

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

**Revised for FY2006 Reporting**

**July 29, 2005**

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## INTRODUCTION

Strategic information is a cornerstone of the scientific basis of The President's Emergency Plan for AIDS Relief (The Emergency Plan). The *United States Leadership Against HIV/AIDS, Tuberculosis, and Malaria Act of 2003* (Public Law 108-25) set aggressive five-year goals to: 1) support treatment for 2 million people living with HIV/AIDS by 2008; 2) prevent 7 million new HIV infections by 2010; and 3) support care for 10 million people infected and affected by HIV/AIDS, including orphans and vulnerable children, by 2008. To reach these goals, it is imperative that focus countries manage their programs using good quality data that is collected in a timely manner from a variety of sources and methods.

Strategic information serves multiple purposes: to assist countries to plan and monitor HIV/AIDS services, to provide information to the Office of US Global AIDS Coordinator (OGAC) for management of The Emergency Plan, to demonstrate progress toward the legislative goals of the Emergency Plan in the annual report to the US Congress, to advocate for continued support of HIV/AIDS prevention, care, and treatment programs, and to coordinate efforts with the international donor community. The two broad types of information required to monitor performance of The Emergency Plan implementation in host countries include:

A limited set of program monitoring indicators to track key USG-supported activities

National outcome and impact indicators that measure joint progress made together with the host country government and other international donors.

The purpose of this document is to provide guidance regarding data collection and reporting for Emergency Plan program results, including outputs, outcomes and impacts. There are two sections:

Program-level indicators: Table 1 shows required program-level indicators at a glance. This is followed by indicator data sheets for each required program-level indicator, which further describe and define the program-level indicators in Table 1

Summary listings for outcome and impact level indicators with their data collection methods and international standard sources, separated into required (which include indicator data sheets) and recommended indicators

### **Emergency Plan Program-level Reporting**

Each country must report on program results every six months to the Office of the U.S. Global AIDS Coordinator (OGAC). The semi-annual program results will be reported in May of each year and cover the first six months of the fiscal year (October 1-March 31); the annual program results update will be reported in November of each year and cover the full fiscal year (October 1-September 30). Thus, the reporting period will vary: for the semi-annual program results, the reporting period is six months; for annual program results the reporting period is for twelve months. Each program results update will include financial information along with joint USG reporting on all the required program-level indicators contained within this document. The program monitoring indicators of The Emergency Plan are collected from program data/reports and routine facility-based HMIS.

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

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

**Table 1: The Emergency Plan Program-Level Reporting Framework**

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

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

For individuals served by multiple program areas, it is acceptable to count individuals once for each program area (e.g., OVC, antiretroviral therapy ART and Palliative Care). Persons receiving services in one reporting cycle can be counted again in the next cycle if they are still receiving services. Thus, the report shows the total number of persons currently being served within each reporting period (6 or 12 months).

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

The indicators presented here are the minimum program-level reporting requirements under The Emergency Plan. However, they represent only a subset of the information needed by programs to effectively monitor, manage and improve their programs locally. A good example of additional information that would be recommended is geographical coverage of service sites. Age of clients served is another useful variable that is not required in the aggregate counts (with the exception of ART), but is recommended for program management planning purposes at the national level. Technical working groups for program areas have many recommendations for programs on country-level indicators for program management and planning purposes that are not required by OGAC.

### **Direct and Indirect Results for Program-level Indicators**

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

- Number of pregnant women who received HIV counseling and testing for PMTCT and received their test results
- Number of pregnant women provided with a complete course of antiretroviral prophylaxis for PMTCT
- Number of individuals who received counseling and testing for HIV and received their test results
- Number of individuals receiving antiretroviral therapy at the end of the reporting period (referred to as CURRENT clients)
- Number of individuals provided with facility-based, community-based and/or home-based HIV-related palliative care including those HIV-infected individuals who received clinical prophylaxis and/or treatment for tuberculosis (TB)

- Number of HIV-infected clients attending HIV care/treatment services that are receiving treatment for TB disease (this is a subset of 8.2)
- Number of orphans and vulnerable children (OVC) served by an OVC program

#### *USG direct support*

Included in direct results are individuals receiving prevention, care and/or treatment through service delivery sites/providers that are directly supported by USG interventions/activities (commodities, drugs, supplies, supervision, training, quality assurance, etc.) **at the point of service delivery**. An intervention or activity is considered to be a type of "direct support" if it can be associated with counts of uniquely identified individuals receiving prevention, care and/or treatment services at a unique program or service delivery point benefiting from the intervention/activity.

#### *USG indirect support*

For indirect results, estimate the number of individuals served as a result of the USG's contribution to system strengthening beyond those counted as receiving direct USG support. Systems strengthening includes support to national, regional or local activities such as policy development; institutional capacity building; logistics; protocol or guideline development; advocacy; laboratory support; national or regional training; national management information systems, etc.

It is assumed that some of the individuals who receive services at sites directly supported by the Emergency Plan are the same individuals who receive services as the result of indirect support through national, regional or local systems strengthening. To avoid double counting, if an individual is being reached directly through a USG supported site and also indirectly through USG support to national, regional or local systems strengthening, only include the individual in the direct counts. Individuals reached through indirect support should be in addition to those reached via direct support in order to make these categories mutually exclusive.

### **Reporting Program-level Results Achieved by Centrally-funded Projects**

Centrally funded activities, referred to as Track 1.0, are funded by headquarters agencies to implement activities in the field. Reporting on the indicators included in this document should include results achieved by Track 1.0 partners as well as local partners funded entirely through field funding. Track 1.0 partners have the added reporting burden to headquarters as well as to the field mission. During the revision of this document, an effort was made to harmonize language in this guide with the existing Track 1.0 reporting requirements. Track 1.0 grantees may be required to report to their Headquarters agencies on additional indicators.

### **Emergency Plan Legislative Targets**

*Support treatment for 2 million people living with HIV/AIDS by 2008*

The achievement of this target will be measured by the number of individuals receiving antiretroviral therapy (INDICATOR 7.4) at the end of the 12-month reporting period in FY 2008 (not cumulative over 5 years). This target includes both direct and indirect counts.

*Prevent 7 million new HIV infections by 2010*

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

*Support care for 10 million people infected and affected by HIV/AIDS, including orphans and vulnerable children, by 2008*

The achievement of this target will be measured by the number of individuals receiving palliative care (INDICATOR 8.2) and OVC served (INDICATOR 9.1) during the 12-month reporting period in FY 2008 (not cumulative over 5 years). This target includes direct and indirect counts.

The legislative targets were set for countries. Interim annual targets are set by countries through their Country Operation Plans but should reflect annual rather than cumulative counts.

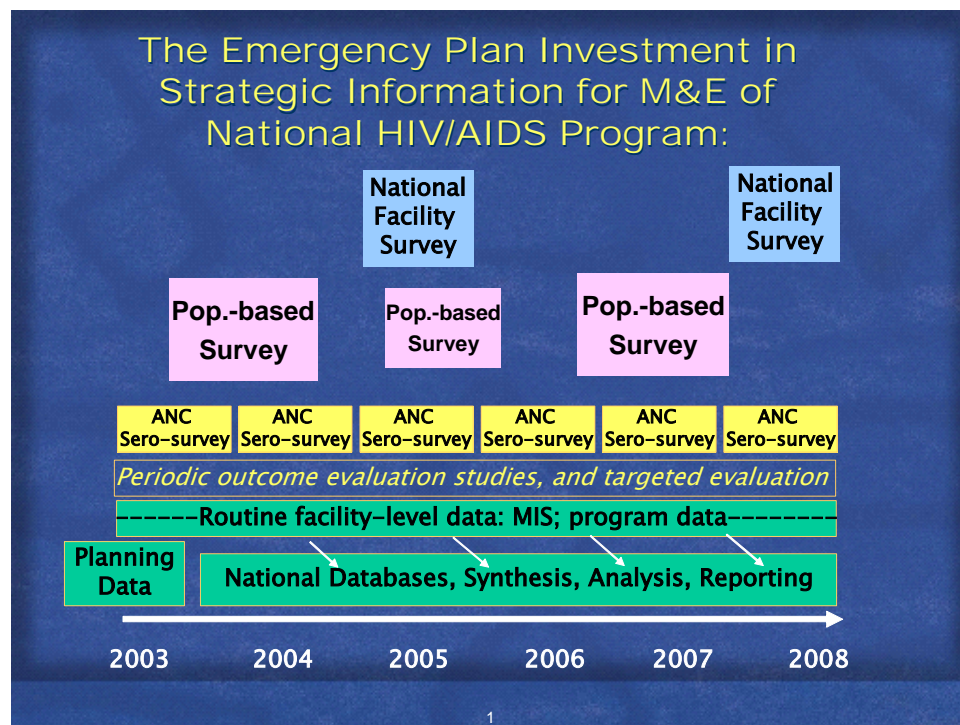
### **Required Emergency Plan Outcome- and Impact-level Indicators**

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

Once per year, in the annual program results due in November, countries will provide updated estimates of the outcome- and impact-level indicators for which data became available during the fiscal year. For example if a country completed an ANC sentinel surveillance survey during the fiscal year, updated prevalence estimates should be reported along with annual program results.

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

The figure below illustrates the proposed timing for the various methodologies necessary to collect all required strategic information data for The Emergency Plan.



### Recommended Emergency Plan Outcome- and Impact-level Indicators

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

For countries with low or concentrated epidemics, there is an additional set of recommended outcome and impact indicators for programs that target the most-at-risk-populations in these countries.



## PROGRAM-LEVEL INDICATORS

<b>Prevention/Abstinence and Being Faithful</b>		
1.1 Number of individuals reached through community outreach that promotes HIV/AIDS prevention through abstinence and/or being faithful		
	Male	
	Female	
1.1.A Number of individuals reached through community outreach that promotes HIV/AIDS prevention through abstinence		
	Male	
	Female	
1.2 Number of individuals trained to promote HIV/AIDS prevention programs through abstinence and/or being faithful		
<b>Prevention/Other Behavior Change</b>		
2.1 Number of targeted condom service outlets		
2.2 Number of individuals reached through community outreach that promotes HIV/AIDS prevention through other behavior change beyond abstinence and/or being faithful		
	Male	
	Female	
2.3 Number of individuals trained to promote HIV/AIDS prevention through other behavior change beyond abstinence and/or being faithful		
<b>Prevention/Medical Transmission/Blood safety</b>		
3.1 Number of service outlets carrying out blood safety activities		
3.2 Number of individuals trained in blood safety		
<b>Prevention/Medical Transmission/Injection Safety</b>		
4.1 Number of individuals trained in medical injection safety		
<b>Prevention of Mother-to-Child Transmission</b>		
5.1 Number of service outlets providing the minimum package of PMTCT services according to national and international standards		
5.2 Number of pregnant women who received HIV counseling and testing for PMTCT and received their test results		
5.3 Number of pregnant women provided with a complete course of antiretroviral prophylaxis in a PMTCT setting		
5.4 Number of health workers trained in the provision of PMTCT services according to national and international standards		
<b>Counseling and Testing</b>		
6.1 Number of service outlets providing counseling and testing according to national and international standards		
6.2 Number of individuals who received counseling and testing for HIV and received their test results		
	Male	

	Female	
6.3 Number of individuals trained in counseling and testing according to national and international standards		
<b>HIV/AIDS Treatment/ARV Services</b>		
7.1 Number of service outlets providing antiretroviral therapy (includes PMTCT+ sites)		
7.2 Number of individuals newly initiating antiretroviral therapy during the reporting period (includes PMTCT+ sites)		
	Male (0-14)	
	Male (15+)	
	Female (0-14)	
	Female (15+)	
	Pregnant female (all ages)	
7.3 Number of individuals who ever received antiretroviral therapy by the end of the reporting period (includes PMTCT+ sites)		
	Male (0-14)	
	Male (15+)	
	Female (0-14)	
	Female (15+)	
	Pregnant female (all ages)	
7.4 Number of individuals receiving antiretroviral therapy at the end of the reporting period (includes PMTCT+ sites)		
	Male (0-14)	
	Male (15+)	
	Female (0-14)	
	Female (15+)	
	Pregnant female (all ages)	
7.5 Total number of health workers trained to deliver ART services, according to national and/or international standards (includes PMTCT+)		
<b>Palliative Care (including TB/HIV care)</b>		
8.1 Total number of service outlets providing HIV-related palliative care (including TB/HIV)		
	8.1.A Number of service outlets providing clinical prophylaxis and/or treatment for tuberculosis (TB) to HIV-infected individuals (diagnosed or presumed) in a palliative care setting (a subset of all palliative care outlets)	
8.2 Total number of individuals provided with HIV-related palliative care (including TB/HIV)		
	Male	
	Female	
	8.2.A Number of HIV-infected clients attending HIV care/treatment services that are receiving treatment for TB disease (a subset of all served with palliative care)	
	Male	
	Female	
	8.2.B Number of HIV-infected clients given TB preventive therapy (a subset of all served with palliative care)	

	Male	
	Female	
8.3 Total number of individuals trained to provide HIV palliative care (including TB/HIV)		
	8.3.A Number of individuals trained to provide clinical prophylaxis and/or treatment for TB to HIV-infected individuals (diagnosed or presumed). Note: This is a subset all trained	
<b>Orphans and Vulnerable Children</b>		
9.1 Number of OVC served by OVC programs		
	Male	
	Female	
9.2 Number of providers/caretakers trained in caring for OVC		
<b>Laboratory Infrastructure</b>		
10.1 Number of laboratories with capacity to perform 1) HIV tests and 2) CD4 tests and/or lymphocyte tests		
10.2 Number of individuals trained in the provision of laboratory-related activities		
10.3 Number of tests performed at USG-supported laboratories during the reporting period: 1) HIV testing, 2) TB diagnostics, 3) syphilis testing, and 4) HIV disease monitoring		
<b>Strategic Information</b>		
11.1 Number of local organizations provided with technical assistance for strategic information activities		
11.2 Number of individuals trained in strategic information (includes M&E, surveillance, and/or HMIS)		
<b>Other/policy development and system strengthening</b>		
12.1 Number of local organizations provided with technical assistance for HIV-related policy development		
12.2 Number of local organizations provided with technical assistance for HIV-related institutional capacity building		
12.3 Number of individuals trained in HIV-related policy development		
12.4 Number of individuals trained in HIV-related institutional capacity building		
12.5 Number of individuals trained in HIV-related stigma and discrimination reduction		
12.6 Number of individuals trained in HIV-related community mobilization for prevention care and/or treatment		

## **Definitions of Program-Level Indicators**

## Prevention: Abstinence and Be Faithful

<b>1.1 Number of individuals reached through community outreach that promotes HIV/AIDS prevention through abstinence and/or being faithful</b>	
<b>Rationale/What It Measures:</b>	This indicator measures the number of individuals who attended community outreach activities focused on abstinence and/or being faithful. In any prevention campaign, the more individuals who receive the message, the higher number who may make the behavioral changes involved.
<b>Definition:</b>	<p>Community outreach is defined as any effort to affect change that might include peer education, classroom, small group and/or one-on-one information, education, communication (IEC) or behavior change communication (BCC) to promote abstinence and/or being faithful.</p> <p>Some programs have clear messages designed to reach a specific audience (i.e., abstinence messages to youth in school or Faithfulness messages to married men), which are fairly easy to classify in this category. Remember that this includes either Abstinence programs or Be Faithful programs or those which have a combination of these approaches as their primary message.</p> <p>Abstinence and/or be faithful are defined below as any of the following:            Activities or programs that promote abstinence:</p> <ol style="list-style-type: none"> <li>1. Importance of abstinence in reducing the prevention of HIV transmission among unmarried individuals;</li> <li>2. Decision of unmarried individuals to delay sexual activity until marriage;</li> <li>3. Development of skills in unmarried individuals for practicing abstinence; and</li> <li>4. Adoption of social and community norms that support delaying sex until marriage and that denounce forced sexual activity among unmarried individuals</li> </ol> <p>AND/OR</p> <p>Activities or programs that promote being faithful:</p> <ol style="list-style-type: none"> <li>1. Importance of being faithful in reducing the transmission of HIV among individuals in long-term sexual partnerships;</li> <li>2. Elimination of casual sex and multiple sexual partnerships;</li> <li>3. Development of skills for sustaining marital fidelity;</li> <li>4. Adoption of social and community norms supportive of marital fidelity and partner reduction using strategies that respect and respond to local customs and norms; and</li> <li>5. Adoption of social and community norms that denounce forced sexual activity in marriage or long-term partnerships</li> </ol>
<b>Measurement Tool:</b>	Program Reports
<b>How To Measure It:</b>	Partners should not double count individuals within a program or service outlet. An individual will count in separate program areas, such as an OVC who may be served separately by an OVC program, ART facility, and prevention program. However, double counting of individuals within a program area is to be avoided among USG funded partners to the extent possible.

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

<b>1.1.A Number of individuals reached through community outreach that promotes HIV/AIDS prevention through abstinence (this is a subset of the total reached with abstinence and/or be faithful – indicator 1.1)</b>	
<b>Rationale/What It Measures:</b>	This indicator measures the number of individuals who attended community outreach activities focused on abstinence and/or being faithful. In any prevention campaign, the more individuals who receive the message, the higher number who may make the behavioral changes involved.
<b>Definition:</b>	<p>Community outreach is defined as any effort to affect change that might include peer education, classroom, small group and/or one-on-one information, education, communication (IEC) or behavior change communication (BCC). In this case, the message will primarily focus on the promotion of abstinence.</p> <p>Abstinence is defined below as any of the following:  Activities or programs that promote abstinence:</p> <ol style="list-style-type: none"> <li>1. Importance of abstinence in reducing the prevention of HIV transmission among unmarried individuals;</li> <li>2. Decision of unmarried individuals to delay sexual activity until marriage;</li> <li>3. Development of skills in unmarried individuals for practicing abstinence; and</li> <li>4. Adoption of social and community norms that support delaying sex until marriage and that denounce forced sexual activity among unmarried individuals</li> </ol>
<b>Measurement Tool:</b>	Program Reports
<b>How To Measure It:</b>	<p>Partners should not double count individuals within a program or service outlet. An individual will count in separate program areas, such as an OVC who may be served separately by an OVC program, ART facility, and prevention program. However, double counting of individuals within a program area is to be avoided among USG funded partners to the extent possible. While programs should be reporting to USG managers on the number of individuals served, the USG team is responsible to the extent possible for adjusting for the overlap between multiple programs serving the same individuals within a program area. All the <b>prevention</b> and <b>care</b> indicators refer to individuals served <i>during the current reporting period</i>. If you served 100 prevention clients last year and served 120 during the current reporting period, this is reported as 120, not 220.</p> <p>In order to avoid double counting, countries will need to monitor their activities by partner, programmatic area, and geographic area. This matrix is an excellent program management tool as well as helping to adjust for double counting by partners, among partners, and among USG agencies.</p>
<b>Interpretation/Strengths and Weaknesses:</b>	Countries will be able to monitor their success in these efforts by setting goals that include tangible increases in this number, indicating further overall reach of the message.

