



Monitoring and evaluation indicators for most-at-risk population (MARP) and PLHIV prevention and care services 2010



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Acknowledgements

This guide results from the efforts of China partners who acknowledge the need for harmonization and who have come together to jointly develop and agree upon a core set of indicators and their definition for most-at-risk population (MARP) interventions.

FHI coordinated the development of this guide with significant inputs from HPI, PSI, RTI and the Alliance, China offices.

A special thank you to Graham Smith, Country Director, Roy Yang, Program Officer for the Alliance/China, Felicity Young, Chief of Party, Hu Bin, Director of Provincial Programs, Leigh Ann Miller Technical Advisor for RTI International/China, Jessica Angelson, PSI/China, Gary Mundy, PSI Regional Researcher, Petra Stankard, Associate Program Manager, PSI Washington HIV department, Marta Jagusztyn, China Program Manager, Pact, and FHI country staff also significantly contributed to this effort. Specifically, Rangsimma Airawanwat, Zhongqiang Ming, Chen Yaohong, and Xu Zhixiang (Charles). The document was written by Shanthi Noriega, FHI Asia/Pacific Regional office.

Funding for this work was provided through the United States Agency for International Development (USAID). Photo credits: John Rae and FHI/China.

Acronyms

AIDS	Acquired Immune Deficiency Syndrome
ART	Antiretroviral therapy
C&T	Care and treatment
CBO	Community-based organization
DIC	Drop-in center
C&S	Care and support
CPP	Comprehensive prevention package
FHI	Family Health International
FP	Family planning
FSW	Female sex workers
GFATM	Global Fund to Fight AIDS, TB and Malaria
HCT	HIV counseling and testing
HCV	Hepatitis C
HIV	Human Immune Deficiency Virus
HPI	Health Policy Initiative
IDU	Injecting drug user
MARPs	Most-at-Risk Populations
MAT	Medication-assisted treatment
MMT	Methadone maintenance therapy
M&E	Monitoring and evaluation
NHSO	National Health Security Office
NGO	Non-governmental organization
OGAC	Office of the US Global AIDS Coordinator
OI	Opportunistic infection
OVC	Orphans and vulnerable children
PEPFAR	(The US) President's Emergency Plan for AIDS Relief
PLHIV	People living with HIV
PMTCT	Prevention of mother to child transmission (of HIV)
PSI	Population Services International
PwP	Prevention with positives
QA	Quality assurance
RH	Reproductive health
RTI	Research Triangle Institute
STI	Sexually transmitted infection
TB	Tuberculosis
TWG	Technical working group
UNAIDS	Joint United Nations Program on HIV/AIDS
UNGASS	United Nations Special Session (on AIDS)
USG	United States Government
USAID	United States Agency for International Development
WHO	World Health Organization

Introduction

The epidemiological importance of most-at-risk populations (MARPs) in Asia cannot be ignored, recent data from the report of the Commission on AIDS in Asia points to a growth in the number of cases within these groups that could contribute to a significant proportion of new cases in the region within the next 10-12 years. Services specific to MARPs are limited but there is evidence to suggest that when these services are available, there is impressive uptake of these by MARPs.¹ The challenge is not only in making these services more widely available, but also tracking their implementation and outcomes.

Many organizations have mobilized to continue and strengthen prevention and care efforts among MARPs. To date however, much of the information resulting from these efforts is fragmented and uncoordinated limiting the ability to compare efforts and assess overall outputs and outcomes. Within the context of the CA integrated workplan for the USAID-funded program in China and in support of the need to strengthen and scale up the response, USAID requested Family Health International (FHI) to spearhead an effort to standardize the operational definitions of program indicators in an effort to harmonize monitoring and evaluation efforts for MARPs programs in China.

This guide outlines the framework for intervention types, provides a list of commonly agreed upon core indicators and their definitions, and provides information on additional indicators to be used depending on data needs and planned evaluation efforts. This document is meant to serve as a reference to USAID partners implementing MARP programs. All indicators are in-line with USAID reporting requirements, and linkages have been made with national level indicators where appropriate.

This guide should be considered a “living” document which will be updated with relevant international, national, and local experience. Based on this initial effort several areas have been highlighted which will be need to be revisited; these include:

- Developing indicators and processes for MSM sub-populations
- Incorporation of additional stigma and discrimination indicators that better reflect the work being done in this area, and which are both measurable and informative
- Additional indicators on IDUs, specifically within the context of the programming being supported by partners in China
- Further refinement of supportive interventions in order to minimize activity overlap

¹ Report of the Commission on AIDS in Asia. *Redefining AIDS in Asia: Crafting an Effective Response*. 2008. Oxford University Press.

How this document is organized

This document is divided into two main parts. The first presents most-at-risk population (MARP) definitions and intervention types. Intervention types are presented as defined by the USAID comprehensive prevention package (CPP) of effective interventions. Intervention definitions are adapted from existing sources and efforts have been made to illustrate activities that are carried out under each intervention type. The hope is that by providing comprehensive definitions with activity examples, programs will gain a better understanding of the various intervention types.

The second section of this document is devoted to presenting three classes of indicators that can be used to monitor and evaluate programs. Indicators have been classified as core (USAID required for reporting), additional (indicators that programs may already be collecting and use, or that could be used in the future as activities are expanded), and evaluation (outcome and impact level indicators based on those reported to UNGASS and MDG). Detailed definitions are presented for each indicator, and include information on how to calculate the indicators, information source, as well as some guidance on how the indicators can be interpreted and used for program strengthening.

Part I: Population and intervention definitions

What do we mean by MARPs?

Female sex workers (FSW)²:

Justification: Unprotected sexual intercourse with multiple partners increases the risk of exposure and transmission of HIV. Female sex workers (FSWs) operating on an economic incentive to have more sexual partners are a critical population to address with HIV prevention programs. FSWs can be formal, establishment-based or street-based, or they can be informal and may not consider themselves to be – or be easily identifiable as – sex workers. Their connection to large numbers of men within the general population acts as a bridge for the virus to other, less-at-risk individuals, and further highlights the importance of prevention among FSWs.

Definition: Women who engage in transactional and commercial sex, that is, they exchange sex for money, gifts, school fees, food, or other commodities.

Men who have sex with men (MSM)³:

Justification: Male sexuality is diverse, particularly in Asia and the Pacific, and biological males who engage in male-to male sex are often categorized under the umbrella term Men Who Have Sex with Men (MSM). This umbrella term often includes a wide range of sexual behaviors and gender identities, it may include for example gay and bi-sexual men, male sex workers and transgender individuals who are born male but live or wish to live in a feminized social role and who may or may not be involved in sex work.

² Source: UNAIDS, 2008. A Framework for Monitoring and Evaluating HIV Prevention Programmes for Most-At-Risk Populations.

This wide range of identities and sexual behaviors demonstrates an equally wide range of prevalence of both HIV and STIs in the region. It is acknowledged that there is a great need to better understand the epidemiological situation and service needs of the various sub-populations included under the term MSM in order to effectively reduce morbidity and mortality associated with HIV. However, it was also acknowledged that the complexity in operationalizing various definitions that could be used to better track these sub-populations is beyond the scope of this document, and will need to be revisited at a future date. In order to facilitate reporting therefore, the term MSM, as defined below, is used for the purposes of this guide.

Definition: “Men who have sex with men” (MSM) is an inclusive public health term used to define the sexual behaviors of males having sex with other males, regardless of gender identity, motivation for engaging in sex or identification with any or no particular ‘community’. The words 'man' and 'sex' are interpreted differently in diverse cultures and societies as well as by the individuals involved. As a result, the term MSM covers a large variety of settings, including commercial sex, and contexts in which male to male sex takes place³.

Injecting drug users (IDUs):

Justification: Using contaminated injecting equipment is a highly efficient means of acquiring HIV. In the absence of effective HIV prevention activities targeting IDUs, HIV prevalence can rise quickly soon after the introduction of the virus into this population. HIV transmission through use of non-sterile equipment is augmented by sexual transmission among IDUs and between IDUs and their non-IDU sexual partners. Injecting drug use stands out as a behavior of special significance to be targeted for preventing the rapid spread of the virus within this population and their sexual partners through medication-assisted treatment and reducing unsafe injecting practices.

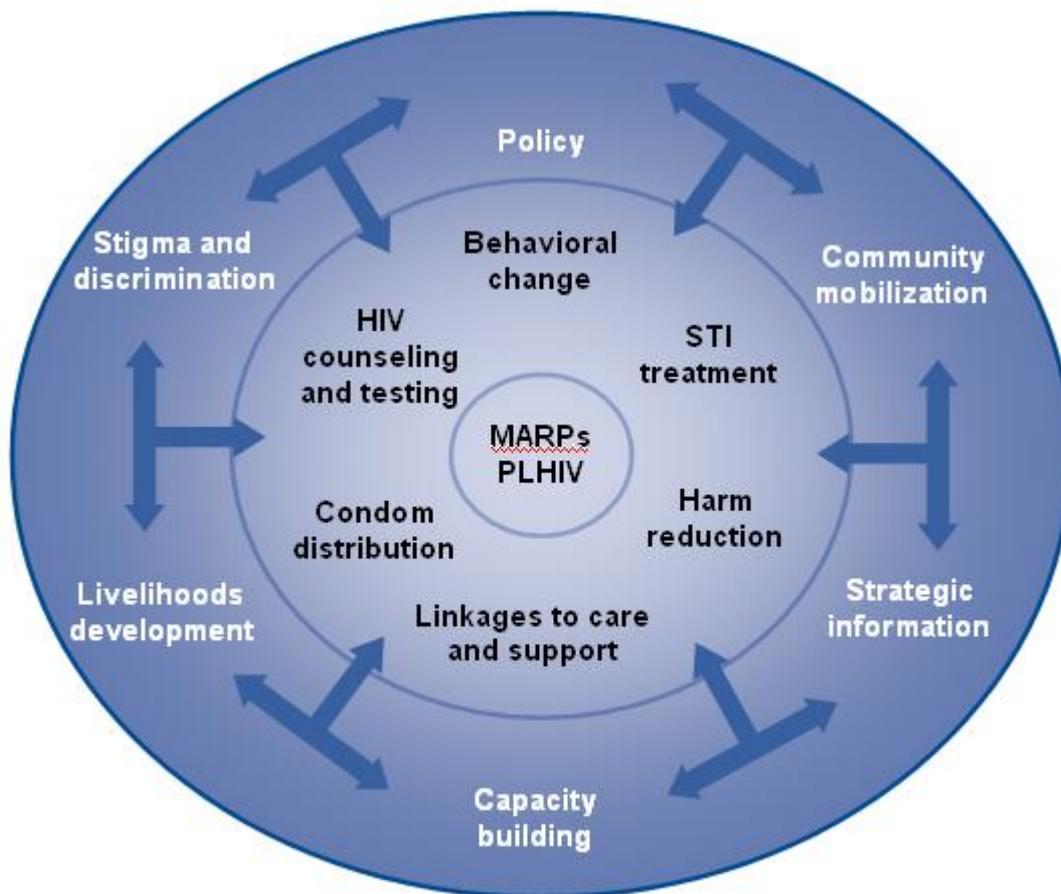
Definition: Individuals, male or female, who actively inject drugs, including individuals located in their communities, in compulsory detoxification centers and in community rehabilitation facilities. This also includes men and women who are undergoing methadone maintenance therapy (MMT) as well as former injecting drug users.

In addition to the above MARPs, there are several related populations that also benefit from interventions. These include people living with HIV (PLHIV), clients of sex workers, families and partners of MARPs, and migrant and mobile population.

Intervention types

Intervention implementation should be evidence based, and while limited work has been carried out in Asia to determine what combination of interventions are most effective amongst most-at-risk populations, a framework based on evidence from Western countries has been developed by USAID. This comprehensive prevention package (CPP) is made up of two broad domains, specific services aimed at MARPs and which generally entail direct service delivery and a wider set of interventions that address the environment in which interventions are implemented (see insert, below).

³ Source: Asia Pacific Coalition on Male Sexual Health (APCOM). <http://www.MSMAsia.org/> (accessed 08/04/09)



The environmental interventions that are broadly referred to as supportive interventions (see outer ring of CPP, above) work synergistically to create an enabling environment. The result is a cross-over between these particular interventions and this guide has attempted to disentangle these by using concrete activity examples. It is acknowledged however, that this will not reduce the overlap in all cases. Further refinement of these interventions and documentation will allow for better disaggregation in the future.

Intervention types and their definitions

<i>Services targeting MARPS</i>
<i>Behavior change</i>
<p>Definition: These can be one-to-one or group (large or small) interventions that include:</p> <ul style="list-style-type: none"> • health education (information on HIV transmission and prevention & promotion of MMT, for example), • assistance in carrying out self risk assessments, • risk-reduction counseling (such as safer sex as well as overdose prevention),

- condom, lubricant, and/or educational material distribution; also includes distribution of sexual responsibility kits (condom, lubricant and educational materials)*, **and**
- referrals to community and clinical services, and care and support for PLHIV

* Condom distribution occurs as part of behavior change communication interventions but the number of condoms distributed is counted under another intervention: condom distribution (below). For this intervention, only count the number of one-to-one or group behavior change interventions, **not** the number of condoms distributed.

