Revolutionary Government of Zanzibar

MINISTRY OF HEALTH

ZANZIBAR INTEGRATED HIV, HEPATITIS, TUBERCULOSIS AND LEPROSY PROGRAMME

MONITORING AND EVALUATION (M&E) PLAN

Zanzibar Health Sector HIV and AIDS Strategic Plan III, 2017-2022 (ZHSHSP III)

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TR-18-303

FOREWORD

According to the Tanzania HIV Impact Survey (THIS), 2016–2017, HIV prevalence in the general population of Zanzibar is less than 1 percent (NBS, 2017). Kaskazini Unguja and Mjini Magharibi regions have the highest HIV prevalence (0.6%), followed by Kusini Pemba (0.3%). The THIS 2017 data show significant reductions in HIV prevalence from the Tanzania HIV and AIDS and Malaria Indicator Survey (THMIS) of 2011/12, which estimated an HIV prevalence of 1.2 percent and 0.3 percent in Unguja and Pemba islands, respectively. However, estimates from the general population mask the HIV problem in Zanzibar, which typically is classified as having a concentrated HIV epidemic, with high HIV prevalence among key populations (KPs). The key populations include people who inject drugs (PWID), men who have sex with men (MSM), and sex workers (SWs) who are also characterized as hidden and hard-to-reach population with high risk of acquiring HIV infection. For example, according to the Integrated Bio-Behavioural Surveillance Survey (IBBSS) conducted in 2011–2012, HIV prevalence amongst SWs, PWID, and MSM was 19.3 percent, 11.3 percent, and 2.6 percent, respectively. The Third Zanzibar Health Sector HIV and AIDS Strategic Plan, 2017–2022 (ZHSHSP III) was designed to respond to the HIV epidemic and identified gaps and challenges in the health sector response in Zanzibar.

This Third Zanzibar Health Sector HIV and AIDS Strategic Plan, 2017–2022 (ZHSHSP III) Monitoring and Evaluation Plan (ZHSHSP III M&E Plan) has been developed to guide stakeholders on how to monitor and evaluate implementation of the ZHSHSP III and determine whether its goals and objectives are being met. The M&E plan has a total of 70 indicators, with indicators for each of the four thematic areas (TAs) defined in the Strategic Plan, namely: (1) prevention of HIV transmission – 32 indicators; (2) care, treatment, and support for PLHIV – 15 indicators; (3) crosscutting technical interventions – 8 indicators; and (4) health systems strengthening – 15 indicators. The guidance includes definition of indicators for the measurement of expected results (impact, outcomes, and outputs), sources of data, frequency of data collection, baseline level, and targets for each indicator and institutions that are responsible for collecting and reporting the data.

Effective implementation of this M&E plan will provide strategic information for planning and decision-making purposes, including any necessary course correction measures required for the attainment of the health-sector goal to ensure “universal access” to good quality, integrated HIV-related services in Zanzibar. The goal is aimed at eliminating HIV as a public health concern by 2030.

All HIV stakeholders, including Zanzibar Integrated HIV, Hepatitis, Tuberculosis and Leprosy Programme (ZIHHTLP) staff, government officials responsible for planning and implementation of HIV prevention, care, and support programs, councils, district health management teams (DHMTs), healthcare providers, faith-based organisations (FBOs), national and international nongovernmental organizations supporting HIV interventions are called upon to contribute to the data collection, analysis, dissemination, and use efforts as defined in this plan.

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ACKNOWLEDGEMENTS

This monitoring and evaluation (M&E) plan for ZHSHSP III has been developed through a collaborative process. Special acknowledgment is given to the Zanzibar Integrated HIV, Hepatitis, Tuberculosis and Leprosy Programme (ZIHHTLP) for the strategic leadership of the entire process. The ZIHHTLP Programme Manager provided overall leadership for the exercise. The Strategic Information Unit, in collaboration with other units within the ZIHHTLP, including HTS, PMTCT, KP/STIs, CTC, Lab, TB, HBC IEC/BCC, played a critical role in the writing and review of several versions of this M&E plan.

We appreciate the contribution of representatives from the following organizations during workshops conducted to review the M&E plan indicators and targets:

- Ministry of Health
- Integrated Reproductive and Child Health (IRCH)
- Zanzibar National Blood Transfusion Services (ZNBTS)
- Central Medical Store (CMS)
- Zanzibar Malaria Elimination Programme (ZAMEP)
- District Health Management Teams (DHMTs)
- Zanzibar AIDS Commission (ZAC)
- UNICEF
- UNFPA
- Tanzania Health Promotion Support (THPS)
- Save the Children

We also express special appreciation for the technical assistance and financial support of the United States Agency for International Development (USAID), through the USAID-funded MEASURE Evaluation–Tanzania project. We acknowledge the contribution of the following staff from MEASURE Evaluation-Tanzania to the development of this M&E plan: Willis Odek, Eveline Nguma, Zaddy Kibao, and Kusekwa Sono.

An M&E plan is a living document. Any experiences gathered during the implementation of this M&E plan should be submitted to ZIHHTLP.

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ABBREVIATIONS

ANC	antenatal care
ART	antiretroviral therapy
ARV	antiretroviral
CBHC	community-based healthcare
CSW	commercial sex worker
CBO	community-based organisation
CHMT	council health management team
CT	counselling and testing
CTC	care and treatment clinic
DACCOM	District AIDS Coordinating Committee
DDU	data demand and use
DHMT	district health management team
DHS	Demographic and Health Survey
DQA	data quality assessment
EQA	external quality assurance proficiency testing
EID	early infant diagnosis
GARP	Global AIDS Response Progress Reporting
HAART	highly active antiretroviral treatment
HBC	home-based care
HCW	healthcare worker
HMIS	health management information system
HPV	human papillomavirus
HTS	HIV testing service
IBBSS	Integrated Bio-Behavioural Surveillance Survey
ICAP	International Center for AIDS Care and Treatment Programs (Columbia University)
IDU	injecting drug users
IPT	isoniazid preventive therapy
KP	key population
M&E	monitoring and evaluation
MARP	most-at-risk population
MoHSW	Ministry of Health and Social Welfare
MSM	men having sex with men
MTCT	mother-to-child transmission

NGO	nongovernmental organisation
OCGS	Office of the Chief Government Statistician
PEP	post-exposure prophylaxis
PEPFAR	United States President's Emergency Plan for AIDS Relief
PLHIV	people living with HIV
PMTCT	prevention of mother-to-child transmission (of HIV)
PWID	people who inject drugs
RCH	reproductive child health
RTI	reproductive tract infection
SI	strategic information
SRH	sexual and reproductive health
STI	sexually transmitted infection
TA	thematic areas
TB	tuberculosis
TDHS	Tanzania Demographic and Health Survey
THIS	Tanzania HIV Impact Survey
THMIS	Tanzania HIV and AIDS and Malaria Indicator Survey
TSPA	Tanzania Service Provision Assessment
UNAIDS	Joint United Nations Programme on HIV/AIDS
UNDP	United Nations Development Programme
UNGASS	United Nations General Assembly Special Session on HIV and AIDS
USAID	Joint United Nations Programme on HIV/AIDS
VIA	visual inspection with acetic acid
WHO	World Health Organization
ZAC	Zanzibar AIDS Commission
ZACP	Zanzibar AIDS Control Program
ZANGOC	Zanzibar Nongovernmental Organization Cluster
ZHAPMoS	Zanzibar HIV and AIDS Program Monitoring System
ZHMIS	Zanzibar Health Management Information System
ZHSHSP III	Zanzibar Health Sector HIV and AIDS Strategic Plan III 2017–2022
ZIHHTLP	Zanzibar Integrated HIV, Hepatitis, Tuberculosis and Leprosy Programme
ZNCCDC	Zanzibar National Commission for the Coordination of Drug Control
ZNSP	Zanzibar National HIV Strategic Plan
ZPRP	Zanzibar Poverty Reduction Plan

1. BACKGROUND

This chapter presents an overview of the HIV and AIDS situation in Zanzibar, and the Zanzibar Health Sector HIV and AIDS Strategic Plan III 2017–2022 (ZHSHSP III 2017–2022), both of which provide the context for this monitoring and evaluation (M&E) plan.

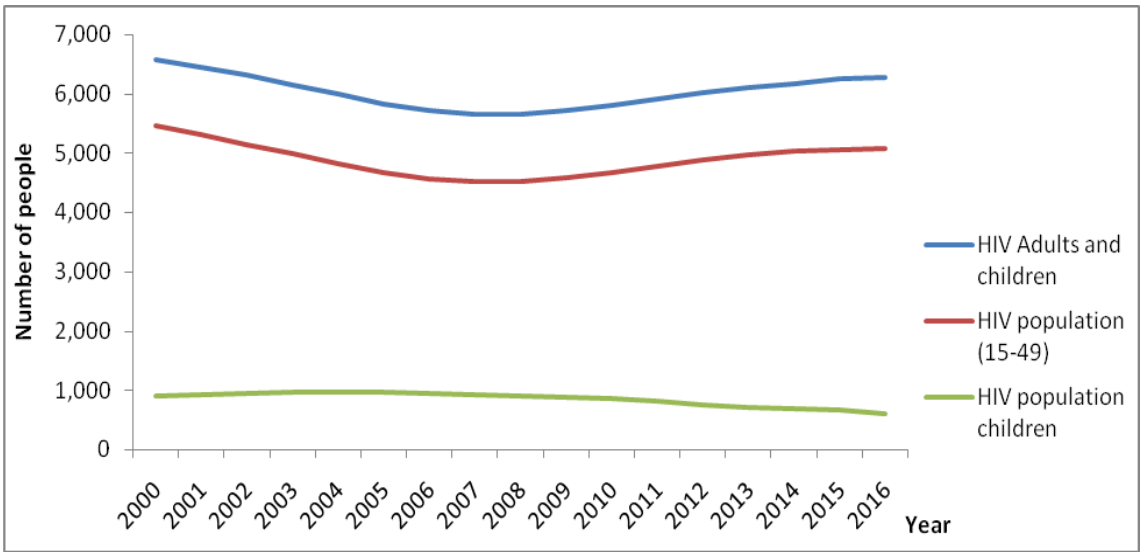
1.1. HIV/AIDS in Zanzibar

According to the Tanzania HIV Impact Survey (THIS), 2016–2017, HIV prevalence in the general population of Zanzibar is less than 1 percent (NBS, 2017). 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 in Zanzibar—Kusini Unguja and Kaskazini Pemba. The THIS 2017 data show significant reductions in HIV prevalence from the Tanzania HIV and AIDS and Malaria Indicator Survey (THMIS) of 2011–12, which estimated an HIV prevalence of 1.2 percent and 0.3 percent in Unguja and Pemba islands, respectively.

However, estimates from the general population mask the HIV problem in Zanzibar, which typically is classified as having a concentrated HIV epidemic, with high HIV prevalence among key populations (KPs). For example, according to the Integrated Bio-Behavioural Surveillance Survey (IBBSS) conducted in 2012, HIV prevalence amongst 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 currently are living with HIV. Amongst them, 5,146 (80%) are people in the age group 15-49 years and 551 (8.8%) are children below age 15. The population living with HIV had been 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 that reduced mortality among people living with HIV (PLHIV).

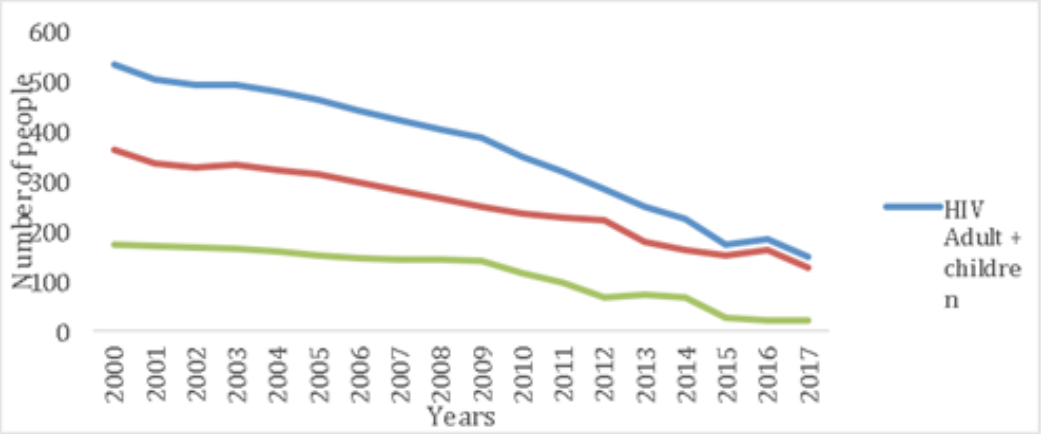
Figure 1. Population estimates of people living with HIV, 2000–2016, Zanzibar



Source: ZIHHTLP Annual Report, 2016.

The number of new HIV infections from 2005 shows a downward trend across all age groups (Figure 2). In 2017, new cases were estimated at 147, including 19 (13%) amongst children below age 15. The decline of new HIV cases indicates that HIV prevention and treatment interventions are bearing fruit.

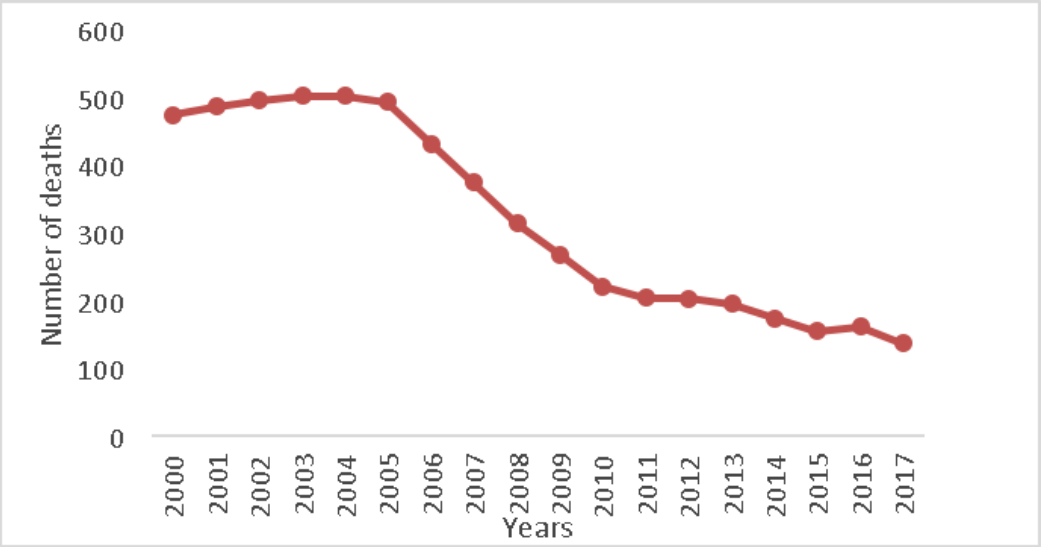
Figure 2. Trend of new HIV infections from 2000–2017, Zanzibar



Source: ZHSHSP III, 2017–2022.

Moreover, the number of deaths amongst PLHIV has decreased over the last 10 years (Figure 3). The decline is remarkable since 2005, which reflects the time period during which a care and treatment programme with access to antiretrovirals (ARVs) was established.

Figure 3. Total HIV-related deaths, 2000 to 2017, Zanzibar



Source: ZHSHSP III, 2017–2022.

1.2. Situation of Hepatitis B and C and HIV/Viral Hepatitis B and C Co-infection

Hepatitis B and C infections (HBV and HCV) are of public health importance in Zanzibar because, like HIV, their prevalence is low in the general population but high in KPs. Through antenatal care (ANC) surveillance conducted in 2014, pregnant women were used as a proxy for the general population;

the prevalence of HBV and HCV was estimated at 1.7 percent and 0.3 percent, respectively. However, the 2012 IBBSS showed an HBV prevalence of 5.9 percent, 2.7 percent, and 2.2 percent amongst PWID, MSM, and SWs, respectively. The corresponding HCV prevalence estimates were 25.4 percent, 1.3 percent, and 1.6 percent amongst the subgroups.

Co-infection of HIV and viral hepatitis also exists. The IBBSS of 2011–2012 demonstrated an HIV/HCV co-infection magnitude of 6.9 percent among PWID. A pilot study conducted between 2012 and 2016 at Mnazi Mmoja Hospital amongst patients on HIV care and treatment found an HIV/HBV co-infection prevalence of 3.7 percent.

