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Expanded Response Guide to Core Indicators for Monitoring and Reporting on HIV/AIDS Programs

November 2002

Contents

Acknowledgments

The *Expanded Response Guide for Monitoring and Reporting on HIV/AIDS Programs* is and will continue to be the product of a lengthy and participatory process. The participants in this process have been the HIV/AIDS New Indicator Working Groups (HANIG) and advisors from the Office of HIV/AIDS/Bureau for Global Health /USAID and USAID cooperating agencies in the HIV/AIDS portfolio, the Synergy Project, Health Resources and Services Administration/U.S. Department of Health and Human Services, MEASURE Evaluation, MEASURE DHS+, Global AIDS Program/Centers for Disease Control and Prevention, and the World Health Organization.

Acronyms

AIDS	Acquired immune deficiency syndrome
ANC	Antenatal care
CA	Cooperating agency (an organization that works with USAID)
CDC	Centers for Disease Control and Prevention
DHS	Demographic and Health Survey
HANIG	HIV/AIDS New Indicators Working Group
HIV	Human immunodeficiency virus
HRSA	Health Resources and Services Administration
IR	Intermediate result
M&E	Monitoring and evaluation
MTCT	Mother-to-child-transmission of HIV
PMTCT	Prevention of mother-to-child transmission
STI	Sexually transmitted infection
TBD	To be developed
UNAIDS	Joint United Nations Programme on HIV-AIDS
USDHHS	United States Department of Health and Human Services
USAID	United States Agency for International Development
VCT	Voluntary counseling and testing
WHO	World Health Organization

I. INTRODUCTION

In fiscal year 2001, USAID developed an "expanded response" strategy to combat the HIV/AIDS pandemic. This strategy was designed to enhance the ability of countries to prevent new HIV/AIDS infections and provide services to those either infected or otherwise affected by the epidemic, especially children, youth, and infected mothers.

As part of this strategy, the agency is establishing an improved, comprehensive system to routinely monitor its HIV/AIDS programs worldwide and periodically report its progress toward achieving its stated results. In the spring of 2003, the agency will issue its first annual report on progress toward achieving program objectives. The first report will cover FY 2002 activities, which are focusing on establishing the expanded programs in the field and are measuring baselines for program targets. The full implementation of the expanded response program will begin in FY 2003 and the agency will report on progress toward achievement of its stated 2007 targets.

While this system will require that some new information, many of the required indicators are already collected by Missions and regional bureaus for the annual report. It is expected that the additional required indicators in this guide will be collected in the same manner. An expanded monitoring and evaluation system to provide information on the national and USAID programs levels will be implemented, with first priority given to rapid scale-up and intensive focus countries. Program reporting will focus on the reduction of HIV transmission, changes in sexual behavior and progress toward the achievement of USAID supported targets and objectives (see Appendix I: *Guidance on New Monitoring & Evaluation Reporting Requirements for HIV/AIDS Programs).*

Effective coordination with other donors and country institutions will be a central feature of the USAID strategy *in all countries*, through seeking partnerships with other U.S. government agencies, private voluntary organizations, NGOs, international agencies, the World Bank and other multilateral organizations in order to leverage resources to achieve the goals established for 2007.

A. Rationale for the Expanded Response Monitoring and Reporting System

As part of USAID's "Expanded Response to HIV/AIDS" the agency is establishing an improved, comprehensive system to routinely monitor its HIV/AIDS program worldwide, manage its resources, and periodically report on the agency's progress toward achieving its stated results. All rapid scale-up and intensive focus country Missions will need to work closely with USAID/Washington to establish this program monitoring and reporting system and issue annual reports on progress at the country level. In addition, all basic countries receiving $1 million or more per year in HIV/AIDS funding[1] beginning in FY 2002 will be required to report annually using this guidance. Regional bureaus may require that other Missions in their respective regions also follow these expanded reporting requirements. Please note that regional programs are also a priority for the agency and will also be required to use the program monitoring and reporting system to the extent that it is appropriate and feasible. USAID/Washington will work closely with

[1] The source/type of funds is irrelevant to the need to adhere to this guidance. This includes funding through regional and central mechanisms.

regional program staff to design program monitoring and reporting systems appropriate to their objectives, targets, and program priorities.

Missions with less than $1 million per year in HIV/AIDS funding should also submit their annual reports using these guidelines to the extent that it is feasible. This additional information will enable the agency to produce a complete and comprehensive report on its efforts to reduce HIV transmission, to care for and treat those infected and affected by HIV, and to mitigate the social and economic effects of the pandemic as a means to achieve our 2007 targets.

Although USAID/Washington will provide some funding and technical assistance to support better data collection, analysis, and reporting, priority Missions and regional programs will also need to invest some of their budget in this effort. Additional resources for data collection, analysis, and reporting have been included in all rapid scale-up and intensive focus country budgets for FY 2002 and FY 2003.

Under these guidelines, each participating Mission will report the following[2]:

- HIV seroprevalence rates (source: national sentinel surveillance, reported annually)
- Changes in sexual behavior (source: national survey, conducted every 3–5 years)
- Progress on USAID-funded program implementation/coverage (source: USAID program data, reported annually).

USAID will collaborate closely with CDC, other U.S. government agencies, the host country government, and other donors, including the World Bank Multicountry AIDS Programme (MAP) and the Global Fund to Fight AIDS, Tuberculosis and Malaria (GFATM), to ensure that this monitoring and reporting system meets the reporting requirements, to the extent possible, of all participating agencies. This approach will also allow each agency to fund a portion of the system at the country level and provide complementary technical assistance. Within this context, however, USAID's priority will be to establish an improved, comprehensive system to report on its expanded response program.

USAID/Washington will provide technical assistance to develop this monitoring and reporting system at the national level, although in a few large countries such as Brazil, India, Nigeria, or Russia, USAID might also want to report sub-national statistics to capture the results of USAID programs. The agency has established a coordinated technical database at USAID headquarters in Washington where this information will be collected, analyzed, and made available to all operating units in the agency. This database has three components:

- Sentinel Surveillance Database managed by the Bureau of the Census;
- National HIV/AIDS Survey Indicator Database managed by the Demographic & Health Survey Project at Macro International in partnership with UNAIDS, UNICEF, WHO, and CDC;
- USAID Programmatic Database managed by the Synergy Project.

B. Targets for the Expanded Response

USAID will work toward the following international targets by 2007:

[2] Please see Appendix I for more information on individual mission requirements for the Expanded Response Monitoring and Reporting System Components.

- Reduce HIV prevalence rates among those 15–24 years of age by 50% in high-prevalence countries;
- Maintain prevalence below 1% among 15- to 49-year-olds in low-prevalence countries;
- Ensure that at least 25% of HIV/AIDS-infected pregnant women in high-prevalence countries receive a complete course of antiretroviral prophylaxis to reduce the risk of mother-to-child-transmission; and
- Enable local institutions to provide basic care and psychosocial support services to at least 25% of HIV-infected persons and to provide community support services to at least 25% of children affected by AIDS in high-prevalence countries.

C. Country Priorities for the Expanded Response

USAID will organize its response around three categories of countries:

- **Rapid scale-up countries:** Four countries (Cambodia, Kenya, Uganda, and Zambia) began receiving significant resource increases in 2001 to achieve measurable impact within 1–2 years and to ensure that at least 80% of the population receives a comprehensive package of prevention and care service within 3–5 years;
- **Priority intensive-focus countries:** In 19 countries, resources have been targeted to reduce the severity and magnitude of HIV/AIDS, or to define focused programs to keep HIV prevalence low, reduce HIV transmission from mothers to infants, and to increase support services for people (including children) living with and affected by AIDS within 3–5 years;

Brazil	Dominican Republic	Ethiopia	Ghana
Haiti	Honduras	India	Indonesia
Malawi	Mozambique	Nepal	Nigeria
Russia	Rwanda	Senegal	South Africa
Tanzania	Ukraine	Zimbabwe	

- **Basic:** Thirty-one countries will maintain a platform of bilateral funding complemented by stronger regional programs, technical assistance, training, and commodity support, and will be encouraged to pursue other sources of funding and support in an effort to achieve the 2007 targets:

Albania	Angola	Armenia	Bangladesh
Benin	Bolivia	Croatia	D.R. Congo
Egypt	El Salvador	Eritrea	Georgia
Guatemala	Guinea	Guyana	Jordan
Jamaica	Kazakhstan	Kosovo	Kyrgyzstan
Madagascar	Mali	Mexico	Namibia
Nicaragua	Peru	Philippines	Romania
Tajikistan	Turkmenistan	Uzbekistan	

- **Regional Programs:** Eight field-based regional programs will be strengthened to provide technical assistance to basic countries and to develop programs to focus on the pre-epidemic among the most-at-risk populations and to implement cross-border activities and other program to address the needs of migrant populations. These regional programs are:

Caribbean	Asia & Near East	Central Asia	REDSO
Central America	Southeastern Europe	Southern Africa	West Africa

D. Indicator Framework

To monitor the progress of the Global/PHN HIV-AIDS strategy, USAID developed a *Handbook of Indicators for HIV/AIDS/STI Programs* in March 2000. The objectives of the handbook are

- Define the key indicators for monitoring and evaluating the SSO4 portfolio;
- Promote the use of standardized indicators for the monitoring and evaluation of USAID HIV/AIDS country programs; and
- Facilitate the adoption of global indicators for the monitoring and evaluation of programmatic areas that would be covered in the SSO4 portfolio in subsequent years.

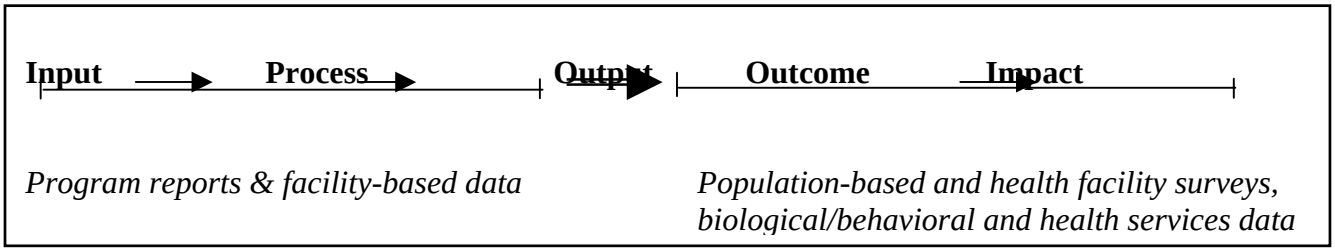
The indicators in this guide were developed to expand the latter sets of indicators described in the handbook, as well as new crosscutting areas under the expanded response. The indicators in this guide are grouped into six distinct program areas:

- Care, support, and treatment;
- Prevention of mother-to-child transmission of HIV;
- Orphans and other vulnerable children;
- Multisectoral;
- Human capacity; and
- Stigma and discrimination.

To facilitate the selection process the indicators in this guide, as in the USAID Handbook, were identified in accordance with three basic levels of evaluation, which correspond with the standard reporting requirements for the expanded response:

- Impact-level, measuring incidence or prevalence;
- Outcome-level, referring to the use of services, behavior change, or both; and
- Process-level, relating to activities and results at the program level.

The primary types of data sources for the different levels of measurement are shown below.



Tracking changes in indicators over time will help program managers and decision-makers assess how successful the program is in meeting its goals. Most indicators are not designed to explain why a situation has changed or has failed to change because they are designed only to measure the change. Therefore, the data collection and analysis plan should focus on the linking of indicators at the different levels of measurement. Program outputs should be interpreted in relation to program inputs. Program outcomes should be analyzed in relation to changes in program outputs. HIV prevalence trends should be interpreted in association with changes in sexual behaviors.

Although efforts were made to make the indicators contained in this guide as applicable as possible to diverse settings, some local adaptation may be necessary, depending both on the level

at which the program is being implemented and the agency or agencies involved in the planning, design, implementation, monitoring, or evaluation of the program. Where necessary, adaptation will be encouraged to ensure that the indicators are relevant to the program and meaningful to stakeholders. Guidance on how to adapt them in ways to further program goals and allow accurate assessment and comparison across programs will be provided by The Synergy Project in collaboration with other SO4 portfolio partners; Mission population, health, and nutrition officers; and regional and global bureaus.

E. Reporting Requirements for Core Indicators and Additional Indicators

As part of the expanded response, USAID is required to annually report progress toward achieving its stated target and results. The agency is committed to reducing seroprevalence in high-prevalence countries; maintaining current seroprevalence levels in low-prevalence countries; and expanding coverage of prevention, care, treatment, and mitigation services to target populations. Hence, it is important that Missions annually report their progress in implementing their HIV/AIDS strategy and increasing the proportion of the target populations covered by both prevention and care/treatment/ mitigation programs. Much of this information is already routinely collected by program managers, but this reporting system will have to be expanded to include new multisectoral programs as well as those in CST, IDU, prevention of mother-to-child transmission, orphans and other vulnerable children, and stigma and discrimination.

The **core indicators** in this guide must be annually reported to USAID/Washington in those program areas in which the Mission supports activities. The **additional indicators** are optional and are intended for use at the program or country level at the Mission's discretion.

CARE, SUPPORT, AND TREATMENT

ILLUSTRATIVE CARE, SUPPORT, AND TREATMENT ACTIVITIES FOR PEOPLE LIVING WITH HIV/AIDS

Develop and implement national policies, guidelines, and strategies for care and support

- Support the development, distribution, and implementation of HIV/AIDS care and support guidelines.
- Adapt established guidelines to local health care needs, the local language, or both.
- Incorporate national guidelines into training programs for clinicians, program staff, and volunteers in HIV/AIDS care, including pharmaceutical care.

Improve HIV/AIDS clinical, palliative, home-based and community-based services and treatments

- Strengthen the capacity of facilities, staff, equipment, drugs, and inventories to deliver appropriate care for HIV-infected persons at different health care settings.
- Develop and implement programs to provide external support for households with chronically ill persons.
- Promote functional drug logistics management.

Enhance training and education for health care providers

- Integrate HIV/AIDS care into pre-service and in-service training sessions for health care professionals.
- Provide ongoing in-service training for health care providers in the diagnosis, care, and management of HIV-infected persons.
- Provide technical assistance and support to training institutions serving a range of care providers.
- Train providers to supply appropriate counseling, including prevention and psychosocial support services.
- Train providers and caregivers to offer palliative and end-of life-care.
- Strengthen home and community care programs through technical assistance programs and training for people in community-based organizations.