Note: In China all methadone maintenance therapy and needle exchange programs are implemented by the government. In this context, partners focus on providing complementary services such as adherence support services which assist in completing the entire package of traditional IDU-related interventions (see Harm reduction, below). Partners in China should be aware that most of their IDU-related interventions will be reported under “behavior change”; this includes “behavior maintenance” interventions which focus on promoting and adhering to specific behaviors, not only changing behaviors.

Activity examples:

- In-person (such as face to face) discussions undertaken as part of community outreach or within a drop-in center (DIC)
- One-to-one discussions during home visits
- One-to-one hotline counseling
- One-to-one internet counseling (this includes counseling provided using “chat”)
- Group (large or small) discussions on risk and risk reduction
- Referral to health services such as STI, HCT, MMT, care and support (C&S), screening and treatment (TB, HCV and HIV).

HIV Counseling and Testing (HCT) interventions

Definition: These are interventions that are made up of three separate activities:

- (1) pre-test counseling (undertaken with groups, couples, or an individual),
- (2) HIV antibody testing, and
- (3) post-test counseling

These interventions are aimed at learning current serostatus; increasing understanding of HIV infection; assessing risk of HIV acquisition and transmission; promoting and planning for behavior change to reduce risk of acquiring or transmitting HIV; and providing referrals for additional medical, preventive, and psychosocial needs. These services could be provided at drop in centers (DICs), integrated HCT/STI clinics, general health service clinics and hospitals, stand alone HCT sites, or mobile clinics.

In order for a site to report an intervention as HCT it **must provide all 3 HCT activities.**

Activity examples

- Pre-test counseling,
- HIV antibody testing (including screening),
- Sending blood for confirmation (in the case where the initial test result is positive), **and**
- Post-test counseling (including referral for positive clients)

Condom distribution

Definition: Distribution of male or female condoms (often along with lubricants); this is most often done in conjunction with another intervention such as behavior change communication sessions where information on HIV transmission and prevention is provided. Condoms can also be distributed during HCT, home visits to PLHIV and/or STI services.

Activity examples:

- Distribution of condoms during behavior change communication (community outreach) interventions that provide prevention messages at places where the target population meet such as bars, sauna, and massage parlors
- Distribution as part of HCT sessions
- Distribution as part of STI sessions
- Distribution to outlets within the community (bars, saunas, condom vending machines)

STI treatment

Definition: These are individualized interventions aimed at sexually transmitted infection (STI) screening, diagnosis, treatment, contact tracing (partner disclosure, support and partner management), counseling (explanation of diagnosis and its significance, risk reduction), condom demonstrations, counseling (adherence with treatment), follow-up, **and** referral. These services are generally provided at DICs, STI and private clinics and hospitals, and mobile clinics.

Activity examples

Core components:

- Screening
- Etiological (laboratory) or syndromic (clinical) diagnosis
- Treatment (presumptive or otherwise)

Additional components:

- Referral to HCT and general health services
- Contact tracing

- Counseling on diagnosis, risk reduction and STI treatment adherence
- Follow up treatment or referral (for example to tertiary care for treatment of STIs not responding to first line drugs)

Harm reduction

Definition: Traditionally, these are programs that provide medication-assisted treatment (MAT), adherence support, and clean needles and syringes for active drug users. In China, these services are delivered by the government and partners “complete” the service so that its prevention or treatment effectiveness is maximized. In this context, partners provide missing but essential components of the service, typically the psycho-social support dimension, which needs to accompany the dispensing of methadone in order to ensure that the drug is properly taken and the treatment course effectively adhered to as well as support to assure safe injecting practices.

In some places people may see harm reduction interventions referred to as “Substitution Therapy and Safer Injection Practices for IDU.”

Note: Because the government is responsible for implementing needle exchange and methadone maintenance therapy (MMT) partners do not monitor these specific activities. Rather, they focus on providing services that are essential to the overall harm reduction service package; these are usually reported under “behavior change” interventions.

Activity examples

- Outreach and promotion events to bring new clients into the MMT clinic
- Registration support and induction into treatment for all new clients
- Drop-out prevention including follow up calls and visits to clients to encourage regular attendance at the clinic
- Retention support through follow up calls and visits to clients whose attendance has dropped off to determine reasons for drop off and encourage them to return to clinic
- Monthly client and family support groups to promote adherence, to nurture family support for MMT clients, to discuss HIV/AIDS prevention (safer sex and clean needles), to help clients rebuild their lives and social function.

(Linkages with) care and support

Definition: These are interventions that include a combination of activities that relieve suffering and improve the quality of life for those facing problems associated with HIV⁴. These interventions aim to ensure equitable access to diagnosis, health care and comprehensive supportive services, reduce morbidity and mortality from

⁴ FHI. *Palliative care strategy for HIV and other diseases*. 2008.

HIV, promote opportunities for preventing HIV transmissions, and improve the quality of life of people affected by and infected with HIV⁵.

Care and support interventions are usually carried out in (or through) DiCs, STI and general health service clinics and hospitals, mobile clinics, home based care programs, and other community based organizations.

Activity examples

- Pre-treatment counseling/education (to develop psychological preparedness) in DiC for PLHIV who are newly determined eligible for treatment.
- ART adherence counseling and support (including preliminary treatment education and text messaging interventions focusing on adherence support)
- Weekly SMS positive living support and nutrition advice.
- Treatment progress check-ins
- PLHIV support/self-help groups including client and family support groups to promote ART adherence, to deliver treatment and disease education, to nurture family support for PLHIV, to discuss HIV/AIDS prevention, and to promote positive living.
- Referral to treatment for opportunistic infections (OIs), including TB and HCV, and ART programs (including for CD4 testing)
- Palliative care (pain and other symptom/side-effects control)
- Mental health counseling
- Positive living/self-care skills building
- Positive Health, Dignity and Prevention services (sometimes referred to as “Prevention with positives”) that includes safer sex counseling and condoms, referral for family planning/reproductive health/STI services, provision of clean needles and syringes, and referral to general health services.
- Nutritional support
- Legal aid (including legal support for issues of discrimination within the workplace and health care setting, and preparing for end of life)
- Referrals to other community-based organizations providing additional care and support services

Supportive interventions

Capacity building

Definition: The range of processes (training, mentoring, provision of technical assistance) undertaken to develop an organization’s or individual’s capacity to carry out their roles and responsibilities. This can be a long term process that aims to improve implementers’ capacity to deliver services, manage programs, and grow as an organization in order to contribute to the overall development and/or strengthening

⁵ UNAIDS. *National AIDS programmes: A Guide to Monitoring and Evaluating HIV/AIDS Care and Support*. 2005.

of the overall supportive environment.

Activity examples

- Technical training on aspects of prevention and care program implementation; VCT/STI service delivery, outreach and behavioral communication skills development, home-based care and peer psycho-social support, MMT/ART treatment adherence support etc.
- Training and mentoring for implementing partners on how to develop program and funding proposals, manage finances, set up organizational governance structures, and develop community leaders and group management capacity
- Mentoring and coaching to MARP groups and networks on how to effectively engage in a policy dialogue, share learning across programs and better represent and report back to their constituents
- Training and mentoring for entrepreneurs from MARP and PLHIV communities on how they can set up livelihood development projects through local support groups
- Training to build capacity on collection, analysis, sharing and management of strategic information to inform program design and assess program outputs and outcomes
- Training to build capacity to identify and assess the impact of stigma and discrimination and design and implement specific interventions to address it
- Setting up of resource libraries or online portals for toolkit dissemination
- Small grants for organizational capacity building projects

Community mobilization

Definition: An approach that recognizes the power of communities in initiating activities in support of HIV-related prevention, treatment and care. This approach recognizes that HIV risk and vulnerability arise from social and structural inequalities and requires a collective response which empowers communities to initiate change based on their analysis and understanding of the causes and responses to HIV-related risk and vulnerability. This does not preclude medical, behavioral, legal responses or other types of responses initiated by actors outside the communities at-risk, rather, it recognizes ‘community’ needs to be a central focus in effective HIV prevention, treatment and care programs and responses. *Community mobilization* supports members of a community to develop and control their own initiatives and be held accountable to their constituency. Dimensions of *community mobilization* are:

- Community leadership of groups and interventions
- Self-governance: support for MARP groups to manage their own affairs transparently, accountably and effectively
- Community ownership of both interventions and groups and a sense of commitment to the quality and impact of the intervention.
- A sense of belonging to a particular community.

Community mobilization is distinguished from community deployment which is a process of engaging communities or community members to do things that other people outside of those communities think need to be done.

Activity examples

- Development and dissemination of self-access toolkits for use by community groups to assess their institutional capacity and plan their group's development
- Learning exchanges between managed community teams and autonomous community groups to inspire and inform development towards greater self-reliance
- Conducting organizational and network capacity assessments, supporting groups to draw up development plans based on the assessment results and providing technical support to help them implement the plans
- Leadership trainings for community group and community network leaders and on-going mentoring support to build leadership capacity
- Development of protocols for community group management
- Training community members to lead participatory community assessments which actively involve their constituents in the assessment of HIV-related needs
- Trainings for governmental organizations setting up and/or managing MARP teams on how to build constructive partnerships with community teams that foster community capacity, leadership and self-governance
- Registration guidance and support for MARP community teams

Livelihood development

Definition: Interventions supplying, protecting, and/or growing physical, natural, financial, human and social assets to improve the well being of individuals and households and to reduce their vulnerability to stresses and shocks, especially those related to living with HIV and/or to being a member of a most-at-risk population.

Assets include:

- Human assets: skills, aptitudes, knowledge, experience, ability to work
- Social assets: networks, groups, trust, mutual understanding, shared values, and access to institutions
- Financial assets: savings, credit, remittances, and pensions
- Natural assets: land, water, wildlife, and biodiversity as well as the resources derived from these
- Physical assets: transport, shelter, water, energy, and communications

HIV- related livelihood development interventions mainly focus on human, social and financial assets. Livelihood development interventions can strengthen the HIV response for PLHIV, MARPs, their families and communities and they are a part of both care and prevention services.

Activity examples

- Setting up and supporting livelihood development groups for PLHIV through micro-enterprise development (business development training and mentoring, start up resources); micro-finance, including access to micro-credit; market development support
- Facilitating of PLHIV and MARPs entrepreneurs networks and role-modeling
- Facilitation and advocacy for access to mainstream livelihood development

services and institutions for MARPs and PLHIV

- Community based assets building
- Identifying job opportunities and occupational counseling/guidance and employability and vocational skills development for MARPs
- Community based programs integrating employment and rehabilitation for former-IDUs
- Development of mechanisms to support community based childcare

Policy

Definition: Interventions that contribute to the development, dissemination and implementation of as national and/or provincial strategic and operational plans and guidelines, law and legal procedural documents and regulations, decrees, protocols and/or other ‘official’ documents issued by government that guide how HIV programs and services are implemented.

Activity examples

- Conducting operational policy assessments to identify policy and operational barriers to implementation
- Conducting legal and regulatory reviews to improve policy understanding, development and implementation
- Providing technical assistance to improve the formulation and implementation of national and provincial prevention, care and treatment policies and laws
- Participating in national working groups that develop guidelines and policies
- Providing TA to national bodies on policy and guideline development
- Organizing and/or participating in national dissemination workshops for new policies and guidelines
- Building capacity among community representatives to participate in policy planning and review processes
- Monitoring policy implementation and reform

Stigma and discrimination

Definition: Interventions aiming to eliminate stigma and discrimination associated with MARPs and PLHIV and its negative effects on public health outcomes.

Stigma is defined as a powerful and discrediting social label that radically changes the way individuals view themselves and are viewed by others. It can be *felt* (internal stigma), leading to an unwillingness to seek help and access resources, or *enacted* (external stigma), leading to *discrimination* on the basis of HIV status or association with someone who is living with HIV. *Discrimination* results from *stigma* and is the unfair and unjust treatment of an individual based on his or her real or perceived HIV status or membership of a group perceived to be at risk of HIV (e.g. IDUs). *Stigma* and *discrimination* breach fundamental human rights and can occur at a number of different levels including political, economic, social, psychological and institutional levels. Examples are rejection by family and friends; physical abuse and gender-based

violence; internalized stigma; poor access to high-quality healthcare; and loss of employment, housing, and educational opportunities.

Interventions to eliminate can focus on stigma and discrimination focus on community systems (such as legal, regulatory and employment) as well as reframing perceptions and value/judgment.

