



Monitoring and evaluation indicators for MSM HIV prevention and care services in Thailand



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Table of Contents

Acknowledgements	4
Acronyms	5
Introduction.....	6
What do we mean by MSM?.....	7
Intervention types	7
Intervention types and their definitions	8
Indicator summary	15
Indicator definitions.....	21
Core Indicators.....	21
<i>Core indicator 1 (C1): # of individuals reached through intensive or casual, individual and/or small group level HIV interventions</i>	<i>21</i>
<i>Core indicator 2 (C2): # of HIV positive MSM reached with a minimum package of positive health, dignity and prevention service [also called prevention with positives (PwP)] interventions.....</i>	<i>23</i>
<i>Core indicator 3 (C3): # of individuals who received counseling and testing for HIV and received their test results.....</i>	<i>24</i>
<i>Core indicator 4 (C4): % of individuals tested that received their results.....</i>	<i>25</i>
<i>Core indicator 5 (C5): # of individuals who were diagnosed for a STI.....</i>	<i>27</i>
<i>Core indicator 6 (C6): # of individuals that were treated for a STI.....</i>	<i>27</i>
<i>Core indicator 7 (C7): # of HIV positive individuals that received a CD4 test</i>	<i>29</i>
<i>Core indicator 8 (C8): # of individuals trained.....</i>	<i>30</i>
Additional Indicators.....	32
<i>Additional indicator 1 (A1): # of contacts (new and old).....</i>	<i>32</i>
<i>Additional indicator 2 (A2): Average number of contacts per individual reached</i>	<i>32</i>
<i>Additional indicator 3 (A3): # of condoms distributed.....</i>	<i>33</i>
<i>Additional indicator 4 (A4): # of lubricant packets distributed</i>	<i>35</i>
<i>Additional indicator 5 (A5): # of condom targeted outlets.....</i>	<i>36</i>
<i>Additional indicator 6 (A6): # of health promotion materials distributed</i>	<i>37</i>
<i>Additional indicator 7 (A7): % of referrals taken up by individuals provided with referrals.....</i>	<i>39</i>
<i>Additional indicator 8 (A8): # of individuals attending skills building classes.....</i>	<i>40</i>
<i>Additional indicator 9 (A9): # of skills building sessions held.....</i>	<i>41</i>
<i>Additional indicator 10 (A10): # of service outlets providing HIV counseling and testing according to national standards</i>	<i>41</i>
<i>Additional indicator 11 (A11): # of HIV positive clients who received assistance from program staff to access care and support services</i>	<i>43</i>
<i>Additional indicator 12 (A12): # of organizations working on HIV prevention, care and support within the community.....</i>	<i>43</i>
<i>Additional indicator 13 (A13): # of organizations provided with technical assistance</i>	<i>44</i>
Evaluation Indicators	46
<i>Evaluation indicator 1 (E1): % of MSM reached by HIV prevention programs.....</i>	<i>46</i>
<i>Evaluation indicator 2 (E2): % of MSM who both correctly identify ways of preventing the sexual transmission of HIV and who reject major misconceptions about HIV transmission</i>	<i>46</i>
<i>Evaluation indicator 3 (E3): % of MSM reporting receiving targeted media through TV, radio or other media channels.....</i>	<i>48</i>

<i>Evaluation indicator 4 (E4): % of MSM reporting the use of a condom the last time they had anal sex with a male partner</i>	49
<i>Evaluation indicator 5 (E5): % of male sex workers reporting the use of a condom with their most recent client</i>	50
<i>Evaluation indicator 6 (E6): % of MSM who received an HIV test in the last 12 months and who know their results</i>	51
<i>Evaluation indicator 7 (E7): % of MSM who are HIV infected</i>	52
<i>Evaluation indicator 8 (E8): % of staff trained in implementing HIV prevention activities</i>	53
<i>Evaluation indicator 9 (E9): % of organizations providing the basic package of community services (prevention, care and support)</i>	53
Counting people	55
Qualitative approaches	55
Further reading	56

Acknowledgements

This guide results from the efforts of many organizations who acknowledge the need for harmonization and who have come together to jointly develop and agree upon a core set of indicators and their definition for MSM interventions.

FHI coordinated the development of this guide with significant inputs from the Technical Working Group (TWG) on Harmonized M&E Guidelines for MSM Interventions in Thailand. This TWG is made up of community-based organizations, government organizations and international agencies and include: Service Workers in Group Foundation (SWING), Rainbow Sky Association of Thailand (RSAT), Thailand Ministry of Public Health, the U.S. Centers for Disease Control and prevention (CDC), the United States Agency for International Development (USAID) and Pact, Thailand.

A special thank you to Jittinee (Jane) Khienvichit who provided valuable inputs throughout the process and translated the documented into Thai to assure all partners could understand and comment on its contents. Additional technical and conceptual inputs were provided by Yupin Chinsanguankiat, Philippe Girault Surang Janyam, Siroat Jittjang, Usanee Kritsanavarin, Danai Linjongrat, Chomnad Manopaiboon, Panus NaNakorn, Shanthi Noriega Minichiello, Jamrong Pangnongyang, Patchara Rumakom, Supol Singhapoom, Amporn Srisamrual, Chatwut Wangwon, and participants of the indicator training sessions held in Bangkok.

Funding for this work was provided through the United States Agency for International Development (USAID). Cover photographs courtesy of FHI, Indonesia.

Acronyms

AIDS	Acquired Immune Deficiency Syndrome
ART	Antiretroviral therapy
DIC	Drop-in center
FHI	Family Health International
FP	Family planning
GFATM	Global Fund to Fight AIDS, TB and Malaria
HIV	Human Immune Deficiency Virus
HCT	HIV counseling and testing
MSM	Men who have sex with men
NHSO	National Health Security Office
NGO	Non-governmental organization
OI	Opportunistic infection
OVC	Orphans and vulnerable children
PLHIV	People living with HIV
PMTCT	Prevention of mother to child transmission (of HIV)
PwP	Prevention with positives
QA	Quality assurance
RH	Reproductive health
STI	Sexually transmitted infection
TB	Tuberculosis
TWG	Technical working group
UNGASS	United Nations Special Session (on AIDS)
USG	United States Government
USAID	United States Agency for International Development
WHO	World Health Organization

Introduction

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

Many organizations have mobilized to continue and strengthen prevention and care efforts among MSM but to date much of the information resulting from these efforts is fragmented and uncoordinated limiting the ability to compare efforts and assess overall outputs and outcomes. Realizing the need to strengthen and scale up the response, USAID requested Family Health International (FHI) to spearhead an effort to harmonize monitoring and evaluation indicators for MSM programs in Thailand.

Initially national and local level organizations working with MSM were identified and brought together to document the wide range of activities being undertaken, discuss current practices in M&E, and identify gaps in information being collected. It quickly became apparent there was a significant need to: (1) document and develop comprehensive, clear guidance on monitoring processes, (2) harmonize definitions related to the target population and the activity areas and, (3) rationalize data collection around a core set of defined indicators. By addressing these issues it is hoped that this guide can contribute towards improved data quality, interpretation and use for program strengthening.

A technical working group (TWG) and led by Family Health International's Asia Pacific Regional Office (APRO) to carry this work forward. Members include representatives from organizations involved in MSM programming. These are: Service Workers in Group Foundation (SWING), Rainbow Sky Association of Thailand (RSAT), Thailand Ministry of Public Health, the U.S. Centers for Disease Control and Prevention (CDC), the United States Agency for International Development (USAID), and Pact Thailand

This guide results from the work of this group; it outlines the framework for intervention types, provides a list of commonly agreed upon core indicators and their definitions, and provides information on additional indicators to be used depending on data needs and planned evaluation efforts.

This guide should be considered a "living" document which will be updated with relevant international, national, and local experience. The TWG is aware, for example, of recent UNAIDS efforts to classify and define MSM interventions; as these become better defined the TWG will revisit the categorizations and definitions presented here in order to assure alignment and minimize confusion.

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

What do we mean by MSM?

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

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

“Men who have sex with men” (MSM) is an inclusive public health term used to define the sexual behaviors of males having sex with other males, regardless of gender identity, motivation for engaging in sex or identification with any or no particular ‘community’. The words ‘man’ and ‘sex’ are interpreted differently in diverse cultures and societies as well as by the individuals involved. As a result, the term MSM covers a large variety of settings and contexts in which male to male sex takes place².

Intervention types

Intervention implementation should be evidence based, and while limited work has been carried out in Asia to determine what combination of interventions are most effective amongst MSM, there is evidence from Western countries to indicate that most effective interventions fit broadly into one of eight types listed below³:

- Individual-level interventions
- Group-level interventions
- Peer outreach
- Comprehensive risk counseling and services
- Partner counseling and referral
- Health communication/ public information
- Care and treatment (C&T)⁴ and referral
- Community-level interventions

² Source: Asia Pacific Coalition on Male Sexual Health (APCOM). <http://www.msmasia.org/> (accessed 08/04/09)

³ CDC (2007). Compendium of HIV Prevention Interventions with Evidence of Effectiveness

⁴ A note on treatment: treatment for HIV infection is a critical intervention that aims to reduce mortality and morbidity among HIV positive individuals. However, this guide does not include treatment-specific indicators; in-depth guidance on treatment and its related indicators are clearly defined in other documents (see the further reading section of this guide).

The TWG used this list as a framework, and made slight adaptations to reflect the scope of work being carried out. Activities such as peer outreach and partner counseling and referral are integrated into a wide range of activities and are therefore not addressed individually in this guide. The TWG also included a category for “STI clinical management” as this is an important activity being carried out by several organizations in Thailand.

The TWG also agreed that the intensity of interventions is an important factor to be taken into consideration. The group agreed that intensity can be looked at in two ways:

1. By the **content** of an intervention
2. By the **range of interventions** an individual is exposed to

This document attempts to measure intensity in terms of the content of an intervention, and some of the activities have been disaggregated into “intense” and “casual” in an effort to make this distinction clear. Activity examples based on current programs implemented by the community-based organizations (CBOs) in Thailand were identified and are presented under the definition of interventions types in order to make the difference between “intense” and “casual” clear to users.

