REVOLUTIONARY GOVERNMENT
OF ZANZIBAR

MONITORING AND EVALUATION (M&E) PLAN

Third Zanzibar National Strategic Plan for HIV and AIDS, 2016/17–2020/21 (ZNSP III)

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Third Zanzibar National Strategic Plan for HIV and AIDS, 2016/17–2020/21 (ZNSP III)

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FOREWORD

The Third Zanzibar National Strategic Plan for HIV and AIDS, 2016/17–2020/21 (ZNSP III) provides a roadmap for the prevention and mitigation of the effects of HIV and AIDS over the next five years. Its mission is "to support the national HIV response to reduce [the] impact of the epidemic on the country's socio-economy through better coordination, access to quality services, leadership, resource mobilization, and financing for effective implementation of the planned interventions." The realisation of this mission calls for ongoing tracking of the services available, the populations they serve, and their quality.

This Zanzibar National HIV and AIDS Monitoring and Evaluation (M&E) Plan, 2016/17–2020/21 (ZNSP III M&E Plan) has been developed to guide stakeholders on how to monitor and evaluate implementation of the ZNSP III, and determine whether its goals and objectives are being met. The guidance includes definitions of indicators for the measurement of expected results (impacts, outcomes, and outputs), sources of data, frequency of data collection, baseline level and targets for each indicator, and the institutions responsible for collecting and reporting the data.

The ZNSP III M&E Plan has 49 indicators with a varied number of indicators for each of the five key result areas (KRA) defined in the strategic plan: (1) KRA 1: HIV prevention, care, and treatment programs for the general population strengthened and scaled up – 25 indicators; (2) KRA 2: Programmes targeting KPs and vulnerable populations improved – 9 indicators; (3) KRA 3: Research, knowledge management, and M&E programmes strengthened – 6 indicators; (4) KRA 4: Alternative and sustainable financing models established – 2 indicators; and (5) KRA 5: Institutional management and integration of services at all levels, enabling environment and impact mitigation interventions strengthened – 7 indicators.

No matter how meticulous a plan, if it is not implemented, it does not make a difference! For this reason, all stakeholders are called upon to contribute to the data collection, analysis, dissemination, and use effort defined in this plan. It is expected that through effective implementation of this ZNSP M&E plan, the Revolutionary Government of Zanzibar (RGZ) and other stakeholders will obtain the strategic information needed for planning and decision-making purposes.

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This document is a result of the concerted efforts of several organisations and individuals whose contributions we wish to acknowledge. The Zanzibar AIDS Commission (ZAC) provided overall coordination of the process for developing this monitoring and evaluation (M&E) plan, including an initial review of key documents for identifying relevant indicators and convening workshops with multisectoral stakeholders to review and refine the draft indicators and the overall document. Due acknowledgement is given to the following organizations for their contributions:

- MEASURE Evaluation Tanzania, funded by the US President's Emergency Plan for AIDS Relief (PEPFAR) and U.S. Agency for International Development (USAID), for their technical assistance for developing the M&E plan
- The Joint United Nations Programme on HIV/AIDS (UNAIDS), for financial and technical assistance
- The Zanzibar Integrated HIV, Hepatitis, TB, and Leprosy Programme (ZIHHTLP)
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ZAC would like also to thank all of those who participated in workshops and other consultations as individuals for demonstrating remarkable commitment towards the production and finalisation of this document.

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CONTENTS

TABLES AND FIGURES

ABBREVIATIONS

AIDS	acquired immunodeficiency syndrome
ANC	antenatal care/clinic
ART	antiretroviral therapy
CFS	Correctional facility students (prisoners)
CSO	civil society organisation
CTC	care and treatment centre/clinics
DHAP	district HIV and AIDS focal person/s
DHIS2	District Health Information System-Version 2
DHMT	district health management team
FBO	faith-based organisation
FSW	female sex worker
GAM	Global AIDS Monitoring
GF	Global Fund
HIV	human immunodeficiency virus
HTS	HIV testing services
IBBSS	Integrated Behavioural and Biological Surveillance Survey
IRCH	Integrated Reproductive and Child Health services
JAPR	Joint Annual Program Review
KP	key population
KRA	key result area
LGA	local government authority
M&E	monitoring and evaluation
MDA	ministries, departments, and agencies
MER	monitoring, evaluation, and reporting
MoEVT	Ministry of Education and Vocational Training
MOH	Ministry of Health
MSM	men who have sex with men
NBS	National Bureau of Statistics
NGO	nongovernmental organisation
OCGS	Office of the Chief Government Statistician
OST	opioid substitution therapy
PEPFAR	U.S. President's Emergency Plan for AIDS Relief
PLHIV	people living with HIV
PMTCT	prevention of mother-to-child transmission
POC	point of care
PWID	people who inject drugs

QSCR	Quarterly Service Coverage Report
REMETTHAZ	Research, Monitoring &Evaluation Task Team for HIV & AIDS in Zanzibar
SRH	sexual and reproductive health
SW	sex worker
TB	tuberculosis
TDHS	Tanzania Demographic and Health Survey
THIS	Tanzania HIV/Impact Assessment Survey
UNAIDS	United Nation Special Commission for AIDS
UNGASS	United Nations General Assembly Special Session on HIV and AIDS
WHO	World Health Organization
WHO SI	WHO Strategic Information Guidelines
ZAC	Zanzibar AIDS Commission
ZAPHA+	Zanzibar Association of People Living with and Affected by HIV and AIDS
ZHAPMoS	Zanzibar HIV and AIDS Program Monitoring System
ZHSHSP	Zanzibar Health Sector HIV and AIDS Strategic Plan
ZIHHTLP	Zanzibar Integrated HIV, Hepatitis, TB, and Leprosy Programme
ZNCDC	Zanzibar Commission for National Coordination and Drug Control
ZNSP	Zanzibar National HIV and AIDS Strategic Plan

1. BACKGROUND

This chapter presents an overview of the HIV and AIDS situation in Zanzibar, and the Zanzibar HIV and AIDS Strategic Plan, 2016/17–2020/21 (ZNSP III), both of which provide the context for this monitoring and evaluation (M&E) plan.

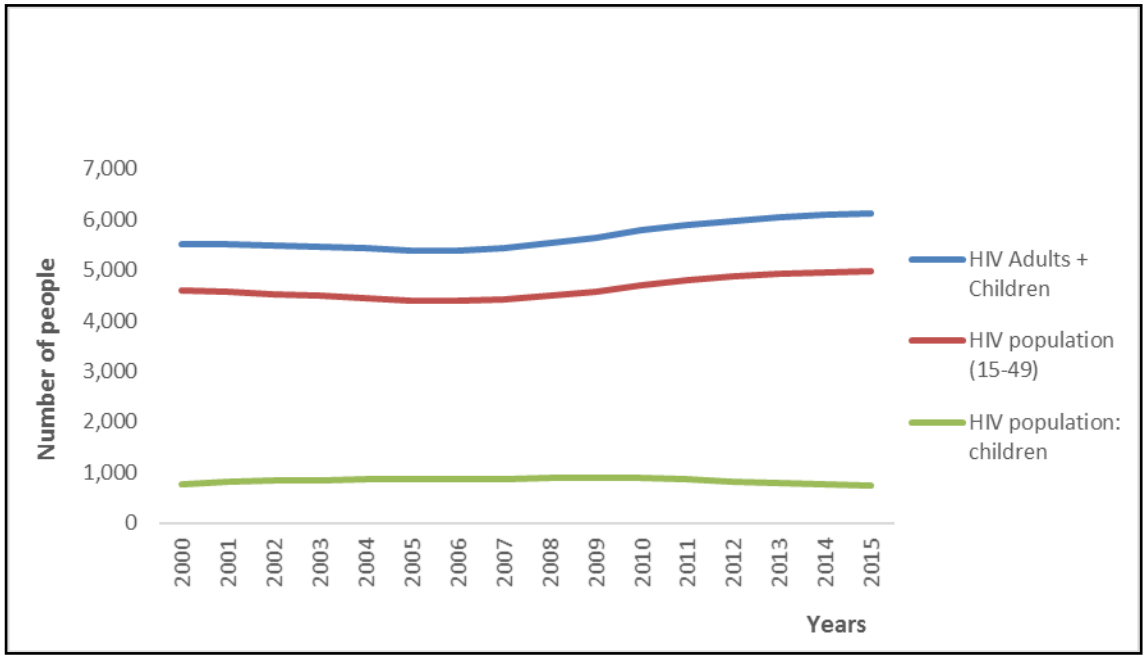
1.2. Magnitude of the HIV and AIDS Problem in Zanzibar

According to the Tanzania HIV Impact Survey (THIS), 2016–2017 (NBS, 2017), HIV prevalence in the general population of Zanzibar is less than 1 percent. Kaskazini Unguja and Mjini Magharibi have the highest HIV prevalence (0.6%), followed by Kusini Pemba (0.3%). HIV prevalence is negligible in the other two regions of Zanzibar—Kusini Unguja and Kaskazini Pemba. The THIS 2017 data show significant reductions in HIV prevalence from the HIV and Malaria Indicator Survey of 2011–2012, which estimated an HIV prevalence of 1.2 percent and 0.3 percent in Unguja and Pemba, respectively.

However, estimates from the general population mask the HIV problem in Zanzibar, which is typically classified as having a concentrated HIV epidemic, with high HIV prevalence among key populations (KPs). For example, according to the Integrated Behavioral and Biological Surveillance Survey (IBBSS) conducted in 2012, HIV prevalence among sex workers (SWs), people who inject drugs (PWID), and men who sex with men (MSM) was 19.3 percent, 11.3 percent, and 2.6 percent, respectively.

Based on Spectrum data, it is estimated that 6,393 residents of Zanzibar are currently living with HIV. Amongst them, 80 percent (5,146) are people in the age group 15–49 years, and 8.8 percent (551) are children below age 15. The population living with HIV was relatively steady between 2000 and 2008, but a slight increase occurred from 2008 through 2015, as illustrated in Figure 1. This uptick can be explained by the establishment of care and treatment services in 2005 and access to ART, which reduced mortality amongst people living with HIV (PLHIV).

Figure 1. Population estimates of people living with HIV, 2000–2015, Zanzibar



Source: ZIHHTLP Annual Report, 2015.

1.3. Third Zanzibar National HIV Strategic Plan, 2016/17 to 2020/21

The ZNSP III provides a roadmap for the prevention and mitigation of the effects of HIV and AIDS in the next five years. The ZNSP III is aligned with the Zanzibar Vision 2020 Strategy for Growth and Reduction of Poverty, and other international strategies, such as the World Health Organization (WHO) "test and treat" strategy and the Joint United Nations Programme on HIV and AIDS (UNAIDS) roadmap for accelerated HIV prevention to reduce new infections by 75 percent by 2020.

1.3.1. Vision, Mission, and Goal of ZNSP III

The vision of ZNSP III is "a Zanzibar population that is free of new HIV infections and empowered to take positive actions." The mission is "to support the national HIV response to reduce [the] impact of the epidemic on the country's socio-economy through better coordination, access to quality services, leadership, resource mobilisation and financing for effective implementation of the planned interventions." The overarching goal is "to prevent the spread of HIV infection among [the] Zanzibar population, with emphasis on key populations, provide [a] quality user friendly continuum of care to all PLHIV, and mitigate the accompanying negative psycho-social outcomes."

1.3.2. Key Result Areas and Outcomes

The ZNSP III has five key result areas, described below.

1.3.2.1. HIV Prevention, Care, and Treatment Programs Strengthened

HIV prevention remains the number one priority for the ZNSP III. The plan sets a reduction in the number of new HIV cases in the general population from 173 (2015) to 80 (2020) through a combination of interventions. Access to antiretroviral therapy (ART) has dramatically improved in the last decade, thus reducing both mortality and morbidity associated with HIV. The government has adopted the 2015 WHO guidelines on testing and treating, which will further enhance HIV prevention. Strategies will be put in place to ensure linkages between HIV testing services (HTS) and care and treatment centres (CTCs) to improve retention in both HIV care and treatment services. Prevention will be strengthened in both KPs and the general population. HTS will receive special attention because it is the entry point for all HIV prevention and care services. By the end of the implementation of ZNSP III, the UNAIDS target of 90-90-90 is expected to be realised. The testing approach will be enhanced to target geographical areas with high burden and low coverage of individuals who know their status. Facility testing will target potential high-yield settings, such as tuberculosis (TB)/HIV clients, sexually transmitted infection (STI) clients, inpatients, and so on. Provider-initiated testing and counselling (PITC) will be better linked to a range of other health services for adults, children, and adolescents, such as outpatient departments, inpatient departments, immunisation services, nutrition services, and growth clinics. In addition, new intervention strategies, such as self-testing and community-driven outreach (including home-based testing), will be explored among marginalised populations.

1.3.2.2. Programmes Targeting Key and Vulnerable Populations Improved

In the coming five years, initiatives that increase access by KPs to HIV services will be enhanced. Innovative ways of engaging KPs in HIV prevention and care will be promoted, and interventions to empower KPs and reduce stigma prioritised. Anti-stigma interventions will be conducted with healthcare providers, government officials, and other key stakeholders (such as religious leaders, police officers, prison officers), with a view to ensuring access to respectful, quality HIV services by KPs. New biomedical prevention technologies, such as microbicides and pre-exposure prophylaxis (PrEP), will be explored to enhance the package of HIV prevention services among KPs and other vulnerable populations.

1.3.2.3. Research, Knowledge Management, and M&E Programmes Strengthened

Planning and implementation of ZNSP III will be evidence based; thus, M&E will be a crucial component of the national response in the next five years. Strategies will build on the M&E successes in ZNSP II and strengthen the weak components of the national M&E system, guided by the UNAIDS framework for the 12 components of a functional national M&E system.

1.3.2.4. Alternative and Sustainable Financing Models Established

Government funding of the health sector is currently at about 5.8 percent of the total Revolutionary Government of Zanzibar resource envelope, which is lower than the 15 percent target recommended in the Abuja Declaration. To address funding challenges, the Zanzibar AIDS Commission (ZAC) will develop a resource mobilisation plan targeted at both local and international potential sources of funds, adopt a health systems-strengthening approach to better integrate programmes and services, reduce duplication, and create a Zanzibar AIDS Trust Fund.

