new NNRIMS Operational Plan (NOP3) that is linked to the Revised National HIV and AIDS Strategic Framework 2021-2025 and other relevant National plans e.g., SDGs.

### Specific Objectives

- To undertake a review of National HIV M&E system that will provide useful evidence for the development of the NOP 3 (2021-2025)
- To develop indicator matrix, obtain baselines and develop National and State targets for the identified indicators in the NOP3.
- To develop and disseminate a final approved NOP 3 that is linked to the National HIV and AIDS Strategic Framework (NSF) 2021-2025 and other National plans e.g., SDGs.
- To develop and provide guidance to states to develop their own state HIV M&E plans frameworks that is linked to their HIV strategic plans and the NOP3 2021 - 2025 at National level

## Findings from the National M&E Assessment:

The M&E assessment was conducted in 2018 using the 12 components assessment checklist template with the engagement of stakeholders (donor agencies, Implementing Partners, Civil society network PLHIV and selected line ministries in the national HIV/AIDS response.

Table 1: Findings from the National M&E Assessment

<b>M&amp;E System Component</b>	<b>Strengths</b>	<b>Weaknesses</b>	<b>Recommendations</b>
<b>Organizational Structures with HIV M&amp;E Functions</b>	<ul style="list-style-type: none"> <li>• Existence of a National M &amp; E plan, NSP, RNSF M &amp; E units/departments</li> <li>• Roles and responsibilities defined</li> <li>• Human resource structure for M&amp;E, as well as clear job descriptions for M&amp;E establishments</li> <li>• Technical assistance for M&amp;E is available (largely)</li> <li>• Relevance of M &amp; E recognized by leadership</li> </ul>	<ul style="list-style-type: none"> <li>• Challenge with data quality</li> <li>• Technical Assistance not always available</li> <li>• Staff attrition issues</li> </ul>	<ul style="list-style-type: none"> <li>• Improve on data quality</li> <li>• Provide Technical Assistance when needed</li> <li>• Address staff attrition issues</li> </ul>
<b>Human Capacity for HIV M&amp;E</b>	<ul style="list-style-type: none"> <li>• An M&amp;E training curriculum available for most organizations</li> <li>• M &amp; E skills exist</li> <li>• M &amp; E capacity building facilities available</li> </ul>	<ul style="list-style-type: none"> <li>• Skills and competencies assessment not being done for all entities</li> <li>• Staff paying for capacity building</li> <li>• No database on M &amp; E training (national)</li> </ul>	<ul style="list-style-type: none"> <li>• Skills and competencies assessment to be done for all entities</li> <li>• Funding should be provided for Staff capacity building</li> <li>• There is the needed to establish a national database on M &amp; E training</li> </ul>
<b>Partnerships to Plan, Coordinate, and Manage the Multi-sector HIV M&amp;E System</b>	<ul style="list-style-type: none"> <li>• NACA leading the role</li> <li>• Existence of a multi-sectorial M&amp;E technical working group</li> <li>• Partners and stakeholders</li> </ul>		<ul style="list-style-type: none"> <li>• More collaboration and synergy</li> </ul>

	<ul style="list-style-type: none"> <li>involved</li> <li>Quarterly meeting of the TWG</li> </ul>		
<b>National Multi-sectorial HIV M&amp;E Plan</b>	<ul style="list-style-type: none"> <li>National M &amp; E plan available</li> <li>Stakeholders involvement in the development of the plan</li> <li>National indicators selected in line with global best practices</li> <li>Stakeholders specific M &amp; E plans</li> </ul>	<ul style="list-style-type: none"> <li>Some partners M&amp;E plan is not linked to the national M&amp;E plan</li> </ul>	<ul style="list-style-type: none"> <li>Partners should link their M&amp;E plan to the national M&amp;E plan</li> </ul>
<b>Costed, National, Multi-sector HIV M&amp;E Workplan</b>	<ul style="list-style-type: none"> <li>Existence of a National M &amp; E work plan</li> <li>Work plan is costed</li> <li>Time frame for implementation set</li> </ul>	<ul style="list-style-type: none"> <li>Other stakeholders are not involved in the national workplan development</li> <li>Work plan not being updated regularly</li> </ul>	<ul style="list-style-type: none"> <li>Update national M&amp;E workplan</li> <li>Improve the frequency of M&amp;E workplan development (at most every two years)</li> <li>Engage stakeholders in the development of the HIV M&amp;E workplan</li> </ul>
<b>Communication, Advocacy, and Culture for HIV M&amp;E</b>	<ul style="list-style-type: none"> <li>Strong Advocacy for M &amp; E</li> <li>Useful M &amp; E system information products</li> <li>Management interested and supportive of M &amp; E</li> </ul>		
<b>Routine HIV Program Monitoring</b>	<ul style="list-style-type: none"> <li>National guidelines for data collection and management available</li> </ul>	<ul style="list-style-type: none"> <li>Private sector reporting is inconsistent</li> </ul>	<ul style="list-style-type: none"> <li>Address the issue of reporting from the private sector</li> </ul>

	<ul style="list-style-type: none"> <li>• Source documents for data auditing mostly available</li> <li>• Guidelines for logistics management</li> <li>• Standardized data collection tools</li> </ul>		
<b>Surveys and Surveillance</b>	<ul style="list-style-type: none"> <li>• Inventory of HIV surveys and surveillance exist</li> <li>• Surveys and Surveillance done contributed to measuring indicators in the M &amp; E plan</li> <li>• The national survey with behavioral component is conducted every four years</li> </ul>	<ul style="list-style-type: none"> <li>• Workplace policy on HIV exists, however there is no workplace survey conducted every two years</li> <li>• Secondary analysis of survey data has not been done</li> </ul>	<ul style="list-style-type: none"> <li>• Development of an inventory of all HIV related survey and surveillance</li> <li>• Conduct national workplace survey including private and public sectors</li> <li>• Undertake secondary analysis of existing biological and behavioral surveillance data</li> </ul>
<b>National and Sub-national Databases</b>	<ul style="list-style-type: none"> <li>• Existence of National Data Repository (NDR)</li> <li>• There exists a functional database at national level (DHIS2)</li> <li>• Quality control in most places</li> <li>• Structures, mechanisms procedures and time frame for transmitting, entering, extracting, merging and</li> </ul>	<ul style="list-style-type: none"> <li>• Inadequate IT equipment and supplies</li> <li>• Lack of an integrated information management system</li> <li>• Human resources for maintaining and updating the IT equipment and infrastructure are not adequate</li> </ul>	<ul style="list-style-type: none"> <li>• Deploy relevant IT staff and provide adequate IT equipment</li> <li>• Fast track integration of data reporting systems into a National single platform</li> <li>• Need for increased capital and human resources to support HIV M&amp;E activities</li> </ul>

	transferring data between databases that support the national HIV M&E system exist	<ul style="list-style-type: none"> <li>Quality control mechanisms are not always in place to ensure that data are accurately captured</li> </ul>	
<b>Supportive Supervision and Data Auditing</b>	<ul style="list-style-type: none"> <li>Guidelines and tools for supportive supervision exist</li> <li>Supportive Supervision in the last 6 months done by <u>lps</u> and NASCP, umbrella organizations</li> <li>National protocol for auditing data used in the national set of HIV indicator values exists</li> </ul>	<ul style="list-style-type: none"> <li>Lack of funds affecting the conduct of supportive supervision</li> <li>Data auditing is not conducted as at when due – paucity of funds</li> <li>Data auditing feedback not always provided to those entities whose data were audited</li> </ul>	<ul style="list-style-type: none"> <li>Improve timing and level of funding</li> </ul>
<b>HIV Evaluation and Research Agenda</b>	<ul style="list-style-type: none"> <li>A mandated national team/committee and procedures exists which is responsible for coordinating and approving (new) HIV research and evaluations.</li> <li>The team/committee has met as scheduled in the last 12 months</li> <li>An HIV research and evaluation agenda exist that directs future HIV research and evaluation</li> </ul>	<ul style="list-style-type: none"> <li>Financial resources for conducting planned research and evaluations not adequate</li> <li>Research and evaluation findings are not regularly disseminated and discussed</li> </ul>	<ul style="list-style-type: none"> <li>Increase funding for research and evaluation</li> </ul>
<b>Data Dissemination and Use</b>	<ul style="list-style-type: none"> <li>HIV stakeholder's information needs mostly assessed</li> <li>Information products regularly disseminated</li> <li>Guidelines to support the analysis, presentation and use of data exist</li> </ul>	<ul style="list-style-type: none"> <li>Assessment of stakeholders need not done frequently to ascertain the stakeholders' current information needs</li> <li>Feedback mechanism in the MDAs not active</li> </ul>	<ul style="list-style-type: none"> <li>Activate feedback mechanism in the MDAs</li> <li>Routine data quality improvement measures need to be improved on through engagement of LGA M&amp;E Officers</li> </ul>



## **Methodology for the development of the NOP3**

The development of this framework was a bottom – up approach undertaken through a wide participatory and consultative process with stakeholders from states and National levels. This is in line with the multi-sectoral nature of HIV and AIDS response and also to align with wide stakeholders buy-in and ownership. A multisectoral constituted M&E technical working group, which included government agencies, development partners, professional bodies and institutions and implementers, spearheaded the development process. The process was largely informed by a strategic review of the M&E of HIV and AIDS in Nigeria. Various consultative fora were held with stakeholders to discuss the draft plan and select National indicators for tracking the HIV response. The previous M&E Framework and International M&E indicators from sources such as the Global AIDS Monitoring (GAM), the President’s Emergency Plan for AIDS Relief (PEPFAR), the Global Fund and Universal Access target largely informed the development of this M&E plan. While a desk review to assess the M & E system was also conducted.

## **M&E System Assessment**

The 12 Components M&E Systems Strengthening tool, developed by the Global Monitoring and Evaluation Reference Group (MERG), was used to assess the National M&E system for effectiveness. The M&E assessment was conducted in 2018 using the 12 components assessment checklist template with the engagement of stakeholders (donor agencies, Implementing Partners, Civil society network PLHIV and selected line ministries in the national HIV/AIDS response.

The application of this tool helped stakeholders to reach a consensus on the performance goals of the M&E system, assess the system capacity, define a capacity-building strategy and define performance measures to monitor the M&E system.

## **The M&E Framework**

Reducing new HIV infections, and improving the quality of life for the infected and affected is the ultimate goal of the National response to HIV and AIDS. NACA’s central role is to establish an effective monitoring and evaluation framework. This section of the framework sets out roles and responsibilities on M&E at different levels; flows of information; systems development requirements; and approach to capacity building for the effective monitoring and evaluation of the National HIV and AIDS response. Some features of the M&E framework are:

- Summarized report using the standard format to be submitted by the State to NACA. The sector and the National level Civil Society Organizations (CSOs) receive detailed reports that are necessary for program implementation monitoring.
- All implementing organizations including the facility, CSOs, and networks will also give a summary report using standard forms developed by NACA to the LGA.
- Sectors will offer supportive supervision and technical back-up in monitoring and evaluation to States/LGAs, networks, and major projects.
- Development Partners will offer supportive supervision and technical back-up in monitoring and evaluation to the States/LGAs, networks, and field project units.
- Bi-annual coordination meetings convened by NACA to monitor the implementation of the National M&E plan.
- National NGOs and Research Institutions will report directly to NACA any specialized studies and research activities. Studies and researches initiated at other levels shall pass through the HIV and AIDS Coordinating Authority at that level along the appropriate channel to NACA.

## **Data Quality**

The importance of collecting good quality data cannot be overemphasized. Data are most useful when they are of high quality. Therefore, data quality needs to be monitored and maintained throughout the data collection process. However, obtaining data of the highest quality has cost implications and often times may not be feasible in which case decisions have to be made to determine what level of quality is adequate.

To ensure high quality data the following strategies will be utilized:

- Data cleaning at all levels of data entry
- Regular supportive supervision and data verification using standardized checklists
- Periodic update and capacity building of data managers and personnel with data management roles
- Establishment of an information feedback mechanism
- Periodic review of data quality issues by all stakeholders.

Data validity is a facet of data quality that means that, data that are collected clearly and adequately represent the result that it is intended to measure. Data sources should clearly report how measurement errors, sampling procedures, and transcription errors have been minimized or avoided. Not only should data be valid, they should also be reliable and timely. This involves consistent data collection and analysis processes over time of both the numerator and denominator. This will allow tracking of the response to the epidemic and analysis of trends.

NACA and sectors/agencies/institutions will jointly develop means and ways of ensuring that data sources that contribute to the core indicators of the monitoring and evaluation framework adhere to minimum data quality requirements. NACA will ensure that the stakeholders who collect data for the core indicators follow established standard statistical and methodological procedures that are incorporated in the tools used. Likewise, periodic reviews will be made to assess data quality issues and steps will be taken to improve the quality of data. Data quality should be assessed initially when indicators are established and baseline data are collected and reassessed annually or every two years.

Nigeria's National HIV and AIDS M&E system consist of routine and non-routine reporting systems. The routine reporting system is faced with challenges such as inadequate skilled human resources for M&E, the poor capacity of M&E officers at the sub-National level, the predominance of paper-based reporting, weak linkage of HIV programme data to DHIS, non-integration of HIV programme databases, and lack of a National Electronic Medical Record (EMR) systems for HIV and AIDS client records. These contribute to poor data quality and subsequently affect decision-making and planning. To tackle some of these weaknesses, the Global Fund to Fight AIDS, Tuberculosis, and Malaria aims to support the development of a National EMR system for Nigeria and ensure that the NDR is linked with DHIS2.

The use of the electronic medical records system in the country, both in the HIV and AIDS programme and in routine health service management is expected to increase going forward. In recognition of this fact and the role of the government in providing policy guidance, the Nigeria EMR Guidelines were developed by FMOH.

Findings showed that the five IPs interviewed have implemented HIV EMRs in health facilities across thirty (30) states in the country, with six different EMRs used across these IPs. Both non-real-time entry (retrospective model) and the real-time (Point of Care (POC) model) were implemented by IPs.

Some challenges faced with EMR implementation were inadequate infrastructures, poor electricity supply and insufficient capable manpower.

### **States level M&E development**

At the state level partners were approached to support the M&E plan development process at the state level. Zonal consultants supported by the state M&E TWG members and NACA were engaged to facilitate the state M&E plan development process. The state M&E plan development process involved the review of the state M&E system with stakeholders in the state, development of indicator matrix and targets using guidance provided by the National team, drafting of the state M&E plan document, printing and dissemination of the state M&E.

# CHAPTER THREE:

# National HIV/AIDS

# M&E SYSTEM

## Background

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Monitoring and evaluation is an essential process and tool to make informed decisions about operations management and service delivery, including efficient use of resources, determining the extent to which a program is on track, making any needed corrections accordingly and evaluating the extent to which the program/project is having or has had the desired impact. Monitoring and Evaluation is of vital importance to the successful implementation of programs since it is the only way of establishing what is being done and if the interventions being undertaken are making a difference. Establishment of an M&E system in the area of HIV/AIDS is very critical especially now that we are tracking progress towards achieving epidemic control. The Nigeria HIV/Epidemic is showing decline as evidence by the recently conducted Nigeria AIDS and Indicators Impact Survey (NAIIS) in 2018.

Efforts must be made to identify interventions that are more effective to make them more central in the national response. The two vision of NACA are achieving epidemic control and sustainability to effectively fulfill its mandate of coordinating the national response to HIV/AIDS, the National Agency for the Control of AIDS (NACA) and stakeholders need to understand the scope and effect of HIV interventions in Nigeria. In order to do this a functional and effective Monitoring and Evaluation (M&E) system needs to be in place. This section of the National M&E Plan provides:

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

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

Objectives of the Monitoring and Evaluation strategy adopted by the plan.

- Program /reporting levels.
- Levels of indicators to be generate

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

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

### NNRIMS Operational Plan (2021-2025)

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1. Understanding the overall goal/s of country's national response
2. Setting the quality standard (i.e defining how we will know when we have achieved the overall goal/s). This is done by defining specific indicators, which would provide guidance as to whether the interventions have been successful in achieving the goal.
3. Further to the definition of a set of indicators, each indicator is also described in detail, including what the indicator measures, how the denominator and numerator are calculated, how often the indicator will be measured and the strengths and limitations of the indicator.
4. Definition of the data sources from where information will be obtained for the measurement of the indicators.
5. A detailed description of the information products that will be produced by the National Agency for the Control of HIV & AIDS on a periodic basis, using the data sources and plans for enhancing the use of this data and information for program and policy decisions.

## M&E Conceptual Framework

The goal of the national HIV response is to end HIV/AIDS in Nigeria by 2030. For key elements of NACA's HIV/AIDS M&E system, as well as the relationships between the elements (see Figure 10).

6. The goal/s, indicators and data sources needed to form the backbone of the M&E system, and it is clearly linked using a conceptual framework such as a logical framework7.

7. A process flowchart that details the activities involved in the data collection, analysis and presentation cycles, the sequencing of these activities as well as the responsibilities internal and external (to NACA) stakeholders responsible for the execution of these activities.

8. Description of the responsibilities of the members of NACA's M&E unit.

9. Annual work plan for the execution of the M&E system, including the annual responsibilities of NACA's internal and external stakeholders.

10. Annual operational budget to execute the M&E work plan.

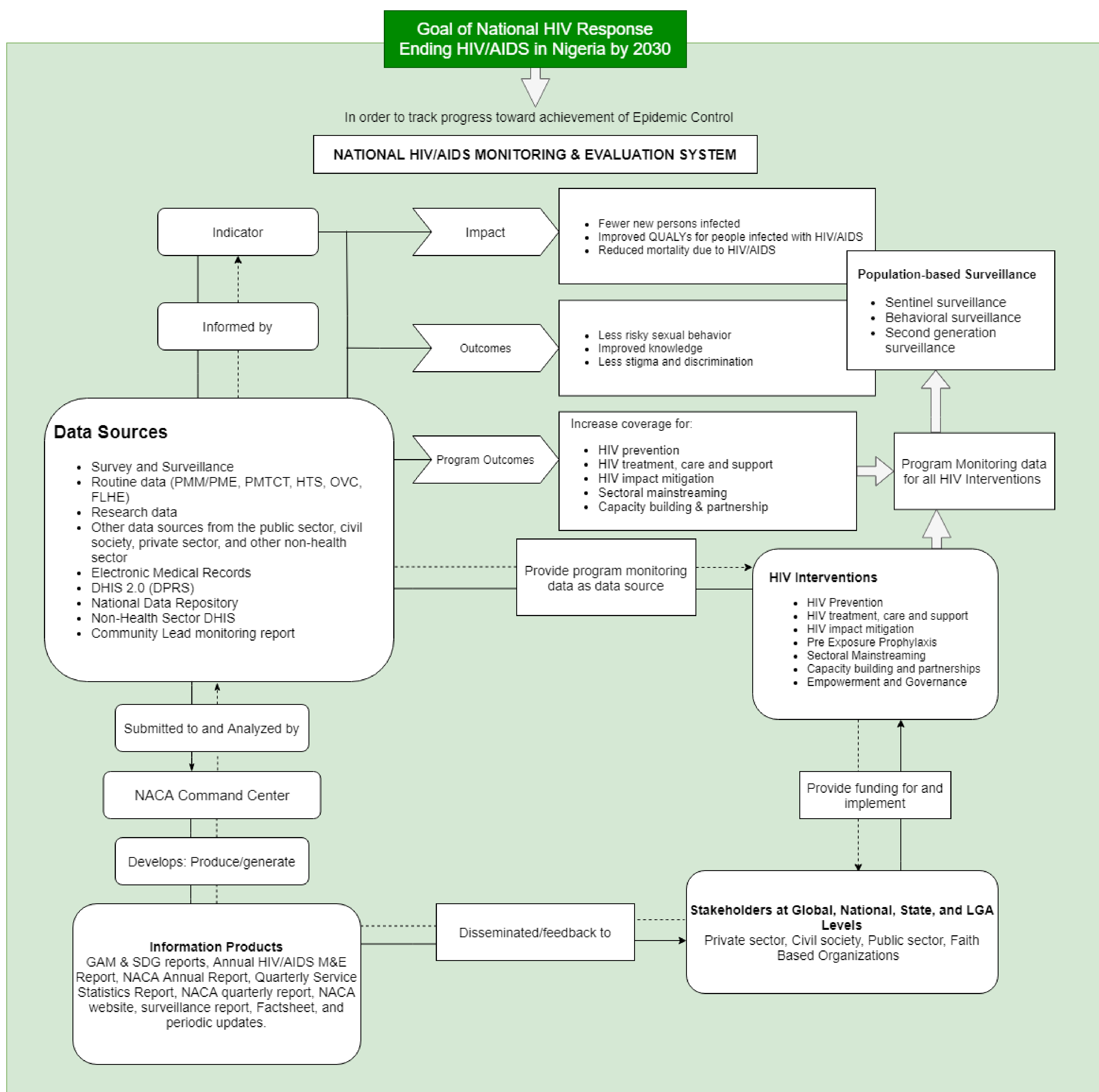


Figure 10: Monitoring and Evaluation Conceptual Framework

## **Relationship between National M&E System and Program-level M&E System**

The M&E conceptual framework showcases the interaction and linkages between the diverse components of the national HIV response. It shows a strong link existing between the national HIV/AIDS M&E system and the M&E systems for specific programmatic areas (HIV Care and Treatment, PMTCT, HTS, PMM system, OVC, and FLHE). The national M&E system provides a broad overview to enabling decision making and monitoring of progress at the national level whereas the programme level M&E system keys into the national M&E system, but has more detailed data collected by the implementers of the various HIV programs.

How and when data is reported to the national M&E system should be defined in each program area's implementation guidelines. This will ensure that implementers of the various programs are clear on their responsibilities in terms of data collection for their own management purposes and for reporting data to the national M&E system.

## **Linkage of the National M&E Framework to National and International Goals**

The M&E processes and systems in Nigeria were established to link national and international goals. NACA, working in collaboration with other sectors, ensures that M&E systems are increasingly aligned with one another and that the best possible data sets are collected and shared across government and with other stakeholders.

## **Linkage of the National M&E framework to Sustainable Development Goals and National Targets**

The Sustainable Development Goals (SDGs) aims to build on the achievements recorded by the Millennium Development Goals and further complete what these did not achieve. 17 goals and 156 targets have been set by the SDG that relate to poverty, education, gender equality, child and maternal mortality, combating HIV/AIDS & malaria, environment sustainability and global partnership and development, which at a glance covers the three dimensions of sustainable development: economic, social and environmental. Although SDG 3.3 (HIV/AIDS) is the goal that is most directly relevant to the National HIV/AIDS Response monitoring and evaluation framework, the achievement of all seventeen goals is intricately linked to the framework.

As such, the response to the HIV/AIDS epidemic should seize the opportunities within the context of SDG and build awareness of its reciprocal relationship between the National commitments, the response to the HIV/AIDS epidemic and the SDG. For instance, there is worsening poverty, disruption of school and a worsening maternal and child mortality picture due to the HIV/AIDS epidemic. In addition, it is affected by gender inequality.

It is obvious that the HIV/AIDS epidemic has the potential to disrupt the achievement of the SDGs and conversely, if the SDGs are achieved, they would contribute to reducing the burden and impact of the epidemic. The relationship between HIV/AIDS and economic development is complex. The HIV/AIDS epidemic has negatively affected economic growth and it is difficult for weakened economies to respond effectively to the epidemic. What HIV/AIDS does to the human body has been likened to what it does to the nation. In both cases, it weakens the system to respond to developmental challenges.

## **NNRIMS Operational Plan (2021-2025)**

In the year 2001 the United Nations General Assembly Special Session (UNGASS) on HIV/AIDS made a commitment for a comprehensive programme of international and national action to fight the HIV/AIDS pandemic by adopting the Declaration of Commitment on HIV/AIDS. The Declaration provides a framework for an expanded response to the global HIV/AIDS epidemic. Its goals and targets are designed to address all dimensions of the epidemic. It represents an agenda for change and a benchmark for global action. Some of the more innovative aspects highlight the challenges facing women, people living with HIV/AIDS, human rights and interaction between prevention and care. It calls for a new type of leadership in response to HIV/AIDS. Such leadership should have governments at its centre, with the full involvement of civil society, the private sector and people living with HIV/AIDS. The emphasis is on a multi-sectoral response, with specific commitments in the following areas: leadership; prevention; care; support and treatment; HIV/AIDS and human rights; reducing vulnerability; children orphaned and made vulnerable by HIV/AIDS; alleviating the social and economic impact; HIV/AIDS in conflict zones and disaster-affected regions; resources; and follow-up.

Indicators for implementation of the Declaration of Commitment are divided into two subgroups: global indicators and national indicators. The global indicators comprise of five indicators that provide information on levels and trends in international commitment to mediate the impact of HIV/AIDS. The national indicators are subdivided into three categories: Indicators of national commitment and action, indicators of national program, knowledge and behavior indicators and indicators of national-level program impact.

## M&E Framework

Establishing an effective monitoring and evaluation framework is a central role of NACA. This section of the framework sets out roles and responsibilities on M&E at different levels; flows of information; systems development requirements; and approach to capacity building for the effective monitoring and evaluation of the national HIV/AIDS response. The linkages within the M&E framework include:

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

## Coordination role of NACA

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

Effective coordination poses a major challenge and requires careful planning and skills development. Coordination of M&E activities will be a major task of the NACA Research Monitoring and Evaluation (RM&E) Department. In line with the mandate of NACA the Director of RM&E will provide a strategic oversight of M&E needs, activities, gaps and new initiatives across the various sectors.

Improved coordination between Ministries, institutions, special projects and surveys and other stakeholders will be essential to:

- Provide good quality, comprehensive and timely information on the state of the epidemic in Nigeria;
- Effectively track and monitor the implementation of the response
- Create a constructive environment and willingness among all partners to work together on a common goal;
- Provide the organizational, institutional settings and mechanism for effective coordination and management; and
- Learn how to cooperate, gain experiences and build trust among all partners.

NACA will convene and coordinate activities that will promote better collaboration between the different stakeholders in the National HIV/AIDS Response:

1. A quarterly M&E TWG meeting will serve as a platform for the exchange of information and experiences between stakeholders.

## Levels of coordination for the National M&E plan

There are various levels of coordination for the national M&E plan which include:

### National Coordination of the M&E Plan by NACA

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

### State Coordination for M&E

State HIV/AIDS Coordinating Authorities are expected to develop their state specific M&E Plan and based on it hold quarterly coordination meetings for all implementing partners to harmonize and analyse the data collected, and discuss the progress made in implementing the national M&E plan and to address whatever challenges that may have arisen during the implementation process. Just as we have in the national, the state TWGs on M&E will coordinate M&E activities and also complement the capacity of SACAs.

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

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

Donor support will be very important to ensure effective and efficient implementation of the M&E Plan. Most donors often require more information than is necessary for national level monitoring. However, a compromise needs to be reached between the three parties, donors, NACA and the implementers on an optimal set of data to be collected so that organizations are not overburdened

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

### **Coordination across Sectors**

NACA will facilitate wide stakeholder consultation across sectors. It will ensure complementarity and consistency with other M&E frameworks especially the Vision 2020 strategic Monitoring Action Plan, Health Sector plan, OVC Plan of Action and the Education Sector framework. It will utilize, as appropriate, internationally agreed indicators at the national level (such as the UNGASS indicator set) to facilitate contribution to regional and global statistics.

Each of the national level core indicators are assigned to a specific sector. For example, the Ministry of Health will have a prime responsibility for the indicators that relate to sero-surveillance and health facility based surveys, the Federal Ministry of Women Affairs and Social Development and its partners will have primary responsibility for the indicators that relate to OVC and the Ministry of Education and its partners will have primary responsibility for the indicators that relate to primary and secondary schools.

All these sectoral or thematic area plans need to be elaborated in detail, including specific indicators and targets, assessment of human and financial resources, training and equipment needs. Interventions and activities must be costed, and monitoring, supervision and quality assurance measures must be identified.