<b>1.2 Number of individuals trained to promote HIV/AIDS prevention through abstinence and/or being faithful</b>	
<b>Rationale/What It Measures:</b>	This indicator is a measure of peer or health care educators who have been trained in the delivery of prevention messages to the target audience. It measures the number of newly trained or retrained individuals who are able to deliver HIV prevention messages with primary focus on abstinence and/or being faithful. Refer to outcome indicators on training for further recommendations.
<b>Definition:</b>	<p>Training refers to new training or retraining of individuals and assumes that training is conducted according to national or international standards when these exist.</p> <p>A training must have specific learning objectives, a course outline or curriculum, and expected knowledge, skills and/or competencies to be gained by participants.</p> <p>Some programs have clear messages designed to reach a specific audience (i.e., abstinence messages to youth in school or Faithfulness messages to married men), which are fairly easy to classify in this category. Remember that this includes either Abstinence programs or Be Faithful programs or those which have a combination of these approaches as their primary message. If the program is targeting sexually active young adults with condom social marketing, it will not count in the Abstinence and Be Faithful category.</p> <p>Abstinence and/or be faithful are defined below as any of the following:</p> <p>Activities or programs that promote abstinence:</p> <ol style="list-style-type: none"> <li>1. Importance of abstinence in reducing the prevention of HIV transmission among unmarried individuals;</li> <li>2. Decision of unmarried individuals to delay sexual activity until marriage;</li> <li>3. Development of skills in unmarried individuals for practicing abstinence; and</li> <li>4. Adoption of social and community norms that support delaying sex until marriage and that denounce forced sexual activity among unmarried individuals</li> </ol> <p>AND/OR</p> <p>Activities or programs that promote being faithful:</p> <ol style="list-style-type: none"> <li>1. Importance of being faithful in reducing the transmission of HIV among individuals in long-term sexual partnerships;</li> <li>2. Elimination of casual sex and multiple sexual partnerships;</li> <li>3. Development of skills for sustaining marital fidelity;</li> <li>4. Adoption of social and community norms supportive of marital fidelity and partner reduction using strategies that respect and respond to local customs and norms; and</li> <li>5. Adoption of social and community norms that denounce forced sexual activity in marriage or long-term partnerships</li> </ol>
<b>Measurement Tool:</b>	Program reports. USG agencies and USG-funded partners should keep a training log including the type of training, date, location, and participants.
<b>How To Measure</b>	Each USG agency and USG-funded partner counts the number of individuals trained in prevention through abstinence and/or



<p><b>It:</b></p>	<p>being faithful by USG staff (HQ or field-based) or USG-funded partners during the specified reporting period (6 months for semi-annual report/12 months for annual report).</p> <p>Only participants who complete the full training course should be counted.  If a training course covers more than one prevention topic, for example abstinence and be faithful, individuals should only be counted once for that training course.  If a training course is conducted in more than one session/training event, only individuals who complete the full course should be counted. Do not sum the participants for each training event.</p> <p>The USG staff responsible for compiling the semi-annual/annual reporting data should use the training log submitted by each USG agency and USG-funded partner reporting on this indicator in order to count the total number of individuals trained in prevention. Individuals trained in training courses co-funded by more than one USG agency/USG-funded partner should only be counted once within the specified reporting period (6 months for semi-annual report/12 months for annual report).</p> <p>In order to avoid double counting, countries will need to monitor their activities by partner, programmatic area, and geographic area. This matrix is an excellent program management tool as well as helping to adjust for double counting by partners, among partners, and among USG agencies.</p>
<p><b>Interpretation/ Strengths and Weaknesses:</b></p>	<p>In many countries, training standards have been defined by the national AIDS coordination body and/or professional organizations. This applies in particular to countries that have introduced certification systems for HIV/AIDS training. The training must equip trainees with a minimum set of competencies needed to take an active role in supporting HIV/AIDS programs in line with national recommendations and/or guidelines. Usually the presence of such competencies is assessed based on successful completion of training and practical experience during the reporting period.</p> <p>This indicator does not measure the quality of training nor does it measure the outcomes of the training in terms of competencies of the individuals trained or their job performance.</p>

## Prevention: Other Behavior Change

<b>2.1 Number of targeted condom service outlets</b>	
<b>Rationale/What It Measures:</b>	This indicator provides a tangible measure of the potential reach of condom distribution to a given community as an important part of a comprehensive prevention message.
<b>Definition:</b>	<p>A targeted condom service outlet refers to fixed distribution points or mobile units with fixed schedules providing condoms for free or for sale.</p> <p>Other behavior change beyond abstinence and/or being faithful includes the targeting of behaviors that increase risk for HIV transmission such as engaging in casual sexual encounters, engaging in sex in exchange for money or favors, having sex with an HIV-positive partner or one whose status is unknown, using drugs or abusing alcohol in the context of sexual interactions, and using intravenous drugs. Women, even if faithful themselves, can still be at risk of becoming infected by their spouse, regular male partner, or someone using force against them. Other high-risk persons or groups include men who have sex with men and workers who are employed away from home. This could include targeted social marketing and/or the promotion of condoms to these high risk groups.</p>
<b>Measurement Tool:</b>	Program Reports
<b>How To Measure It:</b>	A targeted condom service outlet refers to fixed distribution points or mobile units with fixed schedules providing condom distribution. Countries should count the number of distribution points at which condoms are available to their target population.
<b>Interpretation/Strengths and Weaknesses:</b>	This indicator provides a relatively straightforward measure of potential reach in prevention activities that include the distribution of condoms.

<b>2.2 Number of individuals reached through community outreach that promotes HIV/AIDS prevention through other behavior change beyond abstinence and/or being faithful</b>	
<b>Rationale/What It Measures:</b>	This indicator measures the number of individuals who attended community outreach activities focused on other behavior change beyond abstinence and/or being faithful. In any prevention campaign, the more individuals who receive the message, the higher number who may make the behavioral changes involved.
<b>Definition:</b>	<p>Community outreach is defined as any effort to effect change that might include peer education, classroom, small group and/or one-on-one information, education, communication (IEC) or behavior change communication (BCC) to promote comprehensive prevention messages.</p> <p>Other behavior change beyond abstinence and/or being faithful includes the targeting of behaviors that increase risk for HIV transmission such as engaging in casual sexual encounters, engaging in sex in exchange for money or favors, having sex with an HIV-positive partner or one whose status is unknown, using drugs or abusing alcohol in the context of sexual interactions, and using intravenous drugs. Women, even if faithful themselves, can still be at risk of becoming infected by their spouse, regular male partner, or someone using force against them. Other high-risk persons or groups include men who have sex with men and workers who are employed away from home. This could include targeted social marketing and/or the promotion of condoms to these high risk groups.</p>
<b>Measurement Tool:</b>	Program reports
<b>How To Measure It:</b>	<p>Partners should not double count individuals within a program or service outlet. An individual will count in separate program areas, such as an OVC who may be served separately by an OVC program, ART facility, and prevention program. However, double counting of individuals within a program area is to be avoided among USG funded partners to the extent possible. While programs should be reporting to USG managers on the number of individuals served, the USG team is responsible to the extent possible for adjusting for the overlap between multiple programs serving the same individuals within a program area. All the <b>prevention</b> and <b>care</b> indicators refer to individuals served <i>during the current reporting period</i>. If you served 100 prevention clients last year and served 120 during the current reporting period, this is reported as 120, not 220.</p> <p>In order to avoid double counting, countries will need to monitor their activities by partner, programmatic area, and geographic area. This matrix is an excellent program management tool as well as helping to adjust for double counting by partners, among partners, and among USG agencies.</p> <p>For concentrated/low-level epidemic settings where most at risk populations drive HIV transmission, it is recommended (but not required) that this indicator be monitored and disaggregated by the most at risk populations (MARP) as relevant to country context. Please see the next section (pages 78-80)- Disaggregation for Most At Risk Populations -- for an example from Vietnam of MARP disaggregation for Prevention/Other Behavior Change and for Counseling and Testing.</p>
<b>Interpretation/Strengths and Weaknesses:</b>	Countries will be able to monitor their success in these efforts by setting goals that include tangible increases in this number, indicating further overall reach of the message.

<b>2.3 Number of individuals trained to promote HIV/AIDS prevention through other behavior change beyond abstinence and/or being faithful</b>	
<b>Rationale/What It Measures:</b>	This indicator is a measure of peer or health care educators who have been trained in the delivery of prevention messages to the target audience. It measures the number of newly trained or retrained individuals who are able to deliver comprehensive HIV prevention messages.
<b>Definition:</b>	<p>Training refers to new training or retraining of individuals and assumes that training is conducted according to national or international standards when these exist.</p> <p>Other behavior change beyond abstinence and/or being faithful includes targeting those behaviors that increase risk for HIV transmission such as engaging in casual sexual encounters, engaging in sex in exchange for money or favors, having sex with an HIV-positive partner or one whose status is unknown, using drugs or abusing alcohol in the context of sexual interactions, and using intravenous drugs. Women, even if faithful themselves, can still be at risk of becoming infected by their spouse, regular male partner, or someone using force against them. Other high-risk persons or groups include men who have sex with men and workers who are employed away from home. This could include targeted social marketing and/or the promotion of condoms to these high risk groups.</p>
<b>Measurement Tool:</b>	Program reports. USG agencies and USG-funded partners should keep a training log including the type of training, date, location, and participants.
<b>How To Measure It:</b>	<p>Each USG agency and USG-funded partner counts the number of individuals trained in prevention through other behavior change beyond abstinence and/or being faithful by USG staff (HQ or field-based) or USG-funded partners during the specified reporting period (6 months for semi-annual report/12 months for annual report).</p> <p>Only participants who complete the full training course should be counted.  If a training course covers more than one prevention topic, individuals should only be counted once for that training course.  If a training course is conducted in more than one session/training event, only individuals who complete the full course should be counted. Do not sum the participants for each training event.</p> <p>The USG staff responsible for compiling the semi-annual/annual reporting data should use the training log submitted by each USG agency and USG-funded partner reporting on this indicator in order to count the total number of individuals trained in prevention. Individuals trained in training courses co-funded by more than one USG agency/USG-funded partner should only be counted once within the specified reporting period (6 months for semi-annual report/12 months for annual report).</p> <p>In order to avoid double counting, countries will need to monitor their activities by partner, programmatic area, and geographic area. This matrix is an excellent program management tool as well as helping to adjust for double counting by partners, among partners, and among USG agencies.</p>
<b>Interpretation/</b>	This indicator does not measure the quality of the training, nor does it measure the outcomes of the training in terms of the

**Strengths and Weaknesses:**

competencies of individuals trained, nor their job performance.

### Medical Transmission: Blood Safety

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

<b>3.2 Number of individuals trained in blood safety</b>	
<b>Rationale/What It Measures:</b>	The intent of the indicator is to measure progress toward a cadre of professionals trained in blood safety activities according to national or international standards.
<b>Definition:</b>	<p>Blood safety training may address any of the following specific blood safety activities: blood safety policies, infrastructure, equipment, and supplies; blood donor recruitment; blood collection, distribution/supply chain/logistics, testing, screening, and/or transfusion; waste management; and/or management to ensure a safe and adequate blood supply.</p> <p>Training refers to new training or retraining of individuals and assumes that training is conducted according to national or international standards when these exist.</p> <p>The training must follow a curriculum that indicates the objectives and/or expected competencies. Training may be knowledge and/or skills and/or competency-based.</p>
<b>Measurement Tool:</b>	Program reports. USG agencies and USG-funded partners should keep a training log including the type of training, date, location, and participants.
<b>How To Measure It:</b>	<p>Each USG agency and USG-funded partner counts the number of individuals trained in blood safety by USG staff (HQ or field-based) or USG-funded partners during the specified reporting period (6 months for semi-annual report/12 months for annual report).</p> <p>Only participants who complete the full training course should be counted.  If a training course covers more than one blood safety topic, individuals should only be counted once for that training course.  If a training course is conducted in more than one session/training event, only individuals who complete the full course should be counted. Do not sum the participants for each training session.</p> <p>The USG staff responsible for compiling the semi-annual/annual reporting data should use the training log submitted by each USG agency and USG-funded partner reporting on this indicator in order to count the total number of individuals trained in blood safety. Individuals trained in training courses co-funded by more than one USG agency/USG-funded partner should only be counted once within the specified reporting period (6 months for semi-annual report/12 months for annual report).</p> <p>In order to avoid double counting, countries will need to monitor their activities by partner, programmatic area, and geographic area. This matrix is an excellent program management tool as well as helping to adjust for double counting by partners, among partners, and among USG agencies.</p>
<b>Interpretation/Strengths and Weaknesses:</b>	This indicator does not measure the quality of the training, nor does it measure the outcomes of the training in terms of the competencies of individuals trained, nor their job performance.

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

<b>4.1 Number of individuals trained in medical injection safety</b>	
<b>Rationale/What It Measures:</b>	The intent of the indicator is to measure progress toward a cadre of professionals trained in medical injection safety activities according to national or international standards.
<b>Definition:</b>	<p>Medical injection safety training may address any of the following specific medical injection safety activities: medical injection safety policies; appropriate disposal of injection equipment; waste management systems; and/or other injection safety-related distribution/supply chain/logistics.</p> <p>Training refers to new training or retraining of individuals and assumes that training is conducted according to national or international standards when these exist.</p> <p>A training must have specific learning objectives, a course outline or curriculum, and expected knowledge, skills and/or competencies to be gained by participants.</p>
<b>Measurement Tool:</b>	Program reports. USG agencies and USG-funded partners should keep a training log including the type of training, date, location, and participants.
<b>How To Measure It:</b>	<p>Each USG agency and USG-funded partner counts the number of individuals trained in medical injection safety by USG staff (HQ or field-based) or USG-funded partners during the specified reporting period (6 months for semi-annual report/12 months for annual report).</p> <p>Only participants who complete the full training course should be counted. If a training course covers more than one medical injection safety topic, individuals should only be counted once for that training course. If a training course is conducted in more than one session/training event, only individuals who complete the full course should be counted. Do not sum the participants for each training event.</p> <p>The USG staff responsible for compiling the semi-annual/annual reporting data should use the training log submitted by each USG agency and USG-funded partner reporting on this indicator in order to count the total number of individuals trained in medical injection safety. Individuals trained in training courses co-funded by more than one USG agency/USG-funded partner should only be counted once within the specified reporting period (6 months for semi-annual report/12 months for annual report).</p> <p>In order to avoid double counting, countries will need to monitor their activities by partner, programmatic area, and geographic area. This matrix is an excellent program management tool as well as helping to adjust for double counting by partners, among partners, and among USG agencies.</p>
<b>Interpretation/Strengths and</b>	This indicator does not measure the quality of the training, nor does it measure the outcomes of the training in terms of the competencies of individuals trained, nor their job performance.

<b>Weaknesses:</b>	This indicator simply measures number trained in medical injection as opposed to the percent of health facilities with trained staff, which may be measured through health facility surveys.
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## Prevention of Mother-to-Child Transmission Services

<b>5.1 Number of service outlets providing the minimum package of PMTCT services according to national or international standards</b>	
<b>Rationale/What It Measures:</b>	This indicator provides a crude quantitative measure of the stage of PMTCT service expansion and current availability of PMTCT services supported by USG.
<b>Definition:</b>	<p>A service outlet refers to the lowest level of service. For example, a hospital, clinic, or mobile unit.</p> <p>The minimum package of services for preventing mother-to-child transmission (MTCT) of HIV includes at least all four of the following services:</p> <ol style="list-style-type: none"> <li>1. Counseling and testing for pregnant women</li> <li>2. ARV prophylaxis to prevent MTCT</li> <li>3. Counseling and support for safe infant feeding practices</li> <li>4. Family planning counseling or referral</li> </ol>
<b>Measurement Tool:</b>	Program Reports. USG staff and USG-funded partners should keep an inventory of the name and location of service outlets providing PMTCT services, clearly indicating those that provide the minimum package of PMTCT services. This information should be submitted to the USG staff responsible for compiling the semi-annual / annual reporting data as evidence for the reported number of service outlets providing the minimum package of PMTCT services.
<b>How To Measure It:</b>	<p>Each USG agency and USG-funded partner counts the number of service outlets providing the minimum package of PMTCT services at the end of the specified reporting period (6 months for semi-annual report / 12 months for annual report). Count only those service outlets that provide at minimum all four services specified above (1, 2, 3, and 4).</p> <p>The USG staff responsible for compiling the semi-annual / annual reporting data should use the PMTCT service outlets list submitted by each USG agency and USG-funded partner reporting on this indicator in order to count the total number of service outlets providing the minimum package of PMTCT services, avoiding any double-counting of the same PMTCT outlet supported by more than one USG agency/USG-funded partner.</p>
<b>Interpretation/Strengths and Weaknesses:</b>	This indicator does not consider the quality of service provision, which would require more in-depth evaluation efforts like facility surveys. This is not a complete measure of coverage, as there is no denominator of total facilities. This does not account for non-USG supported service outlets.

<b>5.2 Number of pregnant women who received HIV counseling and testing for PMTCT and received their test results</b>	
<b>Rationale/What It Measures:</b>	This indicator reflects one goal of PMTCT which is to increase the number of pregnant women who know their HIV status.
<b>Definition:</b>	The total number of pregnant women who received both HIV counseling and testing including the provision of test results at PMTCT service outlets.
<b>Measurement Tool:</b>	Service outlet log books or HMIS.
<b>How To Measure It:</b>	Count only those pregnant women who received, at minimum, HIV counseling and testing and received results during the specified reporting period (6 months for semi-annual report / 12 months for annual report).
<b>Interpretation/ Strengths and Weaknesses:</b>	This indicator is not an expression of service uptake at a population level, but only the uptake of services at USG-supported PMTCT service outlets. The goal is to track the number of pregnant women who received their test results, however, not all programs are set up to adequately distinguish between those who are tested and those who receive results. In order to provide good quality services, all USG funded PMTCT sites should work toward tracking women through pre-test counseling, testing, post-test counseling, provision of results, and subsequent interventions.

<b>5.3 Number of pregnant women provided with a complete course of antiretroviral prophylaxis for PMTCT</b>	
<b>Rationale/What It Measures:</b>	This indicator is a measure of the delivery and uptake of antiretroviral prophylaxis for PMTCT.
<b>Definition:</b>	The number of women who received a complete course of antiretroviral prophylaxis to prevent MTCT at PMTCT service outlets. ARV prophylaxis may be single dose nevirapine (SD NVP) or short-course combination prophylaxis or highly active anti-retroviral therapy (HAART).
<b>Measurement Tool:</b>	Service outlet log books or HMIS.
<b>How To Measure It:</b>	Count women who received a complete course of antiretroviral prophylaxis to prevent MTCT at PMTCT service outlets during the specified reporting period (6 months for semi-annual report / 12 months for annual report). ARV prophylaxis may be single dose nevirapine (SD NVP) or short-course combination prophylaxis or highly active anti-retroviral therapy (HAART).
<b>Interpretation/Strengths and Weaknesses:</b>	<p>This indicator is not an expression of service coverage at a population level, but only the delivery/uptake of services at USG-supported PMTCT service outlets. This indicator does not distinguish among the different types of prophylaxis (SD NVP, short-course prophylaxis, HAART). It is recommended for program management to track the different types of prophylaxis. This indicator may overestimate the number of women who have received a complete course and does not necessarily allow an estimate of effectiveness if data systems are not set up to verify this information.</p> <p>The definition of a “full course” of antiretroviral prophylaxis will depend on the country’s policy on antiretroviral prophylaxis to reduce the risk of mother-to-child transmission and may or may not include a dose for newborns. Details of the definition used should be provided.</p> <p>Countries will apply different definitions as to what constitutes a “full course” of ARV prophylaxis. Thus, inter-country comparisons may not be entirely valid and should be interpreted with reference to details of the different definitions used in each case</p>

<b>5.4 Number of health workers trained in the provision of PMTCT services according to national or international standards</b>	
<b>Rationale/What It Measures:</b>	The intent of the indicator is to measure progress toward a cadre of professionals trained in PMTCT service delivery according to national or international standards.
<b>Definition:</b>	<p>Training refers to new training or retraining of individuals and assumes that training is conducted according to national or international standards when these exist.</p> <p>A training must have specific learning objectives, a course outline or curriculum, and expected knowledge, skills and/or competencies to be gained by participants. A PMTCT the training curriculum must contain at least one of the PMTCT core elements: PMTCT-related counseling and testing, ARV prophylaxis, infant feeding counseling, and family planning counseling or referral.</p>
<b>Measurement Tool:</b>	Program reports. USG agencies and USG-funded partners should keep a training log including the type of training, date, location, and participants.
<b>How To Measure It:</b>	<p>Each USG agency and USG-funded partner counts the number of individuals trained in PMTCT by USG staff (HQ or field-based) or USG-funded partners during the specified reporting period (6 months for semi-annual report / 12 months for annual report).</p> <p>Only participants who complete the full training course should be counted.  If a training course covers more than one PMTCT topic, for example ARV prophylaxis and infant feeding, individuals should only be counted once for that training course.  If a training course is conducted in more than one session/training event, only individuals who complete the full course should be counted. Do not sum the participants for each training event.</p> <p>The USG staff responsible for compiling the semi-annual/annual reporting data should use the training log submitted by each USG agency and USG-funded partner reporting on this indicator in order to count the total number of individuals trained in PMTCT. Individuals trained in training courses co-funded by more than one USG agency/USG-funded partner should only be counted once within the specified reporting period (6 months for semi-annual report/12 months for annual report).</p> <p>In order to avoid double counting, countries will need to monitor their activities by partner, programmatic area, and geographic area. This matrix is an excellent program management tool as well as helping to adjust for double counting by partners, among partners, and among USG agencies.</p>
<b>Interpretation/Strengths and Weaknesses:</b>	This indicator does not measure the quality of the training, nor does it measure the outcomes of the training in terms of the competencies of individuals trained, nor their job performance. This indicator simply measures number trained in PMTCT as opposed to the percent of health facilities with trained staff, which may be measured through health facility surveys.

