

The President's Emergency Plan for AIDS Relief

FY 2007

INDICATORS REFERENCE GUIDE

**The President's Emergency Plan for AIDS Relief:
Indicators, Reporting Requirements, and Guidelines**

**Indicators Reference Guide
Revised for FY2007 Reporting**

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INTRODUCTION

Since the *United States Leadership Against HIV/AIDS, Tuberculosis, and Malaria Act of 2003* (Public Law 108-25) was enacted, the Office of the U.S. Global AIDS Coordinator launched The President's Emergency Plan for AIDS Relief (The Emergency Plan) and has worked to coordinate the U.S. Government's response to HIV/AIDS around the world, harmonizing the planning and reporting process. Beginning in fiscal year 2006, all countries receiving more than \$1 million from bilateral U.S. Government assistance to implement HIV/AIDS activities are required to report at least annually¹ to the Office of the U.S. Global AIDS Coordinator. The information contained in this document applies to countries that receive over \$1 million in U.S. bilateral HIV/AIDS funds.

Collecting strategic information serves multiple purposes:

- to assist countries to plan and monitor HIV/AIDS activities
- to provide information to the Office of U.S. Global AIDS Coordinator (OGAC) for management of The Emergency Plan
- to demonstrate progress of the Emergency Plan in the annual report to the US Congress
- to advocate for continued support of HIV/AIDS prevention, care, and treatment programs
- to coordinate efforts with the international donor community.

The indicators in this guidance meet the overall needs of the Emergency Plan to demonstrate progress in the fight against HIV/AIDS. ***They are not designed to provide information on all dimensions of a program in country-specific settings.*** Strong program monitoring at the country-level requires a broad range of indicators, which can measure quality, coverage, and other aspects of programs. U.S. Government (USG) country teams are strongly encouraged to refer to national and international guidelines and consult the PEPFAR program technical working groups for further assistance in designing and implementing program-specific monitoring indicators.

The purpose of this document is to provide guidance regarding data collection and reporting for Emergency Plan program results, including outputs, outcomes, and impacts. Shortly after the end of each fiscal year, all USG field offices will be required to report to their respective Agencies or the Office of the U.S. Global AIDS Coordinator describing the progress and accomplishments of U.S.-funded HIV/AIDS activities. These data will be used to report PEPFAR achievements in the Fourth Annual Report to Congress.

For each program area, program level indicators, as well as outcome and impact level indicators have been selected and are described in two sections:

¹ The fifteen focus countries will continue to submit semi-annual reports detailing the progress of the Emergency Plan in country. All other countries receiving more than \$1 million in bilateral HIV/AIDS funding will report annually. Countries receiving over \$1 million, but not required to complete mini-COPs will report to their respective agencies, and this information will be sent to OGAC.

The first section describes program-level indicators: Table 1 on page 8 shows the quantitative program-level indicators framework. Program-level Indicators are listed at-a-glance on pages 20-22. This is followed by indicator reference sheets for each program-level indicator, which further describe and define the program-level indicators.

The second section, beginning on page 89, provides summary listings for outcome and impact level indicators with their data collection methods and international standard sources, separated into generalized and concentrated/low-level epidemic indicators.

Emergency Plan Program-level Reporting

Descriptive Summary

In-country Collaboration and Coordination

The PEPFAR model encourages USG agencies in the specified countries to work in close collaboration/coordination with other donor and international agencies active in the HIV/AIDS arena, as well as a range of in-country partners. Each USG team will have the opportunity to list the organizations with which they are collaborating or coordinating in country and to include a brief description of the type of collaboration or coordination (for example, conducting joint planning or implementation, funding or co-funding, or coordinating of program activities). This type of information may be particularly important for the PEPFAR Other Bilateral countries that are primarily working to strengthen systems and leverage other donors' dollars (See Appendix 1).

Output, Outcome, and Impact Data

In FY 2007, reporting requirements will be fully aligned with OGAC requirements. As a result all PEPFAR countries receiving over \$1 million will have the opportunity to report on the same set of 41 indicators.

The indicators presented here are the **minimum** set of program-level reporting requirements under The Emergency Plan; they represent only a portion of the information needed by programs to effectively monitor, manage, and improve programs locally. Each of the PEPFAR program area technical working groups (TWG) may be used as resources to identify the appropriate indicators needed to effectively monitor and manage programs. In some cases, these recommendations have been formally written into guidance documents. Some examples might include geographical coverage by service site, age of clients served (when not already required), and patient monitoring to determine the number and intensity of care services received.

Program-level indicators are often, though not always, broadly defined. A broad definition allows countries the freedom to develop appropriate region specific programs, which best address the needs of the population (e.g. in areas such as Care and OVC). While

some indicator definitions lack specificity, this should not be confused with lack of interest in program quality. On the contrary, OGAC encourages each country to develop quality programs, which reflect National/International guidelines and standards. Countries may report using their own more specific definitions, but that definition should fit within the broader PEPFAR definition. In the absence of guidelines, countries must use their best judgment in determining for themselves the reasonable level of service that ensures quality.

Each country must report on program results at least once every year according to agency and OGAC reporting guidance (refer to Table 2 for specific reporting requirements by funding level). The annual program results will be reported shortly after the end of the fiscal year and cover the full fiscal year (October 1-September 30). The annual results update will include financial information along with joint USG reporting on program-level indicators contained within this document.

Table 1 shows the framework developed for monitoring program level results achieved by the Emergency Plan. The program-level data required vary by service category. Generally, all program-level indicators fall into one of the following categories:

- Number of organizations provided with TA
- Number of service outlets;
- Number of individuals served; and
- Number of people trained

In addition to specific indicators, countries completing mini-COPs will also have the opportunity to discuss progress towards completion of products or outputs that were proposed in the mini-COP (Mini-COP Section 3.3).

Table 1: The Emergency Plan Program-Level Reporting Framework

Program Area	Number of organizations provided w/ TA	Number of service outlets	Number of individuals served, by sex	Number of people trained
<i>PMTCT</i>		X	X	X
ARV prophylaxis within PMTCT			X	
<i>Prevention</i>				
Abstinence and/or Be faithful			X	X
Abstinence			X	
Medical transmission/Blood safety		X		X
Medical transmission/Medical Injection safety				X
Other Behavior Change			X	X
<i>Palliative Care (Facility/Community or Home-Based)</i>		X (total)	X (adjusted)	X (total)
TB/HIV		X	X	X
<i>OVC</i>			X	X
<i>Counseling and Testing</i>		X	X	X
<i>Treatment (ART)</i>		X	X	X
<i>Labs</i>		X		X
<i>Strategic Information</i>	X			X
<i>Other Policy Analysis and Systems Strengthening</i>				
Policy Development	X			X
Institutional Capacity Building	X			X
Stigma and Discrimination Reduction				X
Community Mobilization for Prevention, Care and/or Treatment				X

Data Quality

The Emergency Plan relies on good quality data to support its programs and demonstrate progress towards goals. Issues such as estimation of indirect and direct support, comparability of reported results over multiple reporting periods, and double-counting can impact data quality. These issues affect every Emergency Plan program, regardless of the unique set of programmatic and sociopolitical factors that make one country program different from another. For more assistance with these issues please refer to the *PEPFAR Data Quality Assurance Tool for Program-Level Indicators* (PEPFAR DQA Tool is available at <http://www.pepfar.gov/c20981.htm>).

Double-counting should be avoided, particularly within a program area and reporting period. For example, if one orphan or vulnerable child (OVC) is receiving school-related expenses from an OVC program and also receives periodic nutritional support and counseling during the same reporting period, this child should only be counted once within the reporting period. USG agencies in country are responsible for ensuring that persons receiving multiple services within one program area are counted only once during the reporting period. Each person served should be given the appropriate quality package of services, according to national/international standards.

For individuals served by multiple program areas, it is acceptable to count individuals once for each program area (e.g., antiretroviral therapy (ART) and Palliative Care).

Persons receiving services in one reporting cycle can be counted again in the next cycle if they are still receiving services. Thus, the report shows the total number of persons served within each reporting period (12 months).

The same applies to counting numbers of people trained. A person trained more than once within a reporting period is only counted as one person trained; however, if this person is trained in a different program area then he/she counts once for each program area in which he/she is trained.

Downstream (Direct) and Upstream (Indirect) Results for Program-level Indicators

Seven of the program level indicators require target setting for and reporting of downstream and upstream results. The indicators for which both downstream and upstream results reporting is required are:

- Number of pregnant women who received HIV counseling and testing for PMTCT and received their test results (#1.2)
- Number of pregnant women provided with a complete course of antiretroviral prophylaxis in a PMTCT setting (#1.3)
- Number of individuals provided with HIV-related palliative care (including TB/HIV) (#6.2)
- Number of HIV-infected clients attending HIV care/treatment services that are receiving treatment for TB disease (this is a subset of all individuals provided with palliative care) (#7.2)
- Number of orphans and vulnerable children (OVC) served by an OVC program (#8.1)
- Number of individuals who received counseling and testing for HIV and received their test results (#9.2)
- Number of individuals receiving antiretroviral therapy at the end of the reporting period (referred to as CURRENT clients) (#10.4)

Note: The indicator reference number is noted in parenthesis (See Table 3).

USG downstream support

An intervention or activity is considered to be a type of “downstream (direct) support” if it can be associated with counts of uniquely identified individuals receiving prevention, care, and/or treatment services at a unique program or service delivery point that receives USG funding. Downstream (direct) support is expected to be limited in PEPFAR Other Bilateral Countries, and therefore the number of downstream results may be zero. Please estimate the number of individuals receiving prevention, care, and treatment services through service delivery sites/providers that are directly supported by USG interventions/activities (commodities, drugs, supplies, supervision, continuing on-site training, quality assurance, etc.) at the point of service delivery. If you do not provide downstream support, please use a zero (“0”) for the downstream result.

USG upstream support

Upstream (indirect) support refers to contributions made by the USG to overall system strengthening and capacity building that occur apart from, and at higher levels than the actual points of service delivery. The level of funding available for USG upstream programs will vary by country. While USG upstream funded activities will contribute to national or regional results, they may not contribute significantly (as defined in the PEPFAR DQA Tool) to these results. Upstream results are set by the national or regional results, if they exist, for the number of individuals receiving prevention, care, and treatment services, minus those counted above under downstream (direct) USG support. Upstream results can be zero (“0”) for program areas without funded upstream activities.

For those results where only upstream funding is provided, use the national or regional figure for that result and provide appropriate documentation of this use at reporting time. If national results do not exist, the USG team needs to estimate the number of individuals served during the fiscal year in the country or region. If the USG contributes significantly to national or regional results, then the upstream results should be national or regional results. If the USG contribution is not significant relative to the national or regional results, then the USG country team should refer to the PEPFAR DQA Tool for further guidance on reporting upstream results.

If downstream (direct) services are supported by the Emergency Plan for the same indicator where upstream (indirect) services are also supported, it is assumed that the individuals who receive the supported services are included in the national results. To avoid double counting, if an individual is being reached directly through a USG supported site and also indirectly through USG support to national systems strengthening, only include the individual in the downstream (direct) counts. Individuals reached through upstream (indirect) support should be in addition to those reached via downstream (direct) support in order to make these categories mutually exclusive.

Reporting Requirements by Funding Level

There is wide recognition of the differences between PEPFAR Focus Countries and PEPFAR Other Bilateral Countries. The expectation for focus countries is that there will be a level of resources high enough to bring programs to scale nationally in all 15 program areas. This is not the case for PEPFAR Other Bilateral Countries; for these countries, there is no expectation that bilateral resources will be sufficient to work in all 15 program areas or to bring programs to scale. Instead, the primary approach to support national-level prevention, care, and treatment programs will be through leveraging other in-country resources, both from international partners and host nation governments. This leveraging should be a key focus and countries will be given the opportunity to fully describe their activities through the “In-Country Collaboration Table” (see Appendix 1).

Countries are requested to report on those indicators in areas, which they are currently funding. Focus countries are expected to have programming in all program areas and thus, will report on all indicators. PEPFAR Other Bilateral Countries may not have programming in all program areas and thus, will not be expected to report on all indicators – but will be expected to report on a subset of the entire list of indicators *within the program areas they are funding*.

Table 2: Reporting Requirements by Funding Level

Country Group	Frequency	Destination
Focus Countries	Semi-annual, Annual	Report to OGAC
Mini-COP Countries	Annual only	Report to OGAC
Over \$1 million reporting directly to Agencies	Annual only	Report according to Agency Guidance*

*A team of HQ agency representatives will compile a joint USG report of the standardized indicators to send to OGAC.

Focus Countries

Definition: There are 15 Focus countries: Botswana, Cote d'Ivoire, Ethiopia, Guyana, Haiti, Kenya, Mozambique, Namibia, Nigeria, Rwanda, South Africa, Tanzania, Uganda, Vietnam, and Zambia.

Setting Targets: The legislative 2-7-10 targets were set for focus countries and based on the specific demographic and prevalence data available at the beginning of The Emergency Plan. Interim yearly targets are set by countries through their Country Operation Plans but should reflect yearly rather than cumulative counts. At this time, the 2-7-10 targets apply only to the Focus countries. For more information on the reporting cycle see Appendix 2.

Emergency Plan Legislative Targets

Support treatment for 2 million people living with HIV/AIDS by 2009

The achievement of this target will be measured by the number of individuals receiving antiretroviral therapy through FY 2008 funding. It will be counted at the end of the 12-month reporting period in FY 2009 given that most FY 2008 funding will be spent in 2009. (This measure is not cumulative over 5 years). This target includes both downstream and upstream counts.

Prevent 7 million new HIV infections by 2010

The Bureau of the Census (BUCEN) will be modeling achievement of this target based on surveillance data. BUCEN will periodically produce estimates towards the achievement of this target based on new surveillance data reported by countries. Countries do not need to invest country funds in modeling infections averted.

Support care for 10 million people infected and affected by HIV/AIDS, including orphans and vulnerable children, by 2009

The achievement of this target will be measured by the number of individuals receiving palliative care and OVC served through FY 2008 funding. It will be counted during the 12-month reporting period in FY 2009 given that most FY 2008 funding will be spent in 2009. (This measure is not cumulative over 5 years). This target includes downstream and upstream counts.

Reporting: Each focus country must report on program results every six months to the Office of the U.S. Global AIDS Coordinator (OGAC). The semi-annual program results will be reported in May of each year and cover the first six months of the fiscal year (October 1-March 31); the annual program results update will be reported shortly after the end of the fiscal year and cover the full fiscal year (October 1-September 30). Thus, the reporting period will vary: for the semi-annual program results, the reporting period is six months; for annual program results the reporting period is for twelve months. The Annual Progress Report (APR) will include financial information along with joint USG reporting on all the required program and country-level indicators contained within this

document. The Semi-Annual Progress Report (SAPR) will not require financial information but will include information on the required program and country-level indicators. The program-level indicators of The Emergency Plan are collected from program data/reports and routine facility-based HMIS.

In reporting your country's semi-annual and annual results, it is critically important to coordinate as a USG Team. It is essential that ALL USG Agencies working in country be included in discussions around reporting. As you develop your annual report and prepare for submission of the document to OGAC, you should ensure that time for review and approval by your Ambassador and review by the Host Nation Government, as appropriate, is included in the schedule.

Required Emergency Plan Program-Level Indicators: Focus countries are expected to have programming in all program areas and thus, will report on all indicators.

The program-level indicators for The Emergency Plan rely heavily on program reports from USG partners in-country and routine facility-based HMIS. Data from these sources will be collated by USG offices in country. The data collection systems for some existing partners may not allow them to report on these indicators; they should work toward incorporating these indicators into their monitoring and evaluation systems so that they will be able to report at the end of the fiscal year. All new agreements should specify that partners will be expected to report according to these guidelines.

Required Emergency Plan Outcome- and Impact-level Indicators

In keeping with the Three Ones – moving toward one harmonized M&E reporting system, outcome and impact indicators and their definitions are drawn from and align with international standards and measurement tools wherever possible and provide evidence of trends related to behavior change, health infrastructure capacity and quality, care and support, and impact of care and treatment, including morbidity and mortality.

Once per year, in the Annual Progress Report (APR) due shortly after the end of the fiscal year, focus countries are required to provide updated estimates of the outcome- and impact-level indicators for which new data became available during the fiscal year (see pages 92-96).

The required outcome and impact indicators are measured using a variety of data sources including population-based surveys, targeted facility surveys, sentinel surveillance systems or sero-surveys, and cohort studies. Baseline data for required indicators should have been collected by the end of fiscal year 2004 or mid-fiscal year 2005. At a minimum, countries should collect and analyze a second data point for each required outcome- and impact-level indicator before the end of The Emergency Plan (September 2009). Routine surveillance information should be collected yearly or every other year; national population and health facility surveys every 2 to 3 years.

Planned country activities should include an analysis of the required indicators already collected by year and source of data collection. Some data come from the national population surveys, (e.g., DHS, AIS); given the long lead time for these surveys, countries with a single data point would have ideally included one in the 2007 COP. Countries should also include in their planned activities for other specific surveys that collect data for required indicators to assure completion of analysis by September 2009. Special studies may be desired in order to supplement existing data to address programmatic needs and to document successful models.

Recommended Emergency Plan Outcome- and Impact-level Indicators

Among the indicators that are recommended under The Emergency Plan at this point, some are appropriate at the sub-national level only, thus their exclusion from the required set of Emergency Plan indicators. Some of the indicators have methodologies that are still under development. The Recommended Emergency Plan Outcome- and Impact-level Indicators Summary Table (see pages 97-98) indicates this, as well as the group leading the piloting or testing of the methodology.

Emergency Plan Outcome- and Impact-level Indicators for Concentrated/Low Prevalence Epidemic Settings

For countries with concentrated or low prevalence epidemics or mixed epidemics, there is an additional set of outcome and impact indicators for programs that target the most-at-risk-populations in these countries (see page 99). Countries, which have a significant proportion of their epidemic stemming from the most-at-risk populations, are encouraged to collect and report progress towards these populations at the program level as well as the outcome- and impact-level.

Mini-COP Countries

Definition: All countries completing mini-COPS for FY 2007 must report on program results once every year to the Office of the U.S. Global AIDS Coordinator (OGAC). These countries are: Angola, Cambodia, China, Democratic Republic of the Congo, Dominican Republic, Ghana, India, Indonesia, Lesotho, Malawi, Russia, Sudan, Swaziland, Thailand, Ukraine, and Zimbabwe.

Setting Targets: Interim yearly targets are set by countries through their Mini-Country Operation Plans. These targets should reflect yearly rather than cumulative counts.

Reporting: Each mini-COP country must report on program results once every year to the Office of the U.S. Global AIDS Coordinator (OGAC). The reporting period covers a 12 month time frame representing the full fiscal year (October 1-September 30) and will be due shortly after the end of the fiscal year. The Annual Progress Report (APR) will include financial information along with joint USG reporting on all the required program and country-level indicators contained within this document that fall within program areas that receive funding. The PEPFAR program-level indicators of The Emergency Plan are collected from program data/reports and routine facility-based HMIS.

In reporting your country's annual results, it is critically important to coordinate as a USG Team. It is essential that ALL USG Agencies working in country be included in discussions around reporting. As you develop your annual results report and prepare for submission of the document to OGAC, you should ensure that time for review and approval by your Ambassador and review by the Host Country Government, as appropriate, is included in the schedule.

Required Emergency Plan Program-Level Indicators:

Countries are requested to report on the indicators that fall in the program areas that they are currently funding. PEPFAR Other Bilateral Countries may not have programming in all areas and thus, will not be expected to report on all indicators – but will be expected to report on a subset of the entire list of indicators *for which they have set targets in the mini-COP*.

The program-level indicators for The Emergency Plan rely heavily on program reports from USG partners in-country and routine facility-based HMIS. Data from these sources will be collated by USG offices in country. The data collection systems for some existing partners may not allow them to report on these indicators; they should work toward incorporating these indicators into their monitoring and evaluation systems so they will be able to report at the end of the fiscal year. All new agreements should specify that partners will be expected to report according to these guidelines.

Emergency Plan Outcome- and Impact-level Indicators

- **These outcome- and impact-level indicators are required for the following Mini-COP countries: Cambodia, India, Malawi, Russia, and Zimbabwe.**
- **PEPFAR Other Bilateral Countries are encouraged to also report this information but are not required to do so.**

In keeping with the Three Ones – moving toward one harmonized M&E reporting system, outcome and impact indicators and their definitions are drawn from and align with international standards and measurement tools wherever possible and provide evidence of trends related to behavior change, health infrastructure capacity and quality, care and support, and impact of care and treatment, including morbidity and mortality.

Once per year, in the annual program results due shortly after the end of the fiscal year, countries have the opportunity to provide updated estimates of the outcome- and impact-level indicators for which data became available during the fiscal year (see pages 92-96).

The outcome and impact indicators are measured using a variety of data sources including population-based surveys, targeted facility surveys, sentinel surveillance systems or sero-surveys, and cohort studies. Baseline data for required indicators should have been collected by the end of fiscal year 2004 or mid-fiscal year 2005. At a minimum, countries should collect and analyze a second data point for each required outcome- and impact-level indicator before the end of the Emergency Plan (September 2009). Routine surveillance information should be collected yearly or every other year; national population and health facility surveys every 2 to 3 years.

