The President's Emergency Plan for AIDS Relief

FY07 Reporting/
FY08 Planning

INDICATORS REFERENCE GUIDE

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

Indicators Reference Guide
FY2007 Reporting/FY2008 Planning

July 2007

Contents

INTRODUCTION

This is the revised PEPFAR Indicators Reference Guide for FY 2007 Reporting and FY 2008 Planning. This version replaces all other previous versions. Please recycle any previous older versions.

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

Collecting strategic information serves multiple purposes:

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

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

Shortly after the end of each fiscal year, all USG field offices will be required to report to their respective Agencies or to OGAC describing the progress and accomplishments of U.S.-funded HIV/AIDS activities. These data will be used to report PEPFAR achievements in the Fourth Annual Report to Congress.

The purpose of this document is to provide guidance on the required output indicators for routine data collection and reporting in the FY 2007 Emergency Plan Annual Program Results (APR). It also provides information for targets setting in the FY 2008 Country Operational Plan (COP or Mini-COP). This document also includes guidance on outcome and impact indicators collected by surveys.

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

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

The first section describes program-level indicators: Table 1 on page 10 shows the quantitative program-level indicators framework. Program-level Indicators are listed at-a-glance on pages 24-27. This is followed by indicator reference sheets for each program-level indicator, which further describe and define the program-level indicators.

The second section, beginning on page 118 provides summary listings for outcome- and impact-level indicators with their data collection methods and international standard sources, separated into generalized and concentrated/low-level epidemic indicators.

Major Changes to FY07 Reporting/FY08 Planning Indicators Reference Guide

- The document is labeled FY2007 Reporting/FY2008 Planning – and references to these dates have been changed where appropriate. This document replaces all previous versions of the guide.
- Three Food & Nutrition indicators have been added to program-level indicators – in PMTCT, OVC, and Treatment. Two Food & Nutrition indicators with no particular program area have been added under "wrap-around" category.
- OVC and Palliative Care indicators have additional clarification on what services are in which domains (additional appendices further explain the eligible services).
- There are additional appendices – Palliative Care Categories, Additional Guidance on the new TB/HIV indicator, Examples of Eligible and Ineligible Activities for Core Program Areas for OVCs, Example for Calculating Wrap-around Food and Nutrition Support, Additional Guidance on the new program-level food and nutrition indicators (PMTCT, ART, OVC), Additional Guidance on the PMTCT Indicator #1.3, and Sample Tools for Tracking Program Geographic Coverage and Tracking Indicators/Partners.
- Cambodia, Malawi, and India were removed from the list of Mini-COP countries – and are now under the category "Full COP (Non-Focus) Countries".
- The TB C&T indicator has been moved to the TB program area.
- For the PMTCT indicator #1.3, this indicator has been harmonized with UNAIDS to reflect HIV-infected pregnant women who received *any* antiretroviral prophylaxis for PMTCT in a PMTCT setting.
- For UNGASS indicators for which there is a corresponding PEPFAR outcome/impact indicator, these indicators have been updated to reflect the UNGASS 2007 guide.

Emergency Plan Program-level Reporting

Descriptive Summary

In-country Collaboration and Coordination

The PEPFAR model encourages USG agencies in the specified countries to work in close collaboration/coordination with other donor and international agencies active in the HIV/AIDS arena, as well as a range of in-country partners. Each USG team will have the opportunity to list the organizations with which they are collaborating or coordinating in-country and to include a brief description of the type of

collaboration or coordination (for example, conducting joint planning or implementation, funding or co-funding, or coordinating of program activities). This type of information may be particularly important for the PEPFAR Other Bilateral countries that are primarily working to strengthen systems and leverage other donors' dollars (See Appendix 1).

Output Data

By the end of FY 2006, HIV reporting requirements were fully aligned with OGAC requirements. As a result, all PEPFAR countries receiving over $1 million will have the opportunity to report on the same set of 46 indicators.

The indicators presented here are the **minimum** set of program-level reporting requirements under The Emergency Plan; they represent only a portion of the information needed by programs to effectively monitor, manage, and improve programs locally. Each of the PEPFAR program area technical working groups (TWG) may be used as resources to identify the appropriate indicators in addition to the required indicators that may be needed to effectively monitor and manage programs. In some cases, these recommendations have been formally written into official guidance documents and USG country teams should refer to official guidance posted publicly on www.pepfar.net and www.pepfar.gov. In these guidance documents, one can find examples of indicators of interest, such as geographical coverage by service site, age of clients served (when not already required), number and intensity of care services, survival rates, and quality of life for individuals receiving ART services.

Program-level indicators are often, though not always, broadly defined. A broad definition allows countries the freedom to develop appropriate region specific programs, which best address the needs of the population (e.g. in areas such as Care and OVC). While some indicator definitions lack specificity, this should not be confused with lack of interest in program quality. On the contrary, OGAC encourages each country to develop quality programs, which reflect National/International guidelines and standards. Countries may report using their own more specific definitions, but that definition should fit within the broader PEPFAR definition. In the absence of guidelines, countries must use their best judgment in determining for themselves the reasonable level of service that ensures quality.

Each country must report on program results at least once every year according to agency and OGAC reporting guidance (refer to Table 2 on page 14 for specific reporting requirements by funding level). The annual program results will be reported shortly after the end of the fiscal year and cover the full fiscal year (October 1-September 30). The annual results update will include financial information along with joint USG reporting on program-level indicators contained within this document.

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

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

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

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**
PMTCT		X	X	X
ARV prophylaxis within PMTCT			X	
Prevention				
Abstinence and/or Be faithful			X	X
Abstinence			X	
Medical transmission/Blood safety		X		X
Medical transmission/Medical Injection safety				X
Other Behavior Change			X	X
Palliative Care (Facility/Community or Home-Based)		X (total)	X (adjusted)	X (total)
TB/HIV		X	X	X
OVC			X	X
Counseling and Testing		X	X	X
Treatment (ART)		X	X	X
Labs		X		X
Strategic Information	X			X
Other Policy Analysis and Systems Strengthening				
Policy Development	X			X
Institutional Capacity Building	X			X
Stigma and Discrimination Reduction				X
Community Mobilization for Prevention, Care and/or Treatment				X

Data Quality

The Emergency Plan relies on good quality data to support its programs and demonstrate progress towards goals. Issues such as estimation of upstream (indirect) and downstream (direct) support, comparability of reported results over multiple reporting periods, and double counting can impact data quality. These issues affect every Emergency Plan program, regardless of the unique set of programmatic and sociopolitical factors that make one country program different from another. For more assistance with these issues, please refer to

the *PEPFAR Data Quality Assurance Tool for Program-Level Indicators* (PEPFAR DQA Tool is available at http://www.pepfar.gov/c20981.htm).

Double counting can occur for any of the Emergency Plan's indicators and can occur in many different circumstances. Some indicators (e.g. OVC, Palliative Care and TB, and prevention) are more prone to double counting because of the difficulty inherent in tracking the individuals being served and/or the multiple types of programs implemented to assist clients. Partners and USG teams should be extra vigilant in examining the risk of double counting and minimize double counting when reporting results.

The problem of double counting can be categorized into four essential types:

Type I: Within Partner Double Counting of Individuals
One partner at one site provides the same service (training, treatment, care, etc.) multiple times to the same individual within one reporting period and counts the individual as having received the service multiple times within the same reporting period.

Type II: Between Partner Double Counting of Individuals
Two or more partners supply the same service (prevention, treatment, care, etc.) to the same individual at the same site or different sites within one reporting period and both partners add the individual to their count of the service delivery.

Type III: Double Counting of Sites
Partners provide the supplies and/or services to the same organization within one reporting period and count that organization as one of their service points.

Type IV: Double Counting Due to Overlap of Upstream and Downstream Support
A partner supports activities that result in a site (and individuals receiving services at that site) as benefiting from both upstream and downstream USG support, and the partner counts the site and individuals served under both the upstream (indirect) and downstream (direct) results.

Double counting of individuals within a program area is to be avoided among USG funded partners. While USG funded partners 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. In order to avoid double counting, countries will need to monitor their activities by partner, programmatic area, and geographic area. For more information regarding how to avoid double counting, please refer to the *PEPFAR DQA Tool.* While there is information presented for avoiding each of the four types of double counting, the guidance in the *PEPFAR DQA Tool* is not intended to address or solve all possible combinations and permutations of double counting, rather is designed as a field-appropriate tool to effectively manage and minimize the problem.

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

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

- Number of pregnant women who received HIV counseling and testing for PMTCT and received their test results (#1.2)
- Number of HIV-infected pregnant women who received antiretroviral prophylaxis for PMTCT in a PMTCT setting (#1.3)
- Number of individuals provided with HIV-related palliative care (including TB/HIV) (#6.2)
- Number of HIV-infected clients attending HIV care/treatment services that are receiving treatment for TB disease (this is a subset of all individuals provided with palliative care) (#7.2)
- Number of orphans and vulnerable children (OVC) served by an OVC program (#8.1)
- Number of individuals who received counseling and testing for HIV and received their test results (#9.2)
- Number of individuals receiving antiretroviral therapy at the end of the reporting period (referred to as CURRENT clients) (#11.4)

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

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

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

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

results should be national or regional results. If the USG contribution is not significant relative to the national or regional results, then the USG country team should refer to the PEPFAR DQA Tool for further guidance on reporting upstream results.

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

Reporting Requirements by Funding Level

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

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

Table 2: Reporting Requirements by Funding Level

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

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

Focus Countries

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

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

Emergency Plan Legislative Targets

Support treatment for 2 million people living with HIV/AIDS by 2009
The achievement of this target will be measured by the number of individuals receiving antiretroviral therapy (Indicator #11.4) through FY 2008 funding. It will be counted at the end of the 12-month reporting period in FY 2009 given that most FY 2008 funding will be spent in 2009. (This measure is not cumulative over 5 years). This target includes both downstream and upstream counts.

Prevent 7 million new HIV infections by 2010
The U.S. Census Bureau will be modeling achievement of this target based on surveillance data. The U.S. Census Bureau will periodically produce estimates towards the achievement of this target based on new surveillance data reported by countries. Countries do not need to invest country funds in modeling infections averted.

Support care for 10 million people infected and affected by HIV/AIDS, including orphans and vulnerable children, by 2009
The achievement of this target will be measured by the number of individuals receiving palliative care (Indicator #6.3) and OVC served (Indicator #8.1) through FY 2008 funding. It will be counted during the 12-month reporting period in FY 2009 given that most FY 2008 funding will be spent in 2009. (This measure is not cumulative over 5 years). This target includes downstream and upstream counts.

Routine Reporting for PEPFAR Output-level Indicators: Each focus country must report on program results every six months to OGAC. The semi-annual program results will be reported in May of each year and cover the first six months of the fiscal year (October 1-March 31); the annual program results update will be reported shortly after the end of the fiscal year and cover the full fiscal year (October 1-September 30). Thus, the reporting period will vary: for the semi-annual program results, the reporting period is six months;

for annual program results the reporting period is for twelve months. The Annual Program Results (APR) will include financial information along with joint USG reporting on all the required program and country-level output indicators contained within this document. The Semi-Annual Program Results (SAPR) will not require financial information but will include information on the required program and country-level output indicators. The program-level output indicators of The Emergency Plan are collected from program data/reports and routine facility-based HMIS.

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

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

Surveillance and Survey Activities for the Collection of 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.

A variety of surveillance and survey activities are used to collect and measure outcome and impact indicators including population-based surveys, targeted facility surveys, sentinel surveillance systems or sero-surveys, and cohort studies. Baseline data should have been collected by the end of fiscal year 2004 or mid-fiscal year 2005. At a minimum, countries should plan for surveillance and/or survey activities to collect and analyze a second data point for each core outcome- and impact-level indicator before the end of The Emergency Plan (September 2009). Routine surveillance information should be collected yearly or every other year. For countries with generalized epidemics, it is recommended that national population surveys be conducted every 2 to 3 years. Countries with concentrated epidemics should plan for Behavioral Surveillance surveys targeted to high-risk groups.

> **Core Outcome- and Impact-level Indicators**
> These indicators 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. This core set of outcome- and impact-level indicators should be included for collection in the country's planned surveillance and/or survey activities (see pages 119-121).

Additional Outcome- and Impact-level Indicators

Among the additional outcome- and impact-level indicators under The Emergency Plan at this point, some are appropriate at the sub-national level only, thus their exclusion from the core set of Emergency Plan indicators. Some of the indicators have methodologies that are still under development. The Additional Emergency Plan Outcome- and Impact-level Indicators Summary Table (see pages 122-123) indicates this, as well as the group leading the piloting or testing of the methodology. USG country team are encouraged to plan surveillance/survey activities that include these additional outcome- and impact-level indicators to collect and report on progress at the program level as well as the outcome and impact level.

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

For countries with concentrated or low prevalence epidemics or mixed epidemics, there is an additional set of outcome- and impact-level indicators for programs that target the most-at-risk-populations in these countries (see page 124). Countries that have a significant proportion of their epidemic stemming from the most-at-risk populations, are encouraged to plan surveillance/survey activities that include these indicators to collect and report progress towards targeting these populations at the program level as well as the outcome and impact levels.

Special studies may be desired in order to supplement existing data to address programmatic needs and to document successful models.

Full COP (non-Focus) Countries

Definition: There are 3 countries which are completing a COP for FY2008 but are not Focus countries: Cambodia, India, and Malawi.

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

Routine Reporting for PEPFAR Output-level indicators: Each of these three countries must report on program results once every year to the Office of the U.S. Global AIDS Coordinator (OGAC). The reporting period covers a 12-month timeframe representing the full fiscal year (October 1-September 30) and will be due shortly after the end of the fiscal year. The Annual Program Results (APR) will include financial information along with joint USG reporting on all the required program and country-level output indicators contained within this document. The program-level output indicators of The Emergency Plan are collected from program data/reports and routine facility-based HMIS.

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

> **Output-level Indicators:** These three countries are requested to report on the indicators that fall in the program areas that they are currently funding. Countries may not have programming in all areas and thus, will not be expected to report on all indicators – but will be expected to report on a subset of the entire list of indicators *for which they have set targets in the COP.*
>
> The program-level output indicators for The Emergency Plan rely heavily on program reports from USG partners in-country and routine facility-based HMIS. Data from these sources will be collated by USG offices in country. The data collection systems for some existing partners may not allow them to report on these indicators; they should work toward incorporating these indicators into their monitoring and evaluation systems so that they will be able to report at the end of the fiscal year. All new agreements should specify that partners will be expected to report according to these guidelines.

Surveillance and Survey Activities for the Collection of 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.

A variety of surveillance and survey activities are used to collect and measure outcome and impact indicators including population-based surveys, targeted facility surveys, sentinel surveillance systems or sero-surveys, and cohort studies. Baseline data should have been collected by the end of fiscal year 2004 or mid-fiscal year 2005. At a minimum, countries should plan for surveillance and/or survey activities to collect and analyze a second data point for each core outcome- and impact-level indicator before the end of The Emergency

Plan (September 2009). Routine surveillance information should be collected yearly or every other year. For countries with generalized epidemics, it is recommended that national population surveys be conducted every 2 to 3 years. Countries with concentrated epidemics should plan for Behavioral Surveillance surveys targeted to high-risk groups.

Core Outcome- and Impact-level Indicators

These indicators 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. This core set of outcome- and impact-level indicators should be included for collection in the country's planned surveillance and/or survey activities (see pages 119-121).

Additional Outcome- and Impact-level Indicators

Among the additional outcome- and impact-level indicators under The Emergency Plan at this point, some are appropriate at the sub-national level only, thus their exclusion from the core set of Emergency Plan indicators. Some of the indicators have methodologies that are still under development. The Additional Emergency Plan Outcome- and Impact-level Indicators Summary Table (see pages 122-123) indicates this, as well as the group leading the piloting or testing of the methodology. USG country team are encouraged to plan surveillance/survey activities that include these additional outcome- and impact-level indicators to collect and report on progress at the program level as well as the outcome and impact level.

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

For countries with concentrated or low prevalence epidemics or mixed epidemics, there is an additional set of outcome- and impact-level indicators for programs that target the most-at-risk-populations in these countries (see page 124). Countries that have a significant proportion of their epidemic stemming from the most-at-risk populations, are encouraged to plan surveillance/survey activities that include these indicators to collect and report progress towards targeting these populations at the program level as well as the outcome and impact levels.

Special studies may be desired in order to supplement existing data to address programmatic needs and to document successful models.

Mini-COP Countries

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

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

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

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

> **Output-Level Indicators:** Countries are requested to report on the indicators that fall in the program areas that they are currently funding. Mini-COP PEPFAR Other Bilateral Countries may not have programming in all areas and thus, will not be expected to report on all indicators – but will be expected to report on a subset of the entire list of indicators *for which they have set targets in the mini-COP.*
>
> The program-level output indicators for The Emergency Plan rely heavily on program reports from USG partners in-country and routine facility-based HMIS. Data from these sources will be collated by USG offices in country. The data collection systems for some existing partners may not allow them to report on these indicators; they should work toward incorporating these indicators into their monitoring and evaluation systems so they will be able to report at the end of the fiscal year. All new agreements should specify that partners will be expected to report according to these guidelines.

Surveillance and Survey Activities for the Collection of 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.

A variety of surveillance and survey activities are used to collect and measure outcome and impact indicators including population-based surveys, targeted facility surveys, sentinel surveillance systems or sero-surveys, and cohort studies. It is recommended that routine surveillance information be collected yearly or every other year. For countries with generalized epidemics, it is recommended that national population surveys be conducted every 2 to 3 years. Countries with concentrated epidemics should plan for Behavioral Surveillance surveys targeted to high-risk groups.

Core Outcome- and Impact-level Indicators

These indicators 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. This core set of outcome- and impact-level indicators should be included for collection in the country's planned surveillance and/or survey activities (see pages 119-121).

Additional Outcome- and Impact-level Indicators

Among the additional outcome- and impact-level indicators under The Emergency Plan at this point, some are appropriate at the sub-national level only, thus their exclusion from the core set of Emergency Plan indicators. Some of the indicators have methodologies that are still under development. The Additional Emergency Plan Outcome- and Impact-level Indicators Summary Table (see pages 122-123) indicates this, as well as the group leading the piloting or testing of the methodology. USG country team are encouraged to plan surveillance/survey activities that include these additional outcome- and impact-level indicators to collect and report on progress at the program level as well as the outcome and impact level.

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

For countries with concentrated or low prevalence epidemics or mixed epidemics, there is an additional set of outcome- and impact-level indicators for programs that target the most-at-risk-populations in these countries (see page 124). Countries that have a significant proportion of their epidemic stemming from the most-at-risk populations, are encouraged to plan surveillance/survey activities that include these indicators to collect and report progress towards targeting these populations at the program level as well as the outcome and impact levels.

Special studies may be desired in order to supplement existing data to address programmatic needs and to document successful models.

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

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

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

Routine Reporting for PEPFAR Output-level indicators: All countries receiving over $1 million in bilateral HIV/AIDS assistance must report on program results once every year according to their respective agencies' guidelines. For USAID missions, this reporting will occur through the new FACTS system. The DFA Operational Plans will request some indicators in addition to the 46 PEPFAR indicators listed here. USAID missions will be required to report on these additional indicators in program areas which they are funding.

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

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

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

Surveillance and Survey Activities for the Collection of 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.

A variety of surveillance and survey activities are used to collect and measure outcome and impact indicators including population-based surveys, targeted facility surveys, sentinel surveillance systems or sero-surveys, and cohort studies. It is recommended that routine surveillance information be collected yearly or every other year. For countries with generalized epidemics, it is recommended that national population surveys be conducted every 2 to 3 years. Countries with concentrated epidemics should plan for Behavioral Surveillance surveys targeted to high-risk groups.

Core Outcome- and Impact-level Indicators

These indicators 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. This core set of outcome- and impact-level indicators should be included for collection in the country's planned surveillance and/or survey activities (see pages 119-121).

Additional Outcome- and Impact-level Indicators

Among the additional outcome- and impact-level indicators under The Emergency Plan at this point, some are appropriate at the sub-national level only, thus their exclusion from the core set of Emergency Plan indicators. Some of the indicators have methodologies that are still under development. The Additional Emergency Plan Outcome- and Impact-level Indicators Summary Table (see pages 122-123) indicates this, as well as the group leading the piloting or testing of the methodology. USG country team are encouraged to plan surveillance/survey activities that include these additional outcome- and impact-level indicators to collect and report on progress at the program level as well as the outcome and impact level.

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

For countries with concentrated or low prevalence epidemics or mixed epidemics, there is an additional set of outcome- and impact-level indicators for programs that target the most-at-risk-populations in these countries (see page 124). Countries that have a significant proportion of their epidemic stemming from the most-at-risk populations, are encouraged to plan surveillance/survey activities that include these indicators to collect and report progress towards targeting these populations at the program level as well as the outcome and impact levels.

Special studies may be desired in order to supplement existing data to address programmatic needs and to document successful models.

Table 3 - PROGRAM-LEVEL INDICATORS

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

	Male
	Female
6.6 Total number of individuals trained to provide HIV palliative care (excluding TB/HIV) [for COP Table 3 only]	
(7) Palliative Care (TB/HIV)	
7.1 Number of service outlets providing treatment for tuberculosis (TB) to HIV-infected individuals (diagnosed or presumed) in a palliative care setting (a subset of indicator number 6.1)	
7.2 Number of HIV-infected clients attending HIV care/treatment services that are receiving treatment for TB disease (a subset of indicator number 6.2)	
	Male
	Female
7.3. Number of individuals trained to provide treatment for TB to HIV-infected individuals (diagnosed or presumed). (a subset of indicator number 6.3)	
7.4 Number of registered TB patients who received HIV counseling, testing, and their test results at a USG supported TB service outlet (a subset of indicator number 9.2)	
	Male
	Female
(8) Orphans and Vulnerable Children	
8.1 Number of OVC served by OVC programs	
	Male
	Female
	8.1.A Primary Direct
	8.1.B Supplemental Direct
8.2 Number of providers/caregivers trained in caring for OVC	
8.3 Number of OVC receiving food and nutritional supplementation through OVC programs	
(9) Counseling and Testing	
9.1 Number of service outlets providing counseling and testing according to national and international standards	
9.2 Number of individuals who received counseling and testing for HIV and received their test results (including TB)	
	Male
	Female
9.3 Number of individuals trained in counseling and testing according to national and international standards	
9.4 Number of individuals who received counseling and testing for HIV and received their test results (excluding TB) [for COP Table 3 only]	
	Male
	Female
(10) HIV/AIDS Treatment/ARV Drugs – No required indicators	
(11) HIV/AIDS Treatment/ARV Services	
11.1 Number of service outlets providing antiretroviral therapy	
11.2 Number of individuals newly initiating antiretroviral therapy during the reporting period	
	Male (0-14)

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

Wrap-around Food Support

Metric tons of non-PEPFAR food aid leveraged by PEPFAR wrap-around activities

Non-PEPFAR food and nutrition dollars leveraged by PEPFAR wrap-around activities for the provision of food or nutritional supplementation.

Definitions of Program-Level Output Indicators

Prevention of Mother-to-Child Transmission Services

1.1 Number of service outlets providing the minimum package of PMTCT services according to national or international standards	
Rationale/What It Measures:	This indicator provides a crude quantitative measure of the stage of PMTCT service expansion and current availability of PMTCT services supported by USG.
Definition:	A service outlet refers to the lowest level of service. For example, a hospital, clinic, or mobile unit. The minimum package of services for preventing mother-to-child transmission (MTCT) of HIV includes at least all four of the following services: 1. Counseling and testing for pregnant women 2. ARV prophylaxis to prevent MTCT 3. Counseling and support for safe infant feeding practices 4. Family planning counseling or referral* *PEPFAR program dollars cannot directly fund provision of family planning services. PEPFAR programs are encouraged to refer to or work in partnership with non-PEPFAR funded family planning programs to ensure comprehensive services.
Measurement Tool:	Program Reports. USG staff and USG-funded partners should keep an inventory of the name and location of service outlets providing PMTCT services, clearly indicating those that provide the minimum package of PMTCT services. This information should be submitted to the USG staff responsible for compiling the annual reporting data as evidence for the reported number of service outlets providing the minimum package of PMTCT services.
How To Measure It:	Each USG agency and USG-funded partner counts the number of service outlets providing the minimum package of PMTCT services at the end of the specified reporting period (12 months for annual report). Count only those service outlets that provide at minimum all four services specified above (1, 2, 3, and 4). The USG staff responsible for compiling the annual reporting data should use the PMTCT service outlets list submitted by each USG agency and USG-funded partner reporting on this indicator in order to count the total number of service outlets providing the minimum package of PMTCT services, avoiding any double-counting of the same PMTCT outlet supported by more than one USG agency/USG-funded partner.
Interpretation/ Strengths and Weaknesses:	This indicator does not consider the quality of service provision, which would require more in-depth evaluation efforts like facility surveys. This is not a complete measure of coverage, as there is no denominator of total facilities. This does not account for non-USG supported service outlets.