Enhance the capacity of local, regional, and national governments to plan and manage care programs

- Provide guidance and support for needs assessment and planning activities.
- Support the involvement of people living with HIV/AIDS in needs assessments and program designs.
- Strengthen pharmaceutical procurement and management capacities.

Develop service linkages across the continuum of care

- Link voluntary, confidential counseling and testing services to a comprehensive continuum of care programs.
- Link services in treatment of sexually transmitted diseases, family planning, maternal and child health, and comprehensive HIV/AIDS prevention, care, and support services.
- Train caregivers to offer appropriate referrals.
- Develop links between home-based and community-based care programs and health centers and hospitals.
- Link successful programs to new programs in a peer mentoring relationship.

Enhance community mobilization/education concerning care services

- Promote awareness of care services in communities through a variety of promotional approaches. Include community groups, churches, and public gatherings.
- Support the development of consumer educational materials on self-care and prevention for persons living with HIV/AIDS.

Improve access to quality antiretroviral therapy

- Improve implementation of national and international guidelines for antiretroviral therapy.
- Support assessment and training of health care providers.
- Strengthen laboratory capacity through the use of improved screening and laboratory systems.
- Improve the monitoring and reporting of patient records, including disease staging, adherence, and drug regimen changes due to toxicity.

Enhance monitoring and evaluation of care programs

- Support assessments of the quality and reach of HIV services.
- Promote the development and use of reasonable, appropriate process and outcome measures.
- Train program staff to monitor programs through the collection and analysis of program data.
- Train staffs and program leaders to use program data to improve and adjust activities to meet identified gaps and services needs.

Care, Support, and Treatment

Global Target	**Method of Data Collection**	**Frequency**
• Number and percent of HIV-infected persons served by basic care and psychosocial support services in FY__. Joint target for USAID and other international donor and host country partners: at least 25% by 2007. (UNGASS target: 2005-20% reduction; 2010-50% reduction) The numerator is the total of the core indicators below adjusted for duplication.	Numerator from aggregation of mission reports; denominator by estimation	Annual
Core Indicators	**Method of Data Collection**	**Frequency**
• *Number of individuals reached by community and home-based care programs in the past 12 months • Number of community and home-based care programs funded by USAID in the past 12 months • *Number of individuals with advanced HIV infection receiving antiretroviral therapy (also an UNGASS Core Indicator) • Number of antiretroviral treatment programs funded by USAID in the past 12 months • *Number of individuals receiving voluntary counseling and testing in the past 12 months • Number of voluntary counseling and testing sites funded by USAID in the past 12 months	Program reports	Annual
Additional Indicators**	**Method of Data Collection**	**Frequency**
• Number of persons trained to monitor and evaluate HIV/AIDS care and support programs at the district level in the past 12 months	Program reports	Annual
• Existence of comprehensive HIV/AIDS care and support policies, strategies, and guidelines in line with current WHO or international standards	Interviews/record review	Biannual
• Existence of medical and allied health training institutions providing training on HIV diagnosis, care, support and treatment, and number of graduates of these institutions in the past 12 months receiving this training	Interviews/record review	Biannual
• Percent of health care facilities at different levels of the health care system who have the facility conditions, trained staff, medical supplies and equipment, and drugs to deliver appropriate care and support for HIV-infected persons (UNGASS Core Indicator)	Health facility survey	2–4 years
• Percent of health facilities, including voluntary counseling and testing and prevention of mother-to-child transmission sites, with referral linkages to comprehensive care and support services for people with HIV.	Health facility survey	2–4 years
• Percent of persons who have been ill for 3 or more months during the past 12 months that received external medical, psychological, or social support.	Household survey	2–4 years

• Percent of HIV patient records with antiretroviral prescriptions in line with national/international guidelines	Health facility survey	2–4 years
• Percent of health facilities that provide antiretrovirals that meet minimum WHO requirements for the provision of these	Health facility survey	2–4 years
• Percent of laboratories with the capacity to monitor antiretroviral therapy according to national/international guidelines	Health facility survey	2–4 years
• Percent of people discontinuing antiretroviral therapy	Special studies	TBD
• Existence of national monitoring and evaluation capacity for HIV/AIDS care and support programs	Interviews/record review	Biannual
• Percent of health facilities with adequate capacity to monitor HIV/AIDS care and support services	Health facility survey/interviews	2–4 years

* Required for numerator of global target
** Additional indicators are optional. Some have been developed and are being made operational for future field-testing and use by USAID and its partners.

The HIV/AIDS pandemic has elicited calls for greater funding and support for international efforts directed at the care and support for HIV-infected persons and their families. In order to improve systematic accountability for these efforts, new monitoring and evaluation methods are being developed by working groups addressing program activities that target specific topics.

This section includes one global indicator, core indicators for program coverage assessment, and additional indicators that address the comprehensive care approach to HIV/AIDS care, support, and treatment. These specific indicators, which are being developed and pilot-tested, include policies, training, health facility capacity, voluntary counseling and testing site referrals for care, home-based care, antiretroviral drugs, and capacity for monitoring and evaluation of care and support activities. These were identified as priorities for monitoring and evaluation. The indicators are based on global objectives and international documents from WHO, UNAIDS, USAID, and its partners.

Program Goals

The goal of the new monitoring and evaluation system is to implement standard indicators within USAID Missions and programs and national AIDS control programs. This will allow a global perspective on care, support, and treatment program efforts and achievements.

The global care and support target for USAID and other international donor and host country partners as part of the expanded response to the HIV/AIDS pandemic is *to enable host country institutions to provide basic care and psychosocial support services to at least 25% of HIV-infected persons in high-prevalence countries by 2007.*

The main purpose of the core indicators and program reports is to better understand the number of people reached by care and support programs in order to track the global target. Three core indicators are required for the numerator of the global target.

Additional indicators are critical in a comprehensive approach to monitoring and evaluation of progress toward HIV/AIDS care, support, and treatment. Without a strong commitment to this expanded level of evaluation, the overall goal of tracking national progress in building capacity,

providing access, and offering quality services for HIV care will not be achieved. This evaluation will be accomplished through the use of health facility surveys, population-based surveys, record reviews, and interviews. Policy, training, and monitoring and evaluation capacity will be monitored through interviews and record reviews. To better understand the content and quality of HIV care for HIV-infected persons the care and support indicators can be further validated through special studies such as qualitative data collection and the use of focus groups.

Measurement challenges

We acknowledge that the proposed list of indicators is not comprehensive or exhaustive. For example, monitoring of training institutions does not give a thorough description of the actual curricula. In addition, the proposed indicators do not give the perspectives and feedback from people living with HIV/AIDS. Qualitative data collection through interviews, focus groups, community advisory boards, or a combination of these could be used for this analysis. Critical issues such as the impact of human rights, stigma and discrimination, and access to care and treatment in rural areas must be further studied and addressed. In addition, the percentage of those who know their HIV-status is also not included in this set of indicators, yet this is a vital step toward care-seeking behavior.

The indicators listed for care, support, and treatment address only voluntary counseling and testing referral to comprehensive care. Additional indicators should be found in other prevention/surveillance listings. Whereas the included indicators measure how much support people living with HIV/AIDS or their families actually receive from care and support programs, the quality of care services is not thoroughly covered. These care and support indicators should evolve over time as more countries provide access and greater coverage for HIV care, and as they further focus on quality of care and quality of life.

Our approach presented here is on monitoring annual indicators based on program data and periodic evaluation to obtain national coverage and capacity based on more resource-intensive methods such as population and facility-based surveys.

GLOBAL TARGET

COVERAGE OF CARE, SUPPORT, AND TREATMENT PROGRAMS

Number and percent of HIV-infected persons served by basic care and psychosocial support services in FY __. Joint target for USAID and other partners: at least 25% by 2007.

What it measures
This indicator measures an estimate of the number and percent of HIV-infected persons provided with basic care, support, and treatment as defined below. The numerator is made up of the total of each of the three core indicators for care, support, and treatment adjusted for duplication. This includes the aggregate of HIV-infected individuals served by community-based and home-based programs, voluntary counseling and testing sites, and those receiving HIV-related drugs. These program reports are required to be collected within the core indicators of all funded programs.

Basic care and psychosocial support services are defined as those services offered by USAID-supported organizations and sites that include counseling and testing, diagnosis and management of common opportunistic infections, psychosocial care and support, home-based care, and referral practices for HIV-specific care and support including antiretrovirals.

How to measure it
USAID/Washington will calculate this indicator by aggregating the numbers reported by each Mission for the numerator, and by estimating the denominator.

USAID-funded

Numerator: The number of HIV-infected persons provided with basic care and support in the last 12 months from USAID-support programs and sites.

Denominator: A standardized denominator protocol will be established in three months.

Disaggregated by: TBD
Frequency: TBD
Data source: TBD

Strengths and Limitations
This indicator uses the total of reports from programs that serve HIV-infected persons. These reports include the number served from VCT at health facilities, stand-alone voluntary counseling and testing sites, home-based care programs, and those receiving HIV-related drugs. The indicator relies on the accuracy of program reports and the accuracy of HIV surveillance in forming an estimate of total HIV infections at the national level. Due to the difficulty in monitoring health facility services for HIV-infected individuals, these services are not included in this estimate and it is important to note this in the interpretation of the estimate.

In order to obtain and track national progress toward the global target, program reports must be collected by a central management information system at the national level. Yet to be determined is where the estimate for the denominator will come from (e.g., UNAIDS, etc.). The estimate could be validated by antenatal care data within HIV sentinel surveillance systems.

We recognize that a problem exists in double counting individuals being served by different programs and from undercounting those with HIV/AIDS who are untested but receive services. Similarly, the indicator used chronically ill served from home-based care rather than those with HIV/AIDS. Double counting may also occur in other divisions of care within USAID such as orphans and other vulnerable children and MTCT. It is also difficult to segregate USAID care services from the support of other donors.

CORE INDICATORS

COVERAGE BY COMMUNITY-BASED AND HOME-BASED CARE PROGRAMS

The number of individuals reached by community-based and home-based care programs in the past 12 months

What it measures
This indicator measures number served with external support for households receiving home care for chronically ill persons.

How to measure it
Program records reported by USAID Missions will be used to generate this indicator. It comprises the number of households that received external support, including counseling, medical care, other supplies for medical care, clothing, extra food, help with household work, companionship, financial support, legal services, training for care givers, school fees, shelter, or other medical or social services. This support is provided to households and families with chronically ill persons.

Disaggregated by: Type of service and frequency of support, gender, and age
Frequency: Annual
Data source: USAID Missions

The number of community and home-based care programs funded by USAID in the past 12 months

What it measures
This indicator measures programs for home-based care for chronically ill persons in the past 12 months funded by USAID

How to measure it
Program records reported by USAID Missions will be used to generate this indicator. It comprises the total of funded programs providing medical, psychological and/or social support for chronically ill persons and their families, including medical care, other supplies for medical care, clothing, extra food, help with household work, companionship, financial support, legal services, training for care givers, school fees, shelter, or other medical or social services.

Disagregated by: Region, Urban/Rural
Frequency: Annual
Data source: USAID Missions

ANTIRETROVIRAL THERAPY

The number and percent of individuals with advanced HIV infection receiving antiretroviral therapy (UNGASS)

What it measures
This indicator measures the number of HIV-infected individuals who received antiretroviral therapy in the last 12 months.

How to measure it
Program records reported by Mission programs will be used to generate this indicator. The numerator comprises the number of individuals with advanced HIV infection receiving antiretroviral therapy from health facilities, pharmacies, community-based organizations, or a combination of these. Preventive antiretroviral treatment for the purpose of preventing mother-to-child transmission is not included in this indicator and will be measured separately in the section that addresses prevention of mother-to-child transmission.

Estimating the number of persons with advanced HIV infection requiring antiretroviral therapy will generate the denominator. This number is estimated to be about 20% of the total number of HIV-infected people (i.e., the HIV prevalence rate).

Numerator: Number of persons with advanced HIV infection receiving antiretroviral therapy

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Denominator: Estimate of total number of persons with advanced HIV infection who are in need of antiretroviral therapy

Disaggregated by: Gender, age
Frequency: Biannual
Data source: Program records that are reported by national AIDS control programs

Strengths and Limitations
Disaggregation of this indicator will be problematic because estimates of HIV prevalence in subpopulations are usually not available. HIV prevalence is usually obtained from antenatal clinics, most of which are located in urban areas.

The number of antiretroviral treatment programs funded by USAID in the past 12 months

What it measures
This indicator measures programs for HIV-infected individuals who received antiretroviral therapy in the last 12 months funded by USAID.

How to measure it
Program records reported by USAID Missions will be used to generate this indicator. It comprises the total of funded programs providing individuals with advanced HIV infection with antiretroviral therapy from health facilities, pharmacies, community-based organizations, or a combination of these. Programs providing preventive antiretroviral treatment for the purpose of preventing mother-to-child transmission are not included in this indicator and will be measured separately in the section that addresses prevention of mother-to-child transmission.

Disagregated by: Region, Urban/Rural
Frequency: Annual
Data source: USAID Missions

VOLUNTARY COUNSELING AND TESTING

Number of HIV-infected individuals receiving voluntary counseling and testing in the past 12 months

What it measures
This indicator measures the number of HIV-infected individuals served at stand-alone and/or integrated health facility voluntary counseling and testing sites funded by USAID in the last year. The indicator is necessary as part of the aggregate numerator in tracking the global target.

How to measure it
This indicator measures the number of HIV-infected individuals who received voluntary counseling and testing from USAID-funded sites. It will be generated by reports from USAID programs. Sites are defined as public or NGO facilities where voluntary counseling and testing is a designated service (i.e., a clinic where counseling and testing is performed). This does not include antenatal clinics (which should be measured using the Mother-to-Child Transmission indicators in the next section).

Disaggregated by: Age (under 15, 15–24, 25–49, 50+)
Frequency: Annual
Data source: USAID Missions

Strengths and Limitations
This may become complicated (or easier) when voluntary counseling and testing sites become more integrated within the public health system.

Number of voluntary counseling and testing sites funded by USAID in the past 12 months

What it measures
This indicator measures the number of USAID-funded HIV voluntary counseling and testing sites, both stand-alone and those integrated within health facilities.

How to measure it
This indicator will be generated by USAID Mission program reports. Sites may be public or non-governmental.