Planned country activities should include an analysis of the required indicators already collected by year and source of data collection. Some data come from the national population surveys, (e.g., DHS, AIS); given the long lead time for these surveys, countries with a single data point would have ideally included one in the 2007 COP. Countries should also include in their planned activities for other specific surveys that collect data for required indicators to assure completion of analysis by September 2009. Special studies may be desired in order to supplement existing data to address programmatic needs and to document successful models.

Recommended Emergency Plan Outcome- and Impact-level Indicators

Among the indicators that are recommended under The Emergency Plan at this point, some are appropriate at the sub-national level only. Some of the indicators have methodologies that are still under development. The Recommended Emergency Plan Outcome- and Impact-level Indicators Summary Table (see pages 97-98) indicates this, as well as the group leading the piloting or testing of the methodology.

Emergency Plan Outcome- and Impact-level Indicators for Concentrated/Low Prevalence Epidemic Settings

For countries with concentrated or low prevalence epidemics or mixed epidemics, there is an additional set of outcome and impact indicators for programs that target the most-at-risk-populations in these countries (see page 99). Countries, which have a significant proportion of their epidemic stemming from the most-at-risk populations, are encouraged to collect and report progress towards these populations at the program level as well as the outcome- and impact-level.

Countries with over \$1 million in Bilateral HIV/AIDS not required to do a Mini-COP

Definition: All countries receiving over \$1 million in bilateral HIV/AIDS assistance must report on HIV program results once every year to their respective agencies. Program results reported to agencies will then be forwarded to OGAC.

Setting Targets: Official target setting will only be required of USAID missions as part of the State Department's Director of Foreign Assistance (DFA) Operational Plan (F-OP) system. These data and targets will be entered into the Foreign Assistance Coordination and Tracking System (FACTS). However, OGAC recommends that appropriate targets are set at the commencement of all HIV/AIDS prevention, care, and treatment efforts. USG agencies working in these countries are encouraged to work together in setting reasonable goals against which they are able to measure success.

Reporting: All countries receiving over \$1 million in bilateral HIV/AIDS assistance must report on program results once every year according to their respective agencies' guidelines. For USAID missions, this reporting will occur through the new FACTS system. The DFA Operational Plans will request some indicators in addition to the 41 PEPFAR indicators listed here. USAID missions will be required to report on these additional indicators in program areas which they are funding.

Required Emergency Plan Program-Level Indicators:

Countries are requested to report on the indicators that fall in the program areas that they are currently funding. PEPFAR Other Bilateral Countries may not have programming in all areas and thus, will not be expected to report on all indicators – but will be expected to report on a subset of the entire list of indicators *within the program areas they are funding*.

The program-level indicators for The Emergency Plan rely heavily on program reports from USG partners in-country and routine facility-based HMIS. Data from these sources will be collated by USG offices in country and submitted to their respective agencies. The data collection systems for some existing partners may not allow them to report on these indicators; they should work toward incorporating these indicators into their monitoring and evaluation systems so that they will be able to report at the end of the fiscal year. All new agreements should specify that partners will be expected to report according to these guidelines.

Note: Each agency's program results are compiled into one document by a USG team represented by all agencies in order to determine the total PEPFAR results by country. The difficulty with compiling individual agency results is that often agency data cannot be added together because in some cases there is overlap between agency programs (e.g. USAID and CDC are reaching the same individuals with a joint program and so are reporting the same individuals to each of their respective agencies). In an attempt to de-duplicate results, in-country agency teams may be asked to estimate the level of overlap between themselves and other agencies in country. Where multiple USG agencies are working with the same populations or

at the same sites, this may require that agencies to come together in-country to discuss any overlap issues and come to a consensus on the total USG results for all agencies in country.

Emergency Plan Outcome- and Impact-level Indicators

- **PEPFAR Other Bilateral Countries are encouraged to also report this information but are not required to do so.**

In keeping with the Three Ones – moving toward one harmonized M&E reporting system, outcome and impact indicators and their definitions are drawn from and align with international standards and measurement tools wherever possible and provide evidence of trends related to behavior change, health infrastructure capacity and quality, care and support, and impact of care and treatment, including morbidity and mortality (see pages 92-96).

The outcome and impact indicators are measured using a variety of data sources including population-based surveys, targeted facility surveys, sentinel surveillance systems or sero-surveys, and cohort studies. PEPFAR Other Bilateral Countries are encouraged to work with host national governments and other multi-lateral donors in country to discuss planning the collection of this set of recommended outcome- and impact-level indicators for national program planning. It is recommended that routine surveillance information be collected yearly or every other year; national population and health facility surveys every 2 to 3 years.

Recommended Emergency Plan Outcome- and Impact-level Indicators

Among the outcome- and impact-level indicators that are recommended under The Emergency Plan, some are appropriate at the sub-national level only, thus their exclusion from the required set of Emergency Plan indicators. Some of the indicators have methodologies that are still under development. The Recommended Emergency Plan Outcome- and Impact-level Indicators Summary Table (see pages 97-98) indicates this, as well as the group leading the piloting or testing of the methodology.

Emergency Plan Outcome- and Impact-level Indicators for Concentrated/Low Prevalence Epidemic Settings

For countries with concentrated or low prevalence epidemics or mixed epidemics, there is an additional set of outcome and impact indicators for programs that target the most-at-risk-populations in these countries (see page 99). Countries, which have a significant proportion of their epidemic stemming from the most-at-risk populations, are encouraged to collect and report progress towards these populations at the program level as well as the outcome- and impact-level.

Table 3 - PROGRAM-LEVEL INDICATORS

(1) Prevention of Mother-to-Child Transmission	
1.1 Number of service outlets providing the minimum package of PMTCT services according to national and international standards	
1.2 Number of pregnant women who received HIV counseling and testing for PMTCT and received their test results	
1.3 Number of pregnant women provided with a complete course of antiretroviral prophylaxis in a PMTCT setting	
1.4 Number of health workers trained in the provision of PMTCT services according to national and international standards	
(2) Prevention/Abstinence and Being Faithful	
2.1 Number of individuals reached through community outreach that promotes HIV/AIDS prevention through abstinence and/or being faithful	
	Male
	Female
2.1.A Number of individuals reached through community outreach that promotes HIV/AIDS prevention through abstinence	
	Male
	Female
2.2 Number of individuals trained to promote HIV/AIDS prevention programs through abstinence and/or being faithful	
(3) Prevention/Medical Transmission/Blood safety	
3.1 Number of service outlets carrying out blood safety activities	
3.2 Number of individuals trained in blood safety	
(4) Prevention/Medical Transmission/Injection Safety	
4.1 Number of individuals trained in medical injection safety	
(5) Prevention/Condoms and other Prevention Activities	
5.1 Number of targeted condom service outlets	
5.2 Number of individuals reached through community outreach that promotes HIV/AIDS prevention through other behavior change beyond abstinence and/or being faithful	
	Male
	Female
5.3 Number of individuals trained to promote HIV/AIDS prevention through other behavior change beyond abstinence and/or being faithful	
(6) Palliative Care (Basic Health Care)	
6.1 Total number of service outlets providing HIV-related palliative care (including TB/HIV)	
6.2 Total number of individuals provided with HIV-related palliative care (including TB/HIV)	
	Male
	Female
6.3 Total number of individuals trained to provide HIV palliative care (including TB/HIV)	
(7) Palliative Care (TB/HIV)	

	7.1. Number of service outlets providing treatment for tuberculosis (TB) to HIV-infected individuals (diagnosed or presumed) in a palliative care setting (a subset of indicator number 6.1)
	7.2. Number of HIV-infected clients attending HIV care/treatment services that are receiving treatment for TB disease (a subset of indicator number 6.2)
	Male
	Female
	7.3. Number of individuals trained to provide treatment for TB to HIV-infected individuals (diagnosed or presumed). (a subset of indicator number 6.3)
(8) Orphans and Vulnerable Children	
8.1 Number of OVC served by OVC programs	
	Male
	Female
	Primary Direct
	Supplemental Direct
8.2 Number of providers/caregivers trained in caring for OVC	
(9) Counseling and Testing	
9.1 Number of service outlets providing counseling and testing according to national and international standards	
9.2 Number of individuals who received counseling and testing for HIV and received their test results	
	Male
	Female
9.2.A Number of registered TB patients who received counseling and testing for HIV and received their test results	
	Male
	Female
9.3 Number of individuals trained in counseling and testing according to national and international standards	
(10) HIV/AIDS Treatment/ARV Drugs – No required indicators	
(11) HIV/AIDS Treatment/ARV Services	
11.1 Number of service outlets providing antiretroviral therapy	
11.2 Number of individuals newly initiating antiretroviral therapy during the reporting period	
	Male (0-14)
	Male (15+)
	Female (0-14)
	Female (15+)
	Pregnant female (all ages)
11.3 Number of individuals who ever received antiretroviral therapy by the end of the reporting period	
	Male (0-14)
	Male (15+)

	Female (0-14)
	Female (15+)
	Pregnant female (all ages)
11.4	Number of individuals receiving antiretroviral therapy at the end of the reporting period
	Male (0-14)
	Male (15+)
	Female (0-14)
	Female (15+)
	Pregnant female (all ages)
11.5	Number of health workers trained to deliver ART services, according to national and/or international standards
(12) Laboratory Infrastructure	
12.1	Number of laboratories with capacity to perform 1) HIV tests and 2) CD4 tests and/or lymphocyte tests
12.2	Number of individuals trained in the provision of laboratory-related activities
12.3	Number of tests performed at USG-supported laboratories during the reporting period: 1) HIV testing, 2) TB diagnostics, 3) syphilis testing, and 4) HIV disease monitoring
(13) Strategic Information	
13.1	Number of local organizations provided with technical assistance for strategic information activities
13.2	Number of individuals trained in strategic information (includes M&E, surveillance, and/or HMIS)
(14) Other/policy development and system strengthening	
14.1	Number of local organizations provided with technical assistance for HIV-related policy development
14.2	Number of local organizations provided with technical assistance for HIV-related institutional capacity building
14.3	Number of individuals trained in HIV-related policy development
14.4	Number of individuals trained in HIV-related institutional capacity building
14.5	Number of individuals trained in HIV-related stigma and discrimination reduction
14.6	Number of individuals trained in HIV-related community mobilization for prevention care and/or treatment
(15) Management and Staffing – No Required Indicators	

Definitions of Program-Level Indicators

Prevention of Mother-to-Child Transmission Services

1.1 Number of service outlets providing the minimum package of PMTCT services according to national or international standards	
Rationale/What It Measures:	This indicator provides a crude quantitative measure of the stage of PMTCT service expansion and current availability of PMTCT services supported by USG.
Definition:	<p>A service outlet refers to the lowest level of service. For example, a hospital, clinic, or mobile unit.</p> <p>The minimum package of services for preventing mother-to-child transmission (MTCT) of HIV includes at least all four of the following services:</p> <ol style="list-style-type: none"> 1. Counseling and testing for pregnant women 2. ARV prophylaxis to prevent MTCT 3. Counseling and support for safe infant feeding practices 4. Family planning counseling or referral
Measurement Tool:	Program Reports. USG staff and USG-funded partners should keep an inventory of the name and location of service outlets providing PMTCT services, clearly indicating those that provide the minimum package of PMTCT services. This information should be submitted to the USG staff responsible for compiling the annual reporting data as evidence for the reported number of service outlets providing the minimum package of PMTCT services.
How To Measure It:	<p>Each USG agency and USG-funded partner counts the number of service outlets providing the minimum package of PMTCT services at the end of the specified reporting period (12 months for annual report). Count only those service outlets that provide at minimum all four services specified above (1, 2, 3, and 4).</p> <p>The USG staff responsible for compiling the annual reporting data should use the PMTCT service outlets list submitted by each USG agency and USG-funded partner reporting on this indicator in order to count the total number of service outlets providing the minimum package of PMTCT services, avoiding any double-counting of the same PMTCT outlet supported by more than one USG agency/USG-funded partner.</p>
Interpretation/Strengths and Weaknesses:	This indicator does not consider the quality of service provision, which would require more in-depth evaluation efforts like facility surveys. This is not a complete measure of coverage, as there is no denominator of total facilities. This does not account for non-USG supported service outlets.

1.2 Number of pregnant women who received HIV counseling and testing for PMTCT and received their test results	
Rationale/What It Measures:	This indicator reflects one goal of PMTCT, which is to increase the number of pregnant women who know their HIV status.
Definition:	The total number of pregnant women who received both HIV counseling and testing including the provision of test results at PMTCT service outlets.
Measurement Tool:	Service outlet log books or HMIS.
How To Measure It:	Count only those pregnant women who received, at minimum, HIV counseling and testing and received results during the specified reporting period (12 months for annual report).
Interpretation/Strengths and Weaknesses:	This indicator is not an expression of service uptake at a population level, but only the uptake of services at USG-supported PMTCT service outlets. The goal is to track the number of pregnant women who received their test results, however, not all programs are set up to adequately distinguish between those who are tested and those who receive results. In order to provide good quality services, all USG funded PMTCT sites should work toward tracking women through pre-test counseling, testing, post-test counseling, provision of results, and subsequent interventions.

1.3 Number of pregnant women provided with a complete course of antiretroviral prophylaxis for PMTCT	
Rationale/What It Measures:	This indicator is a measure of the delivery and uptake of antiretroviral prophylaxis for PMTCT.
Definition:	The number of women who received a complete course of antiretroviral prophylaxis to prevent MTCT at PMTCT service outlets. ARV prophylaxis may be single dose nevirapine (SD NVP) or short-course combination prophylaxis or highly active anti-retroviral therapy (HAART).
Measurement Tool:	Service outlet log books or HMIS.
How To Measure It:	Count women who received a complete course of antiretroviral prophylaxis to prevent MTCT at PMTCT service outlets during the specified reporting period (12 months for annual report). ARV prophylaxis may be single dose nevirapine (SD NVP) or short-course combination prophylaxis or highly active anti-retroviral therapy (HAART).
Interpretation/Strengths and Weaknesses:	<p>This indicator is not an expression of service coverage at a population level, but only the delivery/uptake of services at USG-supported PMTCT service outlets. This indicator does not distinguish among the different types of prophylaxis (SD NVP, short-course prophylaxis, HAART). It is recommended for program management to track the different types of prophylaxis. This indicator may overestimate the number of women who have received a complete course and does not necessarily allow an estimate of effectiveness if data systems are not set up to verify this information.</p> <p>The definition of a “full course” of antiretroviral prophylaxis will depend on the country’s policy on antiretroviral prophylaxis to reduce the risk of mother-to-child transmission and may or may not include a dose for newborns. Details of the definition used should be provided.</p> <p>Countries will apply different definitions as to what constitutes a “full course” of ARV prophylaxis. Thus, inter-country comparisons may not be entirely valid and should be interpreted with reference to details of the different definitions used in each case</p>

1.4 Number of health workers trained in the provision of PMTCT services according to national or international standards	
Rationale/What It Measures:	The intent of the indicator is to measure progress toward a cadre of professionals trained in PMTCT service delivery according to national or international standards.
Definition:	<p>Training refers to new training or retraining of individuals and assumes that training is conducted according to national or international standards when these exist.</p> <p>A training must have specific learning objectives, a course outline or curriculum, and expected knowledge, skills and/or competencies to be gained by participants. A PMTCT training curriculum must contain at least one of the PMTCT core elements: PMTCT-related counseling and testing, ARV prophylaxis, infant feeding counseling, and family planning counseling or referral.</p>
Measurement Tool:	Program reports. USG agencies and USG-funded partners should keep a training log including the type of training, date, location, and participants.
How To Measure It:	<p>Each USG agency and USG-funded partner counts the number of individuals trained in PMTCT by USG staff (HQ or field-based) or USG-funded partners during the specified reporting period (12 months for annual report).</p> <p>Only participants who complete the full training course should be counted. If a training course covers more than one PMTCT topic, for example ARV prophylaxis and infant feeding, individuals should only be counted once for that training course.</p> <p>If a training course is conducted in more than one session/training event, only individuals who complete the full course should be counted. Do not sum the participants for each training event.</p> <p>The USG staff responsible for compiling the annual reporting data should use the training log submitted by each USG agency and USG-funded partner reporting on this indicator in order to count the total number of individuals trained in PMTCT. Individuals trained in training courses co-funded by more than one USG agency/USG-funded partner should only be counted once within the specified reporting period (12 months for annual report).</p> <p>In order to avoid double counting, countries will need to monitor their activities by partner, programmatic area, and geographic area. This matrix is an excellent program management tool as well as helping to adjust for double counting by partners, among partners, and among USG agencies.</p>
Interpretation/Strengths and Weaknesses:	This indicator does not measure the quality of the training, nor does it measure the outcomes of the training in terms of the competencies of individuals trained, nor their job performance. This indicator simply measures number trained in PMTCT as opposed to the percent of health facilities with trained staff, which may be measured through health facility surveys.

Abstinence and Be Faithful

2.1 Number of individuals reached through community outreach that promotes HIV/AIDS prevention through abstinence and/or being faithful	
Rationale/What It Measures:	This indicator measures the number of individuals who attended community outreach activities focused on abstinence and/or being faithful. In any prevention campaign, the more individuals who receive the message, the higher number who may make the behavioral changes involved.
Definition:	<p>Community outreach is defined as any effort to affect change that might include peer education, classroom, small group and/or one-on-one information, education, communication (IEC) or behavior change communication (BCC) to promote abstinence and/or being faithful.</p> <p>Some programs have clear messages designed to reach a specific audience (i.e., abstinence messages to youth in school or faithfulness messages to married men), which are fairly easy to classify in this category. Remember that this includes either Abstinence programs or Be Faithful programs or those, which have a combination of these approaches as their primary message.</p> <p>Abstinence and/or be faithful are defined below as any of the following: Activities or programs that promote abstinence:</p> <ol style="list-style-type: none"> 1. Importance of abstinence in reducing the prevention of HIV transmission among unmarried individuals; 2. Decision of unmarried individuals to delay sexual activity until marriage; 3. Development of skills in unmarried individuals for practicing abstinence; and 4. Adoption of social and community norms that support delaying sex until marriage and that denounce forced sexual activity among unmarried individuals <p>AND/OR</p> <p>Activities or programs that promote being faithful:</p> <ol style="list-style-type: none"> 1. Importance of being faithful in reducing the transmission of HIV among individuals in long-term sexual partnerships; 2. Elimination of casual sex and multiple sexual partnerships; 3. Development of skills for sustaining marital fidelity; 4. Adoption of social and community norms supportive of marital fidelity and partner reduction using strategies that respect and respond to local customs and norms; and 5. Adoption of social and community norms that denounce forced sexual activity in marriage or long-term partnerships
Measurement Tool:	Program Reports
How To Measure It:	Partners should not double count individuals within a program or service outlet. An individual will count in separate program areas, such as an OVC who may be served separately by an OVC program, ART facility, and prevention program. However,

	<p>double counting of individuals within a program area is to be avoided among USG funded partners to the extent possible. While programs should be reporting to USG managers on the number of individuals served, the USG team is responsible to the extent possible for adjusting for the overlap between multiple programs serving the same individuals within a program area. All the prevention and care indicators refer to individuals served <i>during the current reporting period</i>. If you served 100 prevention clients last year and served 120 during the current reporting period, this is reported as 120, not 220.</p> <p>In order to avoid double counting, countries will need to monitor their activities by partner, programmatic area, and geographic area. This matrix is an excellent program management tool as well as helping to adjust for double counting by partners, among partners, and among USG agencies.</p>
<p>Interpretation/ Strengths and Weaknesses:</p>	<p>Countries will be able to monitor their success in these efforts by setting goals that include tangible increases in this number, indicating further overall reach of the message.</p> <p>See “ABC Guidance #1 (Abstinence, Be Faithful, and correct and consistent Condom use)” for more information on this indicator.</p>

2.1.A Number of individuals reached through community outreach that promotes HIV/AIDS prevention through abstinence [this is a subset of the total reached with abstinence and/or be faithful – indicator 2.1]	
Rationale/What It Measures:	This indicator measures the number of individuals who attended community outreach activities focused on abstinence. In any prevention campaign, the more individuals who receive the message, the higher number who may make the behavioral changes involved.
Definition:	<p>Community outreach is defined as any effort to affect change that might include peer education, classroom, small group and/or one-on-one information, education, communication (IEC) or behavior change communication (BCC). In this case, the message will primarily focus on the promotion of abstinence.</p> <p>Abstinence is defined below as any of the following: Activities or programs that promote abstinence:</p> <ol style="list-style-type: none"> 1. Importance of abstinence in reducing the prevention of HIV transmission among unmarried individuals; 2. Decision of unmarried individuals to delay sexual activity until marriage; 3. Development of skills in unmarried individuals for practicing abstinence; and 4. Adoption of social and community norms that support delaying sex until marriage and that denounce forced sexual activity among unmarried individuals
Measurement Tool:	Program Reports
How To Measure It:	<p>Partners should not double count individuals within a program or service outlet. An individual will count in separate program areas, such as an OVC who may be served separately by an OVC program, ART facility, and prevention program. However, double counting of individuals within a program area is to be avoided among USG funded partners to the extent possible. While programs should be reporting to USG managers on the number of individuals served, the USG team is responsible to the extent possible for adjusting for the overlap between multiple programs serving the same individuals within a program area. All the prevention and care indicators refer to individuals served <i>during the current reporting period</i>. If you served 100 prevention clients last year and served 120 during the current reporting period, this is reported as 120, not 220.</p> <p>In order to avoid double counting, countries will need to monitor their activities by partner, programmatic area, and geographic area. This matrix is an excellent program management tool as well as helping to adjust for double counting by partners, among partners, and among USG agencies.</p>
Interpretation/Strengths and Weaknesses:	Countries will be able to monitor their success in these efforts by setting goals that include tangible increases in this number, indicating further overall reach of the message.