1.3. Third Zanzibar Health Sector HIV and AIDS Strategic Plan, 2017–2022 (ZHSHSP III)

The ZHSHSP III has been designed to respond to the HIV epidemic and identified gaps and challenges in the health sector response.

The ZHSHSP III is strongly aligned with the Third Zanzibar National HIV and AIDS Strategic Plan 2017–2022 (ZNSP III). The health sector strategy seeks to ensure "universal access" to quality integrated HIV services in Zanzibar, aimed at eliminating HIV as a public health concern by 2030. The vision, mission, and broad goals are listed below.

1.3.1. Vision

A Zanzibar free of new HIV infections, with people infected and affected by HIV receiving the best available care without discrimination or stigmatisation.

1.3.2. Mission

To consolidate partnerships with other public sectors, the private sector, civil society, and communities to deliver quality essential HIV/AIDS interventions.

1.3.3. Goals

- To strengthen the health system capacity for scaling up essential HIV/AIDS interventions
- To promote access and use of affordable and essential interventions and commodities for HIV/AIDS
- To improve the quality of HIV/AIDS interventions for PLHIV, the general public, KPs, healthcare providers, and other vulnerable groups

1.4. Intervention Areas and Expected Results

ZHSHSP III is structured into the following four thematic areas:

1. Prevention of HIV transmission
2. Care, treatment, and support for PLHIV
3. Crosscutting technical interventions
4. Health systems strengthening

Each thematic area addresses several interventions that jointly will help achieve desired outcomes over the plan's five years.

1.4.1. Prevention of HIV Transmission

This thematic area consists of six interventions focusing on prevention of mother-to-child transmission of HIV (PMTCT), treatment and control of sexually transmitted and reproductive tract infections (STIs/RTIs), and interventions targeting KPs and young people and adolescents. Blood

safety and health sector workplace HIV interventions also fall within this thematic area. Each of these interventions is described below, with a focus on expected results.

1.4.1.1.Prevention of Mother-to-Child Transmission of HIV (PMTCT)

The PMTCT intervention aims to reduce the mother-to-child transmission rate to less than 5 percent by 2022. This is expected to be achieved through ensuring that 100 percent of pregnant women are tested for HIV and receive their results, and at least 95 percent of those testing positive receive antiretroviral therapy (ART). This intervention will be further supported by making PMTCT services more accessible and user friendly through the provision of comprehensive services that include screening for HIV, syphilis, tuberculosis (TB), and viral hepatitis, as well as early infant diagnosis (EID) and family planning services. The strategy also seeks to increase the percentage of male partners accompanying their spouses to PMTCT services from the current 9.6 percent to 30 percent by 2022. Further, the ZHSHSP III intends to establish and scale up DNA polymerase chain reaction testing for EID in Zanzibar.

1.4.1.2. Treatment and Control of Sexually Transmitted and Reproductive Tract Infections

The ZHSHSP III seeks to increased use of STI/RTI services amongst key and general populations through improved health-seeking behaviour, whereby at least 95 percent of patients will be appropriately diagnosed and treated. This n is expected to be achieved through increasing the percentage of health facilities with the capacity to provide quality STI/RTI services from 58 percent in 2016 to 100 percent by 2022. Innovative approaches will be introduced to increase the proportion of sexual partners traced and treated for STI/RTI at health facilities from 0.9 percent in 2016 to 50 percent in 2022. Capacity for aetiological diagnosis to support syndromic management will be strengthened by establishing referral clinics in both Unguja and Pemba. Additional satellite health facilities will also be equipped to do aetiological diagnosis.

1.4.1.3. Interventions Targeting Key Populations

HIV-related interventions for KPs in Zanzibar started in 2003. To date, there are three KP-friendly service centres, all which are in Unguja, based at Mnazi Mmoja Hospital, ZAYEDESA, and the methadone assisted treatment (MAT) Clinic at Kidongo Chekundu. There are also national and local nongovernmental organisations (NGOs) and sober houses, which, in collaboration with KP stakeholders, continue to implement KP interventions in Zanzibar.

The focus for ZHSHSP III will be to strengthen interventions which facilitate the reduction of new HIV infections and other STIs, thus reducing HIV prevalence, by addressing risk factors, promoting service utilisation, and fighting against stigma and discrimination amongst KPs. Studies and surveys will be conducted to understand the impact of HIV/AIDS interventions amongst these groups. Service providers will be equipped with skills and positive attitudes to best serve KPs with the desired HIV services, including linkage to treatment for those KPs found to be infected with HIV, so as to achieve the fast track target of 90-90-90 by 2020. Through expanded and user-friendly community-based services, the ZHSHSP III target is to achieve 95 percent condom use among KPs and 90 percent use of sterile injecting equipment among PWID. In addition, 90 percent of KPs are targeted to be tested for HIV and receive results every year, and at least 80 percent of those infected will receive ART.

1.4.1.4. Interventions Focusing on Young People and Adolescents

Based on projections from the 2012 population census, Zanzibar has 335,970 adolescents (ages 10–19) and 133,714 youth (ages 20–24). For 2017 alone, there were 75 estimated new cases of HIV

infection amongst youth (Spectrum, 2014). Data show that 567 of youth ages 15–24 years in Zanzibar have received care, amongst whom 233 are on ART (ZIHHTLP, 2016).

Adolescents and youth face many challenges, including those predisposing them to HIV infection. These challenges include low numbers of youth enrolled in care and treatment services, low comprehensive knowledge about HIV and AIDS, high-risk behaviours (multiple partnerships, low use of condoms), inadequate youth-friendly services, and low capacity for provision of adolescent- and youth-friendly services.

ZHSHSP III aims to reduce the vulnerability of adolescents and youth to HIV, STI, and viral hepatitis infections by increasing their access to friendly preventive services. Testing for HIV/HBV/HCV will be promoted through social activities amongst the general population, including sports bonanzas, football leagues, and concerts and exhibitions. Those found to be infected will be linked to treatment and care provided at youth-friendly health sites.

1.4.1.5. Blood Safety

The annual need for safe blood in Zanzibar is estimated at 10,500 units. In 2016, 8,918 units were collected (85%). The number of voluntary blood donors has been increasing, from 68 percent in 2015 to 85 percent in 2016. All blood and blood products transfused in Zanzibar will be screened for HIV, HBV, HCV, and syphilis as per the approved national guidelines. This screening will be achieved by supporting supply chain management to ensure the regular and adequate availability of reagent test kits at the central blood bank, and building the human resource capacity and quality blood testing management system in the blood bank. Healthcare workers will be trained in counselling and to refer infected prospective donors to care and treatment services.

1.4.1.6. Health Sector Workplace HIV/AIDS Interventions

According to the International Labor Organization, all employers, including governments, are advised to institute workplace HIV/AIDS programmes to safeguard their workforce and businesses. The package for the health sector should address at least the following: (1) safety at the workplace departments, wards, theatres, mortuaries, laundries, and waste disposal places; (2) post-exposure prophylaxis; (3) care, treatment, and support; (4) prevention of sexual transmission; and (5) special consideration for health workers living with HIV/AIDS (e.g., exemption for working in TB wards). Most of these interventions can be integrated with routine infection prevention control in healthcare settings.

The risk of acquisition of HIV infection amongst health workers will be prevented and the welfare of those infected will be achieved through institutionalisation of workplace HIV/AIDS and HBV/HCV interventions at the central, intermediate, and health facilities levels. The strategy begins with development and dissemination of policy guidelines and training materials to build the capacity of healthcare workers in all healthcare facilities to implement workplace HIV/AIDS interventions.

1.4.2. Care, Treatment, and Support

The care, treatment, and support thematic area comprises three interventions, which focus on adults, adolescents, and children living with HIV; integration of TB and HIV services; and strengthening of community-based healthcare (CBHC) services.

1.4.2.1. Care and Treatment of Adults, Adolescents, and Children Living With HIV/AIDS

HIV care and treatment services in Zanzibar were established in 2005 at Mnazi Mmoja Hospital. Currently, there are eight and four care and treatment clinics (CTCs) in Unguja and Pemba,

respectively. As of December 2016, a total of 9,289 patients had ever been enrolled in CTCs; of this number, 6,956 (75%) were ever started on ARVs. However, the actual number of patients receiving ARVs was 4,346, representing 68 percent of patients estimated to need treatment, according to 2016 Spectrum estimations.

The number of patients currently on ART increased progressively from 2,171 in 2011 to 4,346 by December 2016. This increase came about mainly because of the adaptation of a series of World Health Organization (WHO) recommendations, including the adjustment of cut-off points of cluster of differentiation 4 levels from 200 to 350 and the "test and treat" approach. The percentage of patients currently receiving ART is lower than the target set in the M&E Plan of 80 percent by 2016. Through treatment, care, and support services, the strategy aims to reduce AIDS-related deaths from 9.7/100,000 population per year in 2016 to 4.3/100,000 by 2021. This goal is to be supported by putting at least 95 percent of PLHIV on ART and ensuring that 90 percent of them are retained on treatment.

Strategic actions will include establishing innovative approaches for enrollment of patients, defaulter tracing, strengthening capacity of healthcare workers (HCWs) on enhanced adherence counselling, and adopting a differentiated care framework. These approaches will be supported by improved procurement and distribution of HIV/AIDS medicines and related commodities.

1.4.2.2. TB/HIV Collaborative Activities

Currently only two health facilities are providing comprehensive TB/HIV collaborative services (Mnazi Mmoja and Chake Chake hospitals). During 2016, there were 74 TB/HIV co-infected patients who were treated for TB and received ARV drugs at these clinics. The programme screened 97 percent of people living with HIV attending CTCs for active TB; 99 percent of patients diagnosed with TB were screened for HIV. ZHSHSP III aims to scale up comprehensive TB/HIV collaborative activities that operate under one roof to four more health facilities. Isoniazid preventive therapy (IPT), which was being piloted at Mnazi Mmoja and Chake Chake Hospitals, will be scaled up to 12 more health facilities.

1.4.2.3. Integrated Community-Based Healthcare Services

Home-based care (HBC) services for AIDS patients were established in Zanzibar in 1988 in three districts in Unguja and two in Pemba. To date, CBHC services have been scaled up to 144 health facilities (54 in Pemba and 90 in Unguja) distributed in all 11 districts of Zanzibar. The goal of HBC was initially to provide comprehensive home-based care services to HIV/AIDS patients and those with other chronic illnesses in Zanzibar. However, in the current era of ART success, the number of bedridden HIV patients has decreased, and the role of these services needs to be expanded to include tracing defaulters and referring them back to CTCs. This expansion requires increased mobilisation of community supporters and establishing their formal linkage with health facilities. CBHC volunteers will be pivotal in providing services at the community level. CBHC volunteers will work under the supervision of facility-based service providers. Each health facility has a contact person (a facility supervisor) who is accountable for all CBHC services linked to the health facility.

1.4.3. Crosscutting Interventions

Social behaviour change communication, HIV testing and counselling, and laboratory services are considered crosscutting interventions in the ZHSHSP III.

1.4.3.1. Social and Behavioural Change Communication

Interventions for information, education, and communication (IEC) and behavioural change communication (BCC) are integral to a comprehensive HIV/AIDS prevention, care, and support

programme. IEC and BCC activities will be conducted to reduce risky behaviours associated with the transmission of HIV and other related diseases among adolescents, youth, KPs, and the general population. This reduction will be achieved through increased comprehensive prevention knowledge regarding HIV and other related diseases amongst these populations. The target is to have at least 90 percent of such people possess comprehensive knowledge about HIV transmission and prevention. Increased awareness on consistent and correct use of condoms amongst the general population and KPs is planned to be achieved through innovative condom distribution mechanisms. Through a range of advocacy, communication, and social mobilisation methodologies, the ZHSHSP III aims for 90 percent of the general population to have accepting attitudes towards PLHIV and KPs.

1.4.3.2. HIV Testing Services

The provision of quality HIV testing services (HTS) is the entry point to HIV/AIDS care and treatment, and is effective as a preventive measure for HIV infection for clients and the community. During the implementation of ZIHHTLP II, several HTS approaches were implemented, including client-initiated testing and counselling (CITC), provider-initiated testing and counselling (PITC), and home-based counselling and testing provided in clinical settings and the community through outreach.

Coverage and use of HTS have expanded, from 66 sites in 2012 to 123 sites in 2016, including those in both the public and private health sectors, NGOs, and faith-based organisations. In 2016, 94,507 people were tested and received their results, corresponding to 66 percent of the target for the year. In the first three years of ZHSHSP III, the number of people tested increased above the target but gradually decreased because of recurrent stockouts of HIV test kits.

The intended outcome of ZHSHSP III is the to increase use of quality HTS to the general population, KPs, and youth and adolescents, with at least 22 percent of the general population being tested for HIV and receiving their results every year. A number of measures will be taken to achieve this outcome, including increasing the number of public HTS sites from the current 104 to 132 by 2022; establishing a second Gold Standard HTS Centre in Pemba to complement the efforts of the one in Unguja; and implementing innovative approaches, such as special campaigns, to increase the demand for HTS by youth, adolescents, and the general population. Adoption of the "home testing" approach is still being reviewed in Zanzibar as to its feasibility and acceptability.

1.4.3.3. Laboratory Services

The ZHSHSP III intends to scale up the provision of quality laboratory services to bolster HIV/AIDS prevention, treatment, care, and support at all levels in Zanzibar. The number of laboratories with the capacity to perform HIV clinical tests and emerging technology will be increased to 21 by 2022. Capacity building will include improvement of infrastructure, provision of standard equipment and commodities, and scale-up of "point-of-care" technologies and staff capacity building. The scope of tests will be expanded to include common co-morbidities, such as TB, HBV, HCV, and other STIs. The current challenge of lack of capacity to perform HIV viral load testing will be addressed by introducing this technology at the national and district levels, targeting five sites in the next five years of this strategy. Another aim is to expand the scope of the Strengthening Laboratory Management Towards Accreditation to regional and district levels to include five more sites achieving star ranking according to the WHO/Regional Office for Africa (AFRO) Stepwise Laboratory Improvement Process Towards Accreditation SLIPTA checklist. Proficiency testing will be expanded to all HIV service delivery points from the current 79 to 168.

1.4.4. Health Systems Strengthening

The core interventions under this thematic area are institutional capacity building; strengthening of procurement chain management; and monitoring, evaluation, research, and learning.

1.4.4.1. Institutional Capacity Building

The capacity of the Zanzibar Integrated HIV, TB, and Leprosy Programme (ZIHHTLP) needs to be strengthened to provide adequate and efficient programme management, coordination, and implementation of the ZHSHSP III. The programme will ensure that there is adequate qualified staff at the central and all other levels of HIV/AIDS service delivery. One of the strategic actions will be to build the capacity of three health training institutions to implement integrated HIV/AIDS knowledge and skills in their curricula and training modules. The two ZIHHTLP offices in Zanzibar and Pemba will be renovated, equipped, and provided with adequate transport facilities. To ensure adequate coordination of development and implementing partners, an annual mapping of stakeholders will be conducted, as well as coordination meetings after every two months. ZIHHTLP will mobilise resources from the government and partners based on the costed implementation plan of ZHSHSP III. ZIHHTLP will also organise mid- and end-term programme reviews to guide improved performance of the current strategy and future planning.

1.4.4.2. Procurement Chain Management for HIV/AIDS Medicines and Commodities

Uninterrupted supply of medicines, diagnostics, and other related commodities is an important component in the prevention, care, treatment, and support for HIV/AIDS. The achievement of the logistics system depends mainly on efficient procurement, storage, and distribution of commodities of the desired quality. The main outcome during the implementation of ZHSHSP III will be continuous availability of HIV/AIDS medicines and related commodities at all service delivery points so that the percentage of health facilities reporting stockouts in the last three months of the reporting cycle is kept below 5 percent. This outcome will be achieved through (1) a well-functioning procurement management unit with sufficient capacity to perform supply chain procurement functions; (2) improved safe storage and efficient distribution of quality health commodities that will guarantee last mile accessibility and availability; (3) existence of well-coordinated and functional logistics management systems at all levels of the supply chain; and (4) improved information and knowledge sharing amongst supply chain stakeholders. During the implementation of this strategy, ZIHHTLP will collaborate with the Zanzibar Food and Drugs Safety Board to institutionalise and implement the ARV pharmacovigilance system.