Intervention types and their definitions

Intensive individual interventions

Definition: These are one-to-one interventions that include:

- health education (information on HIV transmission and prevention, for example),
- assistance in carrying out self risk assessments,
- risk-reduction counseling,
- condom, lubricant, and/or educational material distribution; also includes distribution of sexual responsibility kits (condom, lubricant and educational materials), **and**
- referrals to community and clinical services

These are one-to-one interventions that focus on **skills building** by helping clients in making plans for individual behavior change and ongoing assessments of their own behavior. These interventions also make linkages to services in both clinics and the community setting by providing referrals. These interventions last more than a few minutes (i.e., longer than 10 minutes) and the client is actively engaged (they are asking questions, contributing inputs and actively listening).

The decision process below may assist in making a decision about whether or not an individual intervention should be considered “intensive”:

IF the intervention:

- Involves clients in active discussion and participation (versus simply listening)

- **AND** builds skills or capacity, versus simply providing information
- **AND** lasts more than just a few minutes
- **AND** is carried out in a one-to-one basis

⇒ **THEN** it is considered an intensive individual intervention.

Activity examples:

- In-person (such as face to face) counseling
- One-to-one discussions during home visits
- One-to-one hotline counseling
- One-to-one internet counseling (this includes counseling provided using “chat”)
- Outreach in the community involving one-to-one discussions around specific topics

The above activities meet the definition for intensive individual interventions and include referral to health services such as STI and HCT.

Note: Intensive individual interventions usually **do not include** counseling that is carried out as part of HIV antibody testing. This type of counseling is covered under HCT interventions which include pre-test counseling, testing, and post-test counseling. However, some organizations may only provide pre-test counseling and do not provide testing, or post-test counseling. If this is the case, the pre-test counseling provided should be considered intensive individual interventions.

Casual individual interventions

Definition: These are one-to-one interventions that include:

- health education (information on HIV transmission and prevention, for example), **and/or**
- condom, lubricant, and/or educational material distribution; also includes distribution of sexual responsibility kits (condom, lubricant and educational materials)

These are one-to-one interventions which are often delivered by peer educators and opinion leaders. These interventions are likely to last only a few minutes (5-10 minutes) and focus on distributing basic prevention information and related commodities (condoms, lubricant and IEC materials). These interventions are also used as opportunities to build trust between MSM and program staff which can serve as a basis to develop a longer term relationship resulting in opportunities to provide more interventions.

The decision process below may assist in making a decision about whether or not an individual intervention should be considered “casual”:

IF the intervention:

- Focuses only on providing information and/or distributing condoms, lubricants and educational materials without active engagement and

- participation from participants (for example, they are mostly just listening)
- **AND** lasts just a few minutes
- **AND** is carried out in a one-to-one basis

⇒ **THEN** it is considered a casual individual intervention.

Note: In some cases, you may start talking with a client thinking it will be a casual intervention but the client then begins to ask questions. You may then begin talking more in-depth about specific topics and spending a lot of time discussing with the client. In these cases, the intervention can become an intensive individual intervention.

Activity examples:

Peer outreach that provides prevention messages at places where the target population meet such as bars, sauna, and massage parlors together with:

- Condom distribution
- Lubricant distribution
- Educational material (IEC) distribution
- Radio hotlines that include calling in for general questions and answers

Intensive group interventions

Definition: These are interventions that include a group (more than 2 people) of MSM or service providers (including paid and volunteer) and provide:

- health education (information on HIV transmission and prevention, for example),
- assistance in carrying out self risk assessment,
- risk-reduction counseling, **and**
- referrals to community and clinical services

These are provided to target population groups or program staff of up to 25 individuals at a time and which help clients in making plans for individual behavior change and ongoing assessments of their own risk behaviors. These interventions also make linkages to services in both clinics and the community setting by providing referrals. Such interventions use peer and non-peer models involving a wide range of skills, information, education, and support; they **must contain skills building**. Such interventions are likely to last more than a few minutes (i.e., longer than 1 hour) or even have multiple sessions and participants are actively engaged.

If an intensive group intervention includes more than 25 individuals, then the number of intensive group interventions reported should be split. For example, if there is a group intervention that includes 35 participants, these should be reported as 2 group interventions (one with 25 individuals participating and a second with 15 individuals participating). Reporting forms should include a space where it is specified that these interventions occurred at the same time and in the same venue.

Please note: These interventions **do not include** group education sessions that lack a **skills building component**. Group education sessions that aim to only provide

information on HIV prevention and distribute commodities (condoms, lubricants and IEC materials, for example) are considered “Casual group” interventions when they are targeted to MSM. If participants are mostly general population, then these should be considered as “Health communications/public information” interventions (see below).

Activity examples:

Client/beneficiary activities:

- Thematic session for MSM (with intensive group education/discussion), such as movie nights and “Coming Out from the Closet” sessions
- MSM specific workshops in venues (with intensive group education and discussion)
- MSM support group meetings
- MSM skills building workshops (must be HIV prevention related skills) around, for example:
 - Communication skills
 - Negotiation skills
 - Coming out skills
 - Disclosure skills

Provider activities (these are specific to program personnel and includes paid and volunteer staff):

- Peer leader camps
- Peer leader trainings
- HIV education and sensitivity training for health care and NGO staff

Casual group interventions

Definition: These are interventions that include a group (more than 2 people) of MSM and provide:

- health education (information on HIV transmission and prevention, for example), **and/or**
- condom, lubricant, and/or educational material distribution; also includes distribution of sexual responsibility kits (condom, lubricant and educational materials)

These are provided to target population groups of up to 25 individuals at a time. Such interventions are likely to last only a few minutes and the clients are **not** actively engaged; they may only be listening, and can ask a few questions but these are more general and not focused on individual risk. These are usually “one-off” interventions and do not include a skills building component.

If a casual group intervention includes **more than 25 individuals**, then the number of casual group interventions reported should be split. For example, if there is a group intervention that includes 35 participants, these should be reported as 2 group interventions (one with 25 individuals participating and a second with 15 individuals participating). Reporting forms should include a space where it is specified that these

interventions occurred at the same time and in the same venue.

Activity examples

- Mobile activities or edutainment to targeted hot spots where MSM meet (i.e., health corners)
- MSM movie night with informal health education and/or distribution of commodities (condoms and lubricants as well as IEC materials)
- Thematic sessions for MSM (awareness raising, HIV prevention education, for example) in bars, schools, the workplace and communities on HIV prevention
- Peer outreach to small MSM groups in the community focused on providing basic information and/or distributing condoms, lubricant and health education materials
- MSM community-wide events: festivals and parades, condom fashion shows, “Miss Rainbow Sky”, health corners and exhibitions aimed at MSM

HIV Counseling and Testing (HCT) interventions

Definition: These are individualized interventions that are made up of four separate activities:

- (1) pre-test counseling,
- (2) HIV antibody testing, and
- (3) post-test counseling
- (4) documentation of test results

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

In order for a site to report an intervention as HCT it **must provide all 4 HCT activities**. Many sites only provide pre-test counseling, and then refer clients to testing in other facilities. These types of activities should not be counted as an HCT intervention; they should be counted as intensive individual interventions. However, in some cases a site may have strong linkages with a testing facility that allows the reporting site to follow up on a patient, including providing them with post-test counseling if the client wants to receive this at the site; in these cases the site can report the numbers under HCT. If a site provides pre-test counseling, then has an outreach worker accompany a client to a testing facility, and then can link with the testing facility to confirm results and where the client will receive post-test counseling, this can also be reported as an HCT intervention⁵.

⁵ Note that in some cases only sites that provide all 4 services are counted. The definition provided above is adapted to the procedures for organizations working in Thailand and is specific to this context.

Activity examples

- Pre-test counseling
- Referral to testing site (may or may not be accompanied)
- HIV antibody testing
- Follow up with testing site to see the number of referrals taken up
- Post-test counseling (including referral to STI, general health, or psychosocial services and support for access to ART)
- Documentation of the number of HIV positive test results received

STI clinical management

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

STI clinical management must always be combined with an “intensive individual intervention”. For reporting purposes, an individual receiving STI clinical management should also be recorded as having received an “intensive individual intervention”.

Activity examples

- Screening
- Etiological (laboratory) or syndromic (clinical) diagnosis
- Treatment (presumptive or otherwise)
- Referral to HCT and general health services
- Contact tracing
- Counseling on diagnosis, risk reduction and STI treatment adherence
- Follow up treatment or referral (for example to tertiary care for treatment of STIs not responding to first line drugs)

HIV care and support interventions

Definition: These are interventions that include a combination of activities that relieve suffering and improve the quality of life for those facing problems associated with HIV⁶. These interventions aim to ensure equitable access to diagnosis, health care and comprehensive supportive services, reduce morbidity and mortality from HIV, promote opportunities for preventing HIV transmissions, and improve the quality of life of people affected by and infected with HIV⁷.

⁶ FHI. *Palliative care strategy for HIV and other diseases*. 2008.

⁷ UNAIDS. *National AIDS programmes: A Guide to Monitoring and Evaluating HIV/AIDS Care and Support*. 2005.

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

Activity examples

- ART adherence counseling and support
- Referral to treatment for opportunistic infections (OIs) and ART programs (including for CD4 testing)
- Palliative care (pain and other symptom/side-effects control)
- Mental health counseling
- Positive living/self-care skills building
- PLHIV support/self-help groups
- Positive Health, Dignity and Prevention services (sometimes referred to as “Prevention with positives”) that often include safer sex counseling and condoms, referral for family planning/reproductive health/STI services, provision of clean needles and syringe, and referral to general health services.
- Nutritional support
- Referrals to other community-based organizations providing additional care and support services

Community level interventions

Definition: These are interventions that aim to create a supportive environment (i.e., changing the norms in the community) rather than providing intensive behavior change messages to individuals and small groups. These interventions occur within the broader environment in which MSM live and interact- **they are not MSM specific**. These interventions aim to alter social norms (including beliefs and practices), policies, or characteristics of this broader environment.