## **Coordination and Responsibilities at Sub National Levels**

### **State Level**

At State level the State Coordinating Authority will play a primary role in the planning of, implementation, and monitoring of activities. They will provide technical assistance to LGAs and communities in developing their responses and plans. They will be responsible for monitoring LGA HIV/AIDS Operational Plans and compile routine reports and forward them to NACA for further analysis and compilation. The SACA will be responsible for tracking and discussing progress and other issues related to the multi-sector HIV/AIDS responses at the sub-national level.

### **LGA and Community Level**

Each Local Government Council will coordinate all actors working on HIV/AIDS in their respective local government areas. Local Action Committee on AIDS (LACA), the multi-sectoral HIV/AIDS committee at the LGA level, will consist of representatives from the major government sectors, civil society and the private sector. The LACA will be responsible for providing technical assistance to local level actors following guidelines developed by the state and national levels on local level planning, implementing and monitoring of the HIV/ AIDS response.

LACAs will also facilitate the various cluster meetings on HIV/AIDS activities geared towards mainstreaming into the other health activities in the community.

# CHAPTER FOUR:

## HIV and AIDS Indicators, baselines and Targets

An indicator is a variable that measures one aspect of a program/project and is related to the program's goal and objectives. Indicators provide M&E information crucial for decision-making at every stage of program implementation. NACA, in collaboration with its stakeholders, has selected a set of core National indicators to inform management of the National HIV and AIDS program. In addition, there are several donors that contribute financially and technically to the National HIV and AIDS programs. These donors may require reporting of additional indicators that are not included in the core set.

Each level of the health system has different data needs. NNRIMS collects indicators that are relevant at the global, National, and sub-National levels.

Section 4.1 provides a comprehensive list of all of the core national indicators. In addition, refer to Appendix 1 for a detailed indicator reference sheet that includes information on the data source, frequency of collection and reporting, person/institution responsible for collection and reporting and baseline values.

A global indicator provides a measure of the current situation of the epidemic at the global level. In order for global indicators to be meaningful, all countries must agree on the exact indicator definition. They must also all measure the indicator in the same way so that the values are comparable across countries.

At the National level, the National HIV and AIDS Program has a set of indicators that are used to help track the HIV response to the epidemic. These indicators are developed through National consensus and will track the progress made in the National response by partners. The indicators will provide relevant information that will inform future HIV and AIDS intervention plans, strategies and implementation. Many of these indicators overlap with the global ones.

However, sub-National/ program level indicators provide more detailed information so that planners can make decisions on how best to target the program or facility's scarce resources and to meet their clients' needs. They provide information on whether or not the target population is being reached, how well services are being provided, and whether or not sufficient resources exist to be able to provide adequate services.

### Uses of Indicators:

Information is only good when it is used. Data that are not useful or that cannot be used should not be collected. Often, it is not that the data itself are useless, but more training is needed on how to use it effectively.

- Global indicators can be used to:
- Set aspirational but realistic international health agendas
- Monitor the progress that is made towards reaching international long term targets
- Determine the optimal allocation of funds and other resources
- Comparative monitoring of country performance in HIV programming
- National indicators can be used to inform decisions on:
  - How well the national system is functioning, and where additional support is needed
  - The progress and impact that is made by various HIV programs
  - The impact of HIV and AIDS on development
  - The level of donor commitment, and when high-level negotiations and changes are necessary
- At the local level, indicators can provide information for managers and planners that will help to determine:
  - Identify priority target groups
- Effective and fairly determine the allocation of limited funds Determine the right types of targeted interventions and activities for a particular community

- Determine the barriers to accessing services

### Selection of Indicators:

The focal programmatic areas in the National Strategic Framework can be categorized into - Care, Support and Treatment; HIV/AIDS prevention; HIV/AIDS mitigation; Monitoring, Evaluation and Research; and National Capacity Building. HIV/AIDS prevention and HIV/AIDS mitigation are discussed separately, reflecting the fact that as the HIV/AIDS epidemic matures, identifying strategies for mitigating individual and community impact of the disease becomes more and more critical.



At the programme level, each activity that is implemented by the different partners and stakeholders will have input, process and outcome indicators that can be used to monitor progress. Consequently, at this level there are very many indicators that individually contribute towards overall monitoring of different interventions. In order to facilitate monitoring at the national level by NACA, an attempt has been made to identify core indicators that can act as proxy or direct measures for the achievement of the over arching NSF objectives. More detailed monitoring of programme performance will remain within the domain of the lead actors at the program level.

- The selection of the national core indicators were made taking into consideration the following criteria:
- Measureable- the indicator is measureable
- Relevance of the indicator to priority national HIV/AIDS interventions according to the NSF 2021-2025
- Sensitivity of the indicator – ability of the indicator to detect change in the outcome
- Affordability – the indicator can be obtained from data that is already being collected and will not require input of substantial additional financial resources
- Usefulness – the indicator generates data that are useful for policy, program, resource and planning decisions.
- Ethics – the indicator can be obtained ethically, without harming individuals or institutions, and is free of bias.
- Repeatability – the indicator can be measured repeatedly across levels and over time and will generate results that are comparable.
- Validity-the indicator actually measures what is intended to be measured
- The indicator is representative of national and international commitments
- Speaks to existing national HIV/AIDS programmes

The current availability of an indicator was not used as a selection criterion because at the present moment, there are no national level indicators already in place for care and mitigation and capacity building, and furthermore, other than the Federal Ministries of Health, Education and Women Affairs, no other national institution is currently engaged in national level monitoring. The indicators that are already available tend to be specific to projects and programmes, designed to monitor progress of programme implementation and reporting to donors. For example, the Multi-country AIDS Project (MAP), which is a World Bank funded project, indicators are specific to the project and much as it is a big project, it contributes also to the funds budgeted for the NSF.

The PEPFAR project target for PMTCT is to increase availability of services to 80% of pregnant women by 2015 while the national target is to increase availability of services to all hospitals by 2015. There are other equally important players who have their own indicators and their interests have to be taken into consideration if the national response is to be monitored realistically. Selection of the indicators has put into consideration both what and how the key players are currently monitoring the HIV/AIDS interventions. A deliberate attempt was made to build on these and come up with an optimal set of indicators that are sensitive and cost effective for national level monitoring. The sections that follow outline the different programme areas under the four NSF objectives, the strategies and indicators. In the annex section, indicator reference pages are given which provide the precise definition of the indicator, the way the indicator is calculated, the frequency of generating the indicator, the responsible institution and the data limitations. A summary of the list of indicators is given at the end of this Chapter and in Appendix 1.

### **Summary of National Indicators**

The list of all the national indicators is found in the annex. These indicators are used to monitor and evaluate the National Strategic Framework 2021 -2025(NSF). (Refer to annex)

### **Baseline and targets**

For each core National indicator, baseline data and targets were established. National and international commitments were taken into account when setting targets and all assumptions have been documented. It is important to note that targets can potentially be revised in the future depending on the direction of the epidemic or if review of NSF or Annual Program Review is carried out.

**Table 2:** Nigeria National Response Information System Plan Indicators and Targets

<b>NNRIMS OPERATIONAL PLAN INDICATORS AND TARGETS</b>								
Thematic Area 1. HIV Prevention among General and Key Population								
Type of indicator	Indicator		Baseline 2019	Data Source	Baseline (%)	2023 Target 90%	2025 Target 90%	Assumption
Impact	Target 1: 90% of the population have knowledge of HIV prevention methods by 2025	Male 15-49	2019	NDHS 2018	74	86	90	Linear extrapolation used to get to 90% by 2025
		Female 15-49	2019	NDHS 2018	71	84	90	Linear extrapolation used to get to 90% by 2026
		Male 15-24	2019	NDHS 2018	66	80	90	Linear extrapolation used to get to 90% by 2027
		Female 15-24	2019	NDHS 2018	67	81	90	Linear extrapolation used to get to 90% by 2028
		Male 15-19	2019	NDHS 2018	60	78	90	Apply Linear extrapolation to achieve 90% by 2025
		Female 15-19	2019	NDHS 2018	62	78	90	5% for the first 3 years and 7% in the fifth year to achieve 90%
		Male: 20-24	2019	NDHS 2018	75	84	90	Apply annual increment of 3% to achieve 90% by 2025
		Female 20-24	2019	NDHS 2018	73	85	90	Apply this process to the previous
			Target 2: 90% of the population	Male 15-49	2019	NDHS 2018	45	81

	have comprehensive knowledge of HIV by 2025	Female 15-49	2019	NDHS 2018	46	81	90	Apply Linear extrapolation to achieve 90% by 2025
		Male 15-19	2019	NDHS 2018	29	78	90	Apply Linear extrapolation to achieve 90% by 2025
		Female 15-19	2019	NDHS 2018	38	80	90	Apply Linear extrapolation to achieve 90% by 2025
		Male 20-24	2019	NDHS 2018	42	80	90	Apply Linear extrapolation to achieve 90% by 2025
		Female 20-24	2019	NDHS 2018	48	82	90	Apply Linear extrapolation to achieve 90% by 2025
	Target 3: 90% of general population practicing safe sex by 2025. Percentage of persons who had intercourse in the past 12 months with a person who was neither was their husband/ wife nor lived with them and reported using condom during the last sexual intercourse with such a partner	Male 15-49	2019	NDHS 2018	64	73	90	increase by 3% annually
		Female 15-49	2019	NDHS 2018	36	61	90	increase by 10% annually based on historic data

	Target 4: 90% condom use at last paid sexual intercourse by 2025. Among men who paid for sex in the past 12 months, percentage reporting condom use at last paid sexual intercourse	Male 15- 49	2019	NDHS 2018	74	83	90	increase by 3% annually
		Male 20- 24	2019	NDHS 2018	72	81	90	increase by 3% annually
	Target 5: 90% of Key Population accessing appropriat ely- targeted HIV combinati on prevention by 2025. Percent who used condom every time last 6 months (consistent use)	Brothel Based Sex Workers	2019	IBBSS 2020	NA	60	90	Assuming 15% coverage yearly
		Non- Brothel Based Sex Workers	2019	IBBSS 2020	NA	60	90	Assuming 15% increase yearly
		FSW	2020	IBBSS 2020	34	77	90	Annual 10% increase from the baseline
		MSM	2020	IBBSS 2020	34	58	90	Annual 10% increase from the baseline
		TG	2020	IBBSS 2021	41	58	90	Annual 10% increase from the baseline
		Male and Female of the Armed Forces	2019	IBBSS 2020	NA	NA	90	
		Male and Female who Inject Drugs (PWID)	2020	IBBSS 2020	15	45	90	Additional 15% coverage across all the years

	Percentage who knows that the risk MTCT can be reduced by mother taking special drugs							
	Target 9: 100% of ANC facilities offering PMTCT by 2025.	National						
	Target 10: 90-90-90 for PMTCT by 2025	% of pregnant women tested for HIV	2018	Spectrum 2018	36	66	95	10% annual growth
% of positive women on ARV		2019	Program data/spectrum estimate	44	74	90	Numerator: Number of HIV positive pregnant women attending ANC Denominator: Estimated number of positive pregnant needing PMTCT	
% of HEI on ART within 72 hours		2018		56	71	90		
% of HEI given CTX at 2 months		2018		41	71	90		

		% of HEI with PCR results received within 2 months	2018		40	70	90	scale up target with 10% from the first-three years, then 15% in the last year to achieve 95% by 2025
	Target 11: Triple HIV expenditures on PMTCT by 2025. Estimated total HIV spending on PMTCT in USD million, all sources.	National				NA		scale up target with 5% from the first-three years, then 10% in the last year to achieve 95% by 2025
	Target 12: 95% of all PLHIV know their Status by 2025. % of all PLHIV who know their Status	All PLHIV who know their Status	2019	spectrum 2019	77	86	95	
		FSW	2019	Non health Programme Data / KP size estimate	12	36	95	Assuming 10% coverage in the first 2 years and 15% each in the other years, expecting that all FSW reached with prevention intervention receive HIV testing
		MSM	2019	Non health Programme Data)	9	47	95	
		PWID	2019	Non health Programme Data)	6	21	95	

		Transgender	2019	Non health Programme Data)	0	28	95	
	Target 13: Differentiated testing services are broadly available by 2025. Percentage of all testing	Community based testing	0	Non health Programme Data)	TBD		33	
		Self-testing – used test in % of total tests	2019	Program data	0	6	10	yearly coverage of 2%
	Target 14: 95% of all PLHIV who know their status and are on treatment	All PLHIV who know their Status and are on treatment	2019	spectrum 2019	89	94	95	expected to cover 95% by additional 1.2% yearly.
		FSW	2019	2019 non health sector program data		9100%	95	
		MSM	2019	2020 non health sector program data		9600%	95	
		PWID	2019	2021 non health sector program data		9400%	95	
		Transgender	2019	2022 non health			95	

				sector progra m data				
	Target 15: 95% of PLHIV on ART are receiving co- trimoxazole prophylaxis by 2025.	National	2019	Progra mme Data		90%	95	
	Target 16: 95% of PLHIV access care and support services by 2025	% of PLHIV receiving commun ity-based care services	2019	Non health sector data	35	65	95	
		% of PLHIV receiving adherenc e support	2019	Non health sector data	19	59	95	
		% of eligible vulnerab le children enlisted in care receiving social support services	2019		NA			Denominator for this indicator is not available the number is 864853 as at 2019.
	Target 17: 95% of all PLHIV are screened for TB, treated for active TB or placed on TPT by 2025	% of PLHIV placed on treatmen t for active TB within the last 12 months	2019	Progra m data	23	33	95	Based on historical data from 2015. 3% annual increase is expected.



		% of PLHIV screened for TB found negative for active TB and placed on TPT within the last 12 months	2019	2019 health sector HIV/AIDS annual report	44	74	95	10% scale up yearly to achieve 955 by 2025
		% of newly diagnosed PLHIV newly enrolled in TB preventive therapy		Programme Data		NA		
	Target 18: 90% of PLHIV access care and support services	Percentage of PLHIV receiving community-based care services				NA		
		Percent of PLHIV receiving adherence support						
	Target 19: 90% of vulnerable children enlisted for care and support services access those services by	Percentage of eligible vulnerable children enlisted in care receiving social support services						

	2025	(Source).						
	Target 20: 100% of state and FCT having domesticated anti stigma and discrimination law	Percent of state with anti stigma and discrimination law	2019	100	46	66	86	5% scale up in the first two years and 10% for the last two years.
		Percent of children/ Adult age willing to care for people living with HIV						
		Age 5-9						
		Age 10-14						
		Male 15-49						
		Female 15-49						
	Target 21: 90% of PLHIV access PHDP-related services by 2025	Percent of PLHIV provided with 'prevention with positives' services						
		Male						
		Female					95	

	Target 22: >95% of PLHIV On treatment are retained in care by 2025.	National			<80	89	>95	
	Target 23: 95% of PLHIV who are in ARV have achieved sustained Viral Suppression by 2025	%viral load testing coverage	2019	2019 HIV Health Sector programme data	86	95	95	5% yearly increase
		% of PLHIV on ART that have sustained virological suppression (<1000c/ml)	2019	2019 HIV Health Sector Annual Report	TBD		95	5% scale up in the first two years and 10% for the last two years.
	Target 24: 90% of all people displaying non-discriminatory attitudes towards PLHIV and PABA by 2025	Percentage age 15-49 with discriminatory attitudes towards people living with HIV (NDHS)				67		
		Male			58	68	90	
		Female			59	67	90	

		Percent of state with anti stigma and discrimination law enacted	2019	22	22	2	100	
	Target 25: Conduct and facilitate at least 10 operational research annually from 2025	Number of operational researches conducted (source)		10	2		2	minimum of 2 operation reseach is expected yearly
	Target 26: Ensure 100% of Comprehensive Public and Private Health Facilities are implementing the EMR and Reporting on the NDR by 2025	Number of facilities implementing EMR (source))		2300				
		Number of facilities reporting on the NDR		2300	1815			
	Target 27: Strengthened capacities for use of new technologies in analyzing HIV and HIV related data by 2025	Number of HIV and HIV related information products developed using new data technologies (Source)		100				
	Target 27: GoN effectively increases annual contribution to cover treatment cost of at least 50,000 PLHIV per year.	ARV person-year treatments purchased	2019					

# CHAPTER FIVE:

## Data Collection Plan

Data for National indicators will be obtained from two main sources:

### Routine Data Sources

Routine data sources provide data that are collected on a continuous basis, such as information that clinics collect on the patients utilizing their services. Although these data are collected continuously with patient encounters, processing, aggregation and reporting on the data usually takes place on a monthly or quarterly basis.

- Data collection from routine sources is useful because it provides information on a timely basis compared to non-routine sources. Since it is available more frequently, routine data can be used effectively to detect and correct problems in service delivery.
- However, it can be difficult to obtain accurate estimates of catchment areas or target populations through this method, and the quality of the data may be poor because of inaccurate record keeping or incomplete reporting.

### Health Information System

Currently, healthcare delivery in Nigeria is a three-tier system with Federal and State Government owned tertiary hospitals and Specialist centres providing patients' management, teaching and carrying out research. Other levels of service delivery are General Hospital and Primary Health Centres. Data from these service delivery levels are aggregated on paper-based forms and sent directly to the implementing partners and sub-national levels e.g. LGA and States. HIV/AIDS thematic areas (ART, PMTCT and HTS) has its own MIS housed in Federal Ministry of Health that collects data that is fed into the NNRIMS.

### Prevention of Mother to Child Transmission (PMTCT)

FMoH with support from partners identified a number of indicators required to facilitate tracking of the status of the PMTCT program. Several data collection tools including registers and summary forms along with the instruction manual were produced. Furthermore, a computerized Management Information System (MIS) and a comprehensive training curriculum for PMTCT data collection and reporting were developed and are reviewed regularly.

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

### PMTCT Data collection and reporting tools

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

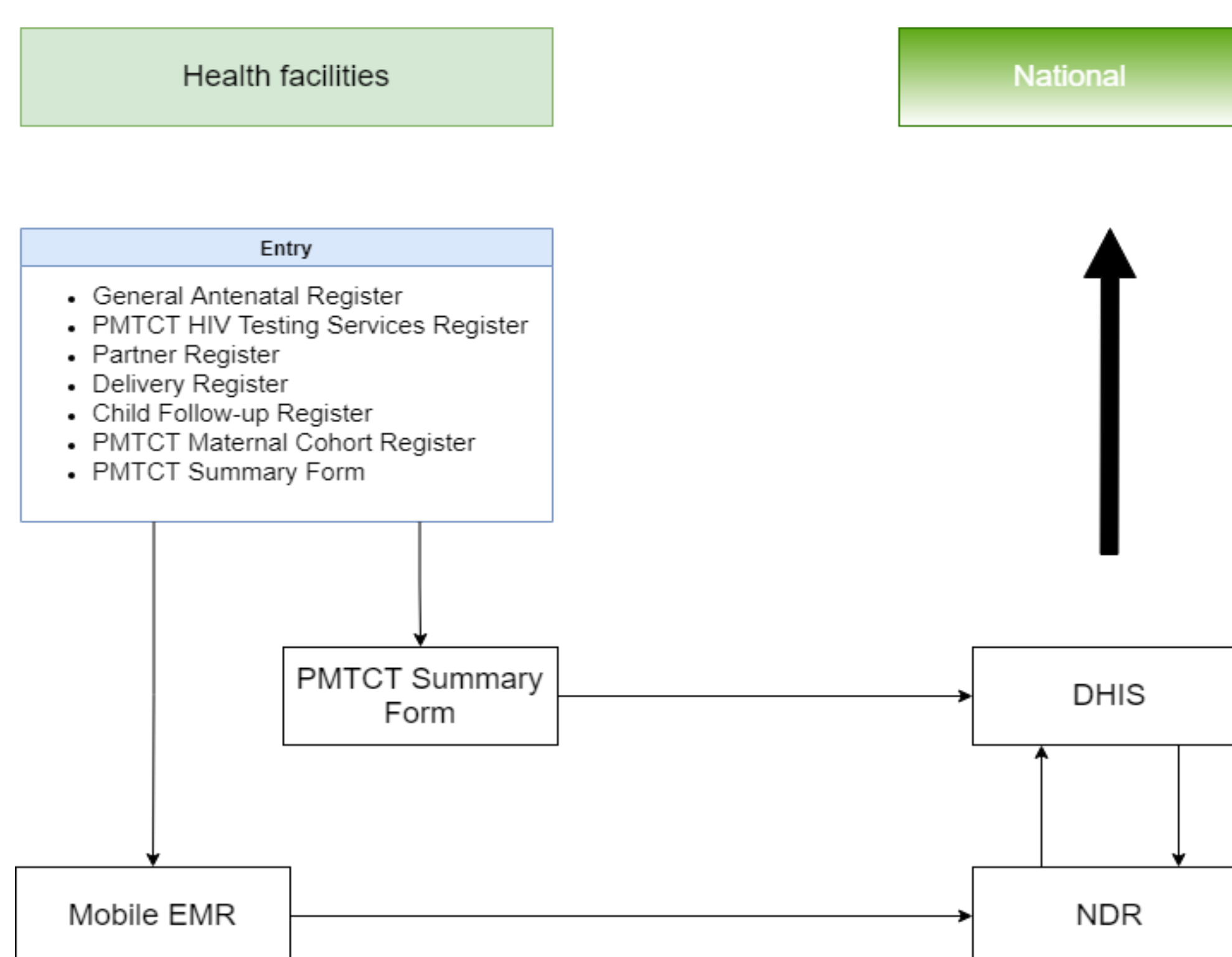


Figure 11: PMTCT Data collection and reporting tools

The first three registers highlighted above, collect pre-delivery data, the labor and delivery register collects information pertaining to delivery related PMTCT services and the last two provide post-delivery information. The system also includes a number of summary forms for the monthly collection of data that is sent to the Ministry of Health for collation and analysis. The PMTCT facility tools will supply data needed to complete the PMTCT component of the NNRIMS Monthly Summary Form.

### Anti-Retroviral Treatment (ART)

The ART program began in 2002 with a plan to provide ART for 15, 000 persons. At that time no M&E system was in place. With support from donor partners, over 1.4 million persons have been placed on treatment as of December 2020. Patient management and monitoring tools (PMM) were developed and reviewed from time to time. These tools contain information such as patient demographic and services obtained such as information on diagnostic procedures, discharge diagnoses; admission, antenatal, postnatal, child health, drug given, adverse effects, family planning, and workload information within the hospital system. The following are the tools for data collection and reporting for ART:

## Summary of National Indicators

Data from Public and Private Health facilities, OSS, CSO, CBOs, FBOs are collected daily with clients or patient-level data collection tools. On a daily or weekly basis, patient-level data will be entered into service-based registers specially designed for each program intervention such as HCT, PMTCT, ART, OVC, Care & Support and prevention Registers, etc. Although these data are collected continuously with patient encounters, aggregation, and reporting on the data usually takes place every month. At the end of each month, harmonized National Monthly Summary Forms (NMSFs) for the different thematic areas are used to summarize the data based on the nationally agreed minimum set of programmatic indicators.

To ensure that data and information flow up to the next level, a copy of each NMSF is retained at the service delivery point (SDP) for storage, data analysis, data use, and audit purposes. Another copy of each of the NMSF flows to the LGAs where computerization of data is done into DHIS for onward transmission to the States and consequently to the National level. A copy of the NMSF from these service delivery levels is also sent directly to the implementing partners. Also, where Electronic Medical Record (EMR) is functioning, those facilities report on EMR.

SACA at the state level are responsible for the collation of monthly data with multi-sectoral organs for consequent use in the planning and decision on HIV programme at various levels. For HIV/AIDS at the national level, NACA is responsible for collating information on the core indicators for Care & Support, Prevention, OVC from multi-sectoral national response stakeholders on HIV/AIDS such as FMoE, FMoWA&SD, and other federal line ministries. Also, the NASCP leads in the collation of health sector response data at the national while SASCP leads at the state level.

Currently, the country has adopted the simultaneous use of both Paper and Electronic-based systems for capturing and reporting on all HIV data. The National Health Management Information (NHMIS) platform is the overarching system for all key routine health data. The country is currently running its entire data collection and reporting systems on a combination of paper-based and electronic systems. The paper-based system is fairly stable than the electronic but with a lot of challenges with data quality. Currently, the electronic-based system operates on DHIS and EMR platform and all states have started using the DHIS platforms while the EMR platform which uploads into the National Data Repository (NDR) is now available in all states but at varying status of operation and completion. Presently, about 80% of ART comprehensive facilities are reporting on NDR.

About 20 HTS data and few PMTC data are on board the NDR. The challenge is transferring the data from a paper form for PMTCT and HTS to EMR. Presently it is planned in the NACA grant to roll out EMR in 396 additional facilities in GF and GON support facilities. There is plan to further strengthened the capacity of 2000 facilities with computers to improve their reporting abilities. Similarly, additional modules for other HIV program areas will be added to the EMR. There will be a need to eventually link NDR to DHIS 2 Platform domiciled in DPRS which will be very crucial. NACA and NASCP will also monitor the use of the HIV module on the DHIS2 which is being implemented under the RSSH grant.

## Data reporting

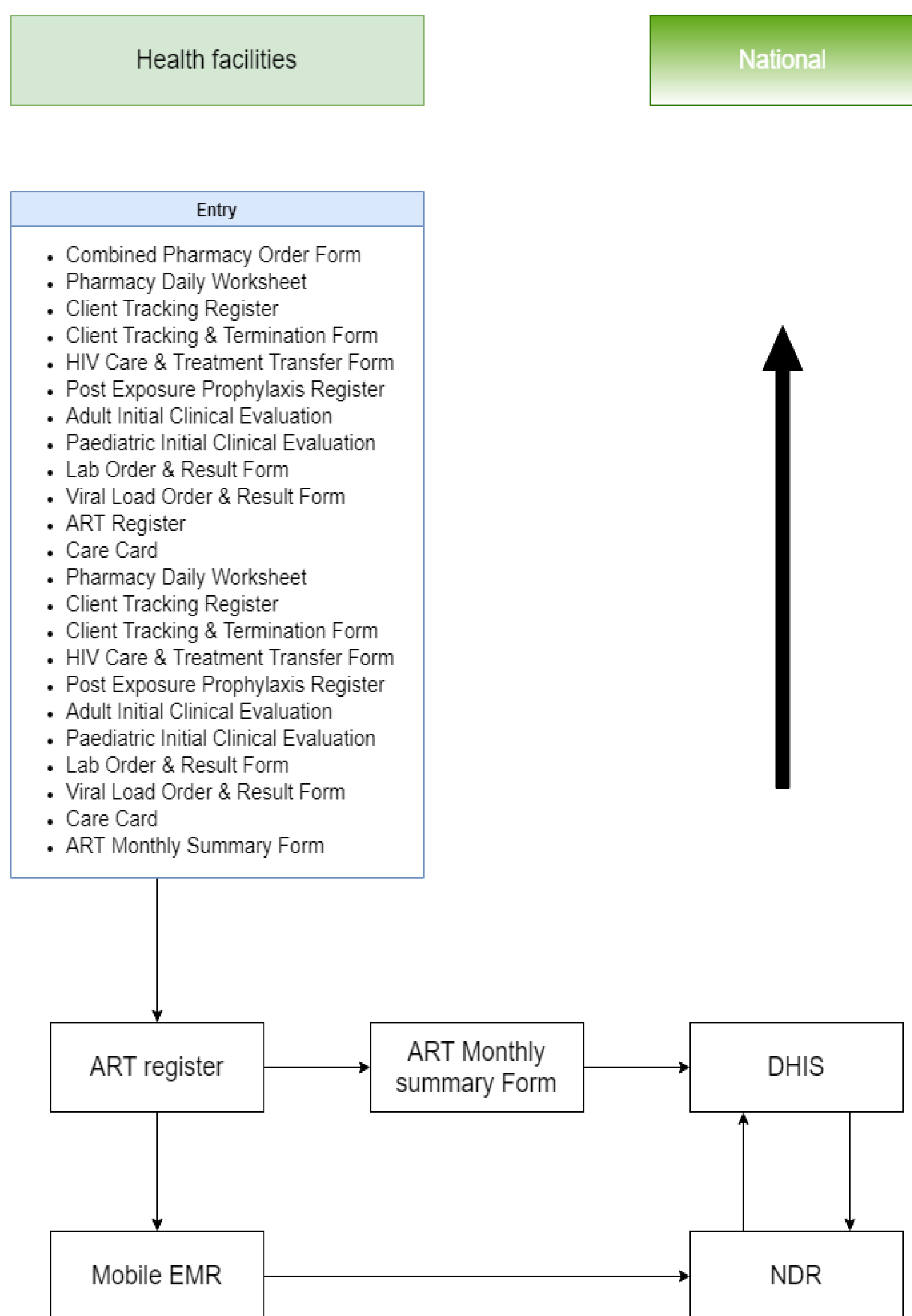
### State level

Presently, quarterly data collation and validation takes place at the state level and is also designed to ensure that states take responsibility and ownership for all HIV data generated in the states. At these quarterly meetings NACA, NASCP and donor partners at national level provide technical guidance to the states led by SACA and SASCP working with implementing partners on process for data collation, validation, and harmonization of data. Once the data has been agreed upon by state stakeholders the data is sent to the national team led by NASCP and NACA. This activity which is a sustainable model will be strengthened during the course of this grant utilization period.