## HIV Counseling and Testing Services

<b>6.1 Number of service outlets providing counseling and testing according to national or international standards</b>	
<b>Rationale/What It Measures:</b>	This indicator provides a gross count of the number of locations which provide basic counseling and testing for HIV. It provides a rough sense of the change in the capacity within a country to provide counseling and testing services. If there is a plan to expand the number of service outlets, this measure will track the progress of meeting that goal.
<b>Definition:</b>	<p>A service outlet refers to the lowest level of service. For example, with regard to clinical activities, the lowest level for which data exists should be a service outlet such as a health center, hospital, clinic, stand alone VCT center, or mobile unit.</p> <p>Counseling and testing includes activities in which both HIV counseling and testing are provided for those who seek to know their status (as in traditional VCT) or as indicated in other contexts (e.g. STI clinics, diagnostic testing, etc.). This indicator excludes service outlets that provide counseling and testing in the context of preventing mother-to-child transmission. Please refer to Indicator 5.1 for more guidance on reporting the number of service outlets that provide services to prevent mother-to-child transmission of HIV.</p>
<b>Measurement Tool:</b>	Program reports
<b>How To Measure It:</b>	Outlets which provide both HIV counseling and testing, except those involved in PMTCT.
<b>Interpretation/Strengths and Weaknesses:</b>	This is purely an output measure. It provides no sense of the geographical spread of CT services, nor any relationship to the percentage of the population which is reached by the service outlet. This indicator does not consider the quality of service provision, which would require more in depth evaluation efforts like facility surveys. This is not a complete measure of coverage, as there is no denominator of total facilities. This does not account for non-USG supported service outlets

<b>6.2 Number of individuals who received counseling and testing for HIV and received their test results, disaggregated by sex</b>	
<b>Rationale/What It Measures:</b>	This indicator provides a count of those individuals who have received counseling and testing during the current reporting period and as a result are now aware of their HIV status.
<b>Definition:</b>	This indicator requires a minimum of counseling, testing, and the provision of test results.
<b>Measurement Tool:</b>	Program reports
<b>How To Measure It:</b>	<p>Partners should not double count individuals seen multiple time within a program. An individual may count in separate program areas, such as an OVC who may be served separately by an OVC program, ART facility, and prevention program. However, double counting of individuals within a program area is to be avoided among USG funded partners to the extent possible. While programs should be reporting to USG managers on the actual number of individuals served, the USG team is responsible to the extent possible for adjusting for the overlap between multiple programs serving the same individuals within a program area. All the <b>prevention</b> and <b>care</b> indicators refer to individuals served <i>during the current reporting period</i>. If you reached 100 OVC last year (in the Annual Report) and now serve 120 during the current reporting period, this is reported as 120, not 220. In order to avoid double counting, countries will need to monitor their activities by partner, programmatic area, and geographic area. This matrix is an excellent program management tool as well as helping to adjust for double counting by partners, among partners, and among USG agencies.</p> <p>For concentrated/low-level epidemic settings where most at risk populations drive HIV transmission, it is recommended (but not required) that this indicator be monitored and disaggregated by the most at risk populations (MARP) as relevant to country context. Please see the next section (<a href="#">Disaggregation of Most At Risk Populations (MARPs) for Program-Level Indicators on Prevention/Other and Counseling and Testing</a> pages 76-78) -- for an example from Vietnam of MARP disaggregation for Prevention/Other Behavior Change and for Counseling and Testing.</p>
<b>Interpretation/Strengths and Weaknesses:</b>	This is an output measure. It doesn't provide a workload count or provide any specific information about the quality of the counseling or the extent to which people are receiving follow up services. The goal is to track the number of individuals who received their test results, however, not all programs are set up to adequately distinguish between those who are tested and those who receive results. All programs should work towards being able to track individuals through pre-test counseling, testing, post-test counseling, provision of results, and subsequent interventions. This indicator also does not track where the counseling and testing is taking place. People may go more than once during the reporting period to different outlets. Refer to outcome level indicators for measurement of percent of population counseled, tested, and receiving results.



<b>6.3 Number of individuals trained in counseling and testing according to national or international standards</b>	
<b>Rationale/What It Measures:</b>	This provides a means to gauge progress toward any training targets which may be incorporated into national plans.
<b>Definition:</b>	<p>Training refers to new training or retraining of individuals and assumes that training is conducted according to national or international standards when these exist.</p> <p>A training must have specific learning objectives, a course outline or curriculum, and expected knowledge, skills and/or competencies to be gained by participants.</p>
<b>Measurement Tool:</b>	Program reports. USG agencies and USG-funded partners should keep a training log including the type of training, date, location, and participants.
<b>How To Measure It:</b>	<p>Each USG agency and USG-funded partner counts the number of individuals trained in prevention by USG staff (HQ or field-based) or USG-funded partners during the specified reporting period (6 months for semi-annual report / 12 months for annual report).</p> <p>Only participants who complete the full training course should be counted.  If a training course covers more than one counseling and testing topic, individuals should only be counted once for that training course.  If a training course is conducted in more than one session/training event, only individuals who complete the full course should be counted. Do not sum the participants for each training event.</p> <p>The USG staff responsible for compiling the semi-annual/annual reporting data should use the training log submitted by each USG agency and USG-funded partner reporting on this indicator in order to count the total number of individuals trained in counseling and testing. Individuals trained in training courses co-funded by more than one USG agency/USG-funded partner should only be counted once within the specified reporting period (6 months for semi-annual report/12 months for annual report).</p> <p>In order to avoid double counting, countries will need to monitor their activities by partner, programmatic area, and geographic area. This matrix is an excellent program management tool as well as helping to adjust for double counting by partners, among partners, and among USG agencies.</p>
<b>Interpretation/Strengths and Weaknesses:</b>	<p>This indicator does not measure the quality of the training, nor does it measure the outcomes of the training in terms of the competencies of individuals trained, nor their job performance.</p> <p>This indicator simply measures number trained in counseling and testing as opposed to the percent of health facilities with trained staff, which may be measured through health facility surveys.</p>

## Treatment: Antiretroviral Services

<b>7.1 Number of service outlets providing ART services according to national or international standards</b>	
<b>Rationale/What It Measures:</b>	Rationale: This indicator measures the progress of a program to expand the number of locations in which ART services are delivered in accordance with national or international standards.
<b>Definitions:</b>	<p>Service outlet: A service outlet refers to the lowest level of service. For example, with regard to clinical activities, the lowest level for which data exists should be a service outlet such as a hospital, clinic, or mobile unit.</p> <p>ART services: Activities including the provision of antiretroviral drugs and clinical monitoring for antiretroviral therapy among those with HIV infection.</p> <p>Antiretroviral therapy: Long-term combination antiretroviral therapy intended primarily to improve the health of the individual on treatment, not to prevent mother-to-child transmission.</p> <p>National or international standards: National guidelines and policies to promote ART training and services in a comprehensive way, linking them with HIV prevention and care and with the strengthening of health systems. National guidelines and policies are often based on existing international ones, and are generally agreed upon in a national forum. Without standards, services of unknown quality and impact can be implemented on an ad hoc basis, making it difficult to monitor and evaluate efforts.</p> <p>PMTCT+ site: A service outlet that provides a minimum package of services which includes HIV counseling and testing for pregnant women, ARV prophylaxis to prevent mother-to-child transmission, counseling for safe infant feeding practices, family planning counseling or referral, and ARV therapy for HIV+ women, their children, and their families.</p>
<b>Measurement Tool:</b>	Program Reports
<b>How To Measure It:</b>	Count all service outlets providing ART including designated PMTCT+ sites.
<b>Interpretation/Strengths and Weaknesses:</b>	<p>This indicator does not describe the geographic location or distribution of service outlets.</p> <p>This indicator does not consider the quality of service provision, which would require more in-depth evaluation efforts like facility surveys. This is not a complete measure of coverage, as there is no denominator of total facilities. This does not account for non-USG supported service outlets.</p>

<b>7.2. Number of individuals newly initiated on antiretroviral therapy during the reporting period, disaggregated by sex and age and pregnancy status (referred to as NEW clients)</b>	
<b>Rationale/What It Measures:</b>	<p>Rationale: There are three program indicators to count individuals receiving antiretroviral therapy at a service outlet directly supported by USG Emergency Plan funds: NEW, CUMULATIVE, and CURRENT.</p> <p>What it measures: NEW refers to individuals newly initiated on antiretroviral therapy during a reporting period.</p>
<b>Definitions:</b>	<p>Antiretroviral therapy: Long-term combination antiretroviral therapy intended primarily to improve the health of the individual on treatment, not to prevent mother-to-child transmission.</p> <p>Newly initiated: Initiated antiretroviral therapy during the reporting period in a program directly supported by USG funds.</p> <p>PMTCT+ site: A service outlet that provides a minimum package of services which includes HIV counseling and testing for pregnant women, ARV prophylaxis to prevent mother-to-child transmission, counseling for safe infant feeding practices, family planning counseling or referral, and ARV therapy for HIV+ women, their children, and their families.</p> <p>Sex: Refers to male or female</p> <p>Age: Age is divided into two categories: age &lt;15 years or age &gt;= 15 years.</p> <p>Pregnant: A new client is counted as pregnant if she is pregnant at the time she is initiated on antiretroviral therapy, regardless of the outcome of the pregnancy.</p>
<b>Measurement Tool:</b>	Program Reports
<b>How To Measure It:</b>	<p>This indicator includes two mutually exclusive sets of individuals on ART: those who receive antiretroviral therapy at a designated PMTCT+ site and those who receive antiretroviral therapy elsewhere.</p> <p>If an individual transfers in to the ART program <i>with records</i> from continuous ART at another facility or program, this person should NOT be counted as new.</p> <p>If an individual transfers in <i>without records</i> or has no documented evidence of previous antiretroviral therapy, this person may be counted as new (because programs have no choice but to enroll this person as a new client).</p> <p>If an individual previously on ART in the program restarts ART after an interruption in therapy, this person should NOT be counted as new.</p> <p>If an individual initiated treatment during the period but died, stopped ART, or transferred out before the end of the</p>

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

<b>7.3 Number of individuals who ever received antiretroviral therapy by the end of the reporting period, disaggregated by sex and age and pregnancy status (referred to as CUMULATIVE clients)</b>	
<b>Rationale/What It Measures:</b>	<p>Rationale: There are three program indicators to count individuals receiving antiretroviral therapy at a service outlet directly supported by USG Emergency Plan funds: NEW, CUMULATIVE, and CURRENT. Collectively, these three program indicators, when combined with the Required Outcome Indicator: Care &amp; Treatment 5 (percentage of people still alive and on therapy at 6, 12, and 24 months after initiation of treatment) give an overview of the progress of a program in achieving targets to begin and maintain individuals on long-term, antiretroviral therapy.</p> <p>What it measures: CUMULATIVE refers to the total number of individuals who were <i>ever</i> on ART since the start of Emergency Plan support to the service outlet.</p>
<b>Definitions:</b>	<p>Antiretroviral therapy: Long-term combination antiretroviral therapy intended primarily to improve the health of the individual on treatment, not to prevent mother-to-child transmission.</p> <p>PMTCT+ site: A service outlet that provides a minimum package of services which includes HIV counseling and testing for pregnant women, ARV prophylaxis to prevent mother-to-child transmission, counseling for safe infant feeding practices, family planning counseling or referral, and ARV therapy for HIV+ women, their children, and their families.</p> <p>Sex: Refers to male or female</p> <p>Age: Age is divided into 2 categories: age &lt;15 years or age ≥ 15 years.</p> <p>Pregnant: A new client is reported as pregnant if she is pregnant at the time she is initiated on antiretroviral therapy, regardless of the outcome of the pregnancy.</p>
<b>Measurement Tool:</b>	Program reports
<b>How To Measure It:</b>	<p>This indicator includes two mutually exclusive sets of individuals on ART: those who receive antiretroviral therapy at a designated PMTCT+ site and those who receive antiretroviral therapy elsewhere.</p> <p>The CUMULATIVE indicator is comprised of the NEW clients plus those who clients who transfer with records into a program directly supported by USG Emergency Plan funds.</p> <p>The cumulative number of clients by the end of any reporting period is the sum of the cumulative number of clients at the end of the <i>previous</i> reporting period plus the clients who newly initiate and transfer into the program <i>during</i> the reporting period.</p>

	<p>The CUMULATIVE count never declines over time, as it represents the total number of individuals who were <i>ever</i> on ART, regardless of whether they died or otherwise left the program.</p> <p>The same individual should never be counted more than once for the CUMULATIVE indicator. (Thus If an individual previously on ART in the program restarts ART after an interruption in therapy, this person should NOT be counted again in the cumulative count as s/he was already counted once.)</p> <p>For the CUMULATIVE indicator, age represents an individual's age at initiation of therapy or when s/he transfers into the program.</p> <p>Disaggregation of pregnant women by age is NOT required. The number of pregnant women is to be shown as a subset of all women.</p>
<p><b>Interpretation/ Strengths and Weaknesses:</b></p>	<p>As the health of ART clients improves and ART services become available at more locations, transferring patients may account for an increasing proportion of ART client load in the health care system and at any given facility. If treatment is not adequately documented or records are not transferred with a client, clients may be newly initiated at more than one program/facility over time. At the country level, these clients will be double counted in the NEW and CUMULATIVE client indicators. Double counting of individuals within a program area is to be avoided among USG funded partners to the extent possible.</p> <p>Since age and pregnancy status change over time, the comparison of NEW, CUMULATIVE, and CURRENT clients by age and pregnancy status is challenging. Because new and cumulative are states defined by <i>beginning</i> in a program, it is expected that the characteristics of new and cumulative clients are recorded at the time they newly initiate or transfer into a program. On the contrary, current is a state defined by vital/treatment status when <i>last</i> seen, so it is expected that characteristics of these clients would be updated each time they are seen by a program.</p>

<b>7.4. Number of individuals receiving antiretroviral therapy at the end of the reporting period, disaggregated by sex and age and pregnancy status (referred to as CURRENT clients)</b>	
<b>Rationale/What It Measures:</b>	<p>Rationale: There are three program indicators to count individuals receiving antiretroviral therapy at a service outlet directly supported by USG Emergency Plan funds: NEW, CUMULATIVE, and CURRENT. Collectively, these three program indicators, when combined with the Required Outcome Indicator: Care &amp; Treatment 5 (percentage of people still alive and on therapy at 6, 12, and 24 months after initiation of treatment) give an overview of the progress of a program in achieving targets to begin and maintain individuals on long-term, antiretroviral therapy.</p> <p>What it measures: CURRENT refers to those individuals on antiretroviral therapy at the end of a reporting period.</p>
<b>Definitions:</b>	<p>Antiretroviral therapy: Long-term combination antiretroviral therapy intended primarily to improve the health of the individual on treatment, not to prevent mother-to-child transmission.</p> <p>At the end of the reporting period: Refers to the last day of the 6-month or 12-month reporting period.</p> <p>PMTCT+ site: A service outlet that provides a minimum package of services which includes HIV counseling and testing for pregnant women, ARV prophylaxis to prevent mother-to-child transmission, counseling for safe infant feeding practices, family planning counseling or referral, and ARV therapy for HIV+ women, their children, and their families.</p> <p>Pregnant: A current client is pregnant if she was pregnant <i>at any time during the reporting period</i>, regardless of the outcome of the pregnancy.</p> <p>Sex: Refers to male or female</p> <p>Age: Age is divided into 2 categories: age &lt;15 years or age &gt;= 15 years.</p>
<b>Measurement Tool:</b>	Program Reports
<b>How To Measure It:</b>	<p>This indicator includes two mutually exclusive sets of individuals on ART: those who receive antiretroviral therapy at a designated PMTCT+ site and those who receive antiretroviral therapy elsewhere.</p> <p>A person on ART who initiated ART or transferred in during the reporting period can be counted as a CURRENT client if s/he is on treatment at the end of the reporting period.</p> <p>Individuals who died, stopped treatment, transferred out, or were otherwise lost to follow up during the reporting period are not on ART at the end of the reporting period, and thus, are NOT counted as a CURRENT client.</p>

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



<b>7.5 Number of health workers trained to deliver ART services according to national or international standards</b>	
<b>Rationale/What It Measures:</b>	<p>Rationale: Building human capacity in health care delivery systems is of the utmost importance for the delivery of quality ART services.</p> <p>What it measures: This indicator measures efforts to train a workforce to achieve targets in ART service delivery. Included are both certified clinical and lay health workers who contribute to the development and implementation of ART services. Health workers trained to deliver ART services at PMTCT+ sites should also be included here.</p>
<b>Definitions:</b>	<p>Health workers: This includes health workers that have been sufficiently trained to take up a direct function in support of scaling up clinical or community-based ART services.</p> <p>Type of health workers include:</p> <ul style="list-style-type: none"> <li>• Physicians and health workers with physician skills (e.g. Medical Officers)</li> <li>• Nurses and other health workers with nursing skills (e.g. Midwives, Clinical Officers)</li> <li>• Other health care workers and lay staff in clinical setting</li> <li>• Laboratory technicians and staff</li> <li>• Pharmacy/dispensing staff</li> <li>• Community treatment supporters (peer educators, outreach workers, volunteers, informal caregivers)</li> </ul> <p>Trained: Refers to new training or retraining of individuals and assumes that training is conducted according to national or international standards when these exist. It is assumed that in most settings such training will occur through a specialized training program that health workers attend after their regular education ("in-service" training). Only health workers who have undergone such training should be included.</p> <p>A training must have specific learning objectives, a course outline, or curriculum, and expected knowledge, skills and/or competencies to be gained by participants.</p> <p>ART services: Activities including the provision of antiretroviral drugs and clinical monitoring for antiretroviral therapy among those with HIV infection.</p> <p>National or international standards: National guidelines and policies to promote ART training and services in a comprehensive way, linking them with HIV prevention and care and with the strengthening of health systems. National guidelines and policies are often based on existing international ones, and are generally agreed upon in a national forum. Without standards, services of unknown quality and impact can be implemented on an ad hoc basis, making it difficult to monitor and evaluate efforts.</p> <p>PMTCT+ site: A service outlet that provides antiretroviral therapy (long-term triple combination antiretroviral therapy primarily intended to improve the health of the individual on treatment, not to prevent mother-to-child transmission) in the</p>

	same clinic and by the same staff who provide PMTCT services.
<b>Measurement Tool:</b>	Program Reports
<b>How To Measure It:</b>	<p>Each USG agency and USG-funded partner counts the number of individuals trained in prevention by USG staff (HQ or field-based) or USG-funded partners during the specified reporting period (6 months for semi-annual report / 12 months for annual report).</p> <p>Only participants who complete the full training course should be counted.  If a training course covers more than one ART delivery topic, individuals should only be counted once for that training course.  If a training course is conducted in more than one session/training event, only individuals who complete the full course should be counted. Do not sum the participants for each training event.</p> <p>The USG staff responsible for compiling the semi-annual/annual reporting data should use the training log submitted by each USG agency and USG-funded partner reporting on this indicator in order to count the total number of individuals trained in ART delivery. Individuals trained in training courses co-funded by more than one USG agency/USG-funded partner should only be counted once within the specified reporting period (6 months for semi-annual report/12 months for annual report).</p> <p>In order to avoid double counting, countries will need to monitor their activities by partner, programmatic area, and geographic area. This matrix is an excellent program management tool as well as helping to adjust for double counting by partners, among partners, and among USG agencies.</p>
<b>Interpretation/ Strengths and Weaknesses:</b>	<p>This indicator is most useful in the initial phases of a response to HIV/AIDS, when the cumulative number of trained health professionals is expected to be continuously increasing until it reaches a critical mass (or desired ceiling). At this point, the quantitative focus of the indicator on the number of health workers trained might become obsolete. The measurement could shift to capture the quality of the training, refresher training, and testing/supervision of the health care practices.</p> <p>This indicator does not measure the distribution of health workers trained to provide ART services.  This indicator does not disaggregate by the type of health worker trained to provide ART services.  This indicator does not measure the type, content or duration of training being counted or whether the health workers counted as trained have been counted as trained in a previous period.</p> <p>Given the importance of human capacity to provide pediatric AIDS services, countries and/or programs may wish to collect additional information on the number of health workers trained to provide pediatric ART services.</p> <p>This indicator does not measure the quality of the training, nor does it measure the outcomes of the training in terms of the</p>

	<p>competencies of individuals trained, nor their job performance.</p>
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	<p>This indicator simply measures number trained in ART services as opposed to the percent of health facilities with trained staff, which may be measured through health facility surveys.</p>
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## Palliative Care (including TB/HIV care)