2.2 Number of individuals trained to promote HIV/AIDS prevention through abstinence and/or being faithful	
Rationale/What It Measures:	This indicator is a measure of peer or health care educators who have been trained in the delivery of prevention messages to the target audience. It measures the number of newly trained or retrained individuals who are able to deliver HIV prevention messages with primary focus on abstinence and/or being faithful. Refer to outcome indicators on training for further recommendations.
Definition:	<p>Training refers to new training or retraining of individuals and assumes that training is conducted according to national or international standards when these exist.</p> <p>A training must have specific learning objectives, a course outline or curriculum, and expected knowledge, skills and/or competencies to be gained by participants.</p> <p>Some programs have clear messages designed to reach a specific audience (i.e., abstinence messages to youth in school or faithfulness messages to married men), which are fairly easy to classify in this category. Remember that this includes either Abstinence programs or Be Faithful programs or those, which have a combination of these approaches as their primary message. If the program is targeting sexually active young adults with condom social marketing, it will not count in the Abstinence and Be Faithful category.</p> <p>Abstinence and/or be faithful are defined below as any of the following:</p> <p>Activities or programs that promote abstinence:</p> <ol style="list-style-type: none"> 1. Importance of abstinence in reducing the prevention of HIV transmission among unmarried individuals; 2. Decision of unmarried individuals to delay sexual activity until marriage; 3. Development of skills in unmarried individuals for practicing abstinence; and 4. Adoption of social and community norms that support delaying sex until marriage and that denounce forced sexual activity among unmarried individuals <p>AND/OR</p> <p>Activities or programs that promote being faithful:</p> <ol style="list-style-type: none"> 1. Importance of being faithful in reducing the transmission of HIV among individuals in long-term sexual partnerships; 2. Elimination of casual sex and multiple sexual partnerships; 3. Development of skills for sustaining marital fidelity; 4. Adoption of social and community norms supportive of marital fidelity and partner reduction using strategies that respect and respond to local customs and norms; and 5. Adoption of social and community norms that denounce forced sexual activity in marriage or long-term partnerships
Measurement Tool:	Program reports. USG agencies and USG-funded partners should keep a training log including the type of training, date, location, and participants.

<p>How To Measure It:</p>	<p>Each USG agency and USG-funded partner counts the number of individuals trained in prevention through abstinence and/or being faithful by USG staff (HQ or field-based) or USG-funded partners during the specified reporting period (12 months for annual report).</p> <p>Only participants who complete the full training course should be counted. If a training course covers more than one prevention topic, for example abstinence and be faithful, individuals should only be counted once for that training course.</p> <p>If a training course is conducted in more than one session/training event, only individuals who complete the full course should be counted. Do not sum the participants for each training event.</p> <p>The USG staff responsible for compiling the annual reporting data should use the training log submitted by each USG agency and USG-funded partner reporting on this indicator in order to count the total number of individuals trained in prevention. Individuals trained in training courses co-funded by more than one USG agency/USG-funded partner should only be counted once within the specified reporting period (12 months for annual report).</p> <p>In order to avoid double counting, countries will need to monitor their activities by partner, programmatic area, and geographic area. This matrix is an excellent program management tool as well as helping to adjust for double counting by partners, among partners, and among USG agencies.</p>
<p>Interpretation/ Strengths and Weaknesses:</p>	<p>In many countries, training standards have been defined by the national AIDS coordination body and/or professional organizations. This applies in particular to countries that have introduced certification systems for HIV/AIDS training. The training must equip trainees with a minimum set of competencies needed to take an active role in supporting HIV/AIDS programs in line with national recommendations and/or guidelines. Usually the presence of such competencies is assessed based on successful completion of training and practical experience during the reporting period.</p> <p>This indicator does not measure the quality of training nor does it measure the outcomes of the training in terms of competencies of the individuals trained or their job performance.</p>

Medical Transmission: Blood Safety

3.1 Number of service outlets carrying out blood safety activities	
Rationale/What It Measures:	This indicator counts the number of facilities, which receive USG support for blood safety activities.
Definition:	<p>A service outlet refers to the lowest level of service. For example, a hospital, clinic, or mobile unit.</p> <p>Blood safety activities include those that support policies, infrastructure, equipment, and supplies; blood donor recruitment activities; blood collection, distribution/supply chain/logistics, testing, screening, and/or transfusion; waste management; training; and/or management to ensure a safe and adequate blood supply.</p>
Measurement Tool:	Program Reports
How To Measure It:	The unit of measurement is the site, not the activity. A site will only count once during a reporting period regardless of the number of on-going activities at the site.
Interpretation/Strengths and Weaknesses:	This indicator does not consider the quality of service provision, which would require more in depth evaluation efforts like facility surveys. This is not a complete measure of coverage, as there is no denominator of total facilities. This does not account for non-USG supported service outlets.

3.2 Number of individuals trained in blood safety	
Rationale/What It Measures:	The intent of the indicator is to measure progress toward a cadre of professionals trained in blood safety activities according to national or international standards.
Definition:	<p>Blood safety training may address any of the following specific blood safety activities: blood safety policies, infrastructure, equipment, and supplies; blood donor recruitment; blood collection, distribution/supply chain/logistics, testing, screening, and/or transfusion; waste management; and/or management to ensure a safe and adequate blood supply.</p> <p>Training refers to new training or retraining of individuals and assumes that training is conducted according to national or international standards when these exist.</p> <p>The training must follow a curriculum that indicates the objectives and/or expected competencies. Training may be knowledge and/or skills and/or competency-based.</p>
Measurement Tool:	Program reports. USG agencies and USG-funded partners should keep a training log including the type of training, date, location, and participants.
How To Measure It:	<p>Each USG agency and USG-funded partner counts the number of individuals trained in blood safety by USG staff (HQ or field-based) or USG-funded partners during the specified reporting period (12 months for annual report).</p> <p>Only participants who complete the full training course should be counted. If a training course covers more than one blood safety topic, individuals should only be counted once for that training course.</p> <p>If a training course is conducted in more than one session/training event, only individuals who complete the full course should be counted. Do not sum the participants for each training session.</p> <p>The USG staff responsible for compiling the annual reporting data should use the training log submitted by each USG agency and USG-funded partner reporting on this indicator in order to count the total number of individuals trained in blood safety. Individuals trained in training courses co-funded by more than one USG agency/USG-funded partner should only be counted once within the specified reporting period (12 months for annual report).</p> <p>In order to avoid double counting, countries will need to monitor their activities by partner, programmatic area, and geographic area. This matrix is an excellent program management tool as well as helping to adjust for double counting by partners, among partners, and among USG agencies.</p>
Interpretation/Strengths and Weaknesses:	This indicator does not measure the quality of the training, nor does it measure the outcomes of the training in terms of the competencies of individuals trained, nor their job performance.

	This indicator simply measures number trained in blood safety as opposed to the percent of health facilities with trained staff, which may be measured through health facility surveys.
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Medical Transmission: Medical Injection Safety

4.1 Number of individuals trained in medical injection safety	
Rationale/What It Measures:	The intent of the indicator is to measure progress toward a cadre of professionals trained in medical injection safety activities according to national or international standards.
Definition:	<p>Medical injection safety training may address any of the following specific medical injection safety activities: medical injection safety policies; appropriate disposal of injection equipment; waste management systems; and/or other injection safety-related distribution/supply chain/logistics.</p> <p>Training refers to new training or retraining of individuals and assumes that training is conducted according to national or international standards when these exist. A training must have specific learning objectives, a course outline or curriculum, and expected knowledge, skills and/or competencies to be gained by participants.</p>
Measurement Tool:	Program reports. USG agencies and USG-funded partners should keep a training log including the type of training, date, location, and participants.
How To Measure It:	<p>Each USG agency and USG-funded partner counts the number of individuals trained in medical injection safety by USG staff (HQ or field-based) or USG-funded partners during the specified reporting period (12 months for annual report).</p> <p>Only participants who complete the full training course should be counted. If a training course covers more than one medical injection safety topic, individuals should only be counted once for that training course.</p> <p>If a training course is conducted in more than one session/training event, only individuals who complete the full course should be counted. Do not sum the participants for each training event.</p> <p>The USG staff responsible for compiling the annual reporting data should use the training log submitted by each USG agency and USG-funded partner reporting on this indicator in order to count the total number of individuals trained in medical injection safety. Individuals trained in training courses co-funded by more than one USG agency/USG-funded partner should only be counted once within the specified reporting period (12 months for annual report).</p> <p>In order to avoid double counting, countries will need to monitor their activities by partner, programmatic area, and geographic area. This matrix is an excellent program management tool as well as helping to adjust for double counting by partners, among partners, and among USG agencies.</p>
Interpretation/Strengths and Weaknesses:	<p>This indicator does not measure the quality of the training, nor does it measure the outcomes of the training in terms of the competencies of individuals trained, nor their job performance.</p> <p>This indicator simply measures number trained in medical injection as opposed to the percent of health facilities with</p>

trained staff, which may be measured through health facility surveys.

Condoms and Other Prevention Activities

5.1 Number of targeted condom service outlets	
Rationale/What It Measures:	This indicator provides a tangible measure of the potential reach of condom distribution to a given community as an important part of a comprehensive prevention message.
Definition:	<p>A targeted condom service outlet refers to fixed distribution points or mobile units with fixed schedules providing condoms for free or for sale.</p> <p>Other behavior change beyond abstinence and/or being faithful includes the targeting of behaviors that increase risk for HIV transmission such as engaging in casual sexual encounters, engaging in sex in exchange for money or favors, having sex with an HIV-positive partner or one whose status is unknown, using drugs or abusing alcohol in the context of sexual interactions, and using intravenous drugs. Women, even if faithful themselves, can still be at risk of becoming infected by their spouse, regular male partner, or someone using force against them. Other high-risk persons or groups include men who have sex with men and workers who are employed away from home. This could include targeted social marketing and/or the promotion of condoms to these high risk groups.</p>
Measurement Tool:	Program Reports
How To Measure It:	A targeted condom service outlet refers to fixed distribution points or mobile units with fixed schedules providing condom distribution. Countries should count the number of distribution points at which condoms are available to their target population.
Interpretation/Strengths and Weaknesses:	This indicator provides a relatively straightforward measure of potential reach in prevention activities that include the distribution of condoms.

5.2 Number of individuals reached through community outreach that promotes HIV/AIDS prevention through other behavior change beyond abstinence and/or being faithful	
Rationale/What It Measures:	This indicator measures the number of individuals who attended community outreach activities focused on other behavior change beyond abstinence and/or being faithful. In any prevention campaign, the more individuals who receive the message, the higher number who may make the behavioral changes involved.
Definition:	<p>Community outreach is defined as any effort to effect change that might include peer education, classroom, small group and/or one-on-one information, education, communication (IEC) or behavior change communication (BCC) to promote comprehensive prevention messages.</p> <p>This indicator is not venue-specific; individuals reached through community outreach, <i>wherever that outreach may have occurred</i> (a park, drop-in center, bar or club, etc) should be counted.</p> <p>Other behavior change beyond abstinence and/or being faithful includes the targeting of behaviors that increase risk for HIV transmission such as engaging in casual sexual encounters, engaging in sex in exchange for money or favors, having sex with an HIV-positive partner or one whose status is unknown, using drugs or abusing alcohol in the context of sexual interactions, and using intravenous drugs. Women, even if faithful themselves, can still be at risk of becoming infected by their spouse, regular male partner, or someone using force against them. Other high-risk persons or groups include men who have sex with men and workers who are employed away from home. This could include targeted social marketing and/or the promotion of condoms to these high risk groups.</p>
Measurement Tool:	Program reports
How To Measure It:	<p>Partners should not double count individuals within a program or service outlet. An individual will count in separate program areas, such as an OVC who may be served separately by an OVC program, ART facility, and prevention program. However, double counting of individuals within a program area is to be avoided among USG funded partners to the extent possible. While programs should be reporting to USG managers on the number of individuals served, the USG team is responsible to the extent possible for adjusting for the overlap between multiple programs serving the same individuals within a program area. All the prevention and care indicators refer to individuals served <i>during the current reporting period</i>. If you served 100 prevention clients last year and served 120 during the current reporting period, this is reported as 120, not 220.</p> <p>In order to avoid double counting, countries will need to monitor their activities by partner, programmatic area, and geographic area. This matrix is an excellent program management tool as well as helping to adjust for double counting by partners, among partners, and among USG agencies.</p> <p>For concentrated/low-level epidemic settings where most-at-risk populations drive HIV transmission, it is recommended (but not required) that this indicator be monitored and disaggregated by the most-at-risk populations (MARPs) as relevant to country context. Please see the next section - Disaggregation for Most-at-Risk Populations -- for an example of MARPs</p>

	disaggregation for Prevention/Other Behavior Change and for Counseling and Testing.
Interpretation/ Strengths and Weaknesses:	<p>Countries will be able to monitor their success in these efforts by setting goals that include tangible increases in this number, indicating further overall reach of the message.</p> <p>See "ABC Guidance #1 (Abstinence, Be Faithful, and correct and consistent Condom use)" for more information on this indicator.</p> <p>See "HIV Prevention among Drug Users Guidance #1: Injection Heroin Use (March 2006)" for more information on this indicator.</p>

5.3 Number of individuals trained to promote HIV/AIDS prevention through other behavior change beyond abstinence and/or being faithful	
Rationale/What It Measures:	This indicator is a measure of peer or health care educators who have been trained in the delivery of prevention messages to the target audience. It measures the number of newly trained or retrained individuals who are able to deliver comprehensive HIV prevention messages.
Definition:	<p>Training refers to new training or retraining of individuals and assumes that training is conducted according to national or international standards when these exist.</p> <p>Other behavior change beyond abstinence and/or being faithful includes targeting those behaviors that increase risk for HIV transmission such as engaging in casual sexual encounters, engaging in sex in exchange for money or favors, having sex with an HIV-positive partner or one whose status is unknown, using drugs or abusing alcohol in the context of sexual interactions, and using intravenous drugs. Women, even if faithful themselves, can still be at risk of becoming infected by their spouse, regular male partner, or someone using force against them. Other high-risk persons or groups include men who have sex with men and workers who are employed away from home. This could include targeted social marketing and/or the promotion of condoms to these high risk groups.</p>
Measurement Tool:	Program reports. USG agencies and USG-funded partners should keep a training log including the type of training, date, location, and participants.
How To Measure It:	<p>Each USG agency and USG-funded partner counts the number of individuals trained in prevention through other behavior change beyond abstinence and/or being faithful by USG staff (HQ or field-based) or USG-funded partners during the specified reporting period (12 months for annual report).</p> <p>Only participants who complete the full training course should be counted. If a training course covers more than one prevention topic, individuals should only be counted once for that training course. If a training course is conducted in more than one session/training event, only individuals who complete the full course should be counted. Do not sum the participants for each training event.</p> <p>The USG staff responsible for compiling the annual reporting data should use the training log submitted by each USG agency and USG-funded partner reporting on this indicator in order to count the total number of individuals trained in prevention. Individuals trained in training courses co-funded by more than one USG agency/USG-funded partner should only be counted once within the specified reporting period (12 months for annual report).</p> <p>In order to avoid double counting, countries will need to monitor their activities by partner, programmatic area, and geographic area. This matrix is an excellent program management tool as well as helping to adjust for double counting by partners, among partners, and among USG agencies.</p>
Interpretation/Strengths and	This indicator does not measure the quality of the training, nor does it measure the outcomes of the training in terms of the competencies of individuals trained, nor their job performance.

Weaknesses:

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Palliative Care (Basic Health Care)

6.1 Total number of service outlets providing HIV-related palliative care	
Rationale/What It Measures:	<p>Palliative care is patient and family-centered care. It optimizes the quality of life of adults and children living with HIV through the active anticipation, prevention, and treatment of pain, symptoms and suffering from the onset of HIV diagnosis through death. Palliative care includes and goes beyond the medical management of infectious, neurological or oncological complications of HIV/AIDS to comprehensively address symptoms and suffering throughout the continuum of illness. The means by which this is achieved will vary according to stage of illness but always with the understanding that quality of life involves clinical, psychological, spiritual, and support care.</p> <p>This indicator includes the total number of service outlets, which provide HIV-related care.</p>
Definition:	<p>A service outlet refers to the lowest level of service. For example, with regard to clinical activities, the lowest level for which data exists should be a service outlet such as a hospital, clinic, or mobile unit.</p> <p>Palliative care services include: A) clinical/medical, B) psychological, C) spiritual, D) support care services, and/or E) prevention care.</p> <p>Clinical care services include: prevention and treatment of TB/HIV, prevention and treatment of other opportunistic infections (OIs), alleviation of HIV-related symptoms and pain, nutritional rehabilitation for malnourished PLWHA.</p> <p>Psychological care services include: interventions that address the non-physical suffering of individuals and family members, such as mental health counseling, support groups, identification and treatment of HIV-related psychiatric illnesses such as depression and related anxieties, and bereavement services.</p> <p>Spiritual care services include: culturally-sensitive interventions that support individuals and families through faith and ritual, life review, assessment and counseling on hopes, fear, meaning of life, guilt, forgiveness and life completion tasks.</p> <p>Supportive care services include: assisting individuals and family members in linking to care services such as child care, adherence to treatment, legal services, housing, food support and income-generating programs.</p> <p>Prevention care services include: interventions for sero-discordant couples, including confidential testing and ongoing counseling; community and clinic-based support groups; case-management and provider-delivered prevention messages focused on disclosure; partner testing; correct and consistent condom use for populations engaged in high-risk behavior and mutual fidelity.</p>
Measurement Tool:	Program Reports

How To Measure It:	The number of service outlets includes those providing medical and clinical care (for opportunistic infections including TB), psychological, spiritual, and/or supportive care for HIV-infected individuals, and their families.
Interpretation/ Strengths and Weaknesses:	<p>One difficulty with this indicator is that while facility-based or community-based service outlets in fixed locations are relatively straight-forward to measure, community-based or home-based outreach activities are too difficult to define as service outlets and are not captured in this indicator. It is recommended that at country level, programs monitor which sites provide each of the key interventions: medical, psychological, spiritual, and social.</p> <p>This indicator does not consider the quality of service provision, which would require more in-depth evaluation efforts like facility surveys. This is not a complete measure of coverage, as there is no denominator of total facilities. This does not account for non-USG supported service outlets.</p> <p>See "HIV//AIDS Palliative Care Guidance #1" for more information on this indicator.</p>

6.2 Total number of individuals provided with HIV-related palliative care including those HIV-infected individuals who received treatment for tuberculosis (TB) (Indicator 6.2.A), disaggregated by sex	
Rationale/What It Measures:	This indicator is the total number of unduplicated individuals receiving palliative care from facilities and/or community/home-based organizations.
Definition:	<p>HIV-related palliative care is patient and family-centered care that optimizes the quality of life of adults and children living with HIV through the active anticipation, prevention, and treatment of pain, symptoms and suffering from the onset of HIV diagnosis through death. Palliative care includes and goes beyond the medical management of infectious, neurological or oncological complications of HIV/AIDS to comprehensively address symptoms and suffering throughout the continuum of illness. The means by which this is achieved will vary according to stage of illness but always with the understanding that quality of life involves clinical, psychological, spiritual, supportive, and prevention care.</p> <p>Palliative care services include: A) clinical/medical, B) psychological, C) spiritual, D) support care services, and/or E) prevention care.</p> <p>Clinical care services include: prevention and treatment of TB/HIV, prevention and treatment of other opportunistic infections (OIs), alleviation of HIV-related symptoms and pain, nutritional rehabilitation for malnourished PLWHA.</p> <p>Psychological care services include: interventions that address the non-physical suffering of individuals and family members, such as mental health counseling, support groups, identification and treatment of HIV-related psychiatric illnesses such as depression and related anxieties, and bereavement services.</p> <p>Spiritual care services include: culturally-sensitive interventions that support individuals and families through faith and ritual, life review, assessment and counseling on hopes, fear, meaning of life, guilt, forgiveness and life completion tasks.</p> <p>Supportive care services include: assisting individuals and family members in linking to care services such as child care, adherence to treatment, legal services, housing, food support and income-generating programs.</p> <p>Prevention care services include: interventions for sero-discordant couples, including confidential testing and ongoing counseling; community and clinic-based support groups; case-management and provider-delivered prevention messages focused on disclosure; partner testing; correct and consistent condom use for populations engaged in high-risk behavior and mutual fidelity.</p> <p>Palliative care is a patient and family-centered service, therefore clients provided with general HIV-related palliative care/basic health care and support during the reporting period may include patients and family members. How much care is needed in order to count within the indicator is currently left to national standards – all persons served during the reporting period will be counted once by a unique program regardless of frequency. HIV-infected individuals and families have varying</p>

	needs for services depending on the stage of illness, type of service, and available resources of HIV-infected persons. Quality assurance and supervision are expected by program managers to ensure that persons are receiving proper care.
Measurement Tool:	Program Reports
How To Measure It:	<p>This indicator is the total number of unduplicated individuals receiving palliative care from facilities and community/home-based organizations. This is not simply the sum of the individuals served by facility-based palliative care (including TB) and community/home-based palliative care partners, as adjustment for the overlap in service to the same individuals should be accounted for in this total.</p> <p>Partners should not double count individuals within a program or service outlet. An individual will count in separate program areas, such as an OVC who may be served separately by an OVC program, ART facility, and prevention program. However, double counting of individuals within a program area is to be avoided among USG funded partners to the extent possible. While programs should be reporting to USG managers on the number of individuals served, the USG team is responsible to the extent possible for adjusting for the overlap between multiple programs serving the same individuals within a program area.</p> <p>Countries will need to monitor their activities by partner, programmatic area, and geographic area. A matrix is an excellent program management tool as well as helping to avoid double counting by a partner, among partners, and among USG agencies.</p>
Interpretation/ Strengths and Weaknesses:	Adjusting for overlap between programs is very difficult, especially when programs are not well linked, and patient confidentiality concerns must be respected.