### National Level

At national level GON and her partners have agreed that the zonal level data validation is not cost effective and efficient and so have agreed to discontinue it. Rather a 2-day national data collation and data quality assurance meeting will be adopted. This meeting will involve all partners including PEPFAR and it will enable the HIV response to collate data from the states and do a data triangulation analysis of the various data sources (states, NDR, DHIS, and partners) This meeting will take place semesterly and annually and efforts will be made to commence the process early enough to be able to meet reporting timelines for all donor partners including GF reporting. Going forward efforts are being in put in place to ensure full transition to electronic medical reporting using EMR and linked to the NDR. It is expected that by the second year of grant implementation the NDR will house at least 80% of routine HIV data in the country.

## ART Data collection and reporting tools



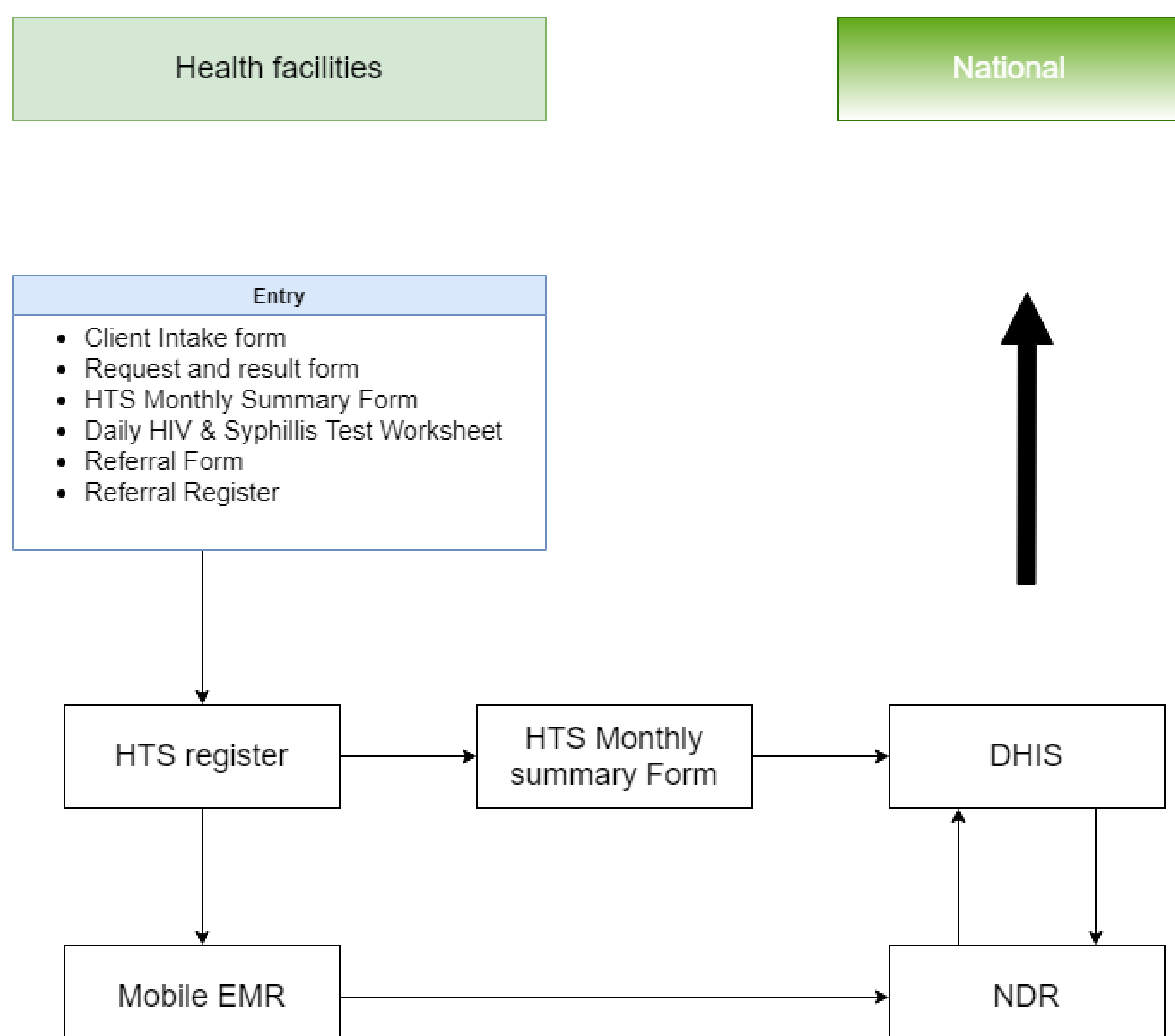
**Figure 12:** ART Data collection and reporting tools

Data from the registers are aggregated on a monthly basis into the ART Monthly Summary Forms, which are transmitted through LGAs to State and National levels.

## HIV Testing Services (HTS)

Data on HTS service provision is captured through the HTS MIS. The HTS program has developed registers for capturing relevant data on service provision.

## HTS Data Collection and Reporting tools



**Figure 13:** HTS Data Collection and Reporting tools

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

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

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

- HIV Testing Worksheet
- HTS Monthly Summary Forms

## Orphans and Vulnerable children (OVC)

Activities targeting orphans and vulnerable children are coordinated by the Federal Ministry of Women Affairs and Social Development. Examples of programs in this area include:

- HIV/AIDS awareness creation targeted at women and girl children awareness of socio- cultural issues that put females at risk and its mainstreaming into all facets of the country's HIV response
- Women empowerment programs targeted at improving their lives and the sexual choices they have at their disposal Care and support for OVC through the provision of comprehensive services according to the national guidelines

## OVC Data collection and reporting tools

- OVC Register
- Initial OVC Assessment forms
- OVC Enrolment form
- Household Assessment form
- OVC Termination form
- NOMIS

## Non-routine Data Sources

Non-routine data sources provide data that are collected on a periodic basis, usually annually or biennially.

- Using non-routine data avoids the problem of incorrectly estimating the target population when calculating coverage indicators
- Non-routine data have two main limitations: collecting them is often expensive, and this collection is done on an irregular basis. In order to make informed program decisions, program managers usually need to receive data at more frequent intervals than non- routine data can accommodate.

## Sentinel Surveillance of ANC and STI Clinic

### Attendees

Sentinel surveillance data is based on antenatal clinics attendees who are women of child bearing age (15-49 years). The sentinel sites will be expanded to target more regions of the country and different population groups to help generate estimates of HIV prevalence that are nationally representative.

The overall purpose of the HIV sentinel surveillance system is to monitor the trends in HIV prevalence in the country.

At the level of the health centre, a rapid test is applied or in some cases, the blood sample is sent to a testing site. Positive rapid tests are then confirmed with ELISA method at a reference or state laboratory, if there is no referral laboratory in the state or zone, positive rapid test is confirmed at the National Public Health Laboratory.

What does the National M&E System need from this data source?

- HIV prevalence among ANC attendees aged 15-24 years
- HIV prevalence among 15–49-year-olds

Frequency of Data Collection and Reporting:

Sentinel surveillance involves testing women who attend ANC typically between April and September of that year. This information is collected every 2-3 years.

### Periodic Surveys (NAIIS, NDHS, MICS)

The National HIV/AIDS Indicator and Impact Survey and other periodic surveys (NDHS and MICS) are population-based surveys conducted. The recently conducted NAIIS in 2018 aimed to examine the distribution of human immunodeficiency virus (HIV) disease in Nigeria, to assess the coverage and impact of HIV services on the population level, and to measure HIV-related risk behaviors using a nationally representative sample of persons aged 0-64 years. The target groups in NARHS are women of reproductive age (15-49 years) and men aged 15-64 years. The survey obtains information on the knowledge, behavior, and practices related to the prevention and transmission of HIV and other STIs. Serological testing to estimate HIV prevalence has been incorporated into the NARHS since 2007.

These surveys provide national-level measures of outcome indicators and focus on partner reduction, consistent use of condoms in regular and non-regular partnerships, delay of sexual activity among young persons, myths, stigma and discrimination and appropriate practices regarding STI/HIV/AIDS, knowledge and awareness of STI, and condom accessibility.

What does the National M&E System need from this data source?

- National HIV incidence (i.e., the prevalence of recent HIV infection).
- National and sub-national (State) prevalence of suppressed HIV viral load (VL) (Less 1000 copies/mL).
- National and sub-national (State) HIV prevalence
- Prevalence of HIV-related risk behaviors, knowledge, and attitudes
- Behavioral and demographic determinants of HIV incidence and prevalence
- National prevalence of HBV infection
- National prevalence of HCV infection
- Prevalence of HIV/ HBV co-infection among HIV+ individual
- Prevalence of HIV/ HCV co-infection among HIV+ individual
- Uptake of HIV-related services (especially prevention of mother-to-child transmission (PMTCT)-related services) and exposure to HIV interventions
- Distribution of CD4 T-cell counts among HIV+
- Prevalence of transmitted drug resistance (DR)
- To estimate the following among adults 18 – 54 years: The population size of men who have sex with men (MSM), female sex workers (FSW), people who inject drugs (PWID) using the network scale-up method (NSUM) National pediatric HIV prevalence

### Integrated Biological and Behavioural Surveillance Survey (IBSS)

These surveys provide national level measures of outcome indicators and prevalence in high-risk groups such as PWIDs, MSMs and CSWs. They focus on use of condoms with regular and non-regular partners, myths and appropriate practices with regards to STI/HIV/AIDS, exposure to interventions, and other high-risk behaviours such as substance abuse. It also includes collection of serological samples for HIV testing to determine the prevalence amongst Key Populations. The last round of IBSS was conducted in 2020. The results are planned to be released in 2021. This survey is conducted every 2 – 3 years.



What does the National M&E System need from this data source?

**MSM:**

- Percentage of MSM who are HIV infected
- Percentage of MSM reporting using a condom at last sex act

**FSW:**

- Percentage of FSWs who are HIV infected
- Percentage of FSWs reporting using a condom at last sex act with the client (paying partner)
- Percentage of FSWs reporting using a condom at last sex act with a non-paying partner

**PWIDs**

- Percentage of PWIDs who are HIV infected
- Percentage of PWIDs reporting the use of a condom the last time they had sexual intercourse
- Percentage of People Who Inject Drugs reporting the use of sterile injecting equipment the last the time they injected other key population
- Percentage of Key Population reached with individual and/or small group level MPP interventions

## Second Generation Surveillance System

HIV surveillance systems track HIV infection or other biological markers of risk such as STIs. Since HIV infection among adults must be preceded by one of a limited number of behaviours, such as unprotected sex with an infected partner or injection with contaminated needles, if these behaviours change, there will be a change in the spread of HIV. Second generation surveillance systems monitor risky behaviours, using them as early warning signs and to explain dynamics of the epidemic. Thus, second generation surveillance uses data from behavioural surveillance to interpret data gathered from sero-surveillance efforts (UNAIDS 2000) and generate hypotheses. Nigeria's second generation surveillance system needs to be tailored to the dynamics of the epidemic.

There are some second generation surveillance opportunities in the country such as HIV data triangulation conducted in 2009 on sexual transmission prevention of HIV to provide decision makers with data on the trend and magnitude of the epidemic, and indications about the effectiveness of national response. Other second generation surveillance analyses conducted in Nigeria recently include Epidemiology, Response and Policy Synthesis (ERPS) at national and state levels, and Mode of Transmission (MOT) analysis.

## Other Data Sources

There are other routine data sources that are at various stages of development. Many of these data sources are managed outside of the Ministry of Health and may even be outside of the health sector, but provide valuable information for the overall HIV/AIDS M&E system. Such data sources include routine data tools for programs such as Behavior Change Communication, Home Based Care, HIV/TB Collaboration, Laboratory Services, HIV Workplace Response, and Family Life HIV/AIDS Education.

Data Source	Development Status	Frequency of Reporting	Responsible Organisation
<b>Military HIV/AIDS Database (Ministry of Defence)</b>	Completed	Quarterly	DoD, AFPAC
<b>OVC database</b>	Completed	Quarterly	FMWASD
<b>National Blood Transmission Service and Public Health Lab</b>	Completed	Quarterly report of the number of HIV tests by group: <ul style="list-style-type: none"> <li>• Risk category</li> <li>• ANC</li> <li>• STI</li> <li>• Outreach</li> <li>• Hospital</li> <li>• Region</li> <li>• Sex</li> <li>• Age</li> </ul>	NBTS/FMOH
<b>TB Records</b>	Completed	Quarterly	NTBLCP/FMOH
<b>Prevention Intervention Tracking Tool (PITT)</b>	Completed	Information comes from NGOs/CSOs to the appropriate Line Ministry Coordinator and to the Surveillance Research Monitoring and Evaluation Department of NACA	

**Table 3:** Other data sources outside the health sector

In addition to the specific instruments and methodologies listed above, the NACA RM&E will access additional data sources and implement other data collection activities over the next few years to obtain data that are not covered by any of the above tools.

Some of these data sources include the following:

### **Health Facility Assessment**

The objective of Health Facility Assessment (HFA) is to determine whether the health centres and hospitals are capable of providing quality HIV/AIDS and STI services, and if not, what materials, equipment and training will be needed to fulfil this goal.

The specific objectives of the HFA are:

- Establish whether the health facilities have the necessary infrastructure and equipment to deliver quality services; such as counselling materials and protocols, testing kits, IEC and job-aids;

- Establish the clinical and management skills of health care personnel;
- Coordinate efforts with other health services and private practitioners

The HFA will provide information on the following indicators:

- Percentage of health care facilities currently stocked with ARV according to national protocol and reporting no stock-outs in the last 3 months
- Percentage of women and men with STIs at health care facilities who are appropriately diagnosed, treated and counselled.
- Percentage of public sector clinicians managing OIs in adult AIDS patients according to national guidelines
- Percentage of health facilities surveyed that practice proper waste management and ways to reduce occupational exposures

## **Workplace survey**

Workplace surveys are conducted to collect data on workplace HIV/AIDS programs, knowledge and behaviors of workers concerning HIV/AIDS, employees' participation in HIV/AIDS activities and small medium enterprises (SME)/Ministries' participation in workplace policy on HIV/AIDS.

## **Data triangulation and secondary data analysis**

There was a national data triangulation project in 2009 which focused on sexual transmission of HIV and prevention efforts. The study used available multiple data sources in the country to generate evidence capable of informing new programs, policy and research. In addition, there have been several secondary data analyses in the country using the NARHS, ANC and IBBSS data to assist in the reporting of UNGASS, Universal Access, and in having deeper understanding of national or state level indicators that were not contained in the primary survey report.

## **Data Flow**

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

It is the responsibility of NACA to collate information on the core indicators of the multi-sectoral national response on HIV/AIDS from FoE, FMWASD and other federal line ministries.

## **M&E Reporting Levels and Information Flow**

Stakeholders implementing HIV/AIDS projects/programs are expected to regularly report on program indicators (see indicators matrix in Chapter 7) that are relevant to the type of activity they are undertaking. For all program indicators, the data collection formats at all levels (from lowest to national) will be developed (NNRIMS – monthly summary form) and included in the M&E Operational Manual and distributed to all stakeholders. The proposed information flow between the different stakeholders and NACA are summarized in figures A and B. Standard reporting formats that summarize the program indicators will be supplied to LGAs and States.

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

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

State Agencies for the Control of AIDS (SACA) will produce quarterly reports by compiling and analyzing data/reports received from LGAs. The state level information would include sector activities during the reporting quarter.

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

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

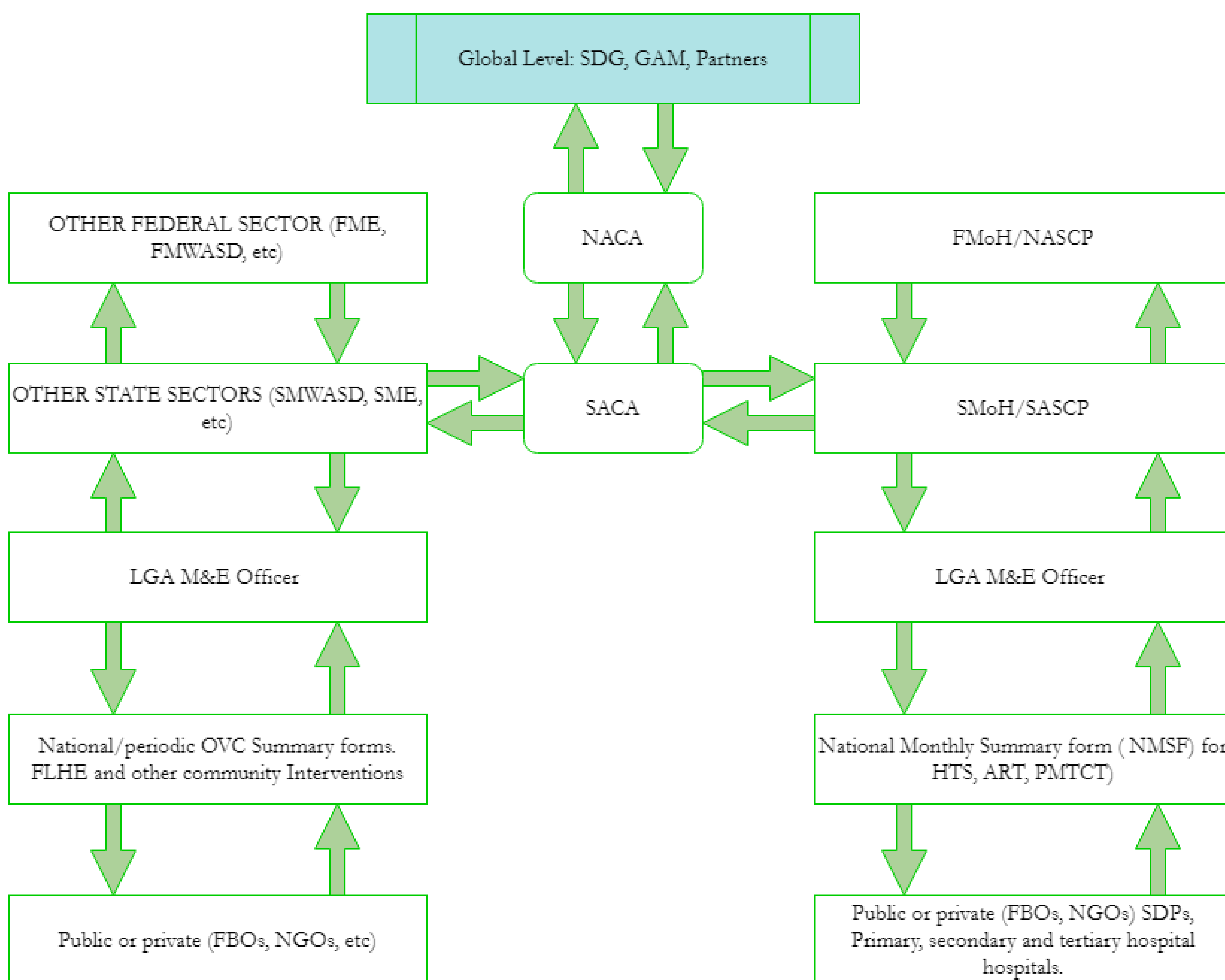


Figure 14: National data flow chart for health and non-health sector

## Data Quality Issues

Data are most useful when they are of high quality. Therefore, data quality needs to be monitored and maintained throughout the data collection process. However, obtaining data of the highest quality has cost implications and often times may not be feasible in which case decisions have to be made to determine what level of quality is adequate.

To ensure high quality data the following strategies will be utilized:

- Data cleaning at all levels of data entry
- Regular supportive supervision and data verification using standardized checklists
- Periodic update and capacity building of data managers and personnel with data management roles
- Establishment of an information feedback mechanism
- Periodic review of data quality issues by all stakeholders. For each data set, the following data quality issues should be considered:
  - Completeness: Are data complete? If not, what is missing? Could missing data be easily obtained? What changes could be made to the system to solve this problem?
  - Accuracy: Do the data collection instruments that are being used result in valid and reliable data?
  - Duplication: Is there a threat of duplication or double counting when services, beneficiaries, etc. are counted? What mechanism is in place to control for this?
  - Frequency: Is the frequency of data collection appropriate?? For example, while the national program may only need data annually, how often do state and LGA programs need data?
  - Reporting Schedule: Do the available data reflect the time periods of interest? How are data needs for different reporting schedules reconciled (for example, data needs for the Nigerian Government Calendar Year, US Federal Fiscal Year etc.)
  - Accessibility: Are data easily accessible and retrievable? If not, what are the barriers?
  - Power: Is the sample size large enough to provide a reasonable estimate or detect change?

## 5.6 Interoperability of the database

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The M&E framework requires the capture and storage of a wide range of data that are needed to monitor the results of the initiatives undertaken as part of the national response. Because of the breadth and volume of data that are being collected, a database is required to enter, verify, store and analyze service coverage M&E data from service delivery points. Without a database, data collection, verification and analysis is unlikely to happen since ministries and other public agencies are rarely equipped to manage such a process. The monitoring and evaluation framework will include a national database that will collect all that data that are required to be reported for national and international purposes. Furthermore, since there are existing databases for various HIV/AIDS programs, the framework will outline protocols to ensure that the various databases currently in use as well as future databases are interoperable with the national database in order to reduce redundancy, and at the same time, leverage resources.

# CHAPTER SIX:

# Data Dissemination and Information Use

## Information Products

The National Agency for the Control of AIDS is responsible for the compilation, management and dissemination of all data collected through the National HIV and AIDS M&E system and subsystems. NACA is serving as the clearing agency for all National multi-sectoral HIV and AIDS data and maintain functional reporting relationships with the National Bureau of Statistics, National Planning Commission and global HIV and AIDS organizations.

NACA is responsible for the following periodic information products:

- Bi-annual Service Coverage Report and fact sheets
- Annual HIV and AIDS progress Report
- Annual GAM Report
- NACA Quarterly Report and Newsletter
- Annual surveillance report Evaluation/Review Reports
- Updated Bibliography of HIV and AIDS Research

## Data Use and Dissemination Fora

In addition to the aforementioned information products, a number of fora have been established to review progress in implementing the National HIV and AIDS response. These have a strong focus on the use and dissemination of data collected for the National HIV and AIDS M&E plan and provide an opportunity to disseminate progress, lessons learned to various stakeholders and enhance evidence-based decision-making by policy makers and program managers. Opportunities for data use and dissemination include the following:

- Nigerian HIV and AIDS Conference
- International Conferences on HIV and AIDS
- NACA Governing Board meeting
- Development Partners' Group meeting
- National AIDS Council
- State level HIV and AIDS feedback meetings
- Expanded Theme Group Meetings
- M&E Technical Working Group Meeting

## Mechanism for Data Dissemination

NOP III will leverage the existing mechanism for data dissemination that has worked well for NACA and the country as a whole.

The existing mechanism for data dissemination is made up of the following:

## National HIV and AIDS Resource Centre

The National HIV and AIDS Resource Centre (NHRC) is a platform to generate, share and use strategic information by all stakeholders within the HIV and AIDS National Response. It will provide evidence to the governance responsibility of NACA and SACA, and contribute to strengthening their stewardship role. Likewise, it will serve as a one-point source of authentic, appropriate and viable information in different contents and categories for all HIV and AIDS topics. It would build a comprehensive data base of information generated in Nigeria in the area of HIV and AIDS and allied areas to facilitate its easy online access and use by the administrators, policy makers, research scholars, health care professionals, programme personnel and the general public. The center will run as an online virtual network with search engines housing research outcome, reports and training manual as well as tools.

The NHRC will provide a new, efficient and cost-effective channel for generating, accessing, sharing and disseminating research, best practices, methodologies and innovative ideas by all stakeholders in HIV and AIDS prevention, treatment, care and support.

The NHRC will serve two main functions: first act as a clearinghouse and repository of National and state level information on HIV and AIDS; and second to serve as a virtual focal point and channel for best practices and resources on conducting effective M&E and operations research.

The central clearinghouse and virtual network will support an online, searchable database of information including research outcomes; inventory of tools developed by researchers; a compendium of bilateral organizations, funders and implementing partners; training manuals and resources; operational plans; and reports that can be accessed by all stakeholders.

The virtual NHRC is a key tool for strengthening NACA's ability to manage information as well as create a community of practice around M&E and operations research. This latter function will build capacity of state-level practitioners and program managers while providing information on cost-effective approaches and programme impact.

### **NACA's website**

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

**News and Events** - Events are always organized with the objective of reducing the impact of HIV and AIDS in Nigeria. These are packaged into event news for publication on the NACA website.

**Research** - HIV and AIDS research in the local and international arena becomes available from time-to-time. Members of the academia, HIV and AIDS researchers, media people and interested members of the public could access these resources on the website.

**Reports** - Activity reports are published on the NACA web platform. Report types that get published include:

- Meetings
- Lectures, symposia, colloquiums
- Local and international conferences
- Visits
- Funding and financial reports
- Partners' activities

**HIV and AIDS Data** - HIV and AIDS statistics of general interest (including prevalence and incidence rate disaggregated by age, gender and geographic spread) are accessible through the Agency's website.

**HIV and AIDS Services** - HIV and AIDS services information such as facilities and types of services offered are put on display via the website for public consumption.

### **NACA Data Command Center**

The command center will integrate and triangulate data from multiple sources to give a holistic view of the epidemic in Nigeria and drive stakeholder decision-making.

The command center has the following goals:

1. Visualize HIV health and non-health programme performance with geographic information
2. Report HIV supply chain analytics and HIV programme expenditure
3. Facilitate actions to enhance effective HIV programme performance

### **Nigeria National Data Repository (NDR)**

UNAIDS 2020 data show an improvement in the progress towards 90-90-90 in Nigeria; 73% (6% improvement when compared to 67% in 2018) of people living with HIV know their HIV status; 89% (22% improvement when compared to 53% in 2018) of people living with HIV are on treatment. In order to accelerate the journey towards epidemic control, it is imperative to have the best intelligence to inform program design and interventions both at population and individual levels. The National Data Repository offers ample opportunity to harness a large pool of nationally representative data to inform this intelligence gathering.

The Nigeria National Data Repository (NDR) is a repository of de-identified patient-level data collected from health facilities across Nigeria and it will be a platform for national stakeholders to review the status of the nation's journey towards HIV epidemic control, identify information gaps, brainstorm on new information needs and make recommendations for generating evidence from proposed or existing datasets on the National Data Repository on client and population characteristics to inform customized and targeted interventions to populations, communities and individuals to fast-track attainment of the epidemic control goals.

Most IPs implementing EMR in the country are already reporting to the NDR but there is the challenge of timeliness in data reporting. Efforts are on top gear to expand the scope and capacity of NDR to report on all the indicators and the need to link NDR to DHIS2.

