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MONITORING & EVALUATION INDICATOR REFERENCE GUIDE

ABUJA CALL FOR ACCELERATED ACTION TOWARDS UNIVERSAL ACCESS TO HIV, AIDS, TB AND MALARIA SERVICES
&
MAPUTO PLAN OF ACTION FOR OPERATIONALIZATION OF THE CONTINENTAL POLICY FRAMEWORK ON SEXUAL AND REPRODUCTIVE HEALTH AND RIGHTS

Department of Social Affairs
African Union Commission

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Abuja Call Progress Assessment Tool (ACPAT)
MPoA Progress Assessment Tool (MPAT)

Acronyms

BCC	Behavior Change Communication
CAMH5	African Union 5th Conference of Ministers of Health
CSW	Commercial Sexual Worker
DHS	Demographic Health Survey
DOTS	Directly Observed Treatment Short course
EC	European Commission
FP	Family Planning
HTP	Harmful Traditional Practices
IDUs	Injecting drug users
IPT	Intermittent Preventive Therapy
M&E	Monitoring and Evaluation
MARP	More At Risk Population
MDG	Millennium Development Goal
MICS	Multiple Indicator Cluster Survey
MIS	Management Information Systems
MIS	Malaria Indicator Surveys
MMR	Maternal Mortality Ratio
MPoA	Maputo Plan of Action
MSM	Men who have sex with men
NHA	National Health Accounts
ORID	Other Related Infectious Diseases
PAC	Post Abortion Care
PEP	Post Exposure Prophylaxis
PHC	Primary Health Care
PLWHA	People Living With HIV/AIDS
PMTCT	Preventing Mother-To-Child-Transmission of HIV
PRSP	Poverty Reduction Strategy Papers
RBM	Roll Back Malaria
RH	Reproductive Health
SDPs	Service Delivery Points
SGBV	Sexual and Gender Based Violence
SRH	Sexual and Reproductive Health
SRHR	Sexual and Reproductive Health and Rights
STI	Sexually Transmitted Infections
UNGASS	UN General Assembly Special Session
VCT	Voluntary Counseling and Testing

1. Purpose

The purpose of this document is to serve as a reference guide and training tool for monitoring the indicators for the "Abuja call for Accelerated Action towards Universal Access to HIV/AIDS, TB and Malaria services in Africa" and the Maputo Plan of Action for the Continental Policy Framework on Sexual and Reproductive Health and Rights (SRHR). These guidelines will also help ensure the consistency, accuracy and validity of member states' reports on these indicators using the Abuja Call Progress Assessment Tool (ACPAT) and the MPoA Progress Assessment Tool (MPAT).

The indicators cover HIV/AIDS, TB, Malaria, SRHR, MNCH and Health Systems Strengthening and have been culled from relevant standard indicator sets especially the UNGASS, World Health Statistics indicators, MDGs and the original set of Maputo Plan of Action indicators.

They will be used by the AUC to monitor and report on progress made in the attainment of the Abuja call and MPoA targets and objectives. Member states will also be provided feedback reports on the progress they have made alongside others, and good practices identified during assessments will be shared. These indicators, if properly reported, analyzed and disseminated, will provide a basis for accountability, ownership, and informed decision-making for HIV/AIDS, TB, and Malaria, SRHR and MNCH policies and programmes at country, regional and continental levels in Africa.

2. Background

In 2005, the African Union Commission (AUC), elaborated a comprehensive Continental Policy Framework for Sexual and Reproductive Health and Rights (SRHR). This policy framework was adopted by the AU Conference of Ministers of Health held in Gaborone, Botswana, in October 2005 and further endorsed by the AU Summit of January 2006 in Khartoum, Sudan. **An operational plan, known as the Maputo Plan of Action (MPoA) was further elaborated and endorsed at the January 2007 Summit of the AU**, while by Executive Council Decision EX.CL/Dec.327 (X) rev.1 *"the African Union Commission was mandated to play advocacy role, resource mobilization, monitoring and evaluation, dissemination of best practices and harmonization of policies and strategies".*

The SRHR Policy Framework was developed in response to the call for the reduction of maternal and infant morbidity and mortality in Africa. It was also designed as Africa's contribution to the implementation of the Programmes of Action for the International Conference on Population and Development (ICPD) since reproductive health and the rights of

women are the key priority objectives of the ICPD. Furthermore, the continental SRHR policy framework was aimed at accelerating action on the attainment of the MDGs, particularly those related to health, including MDGs 4, 5 and 6.

In 2006, the AU Heads of State and Government at a Special Summit on HIV/AIDS, Tuberculosis, and Malaria in Abuja, Nigeria, from 2-4 May 2006, adopted the Abuja Call on *"Universal Access to HIV/AIDS, Tuberculosis and Malaria Services by A United Africa by 2010*". Subsequent to this decision, a plan of action on HIV/AIDS, TB and Malaria was developed to accelerate implementation in Member States. In adopting the Abuja Call, the Heads of State mandated the African Union Commission (AUC) to conduct a five year review of progress in 2010 and report back to the Assembly and Ministers of Health.

It is pertinent to mention that the elaboration and adoption of these policy instruments have been guided by the Vision, Mission and Strategic Framework of the AUC for the period 2003-2007 and continues to benefit from the directives and key strategic plan for the period 2009-2012.

Pursuant to its mandate, the Commission, in 2009, prepared and disseminated a Progress Assessment Tool (PAT) to Member States for monitoring and evaluation of the implementation status of the Maputo PoA. The Maputo PoA contained 109 indicators which were reduced to 37 qualitative and quantitative indicators in the PAT in order to facilitate comprehensive but concise reporting by Member States. AUC received completed PAT reports from forty-three (43) Member States, and these were consolidated by AUC to prepare a progress report on Maputo PoA implementation.

In April 2010, the Progress Report on the implementation of the Maputo PoA was considered at the AU Experts' Meeting organized by the AU Commission in Addis Ababa, and attended by health experts and representatives of international/regional and civil society organizations. The outcomes of this meeting, which included the recommendation to extend the Maputo PoA to 2015 in order to accelerate the implementation of the PoA and to address critical gaps and replicate good practices from the review, were adopted by the AU Ministers of Health at a Special Session held in Geneva, Switzerland on 15 May 2010. Specifically, the Ministers of Health endorsed the recommendation by the Experts that "the indicators of the Maputo PoA should be reviewed to align them with those of the health-related MDGs". The Ministers mandated the African Union Commission to undertake the above activity and submit to the Fifth Session of the African Union Conference of Ministers of Health (CAMH5) in 2011". At the 15th Session of the AU Ordinary Assembly, the Executive Council endorsed this decision.

Also, pursuant to its mandate, the AUC in 2010 conducted a 5-Year review of the implementation of the Declarations and Plans of Action on HIV/AIDS, Tuberculosis and Malaria

was conducted. The outcomes of this review, included the recommendations to extend the "Abuja Call" to 2015 to coincide with the MDGs and "the indicators of the "Abuja Call" should be reviewed and aligned to MDG 6". The AU Ministers of Health at a Special Session held in Geneva, Switzerland on 15 May 2010 endorsed these recommendations and mandated the African Union Commission to undertake the above activity and submit to the Fifth Session of the African Union Conference of Ministers of Health (CAMH5) in 2011". At the 15th Session of the AU Ordinary Assembly in Kampala in July 2010, the Assembly endorsed this Decision.

Subsequently, the AUC social affairs department has:

- Developed indicators for the MPoA and "Abuja Call" which are aligned with MDG 4, 5 and 6 indicators.
- Developed Monitoring and Evaluation tools and an M&E framework to facilitate continuous monitoring of implementation of MPoA and "Abuja Call" as well as progress towards achieving the MDGs by 2015.
- Conducted an M&E experts' peer review meeting to validate aligned indicators. This took place on the 6th to 8th of April in Nairobi, Kenya.

The indicators have been adopted by African Ministers of Health at their last AU Conference of Ministers of Health which took place from the 17th to 21st of April 2011 in Windhoek, Namibia. These tools and framework shall facilitate reporting to the Heads of State and Government as requested by the 15th Session of the Ordinary AU Assembly.

Following the development of this monitoring system, the tools will be piloted in 10 Member States to assess ease of use, validity, accuracy, consistency and other data quality measures. At the time this manual was developed, member states (Ministries of Health) have nominated 2 focal persons experienced in monitoring and evaluation of Maternal Newborn and Child Health (MNCH), Sexual Reproductive Health and Rights (SRHR), HIV and AIDS, TB and Malaria services as contact persons. These focal persons will be oriented and trained on the M&E framework, indicators and tools. The focal points will be equipped with copies of the tools and indicator manuals, and provided with technical assistance to facilitate their reporting according to set timelines.

3. General Guidelines

3.1 Institutional Responsibilities

The Ministries of Health of Member States are responsible for reporting with support from, the Ministries of Finance and Education, RHOs, RECs and international development partners.

The reference document is divided into two sections; A: Abuja Call and, B: MPoA.

3.2 Indicator Definitions and Measurement

This guidance document classifies indicators in two ways:
Standard M&E classification: Input, Process, Output, Outcome or Impact;
Data type: Quantitative or Qualitative

The indicators are organized by objectives/ targets of the policy framework or strategies; and for each indicator the rationale, definition, methodology for collection and calculation, secondary data source and indicator classification/data type is provided.

The secondary data sources are alternate reports from which the data can be obtained. Where alternate data sources are not available it may be necessary to carry out a rapid assessment/enquiry to obtain the relevant information as in the case of some qualitative MPoA Indicators.

Some of the metadata referred to in this document are drawn from existing monitoring systems referenced herewith:

a. UNDP hand book of Indicators for Monitoring the Millennium Development Goals: Definitions Rationale Concepts and Sources, 2003 or on website: http://mdgs.un.org/unsd/mdg

b. In addition:

- ✓ Comprehensive definitions of all the proposed indicators for monitoring HIV/AIDS can be found atwww.indicatorregistry.org
- ✓ Complementary indicators for monitoring HIV/TB collaborative activities can be found in the joint WHO/UNAIDS guide to monitoring and evaluation for collaborative TB/HIV activities,2009 revision. Or on website: www.who.int/hiv/pub/tb/hivtbmonitoring
- ✓ Comprehensive definitions for the complementary indicators for tuberculosis and malaria proposed in this guide can be found on website: www.who.int/whosis/whostat or in the World Health Statistics indicators: Indicator and Metadata Registry, World Health Statistics 2010

3.3 Data Collection, Analysis and Reporting

The reporting tools, to be used at country level are the ACPAT and MPAT (see Appendix)

The frequency of reporting is annually for all indicators; it is imperative to note that even indicators that are collected by surveys which are done over 2-5 year periods should still be reported annually. The figures from the most recent survey should be reported with date of survey quoted.

Data analysis will be conducted by the AUC Social Affairs Department and feedback reports provided at relevant meetings (Ministers of Health Conference, Experts Meetings, and AU Assembly) as required, as well as to member state ministries of health. Annually, representatives from ministry of health in selected member states will present country-specific progress data on these indicators at relevant meetings e.g. CAMH to promote country ownership and accountability.

3.4 M&E Coordination and Related Supportive Supervision

The reports will be submitted annually in the **month of February** during which reminder emails and phone calls will be made to relevant focal persons.

The RECs, RHOs, WHO, UNAIDS and UNFPA officials designated to support this exercise will also provide ministry of health focal persons with relevant technical support to complete the tools.
All reports must be received in the AUC Social Affairs Department by midnight of the **28th day of February.**

3.5 Capacity Building

Trainings will be conducted on initiation of the tools by the AUC Social Affairs Department and subsequently continuous technical support from designated WHO, UNAIDS and UNFPA officials.

The two Ministry of Health focal persons will also be peer reviewers to each other as well as provide on the job training for new focal persons.

There will be biannual reviews of the indicator sets and tools and whenever there are major revisions re-trainings will be conducted.