Activity examples

- Working with health care providers to eliminate stigma and discrimination in clinical settings
- Mainstreaming elimination of internalized stigma in interventions with PLHIV and MARPs
- Establishment of a HIV legal clinic to promote and protect the legal rights of MARPs and PLHIVs and building capacity within the legal profession for improved responses
- Working with MARPs and PLHIV to raise awareness of their rights and building their capacity to advocate for their rights
- Monitoring and documenting rights violations and building an evidence-base to inform policy, advocacy and legal reform
- Working with employers to ensure the rights of HIV positive employees are protected, for example secure employment and freedom from discrimination and stigma in the workplace
- Working with MARPs and PLHIV to raise awareness of their rights

Strategic information

Definition: HIV behavioral and biological surveillance, facility surveys, resource allocation assessments and other related activities that are designed to support health information systems; improve the evidence base for decision-making and the provision of technical assistance to counterparts to establish and/or strengthen such systems and related analyses, data dissemination, and the generation of information for advocacy and policy purposes.

Activity examples

- Implementing the Analysis and Advocacy project (A²) to strengthening capacity in modeling and advocacy
- Supporting and/or directly implementing data collection efforts on biological, behavioral and programmatic indicators
- Supporting community partners to develop forms for data collection
- Training and on-going supervision and mentoring for community partners for data collection, management (sometimes through HMIS), reporting and use
- Synthesizing existing information for modeling scenarios that can be used to advocate for specific resources and policies
- Dissemination and strategic planning workshops to present and use information

Partners may be providing a wider range of activities than those listed above. These can include clinical care for opportunistic infection and TB diagnosis and treatment. In some case these activities are also reported to donors.

Part II: Indicator definitions

Indicator summary

A total of 32 indicators have been identified and can be broken down into 3 broad categories: Core (C), Additional (A), and indicators for evaluation (E). Core indicators have been identified based on internationally harmonized indicators and are required for global reporting by USAID. These indicators represent the basic information that should be collected and used to improve interventions as well as to report progress to donors, staff and beneficiaries; in many cases these indicators also serve as a basis for some of the higher level outcome and impact indicators used to evaluate interventions. The additional indicators are a mix of indicators that reflect what programs are currently collecting for their own purposes and find useful as well as indicators that may be considered as additional by USAID. Additional indicators can be added to routine monitoring where relevant. A program may decide to use these to obtain more information about services being provided.

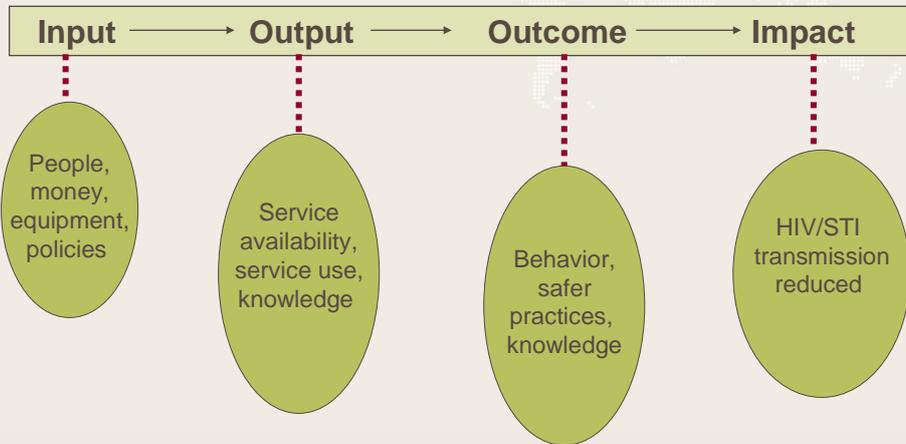
The evaluation indicators proposed here are based on internationally accepted indicators; they often contribute towards measuring progress towards national and international goals such as UNGASS and MDGs; the one exception to this is the IDU evaluation indicator, which is in-line with what is currently being collected by the Government of China at the national level. All evaluation indicators require special studies that may include community surveys; they can be used on a periodic basis to assess overall program outcomes and impact. They are presented here to demonstrate the linkages between routine reporting and reporting required at the national and global level.

The table below summarizes the 15 core indicators, 10 additional and 7 evaluation indicators. Detailed definitions are provided for all core indicators; the definitions for additional and evaluation indicators are presented in the annex.

Note: For core indicators, you are only required to **report indicators that relate to the interventions being carrying out**. There may be some core indicators that are not relevant to a program and which do not need to be reported.

The M&E framework below can be used to illustrate the various levels of information that can be collected. Most programs easily collect data on inputs and their immediate outputs. Measuring and reporting inputs and outputs make up routine program monitoring activities. Additional effort is needed to move towards evaluation, which is generally focused around measuring short term behavioral outcomes and longer term biological and behavioral impact. A program need to have been in place for some time before evaluation can occur, generally 2-4 years to measure outcomes and 5-10 years to measure impact (especially when HIV prevalence is used to measure this).

The M&E framework



Adapted from Boerma T., date unknown

Indicator type: Core (C)/ Additional (A)/ Evaluation (E)	Indicator name	Linkages with RDMA reporting	Linkages with other reporting systems
C1	# of individuals reached with individual and small group interventions	Table 1-2: Program-level monitoring framework: number of clients served, prevention	GFATM, USG (PEPFAR/OGAC)
C2	# of individuals reached with large group interventions	Table 1-2: Program-level monitoring framework: number of clients served, prevention	USG (PEPFAR/OGAC)
C3	# of individuals who were diagnosed/screened for a STI	Table 1-2: Program-level monitoring framework: number of clients served, prevention	USG (PEPFAR/OGAC)
C4	# of individuals that were treated for a STI	Table 1-2: Program-level monitoring framework: number of clients served, prevention	USG (PEPFAR/OGAC), GFATM
C5	# of individuals who received counseling and testing for HIV and received their test results	Table 1-2: Program-level monitoring framework: number of clients served, prevention	GFATM, USG (PEPFAR/OGAC)
C6	# of HIV positive individuals reached with a minimum package of positive health, dignity and prevention services [also called prevention with positives (PwP) interventions]	Table 1-2: Program-level monitoring framework: number of clients served, prevention	USG (PEPFAR/OGAC)

C7	# of condoms distributed	Table 1-5: Program-level monitoring framework: number of outlets, condoms distributed and sold	USG (PEPFAR/OGAC)
C8	# of lubricant packets distributed	Table 1-5: Program-level monitoring framework: number of outlets, condoms distributed and sold	USG (PEPFAR/OGAC)
C9	# of condom outlets	Table 1-5: Program-level monitoring framework: number of outlets, condoms distributed and sold	USG (PEPFAR/OGAC)
C10	ART	Table 1-3: Program-level monitoring framework: number of clients served, treatment, care and support	WHO, USG (PEPFAR/OGAC)
C11	# of PLHIV receiving TB/HIV services	Table 1-3: Program-level monitoring framework: number of clients served, treatment, care and support	USG (PEPFAR/OGAC), WHO, GFATM
C12	# of PLHIV receiving clinical care	Table 1-3: Program-level monitoring framework: number of clients served, treatment, care and support	USG (PEPFAR/OGAC)
C13	# of PLHIV receiving community home-based care	Table 1-3: Program-level monitoring framework: number of clients served, treatment, care and support	USG (PEPFAR/OGAC)
C14	# of individuals trained	Table 1-4.1: Program-level monitoring framework: number of people trained	WHO, USG (PEPFAR/OGAC)
C15	# of local organizations provided with TA	Table 1-4.2: Program-level monitoring framework: capacity and infrastructure building indicators	USG (PEPFAR/OGAC)
A1	# of contacts (new and old)		
A2	Average number of contacts per		

	individual reached		
A3	# of HIV-related materials distributed		
A4	# of PLHIV that received a CD4 test		WHO
A5	% of referrals taken up by individuals provided with referrals		
A6	% of community-based organizations that have received TA and have been able to successfully leverage funding from other sources		HPI IQC
A7	# of individuals who are aware of their HIV + status being revealed to others without their consent		HPI IQC
A8	# of HIV + individuals who report being treated negatively because of their sero-status		HPI IQC
A9	# of MARPs reached with individual and/or small group livelihood interventions		
A10	# of PLHIV and their family members provided with individual and/or small group livelihoods development interventions		

Indicator definitions

In-depth definitions for each of the 15 core indicators are provided below; definitions for additional and evaluation indicators are provided in the annex.

A note on frequency of data reporting:

Reporting of core indicators are required semi-annually and annually by USAID under the RDMA project. These core indicators are meant to provide information not only useful to the donor but to the program itself- they provide information on how well the program is achieving its goals and analysis can assist in program strengthening and future planning.

Some organizations may be reporting core indicators with more frequency (for example, monthly). When deciding how often to report data, it is important to consider how quickly things will change (i.e., do you expect that your numbers will increase or decrease significantly within a month, 2 months, a quarter?). If things do not change rapidly, you may consider reporting with less frequency. Another point to consider is how data will be used; if data are collected too often, there may not be enough time to analyze the numbers, make a data use plan, and implement changes.

Core Indicators	
Core indicator 1 (C1): # of individuals reached with individual and small group interventions	
Definition	<p>Total number of MARPs benefiting from behavior change interventions during the reporting period, disaggregated by population (MARP or other vulnerable group) and gender.</p> <p>This indicator counts the number of individuals who have participated in or benefited from BCC interventions provided:</p> <ul style="list-style-type: none"> • individually (one-on-one) during outreach interventions (within the community, through the internet, or based within a DiC), • in small group (less than 30 people) community outreach interventions, or • within a drop-in center or methadone treatment and rehabilitation site <p>during the reporting period.</p> <p>For each reporting period, MARPs being reached should be categorized as “new” (never before participating or benefiting from these interventions) or “old” (they have participated in or benefited from these interventions at least once during the project year). MARPs should only be counted as “new” once; they are counted the first time that they participate or benefit from these interventions during the project year.</p> <p>A client should be recorded as “new” each time they received an intervention for the first time. For example, if a FSW comes in for an intensive individual intervention such as face-to-face counseling at a DiC, they are counted as “new” the first time they come in; if she were then reached through an outreach program she would be considered</p>

	<p>“old”.</p> <p>This indicator needs to be recorded by intervention received (individual or small group). Therefore, each intervention being implemented needs to collect the number of MARPs reached (disaggregated by “new” and “old”) for every reporting period.</p> <p>The total number of MARPs reached is the sum of all “new” individuals reached during the reporting period.</p>
Numerator	N/A
Denominator	N/A
Rationale	This indicator is needed to monitor achievements towards the overall program target on number of people being reached; it can be used to monitor trends over time and establish annual targets.
Measurement tools	Reporting forms used by outreach volunteers and peer educators are used to collect information on the number of individuals reached. DIC registries can also be used. These forms should indicate whether the individual is “new” or “old”.
Data interpretation and use	<p>This indicator can be used by program managers to establish annual targets and plan for resources. Knowing how many individuals are reached can be used to plan for the number of staff required and commodities to order.</p> <p>Knowing the number of “new” MARPs is needed in order to estimate program coverage during the report period, it is also relevant in establishing targets and monitoring progress.</p> <p>The number of “old” MARPs reached is used to look at intensity (how often did we contact each MARPs?), as well as to plan for staffing needs and determine the level of effort (how many MARPs are being reached by staff members? Do we need more staff?).</p> <p>The biggest challenge in interpreting the number of people reached will be related to the number of “new” individuals, particularly in outreach work. There is a chance of double counting an individual within and between programs. To minimize double counting, all outreach staff should be encouraged to ask all MARPs they encounter whether or not they have received the service previously, this may help in reducing the number of times a person is counted as “new” in the field. For interventions that are delivered within a facility, this is not such an issue because registries and/or registration cards are often available and can be used to confirm whether or not an individual has participated in or benefited from an intervention.</p> <p>Another alternative to reduce double counting and increase a program’s ability to track clients is through the use of <i>unique identification codes</i>. These codes can be built upon basic information all individuals know and will remember such as their name, parents’ names and date of birth. Using the first two letters of a family or personal name, combined with the first two letters of a parent’s name and the year of birth (for example) means that identification cards are not needed, and that all staff (clinical, outreach) can re-construct the ID whenever they interact with clients. When all outreach and clinical staff data are entered into a database, this</p>

	can be sorted to identify all clients, get an idea of the services being sought by each, allow program implementers to track which sub-groups within a population are receiving which key messages, identify the number of times a client has been seen, and minimize duplicates in the number of “new” clients seen in a reporting period. Such information would not only improve program monitoring, but would also provide it with information that would allow for longer term evaluation around the impact of a package of minimum services.
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Core indicator 2 (C2): # of individuals reached with large group interventions

Definition	Total number of MARPs benefiting from a behavior change interventions during the reporting period, disaggregated by population (MARP or other vulnerable group). This indicator counts the number of individuals who have participated in or benefited from BCC interventions provided in a large group setting. Large groups are defined as more than 30 people at one time.
Numerator	N/A
Denominator	N/A
Rationale	This indicator is needed to monitor achievements towards the overall program target on number of people being reached; it can be used to monitor trends over time, establish annual targets, and in planning community events.
Measurement tools	Reporting forms used by outreach volunteers and peer educators are used to collect information on the number of individuals reached. If large group interventions occur within a DIC, then registries can be used to track this number.
Data interpretation and use	This indicator can be used by program managers to establish annual targets and plan for resources. Knowing how many individuals are reached within large group activities can be used to plan for the number of staff required, commodities to order, and venues to use.