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

1.3 Number of HIV-infected pregnant women who received antiretroviral prophylaxis for PMTCT in a PMTCT setting	
Rationale/What It Measures:	This indicator measures the delivery and uptake of antiretroviral prophylaxis for PMTCT. The emphasis is now on receiving "any PMTCT ARVs" rather than a "complete course", and though not required it encourages reporting on the number of HIV-positive pregnant women provided with ARVs by regimen group (i.e. single dose nevirapine, prophylactic regimens using a combination of two ARVs, prophylactic regimes using a combination of three ARVs, or ART-HAART-- for HIV positive pregnant women eligible for treatment). The shift from reporting a "complete course of PMTCT ARV" to "any PMTCT ARV" reflects the confusion about the definition of a "complete course" and the range of different regimens offered.
Definition:	The number of women who received any PMTCT ARVs to prevent MTCT at PMTCT service outlets. ARV prophylaxis includes: (1) single dose nevirapine (SD NVP), (2) prophylactic regimens using a combination of two ARVs, (3) prophylactic regimens using a combination of three ARVs, or (4) ART (HAART) for HIV-positive pregnant women eligible for treatment. Count all of these types of regimen options in the total number of women who received any PMTCT ARVs. Since this indicator is for pregnant woman, do not count women who did not receive PMTCT prophylaxis themselves but whose infants did.
Measurement Tool:	Service outlet log books or HMIS.
How To Measure It:	Double counting of individuals within a program area is to be avoided among USG funded partners. While USG funded partners 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. In order to avoid double counting, countries will need to monitor their activities by partner, programmatic area, and geographic area. Count the number of HIV-infected pregnant women who received antiretrovirals to prevent MTCT at PMTCT service outlets during the specified reporting period (12 months for annual report). ARV prophylaxis includes: (1) SD NVP, (2) prophylactic regimens using a combination of two ARVs, (3) prophylactic regimes using a combination of three ARVs, or (4) ART (HAART) for HIV-positive pregnant women eligible for treatment. It is encouraged to stratify by type of ARV.
Interpretation/ Strengths and Weaknesses:	This indicator is not necessarily an expression of service coverage at a population level, but at a minimum monitors the delivery/uptake of services at USG-supported PMTCT service outlets. In some countries, the PMTCT PEPFAR data are the same as the National data and in other countries they are a subset. This indicator allows monitoring trends in PMTCT antiretroviral drug provision. This indicator does not capture ARV drugs or prophylaxis type; however, it is recommended for program management to track the different types of prophylaxis and stratify by type of ARV. Since countries provide different regimens of antiretroviral drugs for PMTCT, cross country comparisons of aggregate estimates must be interpreted with caution and with reference to the regimens provided. Internationally standardized denominators will be used to calculate the estimated percent coverage.

	One weakness of this indicator is the exclusion of mother-infant pairs who only received infant prophylaxis. Therefore, partial prophylaxis for the infant only is not measured. USG in-country teams will have an opportunity in the narrative section of the APR/SAPR to describe and stratify by ARV type (by number or approximate percent for each subgroup) and describe how this indicator relates to national level data in order to monitor national level trends in PMTCT. This will be optional reporting and is not mandatory. Please see Appendix 3 for more information.

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

Weaknesses:	as opposed to the percent of health facilities with trained staff, which may be measured through health facility surveys.

1.5 Number of HIV-positive pregnant or lactating women receiving food and nutritional supplementation in a PMTCT setting	
Rationale/What It Measures:	This indicator measures the number of HIV-positive pregnant or lactating women who received food or supplementation from programs directly supported by PEPFAR.
Definition:	Food and nutrition supplementation includes: 1. supplementary feeding to provide additional food to prevent clinical malnutrition or treat mild-to-moderate malnutrition 2. therapeutic feeding to provide specialized foods to treat persons with severe malnutrition 3. micronutrient supplementation This indicator counts only HIV-positive pregnant or lactating women. Any of their children who receive replacement or complementary feeding should be counted in the Food & Nutrition indicator for OVC (indicator #8.3).
Measurement tool:	Program Reports
How to measure it:	Double counting of individuals within a program area is to be avoided among USG funded partners. While USG funded partners 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. In order to avoid double counting, countries will need to monitor their activities by partner, programmatic area, and geographic area. Food and Nutrition crosses several program areas. Currently, a pregnant or lactating mother who receives food or nutritional supplementation through downstream supported PMTCT programs who also receives food or nutritional supplementation as a downstream supported ART patient with evidence of severe malnutrition would be counted both in indicator #1.5 and indicator #11.6. However, in the future this indicator may be modified to disallow double counting between the three food and nutrition indicators in order to permit them to be aggregated for one total number of persons served. Count the number of unique pregnant or lactating women who received food and nutritional supplementation in a PMTCT setting during the reporting period according to PEPFAR guidelines. This is NOT the cumulative number of pregnant or lactating women having received food or nutritional supplementation over the life of the Emergency Plan. Please reference the PEPFAR Food and Nutrition Technical Guidance for more information on food or nutritional supplementation. The guidance can be found at www.pepfar.net under "Guidance" under the "Food and Nutrition" program area. For more information please see Appendix 8.
Interpretation/Strengths and	The indicator does not account for non-USG supported services.

Weaknesses:	It does not capture the coverage of HIV-positive pregnant or lactating women in relation to the need for feeding and supplementation. The indicator may not accurately measure the number pregnant and lactating women receiving food or supplementation if the food or supplementation is shared among household members who are not its intended recipients.

Abstinence and Be Faithful

2.1 Number of individuals reached through community outreach that promotes HIV/AIDS prevention through abstinence and/or being faithful	
Rationale/What It Measures:	This indicator measures the number of individuals who attended community outreach activities focused on abstinence and/or being faithful. In any prevention campaign, the more individuals who receive the message, the higher number who may make the behavioral changes involved.
Definition:	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. For the purposes of being counted here, community outreach does not include large-scale public gatherings. 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. Abstinence and/or be faithful are defined below as any of the following: Activities or programs that promote abstinence: 1. Importance of abstinence in reducing the prevention of HIV transmission among unmarried individuals; 2. Decision of unmarried individuals to delay sexual activity until marriage; 3. Development of skills in unmarried individuals for practicing abstinence; and 4. Adoption of social and community norms that support delaying sex until marriage and that denounce forced sexual activity among unmarried individuals AND/OR Activities or programs that promote being faithful: 1. Importance of being faithful in reducing the transmission of HIV among individuals in long-term sexual partnerships; 2. Elimination of casual sex and multiple sexual partnerships; 3. Development of skills for sustaining marital fidelity; 4. Adoption of social and community norms supportive of marital fidelity and partner reduction using strategies that respect and respond to local customs and norms; and 5. Adoption of social and community norms that denounce forced sexual activity in marriage or long-term partnerships
Measurement Tool:	Program Reports
How To Measure It:	Double counting of individuals within a program area is to be avoided among USG funded partners. While USG funded partners 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. In order to avoid double counting, countries will need to monitor their activities by partner, programmatic area, and geographic area. An individual may be counted in separate program areas, such as an OVC who may be served separately by an OVC program, ART facility, and prevention program. All the **prevention** and **care** indicators refer to individuals served *during the current reporting period*. If you served 100 prevention clients last year and served 120 during the current reporting period, this is reported as 120, not 220.
Interpretation/ Strengths and Weaknesses:	Countries will be able to monitor their success in these efforts by setting goals that include tangible increases in this number, indicating further overall reach of the message. See "ABC Guidance #1 (Abstinence, Be Faithful, and correct and consistent Condom use)" for more information on this indicator at www.pepfar.gov.

2.1.A Number of individuals reached through community outreach that promotes HIV/AIDS prevention through abstinence [this is a subset of the total reached with abstinence and/or be faithful – indicator #2.1]	
Rationale/What It Measures:	This indicator measures the number of individuals who attended community outreach activities focused on abstinence. In any prevention campaign, the more individuals who receive the message, the higher number who may make the behavioral changes involved.
Definition:	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. For the purposes of being counted here, community outreach does not include large-scale public gatherings. Abstinence is defined below as any of the following: Activities or programs that promote abstinence: 1. Importance of abstinence in reducing the prevention of HIV transmission among unmarried individuals; 2. Decision of unmarried individuals to delay sexual activity until marriage; 3. Development of skills in unmarried individuals for practicing abstinence; and 4. Adoption of social and community norms that support delaying sex until marriage and that denounce forced sexual activity among unmarried individuals
Measurement Tool:	Program Reports
How To Measure It:	Double counting of individuals within a program area is to be avoided among USG funded partners. While USG funded partners 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. In order to avoid double counting, countries will need to monitor their activities by partner, programmatic area, and geographic area. An individual may be counted in separate program areas, such as an OVC who may be served separately by an OVC program, ART facility, and prevention program. All the **prevention** and **care** indicators refer to individuals served *during the current reporting period*. If you served 100 prevention clients last year and served 120 during the current reporting period, this is reported as 120, not 220.
Interpretation/ Strengths and Weaknesses:	Countries will be able to monitor their success in these efforts by setting goals that include tangible increases in this number, indicating further overall reach of the message.

2.2 Number of individuals trained to promote HIV/AIDS prevention through abstinence and/or being faithful	
Rationale/What It Measures:	This indicator is a measure of peer or health care educators who have been trained in the delivery of prevention messages to the target audience. It measures the number of newly trained or retrained individuals who are able to deliver HIV prevention messages with primary focus on abstinence and/or being faithful. Refer to outcome indicators on training for further recommendations.
Definition:	Training refers to new training or retraining of individuals and assumes that training is conducted according to national or international standards when these exist. A training must have specific learning objectives, a course outline or curriculum, and expected knowledge, skills and/or competencies to be gained by participants. 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. Abstinence and/or be faithful are defined below as any of the following: Activities or programs that promote abstinence: 1. Importance of abstinence in reducing the prevention of HIV transmission among unmarried individuals; 2. Decision of unmarried individuals to delay sexual activity until marriage; 3. Development of skills in unmarried individuals for practicing abstinence; and 4. Adoption of social and community norms that support delaying sex until marriage and that denounce forced sexual activity among unmarried individuals AND/OR Activities or programs that promote being faithful: 1. Importance of being faithful in reducing the transmission of HIV among individuals in long-term sexual partnerships; 2. Elimination of casual sex and multiple sexual partnerships; 3. Development of skills for sustaining marital fidelity; 4. Adoption of social and community norms supportive of marital fidelity and partner reduction using strategies that respect and respond to local customs and norms; and 5. Adoption of social and community norms that denounce forced sexual activity in marriage or long-term partnerships
Measurement Tool:	Program reports. USG agencies and USG-funded partners should keep a training log including the type of training, date, location, and participants.
How To Measure It:	Double counting of individuals within a program area is to be avoided among USG funded partners. While USG funded partners 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. In order to avoid double counting, countries will need to monitor their activities by partner, programmatic area, and geographic area. Each USG agency and USG-funded partner counts the number of individuals trained in prevention through abstinence and/or being faithful by USG staff (HQ or field-based) or USG-funded partners during the specified reporting period (12 months for annual report). 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. The USG staff responsible for compiling the annual reporting data should use the training log submitted by each USG agency and USG-funded partner reporting on this indicator in order to count the total number of individuals trained in prevention. Individuals trained in training courses co-funded by more than one USG agency/USG-funded partner should only be counted once within the specified reporting period (12 months for annual report).
Interpretation/ Strengths and Weaknesses:	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. 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.

Medical Transmission: Blood Safety

3.1 Number of service outlets carrying out blood safety activities	
Rationale/What It Measures:	This indicator counts the number of facilities, which receive USG support for blood safety activities.
Definition:	A service outlet refers to the lowest level of service. For example, a hospital, clinic, or mobile unit. 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.
Measurement Tool:	Program Reports
How To Measure It:	The unit of measurement is the site, not the activity. A site will only count once during a reporting period regardless of the number of on-going activities at the site.
Interpretation/ Strengths and Weaknesses:	This indicator does not consider the quality of service provision, which would require more in depth evaluation efforts like facility surveys. This is not a complete measure of coverage, as there is no denominator of total facilities. This does not account for non-USG supported service outlets.

3.2 Number of individuals trained in blood safety	
Rationale/What It Measures:	The intent of the indicator is to measure progress toward a cadre of professionals trained in blood safety activities according to national or international standards.
Definition:	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. Training refers to new training or retraining of individuals and assumes that training is conducted according to national or international standards when these exist. 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.
Measurement Tool:	Program reports. USG agencies and USG-funded partners should keep a training log including the type of training, date, location, and participants.
How To Measure It:	Double counting of individuals within a program area is to be avoided among USG funded partners. While USG funded partners 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. In order to avoid double counting, countries will need to monitor their activities by partner, programmatic area, and geographic area. Each USG agency and USG-funded partner counts the number of individuals trained in blood safety by USG staff (HQ or field-based) or USG-funded partners during the specified reporting period (12 months for annual report). 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. The USG staff responsible for compiling the annual reporting data should use the training log submitted by each USG agency and USG-funded partner reporting on this indicator in order to count the total number of individuals trained in blood safety. Individuals trained in training courses co-funded by more than one USG agency/USG-funded partner should only be counted once within the specified reporting period (12 months for annual report).
Interpretation/ Strengths and	This indicator does not measure the quality of the training, nor does it measure the outcomes of the training in terms of the competencies of individuals trained, nor their job performance.

Weaknesses:	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.

Medical Transmission: Medical Injection Safety

4.1 Number of individuals trained in medical injection safety	
Rationale/What It Measures:	The intent of the indicator is to measure progress toward a cadre of professionals trained in medical injection safety activities according to national or international standards.
Definition:	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. Training refers to new training or retraining of individuals and assumes that training is conducted according to national or international standards when these exist. A training must have specific learning objectives, a course outline or curriculum, and expected knowledge, skills and/or competencies to be gained by participants.
Measurement Tool:	Program reports. USG agencies and USG-funded partners should keep a training log including the type of training, date, location, and participants.
How To Measure It:	Double counting of individuals within a program area is to be avoided among USG funded partners. While USG funded partners 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. In order to avoid double counting, countries will need to monitor their activities by partner, programmatic area, and geographic area. Each USG agency and USG-funded partner counts the number of individuals trained in medical injection safety by USG staff (HQ or field-based) or USG-funded partners during the specified reporting period (12 months for annual report). 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. The USG staff responsible for compiling the annual reporting data should use the training log submitted by each USG agency and USG-funded partner reporting on this indicator in order to count the total number of individuals trained in medical injection safety. Individuals trained in training courses co-funded by more than one USG agency/USG-funded partner should only be counted once within the specified reporting period (12 months for annual report).
Interpretation/ Strengths and	This indicator does not measure the quality of the training, nor does it measure the outcomes of the training in terms of the competencies of individuals trained, nor their job performance.

Weaknesses:	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.

Condoms and Other Prevention Activities

5.1 Number of targeted condom service outlets	
Rationale/What It Measures:	This indicator provides a tangible measure of the potential reach of condom distribution to a given community as an important part of a comprehensive prevention message.
Definition:	A targeted condom service outlet refers to fixed distribution points or mobile units with fixed schedules providing condoms for free or for sale. 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.
Measurement Tool:	Program Reports
How To Measure It:	A targeted condom service outlet refers to fixed distribution points or mobile units with fixed schedules providing condom distribution. Countries should count the number of distribution points at which condoms are available to their target population.
Interpretation/ Strengths and Weaknesses:	This indicator provides a relatively straightforward measure of potential reach in prevention activities that include the distribution of condoms.

5.2 Number of individuals reached through community outreach that promotes HIV/AIDS prevention through other behavior change beyond abstinence and/or being faithful	
Rationale/What It Measures:	This indicator measures the number of individuals who attended community outreach activities focused on other behavior change beyond abstinence and/or being faithful. In any prevention campaign, the more individuals who receive the message, the higher number who may make the behavioral changes involved.
Definition:	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). For the purposes of being counted here, community outreach does not include large-scale public gatherings. This indicator is not venue-specific; individuals reached through community outreach, *wherever that outreach may have occurred* (a park, drop-in center, bar or club, etc) should be counted. 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.
Measurement Tool:	Program reports
How To Measure It:	Double counting of individuals within a program area is to be avoided among USG funded partners. While USG funded partners 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. In order to avoid double counting, countries will need to monitor their activities by partner, programmatic area, and geographic area. An individual may be counted in separate program areas, such as an OVC who may be served separately by an OVC program, ART facility, and prevention program. All the **prevention** and **care** indicators refer to individuals served *during the current reporting period*. If you served 100 prevention clients last year and served 120 during the current reporting period, this is reported as 120, not 220. For concentrated/low-level epidemic settings where most-at-risk populations drive HIV transmission, it is recommended (but not required) that this indicator be monitored and disaggregated by the most-at-risk populations (MARPs) as relevant to country context. Please see the next section -- Disaggregation for Most-at-Risk Populations -- for an example of MARPs disaggregation for Prevention/Other Behavior Change and for Counseling and Testing.

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

5.3 Number of individuals trained to promote HIV/AIDS prevention through other behavior change beyond abstinence and/or being faithful	
Rationale/What It Measures:	This indicator is a measure of peer or health care educators who have been trained in the delivery of prevention messages to the target audience. It measures the number of newly trained or retrained individuals who are able to deliver comprehensive HIV prevention messages.
Definition:	Training refers to new training or retraining of individuals and assumes that training is conducted according to national or international standards when these exist. 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.
Measurement Tool:	Program reports. USG agencies and USG-funded partners should keep a training log including the type of training, date, location, and participants.
How To Measure It:	Double counting of individuals within a program area is to be avoided among USG funded partners. While USG funded partners 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. In order to avoid double counting, countries will need to monitor their activities by partner, programmatic area, and geographic area. Each USG agency and USG-funded partner counts the number of individuals trained in prevention through other behavior change beyond abstinence and/or being faithful by USG staff (HQ or field-based) or USG-funded partners during the specified reporting period (12 months for annual report). 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. The USG staff responsible for compiling the annual reporting data should use the training log submitted by each USG agency and USG-funded partner reporting on this indicator in order to count the total number of individuals trained in prevention. Individuals trained in training courses co-funded by more than one USG agency/USG-funded partner should only be counted

	once within the specified reporting period (12 months for annual report).
Interpretation/ Strengths and Weaknesses:	This indicator does not measure the quality of the training, nor does it measure the outcomes of the training in terms of the competencies of individuals trained, nor their job performance.

Palliative Care (Basic Health Care)

6.1 Total number of service outlets providing HIV-related palliative care (including TB/HIV)	
Rationale/What It Measures:	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, social, and prevention care. This indicator includes the total number of service outlets, which provide HIV-related care.
Definition:	A service outlet refers to the lowest level that offers at least one palliative care service. For example, with respect to clinical activities, the lowest level that should be counted is a service outlet such as a hospital, clinic, or mobile unit. For community-based or home-based services, the lowest level that should be counted is a service delivery location of the organization that provides palliative care services, like an office or mobile unit. Do not count any single home despite the fact that services may be delivered in the home. Do not count any single community unless the organization serving that community has a recognized office or mobile unit from which palliative care services are delivered. Palliative care services include: A) clinical/medical, B) psychological, C) spiritual, D) social, and E) prevention care. *Clinical/medical care services* include: prevention and treatment of opportunistic infections (OIs) including tuberculosis (TB); alleviation of HIV-related symptoms and pain; nutritional assessment; treatment of HIV-related psychiatric illnesses such as depression and anxiety; routine follow-up to determine the optimal time to initiate ART; and support for adherence to ART. *Psychological care services* include: interventions that address the non-physical suffering of individuals and family members, such as mental health counseling; support groups; support for disclosure of HIV status; and bereavement care. Spiritual care services should be sensitive to the culture and rituals of the individual and community and may include (but are not limited to): life review and assessment; and counseling related to hopes and fears, meaning and purpose, guilt and forgiveness. Spiritual care may involve clergy and/or traditional/spiritual leaders. *Social care services* assist individuals and family members in maintaining linkages to and use of various social services, including: community-based support groups; community mobilization and leadership development of PLWHA; efforts to reduce stigma; transportation support; legal services to assist with succession planning, inheritance rights, and legal documentation (such as a living will or power of attorney); assistance to secure government grants, housing, or health care; linkages to food support and income-generating programs; vocational training; efforts to increase community awareness of HIV care, treatment, and prevention services; and other activities to strengthen affected households and communities.

	Social services must be targeted at PLWHA and their families. *Prevention care service*s are designed to prevent transmission of HIV to others. Models to provide these interventions can include: risk assessment and behavioral counseling to achieve risk reduction; referrals to confidential counseling and testing of family members and sex partners; interventions for sero-discordant couples; community and clinic--based support groups; and case-management and provider-delivered prevention messages focused on disclosure, partner testing, correct and consistent condom use for PLWHA, and mutual fidelity. Currently to be counted as a care service outlet, a site must offer at least one palliative care service. However, per the FY08 COP Technical Considerations, service outlets are encouraged to provide and/or link with at least one clinical service, plus at least one service in another domain of palliative care (psychological, spiritual, social or preventive). Please see Appendix 4.
Measurement Tool:	Program Reports
How To Measure It:	The number of service outlets includes those providing clinical/medical care (for opportunistic infections including TB), psychological, spiritual, social or prevention care services for HIV-infected individuals, and their families.
Interpretation/ Strengths and Weaknesses:	This indicator does not consider the quality of service provision, which would require more in-depth evaluation efforts like facility surveys. This is not a complete measure of coverage, as there is no denominator of total facilities. This does not account for non-USG supported service outlets. It is recommended that at the country level, programs monitor which sites provide each of the palliative care services: clinical/medical, psychological, spiritual, social, and prevention. Please refer to the following documents for additional information related to this indicator: "HIV//AIDS Palliative Care Guidance #1" posted under "Guidance" at www.Pepfar.gov "FY08 COP Technical Considerations" posted under "Guidance" at www.Pepfar.net "List of Palliative Care Services" included in the FY08 COP Technical Considerations and posted under "Guidance" at www.Pepfar.net Please see the Palliative Care Technical Working Group team site for additional information and updates at: https://www.pepfar.net/C10/Care%20and%20Treatment-%20Palliative/default.aspx

6.2 Total number of individuals provided with HIV-related palliative care (including those HIV-infected individuals who received treatment for tuberculosis (TB) Indicator 6.2.A), disaggregated by sex	
Rationale/What It Measures:	This indicator is the total number of unique individuals receiving palliative care from facilities and/or community/home-based organizations.
Definition:	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, social, and prevention care. Palliative care services include: A) clinical/medical, B) psychological, C) spiritual, D) social, and E) prevention care. *Clinical/medical care services* include: prevention and treatment of opportunistic infections (OIs) including tuberculosis (TB); alleviation of HIV-related symptoms and pain; nutritional assessment; treatment of HIV-related psychiatric illnesses such as depression and anxiety; routine follow-up to determine the optimal time to initiate ART; and support for adherence to ART. *Psychological care services* include: interventions that address the non-physical suffering of individuals and family members, such as mental health counseling; support groups; support for disclosure of HIV status; and bereavement care. *Spiritual care services* should be sensitive to the culture and rituals of the individual and community and may include (but are not limited to): life review and assessment; and counseling related to hopes and fears, meaning and purpose, guilt and forgiveness. Spiritual care may involve clergy and/or traditional/spiritual leaders. *Social care services* assist individuals and family members in maintaining linkages to and use of various social services, including: community-based support groups; community mobilization and leadership development of PLWHA; efforts to reduce stigma; transportation support; legal services to assist with succession planning, inheritance rights, and legal documentation (such as a living will or power of attorney); assistance to secure government grants, housing, or health care; linkages to food support and income-generating programs; vocational training; efforts to increase community awareness of HIV care, treatment, and prevention services; and other activities to strengthen affected households and communities. Social services must be targeted at PLWHA and their families. *Prevention care services* are designed to prevent transmission of HIV to others. Models to provide these interventions can include: risk assessment and behavioral counseling to achieve risk reduction; referrals to confidential counseling and testing of family members and sex partners; interventions for sero-discordant couples; community and clinic--based support groups; and case-management and provider-delivered prevention messages focused on disclosure, partner testing, correct and consistent condom use for PLWHA, and mutual fidelity.

	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 HIV-infected individuals and families have varying needs for services depending on the stage of illness. On-site quality assurance and supervision are expected by program managers to ensure that persons are receiving proper care. 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. Currently, in order to be counted under this indicator an individual must be receiving at least one palliative care service. In the future, PEPFAR may ask that HIV-infected persons be provided with at least one clinical service, plus at least one service in another category of palliative care (psychological, spiritual, social, or preventive) to be counted as having received palliative care in reporting to OGAC. Countries should consider how indicator collection processes would need to change to report using this revised indicator definition (please see *Technical Considerations for the FY 2008 COP* document for more information).
Measurement Tool:	Program Reports
How To Measure It:	Double counting of individuals within a program area is to be avoided among USG funded partners. While USG funded partners 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. In order to avoid double counting, countries will need to monitor their activities by partner, programmatic area, and geographic area. This indicator refers to individuals served *during the current reporting period*. This indicator is the total number of unique 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. Palliative care crosses several program areas, such as OVC, ART, and prevention programs. Given that the total number of individuals receiving care and support is calculated by adding the number of OVC served by an OVC program indicator (#8.1) and the total number of individuals receiving palliative care indicator (#6.2), OVC receiving palliative care should only be counted under one of the these two indicators but not in both. When reporting results, please note the indicator under which OVC receiving palliative care are counted. In order to avoid double counting, countries will need to monitor their activities by partner, programmatic area, and geographic area. Using a matrix (see one example in Appendix 9) is an excellent program management tool as well as helping to adjust for double counting by partners, among partners, and among USG agencies. Please see Appendix 4.
Interpretation/ Strengths and	Adjusting for overlap between programs is very difficult, especially when programs are not well linked, and patient confidentiality concerns must be respected.