1.4.4.3. Monitoring, Evaluation, Research, and Learning

Monitoring and evaluation of the HIV health sector response requires greater coordination of all players in the national HIV response to allow optimal use of available resources, sharing of experiences, and fostering of evidence-based programming. The ZIHHTLP, through the Strategic Information (SI) Unit, is responsible for the overall M&E of the health sector HIV response.

The SI Unit mission is to promote the use of quality HIV and AIDS data for decision making at all levels through accurate, complete, and timely HIV/AIDS and viral hepatitis data at all levels, and developing and executing surveillance and operational research studies. Specific targeted achievements include an increased percentage of health facilities submitting complete HIV/AIDS reports, from 75 percent in 2016 to 95 percent by 2022, whereas those reporting on a timely basis will be increased from 47 percent to 90 percent over the same period. The SI Unit will conduct at least two ANC surveys, one IBBS survey, and three operational research studies.

1.4.4.4. Establishment of Viral Hepatitis B and C Services

Zanzibar recognises viral Hepatitis B and C as public health threats, and is aligning its strategy with global recommendations to eliminate these epidemics by 2030. Interventions for these major co-morbidities have been addressed in each intervention area of the strategic plan. Moreover, the Ministry of Health (MOH) Zanzibar intends to develop a specific viral hepatitis strategy as a component of the national response to the epidemic.

1.5. Purpose of the M&E Plan

To be able to determine the extent to which ZHSHSP III results are being achieved, there is a need for systematic data collection on various strategies applied and services provided. The purpose of this M&E plan is to provide guidance for tracking health sector HIV/AIDS programmes and outcomes as per the ZHSHSP III. This M&E plan guides stakeholders on how to monitor and evaluate implementation of the ZHSHSP 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 level and targets for each indicator, and the institutions responsible for collecting and reporting the data.

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

The M&E plan was developed through a consultative process and coordinated by ZIHHTLP with technical support from MEASURE Evaluation Tanzania. The specific processes involved were as follows:

Step 1: MEASURE Evaluation, jointly with ZIHHTLP, conducted a desk review of key documents to identify appropriate indicators for monitoring and evaluating ZHSHSP III performance. The documents reviewed included the ZHSHSP III; Zanzibar National Multisectoral HIV Monitoring and Evaluation System Operational Framework; strategic plans and frameworks from other relevant sectors, departments, and ministries; 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, the United Nations Joint Programme on HIV/AIDS (UNAIDS) Global AIDS Monitoring Indicators, Global Fund M&E guidelines, and the WHO Strategic Information guidelines for HIV in the health sector. A first draft of indicators was developed from this review.

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

a. Review of the ZHSHSP III, 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 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 ZIHHTLP and other implementing partners to incorporate inputs from the review workshop into advanced drafts and the final version of the M&E plan.

1.7. Target Audiences

The target audiences for this M&E plan include the following:

- Zanzibar Integrated TB and Leprosy Programme
- Zanzibar Aids Commission (ZAC)
- Government officials responsible for planning and implementation of the HIV prevention programme
- Development partners
- Other key stakeholders from NGOs and academic institutions
- Healthcare providers
- Other organisations responsible for planning and implementation of HIV prevention and treatment services

1.8. Organisation of the M&E Plan

The M&E plan is organised into eight chapters. After this introductory chapter, Chapter 2 presents the goal and objectives of the M&E plan. Chapter 3 elaborates on the M&E framework, including a presentation of the results pathway and performance indicators. Chapter 4 reviews the health sector M&E system capacity and identifies activities required to strengthen the system; Chapter 5 describes the health sector data collection strategy, including data management and data quality assurance processes. Chapter 6 presents the roles and responsibilities of different stakeholders for implementing the M&E plan. Chapter 7 focuses on data dissemination and use activities; and the final chapter outlines strategies for monitoring and evaluating the implementation of the M&E plan.

2. GOAL AND OBJECTIVES OF THE M&E PLAN

2.1. Introduction

The Zanzibar Health Sector HIV and AIDS Monitoring and Evaluation (M&E) Plan is designed to provide a mechanism for measuring Zanzibar's national health sector response to the HIV/AIDS epidemic based on the ZNSP III.

The overall vision of the M&E plan is to develop a sustainable M&E system that provides the most efficient, high-quality, standard, realistic, appropriate, and timely information, and promotes data sharing and data use for decision making. The mission of the M&E plan is to effectively lead and coordinate the M&E efforts of all stakeholders in the health sector response to the HIV/AIDS epidemic by providing standards and guidelines, and communicating and advocating the key issues of the response to stakeholders.

A comprehensive and efficient M&E plan is critical for any HIV/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 the more efficient use of data and resources by using standard indicators and data recording methodologies that can be compared over time and between different geographical areas.

2.2. Goals and Objectives of the M&E Plan

2.2.1. Purpose

The purpose of the M&E plan is to guide a coordinated, systematic, and efficient collection, collation, analysis, interpretation, and dissemination of information for HIV/AIDS programmes.

2.2.2. Goal

The goal of the M&E plan is to ensure collection and reporting of all Zanzibar national- and subnational-level health-related HIV/AIDS indicators. The M&E plan will be used to measure progress made in Zanzibar's health sector response to HIV/AIDS and enhance informed decision making and policy for health sector HIV/AIDS programmes.

2.2.3. Specific Objectives

The specific objectives of the M&E plan are as follows:

a. Describe a functional M&E system for the ZHSHSP III
b. Strengthen the capacity of ZIHHTLP and implementing partners to collect, analyse, store, and use data in planning and decision making
c. Track the implementation of the ZHSHSP III activities and establish whether objectives have been achieved
d. Improve the availability and use of routine HIV/AIDS data in decision-making processes
e. Strengthen partnerships and coordination for M&E at national and subnational levels
f. Enable timely and quality reporting to the government, partners, funders, and other stakeholders

3. THE HEALTH SECTOR HIV AND AIDS M&E FRAMEWORK

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

3.1. M&E Results Pathway

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

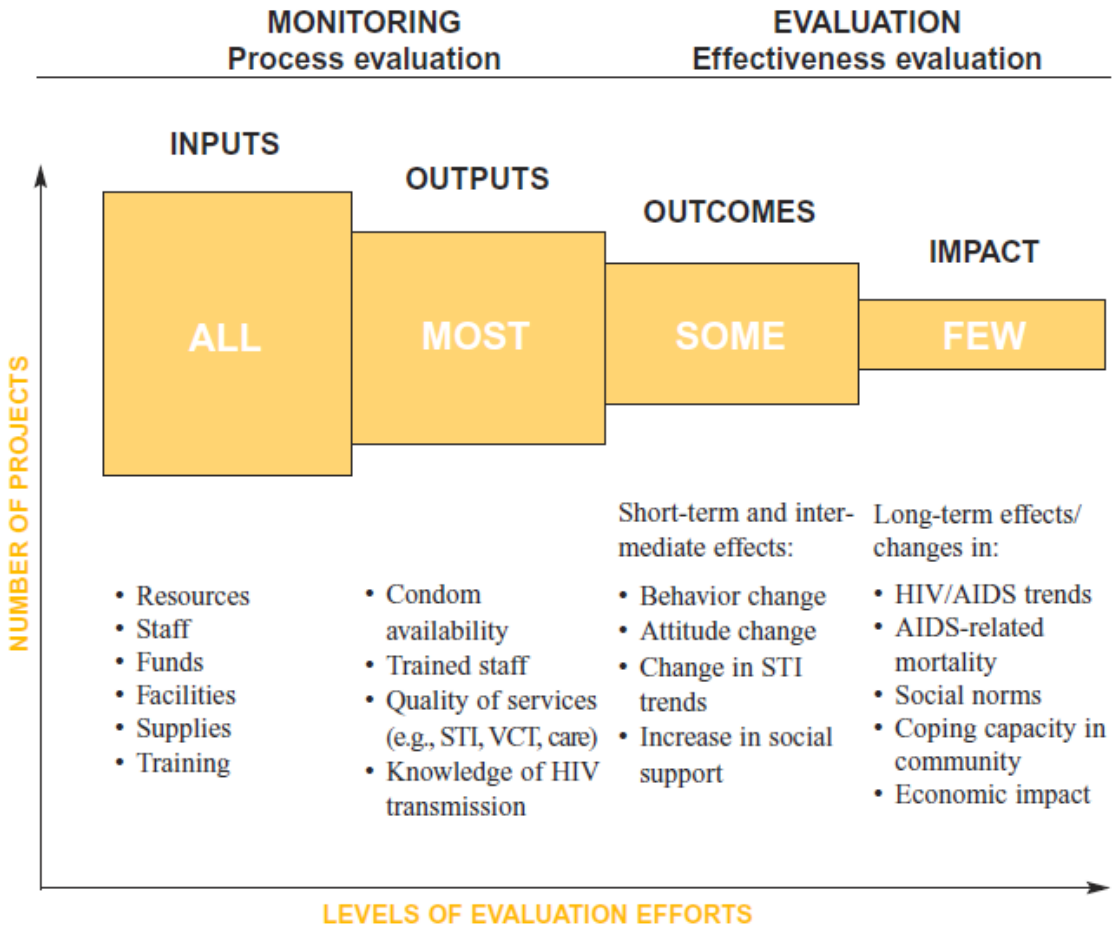
Outcomes are changes in behaviour or skills, especially safer HIV prevention practices and increased ability to cope with HIV and AIDS.

Impacts relate to the long-term programme results; for example, reduced new HIV infections or improved well-being of people living with HIV.

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. M&E that focuses on inputs, the process of their transformation, and outputs is also referred to as “process monitoring,” in contrast to outcomes or effectiveness and impact evaluation. Effectiveness or outcomes and impact evaluations 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 outcomes evaluation or assessment seeks to determine whether, and by how much, programme activities are achieving their intended effects within the target population. Impact evaluation seeks to determine the magnitude

of change that can reliably be attributed to a programme intervention. Figure 4 depicts the M&E results pathway.

Figure 4. Monitoring and evaluation results pathway



Adapted from The Joint United Nations Program on HIV/ 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 normally are collected by all programme implementers. Many implementing partners collect some process data, but far fewer assess outcomes. Even fewer implementing partners and studies normally are required to assess impact (UNAIDS, 2002).

3.2. ZHSHSP III M&E Framework

Table 1 below presents the ZIHHTLP results framework with an overall description of its goals, thematic areas, impacts, and outcome results. The interventions are organised into four thematic areas, each with a range of intervention areas. Each intervention area has several impact and outcome results.

Table 1. Summary of ZHSHSP III results framework

Goal • To prevent the spread of new HIV infections amongst general and key populations • To reduce morbidity and mortality related to HIV/AIDS			
Thematic area 1: Prevention of HIV infection	**Thematic area 2: Care, treatment, and support**	**Thematic area 3: Crosscutting interventions**	**Thematic area 4: Health systems strengthening and support**
Impact 1: Mother-to-child HIV transmission rates reduced to less than 5% by 2022	**Impact 2:** Reduced HIV-related deaths	**Outcome 3.1:** Increased use of quality HTS to the general population, KPs, youth, and adolescents	**Outcome 4.1:** Strengthened programme management, coordination, and implementation of the ZHSHSP III
Outcome1.1: Increased use of STI/RTI services among key and general populations by 30%	**Outcome 2.1:** Increased access to comprehensive TB/HIV collaborative activities by PLHIV	**Outcome 3.2:** Quality laboratory services are provided at all levels	**Outcome 4.2:** HIV/AIDS medicines and related commodities are continuously available at all service delivery points
Outcome 1.2: Reduced risky behaviours among KPs	**Outcome 2.2:** Increased use of quality comprehensive CBHC services by PLHIV	**Outcome 3.3:** Strengthened programme management, coordination, and implementation of the ZHSHSP III	**Outcome 4.3:** Strengthened use of quality HIV/AIDS data for informed decision making at all levels
Outcome 1.3: Increased service use among KPs		**Outcome 3.4:** HIV/AIDS medicines and related commodities are continuously available at all service delivery points	
Outcome 1.4: Increased use of HIV/AIDS, sexual and reproductive health (SRH), viral hepatitis, and TB services by young people		**Outcome 3.5:** Strengthened use of quality HIV/AIDS data for informed decision at all levels	

Outcome 1.5: 100 percent of health sector workplace HIV/AIDS and HBV and HCV interventions institutionalised at the central, intermediate, and health facility levels			
Outcome 1.6: Health sector workplace HIV/AIDS and HBV and HCV interventions institutionalised at the central, intermediate, and health facility levels			

3.3. ZHSHSP 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. Analysing, 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 ZHSHSP III development process and have been refined in this M&E plan. The gathering of baseline data and setting of 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. ZHSHSP 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 in quantity, quality, and timeliness. Unlike performance objectives, an indicator does not specify a level of achievement.

The identification of indicators for the ZHSHSP 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 (2010), 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 well as 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 ZHSHSP III M&E plan has 70 indicators. The number of indicators by thematic areas (TAs) is as follows: TA 1 (32), TA 2 (15), TA 3 (8), and TA 4 (15). Appendix 1 provides a summary of ZHSP III indicators by level in the M&E results pathway (impact, outcome, and output) under each TA. A comprehensive indicator matrix, with indicator definitions, is included in Appendix 2. The indicator matrix is intended to facilitate the tracking of progress towards impact and outcomes, and realisation of outputs. The indicators matrix provides the following information:

- TA 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 (for example, 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: this information defines existing initiatives for collecting 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, Tanzania Health Indicators Survey, etc.)
- Frequency of data collection
- Baseline level of each indicator (where available) and targeted level of the indicator by 2022 (where defined)
- Stakeholders responsible for collecting or ensuring access to data for measuring each indicator

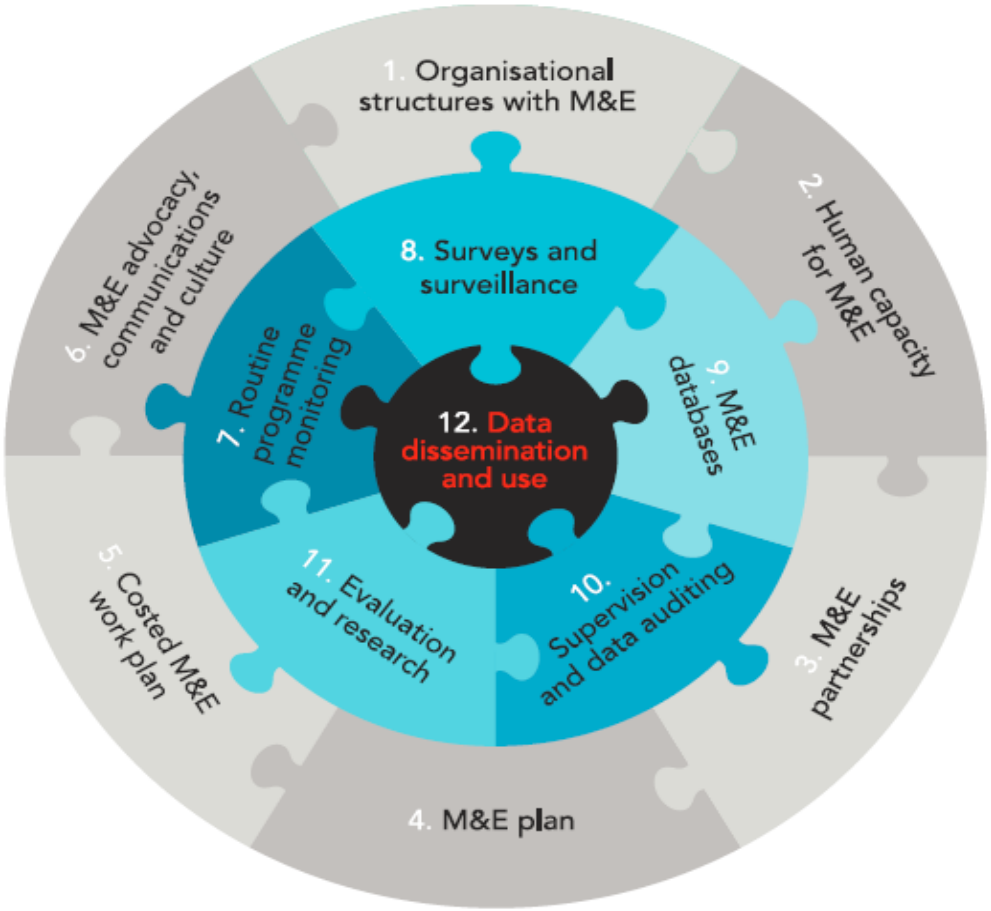
4. THE HEALTH SECTOR M&E SYSTEM CAPACITY

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; an M&E plan is but one of these essential components. The 12 components are (1) organisational structure; (2) human capacity; (3) partnerships and coordination; (4) M&E plan; (5) a costed M&E work plan; (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 data 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 through 11). The third 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 5 presents the 12 components framework.