Activity examples

- HIV related activities held during events such as World AIDS Day and events held during special holidays such as Songkran, Valentine’s Day and New Year’s
- Community-based events such as shows in discotheques, bars or other locations where there are opportunities to reach community members
- Targeted social marketing campaigns
- Policy interventions, including advocacy and other structural interventions that involve entertainment establishment owners and encourage them to create a supportive environment such as supplying condoms and lubricants, displaying printed materials, training their staff on HIV prevention, and referring their staff to sites where they can be tested for HIV or receive STI diagnosis and treatment services.

Health Communication/Public Information

Definition: These are interventions that include the delivery of planned HIV/AIDS prevention messages through one or more media channels to targeted audiences in order to build general support for safe behavior and personal risk-reduction efforts, and/or inform persons at risk for infection how to access specific services.

Activity examples

- Electronic media (i.e., internet Websites, mobile phone text messaging, video clips and short movies)
- Radio ads and discussions
- Posters, postcards, newsletters, billboards, brochures, flyers, posters, flip charts, outreach manuals
- Booth exhibitions at meetings and conferences, as well as at community events

Indicator summary

A total of 30 indicators have been identified and can be broken down into 3 broad categories: Core (C), Additional (A), and indicators for evaluation (E). The table below summarizes the 8 core, 13 additional and 9 evaluation indicators identified for MSM programs. Core indicators have been identified based on internationally harmonized indicators and are required for global reporting by international organizations such as USG, UNAIDS, GFATM and program management requirements. These indicators represent the basic information that should be collected and used to improve interventions as well as to report progress to donors, staff and beneficiaries; in many cases these indicators also serve as a basis for some of the higher level outcome and impact indicators used to evaluate interventions.

The additional indicators can be added to routine monitoring where relevant. A program may decide to use these to obtain more information about services being provided.

The evaluation indicators proposed here are based on internationally accepted indicators; they often contribute towards measuring progress towards national and international goals such as UNGASS. These indicators require special studies that may include community surveys; they can be used on a periodic basis to assess overall program outcomes and impact.

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

Indicator type: Core (C)/ Additional (A)/ Evaluation (E)	Indicator name	Indicator use, by intervention type	Required by
C1	# of individuals reached through intensive or casual, individual and/or small group level HIV interventions	Intensive and casual individual interventions; intensive and casual group interventions; health communication/public information	MoPH, National Health Security Office GFATM, , USG (PEPFAR/OGAC)
C2	# of HIV positive MSM reached with a minimum package of positive health, dignity and prevention service [also called prevention with positives (PwP)] interventions	Intensive individual interventions	USG (PEPFAR/OGAC)
C3	# of individuals who received counseling and testing for HIV and received their test results	HCT interventions	UNGASS #7, GFATM, USG (PEPFAR/OGAC)
C4	% of individuals tested that received their results	HCT interventions	UNGASS #7
C5	# of individuals who were diagnosed for an STI	STI clinical management interventions	USG (Thailand)
C6	# of individuals that were treated for a STI	STI clinical management interventions	USG (Thailand)
C7	# of HIV positive individuals that	HIV care and support	USG (Thailand)

Indicator type: Core (C)/ Additional (A)/ Evaluation (E)	Indicator name	Indicator use, by intervention type	Required by
	received a CD4 test		
C8	# of individuals trained	Intensive individual and/or group interventions	WHO, USG (PEPFAR/OGAC)
A1	# contacts (new and old)	Intensive and casual individual interventions; intensive and casual group interventions	
A2	Average number of contacts per individual reached	Intensive and casual individual interventions; intensive and casual group interventions	
A3	# of condoms distributed	Intensive and casual individual interventions; intensive and casual group interventions ; health communication/public information	USG (Thailand)
A4	# of lubricant packets distributed	Intensive and casual individual interventions; intensive and casual group interventions; health communication/public information	USG (Thailand)
A5	# of condom targeted outlets	Community level interventions	USG (PEPFAR/OGAC)
A6	# of health promotion materials distributed	Intensive and casual individual interventions; intensive and casual group interventions; health communication/public information	
A7	% of referrals taken up by individuals	Intensive and casual individual interventions; intensive and casual	

Indicator type: Core (C)/ Additional (A)/ Evaluation (E)	Indicator name	Indicator use, by intervention type	Required by
	provided with referrals	group interventions; HCT interventions; STI case management interventions	
A8	# of individuals attending skills building classes	Intensive individual and/or group interventions	
A9	# of skills building sessions held	Intensive individual and/or group interventions	
A10	# of service outlets providing HIV counseling and testing according to national standards	HCT interventions	
A11	# of HIV positive clients who received assistance from program staff to access care and support services	HIV care and support	
A12	# of organizations working on HIV prevention, care and support within the community	Community level interventions	
A13	# of organizations provided with technical assistance	Community level interventions	
E1	% of MSM reached by HIV prevention programs	Intensive and casual individual interventions; intensive and casual group interventions	MoPH, National Health Security Office, GFATM, ,

Indicator type: Core (C)/ Additional (A)/ Evaluation (E)	Indicator name	Indicator use, by intervention type	Required by
			USG (PEPFAR/OGAC), UNGASS #9
E2	% of MSM who both correctly identify ways of preventing the sexual transmission of HIV and who reject major misconceptions about HIV transmission	Intensive and casual individual interventions; intensive and casual group interventions	UNGASS #14
E3	% of MSM reporting receiving targeted media through TV, radio or other media channels	Health communications/public information interventions	
E4	% of MSM reporting the use of a condom the last time they had anal sex with a male partner	Intensive and casual individual interventions; intensive and casual group interventions	UNGASS #19, GFATM
E5	% of male sex workers reporting the use of a condom with their most recent client	Intensive and casual individual interventions; intensive and casual group interventions	UNGASS #18
E6	% of MSM who received an HIV test in	HCT interventions	UNGASS #8

Indicator type: Core (C)/ Additional (A)/ Evaluation (E)	Indicator name	Indicator use, by intervention type	Required by
	the last 12 months and who know their results		
E7	% of MSM who are HIV infected	Intensive and casual individual interventions; intensive and casual group interventions; HCT interventions	UNGASS #23, GFATM
E8	% of staff trained in implementing HIV prevention activities	Intensive and casual individual interventions	GFATM
E9	% of organizations providing the basic package of community services (prevention, care and support)	Community level interventions	

Indicator definitions

In-depth definitions for each of the indicators are provided below; core indicators are defined first, then additional and evaluation indicators.

A note on frequency of data reporting:

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

Core Indicators	
Core indicator 1 (C1): # of individuals reached through intensive or casual, individual and/or small group level HIV interventions	
Definition	<p>Total number of MSM benefiting from a specific intervention during the reporting period.</p> <p>This indicator counts the number of MSM who have participated in or benefited from:</p> <ul style="list-style-type: none"> • individual (casual or intensive) intervention, • group (casual or intensive) intervention, • health communication/public intervention <p>during the reporting period. It is disaggregated by HIV intervention (i.e., outreach, capacity building/training, counseling), level of intensity (intensive or casual), and whether it was an individual or small group interaction.</p> <p>For each reporting period, MSM being reached should be categorized as “new” (never before participating or benefiting from an intervention during the reporting period) and “old” (they have participated in or benefited from an intervention already during the reporting period). MSM should only be counted as “new” once; they are counted the first time that they participate or benefit from the intervention during the reporting period.</p> <p>A client should be recorded as “new” each time they received an intervention for the first time. For example, if a MSM client comes in for an intensive individual intervention such as face-to-face counseling at at DiC, they are counted as “new” the first time they come in; if the same MSM then comes back for a casual individual intervention like HIV prevention education they would also be considered “new”. If he returned for more intensive individual interventions such as more counseling he would then become an “old” client.</p> <p>This indicator needs to be recorded by intervention received. Therefore,</p>

	<p>each intervention being implemented needs to collect the number of MSM reached (disaggregated by “new” and “old”) for every reporting period.</p> <p>The total number of MSM reached is the sum of all “new” individuals reached during the reporting period.</p> <p>Note that for health communication/public information interventions which include the general population do not need to be reported by the number of “new” and “old” people reached.</p>
Numerator	N/A
Denominator	N/A
Rationale	This indicator is needed to monitor achievements towards the overall program target on number of people being reached; it can be used to monitor trends over time and establish annual targets.
Measurement tools	<p>Reporting forms used by outreach volunteers, peer educators, STI clinicians and HCT counselors are used to collect information on the number of individuals reached. These forms should indicate whether the individual is “new” or “old”.</p> <p>The data collection forms need to also indicate the intensity of the intervention received:</p> <ul style="list-style-type: none"> • Intensive individual or group • Casual individual or group
Data interpretation and use	<p>This indicator can be used by program managers to establish annual targets and plan for resources. Knowing how many individuals are reached can be used to plan for the number of staff required and commodities to order.</p> <p>Knowing the number of “new” MSM is needed in order to estimate program coverage during the report period, it is also relevant in establishing targets and monitoring progress.</p> <p>The number of “old” MSM reached is used to look intensity (how often did we contact each MSM?), as well as to plan for staffing needs and determine the level of effort (how many MSM are being reached by staff members? Do we need more staff?).</p> <p>The biggest challenge in interpreting the number of people reached will be related to the number of “new” individuals, particularly in outreach work. There is a chance of double counting an individual within and between programs. To minimize double counting, all outreach staff should be encouraged to ask all MSM they encounter whether or not they have received the service previously, this may help in reducing the number of times a person is counted as “new” in the field. For interventions that are delivered within a facility, this is not such a an issue because client files are often available and can be used to confirm whether or not an individual has participated in or benefited form an intervention.</p>