# National Data Repository

## Logical Architecture

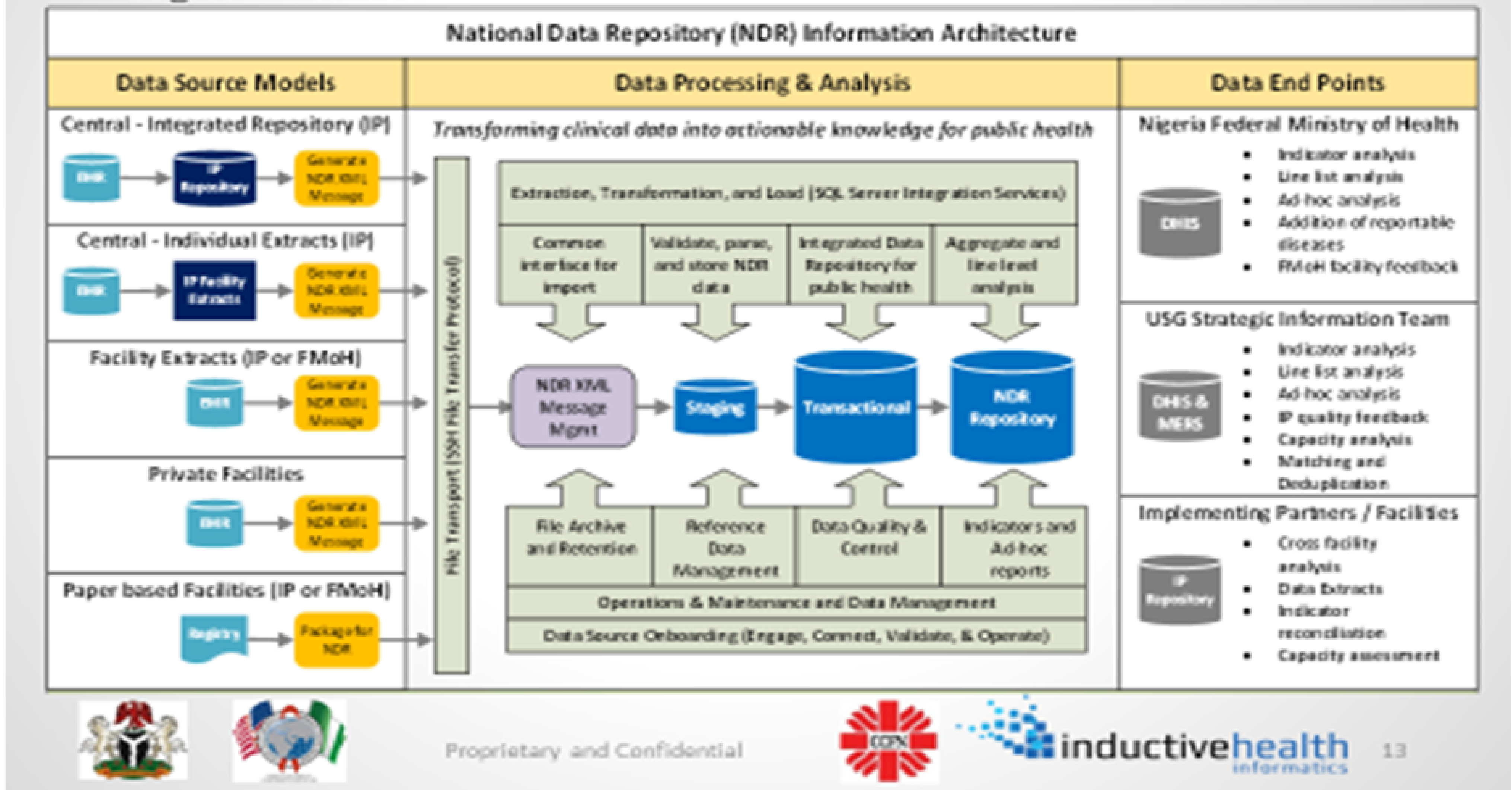


Figure 15: National Data Repository Logical Architecture

## Database Interoperability

The M&E Conceptual Framework requires the capture and storage of a wide range of data that are needed to monitor the results of the initiatives undertaken as part of the National response. Because of the breadth and volume of data that are being collected, a database is required to enter, verify, store and analyze service coverage M&E data from service delivery points. Without a database, data collection, verification and analysis are unlikely to happen since ministries and other public agencies are rarely equipped to manage such a process. The monitoring and evaluation framework will include a National database that will collect all the data required to be reported for National and International purposes. Furthermore, since there are existing databases for various HIV and AIDS programs, the framework will outline protocols to ensure that the various databases currently in use, as well as future databases, are interoperable with the National database in order to reduce redundancy and at the same time, leverage resources. DHIS already has a standard protocol for receiving data from all other databases, through the use of APIs.



# CHAPTER SEVEN:

# Operationalization of the NOP III

The operationalization of the NOP3 will be based on the experience and lessons learned from the NOP1 and NOP2. To achieve the full realization of the operationalization of the NOP3 the following needs to be in place.

## Resource mobilization and funding

Funding for running and maintaining an effective M & E system still remains a problem in Nigeria and other resource-constrained countries. There is the need for increased resources for the M&E sector and efficient use of resources from both within and outside the National program. The recommended 10% of the National HIV and AIDS budget for monitoring and evaluation activities, not including the cost of periodic surveillance of HIV and high-risk behavioral surveys which should be budgeted separately, is yet to be realized. NACA will need to sustain its advocacy to stakeholders allocate a minimum of 10% of their HIV and AIDS budget to M&E at all levels.

Even though, the National response is still donor-driven, efforts should be to see that M&E activities are not entirely donor-dependent. To ensure that this happens, the NOP3 will be costed to estimate resources needed for full implementation of the National M&E system.

Resource gaps and funding requirements need to be clearly identified and strategies to fill the gaps need to be developed. As part of this document the M&E activities will be costed to estimate the total M&E envelope for the period. This would enable accurate identification of what the funding gaps are and the additional funding that is required.

NACA needs to identify and mobilize financial resources internally and externally to support the implementation of the NOP3, from the private sector as well as the public.

## Human Resources

Staffing is a major constraint to M&E in Nigeria. Another challenge is the staff attrition which is very high and costly to the National response. It is not uncommon to train a lot of staff on M & E only for them to be transferred out of the unit or out of the facility entirely.

NACA needs to evolve strategies for advocacy and possibly incentives (not-monetary) to hospital administrations and administrators to retain trained staff in M & E.

M&E units exist at all levels of the National program although, they are generally understaffed. Human capacity needs to be considered broadly in terms of the adequacy of the number of staff with respect to the work that is required, remuneration of staff, competencies and the quality of work. This relates to determining and organizing the appropriate number of staffs that are needed, ensuring that their salaries are competitive, and their capacities are relevant and updated. Processes to assess staff performance are critical and should focus on the productivity as well as the quality of work.

## Institutional Capacity Development

The HIV National response has a strong capacity to implement M & E activities This has enabled NACA to better coordinate the MDAs, LGA institutions, special projects, surveys and other stakeholders to provide good quality, comprehensive and timely information on the state of the epidemic in Nigeria.

However, the same cannot be said about institutional capacity development at the state and LGA levels and line ministries. NACA will need to evolve strategies to engage the state and the LGA levels as well as the relevant MDAs to improve institutional capacity at all levels.

## Building capacity in M&E across the sectors and stakeholders

One of the key recommendations of the M & E assessment is the need for a National database on M & E training and capacity building. A training and development needs assessment of capacity in monitoring and evaluation is needed at different levels and among different stakeholders, with a focus on sub-National levels. This was strongly recommended in the NOP2 and is also recommended for the NOP3. The sub-National level coordinating agencies will need to be trained in M & E and in turn provide training to key people involved in M & E at the LGA, District, Ward and community level.

There is the need to strengthen the existing feedback mechanism to those involved in data collection and reporting. Feedback and provision of useful information will provide incentives that will enhance good quality data and timely reporting.

## Roles and Responsibilities in implementing the NOP3

The Roles and Responsibilities in implementing the NNRIMS Operational Plan are clearly outlined in the NOP2 and NOP1 and will be maintained through NOP3.

**Table 4:** Roles and Responsibilities of Stakeholders

STAKEHOLDER	RESPONSIBILITIES
NACA Board	<p>The board members of NACA have been mandated to provide overall guidance and oversight of the National response. In terms of monitoring and evaluation, the Board members are responsible for:</p> <ul style="list-style-type: none"> <li>• Overall guidance and strategic alignment of M&amp;E to the NSF</li> <li>• Advocacy for allocation of adequate level of resources for M&amp;E in the National response.</li> </ul> <p>Promoting a culture of using information for decision-making at the highest level to serve as an example for the sub-National levels</p>
NACA Director General	<p>The Director General of NACA is responsible for:</p> <ul style="list-style-type: none"> <li>• Promoting the HIV and AIDS M&amp;E system within the public and private sectors, and civil society.</li> <li>• Using information from the National M&amp;E system to shape the National response.</li> <li>• Ensuring that sufficient resources (financial and human) are available to implement the National HIV and AIDS M&amp;E system.</li> <li>• Negotiating with bilateral donors to make it compulsory for call implementers to report to the NOP. Facilitating development of the National HIV and AIDS Research Agenda/ Plan.</li> </ul> <p>Enforcing procedural requirements for all HIV and AIDS data to be officially cleared by NACA before it is shared with the international community.</p>
NACA's Director of Research, Monitoring & Evaluation (R, M & E)	<p>NACA Director of R, M &amp; E is responsible for:</p> <ul style="list-style-type: none"> <li>• Providing overall leadership to the M&amp;E team at NACA.</li> <li>• Supervising the day-to-day work of the M&amp;E team.</li> <li>• Preliminary review and approval of all information products before they are submitted to the NACA DG for clearance.</li> <li>• Representing NACA and providing guidance and leadership during meetings addressing M&amp;E issues.</li> <li>• Chairing the platform for review and evaluation of National Response Priority Issues.</li> <li>• Approving monthly work plans of the R, M &amp; E department</li> <li>• Reconciling, confirming and clearing all HIV and AIDS data reported to stakeholders</li> <li>• Developing annual M&amp;E budgets</li> <li>• Interpreting M&amp;E reports in terms of planning implications</li> </ul> <p>Ensuring that data and M&amp;E results inform the NACA annual work plan</p>
Ministry of Health	<ul style="list-style-type: none"> <li>• Coordinates and implements the health sector response to HIV</li> <li>• Develop and review National health sector M&amp;E tools</li> <li>• Facilitate collection of data, collate, analyze and report data on the health sector response</li> <li>• Training, supervision and mentoring of service providers at the facility</li> <li>• Coordinate periodic National surveys (e.g., NARHS, IBBSS, NDHS, ANC sentinel survey)</li> </ul> <p>Map and update directory of health facilities providing HIV services</p>
Ministries outside of the Health Sector	<ul style="list-style-type: none"> <li>• Coordinates and implements the non-health sector response to HIV</li> <li>• Develop and review National non-health sector M&amp;E tools</li> </ul>

	<ul style="list-style-type: none"> <li>• Facilitate collection of data, collate, analyze and report data on the non-health sector response</li> <li>• Training, supervision and mentoring of service providers at the facility</li> <li>• Coordinate periodic National non-health sector surveys</li> </ul>
NACA R, M & E Staff	<p>The R, M &amp; E team at NACA is the pivot around which the M&amp;E system functions. The team is responsible for:</p> <ul style="list-style-type: none"> <li>• Implementation of the National HIV and AIDS M&amp;E plan</li> <li>• Coordinating and managing the NNRIMS Reporting System</li> <li>• Coordinating and chairing the National M&amp;E TWG</li> <li>• Facilitating the development of the National HIV and AIDS research agenda/ plan</li> <li>• Developing monthly work plans of M&amp;E activities</li> <li>• Attending the National M&amp;E TWG and other sectoral M&amp;E Steering Committee meetings</li> <li>• Liaising with all institutions that provide data sources for the NNRIMS system</li> <li>• Providing periodic information products, as requested by NACA leadership</li> <li>• Representing M&amp;E interests of NACA at meetings, and actively working to improve the coordination of data gathering processes within Nigeria</li> <li>• compilation of an annotated bibliography of research studies conducted in Nigeria</li> <li>• Supporting the dissemination of all information products as defined in the NOP.</li> <li>• Contributing to the development of annual M&amp;E work plans and operational budgets</li> <li>• Ensuring that all data required for the annual HIV and AIDS M&amp;E report is received in a timely manner</li> </ul> <p>Compiling the annual HIV and AIDS M&amp;E Report and managing the NACA institutional approval process</p>
State Agency for the Control of AIDS (SACA)	<p>SACA's are responsible for:</p> <ul style="list-style-type: none"> <li>• Compiling and updating directories of facilities, NGOs and CBOs involved in HIV activities in the state and submitting this information to NACA</li> <li>• Ensuring timely &amp; accurate completion and submission of NNRIMS summary forms from the LGAs and SMOH</li> <li>• Compiling and analyzing the State's NNRIMS Monthly Summary Form, including gathering data from non-health sector stakeholders and other ministries.</li> <li>• Dissemination of the Quarterly Service Coverage Report form and other National Operational Plan Information products to state stakeholders</li> <li>• Reconciling, validating and clearing all state level data that will be reported to the international community Funding, chairing and facilitating of State monthly M&amp;E meetings.</li> <li>• Using data and information products to inform state level planning.</li> </ul>

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

## Monitoring & Evaluation of the NOP3

The NOP3 needs to be reviewed periodically to ensure that needs of the stakeholders are met and that the agreed standards, indicators and timeframes for data collection, reporting and use are followed. The annual review will allow NACA to see which milestones of the NOP3 have been reached, how accurate are the reports, timeliness of reporting, areas of weakness in data collection and management. Remedial actions can then be taken before the problems become unmanageable.

## Monitoring Progress towards achieving Epidemic control

Epidemic control and other indices show that it is a point at which new HIV infections have decreased and fall below the total number of deaths among HIV-infected individuals. Over the last two decades, significant progress has been achieved towards controlling the epidemic in Nigeria with different approaches over time to maximize the benefit.

We have initially seen the Emergency phase of the response to HIV epidemic followed by rationalization of partners, categorization of the response in Local government level as priority and maintenance, then SURGE due to the better characterization of the epidemic from NAIS and recently partner alignment.

In order to achieve this there is a need to track and scale up key service areas such as PMTCT, ART coverage and Testing, intensive case finding and targeted programs will significantly increase the number of patients put on treatment.

Prevention programs should be targeted and tailored to age groups with high incidence. NAIS and IBSB shows where new infections are in the general population as well as the KP, the intervention in this area should be strategic and tracking the core service coverage indicators with aligning Key Performance Indicators (KPI) with global standards with focus on incidence and mortality.

Attention should be paid to data quality, availability of key commodities such as Prep and condoms in controlling the epidemic. Test kits and drugs may need to be produced locally to ensure sustainability. More attention should be paid to the sustainability dashboard, not forgetting the “3 Zeros”- Zero Stigma, Zero AIDS mortality and Zero new infection.

## Parameters for measuring progress towards achieving epidemic control

- A percentage reduction in a nation’s annual HIV infection rate, or number of new infections per year (incidence).
- The ratio of incidence over a nation’s annual death rate.
- The ratio of incidence over the total number of PLHIV in a nation (prevalence)
- The incidence rate as a proportion of a nation’s population

## Strategies identified in the NSF towards epidemic control in Nigeria

- 90 90 90 target attainment
- Prevent/treat comorbidities
- Eliminate new HIV infections
- Eliminate MTC infections – 100% of PMTCT coverage
- Resource and sustainability
- Critical Enablers.

## Community Led monitoring (CLM)

The critical role of communities has been affirmed and recognized in order to meet the Fast-Track Targets and community responses to HIV, to this end and the commitment by the 2016 United Nations Political Declaration on Ending AIDS, at least 30% of services should be community-led by 2030.

Community-led monitoring has been prioritized as a key empowerment strategy to boost their relevance and independent watch-dog role. Through routine and scheduled monitoring of the quality and accessibility of HIV related services (as well as COVID-19)

The overall goal of the Community led programme is to utilize a data-driven approach to improve service delivery and client outcomes for end users of services at the facility and community levels.

The objectives of the CLM.

- To build the capacity of selected community organizations/networks and support the development of a protocol with implementation modalities for the Community led monitoring project.
- To build capacity of community networks to increase COVID case findings, active case search and contact tracing and follow up for testing campaigns.
- To support the community to develop relevant indicators, tools and a comprehensive data base that would be used to effectively carry out the community led monitoring activities.

Community-led monitoring (CLM) will be a process initiated by, led by, and implemented by the beneficiaries. This will be people living with HIV (PLHIV) networks, key populations (KP) and other affected groups, local community-based organizations, and other civil society groups on HIV.

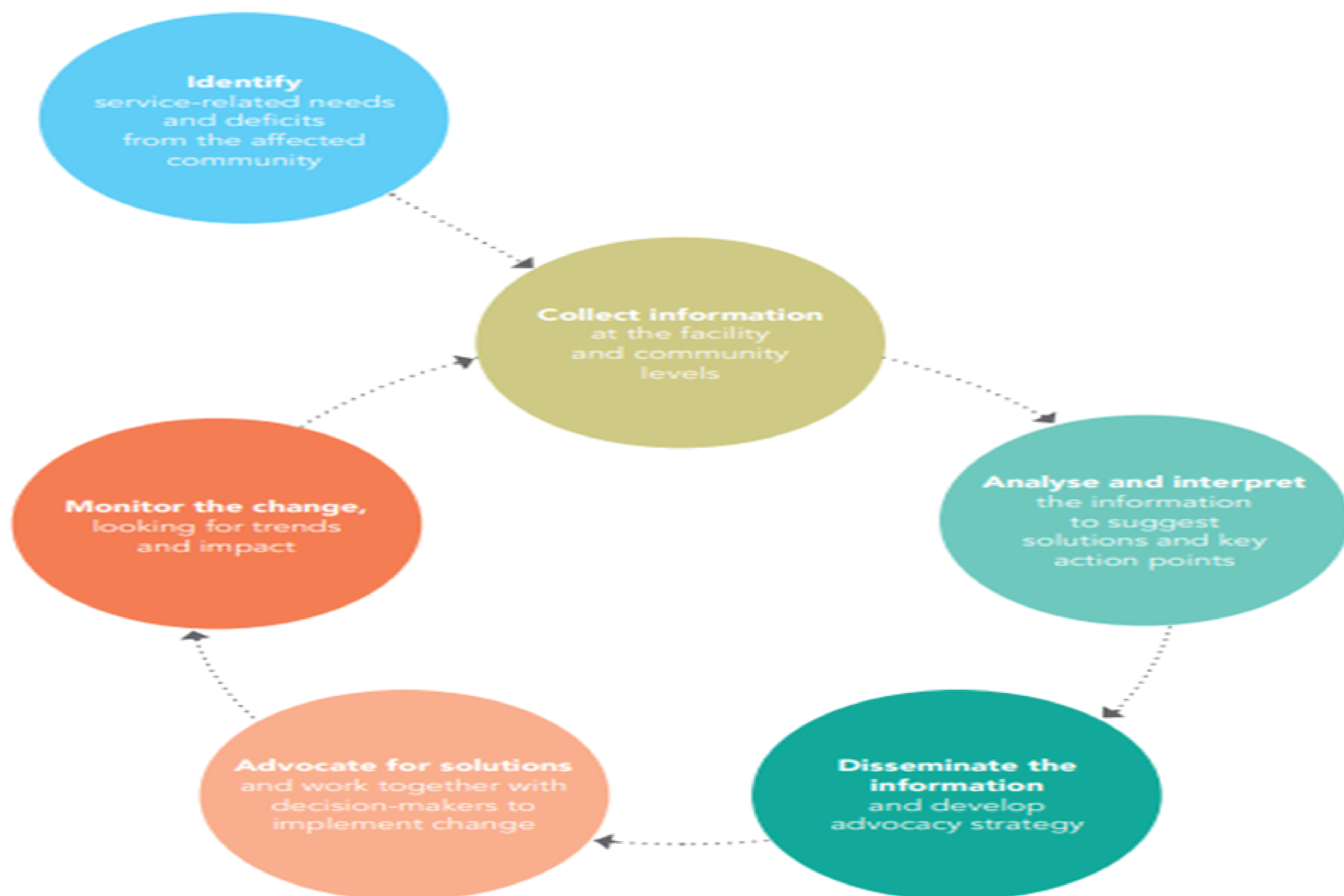


Figure 14: THEORETICAL FRAMEWORK OF HIV CLM IN NIGERIA

The collaborating partners will include the National Agency for the Control of AIDS (NACA), the National AIDS and STI Control Programme (NASCP), the Nigerian Center for the Control of Disease (NCDC), and other technical partners. The national CLM framework for HIV/AIDS will guide the operationalization of the CLM.

The data will form an integral component of the national data set will inform programming. The CLM system will be aligned in terms of some of the used data tracking tools and some common indicators. The framework for the implementation of the CLM is being developed and the indicators to be tracked is yet to be agreed on.

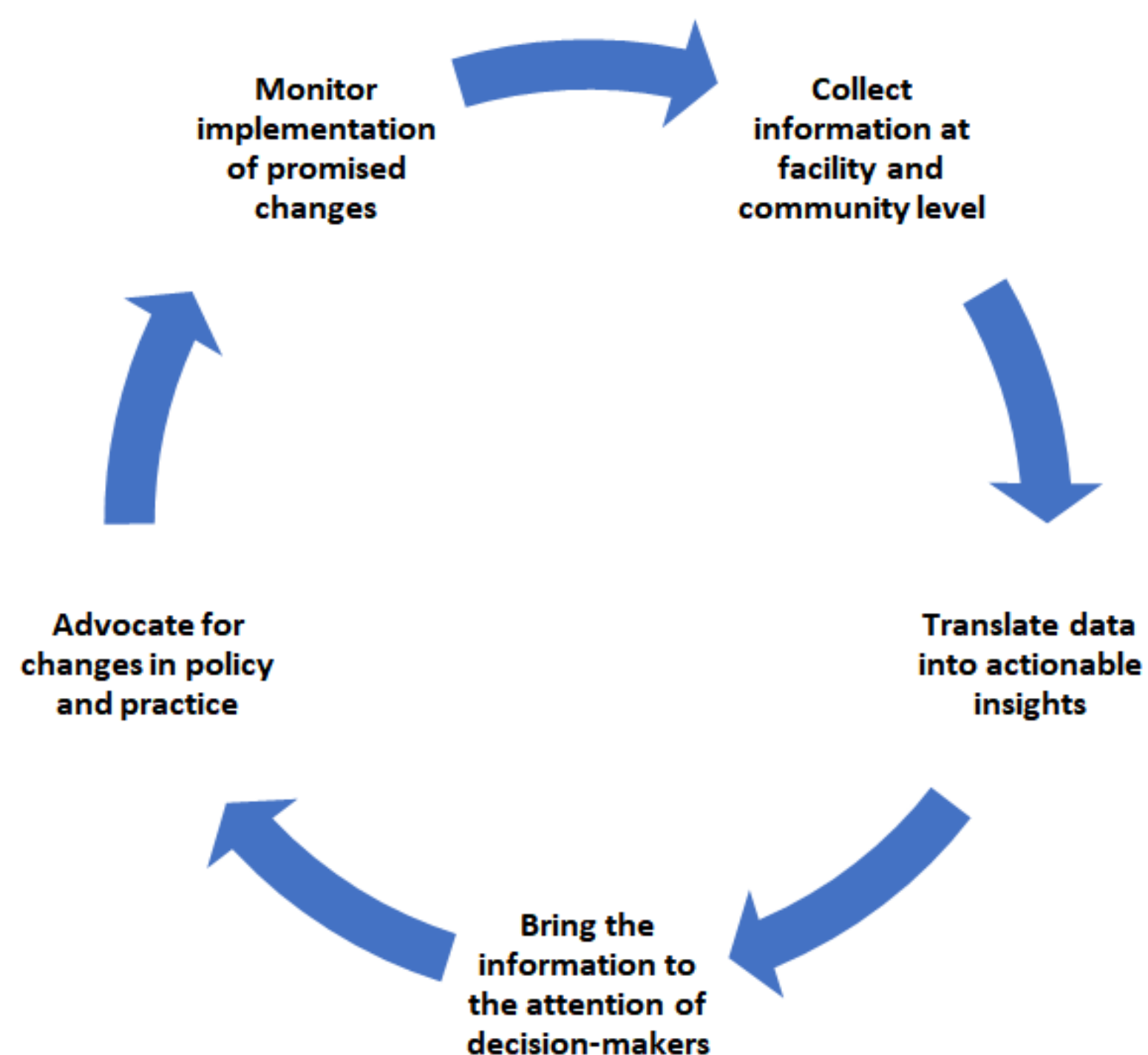


Figure 15: THEORETICAL FRAMEWORK OF HIV CLM

# 8. Annex

Table 5: National Target

National Target								90%			
OU Totals	1,937,571	950,157	166,330	23,929	61,026	13,966	1,215,408	63%	722,163		
State	Est. PLHIV at 2019	Number of PLHIV on ART at Dec 2019 (PEPFAR)	Number of PLHIV on ART @ Nov 2019 (GF)	Number of PLHIV on ART @ Dec 2019 (AHE)	Number of PLHIV on ART @ June 2019 (GOM)	Number of PLHIV on ART @ Dec 2019 (Lagos/GF)	Total Number of PLHIV on ART @ Nov 2019	ART Coverage 2019	ART Gap at the end of 2019/Targets to be achieved	Assumed Program Growth	NAHS HTS Yield
Abia	50,451		2,217		16,099		18,316	36%	32,135	20%	2.13%
Adamawa	41,123	28,906	9,314				38,220	93%	2,903	20%	1.17%
Akwa-Ibom	183,883	72,690					72,690	40%	111,193	20%	5.20%
Anambra	85,096		31,637	1,151			32,788	39%	52,308	20%	2.34%
Bauchi	29,996	17,783	2,266				20,049	67%	9,947	20%	0.45%
Bayelsa	22,068	6,101	1,150				7,251	33%	14,817	20%	2.02%
Benue	192,116	172,127	16,150	13,221			201,498	105%	(9,382)	20%	4.89%
Borno	41,343	11,866	2,121				13,987	34%	27,356	20%	1.14%
Cross River	51,750	41,577	3,483	1,963			47,023	91%	4,727	20%	1.97%
Delta	57,895	23,793	7,116				30,909	53%	26,986	20%	1.78%
Ebonyi	12,170	7,978	1,210				9,188	75%	2,982	20%	0.85%
Edo	40,098	23,463	8,156				31,619	79%	8,479	20%	1.90%
Ekiti	13,320	3,818	664				4,482	34%	8,838	20%	0.66%
Enugu	55,918	23,518	3,895				27,413	49%	28,505	20%	2.03%
FCT	57,965	50,886	6,247	3,994			61,127	105%	(3,162)	20%	1.48%
Gombe	25,795	19,671	2,145				21,816	85%	3,979	20%	1.16%
Imo	54,021	19,806	5,075				24,881	46%	29,140	20%	1.70%
Jigawa	11,463	7,975	1,825				9,800	85%	1,663	20%	0.36%
Kaduna	54,142	49,713	2,807				52,520	97%	1,622	20%	0.99%
Kano	44,610	33,866	4,978				38,844	87%	5,766	20%	0.60%
Katsina	14,802	9,855	2,582				12,437	84%	2,365	20%	0.31%
Kebbi	16,559	7,429	2,345				9,774	59%	6,785	20%	0.67%
Kogi	33,119	19,227	903	1,872			22,002	66%	11,117	20%	1.00%
Kwara	15,276	8,265	767				9,032	59%	6,244	20%	1.09%
Lagos	114,160	63,469				13,966	77,435	68%	36,725	20%	1.46%
Nasarawa	66,549	45,802	6,150	1,728			53,680	81%	12,869	20%	2.00%
Niger	37,091	21,330	2,206				23,536	63%	13,555	20%	0.76%
Ogun	36,775	18,823	7,183				26,006	71%	10,769	20%	1.33%
Ondo	31,421	10,609	601				11,210	36%	20,211	20%	0.89%
Osun	27,732	7,510	3,015				10,525	38%	17,207	20%	0.94%
Oyo	46,784	21,906	6,920				28,826	62%	17,958	20%	0.83%
Plateau	67,133	40,649	2,982				43,631	65%	23,502	20%	1.45%
Rivers	183,029	40,635					40,635	22%	142,394	20%	3.95%
Sokoto	20,311	7,380	1,575				8,955	44%	11,356	20%	0.41%
Taraba	67,429		11,806		44,927		56,733	84%	10,696	20%	2.69%
Yobe	19,851	7,583	3,746				11,329	57%	8,522	20%	0.32%
Zamfara	14,327	4,147	1,093				5,240	37%	9,087	20%	0.43%