Core indicator 3 (C3): # of individuals who were diagnosed/screened for a STI

Definition	Total number of MARPs who underwent diagnosis/screening for STIs during the reporting period, disaggregated by MARP. Diagnosis here can be clinical (symptomatic, i.e. syndromic) or etiological (based on a laboratory test). For each reporting period, MARPs receiving STI diagnosis and/or screening services should be categorized as “ new ” (never before having received an STI diagnosis/screening during the project year) and “ old ” (they have received an STI diagnosis/screening during the reporting period).MARPs should only be counted as “new” once; they are counted the first time that they receive an STI diagnosis/screening during the reporting period. Note: China is only now introducing individual client records, therefore measuring “new” and “old” clients may not be possible initially.
Numerator	N/A
Denominator	N/A
Rationale	Having a STI indicates that an individual is engaging in a risk behavior

	and is therefore at risk for HIV. This indicator is needed to monitor achievements towards the overall program target on number of individuals diagnosed.
Measurement tools	Clinical registers can be used to count the number of MARPs that received an STI diagnosis/screening during the reporting period.
Data interpretation and use	Counting the number of people diagnosed/screened does not provide much information related to treatment, nor does it give any indication about whether or not future risk behavior will be reduced. There may be many issues related to why an individual may not seek out treatment after diagnosis or screening nor change their risk behaviors, and accessibility as well as exposure to services may be one. This indicator can also help with targeting and planning outreach activities based on the rate of or trends in STI diagnosis in specific areas. More investigation would be needed in order to understand the factors influencing health care seeking behavior and behavior change within the context of the program being implemented.
Core indicator 4 (C4): # of individuals that were treated for a STI	
Definition	Total number of MARPs who were treated for an STI during the reporting period. This includes individuals that were treated presumptively or syndromically, disaggregated by MARP. For this indicator, all treatment that is started before the end of the reporting period should be counted, even if treatment is still on-going once the reporting period ends.
Numerator	N/A
Denominator	N/A
Rationale	This indicator is needed to monitor achievements towards the overall program target on numbers of individuals.
Measurement tools	Clinical registries can be used to count the number of people that have received (or are receiving) treatment at the end of the reporting period.
Data interpretation and use	This number should be looked at along with the total number of MARPs that received an STI diagnosis during the reporting period (core indicator 3, above). Together, these can give program managers an idea about the percentage of people that are diagnosed with an STI who received (or are receiving) treatment. The formula below can be used to calculate this proportion: $\frac{\text{Total number of MARPs that were treated (or are still under treatment) for an STI during the reporting period (core indicator 4)}}{\text{Total number of MARPs that were diagnosed with/screened for STI during the reporting period (core indicator 3)}} = \text{Percentage (\%) of MARPs that were diagnosed with an STI and received treatment during the reporting period}$ When used in combination with data that shows how often any one individual seeks treatment, this indicator can be used to identify individuals that continue to engage in risk behavior, or who may be suffering from an STI that is resistant to available treatment. In either case, it is important for the site to develop a record system that allows

	<p>clinicians to see when the same person continues coming in. If an individual comes in for different STIs then they may need additional peer education and other interventions that will assist them in reducing their risk behavior. If the same individual comes in several times with the same STI this could be a sign of resistance and the clinician should refer the client for treatment at a specialized facility that can determine if resistance exists and provide the appropriate treatment.</p> <p>If a program is using presumptive treatment, the number of people receiving diagnosis/screening services is equal to the total number treated.</p>
<p>Core indicator 5 (C5): # of individuals who received counseling and testing for HIV and received their test results</p>	
<p>Definition</p>	<p>Total number of MARPs who received pre-test counseling, total number that took a HIV antibody test, total number that had post-test counseling and received their results during the reporting period, disaggregated by MARP.</p> <p>The indicator should be disaggregated by MARP as follows:</p> <ol style="list-style-type: none"> a. # of individuals who received pre-test counseling, b. # of individuals who received a HIV antibody test c. # of individuals who received post-test counseling, including their test result <p>Note that reporting may only be required for the total number of people who received their results. However, it is useful to collect all the data listed above for programmatic reasons (see “Data interpretation and use”, below).</p> <p>For each reporting period, MARPs being reached through HCT services should be categorized as “new” (never before having received HCT during the reporting period) and “old” (they have received HCT services during the reporting period).MARPs should only be counted as “new” once; they are counted the first time that they receive HCT services during the reporting period.</p>
<p>Numerator</p>	<p>N/A</p>
<p>Denominator</p>	<p>N/A</p>
<p>Rationale</p>	<p>This indicator is needed to monitor achievements towards the overall program target on number of people undertaking testing and total number of people who know their results. It is important to know the number of people accessing HIV counseling and testing (HCT) services in order to estimate coverage of services and increase the number of people knowing their serostatus; positive individuals should always be referred to treatment and care services available in the community.</p>
<p>Measurement tools</p>	<p>HCT service logs or recording forms can be used to count the number of people that received pre-test counseling, those that took an HIV antibody test, those that came back for post-test counseling and received their results.</p> <p>Reporting forms should include a separate place to record each of these three numbers.</p>

<p>Data interpretation and use</p>	<p>For program managers, these numbers are used for planning purposes. Knowing the number of people that come for counseling assists in determining how many counselors are needed. It also assists in knowing the number of lab technicians needed, and the number of test kits to order.</p> <p>Managers may want to look at the differences between the number of people receiving pre-test counseling and taking an HIV antibody test to flag potential problem areas. If many people are receiving the pre-test counseling but are not taking the antibody test, there may be some issues that need to be addressed with the pre-test counseling. Managers would need to investigate further, talking to counselors as well as clients in order to identify exactly why people are not taking the antibody tests. There are many reasons for this and they may include cost or not fully understanding what the test means.</p> <p>This indicator does not measure the quality of counseling services provided, instead focusing on the reach of HCT services and population coverage.</p>
<p>Core indicator 6 (C6): # of HIV positive individuals reached with a minimum package of positive health, dignity and prevention services [also called prevention with positives (PwP) interventions]</p>	
<p>Definition</p>	<p>Total number of HIV positive individuals that benefited from the minimum package of services under positive health, dignity, and prevention interventions during the reporting period, disaggregated by MARP, if possible.</p> <p>These interventions are often referred to as “prevention with positives”.</p> <p>In order to count under this indicator, HIV positive individuals must have received <u>at last visit</u> (in a clinic/facility-based or community/home-based program) the following interventions that constitute the minimum package:</p> <ul style="list-style-type: none"> • Assessment of sexual activity and provision of condoms (and lubricant) and risk reduction counseling (if indicated) • Assessment of partner status (if indicated) and provision of partner testing or referral for partner testing • Assessment for STIs and (if indicated) provision of, or referral for STI treatment and partner treatment • Assessment of family planning needs and (if indicated) provision of contraception or safer pregnancy counseling or referral for family planning services • Assessment of adherence and (if indicated) support or referral for adherence counseling • Assessment of need and (if indicated) refer or enroll PLHIV in community-based program such as home-based care, support groups, post-test-clubs, etc.
<p>Numerator</p>	<p>N/A</p>
<p>Denominator</p>	<p>N/A</p>

<p>Rationale</p>	<p>Positive health, dignity, and prevention efforts with HIV positive persons are part of a comprehensive prevention strategy and include both behavioral and biomedical interventions.</p> <p>The purpose of this indicator is to measure how well clinic/facility-based and community-based programs are reaching PLHIV with a minimum package of prevention interventions and services that includes evidenced based behavioral and biomedical interventions designed to protect the health of the infected person and reduce the spread of HIV to their sexual partners and children.</p> <p>Where possible it is important to determine if the PLHIV benefiting from these services also belongs to a most-at-risk population. This assists in developing specific BCC strategies and materials as well as assures staff is trained in being able to address MARP-specific needs.</p>			
<p>Measurement tools</p>	<p>Reporting forms used by outreach volunteers, peer educators, STI clinicians and HCT counselors are used to collect information on the number of individuals reached. These forms should indicate whether the individual is “new” or “old”.</p>			
<p>Data interpretation and use</p>	<p>Program managers can use this information to plan and make decisions on how well PLHIV are being reached with these interventions. If a small percentage of the intended target population is being reached, then it would be recommended that activities are adjusted to improve reach. If a large percentage of the intended target population is being reached, then staff may want to document lessons learned and disseminate them to partners. The national program can use the information to improve upon the quality of the program as well as scale-up successful models.</p> <p>If the program knows (or has an estimation of) how many HIV positive individuals are living in the community then coverage can also be calculated as follows:</p> <table style="width: 100%; border: none;"> <tr> <td style="width: 60%; border: none;"> <p>Total number of HIV positive individuals that benefited from the minimum package of services under positive health, dignity and prevention interventions during the reporting period</p> <hr style="width: 50%; margin-left: 0;"/> <p>Estimated total number of HIV positive individuals in the community</p> </td> <td style="width: 5%; border: none; text-align: center; vertical-align: middle;">=</td> <td style="width: 35%; border: none;"> <p>Percentage (%) of individuals that have benefited from the minimum package of services under positive health, dignity and prevention interventions</p> </td> </tr> </table>	<p>Total number of HIV positive individuals that benefited from the minimum package of services under positive health, dignity and prevention interventions during the reporting period</p> <hr style="width: 50%; margin-left: 0;"/> <p>Estimated total number of HIV positive individuals in the community</p>	=	<p>Percentage (%) of individuals that have benefited from the minimum package of services under positive health, dignity and prevention interventions</p>
<p>Total number of HIV positive individuals that benefited from the minimum package of services under positive health, dignity and prevention interventions during the reporting period</p> <hr style="width: 50%; margin-left: 0;"/> <p>Estimated total number of HIV positive individuals in the community</p>	=	<p>Percentage (%) of individuals that have benefited from the minimum package of services under positive health, dignity and prevention interventions</p>		
<p>Core indicator 7 (C7): # of condoms distributed</p>				
<p>Definition</p>	<p>Total number of condom distributed during the reporting period, disaggregated by condom type (male or female). This number includes all of the condoms that are handed out free of charge through outreach or other interventions as well as those that are distributed to targeted outlets where they are then sold through social marketing programs.</p> <p>If a program delivers a number of condoms to an outlet- either to be handed out free of charge or to be sold- the program should count the total number of condoms delivered. For example, if the program gives</p>			

	<p>300 condoms to a bar, then all of those 300 condoms are counted as having been distributed, even though the program staff may not know if they are all given or bought by the target population.</p> <p>If a system is in place to track how condoms are distributed in outlets, particularly through social marketing programs, then one may consider disaggregating the indicator into two broad categories: 1) condoms distributed free of charge and 2) condoms distributed through social marketing schemes. A discussion on how these disaggregated data could be used is presented below, in the data interpretation and use section.</p>
Numerator	N/A
Denominator	N/A
Rationale	This indicator can be used to monitor trends over time, forecast condom needs, and establish distribution targets on an annual basis.
Measurement tools	<p>For services that are distributing condoms, the reporting form(s) should include a place where the total number of condoms distributed is included. This indicator is relatively simple to report as long as staff note the number of condoms given out immediately, or shortly after, distribution.</p> <p>An alternative way of counting the number of condoms distributed is to use a well developed commodity tracking system. If the program knows exactly how many condoms they have at the beginning of the reporting period, they can simply calculate how many were distributed by subtracting the total number left at the end of the reporting period.</p> $\begin{array}{r} \text{Total} \\ \text{number of} \\ \text{condoms in} \\ \text{stock,} \\ \text{beginning of} \\ \text{reporting} \\ \text{period} \end{array} - \begin{array}{r} \text{Total} \\ \text{number of} \\ \text{condoms in} \\ \text{stock, end of} \\ \text{reporting} \\ \text{period} \end{array} = \begin{array}{r} \text{Total number of} \\ \text{condoms} \\ \text{distributed} \\ \text{during reporting} \\ \text{period} \end{array}$ <p>A note on condoms that expire during the reporting period: If some of the condoms expire during the reporting period, these should not be distributed and should not be counted as having been distributed. Reporting forms should include a place where the number of condoms that expired during the reporting period can be noted.</p>
Data interpretation and use	<p>This indicator can be used by program managers to establish annual targets and plan for resources. Knowing how many condoms are distributed is needed to know how many may be needed in the future.</p> <p>This number only tells a program how many condoms have been distributed, it does not tell the program anything related to condom use. If a program wants to know if people are using condoms, and using them correctly, they need to do a community survey of the population.</p>
Core indicator 8 (C8): # of lubricant packets distributed	
Definition	Total number of lubricant packets distributed during the reporting period. Like condoms distributed, this number includes all of the lubricant packets that are handed out free of charge through outreach or other