SECTION A: “Abuja Call” Indicators

4A.1 HIV &AIDS

Target 1: Reduce HIV prevalence in young people between 15 and 24 years, by at least 25% in all African countries

Indicator 1: HIV prevalence among population aged 15-24 years
Rationale
HIV and AIDS has become a major public health problem in many countries and monitoring the course of the epidemic and impact of interventions is crucial. This is a current UNGASS indicator, it is feasible to collect and field-tested. This is a proxy indicator for HIV incidence in a country which is used by every stakeholder in a country and is an impact measure for the response.
Summary Definition, Methodology for Collection and Calculation
This is the percentage of persons with HIV infection among all people aged 15-24years. This will aggregated using a variety of data sources. National prevalence estimate using antenatal clinic HIV surveillance data from sentinel surveillance at antenatal clinics, and other sources of data on HIV surveillance. For each data source used to estimate HIV prevalence, the following definitions apply: Numerator: All persons who tested positive for HIV (i.e. young pregnant women who are tested for HIV infection while attending antenatal care clinics (ANC clinics), clients attending VCT, persons donating blood, etc.) Denominator: The total number of blood samples tested (i.e. total number of blood samples collected at ANC sites, at VCT sites, during blood donation, etc.) This indicator can also be calculated through data from household survey (DHS type). But this type of survey is less common (once in 4 to 5 years in general). Indicator scores should be given for the whole age range (15–24 years) and may be disaggregated by five-year age-group (i.e. 15–19 years and 20–24 years), by sex and residence (rural/urban).
Unit of Measurement
Percentage
Secondary Data source
UNGASS Report, MDG Report
Indicator Classification, Data Type
Impact, Quantitative
Institutional Responsibility
Min. of Health, NACs, NAPs of Member States with support from RECs, RHOs and international development partners

Indicator 2: Percentage of young women and men aged 15–24 who both correctly identify ways of preventing the sexual transmission of HIV and who reject major misconceptions about HIV transmission
Rationale
HIV epidemics are perpetuated through primarily sexual transmission of infection to successive generations of young people. Sound knowledge about HIV and AIDS is an essential pre-requisite — albeit, often an insufficient condition — for adoption of behaviors that reduce the risk of HIV transmission. The purpose of this indicator is to assess progress towards universal knowledge of the essential facts about HIV transmission.
Summary Definition, Methodology for Collection and Calculation
Through representative population-based surveys, preferred every two years and at least every 4 to 5 years. Respondents are asked the following five questions: 1. Can having sex with only one faithful, uninfected partner reduce the risk of HIV transmission? 2. Can using condoms reduce the risk of HIV transmission? 3. Can a healthy-looking person have HIV? 4. Can a person get HIV from mosquito bites? 5. Can a person get HIV by sharing a meal with someone who is infected? Numerator: Number of population respondents aged 15-24 who gave the correct answers to all five questions Denominator: Number of population respondents aged 15-24 who gave answers, including “don’t know”, to all five questions. Indicator scores are required for all respondents and should be disaggregated by sex and age group (15-19 and 20-24).
Unit of Measurement
Percentage
Secondary Data source
UNGASS Report, MDG Report
Indicator Classification, Data Type
Outcome, Quantitative
Institutional Responsibility
Min. of Health, NACs, NAPs of Member States with support from RECs, RHOs and international development partners

Target 2: Protect and support in 2015, 5 million children orphaned by AIDS and ensure that 100% of orphans and vulnerable children have access to basic services

Indicator 3: Ratio of school attendance of orphans to school attendance of non-orphans aged 10-14 years
Rationale
Due to HIV/AIDS epidemic, more and more children are becoming orphaned. These orphaned children may be at increased risk of neglect by the community and governments than their peers whose parents are available. Children orphaned by AIDS are likely to drop out of school owing to discrimination, emotional distress, inability to pay school fees, and/or the need to care for parents or caretakers infected with HIV or for younger siblings, thereby making orphaned children face an increasingly uncertain future. Monitoring the variations in different outcomes for orphans and comparing them to their peers gives a measure of how communities and governments are responding to their needs. School attendance of children is one of the indicators that assess the status of orphaned children relative to their peers. The purpose of this indicator is to monitor the extent to which AIDS support programmes succeed in securing educational opportunities for orphaned children. The indicator is confined to children ages 10–14 for comparability, as age at school entry varies across countries.
Summary Definition, Methodology for Collection and Calculation
Strictly defined, the number of children orphaned by HIV/AIDS is the estimated number of children who have lost their mother, father or both parents to AIDS before age 15. In practice, the impact of the AIDS epidemic on orphans is measured through the ratio of orphans to non-orphans who are in school. For every child aged 10-14 living in a household, a household member is asked: 1. Is this child's natural mother still alive? If yes, does she live in the household? 2. Is this child's natural father still alive? If yes, does he live in the household? 3. Did this child attend school at any time during the school year? This is calculated as follows: Numerator: The current school attendance rate of children ages 10–14 for whom both biological parents have died Denominator: The current school attendance rate of children ages 10–14 whose parents are both still alive and who live with at least one biological parent. Data for the indicator are collected through household surveys (such as Demographic and Health Surveys and Multiple Indicator Cluster Surveys). Household surveys, such as Demographic and Health Surveys and Multiple Indicator Cluster Surveys, are generally conducted every three to five years.

(This indicator should be reported disaggregated by sex).
Unit of Measurement
Number
Secondary Data source
UNGASS Report, MDG Report
Indicator Classification, Data Type
Outcome, Quantitative
Institutional Responsibility
Min. of Health, NACs, NAPs of Member States with support from RECs, RHOs and international development partners

Target 3: 100% of pregnant women have access to Prevention of Mother-To-Child Transmission (PMTCT), and treatment for HIV-positive women and children

Indicator 4: Percentage of HIV-positive pregnant women who received antiretroviral drugs to reduce the risk of mother-to-child transmission of HIV
Rationale
The purpose of this indicator is to assess progress in preventing mother-to-child transmission of HIV (PMTCT). In the absence of any preventative interventions, infants born to and breastfed by HIV-infected women have roughly a one-in-three chance of acquiring infection themselves. This can happen during pregnancy, during labour and delivery or after delivery through breastfeeding. The risk of mother-to-child transmission can be significantly reduced through the complementary approaches of antiretroviral regimens for the mother and/or infant, implementation of safe delivery practices and use of safer infant feeding practices.
Summary Definition, Methodology for Collection and Calculation
The number of HIV-infected pregnant women who received antiretrovirals (ARVs) to reduce the risk of mother-to-child transmission during the last 12 months is obtained from program monitoring records compiled from patient records and registers. Data should be collected continuously at the facility level. Data should be aggregated periodically (monthly or quarterly) Numerator: Number of HIV-infected pregnant women who received antiretrovirals during the last 12 months to reduce mother-to-child transmission Denominator: Estimated number of HIV-infected pregnant women in the last 12 months.
Unit of Measurement
Percentage

Secondary Data source
UNGASS Report
Indicator Classification, Data Type
Outcome, Quantitative
Institutional Responsibility
Min. of Health, NACs, NAPs of Member States with support from RECs, RHOs and international development partners

Indicator 5: Percentage of pregnant women attending ANC who were tested for HIV and know their results
Rationale
In order for the pregnant women to protect themselves and to prevent infecting their babies, it is important for pregnant women to know their HIV status.
Summary Definition, Methodology for Collection and Calculation
Data from ANC registers. Data should be collected continuously at the facility level. Data should be aggregated periodically, preferably monthly or quarterly. Numerator: Number of pregnant attending ANC who have been tested for HIV during the last 12 months and who know the results Denominator: Total number of pregnant women attending ANC during the last 12 months.
Unit of Measurement
Percentage
Secondary Data source
UNGASS Report
Indicator Classification, Data Type
Outcome, Quantitative
Institutional Responsibility
Min. of Health, NACs, NAPs of Member States with support from RECs, RHOs and international development partners

Indicator 6: Percentage of infants born to HIV-infected mothers who are infected
Rationale
In low-income countries, several difficulties exist in implementing strategies to reduce the rate of mother-to-child HIV transmission. Nevertheless, substantial reductions in mother-

to-child transmission can be achieved through approaches such as short-course antiretroviral prophylaxis. This indicator measures the effectiveness of PMTCT programmes in a country, thus aims to assess progress towards eliminating mother-to-child HIV transmission.
Summary Definition, Methodology for Collection and Calculation
It is measured using spectrum, or other statistical modeling that uses programme coverage and efficacy studies. The indicator will be calculated by taking the weighted average of the probabilities of mother-to-child transmission for pregnant women receiving and not receiving HIV prophylaxis, the weights being the proportions of women receiving and not receiving various prophylactic regimes**.**
Unit of Measurement
Percentage
Secondary Data source
UNGASS Report
Indicator Classification, Data Type
Impact, Quantitative
Institutional Responsibility
Min. of Health, NACs, NAPs of Member States with support from RECs, RHOs and international development partners

Target 4: 100% access of those in need, particularly children, has access to HIV/AIDS treatment, especially antiretroviral, as well as care and support.

Indicator 7: Proportion of adult and children with advanced HIV infection receiving antiretroviral drugs
Rationale
As the HIV epidemic matures, increasing numbers of people are reaching advanced stages of HIV infection(eligible for ART). Antiretroviral therapy (ART) has been shown to reduce mortality among those infected. This indicator assesses the progress in providing antiretroviral combination therapy to all people with advanced HIV infection.
Summary Definition, Methodology for Collection and Calculation
Data from ART registers HIV surveillance systems. Data should be collected continuously at the facility level. Data should be aggregated periodically, preferably monthly or quarterly. The most recent monthly or quarterly data should be used for annual reporting. Numerator: Number of adults and children with advanced HIV infection who are currently

receiving antiretroviral therapy in accordance with the nationally approved treatment protocol (or WHO/UNAIDS standards) at the end of the reporting period Denominator: Estimated number of adults and children with advanced HIV infection This indicator should be disaggregated by sex and age group (<15, 15+).
Unit of Measurement
Percentage
Secondary Data source
UNGASS Report
Indicator Classification, Data Type
Outcome, Quantitative
Institutional Responsibility
Min. of Health, NACs, NAPs of Member States with support from RECs, RHOs and international development partners

Target 5: Enable 100% of HIV patients to benefit from care and assistance, including treatment of opportunistic diseases as well as accompanying psychological care

Indicator 8: Proportion of associations/networks of PLWHA involved in policy development, program implementation and M&E
Rationale
The involvement of associations/networks of PLHIV in the setting up of policies, planning, implementation and M&E of interventions against HIV/AIDS accentuate the importance of such interventions, reduce stigmatization, encourage the recognition of the needs of PLHIV and give the pandemic a more humane look
Summary Definition, Methodology for Collection and Calculation
This indicator is calculated from data obtained from associations and network of associations of PLHIV on one hand and the coordination of the fight against AIDS on the other hand. Numerator: Number of associations/network of associations who reports their participation in any of the following activities: setting up policies, planning, implementation, monitoring and evaluation of HIV/AIDS interventions during the last 12 months. Denominator: Number of associations and network of existing and active associations in the country during the last 12 months.
Unit of Measurement

Percentage
Secondary Data source
No secondary data source. Rapid assessment maybe required
Indicator Classification, Data Type
Outcome, Quantitative
Institutional Responsibility
Min. of Health, NACs, NAPs of Member States with support from RECs, RHOs and international development partners

Target 6: 100% of target population's access Voluntary Counseling and Testing (VCT).

Indicator 9: Percentage of women and men aged 15–49 who received an HIV test in the last 12 months and who know their results
Rationale
HIV counseling and testing is the premier step in reducing the global burden caused by HIV/AIDS. Treatment services can therefore be provided to infected clients and preventive measures accelerated to prevent infection of others. The more VCT/PICT is accepted, the more the silence is broken and stigmatization reduced.
Summary Definition, Methodology for Collection and Calculation
Measurement is usually via Population-based surveys (Demographic Health Survey, AIDS Indicator Survey, Multiple Indicator Cluster Survey or other representative survey). Respondents are asked the following questions: 1. Have you been tested for HIV in the last 12 months? If yes: 2. I don't want to know the results, but did you receive the results of that test? Numerator: Number respondents who have been tested for HIV during the last 12 months and who know the results Denominator: Number of women and men (15-49 yrs) included in the sample. Data indicator should be disaggregated by sex and age group. Routine data sources like data from VCT registers HIV surveillance systems may be used. Data should be collected continuously at the facility level. Data should be aggregated periodically, preferably monthly or quarterly. The most recent monthly or quarterly data should be used for annual reporting.
Unit of Measurement
Percentage
Secondary Data source

UNGASS Report
Indicator Classification, Data Type
Outcome, Quantitative
Institutional Responsibility
Min. of Health, NACs, NAPs of Member States with support from RECs, RHOs and international development partners

Target 7: 100% of blood and blood products are safe to reduce the rate of transmission of HIV/AIDS.