HTS – 2020

							90%		
1,970,325	1,209,843	209,136	28,715	64,781	16,759	1,549,578	79%	420,747	14,828,259
Est. PLHIV at 2020	Expected Target of PLHIV on ART at Dec 2020 (PEPFAP <sup>1</sup> )	Expected Target of PLHIV on ART @ Dec 2020 (GF)	Expected Target of PLHIV on ART @ Dec 2020 (AHF)	Expected Target of PLHIV on ART @ Dec 2020 (GON <sup>1</sup> )	Expected Target of PLHIV on ART @ Dec 2020 (Lagos/GF)	Expected Total Target of PLHIV on ART @ Dec 2020	Expected ART Coverage 2020	Expected ART Gap at the end of 2020/Targets to be achieved	HTS Need
53,001		4,776		19,319		24,095	45%	28,906	271,169
41,482	30,351	10,389				40,740	98%	742	215,579
188,562	146,290					146,290	78%	42,272	1,414,838
88,597		34,142	1,381			35,523	40%	53,074	116,733
30,017	16,934	2,978				21,052	70%	8,965	224,469
22,938	5,926	2,368				8,294	36%	14,644	51,705
197,000	173,332	17,650	15,865			206,847	105%	(9,847)	109,327
41,755	14,269	3,031				17,300	41%	24,455	290,106
52,301	41,814	4,208	2,356			48,377	92%	3,924	68,668
59,629	45,049	9,898				54,947	92%	4,682	1,353,158
12,168	8,141	1,554				9,695	80%	2,473	59,949
41,142	18,027	9,791				33,200	81%	7,942	83,202
14,069	3,902	783				4,685	33%	9,384	30,655
57,552	26,526	5,655				32,181	56%	25,371	234,364
60,951	57,572	7,177	4,793			69,542	114%	(8,591)	568,633
25,974	19,870	3,080				22,950	88%	3,024	97,994
57,230	21,009	8,776				29,785	52%	27,445	287,651
11,552	8,245	2,554				10,799	93%	753	275,236
54,166	49,794	2,888				52,682	97%	1,484	16,417
44,837	30,166	8,016				40,786	91%	4,051	326,372
14,965	7,825	2,927				13,059	87%	1,906	200,970
16,545	7,393	3,163				10,556	64%	5,989	116,471
33,397	22,360	1,246	2,246			25,852	77%	7,545	388,152
15,602	8,137	995				9,132	59%	6,470	9,150
116,258	92,836				16,759	109,595	94%	6,663	2,197,138
66,301	56,097	6,921	2,074			65,092	98%	1,209	569,979
36,736	26,956	2,554				29,510	80%	7,226	789,472
38,093	12,976	9,062				27,306	72%	10,787	97,854
31,301	12,533	689				13,222	42%	18,079	227,182
28,492	5,660	4,086				11,051	39%	17,441	55,856
47,699	19,220	10,782				30,002	63%	17,697	142,131
67,036	44,071	3,478				47,549	71%	19,487	270,543
188,852	159,062					159,062	84%	29,790	2,986,997
21,118	7,678	2,260				9,938	47%	11,180	242,325
67,042		15,881		45,462		61,343	91%	5,699	171,536
11,449	5,622	3,936				11,896	104%	(447)	178,437
14,516	4,200	1,442				5,642	39%	8,874	92,837



HTS – 2021

							90%		
2,066,718	1,287,693	243,942	31,359	77,737	16,759	1,668,740	81%	397,978	7,612,429
Est. PLHIV at 2021	Expected Target of PLHIV on ART at Dec 2021 (PEPFAR)	Expected Target of PLHIV on ART @ Dec 2021 (GF)	Expected Target of PLHIV on ART @ Dec 2021 (AHF)	Expected Target of PLHIV on ART @ Dec 2021 (GON)	Expected Target of PLHIV on ART @ Dec 2021 (Lagos/GF)	Expected Total Target of PLHIV on ART @ Dec 2021	Expected ART Coverage 2021	Expected ART Gap at the end of 2021/Targets to be achieved	HTS Need
55,017		5,731		23,183		28,914	53%	26,103	226,128
41,633	30,958	10,493				41,451	100%	182	60,810
195,154	165,220					165,220	85%	29,934	363,897
92,483		40,970	1,657			42,628	46%	49,855	303,213
29,691	18,549	3,574				22,123	75%	7,568	239,760
23,742	6,625	2,842				9,467	40%	14,275	58,137
205,647	182,881	18,533	16,658			218,072	106%	(12,425)	229,425
42,119	14,224	3,637				17,861	42%	24,258	49,136
52,981	42,010	5,050	2,827			49,886	94%	3,095	76,528
77,843	49,773	11,878				61,651	79%	16,192	377,366
12,119	9,975	1,865				11,840	98%	279	253,535
41,681	20,756	11,749				34,860	84%	6,821	87,362
14,608	4,414	940				5,354	37%	9,254	100,899
59,244	34,518	6,786				41,304	70%	17,940	448,467
63,473	57,663	7,536	5,032			70,231	111%	(6,758)	46,591
40,898	25,541	3,696				29,237	71%	11,661	543,330
60,414	23,054	10,531				33,585	56%	26,829	222,890
11,654	8,283	3,065				11,347	97%	307	151,068
54,154	49,868	3,466				53,334	98%	820	65,974
45,075	33,461	9,619				43,080	96%	1,995	385,531
15,093	8,358	3,512				13,712	91%	1,381	211,019
16,543	7,897	3,796				11,693	71%	4,850	169,262
33,555	22,868	1,495	2,696			27,059	81%	6,496	120,062
15,811	8,667	1,194				9,861	62%	5,950	66,969
118,586	95,407				16,759	112,166	95%	6,420	175,649
65,822	56,158	6,981	2,488			65,628	100%	194	26,754
36,871	31,929	3,065				34,994	95%	1,877	724,684
39,473	13,946	10,874				28,671	73%	10,802	102,747
31,018	12,387	827				13,883	45%	17,135	74,638
29,407	6,074	4,903				11,604	39%	17,803	58,649
48,506	19,530	12,938				32,468	67%	16,038	298,082
67,815	44,119	4,174				48,293	71%	19,522	51,353
195,182	163,560					163,560	84%	31,622	113,450
22,061	8,408	2,712				11,120	50%	10,941	291,363
85,082		19,057		54,554		73,611	87%	11,471	456,528
11,597	5,860	4,723				12,491	108%	(894)	187,359
14,666	4,751	1,730				6,482	44%	8,184	193,814

HTS – 2022

							95%		
2,155,020	1,444,002	282,760	36,202	93,284	20,111	1,876,359	87%	278,661	13,445,267
Est. PLHIV at 2022	Expected Target of PLHIV on ART at Dec 2022 (PEPFAR)	Expected Target of PLHIV on ART @ Dec 2022 (GF)	Expected Target of PLHIV on ART @ Dec 2022 (AHF)	Expected Target of PLHIV on ART @ Dec 2022 (GON)	Expected Target of PLHIV on ART @ Dec 2022 (Lagos/GF)	Expected Total Target of PLHIV on ART @ Dec 2022	Expected ART Coverage 2022	Expected ART Gap at the end of 2022/Targets to be achieved	HTS Need
56346		6,877		27,819		34,697	62%	21,649	271,354
41939	30,967	10,502				41,469	99%	470	1,555
196904	194,959					194,959	99%	1,945	571,696
96053		49,164	1,989			51,153	53%	44,900	363,856
29272	22,259	4,288				26,547	91%	2,725	990,724
24420	7,950	3,410				11,360	47%	13,060	93,870
214763	184,710	22,239	19,990			226,939	106%	(12,176)	181,234
42520	17,069	4,365				21,433	50%	21,087	312,769
53485	42,165	6,060	3,392			51,616	97%	1,869	87,742
80060	59,728	14,253				73,981	92%	6,079	694,101
16499	11,970	2,238				14,208	86%	2,291	279,915
40787	24,907	14,099				39,006	96%	1,781	218,178
14949	5,297	1,128				6,425	43%	8,524	161,519
60808	41,422	8,143				49,565	82%	11,243	406,084
62697	58,240	7,611	5,083			70,934	113%	(8,237)	47,458
40577	30,649	4,435				35,084	85%	5,493	505,320
63312	27,665	12,637				40,302	64%	23,010	393,969
18928	9,939	3,678				13,617	72%	5,311	625,118
79504	59,842	4,159				64,001	81%	15,503	1,079,667
45178	33,561	9,719				43,280	96%	1,898	33,521
15151	10,030	4,215				14,244	94%	907	172,158
16491	9,476	4,555				14,031	85%	2,460	348,252
33557	27,442	1,794	3,235			32,471	97%	1,086	538,549
15889	10,400	1,433				11,833	74%	4,056	181,176
120783	95,728			20,111		115,839	96%	4,944	250,925
65856	56,167	6,991	2,513			65,672	100%	184	2,214
53746	38,315	3,678				41,993	78%	11,753	924,886
40744	16,735	13,049				29,784	73%	10,960	83,779
30423	14,864	992				15,857	52%	14,566	222,804
30250	7,289	5,884				13,173	44%	17,077	166,550
49012	23,436	15,526				38,962	79%	10,050	784,808
68620	52,943	5,008				57,951	84%	10,669	667,015
200787	196,272					196,272	98%	4,515	825,069
22617	10,090	3,254				13,344	59%	9,273	548,216
85675		19,631		65,465		85,096	99%	579	427,347
11695	5,815	5,668				11,483	98%	212	(317,303)
14723	5,702	2,076				7,778	53%	6,945	299,172

HTS – 2023

		95%		
2,211,339	1,989,472	90%	221,867	9,921,459
Est. PLHIV at 2023	Expected Total Target of PLHIV on ART @ Dec 2023	Expected ART Coverage 2023	Expected ART Gap at the end of 2023/Targets to be achieved	HTS Need
57021	43,371	76%	13,650	407,031
42145	41,884	99%	261	35,472
197899	195,057	99%	2,842	1,869
99231	63,942	64%	35,289	545,783
29029	27,874	96%	1,155	297,217
25007	14,200	57%	10,807	140,805
223938	229,208	102%	(5,270)	46,384
42896	26,792	62%	16,104	469,154
54116	52,132	96%	1,984	26,179
82309	77,680	94%	4,629	208,230
16457	14,918	91%	1,539	83,974
39712	40,957	103%	(1,245)	102,639
15145	8,031	53%	7,114	242,278
62141	52,043	84%	10,098	121,825
61825	71,005	115%	(9,180)	4,793
40283	36,839	91%	3,444	151,596
65838	50,378	77%	15,460	590,953
18466	14,780	80%	3,686	320,402
79137	71,004	90%	8,133	708,834
73330	51,696	70%	21,634	1,414,348
15177	14,957	99%	220	230,178
16409	14,733	90%	1,676	104,476
33416	34,094	102%	(678)	161,565
15838	12,425	78%	3,413	54,353
123153	116,997	95%	6,156	79,140
65410	65,681	100%	(271)	460
53041	42,412	80%	10,629	55,493
41824	37,230	89%	4,594	560,366
29592	19,821	67%	9,771	447,551
30941	16,466	53%	14,475	349,545
49145	40,910	83%	8,235	235,442
69215	60,849	88%	8,366	200,104
207323	206,086	99%	1,237	247,521
22672	16,680	74%	5,992	822,324
85788	85,125	99%	663	1,078
11728	11,494	98%	234	3,334
14742	9,723	66%	5,019	448,759

HTS – 2024

		95%		
2,243,507	2,107,455	94%	136,052	9,017,185
Est. PLHIV at 2024	Expected Total Target of PLHIV on ART @ Dec 2024	Expected ART Coverage 2024	Expected ART Gap at the end of 2024/Targets to be achieved	HTS Need
57073	54,213	95%	2,860	508,789
42143	41,897	99%	246	1,116
197912	195,199	99%	2,713	2,732
102076	79,927	78%	22,149	682,229
28555	27,932	98%	623	12,926
25502	17,750	70%	7,752	176,007
230886	231,500	100%	(614)	46,848
43142	33,490	78%	9,652	586,443
54822	52,232	95%	2,590	5,030
84867	85,448	101%	(581)	437,283
16436	14,995	91%	1,441	9,095
50345	51,196	102%	(851)	538,854
15193	10,039	66%	5,154	302,848
63159	65,054	103%	(1,895)	639,582
61294	71,715	117%	(10,421)	47,980
39714	37,011	93%	2,703	14,883
67938	62,972	93%	4,966	738,692
18818	14,964	80%	3,854	50,762
79285	71,411	90%	7,874	41,160
72273	52,778	73%	19,495	181,771
15178	14,968	99%	210	3,560
16304	14,816	91%	1,488	12,482
33137	34,435	104%	(1,298)	33,929
15666	15,531	99%	135	285,352
124993	117,305	94%	7,688	21,027
65305	66,338	102%	(1,033)	32,806
52954	42,944	81%	10,010	70,228
42669	39,092	92%	3,577	140,092
28614	24,776	87%	3,838	559,439
31450	20,582	65%	10,868	436,932
48917	47,047	96%	1,870	741,643
69665	61,267	88%	8,398	28,889
212595	206,147	97%	6,448	1,560
22937	20,850	91%	2,087	1,027,905
85257	85,976	101%	(719)	31,676
11700	11,506	98%	194	3,688
14733	12,153	82%	2,580	560,948

HTS – 2025

		95%		
2,256,856	2,170,233	96%	86,623	6,924,054
Est. PLHIV at 2025	Expected Total Target of PLHIV on ART @ Dec 2025	Expected ART Coverage 2025	Expected ART Gap at the end of 2025/Targets to be achieved	HTS Need
56536	54,356	96%	2,180	6,710
42255	41,909	99%	346	1,052
196738	195,334	99%	1,404	2,608
104485	91,002	87%	13,483	472,635
27840	27,963	100%	(123)	6,973
25889	23,564	91%	2,325	288,261
237728	231,470	97%	6,258	2,000
43194	40,729	94%	2,465	633,831
55499	52,361	94%	3,138	6,569
87020	85,419	98%	1,601	2,000
16346	15,067	92%	1,279	8,516
48803	51,153	105%	(2,350)	2,000
15096	13,904	92%	1,192	583,129
63828	64,959	102%	(1,131)	2,000
60686	71,194	117%	(10,508)	2,000
39213	37,146	95%	2,067	11,680
69509	63,221	91%	6,288	14,563
19015	16,891	89%	2,124	530,719
79936	71,804	90%	8,132	39,851
70941	62,525	88%	8,416	1,638,010
15160	14,978	99%	182	3,398
16172	14,891	92%	1,281	11,076
32701	34,370	105%	(1,669)	2,000
15385	15,538	101%	(153)	620
126333	117,690	93%	8,643	26,261
65791	66,286	101%	(495)	2,000
52900	47,949	91%	4,951	661,417
43236	39,271	91%	3,965	13,460
27521	26,695	97%	826	216,662
31742	28,733	91%	3,009	865,151
48328	47,140	98%	1,188	11,302
69996	65,466	94%	4,530	289,982
216694	206,470	95%	10,224	8,131
23232	21,894	94%	1,339	257,223
84812	85,940	101%	(1,128)	2,000
11603	11,508	99%	95	612
14693	13,443	91%	1,250	297,654

C. PMTCT

State	2019 PMTCT Coverage (%)	Mothers Receiving PMTCT	Estimated mothers needing PMTCT (100%)						
			2019	2020	2021	2022	2023	2024	2025
Abia	31.1	778	2,499	2,829	2,334	2,348	2,332	2,286	2,211
Adamawa	62.1	710	1,143	1,109	1,135	1,103	1,072	1,041	1,009
Akwa Ibom	37.6	2,390	6,355	6,387	6,486	6,440	6,378	6,260	6,067
Anambra	84.5	4,342	5,141	5,355	5,443	5,546	5,614	5,640	5,622
Bauchi	58.9	404	686	662	691	666	640	615	589
Bayelsa	21.4	322	1,502	1,559	1,782	1,811	1,817	1,810	1,789
Benue	110.1	7,896	7,172	7,233	7,387	7,401	7,391	7,360	7,306
Borno	21.9	637	2,903	2,877	2,569	2,540	2,530	2,515	2,462
Cross River	47.6	969	2,034	2,006	1,996	1,953	1,906	1,854	1,793
Delta	42.3	1,555	3,673	3,726	3,775	3,788	3,762	3,718	3,672
Ebonyi	80.6	487	604	587	569	549	529	507	486
Edo	26.8	956	3,565	3,652	3,666	3,516	3,350	3,174	2,983
Ekiti	19.3	157	814	849	877	876	864	843	813
Enugu	48.0	1,099	2,289	2,309	2,324	2,348	2,356	2,343	2,304
FCT Abuja	83.4	2,434	2,919	2,921	2,916	2,768	2,626	2,491	2,365
Gombe	46.6	615	1,320	1,279	1,240	1,199	1,160	1,123	1,088
Imo	37.9	1,042	2,749	2,886	3,033	3,161	3,257	3,315	3,325
Jigawa	47.0	226	481	473	466	460	453	445	434
Kaduna	155.1	1,971	1,271	1,237	1,234	1,226	1,212	1,189	1,155
Kano	47.6	897	1,883	1,795	1,780	1,742	1,699	1,648	1,586
Katsina	64.3	411	639	623	598	581	561	541	522
Kebbi	20.3	172	847	829	807	780	750	721	690
Kogi	83.3	1,211	1,454	1,428	1,425	1,431	1,416	1,380	1,324
Kwara	48.8	393	805	810	806	791	767	736	699
Lagos	13.0	1,205	9,276	9,225	8,582	8,629	13,852	13,769	13,615
Nasarawa	85.4	2,493	2,919	2,814	2,700	2,608	2,518	2,432	2,351
Niger	57.7	896	1,553	1,522	1,483	1,439	1,393	1,345	1,297
Ogun	33.5	685	2,044	2,080	2,114	2,147	2,169	2,171	2,149
Ondo	42.5	617	1,452	1,433	1,388	1,322	1,248	1,169	1,087
Osun	30.2	359	1,190	1,212	1,240	1,266	1,282	1,283	1,264
Oyo	55.5	1,068	1,923	1,937	1,950	1,945	1,916	1,864	1,790
Plateau	17.9	1,103	6,177	6,117	5,964	5,858	5,788	5,724	5,653
Rivers	12.0	1,038	8,669	8,887	9,122	9,300	9,544	9,645	9,748
Sokoto	53.7	226	421	449	478	505	524	540	551
Taraba	56.8	1,706	3,001	2,906	2,818	2,733	2,652	2,573	2,496
Yobe	58.8	369	628	604	572	568	558	544	525
Zamfara	17.9	171	956	959	971	964	943	918	890
<b>National</b>	<b>46.3</b>	<b>44,010</b>	<b>94,957</b>	<b>95,566</b>	<b>94,721</b>	<b>94,308</b>	<b>98,829</b>	<b>97,532</b>	<b>95,710</b>

D. EID

State	2019 PMTCT Coverage (%)	Mothers Receiving PMTCT 2019	Estimated mothers needing PMTCT						
			2019	2020	2021	2022	2023	2024	2025
Abia	31.1	778	2,499	2,829	2,334	2,348	2,332	2,286	2,211
Adamawa	62.1	710	1,143	1,109	1,135	1,103	1,072	1,041	1,009
Akwa Ibom	37.6	2,390	6,355	6,387	6,486	6,440	6,378	6,260	6,067
Anambra	84.5	4,342	5,141	5,355	5,443	5,546	5,614	5,640	5,622
Bauchi	58.9	404	686	662	691	666	640	615	589
Bayelsa	21.4	322	1,502	1,559	1,782	1,811	1,817	1,810	1,789
Benue	110.1	7,896	7,172	7,233	7,387	7,401	7,391	7,360	7,306
Borno	21.9	637	2,903	2,877	2,569	2,540	2,530	2,515	2,462
Cross River	47.6	969	2,034	2,006	1,996	1,953	1,906	1,854	1,793
Delta	42.3	1,555	3,673	3,726	3,775	3,788	3,762	3,718	3,672
Ebonyi	80.6	487	604	587	569	549	529	507	486
Edo	26.8	956	3,565	3,652	3,666	3,516	3,350	3,174	2,983
Ekiti	19.3	157	814	849	877	876	864	843	813
Enugu	48.0	1,099	2,289	2,309	2,324	2,348	2,356	2,343	2,304
FCT Abuja	83.4	2,434	2,919	2,921	2,916	2,768	2,626	2,491	2,365
Gombe	46.6	615	1,320	1,279	1,240	1,199	1,160	1,123	1,088
Imo	37.9	1,042	2,749	2,886	3,033	3,161	3,257	3,315	3,325
Jigawa	47.0	226	481	473	466	460	453	445	434
Kaduna	155.1	1,971	1,271	1,237	1,234	1,226	1,212	1,189	1,155
Kano	47.6	897	1,883	1,795	1,780	1,742	1,699	1,648	1,586
Katsina	64.3	411	639	623	598	581	561	541	522
Kebbi	20.3	172	847	829	807	780	750	721	690
Kogi	83.3	1,211	1,454	1,428	1,425	1,431	1,416	1,380	1,324
Kwara	48.8	393	805	810	806	791	767	736	699
Lagos	13.0	1,205	9,276	9,225	8,582	8,629	13,852	13,769	13,615
Nasarawa	85.4	2,493	2,919	2,814	2,700	2,608	2,518	2,432	2,351
Niger	57.7	896	1,553	1,522	1,483	1,439	1,393	1,345	1,297
Ogun	33.5	685	2,044	2,080	2,114	2,147	2,169	2,171	2,149
Ondo	42.5	617	1,452	1,433	1,388	1,322	1,248	1,169	1,087
Osun	30.2	359	1,190	1,212	1,240	1,266	1,282	1,283	1,264
Oyo	55.5	1,068	1,923	1,937	1,950	1,945	1,916	1,864	1,790
Plateau	17.9	1,103	6,177	6,117	5,964	5,858	5,788	5,724	5,653
Rivers	12.0	1,038	8,669	8,887	9,122	9,300	9,544	9,645	9,748
Sokoto	53.7	226	421	449	478	505	524	540	551
Taraba	56.8	1,706	3,001	2,906	2,818	2,733	2,652	2,573	2,496
Yobe	58.8	369	628	604	572	568	558	544	525
Zamfara	17.9	171	956	959	971	964	943	918	890
<b>National</b>	<b>46.3</b>	<b>44,010</b>	<b>94,957</b>	<b>95,566</b>	<b>94,721</b>	<b>94,308</b>	<b>98,829</b>	<b>97,532</b>	<b>95,710</b>

E. Assumptions for the targets:

<b>Estimated mothers needing PMTCT (100%)</b>	<b>100 % of women needing PMTCT would be targeted</b>
<b>2019 PMTCT Coverage (%)</b>	<b>Mothers Receiving PMTCT divided by Estimated mothers needing PMTCT .</b>
<b>EID</b>	<b>The same target for PMTCT, assuming that multiple births and still birth will balance up to one live birth per mother</b>
<b>ART</b>	<b>The upper bound of the estimated number of PLHIVs was used to adjust for states with high ART coverage above the mean PLHIV estimate</b>
<b>ART</b>	<b>The National ART treatment target are: 90% in 2020 90% in 2021 90% in 2021 95% in 2022 95% in 2023 95% in 2024 95% in 2025</b>



Table 6: List of HIV ART Program Indicators

<b>1.</b>	Number of HIV-positive individuals newly enrolled in clinical care during the reporting period
<b>2.</b>	Percentage of people living with HIV who are currently in HIV care who received at least one of the following during the reporting period: clinical assessment (WHO staging) OR CD4 count OR viral load OR current on treatment.
<b>3.</b>	Number of people living with HIV newly started on ART during the reporting period
<b>4.</b>	Percentage of people living with HIV who are receiving ART during the reporting period
<b>5.</b>	Percentage of people living with HIV and on ART who are retained on ART 12 months after initiation
<b>6.</b>	Percentage of people in HIV care (including PMTCT) who were clinically screened for TB in HIV care and treatment settings
<b>7.</b>	Percentage of People in HIV care who are Presumptive to TB and were Tested for TB
<b>8.</b>	Percentage of people living with HIV enrolled in HIV care who have active TB disease
<b>9.</b>	Percentage of registered new and relapsed TB cases with a documented HIV status during the reporting period
<b>10.</b>	Percentage of People newly enrolled in HIV care who are commenced on Isoniazid Preventive Therapy (IPT).
<b>11.</b>	Percentage of HIV-positive new and relapsed TB patients on ART during TB treatment
<b>12.</b>	Percentage of people living with HIV with a presumptive diagnosis of TB during the reporting period.
<b>13.</b>	Percentage of reported HIV exposure provided with post exposure prophylaxis (PEP) during the reporting period (excluding HIV exposed babies)
<b>14.</b>	Proportion of people living with HIV co-infected with viral hepatitis
<b>15.</b>	Number of people living with HIV (PLHIV) who received co-trimoxazole prophylaxis during the reporting period
<b>16.</b>	Proportion of people living with HIV (PLHIV) on ART with viral load test results within the reporting period.
<b>17.</b>	Proportion of people living with HIV who are virologically suppressed during the reporting period.
<b>18.</b>	Proportion of facilities reporting a stock-out of antiretroviral drugs during the reporting period.
<b>19.</b>	Number of PLHIV known to have died during the reporting period
<b>20.</b>	Number of PLHIV who are lost to follow up during the reporting period
<b>21.</b>	Number of PLHIV who RESTART ART during the reporting period
<b>22.</b>	Number of PLHIV who STOPPED ART during the reporting period
<b>23.</b>	Number of PLHIV newly enrolled in care who were assessed for malnutrition during the reporting period.