	<p>interventions as well as those that are distributed to targeted outlets where they are then sold through social marketing programs.</p> <p>If a program delivers a number of lubricant packets to an outlet- either to be handed out free of charge or to be sold- the program should count the total number of lubricant packets delivered. For example, if the program gives 300 lubricant packets to a bar, then all of those 300 lubricant packets are counted as having been distributed, even though the program staff may not know if they are all given or bought by the target population. If a system is in place to track how many lubricant packets are distributed in outlets, particularly through social marketing programs, then one may consider disaggregating the indicator into two broad categories: 1) lubricant packets distributed free of charge and 2) lubricant packets distributed through social marketing schemes. A discussion on how these disaggregated data could be used is presented below, in the data interpretation and use section.</p>
Numerator	N/A
Denominator	N/A
Rationale	This indicator can be used to monitor trends over time, forecast lubricant needs, and establish distribution targets on an annual basis.
Measurement tools	<p>For services that are distributing lubricant packets, the reporting form(s) should include a place where the total number of lubricant packets distributed is included. This indicator is relatively simple to report as long as staff note the number of lubricant packets given out immediately, or shortly after distribution.</p> <p>An alternative way of counting the number of lubricant packets distributed is to use a well developed commodity tracking system. If the program knows exactly how many packets they have at the beginning of the reporting period, they can simply calculate how many were distributed by subtracting the total number left at the end of the reporting period.</p> $ \begin{array}{rcl} \text{Total} & & \text{Total} \\ \text{number of} & & \text{number of} \\ \text{lubricant} & & \text{lubricant} \\ \text{packets in} & & \text{packets in} \\ \text{stock,} & - & \text{stock, end o.} = \\ \text{beginning of} & & \text{reporting} \\ \text{reporting} & & \text{period} \\ \text{period} & & \text{Total number of} \\ & & \text{lubricant packets} \\ & & \text{distributed} \\ & & \text{during reporting} \\ & & \text{period} \end{array} $
Data interpretation and use	<p>This indicator can be used by program managers to establish annual targets and plan for resources. Knowing how many lubricant packets are distributed is needed to know how many may be needed in the future.</p> <p>This number only tells a program how many lubricant packets have been distributed, it does not tell the program anything related to their use. If a program wants to know if people are using the lubricant packets, and using them correctly, they need to do a community survey of the population.</p>

Core indicator 9 (C9): # of condom outlets	
Definition	<p>Total number of locations that have a continuous supply of condoms during the reporting period. Disaggregated by “targeted” and “non-targeted” outlets. Targeted outlets are those places where program beneficiaries (usually MARPs) can access the condoms. These types of outlets generally include bars, saunas, and brothels. Non-targeted outlets are those places where anyone, MARP or not, can access condoms. Such outlets include pharmacies, family planning sites, and convenience stores.</p> <p>Continuous supply here is defined as any outlet that is routinely restocked by programs once per month. Outlets include locations that provide condoms either free of charge or sell condoms as part of a social marketing program in the community.</p> <p>Outlets are defined as locations such as bars, schools, and restaurants. In some outlets there may be several condom machines or other places where condoms are available (i.e., a bowl, basket in the outlet).</p>
Numerator	N/A
Denominator	N/A
Rationale	This indicator can be used to estimate condom needs, and to monitor condom availability and accessibility in the community. It can also help present the geographical coverage of the outlets.
Measurement tools	<p>Data for this indicator can be obtained from program records. These records may be part of the commodity tracking system that is also used to monitor the number of condoms and/or lubricant packets distributed during the reporting period.</p> <p>The records should specify the outlet name and location, and indicate the number of condoms provided to the outlet (this number can be reported under core indicator 7 if the data are disaggregated by condoms distributed free of charge and condoms distributed to outlets). In addition, it may be useful to also indicate the number of places or machines that are available within each outlet.</p>
Data interpretation and use	<p>The number of outlets can be used in day-to-day program management, especially in estimating future condom needs. If staff notice that some outlets don't have any condoms left when they go to re-stock, they should report this to arrange for more frequent re-stocking, or to leave more condoms each time they come to re-stock. Knowing how many machines or baskets/bowls of condoms are available within an outlet will also allow the teams to plan to bring enough condoms with them when they come to re-stock the outlet.</p> <p>A potentially more informative indicator is the % of outlets that have a continuous condom supply; this can be calculated as follows:</p>

	<p>Total number of outlets with a continuous supply of condoms during the reporting period</p> <hr style="width: 50%; margin-left: 0;"/> <p>Total number outlets within the community</p>	=	<p>Percentage (%) of outlets with a continuous condom supply</p>
<p>The percentage of outlets with continuous condom supplies can be important to measure periodically in order to plan for scaling up (providing a continuous supply of condoms to more outlets) in an effort to increase accessibility and coverage.</p> <p>When looking at the number of outlets, it is important to realize that this indicator does not provide information on who accesses the condoms so it is not possible to assume that the target population is receiving, or has access to, condoms. You also cannot infer that condom availability will lead to condom use.</p>			

Core indicator 10 (C10): ART

Definition	<p>This indicator provides all information that should be collected for PLHIV on ART. It is disaggregated into the following:</p> <ol style="list-style-type: none"> a. # of individuals newly initiated during the reporting period on ART, disaggregated by age, gender and MARP <ul style="list-style-type: none"> ○ These are people who began taking ART during the reporting period. Note that if an individual started ART, but then died during the reporting period, they should be counted under deaths only- not under newly initiated. b. # of individuals currently on ART (includes all newly initiated plus those who are still receiving treatment) <ul style="list-style-type: none"> ○ This is the total number of people on ART in the reporting period. It is the sum of all newly initiated plus those already on. c. #of individuals that have ever received ART since the beginning of the project <ul style="list-style-type: none"> ○ This is the total (cumulative) number of people who have ever received ART, it includes those that may have been lost to follow up, who discontinued, and who may have died. d. # of individuals that were lost to follow up during the reporting period <ul style="list-style-type: none"> ○ This is the total number of people who were on ART, but who lost contact with the project during the reporting period. You can consider someone as lost to follow up if they have not had contact for 3 consecutive months (90 days). Efforts should be made not to count deaths or discontinuations in this category. e. # of individuals that discontinued using ART during the reporting period <ul style="list-style-type: none"> ○ This is the total number of people who stopped taking ART during the reporting period. f. # of individuals that were on ART and who died during the reporting period <ul style="list-style-type: none"> ○ This is a subset of your cumulative number of people ever on ART. It quantifies the total number of people
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	<p>who died during the reporting period.</p> <p>For the age break down, all of these data should be collected by the following ranges: 0-14 and 15+.</p>
Numerator	N/A
Denominator	N/A
Rationale	Collecting these data can assist in planning and program strengthening efforts. All of these indicators are also potentially needed for reporting to donors and national programs.
Measurement tools	Clinical registries can be used to collect this information.
Data interpretation and use	These data can be used to assess a number of elements related to patient care. Together, they can present a picture of how effective the care services may have been. For example, a high number of deaths within the last year can be looked at to see if this is due to late enrollment, or poor quality care and treatment. High levels of discontinuation can mean that side effects of treatment may not be addressed (among other things). While these data are valuable for individual patient care, there are obvious benefits to the program overall.
Core indicator 11 (C11): # of PLHIV receiving TB/HIV services	
Definition	Number of HIV-positive patients who were screened for TB in HIV care or treatment setting, disaggregated by gender, age (<15 & 15+), and MARP.
Numerator	N/A
Denominator	N/A
Rationale	<p>TB disease is the leading cause of mortality among PLHIV. <i>Screening for TB among PLHIV at initial and subsequent visits is recommended</i> to identify TB suspects and link them to diagnosis and treatment, which is offered by government providers. Currently, available data indicates that despite successes in selected sites, national scale-up of TB screening has been slow in most countries.</p> <p>This indicator will help programs to monitor the number of HIV-positive patients who are screened for active TB disease. The data collected from countries using this indicator will allow USG to monitor increases over time. Programs and partners can use this data to assess scale-up and progress towards goals of TB screening among PLHIV in specific sites.</p>
Measurement tools	Data can be collected from clinical registers and individual patient records.
Data interpretation and use	This indicator is intended to provide information on the number of HIV-positive patients in HIV care and treatment who are screened initially and subsequently (as required) for TB. We assume that if we check to see if a patient was screened for TB at last visit, this will reflect regular TB screening at each visit. An increase in this indicator suggests that a higher proportion of HIV patients are being screened. A decrease in this indicator suggests that a lower proportion of PLHIV are being screened for TB and programs need to assess the cause. Note that this indicator does not provide any information on the quality of screening services.

	<p>Because all HIV positive clients (initially and subsequently as needed based on suspected TB) should be screened, a program may decide to review the proportion of PLHIV screened over a specified period, such as over a year. To calculate this proportion programs can use the formula provided below:</p> $\frac{\text{Total number of PLHIV screened for active TB in last project year}}{\text{Total number PLHIV served by project}} = \text{Percentage (\%) of PLHIV screened for active TB during project year}$
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Core indicator 12 (C12): # of PLHIV receiving clinical care

Definition	<p>Number of HIV-positive adults and children receiving a minimum of one clinical service within a health care facility, disaggregated by gender, age (<15 & 15+), MARP, and service received during the reporting period.</p> <p>Clinical Services include a broad range of services related to the specific clinical needs of HIV-positive persons. Clinical services are provided in facilities and may include both <i>assessment</i> of the need for interventions or provision of needed interventions.</p> <p>At the assessment stage, clinical activities include: determination of WHO stage; assessment of eligibility for ART and/or cotrimoxizole; screening for active TB, assessment of STIs, OIs and cancers; assessment of nutritional status; pain assessment; assessment of depression and anxiety; and assessment of adherence to care in general and to specific medications.</p> <p>General clinical services include: monitoring of pre-ART or ART; management of ART-related side effects; CD-4 cell monitoring; cotrimoxizole prophylaxis; TB treatment; INH prophylaxis for TB; prevention, diagnosis and treatment of STIs, OIs and any cancers; targeted nutritional feeding or supplementary food provision; pain and symptom management; treatment adherence support (for TB and ART); treatment of drug and/or alcohol abuse; treatment of mental disorders; and symptom relief. In some cases, these services may only be provided by the government.</p> <p>The desired outcomes of clinical care are:</p> <ul style="list-style-type: none"> • Prevention and treatment interventions implemented at appropriate disease stages • Symptoms reduced • Patients receive Cotrimoxizole • Diseases/conditions prevented and managed • Nutrition improved • Adherence improved • Activities of daily living conducted <p>All HIV-positive individuals should receive clinical services, including for example <i>assessment</i> for symptoms of tuberculosis or need for OI</p>
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	prophylaxis or ART. To be counted for this indicator, HIV-positive individuals must receive a minimum of one clinical service. This indicator attempts to track progress in providing care and support services within health care facilities to all HIV-positive individuals.
Numerator	N/A
Denominator	N/A
Rationale	<p>People living with HIV (PLHIV) should receive a comprehensive package of services in order to improve quality of life, extend life and delay the need for ART. The goal should be to provide services in each of 5 domains described in PEPFAR care and support guidance (clinical, psychological, spiritual, social, and prevention) and to provide these services using a holistic approach, from the time of HIV diagnosis. While the goal of programs should be to ensure a comprehensive package of care and support services, clinical services are essential for all HIV-positive individuals.</p> <p>This indicator attempts to measure how many HIV-positive individuals received care and support services, defined by receipt of at least one clinical service. Data collected through this indicator will inform country programs about scale up of care services for HIV-positive individuals. It allows country programs to monitor trends and coverage of at least one clinical service to HIV-positive persons.</p>
Measurement tools	Data for this indicator can be collected from clinical registers and CHBC team “log books”.
Data interpretation and use	<p>This indicator is the total number of unduplicated HIV-positive individuals receiving a minimum of one clinical service from facilities. While an individual must receive at least one clinical care service to be counted, this indicator does not capture other care and support services that may have been provided outside of a health facility setting. Data from this indicator will not assess linkages within or between care and support sites.</p> <p>The specific clinical or other care and support services an individual may require will vary according to several factors including stage of disease, treatment, service availability, and cost. This indicator does not measure quality or effectiveness of services.</p>
Core indicator 13 (C13): # of PLHIV receiving community home-based care	
Definition	<p>Number of PLHIV clients registering for CHBC services who were visited by the CHBC team or received services within the community during the reporting period, disaggregated by gender, age (<15 & 15+), MARP, and service received.</p> <p>This indicator should not count clinical services provided in health care facilities, which are captured in core indicator 12, above. Instead, this indicator should count all CHBC services, whether clinical or psycho-social, that are provided within the home or community.</p>
Numerator	N/A
Denominator	N/A
Rationale	This indicator counts the number of PLHIV clients receiving CHBC team services during the reporting period. It can be used to track progress over time, and measure the comprehensiveness of CHBC services. It can also be used for planning to assure that there are enough teams available, and that

	they are trained to meet CHBC needs.
Measurement tools	CHBC registers, team logbooks and DIC registries can be used to calculate this indicator.
Data interpretation and use	<p>This indicator is the total number of unduplicated HIV-positive individuals receiving a minimum of one service from CHBC teams. While an individual must receive at least one service to be counted, data from this indicator will not assess linkages within or between care and support sites to other providers within the community (including clinics).</p> <p>The specific clinical or other care and support services an individual may require will vary according to several factors including stage of disease, treatment, service availability, and cost. This indicator does not measure quality or effectiveness of services.</p>
Core indicator 14 (C14): # of individuals trained	
Definition	<p>Total number of individuals who received training and/or formal and informal capacity building in order to provide quality services in specific program areas during the reporting period. This includes both new training and retaining (in-service training) of individuals who provide services on a paid or un-paid basis.</p> <p>The indicator needs to be disaggregated by area in which training is provided:</p> <ul style="list-style-type: none"> • strategic information including M&E, surveillance and health management information system (HMIS, i.e. database) activities, • HIV-related policy development, • HIV-related institutional capacity building, • HIV-related stigma and discrimination reduction, • HIV-related community mobilization for prevention, care and/ or treatment, and/or • positive prevention • other areas (specify) <p>This indicator is for program staff (paid and/or volunteer) and others who are not target beneficiaries of the interventions. It is not meant to include clients.</p>
Numerator	N/A
Denominator	N/A
Rationale	This indicator is needed to monitor achievements towards the overall program target on number of people trained. It can assist in identifying training needs among staff, as well as in knowing what skills are already present within a program.
Measurement tools	Data on the number of people trained should be recorded in service logs. These logs should include the training date, training topic area(s) and the total number of staff trained. In order for these numbers to be used effectively, indicating the staff names is also useful- this allows managers to know what staff have undergone training.
Data interpretation and use	The number of individuals trained can be used to better understand the skills that are present among program staff. If information is available on who was trained, managers can also decide when re-training is required, particularly if staff leave and new staff are hired. Knowing what topic