1.3.2.5. Institutional Management and Integration of Services at All Levels, Enabling Environment, and Impact Mitigation Interventions Strengthened

ZAC has established a partnership mechanism with critical stakeholders from the public and private sectors, communities, civil society organisations (CSOs)/nongovernmental organisations (NGOs)/faith-based organisations (FBOs), and development partners and the UN system in Tanzania, all of which are involved in the national HIV and AIDS response in Zanzibar. Structures for effective coordination of the multisectoral response will be strengthened at both the national and district levels. In addition, a conducive and supportive social, legal, and policy environment will be created for all, including strengthening HIV policies and legislation to ensure protection of the rights of PLHIV and KPs.

1.4. Purpose of the M&E Plan

ZAC is responsible for monitoring the HIV epidemic and coordinating the national response. All implementers, including government ministries, non-state actors, and development partners are expected to monitor the progress of their efforts and evaluate their responses at the output, outcome, and impact levels. All HIV programme-related information gathered by all stakeholders involved in the response will be shared with ZAC for further dissemination.

The purpose of this M&E plan is to provide guidance for tracking the results of the ZNSP III. This M&E plan guides stakeholders on how to monitor and evaluate implementation of the ZNSP III, and determine whether its goals and objectives are being met. The guidance includes the definition of indicators for the measurement of expected results (impacts, outcomes, and outputs), sources of data, frequency of data collection, baseline levels and targets for each indicator, and the institutions responsible for collecting and reporting the data.

1.5. Process for the Development of the M&E Plan

This M&E plan was developed through a consultative process and coordinated by ZAC, with technical support from MEASURE Evaluation Tanzania. The specific processes involved are described below.

Step 1: MEASURE Evaluation, jointly with ZAC, conducted a desk review of key documents that included the ZNSP III; the Zanzibar National Multisectoral HIV Monitoring and Evaluation System Operational Framework; strategic plans/frameworks from other key sectors, departments, and ministries included in the ZNSP III; and global HIV M&E reference documents, such as the U.S. President's Emergency Plan for AIDS Relief (PEPFAR) 3.0, the United Nations General Assembly Special Session on HIV/AIDS (UNGASS) indicators, UNAIDS Global AIDS Monitoring Indicators, Global Fund M&E guidelines, and WHO's Strategic Information (SI) Guidelines for HIV in the health

sector. This desk review assisted in the identification of appropriate indicators for monitoring and evaluating ZNSP III's performance, which were written up in the first draft of the M&E plan.

Step 2: A five-day workshop was conducted with ZAC and other stakeholders to review the draft indicators for the M&E plan. This review workshop entailed the following tasks:

a. Review of the ZNSP III and identification of indicators (impacts, outcomes, outputs, processes, and targets) provided in the document, and gaps in indicators for any of the identified programme strategies/areas
b. Review of definitions for all of the indicators, ensuring their alignment with definitions in key national and global M&E reference documents
c. Review of all data sources and availability of appropriate data collection tools
d. Setting of baseline levels and targets for each indicator

Step 3: MEASURE Evaluation Tanzania worked with a small taskforce comprising staff from ZAC and other implementing partners to incorporate inputs from the review workshop into advanced drafts and the final version of the M&E plan. The same taskforce was responsible for reviewing and finalising the plan.

1.6. Target Audience

The target audience for this M&E plan includes the following:

- ZAC
- Zanzibar Integrated HIV, Hepatitis, TB, and Leprosy Programme (ZIHHTLP)
- Government officials responsible for planning and implementing the HIV prevention program
- Development partners
- Other key stakeholders from NGOs and academic institutions
- Healthcare providers
- Other organisations responsible for planning and implementing HIV prevention and treatment services

1.7. Organisation of the M&E Plan

The M&E plan is organised into the following eight chapters: After this introductory chapter, Chapter 2 presents the goal and objectives of the M&E plan. Chapter 3 elaborates on the multisectoral HIV and AIDS M&E framework, including a presentation of the results pathway and performance indicators. Chapter 4 reviews the multisectoral response M&E system capacity and identifies activities required to strengthen the system; Chapter 5 describes the national multisectoral HIV and AIDS data collection plan, including non-routine and routine data sources. Chapter 6 presents the roles and responsibilities of different stakeholders for implementing the M&E plan. Chapter 7 focuses on data analysis, dissemination, and use, and the final chapter outlines strategies for monitoring and evaluating the implementation of the national multisectoral M&E plan.

2. GOAL AND OBJECTIVES OF THE M&E PLAN

2.1. Introduction

This M&E plan is designed to provide a mechanism for measuring ZAC's response to the HIV and AIDS epidemic based on the third Zanzibar Health Sector HIV and AIDS Strategic Plan (ZHSHSP III) 2017–2022. The overall vision of the M&E plan is to develop a sustainable multilevel and multisectoral M&E infrastructure to support efficient collection of high-quality, standard, realistic, appropriate, and timely data on the performance of the ZNSP III.

The mission of the M&E plan is to effectively lead and coordinate the efforts of all stakeholders in the HIV and AIDS response to facilitate implementation of the ZNSP III. To this end, the M&E plan provides standards and guidelines for measuring and using data to inform the national response, and advocate with different stakeholders on key issues regarding that response.

A comprehensive and efficient M&E plan is critical for any HIV and AIDS programme that aims to reduce the transmission of the disease and mitigate its impact. This plan provides relevant information to programme managers and policymakers so they can make key decisions. It also contributes to more efficient use of data and resources by using standard indicators and data recording methodologies that can be compared over time and between different geographic areas.

2.2. Purpose and Goal of the M&E Plan

Purpose

The purpose of the M&E plan is to guide stakeholders in coordinated, systematic, and efficient collection, collation, analysis, interpretation, application, and dissemination of information on the national multisectoral response.

Goal

The goal of the M&E plan is to ensure coordination of reporting on results of HIV and AIDS interventions across sectors. The plan will be used to measure progress and guide planning and decision making for the realisation of the ZNSP III targets.

2.3. Objectives of the M&E Plan

This M&E plan is designed and will be implemented to attain the following objectives:

- Strengthen leadership and coordination of the multisectoral HIV and AIDS response
- Link services to their outcomes to better assess coverage, quality, and impact
- Strengthen analysis, disaggregation, and use of data to improve linkage and identify bottlenecks and priorities along the cascade
- Align reporting across programmes, such as testing, care and treatment, TB and HIV, and commodities and procurement to achieve better coordination
- Enhance strategic, human resource, and logistical capacity for monitoring and evaluating the national response
- Improve routine HIV and AIDS data collection, management, quality, analysis, and use for decision making
- Strengthen systems to undertake HIV and AIDS and related biological and behaviour surveillance, surveys, and research
- Enhance HIV and AIDS information and knowledge management
- Strengthen HIV and AIDS financial monitoring, and budget and expenditure analysis

3. MULTISECTORAL HIV AND AIDS M&E FRAMEWORK

This chapter describes the M&E results pathway and presents the ZNSP III results framework and a summary of its impact and outcome indicators.

3.1. M&E Results Pathway

Monitoring and evaluation is concerned with the efficiency, effectiveness, and impact of interventions. **Efficiency** focuses on the application of resources (people, money, skills, and time) to achieve programme goals and objectives. **Effectiveness** is concerned with the extent to which programme activities bring about desired changes in the lives of the people and communities targeted. **Impact** relates to the long-term programme results from a concerted response to a problem.

Monitoring is the routine or regular assessment of ongoing activities and progress being made in a programme or project. Evaluation, in contrast, is the episodic assessment of overall achievements and the extent to which they can be attributed to specific interventions. Monitoring looks at what is being done, whereas evaluation examines what has been achieved (UNAIDS, 2002). **Evaluation** draws from data generated by the monitoring system and links this information to primary beneficiaries to determine the impact of programmes. Monitoring should be integrated within the programme management system.

An M&E framework is designed to help provide data or evidence that programme activities are meeting the objectives of efficiency and effectiveness, and contributing to impact. The common M&E framework considers developmental change as a chain of interrelated components consisting of inputs, processes, outputs, outcomes, and impacts.

Inputs are the people, training, equipment, and resources put into a programme to achieve the delivery of services.

Processes are the activities or services delivered, including HIV and AIDS prevention, care, and support services, either to improve the well-being of beneficiaries or change their behaviours.

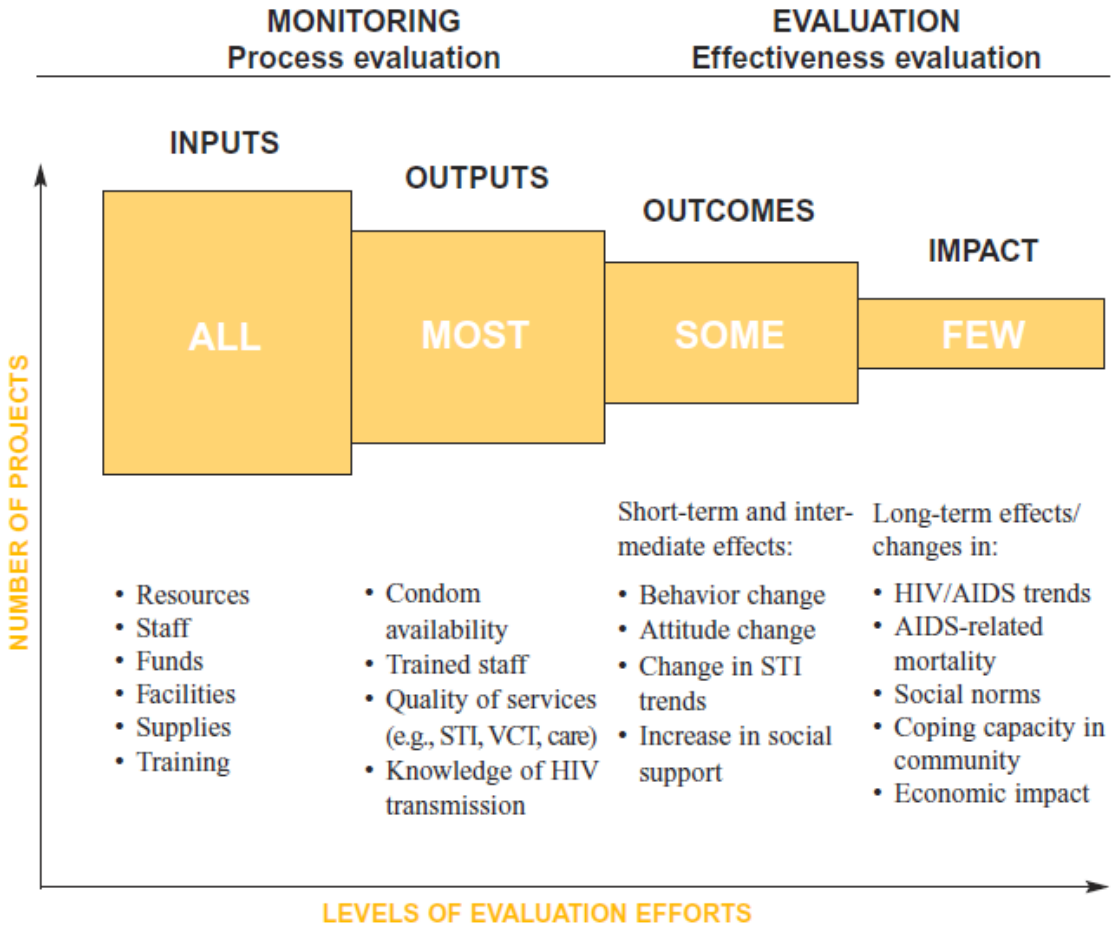
Outputs are the immediate results of the processes—for example, the number of trained staff or stock levels of essential drugs and commodities.

Outcomes are changes in behaviour or skills, especially safer HIV prevention practices and increased ability to cope with HIV and AIDS.

Impact relates to long-term programme results; for example, reduced new HIV infections or improved well-being of PLHIV.

Inputs are transformed into outputs through activities undertaken or services delivered. The transformation of inputs into outputs entails a process which requires attention to quality, unit costs, access, and coverage of services. Monitoring and evaluation that focuses on inputs, the process of their transformation, and outputs is also called “process monitoring,” in contrast to outcomes/effectiveness or impact evaluation, which often require targeted studies conducted at the start of a programme and repeated after a considerable period of programme implementation, usually with a control or comparison group. An outcome evaluation or assessment seeks to determine whether, and by how much, programme activities are achieving their intended effects within the target population. An impact evaluation seeks to determine the magnitude of change that can be attributed reliably to a programme intervention. Figure 2 depicts the M&E results pathway.

Figure 2. Monitoring and evaluation results pathway



Adapted from The Joint United Nations Program on HIV and AIDS (UNAIDS). (2002). *National AIDS Control Councils Monitoring and Evaluation Operations Manual*. Geneva: UNAIDS. Page 3.

As depicted in the results pathway or cycle, the higher up in the results cycle, the fewer organisations are involved in M&E. Input and output data are normally collected by all programme implementers. Many implementing partners should collect some process data, but far fewer will assess outcomes. Even fewer implementing partners and studies are normally required to assess impacts (UNAIDS, 2002).

3.2. ZNSP III M&E Framework

Table 1 below presents the ZNSP III results framework, with an overall description of the goal, key result areas (KRA), impact, and outcome results. The interventions are organised into five KRAs, each with a range of intervention areas and corresponding impact and outcome results.