Table 7: Indicator Reference Sheet

Number of HIV-Positive Individuals Newly Enrolled in Clinical Care during the Reporting Period Program Area: HIV ART
<b>DESCRIPTION</b>
<b>Precise Definition(s):</b>
<b>Purpose/Justification:</b> <p>Following HIV diagnosis, prompt enrollment in care is critical to ensure timely initiation on ART, and provide key care and support services, especially in a Test and Start scenario. Timely initiation of ART has been shown to reduce morbidity and mortality and is a highly effective approach to preventing HIV transmission. Further, enrollment in care facilitates access to key care and support services which may further reduce morbidity and mortality, enhance retention in care, prevent ongoing transmission of HIV, and enhance quality of life for people living with HIV (PLHIV).</p> <p>This indicator will allow the country to:</p> <ul style="list-style-type: none"> <li>• Assess the quality of linkages &amp; referrals between HIV testing and care and treatment programs and identify gaps; when compared with the number testing HIV positive this provides a rough proxy of linkage to care.</li> <li>• Assess the timing of enrollment in care in terms of prompt initiation of ART, preserve immune function, facilitate appropriate screening and prevention of opportunistic infections, and promote epidemic control.</li> </ul>
<b>Numerator:</b> Number of newly diagnosed HIV-positive individuals newly enrolled in clinical care during the reporting period
<b>Denominator:</b> N/A
<b>Disaggregation:</b> Age (<1, 1-4, 5-9, 10-14, 15-19, 20-24, 25-49, 50+ years); sex; pregnancy status, breastfeeding status, TB patients.
<b>How to measure:</b> This indicator can be obtained by counting all of the patients who were newly enrolled in care during the reporting period.  <p>To be counted for this indicator, HIV-positive individuals need to register at a HIV treatment facility and be assigned an enrollment number. With this indicator, the goal should be to document and monitor the number of PLHIV newly enrolled in care. Transfers of existing patients from clinics or health facilities will not count as new enrollees. However current patients at facilities who are newly HIV diagnosed within other clinical programs such as PMTCT or TB should be counted under this indicator.</p>
<b>Method of calculation:</b> N/A
<b>Unit of Measurement:</b> Absolute number
<b>Data Sources:</b> HIV Enrollment Register
<b>Frequency of collection:</b> Monthly
<b>Frequency of reporting:</b> Monthly
<b>Location of Data Storage:</b> Facility Medical Records Unit
<b>Other Notes:</b> High priority

Indicator Reference Sheet

<b>Percentage of People Living with HIV Who are Currently in HIV Care who Received at Least One of the Following during the Reporting Period: Clinical Assessment (WHO Staging) OR CD4 Count OR Viral Load OR Current on Treatment.</b>
<b>Program Area: HIV ART</b>
<b>DESCRIPTION</b>
<b>Precise Definition(s):</b> Proportion of people living with HIV who are currently in HIV care who received at least one of the following by the end of the month: clinical assessment (WHO staging) OR CD4 count OR viral load OR current on treatment
<b>Purpose/Justification:</b> Care and support programs provide a range of services across the continuum of care, addressing clinical and non-clinical needs of people living with HIV (PLHIV). Clinical care is essential for all PLHIV, including periodic assessment of clinical and immune status; with timely initiation of ART for all eligible clients; and provision of other services known to reduce morbidity and mortality, such as screening and prophylaxis for opportunistic infections.  This indicator attempts to measure the proportion of HIV-positive individuals who received clinical care services, defined by receipt of at least one of the following during the reporting period: clinical assessment (WHO staging) OR CD4 count OR viral load OR currently on treatment. Data collected through this indicator will inform the country about scale and coverage of care services for HIV-positive individuals.
<b>Numerator:</b> Number of HIV positive adults and children who received at least one of the following during the reporting period: clinical assessment (WHO staging) OR CD4 count OR viral load OR current on treatment
<b>Denominator:</b> Estimated number of PLHIV
<b>Disaggregation:</b> Age (<1, 1-4, 5-9, 10-14, 15-19, 20-24, 25-49, 50+ years); sex; pregnancy status, breastfeeding status, TB patients
<b>How to measure:</b> The numerator can be generated by counting the number of HIV positive adults and children who received at least one of the following during the reporting period: clinical assessment (WHO staging) OR CD4 count OR viral load OR are currently on treatment. All individuals receiving ART should also be receiving at least one of the following during the reporting period: clinical assessment (WHO staging) OR CD4 count OR viral load and optimally a full range of clinical care services. Thus, every individual counted as receiving ART is also actively receiving clinical care services and therefore should also be counted under the indicator.  Programs should follow national guidelines with regard to monitoring viral load. In general, measurement of viral load should be limited to HIV-positive individuals receiving ART.  The numerator should equal the unique number of adults and children with HIV infection who have received at least one of the above-mentioned services during the reporting period. Individuals should only be counted once under the indicator, regardless of the number of clinical care services received.  While the receipt of at least one clinical care service (clinical assessment (WHO staging) OR CD4 count OR viral load OR current on treatment) is sufficient to count an HIV-positive individual as receiving clinical care using this indicator, programs should strive to provide appropriate, necessary care to all HIV-positive individuals following national guidelines, providing other needed services (clinical and support services) either directly or through referral. Given a Test and Start scenario, the majority (if not all) of the patients will be currently receiving ART. Thus, the number of patients current in care may be greater than or equal to the number of patients currently on ART.  Denominator: This is obtained from spectrum using program, population, and surveillance data.
<b>Method of calculation:</b> The current on care should equal the number of adults and children (including pregnant and breastfeeding mothers) living with HIV who receive a clinical or lab assessment or are on ART, as proxies for receipt of care divided by the estimated number of people living with HIV/AIDS
<b>Unit of Measurement:</b> Percent
<b>Data Sources:</b> ART Register
<b>Frequency of collection:</b> Monthly
<b>Frequency of reporting:</b> Monthly/Bi-annually
<b>Location of Data Storage:</b> Facility Medical Records Unit
<b>Other Notes:</b>

Indicator Reference Sheet

<b>Number of People Living with HIV Newly Started on ART during the Reporting Period Program Area: HIV ART</b>
<b>Name of Indicator:</b> Number of people living with HIV newly started on ART during the reporting period.
<b>DESCRIPTION</b>
<b>Precise Definition(s):</b>
<b>Purpose/Justification:</b> <p>The indicator measures the uptake of ART programs. This measure is critical to monitor along with number of patients currently on ART in relation to the number of PLHIV that are estimated to be eligible for treatment to assess progress in the program's response to the epidemic in specific geographic areas and population as well as at the national level. This is particularly critical in the context of current revisions to ART eligibility. Reporting the numbers of new patients enrolled on ART at the national level is critical to monitoring the HIV services cascade, specifically the successful linkage between HIV diagnosis, enrollment in care services and initiating ART. Disaggregation of pregnant and breastfeeding women informs the quality of linkages between PMTCT and treatment programs, and disaggregation for pediatric and young children allow monitoring of EID and linkage to treatment programs</p>
<b>Numerator:</b> Number of adults and children newly started on ART
<b>Denominator:</b> None
<b>Disaggregation:</b> Age (<1, 1-4, 5-9, 10-14, 15-19, 20-24, 25-49, 50+ years); sex; pregnancy status, breastfeeding status, TB patients
<b>How to measure:</b> The numerator can be generated by counting the number of adults and children who are newly started on ART in the reporting period, in accordance with the National Guidelines.  <p>NEW is a state defined by an individual's beginning in a program. It is expected that the characteristics of new clients are recorded at the time they newly initiate into a program.</p> <p>Patients are "new" on ART only if they are naive to lifelong ART, even though they may have received ARVs for the purposes of prevention of mother-to-child transmission (PMTCT) or post-exposure prophylaxis (PEP). ART taken only for the purpose of prevention of mother-to-child transmission and post-exposure prophylaxis are not included in this indicator. HIV-positive pregnant women who are eligible for and initiate antiretroviral drug therapy for their own treatment are included in this indicator.</p> <p>HIV-positive pregnant and breastfeeding women initiating lifelong ART through PMTCT will also count as "new" on ART under this indicator.</p> <p>Patients with records who transfer in from another facility, or who temporarily stopped therapy and have started again in the time period should not be included in the count.</p> <p>Patients are counted as pregnant or breastfeeding if they were pregnant or breastfeeding respectively at initiation of ART. Age represents an individual's age at initiation of therapy. For example, if a 14-year-old child begins ART and then shortly after turns age 15, the child will still be counted under NEW in the &lt;15 age category.</p>
<b>Method of calculation:</b> N/A
<b>Unit of Measurement:</b> Number
<b>Data Sources:</b> ART Register
<b>Frequency of collection:</b> Monthly
<b>Frequency of reporting:</b> Monthly
<b>Location of Data Storage:</b> Facility Medical Records Unit
<b>Other Notes:</b>

## C. List of Technical Committee members

1. Director NACA RM & E- Chair
2. NASCP/FMOH Strategic Information Unit
3. FMOH/Department of Planning, Research & Statistics
4. UNAIDS SSIA
5. USAID SI
6. DOD SI
7. CDC SI
8. PEPFAR SI
9. WHO SI
10. UNICEF
11. UNDP
12. UNFPA
13. NTBLCP SI
14. NEPWHAN HEAD M & E
15. CISHAN HEAD M & E
16. AFENET
17. AHF SI
18. IHVN SI
19. APIN SI
20. CIHP SI
21. MSH SI
22. FHI 360 SI
23. SFH SI
24. CRS SI
25. NBTS
26. NBS
27. Population Council
28. FCT Agency for the Control of AIDS (FACA), M&E Focal person
30. FMoWA
31. FMoE
32. FMoYD
33. FMoL
34. Nigerian Prisons Service
35. NMOD
36. NPC
37. University of Manitoba
38. University of Maryland
39. Heartland Alliance
40. ARFH-SI
41. NACA DS and M & E Division serves as NOP 3 Secretariat

Indicator Reference Sheet

**Percentage of People Living with HIV who are Currently Receiving ART during the Reporting Period**  
**Program Area: HIV ART**

**DESCRIPTION**

**Precise Definition(s):**

**Purpose/Justification:** This indicator measures the ongoing scale-up and uptake of ART and retention in ART programs as a critical step in the HIV service cascade and assesses progress towards coverage of ART for all

HIV-positive individuals when reviewed against the estimated number of PLHIV. It allows for tracking the response to the epidemic in specific geographic areas as well as at the national level.

**Numerator:** Number of adults and children with HIV infection receiving antiretroviral therapy (ART).

**Denominator:** Estimated Number of people living with HIV.

**Disaggregation:** ART regimen line, Age (<1, 1-4, 5-9, 10-14, 15-19, 20-24, 25-49, 50+ years); sex; pregnant women, breastfeeding women,

**How to measure:**

**Numerator**

Data for this indicator can be generated by counting the number of adults and children who are currently receiving ART in accordance with the nationally approved treatment protocol at the end of the reporting period. The current on ART count should equal the number of adults and children with HIV infection who ever started ART minus those patients who are not currently on treatment at the end of the reporting period.

- Patients on ART who initiated or transferred in during the reporting period should be counted.
- Patients that pick up several months of antiretroviral drugs at one visit, which include ART received for the last month of the reporting period, but not be recorded as visits for the current month should be included in the count.
- HIV-positive pregnant women who are currently receiving anti-retroviral should be included. Patients excluded from the Current on ART count are patients who died, stopped treatment, transferred out, or are lost to follow-up.

DO NOT count other HIV-positive pregnant women taking other ARV regimens for PMTCT only in this indicator, including those taking maternal triple ARV prophylaxis (provided with the intention to stop at the end of the breastfeeding period).

**Denominator:**

This will be calculated using Spectrum estimates.

**Method of calculation:** Numerator/Denominator

**Unit of Measurement:** Proportion

**Data Sources:** ART Register, Population based estimates

**Frequency of collection:** Annually

**Frequency of reporting:** Annually

**Location of Data Storage:** Facility Medical Records Unit

**Other Notes:**

Indicator Reference Sheet

**Percentage of People Living with HIV who are Currently Receiving ART during the Reporting Period**  
**Program Area: HIV ART**

**DESCRIPTION**

**Precise Definition(s):**

**Purpose/Justification:** This indicator measures the ongoing scale-up and uptake of ART and retention in ART programs as a critical step in the HIV service cascade and assesses progress towards coverage of ART for all

HIV-positive individuals when reviewed against the estimated number of PLHIV. It allows for tracking the response to the epidemic in specific geographic areas as well as at the national level.

**Numerator:** Number of adults and children with HIV infection receiving antiretroviral therapy (ART).

**Denominator:** Estimated Number of people living with HIV.

**Disaggregation:** ART regimen line, Age (<1, 1-4, 5-9, 10-14, 15-19, 20-24, 25-49, 50+ years); sex; pregnant women, breastfeeding women,

**How to measure:**

**Numerator**

Data for this indicator can be generated by counting the number of adults and children who are currently receiving ART in accordance with the nationally approved treatment protocol at the end of the reporting period. The current on ART count should equal the number of adults and children with HIV infection who ever started ART minus those patients who are not currently on treatment at the end of the reporting period.

- Patients on ART who initiated or transferred in during the reporting period should be counted.
- Patients that pick up several months of antiretroviral drugs at one visit, which include ART received for the last month of the reporting period, but not be recorded as visits for the current month should be included in the count.
- HIV-positive pregnant women who are currently receiving anti-retroviral should be included. Patients excluded from the Current on ART count are patients who died, stopped treatment, transferred out, or are lost to follow-up.

DO NOT count other HIV-positive pregnant women taking other ARV regimens for PMTCT only in this indicator, including those taking maternal triple ARV prophylaxis (provided with the intention to stop at the end of the breastfeeding period).

**Denominator:**

This will be calculated using Spectrum estimates.

**Method of calculation:** Numerator/Denominator

**Unit of Measurement:** Proportion

**Data Sources:** ART Register, Population based estimates

**Frequency of collection:** Annually

**Frequency of reporting:** Annually

**Location of Data Storage:** Facility Medical Records Unit

**Other Notes:**

Indicator Reference Sheet

**Percentage of People Living with HIV and on ART who are Retained on ART 12 Months after Initiation**  
**Program Area: HIV ART**

**DESCRIPTION**

**Precise Definition(s):** Percentage of people living with HIV and on ART who are retained on ART 12 months after initiation. Also recommended at 24, 36, 48 & 60 months. Age (EMR is highly recommended for 36 to 60 months).

**Purpose/Justification:** Once a patient is on antiretroviral therapy (ART), treatment is lifelong. ART a highly effective approach to prevent HIV transmission and retention on ART is important to achieve the desired outcomes of the HIV care cascade. This indicator measures the proportion of individuals who have been retained on ART at the specified period and is a measure of the quality of services and continuing engagement of people living with HIV on ART. Death and loss to follow-up are the two highest causes of patient attrition from ART, especially in the first few months after initiating on ART. High retention is one important measure of program success, specifically in reducing morbidity and mortality, and is a proxy for overall quality of the ART program. Monitoring the program level retention is a critical quality of service indicator at all program levels as it can highlight barriers to health seeking behaviors and/or gaps in access to and provision of health services.

This indicator is also important for long term sustainability of the ART programs.

**Numerator:** Number of ART patients alive and on ART 12 months (or 24, 36, 48, 60 months) after initiating ART

**Denominator:** Number of patients initiating ART up to 12 months (or 24, 36, 48, 60 months, etc.) before the beginning of the reporting year. This includes those who have died since starting therapy, those who have stopped therapy and those lost to follow-up as of month 12 (or 24, 36, 48, 60, etc.)

**Disaggregation:** Age (<1, 1-4, 5-9, 10-14, 15-19, 20-24, 25-49, 50+ years); sex; pregnant women, breastfeeding women.

**How to measure:**

**Numerator:** Adult and pediatric patients to be counted towards the numerator must be alive and active on ART

12, 24, 36, 48 and 60 months following their initiation on treatment. Determination of the patients to be accounted for in the numerator does not take into consideration if the patients within the cohort temporarily

defaulted on drug pick-up during the period. The critical determining parameter is that the patient must be documented as still alive and receiving treatment at months 12, 24, 36, 48 and 60. This includes patients who were transferred into the facility whose treatment initiation date falls within the reporting cohort but excludes those who were transferred out of the facility.

**Denominator:**

Number of patients initiating ART up to 12 months (or 24, 36, 48, 60 months, etc.) before the beginning of the reporting year. This includes those who have died since starting therapy, those who have stopped therapy and those lost to follow-up as of month 12 (or 24, 36, 48, 60, etc.). Adult and pediatric patients to be counted towards the denominator cohorts includes those who initiated ART 12, 24, 36, 48 and 60 months before the beginning of the reporting period irrespective of their current outcome. To determine patients to be accounted for in the denominator, include patients who started ART and those who were transferred into the facility whose ART start date falls within the reporting cohort of interest. However, patients who were transferred out whose ART start date falls within the months of interest, should be excluded from the denominator.

For example,

Reporting period: At the end of December 2015

Cohort	12 months	24 months	36 months	48 months	60 months
	cohort	cohort	cohort	cohort	cohort
Treatment initiating period	January 2015	January 2014	January 2013	January 2012	January 2011

**Method of calculation:** cohort analysis/ retention determination tool will be used to for data abstraction on an annual basis.

**Unit of Measurement:** Number

**Data Sources:** Patient case folders, ART Registers, Electronic Medical Records (EMR), Cohort analysis documents

**Frequency of collection:** Annually

**Frequency of reporting:** Annually

**Location of Data Storage:** Facility Medical Records Unit



Indicator Reference Sheet

**Proportion of People Living with HIV (PLHIV) on ART with Viral Load Test Results within the Reporting Period.**

**Program Area:** HIV ART

**DESCRIPTION**

**Precise Definition(s):** Number of PLHIV on ART with a viral load test result as a proportion of the total number of PLHIV on ART

**Purpose/Justification:** Indicator tracks the coverage of viral load monitoring among PLHIV on ART. Also measures quality of care in ART programmes

**Numerator:** Number of people living with HIV and on ART with a viral load test result during the reporting period.

**Denominator:** Number of PLHIV currently on ART within the reporting period

**Disaggregation:** Sex and age disaggregated into <1, 1-4, 5-9, 10-14, 15-19, 20-24, 25-49, 50+ (Apply house agreement)  
Indication for viral load test (targeted/routine monitoring)

**How to measure:** Viral load test results will be reported monthly by each facility. Proportions will be calculated annually

**Method of calculation:** Numerator divided by denominator

**Unit of Measurement:** Percentage

**Data Sources:** Programme records.

**Frequency of collection:** Monthly (for the numerator)

**Frequency of reporting:** Annually

**Location of Data Storage:** Facility Medical Records Unit

**Other Notes:**

Indicator Reference Sheet

**Proportion of People Living with HIV who are Virologically Suppressed during the Reporting Period.**  
**Program Area: HIV ART**

**DESCRIPTION**

**Precise Definition(s):** Number of PLHIV currently on ART who are virologically suppressed (<1000 copies/mL) as a proportion of PLHIV on ART with a viral load test result during the reporting period.

**Purpose/Justification:** Measure clinical outcomes in terms of virologic suppression among PLHIV on ART. Virologic suppression is a reflection of quality of care in ART programmes and a reflection of patient adherence.

**Numerator:** Number of PLHIV currently on ART with a viral load test result <1000 copies/mL during the reporting period

**Denominator:** Number of PLHIV on ART with a viral load test result during the reporting period Estimated number of people living with HIV (population based)

**Disaggregation:** Sex, pregnancy status, breastfeeding status, and age disaggregated into <1, 1-4, 5-9, 10-14, 15-19, 20-24, 25-49, 50+

Indication for viral load test (targeted/routine monitoring)

**How to measure:** Programmes to routinely capture this data from all ART clinics and review it annually.

**Method of calculation:** Numerator divided by denominator

**Unit of Measurement:** Percentage

**Data Sources:** ART register, cohort reporting forms

**Frequency of collection:** Monthly

**Frequency of reporting:** Monthly

**Location of Data Storage:** Facility Medical Records Unit

**Other Notes:** The National and State programmes must develop a platform to get this data.

Indicator Reference Sheet

**Percentage of People in HIV Care (Including PMTCT) who were Clinically Screened for TB in HIV Care and Treatment Settings**

**Program Area:** HIV ART

**DESCRIPTION**

**Precise Definition(s):**

Number of people in HIV care (including PMTCT) whose TB status was assessed and recorded during their last visit during the reporting period, expressed as a proportion of all adults and children enrolled in HIV care and seen for care in the reporting period.

**Purpose/Justification:** To assess the extent of implementation of the recommendation to screen all people living with HIV in care for presence of TB symptoms at every visit to HIV care facilities. Routine screening for TB among PLHIV at every clinic visit will ensure early detection and prompt initiation of TB treatment, thereby reducing TB associated mortality among PLHIV.

**Numerator:** Number of persons enrolled in HIV care whose TB status was assessed and recorded at their last visit during the reporting period

**Denominator:** Total number of persons currently receiving HIV care during the reporting period.

**Disaggregation:** Recommended sex and age disaggregation by <1, 1-4, 5-9, 10-14, 15-19, 20-24, 25-49, 50+.

**How to measure:**

TB status should be assessed at every visit during the reporting period and recorded on the enrollment and ART registers.

**Numerator:** Count the total number of people living with HIV assessed for TB symptoms in the enrollment and ART registers by referring to the quarterly/monthly follow-up section

**Denominator:** Count the total number of people living with HIV in the enrollment and ART registers enrolled in HIV care and seen for care during the reporting period

**Method of calculation: Numerator divided by the Denominator**

**Numerator:** Total number of people living with HIV assessed for TB symptoms in the enrollment and ART registers by referring to the quarterly/monthly follow-up section

**Denominator:** Total number of people living with HIV in the enrollment and ART registers enrolled in HIV care and seen for care during the reporting period

**Unit of Measurement:** Percentage

**Data Sources:** Enrollment and ART registers

**Frequency of collection:** Daily

**Frequency of reporting:** Monthly

**Location of Data Storage:** Facility Medical Records Unit

**Other Notes:** High priority

Indicator Reference Sheet

**Percentage of People Living with HIV with a Presumptive Diagnosis of TB during the Reporting Period.**  
**Program Area: HIV ART**

**DESCRIPTION**

**Precise Definition(s):**

Number of people in HIV care with symptoms suggestive of TB during the reporting period, expressed as a proportion of all adults and children currently in HIV care whose TB status was assessed during the reporting period.

**Purpose/Justification:** To assess the extent of implementation of the recommendation to screen all people living with HIV enrolled in care for the presence of TB symptoms at every clinic visit. Routine screening for TB among PLHIV at every clinic visit will ensure early detection and prompt initiation of TB treatment, thereby reducing TB associated mortality among PLHIV.

**Numerator:** Number of persons enrolled in HIV care found to have any one of the symptoms suggestive of TB among those whose TB status was assessed and recorded during the reporting period.

**Denominator:** Total number of persons currently in HIV care whose TB status was assessed and recorded during the reporting period

**Disaggregation:** Recommended sex and age disaggregation by <1, 1-4, 5-9, 10-14, 15-19, 20-24, 25-49, 50+.

**How to measure:**

TB status should be assessed at every visit during the reporting period and recorded on the Care-card and ART register.

**Numerator:** Count the total number of people living with HIV with TB symptoms in the Care-card/ART register by referring to the quarterly/monthly follow-up section. A presumptive TB status is denoted by code 2 in the care card / ART register under TB status.

**Denominator:** Count the total number of people living with HIV in the ART register enrolled in HIV care during the reporting period whose TB status was assessed.

**Method of calculation:** Numerator divided by the Denominator

**Unit of Measurement:** Percentage

**Data Sources:** Care card /ART registers

**Frequency of collection:** Monthly

**Frequency of reporting:** Monthly

**Location of Data Storage:** Facility Medical Records Unit

**Other Notes:** High priority

Indicator Reference Sheet

**Percentage of People in HIV care who are Presumptive to TB and were Tested for TB Program Area: HIV ART**

**DESCRIPTION**

**Precise Definition(s):**

Number of people in HIV care (including PMTCT) who are presumptive to TB and were tested for TB and recorded during their last visit during the reporting period, expressed as a proportion of all adults and children who are presumptive to TB in HIV care and seen for care in the reporting period.

**Purpose/Justification:** To assess the diagnosis of TB in people in HIV care (including PMTCT) who are presumptive to TB. This will ensure proper diagnosis and prompt initiation of TB treatment, thereby reducing TB associated mortality among PLHIV.

**Numerator:** Number of persons enrolled in HIV care who are presumptive to TB and were tested for TB and recorded at their last visit during the reporting period

**Denominator:** Number of persons enrolled in HIV care found to have any one of the symptoms suggestive of TB among those whose TB status were assessed and recorded during the reporting period.

**Disaggregation:** Recommended sex and age disaggregation by <1, 1-4, 5-9, 10-14, 15-19, 20-24, 25-49, 50+. Method of Diagnosis: GeneXpert or AFB Microscopy

**How to measure:**

The results of TB testing should be assessed during the reporting period and recorded on the enrollment and ART registers.

**Numerator:** Count the total number of persons enrolled in HIV care who were confirmed for TB and recorded at their last visit during the reporting period in the enrollment and ART registers.

**Denominator:** Count the total number of people living with HIV in the enrollment and ART registers enrolled in HIV care and seen for care during the reporting period

**Method of calculation:** Numerator divided by the Denominator

**Unit of Measurement:** Percentage

**Data Sources:** Presumptive TB Register, Enrollment and ART registers

**Frequency of collection:** Daily

**Frequency of reporting:** Monthly

**Location of Data Storage:** Facility Medical Records Unit

**Other Notes:** High priority

Indicator Reference Sheet

**Percentage of People Living with HIV Enrolled in HIV Care who have Active TB Disease. Program Area: HIV ART**

**DESCRIPTION**

**Precise Definition(s):** Total number of people living with HIV having active TB expressed as a percentage of all adults and children currently in HIV care during the reporting period.

**Purpose/Justification:** To measure the burden of active TB among people living with HIV.

**Numerator:** Total number of people living with HIV enrolled in care who have active TB disease during the reporting period.

**Denominator:** Total number of people living with HIV currently in HIV care screened for TB during the reporting period.

**Disaggregation:** by sex and age (<1, 1-4, 5-9, 10-14, 15-19, 20-24, 25-49, 50+) and method of laboratory diagnosis (e.g., GeneXpert, AFB Microscopy, etc.).

Footnote:

GeneXpert is the primary diagnostic tool for TB in Nigeria

**How to measure:**

The outcome of TB investigations in presumptive TB cases among people living with HIV should be recorded on HIV care/ART card and in the ART register.

**Numerator:** At the end of the reporting period, count the total number of people living with HIV currently in HIV care who have active TB disease.

**Denominator:** Count the total number of people living with HIV currently in HIV care during the reporting period.

**Method of calculation: Numerator divided by the Denominator**

**Numerator:** Total number of people living with HIV enrolled in care who have active TB disease during the reporting period.

**Denominator:** Total number of people living with HIV currently in HIV care screened for TB during the reporting period.

**Unit of Measurement:** Percentage

**Data Sources:** ART register, TB facility register

**Frequency of collection:** Data should be recorded on a daily basis

**Frequency of reporting:** monthly, quarterly

**Location of Data Storage:** Facility Medical Records Unit

**Other Notes:**

Indicator Reference Sheet

<b>Percentage of Registered New and Relapsed TB Cases with a Documented HIV Status During the Reporting Period</b>
<b>Program Area:</b> HIV ART
<b>DESCRIPTION</b>
<b>Precise Definition(s):</b> Number of new and relapsed TB patients who had an HIV test result recorded in the TB register expressed as a percentage of the number registered during the reporting period.
<b>Purpose/Justification:</b> To measure the ability of HIV and TB programmes to ensure that the HIV status of TB patients are ascertained. HIV infection rates are higher among TB patients than in the general population. Knowledge of HIV status helps promote safe behavior, reduce HIV transmission, and improve access to appropriate HIV care and support for TB patients, including early ART.
<b>Numerator:</b> Number of new and relapsed TB patients registered during the reporting period who had an HIV test result recorded in the TB register.
<b>Denominator:</b> Total number of new and relapsed TB patients registered in the TB register during the reporting period
<b>Disaggregation:</b> Recommended sex and age disaggregation by <1, 1-4, 5-9, 10-14, 15-19, 20-24, 25-49, 50+.
<b>How to measure:</b>  Numerator: Count the total number of new and relapsed TB patients added to the TB register during the reporting period who had their HIV status documented as positive or negative.  Denominator: Count the total number of new and relapsed TB patients registered in the TB register during the reporting period
<b>Method of calculation:</b> Numerator: Count the total number of new and relapsed TB patients added to the TB register during the reporting period who had their HIV status documented as positive or negative.  Denominator: Count the total number of new and relapse TB patients registered in the TB register during the reporting period
<b>Unit of Measurement:</b> Percentage
<b>Data Sources</b> TB LGA/Facility Register
<b>Frequency of collection:</b> collected and recorded daily in the TB patient treatment card and the TB LGA/Facility Register
<b>Frequency of reporting:</b> Monthly, quarterly
<b>Location of Data Storage:</b> Facility Medical Records Unit of the facility
<b>Other Notes:</b>

Indicator Reference Sheet

**Percentage Of HIV-Positive New and Relapsed TB Patients on ART During TB Treatment Program Area: HIV ART**

**DESCRIPTION**

**Precise Definition(s):** Number of HIV-positive new and relapsed TB patients who receive ART during TB treatment expressed as a percentage of those registered during the reporting period

**Purpose/Justification:** To measure the extent to which HIV-positive TB patients receive ART during TB treatment. Prompt TB treatment and early ART are critical for reducing the mortality due to HIV-associated TB. While TB treatment should be started immediately, ART should be started within 8 weeks of TB diagnosis, given that all are eligible for ART irrespective of their CD4 cell count.

**Numerator:** Total number of HIV-positive new and relapsed TB patients started on TB treatment during the reporting period who are already on ART or started on ART during TB treatment.