Figure 5: Organizing 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, Switzerland: 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—to support tracking of programme 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. Health Sector M&E System Strengthening Activities

In 2015, ZIHHTLP assessed its M&E system using the 12 components framework. This assessment provided specific recommendations on activities for strengthening the ZIHHTLP M&E system. This section presents recommended activities for selected components that will be implemented during the term of the ZHSHSP III. These activities have been updated to reflect current needs. Appendix 3 provides a detailed plan to implement the action points. Activities related to data collection, management, and dissemination and use are discussed in later chapters.

1. *Organisational structure for M&E*
    - Review organisational roles and functions, including a well-defined organisational structure; written mandates for planning, coordinating, and managing the M&E system; and well-defined M&E roles and responsibilities for key individuals and organisations at all levels
    - Review job descriptions for M&E staff with defined career paths in M&E
    - Ensure coordination among all partners with M&E responsibilities

2. *Human capacity*
    - Conduct a capacity assessment and develop a costed operational plan for implementation of a capacity-building plan at the national, regional, and local levels
    - Define a set of technical and analytical skills and competencies as requirements when recruiting people to fill M&E positions, including adequate knowledge and educational qualifications
    - Provide pre-service and in-service training at the Zanzibar national and district levels in the areas of epidemiology, surveillance, programmatic M&E, information system operation, data entry and validation, data storage, and data transfer, as identified in the capacity assessment
    - Develop additional capacity for M&E at the district level; the district health management team (DHMT) should be trained on the importance of M&E, and additional personnel trained to provide back-up to the district data managers (DDM) when and if required to ensure timely reporting
    - Provide technical assistance to support the capacity building of Zanzibar national surveillance and M&E staff as required (e.g., to support surveillance data analysis)

3. *Partnerships*

The Zanzibar Health Sector HIV/AIDS M&E technical working group (TWG) is required to harmonise and strengthen the M&E activities of all partners involved in the health sector HIV/AIDS response. Some of the coordination activities to be included in the terms of reference for TWG are as follows:

- Harmonise programmes, interventions, and catchment areas across organisations
- Harmonise data collection tools, indicators, and reports across organisations
- Develop a mutual understanding of data flow so that all organisations understand where data resides and how to access and use these data
- Identify M&E capacity needs and provide or organise training as required

- Lead development and oversight of a Zanzibar Health Sector HIV research and evaluation agenda
- Provide leadership and advocacy for M&E among policymakers, programme managers, programme staff, and other stakeholders—e.g., ensure that M&E is explicitly referenced in Zanzibar's national health sector HIV policies and plans; and that M&E champions are identified and actively involved in endorsing M&E activities, and support data sharing and use

4. *Routine programme monitoring*
   - Ensure the integration of all HIV indicators into the District Health Information System-Version 2 (DHIS 2)
   - Roll out the CTC3 database to allow aggregation of all patient level data from CTC2 databases. This approach will improve generation of care and treatment reports
   - Review KP data collection tools and develop an accompanying database
   - Review M&E data collection tools to ensure their suitability for all programme strategies, such as "Treatment as Prevention" and elimination of mother-to-child transmission (MTCT)

5. *M&E advocacy, communications, and culture*
   - Update ZIHHTLP's website
   - Conduct annual meetings to review progress of the M&E plan

6. *National and subnational databases*
   - Ensure the database in use responds to the decision-making and reporting needs of different stakeholders
   - Support linkages amongst relevant databases to ensure data consistency and avoid duplication of efforts
   - Conduct comprehensive training on the DHIS 2 and CTC3 databases for all users, including in analysis and the use of data for decision making

7. *Surveys and surveillance*
   - Ensure that protocols for all surveys and surveillance are based on Zanzibar national and international standards
   - Conduct an inventory of HIV health sector-related surveys in Zanzibar
   - Develop a specific schedule to conduct surveys and surveillance linked to stakeholders' needs, including identification of resources for implementation and training
   - Seek external technical support and training as required

8. *Supportive supervision and data auditing*
   - Develop Zanzibar national data quality guidelines and an operational plan and budget in collaboration with key stakeholders
   - Conduct routine supervision visits and data quality assessments (DQAs), and provide feedback to local staff
   - Conduct systematic and harmonised data quality audits, and address gaps identified through training and mentoring

9. *HIV evaluation and research*

ZIHHTLP requires a national research and evaluation agenda, which includes the following:

- An inventory of completed and ongoing Zanzibar-specific HIV evaluation and research studies
- A prioritised Zanzibar national HIV evaluation and research agenda for each programme area

- A plan to evaluate the implementation and effectiveness of the ZHSHSP III at the end of five years (including timing of relevant surveys and surveillance to inform this evaluation)
- Ethical approval procedures and standards
- Guidance on evaluation and research standards and appropriate methods, including evaluability assessments (planning for evaluation)
- Tailoring and packaging of research and evaluation findings for public consumption
- Guidance on publication of research findings
- Schedule of conferences or forums for dissemination and discussion of HIV research and evaluation findings

10. Information dissemination and use

At the heart of the Zanzibar health sector HIV M&E system is the use of data for programme improvement. It involves a strategic and operational plan for information use that includes opportunities for data analysis and interpretation. The activities required are as follows:

- Integrate all HIV indicators in DHIS 2 database
- Develop an information use calendar to guide the timetable for major data recording efforts and reporting and dissemination requirements
- Develop a standard format for reporting and data tabulation
- Conduct training on report and manuscript writing
- Strengthen skills in data triangulation to use existing data optimally
- Strengthen skills in packaging of M&E data for different audiences
- Strengthen capacity in use of valuation and research findings—for example, in planning documents

5. HEALTH SECTOR M&E DATA COLLECTION STRATEGY

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 ZHSHSP 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 nonroutine data sources (for evaluation data). Monitoring data will be collected on inputs and outputs, using standard programme-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.

5.2. Routine Data Sources

Routine data sources will facilitate tracking of activities as they are implemented. Routine monitoring data will be collected at health facilities by healthcare providers, with the support of implementing partners using standard tools. In addition, community data will be collected by community workers and peers. Table 3 summarises different standard tools for collecting and monitoring data, and the responsibility for and frequency of their reporting.

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

	Data collection standard tools	Responsible person to complete	Reporting frequency
1	HIV care and treatment	Healthcare providers	Quarterly
2	HIV testing and counselling	Healthcare providers	Monthly
3	HIV home-based care	Home-based care providers and supervisors	Monthly
4	Sexually transmitted infections	Healthcare providers	Monthly
5	Reproductive and child health	Healthcare providers	Monthly
7	HIV laboratory	Healthcare providers	Monthly
8	Key populations (including MAT)	Community providers/healthcare providers	Monthly
9	Post-exposure prophylaxis	Healthcare providers	Monthly

Routine data sources are as follows:

Care and treatment reports: The care and treatment programme unit within ZIHHTLP produces quarterly programme data that will be used to respond to some of the indicators in the M&E plan. The data will include cohort analysis of clients on ART. These data will enable reporting on clients that are on treatment 12 months after its initiation. Even though the reports are prepared on a routine basis, ZIHHTLP will conduct the analysis quarterly and periodically provide results required for purposes of the M&E plan.

Health Management Information System (HMIS) reports: The HMIS is the main source of health facility (public and private) service delivery data for the health sector. It generates routine

integrated reports and provides the bulk of data for monitoring the ZHSHSP III. The DHIS 2 is now the primary national health service data electronic reporting platform. Data collected on health facility- and community-based services are compiled at the facility level and entered into the DHIS 2 on a monthly basis. The DHIS 2 allows the aggregation of national and subnational level data. It will be the primary source of data for the ZHSHSP III M&E plan. All data submitted through this system will be verified and approved by ZIHHTLP before publication.

5.3. Nonroutine Data Sources (Evaluation Data)

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

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

Tanzania Demographic and Health Survey (TDHS): The TDHS is conducted every five years as part of worldwide Demographic Health Surveys (DHS) Program 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 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 (EPP) 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.

ANC surveillance: ANC surveillance is conducted every two years. A plan is in place to compare PMTCT and ANC data to evaluate the potential of switching from ANC surveys to the use of routine programme data for tracking ANC prevalence over time.

KP surveillance: There have been three rounds of integrated bio-behavioural surveillance studies amongst PWID and two rounds of similar studies amongst female sex workers (FSWs) and MSM in Unguja. Additional rounds will be conducted approximately every five years in coordination with strategic plans to measure the progress of activities targeting these KPs.

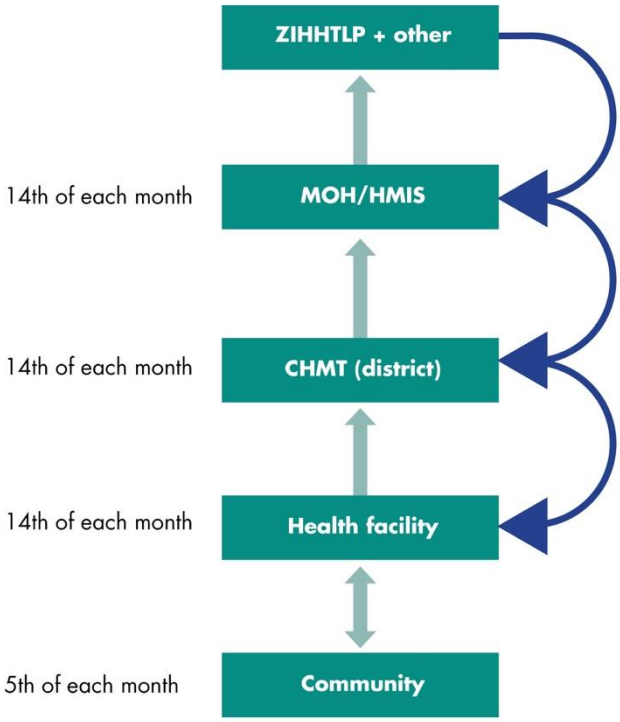
Special studies: Other special studies will be commissioned as deemed necessary to respond to specific indicators not adequately addressed by the other surveys.

5.4. Reporting and Data Flow

The primary source of routine data for the health sector HIV response is the health facility. Additional services are provided at the community level, such as HBC and community outreach. Patient- and client-level data collected at the health facility/community are used to generate

monthly and quarterly summary reports, which are submitted to the council health management teams' (CHMT's) office. The district then aggregates the summary reports from the various health facilities through the DHIS 2. The aggregated data entered at the district level are accessible to stakeholders at all levels, from the regions to the national level, through the DHIS 2. Figure 6 illustrates the reporting timelines, data flow, and feedback process.

Figure 6: Reporting timelines, data flow, and feedback process



5.5. Data Management

Data management includes procedures and standards for handling data, ensuring data quality, and data storage during programme implementation. The data management process includes data sourcing, collection, collation and aggregation, analysis, reporting, and use. Standard procedures for data management will be included in the *Zanzibar Data Quality Audit/Review Guideline* that will be developed during the period of the current health sector strategic plan.

5.5.1. Data Recording and Checking

Both paper-based and electronic systems will be used at the facility level to collect patient- and client-level data during service delivery. A data entry supervisor will perform data checks daily, report any errors, and promptly make corrections with the support of the facility person in-charge. The facility person in-charge will compile monthly reports and share them with the facility management team before submission to the CHMTs. At the district level, reports aggregated from all health facilities will be reviewed by the CHMTs before entry into the DHIS 2. Aggregated data will be entered into the DHIS 2 monthly and reports produced quarterly.

5.5.2. Data Retention

A data retention protocol allows programme implementers to store data for a certain period as back-up in case of any loss and for data quality audit purposes, accountability to the government or

donors, or use in further analysis. The existing MOH data recording and retention policy for government data will be used to document, maintain, and retain HIV/AIDS data at all levels.

5.5.3. Data Storage and Confidentiality

Each data reporting level will ensure appropriate storage, maintenance, and security for archiving their electronic and paper-based records. Confidentiality of patient-level data will be ensured through a password-protected electronic archival and back-up system for electronic data, and storage in a locked area for paper-based data.

5.6. Data Quality Assurance

Crucial to the successful performance of the M&E system is the quality of the data it generates. Currently, ZIHHTLP does not have a Data Quality Audit/Review guideline. However, data verification is done annually 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. A Data Quality Audit/Guideline will be developed during the term of the current strategic plan.

6. STAKEHOLDER ROLES AND RESPONSIBILITIES

Implementation of the health sector HIV/AIDS M&E plan is under the management and supervision of the Directorate of Preventive Services in the MOH through the ZIHHTLP. However, the involvement of other stakeholders from both public and private sectors is critical to successfully implementing the M&E plan.

M&E functions will be implemented at three main levels: national, district, and facility/community. The ZIHHTLP will be directly responsible for implementation of the plan at the national level. The CHMTs will be responsible for implementation at the regional and council/district levels. The roles and responsibilities of different stakeholders in implementing the M&E plan are specified below.

6.1. Ministry of Health (MOH)

- Provides overall technical leadership guidance, advice, and M&E on implementation of the ZHSHSP III
- Facilitates effective development, recruitment, and deployment of skilled health workers at health facilities
- Ensures availability of a harmonised and integrated HMIS
- Ensures adherence to guidelines, standards, and regulations
- Promotes and oversees operational research on health sector HIV prevention, care and treatment, and support services
- Ensures timely submission of reports as well as proper storage and documentation of records
- Provides relevant feedback and dissemination of data and strategic information to all stakeholders involved in health sector HIV/and AIDS interventions
- Ensures integration of data quality activities into routine supervision at all levels
- Conducts a DQA at least once a year to assess the status of the data collected and reported at different levels

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

- Coordinates and oversees the implementation and monitoring and evaluation of health sector HIV prevention, care, treatment, and support services
- Designs and develops an M&E framework and ensures the 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 strengthens and promotes effective and efficient data collection, analysis, and use of HIV/AIDS information at all levels
- Organises and coordinates health sector HIV prevention, care, and treatment, and supports operational research in collaboration with research institutions
- Leads the implementation of operational research on health sector HIV prevention, care, and treatment, and support services

6.3. Research and Academic Institutions

- Plan and conduct research studies and disseminate findings to key stakeholders in the country as part of improving the health sector HIV prevention, care, treatment, and support services
- Jointly coordinate the synthesis of new knowledge from research and support the MOH/ZIHHTLP in translating research findings into policy and practice
- Support the MOH/ZIHHTLP scale-up of proven interventions and best practices through the development of appropriate tools and methodologies

- Establish, maintain, use, or make available research and surveillance platforms to the MOH/ZIHHTLP for the evaluation of national HIV/AIDS interventions

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

- Facilitate effective recruitment and deployment of skilled health workers at health facilities in collaboration with the MOH and the President's Office-Public Services Management (PO-PSM); collaborate with various stakeholders for the planning and implementation of health sector HIV prevention, care, treatment, and support services
- In collaboration with MOH, design and develop planning guidelines to facilitate the implementation of health sector HIV prevention, care, treatment, and support services, such as the Medium-Term Expenditure Framework (MTEF)

6.5. Council Health Management Teams (CHMTs)

- Plan and incorporate ZHSHSP III activities into the comprehensive council health plan
- Strengthen the HMIS by compiling, disseminating, and using health sector HIV prevention, care, treatment, and support data for service improvement
- Ensure that reports are received from all facilities in all programme areas and verify reported numbers before aggregating to produce a district report
- Stamp all reports received to show when they were received and ensure that the data are entered into the appropriate database
- Aggregate facility-level data (paper or electronic) to produce district reports (monthly and quarterly) according to the agreed-upon timeline. The reports must be signed by a designated member of the CHMTs
- Provide relevant feedback to health facilities on the findings of DQAs and ways to improve in weak areas
- Ensure that training and mentorship for service providers are routinely conducted
- Ensure that facilities have cabinets for storage of data collection and reporting tools, including patient files
- Develop an annual data quality plan for the district
- Enforce the implementation of data quality activities in health facilities
- Ensure that healthcare providers involved in data collection and reporting are trained on data quality
- Integrate DQAs into routine supportive supervision
- Ensure that DQAs are conducted at least twice per year for each facility