<b>8.1 Number of service outlets providing HIV-related palliative care</b>	
<b>Rationale/What It Measures:</b>	<p>Palliative care is patient and family-centered care. It optimizes the quality of life of adults and children living with HIV through the active anticipation, prevention, and treatment of pain, symptoms and suffering from the onset of HIV diagnosis through death. Palliative care includes and goes beyond the medical management of infectious, neurological or oncological complications of HIV/AIDS to comprehensively address symptoms and suffering throughout the continuum of illness. The means by which this is achieved will vary according to stage of illness but always with the understanding that quality of life involves clinical, psychological, spiritual, and support care.</p> <p>This indicator includes the total number of service outlets which provide HIV-related care.</p>
<b>Definition:</b>	<p>A service outlet refers to the lowest level of service. For example, with regard to clinical activities, the lowest level for which data exists should be a service outlet such as a hospital, clinic, or mobile unit.</p> <p>Palliative care services include A) clinical/medical, B) psychological, C) spiritual, and/or D) support care services.</p> <p>Clinical care services include: prevention and treatment of TB/HIV, prevention and treatment of other opportunistic infections (OIs), alleviation of HIV-related symptoms and pain, nutritional rehabilitation for malnourished PLWHA.</p> <p>Psychological care services include: interventions that address the non-physical suffering of individuals and family members, such as mental health counseling, support groups, identification and treatment of HIV-related psychiatric illnesses such as depression and related anxieties, and bereavement services.</p> <p>Spiritual care services include: culturally-sensitive interventions that support individuals and families through faith and ritual, life review, assessment and counseling on hopes, fear, meaning of life, guilt, forgiveness and life completion tasks.</p> <p>Supportive care services include: assisting individuals and family members in linking to care services such as child care, adherence to treatment, legal services, housing, food support and income-generating programs.</p>
<b>Measurement Tool:</b>	Program Reports
<b>How To Measure It:</b>	The number of service outlets includes those providing medical and clinical care (for opportunistic infections including TB), psychological, spiritual, and/or supportive care for HIV-infected individuals and their families.
<b>Interpretation/Strengths and Weaknesses:</b>	<p>One difficulty with this indicator is that while facility-based or community-based service outlets in fixed locations are relatively straight-forward to measure, community-based or home-based outreach activities are too difficult to define as service outlets and are not captured in this indicator. It is recommended that at country level, programs monitor which sites provide each of the key interventions: medical, psychological, spiritual and social.</p> <p>This indicator does not consider the quality of service provision, which would require more in-depth evaluation efforts like</p>

	facility surveys. This is not a complete measure of coverage, as there is no denominator of total facilities. This does not account for non-USG supported service outlets.
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<b>8.1.A Number of service outlets providing clinical prophylaxis and/or treatment for tuberculosis (TB) to HIV-infected individuals (diagnosed or presumed) according to national or international standards [This is a subset of the total number of service outlets providing HIV-related palliative care.]</b>	
<b>Rationale/What It Measures:</b>	<p>Palliative care is patient and family-centered care. It optimizes the quality of life of adults and children living with HIV through the active anticipation, prevention, and treatment of pain, symptoms and suffering from the onset of HIV diagnosis through death. Palliative care includes and goes beyond the medical management of infectious, neurological or oncological complications of HIV/AIDS to comprehensively address symptoms and suffering throughout the continuum of illness. The means by which this is achieved will vary according to stage of illness but always with the understanding that quality of life involves clinical, psychological, spiritual, and support care.</p> <p>This indicator measures the subset of service outlets providing TB/HIV care.</p>
<b>Definition:</b>	<p>A service outlet refers to the lowest level of service. For example, with regard to clinical activities, the lowest level for which data exists should be a service outlet such as a hospital, clinic, or mobile unit.</p> <p>A service outlet that will count in this indicator will provide treatment and/or clinical prophylaxis for tuberculosis to HIV-infected individuals (diagnosed or presumed).</p>
<b>Measurement Tool:</b>	Program Reports
<b>How To Measure It:</b>	[This is a subset of the total number of service outlets providing general HIV-related palliative care.] Outreach-only programs are counted through the number of communities served by community/home-based palliative care [Indicator 8.2]
<b>Interpretation/Strengths and Weaknesses:</b>	<p>One difficulty with this indicator is that while facility-based or community-based service outlets in fixed locations are relatively straight-forward to measure, community-based or home-based outreach activities are too difficult to define as service outlets and are not captured in this indicator. It is recommended that at country level, programs monitor which sites provide each of the key interventions: medical, psychological, spiritual and social.</p> <p>This indicator does not consider the quality of service provision, which would require more in-depth evaluation efforts like facility surveys. This is not a complete measure of coverage, as there is no denominator of total facilities. This does not account for non-USG supported service outlets.</p>

<b>8.2 Total number of individuals provided with HIV-related palliative care including those HIV-infected individuals who received clinical prophylaxis and/or treatment for tuberculosis (TB) (Indicator 8.2.A and 8.2.B), disaggregated by sex</b>	
<b>Rationale/What It Measures:</b>	This indicator is the total number of unduplicated individuals receiving palliative care from facilities and/or community/home-based organizations.
<b>Definition:</b>	<p>HIV-related palliative care is= patient and family-centered care that optimizes the quality of life of adults and children living with HIV through the active anticipation, prevention, and treatment of pain, symptoms and suffering from the onset of HIV diagnosis through death. Palliative care includes and goes beyond the medical management of infectious, neurological or oncological complications of HIV/AIDS to comprehensively address symptoms and suffering throughout the continuum of illness. The means by which this is achieved will vary according to stage of illness but always with the understanding that quality of life involves clinical, psychological, spiritual, and supportive care.</p> <p>Palliative care is a patient and family-centered service, therefore clients provided with general HIV-related palliative care/basic health care and support during the reporting period may include patients and family members. How much care is needed in order to count within the indicator is currently left to national standards – all persons served during the reporting period will be counted once by a unique program regardless of frequency. HIV-infected individuals and families have varying needs for services depending on the stage of illness, type of service, and available resources of HIV-infected persons. Quality assurance and supervision are expected by program managers to ensure that persons are receiving proper care.</p>
<b>Measurement Tool:</b>	Program Reports
<b>How To Measure It:</b>	<p>This indicator is the total number of unduplicated individuals receiving palliative care from facilities and community/home-based organizations. This is not simply the sum of the individuals served by facility-based palliative care (including TB) and community/home-based palliative care partners, as adjustment for the overlap in service to the same individuals should be accounted for in this total.</p> <p>Partners should not double count individuals within a program or service outlet. An individual will count in separate program areas, such as an OVC who may be served separately by an OVC program, ART facility, and prevention program. However, double counting of individuals within a program area is to be avoided among USG funded partners to the extent possible. While programs should be reporting to USG managers on the number of individuals served, the USG team is responsible to the extent possible for adjusting for the overlap between multiple programs serving the same individuals within a program area.</p> <p>Countries will need to monitor their activities by partner, programmatic area, and geographic area. A matrix is an excellent program management tool as well as helping to avoid double counting by a partner, among partners, and among USG agencies.</p>
<b>Interpretation/Strengths and Weaknesses:</b>	Adjusting for overlap between programs is very difficult, especially when programs are not well linked and patient confidentiality concerns must be respected.





<b>8.2.A Number of HIV-infected clients attending HIV care/treatment services that are receiving treatment for TB disease (this is a subset of 8.2)</b>	
<b>Rationale/What It Measures:</b>	Evidence has shown that previously undiagnosed tuberculosis was detected in a significant proportion (up to 11%) of HIV-infected clients through routinely TB screening at HIV counseling and testing services. HIV-infected patients with tuberculosis should be identified and placed on appropriate TB treatment in order interrupt TB transmission, and reduce the burden of TB among HIV-infected clients. This indicator will measure the implementation of the recommended activity to integrate TB and HIV activity and reduce the burden of TB in HIV-infected clients.
<b>Definition:</b>	The number of HIV-positive clients accessing HIV care/treatment services HIV (HIV care centers, PMTCT) that are documented to be receiving treatment for TB disease. This treatment should be in-line with National TB Program treatment guidelines.
<b>Measurement Tool:</b>	Program Registries, Reports
<b>How To Measure It:</b>	The data for this indicator can be located in health records service outlets that provide HIV care/treatment (Home/community-based care, PMTCT sites, HIV care centers, general health services that manage HIV/AIDS patients).
<b>Interpretation/Strengths and Weaknesses:</b>	As TB treatment lasts approximately 9 months, this indicator does not measure the outcome of the TB treatment. [Source: WHO: Policy Statement on Preventive Therapy against TB in People Living with HIV: Report of a Meeting held in Geneva 18-20 Feb. 1998]. This indicator does not measure the duration of therapy.

<b>8.2.B Number of HIV-positive clients given TB preventive therapy (this is a subset of 8.2)</b>	
<b>Rationale/What It Measures:</b>	TB preventive therapy is given to individuals with latent TB infection to reduce the likelihood of progression to active disease. As HIV-infection is the most powerful known risk factor for progression from latent infection to active disease, preventive therapy should be part of a package of care for people living with HIV/AIDS.
<b>Definition:</b>	The number of HIV-positive clients in whom active TB has been excluded and have been initiated on treatment for latent TB.
<b>Measurement Tool:</b>	Program Registries, Reports
<b>How To Measure It:</b>	The data for this indicator can be located in places where HIV counseling/testing and care/treatment take place (VCT centers, PMTCT sites, HIV care centers, general health services that manage HIV/AIDS patients. Upon ruling out active TB disease (via the National TB Program Guidelines), HIV-infected patients should be offered TB preventive therapy
<b>Interpretation/Strengths and Weaknesses:</b>	Indicator does not measure completion of TB preventive therapy or adherence to such therapy. [Source: WHO, A guide to monitoring and evaluation for collaborative TB/HIV activities-Field Test Version. Geneva, Switzerland 2004]. This indicator does not measure the duration of therapy.

<b>8.3 Total number of individuals trained to provide HIV-related palliative care for HIV-infected individuals (diagnosed or presumed) that includes those trained in facility-based, community-based and/or home-based care including TB/HIV</b>	
<b>Rationale/What It Measures:</b>	This indicator measures the total number trained for HIV-related palliative care
<b>Definition:</b>	<p>Training refers to new training or retraining of individuals and assumes that training is conducted according to national or international standards when these exist.</p> <p>A training must have specific learning objectives, a course outline or curriculum, and expected knowledge, skills and/or competencies to be gained by participants.</p> <p>Training on HIV-related palliative care services may include: A) clinical/medical including TB/HIV, B) psychological, C) spiritual, and/or D) support care services for HIV-infected individuals and family members.</p> <p>Clinical care services include: prevention and treatment of TB/HIV, prevention and treatment of other opportunistic infections (OIs), alleviation of HIV-related symptoms and pain, nutritional rehabilitation for malnourished PLWHA.</p> <p>Psychological care services include: interventions that address the non-physical suffering of individuals and family members, such as mental health counseling, support groups, identification and treatment of HIV-related psychiatric illnesses such as depression and related anxieties, and bereavement services.</p> <p>Spiritual care services include: culturally-sensitive interventions that support individuals and families through faith and ritual, life review, assessment and counseling on hopes, fear, meaning of life, guilt, forgiveness and life completion tasks.</p> <p>Supportive care services include: assisting individuals and family members in linking to care services such as child care, adherence to treatment, legal services, housing, food support and income-generating programs.</p>
<b>Measurement Tool:</b>	Program reports. USG agencies and USG-funded partners should keep a training log including the type of training, date, location, and participants.
<b>How To Measure It:</b>	<p>This indicator is the total number of individuals receiving training for facility-based palliative care (including those trained in TB/HIV)</p> <p>Each USG agency and USG-funded partner counts the number of individuals trained in HIV-related palliative care by USG staff (HQ or field-based) or USG-funded partners during the specified reporting period (6 months for semi-annual report / 12 months for annual report).</p> <p>Only participants who complete the full training course should be counted.</p> <p>If a training course covers more than one palliative care topic, for example clinical care and psychological care, individuals</p>

	<p>should only be counted once for that training course. If a training course is conducted in more than one session/training event, only individuals who complete the full course should be counted. Do not sum the participants for each training event.</p> <p>The USG staff responsible for compiling the semi-annual / annual reporting data should use the training log submitted by each USG agency and USG-funded partner reporting on this indicator in order to count the total number of individuals trained in HIV-related palliative care. Individuals trained in training courses co-funded by more than one USG agency/USG-funded partner should only be counted once within the specified reporting period (6 months for semi-annual report/12 months for annual report).</p> <p>In order to avoid double counting, countries will need to monitor their activities by partner, programmatic area, and geographic area. This matrix is an excellent program management tool as well as helping to adjust for double counting by partners, among partners, and among USG agencies.</p>
<p><b>Interpretation/ Strengths and Weaknesses:</b></p>	<p>This indicator does not measure the quality of the training, nor does it measure the outcomes of the training in terms of the competencies of individuals trained, nor their job performance.</p> <p>This indicator simply measures number trained in palliative care as opposed to the percent of health facilities with trained staff, which may be measured through health facility surveys.</p>

<b>8.3.A Number of individuals trained to provide tuberculosis (TB) treatment and/or clinical prophylaxis to HIV-infected individuals (diagnosed or presumed) according to national or international standards [This indicator is a subset of the total number trained for HIV-related palliative care in Indicator 8.3]</b>	
<b>Rationale/What It Measures:</b>	This is a subset of the total number trained for HIV-related palliative care who had specific training on TB/HIV
<b>Definition:</b>	<p>Training refers to new training or retraining of individuals and assumes that training is conducted according to national or international standards when these exist.</p> <p>TB/HIV training refers to trainings designed to enhance participants' knowledge of or ability to deliver clinical prophylaxis and/or treatment for TB.</p>
<b>Measurement Tool:</b>	Program reports. USG agencies and USG-funded partners should keep a training log including the type of training, date, location, and participants.
<b>How To Measure It:</b>	<p>This is a subset of the total number trained for HIV-related palliative care who had specific training on TB/HIV including clinical prophylaxis and/or treatment to HIV-infected individuals (diagnosed or presumed).</p> <p>Each USG agency and USG-funded partner counts the number of individuals trained in TB/HIV by USG staff (HQ or field-based) or USG-funded partners during the specified reporting period (6 months for semi-annual report/12 months for annual report).</p> <p>Only participants who complete the full training course should be counted.  If a training course covers more than one TB/HIV topic, individuals should only be counted once for that training course.  If a training course is conducted in more than one session/training event, only individuals who complete the full course should be counted. Do not sum the participants for each training event.</p> <p>The USG staff responsible for compiling the semi-annual/annual reporting data should use the training log submitted by each USG agency and USG-funded partner reporting on this indicator in order to count the total number of individuals trained in TB/HIV. Individuals trained in training courses co-funded by more than one USG agency/USG-funded partner should only be counted once within the specified reporting period (6 months for semi-annual report/12 months for annual report).</p> <p>In order to avoid double counting, countries will need to monitor their activities by partner, programmatic area, and geographic area. This matrix is an excellent program management tool as well as helping to adjust for double counting by partners, among partners, and among USG agencies.</p>
<b>Interpretation/Strengths and Weaknesses:</b>	This indicator does not measure the quality of the training, nor does it measure the outcomes of the training in terms of the competencies of individuals trained, nor their job performance.

	This indicator simply measures number trained in palliative care as opposed to the percent of health facilities with trained staff, which may be measured through health facility surveys.
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## Orphans and Vulnerable Children

<b>9.1 Number of orphans and vulnerable children (OVC) served by an OVC program, disaggregated by sex</b>	
<b>Rationale/What It Measures:</b>	The goal of OVC activities is to provide support aimed at improving the lives of children and families directly affected by AIDS-related morbidity and/or mortality. The emphasis is on strengthening communities to meet the needs of orphans and vulnerable children affected by HIV/AIDS, supporting community-based responses, helping children and adolescents meet their own needs, creating a supportive social environment. This indicator will measure OVC who are receiving: access to education; economic support; targeted food and nutrition support; legal aid; medical, psychological, or emotional care; and/or other social and material support. Institutional responses would also be included.
<b>Definition:</b>	Orphans are defined as children under 18 who have lost either a mother or father. Vulnerable children are those that reside in households affected by HIV/AIDS, for example a household in which a parent or principle caretaker is HIV infected.
<b>Measurement Tool:</b>	Program reports
<b>How To Measure It:</b>	<p>Partners should not double count individuals within a program or service outlet. An individual will count in separate program areas, such as an OVC who may be served separately by an OVC program, ART facility, and prevention program. However, double counting of individuals within a program area is to be avoided among USG funded partners to the extent possible. While programs should be reporting to USG managers on the number of individuals served, the USG team is responsible to the extent possible for adjusting for the overlap between multiple programs serving the same individuals within a program area.</p> <p>While programs for OVC are likely to work with family members, reporting on this indicator is restricted to orphans and vulnerable children; other (non-OVC) family members should not be counted in this indicator. The number of contacts and the extent of services an OVC receives in order to count in this indicator is to be determined by each country based on standards agreed upon by USG and its implementing partners. However, all OVC served during the reporting period will be counted once by a program, regardless of the number of contacts with that OVC during the period. Quality assurance, supervision, and follow-up are expected by program managers to ensure that OVC are receiving quality care.</p> <p>Count the number of OVC reached during the reporting period, that is October through March for the semi-annual report and October through September for the annual report. This is NOT the cumulative number of OVC reached over the life of the Emergency Plan. Although the same OVC may be counted in different fiscal years, you should not add OVC reached from one fiscal year to the next. For example, if you reached 1000 OVC in FY04 and you continue to serve 900 of them in FY05 plus an additional 500 new OVC, you would report 1400 OVC reached in FY05.</p>
<b>Interpretation/Strengths and</b>	OVC policy guidance is under development and this indicator may evolve along with the policy.

<b>Weaknesses:</b>	<p>This is a process indicator, which captures the reach of Emergency Plan funded services, but not the quality or content of those services. In the absence of policy guidance for Emergency Plan funded OVC interventions, the USG team in country may require that certain conditions be met before an OVC can be reported as “served”.</p> <p>The impact of services on the children served is not captured through routinely collected program indicators. National-level outcome and impact indicators will be collected periodically via population-based surveys, and special studies.</p> <p>This indicator does not consider the quality of service provision, which would require more in-depth evaluation efforts like facility surveys. This is not a complete measure of coverage, as there is no denominator of total facilities. This does not account for non-USG supported service outlets.</p>
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<b>9.2 Number of providers/caretakers trained in caring for orphans and vulnerable children</b>	
<b>Rationale/What It Measures:</b>	The goal of OVC activities is to provide support aimed at improving the lives of children and families directly affected by AIDS-related morbidity and/or mortality. The emphasis is on strengthening communities to meet the needs of orphans and vulnerable children affected by HIV/AIDS, supporting community-based responses, helping children and adolescents meet their own needs, creating a supportive social environment. Activities could include training to increase capacity of families, community members, government staff, and staff of NGOs/CBOs/FBOs to provide: increasing access to education; economic support; targeted food and nutrition support; legal aid; medical, psychological, or emotional care; and/or other social and material support. Institutional responses would also be included.
<b>Definition:</b>	<p>Providers/caretakers = anyone who ensures care for OVC, including those who provide, make referrals to, and/or oversee social services. This may include parents, guardians, other caregivers, extended family, neighbors, community leaders, police officers, social workers, national, district, and/or local social welfare ministry staff, as well as health care workers, teachers, or community workers who receive training on how to address the needs of OVC.</p> <p>Training refers to new training or retraining of individuals and assumes that training is conducted according to national or international standards when these exist.</p> <p>A training must have specific learning objectives, a course outline or curriculum, and expected knowledge, skills and/or competencies to be gained by participants.</p>
<b>Measurement Tool:</b>	Program reports. USG agencies and USG-funded partners should keep a training log including the type of training, date, location, and participants.
<b>How To Measure It:</b>	<p>Each USG agency and USG-funded partner counts the number of individuals trained in OVC care by USG staff (HQ or field-based) or USG-funded partners during the specified reporting period (6 months for semi-annual report/12 months for annual report).</p> <p>Only participants who complete the full training course should be counted.</p> <p>If a training course covers more than one OVC care topic, for example abstinence and be faithful, individuals should only be counted once for that training course.</p> <p>If a training course is conducted in more than one session/training event, only individuals who complete the full course should be counted. Do not sum the participants for each training event.</p> <p>The USG staff responsible for compiling the semi-annual/annual reporting data should use the training log submitted by each USG agency and USG-funded partner reporting on this indicator in order to count the total number of individuals trained in OVC care. Individuals trained in training courses co-funded by more than one USG agency / USG-funded partner should only be counted once within the specified reporting period (6 months for semi-annual report/12 months for annual report).</p> <p>In order to avoid double counting, countries will need to monitor their activities by partner, programmatic area, and geographic area. This matrix is an excellent program management tool as well as helping to adjust for double counting by</p>

	partners, among partners, and among USG agencies.
<b>Interpretation/ Strengths and Weaknesses:</b>	This indicator does not measure the quality of the training, nor does it measure the outcomes of the training in terms of the competencies of individuals trained, nor their job performance.