6.3 Total number of individuals trained to provide HIV-related palliative care for HIV-infected individuals (diagnosed or presumed) that includes those trained in facility-based, community-based and/or home-based care including TB/HIV	
Rationale/What It Measures:	This indicator measures the total number trained for HIV-related palliative care
Definition:	<p>Training refers to new training or retraining of individuals and assumes that training is conducted according to national or international standards when these exist.</p> <p>A training must have specific learning objectives, a course outline or curriculum, and expected knowledge, skills and/or competencies to be gained by participants.</p> <p>Training on HIV-related palliative care services may include: A) clinical/medical including TB/HIV, B) psychological, C) spiritual, and/or D) support care services for HIV-infected individuals and family members.</p> <p>Palliative care services include: A) clinical/medical, B) psychological, C) spiritual, D) support care services, and/or E) prevention care.</p> <p>Clinical care services include: prevention and treatment of TB/HIV, prevention and treatment of other opportunistic infections (OIs), alleviation of HIV-related symptoms and pain, nutritional rehabilitation for malnourished PLWHA.</p> <p>Psychological care services include: interventions that address the non-physical suffering of individuals and family members, such as mental health counseling, support groups, identification and treatment of HIV-related psychiatric illnesses such as depression and related anxieties, and bereavement services.</p> <p>Spiritual care services include: culturally-sensitive interventions that support individuals and families through faith and ritual, life review, assessment and counseling on hopes, fear, meaning of life, guilt, forgiveness and life completion tasks.</p> <p>Supportive care services include: assisting individuals and family members in linking to care services such as child care, adherence to treatment, legal services, housing, food support and income-generating programs.</p> <p>Prevention care services include: interventions for sero-discordant couples, including confidential testing and ongoing counseling; community and clinic-based support groups; case-management and provider-delivered prevention messages focused on disclosure; partner testing; correct and consistent condom use for populations engaged in high-risk behavior and mutual fidelity.</p>
Measurement Tool:	Program reports. USG agencies and USG-funded partners should keep a training log including the type of training, date, location, and participants.
How To Measure It:	This indicator is the total number of individuals receiving training for facility-based palliative care (including those trained in TB/HIV)

	<p>Each USG agency and USG-funded partner counts the number of individuals trained in HIV-related palliative care by USG staff (HQ or field-based) or USG-funded partners during the specified reporting period (12 months for annual report).</p> <p>Only participants who complete the full training course should be counted. If a training course covers more than one palliative care topic, for example clinical care and psychological care, individuals should only be counted once for that training course.</p> <p>If a training course is conducted in more than one session/training event, only individuals who complete the full course should be counted. Do not sum the participants for each training event.</p> <p>The USG staff responsible for compiling the annual reporting data should use the training log submitted by each USG agency and USG-funded partner reporting on this indicator in order to count the total number of individuals trained in HIV-related palliative care. Individuals trained in training courses co-funded by more than one USG agency/USG-funded partner should only be counted once within the specified reporting period (12 months for annual report).</p> <p>In order to avoid double counting, countries will need to monitor their activities by partner, programmatic area, and geographic area. This matrix is an excellent program management tool as well as helping to adjust for double counting by partners, among partners, and among USG agencies.</p>
<p>Interpretation/ Strengths and Weaknesses:</p>	<p>This indicator does not measure the quality of the training, nor does it measure the outcomes of the training in terms of the competencies of individuals trained, nor their job performance.</p> <p>This indicator simply measures number trained in palliative care as opposed to the percent of health facilities with trained staff, which may be measured through health facility surveys.</p>

Palliative Care (TB/HIV)

<p>7.1 Number of service outlets providing treatment for tuberculosis (TB) to HIV-infected individuals (diagnosed or presumed) according to national or international standards [this is a subset of the total number of service outlets providing HIV-related palliative care]</p>	
<p>Rationale/What It Measures:</p>	<p>Palliative care is patient and family-centered care. It optimizes the quality of life of adults and children living with HIV through the active anticipation, prevention, and treatment of pain, symptoms and suffering from the onset of HIV diagnosis through death. Palliative care includes and goes beyond the medical management of infectious, neurological or oncological complications of HIV/AIDS to comprehensively address symptoms and suffering throughout the continuum of illness. The means by which this is achieved will vary according to stage of illness but always with the understanding that quality of life involves clinical, psychological, spiritual, supportive, and prevention care.</p> <p>Palliative care services include: A) clinical/medical, B) psychological, C) spiritual, D) support care services, and/or E) prevention care.</p> <p>Clinical care services include: prevention and treatment of TB/HIV, prevention and treatment of other opportunistic infections (OIs), alleviation of HIV-related symptoms and pain, nutritional rehabilitation for malnourished PLWHA.</p> <p>Psychological care services include: interventions that address the non-physical suffering of individuals and family members, such as mental health counseling, support groups, identification and treatment of HIV-related psychiatric illnesses such as depression and related anxieties, and bereavement services.</p> <p>Spiritual care services include: culturally-sensitive interventions that support individuals and families through faith and ritual, life review, assessment and counseling on hopes, fear, meaning of life, guilt, forgiveness and life completion tasks.</p> <p>Supportive care services include: assisting individuals and family members in linking to care services such as child care, adherence to treatment, legal services, housing, food support and income-generating programs.</p> <p>Prevention care services include: interventions for sero-discordant couples, including confidential testing and ongoing counseling; community and clinic-based support groups; case-management and provider-delivered prevention messages focused on disclosure; partner testing; correct and consistent condom use for populations engaged in high-risk behavior and mutual fidelity.</p> <p>This indicator measures the subset of service outlets providing TB/HIV care.</p>
<p>Definition:</p>	<p>A service outlet refers to the lowest level of service. For example, with regard to clinical activities, the lowest level for which data exists should be a service outlet such as a hospital, clinic, or mobile unit.</p>

	A service outlet that will count in this indicator will provide treatment for tuberculosis to HIV-infected individuals (diagnosed or presumed).
Measurement Tool:	Program Reports
How To Measure It:	[This is a subset of the total number of service outlets providing general HIV-related palliative care.] Outreach-only programs are counted through the number of communities served by community/home-based palliative care [Indicator 8.2]
Interpretation/ Strengths and Weaknesses:	<p>One difficulty with this indicator is that while facility-based or community-based service outlets in fixed locations are relatively straight-forward to measure, community-based or home-based outreach activities are too difficult to define as service outlets and are not captured in this indicator. It is recommended that at country level, programs monitor which sites provide each of the key interventions: medical, psychological, spiritual and social.</p> <p>This indicator does not consider the quality of service provision, which would require more in-depth evaluation efforts like facility surveys. This is not a complete measure of coverage, as there is no denominator of total facilities. This does not account for non-USG supported service outlets.</p>

7.2. Number of HIV-infected clients attending HIV care/treatment services that are receiving treatment for TB disease [this is a subset of Indicator 6.2]	
Rationale/What It Measures:	Evidence has shown that previously undiagnosed tuberculosis was detected in a significant proportion (up to 11%) of HIV-infected clients through routinely TB screening at HIV counseling and testing services. HIV-infected patients with tuberculosis should be identified and placed on appropriate TB treatment in order interrupt TB transmission, and reduce the burden of TB among HIV-infected clients. This indicator will measure the implementation of the recommended activity to integrate TB and HIV activity and reduce the burden of TB in HIV-infected clients.
Definition:	The number of HIV-positive clients accessing HIV care/treatment services (HIV care centers, PMTCT) that are documented to be receiving treatment for TB disease. This treatment should be in-line with National TB Program treatment guidelines.
Measurement Tool:	Program Registries, Reports
How To Measure It:	The data for this indicator can be located in health records service outlets that provide HIV care/treatment (Home/community-based care, PMTCT sites, HIV care centers, general health services that manage HIV/AIDS patients).
Interpretation/Strengths and Weaknesses:	As TB treatment lasts approximately 9 months, this indicator does not measure the outcome of the TB treatment. [Source: WHO: Policy Statement on Preventive Therapy against TB in People Living with HIV: Report of a Meeting held in Geneva 18-20 Feb. 1998]. This indicator does not measure the duration of therapy.

7.3 Number of individuals trained to provide tuberculosis (TB) treatment to HIV-infected individuals (diagnosed or presumed) according to national or international standards [This indicator is a subset of the total number trained for HIV-related palliative care in Indicator 6.3]	
Rationale/What It Measures:	This is a subset of the total number trained for HIV-related palliative care who had specific training on TB/HIV
Definition:	<p>Training refers to new training or retraining of individuals and assumes that training is conducted according to national or international standards when these exist.</p> <p>TB/HIV training refers to trainings designed to enhance participants' knowledge of or ability to deliver treatment for TB.</p>
Measurement Tool:	Program reports. USG agencies and USG-funded partners should keep a training log including the type of training, date, location, and participants.
How To Measure It:	<p>This is a subset of the total number trained for HIV-related palliative care who had specific training on TB/HIV including treatment to HIV-infected individuals (diagnosed or presumed).</p> <p>Each USG agency and USG-funded partner counts the number of individuals trained in TB/HIV by USG staff (HQ or field-based) or USG-funded partners during the specified reporting period (12 months for annual report).</p> <p>Only participants who complete the full training course should be counted. If a training course covers more than one TB/HIV topic, individuals should only be counted once for that training course. If a training course is conducted in more than one session/training event, only individuals who complete the full course should be counted. Do not sum the participants for each training event.</p> <p>The USG staff responsible for compiling the annual reporting data should use the training log submitted by each USG agency and USG-funded partner reporting on this indicator in order to count the total number of individuals trained in TB/HIV. Individuals trained in training courses co-funded by more than one USG agency/USG-funded partner should only be counted once within the specified reporting period (12 months for annual report).</p> <p>In order to avoid double counting, countries will need to monitor their activities by partner, programmatic area, and geographic area. This matrix is an excellent program management tool as well as helping to adjust for double counting by partners, among partners, and among USG agencies.</p>
Interpretation/Strengths and Weaknesses:	<p>This indicator does not measure the quality of the training, nor does it measure the outcomes of the training in terms of the competencies of individuals trained, nor their job performance.</p> <p>This indicator simply measures number trained in palliative care as opposed to the percent of health facilities with trained staff, which may be measured through health facility surveys.</p>

Orphans and Vulnerable Children

8.1 Number of orphans and vulnerable children (OVC) served by an OVC program, disaggregated by sex	
Rationale/What It Measures:	The goal of OVC activities is to provide support aimed at improving the lives of children and families directly affected by AIDS-related morbidity and/or mortality. The emphasis is on strengthening communities to meet the needs of orphans and vulnerable children affected by HIV/AIDS, supporting community-based responses, helping children and adolescents meet their own needs, creating a supportive social environment. This indicator will measure OVC who are receiving access to: food/nutrition, shelter and care, protection and legal aid, health care, psychosocial support, education and; economic support. Institutional responses would also be included.
Definition:	<p>A child, 0-17 years old, who is either orphaned or made more vulnerable because of HIV/AIDS.</p> <p>Orphan: Has lost one or both parents to HIV/AIDS</p> <p>Vulnerable: Is more vulnerable because of any or all of the following factors that result from HIV/AIDS:</p> <ul style="list-style-type: none"> • Is HIV-positive; • Lives without adequate adult support (e.g., in a household with chronically ill parents, a household that has experienced a recent death from chronic illness, a household headed by a grandparent, and/or a household headed by a child); • Lives outside of family care (e.g., in residential care or on the streets); or • Is marginalized, stigmatized, or discriminated against. <p>Programs funded from HKID 3.3.08 are considered USG-supported OVC programs for this indicator.</p>
Measurement Tool:	Program reports
How To Measure It:	<p>Starting with the FY07 SAPR and APR, measurement of the OVC directly served target will be divided into two subcategories: OVC receiving primary direct support and those receiving supplemental direct support. If your country's OVC monitoring system is not yet able to provide this breakdown, you must write a one-paragraph justification for providing only total numbers of OVC served. Additionally, work with your partners to put such a monitoring system in place.</p> <p>Direct OVC Support: Direct recipients of support are OVC who are regularly monitored in the six core areas (food/nutrition, shelter and care, protection, health care, psychosocial support, and education) and whose individual needs are addressed accordingly. Economic strengthening should be evaluated according to its benefit to the six core areas.</p> <p><u>Primary Direct Support:</u> Count OVCs who are periodically monitored in all six core areas and who are receiving PEPFAR funded or leveraged* support in three or more areas, in the relevant reporting period, that are appropriate for that child's needs and context.</p>

	<p><u>Supplemental Direct Support</u>: Count OVCs who are periodically monitored in all six core areas and who are receiving PEPFAR funded or leveraged support in one or two areas, in the relevant reporting period, that are appropriate for that child's needs and context.</p> <p><i>Total Direct Support</i>: Sum of Primary and Supplemental Support.</p> <p><i>*Leveraged means that the services are being provided to the child through non-PEPFAR funds by either the same organization or a different one. Regardless, the PEPFAR funded organization that is providing the service and monitoring the OVC, must be tracking to ensure the child is actually receiving all the services, which are being counted as a part of this result.</i></p> <p>Partners should not double count individuals within a program area. An individual can be counted in each separate program area, such as an OVC who may be served by an OVC program, ART facility, and prevention program. However, double counting of individuals within a program area is to be avoided among USG funded partners to the extent possible. While activities should be reporting to USG managers on the number of individuals served, the USG team is responsible to the extent possible for adjusting for the overlap between multiple activities serving the same individuals within a program area.</p> <p>While programs for OVC are likely to also support other family members, reporting on this indicator is restricted to orphans and vulnerable children; other (non-OVC) family members should not be counted in this indicator. The number of contacts and the extent of services an OVC receives in order to count in this indicator is to be determined by each country based on standards agreed upon by USG and its implementing partners. However, all OVC served during the reporting period will be counted once by a program, regardless of the number of contacts with that OVC during the period. Quality assurance, supervision, and follow-up are expected by program managers to ensure that OVC are receiving quality care.</p> <p>Count the number of OVC reached during the reporting period, that is October through September for the annual report. This is NOT the cumulative number of OVC reached over the life of the Emergency Plan. Although the same OVC may be counted in different fiscal years, you should not add OVC reached from one fiscal year to the next. For example, if you reached 1000 OVC in FY04 and you continue to serve 900 of them in FY05 plus an additional 500 new OVC, you would report 1400 OVC reached in FY05.</p>
<p>Interpretation/ Strengths and Weaknesses:</p>	<p>This is a process indicator, which captures the reach of Emergency Plan funded services, but not the quality or content of those services. Such an indicator would require more in-depth evaluation efforts like facility surveys. This is not a complete measure of coverage, as there is no denominator of total facilities. This does not account for non-USG supported service outlets. The impact of services on the children served is not captured through routinely collected program indicators. National-level outcome and impact indicators will be collected periodically via population-based surveys, and special studies.</p>

8.2 Number of providers/caregivers trained in caring for orphans and vulnerable children	
Rationale/What It Measures:	The goal of OVC activities is to provide support aimed at improving the lives of children and families directly affected by AIDS-related morbidity and/or mortality. The emphasis is on strengthening communities to meet the needs of orphans and vulnerable children affected by HIV/AIDS, supporting community-based responses, helping children and adolescents meet their own needs, creating a supportive social environment. Activities could include training to increase capacity of families, community members, government staff, and staff of NGOs/CBOs/FBOs to provide increasing access to: food/nutrition, shelter and care, protection and legal aid, health care, psychosocial support, education and; economic support. Institutional responses would also be included.
Definition:	<p>Providers/caregivers = anyone who ensures care for OVC, including those who provide, make referrals to, and/or oversee social services. This may include parents, guardians, other caregivers, extended family, neighbors, community leaders, police officers, social workers, national, district, and/or local social welfare ministry staff, as well as health care workers, teachers, or community workers who receive training on how to address the needs of OVC.</p> <p>Training refers to new training or retraining of individuals and assumes that training is conducted according to national or international standards when these exist.</p> <p>A training must have specific learning objectives, a course outline or curriculum, and expected knowledge, skills and/or competencies to be gained by participants.</p>
Measurement Tool:	Program reports. USG agencies and USG-funded partners should keep a training log including the type of training, date, location, and participants.
How To Measure It:	<p>Each USG agency and USG-funded partner counts the number of individuals trained in OVC care by USG staff (HQ or field-based) or USG-funded partners during the specified reporting period (12 months for annual report).</p> <p>Only participants who complete the full training course should be counted. If a training course is conducted in more than one session/training event, only individuals who complete the full course should be counted. Do not sum the participants for each training event.</p> <p>If a training course covers more than one OVC care topic, for example nutritional support and educational mentoring, individuals should only be counted once for that training course.</p> <p>The USG staff responsible for compiling the annual reporting data should use the training log submitted by each USG agency and USG-funded partner reporting on this indicator in order to count the total number of individuals trained in OVC care. Individuals trained in training courses co-funded by more than one USG agency / USG-funded partner should only be counted once within the specified reporting period (12 months for annual report).</p> <p>In order to avoid double counting, countries will need to monitor their activities by partner, programmatic area, and</p>

	geographic area. This matrix is an excellent program management tool as well as helping to adjust for double counting by partners, among partners, and among USG agencies.
Interpretation/ Strengths and Weaknesses:	This indicator does not measure the quality of the training, nor does it measure the outcomes of the training in terms of the competencies of individuals trained, nor their job performance.

HIV Counseling and Testing Services

9.1 Number of service outlets providing counseling and testing according to national or international standards	
Rationale/What It Measures:	This indicator provides a gross count of the number of locations, which provide basic counseling and testing for HIV. It provides a rough sense of the change in the capacity within a country to provide counseling and testing services. If there is a plan to expand the number of service outlets, this measure will track the progress of meeting that goal.
Definition:	<p>A service outlet refers to the lowest level of service. For example, with regard to clinical activities, the lowest level for which data exists should be a service outlet such as a health center, hospital, clinic, stand alone VCT center, or mobile unit.</p> <p>Counseling and testing includes activities in which both HIV counseling and testing are provided for those who seek to know their status (as in traditional VCT) or as indicated in other contexts (e.g. STI clinics, diagnostic testing, etc.). This indicator excludes service outlets that provide counseling and testing in the context of preventing mother-to-child transmission. Please refer to Indicator 5.1 for more guidance on reporting the number of service outlets that provide services to prevent mother-to-child transmission of HIV.</p>
Measurement Tool:	Program reports
How To Measure It:	Outlets, which provide both HIV counseling and testing, except those involved in PMTCT.
Interpretation/Strengths and Weaknesses:	This is purely an output measure. It provides no sense of the geographical spread of CT services, nor any relationship to the percentage of the population, which is reached by the service outlet. This indicator does not consider the quality of service provision, which would require more in depth evaluation efforts like facility surveys. This is not a complete measure of coverage, as there is no denominator of total facilities. This does not account for non-USG supported service outlets

9.2 Number of individuals who received counseling and testing for HIV and received their test results, disaggregated by sex	
Rationale/What It Measures:	This indicator provides a count of those individuals who have received counseling and testing during the current reporting period and as a result are now aware of their HIV status.
Definition:	This indicator requires a minimum of counseling, testing, and the provision of test results.
Measurement Tool:	Program reports
How To Measure It:	<p>Partners should not double count individuals seen multiple times within a program. An individual may count in separate program areas, such as a CT client or patient who may be served separately by an OVC program, ART facility, and prevention program. However, double counting of individuals within a program area is to be avoided among USG funded partners to the extent possible. While programs should be reporting to USG managers on the actual number of individuals served, the USG team is responsible to the extent possible for adjusting for the overlap between multiple programs serving the same individuals within a program area. Individuals who receive CT as part of a PMTCT or TB program should be counted under those corresponding indicators (5.2 for PMTCT and 6.2A for TB). All other CT clients or patients should be counted under this indicator, including VCT sites, community-based programs, routine or diagnostic CT in clinical settings, or others.</p> <p>All the prevention and care indicators refer to individuals served <i>during the current reporting period</i>. If you reached 100 individuals with CT last year (in the Annual Report) and now serve 120 during the current reporting period, this is reported as 120, not 220. In order to avoid double counting, countries will need to monitor their activities by partner, programmatic area, and geographic area. This matrix is an excellent program management tool as well as helping to adjust for double counting by partners, among partners, and among USG agencies.</p> <p>For concentrated/low-level epidemic settings where most-at-risk populations drive HIV transmission, it is recommended (but not required) that this indicator be monitored and disaggregated by the most-at-risk populations (MARPs) as relevant to country context. Please see the next section (Disaggregation of Most-at-Risk Populations (MARPs) for Program-Level Indicators on Prevention/Other and Counseling and Testing) -- for an example of MARPs disaggregation for Prevention/Other Behavior Change and for Counseling and Testing.</p>
Interpretation/Strengths and Weaknesses:	This is an output measure. It doesn't provide a workload count or provide any specific information about the quality of the counseling or the extent to which people are receiving follow up services. The goal is to track the number of individuals who received their test results, however, not all programs are set up to adequately distinguish between those who are tested and those who receive results. All programs should work towards being able to track individuals through pre-test counseling, testing, post-test counseling, provision of results, and subsequent interventions. This indicator also does not track where the counseling and testing is taking place. People may go more than once during the reporting period to different outlets. Refer to outcome level indicators for measurement of percent of population counseled, tested, and receiving results.