Core indicator 2 (C2): # of HIV positive MSM reached with a minimum package of positive health, dignity and prevention service [also called prevention with positives (PwP)] interventions	
Definition	<p>Total number of HIV positive MSM that benefited from the minimum package of services under positive health, dignity, and prevention interventions during the reporting period.</p> <p>These interventions are often referred to as “Prevention with positives”.</p> <p>In order to count under this indicator, HIV positive MSM must have received <u>at last visit</u> (in a clinic/facility-based or community/home-based program) the following interventions that constitute the minimum package:</p> <ul style="list-style-type: none"> • Assessment of sexual activity and provision of condoms (and lubricant) and risk reduction counseling (if indicated) • Assessment of partner status and provision of partner testing or referral for partner testing • Assessment for STIs and (if indicated) provision of or referral for STI treatment and partner treatment • Assessment of family planning needs and (if indicated) provision of contraception or safer pregnancy counseling or referral for family planning services • Assessment of adherence and (if indicated) support or referral for adherence counseling • Assessment of need and (if indicated) refer or enroll PLHIV in community-based program such as home-based care, support groups, post-test-clubs, etc.
Numerator	N/A
Denominator	N/A
Rationale	<p>Positive health, dignity, and prevention efforts with HIV positive persons are part of a comprehensive prevention strategy and include both behavioral and biomedical interventions.</p> <p>The purpose of this indicator is to measure how well clinic/facility-based and community-based programs are reaching PLHIV with a minimum package of prevention interventions and services that includes evidenced based behavioral and biomedical interventions designed to protect the health of the infected person and reduce the spread of HIV to their sex partners and children.</p>
Measurement tools	Reporting forms used by outreach volunteers, peer educators, STI clinicians and HCT counselors are used to collect information on the number of individuals reached. These forms should indicate whether the individual is “new” or “old”.
Data	Program managers can use this information to plan and make

interpretation and use	<p>decisions on how well PLHIV are being reached with these interventions. If a small percentage of the intended target population is being reached, then it would be recommended that activities are adjusted to improve reach. If a large percentage of the intended target population is being reached, then staff may want to document lessons learned and disseminate them to partners. The national program can use the information to improve upon the quality of the program as well as scale-up successful models.</p> <p>If the program knows (or has an estimation of) how many HIV positive MSM are living in the community then coverage can also be calculated as follows:</p> <table style="width: 100%; border-collapse: collapse;"> <tr> <td style="width: 50%; border-bottom: 1px solid black;"> Total number of HIV positive MSM that benefited from the minimum package of services under positive health, dignity and prevention interventions during the reporting period </td> <td style="width: 5%; text-align: center; vertical-align: middle;">=</td> <td style="width: 45%;"> Percentage (%) of MSM that have benefited from the minimum package of services under positive health, dignity and prevention interventions </td> </tr> <tr> <td style="border-bottom: 1px solid black;"> Total number of HIV positive MSM in the community </td> <td></td> <td></td> </tr> </table>	Total number of HIV positive MSM that benefited from the minimum package of services under positive health, dignity and prevention interventions during the reporting period	=	Percentage (%) of MSM that have benefited from the minimum package of services under positive health, dignity and prevention interventions	Total number of HIV positive MSM in the community		
Total number of HIV positive MSM that benefited from the minimum package of services under positive health, dignity and prevention interventions during the reporting period	=	Percentage (%) of MSM that have benefited from the minimum package of services under positive health, dignity and prevention interventions					
Total number of HIV positive MSM in the community							

Core indicator 3 (C3): # of individuals who received counseling and testing for HIV and received their test results

Definition	<p>Total number of MSM who received pre-test counseling, total number that took an HIV antibody test, total number that had post-test counseling and received their results and total number of MSM who tested HIV positive. during the reporting period</p> <p>The indicator should be disaggregated as follows:</p> <ol style="list-style-type: none"> a. # of MSM who received pre-test counseling, b. # of MSM who received an HIV antibody test c. # of MSM who received post-test counseling, including their test result d. # of MSM who tested HIV-positive <p>Many sites only provide pre-test counseling, and then refer clients to testing in other facilities. These types of activities should not be counted as an HCT intervention; they should be counted as intensive or casual individual interventions depending on the content of the pre-test counseling session.</p> <p>In some cases a site may have strong linkages with a testing facility that allows the reporting site to follow up on a patient, including providing them with post-test counseling if the client wants to receive this; in these cases the site can report the numbers under HCT. If a site provides pre-test</p>
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	<p>counseling, then has an outreach worker accompany a client to a testing facility, and then can link with the testing facility to confirm results and where the client will receive post-test counseling, this can also be reported as an HCT intervention.</p> <p>For each reporting period, MSM being reached through HCT services should be categorized as “new” (never before having received HCT during the reporting period) and “old” (they have received HCT services during the reporting period). MSM should only be counted as “new” once; they are counted the first time that they receive HCT services during the reporting period.</p>
Numerator	N/A
Denominator	N/A
Rationale	This indicator is needed to monitor achievements towards the overall program target on number of people reached and total number of people testing positive on an annual basis. It is important to know the number of people accessing HIV counseling and testing (HCT) services in order to estimate coverage of services and increase the number of people knowing their serostatus; positive individuals should always be referred to treatment and care services available in the community.
Measurement tools	<p>HCT service logs can be used to count the number of people that received pre-test counseling, those that took an HIV antibody test, those that came back for post-test counseling and received their results and those that tested HIV-positive.</p> <p>Reporting forms should include a separate place to record each of these four numbers.</p>
Data interpretation and use	<p>For program managers, these numbers are used for planning purposes. Knowing the number of people that come for counseling assists in determining how many counselors are needed. It also assists in knowing the number of lab technicians needed, and the number of test kits to order.</p> <p>Managers may want to look at the differences between the number of people receiving pre-test counseling and taking an HIV antibody test to flag potential problem areas. If many people are receiving the pre-test counseling but are not taking the antibody test, there may be some issues that need to be addressed with the pre-test counseling. Managers would need to investigate further, talking to counselors as well as clients in order to identify exactly why people are not taking the antibody tests. There are many reasons for this and they may include cost or not fully understanding what the test means.</p> <p>Core indicator 6 (below) looks specifically at the percentage of people lost between taking a test and receiving post-test counseling and their results.</p>
Core indicator 4 (C4): % of individuals tested that received their results	
Definition	The percentage, of MSM that received an HIV antibody test and their

	<p>results.</p> <p>This indicator is calculated by dividing the total number of individuals that took an HIV antibody test and received their results by the total number of people that took an HIV antibody test during the reporting period.</p> <p>A note on timing: In cases where individuals must wait for a few days for results, it may happen that the reporting period ends but there are still many people who have not returned for results because they are not yet available. In order to avoid confusion, this indicator should be reported up to the last 2 weeks before the reporting period ends- this will allow enough time to pass so that the results of all people who took the test up to two weeks before the end of the reporting period are available before the reporting period ends. Any individual who comes in for an HIV antibody test in the two weeks before the end of the reporting period can be counted in the next reporting period.</p>
Numerator	Total number of MSM who took an HIV antibody test and received their test results
Denominator	Total number of MSM who took an HIV antibody testing
Rationale	<p>This indicator is important for identifying areas where further investigation may be needed.</p> <p>In places where rapid testing is available one can expect this proportion to be close to 100%, and if this trend is maintained the site may decide not to routinely monitor this indicator.</p> <p>In sites where individuals must return for their results this indicator is important for monitoring loss of individuals. It helps to identify potential problems in the service which can then be further investigated and addressed.</p>
Measurement tools	<p>This indicator will be calculated from the numbers reported under core indicator 3.</p> $\frac{\text{Total number of MSM that took an HIV antibody test and received their results during the reporting period ("c" from core indicator 3)}}{\text{Total number of MSM that took an HIV antibody test during the reporting period ("b" from core indicator 3)}} = \text{Percentage (\% of MSM that took an HIV antibody test and received their results)}$
Data interpretation	<p>This is a meaningful indicator that can be used to make programmatic decisions. It measures the number of people that are lost and can help in flagging a problem with HCT service. If a high number of people are not returning for their results further investigation is needed to answer the question "why?"- This additional information can then be used to strengthen the service.</p> <p>The number of people returning for their test results should never be</p>

	higher than the total number of people that took the test during the reporting period- if this happens it could be an indicator that staff may not be correctly reporting numbers.
Core indicator 5 (C5): # of individuals who were diagnosed for a STI	
Definition	<p>Total number of MSM who underwent diagnosis for STIs during the reporting period.</p> <p>Diagnosis here can be clinical (symptomatic, i.e. syndromic) or etiological (based on a laboratory test).</p> <p>A note on timing: This indicator should only count the total number of cases where laboratory results have been received during the reporting period. In cases where individuals receive an etiological diagnosis, it may happen that the reporting period ends before laboratory results are available; these individuals can be counted in the next reporting period, once their laboratory tests are back.</p> <p>If symptomatic (i.e. syndromic) diagnosis is used, then all individuals who come in for diagnosis up to the last day of the reporting period can be counted.</p> <p>For each reporting period, MSM receiving STI diagnosis services should be categorized as “new” (never before having received an STI diagnosis during the reporting period) and “old” (they have received an STI diagnosis during the reporting period).MSM should only be counted as “new” once; they are counted the first time that they receive an STI diagnosis during the reporting period.</p>
Numerator	N/A
Denominator	N/A
Rationale	Having an STI indicates that an individual is engaging in a risk behavior and is therefore at risk for HIV. This indicator is needed to monitor achievements towards the overall program target on number of individuals diagnosed.
Measurement tools	Clinical registers can be used to count the number of MSM that received an STI diagnosis during the reporting period.
Data interpretation and use	<p>Counting the number of people diagnosed does not provide much information related to treatment, nor does it give any indication about whether or not future risk behavior will be reduced. There may be many issues related to why an individual may not seek out treatment after diagnosis nor change their risk behaviors, and accessibility as well as exposure to services may be one. More investigation is needed in order to understand the factors influencing health care seeking behavior and behavior change.</p> <p>However, these numbers can be interpreted as proxies of effective peer education sessions on risk reduction, especially when combined with other information about health seeking behavior, and individual risk perception that may be collected through community surveys.</p>
Core indicator 6 (C6): # of individuals that were treated for a STI	
Definition	Total number of MSM who were treated for an STI during the reporting period. This includes individuals that were treated presumptively or