Indicator 10: Percentage of donated blood units screened for HIV in a quality assured manner
Rationale
Universal (100%) screening of donated blood for HIV and other transfusion-transmissible infections cannot be achieved without mechanisms to ensure quality and continuity in screening. It is therefore crucial to assess progress in screening of blood donations in a quality-assured manner to ensure that all blood units are screened for transfusion-transmissible infections, including HIV, and that only those units that are non-reactive on screening tests are released for clinical use.
Summary Definition, Methodology for Collection and Calculation
The information relates to data from the previous 12 months (January - December). This information should be available from the National Blood Transfusion Center. Numerator: Number of donated blood units screened for HIV in blood centers/ blood screening laboratories that have both: (1) followed documented standard operating procedures and (2) participated in an external qualityassurance scheme Denominator: Total number of blood units donated.
Unit of Measurement
Percentage
Secondary Data source
UNGASS Report
Indicator Classification, Data Type
Outcome, Quantitative
Institutional Responsibility
Min. of Health, NACs, NAPs of Member States with support from RECs, RHOs and international development partners

Target 8: 100% of target population have access to and use condoms for HIV prevention ensured.

Indicator 11: Percentage of women and men aged 15–49 who had more than one sexual partner in the past 12 months reporting the use of a condom during their last sexual intercourse
Rationale
Condom use is an important measure of protection against HIV, especially among people with multiple sexual partners. A rise in the indicator is a sign that condom promotion campaigns are having the desired effect among their main target group. However, condom promotion campaigns aim for consistent use of condoms with non-regular partners rather than simply occasional use. The current indicator is therefore considered adequate to address the target since it is assumed that if consistent use rises, use at last high-risk sex will also increase. Condom use at last high-risk sex is the Percentage of young men and women aged 15–49 reporting the use of a condom during sexual intercourse with a non-cohabiting, non-marital sexual partner in the last 12 months.
Summary Definition, Methodology for Collection and Calculation
Through representative Population-based surveys, respondents are asked whether or not they have ever had sexual intercourse and, if yes, they are asked: 1. In the last 12 months, how many different people have you had sexual intercourse with? If more than one, the respondent is asked: 2. Did you or your partner use a condom the last time you had sex? Preferred every two years and at least every 4 to 5 years Numerator: Number of respondents (aged 15–49) who reported having had more than one sexual partner in the last 12 months who also reported that a condom was used the last time they had sex. Denominator: Number of respondents (15–49) who reported having had more than one sexual partner in the last 12 months The indicator should be presented as separate Percentages for males and females, and may be disaggregated by the age groups 15–19, 20–24 and 25–49 years.
Unit of Measurement
Percentage
Secondary Data source
UNGASS Report, MDG Report
Indicator Classification, Data Type
Outcome, Quantitative
Institutional Responsibility
Min. of Health, NACs, NAPs of Member States with support from RECs, RHOs and

international development partners

Target 9: 100% of MARP including refugees and other displaced persons have access to HIV/AIDS prevention, treatment, care and support when these are available to surrounding host populations.

Indicator 12: Percentage of most-at-risk populations (including refugees and other displaced persons) reached with HIV prevention programmes
Rationale
It is important that the most-at-risk groups and populations (MSM, CSWs, IDUs, refugees and other displaced persons) get access to existing services in order to reduce the risk of transmission from viral reservoirs
Summary Definition, Methodology for Collection and Calculation
Through Behavioral surveillance or other special surveys, they are asked whether during the last 12 months before the survey they have been exposed to prevention intervention (example: have seen/listen to announcements on HIV, received BCC material, HIV testing and counseling, condoms etc.), discuss with peer educators about HIV, etc. Numerator: Number of most-at-risk population respondents who replied "yes" at least one of the questions Denominator: Total number of respondents surveyed Data collected for this indicator should be reported separately for each MARP (MSM, CSWs, IDUs, refugees and other displaced persons) and disaggregated by sex and age group (15–19, 20–24 and 25–49 years).
Unit of Measurement
Percentage
Secondary Data source
UNGASS Report
Indicator Classification, Data Type
Outcome, Quantitative
Institutional Responsibility
Min. of Health, NACs, NAPs of Member States with support from RECs, RHOs and international development partners

Target 10: 100% of all clients accessing HIV care and support services are screened for TB to ensure early detection and treatment.

Indicator 13: Percentage of clients who are receiving HIV care and support services that are screened for TB
Rationale
Tuberculosis (TB) is one of the commonest causes of morbidity and mortality in people living with HIV, even those on antiretroviral therapy. Intensified TB case-finding and access to quality diagnosis and treatment of TB in accordance with international/national guidelines is essential for improving the quality and quantity of life for people living with HIV/AIDS by ensuring early detection and treatment. HIV infection is the single most important factor that increases the risk of developing TB. Implementation of HIV/AIDS control programme should therefore be closely linked with TB prevention and control programme. This indicator helps to assess management and collaboration between HIV and TB treatment programmes as successful collaboration can lead to effective treatment and control of HIV/TB co-infected patients.
Summary Definition, Methodology for Collection and Calculation
Routine administrative data should be collected continuously at the facility level. Numerator: clients who are receiving HIV care and support services that are screened for TB Denominator: clients who are receiving HIV care and support services.
Unit of Measurement
Percentage
Secondary Data source
MDG Report
Indicator Classification, Data Type
Outcome, Quantitative
Institutional Responsibility
Min. of Health, NACs, NAPs of Member States with support from RECs, RHOs and international development partners

Target 11: 100% of HIV-positive TB patient's access antiretroviral treatment.

Indicator 14: Percentage of HIV-positive TB patients that receiving treatment for HIV and TB in case of co-infection
Rationale

Tuberculosis (TB) is one of the commonest causes of morbidity and mortality in people living with HIV, even those on antiretroviral therapy. Intensified TB case-finding and access to quality diagnosis and treatment of TB in accordance with international/national guidelines is essential for improving the quality and quantity of life for people living with HIV/AIDS by ensuring early detection and treatment. HIV infection is the single most important factor that increases the risk of developing TB. Implementation of HIV/AIDS control programme should therefore be closely linked with TB prevention and control programme. This indicator helps to assess management and collaboration between HIV and TB treatment programmes as successful collaboration can lead to effective treatment and control of HIV/TB co-infected patients.
Summary Definition, Methodology for Collection and Calculation
Programme data and estimates of incident TB cases in people living with HIV should be collected continuously at the facility level. Data should be aggregated periodically, preferably monthly or quarterly, and reported annually. The most recent year for which data and estimates are available should be reported here. Numerator: Number of adults with advanced HIV infection who are currently receiving antiretroviral therapy in accordance with the nationally approved treatment protocol (or WHO/UNAIDS standards) and who were started on TB treatment (in accordance with national TB programme guidelines) within the reporting year Denominator: Estimated number of incident TB cases in people living with HIV. Data should be disaggregated by sex
Unit of Measurement
Percentage
Secondary Data source
MDG Report
Indicator Classification, Data Type
Outcome, Quantitative
Institutional Responsibility
Min. of Health, NACs, NAPs of Member States with support from RECs, RHOs and international development partners

4A.2 TUBERCULOSIS

Target 13: Rapidly improve TB case detection and treatment success rates with expanded DOTS coverage at national and district levels

Indicator 15: TB case detection rate
Rationale
TB case detection rate provides an indication of effectiveness of national TB control programs in finding and diagnosing people with TB.
Summary Definition, Methodology for Collection and Calculation
The tuberculosis detection rate is the Percentage of estimated new infectious tuberculosis cases detected under the internationally recommended tuberculosis control strategy DOTS. DOTS combines five elements—political commitment, microscopy services, drug supplies, surveillance and monitoring systems and use of highly efficacious regimes—with direct observation of treatment. Numerator: The number of new smear-positive case notifications in a given year Denominator: Estimated number of new smear-positive TB cases countrywide that year. For some countries, there is a margin of uncertainty in the estimation of the denominator. This indicator is expressed as a ratio
Unit of Measurement
Percentage
Secondary Data source
MDG Report, WHO
Indicator Classification, Data Type
Outcome, Quantitative
Institutional Responsibility
Min. of Health of Member States with support from RECs, RHOs and international development partners

Indicator 16: Treatment success rate
Rationale
It is essential to prevent the spread of the infection and drug resistance. This indicator helps to assess the implementation of TB control programme and measures the program's capacity to retain patients through a complete course of chemotherapy with a favorable clinical result.
Summary Definition, Methodology for Collection and Calculation

The Percentage of a cohort of TB cases registered in a specified period that successfully completed treatment, whether with bacteriologic evidence of success ("cured") or without ("treatment completed"). The cohort of new smear-positive cases successfully treated is calculated as following: Numerator: Number of new smear-positive pulmonary TB cases registered in a specified period that were cured (i.e. laboratory confirmed negative after completing treatment) plus the number that completed treatment Denominator: Total number of new smear-positive pulmonary TB cases registered in the same period
Unit of Measurement
Percentage
Secondary Data source
MDG Report, WHO
Indicator Classification, Data Type
Outcome, Quantitative
Institutional Responsibility
Min. of Health of Member States with support from RECs, RHOs and international development partners

Indicator 17: DOTS Coverage
Rationale
DOTS coverage is an indicator that is particularly useful in the early stages of DOTS implementation. But it is also somewhat simplistic, as it only measures the presence or absence of DOTS services within a given administrative area
Summary Definition, Methodology for Collection and Calculation
This indicator measures the extent of a country's population "covered" by DOTS. The goal is to cover 100% of the population. It is the Percentage of the population living in the area of basic management units implementing the DOTS strategy. Numerator: Population living in the area of basic management units implementing the DOTS strategy Denominator: Total population
Unit of Measurement
Percentage
Secondary Data source
WHO
Indicator Classification, Data Type
Outcome, Quantitative

Institutional Responsibility
Min. of Health of Member States with support from RECs, RHOs and international development partners

Target 14: Ameliorate the detection and treatment of cases of TB-MR

Indicator 18: Surveillance of multidrug-resistant TB
Rationale
The emergence of multi drug resistance poses a threat to the existing control efforts
Summary Definition, Methodology for Collection and Calculation
The national TB control program assesses the prevalence of multidrug-resistant TB at least once within a 5-year period. This is a yes/no indicator. What It Measures: This indicator measures the availability of information on drug susceptibility in new and previously treated TB patients, mainly with regards to multidrug resistance (i.e., resistance to at least isoniazid and rifampicin), on the basis of national or sub national representative surveys. This information is useful for monitoring the quality of the program because MDR-TB prevalence rates indicate the potential effectiveness of the treatment regimens, the expected load of MDR-TB patients for program decisions on treatment implementation of chronic and MDR-TB patients, and the need of resources. How to Measure It: A “yes” response to this indicator should be based on the availability of data from a national or sub national representative survey following protocols and quality assurance mechanisms of the WHO on Anti-Tuberculosis Drug Resistance Surveillance. Data Sources are National TB program data and reports
Unit of Measurement
Yes/No
Secondary Data source
WHO
Indicator Classification, Data Type
Outcome, Qualitative
Institutional Responsibility
Min. of Health of Member States with support from RECs, RHOs and international development partners

Target 15: Scale up interventions to manage TB and HIV together, including increased access to anti-retroviral therapy for TB patients who are co-infected with HIV and to chemoprophylaxis against TB for people with HIV

Indicator 19: HIV Sero-prevalence among TB patients
Rationale
Estimating the prevalence of HIV among TB patients is an important step in planning TB control activities, planning and targeting integrated TB and HIV activities, and monitoring the effectiveness of these activities over time.
Summary Definition, Methodology for Collection and Calculation
Number of all newly registered TB patients who are HIV positive, expressed as a Percentage of all registered TB patients. Numerator: Total number of newly registered TB patients (registered over a given period of time) who are HIV positive Denominator: Total number of newly registered TB patients (registered over the same given time period) who were tested for HIV Should be collected routinely by National TB control programs
Unit of Measurement
Percentage
Secondary Data source
WHO
Indicator Classification, Data Type
Impact, Quantitative
Institutional Responsibility
Min. of Health of Member States with support from RECs, RHOs and international development partners

Target 16: 100% of TB patients has access to HIV testing and counseling services.