Disaggregated by: Region, Urban/Rural
Frequency: Annual
Data Source: USAID Missions

MOTHER–TO-CHILD TRANSMISSION OF HIV

ILLUSTRATIVE ACTIVITIES THAT SUPPORT PREVENTION OF MOTHER-TO-CHILD TRANSMISSION*

Improve antenatal, postnatal, and child health services

- Support assessments of the quality and reach of maternal and child health services
- Provide training to health workers in mother-to-child transmission (MTCT)-related areas
- Support HIV/AIDS education in maternal and child health clinics
- Introduce voluntary counseling and testing into maternal and child health settings
- Promote functional drug logistics management

Promote voluntary, confidential counseling and testing services

- Train peer and professional HIV counselors in mother-to-child transmission prevention and improved voluntary counseling and testing techniques
- Provide HIV rapid test kits and other laboratory equipment
- Train laboratory technicians and fund laboratory quality assurance
- Promote voluntary counseling and testing awareness, education, and support in the community
- Link voluntary counseling and testing services to other support services in the community through referral partnerships

Provide counseling and support for safe infant feeding practices

- Conduct formative research to adapt United Nations guidelines on infant feeding and HIV to local settings
- Review and update national breastfeeding and formula feeding policies
- Support training on counseling about HIV and infant feeding options
- Promote and support exclusive breastfeeding until age 6 months for all breastfeeding mothers and proper formula preparation for mothers choosing to formula feed
- Monitor infant feeding trends in areas of high HIV seroprevalence

Promote optimal obstetrical practices

- Review and update the Safe Motherhood curricula, as well as programs and policies for attention to HIV and MTCT
- Train health workers in safe delivery techniques and life-saving skills for mothers and infants
- Provide safe delivery kits and essential obstetric drugs
- Improve the capacity of health systems and providers to monitor and supervise obstetrical services and practices

Provide short-course antiretroviral therapy for HIV-infected pregnant women

- Support training and other capacity development related to the use of antiretroviral drugs for MTCT
- Prepare essential drug programs to include short-course antiretroviral drugs for prevention of MTCT
- Promote the local approval and licensing of drugs to prevent MTCT
- Support supply and logistics aspects for management of antiretroviral drug supplies
- Support community mobilization efforts to increase acceptance of antiretroviral prophylaxis for MTCT

Link family planning counseling and services with voluntary counseling and testing

- Train family planning workers in HIV/AIDS, MTCT, and contraceptive issues related to HIV-infected women
- Strengthen family planning counseling and services in antenatal and postpartum services

- Establish referral links between voluntary counseling and testing and family planning counseling services
- Promote the use of barrier methods for prevention of HIV and other sexually transmitted infections
- Diagnose and treat sexually transmitted infections (because they contribute to HIV transmission)

Prevention of Mother to Child Transmission of HIV

Global Target	**Method of Data Collection**	**Frequency**
• Percentage of HIV-infected infants born to HIV infected mothers. (UNGASS target: 2005-20% reduction; 2010-50% reduction)	Sentinel sites where 18 month follow-up and/or PCR analysis can be done to determine infant HIV status Estimates based on program coverage (not required from missions)	Biennial
Core Required Indicators	**Method of Data Collection**	**Frequency**
• Number of health facility sites providing at least the minimum package of prevention of mother to child transmission (PMTCT) services (minimum package: services must include VCT, ARV prophylaxis, and infant feeding counselling or as determined by national guidelines) in the past 12 months	Program reports	Annual
• Number and percent of women who attend antenatal clinics with PMTCT services (as defined above) for a new pregnancy in the past 12 months	Program reports	Biannual
• Number and percent of women with known HIV infection among those seen at at antenatal clinics which offer PMTCT services (as defined above) in the past 12 months		
• Percent of HIV-infected pregnant women receiving a complete course of antiretroviral prophylaxis* to reduce the risk of MTCT (UNGASS indicator) *Joint target for USAID and other international donor and host country partners: at least 25% by 2007.*		
Additional Indicators**	**Method of Data Collection**	**Frequency**
• Number and percent of practicing skilled health personnel in antenatal care settings with training in PMTCT services (trained within the last 24 months)	Health facility surveys	
• Number of maternity facilities with appropriate referrals at the institutional level to link HIV positive women and their infants to care and support services		
• Number of health facilities with adequate capacity to monitor and accurately record PMTCT services		
• VCT Cascade		
• Number of pregnant women who attend at least one ANC visit		

ANC visit • Number of pregnant women who attend at least one ANC visit at an MTCT site - Number of pregnant women who receive counseling for HIV testing - Number of pregnant women accepting testing for HIV - Number of women receiving post-test HIV results - Number of pregnant women who receive positive HIV test results • Number of antenatal clinics providing HIV prevention programs to pregnant women (including partner communication strategies, education on HIV prevention during pregnancy through monogamy or condom use) • Number of antenatal clinics providing family planning counseling services during post-test counseling at PMTCT sites • Number of condoms distributed in antenatal clinics • Number of facilities that offer appropriate infant feeding counseling (according to WHO or national standards) during post-test counseling at PMTCT sites • Number of infants born to HIV positive mothers who receive cotrimoxazole prophylaxis for the first year of life	Special studies/observation	

***** A complete prophylactic regimen is determined based on the national or international guidelines on antiretroviral therapy use for prevention of mother-to-child transmission.
** Additional indicators are optional, and have been developed and are being made operational for future field-testing and use by USAID and partners.

Worldwide, 1 in 10 of those who become newly infected with HIV are children under the age of 15 and the vast majority of these children contract HIV through their mothers via what is referred to as mother-to-child transmission. Since the beginning of the epidemic, it is estimated that more than 4 million children under age 15 have died of AIDS, 90% of who lived in Africa. These deaths have severely undermined child survival gains made in earlier years. Prevention of mother-to-child transmission is a new and evolving field, and much of USAID's initial work in this area in recent months necessarily centered around identifying and assessing prevention interventions for their safety, affordability, feasibility, acceptability, and effectiveness. Few USAID Missions have to date found that the countries they assist have implemented or carried to scale any of the prevention interventions listed above. The indicators that follow are intended to monitor USAID's accelerating activity in this field.

Program Goals

Prevention of mother-to child transmission is part of strategic goal 4.4, "HIV transmission and the impact of the HIV/AIDS pandemic in developing countries reduced." Reducing MTCT also contributes to overall Agency strategic goal 4.2, "Infant and child health and nutrition improved and infant and child mortality reduced."

USAID's expanded response goal for prevention of mother-to-child transmission by the year 2007 is consistent with the global target, *ensure that at least 25% of HIV/AIDS-infected pregnant women receive a complete course of antiretroviral prophylaxis to reduce HIV transmission to their infants.*

Congress has directed the agency to work in prevention of mother-to-child transmission by introducing the interventions listed above, and Missions may be asked to report on their activities. Through the Global AIDS and Tuberculosis Relief Act, which authorizes HIV/AIDS funding for the next two years, and the FY 2001 appropriations bill, USAID was directed to devote 8.3% of its funding to prevention of mother-to-child transmission activities. This target is expected to be reached before the end of FY 2003.

USAID is also responding to President Bush's *International Mother and Child HIV Prevention Initiative*, announced on 19 June 2002. This initiative focuses on treatment and care for HIV infected pregnant women to reduce transmission of HIV/AIDS to infants. The Initiative concentrates on two main areas: (1) increasing the availability of preventive care, including drug treatments; and (2) building healthcare delivery systems to reach as many women as possible with the care they need. It targets fourteen countries: Botswana, Cote d'Ivoire, Ethiopia, Kenya, Mozambique, Namibia, Nigeria, Rwanda, South Africa, Tanzania, Uganda, Zambia, Guyana, and Haiti.

USAID in concert with other donor partners strives to significantly improve access for HIV-infected women of reproductive age to the six core interventions for prevention of mother-to-child transmission between now and 2007. USAID Missions will support the background activities that are necessary to introduce the interventions; will increase access to, demand for, and quality of the services; and will increase the use of these services. These steps, in turn, will reduce transmission of HIV and improve child survival.

Measurement Challenges

- Determining rates of mother-to-child transmission over time in a given population (and changes in these rates) is a complex and expensive process. It would also be difficult to attribute any mother-to-child transmission reduction to any specific interventions in a given community.
- A number of preparatory activities have to be completed before interventions to prevent mother-to-child transmission can be introduced. These activities include creating or changing existing policies, establishing or strengthening MTCT task forces, developing new curricula, training health workers, improving community awareness, acceptance of interventions, etc.

- Private sector and public sector availability of interventions to prevent mother-to-child transmission are likely to differ significantly.
- The field of preventing mother-to-child transmission is changing rapidly–new indicators will have to be developed over time to keep up to date with new interventions that emerge.
- The indicators that are most feasible to measure prevention of mother-to-child transmission are quantitative rather than qualitative; however, the quality of services offered is also important.

GLOBAL TARGET

Percent of infants born to HIV-infected mothers who are infected
(UNGASS target: 2005-20% reduction; 2010-50% reduction)

What it measures
This indicator measures the percent of infants born to HIV-infected mothers who are infected. This indicator will be estimated based on program coverage and sentinel sites and is not reported by the Missions.

How to measure it
This indicator can be calculated by taking the weighted average of the probabilities of MTCT for pregnant women receiving and not receiving antiretroviral prophylaxis, the weights being the proportions of women receiving and not receiving ARV, respectively. Expressed as a simple mathematical formula:

Indicator score: {T*91-e) + (1-T)}*V

Where:

T = proportion of HIV-infected pregnant women provided with antiretroviral treatment
v = MTCT rate in the absence of any treatment
e = efficacy of treatment provided

This percentage will also be calculated from sentinel sites where testing of infants born to HIV-infected mothers is available.

Disaggregated by: Urban/rural
Frequency: Biennial
Data source:

CORE INDICATORS

The number of health facility sites providing prevention of mother-to-child transmission services in the past 12 months

What it measures
This indicator measures the number of health facilities that provide at least a minimum package of MTCT services in the past 12 months (minimum package: services must include VCT, ARV prophylaxis, and infant feeding counseling or as determined by national guidelines).

How to measure it

Disaggregated by: Urban/rural
Frequency: Annual
Data source: Program reports

Number and percentage of women who attend antenatal clinics with prevention of mother-to-child transmission services for a new pregnancy in the past 12 months

What it measures
This indicator measures whether pregnant women are accessing services to prevent mother-to-child transmission.

How to measure it

$$\frac{\textit{Numerator:}\ \text{Number of women who attend antenatal clinics that provide at least the minimum package of MTCT services in the past 12 months}}{\textit{Denominator:}\ \text{Number of women who attend antenatal clinics for at least one ANC visit in the past 12 months}}$$

Disaggregated by: urban/rural
Frequency: Annual
Data source: Program reports

Number and percentage of women with known HIV infection among those seen at antenatal clinics which offer prevention of mother-to-child transmission services in the past 12 months

What it measures
This indicator measures how many HIV-infected women have been seen at prevention of mother-to-child transmission sites within the past twelve months.

How to measure it

$$\frac{\textit{Numerator:}\ \text{Number of women with known HIV infection seen at antenatal clinics that offer PMTCT services in the past 12 months}}{\textit{Denominator:}\ \text{Number of women seen at antenatal clinics that offer PMTCT services in the past 12 months}}$$

Disaggregated by:
Frequency: Annual
Data source: Program reports

Percentage of HIV-infected pregnant women receiving a complete course of antiretroviral prophylaxis to reduce the risk of MTCT
Joint target for USAID and other international donor and host country partners: at least 25% by 2007.

What it measures
This indicator measures whether HIV-infected women are receiving a complete course of antiretroviral drugs during pregnancy, labor, or both at antenatal clinics offering prevention of mother-to-child transmission services.

How to measure it

Numerator: The number of pregnant HIV-infected women provided with a full course of antiretroviral prophylaxis to reduce MTCT according to the nationally approved treatment protocol (or WHO/UNAIDS standards) in the last 12 months

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Denominator: Estimated number of HIV-infected pregnant women

Disaggregated by: Urban/rural
Frequency: Biannual
Data Source: Program reports

ORPHANS AND OTHER VULNERABLE CHILDREN

ILLUSTRATIVE ACTIVITIES THAT SUPPORT PROGRAMMING FOR ORPHANS AND OTHER VULNERABLE CHILDREN

The USAID publication *Children on the Brink 2002* sets out five basic strategies to shape USAID-supported programs to benefit orphans and other vulnerable children in HIV/AIDS-affected areas. This strategic framework is also being adopted by other international organizations and provides a basis for USAID's collaboration with UNICEF, UNAIDS, other international organizations, other bilateral donors, host governments, NGOs, and communities. The five strategies are:

1. Strengthen the capacity of families to cope with their problems.
2. Mobilize and strengthen community-based responses.
3. Increase the capacity of children and young people to meet their own needs.
4. Ensure that governments develop appropriate policies, including legal and programmatic frameworks, as well essential services for the most vulnerable children.
5. Raise awareness within societies to create an environment that enables support for children affected by HIV/AIDS.

To make the strategies operational, USAID invests in interventions that mobilize and build the capacity of local initiatives for direct support and protection of orphans and other vulnerable children and their families. Local NGOs, faith-based organizations, women's groups, community committees, a broad coalition of these groups, or other local bodies may undertake these local initiatives.

*Interventions to mobilize and strengthen local initiatives may be implemented directly by a cooperating agency or by intermediary organizations (typically national NGOs) that the cooperating agencies subcontract and support. The following list provides **examples** of some of the most common of these interventions. The list is not exhaustive. In addition, it is important to note that the availability of limited resources necessitates choosing from among those interventions that will have the greatest impact on children and their families. USAID missions and the cooperating agencies they support are encouraged to work with HIV/AIDS-affected communities to develop, document, evaluate, and share information about these and about other types of interventions that strengthen community efforts to assist orphans and other children affected by HIV/AIDS.*

Mobilize development of local initiatives to support and protect orphans and other vulnerable children and their families

- Increase recognition and understanding of the impacts of AIDS on children and families in the community.
- Support community-led situation analysis and planning of community responses to orphans and other vulnerable children.
- Initiate and increase collaborative action among local organizations and individuals assisting vulnerable children and families (NGOs, faith-based organizations, government staff, business persons, traditional and political leaders, etc.)

Strengthen local initiatives' organizational capacity to address the needs of orphans and other vulnerable children

- Build participants' organizational skills, including decision-making, planning, management capacities, monitoring and evaluation, and resource mobilization.
- Train participants to mobilize and manage internal and external resources.
- Link initiatives with external resources.

Help communities support and protect vulnerable children and households

- Help communities seriously affected by HIV/AIDS to develop a process to identify their most vulnerable children.