	<p>syndromically.</p> <p>For this indicator, all treatment that is started before the end of the reporting period should be counted, even if treatment is still on-going once the reporting period ends.</p> <p>For each reporting period, MSM receiving STI treatment services should be categorized as “new” (never before having received STI treatment during the reporting period) and “old” (they have received STI treatment during the reporting period).MSM should only be counted as “new” once; they are counted the first time that they receive STI treatment during the reporting period.</p>
Numerator	N/A
Denominator	N/A
Rationale	This indicator is needed to monitor achievements towards the overall program target on numbers of individuals.
Measurement tools	Clinical registries can be used to count the number of people that have received (or are receiving) treatment at the end of the reporting period.
Data interpretation and use	<p>This number should be looked at along with the total number of MSM that received an STI diagnosis during the reporting period (core indicator 7, above). Together, these can give program managers an idea about the percentage of people that are diagnosed with an STI who received (or are receiving) treatment. The formula below can be used to calculate this proportion:</p> $\frac{\text{Total number of MSM that were treated (or are still under treatment) for an STI during the reporting period (core indicator 8)}}{\text{Total number of MSM that were diagnosed with an STI during the reporting period (core indicator 7)}} = \text{Percentage (\% of MSM that were diagnosed with an STI and received treatment during the reporting period)}$ <p>When used in combination with data that shows how often any one individual seeks treatment, this indicator can be used to identify individuals that continue to engage in risk behavior, or who may be suffering from an STI that is resistant to available treatment. In either case, it is important for the site to develop a record system that allows clinicians to see when the same person continues coming in. If an individual comes in for different STIs then they may need additional peer education and other interventions that will assist them in reducing their risk behavior. If the same individual comes in several times with the same STI this could be a sign of resistance and the clinician should refer the client for treatment at a specialized facility that can determine if resistance exists and provide the appropriate treatment.</p>

Core indicator 7 (C7): # of HIV positive individuals that received a CD4 test	
Definition	Total number of HIV positive MSM who received at least one CD4 test during the reporting period
Numerator	N/A
Denominator	N/A
Rationale	<p>CD4 tests are an important way of reducing morbidity and increasing quality of life among PLHIV. They are needed for all HIV positive individuals to determine eligibility for ART. Knowing CD4 levels assists in clinical management and reduces opportunistic infections by allowing for preventive actions to take place prior to their appearance.</p> <p>This indicator is a nationally required indicator, it is also important for programmatic decision making when combined with other information (see data interpretation and use, below).</p>
Measurement tools	<p>This indicator is routinely reported from health facilities that provide ART to the National Health Security Office (NHSO). However, this information is not disaggregated by risk behaviors and most at risk population groups. Therefore, site records need to maintain a register that not only includes HIV diagnosis and CD4 test history but also most at risk population grouping (in this case, MSM).</p> <p>In sites where CD4 tests are not carried out, but services are provided to HIV positive MSM, staff will need to ask these clients to self report whether or not they have had a CD4 test.</p> <p>If CD4 tests are carried out and laboratory records are available at the site, these can also be used, but these forms also need to be adapted to be able to identify risk behavior or most at risk population grouping.</p>
Data interpretation and use	<p>Knowing the number of HIV positive MSM who have a CD4 test is not enough. For program managers, the proportion of HIV positive MSM that have had a CD4 test can be used to make important programmatic decisions. There may be a need to provide additional training to staff so that they can effectively encourage positive clients to get the test, or there may be barriers such as geographic accessibility and cost that are influencing seeking this service out. Whatever the reason, if it is known that many HIV positive MSM have not taken a CD4 test further investigation should be carried out to understand, and address, “why”.</p> <p>The formula to calculate the percentage of HIV positive MSM that have taken a CD4 test is:</p>

	$\frac{\text{Total number of HIV positive MSM that have taken a CD4 test (core indicator 9)}}{\text{Total number of HIV positive MSM that receive services at the site}} = \text{Percentage (\% of HIV positive MSM that have received a CD4 test)}$
Core indicator 8 (C8): # of individuals trained	
Definition	<p>Total number of staff who received training and/or formal and informal capacity building in order to provide quality services in specific program areas during the reporting period. This includes both new training and retaining (in-service training) of individuals.</p> <p>The indicator needs to be disaggregated by area in which training is provided:</p> <ol style="list-style-type: none"> strategic information including M&E, surveillance and health management information system (HMIS, i.e. database) activities, HIV-related policy development, HIV-related institutional capacity building, HIV-related stigma and discrimination reduction, HIV-related community mobilization for prevention, care and/ or treatment, and/or positive prevention other areas (specify) <p>This indicator is for program staff (paid and/or volunteer) only, it is not meant to include clients.</p>
Numerator	N/A
Denominator	N/A
Rationale	This indicator is needed to monitor achievements towards the overall program target on number of people trained. It can assist in identifying training needs among staff, as well as in knowing what skills are already present within a program.
Measurement tools	Data on the number of people trained should be recorded in service logs. These logs should include the training date, training topic area(s) and the total number of staff trained. In order for these numbers to be used effectively, indicating the staff names is also useful- this allows managers to know what staff have undergone training.
Data interpretation and use	The number of staff trained can be used to better understand the skills that are present among program staff. If information is available on who was trained, managers can also decide when re-training is required, particularly if staff leave and new staff are hired. Knowing what topic areas have been covered will also allow

	<p>managers to plan for additional training in other areas.</p> <p>The indicator only counts the number of people trained, it does not provide information related to how the capacity gained is sustained and applied over time. In order to reinforce the skills gained in training, program managers should consider including on-going mentoring and supervision for staff.</p>
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Additional Indicators	
Additional indicator 1 (A1): # of contacts (new and old)	
Definition	<p>Total number of contacts made with MSM clients during the reporting period.</p> <p>Contact is defined as any time an intervention is provided to a client by project staff; it includes interventions provided to both “new” and “old” clients.</p> <p>This indicator counts the total number of MSM who have participated in or benefited from:</p> <ul style="list-style-type: none"> • Intensive or casual individual interventions, • Intensive or casual group interventions, • HCT interventions • STI clinical case management interventions <p>The total number of contacts during a reporting period is the sum of all “new” and “old” individuals reached during the reporting period. These numbers are available from core indicators 1, 2, 3, 5 and 6 (above) and should be presented disaggregated by the intervention type received.</p>
Numerator	N/A
Denominator	N/A
Rationale	This indicator can provide useful information on the amount of work carried out over a reporting period; it can also serve as a basis for calculating the intensity, in terms of range of interventions an individual is exposed to.
Measurement tools	<p>This number is calculated based on the numbers already being recorded by program staff in order to report on the total number of individuals reached (core indicators 1, 2, 3,5 and 6).</p> <p>It is calculated by adding all of the “new” and “old” individuals reached during the reporting period, by intervention type.</p>
Data interpretation and use	<p>For program managers this number can give an overview of the level of effort, or amount of work, that has been carried out during the reporting period. This number can be used when considering new hires or recruiting new volunteers.</p> <p>It also serves as the basis for determining the average number of times clients are exposed to interventions (see additional indicator 2, below).</p>
Additional indicator 2 (A2): Average number of contacts per individual reached	
Definition	The total number of times, on average, that an MSM client benefited from any intervention during the reporting period.
Numerator	Total number of contacts (additional indicator 1). Sum of the total contacts made. This is calculated as a sum of all “new” and “old” people reached for each core indicators 1, 5, 7 and 8.

Denominator	Total number of individuals reached (core indicator 1)
Rationale	As discussed in the introduction to intervention types, the intensity of interventions can be looked at in terms of the range and number of times an individual is reached. Current research points to behavior change being facilitated when an individual is reached several times by a wide range of interventions. This indicator takes a step towards measuring this, by using routine program data to calculate the average number of times an individual is reached.
Measurement tools	<p>This indicator is calculated using data that is collected through core and additional indicators. The formula used is:</p> $\frac{\text{Total number of contacts during the reporting period (additional indicator 1)}}{\text{Total number of individuals reached during the reporting period (sum of totals from core indicators 1, 5, 7 and 8)}} = \text{Average number of times each MSM was contacted during the reporting period}$
Data interpretation and use	<p>This indicator looks at intensity only from the perspective of number of times an individual is exposed to any interventions. Therefore it doesn't provide information on the types of interventions that were provided, nor the quality of these. However, some organizations have established three as a threshold required to facilitate behavioral change; program managers may decide to also adopt this as a minimum when interpreting this number. Therefore, a number less than three would indicate that more effort is needed to contact MSM.</p> <p>To measure intensity in terms of the range of interventions being received by an individual, program managers may consider providing unique IDs to clients. The program staff can then calculate what range of interventions each individual person is exposed to, and this information, when linked to a community survey, can be used to determine the intervention package that is most effective for generating a behavior change.</p>
Additional indicator 3 (A3): # of condoms distributed	
Definition	<p>Total number of condom distributed during the reporting period. This number includes all of the condoms that are handed out free of charge through outreach or other interventions as well as those that are distributed to targeted outlets where they are then sold through social marketing programs.</p> <p>If a program delivers a number of condoms to an outlet- either to be handed out free of charge or to be sold, the program should count the total number of condoms delivered. For example, if the program gives 300 condoms to a bar, then all of those 300 condoms are counted as having been distributed, even though the program staff may not know if they are</p>

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

	to calculate and monitor the proportion of condoms distributed through social marketing programs. Because individuals have to use their own resources to buy these condoms, it could be inferred that they are also more likely to use them. Therefore, it may be a valuable option to consider reporting this indicator disaggregated by those condoms handed out free of charge and those that reach the target population through social marketing efforts.
Additional indicator 4 (A4): # of lubricant packets distributed	
Definition	<p>Total number of lubricant packets distributed during the reporting period. Like condoms distributed, this number includes all of the lubricant packets that are handed out free of charge through outreach or other interventions as well as those that are distributed to targeted outlets where they are then sold through social marketing programs.</p> <p>If a program delivers a number of lubricant packets to an outlet- either to be handed out free of charge or to be sold, the program should count the total number of lubricant packets delivered. For example, if the program gives 300 lubricant packets to a bar, then all of those 300 lubricant packets are counted as having been distributed, even though the program staff may not know if they are all given or bought by the target population. If a system is in place to track how many lubricant packets are distributed in outlets, particularly through social marketing programs, then one may consider disaggregating the indicator into two broad categories: 1) lubricant packets distributed free of charge and 2) lubricant packets distributed through social marketing schemes. A discussion on how these disaggregated data could be used is presented below, in the data interpretation and use section.</p>
Numerator	N/A
Denominator	N/A
Rationale	This indicator can be used to monitor trends over time, forecast lubricant needs, and establish distribution targets on an annual basis.
Measurement tools	<p>For services that are distributing lubricant packets, the reporting form(s) should include a place where the total number of lubricant packets distributed is included. This indicator is relatively simple to report as long as staff note the number of lubricant packets given out immediately, or shortly after distribution.</p> <p>An alternative way of counting the number of lubricant packets distributed is to use a well developed commodity tracking system. If the program knows exactly how many packets they have at the beginning of the reporting period, they can simply calculate how many were distributed by subtracting the total number left at the end of the reporting period.</p>