Indicator 20: Percentage of TB patients who received HIV testing and counseling services
Rationale
Tuberculosis (TB) is one of the commonest causes of morbidity and mortality in people living with HIV, even those on antiretroviral therapy. Intensified TB case-finding and access to quality diagnosis and treatment of TB in accordance with international/national

guidelines is essential for improving the quality and quantity of life for people living with HIV/AIDS by ensuring early detection and treatment . A measure of the Percentage of HIV-positive TB cases that access appropriate treatment for their TB and HIV is important. This indicator helps to assess management and collaboration between HIV and TB treatment programmes as successful collaboration can lead to effective treatment and control of HIV/TB co-infected patients.
Summary Definition, Methodology for Collection and Calculation
Numerator: Number respondents (TB patients) who have been offered HIV testing and counseling services. Denominator: Total number of TB patients included in the sample. Should be collected routinely by National HIV and TB control programs
Unit of Measurement
Percentage
Secondary Data source
WHO
Indicator Classification, Data Type
Outcome, Quantitative
Institutional Responsibility
Min. of Health of Member States with support from RECs, RHOs and international development partners

4A.3 MALARIA

Target 17: By 2015: Universal coverage continues with effective interventions Global and national mortality is near zero for all preventable deaths

Indicator 21: Proportion of children under 5 years old who slept under an ITN the previous night.
Rationale
In areas of intense malaria transmission, malaria-related morbidity and mortality are concentrated in young children, and the use of insecticide-treated nets (ITN) by children under 5 has been demonstrated to considerably reduce malaria disease incidence, malaria-related anemia and all cause under- 5 mortality.
Summary Definition, Methodology for Collection and Calculation
Data are derived from nationally-representative household surveys such as DHS, MICS, Malaria Indicator Surveys (MIS), and `rider` questions on other representative population-based surveys, that include questions on whether children under five years of age slept under an ITN the previous night. Numerator: The number of children aged 0-59 months who slept under an insecticide-treated mosquito net the night prior to the survey Denominator: The total number of children aged 0-59 months included in the survey
Unit of Measurement
Percentage
Secondary Data source
MDG Report
Indicator Classification, Data Type
Outcome, Quantitative
Institutional Responsibility
Min. of Health of Member States with support from RECs, RHOs and international development partners

Target 18: Global incidence is reduced by 75% from 2000 levels: to less than 85-125 million cases.
The malaria-related Millennium Development Goal is achieved: halting and beginning to reverse the incidence of malaria by 2015; and At least 8-10

countries currently in the elimination stage will have achieved zero incidence of locally transmitted infection.

Indicator 22: Incidence rate of malaria
Rationale
Information on the incidence of malaria is required to determine the needs for treatment of malaria especially for the underserved populations and, in situations of resource constraint, to target interventions to high priority areas. Changes in malaria incidence give an indication of the burden of malaria in a population, and of the size of the task faced by a national malaria control programme. It can help to judge the success of program implementation, and help to determine whether programs are performing as expected or whether adjustments in the scale or in the blend of strategies are required.
Summary Definition, Methodology for Collection and Calculation
The Incidence of malaria is the number of new cases of malaria per 100,000 people each year. Numerator: Number of new malaria cases Denominator: Total population Incidence rates are adjusted downward for populations living in urban settings and the expected impact of ITN and IRS programs.
Unit of Measurement
Per 100,000
Secondary Data source
MDG Report
Indicator Classification, Data Type
Impact, Quantitative
Institutional Responsibility
Min. of Health of Member States with support from RECs, RHOs and international development partners

Indicator 23: Death rate associated with malaria
Rationale
Information on malaria death rates can help to judge the success of program implementation, and may point to failures of programs in terms of prevention of malaria or access to effective treatment.
Summary Definition, Methodology for Collection and Calculation
The death rate associated with malaria is the number of deaths caused by malaria per 100,000 people per year.

The number of malaria deaths is derived by one of two methods: (i) By multiplying the estimated number of P. falciparum malaria cases in a country by a fixed case-fatality rate. This method is used for all countries outside the African Region and for countries in the African Region where estimates of case incidence were derived from routine reporting systems and where malaria comprises less than 5% of all deaths in children under 5 as described in the Global Burden of Disease Incremental Revision for 2004 (GBD 2004). A case fatality rate of 0.45% is applied to the estimated number of P. falciparum cases for countries in the African Region and a case fatality rate of 0.3% for P. falciparum cases in other regions.1 (ii) For countries in the African Region where malaria comprises 5% or more of all deaths in children under 5 the number of deaths are derived from an estimate of the number of people living at high, low or no risk of malaria. Malaria deaths rates for these populations are inferred from longitudinal studies of malaria deaths as recorded in the published literature.
Unit of Measurement
Per 100,000
Secondary Data source
MDG Report
Indicator Classification, Data Type
Impact, Quantitative
Institutional Responsibility
Min. of Health of Member States with support from RECs, RHOs and international development partners

Indicator 24: Proportion of Households with at least one ITN and/or sprayed by IRS in the last 12 months.
Rationale
This indicator measures the success or failure of control programme implementation in terms of prevention of malaria. By 2015: Universal coverage continues with effective interventions for malaria control; include: • Availability of ITN at HH or IRS • Sleeping under ITN • Appropriate and early treatment

Summary Definition, Methodology for Collection and Calculation
Numerator: Households with at least one ITN and/or sprayed by IRS in the last 12 months. Denominator: Estimated number of Households.
Unit of Measurement
Percentage
Secondary Data source
MDG Report
Indicator Classification, Data Type
Outcome, Quantitative
Institutional Responsibility
Min. of Health of Member States with support from RECs, RHOs and international development partners

Indicator 25: Proportion of children under 5 years old with fever in last 2 weeks who received antimalarial treatment according to national policy within 24 hours from onset of fever.
Rationale
Prompt treatment with effective antimalarial drugs for children with fever in malaria-risk areas is a key intervention to reduce mortality. In addition to being listed as a global MDG6, effective treatment for malaria is also identified by WHO, UNICEF, and the World Bank as one of the main interventions to reduce the burden of malaria in Africa. IPT of sulphadoxine pyrimethamine (SP) given to pregnant women has been shown to reduce the risk of maternal anemia, placental parasitemia, and low birth-weight. IPT in pregnancy is therefore a key component of the technical strategy for control and prevention of malaria in pregnancy. This indicator captures the national level use of IPT to prevent malaria among pregnant women.
Summary Definition, Methodology for Collection and Calculation
Percentage of children aged < 5 years with fever in malaria-risk areas being treated with effective antimalarial drugs. Numerator: Number of children under 5 years old with fever in last 2 weeks who received antimalarial treatment according to national policy within 24 hours from onset of fever Denominator: Estimated number of children under 5 years old with fever in last 2 weeks
Unit of Measurement
Percentage
Secondary Data source
MDG Report

Indicator Classification, Data Type
Outcome, Quantitative
Institutional Responsibility
Min. of Health of Member States with support from RECs, RHOs and international development partners

Indicator 26: Proportion of pregnant women who received 2 doses of Intermittent Preventive Treatment of malaria during their last pregnancy (IPT)
Rationale
Prompt treatment with effective antimalarial drugs for children with fever in malaria-risk areas is a key intervention to reduce mortality. In addition to being listed as a global MDG6, effective treatment for malaria is also identified by WHO, UNICEF, and the World Bank as one of the main interventions to reduce the burden of malaria in Africa. IPT of sulphadoxine pyrimethamine (SP) given to pregnant women has been shown to reduce the risk of maternal anemia, placental parasitemia, and low birth-weight. IPT in pregnancy is therefore a key component of the technical strategy for control and prevention of malaria in pregnancy. This indicator captures the national level use of IPT to prevent malaria among pregnant women.
Summary Definition, Methodology for Collection and Calculation
Numerator: Number of pregnant women who received 2 doses of Intermittent Preventive Treatment of malaria during their last pregnancy Denominator: Estimated Number of pregnant women
Unit of Measurement
Percentage
Secondary Data source
MDG Report
Indicator Classification, Data Type
Outcome, Quantitative
Institutional Responsibility
Min. of Health of Member States with support from RECs, RHOs and international development partners

4A.4 HEALTH SYSTEMS STRENGTHENING

Indicator 27: General government expenditure on health as a Percentage of total government expenditure
Indicator 28: General government expenditure on health as a Percentage of total expenditure on health
Indicator 29: Out-of-pocket expenditure as % of total expenditure on health
Rationale
These are core indicators of health financing systems. These indicators contribute to understanding the relative weight of public entities in total expenditure on health. The Abuja Call advocates for the allocation 15% of the national budget to health
Summary Definition, Methodology for Collection and Calculation
These data are generated from sources that WHO has been collecting for over ten years. The most comprehensive and consistent data on health financing is generated from national health accounts (NHA). Not all countries have or update national health accounts and in these instances, data is obtained through technical contacts in-country or from publicly-available documents and reports and harmonized to the NHA framework. Missing values are estimated using various accounting techniques depending on the data available for each country.
Unit of Measurement
Percentage
Secondary Data source
WHO
Indicator Classification, Data Type
Outcome, Quantitative
Institutional Responsibility
Min. of Health of Member States with support from the Ministry of Finance, RECs, RHOs and international development partners

Indicator 30: Percentage of population covered by a demand-side (Social Health Insurance, Community Based Insurance) scheme
Rationale
This is a core indicator of health financing systems and it contributes to understanding the contribution of public sector to the total expenditure on health. This indicator measures the coverage of the community health financing mechanisms or social health insurance in

the population.
Summary Definition, Methodology for Collection and Calculation
Numerator: Number of people covered by a demand-side scheme Denominator: Estimated population. See NHA
Unit of Measurement
Percentage
Secondary Data source
-
Indicator Classification, Data Type
Outcome, Quantitative
Institutional Responsibility
Min. of Health of Member States with support from the Ministry of Finance, RECs, RHOs and international development partners

Indicator 31: Number of health workers per 10 000 population
Rationale
This is a health workforce indicator. It provides the stock of all health workers relative to population and it can be used for advocacy purposes. Measuring and monitoring the availability of health workers is a critical starting point for understanding the health system resources situation in a country. Low density of health personnel usually suggests inadequate capacity to meet minimum coverage of essential services.
Summary Definition, Methodology for Collection and Calculation
Density of health worker per A 10 000 population. WHO recommends 23 health workers per 10000 populations. Data from health facility assessments and administrative reporting systems may be based on head counts of employees, staffing records, payroll records, training records, or tallies from other types of routine administrative records on human resources. Numerator: Estimated number of health workers by professional corps: Medical doctor, Nurse and midwife, Community health worker, Total (medical and paramedical) Denominator: Estimated National population
Unit of Measurement
Per 10,000
Secondary Data source
WHO
Indicator Classification, Data Type
Outcome, Quantitative

Institutional Responsibility
Min. of Health of Member States with support from RECs, RHOs and international development partners

Indicator 32: Proportion of population with access to affordable essential drugs on a sustainable basis

Rationale

Target 8e of the Millennium Development Goals acknowledges the need to improve the availability of affordable medicines for the world's poor. Several countries have made substantial progress towards increasing access to essential medicines and treatments to fight HIV/AIDS, malaria and tuberculosis, but access to essential medicines in developing countries is not adequate. Essential medicines are intended to be available within the context of functioning health systems at all times, in adequate amounts, in the appropriate dosage. This indicator monitors access to essential medicines which is closely intertwined with service delivery and governance.