Weaknesses:	Please refer to the following documents for additional information related to this indicator: "HIV//AIDS Palliative Care Guidance #1" posted under "Guidance" at www.Pepfar.gov "FY08 COP Technical Considerations" posted under "Guidance" at www.Pepfar.net "List of Palliative Care Services" included in the FY08 COP Technical Considerations and posted under "Guidance" at www.Pepfar.net Please see the Palliative Care Technical Working Group team site for additional information and updates at: https://www.pepfar.net/C10/Care%20and%20Treatment-%20Palliative/default.aspx

6.3 Total number of individuals trained to provide HIV-related palliative care for HIV-infected individuals (diagnosed or presumed) that includes those trained in facility-based, community-based and/or home-based care including TB/HIV	
Rationale/What It Measures:	This indicator measures the total number trained for HIV-related palliative care during the reporting period.
Definition:	Training refers to new training or retraining of individuals and assumes that training is conducted according to national or international standards when these exist. A training must have specific learning objectives, a course outline or curriculum, and expected knowledge, skills and/or competencies to be gained by participants. Training on HIV-related palliative care services should include one or more of the following service areas: A) clinical/medical including TB/HIV, B) psychological, C) spiritual, D) social, and/or E) prevention care services for HIV-infected individuals and family members. *Clinical/medical care services* include: prevention and treatment of opportunistic infections (OIs) including tuberculosis (TB); alleviation of HIV-related symptoms and pain; nutritional assessment; treatment of HIV-related psychiatric illnesses such as depression and anxiety; routine follow-up to determine the optimal time to initiate ART; and support for adherence to ART. *Psychological care services* include: interventions that address the non-physical suffering of individuals and family members, such as mental health counseling; support groups; support for disclosure of HIV status; and bereavement care. *Spiritual care services* should be sensitive to the culture and rituals of the individual and community and may include (but are not limited to): life review and assessment; and counseling related to hopes and fears, meaning and purpose, guilt and forgiveness. Spiritual care may involve clergy and/or traditional/spiritual leaders. *Social care services* assist individuals and family members in maintaining linkages to and use of various social services, including: community-based support groups; community mobilization and leadership development of PLWHA; efforts to reduce stigma; transportation support; legal services to assist with succession planning, inheritance rights, and legal documentation (such as a living will or power of attorney); assistance to secure government grants, housing, or health care; linkages to food support and income-generating programs; vocational training; efforts to increase community awareness of HIV care, treatment, and prevention services; and other activities to strengthen affected households and communities. Social services must be targeted at PLWHA and their families. *Prevention care services* are designed to prevent transmission of HIV to others. Models to provide these interventions can include: risk assessment and behavioral counseling to achieve risk reduction; referrals to confidential counseling and testing of family members and sex partners; interventions for sero-discordant couples; community and clinic--based support groups; and case-management and provider-delivered prevention messages focused on disclosure, partner testing, correct and consistent condom use for PLWHA, and mutual fidelity.

Measurement Tool:	Program reports. USG agencies and USG-funded partners should keep a training log including the type of training, date, location, and participants.
How To Measure It:	Double counting of individuals within a program area is to be avoided among USG funded partners. While USG funded partners 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. In order to avoid double counting, countries will need to monitor their activities by partner, programmatic area, and geographic area. This indicator is the total number of individuals receiving training for HIV-related palliative care (including those trained in TB/HIV) Each USG agency and USG-funded partner counts the number of individuals trained in HIV-related palliative care by USG staff (HQ or field-based) or USG-funded partners during the specified reporting period (12 months for annual report). Only participants who complete the full training course should be counted. If a training course covers more than one palliative care topic, for example clinical care and psychological care, individuals should only be counted once for that training course. 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. The USG staff responsible for compiling the annual reporting data should use the training log submitted by each USG agency and USG-funded partner reporting on this indicator in order to count the total number of individuals trained in HIV-related palliative care. Individuals trained in training courses co-funded by more than one USG agency/USG-funded partner should only be counted once within the specified reporting period (12 months for annual report). Please see Appendix 4.
Interpretation/ Strengths and Weaknesses:	This indicator does not measure the quality of the training, nor does it measure the outcomes of the training in terms of the competencies of individuals trained, nor their job performance. This indicator simply measures number trained in palliative care as opposed to the percent of health facilities with trained staff, which may be measured through health facility surveys. Please refer to the following documents for additional information related to this indicator: "HIV//AIDS Palliative Care Guidance #1" posted under "Guidance" at www.Pepfar.gov

	"FY08 COP Technical Considerations" posted under "Guidance" at www.Pepfar.net "List of Palliative Care Services" included in the FY08 COP Technical Considerations and posted under "Guidance" at www.Pepfar.net Please see the Palliative Care Technical Working Group team site for additional information and updates at: https://www.pepfar.net/C10/Care%20and%20Treatment-%20Palliative/default.aspx

For the following three Palliative Care/Basic Health Care and Support indicators, please refer to the indicator reference sheets for Indicators #6.1, #6.2, and #6.3.

6.4 Total number of services outlets providing HIV-related palliative care (excluding TB/HIV) [for COP Table 3 only]	
6.5 Total number of individuals provided with HIV-related palliative care (excluding TB/HIV) [for COP Table 3 only]	
	Male
	Female
6.6 Total number of individuals trained to provide HIV palliative care (excluding TB/HIV) [for COP Table 3 only]	

Palliative Care (TB/HIV)

7.1 Number of service outlets providing treatment for tuberculosis (TB) to HIV-infected individuals (diagnosed or presumed) according to national or international standards [this is a subset of indicator 6.1: the total number of service outlets providing HIV-related palliative care]	
Rationale/What It Measures:	Palliative care is patient and family-centered care. It optimizes the quality of life of adults and children living with HIV through the active anticipation, prevention, and treatment of pain, symptoms and suffering from the onset of HIV diagnosis through death. Palliative care includes and goes beyond the medical management of infectious, neurological or oncological complications of HIV/AIDS to comprehensively address symptoms and suffering throughout the continuum of illness. The means by which this is achieved will vary according to stage of illness but always with the understanding that quality of life involves clinical, psychological, spiritual, supportive, and prevention care. Palliative care services include: A) clinical/medical, B) psychological, C) spiritual, D) support care services, and/or E) prevention care. *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. *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. *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. *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. *Prevention care services* include: interventions for sero-discordant couples, including confidential testing and ongoing counseling; community and clinic-based support groups; case-management and provider-delivered prevention messages focused on disclosure; partner testing; correct and consistent condom use for populations engaged in high-risk behavior and mutual fidelity. **This indicator measures the subset of service outlets providing TB/HIV care.**
Definition:	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. A service outlet that will count in this indicator will provide treatment for tuberculosis to HIV-infected individuals (diagnosed

	or presumed).
Measurement Tool:	Program Reports
How To Measure It:	[This is a subset of the total number of service outlets providing general HIV-related palliative care.] Outreach-only programs are counted through the number of communities served by community/home-based palliative care [Indicator #8.2]
Interpretation/ Strengths and Weaknesses:	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. 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.

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

7.3 Number of individuals trained to provide tuberculosis (TB) treatment to HIV-infected individuals (diagnosed or presumed) according to national or international standards [This indicator is a subset of the total number trained for HIV-related palliative care in Indicator #6.3]	
Rationale/What It Measures:	This is a subset of the total number trained for HIV-related palliative care who had specific training on TB/HIV
Definition:	Training refers to new training or retraining of individuals and assumes that training is conducted according to national or international standards when these exist. TB/HIV training refers to trainings designed to enhance participants' knowledge of or ability to deliver treatment for TB.
Measurement Tool:	Program reports. USG agencies and USG-funded partners should keep a training log including the type of training, date, location, and participants.
How To Measure It:	Double counting of individuals within a program area is to be avoided among USG funded partners. While USG funded partners 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. In order to avoid double counting, countries will need to monitor their activities by partner, programmatic area, and geographic area. This is a subset of the total number trained for HIV-related palliative care who had specific training on TB/HIV including treatment to HIV-infected individuals (diagnosed or presumed). Each USG agency and USG-funded partner counts the number of individuals trained in TB/HIV by USG staff (HQ or field-based) or USG-funded partners during the specified reporting period (12 months for annual report). 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. The USG staff responsible for compiling the annual reporting data should use the training log submitted by each USG agency and USG-funded partner reporting on this indicator in order to count the total number of individuals trained in TB/HIV. Individuals trained in training courses co-funded by more than one USG agency/USG-funded partner should only be counted once within the specified reporting period (12 months for annual report).
Interpretation/ Strengths and	This indicator does not measure the quality of the training, nor does it measure the outcomes of the training in terms of the competencies of individuals trained, nor their job performance.

Weaknesses:	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.

7.4 Number of registered TB patients who received HIV counseling, testing, and their results at a USG supported TB site [This indicator is a subset of the total number individuals who received counseling and testing for HIV and received their test results in Indicator #9.2]	
Rationale/What It Measures:	The prevalence of HIV infection is considerably higher among patients with TB disease than in the general population and in some settings may be as high as 80%. Given this critical relationship between TB and HIV, addressing HIV among TB patients and TB suspects has been identified as a high priority in the Emergency Plan. HIV testing for all TB patients is an important part of TB treatment and care. HIV testing of patients at the same time and location that they receive diagnosis for TB assures higher uptake of HIV testing among TB patients, thus this indicator is included to track the level to which TB programs are adhering to this best practice. This indicator provides a count of the registered TB patients who received HIV counseling, testing, and received their test results at a USG supported TB site during the current reporting period and as a result are now aware of their HIV status. This indicator does not count toward Care.
Definition:	This indicator requires a minimum of counseling, testing, and the provision of test results for HIV.
Measurement Tool:	Facility TB Register – requires registers to make a note of the HIV tests performed *on-site*.
How To Measure It:	Registered TB patients tested for HIV at the USG supported TB service outlet should be counted under this indicator. Individuals who are suspected to have TB (but the TB diagnosis is not confirmed) who visit TB sites and are tested for HIV should NOT be counted. Registered TB patients who are referred to a co-located and integrated USG supported counseling site may be counted under this indicator if <u>all</u> of the following conditions are met: 1. The TB site and the counseling and testing site are located in the same building, hospital, or health center; and, 2. The TB site and the counseling and testing site have an integrated effective referral system a. HIV testing referrals are provided to registered TB patients as a matter of practice, b. HIV test results come back to the TB clinic either by patient or through C&T site, c. HIV test results are notated in the facility TB register, d. The TB site verifies that the patient has received the test result. 3. The TB site and the counseling and testing site communicate on regular basis (at least quarterly) in order to establish and maintain an effective referral system for TB patients, identify and improve gaps in the system, and maintain M&E systems. Registered TB patients who are referred to an off-site, stand alone, or other outreach HIV counseling and testing facility should NOT be counted under this indicator. These individuals will be counted by the facility where the actual HIV testing takes place and will be captured by PMTCT Indicator #1.2 or C&T indicator #9.2, provided this testing occurred at a USG-

	supported PMTCT or C&T site. Double Counting Double counting of individuals within a program area is to be avoided among USG funded partners. While USG funded partners 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. In order to avoid double counting, countries will need to monitor their activities by partner, programmatic area, and geographic area. HIV counseling and testing crosses several program areas. Given that the C & T indicators are added together to get a total number of individuals counseled and tested, registered TB patients who are referred to a co-located C & T site where an integrated referral program has been established and are counted under this indicator (#7.4), they cannot also be counted at the C&T site under C & T indicator #9.2. Individuals counted as HIV tested in the PMTCT and C&T program areas should not also be counted as tested in the TB program area. This indicator refers to individuals served *during the current reporting period*. If 100 TB patients were reported as having received HIV testing in last year's Annual Report and the following year 120 receive testing during the reporting period, this result 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. Using a matrix (see one example in Appendix 9) is an excellent program management tool as well as helping to adjust for double counting by partners, among partners, and among USG agencies. For concentrated/low-level epidemic settings where most-at-risk populations drive HIV transmission, it is recommended (but not required) that this indicator be monitored and disaggregated by the most-at-risk populations (MARPs) as relevant to country context. Please see the next section (Disaggregation of Most-at-Risk Populations (MARPs) for Program-Level Indicators on Prevention/Other and Counseling and Testing) -- for an example of MARPs disaggregation for Prevention/Other Behavior Change and for Counseling and Testing. Please see Appendix 5.
Interpretation/ Strengths and Weaknesses:	This is an output measure. This indicator will be added to the number of pregnant women who receive counseling and testing for PMTCT (Indicator #1.2) and to the number of individuals counseled and tested in other settings (indicator #9.2) in order to calculate the total number of individuals counseled and tested at the OGAC HQ level. This indicator will not capture all registered TB patients who receive HIV testing. Registered TB patients who receive testing in non-USG supported C&T sites or non-integrated stand alone or other outreach C & T sites are not included here. However, USG continues to support national data systems that include HIV testing and counseling of TB patients irrespective of site of testing in order to improve TB/HIV surveillance and program management. This indicator will not capture individuals visiting TB clinics (i.e. TB suspects) who may receive C&T at the TB site. This indicator does not 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 the TB site 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.

Orphans and Vulnerable Children

8.1 Number of orphans and vulnerable children (OVC) served by an OVC program, disaggregated by sex	
Rationale/What It Measures:	The goal of OVC activities is to provide support aimed at improving the lives of children and families directly affected by AIDS-related morbidity and/or mortality. The emphasis is on strengthening communities to meet the needs of orphans and vulnerable children affected by HIV/AIDS, supporting community-based responses, helping children and adolescents meet their own needs, creating a supportive social environment. This indicator will measure the total number of unduplicated OVC who are receiving access to a combination of the following: food/nutrition, shelter and care, protection and legal aid, health care, psychosocial support, education, and economic strengthening.
Definition:	A child, 0-17 years old, who is either orphaned or made more vulnerable because of HIV/AIDS. Orphan: Has lost one or both parents to HIV/AIDS Vulnerable: Is more vulnerable because of any or all of the following factors that result from HIV/AIDS: • Is HIV-positive; • Lives without adequate adult support (e.g., in a household with chronically ill parents, a household that has experienced a recent death from chronic illness, a household headed by a grandparent, and/or a household headed by a child); • Lives outside of family care (e.g., in residential care or on the streets); or • Is marginalized, stigmatized, or discriminated against. USG-supported OVC programs are funded from HKID 3.3.08. The following services[2] are included in the OVC program: food/nutrition, shelter and care, protection, health care, psychosocial, education and vocational training, and economic strengthening. **Food/Nutrition** services are those that have the desired outcome of a child receiving enough food to ensure adequate nutrition for growth and development and an active and productive life. Services can include: cost-shared feeding programs within schools, after care programs, etc.; nutritional assessments and counseling; community gardens; and therapeutic and supplementary feeding of malnourished children. Services do not include broad-based food assistance and food security programs that serve the general population. **Shelter and Care** services are those that have the desired outcome of a child having adequate shelter and supervision, and that the way the child lives is similar to others in the household and community. Services can include: provision of material goods to maintain or build shelter; strengthening family-based care models for children, including transitioning from

[2] Examples of OVC services come from the OVC Programming Guidance and from a country-driven process for defining parameters for services areas; additional examples may be found in Appendix ?? or the OVC Programming Guidance document. Countries are encouraged to further define OVC services within their country context.

	institutional care to a family-setting; and provisions of bedding cookware, and other household necessities. Services do not include funding to establish new residential institutions. **Protection** services are those that have the desired outcome that a child is safe from any abuse, neglect, stigma, discrimination, or exploitation. Services can include: facilitating birth registration and identification documents; preventing children from being in abusive and exploitative situations, and removing children from such situations; supporting child-headed households; facilitating access to child grants, insurance, and inheritance claims. **Health Care** services are those that have the desired outcome of a child having access to the health services s/he needs, including preventative and treatment healthcare. Services can include: referrals and linkages to child health care including appropriate ART, growth monitoring, immunization, malaria prevention, sanitation and clean water, and personal hygiene; and age-appropriate prevention activities. Services do not include: purchase of vaccines (or bulk formulation for vaccines) for immunization programs for the general population; or contraceptives. **Psychosocial** services are those that have the desired outcome of a child having the human attachments necessary for normal development, and being able to participate cooperatively in home and community activities. Services can include: gender-sensitive life skills; improving links between children affected by HIV/AIDS in their communities; referral to counseling where available and appropriate, including that for anxiety, grief, and trauma; and recreational activities. Services do not include mental disability assistance. **Education and Vocational Training** services are those that have the desired outcome of a child receiving educational and vocational opportunities in accord with community norms and market-driven employment options, considering gender equity. Services can include: removing barriers to primary and secondary school attendance; early childhood development programs; and access to vocational trainings and employment. Services do not include strengthening the education system and general teacher training unrelated to the needs of OVC. **Economic Strengthening** services are those that have the desired outcome of improved household economic status to meet the basic needs of OVC. Services can include: small business development; savings and loan/microfinance; livelihood opportunities; vocational training for caregivers; establishing mechanisms to support community-based childcare; and establishing public-private partnerships (e.g., vendor models). Services do not include programs not directly supporting HIV/AIDS-affected OVCs.
Measurement Tool:	Program reports
How To Measure It:	Starting with the FY07 SAPR and APR, measurement of the OVC directly served target will be divided into two subcategories: OVC receiving primary direct support and those receiving supplemental direct support. If your country's OVC monitoring system is not yet able to provide this breakdown, you must write a one-paragraph justification for providing only total numbers of OVC served. Additionally, work with your partners to put such a monitoring system in place.

	Downstream (Direct) OVC Support: Direct recipients of support are OVC who are regularly monitored in the six core areas (food/nutrition, shelter and care, protection, health care, psychosocial support, and education) and whose individual needs are addressed accordingly. Economic strengthening should be evaluated according to its benefit to the six core areas. **8.1.A.: Primary Direct Support:** Count OVCs who are periodically monitored in all six core areas and who are receiving downstream support in three or more areas, in the relevant reporting period, that are appropriate for that child's needs and context. **8.1.B.: Supplemental Direct Support:** Count OVCs who are periodically monitored in all six core areas and who are receiving downstream support in one or two areas, in the relevant reporting period, that are appropriate for that child's needs and context. *Total Downstream (Direct) Support*: Sum of Primary and Supplemental Support. Double counting is a challenge in accounting for support provided to OVCs, since there are many interventions and, often, multiple providers. Double-counting of orphans and vulnerable children served can occur within a program when the same child is counted many times as a result of receiving multiple services. It can also occur when two or more implementing partners support the same child. Double-counting can also occur because of overlap between direct and indirect support. (See the Emergency Plan guidance on data quality.) To avoid double-counting, the monitoring and evaluation of programs demands much more detailed accounts than simply counting the number of children served. Double counting of individuals within a program area is to be avoided among USG funded partners. While USG funded partners 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. In order to avoid double counting, countries will need to monitor their activities by partner, programmatic area, and geographic area. Partners should not double count individuals within a program area. An individual can be counted in each separate program area, such as an OVC who may be served by an OVC program, ART facility, and prevention program. Palliative care crosses several program areas, such as OVC, ART, and prevention programs. Given that the total number of individuals receiving care and support is calculated by adding the number of OVC served by an OVC program indicator (#8.1) and the total number of individuals receiving palliative care indicator (#6.2), OVC receiving palliative care should only be counted under one of these two indicators but not in both. When reporting results, please note the indicator under which OVC receiving palliative care are counted. While programs for OVC are likely to also support other family members, reporting on this indicator is restricted to orphans and vulnerable children; other (non-OVC) family members should not be counted in this indicator. The number of contacts and the extent of services an OVC receives in order to count in this indicator is to be determined by each country based on standards agreed upon by USG and its implementing partners. However, all OVC served during the reporting period will be counted once by a program, regardless of the number of contacts with that OVC during the period. Quality assurance, supervision, and follow-up are expected by program managers to ensure that OVC are receiving quality care. For this indicator, count the number of OVC reached during the reporting period (which is October through September for

	the annual report), and 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. Please see Appendix 6.
Interpretation/ Strengths and Weaknesses:	This is a process indicator, which captures the reach of Emergency Plan funded services, but not the quality or content of those services. Such an indicator would require more in-depth evaluation efforts like facility surveys. This is not a complete measure of coverage, as there is no denominator of total facilities. This does not account for non-USG supported service outlets. The impact of services on the children served is not captured through routinely collected program indicators. National-level outcome and impact indicators will be collected periodically via population-based surveys, and special studies.

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

	The USG staff responsible for compiling the annual reporting data should use the training log submitted by each USG agency and USG-funded partner reporting on this indicator in order to count the total number of individuals trained in OVC care. Individuals trained in training courses co-funded by more than one USG agency / USG-funded partner should only be counted once within the specified reporting period (12 months for annual report).
Interpretation/ Strengths and Weaknesses:	This indicator does not measure the quality of the training, nor does it measure the outcomes of the training in terms of the competencies of individuals trained, nor their job performance.

8.3 Number of OVC receiving food and nutritional supplementation through OVC programs	
Rationale/What it Measures:	This indicator measures the number of orphans and vulnerable children who received food or supplementation from programs supported by downstream PEPFAR funds.
Definition:	Food and nutrition supplementation includes 1. supplementary feeding to provide additional food to prevent clinical malnutrition or treat mild-to-moderate malnutrition 2. therapeutic feeding to provide specialized foods to treat persons with severe malnutrition 3. micronutrient supplementation 4. replacement feeding for infants Children receiving replacement or complementary feeding through a PEPFAR supported PMTCT program should be counted here and not in indicator #1.5.
Measurement tool:	Program Reports
How to measure it:	Double counting of individuals within a program area is to be avoided among USG funded partners. While USG funded partners 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. In order to avoid double counting, countries will need to monitor their activities by partner, programmatic area, and geographic area. Food and Nutrition crosses several program areas. Currently, an OVC who receives food or nutritional supplementation through downstream supported OVC programming who also receives food or nutritional supplementation as a downstream supported ART patient with evidence of clinical malnutrition can be counted both in indicator #8.3 and indicator #11.6. However, in the future this indicator may be modified to disallow double counting between the three food and nutrition indicators in order to permit them to be aggregated for one total number of persons served. While Food and Nutrition programs for OVC are likely to work with family members, reporting on this indicator is restricted to orphans and vulnerable children who receive any food or nutritional supplementation through PEPFAR supported OVC programs; other (non-OVC) family members should not be counted in this indicator. The extent of feeding and nutritional supplementation 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 reporting period. Count the number of unique OVC who received food and nutritional supplementation *during the reporting period*. This is NOT the cumulative number of OVC having received food and nutritional supplementation 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 1000 OVC in FY06 received food or nutritional supplementation and you continue to serve 900 of them in FY07 plus an additional 500 new OVC, you would report 1400 OVC receiving food and nutritional

	supplementation in FY07. Please reference the PEPFAR Food and Nutrition Technical Guidance for more information on food or nutritional supplementation. The guidance can be found at www.pepfar.net under "Guidance" under the "Food and Nutrition" program area. Please see Appendix 8.
Interpretation / Strengths and Weaknesses:	The indicator does not account for non-USG supported services. The indicator does not capture the coverage of OVC in relation to the need for feeding and supplementation. The indicator may not accurately measure the number OVC receiving food and supplementation if the food and supplementation is shared among household members who are not its intended recipients.

HIV Counseling and Testing Services

9.1 Number of service outlets providing counseling and testing according to national or international standards	
Rationale/What It Measures:	This indicator provides a gross count of the number of locations, which provide basic counseling and testing for HIV. It provides a rough sense of the change in the capacity within a country to provide counseling and testing services. If there is a plan to expand the number of service outlets, this measure will track the progress of meeting that goal.
Definition:	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. 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.
Measurement Tool:	Program reports
How To Measure It:	Outlets, which provide both HIV counseling and testing, except those involved in PMTCT.
Interpretation/ Strengths and Weaknesses:	This is purely an output measure. It provides no sense of the geographical spread of CT services, nor any relationship to the percentage of the population, which is reached by the service outlet. This indicator does not consider the quality of service provision, which would require more in depth evaluation efforts like facility surveys. This is not a complete measure of coverage, as there is no denominator of total facilities. This does not account for non-USG supported service outlets

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

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

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

HIV/AIDS Treatment / Antiretroviral Services

11.1 Number of service outlets providing ART services according to national or international standards	
Rationale/What It Measures:	This indicator measures the progress of a program to expand the number of locations in which ART services are delivered in accordance with national or international standards.
Definitions:	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. ART services refer to activities including the provision of antiretroviral drugs and clinical monitoring for antiretroviral therapy among those with HIV infection. ART refers to long-term combination antiretroviral therapy intended primarily to improve the health of the individual on treatment, not to prevent mother-to-child transmission. A PMTCT+ site is a service outlet that provides a minimum package of services which includes HIV counseling and testing for pregnant women, ARV prophylaxis to prevent mother-to-child transmission, counseling for safe infant feeding practices, family planning counseling or referral, and ARV therapy for HIV+ women, their children, and their families.
Measurement Tool:	Program Reports
How To Measure It:	Count all service outlets providing ART including designated PMTCT+ sites.
Interpretation/ Strengths and Weaknesses:	This indicator does not describe the geographic location or distribution of service outlets. 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.