- Help communities organize regular visits to such children and their guardians, to monitor their status, and provide emotional and material support and protection.
- Help communities protect the inheritance rights of widows and orphans.
- Train community members in child protection practices.
- Help communities to support children and youth who care for others affected by HIV/AIDS, including siblings, grandparents, etc.

Strengthen the economic coping capacities of households and communities affected by HIV/AIDS
- Support economic interventions to address the needs of children and their households affected by HIV/AIDS, in order to have a direct impact on the well-being of orphans and other vulnerable children without threatening the sustainability of the implementing organization.
- Facilitate collaborative action between programs that address the needs of orphans and other vulnerable children and their households and economic interventions funded from other sources.

Enhance long-term food security
- Support efforts that will increase the food security of children and their households affected by HIV/AIDS and result in their having a direct impact on the well being of orphans and other vulnerable children.

Support education and training
- Support community efforts to keep orphans and other vulnerable children in school or to provide them with educational alternatives.
- Support skills training and apprenticeships within the community for orphans and other vulnerable adolescents in order to increase the social and psychological well-being of youth, in addition to increasing their skills to generate income.

Improve health care
- Integrate the needs of children and youth who are HIV-infected, as well as affected, into broader efforts that support community-based care for people living with HIV/AIDS.
- Implement activities to help protect vulnerable children and adolescents from HIV infection.
- Support children and youth who care for ill family members.
- Support access to health care, including immunizations, for children affected by HIV/AIDS.

Address psychosocial needs
- Support the development of structured recreation activities that include orphans and other vulnerable children.
- Train key community members so that they can provide counseling and psychosocial support.
- Develop community structures to regularly visit especially vulnerable children, provide emotional support and encouragement to them and their guardians, provide material support as possible, and monitor children's well being.
- Help organize mutual support groups of orphans and other vulnerable children and their caregivers.
- Support succession planning, including development of memory books/boxes/baskets.

Promote labor sharing
- Support cooperative community day care that includes orphans and other vulnerable children.
- Support community gardens that benefit households caring for vulnerable children.
- Encourage youth and adults to help vulnerable households with household and agricultural tasks

Support community-based relief

- Provide ongoing technical, financial, and material support to community efforts to help orphans and other vulnerable children and their families in a manner that will not undermine long-term community initiatives.
- Help community groups secure ongoing supplies of food aid to assist destitute children and households.

Support policy reforms that benefit orphans and other vulnerable children

- Assess the impact of AIDS at the local and national government levels on sectors related to the well-being of children and adolescents affected by HIV/AIDS, including health, education, welfare, etc.
- Support development and implementation of laws and policies that have an impact on children affected by HIV/AIDS and their families, including those that address appropriate forms of family-based and community-based care and prevent inappropriate institutionalization of children affected by HIV/AIDS; appropriate adoption and foster care; inheritance and property law reforms to protect the rights of widows and orphans; and protection of children from sexual abuse, neglect, and other forms of mistreatment.

An important issue to recognize and address is that the multi-faceted needs of children, youth, and their families who are affected by HIV/AIDS, cross-sectoral activities may not always be allowable for support using Child Survival and health Program funds. Therefore, to support multi-sectoral responses, it will sometimes be necessary to link with funding from other sectors or with funding from other donors.

Collaborative action by all stakeholders is essential for developing a network of responses that collectively match the scale of the impacts of AIDS on children. Therefore, USAID Missions and implementing organizations are encouraged to develop mutually reinforcing linkages between interventions that focus on orphans and other vulnerable children and other types of development and relief activities. Strategies for linkages include geographic co-location of programs, joint program design and monitoring, and referral network development. Consider linking interventions with activities in the following sectors:

- Education (strengthening national education structures, making curricula more relevant to children in communities affected by HIV/AIDS, community schools, radio-based education and other forms of distance learning, life skills programs, etc.);
- Health (child survival and development, integrated management of childhood illness, improved access to clean water, etc.);
- Nutrition (improved crop varieties and cropping methods appropriate to the labor capacities of households affected by HIV/AIDS, community-based distribution of food aid, school feeding, etc.);
- Agriculture (extension services, development of less labor-intensive crop varieties, cooperative development, facilitating inter-generation skills transfer, etc.); and
- Economic strengthening (microfinance, apprenticeships, skills training, market access, development, and linkages, etc.).

Missions and implementing organizations are particularly encouraged to develop linkages between interventions that address the needs of orphans and other vulnerable children and other HIV/AIDS interventions, including activities focused on prevention, home-based care, and preventing mother-to-child transmission. It is especially important to integrate interventions for orphans other vulnerable children into care and support programs for adults living with AIDS. Vulnerability begins long before a child is orphaned; many children of AIDS-infected adults are even more vulnerable than orphans due to the high cost of care and the stress of coping with a parent's terminal illness. In addition, worry about their children's future is one of the greatest sources of psychosocial distress for many people living with AIDS.

For additional information on programming approaches to address the needs of orphans and other vulnerable children, see:

Children on the Brink 2002—Report published by USAID, UNICEF, and UNAIDS in 2002 provides data on orphans—maternal, paternal, and double orphans—in 88 countries; analysis of the trends found in those statistics; and strategies and principles for helping children.
<http://www.usaid.gov/pop_health/aids/Publications/index.html>

USAID Project Profiles: Children Affected by HIV/AIDS—More than 75 USAID-supported projects to assist children and youth affected by HIV/AIDS are highlighted in this July 2002 report.
<http://www.usaid.gov/pop_health/aids/Publications/index.html>

Children Affected by AIDS Electronic Discussion Forum, hosted by USAID and the Synergy Project. This forum facilitates discussion and information exchange on efforts to mitigate the impact of HIV/AIDS on children, families, and communities worldwide. Currently, the forum hosts about 600 subscribers from 40 countries.
<http://www.synergyaids.com/caba/>

Displaced Children and Orphans Fund (DCOF)—Numerous technical documents produced by DCOF provide information about strategies and programming focusing on efforts to mitigate the impact of HIV/AIDS on children and families.
<http://displacedchildrenorphansfinds.org/>

Orphans and Other Vulnerable Children

Global Target	**Method of Data Collection**	**Frequency**
• Percent of orphans and other vulnerable children in high prevalence countries to whom community support is provided in FY __. Joint target for USAID and other international donor and host country partners: at least 25% by 2007. **Note: Other global targets are currently in development.**	The method of collecting these data at the national levels is currently being determined as part of the M&E effort associated with USAID's expanded response activities.	Annual
Core Required Indicators	**Method of Data Collection**	**Frequency**
• Number of orphans and other vulnerable children receiving care/support	Program reports Household Survey/Special Study	Annual Every 3–5 years
• Number of community initiatives or community organizations receiving support to care for orphans and other vulnerable children	Program reports	Annual
• Total number of OVC programs supported by USAID in FY __	Mission reports	Annual
Additional Indicators[34]	**Method of Data Collection**	**Frequency**
• Number of OVC receiving/benefiting from improved access to education[3] • Number of OVC receiving/benefiting from improved health care • Number of OVC receiving/benefiting from psychosocial support • Number of OVC receiving/benefiting from protection activities • Number of OVC receiving/benefiting from sustainable nutritional/agricultural assistance • Number of OVC receiving/benefiting from food aid • Number of OVC receiving/benefiting from assistance to become more economically self-supporting	Program reports	Annual
• Number of OVC in households receiving/benefiting from assistance to become more economically self-supporting • Number of OVC receiving/benefiting from assistance to improve their housing/shelter situation	Household survey	Every 2-4 years

Program Goals

The global target for orphans and other vulnerable children established for USAID, to be achieved in conjunction with other partners, as part of the expanded response to the HIV/AIDS pandemic, is *to enable local institutions* (community-based organizations, religious bodies, government agencies, etc.) *to provide*

[3] The phrase "benefiting from" is used to emphasize that USAID's programs for orphans and vulnerable children should seek to benefit vulnerable children, not just deliver services to them. Before determining the number of orphans and vulnerable children *benefiting*, it will be necessary to calculate the number of orphans and vulnerable children *receiving assistance* in each sector. Missions and programs should use the number of orphans and vulnerable children *receiving assistance* in each sector to calculate the OVC-A. Programs should work with partner organizations and communities and with the Mission to develop and apply quality standards that define what constitutes "benefiting."

[4] These indicators are illustrative examples that Missions may choose to use, according o the types of programs for orphans and vulnerable children they are supporting. Missions and programs are free to develop other indicators as well.

community support to at least 25% of orphans and other vulnerable children in high-prevalence countries by 2007.

The Declaration of Commitment agreed to by all countries at the June 2001 UN General Assembly Special Session (UNGASS) on HIV/AIDS establishes the following goal for all HIV/AIDS-affected countries.

By 2003 develop and by 2005 implement national policies and strategies to:

- Build and strengthen governmental, family, and community capacities to provide a supportive environment for orphans and girls and boys infected and affected by HIV/AIDS, including providing appropriate counseling and psychosocial support; ensuring their enrollment in school and access to shelter, good nutrition, health, and social services on an equal basis with other children;
- Protect orphans and other vulnerable children from all forms of abuse, violence, exploitation, discrimination, trafficking, and loss of inheritance.

Over time, USAID hopes to work with other donors to develop joint indicators and a collaborative process for measuring *outcomes* – and perhaps *impacts* – of programs for orphans and other vulnerable children supported by USAID and all other partners, and for measuring progress toward the UNGASS goals. Future editions of this guide will be updated to reflect consensus reached in this effort.

Measurement Challenges

The first challenge in monitoring and evaluating orphans and other vulnerable children programming is to define "orphans and other vulnerable children." For USAID, the term *orphans and other vulnerable children* is essentially synonymous with the term "children[5] affected by HIV/AIDS." USAID recommends against specifically targeting only orphans, children in families identified as affected by HIV/AIDS, or children who are HIV-positive. Instead, it is recommended that beneficiaries of such programs include children identified as most vulnerable within an HIV/AIDS-affected community according to locally defined criteria, regardless of the specific cause of their vulnerability. In most instances, orphans and other vulnerable children should be identified by community groups applying locally developed criteria, rather than by external parties. This method of targeting has been successfully used, especially in areas with extremely high HIV/AIDS-related morbidity and mortality. In areas where HIV/AIDS has affected only a small proportion of the most vulnerable children, such as is the case where some USAID-supported programming for orphans and other vulnerable children has been implemented in parts of Asia and Latin America, alternative ways of identifying children affected by HIV/AIDS are being developed that do not exacerbate stigma and discrimination associated with HIV/AIDS. For example, children whose parents have died or are chronically ill are identified to receive support through interventions that provide community-based care to people living with HIV/AIDS and other debilitating illness.

A second challenge is the need to enormously increase coverage while ensuring that program activities meet appropriate quality standards and result in meaningful benefits for orphans and other vulnerable children. To date, almost 14 million children have lost one or both parents due to AIDS, and many millions more have otherwise been made vulnerable by HIV/AIDS. This crisis is just beginning; tens of millions more children can be expected to lose their parents in the years ahead. Thus it is vital that

[5] USAID supports community-led definition of "child" and does not impose a specific age to divide childhood from adulthood. A generally accepted standard is the definition in the UN Convention on the Rights of the Child: "A child means every human being below the age of eighteen years unless under the law applicable to the child, majority is attained earlier."

USAID and other partners massively increase the reach and impact of their programming. However, focusing solely on numbers of children reached may lead to unacceptable sacrifices in the quality of assistance provided and the level of benefits that result, unless firm quality standards are established. In addition, if assessed on the basis of numbers of children reached, cooperating agencies may select interventions that reach large numbers of children quickly but are not sustainable instead of interventions that reach less children but are more likely to continue for a longer period of time. For example, providing school fees to orphans is a quick way for cooperating agencies to reach many children. However, there may be better ways of reaching children over the longer term through support of community structures and community approaches that will continue to provide support when funds for school fees "dry up". Because the contexts of programs for orphans and other vulnerable children vary among countries, it is recommended that USAID Missions collaborate with the organizations that are implementing programs and their community partners to define clear, contextually appropriate programming and quality standards and to monitor adherence to them.

A third challenge is the difficulty of measuring the long-term outcomes of programs for orphans and other vulnerable children. Most USAID-supported programming for these populations seeks to strengthen the long-term capacities of families and communities to assist and protect orphans and other vulnerable children. The most critical outcomes of these programs are likely to occur after the program period has ended, as family and community groups sustain and expand their efforts to care for orphans and other vulnerable children.

A fourth challenge is the need to avoid two types of double counting when measuring the number of orphans and other vulnerable children affected by programs. First, a child who receives more than one kind of assistance should be counted only once (e.g., a child who receives food aid, a scholarship, and regular visits should be counted as a single beneficiary, not as three beneficiaries). Second, a child who receives the same kind of assistance multiple times within a fiscal year should be counted only once (e.g., a child who visits a feeding program several times should be counted only once). It will not be easy for programs and missions to develop systems to prevent double counting, particularly when children may be benefiting from more than one type of program or simultaneously from more than one organization. Some programs use systems by which individual children are tracked, and therefore it is possible to identify the number of children receiving assistance. However, some programs do not. In such cases, the data are more likely to reflect *the number of times children receive assistance*, rather than *the number of children who received assistance*. Reporting systems should not be made unnecessarily cumbersome to avoid double counting. It is acceptable for programs to use informed estimates in calculating total child beneficiaries. This may require the program to conduct a "special study" to estimate the number of children represented by the type of data being collected on a regular basis.

All of these challenges are further discussed below, in the explanations of the new indicators for orphans and vulnerable children.

GLOBAL TARGET

COMMUNITY SUPPORT FOR ORPHANS AND VULNERABLE CHILDREN

The percentage of orphans and other vulnerable children in high-prevalence countries to whom community support is provided in FY __. Joint target for USAID and other international donor and host country partners: at least 25% by 2007.

What it measures
This indicator is intended to measure the annual coverage of USAID's programs for orphans and other vulnerable children in the high prevalence countries where they operate.

How to measure it
The method of collecting these data at the national level (and the possibility of using household surveys supplemented by data from children who are not in households) is currently being determined as part of the monitoring and evaluation effort associated with USAID's expanded response effort. (At the local level, some implementing organizations are collecting these data at baseline and as part of the evaluation efforts to measure the coverage of their interventions.)

Numerator: The number of orphans and other vulnerable children receiving care/support in high prevalence countries

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Denominator: A standardized denominator protocol will be established in three months.