Table 1. Summary of ZNSP III results framework[1]

Goals To prevent the spread of HIV infection among Zanzibar's population, with emphasis on key populations To provide a quality user-friendly continuum of care to all PLHIV and mitigate the accompanying negative psychosocial outcomes				
KRA 1: HIV prevention, care, and treatment programs for the general population strengthened and scaled up	**KRA 2: Programmes targeting KPs and vulnerable populations improved**	**KRA 3: Research, knowledge management, and M&E programmes strengthened**	**KRA 4: Alternative and sustainable financing models established**	**KRA 5: Institutional management and integration of services at all levels, enabling environment and impact mitigation interventions strengthened**
Impact 1.1. Incidence of HIV in general population is reduced from 274 (0.03%) in 2015 to 75 (0.01%) by 2020, disaggregated by age and population groups (Note: Impact 1 in ZNSP III)	**Impact 2.1:** Reduced HIV incidence and prevalence amongst KPs (Note: Impact 4 in ZNSP III)	**Outcome 3.1**: A "One national HIV & AIDS monitoring and evaluation (M&E) system"	**Outcome 4.1**: Increased funding for the national response (total funding available)	**Outcome 5.1**: Strengthened institutional management and coordination of Zanzibar National Strategic Plan (ZNSP III)
Outcome 1.1.1: Proportion of population estimated to be HIV infected that knows their HIV sero-status increased from 82% (5,051/6,129) in 2015 to 90% (5,825/6,472) by 2020, disaggregated by age and population groups (Note: Outcome 1.1 in ZNSP III)	**Outcome 2.1.1:** Reduced risky behaviours amongst KPs: MSM, FSWs, PWID, and CFS (Note: Outcome 2.1 in ZNSP III)	**Outcome 3.2**: National Systems for HIV and AIDS-related research strengthened	**Outcome 4.2**: Increased funding for the national response (percentage of ZNSP III budget mobilized)	**Outcome 5.2**: Integrated provision of HIV and AIDS, SRH, and TB services at all levels

[1] The indicators have been renumbered from those in the ZNSP III. The numbering used here and in the comprehensive indicator matrix should be used consistently for monitoring and evaluating the implementation of ZNSP III.

Outcome 1.1.2: Safer sexual behaviour increased by 40% by 2020 (Note: Outcome 1.2 in ZNSP III)	**Outcome 2.1.2**: Percentage of HIV-infected KPs and vulnerable populations enrolled on ART achieving viral suppression increased (Note: Outcome 2.2 in ZNSP III)	**Outcome 3.3**: Increased HIV and AIDS knowledge management at all levels	**Outcome 4.3:** Increased domestic financing for HIV response	**Outcome 5.3**: HIV and AIDS interventions mainstreamed in public (i.e., MDAs), LGAs, NGOs, FBOs, and private sector programmes
Outcome 1.1.3: Strengthened capacity to manage (prevent, diagnose, and treat) HIV co-morbidities amongst PLHIV (Note: Outcome 1.4 in ZNSP III)				
Outcome 1.1.4: Sexually active individuals having high-risk sex who use condoms (Note: Outcome 1.5 in ZNSP III)				
Outcome 1.1.5: 1.1.5: All blood and blood products used for transfusion screened and free of HIV and markers of other infectious diseases (Note: Outcome 1.6 in ZNSP III)				
Impact 1.2: Mother-to-child HIV transmission rates reduced to less than 5% by 2020 (Note: Impact 2 in ZNSP III)				
Outcome 1.2.1: Proportion of HIV-infected mothers enrolled in PMTCT services increased from 51.9% (200/385) to 90% by 2020 (Note: Outcome 1.7 in ZNSP III)				

Impact 1.3: HIV mortality and morbidity for adults and children is reduced by 50%, from 125 in 2015 to 63 in 2020 (Note: Impact 3 in ZNSP III)				
Outcome 1.3.1: Proportion of HIV-Infected individuals enrolled on ART increased from 60% in 2016 to 90% in 2020 (Note: Outcome 1.8 in ZNSP III)				
Outcome 1.3.2: Reduced HIV and AIDS-related stigma amongst the general and key populations (Note: Outcome 1.9 in ZNSP III)				

3.3. ZNSP III Performance Indicators

The development of a results-based M&E plan entails six essential actions:

1. Formulation of outcomes and goals
2. Selection of outcome indicators to monitor
3. Gathering baseline information for each indicator
4. Setting specific targets to reach and the timeline for their realisation
5. Regularly collecting data to assess whether the targets set are being reached
6. Analyzing, reporting, and using results for ongoing decision making (Kusek and Rist, 2004)

The formulation of outcomes and goals, and selection of outcome indicators were achieved partly during the ZNSP III development process and are refined in this M&E plan. Gathering baseline data and setting targets was part of the M&E plan development process. The regular collection of data to assess whether targets are being met requires clear procedures for data collection, management, analysis, and use within both routine data collection systems and periodic surveys. This M&E plan addresses all of these dimensions.

3.4. ZNSP III M&E Indicator Matrix

An indicator is a quantitative or qualitative variable that provides a valid and reliable way to measure achievement, assess performance, or reflect changes connected to an intervention. An indicator should reveal whether progress has been made towards expected or planned results regarding quantity, quality, and timeliness. Unlike performance objectives, an indicator does not specify a level of achievement.

The identification of indicators for the ZNSP III has been done carefully to ensure alignment with global M&E reference documents. The indicator prioritisation process was guided by the six criteria identified by the UNAIDS Monitoring and Evaluation Reference Group, as highlighted below.

Table 2. Indicator standards

Indicator Standards: Operational Guidelines for Selecting Indicators for the HIV Response
Standard 1: The indicator is needed and useful An indicator must provide data that are required and will be used by stakeholders in planning and decision making.
Standard 2: The indicator has technical merit An indicator must have substantive merit by measuring something of significance and importance within a particular field, and be sufficiently sensitive to detect changes in performance. In addition, an indicator must have a monitoring merit or reliability. The indicator must be able to produce the same or very similar results, even if measured by different instruments, procedures, or observers.
Standard 3: The indicator is fully defined The purpose and rationale of an indicator must be clear, as must be the methods for its measurement, including any disaggregation. The numerators and denominators of the indicator must be specified as appropriate, and frequency of data collection defined. Equally important is the clarity of the interpretation of the indicator.
Standard 4: It is feasible to collect and analyse data for this indicator The systems and mechanisms for collecting, interpreting, and using data for the indicator, such as surveys, need to be in place. It is also important to consider the financial and human resources required for collecting data for the indicator.

Standard 5: The indicator has been field tested or used in practice
An indicator should have been field tested and reviewed for data availability.

Standard 6: The indicator set is coherent and balanced overall
A good set of indicators should give an overall picture of the adequacy or otherwise of the response being measured. Indicator sets should cover all key elements of the response being assessed, ensuring an appropriate mix of indicators to assess inputs, outputs, outcomes, and impacts.

The ZNSP III has 49 indicators. The number of indicators by KRA is as follows: KRA 1 (25); KRA 2 (9); KRA 3 (6); KRA 4 (2); KRA 5 (7). A comprehensive indicator matrix, with indicator definitions, is included in Appendix 1. The indicator matrix is intended to facilitate the tracking of progress towards impacts, outcomes, and realisation of outputs. The matrix provides the following information:

- KRA and corresponding intervention areas
- Indicators for measuring impacts, outcomes, and outputs
- Definition for each indicator regarding the required numerator and denominator
- Factors of interest for disaggregating data on each indicator (e.g., sex, age, region, etc.)
- The source of the indicator, including both national (e.g., ZHSHSP III) and global (e.g., PEPFAR Monitoring Evaluation, and Reporting [MER] 2.0, WHO, UNGASS, etc.)
- The data sources, which describe existing initiatives for the collection of data that respond to each indicator, including routine data sources, such as the health management information system (HMIS), and special or periodic studies (e.g., Demographic and Health Surveys, AIDS Indicator Surveys, the Tanzania Health Indicators Survey, etc.)
- Frequency of data collection
- Baseline level of each indicator (when available) and targeted level of the indicator by 2021 (when defined)
- Stakeholders responsible for collecting or ensuring access to data for measuring each indicator

4. THE MULTISECTORAL RESPONSE M&E SYSTEM CAPACITY

4.1. Introduction

The UNAIDS (2008) *Organizing Framework for a Functional National HIV Monitoring and Evaluation System* identifies 12 components of an operational M&E system, in which the M&E plan is but one component of an effective M&E system. The 12 components are (1) organisational structure; (2) human capacity; (3) partnerships and coordination; (4) M&E plan; (5) costed M&E workplan; (6) advocacy, communications, and culture; (7) routine programme monitoring; (8) surveys and surveillance; (9) databases; (10) supportive supervision and auditing; (11) evaluation and research; and (12) data dissemination and use.

The 12 components can be organised operationally into three categories. The first category, comprising the first six components, relates to people, partnerships, and planning that support data production and use, which constitute the enabling environment for M&E to function. The second category is concerned with systems for collecting, capturing, and verifying data, and transforming data into useful information (components 7–11); the last category addresses the central purpose of M&E, which is analysis of data to create information that is disseminated to inform and empower decision making at all levels. Figure 2 presents the 12 components framework.

Figure 3. Organising framework for a functional national HIV M&E system – 12 components

Source: Adapted from UNAIDS. (2008). *Organizing framework for a functional national HIV monitoring and evaluation system.* Geneva: UNAIDS. Page 6.

The middle and center rings in the framework above are interlinked and relate specifically to the purpose of an M&E plan, which is to support tracking of program implementation and facilitate decision making. The enabling environment, although critical, is not limited to the M&E function and requires interventions at multiple levels and amongst several institutions. The implementation of

this M&E plan requires attention to all 12 components, even though some of them are prioritised, as described below.

4.2. Zanzibar AIDS Commission M&E System Strengthening Activities

In July 2016, ZAC assessed its M&E system using the 12 components framework. This assessment provided specific recommendations on activities for strengthening its M&E system. This section presents recommended activities for selected components to be implemented during the term of the ZNSP III. These activities have been updated to reflect current needs. Activities related to data collection, management, and dissemination and use are discussed in later chapters.

1. **Organisational structure for the M&E plan**
    - Review ZAC human resources policy and scheme of service
    - Conduct M&E staff needs assessment at the national and district levels, and recruit accordingly
    - Capacitate ZAC to fulfil its M&E mandate by delivering M&E service and deliverables
    - Recruit additional staff to fill the gap in the M&E department (i.e., data officer, head of M&E department, epidemiologist, and IT officer)
    - Review M&E staff job descriptions to include a research component
    - Develop M&E staff motivation and retention mechanisms and strategies
    - Develop M&E technical assistance plan
    - Advocate with the government to assign M&E staff at the district level
2. **M&E human capacity**
    - Engage a consultant to formulate career plans for ZAC staff
    - Develop a human capacity-building plan on M&E-related skills and competencies so the M&E staff can fulfil their responsibilities
    - Develop indicators to monitor an M&E capacity-building program
    - Advocate for integration of M&E HIV and AIDS training modules into a pre-service program (for both health and non-health cadres)
    - Develop and operationalise a database of training programs (showing the number of trainees and trainers, and courses attended)
    - Support the implementation of supportive supervision
3. **Partnerships and planning**
    - Reintroduce Research, Monitoring &Evaluation Task Team for HIV & AIDS in Zanzibar (REMETTHAZ) and actively engage development partners
    - Update REMETTHAZ terms of reference (TOR)
    - Update the list of REMETTHAZ members to cater to the existing HIV situation
    - REMETTHAZ will effectively update and utilise data collection and reporting tools for routine reporting of non-health data (Zanzibar HIV and AIDS Programme Monitoring System, ZHAPMoS)
    - Mobilise resources to support REMETTHAZ meetings on a quarterly basis
    - Advocate for the involvement of development partners in REMETTHAZ meetings
    - Ensure district HIV and AIDS coordination meetings are conducted
    - Resolve bottlenecks related to finances for the ZAC M&E subcommittee
    - Advocate for fund allocation at regional and district levels for HIV and AIDS activities
4. **National HIV and AIDS M&E plan**
    - Support the development/review and operationalisation of the national M&E plan for non-health sectors that align with ZNSP III
    - Estimate M&E resource budget requirements for the new M&E plan

- Support the development and implementation of a resource mobilisation strategy for non-health sector M&E activities
- Advocate for integration of non-health M&E activities into comprehensive district health plans (CDHPs)

5. National M&E workplan

- Support the development and implementation of a costed non-health sector M&E operational workplan based on the new M&E plan
- Support the printing and dissemination of the developed M&E operational plan amongst key stakeholders
- Consistently allocate funds for sustainability of the M&E plan
- Support districts in the development of annual M&E operational plans, complete with costed activities
- Review implementation progress of the national M&E plan and make any necessary modifications

6. Advocacy, communication, and culture

- Review the existing advocacy and communication strategy (2011–2016), and align it with ZNSP III, ensuring that it includes dissemination of M&E information
- Establish HIV and AIDS knowledge management platforms
- Update and maintain the ZAC website, and appoint a dedicated individual with the necessary skills and resources to regularly run and update the website
- Broadcast the use of the ZAC website to all stakeholders, government staff, and the public
- Cascade the development of web-based applications via a local area network across all ZAC offices in Unguja and Pemba
- Produce M&E information products and have them disseminated appropriately
- Disseminate information products (i.e., reports, website content, emails, newsletters, maps, tables, charts) to various stakeholders
- Conduct quarterly M&E feedback meetings
- Advocate with the heads of divisions and coordinators on the importance of using HIV M&E information both before and during the HIV review planning and costing processes

7. Routine programme monitoring

- Review all ZHAPMoS forms and align them to ZNSP III
- Train key implementers on the revised ZHAPMoS forms
- Support data collection and use of the ZHAPMoS forms
- Develop an M&E system and review the current existing system to track information, education, and communication (IEC) and behaviour change communication (BCC) indicators
- Build the capacity of HIV stakeholders on the M&E system, indicators, guidelines, and revised tools for reporting
- Train community stakeholders at the district level on how to verify obvious mistakes related to data before submitting it to ZAC
- Procure and supply IT equipment to enhance the M&E system

8. Surveys and surveillance

- Review and update the existing research agenda to fit ZNSP III needs
- Mobilise resources to implement the revised research agenda and its implementation plan
- Develop a searchable inventory of research, surveillance studies, and evaluations
- Establish a national archive of HIV research and surveillance documentation, and a library

- Improve the collaboration with research and evaluation institutions, including the Office of the Chief Government Statistician (OCGS)
- Build stakeholders' capacity to undertake HIV and AIDS research
- Conduct national a HIV workplace survey (baseline)
- Conduct a comprehensive condom availability and use survey
- Advocate for utilisation of surveys and surveillance findings in planning and decision making
- Strengthen collaboration and involvement with organisations conducting research and surveillance related to HIV and AIDS

9. M&E databases, national and subnational

- Review the existing data management guideline
- Orient and train M&E personnel at all levels on the guidelines and tools
- Develop a web-based national HIV and AIDS database, based on the revised tools, to align with ZNSP III and its M&E plan
- Develop and disseminate a data quality assessment guideline
- Train all key stakeholders on the data quality assessment guidelines and tools

10. Supervision and data auditing

- Review the existing (2006) national comprehensive supportive supervision guidelines to align with ZSNP III
- Develop a comprehensive national guideline and tools for supportive supervision and mentorship on M&E (from the national to shehia levels)
- Strengthen mentorship and supportive supervision

11. Evaluation and research

- Mobilise resources for research and evaluations
- Conduct mid- and end-term evaluations of ZNSP III
- Strengthen the collaboration between the Zanzibar Medical Research and Ethics Committee (ZAMREC) and ZAC in establishing a research inventory
- Liaise with higher learning institutions in conducting research
- Advocate for the culture of using research findings in policy, planning, and for decision-making purposes

12. Data dissemination and use

- Prepare a protocol and conduct stakeholders' information needs assessments
- Develop a data demand and information use guideline to support data analysis, presentation, and use at all levels
- Orient data providers on the guideline for data analysis, presentation, and use at all levels
- Organise quarterly data review meetings at the district and national levels to discuss key programme indicators with programme managers and decision makers
- Strengthen the ZAC resource centre and publicise it for use; additionally, develop online dissemination platforms
- Support the development, printing, and dissemination of information products (annual reports, a quarterly service coverage report, Global AIDS Monitoring [GAM] Indicators, etc.)
- Develop customised information products for KPs and other vulnerable groups
- Upload information products on the ZAC website
- Strengthen the M&E unit in collecting, analysing, and disseminating data to all implementing partners (IPs) to enhance data demand and use
- Support data dissemination and information use training at all levels

5. NATIONAL HIV/AIDS MULTISECTORAL RESPONSE DATA COLLECTION PLAN

5.1. Introduction

A functional M&E system requires standard monitoring indicators and standards for collecting, analysing, and reporting data. This chapter includes information on how data for tracking the implementation of ZNSP III will be collected, reported, and shared to facilitate decision making.