11.2 Number of individuals newly initiated on antiretroviral therapy during the reporting period, disaggregated by sex and age and pregnancy status	
Rationale/What It Measures:	There are three program indicators to count individuals receiving antiretroviral therapy at a service outlet directly supported by USG Emergency Plan funds: NEW, CUMULATIVE, and CURRENT. Collectively, these three program indicators, when combined with the Outcome Indicator: "Care & Treatment 5" (percentage of people still alive and on therapy at 6, 12, and 24 months after initiation of treatment) give an overview of the progress of a program in achieving targets to begin and maintain individuals on long-term, antiretroviral therapy. This indicator refers to NEW clients. NEW refers to individuals newly initiated on antiretroviral therapy during a reporting period.
Definitions:	ART refers to long-term combination antiretroviral therapy intended primarily to improve the health of the individual on treatment, not to prevent mother-to-child transmission. A "newly initiated" client is one who initiated antiretroviral therapy during the reporting period in a program directly supported by USG funds. A PMTCT+ site is a service outlet that provides a minimum package of services which includes HIV counseling and testing for pregnant women, ARV prophylaxis to prevent mother-to-child transmission, counseling for safe infant feeding practices, family planning counseling or referral, and ARV therapy for HIV+ women, their children, and their families. 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.
Measurement Tool:	Program Reports
How To Measure It:	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. If an individual transfers in to the ART program *with records* from continuous ART at another facility or program, this person should NOT be counted as new. If an individual transfers in *without records* 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). If an individual previously on ART in the program restarts ART after an interruption in therapy, this person should NOT be counted as new. If an individual initiated treatment during the period but died, stopped ART, or transferred out before the end of the

	reporting period, this person should still be counted as new (since status at the end of the period does not affect the fact that the person was still new on therapy during the period). 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. For the NEW indicator, age represents an individual's age at initiation of therapy. Disaggregation of pregnant women by age is NOT required. The number of pregnant women is to be shown as a subset of all women.
Interpretation/ Strengths and Weaknesses:	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. 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 *beginning* 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 *last* seen, so it is expected that characteristics of these clients would be updated each time they are seen by a program. Combining all children into one age group of < 15 yrs may not be satisfactory for program managers. For children of different ages, there are different criteria for starting treatment, as well as different disease burdens, care needs, and mortality patterns. Programs may wish to further disaggregate children by age to follow programmatically and clinically meaningful differences as follows: 0-18 months, 18 months-5 years, 6-14 years.

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

	For the CUMULATIVE indicator, age represents an individual's age at initiation of therapy or when s/he transfers into the program. Disaggregation of pregnant women by age is NOT required. The number of pregnant women is to be shown as a subset of all women.
Interpretation/ Strengths and Weaknesses:	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. 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 *beginning* 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 *last* seen, so it is expected that characteristics of these clients would be updated each time they are seen by a program.

11.4 Number of individuals receiving antiretroviral therapy at the end of the reporting period, disaggregated by sex and age and pregnancy status	
Rationale/What It Measures:	There are three program indicators to count individuals receiving antiretroviral therapy at a service outlet directly supported by USG Emergency Plan funds: NEW, CUMULATIVE, and CURRENT. Collectively, these three program indicators, when combined with the Outcome Indicator: Care & Treatment 5 (percentage of people still alive and on therapy at 6, 12, and 24 months after initiation of treatment) give an overview of the progress of a program in achieving targets to begin and maintain individuals on long-term, antiretroviral therapy. This indicator refers to CURRENT clients. CURRENT refers to those individuals on antiretroviral therapy at the end of a reporting period.
Definitions:	ART refers to long-term combination antiretroviral therapy intended primarily to improve the health of the individual on treatment, not to prevent mother-to-child transmission. A PMTCT+ site is a service outlet that provides a minimum package of services which includes HIV counseling and testing for pregnant women, ARV prophylaxis to prevent mother-to-child transmission, counseling for safe infant feeding practices, family planning counseling or referral, and ARV therapy for HIV+ women, their children, and their families. A current client is pregnant if she was pregnant *at any time during the reporting period*, regardless of the outcome of the pregnancy.
Measurement Tool:	Program Reports
How To Measure It:	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. 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. 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. 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).

	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. 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. Disaggregation of pregnant women by age is NOT required. The number of pregnant women is to be shown as a subset of all women.
Interpretation/ Strengths and Weaknesses:	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. 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 *beginning* 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 *last* seen, so it is expected that characteristics of these clients would be updated each time they are seen by a program.

11.5 Number of health workers trained to deliver ART services according to national or international standards	
Rationale/What It Measures:	Building human capacity in health care delivery systems is of the utmost importance for the delivery of quality ART services. 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.
Definitions:	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. Type of health workers include: • Physicians and health workers with physician skills (e.g. Medical Officers) • Nurses and other health workers with nursing skills (e.g. Midwives, Clinical Officers) • Other health care workers and lay staff in clinical setting • Laboratory technicians and staff • Pharmacy/dispensing staff • Community treatment supporters (peer educators, outreach workers, volunteers, informal caregivers) New training or retraining of individuals assumes that training is conducted according to national or international standards when these exist. It is assumed that in most settings such training will occur through a specialized training program that health workers attend after their regular education ("in-service" training). Only health workers who have undergone such training should be included. A training must have specific learning objectives, a course outline, or curriculum, and expected knowledge, skills and/or competencies to be gained by participants. ART services include activities such as the provision of antiretroviral drugs and clinical monitoring for antiretroviral therapy among those with HIV infection. A PMTCT+ site is a service outlet that provides a minimum package of services which includes HIV counseling and testing for pregnant women, ARV prophylaxis to prevent mother-to-child transmission, counseling for safe infant feeding practices, family planning counseling or referral, and ARV therapy for HIV+ women, their children, and their families.
Measurement Tool:	Program Reports
How To Measure It:	Double counting of individuals within a program area is to be avoided among USG funded partners. While USG funded partners 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. In order to avoid double counting, countries will need to monitor their activities by partner, programmatic area, and

	geographic area. Each USG agency and USG-funded partner counts the number of individuals trained in prevention by USG staff (HQ or field-based) or USG-funded partners during the specified reporting period (12 months for annual report). 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. The USG staff responsible for compiling the annual reporting data should use the training log submitted by each USG agency and USG-funded partner reporting on this indicator in order to count the total number of individuals trained in ART delivery. Individuals trained in training courses co-funded by more than one USG agency/USG-funded partner should only be counted once within the specified reporting period (12 months for annual report).
Interpretation/ Strengths and Weaknesses:	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. 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. 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. 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 ART services as opposed to the percent of health facilities with trained staff, which may be measured through health facility surveys.

11.6 Number of individuals receiving ART with evidence of severe malnutrition receiving food and nutritional supplementation during the reporting period	
Rationale/What It Measures:	This indicator measures the number of ART patients with evidence of severe malnutrition who received food or supplementation from programs directly supported by PEPFAR.
Definition:	Food and nutrition supplementation includes 1. supplementary feeding to provide additional food to prevent clinical malnutrition or treat mild-to-moderate malnutrition 2. therapeutic feeding to provide specialized foods to treat persons with severe malnutrition 3. micronutrient supplementation Therapeutic and supplementary feeding for ART patients should have clear anthropometric eligibility and exit criteria based on nutritional assessment and according to the PEPFAR Food and Nutrition Technical Guidance.
Measurement Tool:	Program Reports
How To Measure It:	If national guidelines do not require ART patients to be severely malnourished to receive food and nutritional supplementation directly supported by PEPFAR, efforts should be made to isolate and measure only those ART patients receiving food and nutritional supplementation who are determined to be severely malnourished. If this is the case, please provide a written explanation with reported results. Double counting of individuals within a program area is to be avoided among USG funded partners. While USG funded partners 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. In order to avoid double counting, countries will need to monitor their activities by partner, programmatic area, and geographic area. Food and Nutrition crosses several program areas. A pregnant or lactating mother who receives food or nutritional supplementation through downstream supported PMTCT programs who also receives food or nutritional supplementation as a downstream supported ART patient with evidence of severe malnutrition would be counted both in indicator #1.5 and indicator #11.6. An OVC who receives food or nutritional supplementation through downstream supported OVC programming who also receives food or nutritional supplementation as a downstream supported ART patient with evidence of clinical malnutrition would be counted both in indicator #8.3 and indicator#11.6. Count the number of unique ART patients with evidence of severe malnutrition who received food and nutritional supplementation *during the reporting period*. This is NOT the cumulative number of ART patients with evidence of severe malnutrition having received food and nutritional supplementation over the life of the Emergency Plan. Although the same ART patient may be counted in different fiscal years, you should not add ART patients reached from one fiscal year to the next. For example, if 1000 ART patients in FY06 received food or nutritional supplementation and you continue to serve

	900 of them in FY07 plus an additional 500 new ART patients, you would report 1400 ART patients receiving food and nutritional supplementation in FY07. ART patients with evidence of severe malnutrition who had received food or nutrition supplementation *within the reporting period* who either die, transfer to another ART facility where they receive food or nutritional supplementation, stop ART, or stop and resume ART and resume food and nutritional supplementation, should only be counted once. Please reference the PEPFAR Food and Nutrition Technical Guidance for more information on food or nutritional supplementation. The guidance can be found at www.pepfar.net under "Guidance" under the "Food and Nutrition" program area. Please see Appendix 8.
Interpretation/Strengths and Weaknesses:	The indicator does not account for non-USG supported services. It does not capture the coverage of ART patients in relation to the need for feeding and supplementation. The indicator may not accurately measure the number severely malnourished ART patients receiving food and supplementation if the food and supplementation is shared among household members who are not its intended recipients.

Laboratory Infrastructure

12.1 Number of laboratories with the capacity to perform (1) HIV tests and (2) CD4 tests and/or lymphocyte tests	
Rationale/What It Measures:	This indicator reflects USG efforts to strengthen capacities of laboratories to perform HIV/AIDS related tests, diagnostics, and patient monitoring tasks. This indicator is measuring both the ability to perform HIV tests as well as the ability to monitor patients who are in care.
Definition:	Laboratory capacity is defined as the ability to perform (1) HIV tests and (2) CD4 tests or lymphocyte tests. This refers to both the equipment and personnel necessary to carry out testing.
Measurement Tool:	Program reports. To assess whether the laboratory sites have the capacity to perform the specified testing, special studies using observation techniques may be necessary. USG staff and USG-funded partners should keep an inventory of the name and location of laboratory sites that are able to perform the specified testing. This information should be submitted to the USG staff responsible for compiling the annual reporting data as evidence for the reported number of laboratories with the capacity to perform the specified tests.
How To Measure It:	Each USG agency and USG-funded partner counts the number of laboratory sites that have at minimum the capacity to perform the specified testing at the end of the specified reporting period (12 months for annual report). Count only those laboratory sites that are able to perform both HIV tests and CD4 tests and/or lymphocyte tests. The USG staff responsible for compiling the annual reporting data should use the laboratory sites list submitted by each USG agency and USG-funded partner reporting on this indicator in order to count the total number of laboratory sites that have the stated capacity, avoiding any double-counting of the same laboratory site supported by more than one USG agency/USG-funded partner.
Interpretation/ Strengths and Weaknesses:	This indicator does not measure whether the sites are actually performing the specified tests. 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.

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

12.3 Number of tests performed at USG-supported laboratories during the reporting period: 1) HIV testing, 2) TB diagnostics, 3) syphilis testing, and 4) HIV disease monitoring	
Rationale/What It Measures:	This indicator measures the extent to which USG-supported laboratories are expanding laboratory services to support HIV/AIDS care and treatment services.
Definition:	The number of tests performed at USG-supported laboratories during the reporting period (12 months) • HIV testing: Examples include ELISA and simple rapid tests for serology • Polymerase chain reaction (PCR) for infant diagnosis • TB diagnostics: Acid fast (Ziehl-Neelsen) staining of sputum • Syphilis testing: Rapid Plasma Reagent (RPR), simple syphilis, Treponema pallidum hemagglutination assay (TPHA), Include both screening and confirmation • HIV disease monitoring: CD4 • HIV viral load • Alanine transaminase (ALT), and Creatinine
Measurement Tool:	Systematic review of project documents and records; laboratory records. Data collection must be ongoing and aggregated over the 12 month reporting period. The USG team in country should aggregate data across all USG-supported laboratories.
How To Measure It:	This measure should reflect the number of tests performed, not the number of kits or reagents purchased. Measurement of this indicator is undertaken by systematically reviewing laboratory records maintained at each site, as well as USG project records and documents, to count the number of USG-supported laboratories performing tests within each of the categories listed above. The number of tests should be added within each category. For example, the number of HIV tests should reflect the sum of ELISAs and rapid tests.
Interpretation/ Strengths and Weaknesses:	This indicator is an output indicator of direct support provided to strengthen laboratory capacity in a given country and for the Emergency Plan as a whole. Different sub-categories of HIV monitoring provide an overall picture of USG support. For management purposes, laboratories may want more detailed information about the tests performed. 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. The ability of laboratories to report this information may lag behind their capacity to perform these tests. As a result, counts may underestimate laboratory performance. As record keeping and reporting capacity of laboratories improve, so will the quality and accuracy of the indicator estimate. This indicator should be interpreted along with indicator #11.1.

	This indicator does not consider the quality of service provision, which would require more in-depth evaluation efforts like facility surveys. 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.

Strategic Information
(Surveillance, Health Management Information Systems, Monitoring and Evaluation)

13.1 Number of local organizations provided with technical assistance for strategic information (M&E and/or surveillance and/or HMIS).	
Rationale/What It Measures:	The intent of the indicator is to capture support provided to enhance the capacity of local organizations to collect, analyze, disseminate, and use HIV/AIDS-related data.
Definition:	A **local organization** is defined as any entity whose headquarters is in a country or region served by the Emergency Plan. As such, the majority of the entity's staff (senior, mid-level, support) is comprised of host country and/or regional nationals. "Local organizations" refers to both governmental and non-governmental (NGOs, FBOs, and community-based) organizations. 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. TA should include *regular technical communications and information dissemination sustained over a period of time.* 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. Provision of technical assistance for strategic information refers to activities that aim to strengthen HIV/AIDS surveillance, HMIS and M&E. Examples include providing local organizations with technical assistance in the following areas: developing or improving M&E models, methods and tools for collecting, analyzing, disseminating and using data; establishing or improving information systems; developing or improving program monitoring, planning and or conducting targeted program evaluations including operations research; monitoring and disseminating best practices to improve program efficiency and effectiveness; and/or improving data quality. Strategic information includes HIV/AIDS surveillance, health management information systems, and monitoring and evaluation.
Measurement Tool:	Program reports.
How To Measure It:	Each USG agency and USG-funded partner counts the number of organizations that received technical assistance for SI activities from USG staff (HQ or field-based) or USG-funded partners during the specified reporting period (12 months for annual report). 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

	technical assistance provision. This information should be submitted to the USG staff responsible for compiling the annual reporting data as evidence for the reported number of organizations supported with SI technical assistance. The USG staff responsible for compiling the annual reporting data should use the technical assistance inventory submitted by each USG agency and USG-funded partner reporting on this indicator in order to count the total number of organizations / agencies that received technical assistance for SI activities from USG staff (HQ or field-based) or USG-funded partners during the reporting period. Organizations may only be counted once within the specified reporting period (12 months for annual report). Organizations that received TA for policy development should be reported under Indicator #13.1. Organizations that received TA for institutional capacity building should be counted under Indicator #13.2.
Interpretation/ Strengths and Weaknesses:	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.

13.2 Number of individuals trained in strategic information (M&E and/or surveillance and/or HMIS)	
Rationale/What It Measures:	The intent of the indicator is to measure progress toward creating a cadre of professionals trained in the collection, analysis, dissemination, and use of strategic information for HIV/AIDS programming.
Definition:	Training refers to new training or retraining of individuals and assumes that training is conducted according to national or international standards when these exist. A training must have specific learning objectives, a course outline or curriculum, and expected knowledge, skills and/or competencies to be gained by participants.
Measurement Tool:	Program reports. USG agencies and USG-funded partners should keep a training log including the type of training, date, location, and participants.
How To Measure It:	Double counting of individuals within a program area is to be avoided among USG funded partners. While USG funded partners 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. In order to avoid double counting, countries will need to monitor their activities by partner, programmatic area, and geographic area. Count the number of individuals trained in SI during the specified reporting period (12 months for annual report). Only participants who complete the full training course should be counted. If a training course is conducted in several sessions or covers more than one SI topic, for example M&E and surveillance, individuals should only be counted once for that training course. If a training spans more than 1 programmatic area with separate and specific objectives and curricula for each program (for instance OVC and SI), individuals trained may count in each program area. 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. Each USG agency and USG-funded partner counts the number of individuals trained in SI by USG staff (HQ or field-based) or USG-funded partners during the specified reporting period (12 months for annual report). Only participants who complete the full training course should be counted. If a training course covers more than one SI topic, for example M&E and surveillance, individuals should only be counted once for that training course. 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.

	The USG staff responsible for compiling the annual reporting data should use the training log submitted by each USG agency and USG-funded partner reporting on this indicator in order to count the total number of individuals trained in SI. Individuals trained in training courses co-funded by more than one USG agency / USG-funded partner should only be counted once within the specified reporting period (12 months for annual report).
Interpretation/ Strengths and Weaknesses:	This indicator does not measure the quality of the training, nor does it measure the outcomes of the training in terms of the competencies of individuals trained, nor their job performance.

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

14.1 Number of local organizations provided with technical assistance for HIV-related policy development	
Rationale/What It Measures:	This indicator measures the degree to which local organizations receive technical assistance in support of policy development, a priority area of the Emergency Plan.
Definition:	A **local organization** is defined as any entity whose headquarters is in a country or region served by the Emergency Plan. As such, the majority of the entity's staff (senior, mid-level, support) is comprised of host country and/or regional nationals. "Local organizations" refers to both governmental and non-governmental (NGOs, FBOs, and community-based) organizations. 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. TA should include *regular technical communications and information dissemination sustained over a period of time.* 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. TA for policy development activities aim to: • Broaden and strengthen political and popular support for HIV/AIDS policies and programs; • Improve the operational environment for these programs, including better planning and financing; • Ensure that accurate, up-to-date information informs policy decisions; and • Build in-country and regional capacity to participate in policy development.
Measurement Tool:	Program reports
How To Measure It:	Sum of local organizations that received technical assistance in HIV-related policy. Organizations that received TA for Strategic Information (M&E, HMIS, Surveillance) or Quality Assurance should be counted under SI (Indicator #13.1). Organizations that received TA for institutional capacity building should be reported under Indicator #13.2.
Interpretation/ Strengths and Weaknesses:	This indicator does not measure amount and quality of TA and only indicates the number of organizations that received any TA.

14.2 Number of local organizations provided with technical assistance for HIV-related institutional capacity building	
Rationale/What It Measures:	This indicator measures the degree to which organizations receive technical assistance in support of institutional capacity development, a priority area of The Emergency Plan.
Definition:	A **local organization** is defined as any entity whose headquarters is in a country or region served by the Emergency Plan. As such, the majority of the entity's staff (senior, mid-level, support) is comprised of host country and/or regional nationals. "Local organizations" refers to both governmental and non-governmental (NGOs, FBOs, and community-based) organizations. 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. TA should include *regular technical communications and information dissemination sustained over a period of time.* 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. TA for institutional capacity building may cover the following: • *Strategic Planning:* 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; • *Registration:* organizations that are officially registered as legal entities; • *Financial Management:* 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; • *Human Resource Management:* 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; • *Networks Development:* local networks established/strengthened that deliver prevention, care and treatment services, monitor implementation, and report results; • *Commodities, Equipment and Logistics Management:* 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 • *Infrastructure Development:* laboratories, clinics, and classrooms improved or renovated to provide HIV/AIDS training or services.
Measurement Tool:	Program reports
How To Measure It:	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 #13.1). Organizations that received TA for policy development should be reported under Indicator #13.3.

Interpretation/ Strengths and Weaknesses:	This indicator does not measure amount and quality of TA and only indicates the number of organizations that received any TA.

14.3 Number of individuals trained in HIV-related policy development	
Rationale/What It Measures:	Supportive Interventions strengthen HIV prevention, care, and treatment programs. This indicator measures the number of individuals trained in policy for HIV/AIDS programs.
Definition:	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. A training must have specific learning objectives, a course outline or curriculum, and expected knowledge, skills and/or competencies to be gained by participants. Policy activities aim to: • Broaden and strengthen political and popular support for HIV/AIDS policies and programs; • Improve the operational environment for these programs, including better planning and financing; • Ensure that accurate, up-to-date information informs policy decisions; and • Build in-country and regional capacity to participate in policy development.
Measurement Tool:	Program reports. USG agencies and USG-funded partners should keep a training log including the type of training, date, location, and participants.
How To Measure It:	Double counting of individuals within a program area is to be avoided among USG funded partners. While USG funded partners 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. In order to avoid double counting, countries will need to monitor their activities by partner, programmatic area, and geographic area. Each USG agency and USG-funded partner counts the number of individuals trained in policy development by USG staff (HQ or field-based) or USG-funded partners during the specified reporting period (12 months for annual report). Only participants who complete the full training course should be counted. If a training course covers more than one policy development 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. The USG staff responsible for compiling the annual reporting data should use the training log submitted by each USG agency

	and USG-funded partner reporting on this indicator in order to count the total number of individuals trained in policy development. Individuals trained in training courses co-funded by more than one USG agency/USG-funded partner should only be counted once within the specified reporting period (12 months for annual report).
Interpretation/ Strengths and Weaknesses:	This indicator does not measure the quality of the training, nor does it measure the outcomes of the training in terms of the competencies of individuals trained, nor their job performance. This indicator simply measures number trained in HIV-related policy development as opposed to the percent of organizations with trained staff.

14.4 Number of individuals trained in HIV-related institutional capacity building	
Rationale/What It Measures:	This indicator measures the number of individuals trained in institutional capacity building. As more and more individuals are trained in the different capacity building domains, more individuals can be reached with HIV/AIDS services. In conjunction with indicator #12.2, this gives a picture of the reach of capacity building programs.
Definition:	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. A training must have specific learning objectives, a course outline or curriculum, and expected knowledge, skills and/or competencies to be gained by participants. Institutional capacity building activities may include: • *Strategic Planning:* 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; • *Registration:* organizations that are officially registered as legal entities; • *Financial Management:* 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; • *Human Resource Management:* 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; • *Networks Development:* local networks established/strengthened that deliver prevention, care and treatment services, monitor implementation, and report results; • *Commodities, Equipment and Logistics Management:* 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 • *Infrastructure Development:* laboratories, clinics, and classrooms improved or renovated to provide HIV/AIDS training or services.
Measurement Tool:	Program reports. USG agencies and USG-funded partners should keep a training log including the type of training, date, location, and participants.
How To Measure It:	Double counting of individuals within a program area is to be avoided among USG funded partners. While USG funded partners 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. In order to avoid double counting, countries will need to monitor their activities by partner, programmatic area, and geographic area. Each USG agency and USG-funded partner counts the number of individuals trained in institutional capacity building by USG

	staff (HQ or field-based) or USG-funded partners during the specified reporting period (12 months for annual report). 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 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. The USG staff responsible for compiling the annual reporting data should use the training log submitted by each USG agency and USG-funded partner reporting on this indicator in order to count the total number of individuals trained in institutional capacity building. Individuals trained in training courses co-funded by more than one USG agency / USG-funded partner should only be counted once within the specified reporting period (12 months for annual report).
Interpretation/ Strengths and Weaknesses:	This indicator does not measure the quality of the training, nor does it measure the outcomes of the training in terms of the competencies of individuals trained, nor their job performance. This indicator simply measures number trained in institutional capacity building as opposed to the percent of organizations with trained staff.

14.5 Number of individuals trained in HIV-related stigma and discrimination reduction	
Rationale/What It Measures:	Supportive Interventions strengthen HIV prevention, care, and treatment programs. This indicator measures the number of individuals trained in HIV-related stigma and discrimination reduction.
Definition:	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. A training must have specific learning objectives, a course outline or curriculum, and expected knowledge, skills and/or competencies to be gained by participants. 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. Stigma and discrimination reduction activities may include: • Enhancing practical knowledge to reduce fear of casual transmission; • Providing a safe forum to discuss sensitive topics (sex, death, drug use, inequity); • Finding a common language to talk about stigma; • Strengthening the capacity of people living with HIV and AIDS to challenge stigma in their lives; • Providing a process to determine appropriate and feasible individual and community responses to stigma; • Providing comprehensive, flexible tools for organizations to strengthen staff skills and develop or strengthen interventions to reduce HIV-related stigma; and • Developing a system to compile and address reported acts of discrimination.
Measurement Tool:	Program reports. USG agencies and USG-funded partners should keep a training log including the type of training, date, location, and participants.
How To Measure It:	Double counting of individuals within a program area is to be avoided among USG funded partners. While USG funded partners 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. In order to avoid double counting, countries will need to monitor their activities by partner, programmatic area, and geographic area. Each USG agency and USG-funded partner counts the number of individuals trained in stigma and discrimination reduction by USG staff (HQ or field-based) or USG-funded partners during the specified reporting period (12 months for annual report).

	Only participants who complete the full training course should be counted. If a training course covers more than one stigma and discrimination reduction 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. The USG staff responsible for compiling the annual reporting data should use the training log submitted by each USG agency and USG-funded partner reporting on this indicator in order to count the total number of individuals trained in stigma and discrimination reduction. Individuals trained in training courses co-funded by more than one USG agency/USG-funded partner should only be counted once within the specified reporting period (12 months for annual report).
Interpretation/ Strengths and Weaknesses:	This indicator does not measure the quality of the training, nor does it measure the outcomes of the training in terms of the competencies of individuals trained, nor their job performance. This indicator simply measures number trained in stigma and discrimination reduction as opposed to the percent of organizations with trained staff.

14.6 Number of individuals trained in HIV-related community mobilization for prevention, care and/or treatment	
Rationale/What It Measures:	Supportive Interventions strengthen HIV prevention, care, and treatment programs. This indicator measures the number of individuals trained in HIV-related community mobilization for prevention, care, and/or treatment.
Definition:	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. A training must have specific learning objectives, a course outline or curriculum, and expected knowledge, skills and/or competencies to be gained by participants. Community mobilization activities include: • Identifying social groups and mapping existing formal structures or networks in order to encourage or promote HIV prevention, care and/or treatment interventions and services, such as counseling and testing, PMTCT, HIV care and antiretroviral treatment • Building trust with the community by providing a forum to discuss their perceived needs for HIV prevention, care and/or treatment interventions and services, • Developing communication around social networks to engage in dialogue with the community which encourages or promotes HIV prevention, care and/or treatment interventions and services, • Creating media and events that expose community members to new ideas, involving them in problem solving, and encouraging innovations, which promote HIV prevention, care and/or treatment interventions and services.
Measurement Tool:	Program reports. USG agencies and USG-funded partners should keep a training log including the type of training, date, location, and participants.
How To Measure It:	Double counting of individuals within a program area is to be avoided among USG funded partners. While USG funded partners 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. In order to avoid double counting, countries will need to monitor their activities by partner, programmatic area, and geographic area. Each USG agency and USG-funded partner counts the number of individuals trained in community mobilization by USG staff (HQ or field-based) or USG-funded partners during the specified reporting period (12 months for annual report). 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. The USG staff responsible for compiling the annual reporting data should use the training log submitted by each USG agency and USG-funded partner reporting on this indicator in order to count the total number of individuals trained in community mobilization. Individuals trained in training courses co-funded by more than one USG agency/USG-funded partner should only be counted once within the specified reporting period (12 months for annual report).
Interpretation/ Strengths and Weaknesses:	This indicator does not measure the quality of the training, nor does it measure the outcomes of the training in terms of the competencies of individuals trained, nor their job performance. This indicator simply measures number trained in community mobilization as opposed to the percent of organizations with trained staff.