## Laboratory Infrastructure

<b>10.1 Number of laboratories with the capacity to perform (1) HIV tests and (2) CD4 tests and/or lymphocyte tests</b>	
<b>Rationale/What It Measures:</b>	This indicator reflects USG efforts to strengthen capacities of laboratories to perform HIV/AIDS related tests, diagnostics and monitoring tasks.
<b>Definition:</b>	Laboratory capacity is defined as the ability to perform (1) HIV tests and (2) CD4 tests or lymphocyte tests. This refers to both the equipment and personnel necessary to carry out testing.
<b>Measurement Tool:</b>	<p>Program reports. To assess whether the laboratory sites have the capacity to perform the specified testing, special studies using observation techniques may be necessary.</p> <p>USG staff and USG-funded partners should keep an inventory of the name and location of laboratory sites that are able to perform the specified testing. This information should be submitted to the USG staff responsible for compiling the semi-annual / annual reporting data as evidence for the reported number of laboratories with the capacity to perform the specified tests.</p>
<b>How To Measure It:</b>	<p>Each USG agency and USG-funded partner counts the number of laboratory sites that have at minimum the capacity to perform the specified testing at the end of the specified reporting period (6 months for semi-annual report / 12 months for annual report). Count only those laboratory sites that are able to perform both HIV tests and [CD4 tests and/or lymphocyte tests].</p> <p>The USG staff responsible for compiling the semi-annual / annual reporting data should use the laboratory sites list submitted by each USG agency and USG-funded partner reporting on this indicator in order to count the total number of laboratory sites that have the stated capacity, avoiding any double-counting of the same laboratory site supported by more than one USG agency/USG-funded partner.</p>
<b>Interpretation/Strengths and Weaknesses:</b>	<p>This indicator does not measure whether the sites are actually performing the specified tests.</p> <p>This indicator does not consider the quality of service provision, which would require more in-depth evaluation efforts like facility surveys. This is not a complete measure of coverage, as there is no denominator of total facilities. This does not account for non-USG supported service outlets.</p>

<b>10.2 Number of individuals trained in laboratory-related activities</b>	
<b>Rationale/What It Measures:</b>	The intent of the indicator is to measure progress toward developing and/or maintaining the skills of a cadre of professionals such that they are able to provide laboratory services according to national or international standards.
<b>Definition:</b>	<p>Training refers to new training or retraining of individuals and assumes that training is conducted according to national or international standards when these exist.</p> <p>A training must have specific learning objectives, a course outline or curriculum, and expected knowledge, skills and/or competencies to be gained by participants.</p>
<b>Measurement Tool:</b>	Program reports. USG agencies and USG-funded partners should keep a training log including the type of training, date, location, and participants.
<b>How To Measure It:</b>	<p>Each USG agency and USG-funded partner counts the number of individuals trained in laboratory-related activities by USG staff (HQ or field-based) or USG-funded partners during the specified reporting period (6 months for semi-annual report / 12 months for annual report).</p> <p>Only participants who complete the full training course should be counted.  If a training course covers more than one laboratory-related activities topic, individuals should only be counted once for that training course.  If a training course is conducted in more than one session / training event, only individuals who complete the full course should be counted. Do not sum the participants for each training event.</p> <p>The USG staff responsible for compiling the semi-annual / annual reporting data should use the training log submitted by each USG agency and USG-funded partner reporting on this indicator in order to count the total number of individuals trained in laboratory-related activities. Individuals trained in training courses co-funded by more than one USG agency/USG-funded partner should only be counted once within the specified reporting period (6 months for semi-annual report/12 months for annual report).</p> <p>In order to avoid double counting, countries will need to monitor their activities by partner, programmatic area, and geographic area. This matrix is an excellent program management tool as well as helping to adjust for double counting by partners, among partners, and among USG agencies.</p>
<b>Interpretation/Strengths and Weaknesses:</b>	<p>This indicator does not measure the quality of the training, nor does it measure the outcomes of the training in terms of the competencies of individuals trained, nor their job performance.</p> <p>This indicator simply measures number trained in laboratory-related activities as opposed to the percent of health facilities with trained staff, which may be measured through health facility surveys.</p>

<b>10.3 Number of tests performed at USG-supported laboratories during the reporting period: 1) HIV testing, 2) TB diagnostics, 3) syphilis testing, and 4) HIV disease monitoring</b>	
<b>Rationale/What It Measures:</b>	This indicator measures the extent to which USG-supported laboratories are expanding laboratory services to support HIV/AIDS care and treatment services.
<b>Definition:</b>	<p>The number of tests performed at USG-supported laboratories during the reporting period (6 months/ 12 months)</p> <ul style="list-style-type: none"> <li>• HIV testing: Examples include ELISA and simple rapid tests for serology and polymerase chain reaction (PCR) for infant diagnostics;</li> <li>• TB diagnostics: Acid fast (Ziehl-Neelsen) staining of sputum.</li> <li>• Syphilis testing: Rapid Plasma Reagent (RPR), simple syphilis, Treponema pallidum hemagglutination assay (TPHA), Include both screening and confirmation; and</li> <li>• HIV disease monitoring: CD4, viral load, Alanin transaminase (ALT), and Creatinine.</li> </ul>
<b>Measurement Tool:</b>	Systematic review of project documents and records; laboratory records. Data collection must be ongoing and aggregated over the 6-month and 12 month reporting period. The USG team in country should aggregate data across all USG-supported laboratories.
<b>How To Measure It:</b>	This measure should reflect the number of tests performed, not the number of kits or reagents purchased. Measurement of this indicator is undertaken by systematically reviewing laboratory records maintained at each site, as well as USG project records and documents, to count the number of USG-supported laboratories performing tests within each of the categories listed above. The number of tests should be added within each category. For example, the number of HIV tests should reflect the sum of ELISAs, rapid tests, and PCRs.
<b>Interpretation/Strengths and Weaknesses:</b>	<p>This indicator is an output indicator of direct support provided to strengthen laboratories in a given country and for the Emergency Plan as a whole. Different sub-categories of HIV monitoring provide an overall picture of USG support. For management purposes, laboratories may want more detailed information about the tests performed.</p> <p>When interpreting this indicator, consideration must be given to factors within and beyond USG manageable interests. For example, reagent stock outages and logistical problems greatly reduce the number of tests performed in labs. Often procurement and logistics are being managed independently.</p> <p>The ability of laboratories to report this information may lag behind their capacity to perform these tests. As a result, counts may underestimate laboratory performance. As record keeping and reporting capacity of laboratories improves, so will the quality and accuracy of the indicator estimate.</p>

	<p>This indicator should be interpreted along with indicator 10.1.</p> <p>This indicator does not consider the quality of service provision, which would require more in-depth evaluation efforts like facility surveys.</p> <p>This indicator does not measure the unique contribution of USG, since other donors or countries may also be providing support. This indicator should not be used as a measure of the number of people tested or receiving services since the unit of analysis is the test not the person.</p>
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**Strategic Information**  
**(Surveillance, Health Management Information Systems, Monitoring and Evaluation)**

<b>11.1 Number of local organizations provided with technical assistance for strategic information (M&amp;E and/or surveillance and/or HMIS).</b>	
<b>Rationale/What It Measures:</b>	The intent of the indicator is to capture support provided to enhance the capacity of local organizations to collect, analyze, disseminate and use HIV/AIDS-related data.
<b>Definition:</b>	<p>A <b>local organization</b> is defined as any entity whose headquarters is in a country or region served by the Emergency Plan. As such, the majority of the entity's staff (senior, mid-level, support) is comprised of host country and/or regional nationals. "Local organizations" refers to both governmental and non-governmental (NGOs, FBOs, and community-based) organizations.</p> <p>Technical assistance (TA) is defined as the identification of need for and delivery of practical program and technical support. TA is intended to assist local organizations in building capacity to design, implement and evaluate HIV prevention, care and treatment programs.</p> <p>TA should include <i>regular technical communications and information dissemination sustained over a period of time</i>. TA can be provided through a combination of strategic approaches and dissemination strategies including individualized and on-site peer and expert consultation, site visits, ongoing consultative relationships, national and/or regional meetings, consultative meetings and conferences, conference calls and web-casts, development and implementation of training curricula.</p> <p>Provision of technical assistance for strategic information refers to activities that aim to strengthen HIV/AIDS surveillance, HMIS and M&amp;E. Examples include providing local organizations with technical assistance in the following areas: developing or improving M&amp;E models, methods and tools for collecting, analyzing, disseminating and using data; establishing or improving information systems; developing or improving program monitoring, planning and or conducting targeted program evaluations including operations research; monitoring and disseminating best practices to improve program efficiency and effectiveness; and/or improving data quality.</p> <p>Strategic information includes HIV/AIDS surveillance, health management information systems, and monitoring and evaluation.</p>
<b>Measurement Tool:</b>	Program reports.
<b>How To Measure It:</b>	<p>Each USG agency and USG-funded partner counts the number of organizations that received technical assistance for SI activities from USG staff (HQ or field-based) or USG-funded partners during the specified reporting period (6 months for semi-annual report / 12 months for annual report).</p> <p>USG staff and USG-funded partners should keep an inventory of name of organization to which the technical assistance is provided, the type of technical assistance provided, name of technical assistance provider, and date / time period of</p>

	<p>technical assistance provision. This information should be submitted to the USG staff responsible for compiling the semi-annual / annual reporting data as evidence for the reported number of organizations supported with SI technical assistance.</p> <p>The USG staff responsible for compiling the semi-annual / annual reporting data should use the technical assistance inventory submitted by each USG agency and USG-funded partner reporting on this indicator in order to count the total number of organizations / agencies that received technical assistance for SI activities from USG staff (HQ or field-based) or USG-funded partners during the reporting period. Organizations may only be counted once within the specified reporting period (6 months for semi-annual report / 12 months for annual report).</p> <p>Organizations that received TA for policy development should be reported under Indicator 12.1. Organizations that received TA for institutional capacity building, should be counted under Indicator 12.2.</p>
<p><b>Interpretation/ Strengths and Weaknesses:</b></p>	<p>This indicator does not capture the quality of the technical support provided, nor does it capture changes in the capacity of the organization/agency in collecting, analyzing, disseminating and using HIV/AIDS data.</p>



<b>11.2 Number of individuals trained in strategic information (M&amp;E and/or surveillance and/or HMIS)</b>	
<b>Rationale/What It Measures:</b>	The intent of the indicator is to measure progress toward creating a cadre of professionals trained in the collection, analysis, dissemination and use of strategic information for HIV/AIDS programming.
<b>Definition:</b>	<p>Training refers to new training or retraining of individuals and assumes that training is conducted according to national or international standards when these exist.</p> <p>A training must have specific learning objectives, a course outline or curriculum, and expected knowledge, skills and/or competencies to be gained by participants.</p>
<b>Measurement Tool:</b>	Program reports. USG agencies and USG-funded partners should keep a training log including the type of training, date, location, and participants.
<b>How To Measure It:</b>	<p>Count the number of individuals trained in SI during the specified reporting period (6 months for semi-annual report / 12 months for annual report). Only participants who complete the full training course should be counted. If a training course is conducted in several sessions or covers more than one SI topic, for example M&amp;E and surveillance, individuals should only be counted once for that training course. If a training spans more than 1 programmatic area with separate and specific objectives and curricula for each program (for instance OVC and SI), individuals trained may count in each program area.</p> <p>Individuals trained in training courses co-funded by more than one USG agency / USG-funded partner should only be counted once within the specified reporting period.</p> <p>Each USG agency and USG-funded partner counts the number of individuals trained in SI by USG staff (HQ or field-based) or USG-funded partners during the specified reporting period (6 months for semi-annual report/12 months for annual report).</p> <p>Only participants who complete the full training course should be counted.</p> <p>If a training course covers more than one SI topic, for example M&amp;E and surveillance, individuals should only be counted once for that training course.</p> <p>If a training course is conducted in more than one session / training event, only individuals who complete the full course should be counted. Do not sum the participants for each training event.</p> <p>The USG staff responsible for compiling the semi-annual / annual reporting data should use the training log submitted by each USG agency and USG-funded partner reporting on this indicator in order to count the total number of individuals trained in SI. Individuals trained in training courses co-funded by more than one USG agency / USG-funded partner should only be counted once within the specified reporting period (6 months for semi-annual report / 12 months for annual report).</p>
<b>Interpretation/ Strengths and Weaknesses:</b>	This indicator does not measure the quality of the training, nor does it measure the outcomes of the training in terms of the competencies of individuals trained, nor their job performance.

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

<b>12.1 Number of local organizations provided with technical assistance for HIV-related policy development</b>	
<b>Rationale/What It Measures:</b>	This indicator measures the degree to which local organizations receive technical assistance in support of policy development, a priority area of the Emergency Plan.
<b>Definition:</b>	<p>A <b>local organization</b> is defined as any entity whose headquarters is in a country or region served by the Emergency Plan. As such, the majority of the entity's staff (senior, mid-level, support) is comprised of host country and/or regional nationals. "Local organizations" refers to both governmental and non-governmental (NGOs, FBOs, and community-based) organizations.</p> <p>Technical assistance (TA) is defined as the identification of need for and delivery of practical program and technical support. TA is intended to assist local organizations in building capacity to design, implement and evaluate HIV prevention, care and treatment programs.</p> <p>TA should include <i>regular technical communications and information dissemination sustained over a period of time</i>. TA can be provided through a combination of strategic approaches and dissemination strategies including individualized and on-site peer and expert consultation, site visits, ongoing consultative relationships, national and/or regional meetings, consultative meetings and conferences, conference calls and web-casts, development and implementation of training curricula.</p> <p>TA for policy development activities aim to:</p> <ul style="list-style-type: none"> <li>• Broaden and strengthen political and popular support for HIV/AIDS policies and programs;</li> <li>• Improve the operational environment for these programs, including better planning and financing;</li> <li>• Ensure that accurate, up-to-date information informs policy decisions; and</li> <li>• Build in-country and regional capacity to participate in policy development.</li> </ul>
<b>Measurement Tool:</b>	Program reports
<b>How To Measure It:</b>	Sum of local organizations that received technical assistance in HIV-related policy. Organizations that received TA for Strategic Information (M&E, HMIS, Surveillance) or Quality Assurance, should be counted under SI (Indicator 11.1). Organizations that received TA for institutional capacity building should be reported under Indicator 12.2.
<b>Interpretation/Strengths and Weaknesses:</b>	This indicator does not measure amount and quality of TA and only indicates the number of organizations that received any TA.

<b>12.2 Number of local organizations provided with technical assistance for HIV-related institutional capacity building</b>	
<b>Rationale/What It Measures:</b>	This indicator measures the degree to which organizations receive technical assistance in support of institutional capacity development, a priority area of The Emergency Plan.
<b>Definition:</b>	<p>A <b>local organization</b> is defined as any entity whose headquarters is in a country or region served by the Emergency Plan. As such, the majority of the entity's staff (senior, mid-level, support) is comprised of host country and/or regional nationals. "Local organizations" refers to both governmental and non-governmental (NGOs, FBOs, and community-based) organizations.</p> <p>Technical assistance (TA) is defined as the identification of need for and delivery of practical program and technical support. TA is intended to assist local organizations in building capacity to design, implement and evaluate HIV prevention, care and treatment programs.</p> <p>TA should include <i>regular technical communications and information dissemination sustained over a period of time</i>. TA can be provided through a combination of strategic approaches and dissemination strategies including individualized and on-site peer and expert consultation, site visits, ongoing consultative relationships, national and/or regional meetings, consultative meetings and conferences, conference calls and web-casts, development and implementation of training curricula.</p> <p>TA for institutional capacity building may cover the following:</p> <ul style="list-style-type: none"> <li>• <i>Strategic Planning:</i> organizations that have a Board of Directors, mission statement, and strategies for the short and long-term (5 -10 years), including diversification of funding sources and ability to write their own grant proposals;</li> <li>• <i>Registration:</i> organizations that are officially registered as legal entities;</li> <li>• <i>Financial Management:</i> organizations that have a practical accounting system in place and are able to account for all expenditures in accordance with USG and in-country audit requirements, analyze unit costs, make financial projections, and track expenditures against budgets;</li> <li>• <i>Human Resource Management:</i> organizations with an established personnel system with checks and balances, for recruiting, paying, retaining, training, and supervising adequate numbers of staff at all levels of the organization;</li> <li>• <i>Networks Development:</i> local networks established/strengthened that deliver prevention, care and treatment services, monitor implementation, and report results;</li> <li>• <i>Commodities, Equipment and Logistics Management:</i> organizations that have established a system to assess commodity needs, account for donated product, ensure adequate drug supply at all times, and eventually procure and purchase supplies, equipment, and drugs for HIV/AIDS prevention, care and treatment services; and</li> <li>• <i>Infrastructure Development:</i> laboratories, clinics, and classrooms improved or renovated to provide HIV/AIDS training or services.</li> </ul>
<b>Measurement Tool:</b>	Program reports
<b>How To Measure It:</b>	Sum of local organizations that received technical assistance in HIV-related institutional capacity building. Organizations that received TA for Strategic Information (M&E, HMIS, Surveillance) or Quality Assurance, should be counted under SI (Indicator

	11.1). Organizations that received TA for policy development should be reported under Indicator 12.1.
<b>Interpretation/ Strengths and Weaknesses:</b>	This indicator does not measure amount and quality of TA and only indicates the number of organizations that received any TA.

<b>12.3 Number of individuals trained in HIV-related policy development</b>	
<b>Rationale/What It Measures:</b>	Supportive Interventions strengthen HIV prevention, care and treatment programs. This indicator measures the number of individuals trained in policy for HIV/AIDS programs.
<b>Definition:</b>	<p>Training refers to new training or retraining of individuals and assumes that training is conducted according to national or international standards when these exist. Count all individuals trained, from local organizations or otherwise, during the reporting period.</p> <p>A training must have specific learning objectives, a course outline or curriculum, and expected knowledge, skills and/or competencies to be gained by participants.</p> <p>Policy activities aim to:</p> <ul style="list-style-type: none"> <li>• Broaden and strengthen political and popular support for HIV/AIDS policies and programs;</li> <li>• Improve the operational environment for these programs, including better planning and financing;</li> <li>• Ensure that accurate, up-to-date information informs policy decisions; and</li> <li>• Build in-country and regional capacity to participate in policy development.</li> </ul>
<b>Measurement Tool:</b>	Program reports. USG agencies and USG-funded partners should keep a training log including the type of training, date, location, and participants.
<b>How To Measure It:</b>	<p>Each USG agency and USG-funded partner counts the number of individuals trained in policy development by USG staff (HQ or field-based) or USG-funded partners during the specified reporting period (6 months for semi-annual report/12 months for annual report).</p> <p>Only participants who complete the full training course should be counted.</p> <p>If a training course covers more than one policy development topic, individuals should only be counted once for that training course.</p> <p>If a training course is conducted in more than one session / training event, only individuals who complete the full course should be counted. Do not sum the participants for each training event.</p> <p>The USG staff responsible for compiling the semi-annual / annual reporting data should use the training log submitted by each USG agency and USG-funded partner reporting on this indicator in order to count the total number of individuals trained in policy development. Individuals trained in training courses co-funded by more than one USG agency/USG-funded partner should only be counted once within the specified reporting period (6 months for semi-annual report/12 months for annual report).</p> <p>In order to avoid double counting, countries will need to monitor their activities by partner, programmatic area, and geographic area. This matrix is an excellent program management tool as well as helping to adjust for double counting by</p>

	partners, among partners, and among USG agencies.
<b>Interpretation/ Strengths and Weaknesses:</b>	<p>This indicator does not measure the quality of the training, nor does it measure the outcomes of the training in terms of the competencies of individuals trained, nor their job performance.</p> <p>This indicator simply measures number trained in HIV-related policy development as opposed to the percent of organizations with trained staff.</p>

<b>12.4 Number of individuals trained in HIV-related institutional capacity building</b>	
<b>Rationale/What It Measures:</b>	This indicator measures the number of individuals trained in institutional capacity building. As more and more individuals are trained in the different capacity building domains, more individuals can be reached with HIV/AIDS services. In conjunction with indicator 12.2, this gives a picture of the reach of capacity building programs.
<b>Definition:</b>	<p>Training refers to new training or retraining of individuals and assumes that training is conducted according to national or international standards when these exist. Count all individuals trained, from local organizations or otherwise, during the reporting period.</p> <p>A training must have specific learning objectives, a course outline or curriculum, and expected knowledge, skills and/or competencies to be gained by participants.</p> <p>Institutional capacity building activities may include:</p> <ul style="list-style-type: none"> <li>• <i>Strategic Planning:</i> organizations that have a Board of Directors, mission statement, and strategies for the short and long-term (5 -10 years), including diversification of funding sources and ability to write their own grant proposals;</li> <li>• <i>Registration:</i> organizations that are officially registered as legal entities;</li> <li>• <i>Financial Management:</i> organizations that have a practical accounting system in place and are able to account for all expenditures in accordance with USG and in-country audit requirements, analyze unit costs, make financial projections, and track expenditures against budgets;</li> <li>• <i>Human Resource Management:</i> organizations with an established personnel system with checks and balances, for recruiting, paying, retaining, training, and supervising adequate numbers of staff at all levels of the organization;</li> <li>• <i>Networks Development:</i> local networks established/strengthened that deliver prevention, care and treatment services, monitor implementation, and report results;</li> <li>• <i>Commodities, Equipment and Logistics Management:</i> organizations that have established a system to assess commodity needs, account for donated product, ensure adequate drug supply at all times, and eventually procure and purchase supplies, equipment, and drugs for HIV/AIDS prevention, care and treatment services; and</li> <li>• <i>Infrastructure Development:</i> laboratories, clinics, and classrooms improved or renovated to provide HIV/AIDS training or services.</li> </ul>
<b>Measurement Tool:</b>	Program reports. USG agencies and USG-funded partners should keep a training log including the type of training, date, location, and participants.
<b>How To Measure It:</b>	<p>Each USG agency and USG-funded partner counts the number of individuals trained in institutional capacity building by USG staff (HQ or field-based) or USG-funded partners during the specified reporting period (6 months for semi-annual report/12 months for annual report).</p> <p>Only participants who complete the full training course should be counted. If a training course covers more than one institutional capacity building topic, individuals should only be counted once for</p>

	<p>that training course. If a training course is conducted in more than one session/training event, only individuals who complete the full course should be counted. Do not sum the participants for each training event.</p> <p>The USG staff responsible for compiling the semi-annual/annual reporting data should use the training log submitted by each USG agency and USG-funded partner reporting on this indicator in order to count the total number of individuals trained in institutional capacity building. Individuals trained in training courses co-funded by more than one USG agency / USG-funded partner should only be counted once within the specified reporting period (6 months for semi-annual report/12 months for annual report).</p> <p>In order to avoid double counting, countries will need to monitor their activities by partner, programmatic area, and geographic area. This matrix is an excellent program management tool as well as helping to adjust for double counting by partners, among partners, and among USG agencies.</p>
<p><b>Interpretation/ Strengths and Weaknesses:</b></p>	<p>This indicator does not measure the quality of the training, nor does it measure the outcomes of the training in terms of the competencies of individuals trained, nor their job performance.</p> <p>This indicator simply measures number trained in institutional capacity building as opposed to the percent of organizations with trained staff.</p>