Two broad types of data sources will be used: routine data sources (for monitoring data) and episodic data sources (for evaluation data). Monitoring data will be collected on inputs and outputs, using standard program-based data collection tools. Evaluation data, on the other hand, will be collected on outcomes and impacts, primarily through population-based biological, behavioural, and social surveys and surveillance.

5.1.1. Routine Data Sources

Routine data sources will facilitate tracking activities as they are implemented. Routine monitoring data will be collected from health and non-health sources with the support of implementing partners, using standardised tools. Table 3 summarises different standard tools for collecting monitoring data, who is responsible for reporting, and the frequency of their reporting.

Table 3. Standard tools for monitoring data and the responsibility for and frequency of their reporting

	Data collection standard tools	Stakeholder to complete	Reporting frequency
1	ZHAPMoS tools	CSOs, private sector, LGAs, MDAs	Quarterly
1	HIV testing and counselling tools	Healthcare providers	Monthly
2	HIV care and treatment tools	Healthcare providers	Quarterly
3	HIV home-based care tools	Home-based care providers and coordinators	Monthly
4	Sexually transmitted infections tools	Healthcare providers	Monthly
5	Reproductive and child health tools	Healthcare providers	Quarterly/monthly
8	Key populations	Healthcare providers	Monthly reports

Examples of routine data sources are as follows:

Zanzibar HIV and AIDS Programme Monitoring System (ZHAPMoS)

ZAC has developed a system—the Zanzibar HIV and AIDS Programme Monitoring System (ZHAPMoS)—which is used for capturing data on all non-health sector HIV services (i.e., all HIV services not provided by the Ministry of Health [MOH]), including HIV prevention and impact mitigation services.

ZHAPMoS is a routine data source. It is used to collect and report routine data to measure indicators at the non-health output level in the national set of HIV indicators. For ZHAPMoS to be successful, it needs the **same accurate data from all implementers of non-health HIV services**. The strength of ZHAPMoS depends on the active involvement of HIV implementers through regular and rigorous reporting. For this reason, ZAC has developed a series of standard ZHAPMoS forms to be used by

stakeholders to report data on non-health sector HIV services. A different form has been developed for each sector.

Every quarter, all implementers of non-health HIV services are required to complete their sector's ZHAPMoS form. Every organisation which has implemented non-health HIV services must complete the form in triplicate (blue, green, and white copies), using the ZHAPMoS books supplied by ZAC to every district. Implementers then submit their completed ZHAPMoS forms to their district HIV and AIDS focal persons (DHAPs). The DHAPs collate data from the individual ZHAPMoS forms into one district-level summary form and send it to ZAC. ZAC in turn collates the district-level summary forms and produces a Quarterly Service Coverage Report (QSCR). The QSCR is disseminated every quarter to stakeholders at all levels.

1.1.1. Non-Routine Data Sources

ZAC will collect evaluation data in collaboration with other stakeholders. The major data collection initiatives for measuring the impact of the HIV response include THIS, Tanzania Demographic and Health Survey (TDHS) and other biological and behavioural surveys.

Tanzania HIV Impact/Assessment Surveys (THIS): The THIS survey collects data related to HIV knowledge and behaviour, and HIV prevalence among women and men ages 15–49. The latest THIS survey, conducted in Tanzania in 2016–2017, provides data on HIV viral load and HIV incidence. The surveys are conducted under the leadership of the National Bureau of Statistics (NBS) in collaboration with the OCGS.

Tanzania Demographic and Health Survey (TDHS): The TDHS is conducted every five years as part of a worldwide Demographic Health Surveys (DHS) programme funded by the U.S. Agency for International Development (USAID). The DHS programme assists countries in the collection of data to monitor and evaluate population, health, and nutrition programmes. The last DHS was conducted in 2015–2016.

Tanzania Service Provision Assessment (TSPA): The TSPA survey is a health facility assessment that provides a comprehensive overview of the status of health service delivery. It collects information on the overall availability of different facility-based health services. Two rounds of the TSPA have been conducted in Tanzania—the first one in 2006 and the second in 2014–2015. Like the THIS and TDHS, the TSPA is conducted through the leadership of the NBS.

Epidemic modelling: ZIHHTLP will also continue to use the Estimation and Projection Package and Spectrum AIDS Impact Model developed by WHO/UNAIDS to monitor changes in HIV outcomes. Spectrum modelling is based on routinely collected data, such as adult and child treatment coverage, PMTCT. and sentinel surveillance data.

Antenatal care (ANC) surveillance: ANC surveillance is conducted every two years. There is a plan in place to compare PMTCT and ANC data to evaluate the potential of switching from ANC surveys to using routine programme data for tracking ANC prevalence over time.

KPs surveillance: There have been three rounds of integrated bio-behavioural surveillance studies among PWID and two rounds of similar studies among female sex workers (FSWs) and MSM in Unguja. Additional rounds will be conducted during the approximate period of time of this strategic plan to facilitate the measurement of progress in the outcomes of KPs' programmes.

Special studies: Other special studies will be commissioned as deemed necessary to respond to specific indicators not adequately addressed by the other surveys.

5.2. Reporting and Data Flow System

The primary sources of routine data for the Zanzibar multisectoral response are health and non-health programmes. The non-health data are collected from stakeholders working at national,

district, and community levels. They are MDAs, CSOs, LGAs, and communities. These organisations will have M&E focal persons.

For non-health related data, the M&E focal person of every organisation will fill in one monitoring form every quarter based on the activities it has implemented. The ZHAPMoS focal person will submit the form either to the LGA's HIV focal person or the ZAC office within 14 calendar days after the end of that quarter.

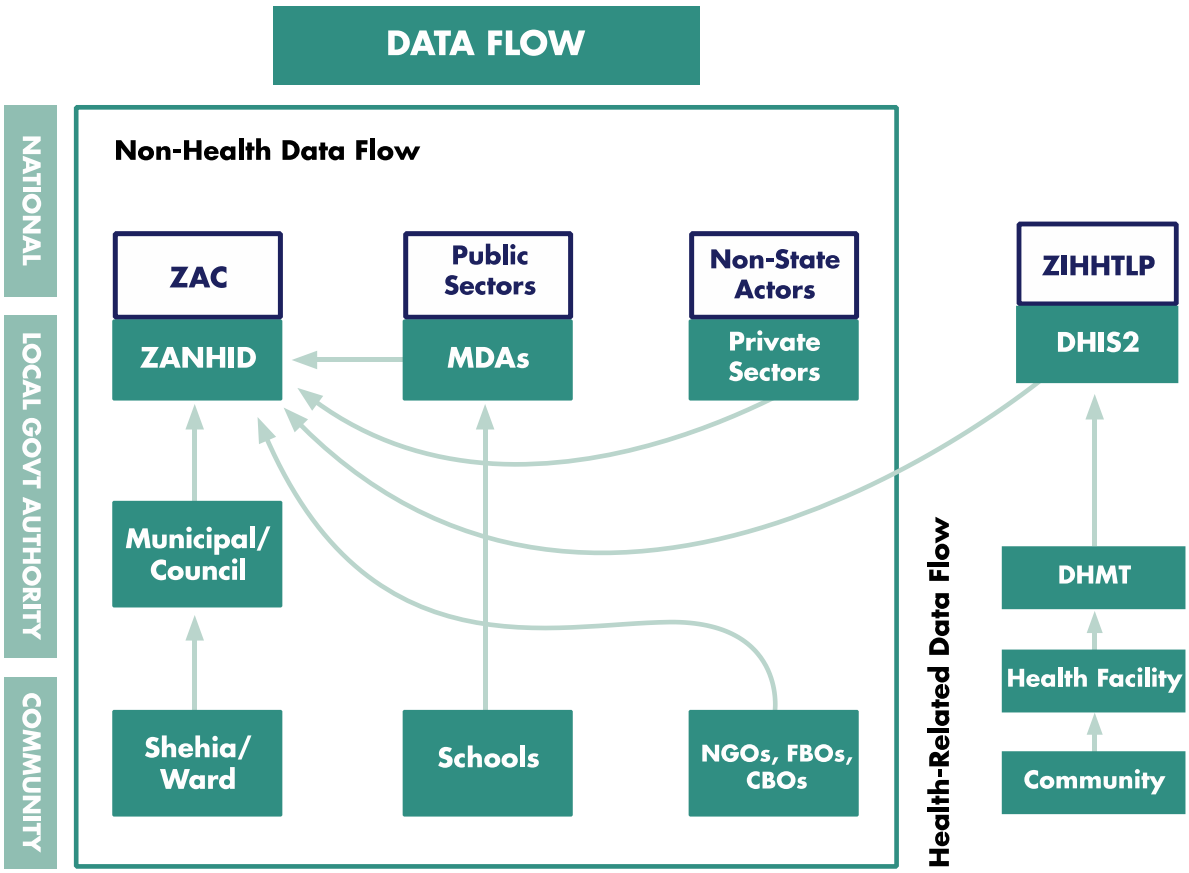
MDAs, the private sector, CSOs (NGOs, FBOs, and community-based organisations) will submit their forms directly to ZAC. All schools will submit their forms to their M&E focal person, who will compile and submit the forms to ZAC.

The LGAs will be responsible for collecting data from communities which implement HIV activities based on their own plans, excluding activities implemented by CSOs at the community level. LGAs will be responsible for compiling all forms submitted by the communities and submitting them to ZAC. LGAs also will be required to submit data gathered from the activities they have implemented themselves.

For health-related data, services will be provided from the community level, such as home-based care and community outreach. Patient- and client-level data collected at the health facility and community levels will be used to generate monthly and quarterly summary reports, for submission to the office of the district medical officer (DMO). The district then will aggregate the summary reports from the various health facilities through the District Health Information System-Version 2 (DHIS2). Data from DHIS2 will be summarised by the ZIHHTLP office before being submitted to ZAC on a quarterly basis.

Figure 4 illustrates the reporting, data flow, and feedback process, as well as timelines.

Figure 4. Reporting timeline, data flow, and feedback mechanism



5.3. Data Management

Data management includes procedures and standards for handling data, and ensuring data quality and storage during programme implementation. The data management process includes data sourcing, collation/aggregation, analysis, reporting, and use. Currently, ZAC does not have data quality assessment guidelines, although initiatives are underway to develop them to include data management processes.

5.3.1. Data Recording and Checking

ZAC will receive data from two types of information sources—those related to non-health and health—which will be reviewed and compiled by a data manager for preparation of information products at the national level. The data management team will cross-check and verify to ensure that the data submitted meet the required standard.

5.3.2. Data Retention

The IT officer from ZAC and ZIHHTLP will use the existing HIV data recording and retention policy so the government can document, maintain, and retain HIV and AIDS data at all levels.

5.3.3. Data Storage and Confidentiality

Each data-reporting level will ensure that its electronic and paper-based records have the appropriate storage, maintenance, and archiving security. The national HIV database and DHIS2 at the MOH will ensure the confidentiality of patient-level data by always using a password-protected electronic archive, a back-up system for electronic data, and storage in a locked area for paper-based data.

5.3.3 Data Quality Assurance

Crucial to the successful performance of the M&E system is the quality of the data it generates. Currently, the system does not have a data quality guideline in place. However, data verification is conducted biannually to verify reported data, identify strengths or gaps in the systems supporting data collection, build M&E capacity, and address challenges found at each level for overall improvement of data quality. ZAC will collaborate with stakeholders capable of supporting the development of the data quality assessment guideline.

6. STAKEHOLDER ROLES AND RESPONSIBILITIES

Implementation of the national multisectoral HIV and AIDS M&E plan is under the management and supervision of the Division of Policy, Planning and National Response within ZAC. However, the involvement of other stakeholders from both public and non-state sectors is critical to successful implementation of the M&E plan.

M&E functions will be implemented at three main levels: the national, LGA, and community levels. The LGAs will be responsible for implementation at the regional, council, and community levels. The roles and responsibilities of different stakeholders in implementing the M&E plan are specified below.