Wrap-around Food Support

Metric tons of non-PEPFAR food aid leveraged by PEPFAR wrap-around activities	
Rationale / What it Measures:	This indicator measures the amount of food aid directed towards HIV-infected or -affected persons as a result of PEPFAR wrap around activities.
Definition:	Leveraged food aid is food aid purchased by non-PEPFAR resources and used to benefit PEPFAR-supported HIV-infected or -affected persons as a result of PEPFAR activities that seek to "wrap-around" programs who do not necessarily target HIV-infected or -affected populations. PEPFAR-supported HIV-infected or -affected persons include persons receiving either upstream or downstream PEPFAR support. Please see the Appendix 7 for guidance and examples of persons receiving upstream and downstream support. A wrap-around activity is one that improves or enhances the quality of life for people infected and affected by HIV/AIDS and their families that complements Emergency Plan "2,7,10" goals, but is not funded with Emergency Plan funds. This may include other programs funded by the USG (e.g. USAID Development Assistance), other donors, the UN (World Food Program, UNICEF, etc) and other partners.
Measurement tool:	Communication with in-country representatives of partners conducting or overseeing wrap-around activities
How to measure it:	Partners implementing wrap-around activities should count the metric tonnes of physical food received by HIV-infected and HIV-affected persons through *direct distribution* of food or nutritional supplementation. Food aid that has been monetized, sold in markets, or sold by government, private enterprises, NGOs, or individuals should not be included. Double counting of individuals within a program area is to be avoided among USG funded partners. While USG funded partners 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. In order to avoid double counting, countries will need to monitor their activities by partner, programmatic area, and geographic area. The PEPFAR Data Quality Assurance Tool for Program Level Indicators is another source of guidance for determining who is receiving upstream and downstream support. for The tool can be found under "Implementer Resources" at www.pepfar.gov. Please see Appendix 7.
Interpretation/ Strengths and Weaknesses:	The indicator captures food support leveraged by PEPFAR through wrap-around programs to communities, households, and persons affected by HIV. The indicator does not capture non-food support leveraged by PEPFAR through wrap-around programs.

	The indicator does not measure how much food is received by target population groups (OVC, pregnant or lactating mothers, patients on ART).

Non-PEPFAR food and nutrition dollars leveraged by PEPFAR wrap-around activities for the provision of food or nutritional supplementation.	
Rationale/What it Measures:	This indicator measures non-PEPFAR funds used to provide food and supplementation to HIV-infected or -affected persons through wrap-around programs.
Definition:	Leveraged funds are non-PEPFAR resources used to benefit PEPFAR-supported HIV-infected or -affected persons as a result of PEPFAR activites that seek to "wrap-around" programs that do not necessarily target HIV-infected or -affected populations. This can include the program's operational costs as well as provision of services and food. PEPFAR-supported HIV-infected or -affected persons include persons receiving either upstream or downstream PEPFAR support. Please see the Appendix 7 for guidance and examples of persons receiving upstream and downstream support. A wrap-around activity is one that improves or enhances the quality of life for people infected and affected by HIV/AIDS and their families that complements Emergency Plan "2,7,10" goals, but is not funded with Emergency Plan funds. This may include other programs funded by the USG (e.g. USAID Development Assistance), other donors, the UN (World Food Program, UNICEF, etc) and other partners.
Measurement tool:	Communication with in-country representatives of partners conducting or overseeing wrap-around activities
How to measure it:	Partners implementing wrap-around activities should count only leveraged dollars used in the *direct distribution* of food or nutritional supplementation to HIV-infected and HIV-affected persons. Dollars leveraged to provide food or nutritional supplementation that is monetized, sold in markets, or sold by government, private enterprises, NGOs, or individuals should not be included. Dollars leveraged to support food security and livelihood activities, nutritional assessment, nutritional counseling, and other nutrition activites should not be included. The full cost of food or nutritional supplementation includes the food or supplementation itself and all operational costs related to the transport, storage, logistics, and marketing of the food or supplementation necessary for its distribution to recipients. The PEPFAR Data Quality Assurance Tool for Program Level Indicators is another source of guidance for determining who is receiving upstream and downstream support. for The tool can be found under "Implementer Resources" at www.pepfar.gov. Please see Appendix 7.
Interpretation/Strengths and Weaknesses:	The indicator does not capture funds leveraged by PEPFAR to food security and livelihood support, nutritional assessment, nutritional counseling, or other nutrition activities.

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

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

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

Program level indicators

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

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

Outcome- and Impact-Level Indicators

Core Outcome- and Impact-Level Indicators

Indicator Type	Indicator Number	Indicator	Source/ Methodology	International Standard
Prevention				
Outcome	1	Percentage of young women and men aged 15–24 who both correctly identify ways of preventing the sexual transmission of HIV and who reject major misconceptions about HIV transmission	Population-based survey	UNGASS 2007
	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	Percentage of women and men aged 15–49 who have had sexual intercourse with more than one partner in the last 12 months	Population-based survey	UNGASS 2007
	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	Percentage of young women and men aged 15–24 who are HIV infected	Sentinel Surveillance, Sero-survey with biomarkers	UNGASS 2007
Prevention of Mother-to-Child Transmission				
Outcome	1	Percentage of HIV-infected pregnant women who received antiretrovirals to reduce the risk of mother-to-child transmission	HMIS and modeling	UNGASS 2007
Impact	2	Percentage of infants born to HIV-infected mothers who are infected	HMIS and modeling	UNGASS 2007
Counseling and Testing				
Outcome	1	Percentage of women and men aged 15-49 who received an HIV test in the last 12 months and who know their results	Program reports and modeling, HMIS, Population-based survey or health facility survey	UNGASS 2007
Care and Treatment				
Outcome	1	Percentage of adults and children with advanced HIV infection receiving antiretroviral therapy	Program reports and modeling, HMIS	UNGASS 2007
	2	Percent of health care facilities that have the capacity and conditions to provide basic-level HIV testing and HIV/AIDS clinical management	Health facility survey	UNAIDS, UNAIDS C&S
	3	Percent of health care facilities that have the capacity and conditions to provide advanced-level HIV/AIDS care and support services, including provision of ART	Health facility survey	UNAIDS, UNAIDS C&S
	4	Percent of adults aged 18–59 who have been chronically ill for 3 or more months during the past 12 months, including those ill for 3 or more months before death whose households have received, free of user charges, basic external support in caring for the chronically ill person	Population-based survey	Adapted from UNAIDS C&S
Impact	5	Percentage of people still alive at 6, 12, and 24 months after initiation of treatment	Cohort study	WHO 3x5

	6	Proportion of all deaths attributable to HIV	National mortality statistics, Sample Vital Registration with Verbal Autopsy (SAVVY)/DSS	The Emergency Plan Surveillance working group
OVC				
Outcome	1	Percentage of orphaned and vulnerable children aged 0–17 whose households received free basic external support in caring for the child	Population-based survey	UNGASS 2007
Labs				
Outcome	1	Percent of designated laboratories with the capacity to monitor antiretroviral combination therapy according to national and international guidelines	Laboratory study	UNAIDS C&S
Strategic Information				
Outcome	1	Percent of health facilities with record-keeping systems for monitoring HIV/AIDS care and support	Health facility survey	UNAIDS C&S
Other: Policy and Systems Strengthening (Capacity Building)				
Outcome	1	National Composite Policy Index (Areas covered: gender, workplace programmes, stigma and discrimination, prevention, care and support, human rights, civil society involvement, and monitoring and evaluation)	Special Study	UNGASS 2007
	2	Percent of the general population with accepting attitudes toward PLWHA	Population-based survey	Adapted from UNAIDS

Additional Outcome- and Impact-Level Indicators

Indicator Type	**Indicator**	**Source/ Methodology**	**International Standard**
Prevention			
Outcome	Percent of patients with STIs at health care facilities who are appropriately diagnosed, treated and counseled	Special study (WHO/UNAIDS revised guidelines on evaluating STI services; Measure Service Provision Assessment)	UNAIDS, GFATM
Care and Treatment			
	Percent of chronically ill persons with severe pain and symptoms who report that their pain and symptoms were controlled	Population survey	Care and Support M&E Working Group
	Percent of HIV-positive patients who are given cotrimoxazole preventive therapy	Program reports/HMIS/special study	GFATM, CDC
	Percent of clients attending HIV testing and counseling who test positive and who are screened for TB symptoms	Program reports/HMIS/special study	GFATM, WHO TB/HIV working group
	Percent of all TB patients who are tested for HIV	Program reports/HMIS/special study	GFATM, WHO TB/HIV working group
	Percentage of estimated HIV-positive incident TB cases that received treatment for TB and HIV	Program reports/HMIS/special study	UNGASS 2007
Impact	Quality of life for PLWHA	Periodic special studies: Cohort study (MOS-HIV scale, SF 12, which includes both physical and mental domains) *(Methodology under development)*	Care and Support M&E Working Group/ World Bank
	AIDS-related morbidity	HMIS AIDS case reporting + modeling, SAVVY *(Methodology under development)*	The Emergency Plan Surveillance working group
OVC			
Impact	Quality of life for OVC	Periodic special studies: Cohort study *(Methodology under development)*	World Bank
Strategic Information			

Outcome	Existence of national strategic information capacity for HIV/AIDS prevention, care, and treatment programs	Record review/ special study	UNAIDS C&S
	Percent of ARV distribution nodes that report on inventory consumption, quality, losses, and adjustments on a monthly basis	HMIS/special study	WHO 3x5
Other: Policy and Systems Strengthening (Capacity Building)			
Outcome	Existence of comprehensive HIV/AIDS policies, strategies, and guidelines	Document review	UNAIDS C&S
	Percent of persons trained who: Demonstrate they are applying competencies/skills; are placed in HIV/AIDS jobs they were trained for; and retain HIV/AIDS jobs after one year	Special study *(Methodology under development)*	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 *(Methodology under development)*	IWG Stigma and Discrimination indicators working group
	Percent of large enterprises/companies that have HIV/AIDS workplace policies and programs	Workplace survey of largest companies in country	UNGASS, GFATM

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

Concentrated/Low Prevalence Epidemics			
Outcome	Percentage of most-at-risk populations that have received an HIV test in the last 12 months and who know their results	Program monitoring/special surveys	UNGASS 2007
	Percentage of most-at-risk populations reached with HIV prevention programmes	Program monitoring/special surveys	UNGASS 2007
	Percentage 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 2007
	Percentage of female and male sex workers reporting the use of a condom with their most recent client	Behavior surveillance surveys	UNGASS 2007
	Percentage of men reporting the use of a condom the last time they had anal sex with a male partner	Behavior surveillance surveys	UNGASS 2007
	Percentage of injecting drug users reporting the use of a condom the last time they had sexual intercourse	Behavior surveillance surveys	UNGASS 2007
	% of injecting drug users who avoid sharing injecting equipment	Behavior surveillance surveys	Adapted from UNGASS 2005
Impact	Percentage of most-at-risk populations who are HIV infected	HIV surveillance	UNGASS 2007

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

OUTCOME- AND IMPACT-LEVEL INDICATOR DEFINITIONS

Prevention

Percentage of young women and men aged 15–24 who both correctly identify ways of preventing the sexual transmission of HIV and who reject major misconceptions about HIV transmission

Rationale/What It Measures:	To assess progress towards universal knowledge of the essential facts about HIV transmission
Definition:	Percent of never married young women and men aged 15–24 who have never had sex
Measurement Tool:	Population-based surveys (Demographic Health Survey, AIDS Indicator Survey, Multiple Indicator Cluster Survey or other representative survey)
Numerator:	Number of respondents aged 15-24 years who gave the correct answer to all five questions
Denominator:	Number of all respondents aged 15–24
How To Measure It:	This indicator is constructed from responses to the following set of prompted questions: 1. Can the risk of HIV transmission be reduced by having sex with only one uninfected partner who has no other partners? 2. Can a person reduce the risk of getting HIV by using a condom every time they have sex? 3. Can a healthy-looking person have HIV? 4. Can a person get HIV from mosquito bites? 5. Can a person get HIV by sharing food with someone who is infected? The first three questions should not be altered. Questions 4 and 5 ask about local misconceptions and may be replaced by the most common misconceptions in your country. Examples include: "Can a person get HIV by hugging or shaking hands with a person who is infected?" and "Can a person get HIV through supernatural means?" Those who have never heard of HIV and AIDS should be excluded from the numerator but included in the denominator. An answer of "don't know" should be recorded as an incorrect answer. The indicator should be presented as separate percentages for males and females and should be disaggregated by the age groups 15-19 and 20–24 years. Scores for each of the individual questions (based on the same denominator) are required as well as the score for the composite indicator.
Frequency:	Preferred: every two years; minimum: every 4–5 years
Interpretation/ Strengths and Weaknesses:	The belief that a healthy-looking person cannot be infected with HIV is a common misconception that can result in unprotected sexual intercourse with infected partners. Rejecting major misconceptions about modes of HIV transmission is as important as correct knowledge of true modes of transmission. For example, belief that HIV is transmitted through mosquito bites can weaken motivation to adopt safer sexual behaviour, while belief that HIV can be transmitted through sharing food reinforces the stigma faced by people living with HIV. This indicator is particularly useful in countries where knowledge about HIV and AIDS is poor because it permits easy measurement of incremental improvements over time. However, it is also important in other countries as it can be used to ensure that pre-existing high levels of knowledge are maintained.
Reference(s):	UNGASS 2007

Percent of never married young men and women aged 15–24 who have never had sex

Rationale/What It Measures:	This indicator is Part 1 of a composite ABC indicator that provides information on important aspects of sexual behavior. This particular indicator describes the proportion of never married young people surveyed who have never had sex, thus the prevalence of virginity among young people. Looking at this prevalence within narrow age ranges (15–16, 17–18, 19–20, 21–22, and 23–24, for example, or better yet, in single ages) across time allows program managers to see if the age at first sex is moving.
Definition:	Percent of never married young women and men aged 15–24 who have never had sex
Measurement Tool:	Population-based surveys such as DHS/AIS, RHS
Numerator:	Number of never married young women and men who have never had sex
Denominator:	Number of never married young women and men aged 15–24 surveyed
How To Measure It:	Respondents (15–24 year olds) are asked if they have ever had sex. The indicator should be reported separately for men and women. 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.
Frequency:	Baseline, then every 2-3 years
Interpretation/ Strengths and Weaknesses:	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. 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. 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.
Reference(s):	Adapted from UNAIDS Young People's Guide (2004) Behavioral Indicator 3

Prevention

Percentage of women and men aged 15–49 who have had sexual intercourse with more than one partner in the last 12 months

Rationale/What It Measures:	Prevention messages should focus on abstinence and also on mutual monogamy. But because sexual relationships among young people are frequently unstable, relationships that were intended to be mutually monogamous may break up and be replaced by other relationships in which similar intentions prevail. Particularly in high HIV prevalence epidemics, serial monogamy is not greatly protective against HIV infection. This indicator measures the proportion of people that have been exposed to more than one partner in the last year.
Definition:	Percent of women and men aged 15–49 who have had sex with more than one partner in the last 12 months, of all people surveyed aged 15–49 surveyed who report being sexually active in the last 12 months
Measurement Tool:	Population-based surveys (Demographic Health Survey, AIDS Indicator Survey, Multiple Indicator Cluster Survey or other representative survey)
Numerator:	Number of respondents aged 15–49 who have had sexual intercourse with more than one partner in the last 12 months
Denominator:	Number of all respondents aged 15–49
How To Measure It:	Respondents are asked whether or not they have ever had sexual intercourse and, if yes, they are asked: In the last 12 months, how many different people have you had sexual intercourse with? The indicator should be presented as separate percentages for males and females and should be disaggregated by the age groups 15–19, 20–24 and 25–49 years.
Frequency:	4–5 years
Interpretation/ Strengths and Weaknesses:	This indicator gives a picture of levels of higher-risk sex. If people have only one sexual partner, the change will be captured by changes in this indicator. However, if people simply decrease the number of sexual partners they have, the indicator will not reflect a change, even though potentially this may have a significant impact on the epidemic spread of HIV and may be counted a programme success. Additional indicators may need to be selected to capture the reduction in multiple sexual partners in general.
Reference(s):	UNGASS 2007

Prevention

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

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

Prevention

Percentage of young women and men aged 15–24 who are HIV infected

Rationale/What It Measures:	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. . This indicator allows assessment of progress toward eradicating HIV infection
Definition:	Percent of young people aged 15–24 that are HIV-infected
Measurement Tool:	WHO guidelines for HIV sentinel surveillance
Numerator:	Number of antenatal clinic attendees (aged 15–24) tested whose HIV test results are positive
Denominator:	Number of antenatal clinic attendees (15–24) tested for their HIV infection status
How To Measure It:	This indicator is calculated using data from pregnant women attending antenatal clinics in HIV sentinel surveillance sites in the capital city, other urban areas and rural areas. Indicator scores should be given for the whole age range (15–24 years) and disaggregated by five-year age-group (i.e. 15–19 years and 20–24 years). The proportion of the total female population aged 15–24 living in the capital city, in other urban areas and in rural areas should be provided so that national estimates can be calculated, where possible.
Frequency:	Annual
Interpretation/ Strengths and Weaknesses:	HIV prevalence at any given age is the difference between the cumulative numbers of people that have become infected with HIV up to this age minus the number who have died, expressed as a percentage of the total number alive at this age. At older ages, changes in HIV prevalence are slow to reflect changes in the rate of new infections (HIV incidence) because the average duration of infection is long. Furthermore, declines in HIV prevalence can reflect saturation of infection among those individuals who are most vulnerable and rising mortality rather than behaviour change. At young ages, trends in HIV prevalence are a better indication of recent trends in HIV incidence and risk behaviour. Thus, reductions in HIV incidence associated with genuine behaviour change should first become detectable in HIV prevalence figures for 15–19-year-olds. Where available, parallel behavioural surveillance survey data should be used to aid interpretation of trends in HIV prevalence. In countries where the age at which young people first have sexual intercourse is late and/or levels of contraception use are high, HIV prevalence among pregnant women of 15–24 years of age will differ from that among all women in the age group. This indicator (using data from antenatal clinics) 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 most-at-risk populations.
Reference(s):	UNGASS 2007

Percent of HIV-infected pregnant women who received antiretrovirals to reduce the risk of mother-to-child transmission

Rationale/What It Measures:	The number of HIV-infected pregnant women who received antiretrovirals (ARVs) to reduce the risk of mother-to-child transmission during the last 12 months is obtained from programme monitoring records compiled from patient records and registers. To assess progress in preventing vertical transmission of HIV.
Definition:	Percent of HIV-infected pregnant women who received antiretroviral to reduce the risk of mother-to-child transmission
Measurement Tool:	For the numerator: programme monitoring tools. For the denominator: antenatal clinic surveillance or estimation model.
Numerator:	Number of HIV-infected pregnant women who received antiretrovirals during the last 12 months to reduce mother-to-child transmission. Explanation of numerator: There are four general antiretroviral treatment options that HIV infected women can receive for the prevention of mother-to-child transmission (PMTCT): 1. Single-dose Nevirapine 2. Prophylactic regimens using a combination of two ARVs 3. Prophylactic regimens using a combination of three ARVs 4. ART for HIV-positive pregnant women eligible for treatment HIV-infected women receiving any of the four options meet the definition for the numerator. Countries should report as the numerator the total number of HIV-infected pregnant women who were provided with any of the antiretroviral treatment regimes in options one to four. In option number four, HIV-infected pregnant women who are eligible for antiretroviral treatment and receive a treatment regimen will also benefit from the prophylactic effect for prevention of mother-to-child transmission and thus are included in the numerator. Antiretroviral drugs can be provided to HIV-infected women during pregnancy, at labour and shortly after delivery, and provision can take place at a number of sites. Countries should focus on compiling data for the numerator from patient registers at antenatal clinics, delivery and care sites, and post-partum care service sites. Women receiving antiretroviral drugs in both the private sector and the public sector should be included in the numerator

	where data for both are available.
Denominator:	Estimated number of HIV-infected pregnant women in the last 12 months. Data for this indicator should be provided for both 2006 and 2007 to track annual trends in coverage. Explanation of Denominator: The denominator is generated by estimating the number of HIV-infected women who were pregnant in the last 12 months. This is based on surveillance data from antenatal clinics. Two methods are possible for generating the estimate for the denominator: 1. Estimates generated by a projection model such as Spectrum or 2. Multiplying: (a) the total number of women who gave birth in the last 12 months, which can be obtained from the Central Statistics Office estimates of births, by (b) the most recent national estimate of HIV prevalence in pregnant women, which can be derived from HIV sentinel surveillance antenatal clinic estimates.
How To Measure It:	The number of HIV-infected pregnant women who received antiretrovirals (ARVs) to reduce the risk of mother-to-child transmission during the last 12 months is obtained from programme monitoring records compiled from patient records and registers.
Frequency:	Data should be collected continuously at the facility level. Data should be aggregated periodically, preferably monthly or quarterly.
Interpretation/ Strengths and Weaknesses:	Countries are encouraged to track and report on the actual or estimated percent distribution of the various regimens provided so that the impact of antiretroviral drugs on mother-to-child-transmission can be modelled based on the efficacy of corresponding regimens. In 2006, international guidelines were updated to recommend more efficacious regimens for prevention of mother-to-child transmission, and countries may be at different phases in adopting the newer recommendations. Although countries may not have a system in place yet to collect and report coverage of antiretroviral drug provision for prevention of mother-to-child transmission by the various regimen possibilities, the goal should be towards setting up such a system. This indicator permits monitoring trends in antiretroviral drug provision that addresses prevention of mother-to-child transmission. However, since countries provide different regimens of antiretroviral drugs for prevention of mother-to-child transmission, cross-country comparisons of aggregate estimates must be interpreted with caution and with reference to the regimens provided. In addition to antiretroviral drugs for the mother, ARV regimens to reduce mother-to-child transmission should be accompanied by an appropriate regimen for the infant, and thus where possible, countries should track and report on whether the infant dose has been provided.