	<p>areas have been covered will also allow managers to plan for additional training in other areas.</p> <p>The indicator only counts the number of people trained, it does not provide information related to how the capacity gained is sustained and applied over time. In order to reinforce the skills gained in training, program managers should consider including on-going mentoring and supervision for staff.</p>
<p>Core indicator 15 (C15): # of local organizations provided with technical assistance</p>	
<p>Definition</p>	<p>Total number of local (indigenous) governmental and non-government organizations working with MARPs that are provided with technical assistance by the program during the reporting period. This indicator should be disaggregated by the topic area (see below) and by organization type (government or non governmental).</p> <p>The indicator needs to specify the area in which assistance is provided:</p> <ul style="list-style-type: none"> • strategic information including M&E, surveillance and HMIS activities, • HIV-related policy development, and/or • HIV-related institutional capacity building (system strengthening) • other areas (specify; includes TA to GFATM and community system strengthening, for example) <p>Technical assistance can include direct technical assistance to the organizations and capacity building in the form of training and mentoring. Capacity building generally requires more than one session, and is focused around one specific area at a time. This is generally carried out in the form of trainings. In some cases, on-going mentoring may be provided as a way to reinforce the training that has been received. Mentoring can be counted as a form of capacity building.</p>
<p>Numerator</p>	N/A
<p>Denominator</p>	N/A
<p>Rationale</p>	This indicator can assist in planning activity schedules; it may also be required by donors.
<p>Measurement tools</p>	The number of organizations can be counted using program records that list all of the capacity building activities, such as trainings and mentoring that have been carried out during the reporting period. The program records should indicate the date(s) of the capacity building, the organization(s) that participated, and the topic(s) covered.
<p>Data interpretation and use</p>	<p>This indicator can be used to plan for future capacity training that may be needed. It can help in reducing duplication by allowing program managers to plan for TA to organizations that have not benefited in the past.</p> <p>This weakness of this indicator is that it does not provide information related to how the capacity gained is sustained and applied over time. However, if mentoring is provided, this can be used as an opportunity to assess how the initial training succeeded, and also in knowing what kind of mentoring is needed.</p>

Counting people

Reporting often requires programs to calculate how many “new” and “old” clients benefited from services during a reporting period. A client should be recorded as “new” each time they received an intervention or service for the first time during a reporting period. For example, if a MARP client comes in for STI diagnosis and treatment, they are counted as “new” the first time they come in; if the same MARP then comes back for an intensive individual intervention like counseling, they would also be considered “new”. If he returned for more counseling he would then become an “old” client, the same as if he returned for more STI diagnosis and treatment services.

For reporting purposes, **all** clients are considered new at the beginning of the reporting period. It does not matter if they had received services the month before the new period began. For example, under USAID reporting requirements a client may be considered “old” in September but once the new reporting period begins in October, they should be counted as “new” the first time they receive any service in the new reporting cycle. Therefore, at the beginning of a reporting period (October 1 in the case of USAID), all clients are recorded as new for the month of October.

Qualitative approaches

There are many qualitative methods, and they generally include discussions in the form of focus groups and in-depth interviews with beneficiaries and program staff as well as observations around how well things are being carried out. The information collected through these discussions and observations can complement the quantitative (numerical) data that is routinely being collected by providing focused information around quality, beliefs and practices. Together, qualitative and quantitative data can provide a more comprehensive understanding about a program.

This guide has focused on guidance around collecting quantitative data, but it is also important to consider how qualitative data can complement these indicators. Qualitative approaches can be used to assess the quality of services, for example. Quality Assurance (QA) checklists can be used to determine how well the program is being implemented in line with established standards. These checklists use a variety of approaches to collect data—observations, in depth interviews and record reviews are all used.

Another approach which can assess quality from the clients’ perspectives are client satisfaction surveys. These surveys can be made available in clinical settings, or handed out during outreach work; they are used to determine how well the service functions from the clients’ view point. To get the community’s perspective, anonymous questionnaires can be left at targeted sites, and clients may be encouraged to fill these out and leave them in a box on their way out.

It is important to think about how qualitative information can assist in program strengthening and in evaluation. The program’s M&E plan can be used to plan for qualitative data collection; unlike quantitative data, these data may only need to be collected periodically. It would be important to collect some qualitative data at the beginning of the project, especially if these data will be used to measure the program’s outcomes. Often, qualitative data are also collected at the mid-point of the program to track progress and inform planning, and again at the program’s end to assess overall outcomes. In some cases a “modular” qualitative component can be considered. These modules may explore specific topics with clients, and can often be linked to routine outreach activities. Through these modules the program can complement numerical data with behavioral data as well. The following section on “Further Reading” provides some resources that provide clear, comprehensive information on how to collect, analyze and use qualitative data in programs.

Further reading

Background:

- Commission on AIDS in Asia (2008). *Redefining AIDS in Asia: Crafting and Effective Response*. New Delhi: Oxford University Press.

Monitoring and evaluation:

- GFATM (2009). *Monitoring and Evaluation Toolkit: HIV, Tuberculosis and Malaria and Health Systems Strengthening*. Geneva: The Global Fund to Fight AIDS, Tuberculosis and Malaria.
- President's Emergency Plan for AIDS Relief (2009). *Planning and Reporting: Next Generation Indicators Reference Guide*. Draft.
- UNAIDS (2007). *A Framework for Monitoring and Evaluating HIV Prevention Programmes for Most-At-Risk Populations*. Geneva: UNAIDS.
- UNAIDS (2007). *Practical Guidelines for Intensifying HIV Prevention: Towards Universal Access*. Geneva: UNAIDS.
- UNAIDS (2005). *National AIDS Programmes: A Guide to Monitoring and Evaluating HIV/AIDS Care and Support*. Geneva: UNAIDS.
- UNAIDS (2009). *Monitoring the Declaration of Commitment on HIV/AIDS: Guidelines on Construction of Core Indicators. Reporting 2010*. Geneva: UNAIDS.
- UNAIDS (2004). *Patient Monitoring Guidelines for HIV Care and Antiretroviral Therapy (ART)*. Geneva: UNAIDS.

Evaluation approaches and qualitative research:

- Davies R. and Dart J. (2005). *The "Most Significant Change" (MSC) Technique: A Guide to Its Use*.
- FHI (2002). *Qualitative Methods: A Field Guide for Applied Research in Sexual and Reproductive Health*. North Carolina: FHI.
- FHI (2000). *Behavioral Surveillance Surveys (BSS): Guidelines for Repeated Behavioral Surveys in Populations at Risk of HIV*. North Carolina: FHI.
- FHI (year unknown). *Clinical Facility Services Assessment Package: Quality Assurance (QA) and Quality Improvement (QI)*. Bangkok: FHI.

Annex: Additional and evaluation indicators

Additional Indicators

Additional indicator 1 (A1): # of contacts (new and old)

Definition	<p>Total number of contacts made with MARPs clients during the reporting period, disaggregated by MARP.</p> <p>Contact is defined as any time an intervention is provided to a client by project staff; it includes interventions provided to both “new” and “old” clients.</p> <p>This indicator counts the total number of MARPs who have participated in or benefited from:</p> <ul style="list-style-type: none"> • Individual and small group interventions (DiC, outreach), • Large group interventions (DiC, outreach), • STI clinical case management interventions (diagnosis) • HCT interventions • ART • PLHIV clinical care • TB/HIV • Community and home based care <p>The total number of contacts during a reporting period is the sum of all “new” and “old” individuals reached during the reporting period. These numbers are available from core indicators 1, 2, 3, 5, 10, 11, 12, and 13.</p>
Numerator	N/A
Denominator	N/A
Rationale	This indicator can provide useful information on the amount of work carried out over a reporting period; it can also serve as a basis for calculating the intensity, in terms of range of interventions an individual is exposed to.
Measurement tools	This number is calculated based on the numbers already being recorded; it is calculated by adding all of the “new” and “old” individuals reached during the reporting period, by intervention type.
Data interpretation and use	<p>For program managers this number can give an overview of the level of effort, or amount of work, that has been carried out during the reporting period. This number can be used when considering new hires or recruiting new volunteers.</p> <p>It also serves as the basis for determining the average number of times clients are exposed to interventions (see additional indicator 2, below).</p>
Additional indicator 2 (A2): Average number of contacts per individual reached	
Definition	The total number of times, on average, that an MARPs client benefited from any intervention during the reporting period, disaggregated by MARP.
Numerator	Total number of contacts (additional indicator 1).
Denominator	Total number of new individuals reached (sum of core indicators 1, 2, 3, 5,

	10, 11, 12, and 13)
Rationale	As discussed in the introduction to intervention types, the intensity of interventions can be looked at in terms of the range and number of times an individual is reached. Current research points to behavior change being facilitated when an individual is reached several times by a wide range of interventions. This indicator takes a step towards measuring this, by using routine program data to calculate the average number of times an individual is reached.
Measurement tools	<p>This indicator is calculated using data that is collected through core and additional indicators. The formula used is:</p> $\frac{\text{Total number of contacts during the reporting period (additional indicator 1)}}{\text{Total number of new individuals reached during the reporting period (sum of core indicators 1, 2, 3, 5, 10, 11, 12, and 13)}} = \text{Average number of times each MARPs was contacted during the reporting period}$
Data interpretation and use	<p>This indicator looks at intensity only from the perspective of number of times an individual is exposed to any interventions. Therefore it doesn't provide information on the types of interventions that were provided, nor the quality of these. However, some organizations have established three as a threshold required to facilitate behavioral change; program managers may decide to also adopt this as a minimum when interpreting this number. Therefore, a number less than three would indicate that more effort is needed to contact MARPs.</p> <p>To measure intensity in terms of the range of interventions being received by an individual, program managers may consider providing unique IDs to clients. The program staff can then calculate what range of interventions each individual person is exposed to, and this information, when linked to a community survey, can be used to determine the intervention package that is most effective for generating a behavior change.</p>
Additional indicator 3 (A3): # of HIV-related materials distributed	
Definition	<p>Total number of health promotion materials (brochures, leaflets, postcards, posters, handouts, booklets) and toolkits (on policy, institutional capacity building, for example) distributed to MARPs and/or distributed to outlets (bars, saunas) during the reporting period.</p> <p>This number should also include all materials distributed during care services such as STI clinical management, HCT and care and support. It includes materials produced by the program, as well as materials that have been given to the program by other organizations.</p> <p>This also includes a count of the number of downloads from websites that serve as portals to materials relevant to MARPs and HIV.</p> <p>Because of the variety of materials that can be produced and distributed it is recommended that the material type also be noted.</p>
Numerator	N/A