6.1. ZAC

The ZAC will be directly responsible for implementing the plan at the national level—specifically for the following actions:

- Lead stakeholders in designing the system and developing the national multisectoral HIV and AIDS M&E plan, policy, guidelines, and tools
- Advocate with stakeholders to generate and utilise strategic information
- Oversee and coordinate stakeholders' M&E-related activities
- Build stakeholders' technical knowledge and practical skills in M&E
- Manage institutional strengthening of key organisations' use of quality assurance for the M&E system processes and products
- Lead the development and distribution of key information products
- Disseminate information generated from the M&E system
- Maintain an inventory and report on the need for and coverage of HIV training and capacity-building services for resource persons
- Lead stakeholders through ZNSP reviews and strategic planning of the national multisectoral HIV and AIDS response

6.2. Zanzibar Integrated HIV, Hepatitis, TB and Leprosy Programme (ZIHHTLP)

- Coordinate and oversee the implementation, monitoring, and evaluation of health sector HIV prevention, care, treatment, and support services
- Design and develop an M&E framework and ensure availability of recording and reporting tools for the ZHSHSP III
- Facilitate the integration of the HIV information system within the national M&E strengthening initiative and strengthen and promote effective and efficient data collection, analysis, and use of HIV and AIDS information at all levels
- Organise and coordinate health sector HIV prevention, care, and treatment and support operational research in collaboration with research institutions
- Lead the implementation of operational research on health sector HIV prevention, care, and treatment and support services

6.3. Research and Academic Institutions

- Provide technical support to HIV and AIDS-related research, surveys, and surveillance when working closely with ZIHHTLP and other stakeholders
- Provide ethical approval for biomedical research

6.4. President's Office-Regional Administration, Local Government and Special Departments (PO-RALGSD)

- Facilitate effective recruitment and deployment of skilled M&E focal persons at the subnational levels
- Collaborate with various stakeholders at that level for planning and implementation of ZNSP III
- Make use of M&E information from LGAs to inform decisions

6.5. Local Government Authorities

- In collaboration with ZAC, build the knowledge and practical skills of regional and council-level stakeholders regarding HIV and AIDS M&E
- Coordinate HIV and AIDS-related M&E activities amongst stakeholders in the regions and councils, including routine monitoring, research, surveys, and surveillance
- Develop, distribute, and disseminate their HIV information products on behalf of the respective regions or councils
- In collaboration with ZAC, design and develop planning guidelines to facilitate M&E of interventions implemented by various stakeholders at the subnational levels

6.6. ReMETTHAZ

- Provide technical input on and formally approve the M&E plan, policy, tools, and guidelines
- Plan, oversee, and evaluate the functionality of the M&E system
- Provide feedback and advice on strengthening human and institutional capacity for M&E
- Act as a technical think tank for multisectoral HIV and AIDS M&E issues
- Promote M&E, data collection, reporting, and information use amongst stakeholders
- Coordinate HIV M&E activities in the various jurisdictions
- Mobilise resources for HIV M&E
- Review and approve research proposals

6.7. Ministries, Departments, and Agencies

- Lead stakeholders design systems and develop an HIV and AIDS M&E section of their sector plans, policies, guidelines, and tools
- Coordinate HIV and AIDS-related M&E activities within the respective sectors, including routine monitoring, research, surveys, and surveillance
- Build technical knowledge and practical skills in M&E for sectors' HIV and AIDS stakeholders
- Develop, distribute, and disseminate HIV information products for each sector's stakeholders

6.8. Office of Chief Government Statistician (OCGS)

- Undertake population-based surveys
- Collect and compile routine data from all government data

6.9. Community/Health Facilities

- Monitor activities
- Collect and document data routinely
- Use data to improve the quality of services provided

6.10. Development Partners

- Provide technical advice for developing and implementing the M&E plan, tools, and guidelines

- Facilitate shared learning on effective strategies, lessons learnt, and experiences on M&E systems from other countries
- Mobilise technical, financial, material, and technological resources towards the national multisectoral HIV and AIDS M&E system
- Assist in capacity building for data analysis, use, and dissemination

6.11. Non-State Actors

- Build the knowledge and practical skills of member organisations to design systems and develop and implement their HIV and AIDS M&E workplans
- Assign a focal person responsible for M&E activity
- Ensure complete and timely submission of monitoring forms to ZAC or councils

6.12. Zanzibar Association of People Living With and Affected by HIV and AIDS (ZAPHA+)

Monitor, collect, and disseminate strategic information on HIV and AIDS which pertains to PLHIV welfare, including health, stigma, discrimination, and access to services

7. DATA DISSEMINATION AND USE

Data collected through this M&E plan must be analysed and packaged appropriately for different audiences to facilitate their use in planning, resource allocation, programme decision making, and assessment of progress against targets set for the national multisectoral HIV and AIDS response. This chapter describes some key barriers to data use and activities to be undertaken to facilitate data analysis, dissemination, and use at different levels.

7.1. Data Analysis

Since 2008, the reporting of HIV and AIDS programme data has been integrated into the Zanzibar National HIV/AIDS Database (ZANHID), the national electronic platform for non-health data reporting. This integration is expected to improve access to data and promote data analysis from the community to LGA and national levels. It is expected that LGAs will input data directly from their respective offices after the establishment of web-based application systems for data entry. LGAs, in collaboration with ZAC, will organise quarterly meetings with their respective stakeholders for data analysis and validation. At the national level, ZAC will organise quarterly and annual data review workshops that will draw together all HIV implementers to review and disseminate reports on the status of the HIV and AIDS response. A data auditing and supervision visit also will be conducted every quarter with HIV implementers to undertake an audit and remedial actions for those who have issues regarding their forms.

The information products from the data analysis will include quarterly and annual reports, and other activity reports based on the activities performed by LGAs. They will include domestic reports: HIV and AIDS and STI surveillance reports, the ANC Report, Care and Treatment Report, and the Spectrum Estimation and Projection Report.

7.2. Data Dissemination and Use

On a biannual basis, ZAC will organise M&E results dissemination meetings with implementing partners at the national, regional, and district levels. The dissemination of the M&E results will serve the following purposes:

- Provide feedback to various implementers on efforts and achievements
- Share and use the data and other information for better targeting and planning of HIV and AIDS interventions at all levels
- Provide feedback on efforts and resource use, and articulate lessons learnt and gaps and challenges faced at the subnational and national levels
- Enhance networking and harmonisation of data use efforts

7.3. Information Products Produced from the HIV and AIDS M&E System

ZAC, in collaboration with other organisations, will produce M&E information products for dissemination to different stakeholders, as summarised in Table 4.

Table 4. Information product description matrix

Name of information product	Frequency	Purpose	Audience distributed to:
ZAC annual report	Annual	To update stakeholders on achievements, challenges, and recommendations for the national HIV and AIDS response	All stakeholders
ZAC newsletter	Annual	To provide a summary update of the main achievements of the national HIV and AIDS response	All stakeholders
ZIHHTLP annual report	Annual	To update stakeholders on achievements, challenges, and recommendations for the HIV and AIDS response in the health sector	All stakeholders
Sector reports	Annual	To update stakeholders on achievements, challenges, and recommendations for the HIV and AIDS response in various sectors	All stakeholders in sectors
GAM report	Two years	To comply with international reporting guidelines and standards	GAM
Research, surveys, and surveillance reports	After completion of research, surveys, and surveillance	As per the research, survey, and surveillance protocol	All audiences listed in research protocol

The information products shown above will be disseminated through regular meetings and platforms. The main mechanisms for information dissemination will include the following: annual stakeholders' meetings at the national and district levels; the ZAC website, where all key information products are posted; the ZAC database; mass media articles and releases; and regular stakeholder coordination and information sharing meetings.

8. MONITORING AND EVALUATION OF THE NATIONAL MULTISECTORAL HIV AND AIDS M&E PLAN IMPLEMENTATION

The ZNSP III M&E plan identifies indicators (Appendix 1) against which programme performance will be assessed. These indicators will be tracked regularly to ensure that the programme targets are being met and implementation of the strategic plan is on course.

8.2. Annual M&E Operational Plans

To ensure effective implementation of the M&E plan, ZAC will develop annual M&E operational plans with active stakeholder involvement, based on the M&E system strengthening and other data quality and data use interventions. The operational plans will be more detailed so as to provide the expected number of participants in different activities, timeline, and associated costs. The implementation status of the operational plans will be reviewed at the end of every year at the Joint Annual Program Review (JAPR) meetings, alongside data collected on the different indicators identified in the M&E plan. The JAPR will bring together ZAC, the MOH, regional/council health management teams, implementing partners, and other stakeholders.

In addition to the JAPR, the health sector HIV M&E subcommittee meetings will provide a critical forum for reviewing progress of the implementation of ZNSP III health-related interventions and promptly instituting any necessary corrective measures.

8.3. Mid- and End-Term Evaluations

Two evaluations will also be conducted to determine the success of the ZNSP III. ZAC will organise a joint mid-term review before the end of the third year of the ZNSP III. This assessment will focus on progress made in implementing the plan and the appropriateness of the overall strategic direction. The evaluation will be designed to inform the remaining period of the plan and recommend adjustments where needed.

ZAC will facilitate an independent external evaluation in the final year of the ZNSP III (end-term evaluation). This evaluation will focus on achievements (impacts and outcomes) of the ZNSP III. The end-term evaluation will also provide contextual information for the subsequent planning period, with significant involvement of stakeholders.

8.4. Assumptions for Successful Implementation of the ZNSP III M&E Plan

The successful implementation of this M&E plan is based on the assumption that ZAC will rally all key stakeholders to help implement the strategic activities identified in the ZNSP III. Stakeholders will commit to an annual work planning process in which programme performance targets will be set and responsibility for their attainment defined, including financial contributions. Another assumption is that implementing partners will harmonise their support for M&E-related activities based on ZAC's annual M&E operational plan. A budgetary provision of 7–10 percent of the total cost of implementing the strategic activities in the ZNSP III will be set aside for M&E-related activities.

APPENDIX 1. SUMMARY OF ZNSP III INDICATORS, BY LEVEL IN THE M&E RESULTS PATHWAY (IMPACT, OUTCOME, AND OUTPUT RESULTS)

Table 5. Summary of ZNSP III indicators, by level in the M&E results pathway[2]

Indicator reference number	Indicator	Level
Key Result Area 1: HIV prevention, care, and treatment programmes for the general population strengthened and scaled up		
Impact 1.1 Incidence of HIV in general population is reduced from 274 (0.03%) in 2015 to 75 (0.01%) by 2020, disaggregated by age and population groups		
1.1	Number of people newly infected with HIV in the reporting period per 1,000 uninfected population	Impact
1.2	HIV incidence rate/ year	Impact
1.3	Percentage of adults and children known to be on treatment 12 months after initiation of ART	Outcome
1.4	Percentage of private workplaces/institutions that have HIV prevention and care policies and programmes	Output
Outcome 1.1.1: Proportion of population estimated to be HIV infected that knows their HIV sero-status increased from 82% (5,051/6,129) in 2015 to 90% (5,825/6,472) by 2020, disaggregated by age and population groups		
1.5	Number and proportion of people who were tested for HIV and received their test results within the past 12 months	Output
Outcome 1.1.2: Safer sexual behaviour increased by 40% by 2020		
1.6	Percentage of respondents who say they used a condom the last time they had sex with a non-marital, non-cohabiting partner, of those who have had sex with such a partner in the last 12 months	Outcome
1.7	Percentage of women and men ages 15–49 who both correctly identify ways of preventing the sexual transmission of HIV and reject major misconceptions about HIV transmission	Outcome
1.8	Percentage of schools with teachers trained in life skills-based HIV education who taught it regularly in the preceding 12 months	Output
1.9	Number of schools with functional youth clubs that incorporate HIV programmes in the clubs' activities in the preceding 12 months	Output
1.10	Number of booklets and brochures about HIV that have been distributed to end users in the preceding 12 months	Output

[2] The indicators have been renumbered from those in the ZNSP III. The numbering used here and in the comprehensive indicator matrix should be used consistently for monitoring and evaluating the implementation of ZNSP III.

1.11	Number of hours of air time that spots or special programmes on HIV aired on the radio and TV within the preceding 12 months	Output
Outcome 1.1.3: Strengthened capacity to manage (prevent, diagnose, and treat) HIV co-morbidities amongst PLHIV		
1.12	Percentage of registered new and relapsed TB patients with documented HIV-positive status Note: This indicator measures HIV prevalence amongst TB patients	Outcome
1.13	Percentage of PLHIV screened for TB	Output
Outcome 1.1.4: Sexually active individuals having high-risk sex who use condoms		
1.14	Percentage of women and men ages 15–49 who had more than one partner in the past 12 months who used a condom during their last sexual intercourse	Outcome
1.15	Number of young people (ages 15–24) who have accessed sexual and reproductive health services in the preceding 12 months	Output
Outcome 1.1.5: All blood and blood products used for transfusion screened and free of HIV and markers of other infectious diseases		
1.16	Percentage of donated blood units screened for bloodborne diseases	Output
Impact 1.2: Mother-to-child HIV transmission rates reduced to less than 5% by 2020		
1.17	Percentage of HIV-infected amongst HIV-exposed infants born in the past 12 months	Outcome
Outcome 1.2.1: Proportion of HIV-infected mothers enrolled in PMTCT services increased from 51.9% (200/385) to 90% by 2020		
1.18	Percentage of pregnant women with known HIV status	Output
1.19	Percentage of pregnant women living with HIV who received ART to reduce the risk of MTCT of HIV	Output
1.20	Percentage of identified HIV-positive infants who were started on ART by 12 months of age	Output
Impact 1.3: HIV mortality and morbidity for adults and children is reduced by 50%, from 125 in 2015 to 63 in 2020		
1.21	Total number of people who have died of AIDS-related causes per 100,000 population	Impact
1.22	Number and percentage of PLHIV who have suppressed viral load at the end of the reporting period	Outcome
Outcome 1.3.1.: Proportion of HIV -Infected individuals enrolled on ART increased from 60% in 2016 to 90% in 2020		
1.23	Number of adults and children newly enrolled on ART	Output
1.24	Number and percentage of PLHIV currently receiving ART	Output
Outcome 1.3.2: Reduced HIV and AIDS-related-stigma amongst the general and key populations		