Disaggregated by: TBD
Frequency: TBD
Data source: TBD

Strengths and limitations
The indicator hopefully will reflect an increase in the coverage of programs for orphans and other vulnerable children from year to year. However, it is important to recognize that the denominator will continue to increase as more children are orphaned or made vulnerable in high-prevalence countries. Thus an increase in the *number* of orphans and other vulnerable children receiving care/support per year will not necessarily lead to an increase in the *percentage* of orphans and other vulnerable children receiving care/support.

CORE INDICATORS

Number of orphans and other vulnerable children receiving care/support

What it measures
This indicator measures the number of orphans and other vulnerable children who received care, support, or both in a given fiscal year through action supported by USAID.

How to measure it
The data for this indicator are collected at the program level and reported to the USAID Mission. The Mission aggregates reports from all programs and reports to USAID/Washington.

This indicator should include those orphans and other vulnerable children who have received assistance provided directly by cooperating agencies; it should also include orphans and other vulnerable children who have received assistance from groups and organizations that were made stronger by cooperating agencies or their subgrantees. For example, if a cooperating agency provides a subgrant to a local NGO to strengthen the capacity of several small community-based organizations to assist orphans and vulnerable children, all the recipients of care/support from the community-based organizations should be counted for this indicator. Cooperating agencies and subgrantees are responsible for collecting this information from community-based organizations with which they have worked.

The term "care/support" is intended to be widely inclusive of many different efforts to assist orphans and vulnerable children. Forms of care/support for orphans and other vulnerable children include regular visits by concerned community members, enabling children to attend school, increasing their access to health care, provision of food aid, psychosocial/recreational activities, etc. Each program is expected to determine what constitutes "care/support" in its own context, in consultation with the USAID Mission.

Each program is expected to develop basic quality standards for each form of care/support provided, in consultation with the USAID Mission. These standards should be determined in collaboration with partner organizations and communities. For example, the standard for providing psychosocial support might range from one visit per year to one visit per week, or even more often, by a trained community worker. Ensuring that the agreed-upon standards are consistently met should be the joint responsibility of the program and its organizational and community partners. The standards developed, the methods of monitoring adherence to them, and the results of this monitoring should be documented and reported to the USAID Mission. The quality of the care/support provided may also be assessed by an external review during or shortly after the program period.

A primary objective of many community mobilization efforts focusing on orphans and other vulnerable children is to build the capacity of communities to provide care/support to children for many years after the program ends. USAID is interested in determining the downstream results of mobilization and capacity building. Consequently, even if cooperating agencies and subgrantees cease working directly with some partner community-based organizations *before* the end of the cooperating agency program period, the cooperating agencies and subgrantees should continue until the *end* of the program period to collect from these organizations the number of orphans and other vulnerable children who are benefiting from care and support. A way of continuing to capture these beneficiaries *after* the program period would be to conduct post-program sample studies in several sites to estimate the number of children who benefit after the program period ends, then develop projections for all such programs based on the findings of the studies.

This indicator must include beneficiary statistics for all programs funded specifically to benefit orphans and other vulnerable children in HIV/AIDS-affected areas[6]. This indicator can also incorporate beneficiary statistics from more broadly focused programs that increase care and support for orphans and other vulnerable children as well as other beneficiaries. For example, a microfinance program implemented in communities heavily affected by HIV/AIDS can be included in this indicator if it can be shown that the household economic strengthening resulting from the program increases or improves the care and support provided to orphans and other vulnerable children in the household. Programs focused specifically on orphans other vulnerable children and those that are not designed specifically to benefit them should provide an explanation of the method or methods by which they determined the number of beneficiaries when they report this indicator.

It is important that programs avoid two types of double counting. First, a child who receives more than one kind of care/support should be counted only once (e.g., a child who receives food aid, a scholarship, and regular visits should be counted as a single beneficiary, not as three beneficiaries). Second, a child who receives the same kind of care/support multiple times within a fiscal year should be counted only once (e.g., a child who visits a feeding program several times should be counted only once). Each program will have to develop controls that prevent these types of double counting.

This indicator includes the orphans and vulnerable children receiving care/support in a single fiscal year. If some of these beneficiaries continue to receive care/support in the following fiscal year, they should be counted as part of that fiscal year's indicator as well.

Disaggregated by:	TBD
Frequency:	Annual reporting from program reports; Household survey/special studies every 3–5 years
Data source:	Program reports for annual reporting; Household surveys and/or special studies for more extensive information

Strengths and limitations

This indicator allows for calculation of the quantity of orphans and other vulnerable children who are receiving some form of care and support. However, this indicator does not capture the quality of the care/support received. It is important to ensure that programs and their partners do not provide substandard care/support in their efforts to reach a high number of orphans and other vulnerable children. Nonetheless, a single quality standard applicable to all contexts cannot be imposed because practices and standards of care/support vary widely among countries and program areas. Devolving responsibility for defining and monitoring quality of care/support to Missions and programs acknowledges that country-level staff are best placed to determine and assess quality in their own national context.

Controlling for double counting will be difficult for many programs. In addition, this indicator does not reflect the results of programs that provide multiple or repeated benefits to a child.

[6] This indicator is required from all programs funded using the CSD/CSH emphasis area codes HKID and VKID (FY2001 only), as well as all programs to benefit AIDS-affected children that are funded using the ORPH code. For a full discussion of these codes, see the accompanying *Guidance on the Use of USAID Funding for programs focusing on orphans and other children and adolescents made vulnerable by HIV/AIDS*. It is optional to include beneficiaries of programs funded using codes other than these.

Number of community initiatives or community organizations receiving support to care for orphans and other vulnerable children

What it measures
This indicator measures the number of community initiatives or community organizations that received support to care for orphans and other vulnerable children in a given fiscal year through action supported by USAID.

How to measure it
The data for this indicator are collected at the program level and given to the USAID Mission. The Mission aggregates reports from all programs and provides the data to USAID/Washington.

The term "community initiative or community organization" in this indicator is intended to be inclusive of any community-level group that receives support from a USAID-funded program—either directly from the cooperating agency or through a subgrantee or another intermediary of the cooperating agency implementing the program.

The term "support" is intended to be widely inclusive of many forms of assistance for community-level organizations assisting orphans and vulnerable children. Forms of support for organizations caring for orphans and vulnerable children include training, technical assistance, financial assistance, material assistance, linkages to other organizations, and a host of other interventions. Each program is expected to consult with its USAID Mission to determine what constitutes "support" to community initiatives and organizations caring for orphans and vulnerable children in its own context. Community initiatives are central to providing long-term support to children. Therefore, criteria for "support" should consider a standard by which interventions are expected to strengthen community initiatives, producing an impact that will continue beyond a short time period. The criteria agreed to by the Mission and the cooperating agency should be specified when the program reports this indicator.

Each program is expected to develop basic quality standards for each form of support provided. These standards should be determined in collaboration with the USAID Mission and with partner organizations and communities. For example, the standard for providing "support" may range from giving a small one-time grant to the community organization to training in fundraising that enables the community organization to access ongoing funds. Ensuring that the agreed-upon standards are consistently met should be the joint responsibility of the program and its community partners. The standards developed, the methods of monitoring adherence to them, and the results of this monitoring should be documented and reported to the USAID Mission. The quality of the support provided to community initiatives/organizations may also be assessed by an external review during or shortly after the program period.

This indicator includes the community initiatives/organizations receiving support in a single fiscal year. The initiatives/organizations that continue to receive support in the following fiscal year should be counted as part of that fiscal year's indicator as well.

Disaggregated by: Not applicable
Frequency: Annual
Data source: Program reports

Strengths and Limitations
This indicator allows for calculation of the quantity of community initiatives and organizations that are receiving some form of support to care for orphans and vulnerable children. Because this indicator has no denominator, it does not report what percentage of all community initiatives and organizations caring for orphans and vulnerable children in the country, region, etc. are being supported by USAID-funded efforts.

This indicator does not capture the quality of the support received by the community groups. It is important to ensure that programs and their partners do not provide substandard support in their efforts to reach a high number of community initiatives and organizations. Thus it is critical that quality standards are devised, respected, and monitored. Nonetheless, a single quality standard applicable to all contexts cannot be imposed because practices and standards of support vary widely among countries and program areas. Devolving responsibility to Missions and programs for defining and monitoring quality of support acknowledges that country-level staff are best placed to determine and assess quality in their own national context.

Total number of programs for orphans and vulnerable children supported by USAID in FY __.

What it measures
This is a basic tabulation of the number of programs supported by USAID Missions in each fiscal year that benefit orphans and other vulnerable children in HIV/AIDS-affected areas.

How to measure it
USAID/Washington will calculate this indicator by adding the number of programs for orphans and vulnerable children reported by each Mission. The main challenge in compiling this indicator is determining what programs qualify as programs for orphans and vulnerable children.

Certainly, Missions should count all programs that are specifically intended to benefit orphans and other vulnerable children in HIV/AIDS-affected areas[7]. Missions may also include programs that are not specifically designed to benefit orphans and vulnerable children but do actually improve the well being of orphans and other vulnerable children. For example, a microfinance program directed to communities with a high proportion of orphans and other vulnerable children can be included if it can be shown that orphans and vulnerable children are benefiting from the economic strengthening that results from the program. If a Mission chooses to include programs that are not designed specifically to benefit orphans and vulnerable children, it is important that the Mission explains the rationale for the inclusion and the method or methods by which each program determines the number of beneficiaries who are orphans or other vulnerable children.

Disaggregated by: NA
Frequency: Annual
Data source: Program reports

Strengths and Limitations
While this indicator does allow for a calculation of the number of programs being implemented, it does not capture the variation in scale and scope of these programs. For example, a program that affects 20,000 orphans and vulnerable children counts the same as a program that affects 200. In addition, there may be different levels of capacity for data collection of the indicator among Missions, different levels of capacity for data collection among Missions and cooperating agencies/CSs, and different levels of resources available to support this data collection.

This indicator, reflecting Mission-supported activities focusing on orphans and vulnerable children, has been used as the basis for the document, *USAID Project Profiles: Children Affected by HIV/AIDS.* The

[7] Missions are required to count all programs funded using the CSD/CSH emphasis area codes HKID and VKID (FY2001 only), as well as all programs to benefit AIDS-affected children that are funded using the ORPH code. For a full discussion of these codes, see *Guidance on the Use of USAID Funding for programs focusing on orphans and other children and adolescents made vulnerable by HIV/AIDS.*

document, which is being updated on a regular basis, offers a comprehensive overview of USAID activities that support children affected by HIV/AIDS. The information provided in the document includes program objectives, accomplishments, materials and tools developed, and contact information. It has been used by partners within USAID and external to USAID, including Congress, donors, implementing organizations, and other potential sources of support and collaborative action. The document can be accessed at the following website: <http://www.usaid.gov/pop_health/aids/Publications/index.html>

OPTIONAL OVC PROGRAM SECTORAL INDICATORS FOR USE BY MISSIONS AND PROGRAMS

Sector	Indicator[1]	Types of Interventions[2]	Possible Quality Assurance Standards[3]
Education	# of OVC benefiting from[4] improved access to education in FY __	Liaise with school officials to increase access through fee reduction, school schedule modification, etc; liaise with caregivers; teacher training to increase recognition of the need for emotional support to OVC, etc.	OVC returned to school stay for at least __ months/years; Proportion of OVC attending school increases to more closely resemble the proportion of non-OVC school attendance, etc.
Health care	# of OVC benefiting from improved health care in FY __	Training of home-based caregivers to address the health needs of children in the household; liaise with health officials to increase access to health care for OVC; training and group discussions about HIV/AIDS/STDs; training and support of youth caring for ill parents, etc.	Children living in households with PLWHA receive medical care as needed; immunization among OVC is similar in proportion to immunization rate among non-OVC; reduction of behaviors that place OVC at risk of becoming HIV-infected; youth caring for ill parents are practicing procedures that do not compromise their own health, etc.
Psychosocial care	# of OVC benefiting from psychosocial support in FY __	Regular visits to OVC by concerned community members; visits to families and caregivers to provide counseling; community-wide stigma reduction activities; structured recreation or sports activities that include OVC, peer support group formation; etc.	Visits to OVC and families are made at least "X number" of times per month; reduced discrimination experienced by OVC; support groups meet "X number" of times per month and function effectively; etc.
Protection	# of OVC benefiting from protection activities in FY __	Support of community-based monitoring of vulnerable children; training community groups in protection practices; support of community advocacy with local authorities for enforcement of child protection regulations, etc.	Community groups effectively intervene in cases of abuse/exploitation/neglect by counseling caregivers, by finding an alternative placement for the child, by calling in government authorities, or other means; the solution endures and the child's well-being is increased; incidence of abuse decrease; incidence of property grabbing decrease, etc.
Agriculture/ Nutrition	# of OVC benefiting from sustainable nutritional/agricultural assistance in FY __ # of OVC benefiting from	Provision of tools, seeds, and other agricultural inputs; provision of training and agricultural extension services to households	Agricultural outputs increase following provision of assistance, extension services are relevant and effective, etc. Food aid reaches highly

	food aid in FY __	caring for OVC, etc. Provision of food aid to vulnerable households; school feeding; etc.	vulnerable children, nutritional status of OVC improves following provision of food aid, etc.
Economic Strengthening	# of OVC benefiting from assistance to become more economically self-supporting in FY __ # of OVC in households benefiting from assistance to become more economically self-supporting in FY __	*For OVC directly:* vocational training, apprenticeships, microfinance, etc. *For households caring for OVC:* microfinance, grants of capital, savings services, market linkages, etc.	% of OVC trained who are earning income 1 year after end of training, % of OVC trained who report satisfaction with training, etc. % of households that report increased capacity to pay for school, health, or other key expenses for OVC following intervention, etc.
Housing/ Shelter	# of OVC benefiting from assistance to improve their housing/shelter situation in FY __	Arrangement of formal or informal foster care, assistance with repair of housing, provision of temporary shelter for street children, etc.	Foster care environments are safe and supportive, housing repairs are durable, temporary shelter is safe and secure, children are able to live together with their siblings, etc.