9.2.A Number of registered TB patients who received counseling and testing for HIV and received their test results, disaggregated by sex [this is a subset of Indicator 9.2]	
Rationale/What It Measures:	This indicator provides a count of those registered TB patients who have received counseling and testing during the current reporting period and as a result are now aware of their HIV status.
Definition:	This indicator requires a minimum of counseling, testing, and the provision of test results.
Measurement Tool:	Program reports
How To Measure It:	<p>Partners should not double count individuals seen multiple times within a program. An individual may count in separate program areas, such as an OVC who may be served separately by an OVC program, ART facility, and prevention program. However, double counting of individuals within a program area is to be avoided among USG funded partners to the extent possible. While programs should be reporting to USG managers on the actual number of individuals served, the USG team is responsible to the extent possible for adjusting for the overlap between multiple programs serving the same individuals within a program area. All the prevention and care indicators refer to individuals served <i>during the current reporting period</i>. If you reached 100 OVC last year (in the Annual Report) and now serve 120 during the current reporting period, this is reported as 120, not 220. In order to avoid double counting, countries will need to monitor their activities by partner, programmatic area, and geographic area. This matrix is an excellent program management tool as well as helping to adjust for double counting by partners, among partners, and among USG agencies.</p> <p>For concentrated/low-level epidemic settings where most-at-risk populations drive HIV transmission, it is recommended (but not required) that this indicator be monitored and disaggregated by the most-at-risk populations (MARPs) as relevant to country context. Please see the next section (Disaggregation of Most-at-Risk Populations (MARPs) for Program-Level Indicators on Prevention/Other and Counseling and Testing) -- for an example of MARPs disaggregation for Prevention/Other Behavior Change and for Counseling and Testing.</p>
Interpretation/Strengths and Weaknesses:	This is an output measure. It doesn't provide a workload count or provide any specific information about the quality of the counseling or the extent to which people are receiving follow up services. The goal is to track the number of individuals who received their test results, however, not all programs are set up to adequately distinguish between those who are tested and those who receive results. All programs should work towards being able to track individuals through pre-test counseling, testing, post-test counseling, provision of results, and subsequent interventions. This indicator also does not track where the counseling and testing is taking place. People may go more than once during the reporting period to different outlets. Refer to outcome level indicators for measurement of percent of population counseled, tested, and receiving results.

9.3 Number of individuals trained in counseling and testing according to national or international standards	
Rationale/What It Measures:	This provides a means to gauge progress toward any training targets, which may be incorporated into national plans.
Definition:	<p>Training refers to new training or retraining of individuals and assumes that training is conducted according to national or international standards when these exist.</p> <p>A training must have specific learning objectives, a course outline or curriculum, and expected knowledge, skills and/or competencies to be gained by participants.</p>
Measurement Tool:	Program reports. USG agencies and USG-funded partners should keep a training log including the type of training, date, location, and participants.
How To Measure It:	<p>Each USG agency and USG-funded partner counts the number of individuals trained in prevention by USG staff (HQ or field-based) or USG-funded partners during the specified reporting period (12 months for annual report).</p> <p>Only participants who complete the full training course should be counted.</p> <p>If a training course covers more than one counseling and testing topic, individuals should only be counted once for that training course.</p> <p>If a training course is conducted in more than one session/training event, only individuals who complete the full course should be counted. Do not sum the participants for each training event.</p> <p>The USG staff responsible for compiling the annual reporting data should use the training log submitted by each USG agency and USG-funded partner reporting on this indicator in order to count the total number of individuals trained in counseling and testing. Individuals trained in training courses co-funded by more than one USG agency/USG-funded partner should only be counted once within the specified reporting period (12 months for annual report).</p> <p>In order to avoid double counting, countries will need to monitor their activities by partner, programmatic area, and geographic area. This matrix is an excellent program management tool as well as helping to adjust for double counting by partners, among partners, and among USG agencies.</p>
Interpretation/Strengths and Weaknesses:	<p>This indicator does not measure the quality of the training, nor does it measure the outcomes of the training in terms of the competencies of individuals trained, nor their job performance.</p> <p>This indicator simply measures number trained in counseling and testing as opposed to the percent of health facilities with trained staff, which may be measured through health facility surveys.</p>

HIV/AIDS Treatment / Antiretroviral Services

11.1 Number of service outlets providing ART services according to national or international standards	
Rationale/What It Measures:	This indicator measures the progress of a program to expand the number of locations in which ART services are delivered in accordance with national or international standards.
Definitions:	<p>A service outlet refers to the lowest level of service. For example, with regard to clinical activities, the lowest level for which data exists should be a service outlet such as a hospital, clinic, or mobile unit.</p> <p>ART services refer to activities including the provision of antiretroviral drugs and clinical monitoring for antiretroviral therapy among those with HIV infection.</p> <p>ART refers to long-term combination antiretroviral therapy intended primarily to improve the health of the individual on treatment, not to prevent mother-to-child transmission.</p> <p>A PMTCT+ site is a service outlet that provides a minimum package of services which includes HIV counseling and testing for pregnant women, ARV prophylaxis to prevent mother-to-child transmission, counseling for safe infant feeding practices, family planning counseling or referral, and ARV therapy for HIV+ women, their children, and their families.</p>
Measurement Tool:	Program Reports
How To Measure It:	Count all service outlets providing ART including designated PMTCT+ sites.
Interpretation/Strengths and Weaknesses:	<p>This indicator does not describe the geographic location or distribution of service outlets.</p> <p>This indicator does not consider the quality of service provision, which would require more in-depth evaluation efforts like facility surveys. This is not a complete measure of coverage, as there is no denominator of total facilities. This does not account for non-USG supported service outlets.</p>

11.2 Number of individuals newly initiated on antiretroviral therapy during the reporting period, disaggregated by sex and age and pregnancy status	
Rationale/What It Measures:	<p>There are three program indicators to count individuals receiving antiretroviral therapy at a service outlet directly supported by USG Emergency Plan funds: NEW, CUMULATIVE, and CURRENT. Collectively, these three program indicators, when combined with the Outcome Indicator: "Care & Treatment 5" (percentage of people still alive and on therapy at 6, 12, and 24 months after initiation of treatment) give an overview of the progress of a program in achieving targets to begin and maintain individuals on long-term, antiretroviral therapy.</p> <p>This indicator refers to NEW clients. NEW refers to individuals newly initiated on antiretroviral therapy during a reporting period.</p>
Definitions:	<p>ART refers to long-term combination antiretroviral therapy intended primarily to improve the health of the individual on treatment, not to prevent mother-to-child transmission.</p> <p>A "newly initiated" client is one who initiated antiretroviral therapy during the reporting period in a program directly supported by USG funds.</p> <p>A PMTCT+ site is a service outlet that provides a minimum package of services which includes HIV counseling and testing for pregnant women, ARV prophylaxis to prevent mother-to-child transmission, counseling for safe infant feeding practices, family planning counseling or referral, and ARV therapy for HIV+ women, their children, and their families.</p> <p>A new client is counted as pregnant if she is pregnant at the time she is initiated on antiretroviral therapy, regardless of the outcome of the pregnancy.</p>
Measurement Tool:	Program Reports
How To Measure It:	<p>This indicator includes two mutually exclusive sets of individuals on ART: those who receive antiretroviral therapy at a designated PMTCT+ site and those who receive antiretroviral therapy elsewhere.</p> <p>If an individual transfers in to the ART program <i>with records</i> from continuous ART at another facility or program, this person should NOT be counted as new.</p> <p>If an individual transfers in <i>without records</i> or has no documented evidence of previous antiretroviral therapy, this person may be counted as new (because programs have no choice but to enroll this person as a new client).</p> <p>If an individual previously on ART in the program restarts ART after an interruption in therapy, this person should NOT be counted as new.</p>

	<p>If an individual initiated treatment during the period but died, stopped ART, or transferred out before the end of the reporting period, this person should still be counted as new (since status at the end of the period does not affect the fact that the person was still new on therapy during the period).</p> <p>The USG indicators do not require reporting of transfers or restarts, but it is expected that programs will keep records of these persons and events. Clients, who transfer in, transfer out, and/or who restart after interruption of therapy will be counted in the CURRENT client load, as long as they are on ART at the end of a reporting period.</p> <p>For the NEW indicator, age represents an individual's age at initiation of therapy.</p> <p>Disaggregation of pregnant women by age is NOT required. The number of pregnant women is to be shown as a subset of all women.</p>
<p>Interpretation/ Strengths and Weaknesses:</p>	<p>As the health of ART clients improves and ART services become available at more locations, transferring patients may account for an increasing proportion of ART client load in the health care system and at any given facility. If treatment is not adequately documented or records are not transferred with a client, clients may be newly initiated at more than one program/facility over time. At the country level, these clients will be double counted in the NEW and CUMULATIVE client indicators. Double counting of individuals within a program area is to be avoided among USG funded partners to the extent possible.</p> <p>Since age and pregnancy status change over time, the comparison of NEW, CUMULATIVE, and CURRENT clients by age and pregnancy status is challenging. Because new and cumulative are states defined by <i>beginning</i> in a program, it is expected that the characteristics of new and cumulative clients are recorded at the time they newly initiate or transfer into a program. On the contrary, current is a state defined by vital/treatment status when <i>last</i> seen, so it is expected that characteristics of these clients would be updated each time they are seen by a program.</p> <p>Combining all children into one age group of < 15 yrs may not be satisfactory for program managers. For children of different ages, there are different criteria for starting treatment, as well as different disease burdens, care needs, and mortality patterns. Programs may wish to further disaggregate children by age to follow programmatically and clinically meaningful differences as follows: 0-18 months, 18 months-5 years, 6-14 years.</p>

11.3 Number of individuals who ever received antiretroviral therapy by the end of the reporting period, disaggregated by sex and age and pregnancy status	
Rationale/What It Measures:	<p>There are three program indicators to count individuals receiving antiretroviral therapy at a service outlet directly supported by USG Emergency Plan funds: NEW, CUMULATIVE, and CURRENT. Collectively, these three program indicators, when combined with the Outcome Indicator: Care & Treatment 5 (percentage of people still alive and on therapy at 6, 12, and 24 months after initiation of treatment) give an overview of the progress of a program in achieving targets to begin and maintain individuals on long-term, antiretroviral therapy.</p> <p>This indicator refers to CUMULATIVE clients. CUMULATIVE refers to the total number of individuals who were <i>ever</i> on ART since the start of Emergency Plan support to the service outlet.</p>
Definitions:	<p>ART refers to long-term combination antiretroviral therapy intended primarily to improve the health of the individual on treatment, not to prevent mother-to-child transmission.</p> <p>A PMTCT+ site is a service outlet that provides a minimum package of services which includes HIV counseling and testing for pregnant women, ARV prophylaxis to prevent mother-to-child transmission, counseling for safe infant feeding practices, family planning counseling or referral, and ARV therapy for HIV+ women, their children, and their families.</p> <p>A new client is reported as pregnant if she is pregnant at the time she is initiated on antiretroviral therapy, regardless of the outcome of the pregnancy.</p>
Measurement Tool:	Program reports
How To Measure It:	<p>This indicator includes two mutually exclusive sets of individuals on ART: those who receive antiretroviral therapy at a designated PMTCT+ site and those who receive antiretroviral therapy elsewhere.</p> <p>The CUMULATIVE indicator is comprised of the NEW clients plus those who clients who transfer with records into a program directly supported by USG Emergency Plan funds.</p> <p>The cumulative number of clients by the end of any reporting period is the sum of the cumulative number of clients at the end of the <i>previous</i> reporting period plus the clients who newly initiate and transfer into the program <i>during</i> the reporting period.</p> <p>The CUMULATIVE count never declines over time, as it represents the total number of individuals who were <i>ever</i> on ART, regardless of whether they died or otherwise left the program.</p> <p>The same individual should never be counted more than once for the CUMULATIVE indicator. (Thus If an individual</p>

	<p>previously on ART in the program restarts ART after an interruption in therapy, this person should NOT be counted again in the cumulative count as s/he was already counted once.)</p> <p>For the CUMULATIVE indicator, age represents an individual's age at initiation of therapy or when s/he transfers into the program.</p> <p>Disaggregation of pregnant women by age is NOT required. The number of pregnant women is to be shown as a subset of all women.</p>
<p>Interpretation/ Strengths and Weaknesses:</p>	<p>As the health of ART clients improves and ART services become available at more locations, transferring patients may account for an increasing proportion of ART client load in the health care system and at any given facility. If treatment is not adequately documented or records are not transferred with a client, clients may be newly initiated at more than one program/facility over time. At the country level, these clients will be double counted in the NEW and CUMULATIVE client indicators. Double counting of individuals within a program area is to be avoided among USG funded partners to the extent possible.</p> <p>Since age and pregnancy status change over time, the comparison of NEW, CUMULATIVE, and CURRENT clients by age and pregnancy status is challenging. Because new and cumulative are states defined by <i>beginning</i> in a program, it is expected that the characteristics of new and cumulative clients are recorded at the time they newly initiate or transfer into a program. On the contrary, current is a state defined by vital/treatment status when <i>last</i> seen, so it is expected that characteristics of these clients would be updated each time they are seen by a program.</p>

11.4 Number of individuals receiving antiretroviral therapy at the end of the reporting period, disaggregated by sex and age and pregnancy status	
Rationale/What It Measures:	<p>There are three program indicators to count individuals receiving antiretroviral therapy at a service outlet directly supported by USG Emergency Plan funds: NEW, CUMULATIVE, and CURRENT. Collectively, these three program indicators, when combined with the Outcome Indicator: Care & Treatment 5 (percentage of people still alive and on therapy at 6, 12, and 24 months after initiation of treatment) give an overview of the progress of a program in achieving targets to begin and maintain individuals on long-term, antiretroviral therapy.</p> <p>This indicator refers to CURRENT clients. CURRENT refers to those individuals on antiretroviral therapy at the end of a reporting period.</p>
Definitions:	<p>ART refers to long-term combination antiretroviral therapy intended primarily to improve the health of the individual on treatment, not to prevent mother-to-child transmission.</p> <p>A PMTCT+ site is a service outlet that provides a minimum package of services which includes HIV counseling and testing for pregnant women, ARV prophylaxis to prevent mother-to-child transmission, counseling for safe infant feeding practices, family planning counseling or referral, and ARV therapy for HIV+ women, their children, and their families.</p> <p>A current client is pregnant if she was pregnant <i>at any time during the reporting period</i>, regardless of the outcome of the pregnancy.</p>
Measurement Tool:	Program Reports
How To Measure It:	<p>This indicator includes two mutually exclusive sets of individuals on ART: those who receive antiretroviral therapy at a designated PMTCT+ site and those who receive antiretroviral therapy elsewhere.</p> <p>A person on ART who initiated ART or transferred in during the reporting period can be counted as a CURRENT client if s/he is on treatment at the end of the reporting period.</p> <p>Individuals who died, stopped treatment, transferred out, or were otherwise lost to follow up during the reporting period are not on ART at the end of the reporting period, and thus, are NOT counted as a CURRENT client.</p> <p>Note that the difference between the CUMULATIVE number ever on treatment by the end of the reporting period and the CURRENT number on treatment at the end of the reporting period should be approximately the number of individuals who died, who permanently stopped treatment or transferred out, or who were otherwise lost to follow-up by the end of the reporting period. In order to measure survival on ART and the number of CURRENT clients, all programs should collect</p>

	<p>information on the number of individuals who are no longer on treatment at the end of a reporting period and the reason (death, stop treatment, transfer out, lost to follow up).</p> <p>Patients pick up ARV drugs on variable schedules, and monitoring systems are not always adequate to flag and follow up each person who misses an appointment. Thus, it may not be possible to get an exact count of current clients on the last day of the reporting period. The recommended method for calculating this indicator is to count the number of individuals who were seen for ARV therapy during the last 3 months of the reporting period (i.e., the last quarter) and to subtract those who were known to have died, stopped treatment, transferred out, or been otherwise lost to follow up since the last time they were seen for a treatment appointment. Those not seen during the last 3 months are presumed lost to follow up.</p> <p>For the CURRENT indicator, age represents an individual's age at the end of the reporting period, or when last seen during the reporting period for an ART appointment.</p> <p>Disaggregation of pregnant women by age is NOT required. The number of pregnant women is to be shown as a subset of all women.</p>
<p>Interpretation/ Strengths and Weaknesses:</p>	<p>Monitoring systems are variable in their ability to measure exactly the client load at the end of the reporting period, thus the reported results may include some people who have recently died, dropped out, transferred out, or been lost to follow up and overestimate the true number of clients at the end of the reporting period.</p> <p>Since age and pregnancy status change over time, the comparison of NEW, CUMULATIVE, and CURRENT clients by age and pregnancy status is challenging. Because new and cumulative are states defined by <i>beginning</i> in a program, it is expected that the characteristics of new and cumulative clients are recorded at the time they newly initiate or transfer into a program. On the contrary, current is a state defined by vital/treatment status when <i>last</i> seen, so it is expected that characteristics of these clients would be updated each time they are seen by a program.</p>

11.5 Number of health workers trained to deliver ART services according to national or international standards	
Rationale/What It Measures:	<p>Building human capacity in health care delivery systems is of the utmost importance for the delivery of quality ART services.</p> <p>This indicator measures efforts to train a workforce to achieve targets in ART service delivery. Included are both certified clinical and lay health workers who contribute to the development and implementation of ART services. Health workers trained to deliver ART services at PMTCT+ sites should also be included here.</p>
Definitions:	<p>This includes health workers that have been sufficiently trained to take up a direct function in support of scaling up clinical or community-based ART services.</p> <p>Type of health workers include:</p> <ul style="list-style-type: none"> • Physicians and health workers with physician skills (e.g. Medical Officers) • Nurses and other health workers with nursing skills (e.g. Midwives, Clinical Officers) • Other health care workers and lay staff in clinical setting • Laboratory technicians and staff • Pharmacy/dispensing staff • Community treatment supporters (peer educators, outreach workers, volunteers, informal caregivers) <p>New training or retraining of individuals assumes that training is conducted according to national or international standards when these exist. It is assumed that in most settings such training will occur through a specialized training program that health workers attend after their regular education ("in-service" training). Only health workers who have undergone such training should be included.</p> <p>A training must have specific learning objectives, a course outline, or curriculum, and expected knowledge, skills and/or competencies to be gained by participants.</p> <p>ART services include activities such as the provision of antiretroviral drugs and clinical monitoring for antiretroviral therapy among those with HIV infection.</p> <p>A PMTCT+ site is a service outlet that provides a minimum package of services which includes HIV counseling and testing for pregnant women, ARV prophylaxis to prevent mother-to-child transmission, counseling for safe infant feeding practices, family planning counseling or referral, and ARV therapy for HIV+ women, their children, and their families.</p>
Measurement Tool:	Program Reports
How To Measure It:	Each USG agency and USG-funded partner counts the number of individuals trained in prevention by USG staff (HQ or field-based) or USG-funded partners during the specified reporting period (12 months for annual report).