	In some countries, large numbers of pregnant women do not have access to antenatal clinic services or choose not to make use of them. Pregnant women with HIV may be more or less likely to use antenatal clinic services (or public rather than private antenatal clinic services) than those who are not infected, particularly where antiretroviral drugs can be accessed via such services or where levels of stigma are particularly high. National estimates of HIV-infected pregnant women should be derived by adjusting surveillance data from antenatal clinic sentinel sites and other sources, taking into consideration characteristics such as rural/ urban patterns of HIV prevalence that may affect the representation of surveillance sites.
Reference(s):	UNGASS 2007

PMTCT

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

Rationale/What It Measures:	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. This indicator allows assessment of progress toward eliminating mother-to-child HIV transmission.
Definition:	Percent of HIV-infected infants born to HIV-infected mothers
Measurement Tool:	Statistical modelling based on programme coverage and efficacy studies
Numerator:	(see below)
Denominator:	(see below)
How To Measure It:	The indicator will be calculated by taking the weighted average of the probabilities of mother-to-child transmission for pregnant women receiving and not receiving HIV prophylaxis, the weights being the proportions of women receiving and not receiving various prophylactic regimes.
Frequency:	Annual
Interpretation/ Strengths and Weaknesses:	This indicator focuses on the prevention of mother-to-child transmission of HIV through increased provision of antiretroviral drugs. Thus, the effect of breastfeeding on mother-to-child transmission of HIV is ignored and the indicator may yield underestimates of true rates of mother-to-child transmission in countries where long periods of breastfeeding are common. Similarly, in countries where other forms of prevention of mother-to-child transmission of HIV (e.g. caesarean section) are widely practised, the indicator will typically provide overestimates of mother-to-child transmission. For these reasons, trends in this indicator may not reflect overall trends in mother-to-child transmission of HIV.
Reference(s):	UNGASS 2007

Counseling and Testing

Percentage of women and men aged 15-49 who received an HIV test in the last 12 months and who know their results

Rationale/What It Measures:	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. 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. 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.
Definition:	Percentage of women and men aged 15–49 who have been tested for HIV in the last 12 months and received their test results the last time they were tested
Measurement Tool:	Population-based surveys (Demographic Health Survey, AIDS Indicator Survey, Multiple Indicator Cluster Survey or other representative survey)
Numerator:	Number of respondents aged 15–49 who have been tested for HIV during the last 12 months and who know their results
Denominator:	Number of all respondents aged 15–49
How To Measure It:	The indicator must be presented as percentages for males and females, and should be disaggregated by the age groups 15–19, 20–24 and 25–49. The denominator includes respondents who have never heard of HIV or AIDS. Respondents are asked: 1. I don't want to know the results, but have you been tested for HIV in the last 12 months? 2. If yes: I don't want to know the results, but did you get the results of that test?
Frequency:	Every two years
Interpretation/ Strengths and Weaknesses:	In order to protect themselves and to prevent infecting others, it is important for individuals to know their HIV status. Knowledge of one's status is also a critical factor in the decision to seek treatment. The introductory statement "I don't want to know the results, but…" allows for better reporting and reduces the risk of underreporting of HIV testing among people who do not wish to disclose their serostatus.
Reference(s):	UNGASS 2007

Care and Treatment

Percentage of adults and children with advanced HIV infection receiving antiretroviral therapy

Rationale/What It Measures:	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. This indicator allows assessment of progress in providing antiretroviral combination therapy to all people with advanced HIV infection
Definition:	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.
Measurement Tool:	For the numerator: facility ART registers and ART cohort analysis report forms, or programme monitoring tools. For the denominator: antenatal clinic surveillance or estimation models.
Numerator:	Number of adults and children with advanced HIV infection who are currently receiving antiretroviral therapy in accordance with the nationally approved treatment protocol (or WHO/UNAIDS standards) at the end of the reporting period The numerator can be generated by counting the number of adults and children who received antiretroviral therapy at the end of the reporting period. The numerator should equal the number of adults and children with advanced HIV infection who ever started antiretroviral treatment minus those patients who are not currently on treatment prior to the end of the reporting period. Patients not currently on treatment at the end of the reporting period, in other words, those who are excluded from the numerator, are patients who died, stopped treatment or are lost to follow-up. Some patients pick up several months of antiretroviral drugs at one visit, which could include antiretroviral therapy received for the last months of the reporting period, but not be recorded as visits for the last months in the patient register. Efforts should be made to account for these patients, as they need to be included in the numerator.
Denominator:	Estimated number of adults and children with advanced HIV infection The denominator is generated by estimating the number of people with advanced HIV infection requiring (in need of/eligible for) antiretroviral therapy. The denominator estimates are most often based on the latest data available from sentinel surveillance which can then follow UNAIDS/WHO Reference Group on Estimates, Modelling and Projections methodology. Need or eligibility for antiretroviral therapy should follow the WHO definitions for the diagnosis of advanced HIV (including AIDS) for adults and children.
How To Measure It:	ART registers, HIV surveillance systems This indicator should be disaggregated by sex and age (<15, 15+) and percentages given for 2006 and 2007 to track annual trends in coverage. Antiretroviral therapy taken only for the purpose of prevention of mother-to-child transmission and post-exposure prophylaxis are not included in this indicator. HIV-infected pregnant women who are eligible for and on antiretroviral drugs

	for their own treatment are included in this indicator. The number of adults and children with advanced HIV infection who are currently receiving antiretroviral combination therapy can be obtained through data collected from drug supply management systems or facility-based antiretroviral treatment registers. These are then tallied and transferred to cross-sectional monthly or quarterly reports which can then be aggregated for national totals. Patients receiving antiretroviral therapy in the private sector and public sector should be included in the numerator where data are available.
Frequency:	Data should be collected continuously at the facility level. Data should be aggregated periodically, preferably monthly or quarterly. The most recent monthly or quarterly data should be used for annual reporting.
Interpretation/ Strengths and Weaknesses:	This indicator permits monitoring trends in coverage but does not attempt to distinguish between different forms of 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. The proportion of people needing antiretroviral therapy varies with the stage of the HIV epidemic and the cumulative coverage and effectiveness of antiretroviral combination therapy among adults and children. The degree of utilization of ART will depend on factors such as cost relative to local incomes, service delivery infrastructure and quality, availability and uptake of voluntary counselling and testing services, and perceptions of effectiveness and possible side effects of treatment.

Care and Treatment

Percent of health care facilities that have the capacity and conditions to provide basic-level HIV testing and HIV/AIDS clinical management

Rationale/What It Measures:	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.
Definition:	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: a. a system for testing and providing results for HIV infection; b. systems and qualified staff for pre- and post-test counseling; c. specific health services relevant to HIV/AIDS, including resources and supplies for providing these services; d. elements for preventing nosocomial infections; and e. trained staff and resources providing basic interventions for prevention and treatment for people living with HIV/AIDS.
Measurement Tool:	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.
Numerator:	1. Number of facilities at which the individual items for each service or item listed above exist 2. Number of facilities at which all components for each individual service or item (a, b, c, d **or** e) exist 3. Number of facilities at which all components for all individual services and items (a, b, c, d **and** e) exist
Denominator:	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
How To Measure It:	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.
Frequency:	Baseline, then every 2-3 years
Interpretation/ Strengths and Weaknesses:	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. 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.

	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.
Reference(s):	WHO/UNAIDS Care & Support Guide (2004) Indicator CS6

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

Rationale/What It Measures:	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.
Definition:	Capacity to provide advanced HIV/AIDS care is defined as: a. 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; b. systems and items to support advanced services for the care of people living with HIV/AIDS; c. systems and items to support antiretroviral combination therapy (including security measures for the ARVs); d. conditions to provide advanced inpatient care for people living with HIV/AIDS; e. conditions to support home-care services; and f. post-exposure prophylaxis.
Measurement Tool:	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.
Numerator:	1. Number of facilities at which the individual items for each service or item listed above exist 2. Number of facilities at which all components for each individual service or item (a, b, c, d, e, **or** f) exist mber of facilities at which all components for all individual services and items (a, b, c, d, e, **and** f) exist
Denominator:	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
How To Measure It:	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.
Frequency:	Baseline, then every 2-3 years
Interpretation/ Strengths and Weaknesses:	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.
Reference(s):	WHO/UNAIDS Care & Support Guide (2004) Indicator CS7

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

Rationale/What It Measures:	This indicator attempts to quantify the extent of support services free of user charges to households with chronically ill people.
Definition:	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 External support for chronically ill adults is defined as: • Medical support; • Emotional and psychological: counseling from a trained counselor, companionship, and emotional or spiritual support; • Material including socioeconomic (clothing, extra food or financial support); and • Other social support or instrumental (help with household work, training for a caregiver or legal services). 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. 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.
Measurement Tool:	Population-based survey such as the UNAIDS general population survey; DHS/AIS; BSS (adult + youth)
Numerator:	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: 1. Medical support at least once a month during illness AND 2. Emotional support in the last 30 days AND 3. Material support in the last 30 days AND 4. Social support in the last 30 days. **OR** 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: 1. Medical support at least once a month during illness

	AND 2. Emotional support in the last 30 days (before the death) AND 3. Material support in the last 30 days (before the death) AND 4. Social support in the last 30 days (before the death).
Denominator:	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.
How To Measure It:	The following methods are recommended: • 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. • 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. Data should be analyzed and reported by gender and age categories when sample size allows (15–24, 25–39, and 40–59 years). 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.
Frequency:	Baseline, then every 2-3 years
Interpretation/ Strengths and Weaknesses:	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.
Reference(s):	WHO/UNAIDS Care & Support Guide (2004) Indicator CS9

Care and Treatment

Percentage of people still alive at 6, 12, and 24 months after initiation of treatment

Rationale/What It Measures:	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.
Definition:	Percentage of people still alive and on therapy at 6, 12, and 24 months after initiation of treatment
Measurement Tool:	HMIS records +cohort studies
Numerator:	Number of individuals still alive and on therapy after initiating treatment after 6, 12, and 24 months
Denominator:	Number of individuals initiating treatment at the same time
How To Measure It:	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.
Frequency:	Periodic (TBD)
Interpretation/ Strengths and Weaknesses:	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.
Reference(s):	WHO 3x5 (2004) Core Indicator 10, See WHO Interim Patient Monitoring Guidelines

Proportion of all deaths attributable to HIV/AIDS

Rationale/What It Measures:	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. 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.
Definition:	Proportion of all deaths attributable to HIV/AIDS
Measurement Tool:	National mortality statistics or sample vital registration with verbal autopsy (SAVVY)
Numerator:	Incident death attributable to HIV/AIDS in the resident population aged 18-59
Denominator:	All deaths in the resident population aged 18-59
How To Measure It:	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. Sampling varies per country, but is a combination of urban/rural. 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.
Frequency:	Baseline, then every 2-3 years
Interpretation/ Strengths and Weaknesses:	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 mortality within that population.

	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. 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.
Reference(s):	WHO, MEASURE Evaluation, and the International Programs Center (IPC) of the U.S. Census Bureau (2003-Reference #15). *Improving Systems for Monitoring and Measurement of Vital Events: An issues paper prepared for the Health Metrics Network*.

Orphans and Vulnerable Children

Percentage of orphaned and vulnerable children aged 0–17 whose households received free basic external support in caring for the child

Rationale/What It Measures:	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.
Definition:	Percent of orphans and vulnerable children aged 0-17 living in a household whose households have received free basic external support in caring for the child
Measurement Tool:	Population-based surveys (Demographic Health Survey, AIDS Indicator Survey, Multiple Indicator Cluster Survey or other representative survey)
Numerator:	Number of orphaned and vulnerable children aged 0–17 who live in households that received at least one of the four types of support for each child (answered "yes" to at least one of questions 1, 2, 3 and 4)
Denominator:	Total number of orphaned and vulnerable children aged 0–17
How To Measure It:	After all orphaned and vulnerable children aged 0-17 in the house have been identified, the household heads are asked the following four questions about the types and frequency of support received, and the primary source of the help for *each* orphan and vulnerable child. Each question is to be asked for each child. 1. Has this household received medical support, including medical care and/or medical care supplies, within the last 12 months? 2. Has this household received school-related assistance, including school fees, within the last 12 months? (This question is to be asked only of children aged 5–17.) 3. Has this household received emotional/psychological support, including counselling from a trained counsellor and/or emotional/spiritual support or companionship within the last three months? 4. Has this household received other social support, including socioeconomic support (e.g. clothing, extra food, financial support, shelter) and/or instrumental support (e.g. help with household work, training for caregivers, childcare, legal services) within the last three months? External support is defined as free help coming from a source other than friends, family or neighbours unless they are working for a community-based group or organization. For the purposes of this indicator, an orphan is defined as a child below the age of 18 that has lost both parents. A child made vulnerable by HIV is below the age of 18 and: i.) has lost one or both parents; or ii.) has a chronically ill parent (regardless of whether the parent lives in the same household as the child); or iii.) lives in a household where, in the last 12 months, at least one adult died and was sick for three of the four months before he or she died; or iv.) lives in a household where at least one adult was seriously ill for at least three of the past 12 months.
Frequency:	Every 4–5 years
Interpretation/	This indicator should only be monitored in settings with high HIV prevalence (5% or greater). The indicator does *not*

Strengths and Weaknesses:	measure the needs of the household or the orphans and vulnerable children. Additional questions could be added to measure expressed needs of families caring for orphans. The indicator implicitly suggests that all households with orphans and vulnerable children need external support; some orphans and vulnerable children are more in need of external support than others. Therefore, it is important to disaggregate the information by other markers of vulnerability such as socioeconomic status of the household, dependency ratio, head of the household, etc. If sample sizes permit, it may be useful for programmatic purposes to investigate differences between values for this indicator for orphans versus other vulnerable children. It may also be useful to look at data disaggregated by age and duration of orphanhood, as both play a key role in determining the type of support needed. For example, an orphan whose parent(s) died 10 years ago will need support of a different kind from one whose parent(s) died within the past year. When considering the four types of support separately, data for school-related assistance should be limited to children aged 5-17.
Reference(s):	UNGASS 2007

Laboratories

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

Rationale/What It Measures:	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.
Definition:	Percentage of designated laboratories with the capacity to monitor antiretroviral combination therapy according to national and international guidelines To scale up antiretroviral use in resource-constrained settings, WHO categorizes currently available testing into four levels of priority: 1. absolute minimum tests before starting antiretroviral combination therapy: HIV antibody test and hemoglobin or hematocrit level; 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; 3. desirable tests: bilirubin, amylase, serum lipid and CD4 count; and 4. optional tests: viral load. Designated laboratories refer to nationally identified laboratories for monitoring antiretroviral combination therapy.
Measurement Tool:	Special laboratory study
Numerator:	Number of designated laboratories with the capacity to monitor antiretroviral combination therapy according to national and international guidelines Laboratories are classified into three levels as follows: • level 1: they meet the minimum testing requirements for testing categories 1 and 2 (above); • level 2: they meet the minimum testing requirements for testing categories 1, 2, and 3; and • level 3: they meet the minimum requirements for all four testing categories.
Denominator:	Total number of designated laboratories
How To Measure It:	Data will be obtained from a survey of designated laboratories. Data collection will entail observing the availability of functioning equipment and supplies to run the tests at each level.
Frequency:	Baseline, then every 2-3 years
Interpretation/ Strengths and Weaknesses:	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.
Reference(s):	WHO/UNAIDS Care & Support Guide (2004) Indicator CS8

Strategic Information

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

Rationale/What It Measures:	This indicator is designed to measure the capacity of health facilities to collect data on care and support services and to compile these data.
Definition:	Percentage of health facilities with record-keeping systems for monitoring HIV/AIDS care and support
Measurement Tool:	Health facility survey such as the Service Provision Assessment
Numerator:	Number of health facilities maintaining adequate records on the services provided
Denominator:	Total number of health facilities surveyed
How To Measure It:	The following methods are recommended: • health facility surveys that examine records on HIV/AIDS care and support services; and • qualitative interviews with people responsible, including interviews with officers of the health management information system. Facilities will be checked for: 1. records indicating clients receiving pre- and post-test counseling, as well as test results; 2. records indicating clients treated for HIV/AIDS-related illness; 3. evidence that reports for HIV/AIDS services are submitted on a routine basis The data should be disaggregated by department and service.
Frequency:	Baseline, then every 2-3 years
Interpretation/ Strengths and Weaknesses:	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.
Reference(s):	WHO/UNAIDS Care & Support Guide (2004) Indicator CS-A2

Other: Policy and Systems Strengthening

National Composite Policy Index (Areas covered: gender, workplace programmes, stigma and discrimination, prevention, care and support, human rights, civil society involvement, and monitoring and evaluation)

Rationale/What It Measures:	The NCPI 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 several main components of an effective national response: gender, workplace programmes, stigma and discrimination, prevention, care and support, human rights, civil society involvement, and monitoring and evaluation
Definition:	The average score given to a national program by a defined group of knowledgeable individuals asked about progress in several areas of programming, grouped into major components
Measurement Tool:	National Composite Policy Index (NCPI) questionnaire
Numerator:	N/A
Denominator:	N/A
How To Measure It:	The composite index covers the following broad areas of policy, strategy and programme implementation: Part A 1. Strategic plan 2. Political support 3. Prevention 4. Treatment, care and support 5. Monitoring and evaluation Part B 1. Human rights 2. Civil society involvement 3. Prevention 4. Treatment, care and support
Frequency:	Every two years
Interpretation/ Strengths and Weaknesses:	It is important to analyse the data for each of the NCPI sections and include a write-up in the Country Progress Report in terms of progress made in (a) policy and strategy development and (b) implementation of policies and strategies, in order to tackle the country's HIV epidemic. Comments on the agreements or discrepancies between overlapping questions in Parts A and B should also be included, as well as a trend analysis on the key NCPI data since 2003, where available.
Reference(s):	UNGASS 2007

Other: Policy and Systems Strengthening

Percent of the general population with accepting attitudes toward PLWHA

Rationale/What It Measures:	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.
Definition:	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
Measurement Tool:	Population-based survey such as the UNAIDS general population survey; DHS/AIS; BSS (adult +youth), RHS
Numerator:	Number of women and men who report an accepting attitude on all four of these questions
Denominator:	Number of all women and men aged 15–49 surveyed who have heard of HIV
How To Measure It:	Respondents in a general population survey who have heard of HIV are asked a series of questions about people with HIV, as follows: • 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? • If you knew that a shopkeeper or food seller had the AIDS virus, would you buy fresh vegetables from him/her? • If a female teacher has the AIDS virus but is not sick, should she be allowed to continue teaching in school? • If a member of your family became infected with the AIDS virus, would you want it to remain a secret? The indicator should be reported separately for men and women.
Frequency:	Baseline, then every 2-3 years
Interpretation/ Strengths and Weaknesses:	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. 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. 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.
Reference(s):	Adapted from UNAIDS (2000-Reference #7) Stigma and Discrimination Indicator 1

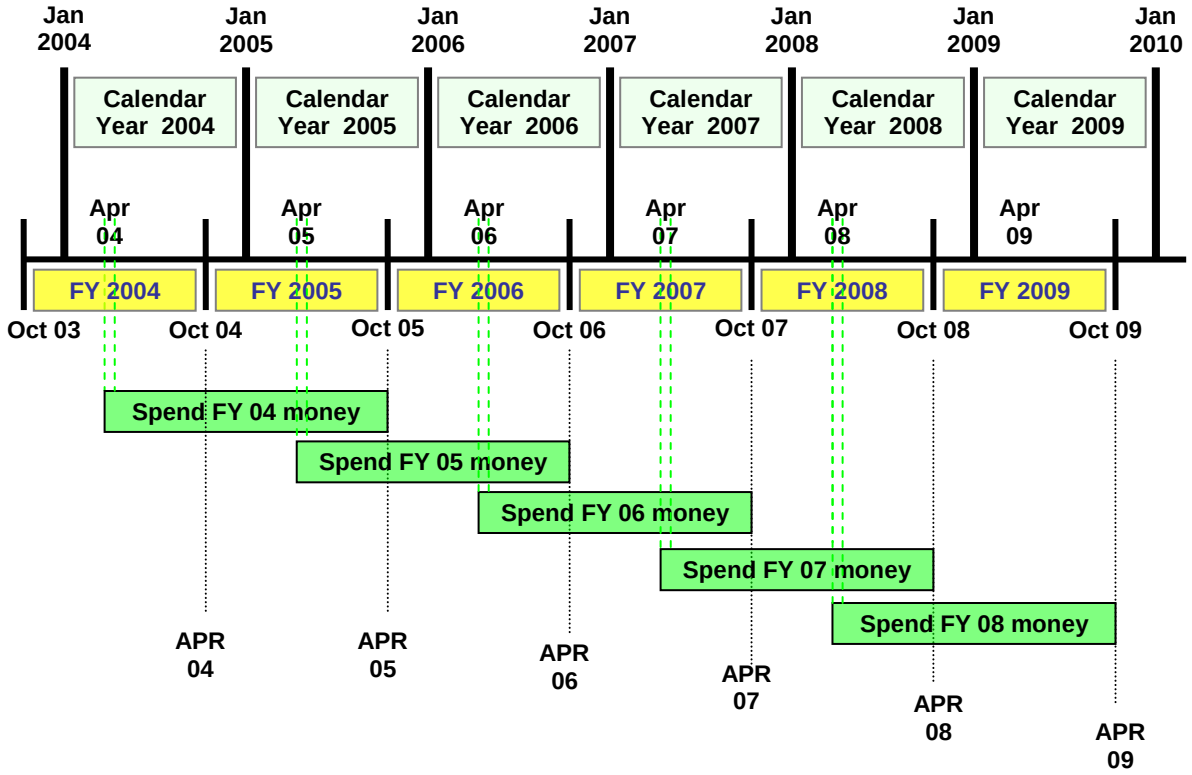
Appendix 1: In-country Collaboration Tables

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

Appendix 2: Reporting Cycle

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

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



APR = Annual Program Results

Appendix 3: Additional Guidance on the PMTCT Indicator #1.3 – Number of HIV-infected pregnant women who received antiretroviral prophylaxis for PMTCT

Background and rationale for revisions to this indicator

Revisions were made this year to the PEPFAR PMTCT ARV indicator in line with the recent change to the UNGASS indicator, *Percentage of HIV-infected pregnant women who received antiretrovirals to reduce the risk of mother-to-child transmission* (pg. 35, Monitoring the Declaration of Commitment to HIV/ AIDS, Guidelines on the Construction of Core Indicators, 2008 Reporting, http://data.unaids.org/pub/Manual/2007/20070411_ungass_core_indicators_manual_en.pdf).

The emphasis is now on receiving "any PMTCT ARVs" rather than a "complete course". Consistent with the UNGASS indicator, it is also now recommended to track and report on the actual or estimated percent distribution of the various regimens provided

- prophylactic regimens using one ARV
- prophylactic regimens using a combination of two ARVs
- prophylactic regimes using a combination of three ARVs
- ART for HIV-positive pregnant women eligible for treatment

so that PEPFRAR can track regimens the impact of antiretroviral drugs on mother-to-child-transmission can be better modeled (accounting for the wide variations in efficacy of different regimens).

Collecting and reporting this indicator

Sources

At facilities, there are often separate data resources for antenatal care, labor and delivery and postpartum care. PMTCT programs need to integrate these data and try to avoid "double-counting".

Reporting and Measurement

In FY 07, USG country teams will not be required to report in the APR on the number of women provided each regimen type ((1) SD NVP, (2) prophylactic regimens using a combination of two ARVs, (3) prophylactic regimes using a combination of three ARVs, or (4) ART for HIV-positive pregnant women eligible for treatment) through the national PMTCT monitoring system. However, this information is important for effective program management and partners should be encouraged to routinely capture and report this information to the in-country USG offices.

While not mandatory, if available, description and stratification by type of ARV can be reported to OGAC in the narrative section for the PMTCT indicators in the APR.

Suggested Language for APR PMTCT Indicator Narrative Section
With USG support, _#_ women received a prophylaxis regimen containing 1 ARV drug; _#_ women received a prophylaxis regimen containing 2 ARV drugs; _#_ women received a prophylaxis regimen containing 3 ARV drugs; _#_ pregnant women received ART; and _#_ infants received ARV prophylaxis."

How to use this indicator

The primary uses of this information are to measure:

- Uptake of any PMTCT ARVs among HIV-positive pregnant women in PMTCT settings
- National coverage of PMTCT ARVs among HIV-positive pregnant women
- Progress towards implementation of more efficacious PMTCT ARVs
- Impact of PMTCT programs to prevent infant HIV infections

Uptake of PMTCT ARVs among HIV-positive pregnant women at PMTCT sites
Several denominators can be used with the numerator of the number of women receiving PMTCT ARVs to demonstrate the uptake of PMTCT ARVs in PMTCT settings. For example,

$$\frac{\text{Number of women provided with PMTCT ARVs in ANC}}{\text{Number of HIV-positive women identified through PMTCT services at ANC sites}}$$

provides information on the uptake of PMTCT ARVs at ANC sites with PMTCT. Although the numerator and denominator may not represent the same individuals (especially if the reporting period is short) given that there is often a lag time between when women are tested or identified as HIV-positive and receive PMTCT ARVs, this simple calculation is the basis for demonstrating PMTCT progress at ANC sites. Similarly,

$$\frac{\text{Number of women delivering who took PMTCT ARVs}}{\text{Number of HIV-positive women delivering at PMTCT sites}}$$

provides information on the uptake of PMTCT ARVs at labor and delivery sites.

National coverage of PMTCT ARVs among HIV-positive pregnant women

$$\frac{\text{Number of women provided with PMTCT ARVs in the past year}}{\text{Number of annual births to HIV-positive pregnant women}}$$

This calculation demonstrates overall coverage of PMTCT ARVs among the estimated number of HIV-positive pregnant women, and is useful for tracking national trends and is one of the UNGASS indicators (*Percentage of HIV-infected pregnant women who received antiretrovirals to reduce the risk of mother-to-child transmission*).

As noted above, decisions will need to be made on the source(s) of the numerator data, and it is advisable to describe how this indicator relates to national data (i.e., what percentage of the national level data the PEPFAR data represents) in the narrative section of the APR and SAPR in order to monitor national level trends in PMTCT.

Progress towards implementation of more efficacious PMTCT ARVs

Most PEPFAR countries have updated their national PMTCT guidelines to expand the use of more efficacious PMTCT ARVs. Countries and USG programs should monitor the numbers and/ or proportions of HIV-positive pregnant women receiving each PMTCT ARV regimen type. The following are example calculations:

$$\frac{\text{Number of HIV-positive pregnant women initiating ART}}{\text{Number of HIV-positive pregnant women provided with PMTCT ARVs}}$$

$$\frac{\text{Number of HIV-positive pregnant women receiving AZT+NVP}}{\text{Number of annual births to HIV-positive pregnant women}}$$

Impact of PMTCT programs to prevent infant HIV infections

One of the original goals of the President's MTCT Initiative was to reduce MTCT by 40% and one of the primary PEPFAR goals is to prevent 7 million HIV infections.

The percent transmission and number of infant HIV infections averted can be calculated using an Excel "Rate calculator" developed by the PEPFAR PMTCT/ Pediatric HIV TWG (https://www.pepfar.net/C11/PMTCT/default.aspx). This tool was developed a number of years ago and is provided as one sample tool that has been used in countries which had specific regimen and breastfeeding data. The PMTCT/ Pediatric HIV TWG will develop and post a simplified rate calculator based on the 4 regimen types.

Table 1 describes the formulas used in the "Rate calculator".

Table 1. Explanation of MTCT rate calculator

National MTCT rate calculator

(Fill in the yellow spaces. All other cells are calculated for you. The green boxes are the indicators for the database.)