<b>12.5 Number of individuals trained in HIV-related stigma and discrimination reduction</b>	
<b>Rationale/What It Measures:</b>	Supportive Interventions strengthen HIV prevention, care and treatment programs. This indicator measures the number of individuals trained in HIV-related stigma and discrimination reduction.
<b>Definition:</b>	<p>Training refers to new training or retraining of individuals and assumes that training is conducted according to national or international standards when these exist. Count all individuals trained, from local organizations or otherwise, during the reporting period.</p> <p>A training must have specific learning objectives, a course outline or curriculum, and expected knowledge, skills and/or competencies to be gained by participants.</p> <p>HIV/AIDS-related stigma can be described as a “process of devaluation” of people either living with or associated with HIV and AIDS. This stigma often stems from the underlying stigmatization of sex and intravenous drug use—two of the primary routes of HIV infection. Discrimination follows stigma and is the unfair and unjust treatment of an individual based on his or her real or perceived HIV status or being perceived to belong to a particular group.</p> <p>Stigma and discrimination reduction activities may include:</p> <ul style="list-style-type: none"> <li>• Enhancing practical knowledge to reduce fear of casual transmission;</li> <li>• Providing a safe forum to discuss sensitive topics (sex, death, drug use, inequity);</li> <li>• Finding a common language to talk about stigma;</li> <li>• Strengthening the capacity of people living with HIV and AIDS to challenge stigma in their lives;</li> <li>• Providing a process to determine appropriate and feasible individual and community responses to stigma;</li> <li>• Providing comprehensive, flexible tools for organizations to strengthen staff skills and develop or strengthen interventions to reduce HIV-related stigma; and</li> <li>• Developing a system to compile and address reported acts of discrimination.</li> </ul>
<b>Measurement Tool:</b>	Program reports. USG agencies and USG-funded partners should keep a training log including the type of training, date, location, and participants.
<b>How To Measure It:</b>	<p>Each USG agency and USG-funded partner counts the number of individuals trained in stigma and discrimination reduction by USG staff (HQ or field-based) or USG-funded partners during the specified reporting period (6 months for semi-annual report/12 months for annual report).</p> <p>Only participants who complete the full training course should be counted.</p> <p>If a training course covers more than one stigma and discrimination reduction topic, individuals should only be counted once for that training course.</p> <p>If a training course is conducted in more than one session/training event, only individuals who complete the full course should be counted. Do not sum the participants for each training event.</p>

	<p>The USG staff responsible for compiling the semi-annual/annual reporting data should use the training log submitted by each USG agency and USG-funded partner reporting on this indicator in order to count the total number of individuals trained in stigma and discrimination reduction. Individuals trained in training courses co-funded by more than one USG agency/USG-funded partner should only be counted once within the specified reporting period (6 months for semi-annual report/12 months for annual report).</p> <p>In order to avoid double counting, countries will need to monitor their activities by partner, programmatic area, and geographic area. This matrix is an excellent program management tool as well as helping to adjust for double counting by partners, among partners, and among USG agencies.</p>
<p><b>Interpretation/ Strengths and Weaknesses:</b></p>	<p>This indicator does not measure the quality of the training, nor does it measure the outcomes of the training in terms of the competencies of individuals trained, nor their job performance.</p> <p>This indicator simply measures number trained in stigma and discrimination reduction as opposed to the percent of organizations with trained staff.</p>

<b>12.6 Number of individuals trained in HIV-related community mobilization for prevention, care and/or treatment</b>	
<b>Rationale/What It Measures:</b>	Supportive Interventions strengthen HIV prevention, care and treatment programs. This indicator measures the number of individuals trained in HIV-related community mobilization for prevention, care and/or treatment.
<b>Definition:</b>	<p>Training refers to new training or retraining of individuals and assumes that training is conducted according to national or international standards when these exist. Count all individuals trained, from local organizations or otherwise, during the reporting period.</p> <p>A training must have specific learning objectives, a course outline or curriculum, and expected knowledge, skills and/or competencies to be gained by participants.</p> <p>Community mobilization activities include:</p> <ul style="list-style-type: none"> <li>• Identifying social groups and mapping existing formal structures or networks in order to encourage or promote HIV prevention, care and/or treatment interventions and services, such as counseling and testing, PMTCT, HIV care and antiretroviral treatment</li> <li>• Building trust with the community by providing a forum to discuss their perceived needs for HIV prevention, care and/or treatment interventions and services,</li> <li>• Developing communication around social networks to engage in dialogue with the community which encourages or promotes HIV prevention, care and/or treatment interventions and services,</li> <li>• Creating media and events that expose community members to new ideas, involving them in problem solving, and encouraging innovations which promote HIV prevention, care and/or treatment interventions and services.</li> </ul>
<b>Measurement Tool:</b>	Program reports. USG agencies and USG-funded partners should keep a training log including the type of training, date, location, and participants.
<b>How To Measure It:</b>	<p>Each USG agency and USG-funded partner counts the number of individuals trained in community mobilization by USG staff (HQ or field-based) or USG-funded partners during the specified reporting period (6 months for semi-annual report/12 months for annual report).</p> <p>Only participants who complete the full training course should be counted.  If a training course covers more than one community mobilization topic, individuals should only be counted once for that training course.  If a training course is conducted in more than one session/training event, only individuals who complete the full course should be counted. Do not sum the participants for each training event.</p> <p>The USG staff responsible for compiling the semi-annual/annual reporting data should use the training log submitted by each USG agency and USG-funded partner reporting on this indicator in order to count the total number of individuals trained in community mobilization. Individuals trained in training courses co-funded by more than one USG agency/USG-funded partner should only be counted once within the specified reporting period (6 months for semi-annual report/12 months for</p>

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

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

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

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

Program level indicators

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

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

## **Outcome- and Impact-Level Indicators**



### Required Outcome- and Impact-Level Indicators

Indicator Type	Indicator Number	Indicator	Source/ Methodology	International Standard
<b>Prevention</b>				
Outcome	1	Percent of young people aged 15–24 who both correctly identify ways of preventing the sexual transmission of HIV and who reject major misconceptions about HIV transmission	Population-based survey	UNGASS, MDG
	2	Percent of never-married young people aged 15–24 who have never had sex	Population-based survey	Adapted from UNAIDS YPG
	3	Percent of never-married women and men aged 15–24 who had sex in the last 12 months, of all never-married women and men (aged 15–24) surveyed	Population-based survey	Adapted from UNAIDS
	4	Percent of women and men aged 15–49 who had sex with more than one partner in the last 12 months	Population-based survey	Adapted from UNAIDS
	5	Percent of women and men aged 15–49 who say they used a condom the last time they had sex with a non-marital, non-cohabiting partner, of those who have had sex with such a partner in the last 12 months	Population-based survey	UNAIDS, MDG, UNAIDS YPG
	6	Percent of men reporting sex with a sex worker in the last 12 months who used a condom during last paid intercourse	Population-based survey	UNAIDS
	7	Percent of blood units transfused in the last 12 months that have been adequately screened for HIV according to national or WHO guidelines	Special Study (MEASURE Evaluation blood safety protocol)	UNAIDS, GFATM
	8	Average number of medical injections per person per year	Population-based survey	WHO SIGN RARG
	9	Proportion of women and men age 15-49 reporting that the last health care injection was given with a syringe and needle set from a new, unopened package	Population-based survey	WHO SIGN RARG
Impact	10	Percent of young people aged 15–24 that are HIV-infected	Sentinel Surveillance, Sero-survey with biomarkers	Adapted from UNGASS, MDG

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

<b>OVC</b>				
Outcome	1	Percent of orphans and vulnerable children under 18 living in households whose households have received, free of user charges, basic external support in caring for the child	Population-based survey	Adapted from UNAIDS, UNAIDS C&S. GFATM
<b>Labs</b>				
Outcome	1	Percent of designated laboratories with the capacity to monitor antiretroviral combination therapy according to national and international guidelines	Laboratory study	UNAIDS C&S
<b>Strategic Information</b>				
Outcome	1	Percent of health facilities with record-keeping systems for monitoring HIV/AIDS care and support	Health facility survey	UNAIDS C&S
<b>Other: Policy and Systems Strengthening (Capacity Building)</b>				
Outcome	1	AIDS Program Effort Index	Special Study	UNAIDS, UNGASS
	2	Percent of the general population with accepting attitudes toward PLWHA	Population-based survey	Adapted from UNAIDS

### Recommended Outcome- and Impact-Level Indicators

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

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

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

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

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

**REQUIRED OUTCOME- AND IMPACT-LEVEL INDICATOR DEFINITIONS**

Prevention 1

**Percent of young people aged 15–24 who both correctly identify ways of preventing the sexual transmission of HIV and reject major misconceptions about HIV transmission**

<b>Rationale/What It Measures:</b>	<p>HIV epidemics are perpetuated through primarily sexual transmission of infection to successive generations of young people. Sound knowledge about HIV/AIDS is an essential prerequisite—although often an insufficient condition—for adoption of behaviors that reduce the risk of HIV transmission.</p> <p>This indicator allows assessment of progress in achieving universal knowledge of the essential facts about HIV transmission.</p>
<b>Definition:</b>	Percentage of young women and men aged 15–24 who, in response to prompted questions, say that people can protect themselves from contracting HIV by having sex with only one faithful, uninfected partner, and using condoms, who know that a healthy-looking person can have the AIDS virus, and who correctly reject the two most common local misconceptions about AIDS transmission.
<b>Measurement Tool:</b>	Population-based survey such as DHS/AIS, MICS, BSS (youth)
<b>Numerator:</b>	Number of young women and men aged 15–24 who, in response to prompted questions, say that people can protect themselves from contracting HIV by having sex with only one faithful, uninfected partner, and using condoms and know that a healthy-looking person can have the AIDS virus, and who correctly reject the two most common local misconceptions about AIDS transmission.
<b>Denominator:</b>	Number of young women and men aged 15–24 surveyed
<b>How To Measure It:</b>	<p>This indicator is constructed from responses to the following set of prompted questions:</p> <ol style="list-style-type: none"> <li>1. Can the risk of HIV transmission be reduced by having sex with only one faithful, uninfected partner?</li> <li>2. Can the risk of HIV transmission be reduced by using condoms?</li> <li>3. Can a healthy-looking person have HIV?</li> <li>4. <i>Can a person get HIV from mosquito bites?</i> (this is an example, local misconceptions should be questioned here)</li> <li>5. <i>Can a person get HIV by sharing a meal with someone who is infected?</i> (this is an example, local misconceptions should be questioned here)</li> </ol> <p>Those who have never heard of HIV/AIDS should be excluded from the numerator but included in the denominator.</p> <p>Indicator scores are required for all respondents aged 15–24 years and should be reported separately for males and females, according to urban/rural residence.</p> <p>Scores for each of the individual questions (based on the same denominator) are required in addition to the score for the composite indicator.</p>
<b>Frequency:</b>	Baseline, then every 2-3 years
<b>Interpretation/</b>	The belief that a healthy-looking person cannot be infected with HIV is a common misconception that can result in



<p><b>Strengths and Weaknesses:</b></p>	<p>unprotected sexual intercourse with infected partners.</p> <p>Correct knowledge of false modes of HIV transmission is as important as correct knowledge of true modes of transmission. For example, the belief that HIV is transmitted through mosquito bites can weaken motivation to adopt safe sexual behavior, while the belief that HIV can be transmitted through sharing food reinforces the stigma faced by people living with AIDS.</p> <p>This indicator is particularly useful in countries where knowledge about HIV/AIDS is poor because it allows for easy measurement of incremental improvements over time. However, it is also important in other countries because it can be used to ensure that pre-existing high levels of knowledge are maintained.</p> <p>The "two most common misconceptions about AIDS transmission" will vary not only from country to country, but from survey to survey in the same country over time. This should be kept in mind when comparing this indicator across countries and over time.</p>
<p><b>Reference(s):</b></p>	<p>UNGASS (2003) National Program and Behavior Indicator 7; MDG HIV/AIDS Indicator 19b (Targets: 2005 – 90%; 2010 – 95%)</p>

## Prevention 2

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

### Prevention 3

**Percent of never married women and men aged 15–24 who had sex in the last 12 months, of all never-married women and men (aged 15–24) surveyed**

<b>Rationale/What It Measures:</b>	This indicator is a measure of premarital sex among young people. A high score on this indicator reflects a failure of prevention messages stressing abstinence until marriage. The converse of this indicator (that is, the indicator score subtracted from 100, functions as an indicator of abstinence among unmarried young people. Success in promoting abstinence should be reflected in a later age at first sex, as measured by Prevention Indicator 2. This indicator, however, captures an additional dimension: anyone who has been abstinent for more than a year (regardless of whether he/she has ever had sex). So the inverse indicator of abstinence will include not only virgins but also people who have given up sex for at least the last year as a protective measure against HIV and other STIs. Given that young people should be the focus of education and prevention programs, deciding to abstain from sex after having precocious sexual activity would be a desired program outcome.
<b>Definition:</b>	Percent of young never married women and men aged 15–24 who have had sexual intercourse in the last 12 months, of all young never-married respondents surveyed
<b>Measurement Tool:</b>	Population-based surveys such as UNAIDS general population survey, DHS/AIS, BSS (youth), RHS
<b>Numerator:</b>	Number of never married women and men aged 15–24 who have had sexual intercourse in the last 12 months
<b>Denominator:</b>	Number of never married women and men aged 15–24 surveyed
<b>How To Measure It:</b>	In a survey among people aged 15–24, respondents are asked about their marital status and their sexual partnerships.  The indicator should be reported separately for men and women. It may also be constructed separately for those aged 15–19 and 20–24, as appropriate. In some settings, the proportion of those aged 20–24 who are never married will be very low, at least among women, and it may not be appropriate to construct the indicator for this age group in these cases.
<b>Frequency:</b>	Baseline, then every 2-3 years
<b>Interpretation/Strengths and Weaknesses:</b>	This indicator has a critical role in advocacy. Resistance to improved sexual education and service provision for young people frequently comes from parents or other authorities who believe that abstinence until marriage is the only acceptable message for young people. An indicator that tracks premarital sex tracks the success or failure of this message and may point to gaps in the current approach. In addition, this indicator measures changes in what may be culturally and socially ascribed norms for early sexual activity. Where programs are advocating a delay of first sex or abstinence outside of a married, monogamous relationship, the indicator should show a decrease.  A limitation may be that small sample sizes of the different age strata could make analysis and interpretation of results quite difficult. As well, in areas where early marriage is both encouraged and acceptable, prevention programs may have limited effect on changing prevailing social and cultural norms around marriage.
<b>Reference(s):</b>	Adapted from UNAIDS (2000) Young People’s Sexual Behavior Indicator 2

## Prevention 4

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

Prevention 5

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

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

## Prevention 6

### Percent of men reporting sex with a sex worker in the last 12 months who used a condom during last paid intercourse

<b>Rationale/What It Measures:</b>	This indicator gives an indication of the success or failure of campaigns to increase condom use among clients of sex workers. It measures condom use by men with partners they consider to be commercial partners.
<b>Definition:</b>	Percent of men aged 15–49 reporting condom use the last time they had sex with a sex worker, of those who report having had sex with a sex worker in the last 12 months
<b>Measurement Tool:</b>	Population-based surveys such as UNAIDS general population survey, DHS/AIS, BSS (adult), RHS
<b>Numerator:</b>	Number of men who report that they used a condom at last sex with a commercial sex worker or when they last paid someone in exchange for sex
<b>Denominator:</b>	Number of men 15–49 who had sex with a commercial sex worker or paid someone in exchange for sex in the last 12 months
<b>How To Measure It:</b>	In general population surveys or in specialized surveys among groups of men who fit the profile of clients of sex workers (e.g., members of the military, truck drivers), men are asked if they have paid someone in exchange for sex in the last 12 months. If they reply yes, they are further asked whether they used a condom the last time they did so.
<b>Frequency:</b>	Baseline, then every 2-3 years
<b>Interpretation/Strengths and Weaknesses:</b>	<p>This indicator is invaluable in tracking the success of major programs to promote condom use in commercial sex.</p> <p>Most AIDS programs aim to increase consistent use of condoms with sex workers. Surveys of clients of sex workers will almost certainly want to ask whether they use a condom always, sometimes, or never in sex with sex workers over the last 12 months. However the pressure to say “always” is strong. Asking about a particular, and recent, act of sex may give a more robust measure of levels of condom use in commercial sex. However, it is strongly recommended that programs focusing prevention resources on increasing condom use in commercial sex also construct an indicator of consistent use of condoms in commercial sex.</p> <p>Where there are several distinct populations of sex workers with different levels of perceived risk—for example, brothel-based prostitutes may be thought of as having riskier behavior than commercial sex workers in nightclubs—data may be collected separately for separate categories of sex worker. This can provide important information for programming. For example, men may report very high levels of consistent condom use in brothels, but much lower levels with commercial sex workers working out of nightclubs. This may be a warning signal for a shift of the high prevalence from one group to another. In constructing the indicator, however, only the last commercial sex partner of any sort should be considered.</p> <p>It is very difficult to define commercial sex in a way that translates from one place to another and this is the major limitation of this indicator. Once commercial sex has been described for a country, however, this is unlikely to change much over time.</p> <p>An increase over time of this indicator does not necessarily mean an increase in “safe sex” in commercial sex; the</p>

	percentage of men having sex with commercial sex workers may be decreasing. This indicator should be analyzed in combination with an estimate of the percentage of men having sex with a commercial sex partner.
<b>Reference(s):</b>	UNAIDS (2000) Sexual Behavior Indicator 4, denominator is UNAIDS (2000) Sexual Behavior Indicator 3

## Prevention 7

### Percent of blood units transfused in the last 12 months that have been adequately screened for HIV according to national or WHO guidelines

<b>Rationale/What It Measures:</b>	Blood safety programs aim to ensure that the overwhelming majority (ideally 100 percent) of blood units are screened for HIV and those that are included in the national blood supply are indeed uninfected. This is demonstrably not the case in many countries. Some blood units are not screened at all; others are screened by poorly trained personnel using outdated equipment or insufficient inputs. What's more, poor blood testing facilities mean that some blood is screened using antibody tests at a time after the donor has become infected with HIV but before he/she has developed antibodies to the virus. Together, these factors mean that a significant proportion of blood units may be classified as safe even though they are infected. This indicator gives an idea of the overall percentage of blood units that have been screened to high enough standards that they can confidently be declared free of HIV.
<b>Definition:</b>	Percent of blood units transfused in the last 12 months that have been adequately screened for HIV according to national or WHO guidelines
<b>Measurement Tool:</b>	MEASURE <i>Evaluation</i> blood safety protocol (Special study)
<b>Numerator:</b>	(see below)
<b>Denominator:</b>	(see below)
<b>How To Measure It:</b>	<p>Three pieces of information are needed for this indicator: the number of blood units transfused in the previous 12 months; the number of blood units screened for HIV in the previous 12 months; and among the units screened, the number screened up to WHO or national standards.</p> <p>The number of units transfused and the number screened for HIV should be available from health information systems. Quality of screening may be determined from a special study that re-tests a sample of blood previously screened, or from an assessment of the conditions under which screening occurred. In situations where this approach is not feasible, data on the percentage of facilities with good screening and transfusion records and no stock outs of test kits may be used to estimate adequately screened blood for this indicator.</p>
<b>Frequency:</b>	Baseline, then every 2-3 years
<b>Interpretation/Strengths and Weaknesses:</b>	<p>Where sufficient information exists to construct it, this measure is a strong indicator of the overall safety of the blood supply. However, changes in the indicator could reflect changes in the proportion of blood units screened or changes in the quality of the screening process. A successful campaign to reduce unnecessary transfusions may also be reflected in the indicator, since the overall number of transfused units would fall and the proportion of those screened to WHO/national standards should rise in consequence. However, the different elements of the indicator should therefore be reported separately for programmatic purposes.</p> <p>Where health systems are decentralized, or where the private sector is involved in blood screening and blood banking, it</p>



	may be difficult to obtain good enough information to construct a robust indicator on a national scale. In this case, it may be necessary to select sentinel hospitals and laboratories in both the public and the private sector for facility-based surveys of blood transfusion and screening quality.
<b>Reference(s):</b>	UNAIDS (2000) Blood Safety Indicator 1; GFATM Toolkit (2004) Prevention Indicator 11

Prevention 8

<b>Average number of medical injections per person per year</b>	
<b>Rationale/What It Measures:</b>	Injection overuse contributes to the transmission of blood borne pathogens through health care injections as it amplifies the effect of unsafe practices. This indicator captures the number of injections received each year to document trends in the effectiveness of interventions to decrease injection overuse.
<b>Definition:</b>	Average number of medical injections per person (women and men aged 15-49) per year
<b>Measurement Tool:</b>	Population-based survey such as the DHS/AIS
<b>Numerator</b>	Number of injections administered by a doctor, a nurse, a pharmacist, or any other health worker to all respondents aged 15-49 in the last 6 months
<b>Denominator</b>	Number of women and men aged 15-49 surveyed
<b>How to measure it:</b>	<p>In a population survey men and women aged 15-49 are asked:</p> <ul style="list-style-type: none"> <li>• if they have had any injections for any reason in the last six months;</li> <li>• if yes, how many.</li> </ul> <p>Frequency of injections in six months is multiplied by two to arrive at the frequency for the year.</p> <p>It should be noted that medical injections can be self-administered (e.g., insulin for diabetes). These injections should NOT be included in the numerator.</p> <p>The indicator should be reported separately for men and women.</p>
<b>Frequency:</b>	Baseline, then every 2-3 years
<b>Interpretation/Strengths and Weaknesses:</b>	The distribution of the frequency of injections received is usually skewed to the right. A small proportion of the population (e.g., diabetics) receives a substantial proportion of all injections. Thus, population surveys using a small sample size may underestimate the annual number of injections per person because none of the persons receiving many injections were included in the sample.
<b>Reference(s):</b>	WHO Injection practices: Rapid assessment and response guide (2002). (Target: $\leq 1$ injection per person per year)