6.6. Health Facilities

- Ensure the collection, analysis, use, and dissemination of data for improved service delivery
- Ensure availability of data collection and reporting tools
- Ensure completeness of all variables in the data collection and reporting tools
- Verify the accuracy and reliability of the recorded and reported data
- Ensure the availability of all standard operating procedures (SOPs) and guidelines on how to fill out data collection, as well as reporting tools, and that they are used accordingly
- Produce facility (monthly and quarterly) reports and ensure timely submission to the district
- Ensure that analysis and summarisation of data and reports are done properly
- Ensure the availability of cabinets for storage of files, reports, and all data related to HIV/AIDS, as well as a proper filing system that uses appropriate registration numbers to simplify storage and retrieval of documents

- Ensure that staff involved in data recording and reporting are trained on the data quality guidelines
- Implement data quality activities in all sections of the health facility where data are being collected and reported

6.7. Communities

- Collect data on community-based HIV services, such as HBC and KPs
- Maintain records of all services provided using standard reporting tools
- Submit activity reports regularly (monthly and quarterly) to the nearest health facility, as guided

6.8. Implementing Partners

- Support the MOH in formulating national guidelines and SOPs related to M&E activities
- Collaborate with the MOH in ensuring sustainable availability of recording and reporting tools
- Collaborate with the MOH in conducting supportive supervision visits to the CHMTs and facilities
- Provide support to the councils being covered to conduct DQAs and improve systems for data collection and reporting
- Collaborate with district teams in training, supportive supervision, and mentoring of healthcare workers on data quality activities
- Support the CHMTs to ensure proper verification and completeness of the data recorded at the facility level
- Support the CHMTs in submitting all reports in a timely manner
- Assist in capacity building for data analysis, use, and dissemination at the regional, district, facility, and community levels

7. DATA DISSEMINATION AND USE

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

7.1. Barriers to Data Use and Potential Solutions

ZIHHTLP conducted a data demand and use assessment in 2015 with MEASURE Evaluation's technical assistance. The assessment included (1) group assessments of the data demand and use (DDU) component of the M&E system, (2) key informant interviews, (3) a self-assessment questionnaire, and (4) health facility site visits. The findings were compared across data collection approaches to identify prevalent themes and potential interventions to strengthen the demand for and use of health data.

Group assessments indicated a need to develop a data use strategy in addition to existing M&E plans. Recommendations included creating guidance on data analysis and updating existing guidelines for supportive supervision to include data use. Additional forums to review data and increase understanding of indicators were needed to promote a data use culture. More information products that facilitated the use of data and capacity building were additional recommended activities.

Key informants identified the need for guidance on how to conduct a formal review of data, along with recommendations for the analysis and interpretation of specific key indicators. The number of qualified staff, staff turnover, and staff reallocation were identified as contributing to a limited capability for health facilities to both capture and promote the use of data. Any data use promotion efforts should consider expanding staff with the capabilities to both supply the HMIS with quality data and adequately prepare for the effective review of data for programme-related decision making. The HMIS unit at the MOH should also consider producing routine, tailored feedback for the districts in preparation for key decision-making moments, such as quarterly district health management team (DHMT) meetings. Additional capacity building in the form of training or supportive supervision should prepare staff to present information at these key decision-making events.

The self-assessment questionnaire identified the need for additional training in the interpretation of multiple but related data sources and relating conclusions to ongoing service delivery activities. Particular focus should be on the zones/districts and lower levels of the health system. There is also a need to involve senior managers and other key data users in regular reviews of data.

Site visits confirmed the lack of guidance for managing data quality, data aggregation or analysis, and developing information products. There was no evidence of service performance analysis feedback from other levels of the health system or reports being shared among decision makers at the health facility level. Staff could not produce a training schedule, and public display of data visuals was limited. Some health facilities were able to show a map of their catchment area, population estimates by target group, feedback reports on data quality, guidelines for reporting requirements, and a recent supportive supervision trip report.

This DDU assessment recommended several interventions, some of which will be addressed as part of the M&E system strengthening during the current strategic plan. These interventions include the following:

1. Developing a specific data use strategy/plan

2. Creating guidelines for data analysis, presentation, and use
3. Conducting an information needs assessment to inform development of information products
4. Assigning M&E staff to senior management meetings
5. Expanding staff with responsibility to promote data use as part of their job description
6. Updating supervision guidelines to include data use
7. Assessing HMIS staff and resource needs to supply quality data

7.2. Data Analysis

Since 2010, the reporting of HIV/AIDS programme has been integrated into the DHIS 2—the national electronic platform for health data reporting. This integration is expected to improve access to data and promote data analysis from the health facility to the district and national levels. CHMTs that can now input data directly into the DHIS 2 will conduct monthly and quarterly analysis of their data. The CHMTs will organise quarterly data analysis and validation meetings, during which they will look at overall reporting rates, report submission timeliness, data quality, and performance against key indicators. At the national level, ZIHHTLP will organise annual data review workshops that will draw together subnational health management teams and implementing partners to review their data and develop reports on the status of the health sector HIV/AIDS response.

Data analysis activities will be organised to coincide with key decision-making moments at different levels. These key decision-making moments include the following:

- HIV/AIDS M&E quarterly meetings (national level)
- ZIHHTLP strategic review meetings (national level)
- ZIHHTLP quarterly M&E subcommittee meetings (national level)
- ZIHHTLP biannual data review meetings (national level)
- CHMTs' and implementing partners' quarterly meetings (regional/council level)
- Weekly performance review meetings (health facility level)

Based on information needs, the health sector HIV M&E system will produce the following periodic information products:

Quarterly Programme Monitoring Report: ZIHHTLP will produce a Quarterly Programme Monitoring Report, which will provide information on coverage statistics per HIV programme area and will be based on the information provided by all stakeholders in the Quarterly Programme Monitoring Form. The production of this report will also ensure that ZIHHTLP meets requirements for minimum reporting standards, as well as reporting to its donors.

Annual HIV and AIDS M&E Report: The purpose of this report is to provide a comprehensive overview of ZIHHTLP's response to HIV/AIDS over a 12-month period. It will be done by reporting on all indicators contained in the ZHSHSP III and included in the health sector HIV/AIDS M&E plan, and providing key observations and guidance for future implementation.

Annual HIV and AIDS M&E Report: This report will be disseminated to the stakeholders at an annual HIV/AIDS M&E dissemination seminar to which all stakeholders from the public and private sectors and civil society organisations (CSOs) will be invited. In addition to the Zanzibar national dissemination seminar for M&E results, zonal dissemination seminars will be organised to ensure distribution of information at the zonal level.

Regular information system updates: All M&E reports produced by ZIHHTLP (the annual HIV/AIDS M&E report, quarterly programme monitoring report, and international and regional reporting requirements) will be made available on ZIHHTLP's website for electronic download (in PDF or

Microsoft Word formats). This availability will ensure that stakeholders can access up-to-date information.

Ad hoc information needs: Some stakeholders may have specific information needs at some stage which are not covered by the reports or updates listed above. Although ZIHHTLP encourages the use of existing information products, it will assist if there are any specific or ad hoc information needs not covered in one of the information products listed above. Such a request should be made in writing to ZIHHTLP.

7.3. Data Dissemination and Use

ZIHHTLP will organise M&E results dissemination meetings at the national, regional, and district levels with implementing partners, communities, and health facilities on a quarterly and biannual basis. The dissemination of the M&E results will serve the following purposes:

- Provide feedback to various implementers on efforts being made and achievements
- Share and use the data and information for better targeting and planning of HIV/AIDS interventions at the district level
- Provide feedback on efforts and resource use in the health sector HIV/AIDS response, and articulate lessons learned, gaps, and challenges faced at the subnational and national levels
- Enhance networking and harmonisation of data use efforts

The types of feedback approaches to be used to promote data use will include the following:

- Performance comparisons amongst districts and facilities
- Recommendations on how to improve performance
- Dissemination of exemplary best practices
- Recognition of good performance
- Focusing or helping to find resources
- Directing feedback to those with authority to make decisions
- Linking routine to nonroutine data for a comprehensive view of performance

Table 4 summarises the dissemination plan for different information products arising from the M&E plan.

Table 4. Dissemination plan for informational products from the ZHSHSP III M&E plan

Product	Frequency/ timeline	Responsible	Contents	Audience	Dissemination format	Evaluation/ criteria for success
Programme monitoring report	Quarterly	ZIHHTLP	Progress on programme monitoring	MOH	Summary, reports, executive summaries	Feedback received
				ZAC	Summary, reports, executive summaries	Feedback received
				Implementing partners	Summary, reports, presentations, dissemination workshops	Number of workshops conducted, number of participants, range of stakeholders represented, participant feedback
				Districts and facilities	Summary, reports, presentations, dissemination workshops	Number of workshops conducted, number of participants, range of stakeholders represented, participant feedback
ZIHHTLP annual report	Annual	ZIHHTLP	Progress on programme monitoring indicators	MOH	Summary, reports, executive summaries	
				Stakeholders	Summary, reports, executive summaries, presentations, dissemination workshops	
HIV/AIDS surveillance reports		ZIHHTLP	Survey results	Donors/ funders	Full reports, ZIHHTLP website	
				Politicians and government officials	Policy briefs, executive summaries, ZIHHTLP website	Number of policy briefs issued, feedback received
				Stakeholders	Full reports, presentations, dissemination workshops	Records on information used in planning, monitoring, advocacy, policy; decisions made

Product	Frequency/ timeline	Responsible	Contents	Audience	Dissemination format	Evaluation/ criteria for success
District-level reports	Quarterly	CHMTs	Service provision data update	District implementing partners, health workers	Full reports, presentation	Records on information used in planning, monitoring, advocacy, policy; decisions made

7.4. Capacity Building

In addition to tailored feedback and analysis, continuous capacity building will be conducted to enable key decision makers from the health facility to the national level to independently synthesize, analyse, and interpret data for programming. The large number of staff in need of capacity building, as well as staff turnover, requires a continuous capacity-building approach. This capacity building will include support for district-level review forums, HMIS/DDU trainings, and supportive supervision linked to key decision-making moments.

8. MONITORING AND EVALUATION OF THE HEALTH SECTOR HIV M&E PLAN IMPLEMENTATION

The ZHSHSP III M&E plan identifies a comprehensive list of indicators (Appendix 2) against which programme performance will be assessed. These indicators will be tracked regularly to ensure that programme targets are being met and implementation of the strategic plan is on course.

8.1. Annual M&E Operational Plans

To ensure effective implementation of the M&E plan, ZIHHTLP will develop **annual M&E operational plans**, with active stakeholder involvement, based on M&E system strengthening and other data quality and use interventions. The operational plans will be more detailed so as to provide the expected number of participants in different activities, timelines, and associated costs. The implementation status of the operational plans will be reviewed at the end of every year.

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

8.2. Mid- and End-Term Evaluations

Two evaluations will also be conducted to determine the success of the ZHSHSP III. ZIHHTLP will organise a joint mid-term review (MTR) before the end of the third year of the ZHSHSP 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.

ZIHHTLP will facilitate an independent external evaluation in the final year of the ZHSHSP III (end-term evaluation). This evaluation will focus on the achievements (impacts and outcomes) of the ZHSHSP III. The end-term evaluation will also provide contextual information for the subsequent planning period. Both evaluations will be conducted with significant involvement by stakeholders. The costs for the evaluations will be included in the health sector budget.

8.3. Assumptions for the Successful Implementation of the ZHSHSP III M&E Plan

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

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

Indicator reference number	Indicator	Level
THEMATIC AREA 1: PREVENTION OF HIV INFECTION		
Intervention area 1.1: Prevention of mother-to-child transmission of HIV		
Impact 1: Mother-to-child HIV transmission rates reduced to less than 5% by 2022		
1.1	Percentage of pregnant women with known HIV status	Outcome
1.2	Percentage of pregnant women living with HIV who received antiretroviral therapy (ART) to reduce the risk of mother-to-child transmission of HIV	Output
1.3	Percentage of pregnant women attending ANC whose male partner was tested for HIV during pregnancy	Outcome
1.4	Percentage of pregnant women who were tested for HBV	Output
1.5	Percentage of pregnant women who were tested for syphilis	Output
1.6	Percentage of HIV-exposed infants who started on initiated ARV prophylaxis	Outcome
1.7	Percentage of HIV-exposed infants receiving virological test for HIV within 12 months of birth	Output
1.8	Percentage of HIV-exposed infants receiving test for HIV 6 weeks after cessation of breastfeeding	Outcome
1.9	Percentage of HIV infections among HIV-exposed infants born in the past 12 months	Outcome/ Impact
1.10	Percentage of HIV-exposed infants started on CTX prophylaxis within 2 months of birth	Output
1.11	Percentage of identified HIV-positive infants who started on ART by 12 months of age	Outcome
Intervention area 1.2: Prevention and control of sexually transmitted and reproductive tract infections		
Outcome 1.1: Increased utilization of STI/RTI services amongst key and general population by 30%		
1.12	Number of men and women diagnosed with and treated for a sexually transmitted/reproductive tract infection	Output
1.13	Number of health facilities with capacity to provide STI/RTI aetiological diagnosis	Output
1.14	Proportion of sexual partners traced and treated for STI/RTI at health facilities	Output

Intervention area 1.3: Interventions targeting key populations		
Outcome 1.2: Reduced risky behaviours among key populations		
1.15	Percentage of sex workers reporting the use of condoms with their most recent clients	Outcome
1.16	Percentage of MSM reporting using a condom the last time they had anal sex with a male partner	Outcome
1.17	Percentage of PWID reporting the use of sterile injecting equipment the last time they injected	Outcome
1.18	Percentage of KPs reached with individual or small-group-level HIV prevention interventions designed for the target population	Output
Outcome 1.3: increased service utilisation among key populations		
1.19	Percentage of KPs tested for HIV and received their results in the past 12 months	Outcome
1.20	Percentage of HIV-infected KPs who are HIV infected	Impact
1.21	Proportion of HIV-infected KPs receiving ART	Outcome
1.22	Percentage of people who inject drugs receiving OST	Outcome
1.23	Percentage of PWID receiving OST for 6 months	Outcome
Intervention area 1.4: Interventions for adolescents and youth		
Outcome 1.4: Increased utilization of HIV/AIDS, SRH, viral hepatitis, and TB services by young people		
1.24	Percentage of women and men ages 15–24 with multiple sexual partners in the past 12 months	Outcome
1.25	Percentage of young men and women ages15–24 with comprehensive knowledge of HIV/AIDS	Outcome
1.26	Number of adolescents and youth who receive HIV testing services (HTS) and receive their test results	Output
Intervention area 1.5: Blood safety		
Outcome 1.5: All blood and blood products transfused in Zanzibar are screened for HIV/HBV/HCV/Syphilis as per the approved national guidelines		
1.27	Percentage of transfused blood units that are screened for TTIS according to standard guidelines	Output
1.28	Proportion of blood donors found to be HIV positive linked to HIV care, treatment, and support clinics	Output
1.29	Proportion of blood donors diagnosed with syphilis linked to appropriate treatment services	Output
Intervention area 1.6: Health sector workplace HIV/AIDS/HBV/HCV interventions institutionalised at central, intermediate, and health facilities levels		
1.30	Percentage of healthcare facilities with policy guidance for HIV/AIDS interventions	Output
1.31	Proportion of HCWs tested for HIV	Output
1.32	Proportion of healthcare workers exposed to HIV received PEP service	Output