Denominator	N/A
Rationale	This indicator can be used to track progress towards programmatic goals. It can also be used to forecast how many materials may be needed in the future.
Measurement tools	<p>For services that are distributing materials, the reporting form(s) should include a place where the total number of materials distributed is included. This indicator is relatively simple to report as long as staff note the number of materials given out immediately, or shortly after distribution.</p> <p>When materials are left to be distributed elsewhere, such as in bars, workplaces, or condom outlets, then the total number left should be recorded on the appropriate forms.</p> <p>If a commodity tracking system is in place, this can be used to calculate the total number of materials being distributed. If the program knows exactly how many materials they have at the beginning of the reporting period, they can simply calculate how many were distributed by subtracting the total number left at the end of the reporting period.</p> $\begin{array}{rcl} \text{Total} & & \text{Total} \\ \text{number of} & & \text{number of} \\ \text{materials in} & & \text{materials in} \\ \text{stock,} & - & \text{stock, end of} \\ \text{beginning of} & & \text{reporting} \\ \text{reporting} & & \text{period} \\ \text{period} & & \end{array} = \begin{array}{l} \text{Total number of} \\ \text{materials} \\ \text{distributed} \\ \text{during reporting} \\ \text{period} \end{array}$ <p>Program managers may compare the reported numbers from staff and the number in a commodity tracking system in order to verify numbers.</p>
Data interpretation and use	<p>This indicator's main use will be in forecasting need for additional materials. Establishing a threshold in terms of the minimum number to have in stock will help to know when new materials should be ordered or printed.</p> <p>When interpretation of the number program managers should know that the number distributed does not measure anything related to use of the information presented in the materials, whether or not the materials are appropriate for MARPs, or even if MARPs have accessed the materials (this is especially the case when leaving materials in other locations for distribution).</p>
Additional indicator 4 (A4): # of PLHIV that received a CD4 test	
Definition	Total number of HIV positive MARPs who received at least one CD4 test during the reporting period, disaggregated by MARP.
Numerator	N/A
Denominator	N/A
Rationale	<p>CD4 tests are an important way of reducing morbidity and increasing quality of life among PLHIV. They are needed for all HIV positive individuals to determine eligibility for ART. Knowing CD4 levels assists in clinical management and reduces opportunistic infections by allowing for preventive actions to take place prior to their appearance.</p> <p>This indicator is a nationally required indicator, it is also important for</p>

	programmatic decision making when combined with other information (see data interpretation and use, below).
Measurement tools	<p>In sites where CD4 tests are not carried out, but services are provided to HIV positive MARPs, staff will need to ask these clients to self report whether or not they have had a CD4 test.</p> <p>If CD4 tests are carried out and laboratory records are available at the site, these can also be used, but these forms also need to be adapted to be able to identify risk behavior or most-at-risk population grouping.</p>
Data interpretation and use	<p>Knowing the number of HIV positive MARPs who have a CD4 test is not enough. For program managers, the proportion of HIV positive MARPs that have had a CD4 test can be used to make important programmatic decisions. There may be a need to provide additional training to staff so that they can effectively encourage positive clients to get the test, or there may be barriers such as geographic accessibility and cost that are influencing seeking this service out. Whatever the reason, if it is known that many HIV positive MARPs have not taken a CD4 test further investigation should be carried out to understand, and address, “why”.</p> <p>The formula to calculate the percentage of HIV positive MARPs that have taken a CD4 test is:</p> $\frac{\text{Total number of HIV positive MARPs that have taken a CD4 test}}{\text{Total number of HIV positive MARPs that receive services at the site}} = \text{Percentage (\%) of HIV positive MARPs that have received a CD4 test}$
Additional indicator 5 (A5): % of referrals taken up by individuals provided with referrals	
Definition	<p>The percentage of MARPs that access any community based and/or clinical services to which they have been referred by program staff during the reporting period.</p> <p>This includes all referrals made through outreach and clinical interventions. For example, they can include referrals to community support groups, to clinical services such as HCT and STI clinical management.</p> <p>This indicator should be disaggregated by service type (i.e. to HCT or STI clinical management).</p>
Numerator	<p>For this indicator, two different numerators can be used:</p> <ol style="list-style-type: none"> 1) Total number of MARPs who access any community and/or clinical services and self report that they were referred by program staff during the reporting period. 2) Total number of referral cards collected in clinical services during the reporting period.
Denominator	The total number of referrals given to MARPs by program staff for any (community and/or clinical) services during the reporting period.
Rationale	This indicator can help assess the uptake of services, and can be used as a

	proxy of effective referral practices in the program.
Measurement tools	<p>This indicator is calculated by reviewing program records including clinical records and outreach worker daily diaries or logs to determine the total number of referrals given to MARPs during the reporting period. Forms reporting referrals should indicate most-at-risk population grouping, and also indicate to what service individuals have been referred.</p> <p>The total number of referrals provided is then compared to the total number of MARPs who self report that they received a referral or to the total number of referral cards collected from each service site during the reporting period.. If using the numerator that requires MARPs to self-report whether or not they received a referral, then service providers will need to be instructed to ask if individuals were referred when they are seeing clients, they will also need to indicate the most-at-risk population grouping for these clients.</p> <p>The indicator is calculated as follows:</p> <p style="padding-left: 40px;">Total number of MARPs who access clinical services and self report that they were referred by program staff.</p> <p style="padding-left: 40px;">Or</p> <p style="padding-left: 40px;">Total number of referral cards collected in clinical services</p> $\frac{\text{Total number of referral cards collected in clinical services}}{\text{Total number of MARPs who access clinical services and self report that they were referred by program staff.}} = \text{Percentage (\%) of MARPs that took up referrals to clinical services}$ <p style="padding-left: 40px;">The total number of referrals given to MARPs by program staff for clinical services during the reporting period.</p>
Data interpretation and use	<p>This information can be used to assess the effectiveness of referrals, especially when these are made within a program (i.e., from outreach in the field to clinical services provided by the same program). It is much more difficult to measure this when referrals are provided to clinical services provided by another program – such as when referrals are made to government facilities or facilities managed by other organizations. In these cases, to measure this indicator an agreement between the programs and organizations involved needs to be reached. This way, information on the number of referral cards or on the number of MARPs self reporting that they have been referred can be obtained.</p> <p>If the program is relying on self reports, it may be difficult to know if the client was referred by program staff, or by staff in other programs working in the same geographical area. It may be necessary to ask more questions to the client in order to know if he was referred by program staff.</p>
Additional indicator 6 (A6): % of community-based organizations that have received TA and have been able to successfully leverage funding from other sources	
Definition	The proportion of community-based organizations that have received TA related to leveraging funds and who used this skill successfully to gain additional funding for program implementation.
Numerator	# of community-based organizations that received TA related to leveraging

	of funds and who successfully used this skill to gain additional funding
Denominator	Total # of community-based organizations that received TA related to leveraging funding
Rationale	As organizations increasingly shift to a role as TA providers, there is a clear need to measure the outcome of these efforts. This indicator attempts to move this effort forward by focusing in one area of TA that is commonly provided under institutional capacity building- namely, skills to solicit additional funding that can be used in program implementation. This indicator therefore measures the short- and medium-term success of TA activities in this specific area.
Measurement tools	Program records.
Data interpretation and use	This indicator will provide information on the success of TA efforts in only one area, it cannot be used to measure the outcome of other TA efforts. It also cannot provide any information related to how effectively additional funding that is received is used.
Additional indicator 7 (A7): # of individuals who are aware of their HIV+ status being revealed to others without their consent	
Definition	The number of individuals who are aware of their HIV+ status being revealed to others without their consent.
Numerator	N/A
Denominator	N/A
Rationale	In the China Stigma index report (2009), PLHIV report their greatest fear is having their HIV status revealed without their consent. They are concerned about this because of fears of being gossiped about, excluded from social events, and/or being insulted or physically attacked.
Measurement tools	Program records from client contacts.
Data interpretation and use	<p>This indicator will provide information about how many individuals know their HIV status has been revealed without their consent. The aim is for this number to decrease over time.</p> <p>This indicator does not tell by whom status is revealed, but this could be asked as a follow-on question or collected as qualitative information. People who could reveal HIV status without a person's consent include: family member, partner/spouse, health care worker or social worker, and peer (another HIV+ person). Knowing if it was a personal contact or professional one would help track breach of confidentiality in service provision.</p>
Additional indicator 8 (A8): # of HIV + individuals who report being treated negatively because of their sero-status	
Definition	Number of HIV+ individuals who report perceiving stigma or discrimination by others. This is the number of people reported being treated negatively due to their HIV status. Ways of being treated negatively can include social exclusion, being abandoned by family or friends, denial of services, being called names, being gossiped about, and being denied services, for example.
Numerator	N/A
Denominator	N/A

Rationale	In the China Stigma index report (2009), PLHIV reported experiences including loss of social/family/friend support; not being allowed around other people's children; and/or thought of as immoral.
Measurement tools	Program records from client contacts.
Data interpretation and use	<p>This indicator will provide information about how many individuals have been treated negatively because of their HIV status. The aim is for this number to decrease over time.</p> <p>This indicator does not tell by whom PLHIV have been treated negatively, but this could be asked as a follow-on question or collected as qualitative information. People who could treat someone HIV+ negatively include: family member; partner/spouse; health care worker or social worker; peer (another HIV+ person); employer, etc. Knowing if it was a personal contact or professional or would help track discrimination in service provision and by employment discrimination.</p>
Additional indicator 9 (A9): # of MARPs reached with individual and/or small group livelihoods development interventions	
Definition	<p>Number of unique MARPs reached with individual and/or small group interventions related to increasing employability and employment skills or business development skills during the reporting period.</p> <p>This indicator should be disaggregated by activity:</p> <ul style="list-style-type: none"> • Long term employability and vocational skills training and mentoring for rehabilitated IDUs combined with social re-entry support inside the workplace • One time orientation sessions on employment for IDUs in treatment facilities who are about to leave the facilities and community based rehabilitation setting • Long term employability and employment skills training and mentoring combined with job placement support for clients of MMT clinics (as a part of a wider peer support program) • Other (specify) <p>For each type of intervention a minimum package of services is defined for an individual to considered reached by the intervention.</p> <p>The interventions must be rigorously monitored and meet the minimum requirements, which are as follows:</p> <ul style="list-style-type: none"> • have a clearly defined audience, • have clearly defined goals and objectives, • be based on sound behavioral and social science theory, • be focused on reducing specific risk behaviors through livelihood development • have activities that address the targeted risk behaviors, <p>Note: This indicator should also be disaggregated by type of MARP. Current work in this area is focused on IDU but will be scaled up for other MARPs; at that point this indicator will be re-visited.</p>
Numerator	N/A
Denominator	N/A
Rationale	This indicator is needed to monitor achievements towards the overall program target on number of MARPs reached by livelihood development

	interventions.
Measurement tools	Data will be tracked through training, employee lists and activity attendance sheets collected by project staff.
Data interpretation and use	The indicator only counts the number of people reached, it does not provide information related to effectiveness and quality and especially to appropriateness of economic needs targeting, how interventions reduce the vulnerability of livelihood and how it impacts core health interventions over time. This additional information should be collected via project reviews and evaluations.
Additional indicator 10 (A10): # of PLHIV and their family members provided with individual and/or small group livelihoods development support	
Definition	<p>This indicator captures number of PLHIV and their family members (eligible adults and children) who benefit from livelihood development support service during the reporting period.</p> <p>Data should be disaggregated by:</p> <ul style="list-style-type: none"> • Gender • HIV status (PLHIV or other eligible adults and children) • Type of service received (micro-loans and other livelihoods development support or other livelihoods development support only) <p>Individuals eligible for support services are:</p> <ul style="list-style-type: none"> • Adults and children living with HIV (PLHIV), including pregnant women • Family members, caregivers, or other household members living with or caring for an HIV-positive individual or an OVC • Children made vulnerable due to HIV (<18 years old) including children who have lost one or both parents to AIDS, and/or who live in households made increasingly vulnerable because of HIV. Note that in high prevalence communities, all children may be affected due to a break down in community support, loss of teachers, or other social support as a result of the HIV epidemic. • Infants born to HIV-positive mothers <p>Receiving livelihood development support is understood as receiving at least one of the following services:</p> <ul style="list-style-type: none"> • business development training • non-business development related livelihood training • being a member of a livelihood development group • have a chance to apply for project provided micro-loans <p>Note: As more models of work on livelihoods with PLHIV are developed the list of the services will be revisited</p>
Numerator	N/A
Denominator	N/A
Rationale	This indicator is needed to monitor achievements towards the overall program target on number of PLHIVs and family members reached by livelihoods development interventions.
Measurement tools	Data will be collected by support groups implementing the intervention through meeting and training attendance logs, signatures on livelihoods development group rules and regulations and forms used in micro-loans schemes.