Summary Definition, Methodology for Collection and Calculation

Access is defined as having medicines continuously available and affordable at public or private health facilities or medicine outlets that are within one hour's walk from the homes of the population. Given its complexity, an overall picture of the degree of access to essential medicines can only be generated using a range of World Health Organization (WHO) medicine access indicators that provide data on medicine availability and price in both the public and the private sectors, in combination with key policy indicators. These are:

- Access to essential medicines/technologies as part of the fulfillment of the right to health, recognized in the constitution or national legislation.
- Existence and year of last update of a published national medicines policy.
- Existence and year of last update of a published national list of essential medicines.
- Legal provisions to allow/encourage generic substitution in the private sector.
- Public and private per capita expenditure on medicines.
- Percentage of population covered by health insurance.
- Average availability of 30 selected essential medicines in public and private health facilities
- Median consumer price ratio of 30 selected essential medicines in public and private health facilities
- Margin or mark-up (in per cent) between producer and consumer price

Method of computation: The World Health Organization regularly monitors access to a

minimum of 20 most essential drugs. Data collection and source: The Action Programme on Essential Drugs of the World Health Organization periodically interviews experts in each country about the pharmaceutical situation, asking them to rate access by the population to essential drugs at less than 50 per cent, 50–80 per cent, 80–95 per cent or more than 95 per cent (WHO Expert Committee on Essential Drugs, November 1999).
Unit of Measurement
Percentage
Secondary Data source
WHO, MDG Report
Indicator Classification, Data Type
Outcome, Quantitative
Institutional Responsibility
Min. of Health of Member States with support from RECs, RHOs and international development partners

Indicator 33: A nationally coordinated multi-year disease-specific M&E plan with a schedule for survey implementation and data analysis has been prepared and is being implemented
Rationale
The development of a coordinated multi-year disease M&E plan is an important tool that could address program weaknesses in terms of timely, high-quality data that will enable evidence-based decision making for decision-makers, including program managers, to facilitate improved health outcomes. This indicator helps to monitor the existence of the plan and whether it is being implemented as outlined.
Summary Definition, Methodology for Collection and Calculation
This indicator measures existence of a national disease-specific M&E plan for HIV, TB or malaria. The indicator has two parts. • The first is the existence of a coordinated multi-year disease-specific M&E plan with a schedule for survey implementation and data analysis. • The second part is whether the plan is being implemented as outlined. Measurement: The indicator is generated by conducting a desk review of M&E plan and checking whether it is a multiyear plan, whether it has a survey implementation schedule and whether it has a data analysis schedule. The second part after the review of the plan is to monitor its implementation. An annual review is therefore conducted to determine

whether the plan is being implemented according to what is outlined in the plan. The response here will be a Yes or No, Yes if the requirements of both parts are fulfilled
Unit of Measurement
Yes/No/In progress
Secondary Data source
-
Indicator Classification, Data Type
Outcome, Qualitative
Institutional Responsibility
Min. of Health of Member States

Indicator 34: Policy index
Rationale
Government policies are widely recognized as framing the rules which govern the behavior of actors in the health system and ensuring compliance with these rules.
Summary Definition, Methodology for Collection and Calculation
Ten rules-based indicators are proposed that cover most of the key aspects of health policy in low-and middle income countries. These indicators assess whether countries have policies, regulations, and strategies in place to promote good governance in the health sector. The index consists of ten items, each of which would be rated as zero (adequate policy does not exist or cannot be assessed) or one (adequate policy is available). The maximum score would therefore by 10. **Components of the Policy Index** 1. Existence of up-to-date national health strategy linked to national needs and priorities 2. Existence of an essential medicines list updated within the last five years and disseminated annually: 3. Existence of policies on drug procurement which specify: (i) procurement of the most cost-effective drugs in the right quantities; and (ii) open, competitive bidding of suppliers of quality products. 4. TB: Existence of a national strategic plan for TB which reflects the six principal components of the Stop TB Strategy as outlined in the Global Plan to Stop TB 2006–2015 5. Malaria: Existence of a national malaria strategy/policy which includes drug efficacy monitoring, vector control, and insecticide resistance monitoring 6. HIV/AIDS: Completion of the UNGASS National Composite Policy Index Questionnaire for HIV/AIDS 7. Maternal Health: Existence of a comprehensive reproductive health policy consistent with the ICPD action plan

8. Child Health: Existence of an updated comprehensive, multi-year plan for childhood immunization
9. Existence of key health sector documents, which are published and disseminated annually (such as budget documents, annual performance reviews, health indicators).
10. Existence of mechanisms, such as surveys, for obtaining timely client input on the existence of appropriate, timely and effective access to health services.

Indicators Sources

- National Heath Policy
- Pharmaceutical policies with norms for treatment protocols, procurement
- National pharmaceutical assessments
- Partnerships and UN Agencies (Stop TB, RBM, UNAIDS, WHO, UNFPA)
- Facility surveys to monitor availability of essential medicines available at health facilities

Unit of Measurement
Number scale (0-10)
Secondary Data source
WHO
Indicator Classification, Data Type
Outcome, Qualitative
Institutional Responsibility
Min. of Health of Member States with support from RECs, RHOs and international development partners

SECTION B: “MPoA” Indicators

4B.1 OBJECTIVE: TO INTEGRATE HIV, STI, MALARIA AND SRH SERVICES INTO PRIMARY HEALTH CARE SERVICES

Target 1: Integrate SRHR and HIV/AIDS/STI and malaria in key national health policy documents and plans

Indicator 1: Existence of national health policy frameworks and plans that integrates SRHR, HIV/AIDS/STI and Malaria services
Rationale
The integration of HIV/AIDS/STIs is rational in terms of co-infection and common prevention strategies. Because of the devastating nature of malaria and its high prevalence in many parts of Africa, screening for malaria improves the opportunity for treatment.
Summary Definition, Methodology for Collection and Calculation
According to WHO, integration of services means "The management and delivery of health services so that clients receive a continuum of preventive and curative services according to their needs over time and across different levels of the health system." At national level, find out if the country has policy documents and plans in which malaria and SHR services are integrated into PHC. Sources of Data are Ministries of Health. Recorded result is Yes or No or In Progress. Rapid assessment required.
Unit of Measurement
Yes/ No/ In Progress
Indicator Classification, Data Type
Output, Qualitative
Institutional Responsibility
Min. of Health of Member States with support from RECs and RHOs and international development partners

Target 2: Develop and/or implement strategies to address Sexual & Gender Based Violence (SGBV) in collaboration with other relevant stakeholders

Indicator 2: Existence of laws dealing with SGBV
Rationale
The high prevalence of sexual and gender based violence requires specific laws and

policies to provide a framework for addressing the problem in many countries of the continent.
Summary Definition, Methodology for Collection and Calculation
SGBV encompasses a wide variety of abuses; sexual threats, exploitation, humiliation, assaults, molestation, domestic violence, incest, involuntary prostitution (sexual bartering), torture, insertion of objects into genital openings and attempted rape. At national level, find out if the country has laws that address SGBV. Recorded result is Yes or No or In Progress Rapid assessment required.
Unit of Measurement
Yes/ No/ In Progress
Indicator Classification, Data Type
Output, Qualitative
Institutional Responsibility
Min. of Health of Member States with support from the Ministry of Gender, RECs and RHOs and international development partners

Target 3: Conduct Research and Develop and/or implement strategies to address early marriages and harmful traditional practices (HTP) such as Female Genital Mutilation (FGM)

Indicator 3: Existence of programmes to address HTP
Rationale
There is limited knowledge of harmful traditional practices and these vary according to countries and regions. In the past 20 years, there has been an increase in issues relating female genital mutilation.
Summary Definition, Methodology for Collection and Calculation
Programmes would address the son preference as a tradition, early and forced child marriage & female genital mutilation and wife inheritance. At national level, find out if the country has programmes that address harmful traditional practices. Examples of such practices are wife inheritance, FGM, child marriages. Recorded result is Yes or No or In Progress Rapid assessment required.
Unit of Measurement
Yes/ No/ In Progress
Indicator Classification, Data Type

Output, Qualitative
Institutional Responsibility
Min. of Health of Member States with support from the Ministry of Gender, RECs and RHOs and international development partners

Target 4: Review and adopt training curricula for service providers to incorporate integration of SRH with STI/HIV/AIDS and nutrition for use in training institutions.

Indicator 4: Percentage of Training institutions using the revised curriculum that integrates SRHR into HIV/STI services
Rationale
A precursor to implementation of integration of defined services is adequate training for service providers.
Summary Definition, Methodology for Collection and Calculation
This is the Percentage of Training institutions using the revised SRHR integrated curricula (integrating SRHR with STI/HIV/AIDS and nutrition) Numerator: Number of institutions in the country with SRHR integrated with STI/HIV/AIDS and nutrition as evidenced by their curriculum. Denominator: Total number of government registered health training institutions, namely colleges training nurses, doctors and other public health workers. Rapid assessment required.
Unit of Measurement
Percentage
Indicator Classification, Data Type
Output, Quantitative
Institutional Responsibility
Min. of Health of Member States with support from the Ministry of Education, RECs and RHOs and international development partners

Target 5: Ensure access to services that address gender-based violence including management of sexual abuse, emergency contraception and HIV post exposure prophylaxis and STI treatment in an integrated and coordinated manner

Indicator 5: Percentage of PHCs offering GBV management services (including STI, PEP and EC services) for SGBV victims

Rationale
SGBV services span from prevention, treatment, care and support of victims. PHC services occupy a crucial role for women to receive services.
Summary Definition, Methodology for Collection and Calculation
This is the Percentage of PHCs offering STI, PEP and EC services for SGBV victims. This indicator should be computed at national level. Numerator: Number of service delivery points that offer post rape services to victims. The services should include all the three components of STI, PEP and EC. Denominator: Total number of government health facilities. Rapid assessment required
Unit of Measurement
Percentage
Indicator Classification, Data Type
Outcome, Quantitative
Institutional Responsibility
Min. of Health of Member States with support from RECs and RHOs and international development partners

Target 6: Provide screening and management services for Cancers of the reproductive system

Indicator 6: Proportion of PHCs~~facilities~~offering screening services for cancers of the reproductive system for both men and women
Rationale
Cancers of the reproductive health system are a neglected area for males and females.
Summary Definition, Methodology for Collection and Calculation
PHCs offering screening services for cancers of the reproductive system for both men and women. This indicator should be computed at national level. Numerator: Number of service delivery points that offer screening and management of services for cancer of the reproductive system for men and women. Denominator: Total number of government health facilities providing clinical services.
Unit of Measurement
Percentage
Indicator Classification, Data Type
Outcome, Quantitative
Institutional Responsibility

Min. of Health of Member States with support from RECs and RHOs and international development partners

Target 7: Integrate nutrition education and food supplementation programmes with SRHR and HIV/AIDS/STI services.

Indicator 7: Prevalence of underweight children under 5 years of age
Rationale
This indicator measures the nutritional imbalance and malnutrition resulting in under-nutrition (assessed by under-weight, stunting and wasting). Child growth is the most widely used indicator of nutritional status in a community. Children who suffer from growth retardation as a result of poor diets and/or recurrent infections tend to have a greater risk of suffering illness and death. Nutrition and other problems of growth may be identified through weight for height and for age for children.
Summary Definition, Methodology for Collection and Calculation
This is the Percentage of children under 5 years of age whose weight is less than -2 standard deviation from the median for the international reference population (0-59 months) Numerator: Number of children under age five that fall below minus two standard deviations from the median weight for age of the WHO standard \ Denominator: Total number of children under age five that were weighed Report the computations by age group for 0 to less than 60 months. Disaggregation by gender is encouraged for monitoring purposes. Data are available from DHSs, household, nutrition and cluster surveys.
Unit of Measurement
Percentage
Secondary Data source
MDG Report
Indicator Classification, Data Type
Outcome, Quantitative
Institutional Responsibility
Min. of Health of Member States with support from RECs and RHOs and international development partners

Indicator 8: Prevalence of anaemia in pregnancy
Rationale
Anaemia during pregnancy means a women's body is a little short of red blood cells which contain haemoglobin for carrying oxygen for the mother and baby. These are necessary for proper development of the foetus.
Summary Definition, Methodology for Collection and Calculation
Prevalence of anaemia in pregnancy Numerator: Number of women who are anemic Denominator: Number of women who are pregnant for a defined time period
Unit of Measurement
Percentage
Secondary Data source
MDG Report
Indicator Classification, Data Type
Outcome, Quantitative
Institutional Responsibility
Min. of Health of Member States with support from RECs and RHOs and international development partners

4B.2 OBJECTIVE: TO STRENGTHEN COMMUNITY-BASED STI/HIV/AIDS/STI, SRHR, MALARIA AND NUTRITION SERVICES

Target 8: Develop and implement behavior change communication strategy for community mobilization and education on health promotion and utilization of integrated SRH with STI/HIV/AIDS, malaria and nutrition.