THEMATIC AREA 2: CARE, TREATMENT AND SUPPORT		
Intervention area 2.1: Care and treatment of adults, adolescents, and children living with HIV/AIDS		
Impact 2: Reduced HIV-related deaths		
2.1	AIDS mortality per 100,000 per year	Impact
2.2	Number and percent of PLHIV who are currently on ART.	Outcome/ Output
2.3	Number of PMTCT sites that are providing comprehensive care and treatment services	Output
2.4	Number of new PLHIV started on ART during reporting period	Output
2.5	Percentage of adults and children known to be on treatment 12 months after initiation of ART (Note: reporting 24 and 36 months is recommended, but optional)	Outcome
2.6	Proportion of people starting ART who were tested for hepatitis B	Output
2.7	Proportion of women living with HIV ages 30–49 who report being screened for cervical cancer using any of the following methods: Visual inspection with acetic acid (VIA), Pap smear or human papillomavirus (HPV) test	Outcome
2.8	Percentage of ART clients with viral load results documented in the medical records and laboratory information system (LIS) within the past 12 months with a suppressed viral load less than 1,000 copies/ml	Outcome
Intervention area 2.2: TB/HIV collaborative activities		
Outcome 2.1: Increased access to comprehensive TB/HIV collaborative activities by PLHIV		
2.9	Percentage of PLHIV screened for TB	Output
2.10	Percentage of PLHIV who started TB treatment in the reporting period	Output
2.11	Number of health facilities providing TB/HIV collaborative activities (Under-One-Roof)	Output
2.12	Number of care and treatment clinics (CTCs) providing IPT services	Output
2.13	Percentage of people newly enrolled on HIV care who are started on TB preventive therapy	Outcome
Intervention area 2.3: Integrated community based healthcare services		
Outcome 2.2: Increased utilisation of quality comprehensive CBHC services by PLHIV		
2.14	Percentage of PLHIV receiving comprehensive HBC services	Output
2.15	Percentage of missed appointment and LTFU clients followed up and linked back to health facility services by community-based HIV and AIDS services providers	Output
THEMATIC AREA 3: CROSSCUTTING INTERVENTIONS		
Intervention area 3.1: Social and behavioural change communication		
3.1	Percentage of people who have more than one sexual partner who used condom at last sexual intercourse	Outcome
3.2	Percentage of people with comprehensive knowledge on HIV transmission and prevention	Outcome
3.3	Percentage of people ages (15–49) expressing accepting attitudes towards PLHIV	Outcome
Intervention area 3.2 HIV testing services		
Outcome 3.1: Increased use of quality HTS to the general population, KPs, youth and adolescents		

3.4	Number and percentage of health facilities providing HTS services	Output
3.5	Number and proportion of people who were tested for HIV and received their results within the past 12 months	Outcome
Intervention area 3.3: HIV laboratory support services		
Outcome 3.2: Quality laboratory services are provided at all levels		
3.6	Number of laboratories engaged in continuous quality improvement (CQI) activities audited and achieved accreditation	Output
3.7	Number of laboratories with capacity to perform HIV viral load testing	Output
3.8	Percentage of testing sites with satisfactory performance in external quality assurance proficiency testing (EQA PT)	Output
THEMATIC AREA 4: HEALTH SYSTEM S STRENGTHENING AND SUPPORT		
Intervention area 4.1: Social and behavioural change communication		
Outcome 4.1: Strengthened programme management, coordination, and implementation of the ZHSHSP III		
4.1	Number of health training institutions integrating HIV knowledge and skills in their training curricula.	Output
4.2	Number of partners coordination meetings conducted by ZIHHTLP per year	Output
4.3	Proportion of required funds mobilised	Output
Intervention area 4.2: Procurement and supply chain management for HIV/AIDS		
Outcome 4.2: HIV/AIDS medicines and related commodities are continuously available at all service delivery points		
4.4	Percentage of tracer HIV/AIDS commodities received	Output
4.5	Percentage of facilities reporting stockout of tracer HIV commodities in the last 3 months of their ordering cycle	Output
4.6	Percentage of tracer commodities orders delivered on time by Central Medical Stores (CMS)	Output
4.7	Percentage of facilities reporting and requesting HIV/AIDS commodities in a timely way	Output
Intervention area 4.3: Monitoring, evaluation, research and learning		
Outcome 4.3: Strengthened use of quality HIV and AIDS data for informed decision making at all levels		
4.8	Percentage of health facilities submitting HIV/AIDS report in a timely way into DHIS 2	Output
4.9	Percentage of health facilities which submitted HIV report into DHIS 2	Output
4.10	Number of HIV surveillances conducted	Output
4.11	Number of HIV operational researches conducted based on national HIV health sector research agenda	Output
4.12	Percentage of health facilities utilising HIV data for planning purposes	Output
4.13	Number of HIV data review meetings conducted at district and facility levels	Output
4.14	Number of HIV information dissemination products produced and disseminated by ZIHHTLP	Output
4.15	Proportion of health facilities with DQA conducted at least every 6 months	Output

APPENDIX 2. COMPREHENSIVE ZHSHSP III INDICATORS MATRIX

No.	Indicator	Indicator definition (numerator & denominator)	Disaggregation	Indicator source	Data source	Frequency	Baseline	Target	Stakeholder
THEMATIC AREA 1: PREVENTION OF HIV INFECTION									
Intervention area 1.1: Prevention of mother-to-child transmission of HIV									
Impact 1: Mother-to-child HIV transmission rates reduced to less than 5% by 2022									
1.1	Percentage of pregnant women with known HIV status	**Numerator:** Number of pregnant women attending antenatal clinics and/or had a facility-based delivery and were tested for HIV during pregnancy, or already knew they were HIV positive **Denominator 1: Population based:** Number of pregnant women expected to be pregnant Denominator 2: Programme based: No of pregnant women who attended ANC or had a facility-based delivery during the reporting period	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 Tested at ANC or maternity By geographical location Age	PEPFAR MER 2.0/WHO/ GAM	DHIS 2	Quarterly and annually	98% (2017)	5 yrs: 100% 2018: 90% 2019: 100% 2020: 100% 2021: 100%	ZIHHTLP, MOH, IRCH, DHMT, ZAC, GF, PEPFAR, and UN agencies

No.	Indicator	Indicator definition (numerator & denominator)	Disaggregation	Indicator source	Data source	Frequency	Baseline	Target	Stakeholder
1.2	Percentage of pregnant women living with HIV who received ART to reduce the risk of mother-to-child transmission 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 mother-to-child transmission of HIV **Denominator:** **Population based:** Estimated number of HIV-positive pregnant women who delivered within the past 12 months **Denominator 2:** **Program based:** Total number of HIV positive pregnant women who delivered within the first 12 months and attend ANC or had facility-based delivery	Already on ART By District Newly on ART	GAM 2018 p. 54	ZIHHTLP quarterly and annual reports	Quarterly and annually	47% (2016) **2.** 87.7% (2017)	5 yrs: 93% 2017: 88%. 2018: 90% 2019: 91% 2020: 93% 2021: 95% **2.** 5 yrs: 95%. 2018: 87% 2019: 89% 2020: 91% 2021: 93%	ZIHHTLP, MOH, IRCH, DHMT, ZAC, GF, PEPFAR, and UN agencies
1.3	Percentage of pregnant women attending ANC whose male partner was tested for HIV during pregnancy	**Numerator:** Number of pregnant women attending antenatal care (ANC) whose male partner was tested in the last 12 months **Denominator:** Number of pregnant women attending ANC	Newly tested HIV positive Tested negative By geographical location	WHO SI Guidelines 2015	DHIS 2	Quarterly and annually	9.7% (2017)	5 yrs: 25% 2018: 10% 2019: 15% 2020: 20% 2021: 25%	ZIHHTLP, MOH, IRCH, ZAC, DHMTs, GF, PEPFAR, and UN agencies
1.4	Percentage of pregnant women who were tested for HBV	**Numerator:** Number of pregnant women attending antenatal clinics who were tested for HBV during pregnancy **Denominator:** Total number of	Newly tested positive Newly tested negative	ZHSHSP III 2017–2022	DHIS 2	Quarterly and annually	0% (2017)	5 yrs: 50% 2018: 10% 2019: 20% 2020: 30% 2021: 40%	ZIHHTLP, MOH, IRCH, DHMTs, ZAC, GF, PEPFAR, and UN agencies, UNFPA, UNICEF

No.	Indicator	Indicator definition (numerator & denominator)	Disaggregation	Indicator source	Data source	Frequency	Baseline	Target	Stakeholder
		pregnant women who attended ANC							
1.5	Percentage of pregnant women who were tested for syphilis	**Numerator:** Number of ANC attendees screened for syphilis **Denominator:** Total number of ANC attendees	Tested positive Tested negative Treated Age ranges: 15–24 years and 25+ years		DHIS 2	Quarterly		5 yrs-70% 2018-50% 2019-55% 2020-60% 2021-70%	ZIHHTLP, MOH, IRCH, ZAC, GF, PEPFAR &UN agencies UNFPA, UNICEF
1.6	Percentage of HIV-exposed infants who started on ARV prophylaxis	**Numerator:** Number of HIV-exposed infants born within the past 12 months who were started on ARV prophylaxis **Denominator:** Estimated number of HIV-positive pregnant women	By geographical allocation	[WHO SI Guidelines 2015]	DHIS 2	Quarterly and annually	68% (2017)	5 yrs: 95% 2018: 75% 2019: 85% 2020: 90% 2021: 95%	ZIHHTLP, MOH, IRCH, DHMTs, ZAC, GF, PEPFAR and UN agencies
1.7	Percentage of HIV-exposed infants receiving virological test for HIV within 12 months of birth	**Numerator:** Number of HIV-exposed infants who received virological test (DNA polymerase chain reaction) during the reporting period **Denominator:** Estimated number of HIV-positive pregnant women	Below 2 months 2–12 months By geographical location Test result	[WHO SI Guidelines 2015]/PEPFAR MER 2.0	DHIS 2	Quarterly and annually	72.5% (2017)	5 yrs: 95% 2018: 75% 2019: 80% 2020: 85% 2021: 90%	ZIHHTLP, MOH, IRCH, DHMT,ZAC, GF, PEPFAR and UN agencies
1.8	Percentage of HIV-exposed infants receiving test for HIV 6 weeks after cessation of breastfeeding	**Numerator:** Number of HIV-exposed infants who received HIV test six weeks after cessation of breastfeeding during the reporting period **Denominator:** Estimated HIV-positive pregnant women	Test results: 1. Positive 2. Negative 3. By type of test 4. By sex	ZHSHSP III 2017–2022	DHIS 2	Quarterly and annually	7.1%	5 yrs: 80% 2018: 20% 2019: 40% 2020: 60% 2021: 80%	ZIHHTLP, MOH, IRCH, DHMTs, ZAC, GF, PEPFAR, and UN agencies

No.	Indicator	Indicator definition (numerator & denominator)	Disaggregation	Indicator source	Data source	Frequency	Baseline	Target	Stakeholder
1.9	Percentage of HIV-infections among 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 3. By sex	WHO SI Guidelines 2015	DHIS 2	Quarterly and annually	3.9%	5 yrs: <5%	ZIHHTLP, MOH, IRCH, DHMTs, ZAC, GF, PEPFAR, and UN agencies
1.10	Percentage of HIV-exposed infants started on CTX prophylaxis within 2 months of birth	**Numerator:** Number of HIV-exposed infants born within the past 12 months who started CTX prophylaxis within 2 months of birth: **Denominator:** Estimated number of HIV-positive pregnant women	By geographical location	WHO SI Guidelines 2015	DHIS 2	Quarterly and annually	74% (2017)	5 yrs: 95% 2018: 75% 2019: 80% 2020: 85% 2021: 90%	ZIHHTLP, MOH, IRCH, DHMT, ZAC, GF, PEPFAR, and UN agencies
1.11	Percentage of identified HIV-positive infants who 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, and UN agencies
Intervention area 1.2: Prevention and control of sexually transmitted and reproductive tract infections									
Outcome 1.1: Increased utilisation of STI/RTI services among Key and General population by 30%									
1.12	Number of men and women diagnosed with and treated for an STI/RTI		Age, sex, geographical location, by referral point; i.e., outreach and facility KP (MSM, IDU, FSW), diagnosis (syndromic or aetiology)	(ZHSHSP III) 2017–2022	DHIS 2	Quarterly and annually	11,533 (2017)	5 yrs: 12,110 2018; 14,993 (30%↑) 2019: 13,840 (20%↑) 2020: 12,686 (10%↑) 2021: 12,110 5%↑)	ZIHHTLP, MOH, IRCH, DHMTs, ZAC, GF, PEPFAR, and UN agencies

No.	Indicator	Indicator definition (numerator & denominator)	Disaggregation	Indicator source	Data source	Frequency	Baseline	Target	Stakeholder
1.13	Number of health facilities with capacity to provide STI/RTI aetiological diagnosis		Geographical location	(ZHSHSP III) 2017–2022	Annual report	Annually	0	5 yrs: 2 2018: 0 2019: 1 2020: 1 2021: 2	ZIHHTLP, MOH, IRCH, DHMTs, ZAC, GF, PEPFAR, and UN agencies
1.14	Proportion of sexual partners traced and treated for STI/RTI at health facilities	**Numerator**: Number of sexual partners traced and treated for STI/RTI at health facilities **Denominator**: Total cases of STI/RTI reported	By geographical location, age, sex, syndromic, aetiology	(ZHSHSP III) 2017–2022	DHIS 2	Quarterly and annually	12% (2017)	5 yrs: 30% 2018: 15% 2019: 20% 2020: 25% 2021: 30%	ZIHHTLP, MOH, IRCH, DHMTs, ZAC, GF, PEPFAR, and UN agencies
Intervention area 1.3: Interventions targeting key populations									
Outcome 1.2: Reduced risky behaviours amongst key populations									
1.15	Percentage of sex workers reporting the use of condoms with their most recent clients	Commercial sex worker (CSW) **Numerator**: Number of sex workers who reported using a condom with their last client **Denominator**: Number of sex workers who reported having commercial sex in the past one month	Age (<25 vs. >25) Geographical location	GAM 2017	IBBS or other special surveys	3–5 years	78.9% (2012)	5 yrs: 95%	ZIHHTLP, MOH, IRCH, DHMTs, ZAC, GF, PEPFAR, and UN agencies
1.16	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	IBBS or other special surveys	3–5 yrs	36.6% (2012)	5 yrs: 80%	ZIHHTLP, MOH, IRCH, DHMTs, ZAC, GF, PEPFAR, and UN agencies

No.	Indicator	Indicator definition (numerator & denominator)	Disaggregation	Indicator source	Data source	Frequency	Baseline	Target	Stakeholder
1.17	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 last time they injected **Denominator**: Number of people who report injecting drugs in the past three months	Sex Geographical location Age (<25 vs. >25)	GAM 2017	IBBS	3–5 yrs	71.4% (2012)	5 yrs: 90%	ZIHHTLP, MOH, IRCH, DHMTs, ZAC, (Zanzibar National Commission for the Coordination of Drug Control (ZNCDC), GF, PEPFAR, and UN agencies
1.18	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	By KPs category Sex Age Geographical location	GAM 2017, PEPFAR MER 2.0 p. 24	KP reports	Quarterly and annually	PWID: 64% SW: 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 agencies
Outcome 1.3: Increased service utilisation among key populations									
1.19	Percentage of KPs tested for HIV and received their results in the past 12 months	**Numerator:** Number of KP'S 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, IDU, MSM	WHO, GAM 2017, PEPFAR	HTS database	Quarterly and annually	PWID: 49% MSM: 69% SWs: 54%	5 yrs: 90% for each KP category 2018: 50% 2019: 65% 2020: 75% 2021: 85%	ZIHHTLP, MOH, IRCH, DHMTs, ZAC, ZNCDC, GF, PEPFAR, and UN agencies
1.20	Percentage of HIV-infected KPs who are HIV infected	**Numerator:** Number of KP respondents who have tested positive for HIV **Denominator:** Number of KPs tested for HIV	Sex, age (15–19, 20–24, 25+), category (MSM, SW, PWID)	WHO SI guideline (2015) p. 178	IBBSS (2012)	5 yrs	IBBSS: 2012 MSM: 2.6%, SWs: 19.3%,	PWID: 7.9% SWs: 9.7% MSM: 1.3%	ZIHHTLP, CDC, and ZAC