[1] At the end of each indicator, the phrase "through action supported by USAID" is implied.
[2] These interventions may be implemented directly by a CA/CS, by a subgrantee of a CA/CS, or by organizational and community partners that a CA/CS strengthens.
[3] These standards are intended only as illustrative examples. The exact quality standards and the process for assuring quality should be negotiated and agreed on by the mission and the CA/CS, preferably in consultation with partner organizations and communities. In most instances, the CA's/CS's own means of assuring quality should be supplemented by an external review at some point during or shortly after the program period.
[4] The phrase "benefiting from" is used to emphasize that USAID's OVC programs should seek to benefit vulnerable children, not just deliver services to them. Before determining the number of OVC *benefiting*, it will be necessary to calculate the number of OVC *receiving assistance* in each of these sectors. Missions and programs should use the number of OVC *receiving assistance* in each sector to calculate the overall indicator "# of orphans and other vulnerable children receiving care/support in FY __". As discussed in #3 above, programs should work with partner organizations and communities and with the mission to develop and apply quality standards that determine what constitutes "benefiting."

[TAA1]DefineCS.

MULTISECTORAL HIV/AIDS PROGRAMS

ILLUSTRATIVE ACTIVITIES FOR MULTISECTORAL HIV/AIDS PROGRAMS

Multisectoral activities can be sectoral or intersectoral. The sectoral activities consist of those undertaken by each sector to address HIV/AIDS issues relevant to the sector. Intersectoral activities are those in which different sectors work together to achieve a common objective such as care and support, capacity building and youth. This section provides illustrative sectoral activities, as the intersectoral activities are covered by care and support and other monitoring and evaluation subgroups.

Education:

- Assessing the impact of HIV/AIDS on the internal capacity of the education sector and externally on the students and their learning capacity using the education toolkit;
- Generating commitment among concerned officials to take speedy actions;
- Preparing an action plan to reduce the impact on the sector and on the delivery of education;
- Implementing and evaluating the action plan over next five years with particular focus on:
    - Strengthening the implementation capacity in the light of HIV/AIDS especially training of teachers and better use of financial resources;
    - Protecting teachers and students from the spread of HIV/AIDS;
    - Providing basic education and social and psychological support to vulnerable groups such as orphans, particularly girls, through the school system;
    - Including life skills and HIV/AIDS education in school curricula;
    - Strengthening schools to play multiple roles in prevention and care for the community;
    - Adopting different innovative means of delivering education to children in affected areas; and
    - Mobilizing communities to provide education, particularly in high-risk areas.

Health:

- Assessing the impact of HIV/AIDS on the health systems and the ability to deliver basic services using health toolkit;
- Generation of commitment at each level of administration to undertake measures to strengthen the health sector and implement appropriate responses;
- Developing a response to the epidemic and implementing key actions during the next five years particularly:
    - Rapid expansion of health education;
    - Training of health manpower to replace lost workers;
    - Protection of health workers and clients from the spread of the disease;
    - In-service training of health manpower;
    - Provision of gloves and needles etc.;
    - Treatment for sexually transmitted diseases;
    - Voluntary counseling and testing;
    - Prevention of mother to child transmission;
    - Blood safety; and
    - Availability of drugs for treatment of the disease and other infections on the basis of defined policies that create equitable access to drugs and services.

Democracy and Governance:

- Strengthening national political commitment to fighting the disease;
- Implementing civil service reforms to improve the availability of skilled manpower;
- Strengthening civil society and community mobilization;
- Working with local and national leaders to reduce stigma;

- Strengthening management capacity and governance and financial management of key ministries such as health and education;
- Encouraging and facilitating decentralization and community empowerment;
- Improving human rights and legal frameworks, particularly those for women, people living with HIV/AIDS; and vulnerable children; and
- Educating and sensitizing judicial systems on HIV, human rights, and stigma.

Agriculture and Natural Resource Management:

- Assessing the impact of HIV/AIDS on agriculture and natural resource management sectors using the toolkits;
- Generating commitment among policy makers and implementers;
- Developing and implementing an adequate response to HIV/AIDS such as
    - Sensitizing and protecting the workers in the field;
    - Using outreach mechanisms to convey the prevention messages;
    - Training additional workers to mitigate the impact on manpower;
    - Helping mobilize and organize communities to undertake mitigation and prevention measures;
    - Changing cropping pattern and production practices for communities severely affected by HIV/AIDS; and
    - Mapping through geographic information systems the high-risk areas for prioritizing HIV/AIDS program implementation.

Microenterprise and Income Generation:

- Assessing the impact of HIV on microenterprise and microfinance programs;
- Determining an action plan to respond to the impact;
- Providing HIV education to those working in NGOs that support income generation and microenterprise; and
- Adapting microenterprise and income-generation programs to meet the needs of those affected by HIV/AIDS.

Multisectoral HIV/AIDS Programs

Global Target	**Method of Data Collection**	**Frequency**
Development, integration and implementation of multisectoral national strategic plan (UNGASS)	National Composite Index survey	Annual
Core Required Indicator	**Method of Data Collection**	**Frequency**
Number of sectors with an HIV/AIDS impact assessment completed and disseminated to stakeholders	Special Study	1st Year
Additional Indicators (Sector Specific)	**Method of Data Collection**	**Frequency**

Democracy & Governance		
• Number of CBOs/NGOs including protection of human rights of persons living with HIV/AIDS in their mandate	National reports	Annual
• National laws protecting human rights of persons living with HIV/AIDS enacted and/or disseminated	National Composite Index survey	Annual
• Number of human rights violations filed for discrimination because of HIV	National reports	Annual
• Laws enacted/enforced to protect the rights of women and orphans to own and inherit property, including land	National Composite Index Survey	Annual
• Number of widows/orphans in selected communities who have retained land ownership	Special Study	Annual (?)
Education		
• Ministry of Education strategic plan and operational matrix for integrating HIV/AIDS in Ministry of Education completed and disseminated to stakeholders	MoE reports	Annual
• Number of activities in operational matrix supported by Mission (through technical assistance or direct funding)	Mission Reports	Annual
• Number and percent of working teachers and teacher trainees aware of professional policies on codes of conduct	Special study	1st Year
• Number and percent of major teacher training institutions providing HIV/AIDS prevention and skills building training to protect teacher trainees	MoE Reports	Annual
• Number and percent of major teacher training institutions preparing teacher trainees to teach family skills course	MoE Reports	Annual
• Number of communities/school districts in selected areas starting innovative approaches to teach a basic educational curriculum to out of school youth	MoE Reports	Annual
• Number of orpahns and vulnerable children benefiting from improved access to education	MoE Reports/Special Studies	Annual
Health		
• Effective health information system set up/updated (by Ministry of Health) for reporting on HIV/AIDS and other priority health needs (e.g., prevalence, financing, human resources, utilization expenditures)	MoH Reports	Annual
• Formal assessment of commodities needed for projected HIV/AIDS caseload developed for stakeholders	Special Study	1st Year
• Policies to increase access of persons living with HIV/AIDS to health care services implemented	National Composite Index survey	Annual
• Policies to increase access of population to prevention and VCT services implemented	National Composite Index survey	Annual
Economic Growth / Microenterprise		
• Sectoral assessment of HIV/AIDS impact on trade completed by Ministry of Trade and disseminated to stakeholders	MoT Reports	Annual
• Up to five new microenterprise or micro-finance interventions for populations affected by HIV/AIDS implemented per year	CA/IA reports	Annual
• At least one new microenterprise or microfinance intervention for populations affected by HIV/AIDS implemented per year	CA/IA reports	Annual
• Percent of microfinance partners funded by USAID providing any HIV prevention education to clients or employees directly or through linkages	IA Reports	Annual
Agriculture and Natural Resource Management		
• Stocktaking/assessment of HIV/AIDS on agriculture sector completed	MoA Reports	Annual
• Mission strategy to respond to HIV/AIDS impact on agricultural sector completed	Country Strategic Plan	1st Year

• Assessment of HIV/AIDS impact on USAID-funded projects conducted and disseminated to stakeholders • National laws/policies/regulations protecting widows right to own/inherit property enacted/or enforced • HIV/AIDS and agriculture training conducted for the strategic objective team • Percent of agriculture strategic objective partners including HIV prevention education, directly or through linkage with health organizations, to clients and staff • Laws/policies/regulations protecting widows' rights to own/inherit land/property enacted and/or enforced	Special Study National Composite Index survey Mission Reports IA Reports	1st Year Annual 1st Year Annual

Core Indicator

Number of sectors with an HIV/AIDS impact assessment completed and disseminated to stakeholders

What it measures
While this generic indicator is primarily intended to measure the status of programming in each sector in response to the impact HIV/AIDS could have in that sector, it will also contribute to measuring 1) the number of current programs that are already responding to the impact of HIV/AIDS in that sector, and 2) the number of new programs that will be designed to mitigate the impact of HIV/AIDS in that sector.

The assessment of the impact of HIV/AIDS on the development of each sector will allow for a retrospective analysis of which programs have already been addressing or have been designed to address the impact of HIV/AIDS in that sector.

How to measure it

Overall: *Numerator:* Number of sector assessments completed & disseminated to stakeholders
Denominator: Total number of USAID-funded sectors in country

Sector (a): *Numerator:* Number of current programs addressing impact of HIV/AIDS
Denominator: Total number of programs in sector

Sector (b): *Numerator:* Number of new programs designed to address impact of HIV/AIDS
Denominator: Total number of new programs designed in sector

Frequency: **Overall indicator** first year and when new CSP is designed
Sector indicator (a) first year and annually
Sector indicator (b) first year and annually

Source: Special study in first year and when new CSP is designed
Annual reports

HUMAN CAPACITY DEVELOPMENT

Problem Statement

There is a demonstrated, worldwide shortage of personnel educated and trained to deliver the 18 sets of care and prevention activities required for scaling up and implementing HIV/AIDS programs. The shortfall is found among all categories and levels of health care workers, educators, counselors, home care providers and HIV/AIDS program planners, managers, and evaluators, among others. Several studies in sub-Saharan Africa indicate that certain health personnel working in a variety of health service capacities have fearful attitudes, less than optimal knowledge and skills for managing HIV/AIDS cases, and unsatisfactory practices that compromise quality of care and their own safety.

The capacities of education and training institutions and in-service agencies therefore need to be strengthened and expanded in order to produce additional skilled personnel and to maintain continuing learning support for diverse categories of personnel. This human capacity development need must be met in both preservice and in-service training arenas as well as in the public and private sectors.

There is need to address policy issues that influence human resource development from the viewpoint of the need to strengthen systems. This requires adequate information on the current status of human resource capacities and service needs. Such information initially could be provided by baseline assessments, followed by additional reviews using the identified monitoring and evaluation indicators.

Another issue is that we are behind in identifying and adapting at regional or national levels a set of core indicators that include human capacity development indicators. We likewise lack the capability to use them.

Human Capacity Objectives

Development of human capacities is particularly important to the effectiveness of USAID's expanded response efforts. Of importance to success is the capacity of in-country personnel of all public and private sector categories to plan, manage, and evaluate HIV/AIDS care and prevention programs and to deliver high-quality services in these programs. There needs to be continuing supply of fresh personnel for these purposes. For purposes of this component in assessing results in HIV/AIDS programs, we focus on human capacity development. We expand the category from just health personnel to multiple categories of persons providing prevention, care, planning, management, and monitoring and evaluation services in HIV/AIDS programs.

Capacity is generally defined as "the ability to carry out stated objectives." It is also described as a process and an outcome, developing in stages and across multiple dimensions. In the health sector, for example, capacity is required at four levels: health system, organizational, health personnel, and individual/community. In examining the first three levels, we should note whether capacities pertain to a national, regional, or district coverage.

Essential to human capacity development is the assumption that capacity is linked to performance. Thus, we can define human capacity as the ability of a person to meet objectives for delivering the services needed in HIV/AIDS programs. These services include but are not limited to raising awareness, advocacy, networking, resource solicitation, policy making, management, preventive services, clinical care, home care, logistics, and monitoring and evaluation services.

For persons to perform effectively and contribute to overall program and system performance in all these components there must be basic professional education and training tailored specifically to participants acquiring the specific knowledge and skills needed. We also note that human capacity building is a continual process of performance improvement.

The general objectives for human capacity development in this context stated in basic terms are:

- Concise descriptions and definitions of the knowledge and skills required for each category of HIV/AIDS service provider according to which education and training courses are designed;
- Established courses at schools, institutes, agencies, and centers with all necessary course curricula, materials, manuals, training aids, readings, and associated items enabling service providers to acquire necessary knowledge and skills;
- Corps of trainers and facilitators to deliver these courses with necessary institutionalized capabilities and resources to sustain courses; and
- Functioning monitoring and evaluation procedures and systems to determine effectiveness of courses. Effectiveness should be gauged in terms of services being delivered, number of trained personnel on the job, the quality of their service provision, and feedback regarding job performance that leads back to beneficial modifications in course content and methodologies as needed.

Illustrative activities

- Inventory-taking of current courses and training events that produce knowledgeable and skilled service providers and that can be replicated;
- Defining precise knowledge and skills needed for all categories of service providers;
- Calculating the number of personnel in all categories needed to run HIV/AIDS programs;
- Developing courses and training events to produce the number of personnel required in each category to meet program needs;
- Designing and implementing processes, procedures, and interventions aimed at retaining health personnel trained to provide services; and
- Developing monitoring, evaluation, and follow-up systems to assess the effectiveness of capacity-building efforts and to provide feedback to improve and sustain capacity building.

Illustrative indicators

Existing indicators to measure the effects of human capacity building in health and population programs vary enormously. Methodological challenges exist related to measurement tools and indicators. There is relatively little empirical evidence that indicates which elements of capacity building are critical to performance. The choice of indicators remains therefore somewhat experimental. Another issue is the lack of experience in monitoring changes in capacity over time.

Nonetheless, we take cues to a certain extent from clinical care, where there are some “gold standards” against which to measure aspects of health personnel capacity required for effective and sustainable health service delivery or health system performance.

The following list of indicators represents those that can be reasonably measured without undue expenditure of time and resources.

Human Capacity Development

Optional Indicators	Method of Data Collection	Frequency
• Number and percent of medical and paramedical training institutions providing training in HIV diagnosis, care, support. and treatment	Institution report review, 5-year survey	Initial baseline, then every 5 years
• Number of HIV/AIDS education and training courses with associated training materials developed, tested, and available according to local and national standards.	Institution report review Ministry of Education reports	Annual
• Number of persons trained in HIV/AIDS diagnosis, care, support, and treatment in the past 12 months	Report review MoH	Annual
▪ Number of persons delivering HIV/AIDS interventions and services for which they were specifically trained in formal courses	Facility survey	Every 2–4 years
▪ Number of service delivery personnel who have left their HIV/AIDS service delivery responsibilities in the past 12 months in the public sector	MoH	Annual

OPTIONAL INDICATORS

Number and percent of medical and paramedical training institutions providing training in HIV diagnosis, care, support, and treatment

What it measures
This indicator examines whether the natural history of HIV, HIV health education, counseling, testing, diagnosis, and management of common opportunistic infections, psychosocial care and support, pediatric AIDS care, prevention of mother-to-child transmission, and antiretroviral therapy are included in training programs at schools of medicine, nursing, midwifery, public health, health administration, and other allied health institutions.