	$\begin{array}{l} \text{Total} \\ \text{number of} \\ \text{lubricant} \\ \text{packets in} \\ \text{stock,} \\ \text{beginning} \\ \text{of reporting} \\ \text{period} \end{array} - \begin{array}{l} \text{Total} \\ \text{number of} \\ \text{lubricant} \\ \text{packets in} \\ \text{stock, end} \\ \text{of reporting} \\ \text{period} \end{array} = \begin{array}{l} \text{Total number} \\ \text{of lubricant} \\ \text{packets} \\ \text{distributed} \\ \text{during} \\ \text{reporting} \\ \text{period} \end{array}$
Data interpretation and use	<p>This indicator can be used by program managers to establish annual targets and plan for resources. Knowing how many lubricant packets are distributed is needed to know how many may be needed in the future.</p> <p>This number only tells a program how many lubricant packets have been distributed, it does not tell the program anything related to their use. If a program wants to know if people are using the lubricant packets, and using them correctly, they need to do a community survey of the population. However, one important measure that can be used as a proxy to look at use, as well as individual behavior change, would be to calculate and monitor the proportion of lubricant packets distributed through social marketing programs. Because individuals have to use their own resources to buy these packets, it could be inferred that they are also more likely to use them. Therefore, it may be a valuable option to consider reporting this indicator disaggregated by those lubricant packets handed out for free and those that reach the target population through social marketing.</p>
Additional indicator 5 (A5): # of condom targeted outlets	
Definition	<p>Total number of locations that have a continuous supply of condoms during the reporting period.</p> <p>Continuous supply here is defined as any outlet that is routinely restocked by programs once per month. Outlets include locations that provide condoms either free of charge or sell condoms as part of a social marketing program in the community.</p> <p>Outlets are defined as locations such as bars, schools, and restaurants. In some outlets there may be several condom machines or other places where condoms are available (i.e., a bowl, basket in the outlet).</p>
Numerator	N/A
Denominator	N/A
Rationale	This indicator can be used to estimate condom needs, and to monitor condom availability and accessibility in the community. It can also help present the geographical coverage of the outlets.

Measurement tools	<p>Data for this indicator can be obtained from program records. These records may be part of the commodity tracking system that is also used to monitor the number of condoms and/or lubricant packets distributed during the reporting period.</p> <p>The records should specify the outlet name and location, and indicate the number of condoms provided to the outlet (this number can be reported under core indicator 2 if the data are disaggregated by condoms distributed free of charge and condoms distributed to outlets). In addition, it may be useful to also indicate the number of places or machines that are available within each outlet.</p>
Data interpretation and use	<p>The number of outlets can be used in day-to-day program management, especially in estimating future condom needs. If staff notice that some outlets don't have any condoms left when they go to re-stock, they should report this to arrange for more frequent re-stocking, or to leave more condoms each time they come to re-stock. Knowing how many machines or baskets/bowls of condoms are available within an outlet will also allow the teams to plan to bring enough condoms with them when they come to re-stock the outlet.</p> <p>This number would be most useful if used to estimate coverage of outlets within a community; this can be calculated as follows:</p> $\frac{\text{Total number of outlets with a continuous supply of condoms during the reporting period}}{\text{Total number outlets within the community}} = \text{Percentage (\% of outlets with a continuous condom supply)}$ <p>The percentage of outlets with continuous condom supplies can be important to measure periodically in order to plan for scaling up (providing a continuous supply of condoms to more outlets) in an effort to increase accessibility.</p> <p>When looking at the number of outlets, it is important to realize that this indicator does not provide information on who accesses the condoms so it is not possible to assume that the target population is receiving, or has access to, condoms. You also cannot infer that condom availability will lead to condom use.</p>
Additional indicator 6 (A6): # of health promotion materials distributed	
Definition	<p>Total number of health promotion materials (brochures, leaflets, postcards, posters, handouts, booklets) distributed to MSM and/or distributed to outlets (bars, saunas) during the reporting period.</p> <p>This number should also include all materials distributed during care services such as STI clinical management, HCT and care and</p>

	support. It includes materials produced by the program, as well as materials that have been given to the program by other organizations.
Numerator	N/A
Denominator	N/A
Rationale	This indicator can be used to track progress towards programmatic goals. It can also be used to forecast how many materials may be needed in the future.
Measurement tools	<p>For services that are distributing health promotion materials, the reporting form(s) should include a place where the total number of materials distributed is included. This indicator is relatively simple to report as long as staff note the number of materials given out immediately, or shortly after distribution.</p> <p>When materials are left to be distributed elsewhere, such as in bars, workplaces, or condom outlets, then the total number left should be recorded on the appropriate forms.</p> <p>If a commodity tracking system is in place, this can be used to calculate the total number of health promotion materials being distributed. If the program knows exactly how many materials they have at the beginning of the reporting period, they can simply calculate how many were distributed by subtracting the total number left at the end of the reporting period.</p> $ \begin{array}{rcl} \text{Total} & & \text{Total} \\ \text{number of} & & \text{number of} \\ \text{health} & & \text{health} \\ \text{promotion} & - & \text{promotion} \\ \text{materials in} & & \text{materials in} \\ \text{stock,} & & \text{stock, end} \\ \text{beginning} & & \text{of reporting} \\ \text{of reporting} & & \text{period} \\ \text{period} & & \\ & & \text{Total number} \\ & & \text{of health} \\ & & \text{promotion} \\ & & \text{materials} \\ & & \text{distributed} \\ & & \text{during} \\ & & \text{reporting} \\ & & \text{period} \end{array} $ <p>Program managers may compare the reported numbers from staff and the number in a commodity tracking system in order to verify numbers.</p>
Data interpretation and use	<p>This indicator's main use will be in forecasting need for additional health promotion materials. Establishing a threshold in terms of the minimum number to have in stock will help to know when new materials should be ordered or printed.</p> <p>When interpretation of the number program managers should know that the number distributed does not measure anything related to use of the information presented in the materials, whether or not the materials are appropriate for MSM, or even if MSM have accessed the materials (this is especially the case when leaving materials in</p>

	other locations for distribution).
Additional indicator 7 (A7): % of referrals taken up by individuals provided with referrals	
Definition	<p>The percentage of MSM that access any community based and/or clinical services to which they have been referred by program staff during the reporting period.</p> <p>This includes all referrals made through outreach and clinical interventions. For example, they can include referrals to community support groups, to clinical services such as HCT and STI clinical management.</p> <p>This indicator should be disaggregated by service type (i.e. to HCT or STI clinical management), if possible.</p>
Numerator	<p>For this indicator, two different numerators can be used:</p> <ol style="list-style-type: none"> 1) Total number of MSM who access any community and/or clinical services and self report that they were referred by program staff during the reporting period. 2) Total number of referral cards collected in clinical services during the reporting period.
Denominator	The total number of referrals given to MSM by program staff for any (community and/or clinical) services during the reporting period.
Rationale	This indicator can help assess the uptake of services, and can be used as a proxy of effective referral practices in the program.
Measurement tools	<p>This indicator is calculated by reviewing program records including clinical records and outreach worker daily diaries or logs to determine the total number of referrals given to MSM during the reporting period. Forms reporting referrals should indicate most-at-risk population grouping, and also indicate to what service individuals have been referred.</p> <p>The total number of referrals provided is then compared to the total number of MSM who self report that they received a referral or to the total number of referral cards collected from each service site during the reporting period.. If using the numerator that requires MSM to self-report whether or not they received a referral, then service providers will need to be instructed to ask if individuals were referred when they are seeing clients, they will also need to indicate the most-at-risk population grouping for these clients.</p> <p>The indicator is calculated as follows:</p>

	<p>Total number of MSM who access clinical services and self report that they were referred by program staff.</p> <p>Or</p> <p>Total number of referral cards collected in clinical services</p> <hr/> <p>The total number of referrals given to MSM by program staff for clinical services during the reporting period.</p>	<p>Percentage (%) of MSM that took up referrals to clinical services</p>
Data interpretation and use	<p>This information can be used to assess the effectiveness of referrals, especially when these are made within a program (i.e., from outreach in the field to clinical services provided by the same program). It is much more difficult to measure this when referrals are provided to clinical services provided by another program – such as when referrals are made to government facilities or facilities managed by other organizations. In these cases, to measure this indicator an agreement between the programs and organizations involved needs to be reached. This way, information on the number of referral cards or on the number of MSM self reporting that they have been referred can be obtained.</p> <p>If the program is relying on self reports, it may be difficult to know if the client was referred by program staff, or by staff in other programs working in the same geographical area. It may be necessary to ask more questions to the client in order to know if he was referred by program staff.</p>	
Additional indicator 8 (A8): # of individuals attending skills building classes		
Definition	<p>Total number of MSM who participated in a skills building activities related to HIV prevention and care during the reporting period</p> <p>This indicator usually only includes MSM that participate in skill building sessions that are carried out in small groups. It does not include MSM participating in individual skills building sessions that may be carried out as part of intensive individual interventions.</p>	
Numerator	N/A	
Denominator	N/A	
Rationale	<p>This indicator can be used to monitor achievements towards the overall program targets and can be used to plan for future skills building efforts.</p>	
Measurement tools	<p>These numbers are usually obtained from program records that record attendance at skills building classes. These attendance sheets should include the date, topic covered, total number of participants, and should try to also include information on the most-at-risk population groups present (only in cases where skills building is not specific to MSM, but may include them).</p>	

Data interpretation and use	<p>This indicator can be used to provide information on the types of skills building that has taken place- allowing for future planning of skills building sessions in additional areas, or periodic refresher classes to reinforce messages. This information can also be used when designing a community survey that can be used to evaluate the effectiveness of skill building efforts.</p> <p>One of the major limitations of this indicator is that it does not provide information related to how the capacity gained is sustained and applied over time.</p>
Additional indicator 9 (A9): # of skills building sessions held	
Definition	<p>Total number of skills building sessions conducted for MSM that relate to HIV prevention and care during the reporting period</p> <p>This indicator usually only includes skill building sessions that are carried out in small groups. It does not include individual skills building sessions that may be carried out as part of intensive individual interventions.</p>
Numerator	N/A
Denominator	N/A
Rationale	This indicator can be used to monitor achievements towards the overall program target.
Measurement tools	This number can be obtained from program records such as attendance forms collected during the sessions (see additional indicator 5); any forms used should include the date, topic covered, and total number of MSM participants.
Data interpretation	<p>This data can be used by program managers to establish the number of skills building sessions to be carried out in the future; it can be used to look at the level of effort of the program.</p> <p>One of the major limitations of this indicator is that it does not provide information related to quality of skills building sessions conducted. To assess program quality other tools and methods such as checklists and observation are needed.</p>
Additional indicator 10 (A10): # of service outlets providing HIV counseling and testing according to national standards	
Definition	The total number of services outlets within a specific geographical area providing HIV pre-and post-test counseling and HIV antibody testing services according to national standards
Numerator	N/A
Denominator	N/A
Rationale	This indicator can be used to assess the quality of HCT services being provided to MSM.