No.	Indicator	Indicator definition (numerator & denominator)	Disaggregation	Indicator source	Data source	Frequency	Baseline	Target	Stakeholder
							PWID: 11.3%		
1.21	Proportion of HIV-infected KPs receiving ART	**Numerator:** Number of HIV-positive KPs receiving ART **Denominator:** Total number of estimated HIV-positive KPs	KP type: CSW, IDU, MSM, sex, Age Geographical location	(ZHSHSP III) 2017–2022	IBBSS	3 5 years Quarterly and annually	None (TBD) PWID: 100% (2017) MSM: 92% (2017) SWs: 93% (2017)	5 yrs: 90% for each KP category 5 yrs: 100% for each KP category 2018: 100% 2019: 100% 2020: 100% 2021: 100%	ZIHHTLP, MOH, IRCH, DHMTs, ZAC, ZNCDC, GF, PEPFAR, and UN agencies
1.22	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 <25 vs. >25)	WHO SI 2015	Program reports	Quarterly and annually	10% (2017)	5 yrs: 25% 2018: 15% 2019: 17% 2020: 21% 2021: 23%	ZIHHTLP, MOH, IRCH, DHMTs, ZAC, ZNCDC, GF, PEPFAR, and UN agencies
1.23	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 started OST during the time defined as a cohort recruitment period	Sex Age (25 <25 vs. >25)	PEPFAR MER 2.0	Program reports	Quarterly and annually	63%	5 yrs: 90% 2018: 70% 2019: 80% 2020: 90% 2021: 90%	ZIHHTLP, MOH, IRCH, DHMTs, ZAC, ZNCDC, GF, PEPFAR, and UN agencies

Intervention area 1.4: Interventions for adolescents and youth									
Outcome 1.4: Increased utilisation of HIV/AIDS, SRH, viral hepatitis, and TB services by young people									
1.24	Percentage of women and men ages 15–24 with multiple sexual partners in the past 12 months	**Numerator**: Number of respondents ages 15–24 with more than one sexual partner in the past 12 months **Denominator**: Number of all respondents ages 15–24	Female vs. male Age range: 15–19, 20–24	UNGASS	Survey THIS	5 yrs	8% (THMIS 2012)	5%	ZIHHTLP, MOH, IRCH, DHMTs, ZAC, GF, PEPFAR, and UN agencies
1.25	Percentage of young men and women ages 15–24 with comprehensive knowledge of HIV/AIDS	**Numerator**: Number of respondents ages 15–24 years who gave the correct answer to five standard questions about HIV transmission **Denominator**: Number of all respondents ages 15–24 surveyed	Female vs. male Age range: 15–19, 20–24	UNGASS	Survey THIS	5 yrs	30.8% (2012)	5 yrs: 50%	ZIHHTLP, MOH, IRCH, DHMTs, ZAC, GF, PEPFAR, and UN agencies
1.26	Number of adolescents and youth who receive HIV testing services (HTS) and receive their test results	N/A	Sex: Male vs. female Age ranges: 15–19, 20–24 Marital status Geographic area	(ZHSHSP III) 2017–2022	HTS database	Quarterly and annually	50,772	5 yrs: 70,000 2018: 55,000 2019: 60,000 2020: 65,000 2021: 70,000	ZIHHTLP, MOH, IRCH, DHMTs, ZAC, GF, PEPFAR, and UN agencies
Intervention area 1.5: Blood safety									
Outcome 1.5: All blood and blood products transfused in Zanzibar are screened for HIV/HBV/HCV/syphilis as per the approved national guidelines									
1.27	Percentage of transfused blood units that are screened for TTIS according to standard guidelines	**Numerator:** Number of units of donated blood screened for TTIs **Denominator:** Number of all blood units donated	Infection status (infected or not) Type of infection	(ZHSHSP III) 2017–2022	Blood collection register TTIs testing register BECS (Blood Electronic Computerised System)	Quarterly	100% (2017)	5 yrs: 100% 2017/18: 100% 2018/19: 100% 2019/20: 100% 2020/21: 100%	ZNBTS, HMIS, ZIHHTLP, and Partners

								2021/22: 100%	
1.28	Proportion of blood donors found to be HIV positive linked to HIV care, treatment, and support clinics	**Numerator:** Number of HIV-positive blood donors that are linked with support services for HIV prevention, treatment, care, and support **Denominator:** Number of HIV-positive blood donors	Sex	(ZHSHSP III) 2017–2022	HTS register Case based surveillance database	Quarterly and annually	Not available	5 yrs: 100% 2017/18: 100% 2018/19: 100% 2019/20: 100% 2020/21: 100% 2021/22: 100%	ZNBTS, HMIS, ZIHHTLP, and Partners
1.29	Proportion of blood donors diagnosed with syphilis linked to appropriate treatment services	**Numerator:** Number of blood donors diagnosed with syphilis linked to appropriate treatment services **Denominator:** Number of syphilis- positive blood donors	Sex Geographical location	(ZHSHSP III) 2017–2022	Donor notification register	Quarterly and annually	0%	5 yrs: 100% 2017/18: 100% 2018/19: 100% 2019/20: 100% 2020/2: 100% 2021/22: 100%	ZNBTS, HMIS, ZIHHTLP, and Partners
Intervention area 1.6: Health sector workplace HIV/AIDS and HBV and HCV interventions institutionalised at central, intermediate, and health facilities levels									
1.30	Percentage of healthcare facilities with policy guidance for HIV/AIDS interventions	**Numerator:** Number of healthcare facilities with policy guidance for HIV/AIDS interventions **Denominator:** Total number of health facilities providing HIV interventions	Facility type (hospital, health center, dispensary) Ownership (public, private)	(ZHSHSP III) 2017–2022	Supervision report	Semi annually	Data not available	5 yrs: 100% 2017/18: 100% 2018/19: 100% 2019/20: 100% 2020/21: 100% 2021/22: 100%	ZIHHTLP

1.31	Proportion of HCWs tested for HIV	**Numerator:** Number of HCWs tested for HIV **Denominator**: Total number of HCWs	Carder Sex Facility level	(ZHSHSP III) 2017–2022	HTS database (occupation of client tested) HCWs Survey	Annually	Not available	5 yrs: 90% 2017/18 : 25% 2018/19: 40% 2019/20: 60% 2020/21: 80% 2021/22: 90%	ZIHHTLP
1.32	Proportion of healthcare workers exposed to HIV received PEP service	**Numerator**: Number of healthcare workers exposed and received PEP service **Denominator**: Total healthcare workers exposed to HIV	Carder Sex	(ZHSHSP III) 2017–2022	HCWs Survey	Every two years	Not available	5 yrs: 100% 2017/18: 2018/19: 100% 2019/20: 100% 2020/21: 100% 2021/22: 100%	ZIHHTLP
THEMATIC AREA 2: CARE, TREATMENT, AND SUPPORT									
Intervention area 2.1: Care and treatment of adults, adolescents, and children living with HIV/AIDS									
Impact 2: Reduced HIV-related deaths									
2.1	AIDS mortality per 100,000 per year	**Numerator:** Number of all AIDs-related deaths **Denominator:** Total population of Zanzibar	Age and sex Age range: 0–4, 5–9, 10–14, 15–19, 20–24, 25–49, and 50+ years	GAM 2017 WHO SI 2015	Zanzibar Spectrum file	Annually	7.8 (2017)	5 yrs: 4.3 2018: 6.0 2019: 5.1 2020: 4.7 2021: 4.3	ZIHHTLP, ZAC UNAIDS, WHO, GF, PEPFAR, and MOH
2.2	Number and percentage of PLHIV who are currently on ART	**Numerator:** Number of adults and children currently receiving ART in the reporting period **Denominator:** Estimated number of PLHIV	Age and sex Age range: 0–11 months, 1–4, 5–9, 10–14, 15–19, 20–24, 25–49, and 50+ years	PEPFAR MER 2.0 p. 158 WHO SI 2015 GAM GF	CTC2 Database	Quarterly and annually	5,269 (2017) 82.4% (2017)	5 yrs: 95% 2018: 85% 2019: 90% 2020: 93% 2021: 95%	ZIHHTLP, ZAC, UNAIDS, WHO, GF, PEPFAR, MOH, and DHMTs

2.3	Number of PMTCT sites that are providing comprehensive care and treatment services	N/A	NONE	(ZHSHSP III) 2017–2022	Annual report	Annually	0 (2017)	5 yrs: 6 2018: 2 2019-3 2020: 4 2021: 5	ZIHHTLP, ZAC, UNAIDS, WHO, GF, PEPFAR, MOH, and DHMTs
2.4	Number of new PLHIV started on ART during reporting period	N/A	Age and sex Age range: 0–11 month,1–4, 5–9,10–14, 15–19, 20–24, 25–49, and 50+ years KPs, Pregnant women and TB	PEPFAR MER 2.0 WHO SI 2015 GAM	ART Register and CTC2 Data Base	Quarterly	935 (2017)	5 yrs: 400 2018: 400 2019: 400 2020: 400 2021: 400	ZIHHTLP, ZAC, UNAIDS, WHO, GF, PEPFAR, MOH, and DHMTs
2.5	Percentage of adults and children known to be on treatment 12 months after initiation of ART (Note: reporting 24 and 36 months is recommended, but optional)	**Numerator:** Number of adults and children who are still on treatment at 12 months after initiating ART **Denominator:** Number of adults and children who initiated ART in the 12 months before the beginning of the reporting period, including those who have died and those who have stopped ART (does not include transfer outs)	Age and sex Age range 0–14, 15+ Pregnant women	PEPFAR MER 2.0(pg. 102)	Care and treatment report cohort analysis	Quarterly and annually	87.5% (2017)	5 yrs: 95% 2018: 89% 2019: 92% 2020: 95% 2021: 95% ;	ZIHHTLP, ZAC, UNAIDS, WHO, GF, PEPFAR, MOH, and DHMTs

2.6	Proportion of people starting ART who were tested for hepatitis B	**Numerator:** Number of people started on antiretroviral therapy who were tested for hepatitis B during the reporting period using hepatitis B surface antigen tests **Denominator:** Number of people starting antiretroviral therapy during the reporting period	Age and sex Age range: 0–11 months;1–4, 5–9,10–14, 15–19, 20–24, 25–49, and 50+ years 25+ years People who inject drugs	ZHSHSP III) 2017–2022 UNAIDS	CTC2 Database	Annually	none	5 yrs: 90% 2018: 10% 2019: 30% 2020: 50% 2021: 70%	ZIHHTLP, ZAC, UNAIDS, WHO, GF, PEPFAR, MOH, and DHMTs
2.7	Proportion of women living with HIV ages 30–49 who report being screened for cervical cancer using any of the following methods: VIA, Pap smear, or HPV test	**Numerator:** Number of women living with HIV 30–49 years old who were screened for cervical cancer using any of these methods: VIA, Pap smear, and HPV test during the reporting period **Denominator:** All women respondents living with HIV 30–49 years old currently on care	Geographical location	UNAIDS	Cancer screening register	Annually	15.6% (2017)	5 yrs: 60% 2018: 20% 2019: 30% 2020: 40% 2021: 50%	ZIHHTLP, ZAC, UNAIDS, WHO, GF, PEPFAR, MOH, DHMTs, and UNFPA
2.8	Percentage of ART clients with viral load results documented in the medical records and laboratory information system (LIS) within the past 12 months with a suppressed viral load less than 1,000 copies/ml	**Numerator:** Number of adult and children on ART clients with suppressed Viral Load results less than 1000 copies/ml documented in the medical records and laboratory information system (LIS) within the past 12 months **Denominator 1:** **Program based:** Number of adults and children on ART with viral load result documented in the past 12 months	Age, sex, and type (routine/targeted), pregnant status Age range: 0–11 month,1–4, 5–9,10–14, 15–-19, 20–24, 25–49, and 50+ years	PEPFAR MER 2.0, WHO	Viral load register, DHIS 2 CTC2 Database	Quarterly and annually	Programme based: 80.3% (2017) Baseline 2: 51.3% (2017)	Target 1: 5 yrs: 90% 2018: 85% 2019: 88% 2020-90% 2021-90% Target 2 5 yrs (73%) 2018-55% 2019-60% 2020-65% 2021-73%	ZIHHTLP, ZAC, UN-FAMILY, GF, PEPFAR, MOH, DHMTs, and HMIS

		Denominator 2: Population based: Estimated number of PLHIV							
Intervention area 2.2: TB/HIV collaborative activities									
Outcome 2.1: Increased access to comprehensive TB/HIV collaborative activities by PLHIV									
2.9	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 currently on care	Age, sex and pregnancy Age range: 0–11 months,1–4, 5–9,10–14, 15–19, 20–24, 25–49, and 50+ years	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, GF, PEPFAR, MOH, and DHMTs
2.10	Percentage of PLHIV who started TB treatment in the reporting period	**Numerator:** Number of PLHIV TB patients started on TB treatment during the reporting period **Denominator:** Total number of HIV patients currently on care	Age and sex Age range: 0–11 months, 1–4, 5–9, 10–14, 15–19, 20–24, 25–49, and 50+ years	PEPFAR MER 2.0	CTC2 Database	Quarterly and annually	1.5% (2017)	5 yrs: 2% 2018: 4% 2019: 3% 2020: 2% 2021: 2%	UNAIDS, WHO, GF, PEPFAR, MOH, DHMTs, and ZAC
2.11	Number of health facilities providing TB/HIV collaborative activities (under one roof)	N/A	Geographical location	(ZHSHSP III) 2017–2022	Annual report	Annually	2 (2017)	5 yrs: 4 2018: 2 2019: 3 2020: 3 2021: 4	ZIHHTLP, WHO, GF, PEPFAR, MOH, DHMTs, and ZAC
2.12	Number of CTCs providing IPT services	N/A	Geographical location	(ZHSHSP III) 2017–2022	Annual report	Annually	6 (2017)	5 yrs: 13 2018: 7 2019: 8 2020: 10 2021: 12	ZIHHTLP, WHO, GF, PEPFAR, MOH, DHMTs, and ZAC

2.13	Percentage of people newly enrolled in HIV care who are started on TB preventive therapy	**Numerator**: Number of people living with HIV newly enrolled in HIV care who are started on treatment for latent TB infection (e.g., IPT) during the reporting period **Denominator:** Number of persons living with HIV newly enrolled in HIV care; that is, registered in the pre-ART or ART register during the reporting period, excluding confirmed TB cases	Geographical location sex, age (0–4,5–14, 15+) Key populations	WHO SI 2015 p. 118	CTC2 Data Base HIV care register ART card	Quarterly and annually	2017	5 yrs: 80% 2018 2019 2020 2021	MOH, ZIHHTLP, GF, and THPS
Intervention area 2.3: Integrated community-based healthcare services									
Outcome 2.2: Increased utilisation of quality comprehensive CBHC services by PLHIV									
2.14	Percentage of PLHIV receiving comprehensive HBC services	**Numerator:** Number of PLHIV receiving comprehensive HBC services **Denominator:** Total number of PLHIV currently receiving care	Age and sex Age range: 0–4, 5–14, 15+	(ZHSHSP III) 2017–2022	DHIS 2	Quarterly and annually	1211/5385 22.4% (2017)	5 yrs: 30% 18: 24% 19: 26% 20: 28% 21: 30%	ZIHHTLP, WHO, GF, PEPFAR, MOH, DHMTs, and ZAC
2.15	Percentage of missed appointment and LTFU clients followed up and linked back to health facility services by community-based HIV and AIDS services providers	**Numerator:** Number of missed appointment and LTFU clients linked back to health facility services by CBHS providers **Denominator:** Number of missed appointment and LTFU clients reported in the reporting period	By LTFU and missed appointment Age and sex Age range: 0–11 months,1–4, 5–9,10–14, 15–19, 20–24, 25–49, and 50+ yrs	(ZHSHSP III) 2017–2022	CTC2 database	Quarterly	None	90%	ZIHHTLP, WHO, GF, PEPFAR, MOH, DHMTs, ZAC, and MLEEYWC

THEMATIC AREA 3: CROSSCUTTING INTERVENTIONS									
Intervention area 3.1: Social and behavioural change communication									
3.1	Percentage of people who have more than one sexual partner who used condom at last sexual intercourse	Numerator: The number of respondents who report using a condom the last time they had sex with a nonmarital, non-cohabiting partner. Denominator: Total number of respondents who report that they had sex with a nonmarital, non-cohabiting partner in the last 12 months	Sex Age (15–19, 20–24 and 25–49 years)	GAM 2018	THIS 2017	4 yrs	Male: 25.4% Female: 11.2% THIS 2017	Male: 90% Female: 90% by 2021	OCGS and ZIHHTLP
3.2	Percentage of people with comprehensive knowledge on HIV transmission and prevention	**Numerator:** number of respondents who gave the correct answer to five standard questions about HIV transmission **Denominator:** number of all respondents surveyed	Female vs. Male Age range: 15-19, 20-24, and 25-49, 50+ Geographical location	(WHO SI GUIDELINE HEALTH SECTOR 2015)	THIS/THMIS	Every 5 yrs	30.8 (2012)	50%	OCGS ZIHHTLP WHO GF PEPFAR MOH DHMTs ZAC