# Deliveries per year in country	**A**			
HIV prevalence in pregnant women (as proportion)	**B**			
Total number of HIV+ pregnant women delivering per year	**C**=A*B			
PMTCT regimen**	**Expected transmission rate**	**# HIV+ women receiving regimen***	**Proportion of all HIV infected pregnant women who receive regimen**	**Proportion of all infants infected under this regimen**
None *(this number is calculated based on inputs below)*	0.35	**E**=C-(F+P)	E/C	.35*(E/C)
SD NVP to mother and infant; breastfeeding	0.16	**F**	F/C	.16*(F/C)
Short course AZT and SD NVP to mother and infant; breastfeeding	0.12	**G**	G/C	.12*(G/C)
Short course AZT and SD NVP to mother and infant; formula feeding	0.05	**H**	H/C	.05*(H/C)
AZT and NVP to infant only; breastfeeding	0.25	**I**	I/C	.25*(I/C)
Short course AZT + 3TC to mother and infant; breastfeeding	0.15	**J**	J/C	.15*(J/C)
Short course AZT + 3TC to mother and infant; formula feeding	0.10	**K**	K/C	.10*(K/C)
Long course AZT + SD NVP to mother and infant, breastfeeding	0.07	**L**	L/C	.07*(I/C)
Long course AZT + SD NVP to mother and infant, formula feeding	0.02	**M**	M/C	.02*(M/C)
HAART; breastfeeding	0.05	**N**	N/C	.05*(N/C)
HAART; formula feeding	0.007	**O**	O/C	.0007*(O/C)
Other regimen or local transmission data (type over this text, enter regimen and expected transmission)	***D***	**P**	P/C	D*(P/C)
			1.00	**% Transmission expected overall Q=SUM OF ALL ABOVE**
				# infections averted C*(.35-Q)

***Many countries use only one regimen. If no women are receiving a given regimen, leave the yellow space blank.**

****Expected transmission rates are estimates based on published data. If you have local transmission data, please fill in under "other regimen".**

Appendix 4: Palliative Care Categories

CATEGORY 1: CLINICAL/MEDICAL CARE	
Entrance & adherence to antiretroviral treatment	**Pain management**
Entrance to antiretroviral therapy (ART)	Screening for pain
Routine clinical monitoring (for those on ART)	Assessment of pain
Routine clinical monitoring (for those in need but not yet on ART)	Treatment step 1 (WHO Analgesic Ladder)
Routine clinical monitoring (for those not yet in need of ART)	Treatment step 2 and 3 (WHO analgesic ladder)
Management of side effects related to ART medications	Referral for pain management
Treatment and prevention of opportunistic infections	Management of side effects of pain medications
Cotrimoxazole prophylaxis	**Skin problems**
Prophylaxis for cryptococcosis (e.g. Diflucan)	Gentian violet/ointments/other treatments to reduce HIV-related skin diseases
Isoniazid (INH) prophylaxis for TB	Management of symptoms* related to skin diseases (i.e. herpes simplex, bedsores, and other skin ulcers)
Treatment of opportunistic infections including sexually transmitted infections (STI) and TB	**Bowel/bladder care and genital problems**
Support for TB/OI treatment adherence	Referral and/or treatment of diarrheal disease Prevention of diarrheal disease (e.g., provision of household safe water system)
Management of side effects related to opportunistic infections, STI and TB therapies	Management of symptoms* related to diarrheal diseases, constipation or incontinence
Management of symptoms* related to opportunistic infections	Oral rehydration salts and/or zinc for diarrheal disease
Treatment and prevention of malaria	Referral and/or treatment of STI
Insecticide-treated bed nets	Management of symptoms* related to genital problems (including management of genital discharge)
Intermittent presumptive treatment	**Respiratory problems**
Other interventions to prevent or treat malaria in HIV-infected individuals	Referral and/or treatment of HIV-related respiratory illnesses
Management of symptoms of malaria*	Management of symptoms* of cough, breathlessness or respiratory disease
Management of side effects related to malaria medications	**Other clinical/physical care**
Nutrition	Psychiatric assessment and psychiatric treatment of HIV-related mental disorders
Routine nutritional assessment and monitoring	Treatment of HIV-related malignancies
Micronutrient supplementation according to WHO guidelines)	Clinical treatment of other HIV-related diseases
Targeted nutrition supplementation according to WHO criteria (supplementary feeding)	**Additional pediatric considerations**
Targeted therapeutic nutritional feeding (WHO criteria)	Referral for Early Infant Diagnosis (DBS)
Promotion of exclusive breastfeeding until weaning	Appropriate child survival interventions within HIV services (e.g. Immunizations)
Provide for appropriate, safe complementary feeding practices	Routine growth and development monitoring
Provide for formula feeding if AFASS criteria met	Other routine pediatric HIV care interventions

Provide for early weaning if AFASS criteria met	**Physical care**
	Oral care (e.g, removal of secretions, toothbrushing)
	Correct positioning and treatment of contractures in muscles and joints

CATEGORY 2: SPIRITUAL CARE	CATEGORY 3: PSYCHOLOGICAL CARE
Life Completion Tasks	**Emotional support**
Screening of spiritual problems related to HIV disease	Screening of emotional problems related to HIV disease
Visitation by spiritual mentors, pastors, healers, imams, priests, rabbis, etc	Participation in HIV-related support groups
Participation in spiritual support groups	Basic assistance with HIV-related agitation, fears, loss, worries, sadness, stigma-related issues or difficulties with sleeping
Participation in religious events/ceremonies	Future life planning
Participation in traditional healers groups	**Mental health care (note: psychiatric care is categorized under clinical/medical care)**
Prayer or guided meditation	Screening and assessment for psychological problems l
Preparing for and coping with death and the dying process	Provision of counseling for psychological problems
Life review and assessment	**Other psychological care, counseling and support**
Counseling related to hopes, fears, meaning and purpose, guilt and forgiveness	Support for disclosure of HIV status
	Assistance with social interaction or therapeutic play
	Assistance with succession planning (i.e. creating a willl, guardianship, preparing burial procedures, etc.)
	Preparing for and coping with death and the dying process
CATEGORY 4: SOCIAL CARE	**CATEGORY 5: INTEGRATED PREVENTION SERVICES WITHIN THE CARE PROGRAM**
Social support	**HIV risk reduction messaging and counseling**
Screening of social problems related to HIV disease	Delivering consistent messages to clients about Abstinence, Faithfulness and Correct and Consistent Condom use (ABC) on an ongoing basis
Linking to food security interventions, income generation activities, livelihood strengthening interventions, etc. (Wrap around food and nutrition programs)	Delivering 'prevention with positives' messages to HIV-infected clients about ABC risk reduction measures, family planning services, STI care, testing/counseling (pre and post), PMTCT services (for the unborn and breastfeeding child)
Linking to education, safe water and sanitation systems and other wrap around programs	Counseling and support for family members of HIV-infected persons to help families keep negative and further reduce risk of transmission
Development of People Living with HIV and AIDS (PLHIV) support groups or People Affected By Aids (PABA) support groups	Counseling and support for discordant couples to help partners keep negative and further reduce risk of transmission
Inclusion of gender-specific care activities (e.g. male involvement, screening for violence, etc.)	Counseling and support for sex partners to help partners keep negative and further reduce risk of transmission
Assistance in accessing legal services or child protection interventions	Provision of or referral for condoms

Assistance in accessing government grants/social welfare support	**Other key prevention services**
Community mobilization and promotion of awareness of HIV and AIDS prevention, counseling/testing, care or treatment services	Referral for family planning services
Household and family support	Referral for STI care
Assistance with house cleaning, maintaining a hygiene and safe home environment or household repairs	Referral for testing and counseling - pre and post
Assistance with meal preparation, proper food storage, cooking or feeding	Referral for PMTCT services (for the unborn and breastfeeding child)
Assistance with miscellaneous errands for the client or family	Universal precautions and infection control to protect the client from transmitting HIV
Provision of comfort measures for the client or family (e.g. Quality communication and culturally-appropriate therapeutic touch, empathy and affection)	
Assistance with assessments on household and family support (including genogram development, economic planning, etc)	
Efforts to reduce HIV-related stigma	
Provision of measures that facilitate self-care and care for caregivers both physically and emotionally	
Supervision, mentorship and financial/incentive support for caregivers	
Training on the use of universal precautions at the household level	
Assistance client hygiene, bathing, or changing of linens/clothes	

Notes:
HIV-related Palliative Care is grouped in 5 categories: Clinical/Physical Care, Spiritual Care, Psychological Care, Social Care, and Integrated Prevention Services.
HIV-related Palliative Care services may be provided in facility and community home based settings.
Education and Counseling related to each of the above service delivery elements is an integral component of Palliative Care service delivery.
Referral includes follow up ensuring that the referred services were provided.
**Symptom management may include screening, assessment, care, and treatment with appropriate symptom relieving medications or therapies.*

Appendix 5: Additional Guidance on the New HIV/TB Indicator # 7.4

There has been a great deal of discussion over the new indicator that was recently added to the PEPFAR set of required indicators to capture the number of registered TB patients who receive HIV C&T at a USG supported TB site. The TB/HIV and CT TWGs recognize that HIV testing of TB patients (not previously diagnosed with HIV) is an important part of TB treatment and care; and that, providing HIV testing to patients at the same time and location that they receive TB treatment assures higher uptake of HIV testing among TB patients. This new indicator is included to track the level to which TB programs are implementing this best practice.

This new indicator has its challenges. For one, it crosses over at least two programs areas (C&T, TB/HIV, and perhaps even PMTCT). In addition, the models used across PEPFAR countries to test TB patients are widely variable. In some countries, the majority of HIV testing of TB patients takes place in the TB clinic. In others, a strong referral network exists and 100% of HIV testing takes place outside of the TB clinic. Most countries find themselves somewhere in between.

In 2006, WHO released revised recommended TB recording and reporting tools that include several HIV variables including HIV testing and counseling (http://www.who.int/tb/dots/r_and_r_forms/en/index.html). PEPFAR programs should work with the Ministries of Health and other key partners in-country to adapt, implement, and evaluate the use of these tools as appropriate.

Please see schematic below, which provides an example of levels of measurement that one might wish to collect on new patients presenting to a TB clinic. In any program there are many different levels of information that are important in order to effectively manage a program and understand the epidemic in which the program is taking place. The program's ability to capture data at each level will differ by country and by site. Programs will need to look at what is happening at each level to improve HIV testing at TB sites. While not all of this information will be translated through the COP, OGAC encourages all PEPFAR countries to collect a greater degree of detail on their programs so that these types of analyses can take place.

OGAC recognizes the limitations of this indicator and that it may not capture all of the HIV counseling and testing for TB patients. Additionally, this indicator cannot be used as an HIV surveillance indicator for TB patients.

Setting targets for the new HIV C&T of TB patients: Countries will be required to set targets on this indicator in the FY08 COP.

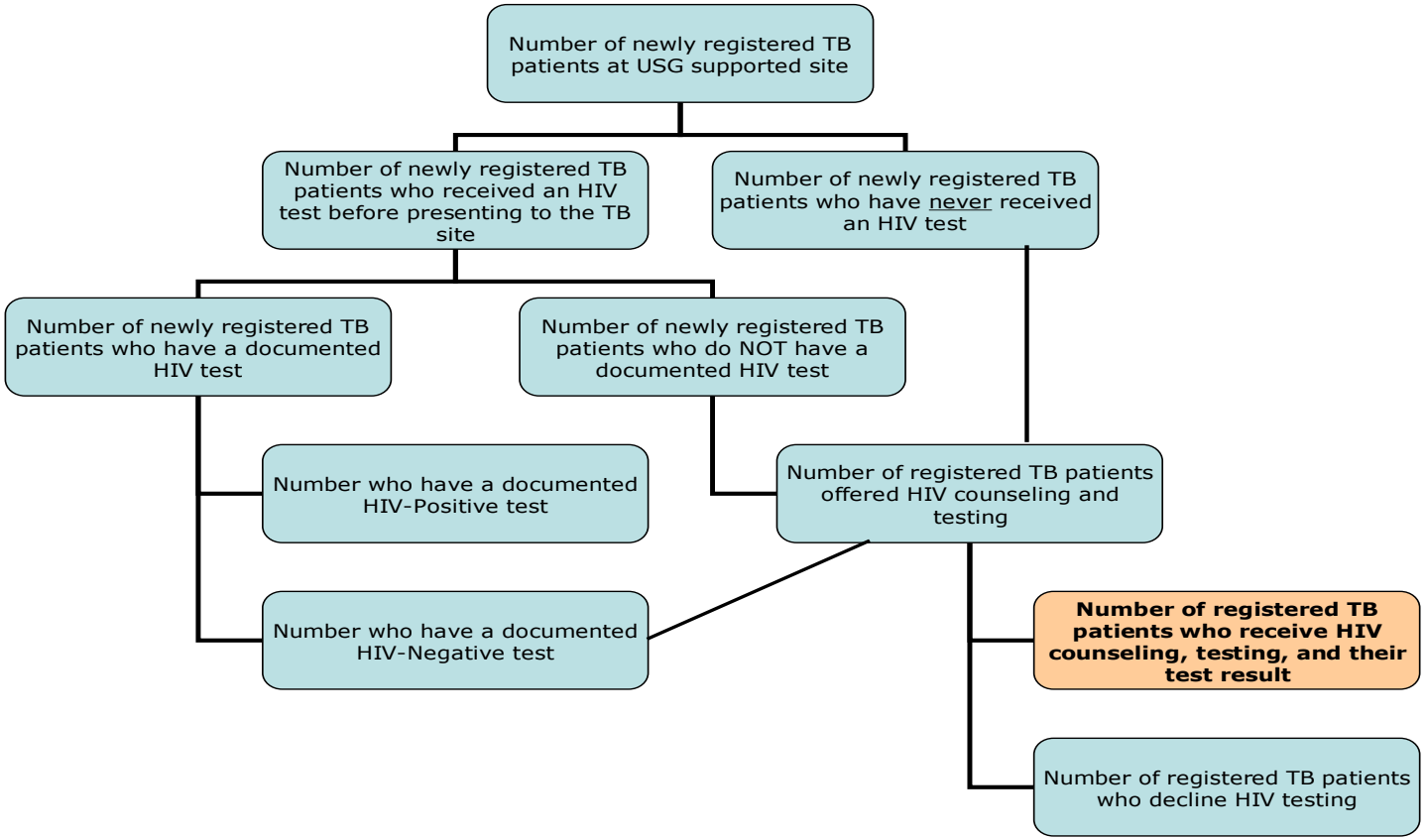
Please describe in the activity/program narratives what is happening on the ground in terms of testing TB patients for HIV. Describe national policy, extent of testing and USG support.

Target population – Registered TB patients with unknown sero-status or previously negative HIV test

Reporting on the new HIV C&T of TB patients: Countries will be required to report on this indicator for the first time in the FY07 APR

Your comments and feedback following the first reporting of this indicator are welcome.

EXAMPLE OF HIV TESTING AMONG NEWLY REGISTERED TB PATIENTS (Indicator #7.4)



Appendix 6: Examples of Eligible and Ineligible Activities for Core Program Areas for OVCs

Below please find illustrative examples of interventions PEPFAR funds can support for children affected by HIV/AIDS. This list is not intended to be fully comprehensive.

1. Food and Nutritional Support

Food and nutritional support are usually the most costly of interventions needed by OVCs, and are certainly essential. Ensuring adequate food and nutrition requires interventions and coordination at many levels. Working with national Governments, communities and food agencies, the Emergency Plan intends to contribute to achieving food goals for OVCs, but in a way consistent with its mandate. Emergency Plan funds can support OVC food and nutritional support interventions at three levels. Please refer to the *Report on Food and Nutrition for People Living with HIV/AIDS*[30] for additional details. Examples of potential interventions that PEPFAR programs may fund include the following:

Child Level

- Nutritional assessment and counseling;
- Weaning foods and other nutritional support for children under two years of age;
- Therapeutic and supplementary feeding of malnourished children based on anthropometric assessment and World Health Organization (WHO) guidelines; and
- Support to link children with other health and nutrition interventions provided by public or private health providers.

Caregiver or Family Level

- Training, course materials, and other program support for facility- and community-based counseling of families and caregivers on nutrition, diet and food preparation techniques.

Systems Level

- Development of policies and technical guidelines, training curricula and job aides for nutrition assessment and counseling;
- Working with appropriate national and District implementers to ensure targeting of OVCs for food and nutrition interventions and programs;
- Technical assistance and coordination with food industry to promote production of and access to nutritious foods, including fortified foods, for OVC; and
- Advocacy and resource mobilization for programs to address the nutritional needs of OVCs.

***Emergency Plan funds for OVC cannot support*:**

- Strengthening the general administrative and management capacities of the food/agriculture sector that have deteriorated because of the impact of HIV/AIDS;

– School feeding programs for all school children; and
– Broad-based food-assistance and food-security programs

2. Shelter and Care

Working with communities, families and other international partners, Emergency Plan OVC programs should work to ensure no child goes without shelter, clothing, or basic personal hygiene. Yet, programs must meet these life-long needs through sustainable, community-based interventions consistent with and responsive to local circumstances. Partners who are working with OVCs affected by HIV/AIDS should work with other international partners, Governments, local authorities, NGOs, FBOs and CBOs to identify OVCs with unmet needs, and to offer, when required, temporary assistance. However, to encourage sustainable, effective solutions that support children who are without shelter or care, Emergency Plan programs should primarily intervene through referral and leveraging. Examples of potential interventions that PEPFAR programs may fund include the following:

Child Level

– Assisting children and family members in identifying potential caregivers, prior to a parent's death;
– Reintegrating children who are currently in institutional care through family tracing and fostering;
– Providing access to temporary shelter for children in transition; and
– Supporting child- or youth-headed households in maintaining their homes.

Caregiver Level

– Supporting family reunification and temporary shelter to take children off the streets;
– Supporting referrals and access to programs that provide incentives for adoption or the provision of foster care.

Systems Level

– Strengthening community-based programs that provide temporary shelter for children in transition and longer term shelter for those with no community option;
– Strengthening family-based care models for children (i.e., extended families, local adoption, and foster care);
– Developing innovative community responses to provide care in personalized settings when family options are not available (live-in schools, drop-in centers, etc.);
– Providing quality-assurance monitoring for institutionalized care; and
– Strengthening reintegration programs and providing training to accomplish family tracing for OVCs who are leaving institutional care.

3. Protection

In many countries where PEPFAR is working, the national government and international partners have introduced governance and legal reform. In keeping with the Emergency Plan's focus on HIV/AIDS, partners who are supporting OVCs should find ways to incorporate youth-protection measures into ongoing or proposed reforms. Developing and implementing programs that place the best interests of children and their families above all else is a key value. All policy projects must have clearly delineated outcomes, e.g. an increase in number of registrations in X amount of time, etc. General policy work without specific outcomes should not be supported with PEPFAR resources. Examples of potential interventions that PEPFAR programs may fund include the following:

Child Level

- Facilitating basic birth registration and identification necessary for long-term access to education, health care and social services;
- Providing community-based assistance to OVCs for inheritance claims;
- Strengthening child-headed households with the intent of promoting community support and prevent sibling separations; and
- Removing children from abusive situations into safe, temporary or permanent placements.

Caregiver Level

- Activities to support families and caregivers to better manage stress and improve parenting when they are in situations of chronic illness, are caring for multiple orphans, and have decreasing material resources; and
- Coaching caregivers to better access community and system-level support to which OVCs are entitled.

Systems Level

- Strengthening local community structures (such as Child Protection Committees) that carry accepted responsibility for monitoring and protecting OVCs;
- Providing training and support to frontline workers who are the "gatekeepers" – those most likely to come into contact with OVCs, including local NGO field staff, local volunteers, police, emergency hospital workers, school counselors and nurses, and staff of child residential care facilities; assist police in how to constructively deal with OVCs who are in violation of the law.
- Networking with programs that confront incidents of child trafficking and sexual abuse;
- Improving mechanisms/systems to increase birth registration, improve access to basic social services, and facilitate inheritance claims;
- Policy development, such as technical assistance to local authorities on improving the investigation, reporting and follow-up on cases of rape, abuse, and neglect;
- Reviewing and assisting in the development and strengthening of child law and protection services and policies, including adoption;

– Communication or multi-media campaigns to support social norms that protect children and prevent child abuse and exploitation (e.g., increase reporting and legal action); and
– Activities to reinforce or change social norms to increase the practice of will writing, succession planning, and the enforcement of inheritance laws.

4. Health Care

a. General Health Needs of OVCs

OVC programs need to take active measures to meet the general health needs of vulnerable children at every age level. This often means making sure the caretakers bring the child to a clinic for health care. HIV care is also an important element for these children, as they might have been exposed to HIV and require testing and care. Emergency Plan resources for OVCs can be used to support the preventive and primary health care needs of children. To be cost-effective, however, interventions should rely largely upon existing health programs sponsored by Governments and international partners to ensure immunization coverage, maternal and health care (including antenatal and postnatal care, HIV testing, etc.). Examples of potential interventions that PEPFAR programs may fund include the following:

Child Level

– Referrals and linkages to child health care, including, but not limited to, immunization, growth monitoring, malaria prevention and HIV testing, where appropriate; and
– Provision of support for survivors of sexual or physical abuse, including post-exposure prophylaxis (PEP) for rape victims, and education and messaging to prevent abuse.

Caregiver Level

– Training of caregivers to monitor children's health and gain access to available health care when services are needed; and
– Training of caregivers and guardians on how to talk to children about abstinence and safe sexual behaviors and support healthy life decisions.

Systems Level

– Training of HIV counselors, home-based care providers, traditional healers, educational staff and staff of PMTCT and ART clinics to identify, monitor, and make referrals to health care and basic social services for children and clients' children;
– Work with public and private health care providers to integrate HIV elements and awareness of the special vulnerabilities of HIV-positive OVCs;
– Training of health workers in the WHO integrated infant and young child practices course or similar; and
– Bolstering the capacity of public and private health providers to improve the provision of immunizations, growth monitoring, bed-nets, malaria and tuberculosis meds, diarrhea control and treatment, and other basic prevention and care.

***Emergency Plan funds for OVCs cannot support*:**
– Purchase of vaccines (or bulk formulation for vaccines) for immunization programs
– Contraceptives

b. Health Care for HIV- positive children

PEPFAR considers the provision of HIV-related health care to exposed or infected infants a high priority. Appropriate health care services for children born to HIV-infected mothers and known HIV-positive children are described in the *Guidance for a Preventative Care Package for Children Aged 0-14 Years Old Born to HIV-Infected Mothers*.[31] Palliative care for HIV-positive children is outlined in *HIV/AIDS Palliative Care Guidance #1: An Overview of Comprehensive HIV/AIDS Care Services*.[32] The *Report to Congress on Pediatric AIDS*[33] is also a reference for a discussion of ART for children.

c. Prevention of HIV

Prevention of HIV is a priority health intervention, particularly among adolescents, and especially in regions where the risk of infection is high. Please refer to the *Guidance for Applying the ABC Approach to Preventing Sexually-Transmitted HIV Infections*[34] for complete details.

5. Psychosocial Support

Healthy child development hinges greatly upon the continuity of social relationships. Programs should supply both children and their caregivers with emotional support, as well as support local staff that serve on the frontline. To respond to psychosocial needs, examples of potential interventions that PEPFAR programs may fund include the following:

Child Level

– Gender-sensitive life skills and experiential learning opportunities for OVCs that build resilience and self-esteem;
– Activities that encourage the integration of OVCs into traditional support systems within the community in order to increase the social and psychological well-being of vulnerable youth (mentoring, apprenticeships, etc.);
– Improving links between children affected by HIV/AIDS and their communities;
– Referral to counseling where available and appropriate, particularly for HIV-positive youth; and
– Rehabilitation/re-integration for children who are living outside of family care.

Caregiver Level

– Strengthening the capacity of caregivers to listen to and talk with children;
– Access to family-centered activities that address the dynamics and stages of illness, treatment, and/or pending death (e.g., communication on the disclosure of HIV status, ART, succession planning, grief counseling); and
– Activities that help children to give expression to their feelings and perceptions of loss and help in the preservation of

attachment and personal history, (e.g., art therapy, memory box methodologies, etc).

Systems Level

- Increasing communities' understanding of and action on the psychosocial needs of children and youth and the responsive roles community members can take to improve social or psychological wellness, including roles in schools and religious organizations;
- Providing training in age- and situation-appropriate communication;
- Strengthening local capacities to provide psychosocial support for distressed children (e.g., training of clinicians and community workers);
- Providing opportunities for networking, training, and reflection for frontline local staff who work with local partners in AIDS-affected communities; and
- Further investigation and refinement of culturally relevant measures to promote psychosocial well-being and factors that contribute to improved child welfare.

6. Education and Vocational Training

Increasingly, stakeholders in the fight against HIV/AIDS are recognizing and promoting the fact that education can bring about significant improvements in the lives of orphans and other vulnerable children. A growing body of research from sub-Saharan Africa makes clear the importance of timely, cost-effective interventions to secure access to primary and secondary education as well as livelihood training for children affected by HIV/AIDS.[35] Children orphaned in the region are much less likely to attend school, and can be unable to care and provide for themselves as a consequence. If school fees are the issue, international partners or communities can intervene to keep OVCs in school. Longer-term solutions, however, lie in mobilizing the community to establish fee-reduction for the disadvantaged, in providing direct support to schools for improving education (using non-AIDS funding), and negotiating scholarships for the needy. Collaboration with other programs, such as with the Education for All Initiative, is an important way of leveraging educational funds.[36] Programs often must address additional factors to enable children to attend school, such as care-taking responsibilities at home, or issues of stigma. Recognizing the importance of education, examples of potential interventions that PEPFAR programs may fund include the following:

Child Level

- Activities that encourage access to the formal education system for OVCs;
- Short-term, direct assistance to subsidize school-related costs (e.g., fees, books, uniforms) or to leverage cost-avoidance programs that lead to broader school access and completion and complement a long-term strategy for sustainability;
- Activities that encourage access for OVCs into early childhood development programs and services; and
- Activities that encourage access for OVCs to vocational training.

Caregiver Level

- Training and materials for health providers and caregivers on identifying vulnerable children and appropriate care procedures;
- Activities to monitor OVC status and to integrate OVCs into community social life; and
- Anti-stigma education, particularly education aimed at reducing the stigma faced by HIV/AIDS orphans.