**Denominator:** Total number of HIV-positive new and relapsed TB patients registered during the reporting period

**Disaggregation:** Sex and age <1, 1-4, 5-9, 10-14, 15-19, 20-24, 25-49, 50+.

**How to measure:**

Count all HIV positive new and relapsed TB patients who initiate or are currently on ART while on TB treatment during the reporting period.

Numerator: Count the total number of HIV-positive new and relapsed TB patients who were started on TB treatment (as recorded in the TB register) and on ART or were already on ART (as recorded in the ART register).

Denominator: Count the total number of HIV-positive new and relapsed TB patients identified during the reporting period as recorded in the TB register and the ART register.

**Method of calculation:** Numerator divided by the denominator

**Numerator:** Total number of HIV-positive new and relapsed TB patients started on TB treatment during the reporting period who are already on ART or started on ART during TB treatment.

**Denominator:** Total number of HIV-positive new and relapsed TB patients registered during the reporting period.

**Unit of Measurement:** percentage

**Data Sources** TB LGA/Facility Register and the ART register

**Frequency of collection:** Data should be collected and recorded on a daily basis

**Frequency of reporting:** Monthly, Quarterly

**Location of Data Storage:** Facility Medical Records Unit of the facility

**Other Notes:** The responsibility for this indicator is with the HIV and TB programmes



Indicator Reference Sheet

**Number of people in HIV care who are eligible for INH and started INH prophylaxis during the month**  
**Program Area: HIV ART.**

**DESCRIPTION**

**Precise Definition(s):** Number of people in HIV care who are eligible for INH and started INH prophylaxis during the month during the reporting period.

**Purpose/Justification:** To measure the extent to which people living with HIV in HIV care are started on IPT (the treatment for latent TB infection).

**Numerator:** Total number of people in HIV care who are eligible for INH and started INH prophylaxis treatment for latent TB infection during the reporting period.

**Denominator:** NA

**Disaggregation:** sex and age; by <1, 1-4, 5-9, 10-14, 15-19, 20-24, 25-49, 50+.

**How to measure:**

TB preventive therapy should be started in all eligible persons and the date of starting should be recorded on HIV care/ART card. Those who accept treatment and receive at least the first dose should then be recorded in the ART registers (INH start month/year column).

**Numerator:** Count the total number of people in HIV care who are eligible for INH and started INH prophylaxis during the reporting period who are started on treatment for latent TB infection, that is, who are given at least one dose of isoniazid.

**Denominator:** NA

For accurate planning, patients and drug management, more detailed information needs to be collected in addition to the above. The IPT register for PLHIV is used for this purpose. All HIV service delivery centers providing IPT must have IPT register for PLHIV. This register will among others, facilitate understanding of the number of new and continuing patients on IPT as well as the treatment completion rates and adverse events.

**Method of calculation:** Numerator divided by the Denominator

**Numerator:** Count the total number of people in HIV care who are eligible for INH and started INH prophylaxis during the month for latent TB infection, that is, who are given at least one dose of isoniazid.

**Unit of Measurement:** Number

**Data Sources:** IPT register for PLHIV

**Frequency of collection:** Collected and recorded daily in the IPT register and the ART register

**Frequency of reporting:** Monthly, Quarterly

**Location of Data Storage:** Facility Medical Records Unit

**Other Notes:** Responsibility for reporting this indicator is with the HIV programme

Indicator Reference Sheet

**Percentage Of Reported HIV Exposure Provided With Post Exposure Prophylaxis (PEP) During The Reporting Period (Excluding HIV Exposed Babies).**

**Program Area:** HIV ART

**DESCRIPTION**

**Precise Definition(s):**

**Purpose/Justification:**

Post exposure prophylaxis (PEP) is the critical intervention provided to HIV-exposed individuals to prevent the transmission of HIV as a result of inadvertent HIV exposure e.g. occupational or non-occupational exposure. It is important to track this intervention as a prevention measure.

**Numerator:** Number of exposed persons provided with PEP for HIV

**Denominator:** Number of reported HIV exposure during the reporting month (excluding HIV exposed babies).

**Disaggregation:** Sex, mode of exposure, and age disaggregated into <1, 1-4, 5-9, 10-14, 15-19, 20-24, 25-49, 50+

**How to measure:**

This indicator measures post exposure prophylaxis by counting the number of HIV-exposed individuals provided with ART as a proportion of the total number of HIV exposed individuals identified during the reporting period (excluding HIV exposed babies).

The count is disaggregated by type of exposure (occupational or non-occupational exposure).

- Occupational exposure occurs in work settings
- Non-occupational exposure includes cases of sexual violence (e.g. rape, incest, pedophile) and domestic accidents.

It is targeted at preventing HIV infection and should be indicated if the individual receives PEP treatment (i.e. drugs) in accordance with national protocols and/or guidelines and if the individual completes the full course of treatment. Individuals in this criteria should not be counted under treatment indicators.

**Method of calculation:** Numerator divided by denominator

**Unit of Measurement :** Percentage

**Data Sources:** PEP register

**Frequency of collection:** Monthly

**Frequency of reporting:** Monthly

**Location of Data Storage:** Facility Medical Records Unit

**Other Notes:**

Indicator Reference Sheet

<b>Proportion of People Living with HIV Co-Infected with Viral Hepatitis</b>
<b>Program Area: HIV ART</b>
<b>DESCRIPTION</b>
<b>Precise Definition(s):</b> Number of PLHIV co-infected with viral hepatitis (B or C) as a proportion of the total number of PLHIV
<b>Purpose/Justification:</b> To determine the rate of co-infection of viral hepatitis among PLHIV.
<b>Numerator:</b> Number of PLHIV with reported co-infected with viral hepatitis during the reporting period.
<b>Denominator:</b> Estimated number of people living with HIV during the reporting period.
<b>Disaggregation:</b> Sex, type of co-infection (Hepatitis B/C), and age disaggregated into <1, 1-4, 5-9, 10-14, 15-19, 20-24, 25-49, 50+
<b>How to measure:</b>
<b>Numerator:</b> Count the total number of PLHIV diagnosed with viral hepatitis during the reporting period.
<b>Denominator:</b> Determined using spectrum estimates
<b>Method of calculation:</b> Numerator divided by denominator
<b>Unit of Measurement:</b> Number and Percentage
<b>Data Sources:</b> Enrollment and ART registers
<b>Frequency of collection:</b> Monthly
<b>Frequency of reporting:</b> Monthly
<b>Location of Data Storage:</b> Facility Medical Records Unit
<b>Other Notes:</b>

Indicator Reference Sheet

<b>Number of People Living with HIV (PLHIV) who commenced Co-trimoxazole Prophylaxis during the Reporting Period</b> <b>Program Area: HIV ART</b>
<b>DESCRIPTION</b>
<b>Precise Definition(s):</b> Number of eligible people living with HIV (PLHIV) who received co-trimoxazole prophylaxis during the reporting period to prevent opportunistic infections.
<b>Purpose/Justification:</b> This indicator tracks the uptake of co-trimoxazole among eligible PLHIV.
<b>Numerator:</b> Number of people living with HIV (PLHIV) who received co-trimoxazole prophylaxis during the reporting period
<b>Denominator:</b> N/A
<b>Disaggregation:</b> Sex and age disaggregated into <1, 1-4, 5-9, 10-14, 15-19, 20-24, 25-49, 50+
<b>How to measure:</b> Count each month the number of new/unique prescriptions of co-trimoxazole. This will be aggregated at the end of the reporting period to give the actual count of co-trimoxazole uptake among the PLHIV during the reporting period.
<b>Method of calculation:</b>
<b>Unit of Measurement:</b> Number
<b>Data Sources:</b> Pharmacy Records
<b>Frequency of collection:</b> Monthly
<b>Frequency of reporting:</b> Monthly
<b>Location of Data Storage:</b> Facility Medical Records Unit
<b>Other Notes:</b>

Indicator Reference Sheet

**Proportion of Facilities Reporting A Stock-Out of Antiretroviral Drugs During the Reporting Period.**

**Program Area:** HIV ART

**DESCRIPTION**

**Precise Definition(s):** Number of facilities providing ART who reported a stock-out of any antiretroviral as a proportion of the total number of facilities providing ART during the reporting period.

**Purpose/Justification:** Indicator assesses the performance of the supply chain system. Measures ability of facilities to maintain supply of ARV drugs and avoid interruption of ART.

**Numerator:** Number of facilities providing ART who reported a stock-out of any antiretroviral during the reporting period.

**Denominator:** Total number of facilities providing ART during the reporting period.

**Disaggregation:** Level of Facility, Type of drug.

**How to measure:** LMIS tools will be used to document facilities reporting a stock out of antiretrovirals during the reporting period.

**Method of calculation:** Collation and analysis of the facility LMIS report over a period of one year.

**Unit of Measurement:** Percentage

**Data Sources:** LMIS tools (CRIRRF)

**Frequency of collection:** Monthly

**Frequency of reporting:** Monthly

**Location of Data Storage:** Facility Medical Records Unit

**Other Notes:**

Indicator Reference Sheet

<b>Number of PLHIV Known to Have Died During the Reporting Period</b>
<b>Program Area: HIV ART</b>
<b>DESCRIPTION</b>
<b>Precise Definition(s):</b> As in name of indicator above
<b>Purpose/Justification:</b> Tracking of patient retention.
<b>Numerator:</b> Number of PLHIV who died or were reported to have died during the reporting period.
<b>Denominator:</b> N/A
<b>Disaggregation:</b> Sex, and age disaggregated into <1, 1-4, 5-9, 10-14, 15-19, 20-24, 25-49, 50+
<b>How to measure:</b> Indicator will be measured from tracking activities in the facility and documentation of deaths either in the patient's records, ART registers, or client tracking register
<b>Method of calculation:</b> Count the number of reported cases of deaths in the registers
<b>Unit of Measurement:</b> Number
<b>Data Sources:</b> Client tracking register, ART register
<b>Frequency of collection:</b> Monthly
<b>Frequency of reporting:</b> Monthly
<b>Location of Data Storage:</b> Facility Medical Records Unit
<b>Other Notes:</b>

## Indicator Reference Sheet

<b>Number of PLHIV Who STOPPED ART During the Reporting Period</b>
<b>Program Area: HIV ART</b>
DESCRIPTION
<b>Precise Definition(s):</b> As in name of indicator above
<b>Purpose/Justification:</b> Tracking of patient retention.
<b>Numerator:</b> Number of PLHIV on ART who stopped ART during the reporting period.
<b>Denominator:</b> N/A
<b>Disaggregation:</b> Sex and age disaggregated into <1, 1-4, 5-9, 10-14, 15-19, 20-24, 25-49, 50+
<b>How to measure:</b> Document patients who were on ART who stopped ART for either clinical or other reasons during the reporting period.
<b>Method of calculation:</b> Count the number of PLHIV who stopped ART during the reporting period. Reasons for stopping ART should be documented in the patient's records.
<b>Unit of Measurement:</b> Number
<b>Data Sources:</b> ART register
<b>Frequency of collection:</b> Monthly
<b>Frequency of reporting:</b> Monthly
<b>Location of Data Storage:</b> Facility Medical Records Unit
<b>Other Notes:</b>

Indicator Reference Sheet

<b>Number of PLHIV Who Are Lost to Follow Up During the Reporting Period</b>
<b>Program Area: HIV ART</b>
<b>DESCRIPTION</b>
<b>Precise Definition(s):</b> As in name of indicator above
<b>Purpose/Justification:</b> Tracking of patient retention.
<b>Numerator:</b> Number of PLHIV who were lost to follow up (LTFU) during the reporting period.
<b>Denominator:</b> N/A
<b>Disaggregation:</b> Sex and age disaggregated into <1, 1-4, 5-9, 10-14, 15-19, 20-24, 25-49, 50+
<b>How to measure:</b> A PLHIV is declared LTFU 3 months from his\her last missed appointment, after the prerequisite attempts at tracking the patient have been made. Facilities need to have an active system for tracking patient appointments. Patients who miss appointments should have tracking initiated within 24 hours of the missed appointment. The duration of tracking is 3 months and at the end of the period, the status of the patient should be determined and documented in the Client Tracking Register, and/or the ART register.
<b>Method of calculation:</b> At the end of each reporting period, go back 3 months in the Client Tracking Register to determine patients who have not returned to the facility.
<b>Unit of Measurement:</b> Number
<b>Data Sources:</b> Client tracking register, ART register
<b>Frequency of collection:</b> Monthly
<b>Frequency of reporting:</b> Monthly
<b>Location of Data Storage:</b> Facility Medical Records Unit
<b>Other Notes:</b>



Indicator Reference Sheet

<b>Number of PLHIV who RESTART ART during the reporting period</b>
<b>Program Area: HIV ART</b>
<b>DESCRIPTION</b>
<b>Precise Definition(s):</b> As in Name of Indicator above
<b>Purpose/Justification:</b> Tracking of patient retention.
<b>Numerator:</b> Number of PLHIV on ART who restarted ART during the reporting period.
<b>Denominator:</b> N/A
<b>Disaggregation:</b> Sex and age disaggregated into <1, 1-4, 5-9, 10-14, 15-19, 20-24, 25-49, 50+
<b>How to measure:</b> Document patients who were on ART who were either previously LTFU and returned to the facility or patients who stopped ART (for various reasons) and restarted ART during the reporting period.
<b>Method of calculation:</b> Count who restarted ART during the month
<b>Unit of Measurement :</b> Number
<b>Data Sources:</b> ART register
<b>Frequency of collection:</b> Monthly
<b>Frequency of reporting:</b> Monthly
<b>Location of Data Storage:</b> Facility Medical Records Unit
<b>Other Notes:</b>

Table 8: Summary Of Facility Level Indicators

<b>CODE</b>	<b>Name</b>
<b>INDICATOR 1</b>	Total number of people who tested for HIV and received results
<b>INDICATOR 2</b>	Total number of people who were re-tested for HIV and received their results more than once within the Present year
<b>INDICATOR 3</b>	Number of people tested HIV positive that were identified as known HIV positive during post-test counselling-Female (subset of people retested)
<b>INDICATOR 4</b>	Number of couples counseled, tested for HIV and received result
<b>INDICATOR 5</b>	Number of couples counseled, tested for HIV and received discordant result
<b>INDICATOR 6</b>	Number of HTS clients clinically screened for TB
<b>INDICATOR 7</b>	Number of HTS clients clinically screened for STI
<b>INDICATOR 8</b>	Number of HTS clients tested negative for Hepatitis B
<b>INDICATOR 9</b>	Number of HTS clients tested positive for Hepatitis B
<b>INDICATOR 10</b>	Number of HTS clients tested negative for Hepatitis C
<b>INDICATOR 11</b>	Number of HTS clients tested positive for Hepatitis C
<b>INDICATOR 12</b>	Number of people tested HIV positive who are successfully enrolled in HIV Care
<b>INDICATOR 13</b>	Number of donated blood units
<b>INDICATOR 14</b>	Number of donated blood units screened for HIV, HBV, HCV and syphilis using ELISA

Table 9: Program Area: HIV Prevention – HIV Testing Services

Facility Based Indicator Reference Sheet Program Area: HIV Prevention- Indicator 1	
<b>Name of Indicator:</b>	Total number of people who tested for HIV and received results
<b>DESCRIPTION</b>	
<b>Precise Definition(s):</b>	This indicator is the sum total of people who have been tested for HIV and received their test result as either positive or negative within the reporting month. This excludes pregnant women counseled and tested at facility.
<b>Purpose/Justification:</b>	It is a data source for the global indicator on people tested for HIV and received their result. This is measured through routine program data generated at the facility.
<b>Numerator:</b>	Number of people tested for HIV who received their results
<b>Denominator:</b>	N/A
<b>Disaggregation:</b>	<ol style="list-style-type: none"> <li>1. Sex (Male/Female);</li> <li>2. Age (1-4, 5-9, 10-14, 15-19, 20-24, 25-29, 30-34, 35-39, 40-44, 45-49, 50-64, 65+ years)</li> <li>3. Results: Positive and negative</li> <li>4. Service delivery points (Counseling and testing, TB/DOT, Family Planning, Inpatient Ward, STI clinic, etc.).</li> </ol>
<b>How to measure:</b>	Report total number of people that were tested for HIV and received their results from all service delivery points within the facility and community (outreach) excluding those tested at the ANC and maternity units.
<b>Method of calculation:</b>	Individual count of number of persons tested HIV positive and HIV negative from all points of services and aggregate into one summary form for the facility on a monthly basis.
<b>Unit of Measurement:</b>	Number
<b>Data Sources:</b>	HTS register
<b>Frequency of collection:</b>	Monthly
<b>Frequency of reporting:</b>	Monthly
<b>Location of Data Storage:</b>	Service Delivery Points, Facility M&E Unit, LGA M & E Unit, State M & E and National M & E Unit.

**Facility Based Indicator Reference Sheet Program Area: HIV Prevention - Indicator 2**

**Name of Indicator:** Total number of people who were re-tested for HIV and received their results more than once within the Present year

**DESCRIPTION**

**Precise Definition(s):** This indicator measures individuals who had prior HIV testing and were re-tested for HIV within the same calendar year.

**Purpose/Justification:** The Indicator would differentiate between those tested for the first time and those re-tested within the same year. Quantifying the number of re-testers and subtracting re-testers from the total number of testers helps to determine the number of individuals tested. Knowing the reasons for retests can help explain re-testing patterns.

**Numerator:** Number of people who were tested and received their results more than once within the Present year.

**Denominator:** NA

**Disaggregation:**

1. Sex (Male/Female);
2. Age (1-4, 5-9, 10-14, 15-19, 20-24, 25-29, 30-34, 35-39, 40-44, 45-49, 50-64, 65+ years)
3. Service delivery points (Counseling and testing, TB/DOT, Family Planning, Inpatient Ward, STI clinic, etc.).

**How to measure:** Report total number of people that were re-tested for HIV and received their results from all service delivery points within the facility and community (outreach) excluding those re-tested at the ANC and maternity units.

**Method of calculation:** Count all the individuals who were re-tested for HIV within the present year.

**Unit of Measurement:** Number

**Data Sources:** HTS Registers

**Frequency of collection:** Monthly

**Frequency of reporting:** Monthly

**Location of Data Storage:** Service Delivery Points, Facility M&E Unit, LGA M & E Unit, State M & E and National M & E Unit.

**Other Notes:** Present year refers to January to December of the reporting year

**Facility Based Indicator Reference Sheet Program Area: HIV Prevention- Indicator 3**

**Name of Indicator:** Number of people tested HIV positive that were identified as known HIV positive during post-test counselling-Female (subset of people retested)

**DESCRIPTION**

**Precise Definition(s):** This indicator measures individuals who were tested HIV positive and subsequently identified as previously known HIV positive

**Purpose/Justification:** The Indicator would differentiate between individuals tested HIV positive and those previously known HIV positives. This helps to determine new HIV positives. This excludes pregnant women counseled and tested at facility.

**Numerator:** Total Number of people tested HIV positive that were identified as known HIV positive during post-test counselling

**Denominator:** NA

**Disaggregation:**

1. Sex (Male/Female);
2. Age (1-4, 5-9, 10-14, 15-19, 20-24, 25-29, 30-34, 35-39, 40-44, 45-49, 50-64, 65+ years)
3. Service delivery points (Counseling and testing, TB/DOT, Family Planning, Inpatient Ward, STI clinic, etc.).

**How to measure:** Report total number of known positives that were re-tested for HIV and received their results from all service delivery points within the facility and community (outreach) excluding those re-tested at the ANC and maternity units.

**Method of calculation:** Count all the known positives individuals who were re-tested for HIV identified during post-test counselling within the present year.

**Unit of Measurement:** Number

**Data Sources:** HTS Registers

**Frequency of collection:** Monthly

**Frequency of reporting:** Monthly

**Location of Data Storage:** Service Delivery Points, Facility M&E Unit, LGA M & E Unit, State M & E and National M & E Unit.

**Other Notes:** Present year refers to January to December of the reporting year

**Facility Based Indicator Reference Sheet Program Area: HIV Prevention- Indicator 4**

**Name of Indicator:** Number of couples counseled, tested for HIV and received result

**DESCRIPTION**

**Precise Definition(s):** This indicator measures the number of couples who were counseled and tested for HIV and received their results in the reporting year

**Purpose/Justification:** To determine the total number of couples counseled, tested and received their results. This facilitates programming for couples' counseling.

**Numerator:** Number of couples counseled tested and received results.

**Denominator:** N/A

**Disaggregation:** Nil

**How to measure:** Count the number of couples counseled and tested for HIV and who received their results. A couple is counted as a pair who are in a sexual relationship. Couples are documented in the HTS register using the same client's code and letters to identify the index client and partner(s).

**Method of calculation:** Count all couples who were counseled and tested together for HIV and received their results together.

**Unit of Measurement:** Number

**Data Sources:** HTS registers

**Frequency of collection:** Monthly

**Frequency of reporting:** Monthly

**Location of Data Storage:** SDPs, Facility M&E Unit, LGA M & E Unit, State M & E and National M & E Unit

**Other Notes:** Couples are counted as one entity irrespective of the number of partners as long as they present together for HTS.

**Facility Based Indicator Reference Sheet Program Area: HIV Prevention- Indicator 5**

**Name of Indicator:** Number of couples counseled, tested for HIV and received discordant result

**DESCRIPTION**

**Precise Definition(s):** This indicator measures the number of discordant couples amongst couples who were counseled and tested for HIV and received their results.

**Purpose/Justification:** To determine the number of discordant couples identified from among couples counseled, tested and received their results. To increase access for couples counseling

**Numerator:** Number of couples counseled, tested and received discordant result

**Denominator:** N/A

**Disaggregation:** Nil

**How to measure:** Count the number of couples counseled, tested for HIV and who received discordant results. Couples are documented in the HTS register using the same client codes and letters to identify the index client and partner(s). This excludes partners tested at the ANC and maternity units.

**Method of calculation:** Count all couples who were counseled, tested together for HIV and received their results together with one tested positive.

**Unit of Measurement:** Number

**Data Sources:** HTS registers

**Frequency of collection:** Monthly

**Frequency of reporting:** Monthly

**Location of Data Storage:** SDPs, Facility M&E Unit, LGA M & E Unit, State M & E and National M & E Unit

**Other Notes:** Couples are counted as one entity irrespective of the number of partners, as long as they present together.

**Facility Based Indicator Reference Sheet****Program Area:** HIV Prevention- Indicator 6**Name of Indicator:** Number of HTS clients clinically screened for TB**DESCRIPTION****Precise Definition(s):** This indicator measures the total number of clients accessing HIV counseling and testing services who were clinically screened for TB**Purpose/Justification:** This indicator is to identify potential TB suspects amongst clients tested for HIV**Numerator:** Number of HTS clients clinically screened for TB.**Denominator:** N/A**Disaggregation:** 1. Sex (Male/Female);  
2. Service delivery points (Counseling and testing, TB/DOT, Family Planning, Inpatient Ward, STI clinic, etc.).**How to measure:** Count all clients indicated in the TB screening column in the HTS register.**Method of calculation:** Aggregate all clients who scored 0 and 1+ in the yes sub-column of the TB screening column in the HTS register.**Unit of Measurement:** Number**Data Sources:** HTS register.**Frequency of collection:** Monthly**Frequency of reporting:** Monthly**Location of Data Storage:** SDPs, Facility M&E Unit, LGA M & E Unit, State M & E and National M & E Unit**Other Notes:**



**Facility Based Indicator Reference Sheet Program Area: HIV Prevention- Indicator 7**

**Name of Indicator:** Number of HTS clients clinically screened for STI

**DESCRIPTION**

**Precise Definition(s):** This indicator measures the total number of clients accessing HIV counseling and testing services who were clinically screened for STI

**Purpose/Justification:** This indicator is to identify potential STI suspects amongst clients tested for HIV

**Numerator:** Number. of HTS clients clinically screened for STI

**Denominator:** NA

**Disaggregation:** 1. Sex (Male/Female);  
 2. Service delivery points (Counseling and testing, TB/DOT, Family Planning, Inpatient Ward, STI clinic, etc.).  
 3. Positive screening outcome and negative screening outcome

**How to measure:** Count all clients marked X in the STI screening columns in the HTS register

**Method of calculation:** Aggregate all clients who scored 0 and 1+ in the yes sub column of the STI screening column in the HTS register.

**Unit of Measurement:** Number

**Data Sources:** HTS register

**Frequency of collection:** Monthly

**Frequency of reporting:** Monthly

**Location of Data Storage:** SDPs, Facility M&E Unit, LGA M & E Unit, State M & E and National M & E Unit

**Other Notes:** Use same approach to complete reports for positive and negative syphilis screening outcome on the HTS Monthly summary form.



**Facility Based Indicator Reference Sheet Program Area: HIV Prevention- Indicator 8**

**Name of Indicator: Number of HTS clients tested negative for Hepatitis B**

**DESCRIPTION**

**Precise Definition(s):** This indicator measures the Number of individuals receiving HIV counseling and testing whose screening outcome for Hepatitis B is Non- reactive.

**Purpose/Justification:** Measures number of individuals HBV non- reactive in a population

**Numerator:** Number of people who are non-reactive for Hepatitis B

**Denominator:** N/A

**Disaggregation:** 1. Sex (Male/Female);  
2. Service delivery points (Counseling and testing, TB/DOT, Family Planning, Inpatient Ward, STI clinic, etc.).

**How to measure:** Count the individuals who received HIV counseling and testing and that were screened negative for Hepatitis B.

**Method of calculation:** Aggregate total number of all clients screened negative for Hepatitis B.

**Unit of Measurement:** Number

**Data Sources:** HTS Register,

**Frequency of collection:** Monthly

**Frequency of reporting:** Monthly

**Location of Data Storage:** SDP, Facility M&E Unit, LGA M & E Unit, State M & E and National M & E Unit

**Other Notes:**

**Facility Based Indicator Reference Sheet Program Area: HIV Prevention- Indicator 9**

**Name of Indicator:** Number of HTS clients tested positive for Hepatitis B

**DESCRIPTION**

**Precise Definition(s):** This indicator measures the Number of individuals receiving HIV counseling and testing whose screening outcome for Hepatitis B is Reactive.

**Purpose/Justification:** Measures number of individuals HBV reactive in a population.

**Numerator:** Number of people who are reactive for Hepatitis B

**Denominator:** N/A

**Disaggregation:** 1. Sex (Male/Female);  
2. Service delivery points (Counseling and testing, TB/DOT, Family Planning, Inpatient Ward, STI clinic, etc.).

**How to measure:** Count the individuals who received HIV counseling and testing and that were screened positive for Hepatitis B.

**Method of calculation:** Aggregate total number of all clients screened negative for Hepatitis B.

**Unit of Measurement:** Number

**Data Sources:** HTS Register,

**Frequency of collection:** Monthly

**Frequency of reporting:** Monthly

**Location of Data Storage:** SDP, Facility M&E Unit, LGA M & E Unit, State M & E and National M & E Unit

**Other Notes:**

**Facility Based Indicator Reference Sheet Program Area: HIV Prevention- Indicator 10****Name of Indicator: Number of HTS clients tested negative for Hepatitis C****DESCRIPTION****Precise Definition(s):** This indicator measures the Number of individuals receiving HIV counseling and testing whose screening outcome for Hepatitis C is Non- reactive.**Purpose/Justification:** Measures number of individuals HBV non- reactive in a population**Numerator:** Number of people who are non-reactive for Hepatitis C**Denominator:** N/A**Disaggregation:** 1. Sex (Male/Female);  
2. Service delivery points (Counseling and testing, TB/DOT, Family Planning, Inpatient Ward, STI clinic, etc.).**How to measure:** Count the individuals who received HIV counseling and testing and that were screened negative for Hepatitis C.**Method of calculation:** Aggregate total number of all clients screened negative for Hepatitis C.**Unit of Measurement:** Number**Data Sources:** HTS Register,**Frequency of collection:** Monthly**Frequency of reporting:** Monthly**Location of Data Storage:** SDP, Facility M&E Unit, LGA M & E Unit, State M & E and National M & E Unit**Other Notes:**

**Facility Based Indicator Reference Sheet Program Area: HIV Prevention- Indicator 11**

**Name of Indicator:** Number of HTS clients tested positive for Hepatitis C

**DESCRIPTION**

**Precise Definition(s):** This indicator measures the Number of individuals receiving HIV counseling and testing whose screening outcome for Hepatitis C is Reactive.