3.3	Percentage of people ages (15–49) expressing accepting attitudes towards PLHIV	**Numerator**: Number of people ages 15–49 who respond "No" or "It depends" to either of two survey questions on stigma against people with HIV **Denominator:** Number of women and men ages 15–49 years who have heard of HIV	Sex, age (15-49), location (e.g., urban, rural), educational attainment, employment status	(WHO SI GUIDELINE HEALTH SECTOR 2015)	THIS/THMIS	Every 5 yrs	73.7 (2012)	90%	OCGS/ZAC, OCGS, ZIHHTLP, WHO, GF, PEPFAR, MOH, DHMTs, and ZAC
Intervention area 3.2: HIV testing services									
Outcome .1: Increased utilisation of quality HTS to the general population, KPs, youth, and adolescents									
3.4	Number and percentage of health facilities providing HTS services	**Numerator:** Number of health facilities providing HTS services **Denominator:** Total number of health facilities in Zanzibar	Public vs. Private, Geographical location	(ZHSHSP III) 2017–2022	Programme reports	Annually	120/274 (2017) 43.7%	168 5 yrs: 61.3% 2018: 50% 2019: 54% 2020: 58% 2021: 61.3%	ZIHHTLP, WHO, GF, PEPFAR, MOH, DHMTs, and ZAC
3.5	Number and proportion of people who were tested for HIV and received their results within the past 12 months	**Numerator:** Number of people who were tested for HIV and received their results within the past 12 months **Denominator:** Projected population of Zanzibar	HTC modality: CITC/VCT, PITC, Outreach, PMTC, EID and Blood donor and Age (<1, 1–4, 5–9,10–19, 20–24, 25–49, 50+), Sex/KP category	PEFAR MER2.0, WHO	HTS database	Quarterly and annually	10.8% (2017)	5 yrs: 22% 2018: 16% 2019: 18% 2020: 20% 2021: 21%	ZIHHTLP, WHO, GF, PEPFAR, MOH, DHMTs, and ZAC
Intervention area 3.3: HIV laboratory support services									
Outcome 3.2: Quality laboratory services are provided at all levels									
3.6	Number of laboratories engaged in Continuous Quality Improvement	N/A	1. Not audited 2. Externally audited but does not meet full accreditation	PEPFAR MER 2.0	Assessment report	Annually	1(2017)	5 yrs: 5 2018: 1 2019: 2 2020: 3 2021: 4	ZIHHTLP, WHO, GF, PEPFAR, MOH, DHMTs, and ZAC

	(CQI) activities audited and achieved accreditation		standards 3. Fully accredited .						
3.7	Number of laboratories with capacity to perform HIV viral load testing	N/A	Geographical location	ZHSHSP III 2017–2022	Program report	Annually	0 (2017)	5 yrs: 5 2018: 2 2019: 3 2020: 4 2021: 5	ZIHHTLP, WHO, GF, PEPFAR, MOH, DHMTs, and ZAC
3.8	Percentage of testing sites with satisfactory performance in external quality assurance proficiency testing (EQA PT)	**Numerator:** Number of testing sites with satisfactory performance in EQA/PT **Denominator:** Number of testing sites participating in EQA/PT	Type of services Type of test	WHO SI GUIDELINE HEALTH SECTOR 2015 PEPFAR MER 2.0	Programme report	Annually	120/147 (2017) 81.6%	5 yrs: 100% 2018: 95% 2019: 98% 2020: 98% 2021: 100%	ZIHHTLP, WHO GF, PEPFAR, MOH, DHMTs, and ZAC
THEMATIC AREA 4: HEALTH SYSTEM S STRENGTHENING AND SUPPORT									
Intervention area 4.1: Social and behavioural change communication									
Outcome 4.1: Strengthened programme management, coordination, and implementation of the ZHSHSP III									
4.1	Number of health training institutions integrating HIV knowledge and skills in their training curricula	NA	Cadre Level of education	ZHSHSP III 2017–2022	Health Training institution	Annually	1 (2017)	5 yrs: 3 2018: 1 2019: 2 2020: 2 2021: 3	MOE, MOH, ZIHHTLP, GF, ZAC, UN-FAMILY, and PEPFAR
4.2	Number of partners coordination meetings conducted by ZIHHTLP per year	N/A	NONE	ZHSHSP III 2017–2022	Minutes	Annually	0 (2017)	5 yrs: 5 2018: 1 2019: 1 2020: 1 2021: 1	MOH, ZIHHTLP, GF, ZAC, UN-FAMILY, and PEPFAR

4.3	Proportion of required funds mobilised	**Numerator:** Amount of funds mobilised **Denominator:** Total amount of fund required	Source of fund (GOZ, development partners, implementing partners)	ZHSHSP III 2017–2022	Costed ZHHSP operational plan Annual financial repots	Annually	NONE	5 yrs: 90% 2018: 60% 2019:70% 2020:75% 2021: 80%	MOH, ZIHHTLP, GF, ZAC, UN-FAMILY, and PEPFAR
Intervention area 4.2: Procurement and supply chain management for HIV/AIDS									
Outcome 4.2: HIV/AIDS medicines and related commodities are continuously available at all service delivery points									
4.4	Percentage of tracer HIV/AIDS commodities received	**Numerator:** Total number of commodities received **Denominator:** Total number of planned commodities	ARVs Rapid HIV test kits Condoms	ZHSHSP III 2017–2022	ZIHHTLP CMS	Annually	100% (2017)	5 yrs: 100% 2018: 100% 2019:100% 2020:100% 2021: 100%	CMS, LMU, MOH, ZIHHTLP, GF, ZAC, UN-FAMILY, and PEPFAR
4.5	Percentage of facilities reporting stockout of tracer HIV commodities in the last 3 months of their ordering cycle	**Numerator:** Number of facilities reporting stock outs in the last three months **Denominator:** Total number of HFs	Rapid HIV test kits Condoms ARVs	ZHSHSP III 2017–2022	R&R	Quarterly and annually	Test kits 5.45 (2017) Condoms 6.06% (2017) ARVs - 0% (2017)	5 yrs: <5% 2018: <5% 2019: <5% 2020: <5% 2021: <5%	CMS, LMU, MOH, ZIHHTLP, GF, ZAC, UN-FAMILY, and PEPFAR
4.6	Percentage of tracer commodities orders delivered on time by the Central Medical Stores (CMS)	**Numerator:** Total number of orders delivered within the lead time period **Denominator**: Total number of orders received by CMS	ARVs Lab reagents Rapid HIV test kits Condoms OI drugs STI drugs	ZHSHSP III 2017–2022	CMS Invoices (mSup-ply)	Quarterly and annually	70% (2017)	5 yrs: 95% 2018: 75% 2019: 80% 2020: 85% 2021: 90%	CMS, LMU, MOH, ZIHHTLP, GF, ZAC, UN-FAMILY, and PEPFAR
4.7	Percentage of facilities reporting and requesting HIV/AIDS commodities in a timely way	**Numerator:** Number of facilities submitting reports on time per quarter **Denominator:** Total number of facilities reporting per quarter	ARVs Lab reagents Rapid HIV test kits Condoms OI drugs STI drugs	ZHSHSP III 2017–2022	eLMIS	Quarterly	91% (2017)	5 yrs: 100% 2018: 95% 2019: 97% 2020: 100% 2021: 100%	CMS, LMU, MOH, ZIHHTLP GF, ZAC, UN-FAMILY, and PEPFAR

Intervention area 4.3: Monitoring, evaluation, research, and learning									
Outcome 4.3: Strengthened use of quality HIV and AIDS data for informed decision making at all levels									
4.8	Percentage of health facilities submitting HIV/AIDS report in a timely way into DHIS 2	**Numerator:** Number of health facilities submitted HIV report timely **Denominator:** Total number of health facilities expected to submit report timely	Geographical location Type of ownership (public, private)	ZHSHSP III 2017–2022	DHIS 2	Quarterly and annually	54% (2017)	5 yrs; 90% 2018: 60% 2019: 67% 2020: 74% 2021: 82%	HMIS, MOH, ZIHHTLP, GF, ZAC, UN-FAMILY, and PEPFAR
4.9	Percentage of health facilities which submitted HIV report into DHIS 2	**Numerator:** Number of health facilities which submitted HIV report into DHIS 2 **Denominator:** Total number of health facilities expected to submit HIV reports	Geographical location Type of ownership (public, private) By type of HIV services	ZHSHSP III 2017–2022	DHIS 2	Quarterly and annually	77.4 (2017)	5Yrs -96% 2018: 81% 2019: 85% 2020: 88% 2021: 92%	HMIS, MOH, ZIHHTLP, GF, ZAC, UN-FAMILY, and PEPFAR
4.10	Number of HIV surveillances conducted	NA	Type of Surveillance: ANC Surveillance IBBSS	ZHSHSP III 2017–2022	ANC Surveillance report IBBSS report	Biannually 5 years	1 1	5 yrs: 2. ANC surveillance 1: IBBSS	HMIS, MOH, ZIHHTLP, GF, ZAC, UN-FAMILY, and PEPFAR
4.11	Number of HIV operational researches conducted based on national HIV health sector research agenda	NA	By type of HIV services	ZHSHSP III 2017–2022	ORs reports	Annually	1(2017)	5yrs: 3. ORs 2018: NONE 2019: 1 2020: 1 2021: 1	HMIS, MOH, ZIHHTLP, GF, ZAC, UN-FAMILY, and PEPFAR
4.12	Percentage of health facilities utilising HIV data for planning purposes	**Numerator:** Number of health facilities using HIV data **Denominator:** Total number of health facilities expected to utilize HIV data	Geographical location	ZHSHSP III 2017–2022	Survey	Biannually	NONE	5 yrs: 50% 2018: 30% 2019: 35% 2020: 40% 2021: 45%	HMIS, MOH, ZIHHTLP, GF, ZAC, UN-FAMILY, and PEPFAR

4.13	Number of HIV data review meetings conducted at district and facility levels	NA	Geographical location	ZHSHSP III 2017–2022	Data review meeting report	Quarterly	1(2017)	5 yrs: 20 2018: 4 2019: 4 2020: 4 2021: 4	HMIS, MOH, ZIHHTLP, GF, ZAC, UN-FAMILY, and PEPFAR
4.14	Number of HIV information dissemination products produced and disseminated by ZIHHTLP	NA	Type of products	ZHSHSP III 2017–2022	Programme report	Annually	1 (2016)	5 yrs: 10 2018: 2 2019: 2 2020: 2 2021: 2	HMIS, MOH, ZIHHTLP, GF, ZAC, UN-FAMILY, and PEPFAR
4.15	Proportion of health facilities with DQA conducted at least every 6 months	**Numerator:** Number of health facilities with DQA conducted at least every 6 months **Denominator:** Total HFs which provide HIV related intervention	Geographic location HIV intervention	ZHSHSP III 2017–2022	DQA reports	Semian-nually and annually	NONE	5 yrs: 10 2018: 2 2019: 2 2020: 2 2021: 2	HMIS, MOH, ZIHHTLP, GF, ZAC, UN-FAMILY, and PEPFAR

APPENDIX 3. ZANZIBAR HEALTH SECTOR HIV M&E SYSTEM STRENGTHENING ACTION PLAN

M&E system component	Specific activities	Timeline	Responsibility
1. Organisational structure for M&E	1.1 Review organisational roles and functions, including well-defined organisational structure; written mandates for planning, coordinating, and managing the M&E system; and well-defined M&E roles and responsibilities for key individuals and organisations at all levels	July–December 2018	ZIHHTLP management
	1.2 Review job descriptions for M&E staff with defined career paths in M&E	July–December 2018	ZIHHTLP management
2. Human capacity	2.1 Conduct capacity assessment and develop costed operational plan for implementation of capacity-building plan at national, regional, and local levels	January–March 2019	ZIHHTLP management
	2.2 Define a set of technical and analytical skills and competencies as requirements while recruiting people to fill M&E positions, including adequate knowledge and educational qualifications	January–June 2019	ZIHHTLP management
	2.3 Provide pre-service and in-service training at the Zanzibar national and district levels in the areas of epidemiology, surveillance, programmatic M&E, information system operation, data entry and validation, data storage, and data transfer as identified in the capacity assessment	July –December 2019	ZIHHTLP management
	2.4 Develop additional capacity for M&E at the district level	July–December 2018	ZIHHTLP management
	2.5 Provide technical assistance to support the capacity building of Zanzibar national surveillance and M&E staff as required (e.g., to support surveillance data analysis)	January 2018–June 2022	Management/SI unit
3 Partnerships	3.1 Establish the Zanzibar Health Sector HIV/AIDS M&E Working Group and its detailed TOR	July–December 2018	Management/SI unit
	3.2 Convene regular Zanzibar Health Sector HIV/AIDS M&E Working Group meetings	July 2018–June 2022 (Immediately ongoing)	Management/SI unit
4. Costed Zanzibar	4.1 Develop costed M&E workplan	July–September 2018	SI unit

national HIV M&E workplan	4.2 Explicitly link the M&E workplan to the workplans and budget of the government	July–September 2018	SI unit
	4.3 Resources (human, physical, financial) are committed to implementing the M&E workplan	July 2018–June 2022	SI unit
	4.4 Update the M&E workplan annually on the basis of performance monitoring	July 2018–June 2022	SI unit
5. Routine programme monitoring	5.1 Roll out the CTC3 database	July–December 2018	SI unit
	5.2 Roll out the KP database	July–December 2018	SI unit
6. M&E advocacy, communication and culture	6.1 Update the ZIHHTLP website	July 2018–June 2022 (Immediately and ongoing)	SI unit
	6.2 Conduct annul M&E meetings to discuss and plan for the M&E system	July 2018–June 2022 (Immediately and ongoing)	SI unit
7. National and subnational databases	7.1 Create linkages among relevant databases to ensure data consistency and avoid duplication of efforts	July 2018–June 2022	SI unit
	7.2 Create a well-defined and managed health sector HIV database to capture, verify, analyse, and present programme monitoring data from all levels and sectors	July 2018–June 2022	SI unit
	7.3 Conduct comprehensive training on the DHIS 2 and CTC3 databases for all users	July–September 2018	SI unit
8. Surveys and surveillance	8.1 Conduct an inventory of HIV health sector-related surveys in Zanzibar	January–March 2019	SI unit
	8.2 Ensure that protocols for all surveys and surveillance are based on Zanzibar national and international standards	July 2018–June 2022	SI unit
	8.3 Develop a specific schedule to conduct surveys and surveillance linked to stakeholders' needs, including identification of resources for implementation and training	July–December 2018	SI unit
	8.4 Seek external technical support and training as required	July 2018–June 2022	Management/SI unit
9. Supportive supervision and data auditing	9.1 Develop Zanzibar National Data Quality Guidelines and an operational plan/budget	October–December 2018	SI unit
	9.2 Supervise routine data recording at facility- and community-based HIV service delivery levels	July 2018–June 2022	SI unit

	9.3 Conduct routine supervision visits, data quality assessments, and feedback for local staff	July 2018–June 2022	SI unit
	9.4 Conduct systematic and harmonised data quality audits	July 2018–June 2022	SI unit
10. Evaluation and research	10.1 Develop an inventory of completed and ongoing Zanzibar-specific HIV evaluation and research studies	January–March 2019	SI unit
	10.2 Develop a prioritised Zanzibar National Research and Evaluation Agenda	July–December 2018	SI unit
11. Information dissemination and use	11.1 Ensure that all required indicators for reporting are available from the DHIS database	July 2018–June 2022	SI unit
	11.2 Develop an information use calendar to guide the timetable for major data recording efforts and reporting requirements and time	July–September 2018	SI unit
	11.3 Develop a standard format for reporting and data tabulation	July 2018–June 2022	SI unit
	11.4 Train personnel on report and manuscript writing	Jan 2019–June 2022	ZIHHTLP management
	11.5 Package M&E report data for use by multiple audiences	July 2018–June 2022	SI unit
	11.6 Secure evidence of use of evaluation and research findings (e.g., referenced in planning documents)	July 2018–June 2022	SI unit


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