	<p>Only participants who complete the full training course should be counted. If a training course covers more than one ART delivery topic, individuals should only be counted once for that training course.</p> <p>If a training course is conducted in more than one session/training event, only individuals who complete the full course should be counted. Do not sum the participants for each training event.</p> <p>The USG staff responsible for compiling the annual reporting data should use the training log submitted by each USG agency and USG-funded partner reporting on this indicator in order to count the total number of individuals trained in ART delivery. Individuals trained in training courses co-funded by more than one USG agency/USG-funded partner should only be counted once within the specified reporting period (12 months for annual report).</p> <p>In order to avoid double counting, countries will need to monitor their activities by partner, programmatic area, and geographic area. This matrix is an excellent program management tool as well as helping to adjust for double counting by partners, among partners, and among USG agencies.</p>
<p>Interpretation/ Strengths and Weaknesses:</p>	<p>This indicator is most useful in the initial phases of a response to HIV/AIDS, when the cumulative number of trained health professionals is expected to be continuously increasing until it reaches a critical mass (or desired ceiling). At this point, the quantitative focus of the indicator on the number of health workers trained might become obsolete. The measurement could shift to capture the quality of the training, refresher training, and testing/supervision of the health care practices.</p> <p>This indicator does not measure the distribution of health workers trained to provide ART services. This indicator does not disaggregate by the type of health worker trained to provide ART services. This indicator does not measure the type, content or duration of training being counted or whether the health workers counted as trained have been counted as trained in a previous period.</p> <p>Given the importance of human capacity to provide pediatric AIDS services, countries, and/or programs may wish to collect additional information on the number of health workers trained to provide pediatric ART services.</p> <p>This indicator does not measure the quality of the training, nor does it measure the outcomes of the training in terms of the competencies of individuals trained, nor their job performance.</p> <p>This indicator simply measures number trained in ART services as opposed to the percent of health facilities with trained staff, which may be measured through health facility surveys.</p>

Laboratory Infrastructure

12.1 Number of laboratories with the capacity to perform (1) HIV tests and (2) CD4 tests and/or lymphocyte tests	
Rationale/What It Measures:	This indicator reflects USG efforts to strengthen capacities of laboratories to perform HIV/AIDS related tests, diagnostics, and patient monitoring tasks. This indicator is measuring both the ability to perform HIV tests as well as the ability to monitor patients who are in care.
Definition:	Laboratory capacity is defined as the ability to perform (1) HIV tests <u>and</u> (2) CD4 tests or lymphocyte tests. This refers to both the equipment and personnel necessary to carry out testing.
Measurement Tool:	<p>Program reports. To assess whether the laboratory sites have the capacity to perform the specified testing, special studies using observation techniques may be necessary.</p> <p>USG staff and USG-funded partners should keep an inventory of the name and location of laboratory sites that are able to perform the specified testing. This information should be submitted to the USG staff responsible for compiling the annual reporting data as evidence for the reported number of laboratories with the capacity to perform the specified tests.</p>
How To Measure It:	<p>Each USG agency and USG-funded partner counts the number of laboratory sites that have at minimum the capacity to perform the specified testing at the end of the specified reporting period (12 months for annual report). Count only those laboratory sites that are able to perform both HIV tests and CD4 tests and/or lymphocyte tests.</p> <p>The USG staff responsible for compiling the annual reporting data should use the laboratory sites list submitted by each USG agency and USG-funded partner reporting on this indicator in order to count the total number of laboratory sites that have the stated capacity, avoiding any double-counting of the same laboratory site supported by more than one USG agency/USG-funded partner.</p>
Interpretation/Strengths and Weaknesses:	<p>This indicator does not measure whether the sites are actually performing the specified tests.</p> <p>This indicator does not consider the quality of service provision, which would require more in-depth evaluation efforts like facility surveys. This is not a complete measure of coverage, as there is no denominator of total facilities. This does not account for non-USG supported service outlets.</p>

12.2 Number of individuals trained in laboratory-related activities	
Rationale/What It Measures:	The intent of the indicator is to measure progress toward developing and/or maintaining the skills of a cadre of professionals such that they are able to provide laboratory services according to national or international standards.
Definition:	<p>Training refers to new training or retraining of individuals and assumes that training is conducted according to national or international standards when these exist.</p> <p>A training must have specific learning objectives, a course outline or curriculum, and expected knowledge, skills and/or competencies to be gained by participants.</p>
Measurement Tool:	Program reports. USG agencies and USG-funded partners should keep a training log including the type of training, date, location, and participants.
How To Measure It:	<p>Each USG agency and USG-funded partner counts the number of individuals trained in laboratory-related activities by USG staff (HQ or field-based) or USG-funded partners during the specified reporting period (12 months for annual report).</p> <p>Only participants who complete the full training course should be counted. If a training course covers more than one laboratory-related activities topic, individuals should only be counted once for that training course.</p> <p>If a training course is conducted in more than one session / training event, only individuals who complete the full course should be counted. Do not sum the participants for each training event.</p> <p>The USG staff responsible for compiling the annual reporting data should use the training log submitted by each USG agency and USG-funded partner reporting on this indicator in order to count the total number of individuals trained in laboratory-related activities. Individuals trained in training courses co-funded by more than one USG agency/USG-funded partner should only be counted once within the specified reporting period (12 months for annual report).</p> <p>In order to avoid double counting, countries will need to monitor their activities by partner, programmatic area, and geographic area. This matrix is an excellent program management tool as well as helping to adjust for double counting by partners, among partners, and among USG agencies.</p>
Interpretation/Strengths and Weaknesses:	<p>This indicator does not measure the quality of the training, nor does it measure the outcomes of the training in terms of the competencies of individuals trained, nor their job performance.</p> <p>This indicator does not disaggregate by in-service and pre-service training and is a gross measure of all training conducted.</p> <p>This indicator simply measures number trained in laboratory-related activities as opposed to the percent of health facilities with trained staff, which may be measured through health facility surveys.</p>

12.3 Number of tests performed at USG-supported laboratories during the reporting period: 1) HIV testing, 2) TB diagnostics, 3) syphilis testing, and 4) HIV disease monitoring	
Rationale/What It Measures:	This indicator measures the extent to which USG-supported laboratories are expanding laboratory services to support HIV/AIDS care and treatment services.
Definition:	<p>The number of tests performed at USG-supported laboratories during the reporting period (12 months)</p> <ul style="list-style-type: none"> • HIV testing: Examples include ELISA and simple rapid tests for serology • Polymerase chain reaction (PCR) for infant diagnosis • TB diagnostics: Acid fast (Ziehl-Neelsen) staining of sputum • Syphilis testing: Rapid Plasma Reagent (RPR), simple syphilis, Treponema pallidum hemagglutination assay (TPHA), Include both screening and confirmation • HIV disease monitoring: CD4 • HIV viral load • Alanine transaminase (ALT), and Creatinine
Measurement Tool:	Systematic review of project documents and records; laboratory records. Data collection must be ongoing and aggregated over the 12 month reporting period. The USG team in country should aggregate data across all USG-supported laboratories.
How To Measure It:	This measure should reflect the number of tests performed, not the number of kits or reagents purchased. Measurement of this indicator is undertaken by systematically reviewing laboratory records maintained at each site, as well as USG project records and documents, to count the number of USG-supported laboratories performing tests within each of the categories listed above. The number of tests should be added within each category. For example, the number of HIV tests should reflect the sum of ELISAs and rapid tests.
Interpretation/Strengths and Weaknesses:	<p>This indicator is an output indicator of direct support provided to strengthen laboratory capacity in a given country and for the Emergency Plan as a whole. Different sub-categories of HIV monitoring provide an overall picture of USG support. For management purposes, laboratories may want more detailed information about the tests performed.</p> <p>When interpreting this indicator, consideration must be given to factors within and beyond USG manageable interests. For example, reagent stock outages and logistical problems greatly reduce the number of tests performed in labs. Often procurement and logistics are being managed independently.</p> <p>The ability of laboratories to report this information may lag behind their capacity to perform these tests. As a result, counts may underestimate laboratory performance. As record keeping and reporting capacity of laboratories improve, so will the quality and accuracy of the indicator estimate.</p>

	<p>This indicator should be interpreted along with indicator 11.1.</p> <p>This indicator does not consider the quality of service provision, which would require more in-depth evaluation efforts like facility surveys.</p> <p>This indicator does not measure the unique contribution of USG, since other donors or countries may also be providing support. This indicator should not be used as a measure of the number of people tested or receiving services since the unit of analysis is the test not the person.</p>
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Strategic Information
(Surveillance, Health Management Information Systems, Monitoring and Evaluation)

13.1 Number of local organizations provided with technical assistance for strategic information (M&E and/or surveillance and/or HMIS).	
Rationale/What It Measures:	The intent of the indicator is to capture support provided to enhance the capacity of local organizations to collect, analyze, disseminate, and use HIV/AIDS-related data.
Definition:	<p>A local organization is defined as any entity whose headquarters is in a country or region served by the Emergency Plan. As such, the majority of the entity's staff (senior, mid-level, support) is comprised of host country and/or regional nationals. "Local organizations" refers to both governmental and non-governmental (NGOs, FBOs, and community-based) organizations.</p> <p>Technical assistance (TA) is defined as the identification of need for and delivery of practical program and technical support. TA is intended to assist local organizations in building capacity to design, implement and evaluate HIV prevention, care and treatment programs.</p> <p>TA should include <i>regular technical communications and information dissemination sustained over a period of time</i>. TA can be provided through a combination of strategic approaches and dissemination strategies including individualized and on-site peer and expert consultation, site visits, ongoing consultative relationships, national and/or regional meetings, consultative meetings and conferences, conference calls and web-casts, development and implementation of training curricula.</p> <p>Provision of technical assistance for strategic information refers to activities that aim to strengthen HIV/AIDS surveillance, HMIS and M&E. Examples include providing local organizations with technical assistance in the following areas: developing or improving M&E models, methods and tools for collecting, analyzing, disseminating and using data; establishing or improving information systems; developing or improving program monitoring, planning and or conducting targeted program evaluations including operations research; monitoring and disseminating best practices to improve program efficiency and effectiveness; and/or improving data quality.</p> <p>Strategic information includes HIV/AIDS surveillance, health management information systems, and monitoring and evaluation.</p>
Measurement Tool:	Program reports.
How To Measure It:	<p>Each USG agency and USG-funded partner counts the number of organizations that received technical assistance for SI activities from USG staff (HQ or field-based) or USG-funded partners during the specified reporting period (12 months for annual report).</p> <p>USG staff and USG-funded partners should keep an inventory of name of organization to which the technical assistance is</p>

	<p>provided, the type of technical assistance provided, name of technical assistance provider, and date / time period of technical assistance provision. This information should be submitted to the USG staff responsible for compiling the annual reporting data as evidence for the reported number of organizations supported with SI technical assistance.</p> <p>The USG staff responsible for compiling the annual reporting data should use the technical assistance inventory submitted by each USG agency and USG-funded partner reporting on this indicator in order to count the total number of organizations / agencies that received technical assistance for SI activities from USG staff (HQ or field-based) or USG-funded partners during the reporting period. Organizations may only be counted once within the specified reporting period (12 months for annual report).</p> <p>Organizations that received TA for policy development should be reported under Indicator 12.1. Organizations that received TA for institutional capacity building should be counted under Indicator 12.2.</p>
<p>Interpretation/ Strengths and Weaknesses:</p>	<p>This indicator does not capture the quality of the technical support provided, nor does it capture changes in the capacity of the organization/agency in collecting, analyzing, disseminating and using HIV/AIDS data.</p>

13.2 Number of individuals trained in strategic information (M&E and/or surveillance and/or HMIS)	
Rationale/What It Measures:	The intent of the indicator is to measure progress toward creating a cadre of professionals trained in the collection, analysis, dissemination, and use of strategic information for HIV/AIDS programming.
Definition:	<p>Training refers to new training or retraining of individuals and assumes that training is conducted according to national or international standards when these exist.</p> <p>A training must have specific learning objectives, a course outline or curriculum, and expected knowledge, skills and/or competencies to be gained by participants.</p>
Measurement Tool:	Program reports. USG agencies and USG-funded partners should keep a training log including the type of training, date, location, and participants.
How To Measure It:	<p>Count the number of individuals trained in SI during the specified reporting period (12 months for annual report). Only participants who complete the full training course should be counted. If a training course is conducted in several sessions or covers more than one SI topic, for example M&E and surveillance, individuals should only be counted once for that training course. If a training spans more than 1 programmatic area with separate and specific objectives and curricula for each program (for instance OVC and SI), individuals trained may count in each program area.</p> <p>Individuals trained in training courses co-funded by more than one USG agency / USG-funded partner should only be counted once within the specified reporting period.</p> <p>Each USG agency and USG-funded partner counts the number of individuals trained in SI by USG staff (HQ or field-based) or USG-funded partners during the specified reporting period (12 months for annual report).</p> <p>Only participants who complete the full training course should be counted.</p> <p>If a training course covers more than one SI topic, for example M&E and surveillance, individuals should only be counted once for that training course.</p> <p>If a training course is conducted in more than one session / training event, only individuals who complete the full course should be counted. Do not sum the participants for each training event.</p> <p>The USG staff responsible for compiling the annual reporting data should use the training log submitted by each USG agency and USG-funded partner reporting on this indicator in order to count the total number of individuals trained in SI. Individuals trained in training courses co-funded by more than one USG agency / USG-funded partner should only be counted once within the specified reporting period (12 months for annual report).</p>

**Interpretation/
Strengths and
Weaknesses:**

This indicator does not measure the quality of the training, nor does it measure the outcomes of the training in terms of the competencies of individuals trained, nor their job performance.

**Other Policy Analysis and System Strengthening
(Policy, Institutional Capacity Building, Stigma and Discrimination Reduction,
and Community Mobilization for HIV Prevention, Care and Treatment)**

14.1 Number of local organizations provided with technical assistance for HIV-related policy development	
Rationale/What It Measures:	This indicator measures the degree to which local organizations receive technical assistance in support of policy development, a priority area of the Emergency Plan.
Definition:	<p>A local organization is defined as any entity whose headquarters is in a country or region served by the Emergency Plan. As such, the majority of the entity's staff (senior, mid-level, support) is comprised of host country and/or regional nationals. "Local organizations" refers to both governmental and non-governmental (NGOs, FBOs, and community-based) organizations.</p> <p>Technical assistance (TA) is defined as the identification of need for and delivery of practical program and technical support. TA is intended to assist local organizations in building capacity to design, implement and evaluate HIV prevention, care and treatment programs.</p> <p>TA should include <i>regular technical communications and information dissemination sustained over a period of time</i>. TA can be provided through a combination of strategic approaches and dissemination strategies including individualized and on-site peer and expert consultation, site visits, ongoing consultative relationships, national and/or regional meetings, consultative meetings and conferences, conference calls and web-casts, development and implementation of training curricula.</p> <p>TA for policy development activities aim to:</p> <ul style="list-style-type: none"> • Broaden and strengthen political and popular support for HIV/AIDS policies and programs; • Improve the operational environment for these programs, including better planning and financing; • Ensure that accurate, up-to-date information informs policy decisions; and • Build in-country and regional capacity to participate in policy development.
Measurement Tool:	Program reports
How To Measure It:	Sum of local organizations that received technical assistance in HIV-related policy. Organizations that received TA for Strategic Information (M&E, HMIS, Surveillance) or Quality Assurance should be counted under SI (Indicator 12.1). Organizations that received TA for institutional capacity building should be reported under Indicator 13.2.
Interpretation/Strengths and Weaknesses:	This indicator does not measure amount and quality of TA and only indicates the number of organizations that received any TA.

14.2 Number of local organizations provided with technical assistance for HIV-related institutional capacity building	
Rationale/What It Measures:	This indicator measures the degree to which organizations receive technical assistance in support of institutional capacity development, a priority area of The Emergency Plan.
Definition:	<p>A local organization is defined as any entity whose headquarters is in a country or region served by the Emergency Plan. As such, the majority of the entity's staff (senior, mid-level, support) is comprised of host country and/or regional nationals. "Local organizations" refers to both governmental and non-governmental (NGOs, FBOs, and community-based) organizations.</p> <p>Technical assistance (TA) is defined as the identification of need for and delivery of practical program and technical support. TA is intended to assist local organizations in building capacity to design, implement and evaluate HIV prevention, care and treatment programs.</p> <p>TA should include <i>regular technical communications and information dissemination sustained over a period of time</i>. TA can be provided through a combination of strategic approaches and dissemination strategies including individualized and on-site peer and expert consultation, site visits, ongoing consultative relationships, national and/or regional meetings, consultative meetings and conferences, conference calls and web-casts, development and implementation of training curricula.</p> <p>TA for institutional capacity building may cover the following:</p> <ul style="list-style-type: none"> • <i>Strategic Planning</i>: organizations that have a Board of Directors, mission statement, and strategies for the short and long-term (5 -10 years), including diversification of funding sources and ability to write their own grant proposals; • <i>Registration</i>: organizations that are officially registered as legal entities; • <i>Financial Management</i>: organizations that have a practical accounting system in place and are able to account for all expenditures in accordance with USG and in-country audit requirements, analyze unit costs, make financial projections, and track expenditures against budgets; • <i>Human Resource Management</i>: organizations with an established personnel system with checks and balances, for recruiting, paying, retaining, training, and supervising adequate numbers of staff at all levels of the organization; • <i>Networks Development</i>: local networks established/strengthened that deliver prevention, care and treatment services, monitor implementation, and report results; • <i>Commodities, Equipment and Logistics Management</i>: organizations that have established a system to assess commodity needs, account for donated product, ensure adequate drug supply at all times, and eventually procure and purchase supplies, equipment, and drugs for HIV/AIDS prevention, care and treatment services; and • <i>Infrastructure Development</i>: laboratories, clinics, and classrooms improved or renovated to provide HIV/AIDS training or services.
Measurement Tool:	Program reports
How To Measure	Sum of local organizations that received technical assistance in HIV-related institutional capacity building. Organizations that

It:	received TA for Strategic Information (M&E, HMIS, Surveillance) or Quality Assurance should be counted under SI (Indicator 12.1). Organizations that received TA for policy development should be reported under Indicator 13.3.
Interpretation/ Strengths and Weaknesses:	This indicator does not measure amount and quality of TA and only indicates the number of organizations that received any TA.

14.3 Number of individuals trained in HIV-related policy development	
Rationale/What It Measures:	Supportive Interventions strengthen HIV prevention, care, and treatment programs. This indicator measures the number of individuals trained in policy for HIV/AIDS programs.
Definition:	<p>Training refers to new training or retraining of individuals and assumes that training is conducted according to national or international standards when these exist. Count all individuals trained, from local organizations or otherwise, during the reporting period.</p> <p>A training must have specific learning objectives, a course outline or curriculum, and expected knowledge, skills and/or competencies to be gained by participants.</p> <p>Policy activities aim to:</p> <ul style="list-style-type: none"> • Broaden and strengthen political and popular support for HIV/AIDS policies and programs; • Improve the operational environment for these programs, including better planning and financing; • Ensure that accurate, up-to-date information informs policy decisions; and • Build in-country and regional capacity to participate in policy development.
Measurement Tool:	Program reports. USG agencies and USG-funded partners should keep a training log including the type of training, date, location, and participants.
How To Measure It:	<p>Each USG agency and USG-funded partner counts the number of individuals trained in policy development by USG staff (HQ or field-based) or USG-funded partners during the specified reporting period (12 months for annual report).</p> <p>Only participants who complete the full training course should be counted.</p> <p>If a training course covers more than one policy development topic, individuals should only be counted once for that training course.</p> <p>If a training course is conducted in more than one session / training event, only individuals who complete the full course should be counted. Do not sum the participants for each training event.</p> <p>The USG staff responsible for compiling the annual reporting data should use the training log submitted by each USG agency and USG-funded partner reporting on this indicator in order to count the total number of individuals trained in policy development. Individuals trained in training courses co-funded by more than one USG agency/USG-funded partner should only be counted once within the specified reporting period (12 months for annual report).</p> <p>In order to avoid double counting, countries will need to monitor their activities by partner, programmatic area, and geographic area. This matrix is an excellent program management tool as well as helping to adjust for double counting by partners, among partners, and among USG agencies.</p>

Interpretation/ Strengths and Weaknesses:	<p>This indicator does not measure the quality of the training, nor does it measure the outcomes of the training in terms of the competencies of individuals trained, nor their job performance.</p> <p>This indicator simply measures number trained in HIV-related policy development as opposed to the percent of organizations with trained staff.</p>
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14.4 Number of individuals trained in HIV-related institutional capacity building	
Rationale/What It Measures:	This indicator measures the number of individuals trained in institutional capacity building. As more and more individuals are trained in the different capacity building domains, more individuals can be reached with HIV/AIDS services. In conjunction with indicator 12.2, this gives a picture of the reach of capacity building programs.
Definition:	<p>Training refers to new training or retraining of individuals and assumes that training is conducted according to national or international standards when these exist. Count all individuals trained, from local organizations or otherwise, during the reporting period.</p> <p>A training must have specific learning objectives, a course outline or curriculum, and expected knowledge, skills and/or competencies to be gained by participants.</p> <p>Institutional capacity building activities may include:</p> <ul style="list-style-type: none"> • <i>Strategic Planning:</i> organizations that have a Board of Directors, mission statement, and strategies for the short and long-term (5 -10 years), including diversification of funding sources and ability to write their own grant proposals; • <i>Registration:</i> organizations that are officially registered as legal entities; • <i>Financial Management:</i> organizations that have a practical accounting system in place and are able to account for all expenditures in accordance with USG and in-country audit requirements, analyze unit costs, make financial projections, and track expenditures against budgets; • <i>Human Resource Management:</i> organizations with an established personnel system with checks and balances, for recruiting, paying, retaining, training, and supervising adequate numbers of staff at all levels of the organization; • <i>Networks Development:</i> local networks established/strengthened that deliver prevention, care and treatment services, monitor implementation, and report results; • <i>Commodities, Equipment and Logistics Management:</i> organizations that have established a system to assess commodity needs, account for donated product, ensure adequate drug supply at all times, and eventually procure and purchase supplies, equipment, and drugs for HIV/AIDS prevention, care and treatment services; and • <i>Infrastructure Development:</i> laboratories, clinics, and classrooms improved or renovated to provide HIV/AIDS training or services.
Measurement Tool:	Program reports. USG agencies and USG-funded partners should keep a training log including the type of training, date, location, and participants.
How To Measure It:	<p>Each USG agency and USG-funded partner counts the number of individuals trained in institutional capacity building by USG staff (HQ or field-based) or USG-funded partners during the specified reporting period (12 months for annual report).</p> <p>Only participants who complete the full training course should be counted.</p> <p>If a training course covers more than one institutional capacity building topic, individuals should only be counted once for</p>