Indicator 9: Existence of a national comprehensive BCC strategy
Rationale
A National Behavior Change Communication (BCC) Strategy enables the public and private sector, civil society and all implementing partners in a country to develop and implement more effective and harmonized SRH interventions by strengthening the BCC capacity of their program managers. It will also provide a strategic focus to planning BCC for coordinated response at all levels
Summary Definition, Methodology for Collection and Calculation
Whether the country has a comprehensive BCC strategy focused on health promotion and

utilization of integrated SRHR with STI/HIV/AIDS, malaria and nutrition services At national level, find out if the country has a communication strategy to promote positive health outcomes with respect to promotion and utilization of integrated SRH with STI/HIV/AIDS, malaria and nutrition. Recorded result is Yes or No or In Progress. Rapid assessment required
Unit of Measurement
Yes/ No/ In Progress
Indicator Classification, Data Type
Output, Qualitative
Institutional Responsibility
Min. of Health of Member States with support from RECs and RHOs and international development partners

Target 9: Existence of supportive legislation protocols and guidelines for family planning in the country

Indicator 10: Existence of supportive legislation, protocols and guidelines for family planning ~~exist~~ services.
Rationale
An existence of legislative instruments and guidelines implies that women have a greater chance to access services at various levels.
Summary Definition, Methodology for Collection and Calculation
Does the country have supportive legislation, protocols and guidelines for family planning? At national level, find out if the country has supportive legislation, protocols and guidelines for family planning. Recorded result is Yes or No or In Progress. Rapid assessment required
Unit of Measurement
Yes/ No/ In Progress
Indicator Classification, Data Type
Output, Qualitative
Institutional Responsibility
Min. of Health of Member States with support from RECs and RHOs and international development partners

4B.3 OBJECTIVE: TO REPOSITION FAMILY PLANNING AS A KEY STRATEGY FOR ATTAINMENT OF THE MDGS

Target 10: Integrate and provide FP as a component of Maternal, New born and Child Health service package

Indicator 11: Contraceptive Prevalence Rate
Rationale
This is an important measure of the level of use of contraceptives for women. Contraceptive prevalence rate is an indicator of health, population, development and women's empowerment. The indicator provides a measure of population coverage of contraceptive use from all sources of supply and all methods. It is a proxy measure of access to reproductive health services related to child mortality, maternal health, HIV/ADS and gender equality. In addition, it is a measure of outcome for family planning programme and the population level.
Summary Definition, Methodology for Collection and Calculation
The contraceptive prevalence rate is the Percentage of women who are practicing, or whose sexual partners are practicing, any form of contraception. It is usually reported for women ages 15–49 in marital or consensual unions Numerator: The number of women ages 15–49 in marital or consensual unions who report that they are practicing (or whose sexual partners are practicing) contraception Denominator: Total number of women ages 15–49. Contraceptive prevalence data are obtained mainly from household surveys, e.g. Demographic and Health Surveys, Multiple Indicator Cluster Surveys and contraceptive prevalence surveys.
Unit of Measurement
Percentage
Secondary Data source
MDG Report
Indicator Classification, Data Type
Outcome, Quantitative
Institutional Responsibility
Min. of Health of Member States with support from RECs and RHOs and international development partners

Indicator 12: Unmet need for Family Planning
Rationale
The indicator measures the extent of a country's health system and social conditions support the ability of women to realize their stated preference to delay or limit births. Unmet need for family planning provides a measurement of the ability of women in achieving their desired family size and birth spacing. It also provides an indication of the success of reproductive health programmes in addressing the demand for family planning services. Unmet need for family planning services means there is a gap in supplying services for family planning where there is a demand and therefore, the programme should seek to fill the gap.
Summary Definition, Methodology for Collection and Calculation
Women with unmet need for family planning for limiting births are those who are fecund and sexually active but are not using any method of contraception, and report not wanting any more children. This is a subcategory of total unmet need for family planning, which also includes unmet need for spacing births. The concept of unmet need points to the gap between women's reproductive intentions and their contraceptive behavior. For MDG monitoring, unmet need is expressed as a Percentage of women who are married or in a consensual union who are not using a contraceptive method. Numerator: Number of women, currently married or in union, who do not want any more children or who want delay the birth of their next childthat are not using contraception Denominator: Total number of women of reproductive age (15-49) who are married or in consensual union. Data are obtained mainly from household surveys, e.g. Demographic and Health Surveys, Multiple Indicator Cluster Surveys and contraceptive prevalence surveys.
Unit of Measurement
Percentage
Secondary Data source
MDG Report
Indicator Classification, Data Type
Outcome, Quantitative
Institutional Responsibility
Min. of Health of Member States with support from RECs and RHOs and international development partners

4B.4 OBJECTIVE: TO POSITION YOUTH-FRIENDLY SRHR SERVICES AS A KEY STRATEGY FOR YOUTH EMPOWERMENT, DEVELOPMENT AND WELLBEING

Target 11: Strengthen implementation and/or advocacy for policies that support the provision of SRHR services addressing the needs of young people

Indicator 13: Existence of developed policies to support SRH services for young people in the country
Rationale
In countries where pregnancies among youth are high, evidence indicates that youth require services that meet their needs. Infections among young people is high and therefore, it is important to provide services that meet the demand of services for young people in terms of the whole range of SRH.
Summary Definition, Methodology for Collection and Calculation
Existence of developed policies to support SRH services for young people in the country At national level, find out if the country has developed policies to support SRH services for young people. Sources of Data are Ministries for Health. Recorded result is Yes or No or In Progress. Rapid assessment required
Unit of Measurement
Yes/ No/ In Progress
Indicator Classification, Data Type
Output, Qualitative
Institutional Responsibility
Min. of Health of Member States with support from RECs and RHOs and international development partners

Target 12: Develop and implement the SRHR training curriculum for the young people

Indicator 14: Percentage of youth-friendly centers using the SRHR training curricula
Rationale

Integration of a training curriculum at youth friendly centers is important for providing training for proper delivery of services.
Summary Definition, Methodology for Collection and Calculation
This measures the number of youth friendly centers that are using the training curriculum to the total enumerated centers. To be computed at national level. Numerator: Number of youth friendly centers that are using the SRHR training curriculum Denominator: Total number of youth friendly centers enumerated. Sources of Data are Ministries for Health. Rapid assessment required may be required
Unit of Measurement
Percentage
Indicator Classification, Data Type
Outcome, Quantitative
Institutional Responsibility
Min. of Health of Member States, RECs & RHOs, with support from international development partners

Target 13: Integrate provision of youth friendly services including promotion of abstinence and dual protection methods within existing services

Indicator 15: Teenage Pregnancy Rate
Rationale
Pregnancy rates can be reduced by promoting abstinence and use of condoms for protection against sexually transmitted infections as well as pregnancies.
Summary Definition, Methodology for Collection and Calculation
The teenage pregnancy rate measures the annual number of pregnancies to women 10-19 years of age per 1,000 women in that age group. Numerator: Total number of deliveries (live births and stillbirths) and therapeutic abortions for females age 10-19 years Denominator: Total number of females age 10-19 years DHS, Census, BCC Surveys
Unit of Measurement
Per 1,000
Indicator Classification, Data Type
Impact, Quantitative
Institutional Responsibility

Min. of Health of Member States with support from RECs and RHOs and international development partners

4B.5 OBJECTIVE: TO INCREASE ACCESS TO QUALITY SAFE MOTHERHOOD AND CHILD SURVIVAL SERVICES

Target 14: Enact policies and legal frameworks to reduce incidence of unsafe abortion

Indicator 16: Existence of non-punitive legislative/framework on abortion.
Rationale
The issue of unsafe abortion in the continent is of great concern and there is acknowledgement that punitive abortion laws exist.
Summary Definition, Methodology for Collection and Calculation
Many countries have laws against abortion; therefore, this measures the existence of non-punitive legislative policy frameworks on abortion At national level, does the country have non-punitive legislative/policy framework on abortion? Rapid assessment required
Unit of Measurement
Yes/ No/ In Progress
Indicator Classification, Data Type
Output, Qualitative
Institutional Responsibility
Min. of Health of Member States with support from RECs and RHOs and international development partners

Target 15: Prepare and implement national plans of action to reduce incidence of unwanted pregnancies and unsafe abortion

Indicator 17: Proportion of unsafe abortion in a country
Rationale
Unsafe abortion indicates a gap in abortion prevention and post abortion care services.

Summary Definition, Methodology for Collection and Calculation
This measures number of unsafe abortions against the total number of all abortions in a country. The unsafe abortion rate is the number of unsafe abortions per 1000 women aged 15–49 years in a year. Routine service statistics
Unit of Measurement
Per 1,000
Secondary Data source
WHO
Indicator Classification, Data Type
Impact, Quantitative
Institutional Responsibility
Min. of Health of Member States with support from RECs and RHOs and international development partners

Target 16: Develop and/or roll out the road map for the reduction of maternal and new-born morbidity and mortality

Indicator 18: Presence of a costed roadmap for the reduction of maternal and new-born morbidity and mortality
Rationale
It is important that a budget is associated with the roadmap, as this indicates a national strategic plan for monitoring and achievement of reduction of maternal and newborn morbidity/mortality
Summary Definition, Methodology for Collection and Calculation
Is there a standardized document to speed up the progress towards the reduction of maternal and new-born morbidity and mortality? Administrative planning documents from Ministry of Health planning departments Rapid assessment required
Unit of Measurement
Yes/ No/ In progress
Indicator Classification, Data Type
Output, Qualitative
Institutional Responsibility
Min. of Health of Member States with support from RECs and RHOs and international development partners

Target 17: Develop and implement national strategies for rapid production, deployment and retention of midwives, including harmonization and accreditation of curriculum at regional level

Indicator 19: Proportion of births attended by skilled health personnel
Rationale
All women should have access to skilled care during pregnancy and child birth. This indicator provides information on women's use of delivery care services. It measures the health system ability to provide adequate care during birth and it is a single most intervention in reducing maternal mortality. It is used as a benchmark for monitoring progress towards MDGs. Skilled health workers' refers to doctors, nurses or paramedics and they would have received training for them to be referred to as skilled.
Summary Definition, Methodology for Collection and Calculation
The proportion of births attended by skilled health personnel is the Percentage of deliveries attended by personnel trained to give the necessary supervision, care and advice to women during pregnancy, labor and the post-partum period; to conduct deliveries on their own; and to care for new-born. Numerator: Number of births to women aged 15-49 years that were attended by skilled health personnel Denominator: Total number of births to women aged 15-49 years DHS, large surveys
Unit of Measurement
Percentage
Secondary Data source
MDG Report
Indicator Classification, Data Type
Outcome, Quantitative
Institutional Responsibility
Min. of Health of Member States with support from RECs and RHOs and international development partners

Target 18: Incorporate essential Neonatal care (ENC) including Helping Babies Breathe (HBB) into Emergency Obstetric Care in pre and in-service training curricula for health care providers.

Indicator 20: Percentage of training institutions using curricula that integrate essential Neonatal care (ENC) including Helping Babies Breathe (HBB) into Emergency Obstetric Care in pre and in-service training curricula for health care providers
Rationale
Integration of all components of essential neonatal care (HBB which focuses on building capacity of health workers in newborn resuscitation) into emergency obstetrics care has been found to be an effective strategy for reduction of neonatal mortality. Therefore, it is imperative for pre- and in-service training institutions to utilize this integrated curriculum to enhance the capacity of health care providers. Training is a prerequisite for providing high quality services.
Summary Definition, Methodology for Collection and Calculation
Numerator: Number of training health-related institutions using integrated curriculum (ENC/HBB/EmOC) Denominator: Total number of training health-related institutions in a country. Ministry of Health planning departments Rapid assessment required
Unit of Measurement
Percentage
Indicator Classification, Data Type
Outcome, Quantitative
Institutional Responsibility
Min. of Health of Member States with support from RECs and RHOs and international development partners

Target 19: Scale up safe motherhood services through the implementation of the Road Map for the reduction of maternal and new-born morbidity and mortality

Indicator 21: Maternal Mortality Ratio (MMR)
Rationale
Complications during pregnancy and childbirth are a leading cause of death and disability among women of reproductive age in developing countries. The maternal mortality ratio represents the risk associated with each pregnancy, i.e. the obstetric risk. The purpose of this indicator is to monitor deaths related to pregnancy and child birth. It reflects the capacity of the health systems to provide effective health care in preventing and addressing complications occurring during pregnancy and childbirth. It is an MDG indicator for improving maternal health.