Allied health institutions are defined as those offering training to professionals or staff in nursing, psychosocial services, social work, case management, counseling, midwifery, laboratory technology, clinical health, pharmacy, and health planning, management, and administration.

The indicator also measures the number of education and training settings that are stable, permanent, and generally likely to provide such formal education and training courses in accord with policies, planning, and management of the health care education and delivery systems, both public and private, at all key levels.

How to measure it
The information to measure this indicator is found through a review of institution reports.

Numerator:	Number of medical and paramedical training institutions providing training in HIV diagnosis, care, support, and treatment
Denominator:	Total number of medical and paramedical training institutions
Disaggregated by:	Public and private sectors, technical areas (i.e., prevention, CST, VCT, MTCT, OVC), and topics of planning, management, administration, and financing of HIV/AIDS
Frequency:	Initial baseline survey and five-year survey
Data sources:	Records from institutions with formal courses in HIV/AIDS, Ministry of Education reports

Number of HIV/AIDS education and training courses with associated training materials developed, tested, and available

What it measures
This indicator measures the number of formally approved HIV/AIDS education and training courses with associated training materials developed, tested, and available according to local and national standards.

Education and training courses must be authorized by preservice and in-service institutions and agencies in both public and private sectors such as ministries of education (schools of medicine, public health, nursing, midwifery, allied health, etc.); ministries of health (in-service training, refresher courses, continuing medical education); other specialized training institutes on public administration, planning and management, social sector development, NGOs, and the military sector.

How to measure it
The information to measure this indicator is found through a review of institution reports.

Numerator: Number of courses with formally approved curricula and materials

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Denominator: Total number of courses that claim to train persons for HIV/AIDS work

Disaggregated by: Public and private sectors, technical areas (i.e., prevention, CST, VCT, MTCT, OVC), and topics of planning, management, administration and financing of HIV/AIDS, gender, national, local or district levels.
Frequency: Annual
Data sources: Schools of medicine, public health, nursing, midwifery, allied health, etc.; ministries of education for preservice training; ministries of health for in-service training, refresher courses, continuing medical education; other specialized training institutes in public administration, planning and management, social sector development, etc.; NGOs; and military sector.

Numbers of persons trained in HIV/AIDS diagnosis, care, support, and treatment in the past 12 months

What it measures
This indicator measures the number of individuals satisfactorily completing formal education and training courses authorized by preservice and in-service institutions and agencies in both public and private sectors such as ministries of education (schools of medicine, public health, nursing, midwifery, allied health, etc.); ministries of health (in-service training, refresher courses, continuing medical education); other specialized training institutes in public administration, planning and management, social sector development, etc.; NGOs; and military sector.

How to measure it
This indicator is measured by reviewing annual reports by the national HIV/AIDS coordinating body; reports of ministries of education and health; reports of other selected training institutions and NGOs.

Numerator: Number of persons who successfully completed training in approved HIV/AIDS courses in the past 12 months

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Denominator: Total number of persons who completed courses in health care delivery and management in the past 12 months

Disaggregated by: Type of course; by national or local/district level; by gender
Frequency: Annual
Data sources: Reports by national HIV/AIDS coordinating body, reports of ministries of education and health, reports of other selected training institutions, and NGOs

Number of persons delivering HIV/AIDS interventions and services for which they were specifically trained in formal courses

What it measures
This indicator measures the number of individuals with completed formal education and training courses who are delivering HIV/AIDS services for which they trained.

The formal education and training courses may be authorized by pre-service and in-service institutions and agencies in both public and private sector such as ministries of education (schools of medicine, public health, nursing, midwifery, allied health, etc.); ministries of health (in-service training, refresher courses, continuing medical education); other specialized training institutes on public administration, planning and management, social sector development, etc.; NGOs; and military sector.

How to measure it

This indicator is measured by reviewing annual reports by the national HIV/AIDS coordinating body; reports of ministries of education and health; reports of other selected training institutions and NGOs.

Numerator:	Number of persons formally trained for HIV/AIDS service delivery actually delivering services
Denominator:	Total number of persons formally trained for HIV/AIDS service delivery
Disaggregated by:	Type of services (i.e., prevention, care, treatment and support, VCT, MTCT, and OVC), planning, management, administration and financing of HIV/AIDS programs; national or local/district levels; gender
Frequency:	Annual
Data sources:	Reports by national HIV/AIDS coordinating body, reports of ministries of health, reports of other selected training institutions, and NGOs.

Number of service delivery personnel who have left their HIV/AIDS service delivery responsibilities in the past 12 months

What it measures
This indicator measures the number of trained HIV/AIDS service providers who no longer provide the HIV/AIDS services for which they were trained and the reasons for which they ceased this work.

How to measure it
This indicator is measured by reviewing annual reports by the national HIV/AIDS coordinating body; reports of ministries of education and health; reports of other selected training institutions, and NGOs.

$$\frac{\textit{Numerator:}\ \text{Number of persons formally trained for HIV/AIDS service delivery who ceased actually delivering services in public sector facilities in the past 12 months}}{\textit{Denominator:}\ \text{Total number of persons formally trained for HIV/AIDS service delivery actually delivering services in public sector facilities}}$$

Disaggregated by: Type of service personnel, by national or local/district level, by gender, and by reason for which they ceased this work.
Frequency: Annual
Data sources: Reports by national HIV/AIDS coordinating body, reports of ministries of education and health, reports of other selected training institutions, and NGOs.

STIGMA AND DISCRIMINATION

Stigma and Discrimination

Optional Indicators	Method of Data Collection	Frequency
Number or percent of programs or institutions (e.g., schools, workplaces) with policies/guidelines to protect against discrimination	Program reports/observation, and document review	Annual
Number or percent of health care facilities that protect against discrimination (e.g., HIV tests with informed consent, persons living with HIV/AIDS not segregated)	Health facility survey, observation of facility	Every 2–3 years
Percent of health care providers with accepting attitudes toward people living with HIV/AIDS	Health provider survey, observation of client provider interaction, mystery client	Every 2–3 years
Percent of reported experiences or fear of stigma and discrimination among persons living with HIV/AIDS and those affected by AIDS (in catchment area of program)	Special population survey in catchment area of program	Every 2–3 years
▪ Number of people in the general population who have been sensitized by antistigma and discrimination messages and programs ▪ Number of people living with HIV/AIDS who have been referred to stigma-reduction activities (e.g., support groups for persons living with HIV/AIDS) ▪ Percent of people who would refuse casual contact with a person living with HIV/AIDS ▪ Percent of people who judge or blame persons living with HIV/AIDS for their illness ▪ Percent of people who would feel shame if they associated with a person living with HIV/AIDS ▪ Percent of people who fear disclosing HIV status because of negative reaction ▪ Percent of people who support discrimination toward people living with HIV/AIDS ▪ Percent of reported experiences or fear of stigma among persons living with HIV/AIDS and those affected by AIDS ▪ Percent of persons living with HIV/AIDS who have disclosed their serostatus to anyone ▪ Percent of persons living with HIV/AIDS who would be willing to or plan to disclose serostatus	Program reports DHS/household surveys Special survey for persons living with HIV/AIDS, for those affected by AIDS, or both	Annual Every 2–3 years Every 2–3 years

▪ Percent of people knowing of discrimination against persons living with HIV/AIDS ▪ Percent of people expressing willingness to discriminate against persons living with HIV/AIDS ▪ Percent of people knowledgeable of laws/policies against discrimination	DHS/household surveys	Every 2–3 years
▪ Country has legislation, regulations, or other measures to eliminate all forms of discrimination against persons living with HIV/AIDS (UNGASS) ▪ Country has a national legal and policy framework that protects the rights of workers living with and affected by HIV/AIDS in the workplace (UNGASS)	National-level report and document review	Annual
▪ Number or percent of institutions/facilities enforcing policies guaranteeing access/rights to persons living with HIV/AIDS ▪ Percent of people in institutions or facilities (e.g., managers, health care workers) who are aware of policies guaranteeing access or rights to persons living with HIV/AIDS	Facility-based survey/program reports	Every 2–3 years
▪ Percent of people in institutions or facilities (e.g., managers, health care workers) willing to report discrimination against persons living with HIV/AIDS ▪ Percent of persons living with HIV/AIDS aware of antidiscrimination policies ▪ Percent of reported experiences or fear of discrimination among persons living with HIV/AIDS and people affected by AIDS (e.g., denied care, fired from job)	Special surveys of persons living with HIV/AIDS	Every 2–3 years

*The additional indicators are optional and have been developed and are being made operational for future field-testing and use by USAID and partners.

Stigma is literally a mark or blemish on someone or something, with the mark or suspicion of HIV having negative connotations in most societies. Discrimination is defined in terms of legal and human rights issues.

Stigma has many roots, among them the association of the disease in the public eye with margin groups, such as homosexuals, drug injectors, and sex workers, and with inappropriate behavior or wrongdoing such as promiscuity. HIV is far more heavily stigmatized than other sexually transmitted infections, or hepatitis B or C, which share many modes of transmission. This stigma is institutionalized, resulting in open discrimination in employment, schooling, or access to health care services, because those affected (or the people close to them) are infected with HIV.

Program Goals

Stigma and discrimination are of concern to AIDS programs for two main reasons: they can make life unbearable for those who live with the disease and they affect prevention and care efforts. People who have been exposed to HIV through their behavior or that of their partner may be unwilling to be tested or to change their behavior in any way for fear of being suspected of being infected with HIV. If they are indeed infected, they may continue to spread the virus and will not be able to access adequate care. For example, a pregnant woman who knows she is HIV-positive but feels forced to breastfeed her child for fear that bottle feeding will brand her as infected and lead to her being thrown out of the family.

Sexual behavior that carries a high risk of HIV transmission is often a survival strategy for people with no access to less dangerous ways to secure their living. If people with HIV or their families are denied access to jobs, education, or basic services, they may resort to survival strategies that further fuel the epidemic.

Programs aim to combat active discrimination by changing laws to support those living with HIV and AIDS and by ensuring that those laws are enforced. They seek to change attitudes toward infected people and their families. More supportive attitudes should translate into more supportive behavior, transforming a hostile world into one that is compassionate and constructive. They seek to break the silence surrounding the disease, partly by actively involving people living with HIV and their communities in an active response. It is hoped that more open discussion will reduce the fears and misconceptions that reinforce risky behavior.

Measurement Challenges

Stigma and discrimination, but especially the former is among the most difficult aspects of the epidemic to quantify. It is perhaps for this reason that many prevention and care programs have the reduction of stigma and the fostering of more supportive attitudes as a stated objective, but virtually none has developed a reliable way of measuring this most intangible of phenomena. In the first place, no clear definitions exist of stigma or the qualities that characterize it. Is it even possible to measure something that has not been clearly defined?

While some stigmatizing attitudes and discriminatory practices are all too obvious, others remain largely hidden. There is no clear relationship between attitudes and behavior in this context. What people actually do in the face of something as frightening as AIDS may well differ from what they say they would do, and the discrepancy seems to run in different directions. Some studies have found, for example, that people expressing very negative attitudes to those infected with HIV actually provide supportive care for an HIV-infected relative in their own home. To the contrary, some people who deny any negative attitudes toward people with HIV actively discriminate against them in specific settings, such as the provision of health care.

Interventions designed to reduce discriminatory attitudes may have a more rapid or profound effect on reported attitudes than on the embedded attitudes that drive an individual's behavior. Decades of human rights campaigning in the United States have, for instance, greatly reduced the proportion of people who openly admit to being racially prejudiced. Whether this change in stated attitudes is reflected in a similarly large reduction in active discrimination in practice is open to doubt.

To complicate matters still further, active discrimination is sometimes difficult to discern. It can take highly visible forms, such as being fired from a job. But it can also be noticed in the failure to provide services available to other members of society or even the absence of compassion and supportive advice from church or community leaders.

It is difficult to collect information about behavior toward those infected with HIV. Partly because of stigma itself, the HIV status of people who are in fact infected is rarely openly acknowledged, even within their own families. Therefore, most questions that attempt to measure stigma focus on hypothetical situations, such as the willingness to care for a relative with AIDS or beliefs about whether people with HIV should be permitted to continue working with others. It is not clear to what extent hypothetical willingness to care for a sick family member is matched in practice, or indeed, to what extent it is a useful indicator of social stigma. Other hypothetical questions, such as a willingness to be tested for HIV, have been shown to be poor predictors of actual behavior, possibly because of the magnitude of social stigma. However, for lack of better predictors, hypothetical questions about a person's attitude are likely to remain central to attempts to track changes in negative attitudes toward people with HIV.

Studies in several countries suggest that the stigma attached to being infected with HIV vary for men and women. Respondents of both sexes are far more likely to express stigmatizing or disapproving attitudes toward women living with HIV than toward men. To capture this difference, questions (whether or not they are hypothetical) should be asked and analyzed separately about situations relating to infected women and to infected men.

Measures of discrimination have tended to be of the yes/no variety, for instance, "Does legislation exist to protect against discrimination?" In some measures, there is also an attempt to judge whether or not the legislation is enforced. This may be useful in identifying important gaps and areas for program effort. It is of limited use, however, in the regular monitoring and evaluation of national AIDS programs. Composite indicators of these yes/no questions are almost impossible to interpret. A gain in passing legislation in one area may be counteracted by a backsliding in enforcement in another. It is noted that the AIDS Program Effort Index (API), a composite index designed to monitor political commitment and program effort in the areas of HIV prevention and AIDS care, will partly measure the extent to which the legal system protects the human rights of HIV-infected persons. Components of the API include human rights and the legal and regulatory environment.

OPTIONAL INDICATORS

Number or percent of programs or institutions with policies/guidelines to protect against discrimination

What it measures
This indicator measures the number or percent of programs or institutions that have policies, guidelines, or both to protect the program's staff, clients, or patients against discrimination.

This indicator is appropriate for all programs.