	<p>that training course. If a training course is conducted in more than one session/training event, only individuals who complete the full course should be counted. Do not sum the participants for each training event.</p> <p>The USG staff responsible for compiling the annual reporting data should use the training log submitted by each USG agency and USG-funded partner reporting on this indicator in order to count the total number of individuals trained in institutional capacity building. Individuals trained in training courses co-funded by more than one USG agency / USG-funded partner should only be counted once within the specified reporting period (12 months for annual report).</p> <p>In order to avoid double counting, countries will need to monitor their activities by partner, programmatic area, and geographic area. This matrix is an excellent program management tool as well as helping to adjust for double counting by partners, among partners, and among USG agencies.</p>
<p>Interpretation/ Strengths and Weaknesses:</p>	<p>This indicator does not measure the quality of the training, nor does it measure the outcomes of the training in terms of the competencies of individuals trained, nor their job performance.</p> <p>This indicator simply measures number trained in institutional capacity building as opposed to the percent of organizations with trained staff.</p>

14.5 Number of individuals trained in HIV-related stigma and discrimination reduction	
Rationale/What It Measures:	Supportive Interventions strengthen HIV prevention, care, and treatment programs. This indicator measures the number of individuals trained in HIV-related stigma and discrimination reduction.
Definition:	<p>Training refers to new training or retraining of individuals and assumes that training is conducted according to national or international standards when these exist. Count all individuals trained, from local organizations or otherwise, during the reporting period.</p> <p>A training must have specific learning objectives, a course outline or curriculum, and expected knowledge, skills and/or competencies to be gained by participants.</p> <p>HIV/AIDS-related stigma can be described as a “process of devaluation” of people either living with or associated with HIV and AIDS. This stigma often stems from the underlying stigmatization of sex and intravenous drug use—two of the primary routes of HIV infection. Discrimination follows stigma and is the unfair and unjust treatment of an individual based on his or her real or perceived HIV status or being perceived to belong to a particular group.</p> <p>Stigma and discrimination reduction activities may include:</p> <ul style="list-style-type: none"> • Enhancing practical knowledge to reduce fear of casual transmission; • Providing a safe forum to discuss sensitive topics (sex, death, drug use, inequity); • Finding a common language to talk about stigma; • Strengthening the capacity of people living with HIV and AIDS to challenge stigma in their lives; • Providing a process to determine appropriate and feasible individual and community responses to stigma; • Providing comprehensive, flexible tools for organizations to strengthen staff skills and develop or strengthen interventions to reduce HIV-related stigma; and • Developing a system to compile and address reported acts of discrimination.
Measurement Tool:	Program reports. USG agencies and USG-funded partners should keep a training log including the type of training, date, location, and participants.
How To Measure It:	<p>Each USG agency and USG-funded partner counts the number of individuals trained in stigma and discrimination reduction by USG staff (HQ or field-based) or USG-funded partners during the specified reporting period (12 months for annual report).</p> <p>Only participants who complete the full training course should be counted.</p> <p>If a training course covers more than one stigma and discrimination reduction topic, individuals should only be counted once for that training course.</p> <p>If a training course is conducted in more than one session/training event, only individuals who complete the full course should be counted. Do not sum the participants for each training event.</p>

	<p>The USG staff responsible for compiling the annual reporting data should use the training log submitted by each USG agency and USG-funded partner reporting on this indicator in order to count the total number of individuals trained in stigma and discrimination reduction. Individuals trained in training courses co-funded by more than one USG agency/USG-funded partner should only be counted once within the specified reporting period (12 months for annual report).</p> <p>In order to avoid double counting, countries will need to monitor their activities by partner, programmatic area, and geographic area. This matrix is an excellent program management tool as well as helping to adjust for double counting by partners, among partners, and among USG agencies.</p>
<p>Interpretation/ Strengths and Weaknesses:</p>	<p>This indicator does not measure the quality of the training, nor does it measure the outcomes of the training in terms of the competencies of individuals trained, nor their job performance.</p> <p>This indicator simply measures number trained in stigma and discrimination reduction as opposed to the percent of organizations with trained staff.</p>

14.6 Number of individuals trained in HIV-related community mobilization for prevention, care and/or treatment	
Rationale/What It Measures:	Supportive Interventions strengthen HIV prevention, care, and treatment programs. This indicator measures the number of individuals trained in HIV-related community mobilization for prevention, care, and/or treatment.
Definition:	<p>Training refers to new training or retraining of individuals and assumes that training is conducted according to national or international standards when these exist. Count all individuals trained, from local organizations or otherwise, during the reporting period.</p> <p>A training must have specific learning objectives, a course outline or curriculum, and expected knowledge, skills and/or competencies to be gained by participants.</p> <p>Community mobilization activities include:</p> <ul style="list-style-type: none"> • Identifying social groups and mapping existing formal structures or networks in order to encourage or promote HIV prevention, care and/or treatment interventions and services, such as counseling and testing, PMTCT, HIV care and antiretroviral treatment • Building trust with the community by providing a forum to discuss their perceived needs for HIV prevention, care and/or treatment interventions and services, • Developing communication around social networks to engage in dialogue with the community which encourages or promotes HIV prevention, care and/or treatment interventions and services, • Creating media and events that expose community members to new ideas, involving them in problem solving, and encouraging innovations, which promote HIV prevention, care and/or treatment interventions and services.
Measurement Tool:	Program reports. USG agencies and USG-funded partners should keep a training log including the type of training, date, location, and participants.
How To Measure It:	<p>Each USG agency and USG-funded partner counts the number of individuals trained in community mobilization by USG staff (HQ or field-based) or USG-funded partners during the specified reporting period (12 months for annual report).</p> <p>Only participants who complete the full training course should be counted. If a training course covers more than one community mobilization topic, individuals should only be counted once for that training course. If a training course is conducted in more than one session/training event, only individuals who complete the full course should be counted. Do not sum the participants for each training event.</p> <p>The USG staff responsible for compiling the annual reporting data should use the training log submitted by each USG agency and USG-funded partner reporting on this indicator in order to count the total number of individuals trained in community mobilization. Individuals trained in training courses co-funded by more than one USG agency/USG-funded partner should only be counted once within the specified reporting period (12 months for annual report).</p>

	<p>In order to avoid double counting, countries will need to monitor their activities by partner, programmatic area, and geographic area. This matrix is an excellent program management tool as well as helping to adjust for double counting by partners, among partners, and among USG agencies.</p>
<p>Interpretation/ Strengths and Weaknesses:</p>	<p>This indicator does not measure the quality of the training, nor does it measure the outcomes of the training in terms of the competencies of individuals trained, nor their job performance.</p> <p>This indicator simply measures number trained in community mobilization as opposed to the percent of organizations with trained staff.</p>

Disaggregation of Most-at-Risk Populations (MARPs) for Program-Level Indicators on Prevention/Other and Counseling and Testing

Disaggregation of Most-at-Risk Populations (MARPs) for Program-Level Indicators on Prevention/Other and Counseling and Testing

This is an example showing how the country team tracks MARPs for two *existing* Emergency Plan indicators: 1) Prevention/Other Behavior Change – number of people reached with community outreach programs, and 2) Counseling and Testing – number of clients receiving counseling and testing, will have sub-sets for the most-at-risk populations (MARPs) among males and females. For Prevention, PLWHA are also added – this category includes multiple risk groups. Other categories are mutually exclusive. “Other” includes military/uniform services, workplace employee, and mobile/migrant populations or other non-specified or low/no risk populations. This method can be adapted to the epidemiology and country context for other Emergency Plan countries.

Program level indicators

Prevention/Other Behavior Change		
Number of people reached with community outreach programs (that are NOT A or A/B focused)		
	TOTAL Male	
	PLWHA	
	IDU	
	IDU/MSM (including male SW)	
	MSM (including male SW)	
	Sex partners of PLWHA	
	Sex partners of MARPs (IDU, CSW)	
	Other	
	TOTAL Female	
	PLWHA	
	IDU	
	IDU/CSW	
	CSW	
	Sex partners of PLWHA	
	Sex partners of MARPs (IDU, MSM)	
	Other	

Counseling and Testing		
Number of clients receiving Counseling and Testing		
	TOTAL Male	
	IDU	
	IDU/MSM (including male SW)	
	MSM (including male SW)	
	Sex partners of PLWHA	
	Sex partners of MARPs (IDU, CSW)	
	Other	
	TOTAL Female	
	IDU	
	IDU/CSW	
	CSW	
	Sex partners of PLWHA	
	Sex partners of MARPs (IDU, MSM)	
	Other	

Outcome- and Impact-Level Indicators

Required (for Focus Countries) Outcome- and Impact-Level Indicators

In keeping with the Three Ones – in moving toward one harmonized M&E reporting system, outcome and impact indicators and their definitions are drawn from and align with international standards and measurement tools wherever possible and provide evidence of trends related to behavior change, health infrastructure capacity and quality, care and support, and impact of care and treatment, including morbidity and mortality.

Once per year, in the annual program results due shortly after the end of the fiscal year,

- **Focus countries are required to provide updated estimates of the outcome- and impact-level indicators for which data became available during the fiscal year.**
- **These outcome- and impact-level indicators are required for the following Mini-COP countries: Cambodia, India, Malawi, Russia, and Zimbabwe**
- **PEPFAR Other Bilateral Countries are encouraged to also report this information but are not required to do so.**

The required outcome and impact indicators are measured using a variety of data sources including population-based surveys, targeted facility surveys, sentinel surveillance systems or sero-surveys, and cohort studies. Baseline data for required indicators should have been collected by the end of fiscal year 2004 or mid-fiscal year 2005 (in focus countries). Surveillance information should be collected yearly or every other year; national population and health facility surveys every 2 to 3 years. Special studies may be desired in order to supplement existing data to address programmatic needs and to document successful models.

Indicator Type	Indicator Number	Indicator	Source/ Methodology	International Standard
Prevention				
Outcome	1	Percent of young people aged 15–24 who both correctly identify ways of preventing the sexual transmission of HIV and who reject major misconceptions about HIV transmission	Population-based survey	UNGASS, MDG
	2	Percent of never-married young people aged 15–24 who have never had sex	Population-based survey	Adapted from UNAIDS YPG
	3	Percent of never-married women and men aged 15–24 who had sex in the last 12 months, of all never-married women and men (aged 15–24) surveyed	Population-based survey	Adapted from UNAIDS

	4	Percent of women and men aged 15–49 who had sex with more than one partner in the last 12 months	Population-based survey	Adapted from UNAIDS
	5	Percent of women and men aged 15–49 who say they used a condom the last time they had sex with a non-marital, non-cohabiting partner, of those who have had sex with such a partner in the last 12 months	Population-based survey	UNAIDS, MDG, UNAIDS YPG
	6	Percent of men reporting sex with a sex worker in the last 12 months who used a condom during last paid intercourse	Population-based survey	UNAIDS
	7	Percent of blood units transfused in the last 12 months that have been adequately screened for HIV according to national or WHO guidelines	Special Study (MEASURE Evaluation blood safety protocol)	UNAIDS, GFATM
	8	Average number of medical injections per person per year	Population-based survey	WHO SIGN RARG
	9	Proportion of women and men age 15-49 reporting that the last health care injection was given with a syringe and needle set from a new, unopened package	Population-based survey	WHO SIGN RARG
Impact	10	Percent of young people aged 15–24 that are HIV-infected	Sentinel Surveillance, Sero-survey with biomarkers	Adapted from UNGASS, MDG
Prevention of Mother-to-Child Transmission				
Outcome	1	Percent of HIV-infected pregnant women receiving a complete course of antiretroviral prophylaxis to reduce the risk of MTCT	HMIS and modeling	UNGASS, GFATM
Impact	2	Percent of HIV-infected infants born to HIV-infected mothers	HMIS and modeling	UNGASS
Counseling and Testing				

Outcome	1	Percent of the general population aged 15–49 receiving HIV test results in the last 12 months	Program reports and modeling, HMIS, Population-based survey or health facility survey	Adapted from UNAIDS
Care and Treatment				
Outcome	1	Percent of people with advanced HIV infection receiving ART	Program reports and modeling, HMIS	UNGASS, GFATM
	2	Percent of health care facilities that have the capacity and conditions to provide basic-level HIV testing and HIV/AIDS clinical management	Health facility survey	UNAIDS, UNAIDS C&S
	3	Percent of health care facilities that have the capacity and conditions to provide advanced-level HIV/AIDS care and support services, including provision of ART	Health facility survey	UNAIDS, UNAIDS C&S
	4	Percent of adults aged 18–59 who have been chronically ill for 3 or more months during the past 12 months, including those ill for 3 or more months before death whose households have received, free of user charges, basic external support in caring for the chronically ill person	Population-based survey	Adapted from UNAIDS C&S
Impact	5	Percentage of people still alive at 6, 12, and 24 months after initiation of treatment	Cohort study	WHO 3x5
	6	Proportion of all deaths attributable to HIV	National mortality statistics, Sample Vital Registration with Verbal Autopsy (SAVVY)/DSS	The Emergency Plan Surveillance working group
OVC				
Outcome	1	Percent of orphans and vulnerable children under 18 living in households whose households have received, free of user charges, basic external support in caring for the child	Population-based survey	Adapted from UNAIDS, UNAIDS C&S. GFATM

Labs				
Outcome	1	Percent of designated laboratories with the capacity to monitor antiretroviral combination therapy according to national and international guidelines	Laboratory study	UNAIDS C&S
Strategic Information				
Outcome	1	Percent of health facilities with record-keeping systems for monitoring HIV/AIDS care and support	Health facility survey	UNAIDS C&S
Other: Policy and Systems Strengthening (Capacity Building)				
Outcome	1	AIDS Program Effort Index	Special Study	UNAIDS, UNGASS
	2	Percent of the general population with accepting attitudes toward PLWHA	Population-based survey	Adapted from UNAIDS

Recommended (for all countries receiving over \$1 million) Outcome- and Impact-Level Indicators

The following indicators are recommended for all countries receiving over \$1 million. Where an International Standard exists, it is indicated. Some of these indicators are appropriate at the sub-national level only, thus their exclusion from the required set of The Emergency Plan indicators. Some of the indicators have methodologies that are still under development. This is also indicated, as is the group leading the piloting or testing of the methodology.

Indicator Type	Indicator	Source/ Methodology	International Standard
Prevention			
Outcome	Percent of patients with STIs at health care facilities who are appropriately diagnosed, treated and counseled	Special study (WHO/UNAIDS revised guidelines on evaluating STI services; Measure Service Provision Assessment)	UNAIDS, GFATM
Care and Treatment			
	Percent of chronically ill persons with severe pain and symptoms who report that their pain and symptoms were controlled	Population survey	Care and Support M&E Working Group
	Percent of HIV-positive patients who are given cotrimoxazole preventive therapy	Program reports/HMIS/special study	GFATM, CDC
	Percent of clients attending HIV testing and counseling who test positive and who are screened for TB symptoms	Program reports/HMIS/special study	GFATM, WHO TB/HIV working group
	Percent of all TB patients who are tested for HIV	Program reports/HMIS/special study	GFATM, WHO TB/HIV working group
	Percent of all HIV positive TB patients who are given ART	Program reports/HMIS/special study	GFATM, WHO TB/HIV working group
Impact	Quality of life for PLWHA	Periodic special studies: Cohort study (MOS-HIV scale, SF 12, which includes both physical and mental domains) <i>(Methodology under development)</i>	Care and Support M&E Working Group/ World Bank

	AIDS-related morbidity	HMIS AIDS case reporting + modeling, SAVVY (<i>Methodology under development</i>)	The Emergency Plan Surveillance working group
OVC			
Impact	Quality of life for OVC	Periodic special studies: Cohort study (<i>Methodology under development</i>)	World Bank
Strategic Information			
Outcome	Existence of national strategic information capacity for HIV/AIDS prevention, care, and treatment programs	Record review/ special study	UNAIDS C&S
	Percent of ARV distribution nodes that report on inventory consumption, quality, losses, and adjustments on a monthly basis	HMIS/special study	WHO 3x5
Other: Policy and Systems Strengthening (Capacity Building)			
Outcome	Existence of comprehensive HIV/AIDS policies, strategies, and guidelines	Document review	UNAIDS C&S
	Percent of persons trained who: a. Demonstrate they are applying competencies/skills; b. are placed in HIV/AIDS jobs they were trained for; and c. retain HIV/AIDS jobs after one year	Special study (<i>Methodology under development</i>)	IWG HCD work group
	Percent of persons (health care workers and/or others) with accepting attitudes toward PLWHA and/or Percent of persons (general population, health care workers, and/or others) reporting personal knowledge of someone who has experienced discrimination due to known or suspected HIV status	Population-based survey, Health Facility Survey, Special Study (<i>Methodology under development</i>)	IWG Stigma and Discrimination indicators working group
	Percent of large enterprises/companies that have HIV/AIDS workplace policies and programs	Workplace survey of largest companies in country	UNGASS, GFATM

Outcome- and Impact-Level Indicators for Concentrated/Low Prevalence Epidemic Settings

The following indicators are in line with the most recent UNGASS guidance, which gave countries with concentrated or low prevalence or mixed epidemics more relevant indicators as international standards. Some of these indicators are appropriate at the sub-national level only. Countries, which have a significant proportion of their epidemic stemming from the most-at-risk populations, are encouraged to collect and report progress towards these populations at the program level as well as the outcome and impact level here.

Concentrated/Low Prevalence Epidemics			
Outcome	% (most-at-risk populations) who received HIV testing in the last 12 months and who know the results	Program monitoring/special surveys	UNGASS 2005
	% (most-at-risk populations) reached by prevention programs	Program monitoring/special surveys	UNGASS 2005
	% of (most-at-risk populations) who both correctly identify ways of preventing the sexual transmission of HIV and who reject major misconceptions about HIV transmission	Behavior surveillance surveys	UNGASS 2005
	% of female (and male) sex workers reporting the use of a condom with their most recent client	Behavior surveillance surveys	UNGASS 2005
	% of men reporting the use of a condom the last time they had anal sex with a male partner	Behavior surveillance surveys	UNGASS 2005
	% of sexually active injecting drug users who report use of a condom at last sex	Behavior surveillance surveys	UNGASS 2005
	% of injecting drug users who avoid sharing injecting equipment	Behavior surveillance surveys	UNGASS 2005
Impact	% of (most-at-risk populations) who are HIV infected	HIV surveillance	UNGASS 2005

Note: The term "most-at-risk populations" included in the above-mentioned indicators should be replaced with a defined segment of the population (e.g., sex workers, injecting drug users, men who have sex with men), which are being measured. In countries where there are multiple most-at-risk populations, the indicators should be reported for each relevant population. For more information on each of these UNGASS indicators, see UNAIDS guidance.