Summary Definition, Methodology for Collection and Calculation
The maternal mortality ratio is the number of women who die from any cause related to or aggravated by pregnancy or its management (excluding accidental or incidental causes) during pregnancy and childbirth or within 42 days of termination of pregnancy, irrespective of the duration and site of the pregnancy, per 100,000 live births The maternal mortality ratio can be calculated by dividing recorded (or estimated) maternal deaths by total recorded (or estimated) live births in the same period and multiplying by 100,000 Numerator: Number of women who die while pregnant or within 42 days of delivery/termination of pregnancy, irrespective of the duration and site of the pregnancy, from any cause related to or aggravated by the pregnancy or its management but not from accidental or incidental causes Denominator: Total number of live births in a given year
Unit of Measurement
Per 100,000
Secondary Data source
MDG Report
Indicator Classification, Data Type
Impact, Quantitative
Institutional Responsibility
Min. of Health of Member States with support from RECs and RHOs and international development partners

Indicator 22: Perinatal mortality rate
Rationale
Death during the perinatal stage occurs for many different reasons, but in many cases maternal exposures to environmental hazards are major risk factors. The perinatal mortality rate thus provides a general measure of the health environment during the earliest stages of life.
Summary Definition, Methodology for Collection and Calculation
This is defined as the number of death of foetus from 28 weeks of gestation to the first seven days of life per 1,000 live births in a given year. Health death registrations, surveillance systems, larges surveys and indirect estimation techniques
Unit of Measurement
Per 1,000
Secondary Data source

WHO
Indicator Classification, Data Type
Impact, Quantitative
Institutional Responsibility
Min. of Health of Member States with support from RECs and RHOs and international development partners

Target 20: Scale up neonatal care services including the creation of neonatal resuscitation care in maternity units

Indicator 23: Percentage of babies not breathing at birth, resuscitated successfully
Rationale
This indicator measures the preparedness of health facilities to save babies. It indicates the effectiveness of the integrated essential neonatal care (HBB which focuses on building capacity of health workers in newborn resuscitation)/emergency obstetrics care service programmes in a country
Summary Definition, Methodology for Collection and Calculation
Defined as the number of babies that finally live against total who were not breathing at birth Numerator: Number of babies who were successfully resuscitated at birth Denominator: Total number of babies who required resuscitation at birth (those who were successful and those who were not) A wide variety of household surveys, including service statistics from the ministries/departments
Unit of Measurement
Percentage
Indicator Classification, Data Type
Impact, Quantitative
Institutional Responsibility
Min. of Health of Member States with support from RECs and RHOs and international development partners

Indicator 24: Neonatal mortality rate
Rationale
Mortality during the neonatal period accounts for a large proportion of child deaths, and is considered to be a useful indicator of maternal and newborn neonatal health and care. This indicator monitors the quality of care for the neonate.
Summary Definition, Methodology for Collection and Calculation
Defined as the number of deaths from birth to the first 28 days of life per 1,000 live births in a given year Numerator: Number of deaths occurring among infants aged 0 to28 days Denominator: Total number of live births in a given year A wide variety of household surveys, including Multiple Indicator Cluster Surveys and Demographic and Health Surveys
Unit of Measurement
Per 1,000
Secondary Data source
MDG Report
Indicator Classification, Data Type
Impact, Quantitative
Institutional Responsibility
Min. of Health of Member States with support from RECs and RHOs and international development partners

Target 21: Increase coverage of child survival services (expanded programme for immunization [EPI], oral rehydration solutions [ORS]), early initiation of breast feeding, and other appropriate nutritional intervention, 1st week consultations

Indicator 25: Proportion of one year old children immunized against the recommended standard in that country
Rationale
This is an indicator for immunization coverage and this means that a child should have received the nationally recommended dosage of vaccine preventable diseases. It is a valuable way to reduce infant mortality.
Summary Definition, Methodology for Collection and Calculation
The proportion of 1-year-old children immunized against measles is the Percentage of children under one year of age who have received at least one dose of measles vaccine

In most countries in Africa, measles immunization is used a proxy for completion of under-1 immunization. A wide variety of household surveys, including Multiple Indicator Cluster Surveys and Demographic and Health Surveys
Unit of Measurement
Percentage
Secondary Data source
MDG Report
Indicator Classification, Data Type
Outcome, Quantitative
Institutional Responsibility
Min. of Health of Member States with support from RECs and RHOs and international development partners

Target 22: Adopt integrated management of childhood illnesses (IMCI)

Indicator 26: Infant Mortality Rate (IMR)
Rationale
Infant mortality is an important component of under-5 mortality. It measures child survival and reflects the social, economic and environmental conditions in which children live. Infant mortality rate is a Millennium Development Goal (MDG) indicator. Infant mortality rates are good indicators of discrepancies in the quality of education and medical care available to different socioeconomic or ethnic populations in a country, state, or even a city. Challenges relate to provision of adequate pre& post natal services, education & nutrition.
Summary Definition, Methodology for Collection and Calculation
The infant mortality rate is the probability of a child dying between birth and 1 year of age per 1000 live births, i.e. the number of deaths to children aged 0 to exactly 1 year expressed per 1000 live births in the same year. Numerator: Number of deaths of children aged 0 to exactly 1 year Denominator: Total number of live births in a given year A wide variety of household surveys, including Multiple Indicator Cluster Surveys and Demographic and Health
Unit of Measurement
Per 1,000
Secondary Data source

MDG Report
Indicator Classification, Data Type
Impact, Quantitative
Institutional Responsibility
Min. of Health of Member States with support from RECs and RHOs and international development partners

Indicator 27: Under-5 mortality rate
Rationale
Under-five mortality rate is a general indicator of the level of child health. It measures more the socio-economic, environmental and nutrition status of children, rather than direct health care delivery. Under five mortality rate is a Millennium Development Goal (MDG) indicator.
Summary Definition, Methodology for Collection and Calculation
The under-five mortality rate is the probability (expressed as a rate per 1,000 live births) of a child born in a specified year dying before reaching the age of five if subject to current age-specific mortality rates. Numerator: Number of deaths of children below 5 years Denominator: Total number of live births in a given year A wide variety of household surveys, including Multiple Indicator Cluster Surveys and Demographic and Health
Unit of Measurement
Per 1,000
Secondary Data source
MDG Report
Indicator Classification, Data Type
Impact, Quantitative
Institutional Responsibility
Min. of Health of Member States with support from RECs and RHOs and international development partners

4B.6 OBJECTIVE: TO INCREASE RESOURCES FOR SRHR

Target 23: Implement the Abuja Heads of State Declaration on national budgetary allocation for health to at least 15% of the total national budget, with an appropriate proportion of that for SRHR

Indicator 28: Proportion of country budget allocated to health
Rationale
Aiming for a goal of at least 15% of amount set for the health budget.
Summary Definition, Methodology for Collection and Calculation
This indicator measures the portion of the national budget allocated to health Documents from government departments/ministries Rapid assessment required
Unit of Measurement
Percentage
Indicator Classification, Data Type
Output, Quantitative
Institutional Responsibility
Min. of Health of Member States with support from the Ministry of Finance, RECs, RHOs and international development partners

Indicator 29: Proportion of health budget allocated for SRHR
Rationale
An SRHR budget helps towards setting targets and financing activities to achieve outputs, outcomes and target of the MPoA.
Summary Definition, Methodology for Collection and Calculation
This the Percentage of the health budget allocated to SRHR Documents from government departments/ministries, Rapid assessment required
Unit of Measurement
Percentage
Indicator Classification, Data Type
Output, Quantitative
Institutional Responsibility
Min. of Health of Member States with support from the Ministry of Finance, RECs, RHOs and international development partners

Target 24: Advocate for prioritization of SRHR in national poverty reduction strategy papers (PRSPs) and other national development plans

Indicator 30: Existence of costed SHRH plans integrated into PSRP or national development plans
Rationale
Costed SHRH plans are essential for setting targets for programmes measuring outputs, outcomes and impact as well as monitoring resources.
Summary Definition, Methodology for Collection and Calculation
Is there a costed SRHR plan integrated into PSRP or national development plans in the country? Recorded result is Yes or No or In Progress. Documents from government departments/ministries, Rapid assessment required
Unit of Measurement
Yes/ No/ In Progress
Indicator Classification, Data Type
Output, Qualitative
Institutional Responsibility
Min. of Health of Member States with support from the Ministry of Finance, RECs, RHOs and international development partners

4B.7 OBJECTIVE: TO DEVELOP AND IMPLEMENT SRH COMMODITY SECURITY STRATEGIES FOR ALL SRH COMPONENTS

Target 25: Develop national and where appropriate regional Reproductive Health Commodity Security (RHCS) strategy and action plans

Indicator 31: National RH commodity security strategy plan(s) in place
Rationale
Availability of commodity security strategy and action plan(s) will ensure continuous availability of RH commodities in a country.
Summary Definition, Methodology for Collection and Calculation
The RH commodity security strategy and action plan(s) are in place. Recorded result is

Yes or No. Documents from government departments/ministries, Rapid assessment required
Unit of Measurement
Yes/ No/In Progress
Indicator Classification, Data Type
Output, Qualitative
Institutional Responsibility
Min. of Health of Member States with support from RECs and RHOs and international development partners

Target 26: Revise essential medicines lists to include reproductive health commodities

Indicator 32: RH commodities included in essential medicines list
Rationale
This will ensure continuous availability of RH commodities.
Summary Definition, Methodology for Collection and Calculation
At national level, find out if the country has the RH commodities in the essential medicines list. Recorded result is Yes or No Documents from government departments/ministries Rapid assessment required
Unit of Measurement
Yes/ No/In progress
Indicator Classification, Data Type
Output, Qualitative
Institutional Responsibility
Min. of Health of Member States with support from RECs and RHOs and international development partners

Target 27: Establish a budget line for SRH commodities

Indicator 33: Percentage of the RH budget allocated to RH commodities
Rationale

This will indicate level of government commitment/support to ensure SRH commodity security in a country
Summary Definition, Methodology for Collection and Calculation
Record the given value of the health budget in comparison to the total national budget Documents from government departments/ministries, Numerator: value of RH budget allocated to RH commodities Denominator: Total value of RH budget Rapid assessment required
Unit of Measurement
Percentage
Indicator Classification, Data Type
Output, Quantitative
Institutional Responsibility
Min. of Health of Member States with support from RECs and RHOs and international development partners

Target 28: Develop capacity for bulk purchasing through pooling of purchase orders at national and regional levels

Indicator 34: Existence of integrated systems for bulk purchasing and supply
Rationale
Reduction of costs through bulk purchasing is a recommended strategy which can eliminate shortages.
Summary Definition, Methodology for Collection and Calculation
Find out if the country has a mechanism for purchasing in bulk. Recorded result is Yes or No Documents from government departments/ministries Rapid assessment required
Unit of Measurement
Yes/ No/ In progress
Indicator Classification, Data Type
Output, Qualitative
Institutional Responsibility
Min. of Health of Member States with support from RECs and RHOs and international development partners

4B.8 OBJECTIVE: TO ESTABLISH A MONITORING, EVALUATION AND COORDINATION MECHANISM FOR THE PLAN OF ACTION.

Target 29: Advocate for allocation of national resources for conducting regular censuses, DHS, and annual maternal death reviews

Indicator 35: Existence of national budget line allocated to population-health research and M&E (DHS, MICs, MIS, AIS…)
Rationale
Allocation of a budget for heath research is a bold step towards evidence based planning for any country.
Summary Definition, Methodology for Collection and Calculation
At country level find out if the country has a budget for conducting censuses, DHS & annual maternal death reviews? Recorded result is Yes or No or In Progress Rapid assessment required
Unit of Measurement
Yes/ No/ In Progress
Indicator Classification, Data Type
Output, Qualitative
Institutional Responsibility
Min. of Health of Member States with support from RECs and RHOs and international development partners

Target 30: Institutionalize M&E at the public administration and NGOs levels and allocate adequate human and financial resources to support it

Indicator 36: Existence of a robust integrated M&E system
Rationale
There is need to set targets for programmes measuring outputs, outcomes and impact as well as monitoring resources.
Summary Definition, Methodology for Collection and Calculation
At country level find out if the country has a routine data management system and if they regularly conduct censuses, DHS & annual maternal death reviews? Recorded result is Yes or No or In Progress

Rapid assessment required
Unit of Measurement
Yes/ No/ In Progress
Indicator Classification, Data Type
Output, Qualitative
Institutional Responsibility
Min. of Health of Member States with support from RECs and RHOs and international development partners

Target 31: Put in place coordination mechanisms to monitor and evaluate the efficient allocation of resources

Indicator 37: Existence of NHA subaccounts for RH
Rationale
National health accounts for RH means there is an existing standard mechanism to monitor RH budget and implementation.
Summary Definition, Methodology for Collection and Calculation
NHA as a tool for tracking health expenditures At national level, find out if the country is able to monitor & evaluate allocation of RH resources and implementation of laws using NHA subaccount for RH. Recorded result is Yes or No or In Progress
Unit of Measurement
Yes/ No/ In Progress
Indicator Classification, Data Type
Output, Qualitative
Institutional Responsibility
Min. of Health of Member States with support from Ministries of Finance, RECs and RHOs and international development partners

Appendix

ABUJA CALL PROGRESS ASSESSMENT TOOL (ACPAT)

Country Assessment

AFRICAN UNION COMMISSION

Department of Social Affairs

[……..Date]

Abuja Call for Accelerated Action towards Universal Access to HIV/AIDS, Tuberculosis and Malaria (ATM) Services in Africa

IDENTIFICATION

Name of Country:	
Date of compilation of Report:	
Frequency:	

DETAILS OF PERSONNEL WHO COMPILED THE REPORT:

Name of Officer Compiling data:	
Position:	
Institution:	
Contact Address:	
Telephone:	
E-mail:	

1. INTRODUCTION

The Special Summit on HIV/AIDS, Tuberculosis, and Malaria was held in Abuja, Nigeria, 2-4 May 2006 on the theme: "Universal Access to HIV/AIDS, Tuberculosis and Malaria Services by a United Africa by 2010". Its objective was to conduct the 5-Year review of the implementation of the 2000 and 2001 Declarations and Plans of Action on HIV/AIDS, Tuberculosis and Malaria (2000 and 2001 Special Summits respectively); and adopt renewed commitments for scaling up action towards universal access to comprehensive health services by 2010. At the end of the Special Summit, the Abuja Call for Accelerated Action towards Universal Access to HIV/AIDS, Tuberculosis and Malaria (ATM) Services in Africa as well as Africa's Common Position to the UN General Assembly Special Session (UNGASS) on HIV/AIDS were, among others, adopted and subsequently endorsed by the Ordinary Session of the AU Assembly (Banjul, The Gambia, 1-2 July 2006). The AUC in collaboration with relevant partners have developed a tool to assess progress made by Member States on implementation of the 'Abuja Call'.