Prevention 9

**Proportion of women and men age 15-49 reporting that the last health care injection was given with a syringe and needle set from a new, unopened package**

<b>Rationale/What It Measures:</b>	Reuse of injection equipment in health care setting is a potential vector of HIV/AIDS. Thus, the proportion of injections given with reused injection equipment is an important prevention indicator in an initiative to prevent and control HIV AIDS.
<b>Definition:</b>	Proportion of women and men age 15-49 reporting that the last health care injection was given with a syringe and needle set from a new, unopened package
<b>Measurement Tool:</b>	Population survey such as DHS/AIS
<b>Numerator</b>	Number of those men and women from the denominator who mention that the last injection received was given with a syringe and needle set from a new, freshly opened package
<b>Denominator</b>	Number of men and women aged 15-49 who can recall receiving an injection in the last six months
<b>How to measure it:</b>	In a population survey men and women aged 15-49 are asked: <ul style="list-style-type: none"> <li>• if they have had any injections for any reason in the last six months;</li> <li>• if yes, how many;</li> <li>• among those injections, how many were administered by a doctor, nurse, pharmacist, dentist, or any other health worker;</li> <li>• where the last injection was given; and</li> <li>• for the last injection, did the person who gave the injection take the syringe and needle from a new, unopened package.</li> </ul>
<b>Frequency:</b>	Baseline, then every 2-3 years
<b>Interpretation/Strengths and Weaknesses:</b>	Population-based surveys provide a good surrogate measure of the proportion of reuse of injection equipment. Results of combined assessments of injection practices that have used both observational and population-based survey approaches indicate that there is a good correlation between the results obtained with the two methods.  Persons interviewed who recall receiving an injection in the last six months but who do not remember the circumstances of it should not be included in the numerator and should not be excluded from the denominator. This lack of recall is an indication of an absence of consumer demand.
<b>Reference(s):</b>	<i>WHO Injection practices: Rapid assessment and response guide (2002); WHO Injection Safety CD ROM: His life and her trust are in your hands. WHO/HTP/EHT</i>

## Prevention 10

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

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

PMTCT 1

**Percent of HIV-infected pregnant women receiving a complete course of antiretroviral prophylaxis to reduce the risk of MTCT**

<b>Rationale/What It Measures:</b>	<p>In high-income countries, strategies such as antiretroviral treatment during pregnancy and following birth and use of breastfeeding substitutes have greatly reduced the rate of mother-to-child HIV transmission. In developing countries, significant difficulties exist in implementing these strategies due to constraints in accessing, affording and using VCT and reproductive health and maternal- and child-health services that offer MTCT prevention support. Nevertheless, substantial reductions in MTCT can be achieved in these settings through approaches such as short-course antiretroviral prophylaxis.</p> <p>This indicator allows assessment of progress in preventing mother-to-child HIV transmission.</p>
<b>Definition:</b>	Percent of HIV-infected pregnant women receiving a complete course of antiretroviral prophylaxis to reduce the risk of MTCT
<b>Measurement Tool:</b>	Program monitoring (HMIS) and estimates (modeling)
<b>Numerator:</b>	Number of HIV-infected pregnant women provided with a full course of antiretroviral prophylaxis to reduce MTCT according to the nationally approved treatment protocol (or WHO/UNAIDS standards) in the last 12 months (program reports or HMIS)
<b>Denominator:</b>	Estimated number of HIV-infected pregnant women (modeled)
<b>How To Measure It:</b>	<p>The number of HIV-infected pregnant women provided with antiretroviral prophylaxis to reduce the risk of MTCT in the last 12 months is obtained from program monitoring records. Only those women who completed the full course should be included. The definition of a 'full course' of antiretroviral prophylaxis will depend on the country's policy on antiretroviral prophylaxis to reduce the risk of MTCT and may or may not include a dose for newborns. Details of the definition used should be provided.</p> <p>The number of HIV-infected pregnant women to whom antiretroviral prophylaxis to reduce the risk of MTCT <i>could potentially have been given</i> is estimated by multiplying the total number of women who gave birth in the last 12 months (Central Statistics Office estimates of births) by the most recent national estimate of HIV prevalence in pregnant women (HIV sentinel surveillance antenatal clinic estimates).</p> <p>The decision as to whether or not to include women who receive treatment from private-sector and NGO clinics in the calculation of the indicator is left to the discretion of the country concerned. However, the decision taken should be noted and applied consistently in calculating both the numerator and the denominator. Private-sector and NGO clinics that provide prescriptions for antiretrovirals but assume that the drugs will be acquired by the individuals elsewhere are not included in this indicator, even though such clinics may be major providers of MTCT-reduction services.</p> <p>Separate estimates of the numbers of pregnant women provided with antiretroviral prophylaxis at public- and private-sector clinics should be given.</p> <p>The indicator should be constructed separately for those aged 15–24 and 15–49.</p>

<b>Frequency:</b>	
<b>Interpretation/ Strengths and Weaknesses:</b>	<p>In many countries, the estimate of HIV prevalence among pregnant women used in the calculation of this indicator will be based on antenatal clinic-based HIV surveillance data. In some of these countries, large numbers of pregnant women do not have access to ANC services or choose not to make use of them. Pregnant women with HIV may be more or less likely to use ANC services (or public rather than private ANC services) than those who are not infected, particularly where antiretroviral prophylaxis can be accessed via such services. In such circumstances, this indicator should be interpreted with reference to recent estimates of utilization of national ANC services.</p> <p>HIV testing and counseling for HIV, and antiretroviral prophylaxis to reduce MTCT can be made available but, ultimately, it is up to individual women to decide whether or not to make use of these services. Thus, a country's score on this indicator will reflect the degree of interest in these services (partly a function of the way in which they are promoted), as well as the extent to which they are available.</p> <p>Countries will apply different definitions as to what constitutes a 'full course' of antiretroviral prophylaxis. Thus, inter-country comparisons may not be entirely valid and should be interpreted with reference to details of the different definitions used in each case.</p> <p>This indicator does not measure compliance with the antiretroviral treatment regime because it is not possible to monitor drug compliance, unless direct supervision is undertaken.</p>
<b>Reference(s):</b>	UNGASS (2003) National Program and Behavior Indicator 4; GFATM Toolkit (2004) Prevention Indicator 8

Note: It is recommended that USG country teams actively support annual updates of this indicator to help improve national program monitoring and performance. This indicator may overestimate the number of women who have received a complete course and does not necessarily allow an estimate of effectiveness if data systems are not set up to verify this information. It is also recommended to provide an estimate of percent of women receiving the different levels of ARV interventions (SD NVP, short-course ARV, HAART).

PMTCT 2

**Percentage of infants born to HIV-infected mothers who are infected**

Note: This is the estimated transmission rate in the context of interventions

<b>Rationale/What It Measures:</b>	<p>In the absence of preventative interventions, infants born to, and breastfed by, HIV-infected women have roughly a one-in-three chance of acquiring infection themselves. This can happen during pregnancy, during labour and delivery, or after delivery through breastfeeding. The risk of MTCT can be reduced through the complementary approaches of antiretroviral prophylaxis for the mother, with or without prophylaxis to the infant, implementation of safe delivery practices, and use of safe alternatives to breastfeeding. Antiretroviral prophylaxis followed by exclusive breastfeeding may also reduce the risk of vertical transmission when breastfeeding is limited to the first six months.</p> <p>This indicator allows assessment of progress toward eliminating mother-to-child HIV transmission.</p>
<b>Definition:</b>	Percent of HIV-infected infants born to HIV-infected mothers
<b>Measurement Tool:</b>	Estimates based on program coverage (HMIS and modeling)
<b>Numerator:</b>	(see below)
<b>Denominator:</b>	(see below)
<b>How To Measure It:</b>	<p>The indicator is calculated by taking the weighted average of the probabilities of MTCT for pregnant women receiving and not receiving antiretroviral, the weights being the proportions of women receiving and not receiving ARV, respectively. Expressed as a simple mathematical formula:</p> $\text{Indicator score} = \{ T*(1-e) + (1-T) \} * v$ <p><i>where:</i></p> <p>T = proportion of HIV-infected pregnant women provided with antiretroviral treatment  v = MTCT rate in the absence of any treatment  e = efficacy of treatment provided  T = the value for PMTCT Indicator 1</p> <p>Default values of 25% and 50%, respectively, can be used for v and e. However, where scientific estimates of the efficacy of the specific forms of antiretroviral treatment (e.g., nevirapine) used in the country are available, these can be used in applying the formula. When this is done, the values of these estimates should be recorded. The most common forms of treatment provided during the last 12 months should be noted.</p>
<b>Frequency:</b>	Every 2 years
<b>Interpretation/Strengths and</b>	This indicator focuses on prevention of MTCT of HIV through increased provision of antiretroviral prophylaxis. Thus, the effect of breastfeeding on MTCT of HIV is ignored and the indicator may yield underestimates of true rates of MTCT in



<b>Weaknesses:</b>	countries where long periods of breastfeeding are common. Similarly, in countries where other forms of prevention of MTCT of HIV (e.g., caesarean section) are widely practiced, the indicator will typically provide overestimates of MTCT. For these reasons, trends in this indicator may not reflect overall trends in MTCT of HIV.  PMTCT Indicator 1 may provide a poor estimate for T in circumstances where usage of antenatal clinic services is low.
<b>Reference(s):</b>	UNGASS (2003) Impact Indicator 2 (Targets: 2005 – 20% reduction; 2010 – 50% reduction)

Note: It is recommended that USG country teams actively support annual updates of this indicator to help improve national program monitoring and performance. It is also recommended to estimate the variable “e” (efficacy) on the basis of the proportion of women on different regimens or interventions.

## Counseling and Testing 1

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

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

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

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

## Care and Treatment and/or Support 1

<b>Percent of people with advanced HIV infection receiving ART</b>	
<b>Rationale/What It Measures:</b>	<p>As the HIV pandemic matures, increasing numbers of people are reaching advanced stages of HIV infection. Antiretroviral combination therapy has been shown to reduce mortality among those infected and efforts are being made to make it more affordable even within less developed countries. Antiretroviral combination therapy should be provided in conjunction with broader care and support services, including counselling for family caregivers.</p> <p>This indicator allows assessment of progress in providing antiretroviral combination therapy to all people with advanced HIV infection</p>
<b>Definition:</b>	Percent of people with advanced HIV infection receiving ART. Advance HIV infection, for modeling purposes, is defined as HIV infected persons with HIV-related conditions that most likely will result in death within two years if untreated.
<b>Measurement Tool:</b>	Program monitoring (Program reports, modeling, HMIS)
<b>Numerator:</b>	Number of people with advanced HIV infection who receive antiretroviral combination therapy according to the nationally approved treatment protocol (or WHO/UNAIDS standards) (service statistics from program reports or HMIS)
<b>Denominator:</b>	Estimated number of people with advanced HIV infection (modeled, see below)
<b>How To Measure It:</b>	<p>The number of people (i.e., adults and children) with advanced HIV infection who currently receive antiretroviral combination therapy can be calculated as follows:</p> <p>A: Number of people receiving treatment at start of year + B: Number of people who commenced treatment in the last 12 months - C: Number of people for whom treatment was terminated in the last 12 months (including those who died).</p> <p>For the purpose of this indicator, the number of people with advanced HIV infection is taken to be 15% of the total number of people currently infected. The latter is estimated using the most recent national sentinel surveillance data.</p> <p>Private-sector antiretroviral provision should be included in the calculation of the indicator wherever possible, and the extent of such provision should be recorded separately.</p> <p>The start and end dates of the period for which the antiretroviral combination therapy is given should be stated. Overlaps between reporting periods should be avoided wherever possible.</p> <p>The indicator should be reported separately for men and women.</p>
<b>Frequency:</b>	Every 2 years
<b>Interpretation/</b>	The indicator permits monitoring of trends in coverage, but does not attempt to distinguish between different forms of

<b>Strengths and Weaknesses:</b>	<p>antiretroviral therapy, or to measure the cost, quality, or effectiveness of treatment provided. These will each vary within and between countries and are liable to change over time.</p> <p>The proportion of people with advanced stages of HIV infection will vary according to the stage of the HIV epidemic and the cumulative coverage and effectiveness of antiretroviral therapy among adults and children. The proportion currently recommended for use in calculating this indicator (15%) is a crude estimate and may be subject to revision, especially if reporting of persons with AIDS or advanced HIV infection from health care facilities is improved. This figure is particularly relevant in situations where the current coverage of antiretroviral combination therapy is low.</p> <p>The degree of utilization of antiretroviral therapy will depend on cost relative to local incomes, service delivery infrastructure and quality, availability and uptake of VCT services, perceptions of effectiveness, and possible side effects of treatment.</p> <p>Preventative antiretroviral therapy for the purpose of prevention of MTCT and post-exposure prophylaxis are not included in this indicator.</p>
<b>Reference(s):</b>	<p>UNGASS (2003) National Program and Behavior Indicator 5; WHO/UNAIDS Care &amp; Support Guide (2004) Indicator CS3; GFATM Toolkit (2004) Treatment Indicator 1</p>

## Care, Treatment, and/or Support 2

<b>Percent of health care facilities that have the capacity and conditions to provide basic-level HIV testing and HIV/AIDS clinical management</b>	
<b>Rationale/What It Measures:</b>	Many facilities that provide general curative care are also providing services related to HIV/AIDS and are caring for people living with HIV/AIDS. This may occur in settings that have no specific HIV/AIDS program. For facilities that are providing these services, evaluating the degree to which capacity exists to carry out these HIV services is therefore important. The HIV/AIDS specific services and components identified and defined by this indicator are those that both support HIV/AIDS services and can reasonably be expected to exist in almost any health facility.
<b>Definition:</b>	Percentage of health facilities that have the capacity and conditions to provide basic HIV counseling and testing and to manage HIV/AIDS clinical services. Capacity to provide basic HIV counseling and testing and health services is defined as: <ul style="list-style-type: none"> <li>a. a system for testing and providing results for HIV infection;</li> <li>b. systems and qualified staff for pre- and post-test counseling;</li> <li>c. specific health services relevant to HIV/AIDS, including resources and supplies for providing these services;</li> <li>d. elements for preventing nosocomial infections; and</li> <li>e. trained staff and resources providing basic interventions for prevention and treatment for people living with HIV/AIDS.</li> </ul>
<b>Measurement Tool:</b>	This information should be collected through a health facility survey. The recommended tool is the piloted Service Provision Assessment covering all relevant service areas. HIV/AIDS service providers should also be interviewed.
<b>Numerator:</b>	<ol style="list-style-type: none"> <li>1. Number of facilities at which the individual items for each service or item listed above exist</li> <li>2. Number of facilities at which all components for each individual service or item (a, b, c, d <b>or</b> e) exist</li> <li>3. Number of facilities at which all components for all individual services and items (a, b, c, d <b>and</b> e) exist</li> </ol>
<b>Denominator:</b>	For 1, the total number of health facilities surveyed For 2 and 3, the total number of health facilities at which HIV/AIDS services in each of the areas identified in the definition are offered or relevant
<b>How To Measure It:</b>	This information should be collected through a health facility survey in all relevant service areas. HIV/AIDS service providers should also be interviewed. See Annex 1 of the WHO/UNAIDS C&S M&E Guide for details of the individual items identified for each of these, including detailed measurement instructions.
<b>Frequency:</b>	Baseline, then every 2-3 years
<b>Interpretation/Strengths and Weaknesses:</b>	Although the objective is to determine the percentage of facilities that have all items within all service and item areas (a, b, c, d and e), few, if any, facilities will have this level of services. In many settings, facilities do not have all items for each service. The specific items to support each service should therefore be presented individually.

	<p>This indicator does not provide individual information for voluntary counseling and testing services or for services for preventing the mother-to-child transmission of HIV except if: 1) the services are integrated within the health facility; and 2) the components of these services are relevant to the areas assessed.</p> <p>The list of components (for Part a) also excludes facilities that only conduct or refer for pre-employment HIV tests, excludes testing blood prior to transfusion, and excludes facilities that refer people living with HIV/AIDS to another facility for assessment and testing if the referral facility is responsible for further services.</p>
<b>Reference(s):</b>	WHO/UNAIDS Care & Support Guide (2004) Indicator CS6



### Care, Treatment, and/or Support 3

#### Percent of health care facilities that have the capacity and conditions to provide advanced-level HIV/AIDS care and support services, including provision of ART

<b>Rationale/What It Measures:</b>	This indicator measures the availability of advanced services specific to people living with HIV/AIDS. It is assumed that the services and items measured in this indicator require substantial input and personnel training beyond what is routine for most health systems.
<b>Definition:</b>	Capacity to provide advanced HIV/AIDS care is defined as: <ol style="list-style-type: none"> <li>systems and items to support the management of opportunistic infections and the provision of palliative care (symptomatic treatment) for the advanced care of people living with HIV/AIDS;</li> <li>systems and items to support advanced services for the care of people living with HIV/AIDS;</li> <li>systems and items to support antiretroviral combination therapy (including security measures for the ARVs);</li> <li>conditions to provide advanced inpatient care for people living with HIV/AIDS;</li> <li>conditions to support home-care services; and</li> <li>post-exposure prophylaxis.</li> </ol>
<b>Measurement Tool:</b>	This information should be collected through a health facility survey with observation in all relevant service areas. Like Care, Treatment, and/or Support Indicator 2, interviews of HIV/AIDS service providers would also be needed.
<b>Numerator:</b>	<ol style="list-style-type: none"> <li>Number of facilities at which the individual items for each service or item listed above exist</li> <li>Number of facilities at which all components for each individual service or item (a, b, c, d, e, or f) exist</li> <li>Number of facilities at which all components for all individual services and items (a, b, c, d, e, and f) exist</li> </ol>
<b>Denominator:</b>	For 1, the total number of health facilities surveyed For 2 and 3, the total number of health facilities at which HIV/AIDS services in each of the areas identified in the definition are offered or relevant
<b>How To Measure It:</b>	The specific items for each service should be presented individually and at a first level of aggregation (all components of each service or item). When a reasonable proportion of facilities begin to have all first-level aggregated components, a second-level aggregation can be presented when appropriate. See Annex 1 of the WHO/UNAIDS C&S for details of the individual items identified for each of these, including detailed measurement instructions.
<b>Frequency:</b>	Baseline, then every 2-3 years
<b>Interpretation/Strengths and Weaknesses:</b>	This indicator examines advanced HIV/AIDS services among all health facilities. In some settings, facilities will not have all items for each item or component, and countries may have different strategies for providing select advanced services at only certain levels of the health care system (that is, referral hospitals may offer a wider range of advanced care than health centers). Although this indicator does not stratify by level of health care facility, managers of national AIDS programs can analyze this information if desired.
<b>Reference(s):</b>	WHO/UNAIDS Care & Support Guide (2004) Indicator CS7

## Care, Treatment and/or Support 4

**Percent of adults aged 18–59 who have been chronically ill for 3 or more months during the past 12 months, including those ill for 3 or more months before death, whose households have received, free of user charges, basic external support in caring for the chronically ill person**

<b>Rationale/What It Measures:</b>	This indicator attempts to quantify the extent of support services free of user charges to households with chronically ill people.
<b>Definition:</b>	<p>Percentage of adults aged 18–59 who have been chronically ill for 3 or more months in the past 12 months, including those ill for 3 or more months before death, whose households received, free of user charges, basic external support in caring for chronically ill people, including health, psychological, or emotional, and other social and material support</p> <p>External support for chronically ill adults is defined as:</p> <ul style="list-style-type: none"> <li>• Medical support;</li> <li>• Emotional and psychological: counseling from a trained counselor, companionship, and emotional or spiritual support;</li> <li>• Material including socioeconomic (clothing, extra food or financial support); and</li> <li>• Other social support or instrumental (help with household work, training for a caregiver or legal services).</li> </ul> <p>External support is defined here as help free of user charges coming from a source other than friends, family or neighbors unless they are working for a community-based group or organization. In settings in which friends, family, or neighbors provide most external support, program managers may consider adapting this.</p> <p>The definition of chronically ill varies from setting to setting. Developing and noting a commonly agreed upon definition prior to initiating work are therefore important.</p>
<b>Measurement Tool:</b>	Population-based survey such as the UNAIDS general population survey; DHS/AIS; BSS (adult + youth)
<b>Numerator:</b>	<p>Women and men aged 18–59 who have been ill for 3 or more months during the past 12 months and whose household received the following support:</p> <ol style="list-style-type: none"> <li>1. Medical support at least once a month during illness AND</li> <li>2. Emotional support in the last 30 days AND</li> <li>3. Material support in the last 30 days AND</li> <li>4. Social support in the last 30 days.</li> </ol> <p style="text-align: center;"><b>OR</b></p>