1.25	Percentage of women and men ages 15–49 who report discriminatory attitudes towards PLHIV	Outcome
KRA 2: Programmes targeting KPs and vulnerable populations improved Impact 2.1: Reduced HIV incidence and prevalence among KPs		
2.1	Percentage of KPs tested for HIV and received their results in the past 12 months	Output
2.2	Percentage of people from KPs who are HIV infected	Outcome
2.3	Percentage of KPs reached with individual- or small group-level HIV prevention interventions designed for the target population	Output
Outcome 2.1.1: Reduced risky behaviours amongst KPs: MSM, FSWs, PWID, and CFS		
2.4	Percentage of sex workers reporting the use of condoms with their most recent clients	Outcome
2.5	Percentage of MSM reporting using a condom the last time they had anal sex with a male partner	Outcome
2.6	Percentage of PWID reporting the use of sterile injecting equipment the last time they injected	Outcome
2.7	Percentage of people who inject drugs receiving OST	Output
2.8	Percentage of PWID receiving OST for 6 months	Outcome
Outcome 2.1.2: Percentage of HIV-infected KPs and vulnerable populations enrolled on ART achieving viral suppression increased		
2.9	Proportion of HIV-infected KPs receiving ART	Outcome
KRA 3: Research, knowledge management, M&E programmes strengthened		
Outcome 3.1: A "One national HIV & AIDS monitoring and evaluation (M&E) system"		
3.1	Percentage of ZNSP III M&E indicators reported on in the past 12 months	Output
3.2	Number of HIV implementers submitting timely and complete reports	Output
3.3	Number of organisations with staff trained in the planning, management, or monitoring of HIV services delivery in the preceding 12 months	Output
Outcome 3.2: National systems for HIV and AIDS-related research strengthened		
3.4	Number of HIV operational research activities conducted based on national HIV multisectoral research agenda	Output
3.5	Number of actionable policy briefs based on HIV research and surveillance data produced and disseminated	Outcome
Outcome 3.3: Increased HIV and AIDS knowledge management at all levels		
3.6	Number of ZNSP III M&E information products produced	Output
KRA 4: Alternative and sustainable financing models established		
Outcome 4.1: Increased funding for the national response (total funding available)		
4.1	Percentage of domestic and international HIV expenditure, by programme categories and financing sources	Output

Outcome 4.2: Increased funding for the national response (percentage of ZNSP III budget mobilized0		
4.2.	Percentage of total ZNSP III budget mobilized	Output
Outcome 4.3. Increased domestic financing for the HIV response		
4.3	Percentage of HIV response financed domestically	Outcome
KRA 5: Institutional management and integration of services at all levels, enabling environment and impact mitigation interventions strengthened		
Outcome 5.1: Strengthened institutional management and coordination of Zanzibar National Strategic Plan (ZNSP III)		
5.1	Percentage of functional HIV coordinating committees	Output
5.2	Number of MDAs, LGAs, and CSOs that have implemented HIV workplans in the preceding 12 months	Output
Outcome 5.2: Integrated provision of HIV and AIDS, SRH, and TB services at all levels		
5.3	Percentage of points of care providing integrated services	Output
5.4	Percentage of PLHIV who received integrated services	Output
Outcome 5.3: HIV and AIDS interventions mainstreamed in public (MDAs), LGAs, NGOs, FBOs, and private sector programmes		
5.5	Percentage of organisations with HIV and AIDS mainstreaming plans and budgets	Output
5.6	Percentage of orphaned and vulnerable children whose households received free basic external support and caring for the children	Output
5.7	Number of people reached with individuals and small group-level HIV prevention interventions in the past 12 months	Output

APPENDIX 2. COMPREHENSIVE ZNSP III INDICATORS MATRIX

No.	Indicator	Indicator definition	Disaggregation	Indicator source	Data source	Frequency	Baseline	Target	Stakeholder
Key Result Area 1: HIV prevention, care, and treatment programmes for the general population strengthened and scaled up **Impact 1.1: Incidence of HIV in general population is reduced from 274 (0.03%) in 2015 to 75 (0.01%) by 2020, disaggregated by age and population groups**									
1.1	Number of people newly infected with HIV in the reporting period per 1,000 uninfected population	**Numerator:** Number of people infected with HIV during the reporting period **Denominator:** Total number of uninfected population	MTCT Sex Age (0–14, 15–24, 25–49, and 50+)	GAM, p. 61	Spectrum	Annually	248 (2016)	75 by 2020	ZIHHTLP UNAIDS
1.2	HIV incidence rate/ year	**Numerator:** Number of new HIV infections per year **Denominator:** Total population x 100	Sex Age (0–14, 15–24, 25–49, 50+) Time/period	WHO SI guideline (2015), p. 177	Spectrum	Annually	0.17	0.03	ZIHHTLP UNAIDS
1.3	Percentage of adults and children known to be on treatment 12 months after initiation of ART	**Numerator:** Number of adults and children who are still on treatment at 12 months after initiation of ART **Denominator:** Total number of adults and children initiated on ART in the 12 months before the beginning of the reporting period, including	Sex Age (0–14, 15–24, 25–49, 50+)	PEPFAR MER 2.0 2017, p. 103	ZIHHTLP Annual Report	Annually	71.2% (2016)	5 yrs: 90% 2017: 80% 2018: 85% 2019: 87% 2020: 90% 2021: 90%	ZIHHTLP

No.	Indicator	Indicator definition	Disaggregation	Indicator source	Data source	Frequency	Baseline	Target	Stakeholder
		those who have died and those who have stopped ART; does not include transfer outs							
1.4	Percentage of private workplaces/institutions that have HIV prevention and care policies and programmes	**Numerator:** Private workplaces/institutions that have HIV preventions and care policies and programmes **Denominator:** Total number of private workplaces/institutions	Type of institutions (MDAs, LGAs, CSOs) Geographical locations	ZNMHMES (2006)	ZAC Quarterly Report	Quarterly	41 (25%)	162: (90%) 2018: 35% 2019: 60% 2020: 80% 2021: 90%	ZAC Private institutions
Outcome 1.1.1: Proportion of population estimated to be HIV infected that knows their HIV sero-status increased from 82% (5,051/6,129) in 2015 to 90% (5,825/6,472) by 2020, disaggregated by age and population groups									
1.5	Number and proportion of people who were tested for HIV and received their test results within the past 12 months	**Numerator:** Number of people who were tested for HIV and received their test results within the past 12 months **Denominator:** Projected population of Zanzibar	HIV testing and counselling modality: client-initiated testing and counselling (CITC)/voluntary testing and counselling, PITC, outreach, PMTC, early infant diagnosis (EID), and blood donor Age (<1, 1–4, 5–9, 10–19, 20–24, 25–49, 50+), Sex KP category	PEPFAR MER2.0, WHO	HTS database	Quarterly and annually	15.2% (2017)	5 yrs: 22% 2018: 16% 2019: 18% 2020: 20% 2021: 21%	ZIHHTLP WHO GF (Global Fund) PEPFAR MOH District health management teams (DHMTs) ZAC

No.	Indicator	Indicator definition	Disaggregation	Indicator source	Data source	Frequency	Baseline	Target	Stakeholder
Outcome 1.1.2: Safer sexual behaviour increased by 40% by 2020									
1.6	Percentage of respondents who say they used a condom the last time they had sex with a non-marital, non-cohabiting partner, of those who have had sex with such a partner in the last 12 months	**Numerator:** The number of respondents who report using a condom the last time they had sex with a non-marital, non-cohabiting partner **Denominator:** Total number of respondents who report that they had sex with a non-marital, non-cohabiting partner in the last 12 months	Sex Age (15–19, 20–24, and 25–49)	GAM 2018	THIS 2017	4 yrs	Male: 25.4% Female: 11.2% THIS: 2017	Male: 90% Female: 90% by 2021	OCGS ZIHHTLP
1.7	Percentage of women and men ages 15–49 who both correctly identify ways of preventing the sexual transmission of HIV and reject major misconceptions about HIV transmission	**Numerator:** Number of respondent ages 15–49 who correctly answered all five questions about prevention and misconceptions **Denominator:** Number of all respondents ages 15–49	Sex Age (15–19,20–24, 25+) Geographical location	GAM 2018	THIS 2017	4 yrs			OCGS
1.8	Percentage of schools with teachers trained in	**Numerator:** Number of schools with staff members trained in	Level of school District	UNGASS 2009, p. 46	MoEVT	Quarterly		5 yrs: 80% 2018: 50% 2019: 70%	ZAC MoEVT

No.	Indicator	Indicator definition	Disaggregation	Indicator source	Data source	Frequency	Baseline	Target	Stakeholder
	life skills-based HIV education who taught it regularly in the preceding 12 months	and regularly teaching life skills-based HIV education **Denominator:** Number of schools surveyed						2020: 80% 2021: 80%	
1.9	Number of schools with functional youth clubs that incorporate HIV programmes in the clubs' activities in the preceding 12 months	N/A	Level of school District		MoEVT	Quarterly	109	5 yrs: 400 2018: 70 2019: 70 2020: 70 2021: 70	ZAC MoEVT
1.10	Number of booklets and brochures about HIV that have been distributed to end users in the preceding 12 months	N/A	By type Theme Age (10–14, 15–19, 20–24, 25+) By target group		ZAC	Quarterly	19,500 (2017)	5 yrs: 60,000 2018: 15,000 2019: 15,000 2020: 15,000 2021: 15,000	ZAC
1.11	Number of hours of air time that spots or special programmes on HIV aired on the radio and TV within the preceding 12 months	N/A	Theme (stigma, PMTCT, ART uptake, OVC, KPs, condoms, parent-child communication, SRH)	ZHAPMoS 2006	ZAC	Quarterly	39 hours (2017)	160 hours (years) 2018: 40 hours 2019: 40 hours 2020: 40 hours	ZAC

No.	Indicator	Indicator definition	Disaggregation	Indicator source	Data source	Frequency	Baseline	Target	Stakeholder
								2021: 40 hours	
Outcome 1.1.3: Strengthened capacity to manage (prevent, diagnose, and treat) HIV co-morbidities amongst PLHIV									
1.12	Percentage of registered new and relapsed TB patients with documented HIV-positive status Note: This indicator measures HIV prevalence amongst TB patients	**Numerator:** Number of new and relapsed TB patients registered during the reporting period who are documented as HIV positive **Denominator:** Number of new and relapsed TB patients registered during the reporting period and having a documented HIV status, positive or negative	Sex Age (0–4, 5–14, 15+) New or relapsed TB case, place of residence	WHO SI guideline for health sector, 2015, p. 117	ZIHHTLP Annual Report	Annually	99%	100%	UNAIDS WHO GF PEPFAR MOH DHMTs
1.13	Percentage of PLHIV screened for TB	**Numerator:** Number of adults and children enrolled into HIV care whose TB status was assessed and recorded in the reporting period **Denominator:** Total number of adults and children living with HIV and currently on care	Age (0–11 months, 1–4, 5–9, 10–14, 15–19, 20–24, 25–49, and 50+ years) Sex Pregnancy	WHO SI 2015 GAM GF	CTC2 database	Quarterly and annually	99.3% (2017)	5 yrs: 100% 2018: 100% 2019: 100% 2020: 100% 2021: 100%	UNAIDS WHO GF PEPFAR MOH DHMTs

No.	Indicator	Indicator definition	Disaggregation	Indicator source	Data source	Frequency	Baseline	Target	Stakeholder
Outcome 1.1.4: Sexually active individuals having high-risk sex who use condoms									
1.14	Percentage of women and men ages 15–49 who had more than one partner in the past 12 months who used a condom during their last sexual intercourse	**Numerator:** Number of respondents (ages 15–49) who reported having had more than one sexual partner in the last 12 months who also reported that a condom was used the last time they had sex **Denominator:** Number of respondents ages 15–49 who reported having had more than one sexual partner in the last 12 months	Female vs. male Age (15–19, 20–24, 25+)	UNGASS 2009	Survey THIS	5 yrs			OCGS
1.15	Number of young people (ages 15–24) who have accessed sexual and reproductive health services in the preceding 12 months	N/A	Sex Type of service (family planning, STI, HIV testing)		NGO reports IRCH	Quarterly	7,646 (2017)	5 yrs: 56,000 2018: 14,000 2019: 14,000 2020: 14,000 2021: 14,000	

No.	Indicator	Indicator definition	Disaggregation	Indicator source	Data source	Frequency	Baseline	Target	Stakeholder
Outcome 1.1.5: All blood and blood products used for transfusion screened and free of HIV and markers of other infectious diseases									
1.16	Percentage of donated blood units screened for bloodborne diseases	**Numerator:** Number of donated blood units tested for HIV, hepatitis B virus (HBV), hepatitis C virus (HCV), and syphilis **Denominator:** Number of donated blood units	Infection status (infected or not) Type of infection	WHO SI 2015 pg. 85	National Blood Transfusion Service (NBTS)	Annually	100% (Programme projections and records, 2017)	100%	NBTS ZIHHTLP
Impact 1.2: Mother-to-child HIV transmission rates reduced to less than 5% by 2020									
1.17	Percentage of HIV-infected amongst HIV-exposed infants born in the past 12 months	**Numerator:** Number of HIV-exposed infants born within the past 12 months who were infected during the MTCT risk period **Denominator:** Estimated number of HIV-positive pregnant women	Test results: 1. Positive 2. Negative Sex	WHO SI guidelines, 2015, p. 163	Spectrum	Quarterly and annually	17.9% (2016)	5 yrs: <5% 2017: 10% 2018: 7% 2019: 5% 2020: 3% 2021: 2%	ZIHHTLP MOH IRCH DHMTs ZAC GF PEPFAR and UN Family
Outcome 1.2.1: Proportion of HIV-infected mothers enrolled in PMTCT services increased from 51.9% (200/385) to 90% by 2020									
1.18	Percentage of pregnant women with known HIV status	**Numerator:** Number of pregnant women attending antenatal clinics (ANCs) or had a facility-based delivery and were tested for HIV during pregnancy or already	HIV status/test results (i.e., known) HIV positive at ANC clinic entry Newly tested positive at ANC entry Newly tested negative at ANC entry	GAM 2018, p. 60	ZIHHTLP Quarterly and annual reports	Quarterly and annually	72% (2016)	5 yrs: 100% 2017: 98% 2018: 100% 2019: 100% 2020: 100% 2021: 100%	ZIHHTLP MOH IRCH DHMTs ZAC GF PEPFAR and UN Family