PROGRESS ASSESSMENT TOOL FOR ABUJA CALL FOR ACCELERATI UNIVERSAL ACCESS TO HIV/AIDS, TUBERCULOSIS AND MALARIA AFRICA

The AU Commission would like to kindly request your institution/agency to complete progress of implementation of the Abuja Call for Accelerated Action towards Univers Tuberculosis and Malaria (ATM) Services in Africa

No	HIV & AIDS Indicators	Total Value	Data Source	Rural	Urban	Male							
						0-18 months	<15	>15	10 – 14 yrs	15-24 yrs	15-49 yrs	0-18 months	<15
1	HIV prevalence among population aged 15-24 years												
2	Percentage of young women and men aged 15–24 who both correctly identify ways of preventing the sexual transmission of HIV and who reject major misconceptions about HIV transmission												
3	Ratio of school attendance of orphans to school attendance of non-orphans aged 10-14 years												
4	Percentage of HIV-positive pregnant women who receive antiretroviral drugs to reduce the risk of mother-to-child transmission on HIV												
5	Percentage of pregnant women attending ANC who were tested for HIV and Know their results												
6	Percentage of infants born to HIV-infected mothers who are infected												
7	Proportion of adult and children with advanced HIV infection receiving antiretroviral drugs												
8	Proportion of associations/networks of PLWHA involved in policy development, programme implementation and M&E												

9	Percentage of women and men aged 15–49 who received an HIV test in the last 12 months and who know their results												
10	Percentage of donated blood units screened for HIV in a quality assured manner												
11	Percentage of women and men aged 15–49 who had more than one sexual partner in the past 12 months reporting the use of a condom during their last sexual intercourse												
12	Percentage of most-at-risk populations (including refugees and other displaced persons) reached with HIV prevention programmes												
13	Percentage of clients who are receiving HIV care and support services that are screened for TB												
14	Percentage of HIV-positive TB patients that receiving treatment for HIV and TB in case of co-infection												

No.	TB Indicators	Value	Data Source	Rural	Urban	Male				Female			
						<1	0-5	<15	>15	<1	0-5	<15	>15
15	TB case detection rate												
16	Treatment success rate												
17	DOTS Coverage												
18	Surveillance of multi-drug resistance among TB cases	Y OR N											
19	HIV Seroprevalence among TB patients												
20	Percentage of TB patients who received HIV testing and counseling services												

No.	Malaria Indicators	Value	Data Source	Rural	Urban	Male		Female		Pregnant Woman
						0-5	>5	0-5	>5	
21	Proportion of children under 5 years old who slept under an ITN the previous night.									
22	Incidence rate of malaria									
23	Death rate associated with malaria									
24	Proportion of Households with at least one ITN and/or sprayed by IRS in the last 12 months									
25	Proportion of children under 5 years old with fever in last 2 weeks who received antimalarial treatment according to national policy within 24 hours from onset of fever.									
26	Proportion of pregnant women who received 2 doses of Intermittent Preventive Treatment of malaria during their last pregnancy (IPTp)									

	HSS Indicators	Value	Data Source	Rural	Urban

No.					
27	General government expenditure on health as a percentage of total government expenditure				
28	General government expenditure on health as a percentage of total expenditure on health				
29	Out-of-pocket expenditure as % of total expenditure on health				
30	Percentage of population covered by a demand-side (Social Health Insurance, Community based insurance) scheme				
31	Number of health workers per 10 000 population				
32	Proportion of population with access to affordable essential drugs for HIV and Aids, Tuberculosis and Malaria on a sustainable basis				
33	A nationally coordinated multi-year disease-specific M&E plan with a schedule for survey implementation and data analysis has been prepared and is being implemented				
34	Policy Index Score				

MPoA PROGRESS ASSESSMENT TOOL (MPAT)

Country Assessment

AFRICAN UNION COMMISSION

Department of Social Affairs

[……..Date]

Maputo Plan of Action for the Operationalisation of the Continental Policy Framework for Sexual and Reproductive Health and Rights

IDENTIFICATION

Name of Country:	
Date of compilation of Report:	
Frequency:	

DETAILS OF PERSONNEL WHO COMPILED THE REPORT:

Name of Officer Compiling data:	
Position:	
Institution:	
Contact Address:	
Telephone:	
E-mail:	

1. INTRODUCTION

The 2nd Ordinary Session of the African Union Conference of Ministers of Health which took place in Gaborone, Botswana from October 10-14, 2005, adopted the Continental Policy Framework on Sexual and Reproductive Health and Rights which was subsequently endorsed by the AU Heads of States and Government in January 2006.The framework seeks to take the continent forward towards the achievement of universal access to comprehensive sexual and reproductive health services by 2015. African Union Ministers of Health held a special session in Maputo Mozambique in September 2006 under the theme: “Universal Access to Comprehensive Sexual and Reproductive Health Services in Africa” and adopted the Maputo Plan of Action for Operationalisation of the Continental Framework for Sexual and Reproductive Health and Rights (2007-2010). The AUC in collaboration with relevant partners have developed a tool to assess progress made by Member States on implementation of the Maputo PoA. Each reporting objective is composed of three sections: A) Data on specific indicators, B) Challenges encountered in the implementation and C) Recommendations for the way forward.

PROGRESS ASSESSMENT TOOL FOR MAPUTO PLAN OF ACTION ON THE OPERATIONALISATION OF THE POLICY FRAMEWORK ON SEXUAL REPRODUCTIVE HEALTH AND RIGHTS

The AU Commission would like to kindly request your institution/agency to prepare a country report on the progress of implementation of the Maputo Plan of Action for the operationalisation of the Continental Framework for Sexual and Reproductive Health and Rights. The country report should include the following key information:

Objective 1: Integration of HIV/STI, Malaria and SRHR Services into PHC				
	1=Yes	**2= In progress**	**3= No**	**Remark(s) – reasons for success or failure**
Indicator 1 Has the country integrated HIV/STI, Malaria and SRHR services into PHC?				
Indicator 2 Are there Laws in place that deal with GBV?				
Indicator 3 Does the country have programmes to address HTP?				
Indicator 4 What is the % of training institutions with SRHR integrated with STI/HIV/AIDS and nutrition in their curricula	**Indicate %**			
Indicator 5 What is the % of SDPs offering STI,PEP and EC services for SGBV victims	**Indicate %**			
Indicator 6 What is the % of SDPs offering screening and management services for cancers of the Reproductive system for both men and women	**Indicate %**			
Indicator 7 Prevalence of underweight by age group	**Indicate figure**			

Indicator 8 Prevalence of anaemia in pregnancy	Indicate figure			
Challenges(up to 3 main challenges): **a.**				
b.				
c.				
Recommendations/way forward(up to 3 recommendations): **a.**				
b.				
c.				
Objective 2: Strengthening of Community based STI/HIV/AIDS and SRHR Services				
	Yes	**In progress**	**No**	**Remark(s) – reasons for success or failure**
Indicator 9 Does the country have a comprehensive BCC strategy				
Objective 3. Family Planning repositioning as key strategy for attainment of MDGs				
	Yes	**In progress**	**No**	**Remark(s) – reasons for success or failure**
Indicator 10 Are there supportive legislation, protocols and guidelines for family planning				
Indicator 11 Contraceptive prevalence rate				

Challenges(up to 3 main challenges):

a.

b.

c.

Recommendations/way forward(up to 3 recommendations):

a.

b.

c.

Objective 4. Youth-friendly SRHR services positioned as key strategy for youth empowerment, development and well being

	Yes	In progress	No	Remark(s) – reasons for success or failure
Indicator12 Unmet need for family planning				
Indicator 13 Does the country have developed policies to support SRHR services for young people				
Indicator 14 Does the country have youth-friendly health services within their training curricula				
Indicator 15 Teenage pregnancy rate	**Indicate figure**			

Challenges(up to 3 main challenges):

a.

b.			
c.			
Recommendations/way forward(up to 3 recommendations): **a.**			
b.			
c.			
Objective 5. Incidence of unsafe abortion reduced			
Indicator 16 Does the country have legislative/policy framework on abortion?			
Indicator 17 Does the country have action plans to reduce unwanted pregnancies and unsafe abortion?			
Challenges(up to 3 main challenges): **a.**			
b.			
c.			
Recommendations/way forward(up to 3 recommendations): **a.**			
b.			

c.				
Objective 6. Access to safe motherhood and child survival services increased				
	Yes	**In progress**	**No**	**Remark(s) – reasons for success or failure**
Indicator 18 Does the country have a developed Roadmap for the reduction of maternal and newborn morbidity and mortality?				
Indicator 19 Proportion of births attended by skilled health personnel	**Indicate figure**			
Indicator 20 % of training institutions using curricula that integrate essential Neonatal care (ENC) including Helping Babies Breathe(HBB) into Emergency Obstetric Care in pre and in-service training curricula for health care providers.	**Indicate %**			
Indicator21 Maternal Mortality Ratio (MMR)	**Indicate figure**			
Indicator 22 Peri-natal mortality rate	**Indicate figure**			
Indicator 23 % of babies not breathing at birth, resuscitated successfully	**Indicate %**			
Indicator 24 Neonatal mortality rate[MDG]	**Indicate figure**			
Indicator25 Proportion of 1 year-old children immunized against measles	**Indicate figure**			
Indicator 26 Infant mortality rate	**Indicate figure**			

Indicator27 U-5 mortality	Indicate figure			
Challenges(mention up to 3 main challenges): **a.**				
b.				
c.				
Recommendations/way forward(Suggest up to 3 recommendations): **a.**				
b.				
c.				
Objective 7. Resources for SRHR increased				
	Yes	**In progress**	**No**	**Remark(s) – reasons for success or failure**
Indicator 28 Does the country have at least 15% of budget allocated to health?				
Indicator 29 Proportion of health budget allocated for SRHR	Indicate %			
Indicator 30 Does the country have SRHR in their national PRSP or development plans?				
Challenges (mention up to 3 main challenges):				

a.
b.
c.
Recommendations/way forward(up to 3 recommendations): **a.**
b.
c.

Objective 8. SRH Commodity security strategies for all SRH components achieved				
	Yes	**In progress**	**No**	**Remark(s) – reasons for success or failure**
Indicator 31 Does the country have a regional/national RH commodity security strategy and action plan(s) in place?				
Indicator 32 Does the country have RH commodities in essential medicines list?				
Indicator 33 a) Does the country have a national budget line for SRH commodity security?				
b) What is the % of the health budget allocated to RH commodities?	**Indicate %**			
Indicator 34				

Does the country have integrated systems of bulk purchasing and supplies?				
Challenges(up to 3 main challenges): **a.**				
b.				
c.				
Recommendations/way forward(up to 3 recommendations): **a.**				
b.				
c.				
Objective 9. Monitoring, evaluation and coordination mechanism				
	Yes	**In progress**	**No**	**Remark(s) – reasons for success or failure**
Indicator 35 What is the proportion of national budget allocated to population-health research and M&E (DHS, MICs, MIS, AIS…?)	**Indicate %**			
Indicator 36a Does the country regularly conduct censuses, DHS & annual maternal death reviews (Target?- Dates of most recent)				
Indicator 36b Does the country have a routine data management and reporting system				

Indicator 36c Does the country utilize research and information systems output in planning				
Indicator 37 Does the country have NHA subaccounts for RH				
Challenges(up to 3 main challenges): **a.**				
b.				
c.				
Recommendations/way forward(up to 3 recommendations): **a.**				
b.				
c.				
Lessons learned Mention up to 5 lessons learned: **a.**				
b.				
c.				
d.				
e.				