	<p>Women and men who died in the past 12 months, age 18–59 when they died, and who had been chronically ill for 3 months before death and whose household received the following support:</p> <ol style="list-style-type: none"> <li>1. Medical support at least once a month during illness AND</li> <li>2. Emotional support in the last 30 days (before the death) AND</li> <li>3. Material support in the last 30 days (before the death) AND</li> <li>4. Social support in the last 30 days (before the death).</li> </ol>
<b>Denominator:</b>	All adults aged 18–59 who were ill for 3 or more months during the past 12 months, including those ill for 3 or more months before death.
<b>How To Measure It:</b>	<p>The following methods are recommended:</p> <ul style="list-style-type: none"> <li>• A population-based household survey can be used in high-prevalence settings. As part of a household survey, household rosters can be used to identify all eligible chronically ill people aged 15–59. For each household with a chronically ill member, a series of questions is asked about the types and frequency of support received and primary source of the help.</li> <li>• A special study: the household survey tool may be used in low-prevalence settings or targeted populations with similar but adapted methods sampling networks of people living with HIV/AIDS and/or recipients of services from care and support programs.</li> </ul> <p>Data should be analyzed and reported by gender and age categories when sample size allows (15–24, 25–39, and 40–59 years).</p> <p>Each component on type of support will also be reported on separately, i.e., percentage whose households received medical support, percentage whose households received emotional support, and so on.</p>
<b>Frequency:</b>	Baseline, then every 2-3 years
<b>Interpretation/ Strengths and Weaknesses:</b>	Household-based samples of chronically ill people are not nationally representative of all chronically ill people because they exclude those who are hospitalized, institutionalized, or homeless. As a result, the proportion of the population “missed” varies. Other targeted sampling among groups such as facility clients, home-based care recipients, or PLWHA network members (as discussed above in “How To Measure It”) should be done to address this problem.
<b>Reference(s):</b>	WHO/UNAIDS Care & Support Guide (2004) Indicator CS9

## Care, Treatment and/or Support 5

<b>Percentage of people still alive at 6, 12, and 24 months after initiation of treatment</b>	
<b>Rationale/What It Measures:</b>	One of the goals of any ART program should be to increase survival among infected individuals. This indicator measures the degree to which treatment can prolong a person's life by assessing how many individuals survived after 6, 12, and 24 months of continuous treatment.
<b>Definition:</b>	Percentage of people still alive and on therapy at 6, 12, and 24 months after initiation of treatment
<b>Measurement Tool:</b>	HMIS records +cohort studies
<b>Numerator:</b>	Number of individuals still alive and on therapy after initiating treatment after 6, 12, and 24 months
<b>Denominator:</b>	Number of individuals initiating treatment at the same time
<b>How To Measure It:</b>	Information on survival beyond specific points in time can be collected in patient registers. This indicator will require that a cohort of patients be followed up. Individual patient level data records must be collected electronically for analysis.  Data should be analyzed for treatment cohorts by sex, pregnancy status and age.
<b>Frequency:</b>	Periodic (TBD)
<b>Interpretation/Strengths and Weaknesses:</b>	The strengths of this indicator lay in the ease of data collection, as any ART program should monitor patients on treatment and determine the number of individuals who survive beyond specific periods in time. For some patients, follow-up information may not be available as a result of migration, complete treatment failure, or even death. Programs may deal with this loss by including only those individuals for whom they have full information in the numerator and denominator. This approach likely overestimate survival due to the exclusion of those lost to follow-up. Further in-depth study will be necessary to further probe the effect of loss to follow-up, treatment interruption, transfer to a new facility, treatment discontinuation or death.  Interpretation of trends in this indicator is enhanced when information on health status at treatment initiation is also available. Health outcomes, including survival rate, at the beginning of programs will be poor because this first cohort will be the sickest. Over time, this effect will level out. Clinical staging or mean CD4 count is helpful information for interpretation of trends.
<b>Reference(s):</b>	WHO 3x5 (2004) Core Indicator 10, See WHO Interim Patient Monitoring Guidelines

## Care, Treatment and/or Support 6

<b>Proportion of all deaths attributable to HIV/AIDS</b>	
<b>Rationale/What It Measures:</b>	<p>Measuring impact of scaled-up ART programs will not be accomplished simply using ANC sentinel surveillance data. These data will be insufficient to model the estimated number of persons with AIDS and the number of deaths due to AIDS, or to assess trends. Additional information is urgently needed to improve these estimates.</p> <p>Sample registration approaches offer an important near-term solution to the current state of ignorance (particularly on the levels, causes, and trends of adult health mortality) in countries where good coverage of routine vital registration with reliable cause of death attribution is still years, if not decades, away. Although, by definition, they do not have the coverage of routine systems or censuses, continuous sample registration systems can also complement sources such as decennial censuses, which provide no way of directly monitoring progress in many key indicators at regional or national levels during inter-censal periods.</p>
<b>Definition:</b>	Proportion of all deaths attributable to HIV/AIDS
<b>Measurement Tool:</b>	National mortality statistics or sample vital registration with verbal autopsy (SAVVY)
<b>Numerator:</b>	Incident death attributable to HIV/AIDS in the resident population aged 18-59
<b>Denominator:</b>	All deaths in the resident population aged 18-59
<b>How To Measure It:</b>	<p>Sample vital registration through verbal autopsy consists of a set of large samples selected to be nationally representative and/or to represent sentinel areas or populations in which sample vital registration and mortality surveillance are carried out over a ten-year cycle. The 'backbone' of SAVVY is routine demographic surveillance, continuous (e.g., every 6 months in urban areas) mortality surveillance using verbal autopsy techniques, and the application of a validated income poverty measurement tool. During annual census update rounds, nested sample household surveys are conducted on health service coverage, poverty monitoring, or morbidity. These 'modules,' which can be harmonized with the DHS or other national household surveys, can generate enormous amounts of information about service coverage, population health status, food security, or any other topic amenable to household data collection and survey methods.</p> <p>Sampling varies per country, but is a combination of urban/rural.</p> <p>Verbal autopsy methods comprise of an interview by trained personnel with relatives of deceased individuals within a specified time period after death, using standard field instruments and interviewing techniques, with the objective of obtaining the best available information on the symptoms and events during the illness preceding death. Following the interview, the data collected are reviewed, usually by a physician panel, which assimilates all the information and attributes a probable underlying cause of death.</p>
<b>Frequency:</b>	Baseline, then every 2-3 years
<b>Interpretation/Strengths and</b>	For populations in which a majority of deaths occur outside of health facilities, verbal autopsy techniques are possibly the only systematic way of ascertaining probable cause of death and developing an accurate picture of the cause structure of

<b>Weaknesses:</b>	<p>mortality within that population.</p> <p>The Emergency Plan support for lifelong antiretroviral therapy and other services is being mounted in countries where health systems have been geared to treat acute and episodic illnesses in clinical settings—not to deliver and monitor long-term care and management of chronic conditions that will entail significant outreach and follow-up components. There are no 'off the shelf' models for delivering this care in such resource-constrained settings, or for monitoring its successes and failures. Cross-sectional surveys and facility-based systems are unlikely to be able to meet these demands alone.</p> <p>Sample vital registration with verbal autopsy is an adaptable and cost-effective standard for the continuous monitoring of population health (morbidity and mortality) and poverty. SAVVY is an information system based largely on over a decade of experience from Tanzania in developing and packaging the methods, proving their sustainability and cost-effectiveness. It also draws upon the well-established systems of sample registration in India and China.</p>
<b>Reference(s):</b>	<p>WHO, MEASURE Evaluation, and the International Programs Center (IPC) of the U.S. Census Bureau (2003-Reference #15). <i>Improving Systems for Monitoring and Measurement of Vital Events: An issues paper prepared for the Health Metrics Network.</i></p>

## Orphans and Vulnerable Children 1

<b>Percent of orphans and vulnerable children under 18 living in households whose households have received, free of user charges, basic external support in caring for the child</b>
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<b>Rationale/What It Measures:</b>	This indicator measures support coming from a source other than friends, family, or neighbors (unless they are working for a community-based group or organization) given free of user charges to households with orphans and vulnerable children.
<b>Definition:</b>	Percent of orphans and vulnerable children under 18 living in a household whose households have received, free of user charges, basic external support in caring for the child
<b>Measurement Tool:</b>	Population-based survey such as DHS/AIS, MICS
<b>Numerator:</b>	<p>Number of orphans and vulnerable children residing in households that received:</p> <ol style="list-style-type: none"> <li>a. health care support within the past 12 months;</li> <li>b. emotional support within the past 3 months;</li> <li>c. school-related assistance within the past 12 months;</li> <li>d. other social support, including material support, within the past 3 months; and</li> <li>e. all four types of support.</li> </ol> <p>Orphan (at least one dead parent) AND/OR vulnerable child (at least one chronically ill parent) whose household has received:</p> <ol style="list-style-type: none"> <li>1. Medical support within the last 12 months; AND</li> <li>2. Emotional/psychological support within the last 3 months AND</li> <li>3. Material support within the last 3 months AND</li> <li>4. Social support within the last 3 months AND</li> <li>5. School-related assistance within the past 12 months.</li> </ol>
<b>Denominator:</b>	<p>ORPHANS: All children under 18 who have at least one dead parent (mother or father) AND</p> <p>VULNERABLE CHILDREN: All children under 18 who have a chronically ill parent (mother or father) defined as a parent who has been very sick for 3 or more months during the last 12 months, regardless of whether or not the ill parent lives in the household.</p>
<b>How To Measure It:</b>	As part of a household survey, household rosters can be used to identify all eligible orphans and vulnerable children (under 18 years of age). For each household with orphans and vulnerable children, a series of questions is asked about the types and frequency of support received and the primary source of the help.

	<p>The following methods are recommended:</p> <ul style="list-style-type: none"> <li>• A population-based household survey can be used in high-prevalence settings. As part of a household survey, household rosters can be used to identify all eligible chronically ill people 15–59 years old. For each household with a chronically ill member, a series of questions is asked about the types and frequency of support received and primary source of the help.</li> <li>• A special study: the household survey tool may be used in low-prevalence settings or targeted populations with similar but adapted methods sampling networks of people living with HIV/AIDS and/or recipients of services from care and support programs.</li> </ul> <p>Data should be analyzed and reported by age (0–5, 6–9, 10–14, and 15–17 years) and gender. Depending on the epidemiological situation and available resources, program managers may decide to aggregate age data into larger ranges (0–9, 10–14, and 15–17 years).</p> <p>Each component of type of support will also be reported on separately, i.e., percentage whose households received medical support, percentage whose households received emotional support, and so on.</p>
<b>Frequency:</b>	Baseline, then every 2-3 years
<b>Interpretation/ Strengths and Weaknesses:</b>	<p>The greatest limitation of this indicator is its inability to distinguish whether needs are being met. Not all households caring for orphans need help. The needs of households with multiple orphans may be greater than those with a single orphan, but this will not be captured in this measure. Unfortunately, needs assessment is beyond the scope of a regular population-based survey. Experience shows that response rates are very high when people are asked whether they need extra support, though more qualitative work distinguishes large differences in actual coping capacity of households that say they would like extra help. Although it gives a picture of overall coverage or orphan support programs, this indicator does not measure the extent to which support is reaching the neediest.</p> <p>Orphans are a very mobile population. Those most in need of care may be in child-headed households that do not even qualify for inclusion in a household survey. Street children and others who live outside regular households will also be missed; in some urban areas these children may make up a substantial fraction of orphans in greatest need of care.</p> <p>By using a measure based on children currently in care, the measure will also miss households who have recently passed on orphans to other homes (perhaps precisely because they received no help with care). Using a measure based on orphan residence in households in the previous 12 months would, however, lead to problems of double counting and other measurement difficulties.</p>
<b>Reference(s):</b>	Adapted from UNAIDS (2000) Care and Support Indicator 5; WHO/UNAIDS Care & Support Guide (2004) Indicator CS10; and GFTAM Toolkit (2004) Care and Support Indicator 1



## Laboratories 1

### Percent of designated laboratories with the capacity to monitor antiretroviral combination therapy according to national and international guidelines

<b>Rationale/What It Measures:</b>	Laboratory assessment of HIV status and need for treatment is essential to ensure the appropriate and effective use of antiretroviral combination therapy. Monitoring the ability of laboratories to carry out minimal, as well as more advanced, testing requirements is therefore essential. The purpose of this indicator is therefore to assess the availability of laboratories with the capacity to monitor the people receiving antiretroviral combination therapy according to international guidelines.
<b>Definition:</b>	<p>Percentage of designated laboratories with the capacity to monitor antiretroviral combination therapy according to national and international guidelines</p> <p>To scale up antiretroviral use in resource-constrained settings, WHO categorizes currently available testing into four levels of priority:</p> <ol style="list-style-type: none"> <li>1. absolute minimum tests before starting antiretroviral combination therapy: HIV antibody test and hemoglobin or hematocrit level;</li> <li>2. basic tests: white blood cell count and differential, serum alanine or aspartate aminotransferase level, serum creatinine, blood urea nitrogen, serum glucose and pregnancy test;</li> <li>3. desirable tests: bilirubin, amylase, serum lipid and CD4 count; and</li> <li>4. optional tests: viral load.</li> </ol> <p>Designated laboratories refer to nationally identified laboratories for monitoring antiretroviral combination therapy.</p>
<b>Measurement Tool:</b>	Special laboratory study
<b>Numerator:</b>	<p>Number of designated laboratories with the capacity to monitor antiretroviral combination therapy according to national and international guidelines</p> <p>Laboratories are classified into three levels as follows:</p> <ul style="list-style-type: none"> <li>• level 1: they meet the minimum testing requirements for testing categories 1 and 2 (above);</li> <li>• level 2: they meet the minimum testing requirements for testing categories 1, 2, and 3; and</li> <li>• level 3: they meet the minimum requirements for all four testing categories.</li> </ul>
<b>Denominator:</b>	Total number of designated laboratories
<b>How To Measure It:</b>	<p>Data will be obtained from a survey of designated laboratories.</p> <p>Data collection will entail observing the availability of functioning equipment and supplies to run the tests at each level.</p>
<b>Frequency:</b>	Baseline, then every 2-3 years
<b>Interpretation/ Strengths and Weaknesses:</b>	Although this indicator attempts to assess the quality of laboratories by assessing the existence of specific equipment, it does not address human resource needs. Specifically, the presence of a trained laboratory technician available on site to perform the tests required at each level is not currently included.

<b>Reference(s):</b>	WHO/UNAIDS Care & Support Guide (2004) Indicator CS8
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## Strategic Information 1

### Percent of health facilities with record-keeping systems for monitoring HIV/AIDS care and support

<b>Rationale/What It Measures:</b>	This indicator is designed to measure the capacity of health facilities to collect data on care and support services and to compile these data.
<b>Definition:</b>	Percentage of health facilities with record-keeping systems for monitoring HIV/AIDS care and support
<b>Measurement Tool:</b>	Health facility survey such as the Service Provision Assessment
<b>Numerator:</b>	Number of health facilities maintaining adequate records on the services provided
<b>Denominator:</b>	Total number of health facilities surveyed
<b>How To Measure It:</b>	<p>The following methods are recommended:</p> <ul style="list-style-type: none"> <li>• health facility surveys that examine records on HIV/AIDS care and support services; and</li> <li>• qualitative interviews with people responsible, including interviews with officers of the health management information system.</li> </ul> <p>Facilities will be checked for:</p> <ol style="list-style-type: none"> <li>1. records indicating clients receiving pre- and post-test counseling, as well as test results;</li> <li>2. records indicating clients treated for HIV/AIDS-related illness;</li> <li>3. evidence that reports for HIV/AIDS services are submitted on a routine basis</li> </ol> <p>The data should be disaggregated by department and service.</p>
<b>Frequency:</b>	Baseline, then every 2-3 years
<b>Interpretation/Strengths and Weaknesses:</b>	Patient record systems are diverse within facilities, making comparison across sites difficult. There is also no international (or national) standard for data reporting that can be used to assess whether the record-keeping system is adequate.
<b>Reference(s):</b>	WHO/UNAIDS Care & Support Guide (2004) Indicator CS-A2

Other: Policy and Systems Strengthening (Capacity Building) 1

<b>AIDS Program Effort Index</b>	
<b>Rationale/What It Measures:</b>	The AIDS Program Effort Index is a composite index designed to measure political commitment and program effort in the areas of HIV prevention and care. It tries to capture many of the inputs and outputs of a national HIV/AIDS program. The score is made up of 10 main components of an effective national response: political support, policy formulation, organizational structure, program resources, evaluation and research, legal and regulatory aspects, human rights, prevention programs, care programs and service availability.
<b>Definition:</b>	The average score given to a national program by a defined group of knowledgeable individuals asked about progress in over 90 individual areas of programming, grouped into 10 major components
<b>Measurement Tool:</b>	The AIDS Program Effort Index (API) questionnaire and protocol (Special study)
<b>Numerator:</b>	N/A
<b>Denominator:</b>	N/A
<b>How To Measure It:</b>	The API uses key informants from a designated mix of institutions to give opinions about central areas of commitment and programming, compiling an index out of scores given in various areas. The score, which is calculated as a percentage with zero indicating no program effort and 100 indicating maximum effort, may be converted into a grade to minimize informant variation. Suggested grades range from very weak and weak through moderate and strong to very strong, depending on the range in which the numerical scores fall.
<b>Frequency:</b>	Baseline, then every 2-3 years
<b>Interpretation/Strengths and Weaknesses:</b>	<p>The major concerns surrounding the API are its subjectivity and its reliability. The outcome depends entirely on the choice of informants, and informants will likely change from year to year. Since the indicator is still under development, the choice of informants has not yet been standardized.</p> <p>Questions have also been raised about the utility of a single composite score, in which improvements in some areas may be masked by deterioration in other areas. For diagnostic as well as monitoring purposes, it may be more useful simply to publish the indices separately by category. The separate category scores may stand alone as indicators, although for several areas of program effort, this document proposes alternatives which are based on measured parameters rather than expert opinion and may therefore be more useful in tracking trends over time.</p> <p>One area in which the API process may yield a particularly useful indicator is in the area of policy formulation (Section 20 of the API protocol).</p>
<b>Reference(s):</b>	UNAIDS (2000) Policy Indicator 1

Other: Policy and Systems Strengthening (Capacity Building) 2

<b>Percent of the general population with accepting attitudes toward PLWHA</b>	
<b>Rationale/What It Measures:</b>	This is an indicator based on answers to a series of hypothetical questions about men and women with HIV. It reflects what people are prepared to say they feel or would do when confronted with various situations involving people living with HIV.
<b>Definition:</b>	Percent of women and men aged 15–49 expressing accepting attitudes toward people with HIV, of all women and men aged 15–49 surveyed who have heard of HIV
<b>Measurement Tool:</b>	Population-based survey such as the UNAIDS general population survey; DHS/AIS; BSS (adult +youth), RHS
<b>Numerator:</b>	Number of women and men who report an accepting attitude on all four of these questions
<b>Denominator:</b>	Number of all women and men aged 15–49 surveyed who have heard of HIV
<b>How To Measure It:</b>	<p>Respondents in a general population survey who have heard of HIV are asked a series of questions about people with HIV, as follows:</p> <ul style="list-style-type: none"> <li>• If a member of your family became sick with the AIDS virus, would you be willing to care for him or her in your household?</li> <li>• If you knew that a shopkeeper or food seller had the AIDS virus, would you buy fresh vegetables from him/her?</li> <li>• If a female teacher has the AIDS virus but is not sick, should she be allowed to continue teaching in school?</li> <li>• If a member of your family became infected with the AIDS virus, would you want it to remain a secret?</li> </ul> <p>The indicator should be reported separately for men and women.</p>
<b>Frequency:</b>	Baseline, then every 2-3 years
<b>Interpretation/Strengths and Weaknesses:</b>	<p>Methodologically, this is a relatively easy way to construct an indicator of attitudes toward people with HIV. A low score on the indicator is a fairly sound indication of high levels of stigma, and for that reason alone it is worth measuring.</p> <p>There are, however, difficulties in interpreting indicators based on hypothetical questions, and a high score on the indicator is harder to understand. It could mean there is little real stigma attached to HIV. Or it could mean that people know they should not discriminate, and therefore report accepting attitudes. This may not change their behavior, which may continue to be discriminatory toward people with HIV. Changes in the indicator could therefore reflect a reduction in stigma or simply a growing awareness that it is not nice to own up to one's prejudices. That in itself may, however, constitute the first step in program success. High scores may also reflect the respondent's limited personal experience with someone who is HIV-infected.</p> <p>The proposed indicator is similar to an earlier measure developed by WHO, but questions have been changed following field testing to better reflect situations in which people with HIV actually suffer from stigma. Field tests revealed that responses are greatly affected by the exact wording of the indicator. When the gender of the teacher was not specified, for example, one country registered very high levels of "discriminatory" attitudes on that question, for example. Further investigation showed that the negative attitudes were related to recent news reports of male teachers infecting female pupils with HIV.</p>

<b>Reference(s):</b>	Adapted from UNAIDS (2000-Reference #7) Stigma and Discrimination Indicator 1
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## ACRONYMS AND ABBREVIATIONS

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



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