No.	Indicator	Indicator definition	Disaggregation	Indicator source	Data source	Frequency	Baseline	Target	Stakeholder
		knew they were HIV positive **Denominator:** Population based: Number of women expected to be pregnant	Tested at ANC or maternity clinic Geographical location Age						
1.19	Percentage of pregnant women living with HIV who received ART to reduce the risk of MTCT of HIV	**Numerator:** Number of pregnant women living with HIV who delivered during the past 12 months and received antiretroviral medicine to reduce the risk of MTCT of HIV **Denominator:** Population based: Estimated number of HIV-positive pregnant women who delivered within the past 12 months	Already on ART, by District Newly on ART	GAM 2018, p. 54	ZIHHTLP Quarterly and annual reports	Quarterly and annually	47% (2016)	5 yrs: 93% 2017: 88% 2018: 90% 2019: 91% 2020: 93% 2021: 95%	ZIHHTLP MOH IRCH DHMTs ZA GF PEPFAR and UN Family
1.20	Percentage of identified HIV-positive infants who were started on ART by 12 months of age	**Numerator:** Number of infants started on ART by 12 months of age **Denominator:** Number of infants identified as HIV positive by 12 months of age	By geographical location Age Sex	WHO SI guidelines, 2015 p. 166	ZIHHTLP Quarterly and annual reports	Quarterly and annually	90% (2016)	5 yrs: 100% 2017: 90% 2018: 100% 2019: 100% 2020: 100% 2021: 100%	ZIHHTLP MOH IRCH DHMTs ZAC GF PEPFAR & UN Family

No.	Indicator	Indicator definition	Disaggregation	Indicator source	Data source	Frequency	Baseline	Target	Stakeholder
Impact 1.3: HIV mortality and morbidity for adults and children is reduced by 50%, from 125 in 2015 to 63 in 2020									
1.21	Total number of people who have died of AIDS-related causes per 100,000 population	**Numerator:** Number of people who have died from AIDS-related causes **Denominator:** Total population of Zanzibar, regardless of HIV status	Age (< 1, 1–4, 5–9, 10–4, 15–19, 20–24, 25–49, and 50+ years) Sex	GAM 2018, p. 49	Zanzibar Spectrum 2016	Annually	9.7 (2016)	5 yrs: 4.3% 2018: 7.03% 2019: 5.43% 2020: 4.95% 2021: 4.49%	ZIHHTLP ZAC UNAIDS WHO GF PEPFAR MOH
1.22	Number and percentage of PLHIV who have suppressed viral load at the end of the reporting period	**Numerator:** Number of PLHIV in the reporting period with a suppressed viral load of less than 1,000 copies/ml **Denominator:** Estimated number of PLHIV	Age (0–11 months, 1–4, 5–9, 10–14, 15–19, 20–24, 25–49, and 50+ years) Sex Type (routine/targeted) Pregnancy status KP category	GAM 2018, p. 44	ZIHHTLP Quarterly and annual reports	Quarterly and annually	51.3% (2017)	5 yrs: 90% 2018: 85% 2019: 88% 2020: 90% 2021: 90%	ZIHHTLP ZAC UN- GF PEPFAR MOH DHMTs Family
Outcome 1.3.1.: Proportion of HIV-Infected individuals enrolled on ART increased from 60% in 2016 to 90% in 2020									
1.23	Number of adults and children newly enrolled on ART	**Numerator:** Number of adults and children newly enrolled on ART **Denominator:** N/A	Age (0–11 months, 1–4, 5–9, 10–14, 15–19, 20–24, 25–49, and 50+ years) Sex KPs Pregnant women TB	PEPFAR MER 2.0, p. 88	ZIHHTLP Quarterly and annual reports	Quarterly and annually	4,346 (2016)	2017: 400 2018: 400 2019: 400 2020: 400	ZIHHTLP ZAC UNAIDS WHO GF PEPFAR MOH DHMTs

No.	Indicator	Indicator definition	Disaggregation	Indicator source	Data source	Frequency	Baseline	Target	Stakeholder
1.24	Number and percentage of PLHIV currently receiving ART	**Numerator:** Number of PLHIV currently receiving ART **Denominator:** Number of PLHIV	Age (0–11 months, 1–4, 5–9, 10–14, 15–19, 20–24, 25–49, and 50+ years)	WHO SI 2015, p. 43	ZIHHTLP Quarterly and annual reports	Quarterly and annually	60% (2016)	5 yrs: 95% 2017: 82% 2018: 85% 2019: 90% 2020: 93% 2021: 95%	ZIHHTLP ZAC UNAIDS WHO GF PEPFAR MOH DHMTs
Outcome 1.3.2: Reduced HIV and AIDS-related stigma amongst the general and key populations									
1.25	Percentage of women and men ages 15–49 who report discriminatory attitudes towards PLHIV	**Numerator:** Number of respondents ages 15–49 who respond "no" to either of the two questions about discriminatory attitudes **Denominator:** Number of all respondents ages 15–49 who have heard of HIV	Age (15–19, 20–24, and 25–49) Sex Category (MSM, SW, PWID)	GAM 2017, p. 94	THIS 2017, Stigma Index Survey (2008)	4 yrs		0.0%	THIS ZIHHTLP
KRA 2: Programmes targeting KPs and vulnerable populations improved									
Impact 2.1: Reduced HIV incidence and prevalence amongst KPs									
2.1	Percentage of KPs tested for HIV and received their results in the past 12 months	**Numerator:** Number of KPs tested for HIV and received their results in the past 12 months **Denominator:** Total estimated number of KPs in the catchment area	Geographical location Age (adult, youth) KP type: CSW, injecting drug user, MSM	WHO GAM 2017 PEPFAR	HTS database	Quarterly and annually	PWID: 49% MSM: 69% SWs: 54%	90% for each KP category 2018: 50% 2019: 65% 2020: 75% 2021: 85%	ZIHHTL MO IRCH DHMTs ZA ZNCDC GF PEPFAR and UN

No.	Indicator	Indicator definition	Disaggregation	Indicator source	Data source	Frequency	Baseline	Target	Stakeholder
									Family
2.2	Percentage of people from KPs who are HIV infected	**Numerator:** Number of KP respondents who have tested positive for HIV **Denominator:** Number of KPs tested for HIV	Age (15–19, 20–24, 25+) Sex Category (MSM, SW, PWID)	WHO SI guideline, 2015, p. 178	IBBSS (2012)	5 yrs	IBBSS 2012 MSM: 2.6%, SWs: 19.3%, PWID: 11.3%	PWID: 7.9% SWs: 9.7% MSM: 1.3%	ZIHHTLP CDC ZAC
2.3	Percentage of KPs reached with individual- or small group-level HIV prevention interventions designed for the target population	**Numerator:** Number of KPs reached with individual- or small group-level HIV prevention interventions designed for the target population **Denominator:** Total estimated number of KPs in the catchment area	Age Sex KP category Geographical location	GAM 2017, PEPFAR MER 2.0, p. 24	KP reports	Quarterly and annually	PWID: 64% SWs: 67% MSM: 32% (2017)	5 yrs: 90% 2018: 60% 2019: 70% 2020: 80% 2021: 90%	ZIHHTLP MOH IRCH DHMTs ZAC ZNCDC GF PEPFAR and UN Family
Outcome 2.1.1: Reduced risky behaviours amongst KPs: MSM, FSWs, PWID, and CFS									
2.4	Percentage of sex workers reporting the use of condoms with their most recent clients	**Numerator:** Number of sex workers who reported using a condom with their last client **Denominator:** Number of sex workers who reported having	Age (<25 vs. >25) Geographical location	GAM, 2017	IBBSS or other special surveys	3–5 yrs	78.9% (2012)	5 yrs: 90%	ZIHHTLP MOH IRCH DHMTs ZAC GF PEPFAR and UN Family

No.	Indicator	Indicator definition	Disaggregation	Indicator source	Data source	Frequency	Baseline	Target	Stakeholder
		commercial sex in the past one month							
2.5	Percentage of MSM reporting using a condom the last time they had anal sex with a male partner	**Numerator:** Number of MSM who reported using a condom the last time they had anal sex **Denominator:** Number of MSM who reported having had anal sex with a male partner in the past 3 months	Age (<25 vs. >25) Geographical location	GAM, 2017	IBBSS or other special surveys	3–5 yrs	36.6% (2012)	5 yrs: 90%	ZIHHTLP MOHI RCH DHMTs ZAC GF PEPFAR and UN Family
2.6	Percentage of PWID reporting the use of sterile injecting equipment the last time they injected	Numerator: Number of people who inject drugs who reported use of sterile injecting equipment the last time they injected **Denominator:** Number of people who report injecting drugs in the past three months	Age (<25 vs. >25) Sex Geographical location	GAM, 2017	IBBS	3–5 yrs	71.4% (2012)	5 yrs: 90%	ZIHHTLP MOH IRCH DHMTs ZAC ZNCDC GF PEPFAR and UN Family
2.7	Percentage of people who inject drugs receiving OST	**Numerator:** Number of people who inject drugs receiving OST during the reporting period **Denominator:** Estimated number of PWID	Sex Age (<25 vs. >25)	WHO SI, 2015	Program me reports	Quarterly and annually	10% (2017)	5 yrs: 25% 2018: 15% 2019: 17% 2020: 21% 2021: 25%	ZIHHTLP MOH IRCH DHMTs ZAC ZNCDC GF PEPFAR and UN Family

No.	Indicator	Indicator definition	Disaggregation	Indicator source	Data source	Frequency	Baseline	Target	Stakeholder
2.8	Percentage of PWID receiving OST for 6 months	**Numerator:** Number of people from the cohort still in treatment 6 months after starting OST **Denominator:** Number of people who started OST during the time defined as a cohort recruitment period	Sex Age (<25 vs. >25)		Programme reports	Quarterly and annually	63% (2017)	5 yrs: 90% 2018: 70% 2019: 80% 2020: 90% 2021: 90%	ZIHHTLP MOH IRCH DHMTs ZAC ZNCDC GF PEPFAR and UN Family
Outcome 2.1.2: Percentage of HIV-infected KPs and vulnerable populations enrolled on ART achieving viral suppression increased									
2.9	Proportion of HIV-infected KPs receiving ART	**Numerator:** Number of HIV-positive KPs receiving ART **Denominator:** Total number of estimated HIV-positive KPs	Age (15–19, 20–24, 25–49, 50+) Sex KP category (FSWs, IDUs, MSM, other)	ZHSHSP III, 2017–2022	ZIHHTLP annual report	Quarterly		90%	MOH ZIHHTLP
KRA 3: Research, knowledge management, M&E programmes strengthened									
Outcome 3.1: A "One national HIV & AIDS monitoring and evaluation (M&E) system"									
3.1	Percentage of ZNSP III M&E indicators reported on in the past 12 months	**Numerator:** Number of indicators in the ZNSP III M&E plan that have been reported on in the past 12 months **Denominator:** Total number of Indicators in the ZNSP III M&E plan	Health and non-health indicators	Global AIDS Response Progress Reporting (GARPR)/UNGASS	ZAC M&E annual report	Annually	0.0%	80%	ZAC

No.	Indicator	Indicator definition	Disaggregation	Indicator source	Data source	Frequency	Baseline	Target	Stakeholder
3.2	Number of HIV implementers submitting timely and complete reports	**Numerator:** Number of HIV implementers submitting timely and complete reports **Denominator:** Total number of HIV implementers	Sector	ZNSP III	ZAC report	Annually	41	300	ZAC
3.3	Number of organisations with staff trained in the planning, management, or monitoring of HIV services delivery in the preceding 12 months	N/A	Type of organisation (MDAs, CSOs, LGAs) Type of training (M&E, planning, HIV, mainstreaming)	ZHAPMoS, 2006	ZAC report	Annually		90%	ZAC
Outcome 3.2: National Systems for HIV and AIDS-related research strengthened									
3.4	Number of HIV operational research activities conducted based on national HIV multisectoral research agenda	N/A	Type of HIV services	ZNSP III 2017–2022	Operational research reports	Annually	None	5	HMIS MOH ZIHHTLP GF ZAC PEPFAR and UN Family
3.5	Number of actionable policy briefs based on HIV research and surveillance data		Health and non-health research	ZNSP III 2017–2022	ZAC annual report	Annually	None	8 ZAC	OCGS MOH Universities Commission for Science and

No.	Indicator	Indicator definition	Disaggregation	Indicator source	Data source	Frequency	Baseline	Target	Stakeholder
	produced and disseminated								Technology (COSTECH) Research institutions
Outcome 3.3: Increased HIV and AIDS knowledge management at all levels									
3.6	Number of ZNSP III M&E information products produced	N/A					2	10	ZAC
KRA 4: Alternative and sustainable financing models established									
Outcome 4.1: Increased funding for the national response (total funding available)									
4.1	Percentage of domestic and international HIV expenditure, by programme categories and financing sources	N/A	Programme categories and financing sources (domestic public, international, domestic private)	UNGASS, p. 24	National HIV and AIDS Spending Assessment	Every 2 yrs	GHARIB	100%	Ministry of Finance MOH Development partners Key implementers
Outcome 4.2: Increased funding for the national response (percentage of ZNSP III budget mobilized)									
4.2	Percentage of total ZNSP III budget mobilized	**Numerator:** Total ZNSP III budget mobilized **Denominator:** Total ZNSP III budget	N/A						Ministry of Finance MOH Development partners Key implementers
Outcome 4.3: Increased domestic financing for HIV response									
4.3	Percentage of HIV response financed domestically	**Numerator:** HIV domestic public expenditure	Sector	WHO SI 2015, p. 274	Public expenditure	Every 2 yrs		2% of governme	Ministry of Finance MOH

No.	Indicator	Indicator definition	Disaggregation	Indicator source	Data source	Frequency	Baseline	Target	Stakeholder
		Denominator: Total HIV expenditure			review (PER)			nt annual budget	Key implementers
KRA 5: Institutional management and integration of services at all levels, enabling environment and impact mitigation interventions strengthened									
Outcome 5.1: Strengthened institutional management and coordination of Zanzibar National Strategic Plan (ZNSP III)									
5.1	Percentage of functional HIV coordinating committees	**Numerator:** Number of committees that are functioning **Denominator:** Number of existing committees at all levels	By level		ZAC annual reports	Annually	MDAs: 32 Districts: 11 LGAs: 0 Shehia: 180	100% 100% 70% 70%	MDAs Districts LGAs Private sectors
5.2	Number of MDAs, LGAs, and CSOs that have implemented HIV workplans in the preceding 12 months	None	By district	ZHAPMoS, 2006	ZAC annual reports	Quarterly	LGAs: 11 MDAs: 44 CSOs: 40	95	ZAC LGAs CSOs
Outcome 5.2: Integrated provision of HIV and AIDS, SRH, and TB services at all levels									
5.3	Percentage of points of care providing integrated services	**Numerator:** Number of points of care which provide integrated services **Denominator:** Total estimated points of care	Type of service (family planning, cancer screening, STI) Geographical location	ZNSP III	ZAC annual reports	Quarterly			MOH