OUTCOME- AND IMPACT-LEVEL INDICATOR DEFINITIONS

Prevention 1

Percent of never married young men and women aged 15–24 who have never had sex	
Rationale/What It Measures:	This indicator is Part 1 of a composite ABC indicator that provides information on important aspects of sexual behavior. This particular indicator describes the proportion of never married young people surveyed who have never had sex, thus the prevalence of virginity among young people. Looking at this prevalence within narrow age ranges (15–16, 17–18, 19–20, 21–22, and 23–24, for example, or better yet, in single ages) across time allows program managers to see if the age at first sex is moving.
Definition:	Percent of never married young women and men aged 15–24 who have never had sex
Measurement Tool:	Population-based surveys such as DHS/AIS, RHS
Numerator:	Number of never married young women and men who have never had sex
Denominator:	Number of never married young women and men aged 15–24 surveyed
How To Measure It:	<p>Respondents (15–24 year olds) are asked if they have ever had sex.</p> <p>The indicator should be reported separately for men and women.</p> <p>If the indicator is calculated for groupings of ages that are broader than the period of time that has passed, the indicator will not be able to reflect changes that may in fact be occurring. It is therefore recommended that this indicator be reported by single age.</p>
Frequency:	Baseline, then every 2-3 years
Interpretation/Strengths and Weaknesses:	<p>Abstinence from sex, being faithful to one partner, and using condoms are the ways of preventing HIV infection that form the central message of USG programs. This indicator describes the extent to which abstinence is practiced among youth.</p> <p>In some settings, the proportion of those aged 20–24 who are never married will be very low, at least among women, and it may not be appropriate to construct the indicator for this age group in these cases.</p> <p>The other parts of the ABC composite should be considered as additional indicators as the composite shows movement of youth among the different behaviors if collected across time. Considering all six aspects of behavior together makes sense, as each component affects the other and each component is of progressively riskier behavior.</p>
Reference(s):	Adapted from UNAIDS Young People's Guide (2004) Behavioral Indicator 3

Prevention 2

Percent of women and men aged 15–49 who had sex with more than one partner in the last 12 months	
Rationale/What It Measures:	Prevention messages should focus on abstinence and also on mutual monogamy. But because sexual relationships among young people are frequently unstable, relationships that were intended to be mutually monogamous may break up and be replaced by other relationships in which similar intentions prevail. Particularly in high HIV prevalence epidemics, serial monogamy is not greatly protective against HIV infection. This indicator measures the proportion of people that have been exposed to more than one partner in the last year.
Definition:	Percent of women and men aged 15–49 who have had sex with more than one partner in the last 12 months, of all people surveyed aged 15–49 surveyed who report being sexually active in the last 12 months
Measurement Tool:	Population-based surveys such as UNAIDS general population survey, DHS/AIS, BSS (youth), RHS
Numerator:	Number of women and men aged 15–49 who have had sexual intercourse with more than one partner in the last 12 months
Denominator:	Number of women and men aged 15–49, who report being sexually active in last 12 months
How To Measure It:	<p>In a survey among people aged 15–49, respondents are asked about their sexual partnerships in the last year.</p> <p>The indicator should be reported separately for men and women. It should also be constructed separately for those aged 15–19, and 20–24, 15–24, and 15–49 if sample size allows.</p> <p>To cope with the measurement challenge posed by men in polygamous societies, who may have multiple partners within marriage, it is necessary to disaggregate this indicator by marital status including polygamy. Furthermore, given that the likelihood of HIV transmission during recent (acute) infection may be a order of magnitude greater than during chronic infection, it may be desirable to conduct further analyses to assess the percentage of sexually active individuals who had two or more partners during the previous two months. Quantifying the prevalence of overlapping or concurrent partnerships may provide a useful proxy for quantifying possible exposures to HIV during the period of acute infection.</p>
Frequency:	Baseline, then every 2-3 years
Interpretation/Strengths and Weaknesses:	This indicator tracks all multiple partnerships, regardless of their relative levels of risk. It does not distinguish between marital and non-marital partners, nor does it account for hypothetical increases in HIV transmission risk associated with concurrent partnerships vs. serial monogamy. The indicator also suffers from the expected respondent and social desirability bias. For people saturated with prevention messages, there will be high motivation to under-report partners. Likewise, social pressure for women to give untruthful answers may be strong.
Reference(s):	Adapted from UNAIDS (2000) Young People's Sexual Behavior Indicator 4

Prevention 3

Percent of women and men aged 15–49 who say they used a condom the last time they had sex with a non-marital, non-cohabiting partner, of those who have had sex with such a partner in the last 12 months

Rationale/What It Measures:	If everyone used a condom every time they had sex with a non-marital or non-cohabiting partner, a heterosexually transmitted HIV epidemic would be almost impossible to sustain. While AIDS programs may try to reduce casual partnerships, they must also, if they are to succeed in curbing the epidemic, promote condom use in the casual partnerships that remain. This indicator tracks changes in condom use in these partnerships.
Definition:	Percent of women and men aged 15-49 who say they used a condom the last time they had sex with a non-marital, non-cohabiting partner, of those who have had sex with such a partner in the last 12 months
Measurement Tool:	Population-based surveys such as UNAIDS general population survey, DHS/AIS, BSS (adult), RHS
Numerator:	Number of those women and men in the denominator who used a condom the last time they had sex with their <i>most recent</i> non-marital, non-cohabiting partner
Denominator:	Number of women and men aged 15–49 who report at least one non-marital, non-cohabiting partner in the last 12 months
How To Measure It:	For each partner listed in the last 12 months, respondents are asked whether they used a condom the last time the couple had sex. Other questions will allow for the classification of partnerships as non-marital and non-cohabiting. The indicator should be reported separately for men and women. It should also be constructed separately for those aged 15–24 and 15–49.
Frequency:	Baseline, then every 2-3 years
Interpretation/Strengths and Weaknesses:	A rise in this indicator is an extremely powerful indication that condom promotion campaigns are having the desired effect among those high-risk individuals with multiple partners. Since condom promotion campaigns aim for consistent use of condoms with non-regular partners rather than simply occasional use, some surveys have tried to ask directly about consistent use, often using an always/sometimes/never question. While this may be useful in sub-population surveys, it is subject to recall bias and other biases and is not sufficiently robust for use in a general population survey. Asking about the most recent act of non-marital, non-cohabiting sex minimizes recall bias and gives a good cross-sectional picture of levels of condom use. It is recognized that consistent use of condoms is an important goal. But inevitably, if consistent use rises, this indicator will also rise. An increase over time of this indicator does not necessarily mean an increase in “safe sex” practices; the percentage of non-marital, non-cohabiting partners may be decreasing. This indicator should be analyzed in combination with an estimate of the percentage of respondents having sex with a non-marital, non-cohabiting partner.
Reference(s):	UNAIDS (2000) Sexual Behavior Indicator 2; MDG HIV/AIDS Indicator 19a; Adapted from UNAIDS Young People’s Guide (2004) Behavioral Indicator 2, denominator is UNAIDS (2000) Sexual Behavior Indicator 1

Prevention 4

Percent of young people aged 15–24 that are HIV-infected	
Rationale/What It Measures:	<p>The ultimate goal in the fight against HIV/AIDS is to eradicate HIV infection. As the highest rates of new HIV infections typically occur among young adults, more than 180 countries have committed themselves to achieving major reductions in HIV prevalence among young people. .</p> <p>This indicator allows assessment of progress toward eradicating HIV infection</p>
Definition:	Percent of young people aged 15–24 that are HIV-infected
Measurement Tool:	<p>1. <i>HIV sentinel surveillance</i>: it is recommended that this indicator is measured through use of existing ANC-based sentinel surveillance data (15-24 year old pregnant women) and epidemiologic models (EPP). WHO guidelines.</p> <p>2. <i>General Population Survey</i>: Where feasible, the indicator should be periodically measured <u>directly</u> through serological survey of the general population (women and men age 15-24), during DHS-type or AIS-type surveys. This allows sex-specific, age-specific estimates to be produced.</p> <p>NOTE: Numerator and denominator definitions below refer to the direct measurement approach (see below).</p>
Numerator:	Number of persons age 15-24 who tested positive for HIV
Denominator:	Number of persons age 15–24 tested for their HIV infection status
How To Measure It:	<p><i>Sentinel Surveillance and Modeling</i>: This indicator is calculated using data from pregnant women attending ANC in HIV sentinel surveillance sites in the capital city, other urban areas, and rural areas. Aggregated national estimates of age-specific trends in HIV prevalence are obtained through epidemiologic modeling (EPP). Details on EPP methods can be found on the UNAIDS website.</p> <p><i>Direct estimation</i>: HIV tests are performed on a probability sample of women and men in the reference age group, during a DHS-type or AIS-type general population survey.</p> <p>Indicator estimates should be given for the whole age range (15–24 years). Should direct estimates be available (i.e. from general population survey), male and female estimates should be given separately. Because of the different methodologies used, estimates obtained from ANC sentinel surveillance and those from general population surveys could not be directly combined to ascertain trends. However, EPP modeling methods have been refined for sub-Saharan Africa to reflect findings of populations based surveys. Guidelines on how to analyze and interpret ANC sentinel surveillance along with population based survey scan also be found on the UNAIDS website.</p>
Frequency:	Annual or every 2 years

<p>Interpretation/ Strengths and Weaknesses:</p>	<p>HIV prevalence at any given age is the difference between the cumulative numbers of people who have become infected with HIV up to this age and the number who died, expressed as a percentage of the total number alive at this age. At older ages, changes in HIV prevalence are slow to reflect changes in the rate of new infections (HIV incidence) because the average duration of infection is long. Furthermore, declines in HIV prevalence can reflect saturation of infection among those individuals most vulnerable and rising mortality rather than behavioral change. To truly measure incidence, one would need to have cohort studies in place that follow persons over time and measure HIV seroconversion rates. However, these cohorts require extensive resources. Therefore, young age is chosen as a surrogate for incident infections. At young ages, trends in HIV prevalence are a better indication of recent trends in HIV incidence and risk behavior. Thus, reductions in HIV incidence associated with genuine behavioral change may first become detectable in HIV prevalence figures for the age group. Where available, parallel behavioral surveillance survey (BSS) data should be used to aid interpretation of trends in HIV prevalence.</p> <p>In countries where first sexual intercourse occurs at an older age and/or levels of contraception are high, HIV prevalence among pregnant 15–24-year-old women will differ from that among all women in the age group.</p> <p>This indicator gives a fairly good estimate of relatively recent trends in HIV infection in locations where the epidemic is heterosexually driven. It is less reliable as an indicator of HIV epidemic trends in locations where most infections remain temporarily confined to sub-populations with high-risk behaviors.</p>
<p>Reference(s):</p>	<p>UNGASS (2003) Impact Indicator 1; MGD Indicator 18 (Targets: 2005 – 25% reduction; 2010 – 50% reduction)</p>

Counseling and Testing 1

Percent of the general population aged 15–49 receiving HIV test results in the last 12 months

Rationale/What It Measures:	<p>HIV testing and counseling are important entry points for prevention and care needs. Measuring the number of people who access these services is therefore important to indicate the number of people who could potentially benefit from prevention and care. In addition, over time this indicator provides information on the number of new people tested.</p> <p>This indicator is designed to show how many people have been tested and received their results in the last 12 months. This indicator can be used as a proxy for the coverage of HIV counseling and testing services. Estimates of coverage of counseling and testing services help to determine whether those services are achieving their threefold aims of providing an entry point for care and support, promoting safe behavior, and breaking the cycle of silence and stigma.</p> <p>This indicator aims to give an idea of the reach of HIV testing services in the general population and of the percentage of people who now know their HIV status. It can also be constructed for specific sub-populations with high-risk behavior among whom counseling and testing services are being promoted.</p>
Definition:	Percentage of women and men aged 15–49 who have been tested for HIV in the last 12 months and received their test results the last time they were tested
Measurement Tool:	Ideally, these data would be collected regularly and aggregated at the national level through a strong health management information system, but this may not yet be possible in all settings. Alternative methods for collecting this information include health facility surveys and population-based surveys such as the UNAIDS general population survey; DHS/AIS; and/or BSS (adult and youth).
Numerator:	Number of women and men aged 15–49 who report receiving HIV test results in the last 12 months
Denominator:	Number of women and men aged 15–49 surveyed
How To Measure It:	<p>In a general population or sub-population survey, respondents are asked whether they were tested in the last 12 months, and, if so, whether they have received the results.</p> <p>The questionnaire prefaces the questions by saying, “I do not want to know the results of the test...”, in an attempt to minimize stigma-based fear of answering the questions truthfully.</p> <p>The indicator needs to be stratified by how these services are delivered. Distinguishing how counseling and testing are provided is important to service delivery. In general, three service delivery methods should be considered: stand-alone or free-standing voluntary counseling and testing sites; counseling and testing units within health facilities to which people are referred (from tuberculosis, family planning and other health units, for example); and fully integrated counseling and testing services in which a provider can refer the person to a laboratory for a test, but the provider carries out the counseling.</p> <p>Age should also be stratified to determine what age ranges are accessing and receiving these services. The age ranges could be: 15–24, 25–34 and 35–49 years.</p>

	The indicator should be reported separately for men and women.
Frequency:	Baseline, then every 2-3 years
Interpretation/ Strengths and Weaknesses:	<p>Because testing and counseling services are often not performed within discrete units (that is, outpatient or inpatient departments) or departments, reports can potentially be duplicated for the same individual being tested in multiple units or those being tested multiple times during the 12-month period. In other cases, such as preventing the mother-to-child transmission of HIV and other HIV testing and counseling, services are performed in the same place. This too will lead to double reporting in the number of people tested. In addition, because of these various points of HIV testing and counseling services, linking testing to counseling through facility records may be difficult in some situations unless a strong records system is in place to track testing and counseling.</p> <p>If a household survey is used, double counting can be minimized.</p> <p>In areas where HIV is highly stigmatized, respondents may be unwilling even to admit to having taken an HIV test, since it may be counted an admission that they fear they may be infected. This is all the more true when the question is posed in the context of a questionnaire about risk behavior. On the other hand, in countries where testing has been heavily promoted as a “responsible” thing to do, some people may say they have been tested when in fact they have not. Despite these potential biases, the indicator is useful for getting a rough idea of the proportion of people likely to know their HIV status at all. Because the indicator is constructed to capture the percentage of respondents receiving an HIV test and receiving results <i>in the last 12 months</i>, the measure will reflect recent changes in testing services. Those people at higher risk for HIV should be targeted for repeat testing. Note, however, that in high-prevalence populations with good coverage of testing services, trends in the time-bound indicator can be expected to be affected by the fact that people who have tested HIV positive will not return for further testing in future years.</p> <p>A breakdown of the indicator into its component parts (looking, for example, at people who received a test but never received their results) can point to gaps in program service provision and quality of care. Data on those who do not return for results or know their results may offer insight, for example, into levels of stigma and/or reluctance to learn their HIV status based on lack of available options for care.</p> <p>Due to the difficulty in defining post-counseling and ethical issues in asking questions on post-counseling associated with HIV+ status, no information on post-counseling should be collected through population surveys. Additional information on post-test counseling should be collected through alternative methodologies such as facility-based surveys.</p> <p>At the local level, program managers may be interested in collecting additional information, such as the number of people tested and counseled, the number receiving their results of those tested, and the number found to be HIV positive of those tested.</p> <p>It should be noted that this indicator is most useful for tracking the scale-up of counseling and testing services. For</p>

	individuals who tested positive beyond the past 12 months, this indicator does not reflect the fact that they would not need to be re-tested every year. Thus, this indicator will not reflect on the numbers who know their status, but simply those tested in the last year.
Reference(s):	Adapted from UNAIDS (2000) Voluntary Counseling and Testing Indicator 1; and WHO/UNAIDS Care & Support Guide (2004) Indicator CS1

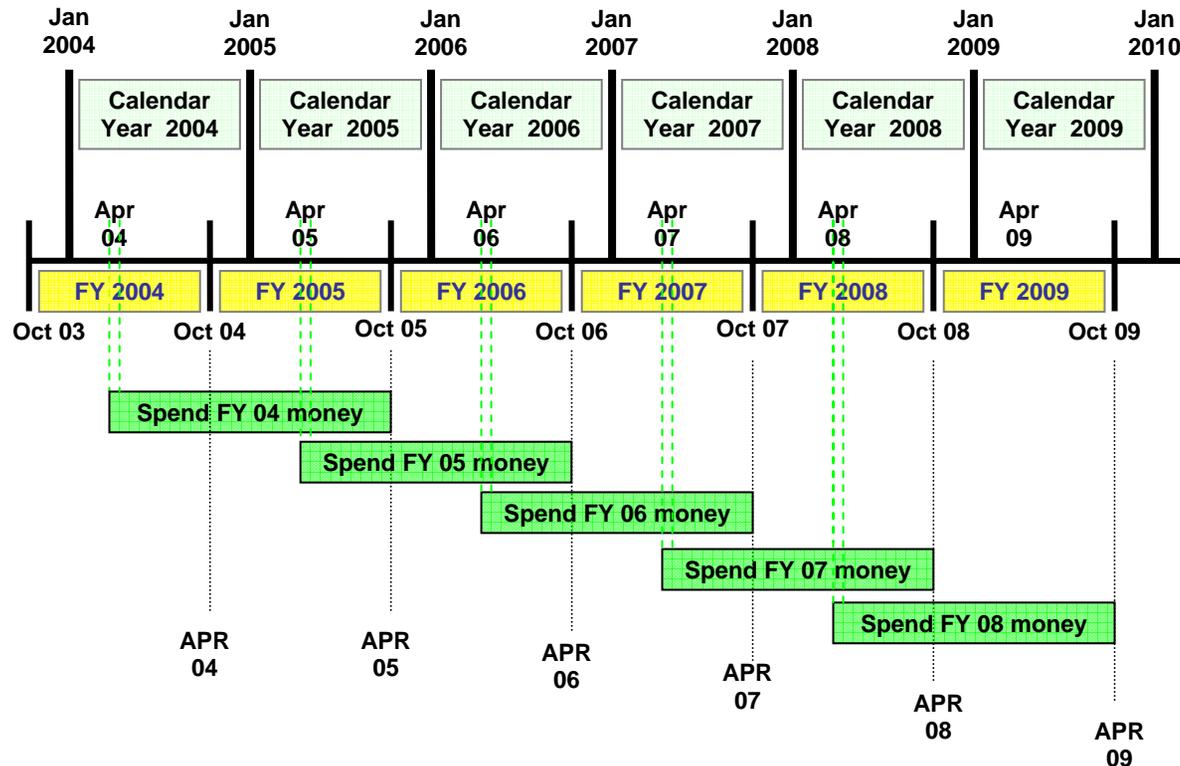
Appendix 1: In-country Collaboration Tables

Agency Name	Description of Collaboration
USG agencies (USAID, NASDAD, US Embassy, Peace Corps, CDC, HRSA, DOD, etc.)	
[Add rows as needed]	
Host Country agencies (MOH, NAP, NAC, district/local health units, NGOs, etc.)	
[Add rows as needed]	
Multi-lateral agencies (GFATM, UNAIDS, WHO, UNICEF, UNDP, WFP, World Bank, etc.)	
[Add rows as needed]	
Other bilateral agencies (GTZ, EU, DANIDA, CIDA, AusAID, DFiD, Gates Foundation, etc.)	
[Add rows as needed]	
Other (CARE, MSF, PSI, etc.)	
[Add rows as needed]	

Appendix 2: Reporting Cycle

Typically, Fiscal Year funding is not obligated to partners until late in the Fiscal Year, and therefore activities paid for with one Fiscal Year funding will often extend into the next Fiscal Year. For any program area target, it is expected that the target will be achieved in a 12-month window ending no later than September 30 of the next fiscal year. For example, due to delays in appropriations, establishment of mechanism or approval of funding levels through country bureaucracy, FY 2007 funds for a given partner may not be provided to the partner until July 30, 2007. In this case the partner has from July 30, 2007 to July 29, 2008 to achieve the proposed target. This 12-month window ends before the end of FY 2008 (September 30, 2008).

The graphic below shows the reporting schedules against the calendar and fiscal years.



APR=Annual Progress Report

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ACRONYMS AND ABBREVIATIONS

AIDS	acquired immunodeficiency syndrome
AIS	AIDS Indicator Survey
ANC	antenatal care
API	AIDS Program Effort Index
ART	antiretroviral therapy
ARV	antiretroviral (drug)
BCC	behavior change communication
BSS	behavioral surveillance survey
BUCEN	United States Bureau of the Census
CS, C&S	care and support; UNAIDS document: <i>National AIDS Programmes: A Guide to Monitoring and Evaluating HIV/AIDS Care and Support</i> (see References)
CDC	Centers for Disease Control and Prevention
COP	Country Operational Plan
CRIS+	Country Reporting Information System Plus
CSW	commercial sex worker
DHS	Demographic and Health Survey
DOD	United States Department of Defense
DSS	Demographic Surveillance System
EPP	Estimate and Projection Package
GFATM	Global Fund to Fight AIDS, Tuberculosis and Malaria; <i>Monitoring and Evaluation Toolkit: HIV/AIDS, Tuberculosis, and Malaria</i> (see references)
HCD	human capacity development
HHS	Health and Human Services
HIV	human immunodeficiency virus
HMIS	health management information system(s)
HMN	Health Metrics Network (WHO)
HRSA	Health Resources and Services Administration
IDU	injecting drug user
IEC	information, education, communication
IPC	International Programs Center (BUCEN)
IWG	Implementation Working Group (USAID HIV/AIDS Coordination)
M&E	monitoring and evaluation
MDG	Millennium Development Goals

MICS	Multiple Indicator Cluster Survey
MIS	management information system(s)
MOS	Medical Outcome Survey
MSM	men who have sex with men
NAC	National AIDS Councils
OGAC	Office of the Global AIDS Coordinator
OI	opportunistic infection
OVC	orphans and vulnerable children
PDB	Programmatic Database (The Synergy Project)
PLWHA	people living with HIV/AIDS
PMTCT	prevention of mother-to-child transmission
PMTCT+	prevention of mother-to-child transmission plus treatment
RARG	<i>WHO Injection Practices: Rapid Assessment and Response Guide</i> (see references)
RHS	Reproductive Health Survey
SAVVY	Sample Vital Registration through Verbal Autopsy
SI	Strategic Information
SIGN	Safe Injection Global Network
STI	sexually transmitted infection
TB	tuberculosis
UNAIDS	Joint United Nations AIDS Programme; UNAIDS document: <i>National AIDS Programmes: A Guide to Monitoring and Evaluation</i> . (see references)
UNGASS	United Nations General Assembly Special Session on HIV/AIDS
USAID	United States Agency for International Development
USG	United States Government
VA	verbal autopsy
VCT	voluntary counseling and testing
WHO	World Health Organization
YPG	UNAIDS document: <i>Guide to Monitoring and Evaluating National HIV/AIDS Programmes for Young People</i> (see References)