**Purpose/Justification:** Measures number of individuals HBV reactive in a population.

**Numerator:** Number of people who are reactive for Hepatitis C

**Denominator:** N/A

**Disaggregation:** 1. Sex (Male/Female);  
2. Service delivery points (Counseling and testing, TB/DOT, Family Planning, Inpatient Ward, STI clinic, etc.).

**How to measure:** Count the individuals who received HIV counseling and testing and that were screened positive for Hepatitis C.

**Method of calculation:** Aggregate total number of all clients screened negative for Hepatitis C.

**Unit of Measurement:** Number

**Data Sources:** HTS Register,

**Frequency of collection:** Monthly

**Frequency of reporting:** Monthly

**Location of Data Storage:** SDP, Facility M&E Unit, LGA M & E Unit, State M & E and National M & E Unit

**Other Notes:**

**Facility Based Indicator Reference Sheet Program Area: HIV Prevention- Indicator 12**

**Name of Indicator:** Number of people tested HIV positive who are successfully enrolled in HIV Care

**DESCRIPTION**

**Precise Definition(s):** This indicator measures the effectiveness of linkage of HIV positive individuals within the continuum of HIV care from the HTS service delivery points

**Purpose/Justification:** To access the linkage of HIV positive individuals referred for HIV care

**Numerator:** Number of people tested HIV positive who were referred and successfully enrolled into HIV Care

**Denominator:** N/A

**Disaggregation:**

1. Sex (Male/Female)
2. Service delivery points (Counseling and testing, TB/DOT, Family Planning, Inpatient Ward, STI clinic, etc.).

**How to measure:** Count all HIV positive individuals that were referred for enrollment into HIV care and indicated as successfully enrolled with documented enrolment ID during the reporting period.

**Method of calculation:** Counting

**Unit of Measurement:** Number

**Data Sources:** Referral register

**Frequency of collection:** Monthly

**Frequency of reporting:** Monthly

**Location of Data Storage:** HTS point of service at different SDP

**Other Notes:** Data should be collected from referral register only with evidence of feedback received on client enrolment in HIV care be available.

**Facility Based Indicator Reference Sheet Program Area: HIV Prevention- Indicator 13**

**Name of Indicator:** Number of donated blood units

**DESCRIPTION**

**Precise Definition(s):** This indicator measures the number of blood units donated for use in the facility

**Purpose/Justification:** Donated blood units require proper documentation to facilitate tracking of all blood units received in the laboratory prior to screening

**Numerator:** Number of donated blood units

**Denominator:** N/A.

**Disaggregation:** Nil

**How to measure:** Count all blood units received in the facility from the blood donor register or blood bank register.

**Method of calculation:** Counting of blood units

**Unit of Measurement:** Number

**Data Sources:** Blood Donor Register

**Frequency of collection:** Monthly

**Frequency of reporting:** Monthly

**Location of Data Storage:** Facility Laboratory, Facility M&E Unit, LGA M & E Unit, State M & E and National M & E Unit

**Other Notes:** Data should be collected from the laboratory /blood banks. Do not include the number from this indicator to number counselled, tested and received results.



**Facility Based Indicator Reference Sheet Program Area: HIV Prevention- Indicator 14**

**Name of Indicator:** Number of donated blood units screened for HIV, HBV, HCV and syphilis using ELISA

**DESCRIPTION**

**Precise Definition(s):** This indicator measures the number of blood units screened for four transfusion transmissible infections (HIV, HEP B, HEP C and Syphilis) using Enzyme-Linked Immuno-Sorbent Assay (ELISA)

**Purpose/Justification:** Blood units donated must be screened for the four transfusion transmissible infections (TTIs), to ensure safe blood transfusion. Less than 100% screening signals a breakdown in proper processing of blood units (e.g. lack of test kits or personnel) and should be holistically addressed.

**Numerator:** Number of donated blood units screened for HIV, HBV, HCV and syphilis using ELISA

**Denominator:** N/A.

**Disaggregation:** Nil

**How to measure:** Count the number of donated blood units screened for HIV, HBV, HCV and syphilis using ELISA from the blood screening and processing register.

**Method of calculation:** Count donated blood units screened with ELISA

**Unit of Measurement:** Number

**Data Sources:** Blood Screening and Processing Register

**Frequency of collection:** Monthly

**Frequency of reporting:** Monthly

**Location of Data Storage:** Facility laboratory, Facility M&E Unit, LGA M & E Unit, State M & E and National M & E Unit

**Other Notes:** Data should be collected from the laboratory /blood banks. Do not include the number from this indicator to number counselled, tested and received results.



**Table 10: PMTCT Indicators**

<b>SN</b>	<b>INDICATORS</b>
<b>PMTCT. 1</b>	Percentage of pregnant women with known HIV status
<b>PMTCT. 2</b>	Percentage of HIV-positive pregnant women who received ART during pregnancy
<b>PMTCT. 3</b>	Percentage of HIV-exposed infants who initiated ARV prophylaxis at birth
<b>PMTCT. 4</b>	Percentage of enrolled HIV +ve pregnant and breastfeeding women retained in PMTCT at 6 and 12 months
<b>PMTCT. 5</b>	Percentage of HIV-exposed infants receiving a virological test for HIV within 12 months of birth
<b>PMTCT. 6</b>	Percentage of HIV-infected infants identified during the reporting period
<b>PMTCT. 7</b>	Percentage distribution of HIV-exposed infants by final outcome status
<b>PMTCT. 8</b>	Percentage of HIV-exposed infants started on CTX prophylaxis within 2 months of birth
<b>PMTCT. 9</b>	Percentage of HIV-negative pregnant women who are retested for HIV
<b>PMTCT. 10</b>	Percentage of pregnant women attending ANC whose male partners were tested for HIV
<b>PMTCT. 11</b>	Percentage of early infant diagnosis test results returned in a timely manner (within 4 weeks of specimen collection)
<b>PMTCT. 12</b>	Percentage of HIV-positive pregnant women who deliver at the health facility
<b>PMTCT. 13</b>	Percentage of pregnant women with known HBV status
<b>PMTCT. 14</b>	Percentage of pregnant women with known HCV status
<b>PMTCT. 15</b>	Percentage of babies born to hepatitis B positive mothers who received dose of viral hepatitis B immunoglobulin within 24 hrs of delivery
<b>PMTCT. 16</b>	Percentage of pregnant women tested for Syphilis at ANC
<b>PMTCT. 17</b>	Percentage of syphilis +ve pregnant women who received penicillin treatment

<b>PMTCT .1: Percentage of pregnant women with known HIV status</b>	
<b>Type of Indicator</b>	Outcome
<b>Numerator</b>	Number of pregnant women attending ANC and/or having had a facility-based delivery who were tested for HIV during pregnancy or already knew they were HIV positive
<b>Denominator</b>	<b>Population-based denominator:</b> Estimated pregnancies during the reporting period. Estimates from National Population Commission (NPC) and Spectrum estimates <b>Facility-based denominator:</b> Number of pregnant women who attended ANC or had a facility-based delivery within the reporting period.
<b>Disaggregation</b>	<b>HIV status/test results:</b> 1. Known HIV infection at entry. 2. Newly tested HIV Positive during ANC/L&D/within 72 hrs postpartum. 3. Newly tested HIV Negative during ANC/L&D/within 72 hrs postpartum. Total identified HIV positive women = 1 + 2
<b>Purpose</b>	Measures coverage of the first step in the PMTCT cascade. High coverage enables early initiation of care and treatment for HIV-infected mothers.
<b>Data collection frequency</b>	Monthly
<b>Measurement tool</b>	Program monitoring tool; PMTCT HTS Register, & Spectrum, or other statistical modeling that uses program coverage and efficacy studies
<b>Method of measurement</b>	All pregnant women provided with testing at ANC and L&D. Women who were provided with HIV testing within 72 hrs after delivery should be counted. The source document for the Numerator is the HTS register and should be kept at every point where HTS are provided for PMTCT

<b>PMTCT. 2: Percentage of HIV positive pregnant women who received ART during pregnancy</b>	
<b>Type of Indicator</b>	Output
<b>Numerator</b>	Number of HIV positive pregnant women attending ANC and/or had a facility-based delivery and/or presented during post-partum that received ART to reduce MTCT risk during the reporting period
<b>Denominator</b>	<b>Population-based denominator:</b> Estimated number of positive pregnant women during the reporting period - Internationally consistent Modeling estimates, e.g. Spectrum AIM. <b>Facility-based denominator:</b> Number of HIV positive pregnant women who attended ANC and/or had a facility-based delivery and/or presented during post-partum within the reporting period
<b>Disaggregation</b>	1. Already on ART 2. Newly on ART a. newly started on ART during ANC $\leq$ 36wks of pregnancy b. newly started on ART during ANC $>$ 36wks of pregnancy c. newly started on ART during Labour d. newly started on ART during Post-Partum
<b>Purpose</b>	Measures whether ART has been provided to HIV positive pregnant women. Does not reflect adherence to the ARV drug regimen throughout the MTCT risk period
<b>Data collection frequency</b>	Monthly
<b>Measurement tool</b>	Program monitoring tool; PMTCT Cohort Register, Delivery Register, & Spectrum
<b>Method of measurement</b>	Total number of HIV positive pregnant women that received ART during pregnancy and delivery. Including those already receiving ART before current pregnancy and those newly started on ART during the current pregnancy.

<b>PMTCT. 3: Percentage of HIV-exposed infants who initiated ARV prophylaxis at birth</b>	
<b>Type of Indicator</b>	Output
<b>Numerator</b>	Number of HIV exposed infants who were started on ARV prophylaxis within 72 hours of birth during the reporting period
<b>Denominator</b>	<b>Population-based denominator:</b> Estimated number of positive pregnant women during the reporting period - Internationally consistent Modeling estimates, e.g. Spectrum AIM. <b>Facility-based denominator:</b> Number of live births by HIV positive women during the reporting period
<b>Disaggregation</b>	<b>Numerator</b> Site of delivery 1. At the health facility 2. Outside the health facility
<b>Purpose</b>	Measures the programme efforts to reduce the risk of MTCT in the immediate postpartum period (Prong 3).
<b>Data collection frequency</b>	Monthly
<b>Measurement tool</b>	Measures the programme efforts to reduce the risk of MTCT in the immediate postpartum period (Prong 3).
<b>Method of measurement</b>	<b>Numerator:</b> Include all children delivered in the facility who received ARV prophylaxis within 72 hrs of birth and those brought from outside the facility with evidence of delivery within 72 hrs <b>Facility Denominator:</b> All children delivered in the facility during the reporting period should be counted. In addition, the children that were brought in from outside the facility with evidence of delivery within 72 hrs to also be included.

<b>PMTCT. 4: Percentage of enrolled HIV positive pregnant and breastfeeding women retained in PMTCT at 6 and 12 months</b>	
<b>Type of Indicator</b>	Outcome
<b>Numerator</b>	Number of HIV +ve pregnant women who are retained at 6 and 12 months after enrolment in PMTCT.
<b>Denominator</b>	<b>Denominator:</b> This includes those who have died since starting therapy, those who have stopped therapy and those recorded as lost to follow-up at (6 months and 12 months) Number of HIV positive pregnant women who are retained at 6 and 12 months after enrolment in PMTCT
<b>Disaggregation</b>	<b>Status at ART initiation:</b> 1. pregnant 2. breastfeeding
<b>Purpose</b>	
<b>Data collection frequency</b>	Monthly
<b>Measurement tool</b>	Program monitoring tool; Maternal Cohort Register
<b>Method of measurement</b>	All pregnant women provided with testing at ANC and L&D. Women who were provided with HIV testing within 72 hrs after delivery should be counted. The source document for the Numerator is the HTS register and should be kept at every point where HTS are provided for PMTCT

<b>PMTCT. 5: Percentage of infants born to HIV-positive women receiving a virological test for HIV within 12 months of birth</b>	
<b>Type of Indicator</b>	Output
<b>Numerator</b>	Number of HIV-exposed infants who received EID/PCR test for HIV within twelve months of birth during the reporting period
<b>Denominator</b>	<b>Population-based denominator:</b> Estimated number of positive pregnant women during the reporting period - Internationally consistent Modeling estimates, e.g. Spectrum AIM. <b>Facility-based denominator:</b> Number of HIV exposed infants delivered in the facility
<b>Disaggregation</b>	<b>Time of sample collection</b> 1. Within 2 months of birth 2. Between 2 – 12 months of birth
<b>Purpose</b>	This indicator allows countries to monitor progress in providing early HIV virologic testing to HIV-exposed infants aged two months or less, critical for appropriate follow-up care and treatment.
<b>Data collection frequency</b>	Monthly
<b>Measurement tool</b>	Program monitoring tool; Delivery register and child follow up register
<b>Method of measurement</b>	Infants tested should only be counted once. Only one count for each HIV exposed infant irrespective of the number of PCR test done.

<b>PMTCT .6: Percentage of HIV-infected infants identified during the reporting period</b>	
<b>Type of Indicator</b>	Outcome
<b>Numerator</b>	Number of HIV infected infants identified through EID/PCR who were infected during the MTCT risk period
<b>Denominator</b>	<b>Facility-based denominator.</b> Number of HIV exposed infants that had EID results during the reporting period
<b>Disaggregation</b>	<b>Numerator:</b> <b>Test Result:</b> Pos/Neg <b>Time of sample collection</b> 1. Within 2 months of birth 2. Between 2 – 12 months of birth
<b>Purpose</b>	Measures overall rate of transmission over MTCT risk period. Validation criterion for the elimination of MTCT of HIV
<b>Data collection frequency</b>	Monthly
<b>Measurement tool</b>	Program monitoring tool; Child follow up register & Spectrum
<b>Method of measurement</b>	The indicator itself is also modelled using spectrum. The modelled data is also used to validate programme data.

<b>PMTCT .7: Percentage distribution of HIV-exposed infants by final outcome status</b>	
<b>Type of Indicator</b>	Outcome
<b>Numerator</b>	HIV-exposed infants born within the past 12 months (or 24 months in breastfeeding settings) with various final outcome statuses.
<b>Denominator</b>	Number of HIV positive women who delivered within the past 12 months (or 24 months in breastfeeding settings).
<b>Disaggregation</b>	Outcome status: 1. HIV-positive 2. HIV-negative, no longer breastfeeding 3. HIV status unknown a. died b. lost to follow-up c. transferred out d. HIV negative still breastfeeding
<b>Purpose</b>	Measures overall rate of transmission over the entire MTCT risk period. Validation criterion for the elimination of MTCT of HIV.
<b>Data collection frequency</b>	Annually
<b>Measurement tool</b>	Program monitoring tool; Child follow up register and Delivery register.
<b>Method of measurement</b>	The indicator will be collected through special study. It will be a systematic review of data captured in PMTCT tools over two year period.

<b>PMTCT. 8: Percentage of HIV-exposed infants started on CTX prophylaxis within 2 months of birth</b>	
<b>Type of Indicator</b>	Outcome
<b>Type of Indicator Numerator</b>	HIV-exposed infants born within the past 12 months (or 24 months in breastfeeding settings) with various final outcome statuses.
<b>Denominator</b>	Number of HIV positive women who delivered within the past 12 months (or 24 months in breastfeeding settings).
<b>Disaggregation</b>	Outcome status: 1. HIV-positive 2. HIV-negative, no longer breastfeeding 3. HIV status unknown a. died b. lost to follow-up c. transferred out d. HIV negative still breastfeeding
<b>Purpose</b>	Measures overall rate of transmission over the entire MTCT risk period. Validation criterion for the elimination of MTCT of HIV.
<b>Data collection frequency</b>	Annually
<b>Measurement tool</b>	Program monitoring tool; Child follow up register and Delivery register.
<b>Method of measurement</b>	The indicator will be collected through special study. It will be a systematic review of data captured in PMTCT tools over two year period.

<b>PMTCT. 9: Percentage of HIV-negative pregnant women who are re-tested for HIV</b>	
<b>Type of Indicator</b>	Output
<b>Numerator</b>	Number of pregnant women who were re-tested for HIV after an initial negative HIV test during pregnancy
<b>Denominator</b>	<b>National level denominator:</b> Number of women attending ANC who had an initial negative HIV test result during pregnancy
<b>Disaggregation</b>	<b>Sero conversion status:</b> A. remained HIV negative B. sero converted to HIV-positive
<b>Purpose</b>	Measures the programme efforts to reduce the risk of MTCT during pregnancy, labour and delivery
<b>Data collection frequency</b>	Monthly
<b>Measurement tool</b>	Program monitoring tool; PMTCT HTS Register
<b>Method of measurement</b>	All HIV negative pregnant women who were re-tested before delivery during the reporting period should be counted. Also, those re-testing within 72 hrs post-partum should be included.

<b>PMTCT. 10: Percentage of pregnant women attending ANC whose male partners were tested for HIV</b>	
<b>Type of Indicator</b>	Output
<b>Numerator</b>	Number of pregnant women attending ANC whose male partners were tested or were already known to be HIV-positive
<b>Denominator</b>	<b>Denominator:</b> <b>Population-based denominator:</b> Estimated pregnancies during the reporting period. Estimates from National Population Commission (NPC) and Spectrum estimates <b>Facility-based denominator:</b> Number of pregnant women who attended ANC
<b>Disaggregation</b>	1. Test outcome – Neg/Pos 2. concordance/discordance results
<b>Purpose</b>	Male involvements are critical in providing critical family focused services to HIV infected pregnant mothers, their infants and family members.
<b>Data collection frequency</b>	Monthly
<b>Measurement tool</b>	Program monitoring tool; Partner Register, General ANC
<b>Method of measurement</b>	All partners of pregnant women attending ANC should be targeted for HIV testing irrespective of the pregnant woman HIV status.

**PMTCT. 11: Percentage of early infant diagnosis test results returned in a timely manner within 4 weeks of specimen collection**

<b>Type of Indicator</b>	Process
<b>Numerator</b>	Number of EID results received within 4 weeks of specimen collection in the past 12 months
<b>Denominator</b>	Number of EID results received within the past 12 months.
<b>Disaggregation</b>	None
<b>Purpose</b>	It monitors programme efforts in providing early HIV virologic testing to HIV-exposed infants, critical for appropriate follow-up and early initiation into ART
<b>Data collection frequency</b>	Annually
<b>Measurement tool</b>	Program monitoring tool; Child follow up register
<b>Method of measurement</b>	The indicator will be collected through special study. It will be a systematic review of data captured in PMTCT tools over a year period.

**PMTCT. 12: Percentage of HIV-positive pregnant women who delivered at the health facility**

<b>Type of Indicator</b>	Output
<b>Numerator</b>	Number of HIV-positive pregnant women who deliver at the health facility
<b>Denominator</b>	Number of HIV-positive pregnant women
<b>Disaggregation</b>	None
<b>Purpose</b>	To monitor percentage of positive women having facility based delivery
<b>Data collection frequency</b>	Monthly
<b>Measurement tool</b>	Program monitoring tool; Delivery register, PMTCT HTS Register
<b>Method of measurement</b>	Numerator: Populate the total HIV positive women delivery at the health facility (booked and unbooked) Denominator: Add identified positive pregnant women at ANC, labour/delivery and within 72 hours post-partum in the facility.

<b>PMTCT. 13: Percentage of pregnant women with known HBV status</b>	
<b>Type of Indicator</b>	Output
<b>Numerator</b>	Number of women who received HBV testing during ANC
<b>Denominator</b>	Number of women attending ANC during the reporting period
<b>Disaggregation</b>	<b>Test result</b> Pos/Neg <b>HBV co-infection with HIV</b>
<b>Purpose</b>	To measure coverage of HBV screening at ANC. High coverage enables early initiation of care and treatment, reverses poor MTCT outcomes in HIV/HBV Co-infected mothers.
<b>Data collection frequency</b>	Monthly
<b>Measurement tool</b>	Program monitoring tool; PMTCT HTS Register
<b>Method of measurement</b>	Numerator: Populate the total number of pregnant women who had test for hepatitis B at ANC. Note that this is irrespective of the HIV status. health facility (booked and unbooked) Denominator: Total pregnant women at ANC,labour/delivery and Post Partum in the facility.

<b>PMTCT. 14: Percentage of pregnant women with known hepatitis C Virus (HCV) status</b>	
<b>Type of Indicator</b>	Outcome
<b>Numerator</b>	Number of women who received HCV testing during ANC, Labour/Delivery & Post Partum
<b>Denominator</b>	Number of women attending ANC, Labour/Delivery & Post Partum during the reporting period
<b>Disaggregation</b>	<b>Test result</b> HCV – Positive / Negative <b>HCV coinfection with HIV</b>
<b>Purpose</b>	To measure coverage of HCV screening at ANC, Labour/Delivery & Post Partum. High coverage enables early initiation of care and treatment, reverses poor MTCT outcomes in HIV/HCV Co-infected mothers.
<b>Data collection frequency</b>	Monthly
<b>Measurement tool</b>	PMTCT HTS Register
<b>Method of measurement</b>	Numerator: Populate the total number of pregnant women who had test for hepatitis C virus (HCV). Note that this is irrespective of the HIV status. Denominator: Total pregnant women at ANC, Labour/Delivery & within 72hrs Post Partum in the facility.



**PMTCT. 15: Percentage of babies born to hepatitis B positive mothers who received dose of viral hepatitis B immunoglobulin within 24 hrs of delivery**

<b>Type of Indicator</b>	Output
<b>Numerator</b>	Number of HBV exposed infants who received HBIg within 24hrs of delivery at the facility during the reporting period
<b>Denominator</b>	Number of infants born to HBV positive pregnant women at the facility during the reporting period
<b>Disaggregation</b>	None
<b>Purpose</b>	Measures programme efficiency at preventing vertical transmission of HBV
<b>Data collection frequency</b>	Monthly
<b>Measurement tool</b>	PMTCT Delivery register
<b>Method of measurement</b>	This indicator focuses on infant born to mothers who are co-infected with HIV and HBV. Infants administered with the vaccine HBIg after 24 hrs of delivery will not be counted.

**PMTCT. 16: Percentage of pregnant women tested for Syphilis at ANC**

<b>Type of Indicator</b>	Output
<b>Numerator</b>	Number of women who were tested for syphilis at ANC during the reporting period
<b>Denominator</b>	Number of women attending ANC during the reporting period
<b>Disaggregation</b>	<b>Test result</b> Positive/Negative
<b>Purpose</b>	To measure coverage of Syphilis screening at ANC. High coverage reduces transmission risk
<b>Data collection frequency</b>	Monthly
<b>Measurement tool</b>	General ANC Register
<b>Method of measurement</b>	Numerator: Populate the total number of pregnant women tested for syphilis. Note that this is irrespective of the HIV status. Denominator: Total number of pregnant women at ANC in the facility.

**PMTCT. 17: Percentage of syphilis positive pregnant women who received penicillin treatment**

<b>Type of Indicator</b>	Output
<b>Numerator</b>	Number of syphilis positive pregnant women attending ANC treated for syphilis at the facility during the reporting period
<b>Denominator</b>	Number of syphilis positive pregnant women attending ANC during the reporting period
<b>Disaggregation</b>	None
<b>Purpose</b>	High treatment coverage reduces syphilis transmission risk to infants
<b>Data collection frequency</b>	Monthly
<b>Measurement tool</b>	General ANC Register
<b>Method of measurement</b>	Numerator: Populate the total number of pregnant women treated for syphilis. Note that this is irrespective of the HIV status. Denominator: Total number of pregnant women at ANC and labour/delivery in the facility.

# Table 11: Non Health Sector Indicators

S/N	Indicator : Primary Prevention	Definition	Disaggregation /Frequency	Source
1	Number of key populations reached with individual and/or small group-level HIV prevention interventions	At a minimum, : must provide at least one of the following: <ul style="list-style-type: none"> <li>• Information, condom, STI screening, needle exchange, etc</li> </ul> AND <ul style="list-style-type: none"> <li>• Offer or refer for HIV testing unless the KP is known HIV positive</li> </ul>	<u>KP type</u> FSW. MSM TG PWID Prisons  <u>Age and sex</u>  Monthly reporting	Outreach forms Peer forms
2	Number of key populations counselled tested and received result	<u>Testing status</u> <ul style="list-style-type: none"> <li>• New tester – KPs tested for the first time within the year.</li> <li>• Repeat tester – KPs tested more than once within the year.</li> <li>• Note: Repeat testers are not included in the number of persons tested in the reporting period.</li> </ul>	<u>Test result</u> Negative Positive  KP type FSW. MSM TG PWID Prisons  <u>Age and sex</u>  Monthly reporting	HTS registers and data collections tools.
3	Number of Key populations who NEWLY received HIV Testing and received their test results			
4	No. of KPs provided with condoms	This indicator provides a count (by age and sex) of individuals who were given condoms during the month	<u>KP type</u> FSW. MSM TG PWID male. PWID female Prisons Male Prisons Female  <u>Condom type</u>  Monthly reporting	

5.	No. of KPs screened for eligibility for PrEP		<u>KP type</u> FSW. MSM TG	PrEP Register
6.	No. of KPs newly enrolled on PrEP		PWID male. PWID female Prisons Male Prisons Female	
7.	No. of KPs currently receiving PrEP		<u>Age/sex</u>  Monthly reporting	
8.	No. of KPs diagnosed with Sexually Transmitted Infections (STI)	count numbers (by KP type, age and sex) of STI diagnosed	KP type FSW. MSM TG PWID male. PWID female Prisons Male Prisons Female	
9.	No. of KPs treated for STIs	count numbers (by KP type, age and sex) who received treatment for STIs	<u>Age/sex</u>  Monthly reporting	
10.	Number of KPs newly enrolled on antiretroviral therapy (ART)		<u>KP type</u> FSW. MSM TG PWID Prisons	ART registers
11.	Number of KPs currently receiving antiretroviral therapy (ART)		<u>Age/sex</u>	
12.	Percentage of KPs with a suppressed viral load (< 1000/ml)		Disaggregate : Pregnant, Breastfeeding and regimen line (1 <sup>st</sup> and 2 <sup>nd</sup> ).  Monthly reporting	
13.	Number of PWIDs who accessed a Needle Syringe Program (NSP) over the reporting period		<u>Age/sex</u>  Monthly reporting	
14.	Number of people starting Opioid Substitution Therapy (OST) as a cohort during the reporting period			
15.	Number of all individuals on Opioid Substitution Therapy (OST) at the reporting period			
16.	Number of individual HIV self-test kits distributed for unassisted testing.		<u>KP type</u> FSW. MSM TG PWID Prisons  <u>Age/sex</u>  Monthly reporting	

## List of Steering Committee Members

1. Director NACA R, M&E – Chairman
2. Head of Strategic information NASCP, FMOH – Co chair
3. FMOH/DPRS
4. NASCP
5. UNAIDS
6. PEPFAR
7. USAID
8. DOD
9. CDC
10. WHO
11. UNICEF
12. UNDP
13. Population Council
14. NTBLCP
15. NEPHWAN
16. CISHAN
17. FMOWA, M&E Focal person
18. FMOE, M&E Focal person
19. FCT Agency for the Control of AIDS (FACA), M&E Focal
20. person
21. NBS
22. NMOD, Director MOP HIP
23. SFH DIRECTOR STRATEGIC INFORMATION
24. AHF DIRECTOR STRATEGIC INFORMATION
25. Country Coordinator of University of Manitoba
26. Country Director of University of Maryland, Baltimore
27. NAT. BLOOD TRANSFUSION SERVICE
28. DR and M & E Division serves as NOP 3 Secretariat



# NOP III 2021-2025



For further information please contact:

**National Agency for the Control of AIDS.**  
No 3, Ziguinchor Street, off IBB  
Way Behind Abuja Electricity Distribution  
Company, Wuse, Zone 4, FCT,  
Abuja, Nigeria