Systems Level

- Community-mobilization efforts to keep orphans and other vulnerable children in school and/or to provide them with educational alternatives;
- Advocacy and technical support to provide school-based counseling services, flexible school schedules and school curricula that include life skills, business and household management, and agriculture training, plus establishing mechanisms to provide linkages with community-and faith-based organizations for referrals to school-based programs;
- Teacher training on how to address issues that often plague children from households affected by HIV/AIDS, such as how to identify children at risk and how to counsel and refer children; and
- Train parent-teacher associations in school communities to support and enable OVCs to remain in school, such as supporting fee waivers, tutoring and psychosocial support.

***Emergency Plan funds for OVC cannot support*:**

- Strengthening the education system and general teacher training unrelated to the needs of orphans and other children made vulnerable due because of HIV/AIDS.
- Scholarships and other access interventions for non-HIV/AIDS OVCs.

7. Economic Opportunity/Strengthening

Economic strengthening is often needed for the family/caregivers to meet expanding responsibilities for ill family members or OVCs who join the household. Maturing children need to learn how to provide for themselves and establish sustainable livelihoods. PEPFAR encourages the use of OVC funds for economic-strengthening activities, as well as cooperation and joint efforts with organizations that have strong experience and a high level of expertise in this area. This is particularly appropriate for interventions focused on adolescents as well as caregivers. Economic strengthening interventions should be market-driven and contextually relevant. Examples of potential interventions that PEPFAR programs may fund include the following:

Child and Caregiver Level

- Vocational and technical training;
- Livelihood opportunities (e.g., income-generating activities, links with the private sector);

- Small-business development and activities to promote entrepreneurism among older HIV/AIDS OVCs and caregivers;
- Household economic-strengthening activities focused on increasing coverage of school-related expenses, such as incentive-driven, conditional grants and training for HIV/AIDS OVC caregivers;
- Support for drip-kit irrigation and use of drought-resistant crops with gardens for child-headed households;
- Purchasing of seeds and tools for household or community gardens for HIV/AIDS OVCs;
- Setting-up small-scale animal husbandry for HIV/AIDS-vulnerable households, especially in collaboration with efforts supported by other international partners;
- Household laborsaving devices; examples include improved charcoal cook stoves that use 50 % less fuel than traditional stoves; improved pestles that reduce the amount of effort and time for women to pound grain into flour; and, high-density kitchen gardens that require little labor, but produce sufficient vegetables to meet household nutritional requirements.
- Activities that provide access to micro-finance, primarily opportunities to save, access credit, and, in some cases, access insurance;
- Community-based asset-building; and
- Establishing mechanisms to support community-based childcare.

***Emergency Plan funds for OVCs cannot support*:**

- Any programs not directly supporting HIV/AIDS-affected OVCs.

Appendix 7: Example for Calculating Wrap-around Food and Nutrition Support

The country of Ethiamibia has 10 Districts and two organizations working in-country.

"Fighting AIDS (FA)" has a PEPFAR grant to work in support of MOH clinical support in eight districts in the Northwest of Ethiamibia and to provide clinical support at health facilities. "Feeding the Needy Worldwide (FNW)" has a Title II grant working in four districts where it directly distributes food aid to beneficiaries.

The two organizations overlap in three districts and about 25% of FNW's beneficiaries are in the FA districts. FNW hasn't done a census but estimates that only about 5% of those beneficiaries are HIV affected and attending FA clinics.

In District G, FA has about 175 HIV+ mothers who have now weaned their babies but have also begun to lose weight. However, their BMI are between 17.5 and 20 and their CD4 counts are between 250 and 300. The women are not eligible for ART or for food or nutritional supplementation. FA staff feel frustrated because they no longer have any direct way to support these clinic patients and hope that FNW can help them.

After several meetings FA and FNW, along with Ministry of Health and the Ministry of Agriculture and Food Security, announced the "Coming Together to Confront HIV/AIDS Initiative". In the next reporting period…

- FNW will support the HIV+ mothers that FA can no longer directly support under PEPFAR guidelines in the 3 overlapping districts.
- FNW will also support 75 moderately malnourished PLWHA receiving care in FA facilities and their families in District G.
- FA has also agreed to take over the support of 100 OVCs in District H.

Also, District F has recently adopted a treatment policy developed with PEPFAR support and has implemented it in all PEPFAR and non-PEPFAR treatment facilities. The facilities provide service to a total of 400 PLWHA.

District	Organization 1	Organization 2 (wrap-around)	Upstream Support	# persons served by Organization 2
A	FA			
B	FA			
C	FA			
D	FA			
E	FA			
F	FA	FNW	District treatment policy (PEPFAR supported)	1,000
G	FA	FNW		1,000
H	FA	FNW		1,000
I		FNW		9,000
J				

Q: How many people receive leveraged food aid in the next reporting period?

A:
In District F, all 400 PLWHA receive upstream support from PEPFAR. FNW estimates that 5% of its beneficiaries are HIV+. Since FNW does not know how many of its beneficiaries in District F are HIV+, it assumes that 5% are HIV+.
Then 1,000 beneficiaries x 5% = 50 beneficiaries receiving upstream support in District F receiving support from FNW.

Across Districts F, G, and H, there would be a total of 5% x 3,000 = 150 PLWHA receiving downstream PEPFAR support from FA who also are beneficiaries of FNW.

In District G, FNW will provide food aid to 175 mothers receiving downstream support from FA. FNW will also provide food aid to 75 moderately malnourished PLWHA receiving downstream support from FA and their families. Assuming there are 4 other persons in the family, the total number of HIV-affected persons supported through FA that FNW will support is

175 mothers + 75 moderately malnourished PLWHA + 300 family members
= 500 persons.

Double Counting: The 50 beneficiaries of FNW in District F who receive downstream PEPFAR support through FA, also receive upstream PEPFAR support through the new policy. Therefore, these 50 beneficiaries and the aid they receive should only be counted once.

Total # HIV-infected & HIV-affected persons receiving food or nutritional supplementation:

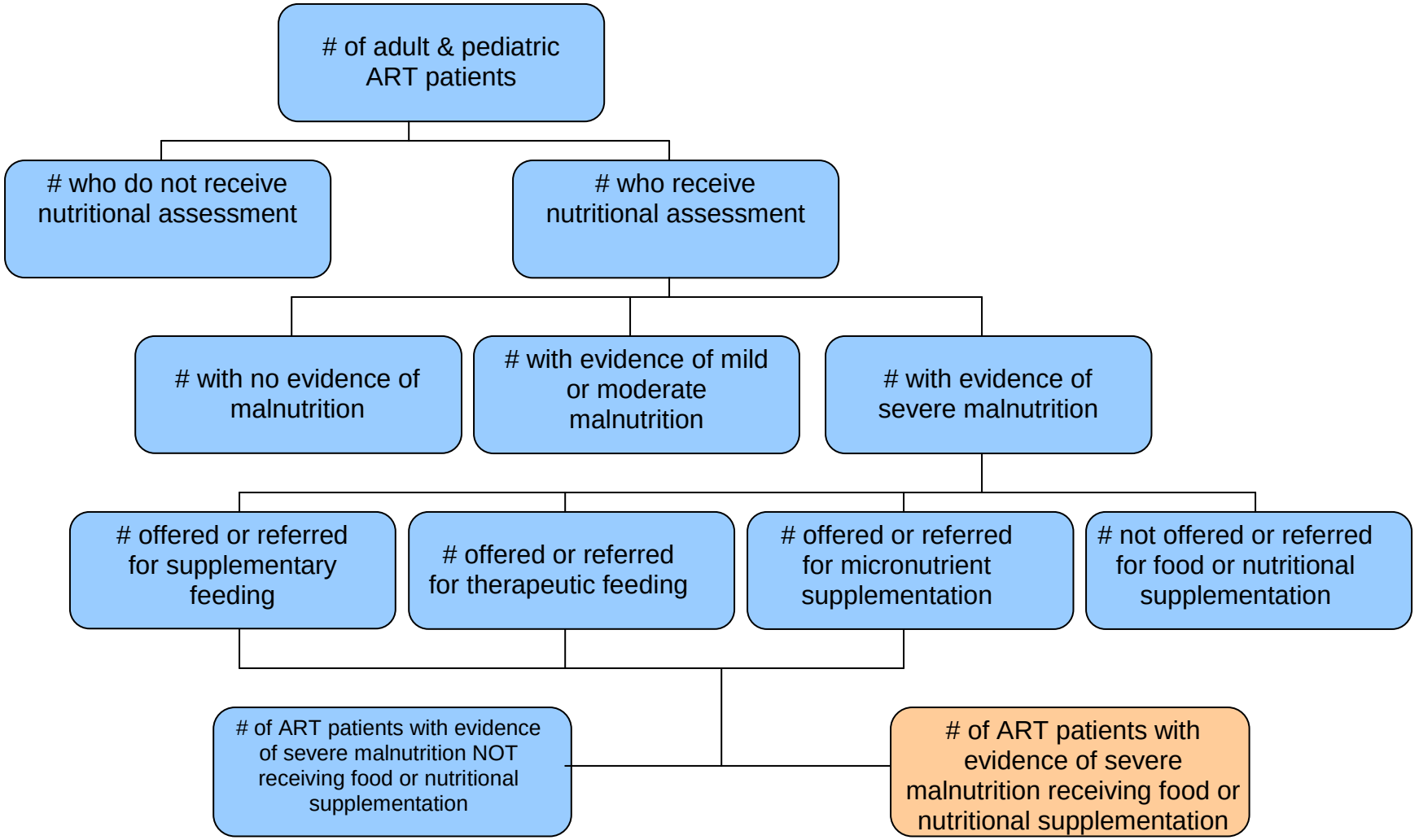
50 (upstream) + 150 (downstream) + 500 (downstream) – 50 (double counting)
= 650 persons

Note that the 100 OVC in District H that FA will provide for in the next reporting period (instead of FNW) are not counted as receiving leveraged food aid. They receive food or nutritional supplementation through OVC programs supported by downstream PEPFAR funds, and their counts will be included under the OVC program area.

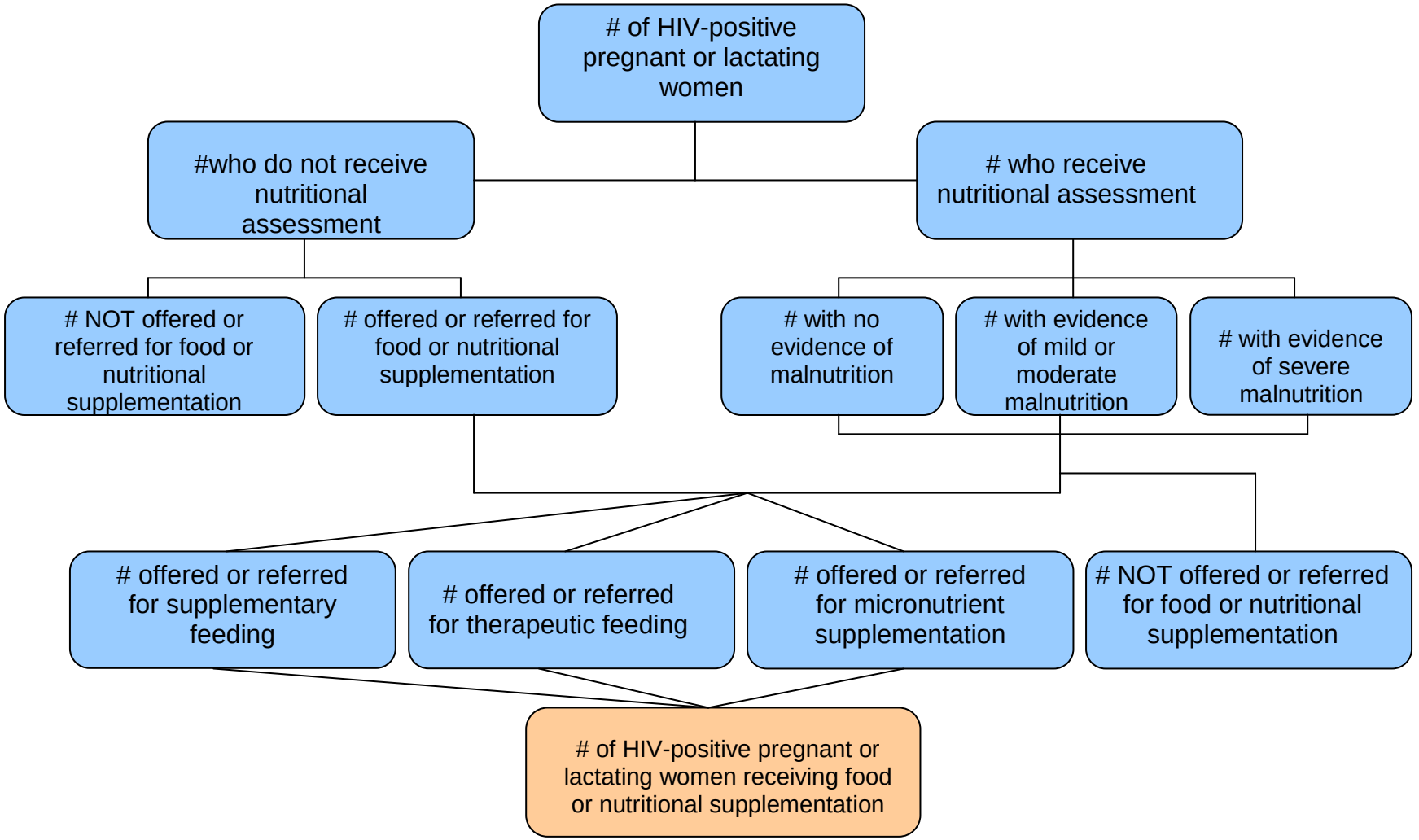
Partners conducting or overseeing wrap-around services then calculate the total metric tons distributed to those 650 persons or the dollars leveraged to provide directly distributed food aid to them.

Appendix 8: Additional Guidance on the new program-level food and nutrition indicators (PMTCT, ART, OVC)

EXAMPLE OF FOOD OR NUTRITIONAL SUPPLEMENTATION AMONG ART PATIENTS - Indicator #11.6

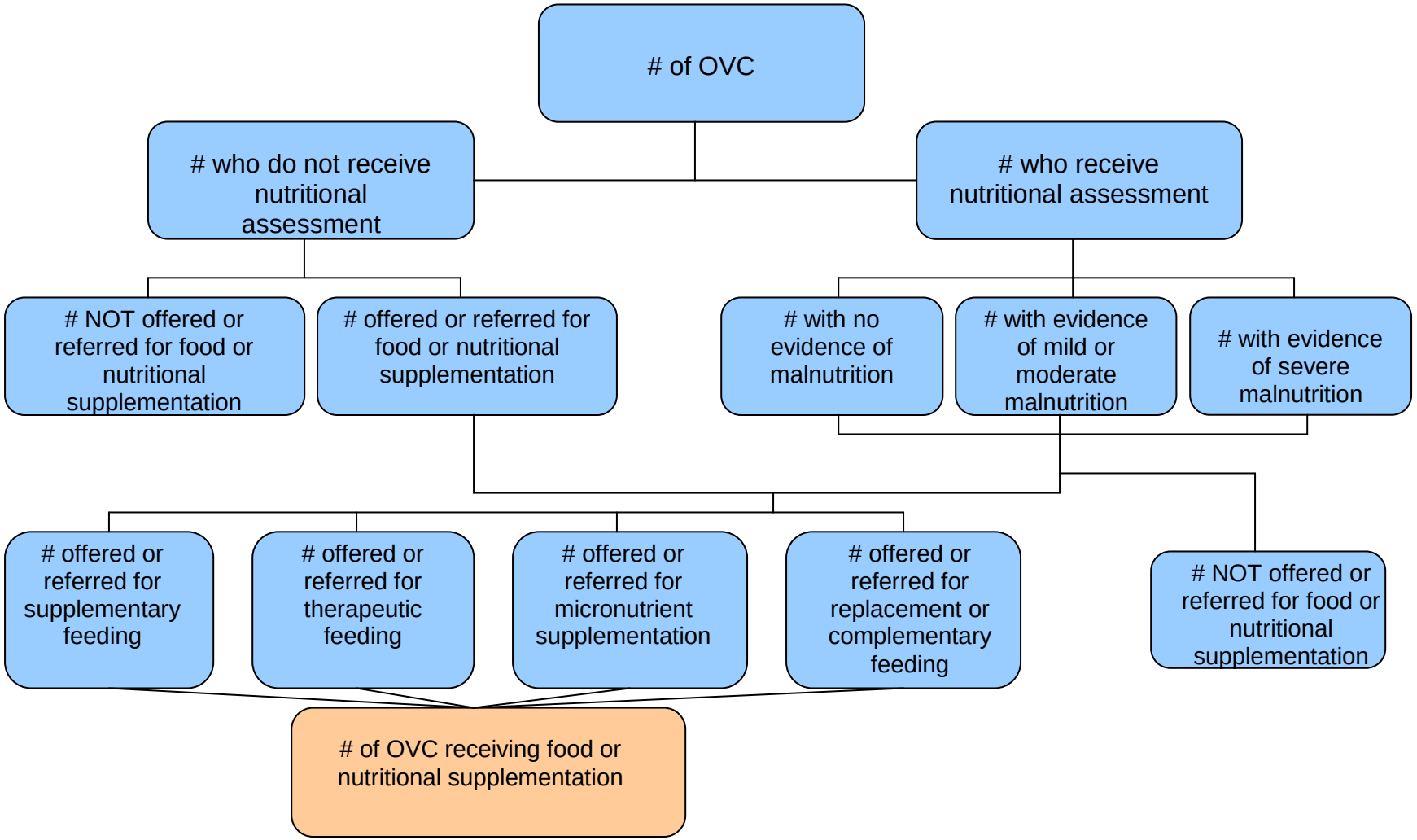


EXAMPLE OF FOOD OR NUTRITIONAL SUPPLEMENTATION FOR PREGNANT OR LACTATING WOMEN
Indicator #1.5



This indicator counts only HIV-positive pregnant or lactating women. Any of their children who receive replacement or complementary feeding should be counted in the Food & Nutrition indicator for OVC (indicator #8.3).

EXAMPLE OF FOOD OR NUTRITIONAL SUPPLEMENTATION FOR OVC
Indicator #8.3



Appendix 9: Sample Tools for Tracking Program Geographic Coverage and Tracking Indicators/Partners

Program Geographic Coverage Matrix

Instructions for use:

This is a basic sample tool that USG country teams may use to track the geographic program coverage (by region, province, district, city, etc.) of the major activities of their implementing partners. These activities should fall into 3 major categories with sub-categories:

1) Prevention: PMTCT, AB, Other prevention
2) Care: Basic health care, TB/HIV, OVC, C&T
3) Treatment: ARV

Questions that the USG country team should ask themselves and their implementing partners after completing this matrix:

- Are all geographic areas covered by the PEPFAR program?
- Do the geographic areas covered match the countries epidemic and need?
- Are some organizations concentrated in certain areas or are they dispersed over several areas?
- What are the implications of this for data collection?
- What sorts of overlap are there?
- Are the overlaps easily identifiable by client groups?
- How would you go about disentangling this information and making any adjustment for overlaps for reporting purposes?
- Do you see these overlaps as an indication to reassess programming?
- Does this mapping highlight any gaps in geographic coverage or your programs?

Program/Geographic Coverage Matrix

Program Area →	Prevention			Care & Support				Treatment	Notes/Justification
Geographic Focus ↓	PMTCT	AB	Other Prevention (OP)	Basic health care	TB/HIV	OVC	C&T	ARV	
District: Dist1		Org1	Org1, Org4, Org 6	Org2			Org6		OVERLAP – For OP, just count Org4 & Org6
City: Cit1.1			Org6	Org2		Org2, Org3		Org2	No overlap
District: Dist2	Org1, Org6		Org4						No overlap
City: Cit 2.1			Org3				Org6	Org2	
District: Dist3		Org1		Org2, Org7, Org 8, Org9		Org3			OVERLAP – For BHC, count Org2, Org7 at 80%, Org8, & Org9
City: Cit3.1			Org1, Org4				Org1		OVERLAP – For OP, count Org4 at 50%
District 4: Dist4	Org6					Org3			
City: Cit4.1			Org6	Org2					
City: Cit4.2								Org2	

Indicators/Implementing Partner Matrix
Instructions for use:

This is a basic sample tool that USG country teams may use to track their implementing partners' activities and which of the PEPFAR indicators they contribute to

Questions that the USG country team should ask themselves after completing this matrix:

- Are organizations evenly distributed across indicators or do organizations focus in one area?
- What are the implications of this for data collection?
- What sorts of overlap are there?
- Are the overlaps easily identifiable by client groups?
- How would you go about disentangling this information and making any adjustment for overlaps for reporting purposes?
- How will the USG country team adjust for overlap to minimize double-counting?
- Do you see these overlaps as an indication to reassess programming?
- Are there indicators that are not being reported on?
- Do these indicators suggest a gap in programming?
- Is each organization contributing to an indicator?
- What is the implication of this for programming – will some organizations feel "left out" if they are not contributing to a specific PEPFAR indicator?

	Implementing Partners										
PEPFAR Indicators	**Org1**	**Org2**	**Org3**	**Org4**	**Org5**	**Org6**	**Org7**	**Org8**	**Org9**	**Total**	**Potential Overlap**
(1) Prevention of Mother-to-Child Transmission											
1.1 Number of service outlets providing the minimum package of PMTCT services according to national and international standards	25					15				**40**	No overlap

	Implementing Partners										
PEPFAR Indicators	**Org1**	**Org2**	**Org3**	**Org4**	**Org5**	**Org6**	**Org7**	**Org8**	**Org9**	**Total**	**Potential Overlap**
1.2 Number of pregnant women who received HIV counseling and testing for PMTCT and received their test results	500					350				**850**	No overlap
1.3 Number of pregnant women provided with a complete course of antiretroviral prophylaxis in a PMTCT setting	300					230				**530**	No overlap
1.4 Number of health workers trained in the provision of PMTCT services according to national and international standards	50					12				**62**	No overlap
(2) Prevention/Abstinence and Being Faithful											
2.2 Number of individuals trained to promote HIV/AIDS prevention programs through abstinence and/or being faithful	12	20	10		7	10		15		**274**	No overlap
(3) Prevention/Medical Transmission/Blood safety											
(4) Prevention/Medical Transmission/Injection Safety											
4.1 Number of individuals trained in medical injection safety											
(5) Prevention/Condoms											

	Implementing Partners										
PEPFAR Indicators	**Org1**	**Org2**	**Org3**	**Org4**	**Org5**	**Org6**	**Org7**	**Org8**	**Org9**	**Total**	**Potential Overlap**
and other Prevention Activities											
5.1 Number of targeted condom service outlets				3						**3**	
5.2 Number of individuals reached through community outreach that promotes HIV/AIDS prevention through other behavior change beyond abstinence and/or being faithful	50		87	100		135				**50+87+(100 x 50%)+135 =322**	For OP: count Org1 + Org3 + Org4* (**count Org4 at 50%*) + Org6 = TOTAL OP
5.3 Number of individuals trained to promote HIV/AIDS prevention through other behavior change beyond abstinence and/or being faithful	5		21			45				**71**	No overlap in training
(6) Palliative Care (Basic Health Care)											
6.1 Total number of service outlets providing HIV-related palliative care (including TB/HIV)		12					20	15	9	**56**	No overlap
6.2 Total number of individuals provided with HIV-related palliative care (including TB/HIV)		1000			500		2500	1800	835	**100+500+(2500 x 80%)+1800 +835 = 5235**	For BHC: count Org2 + Org5 + Org7* (count Org7 at 80%) + Org8 + Org9 = TOTAL BHC
(7) Palliative Care (TB/HIV)											
7.1. Number of service outlets providing treatment for tuberculosis (TB) to HIV-infected individuals (diagnosed or presumed) in a palliative											

	Implementing Partners										
PEPFAR Indicators	**Org1**	**Org2**	**Org3**	**Org4**	**Org5**	**Org6**	**Org7**	**Org8**	**Org9**	**Total**	**Potential Overlap**
care setting (a subset of indicator number 6.1)											
(8) Orphans and Vulnerable Children											
8.1 Number of OVC served by OVC programs		1000	1200							**2200**	No overlap
8.2 Number of providers/caregivers trained in caring for OVC		50	45							**95**	No overlap
8.3 Number of OVC receiving food and nutritional supplementation through OVC programs											
(9) Counseling and Testing											

NOTE: These sample tools were based on actual excel spreadsheet tools that were developed and used by the USG Cambodia in-country team. For more information, please contact OGAC SI.

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ACRONYMS AND ABBREVIATIONS

ABC	Abstinence, Be Faithful, and correct and consistent Condom use
AIDS	acquired immunodeficiency syndrome
AIS	AIDS Indicator Survey
ANC	antenatal care
API	AIDS Program Effort Index
APR	Annual Program Results
ART	antiretroviral therapy
ARV	antiretroviral (drug)
BCC	behavior change communication
BSS	behavioral surveillance survey
CS, C&S	care and support; UNAIDS document: *National AIDS Programmes: A Guide to Monitoring and Evaluating HIV/AIDS Care and Support* (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
DQA	Data Quality Assurance
DSS	Demographic Surveillance System
EPP	Estimate and Projection Package
GFATM	Global Fund to Fight AIDS, Tuberculosis and Malaria; *Monitoring and Evaluation Toolkit: HIV/AIDS, Tuberculosis, and Malaria* (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 (U.S. Bureau of the Census)
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
NCPI	National Composite Policy Index
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	*WHO Injection Practices: Rapid Assessment and Response Guide* (see references)
RHS	Reproductive Health Survey
SAPR	Semi-Annual Program Results
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: *National AIDS Programmes: A Guide to Monitoring and Evaluation*. (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: *Guide to Monitoring and Evaluating National HIV/AIDS Programmes for Young People* (see References)