<p>Measurement tools</p>	<p>This information can be collected using quality assurance checklists that have been developed in line with the national standards for HCT. These checklists require staff to be trained in their use, and they need to be applied periodically. To determine how often a checklist should be applied, one needs to consider how much the program has, or could have, changed since the last time a quality assessment was carried out. If not too much is expected to have changed, the checklist can be applied once a year, if many things may have changed (or were expected to change as a result of recommendations from the last quality assurance assessment) then the checklist can be applied more often- once a quarter or twice a year for example.</p> <p>Results of a quality assurance checklist should be shared with the sites and it should be complemented with an action plan to address any issues that are found.</p>
<p>Data interpretation and use</p>	<p>National standards can be considered a “minimum” in terms of what is essential in order to carry out quality HCT services. Knowing how many sites comply with these standards therefore gives an idea about the ability of the target population to access good services.</p> <p>This indicator is particularly useful when looked at as a proportion rather than a whole number. This way, some idea of coverage of quality services can also be obtained. The following formula can be used to calculate the proportion of facilities that are providing HCT in line with national standards:</p> $\frac{\text{The total number of services outlets within a specific geographical area providing HIV pre-and post-test counseling and HIV antibody tests according to national standards}}{\text{The total number of services outlets within a specific geographical area providing HIV pre-and post-test counseling and HIV antibody tests}} = \text{Percentage (\% of services outlets within a specific geographical area providing HIV pre-and post-test counseling and HIV antibody tests according to national standards)}$ <p>When interpreting these numbers and proportions it is important to realize that even in cases where service outlets are providing quality care in line with national standards, this may not be enough to encourage MSM to access HCT services. It is important therefore to also look at the number of MSM accessing these services as well. If the majority of service outlets are in line with national standards, but MSM numbers are low, then further investigation using focus group discussions, or staff and client interviews may be considered in order to determine how HCT services can be further strengthened to attract more MSM.</p>

Additional indicator 11 (A11): # of HIV positive clients who received assistance from program staff to access care and support services

Definition	<p>Total number of HIV positive MSM that were assisted by program staff to access care and support services available in the community during the last reporting period.</p> <p>Assistance is defined as any time the client is physically accompanied to the care and support services by program staff. These staff can be outreach staff who identify clients in the community and accompany them to clinics or other sites to access services; it also includes clinical staff who may see a client in one service area (i.e., STI), and then accompany the client to another service (i.e., HCT).</p>
Numerator	N/A
Denominator	N/A
Rationale	This indicator can be used to measure the effectiveness of a continuum of care, where an HIV positive MSM is helped to access additional services available to them in the community or clinical setting. It is important to measure in order to measure the quality of services operating under a continuum scheme.
Measurement tools	The recording form used for this indicator will depend on what staff member is providing the assistance. For example, if an outreach volunteer takes an MSM client to a community support service site, he or she should note this into their daily diary or log. In clinical sites a register can be adapted to include a column to indicate whether or not staff accompanied a client to another service area. This register should include the date of assistance and where the client was taken.
Data interpretation	For program managers, this indicator can be used to measure the active provision of linkages between services. It will not be able to provide any information on the effectiveness of this linkage as it does not tell us whether or not the client continued to get support from these services, or if he accessed additional services. In order to collect this type of information a special survey among positive clients may be considered in order to determine what care and support services they are accessing, how often they are using the services, and how well the services address their needs.

Additional indicator 12 (A12): # of organizations working on HIV prevention, care and support within the community

Definition	<p>The total number of governmental and non-government organizations, actively working on HIV prevention, care and support for MSM within the community during the reporting period.</p> <p>Organizations here include both registered and non-registered groups of people who have come together to provide prevention, care and support services to MSM. These services can include psychosocial support (either individual, or in group), STI clinical management, HCT, peer outreach, and home based care, for example.</p>
Numerator	N/A
Denominator	N/A

Rationale	This indicator is used for tracking the number of active organizations working with MSM and HIV prevention, care and support. It can be used for planning purposes in order to avoid overlap and address programmatic gaps. It also serves as a denominator for evaluation indicator 9.
Measurement tools	<p>This information can be collected through a community mapping that is carried out in close collaboration with MSM in the community. It can also be collected by reviewing local records to identify registered organizations.</p> <p>The indicator does not need to be collected very often when it is known that not many organizations are active and/or where it is not expected that there will be a large and rapid change in the number of organizations working with MSM.</p>
Data interpretation and use	<p>This indicator can be used to plan program activities, by avoiding overlapping in activities between organizations and therefore increasing the range of activities aimed at MSM. Within a “continuum of care” scheme, this indicator can help to establish networks; these are defined as a formal grouping of organizations that are involved in providing HIV prevention, care and treatment services to MSM.</p> <p>Depending on the organization, you may decide to present the data in a disaggregated form, showing the numbers by service area (prevention, care and/or support), rather than as one aggregated number.</p> <p>This indicator only counts the number of organizations within a specific geographical area; it does not measure anything related to the quality of services being provided. However, it is useful in providing an overview about the number and scope of work being undertaken and can be useful when planning interventions in a rational manner.</p>
Additional indicator 13 (A13): # of organizations provided with technical assistance	
Definition	<p>Total number of governmental and non-government organizations working with MSM that are provided with technical assistance by the program during the reporting period.</p> <p>The indicator needs to specify the area in which assistance is provided:</p> <ol style="list-style-type: none"> a. strategic information including M&E, surveillance and HMIS activities, b. HIV-related policy development, and/or c. HIV-related institutional capacity building d. HIV-related stigma and discrimination reduction, e. HIV-related community mobilization for prevention, care and/ or treatment, and/or f. positive prevention

	<p>g. Other areas (specify)</p> <p>Capacity building generally requires more than one session, and is focused around one specific area at a time. This is generally carried out in the form of trainings. In some cases, on-going mentoring may be provided as a way to reinforce the training that has been received. Mentoring can be counted as a form of capacity building.</p>
Numerator	N/A
Denominator	N/A
Rationale	This indicator can assist in planning activity schedules; it may also be required by donors.
Measurement tools	<p>The number of organizations can be counted using program records that list all of the capacity building activities, such as trainings and mentoring that have been carried out during the reporting period. The program records should indicate the date(s) of the capacity building, the organization(s) that participated, and the topic(s) covered.</p>
Data interpretation and use	<p>This indicator can be used to plan for future training that may be needed. It can help in reducing duplication by allowing program managers to plan for training to organizations that have not benefited in the past.</p> <p>This weakness of this indicator is that it does not provide information related to how the capacity gained is sustained and applied over time. However, if mentoring is provided, this can be used as an opportunity to assess how the initial training succeeded, and also in knowing what kind of mentoring is needed.</p>

Evaluation Indicators

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

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

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

Definition	Percentage of MSM who both correctly identify ways of preventing the sexual transmission of HIV and who reject major misconceptions about HIV transmission This percentage is defined as the total number of MSM that correctly answered the knowledge questions (see below) divided by the total number of MSM who took part in the survey and responded to the question.
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Numerator	Number of MSM respondents who gave the correct answers to all five questions
Denominator	Total number of MSM who responded to the question; this includes MSM who gave 'don't know' answers
Rationale	This indicator can be used to assess progress in building knowledge of the essential facts about HIV transmission among MSM
Measurement tools	<p>Behavioral surveillance or other special surveys.</p> <p>Respondents are asked the following five questions:</p> <ol style="list-style-type: none"> 1. Can having sex with only one faithful, uninfected partner reduce the risk of HIV transmission? 2. Can using condoms reduce the risk of HIV transmission? 3. Can a healthy-looking person have HIV? 4. Can a person get HIV from mosquito bites? 5. Can a person get HIV by sharing a meal with someone who is infected? <p>This indicator should be disaggregated by age (under 25 and 25 and older).</p> <p>The first three questions should not be altered. Questions 4 and 5 may be replaced by the most common misconceptions in the area.</p> <p>Respondents who have never heard of HIV and AIDS (those that would respond "don't know") should be excluded from the numerator but included in the denominator.</p> <p>Whenever possible, data for MSM should be collected through civil society organizations that have worked closely with this population in the field. Access to survey respondents as well as the data collected from them must remain confidential.</p>
Data interpretation and use	<p>This indicator is particularly useful in places where knowledge about HIV and AIDS is poor because it allows for easy measurement of incremental improvements over time. However, it is also important in other places because it can be used to ensure that pre-existing high levels of knowledge are maintained.</p> <p>Surveying MSM can be challenging. Consequently, data obtained may not be based on a representative sample of MSM. If there are concerns that the data are not based on a representative sample, these concerns should be reflected in the interpretation of the survey data. Where different sources of data exist, the best available estimate should be used. Information on the sample size, the quality and reliability of the data, and any related issues should be included in the report submitted with this indicator.</p>