	<p>Programs encourages participation of PLHIV and their family members. For example, family members are encouraged to join the livelihoods development activities. Information should be collected on how many people in the family are benefiting from the livelihoods development support service. In some cases, when PLHIV have not disclosed their status to family members, no family members are benefiting. In other cases several members could be attending the training and working in a small business supported by the intervention or benefiting from the increased income of a PLHIV.</p> <p>If the family involvement information is not available it is assumed for this indicator that for each PLHIV who is a member of a livelihoods development group TWO family members are also benefiting.</p>
<p>Data interpretation and use</p>	<p>The indicator only counts the number of people reached, it does not provide information related to effectiveness and quality and especially to appropriateness of economic needs targeting, how interventions reduce the vulnerability of livelihoods and how it impacts core health interventions over time. This additional information should be collected via project reviews and evaluations.</p>

Evaluation Indicators

Evaluation indicator 1 (E1): % of individuals reached by HIV prevention programs

Definition	<p>Percentage of MARPs reached with HIV prevention programs, disaggregated by MARP.</p> <p>This percentage is defined as the total number of MARPs who know where to get an HIV antibody test and who have received a condom in the last 12 months. This number is then divided by the total number of MARPs who took part in the survey and responded to the question.</p>
Numerator	Number of MARPs respondents who replied 'yes' to both questions
Denominator	Total number of MARPs surveyed
Rationale	This indicator can be used to assess progress in implementing the basic package of prevention programs for MARPs.
Measurement tools	<p>Behavioral surveillance or other special surveys.</p> <p>Respondents are asked the following questions:</p> <ol style="list-style-type: none"> 1. Do you know where you can go if you wish to receive an HIV test? 2. In the last 12 months, have you been reached or given condom (e.g. through an outreach service, drop-in center or sexual health clinic)? <p>Data collected for this indicator should be disaggregated by age (under 25 and 25 or older). Whenever possible, data for MARPs populations should be collected through civil society organizations that have worked closely with this population in the field. Access to survey respondents as well as the data collected from them must remain confidential.</p>
Data interpretation and use	<p>Accessing and/ or surveying MARPs populations can be challenging. Consequently, data obtained may not be based on a representative sample of MARPs. If there are concerns that the data are not based on a representative sample, these concerns should be reflected in the interpretation of the survey data. Where different sources of data exist, the best available estimate should be used. Information on the sample size, the quality and reliability of the data, and any related issues should be included in the report submitted with this indicator</p>

Evaluation indicator 2 (E2): % of individuals who both correctly identify ways of preventing the sexual transmission of HIV and who reject major misconceptions about HIV transmission

Definition	<p>Percentage of MARPs who both correctly identify ways of preventing the sexual transmission of HIV and who reject major misconceptions about HIV transmission</p> <p>This percentage is defined as the total number of MARPs that correctly answered the knowledge questions (see below) divided by the total number of MARPs who took part in the survey and responded to the question.</p>
Numerator	Number of MARPs respondents who gave the correct answers to all five questions

Denominator	Total number of MARPs who responded to the question; this includes MARPs who gave 'don't know' answers
Rationale	This indicator can be used to assess progress in building knowledge of the essential facts about HIV transmission among MARPs
Measurement tools	<p>Behavioral surveillance or other special surveys.</p> <p>Respondents are asked the following five questions:</p> <ol style="list-style-type: none"> 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? <p>This indicator should be disaggregated by age (under 25 and 25 and older).</p> <p>The first three questions should not be altered. Questions 4 and 5 may be replaced by the most common misconceptions in the area.</p> <p>Respondents who have never heard of HIV and AIDS (those that would respond "don't know") should be excluded from the numerator but included in the denominator.</p> <p>Whenever possible, data for MARPs should be collected through civil society organizations that have worked closely with this population in the field. Access to survey respondents as well as the data collected from them must remain confidential.</p>
Data interpretation and use	<p>This indicator is particularly useful in places where knowledge about HIV and AIDS is poor because it allows for easy measurement of incremental improvements over time. However, it is also important in other places because it can be used to ensure that pre-existing high levels of knowledge are maintained.</p> <p>Surveying MARPs can be challenging. Consequently, data obtained may not be based on a representative sample of MARPs. If there are concerns that the data are not based on a representative sample, these concerns should be reflected in the interpretation of the survey data. Where different sources of data exist, the best available estimate should be used.</p> <p>Information on the sample size, the quality and reliability of the data, and any related issues should be included in the report submitted with this indicator.</p>

Evaluation indicator 3 (E3): % of individuals reporting the use of a condom the last time they had sex with a female or a male partner

<p>Definition</p>	<p>Percentage of MARPs reporting the use of condom the last time they had sex with a female or male partner, disaggregated by MARP.</p> <p>This percentage is defined as the total number of MARPs who reported that a condom was used the last time they had vaginal or anal sex with a female or male partner divided by the total number of respondents who reported having had sex with a female or male partner in the last six months.</p>
<p>Numerator</p>	<p>Number of MARPs who reported that a condom was used the last time they had sex with a female or male partner</p>
<p>Denominator</p>	<p>Number of MARPs who reported having had sex with a female or male partner in the last six months</p>
<p>Rationale</p>	<p>Condoms can substantially reduce the risk of the sexual transmission of HIV. Consequently, consistent and correct condom use is important for MARPs because of the high risk of HIV transmission during unprotected sex with a female or a male partner.</p> <p>Condom use with their most recent partner is considered a reliable indicator of longer-term behavior. This indicator can be used to assess progress in preventing exposure to HIV among MARPs who have unprotected sex with their partners.</p>
<p>Measurement tools</p>	<p>Behavioral surveillance or other special surveys</p> <p>Data for this indicator should be disaggregated by age (under 25 and 25 and older).</p> <p>There are several instruments such as the behavioral surveillance surveys that can be referred to in order to identify how this question should be asked. Cultural norms should be taken into account and all interviewers should be trained in order to assure that the question is asked in an acceptable manner and that the respondents feel comfortable in providing truthful answers.</p> <p>Whenever possible, data for MARPs should be collected through civil society organizations that have worked closely with this population in this field. Access to survey respondents as well as the data collected from them must remain confidential.</p>
<p>Data interpretation and use</p>	<p>For MARPs, condom use at last sex with any partner gives a good indication of overall levels and trends of protected and unprotected sex in MARPs. This indicator does not give any idea of risk behavior among men who have sex with both women and men unless the survey asks respondents to specify who their last partner was. In areas where men in the sub-population surveyed are likely to have partners of both sexes, condom use with female as well as male partners should be investigated. In these cases, data on condom use should always be presented separately for female and male partners.</p> <p>Surveying MARPs can be challenging. Consequently, data obtained may not be based on a representative sample of MARPs. If there are concerns that the data are not based on a representative sample, these concerns should be reflected in the interpretation of the survey data. Where different sources of data exist, the best available estimate should be used. Information on the sample size, the quality and reliability of the data, and any related issues should be included in the report submitted with this indicator.</p>

Evaluation indicator 4 (E4): % of female or male sex workers reporting the use of a condom with their most recent client

Definition	<p>Percentage of female or male sex workers reporting the use of a condom with their most recent male client during penetrative sex (Anal and/or vaginal), disaggregated by gender of sex worker.</p> <p>This percentage is defined as the total number of respondents who reported that a condom was used with their last male client divided by the total number of respondents who reported engaging in commercial sex in the last 12 months. Here commercial sex means the exchange of sex for money, goods or services.</p>
Numerator	Number of female or male sex workers who reported that a condom was used with their last client
Denominator	Number of female or male sex workers who reported engaging in commercial sex in the last 12 months
Rationale	This indicator can be used to assess progress in preventing exposure to HIV among male sex workers through unprotected sex with clients.
Measurement tools	<p>Behavioral surveillance or other special surveys</p> <p>Respondents are asked the following question:</p> <p style="padding-left: 40px;">1. Did you use a condom with your most recent male client?</p> <p>Data for this indicator should be disaggregated by age (under 25 and 25 and older).</p> <p>Whenever possible, data for sex workers should be collected through civil society organizations that have worked closely with this population in the field. Access to survey respondents as well as the data collected from them must remain confidential.</p>
Data interpretation and use	<p>This indicator will generally provide an overestimate of the level of consistent condom with clients use due to respondent bias. However, the alternative method of asking whether condoms are always/ sometimes/ never used in sexual encounters with clients in a specified period is subject to recall bias.</p> <p>Furthermore, the trend in condom use in the most recent sexual act will generally reflect the trend in consistent condom use.</p> <p>Surveying sex workers can be challenging. Consequently, data obtained may not be based on a representative sample. If there are concerns that the data are not based on a representative sample, these concerns should be reflected in the interpretation of the survey data. Where different sources of data exist, the best available estimate should be used. Information on the sample size, the quality and reliability of the data, and any related issues should be included in the report submitted with this indicator.</p>

Evaluation indicator 5 (E5): % of individuals who received an HIV test in the last 12 months and who know their results

Definition	<p>Percentage of MARPs who received an HIV test in the last 12 months and who know their results, disaggregated by MARP.</p> <p>This percentage is defined as the total number of MARPs that took an HIV</p>
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	test and know their results within the last 12 months divided by the total number of MARPs responding to the question.
Numerator	Number of MARPs who have been tested for HIV during the last 12 months and who know the results
Denominator	Number of MARPs surveyed
Rationale	This indicator's purpose is to assess progress in implementing HIV testing and counseling among MARPs. It is important for MARPs to know their HIV status in order to protect themselves and to prevent infecting others. Knowledge of one's status is also a critical factor in the decision to seek treatment.
Measurement tools	Behavioral surveillance or other special surveys. Respondents are asked the following questions: <ol style="list-style-type: none"> 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? Data for this indicator should be disaggregated by age (under 25 and 25 or older). Whenever possible, data for MARPs should be collected through civil society organizations that have worked closely with this population in the field. Access to survey respondents as well as the data collected from them must remain confidential.
Data interpretation and use	This indicator can be used to assess coverage of HCT at the community level. Accessing and/or surveying MARPs can be challenging. Consequently, data obtained may not be based on a representative sample of MARPs. If there are concerns that the data are not based on a representative sample, these concerns should be reflected in the interpretation of the survey data. Where different sources of data exist, the best available estimate should be used. Information on the sample size, the quality and reliability of the data, and any related issues should be included in the report submitted with this indicator.
Evaluation indicator 6 (E6): % of IDU reporting no needle sharing in last month	
Definition	The percentage of IDUs reporting that they have not shared injection equipment during the last month. This percentage is defined as the total number of IDUs who have injected in the last month and who report that they have not shared any injecting equipment divided by the total number of IDUs responding to the question. This indicator should be disaggregated by sex and age (<25/25+).
Numerator	Number of respondents who report that they have not shared any injecting equipment in the last month
Denominator	Number of respondents who report injecting drugs in the last month
Rationale	To assess progress in preventing injecting drug use-associated HIV transmission
Measurement tools	Special surveys including the Family Health International Behaviour Surveillance Survey (IBBS) for injecting drug users.

	<p>Respondents are asked the following questions:</p> <ol style="list-style-type: none"> 1. Have you injected drugs at any time in the last month? 2. If yes: In the last month, have you shared needles or syringes with others? <p>Whenever possible, data for injecting drug users should be collected through civil society organizations that have worked closely with this population in the field. Access to survey respondents as well as the data collected from them must remain confidential.</p>
<p>Data interpretation and use</p>	<p>Surveying injecting drug users can be challenging. Consequently, data obtained may not be based on a representative sample of the national injecting drug user population being surveyed. If there are concerns that the data are not based on a representative sample, these concerns should be reflected in the interpretation of the survey data. Where different sources of data exist, the best available estimate should be used.</p> <p>Information on the sample size, the quality and reliability of the data, and any related issues should be included in the report submitted with this indicator.</p> <p>The extent of injecting drug use-associated HIV transmission within a country depends on four factors: (i) the size, stage and pattern of dissemination of the national AIDS epidemic; (ii) the extent of injecting drug use; (iii) the degree to which injecting drug users use contaminated injecting equipment; and (iv) the patterns of sexual mixing and condom use among injecting drug users and between injecting drug users and the wider population. This indicator provides information on the third factor.</p> <p>To maximize the utility of these data, it is recommended that the same sample used for the calculation of this indicator be used for the calculation of the other indicators related to these populations.</p> <p>This question may need to be modified in certain local contexts. In certain drug injecting cultures, for example, needles and syringes may be exposed to HIV without being shared between users (e.g. through shared drug solutions). The questions used must ascertain that the relevant materials (needles, syringes and/or drug solutions) were not shared.</p>
<p>Evaluation indicator 7 (E7): % of individuals who are HIV infected</p>	
<p>Definition</p>	<p>Percentage of MARPs who are HIV infected, disaggregated by MARP.</p> <p>This percentage is defined as the total number of MARPs that are HIV infected divided by the total number of MARPs tested in the last 12 months.</p>
<p>Numerator</p>	<p>Number of MARPs who test positive for HIV in the last 12 months</p>
<p>Denominator</p>	<p>Number of MARPs tested for HIV in the last 12 months (core indicator 3)</p>
<p>Rationale</p>	<p>This indicator is used for assessing progress in reducing HIV prevalence among MARPs.</p>

Measurement tools	Counseling records can be used to determine the number of MARPs that took an HIV antibody test in the last 12 months, they should also be reviewed to count the number of MARPs who were found to be positive.
Data interpretation and use	<p>This indicator is calculated using data from HIV tests conducted among MARPs.</p> <p>Due to difficulties in accessing MARPs, biases in data are likely to be far more significant than in data from a more general population. If there are concerns about the data, these concerns should be reflected in the interpretation.</p> <p>This indicator will only represent those MARPs accessing HCT services; it will not be representative of the situation everywhere else in the district or country.</p>