No.	Indicator	Indicator definition	Disaggregation	Indicator source	Data source	Frequency	Baseline	Target	Stakeholder
5.4	Percentage of PLHIV who received integrated services	**Numerator:** Number of PLHIV who attended points of care and received integrated services **Denominator:** Number of PLHIV who attended points of care surveyed	Type of service Age Sex	ZNSP III	ZAC points of care clients survey	Annual			MOH Private hospitals NGOs ZAC
Outcome 5.3: HIV and AIDS interventions mainstreamed in public (i.e., MDAs), LGAs, NGOs, FBOs, and private sector programmes									
5.5	Percentage of organisations with HIV and AIDS mainstreaming plans and budgets	**Numerator:** Number of MDAs, LGAs, and business organisations with HIV and AIDS mainstreaming plans and budgets **Denominator:** Total number of MDAs, LGAs, CSOs, and business organisations	District LGA MDAs Business sector	ZNSP III	ZAC annual report	Annually	MDAs: 34 LGAs: 0 Business sectors: 22 Districts: 11	100% 100% 50%	MDAs LGAs CSOs Business organisations

No.	Indicator	Indicator definition	Disaggregation	Indicator source	Data source	Frequency	Baseline	Target	Stakeholder
5.6	Percentage of orphaned and vulnerable children whose households received free basic external support and caring for the children	**Numerator:** Number of orphaned and vulnerable children who live in households that received at least one of the four types of support for each child (answered "yes" to at least one of questions 1, 2, 3, and 4) **Denominator:** Total number of orphaned and vulnerable children ages 0–17		UNGASS, p. 44		Every 4 to 5 yrs	THIS		ZAC
5.7	Number of people reached with individuals and small group-level HIV prevention interventions in the past 12 months	N/A	Sex Sectors Geographical location	ZNMHMES, 2006	ZAC Annual report	Quarterly and annually			ZAC

APPENDIX 3. ZANZIBAR NATIONAL MULTISECTORAL HIV M&E SYSTEM STRENGTHENING ACTION PLAN

M&E system component	Specific activities	Timeline	Responsibility
1. Organisational structure for M&E	1.1 Review ZAC human resources policy and scheme of service • Policy and scheme of service are dependent on the existence of an organisational structure • Organisational structure has been developed and submitted to the Public Service Commission for review and further steps	December 2019	Executive director
	1.2 ZAC to conduct M&E staff needs assessment at national and district levels, and recruit accordingly	October–December 2018	M&E officer
	1.3 Capacitate ZAC to fulfil its M&E mandate by delivering M&E service and deliverables	October–December 2018	M&E officer
	1.4 Establish research desk on ZAC (this should be the part of the job description of recruited M&E staff)	December 2019	Human resources officer
	1.5 Recruit additional staff to fill the gaps in the M&E department (i.e., data officer, head of M&E department, epidemiologist, IT staff)	December 2019	Executive director
	1.6 Review M&E staff job descriptions to include a research component	July–September 2018	Human resources officer
	1.7 Develop M&E staff motivation and retention mechanisms and strategies	June 2019	Executive director
	1.8 Develop M&E technical assistance plan	July–September 2018	M&E officer
	1.9 Engage LGAs in recruiting new staff to establish an M&E unit at district level (starting with an M&E special officer)	October–December 2018	Head, Division of Planning and Policy
2. M&E human capacity	2.1 Engage a consultant to formulate career plan for ZAC staff	October–December 2018	M&E officer
	2.2 Develop a human capacity-building plan on M&E-related skills and competencies for the M&E staff to fulfil their responsibilities	July–September 2018	M&E officer
	2.3 Develop indicators to monitor the M&E capacity-building programme	July–September 2018	M&E officer
	2.4 Advocate for integration of M&E HIV and AIDS training modules into pre-service programme (for health and non-health staff)	October–December 2018	Executive director

	2.5 Develop and operationalise a database of training programmes (showing number of trainees and trainers, and courses attended)	October–December 2018	M&E officer
	2.6 Support the implementation of supportive supervision; ongoing	June 2021	M&E officer
3. Partnerships	3.1 Reintroduce REMETTHAZ and actively engage development partners in its meetings.	July–September 2018	M&E Officer
	3.2 Update REMETTHAZ TOR	July–September 2018	M&E officer
	3.3 Update the list of REMETTHAZ members to cater to the existing HIV situation	July–September 2018	M&E officer
	3.4 REMETTHAZ to update and use data collection and reporting tools effectively for routine reporting of non-health data (ZHAPMoS); review process is ongoing; include two members from DHAPs (1 from Pemba and 1 from Unguja)	October–December 2018	M&E officer
	3.5 ZAC to ensure that before decision making and resolutions are passed on the national HIV and M&E system, consensus must be built in consultation with technical working group members; ongoing		
	3.6 Mobilise resources to support REMETTHAZ meetings on a quarterly basis; ongoing	July 2021	M&E officer
	3.7 Advocate for the involvement of development partners in REMETTHAZ meetings; ongoing	July 2021	Executive director
	3.9 ZAC to develop mechanisms regarding distribution of reports and newsletters to communicate about HIV M&E activities; ongoing	July 2021	Head, Division of Policy and Planning
	3.10 Encourage district HIV and AIDS coordination meetings	July 2021	Executive director
	3.11 ZAC should provide feedback to districts on the national M&E quarterly coordination meetings; ongoing	July–December 2018	M&E officer
	3.12 Resolve bottlenecks related to finances for the ZAC M&E subcommittee; ongoing	July 2021	Executive director
	3.13 ZAC to advocate for fund allocation at the regional and district levels on HIV/AIDS activities; ongoing	July 2021	Executive director

4. National HIV and AIDS M&E Plan	4.1 Support the development and review and operationalisation of the national M&E plan for non-health sectors that align with ZNSP III	July–September 2018	M&E officer
	4.2 Include indicators in the national HIV/AIDS M&E plan to monitor progress and performance of the M&E system (the national M&E plan indicators have been included for monitoring progress and performance of the M&E system)		
	4.3 Establish baseline values for key indicators; most of the baseline key indicators have been established but a few baseline indicators are missing, particularly those from the last THIS because the report was incomplete		
	4.4 Estimate the M&E resource budget requirement for the new M&E plan	July–December 2018	Executive director
	4.5 Support the development of resource mobilisation strategies for the non-health sector's M&E activities; it has not yet been done but some initiatives are ongoing, including engagement of high-level policymakers on the establishment of an AIDS trust fund	October–December 2018	Head, Division of Policy and Planning
	4.6 Support the implementation of a resource mobilisation strategy	January 2019–2021	Executive director
	4.7 Advocate for integration of non-health M&E activities into comprehensive district health plans (CDHPs)	July 2018–2021	Head, Division of Policy and Planning
	4.8 Advocate with the government and development partners to allocate funding to M&E functions at all levels; ongoing	July 2018–2021	Executive director
	4.9 Conduct advocacy meetings to link national the non-health sector M&E plan with district health plans; ongoing	July 2018–2021	M&E officer
5. National M&E Workplan	5.1 Support development and implementation of a costed non-health sector M&E operational work plan based on the new M&E plan	July–December 2018	M&E officer
	5.2 Support printing and the dissemination of the developed M&E operational plan amongst key stakeholders	July–December 2018	M&E officer
	5.3 Consistently allocate funds for the M&E plan for sustainability; ongoing	July 2018–2021	Executive director

	5.4 Support districts in the development of annual M&E operational plans, complete with costed activities; ongoing; can be mainstreamed in the quarterly coordination meetings with LGAs	July 2018–2021	M&E officer
	5.5 Review implementation progress of the national M&E plan and make any necessary modifications	July 2018–2021	M&E officer
6. Advocacy, Communication, and Culture	6.1 Review the existing advocacy and communication strategy (2011–,2016) and align it with ZNSP III, making sure it includes dissemination of M&E information: • Advocacy and communication strategy reviewed • Cross-check whether the M&E information is included in the reviewed strategy	July–September 2018	M&E officer
	6.2 Establish HIV and AIDS knowledge management platforms; not yet established	July–December 2018	M&E officer
	6.3 Update and maintain the ZAC website; ongoing	July 2018–2021	M&E officer
	6.4 Appoint a dedicated individual with necessary skills and resources to regularly run and update the website; previously appointed officer has been transferred and new officer will be appointed	July–September 2018	M&E officer
	6.5 Broadcast the use of the ZAC website to all stakeholders, government staff, and general public; ongoing	July 2018–2021	M&E officer
	6.6 Cascade the development of a web-based applications LAN across all ZAC offices (Unguja and Pemba); the LAN in the Unguja office is in place—follow-up needed for Pemba office	July–September 2018	M&E officer
	6.7 Produce M&E information products and have them disseminated appropriately; ongoing	July 2021	M&E officer
	6.8 Disseminate information products (i.e., reports, website content, emails, newsletters, maps, tables, charts) to various stakeholders; ongoing	July 2018–2021	M&E officer
	6.9 Conduct quarterly M&E feedback meetings; revive the M&E feedback meetings	July 2018–2021	M&E officer

	6.10 Advocate with heads of divisions and coordinators on the importance of using HIV M&E information before and during the HIV review planning and costing processes	July 2018–2021	Executive director
7. Routine Programme Monitoring	7.1 Review all ZHAPMoS forms and align them to ZNSP III	July–September 2018	M&E officer
	7.2 Train key implementers on the revised ZHAPMoS forms	July–September 2018	M&E officer
	7.3 Support data collection and use of ZHAPMoS forms	October 2018–2021	M&E officer
	7.4 Develop M&E system/review the current existing system to track IEC/BCC indicators; has already been done		
	7.5 Build capacity of HIV stakeholders on M&E system, indicators, guidelines, and revised tools for reporting	July–December 2018	M&E officer
	7.6 Train community stakeholders at the district level on how to verify obvious mistakes related to data before submitting them to ZAC	July 2018–2021	M&E officer
	7.7 Procure and supply IT equipment to enhance M&E system	July 2018–2021	M&E officer
8. Surveys and Surveillance	8.1 Review and update the existing research agenda to fit the ZNSP III needs	July 2018–December 2018	M&E Officer
	8.2 Mobilise resources to implement the revised research agenda and its implementation plan	October–December 2018	*ED*
	8.3 Develop a searchable inventory of research, surveillance studies, and evaluation	July 2018–December 2018	M&E officer
	8.4 Establish a national archives of HIV research and surveillance documentation and library	July 2018–2021	ED
	8.5 Improve the collaboration with research and evaluation institutions, including Office of the Chief Government Statistician (OCGS)	July 2018–2021	ED
	8.6 Build stakeholders' capacity to undertake HIV and AIDS research	July–December 2018	M&E officer
	8.7 Conduct national HIV workplace survey (baseline)	January–December 2019	M&E officer
	8.8 Conduct a comprehensive condom survey	January–March 2019	M&E officer

	8.9 Advocate for utilisation of surveys/surveillance findings in planning and decision making	July 2018–2021	ED
	8.10 Strengthen collaboration and involvement with organisations conducting research and surveillance related to HIV and AIDS	July 2018–2021	ED
9. Database, National and Subnational	9.1 Review the existing guideline	July–December 2018	M&E officer
	9.2 Orient and train M&E personnel at all levels on the reviewed guideline and tools	July–December 2018	M&E officer
	9.3 Develop a web-based national HIV and AIDS database based on the revised tools to align with ZNSP III and its M&E plan	July–December 2018	M&E officer
	9.4 Develop data quality assessment guideline	July–September 2018	M&E Officer
	9.5 Disseminate the developed data auditing guidelines and tools to all stakeholders	October–December 2018	M&E Officer
	9.6 Train all key stakeholders on the developed data auditing guidelines and tools	October–December 2018	M&E officer
10. Supervision and Auditing	10.1 Review existing (2006) national comprehensive supportive supervision guidelines to align with ZSNP III	July–December 2018	M&E officer
	10.2 Develop comprehensive national guideline and tools for supportive supervision and mentorship on M&E (from national to shehia level)	July–December 2018	M&E officer
	10.3 Support data auditing and supportive supervision at ZAC and district levels	July–December 2018	M&E officer
	10.4 Develop data auditing supervision guidelines and tools based on ZNSP III	July–December 2018	M&E officer
	10.5 Disseminate the developed data auditing guidelines and tools to all stakeholders	July 2018–2021	M&E officer
	10.6 Provide a refresher training to all key stakeholders on developed data auditing guidelines and tools	July–December 2018	M&E officer
	10.7 Strengthen mentorship and supportive supervision	July–December 2018	M&E officer
11. Evaluation and Research	11.4 Mobilise resources for research and evaluations	January–March 2019	ED

	11.5 Conduct mid- and end-term evaluation for ZNSP III	October–December 2019	M&E officer
	11.6 Strengthen the collaboration between ZAMREC and ZAC in the establishment of a research inventory	July–2021	M&E officer
	11.7 ZAC to liaise with higher learning institutions in conducting research	July–2021	M&E officer
	11.8 Advocate for the culture of using research findings in policy, planning, and decision making	July–2021	Policy and Planning
12. Data Dissemination and Use	12.1 ZAC to prepare a protocol and conduct stakeholders' information needs assessment	October–December 2018	M&E officer
	12.3 Develop data demand and information use guideline to support analysis, presentation, and data use at all levels	January–March 2019	ED
	12.4 Orient data providers on the developed guideline for data analysis, presentation, and use at all levels	April–June 2019	M&E officer
	12.5 Organise quarterly data review meetings at district and national levels to discuss key programme indicators with programme managers and decision makers	2018–2021	M&E officer
	12.6 Strengthen the ZAC resource centre and publicise it for use; additionally, develop online dissemination platforms, etc.	July 2018–2021	M&E officer
	12.7 Support the development, printing, and dissemination of information products (QSCR, annual reports, GAM, etc.)	January 2019–2021	M&E officer
	12.8 Develop customised information products for KPs and other vulnerable groups	July 2018–2021	M&E officer
	12.10 Upload information products on the ZAC website	July 2018–2021	M&E officer
	12.11 Strengthen the M&E unit to collect, analyse, and disseminate data to all IPs, to enhance data demand and use	July 2018–2021	M&E officer
	12.12 Support data dissemination and information use training at all levels	July 2018–2021	M&E officer

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