Evaluation indicator 3 (E3): % of MSM reporting receiving targeted media through TV, radio or other media channels	
Definition	<p>Percentage of MSM who report having received HIV prevention messages through media channels such as TV, radio and internet within the last 12 months.</p> <p>This percentage is defined as the total number of MSM that received a message divided by the total number of MSM surveyed.</p>
Numerator	Number of MSM respondents who answered “yes” to any one of the three questions below
Denominator	Total number of MSM surveyed
Rationale	This indicator can be used to assess health communication/public information interventions.
Measurement tools	<p>Behavioral surveillance or other special surveys.</p> <p>Respondents may be asked the following questions:</p> <ol style="list-style-type: none"> 1. In the last 12 months, have you heard any radio announcements that talked about HIV prevention for MSM? 2. In the last 12 months, have you used any MSM website and seen HIV related information? 3. In the last 12 months, have you watched any TV show where HIV prevention was discussed? <p>Questions can be added and adapted depending on the type of media campaigns being implemented in the area.</p> <p>This indicator should be disaggregated by age (under 25 and 25 and older).</p> <p>Note: You may want to analyze this by looking at what % of MSM responded “yes” to two, or all three of the questions. This may be especially relevant if specific media has been used in the program.</p>
Data interpretation and use	<p>This indicator is useful only in areas where health communication/public interventions are being implemented. Interpretation will be based on the MSM surveyed.</p> <p>Surveying MSM can be challenging. Consequently, data obtained may not be based on a representative sample of MSM. If there are concerns that the data are not based on a representative sample, these concerns should be reflected in the interpretation of the survey data. Where different sources of data exist, the best available estimate should be used. Information on the sample size, the quality and reliability of the data, and any related issues should be included in the report submitted with this indicator.</p>

Evaluation indicator 4 (E4): % of MSM reporting the use of a condom the last time they had anal sex with a male partner

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

	<p>Surveying MSM can be challenging. Consequently, data obtained may not be based on a representative sample of. If there are concerns that the data are not based on a representative sample, these concerns should be reflected in the interpretation of the survey data. Where different sources of data exist, the best available estimate should be used. Information on the sample size, the quality and reliability of the data, and any related issues should be included in the report submitted with this indicator.</p>
<p>Evaluation indicator 5 (E5): % of male sex workers reporting the use of a condom with their most recent client</p>	
Definition	<p>Percentage of male sex workers reporting the use of a condom with their most recent male client</p> <p>This percentage is defined as the total number of respondents who reported that a condom was used with their last male client divided by the total number of respondents who reported engaging in commercial sex in the last 12 months. Here commercial sex means the exchange of sex for money, goods or services.</p>
Numerator	Number of MSM who reported that a condom was used with their last client
Denominator	Number of MSM who reported engaging in commercial sex in the last 12 months
Rationale	This indicator can be used to assess progress in preventing exposure to HIV among male sex workers through unprotected sex with clients.
Measurement tools	<p>Behavioral surveillance or other special surveys</p> <p>Respondents are asked the following question:</p> <p style="padding-left: 40px;">1. Did you use a condom with your most recent male client?</p> <p>Data for this indicator should be disaggregated by age (under 25 and 25 and older).</p> <p>Whenever possible, data for sex workers should be collected through civil society organizations that have worked closely with this population in the field. Access to survey respondents as well as the data collected from them must remain confidential.</p>
Data interpretation and use	<p>This indicator will also provide an overestimate of the level of consistent condom use. However, the alternative method of asking whether condoms are always/ sometimes/ never used in sexual encounters with clients in a specified period is subject to recall bias.</p> <p>Furthermore, the trend in condom use in the most recent sexual act will generally reflect the trend in consistent condom use.</p> <p>This indicator asks specifically about condom use with last male clients, but if it is known that MSW have female clients, then the question used to assess condom use should disaggregate for male</p>

	<p>and female clients.</p> <p>Surveying sex workers can be challenging. Consequently, data obtained may not be based on a representative sample. If there are concerns that the data are not based on a representative sample, these concerns should be reflected in the interpretation of the survey data. Where different sources of data exist, the best available estimate should be used. Information on the sample size, the quality and reliability of the data, and any related issues should be included in the report submitted with this indicator.</p>
<p>Evaluation indicator 6 (E6): % of MSM who received an HIV test in the last 12 months and who know their results</p>	
Definition	<p>Percentage of MSM who received an HIV test in the last 12 months and who know their results</p> <p>This percentage is defined as the total number of MSM that took an HIV test and know their results within the last 12 months divided by the total number of MSM surveyed.</p>
Numerator	Number of MSM who have been tested for HIV during the last 12 months and who know the results
Denominator	Number of MSM surveyed
Rationale	This indicator's purpose is to assess progress in implementing HIV testing and counseling among MSM. It is important for MSM to know their HIV status in order to protect themselves and to prevent infecting others. Knowledge of one's status is also a critical factor in the decision to seek treatment.
Measurement tools	<p>Behavioral surveillance or other special surveys.</p> <p>Respondents are asked the following questions:</p> <ol style="list-style-type: none"> 1. Have you been tested for HIV in the last 12 months? If yes: 2. I don't want to know the results, but did you receive the results of that test? <p>Data for this indicator should be disaggregated by age (under 25 and 25 or older).</p> <p>Whenever possible, data for MSM should be collected through civil society organizations that have worked closely with this population in the field.</p> <p>Access to survey respondents as well as the data collected from them must remain confidential.</p>
Data interpretation and use	<p>This indicator can be used to assess coverage of HCT at the community level.</p> <p>Accessing and/or surveying MSM can be challenging. Consequently, data obtained may not be based on a representative sample of MSM. If there are concerns that the data are not based on a representative</p>

	sample, these concerns should be reflected in the interpretation of the survey data. Where different sources of data exist, the best available estimate should be used. Information on the sample size, the quality and reliability of the data, and any related issues should be included in the report submitted with this indicator.
Evaluation indicator 7 (E7): % of MSM who are HIV infected	
Definition	Percentage of MSM who are HIV infected This percentage is defined as the total number of MSM that are HIV infected divided by the total number of MSM tested in the last 12 months.
Numerator	Number of MSM who test positive for HIV in the last 12 months (core indicator 6)
Denominator	Number of MSM tested for HIV in the last 12 months (core indicator 6)
Rationale	This indicator is used for assessing progress in reducing HIV prevalence among MSM.
Measurement tools	Counseling records can be used to determine the number of MSM that took an HIV antibody test in the last 12 months, they should also be reviewed to count the number of MSM who were found to be positive.
Data interpretation and use	This indicator is calculated using data from HIV tests conducted among MSM. Due to difficulties in accessing MSM, biases in data are likely to be far more significant than in data from a more general population. If there are concerns about the data, these concerns should be reflected in the interpretation. This indicator will only represent those MSM accessing HCT services; it will not be representative of the situation everywhere else in the district or country.

Evaluation indicator 8 (E8): % of staff trained in implementing HIV prevention activities	
Definition	<p>The total number of staff that have been undergone capacity building and/or training in implementing HIV prevention activities in the last 12 months divided by the total number of staff.</p> <p>The total number of all staff should only include staff that provide and/or manage services; this would exclude cleaners and other maintenance personnel.</p>
Numerator	Number of staff that have undergone at least one training and/or capacity building workshop in the last 12 months
Denominator	Total number of staff that provide and/or manage services to clients
Rationale	This indicator can be used to assess capacity building efforts carried out as part of the program. It helps assess to what extent staff have the skills to complete their job responsibilities.
Measurement tools	The numbers needed to calculate this indicator can be obtained from a review of program records used to track capacity building efforts.
Data interpretation and use	This information can be useful in assessing the skills mix available with the program, and the appropriateness of skills available. When presented by training area, it can provide guidance regarding training priorities.
Evaluation indicator 9 (E9): % of organizations providing the basic package of community services (prevention, care and support)	
Definition	<p>The total number of governmental and non-governmental organizations providing the basic package of prevention, care and support services within the community divided by the total number of governmental and non-governmental organizations providing any prevention, care and/or support services.</p> <p>The basic package of community services includes⁸:</p> <ul style="list-style-type: none"> • Behavior change communication • HIV counseling and testing • Condom distribution • STI treatment • Linkages with care and treatment <p>Organizations here include both registered and non-registered groups of people who have come together to provide prevention, care and support services to MSM.</p>
Numerator	Number of governmental and non-governmental organizations providing the basic package of prevention, care and/or support services within the community
Denominator	Number of governmental and non-governmental organizations

⁸ Cortez C. et al. USG/UNAIDS Implementers Meeting, Kigali, Rwanda, 2007

	providing any prevention, care and/or support services (additional indicator 10)
Rationale	This indicator can be used to assess the coverage of basic packages for MSM in the community.
Measurement tools	A community mapping exercise complemented by a survey of organizations can be used to determine the number of organizations present in the area, and inventorying what activities each is carrying out. If the facility questionnaire is complemented by a QA checklist, information on service quality can also be obtained.
Data interpretation and use	<p>This indicator is useful in assessing coverage, in terms of availability, within a specific area. It cannot assess coverage in terms of accessibility- to measure this a community survey would need to be done to determine the percentage of MSM that knew about and used the services.</p> <p>Depending on the organization, you may decide to measure this by service area (prevention, care, and support), rather than presenting it as an aggregated number.</p>

Counting people

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

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

Qualitative approaches

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

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

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

It is important to think about how qualitative information can assist in program strengthening and in evaluation. The program’s M&E plan can be used to plan for qualitative data collection; unlike quantitative data, these data may only need to be collected periodically. It would be important to collect some qualitative data at the beginning of the project, especially if these data will be used to measure the program’s outcomes. Often, qualitative data are also collected at the mid-point of the program to track progress and inform planning, and again at the program’s end to assess overall outcomes. The following section on “Further Reading” provides some resources that provide clear, comprehensive information on how to collect, analyze and use qualitative data in programs.

Further reading

Background:

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

Monitoring and evaluation:

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

Evaluation approaches and qualitative research:

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