How to measure it
This indicator is designed to be integrated into the monitoring and evaluation of any HIV/AIDS program and will be measured by program documents that describe the policies or guidelines that protect against HIV/AIDS related discrimination. This indicator could be used with a number of different types of programs and institutions supported by USAID in a particular country. A program could include orphans and vulnerable children, mother-to-child transmission, home-based care and support, voluntary counseling and testing, etc. Institutions could include health care facilities such as hospitals or orphanages that receive USAID support to provide HIV/AIDS services.

To be counted as having a policy or guideline to protect against HIV/AIDS-related discrimination it must describe the rights of the individuals involved in the program or institution. This could include staff, clients, or patients. The rights should include privacy (e.g., informed consent, and confidentiality of records). Second, the policies and guidelines should state what recourse that individual has in case of discrimination.

The numerator includes the number of programs or institutions that have policies or guidelines to protect against HIV/AIDS-related discrimination.

The denominator (if available) will be the total number of programs or institutions that receive support from USAID for HIV/AIDS related activities.

Both the numerator and denominator will be taken from program reports, observation, and document review.

$$\frac{\textit{Numerator}: \text{ Number of programs or institutions that have policies or guidelines to protect against HIV/AIDS-related discrimination}}{\textit{Denominator}: \text{ The total number of programs or institutions that receive support from USAID for HIV/AIDS-related activities}}$$

Disaggregated by: Type of program (e.g., orphans and vulnerable children, prevention of mother-to-child transmission, home-based care, voluntary counseling and testing, etc.)
Frequency: Annual
Data source: Program documents that describe the policy or guideline

Number and percent of health care facilities that protect against discrimination

What it measures
This indicator measures the number and percent of health care facilities that have procedures in place to protect against discrimination.

This indicator is appropriate for all facility-based programs.

How to measure it
This indicator is designed to be integrated into the monitoring and evaluation of any health care facility–based HIV/AIDS program, including mother-to-child transmission, sexually transmitted infection treatment, care and support, voluntary counseling and testing, etc.

The following are possible items to be included in the facility survey:
- Care for persons living with HIV/AIDS is not denied or delayed, or they are not referred elsewhere for services available within the facility.
- Care for patients awaiting HIV tests results is not denied or delayed, or they are not referred elsewhere for services available within the facility.
- Persons living with HIV/AIDS are not segregated or isolated.
- Care for persons living with HIV/AIDS is of the same quality as the care provided to other patients.
- Staff training and policies enforce the above.

The numerator includes the number of health care facilities that have procedures in place to protect against HIV/AIDS-related discrimination.

The denominator (if available) will be the total number of health care facilities that receive support from USAID for HIV/AIDS-related activities.

$$\frac{\textit{Numerator}: \text{ Number of health care facilities that have procedures in place to protect against HIV/AIDS-related discrimination}}{\textit{Denominator}: \text{ The total number of health care facilities that receive support from USAID for HIV/AIDS-related activities}}$$

Disaggregated by: Type and level of facility (e.g., hospital and clinic)
Frequency: Every 2–3 years
Data source: Health facility survey, observation of facility

Percent of health care providers with accepting attitudes toward people living with HIV/AIDS

What it measures
This indicator measures health care providers' attitudes toward those living with HIV and AIDS.

How to measure it
This indicator is designed to be integrated into the monitoring and evaluation of programs at health facilities that address HIV/AIDS and will be measured by health provider surveys. These surveys can be administered to any type of health care provider, including physicians, nurses, counselors, technicians, and assistants. It is recommended that these surveys be complemented by other sources of data, especially observation of client-provider interaction, such as through the use of "mystery clients."

There are multiple conceptual domains within this indicator and questions should address all of the relevant domains. Domains include 1) whether providers will provide care to persons living with HIV/AIDS, 2) whether providers fear casual contact with persons living with HIV/AIDS, and 3) whether providers believe persons living with HIV/AIDS are to blame for their illness. Examples of questions are provided below. Many of these questions are still in development, and additional work to pretest and validate specific questions is needed.

The following are possible items to be included in the provider survey:

- I would feel uncomfortable shaking the hands of a person living with HIV/AIDS.
- I would feel uncomfortable treating a person living with HIV/AIDS.
- I would feel uncomfortable sharing a plate of food with a person living with HIV/AIDS.
- Persons living with HIV/AIDS should be referred to other hospitals/health care facilities.
- Persons living with HIV/AIDS should be segregated or isolated.
- AIDS is a punishment by God for bad behavior.
- AIDS is a punishment for bad behavior.
- People with AIDS deserve help and support.
- I would be too ashamed to tell anyone that someone in my family had AIDS.
- If I had AIDS I would be ashamed to tell others.

These items can be asked either as statements that the respondent needs to agree or disagree with (strongly agree/agree, disagree/strongly disagree [always/sometimes/never]), or can be asked as questions that would require yes/no answers (with a possible third option of sometimes).

Both the numerator and denominator will be taken from the health provider survey.

Numerator:	Number of respondents who report accepting attitudes and deny intolerant attitudes toward people living with HIV and AIDS
Denominator:	Total number of respondents

Disaggregated by:	Type of health care provider (e.g., physician, nurse, and counselor)
Frequency:	Every 2–3 years
Data source:	Health provider survey. Also possible: observation of client provider interaction, mystery client

Percent of reported experiences or fear of stigma and discrimination among persons living with HIV/AIDS and those affected by AIDS

What it measures
This indicator measures experiences and fears of stigma and discrimination among people living with HIV/AIDS, those affected by AIDS, or both (e.g., family members of persons living with HIV/AIDS).

How to measure it
This indicator is designed to be integrated into the monitoring and evaluation of HIV/AIDS programs. It is appropriate for all types of programs, including orphans and vulnerable children, care and support, and mother-to-child transmission, among others. This survey is intended to measure fears and experiences of stigma and discrimination among program participants who live with HIV/AIDS, those affected by AIDS (e.g., family members of persons living with HIV/AIDS), or both. These surveys can be administered to people living with HIV or AIDS, by people affected by AIDS, or both. It is recommended that these surveys are complemented by other sources of data, especially qualitative interviews with persons living with HIV/AIDS and those affected by AIDS.

Multiple conceptual domains within this indicator and questions should address all of the relevant domains. Domains include 1) experience, fear of being refused access to program activities or services (e.g., health care, psycho-social counseling), or both; 2) experience, fear of lack of confidentiality or lack of consent, or both; experience, fear of being treated badly within the program (e.g., ridiculed, socially isolated), or both. Examples of questions are provided below. Many of these questions are still in development, and additional work to pretest and validate specific questions is needed.

The following are possible items to be included in the special population survey:
- I was refused care at X program (or I worry that this would happen).
- I was ridiculed because of my HIV status at X program (or I worry that this would happen).
- People avoid me at X program (or I worry that this would happen).
- My HIV test results were not kept confidential (or I worry that this would happen).
- I was given an HIV test without my permission (or I worry that this would happen).

These items can be asked either as statements that the respondent needs to agree or disagree with (strongly agree/agree, disagree/strongly disagree [always/sometimes/never]), or can be asked as questions that would require yes/no answers (with a possible third option of sometimes).

Numerator:	Number of respondents with experiences or fear of HIV-related stigma and discrimination
Denominator:	Total number of respondents
Disaggregated by:	When possible, whether person living with HIV, AIDS, or person affected by HIV/AIDS
Frequency:	Every 2–3 years
Data source:	Special population survey 1) in catchment area of program or 2) of clients of the program

Guidance on the New Monitoring & Reporting System Requirements for HIV/AIDS Programs
Reference: A) STATE 097109, B) STATE 208062, C) STATE 046436

I. Introduction

As part of USAID's "Expanded Response to HIV/AIDS," the Agency is establishing an improved, comprehensive system to routinely monitor its HIV/AIDS program world-wide, manage its resources and periodically report on the Agency's progress toward achieving its stated results. In the spring 2003, the Agency will issue its first annual report on our progress toward achieving our program objectives (see Section IV for a draft outline). This first report will cover FY02 activities which are focusing on establishing our expanded programs in the field and measuring baselines for our program targets. The full implementation of the Expanded Response program will begin in FY03 and the Agency will report on progress toward the achievement of its stated 2007 targets in this second annual report to be issued in spring, 2004. **While this system will require that some new information be gathered, many of the required indicators are already being collected by field missions and regional bureaus for the Annual Report. It is expected that any additional data will be collected in the same manner.**

All Rapid Scale-Up and Intensive Focus Country missions world-wide will need to work closely with USAID/W to establish this program monitoring and reporting system and issue annual reports on progress at the country level. In addition, all basic countries receiving $1 million or more per year in HIV/AIDS funding[8] beginning in FY 2002 will required to report annually using this guidance. Regional bureaus may require that other missions in their respective regions also follow these expanded reporting requirements. Please note that Regional Programs are also a priority for the Agency and will also be required to use this monitoring and reporting system to the extent it is appropriate and feasible. USAID/W will work closely with Regional Program staff to design monitoring and reporting systems appropriate to their objectives, targets and program priorities.

Missions with less than one million dollars per year in HIV/AIDS activities should also submit their annual reports using these guidelines to the extent that it is feasible. This additional information will enable the Agency to produce the most complete and comprehensive report on its efforts to reduce HIV transmission, treat those infected and affected and mitigate the social and economic effects of the pandemic as means to achieve our 2007 targets.

While USAID/W will provide some funding and technical assistance to support this improved data collection, analysis and reporting system, priority country missions and regional programs will also need to invest some of their increased budgets in this effort. Additional resources for

[8] The source/type of funds is irrelevant to the need to adhere to this guidance. This specifically includes funding through regional and central mechanisms.

data collection, analysis and reporting have been included in all Rapid Scale-Up and Intensive Focus (priority) country budgets for FY02 and FY03.

Under these guidelines, each participating mission will report the following:

- HIV seroprevalence levels (Source: national sentinel surveillance system/reported annually)
- Changes in sexual risk reduction behavior (Source: national survey/conducted every 3-5 years)
- Progress on implementing all six USAID program areas and population covered (Source: USAID program data/reported annually)

USAID will collaborate closely with CDC, other USG agencies, the host country government and other donors, including the World Bank/MAP program and the Global Fund to Fight AIDS, Tuberculosis and Malaria, to ensure that this monitoring and reporting system meets the reporting requirements, to the extent possible, of all participating agencies. This approach will allow each agency to fund a portion of the system at the country level and provide complementary technical assistance. Within this context, however, USAID's priority will be to establish an improved, comprehensive system to report on its Expanded Response program.

USAID/W will provide technical assistance to develop this monitoring and reporting system at the national level although in a few large countries like India, Nigeria, Brazil or Russia, USAID might also want to report at the sub-national level to capture the results of USAID programs. The Agency has also established a coordinated technical database at USAID headquarters in Washington where this information will be collected, analyzed and made available to all operating units. This technical database has three components: the sentinel surveillance database managed by the Bureau of the Census (BuCen), a national HIV/AIDS survey database managed by the Demographic & Health Survey (DHS+) Project, and the USAID Program Database managed by the Synergy Project.

II. Monitoring & Reporting System Components

This expanded, comprehensive system will collect and report information on three levels:

- **HIV Seroprevalence Level/National Level Impact**: USAID's most important health objective is to reduce the rate of HIV transmission. USAID, in collaboration with CDC, UNAIDS, WHO and others, will assist with the improvement and expansion of national sentinel surveillance systems. **By 2007,** the sentinel surveillance systems in all Rapid Scale-Up and Intensive Focus Countries must report annually on HIV seroprevalence to measure the overall effect on the pandemic of national HIV/AIDS prevention and mitigation programs. **Please note that while USAID cannot unilaterally be held accountable for changes in seroprevalence levels,** it is important that field missions support, to the extent feasible within USAID's limited "comparative advantage," the establishment and/or improvement of national sentinel surveillance systems.

Please also note that surveillance programs in low prevalence countries[9] should focus on groups who practice "high risk" behaviors such as STI patients, commercial sex workers (CSWs), injecting drug users (IDUs), and men-who-have-sex-with-men (MSM) while still monitoring the general population (usually measured with samples of antenatal women). In priority countries, USAID/W will provide technical assistance to missions to design these sentinel surveillance systems. This may also be appropriate for regional programs implementing cross border programs.

Standard Indicator: HIV seroprevalence levels for 15-24 year olds. (In addition, desegregated rates should be reported for 15-19 and 20-24 year olds.)

Definition: Percent of blood samples taken from women aged 15-24 that test positive for HIV during routine sentinel surveillance at selected antenatal clinics. (UNAIDS Handbook, Impact Indicator 1, page 134-135/ USAID Handbook, SSO 4.0.3 Indicator, pages 18-19)

Implementation Mechanisms: Since the development/improvement of national sentinel surveillance systems is not within USAID's "comparative advantage," USAID's collaborators (CDC, WHO, UNAIDS, EU) will need to provide most of the funding and technical assistance to achieve the **2007 target** of functioning surveillance systems in all Rapid Scale-Up and Intensive Focus countries. In cases where necessary improvements in the sentinel surveillance system will not be completely funded by another donor, the mission should include a plan to assist with the establishment of a sentinel surveillance system and/or the improvement of the existing system to report annually by the **2007 target date.**

- **National Level Changes in Sexual Risk Reduction Behavior:** Monitoring changes in risk-reduction behavior is important both to measure the success of and to improve the efficiency and coverage of national (and USAID) HIV/AIDS prevention and mitigation programs. The planning and/or implementation (depending upon whether such a survey has been completed recently) of regular (every 3-5 years), standardized national risk-reduction behavior surveys should begin **in 2003.** In some cases, where the epidemic is "low prevalence" or "concentrated," national level monitoring and reporting may focus principally on behavior change among key "high risk" sub-national populations. Please note that every 3-5 years is the minimum interval and more frequent surveys may be required to adequately monitor program progress – especially among groups that practice "high-risk" behaviors .

  Standard Indicator: Percentage of sexually active population with multiple partners **(Two indicators)**

  (1) For those in a "stable" (ie. married/living together) relationship: Higher risk sex in last year

[9] Low prevalence is defined as less than 1% HIV seroprevalence in the general population and less than 5% HIV seroprevalence in groups who practice "high risk" behaviors.

Definition: Proportion of respondents (15-49) who have had sex with a non-marital, non-cohabiting partner in the last 12 months of all respondents reporting sexual activity in the last 12 months (UNAIDS Handbook, page 81)

(2) For those not in a "stable" (ie. married/living together) relationship: Number of respondents (15-49) who have sex with more than one partner

Definition: Percent of respondents who are not in a "stable" relationship who have had sex with more than one partner in the last 12 months, of all people surveyed.

Standard Indicator: Condom use at last risky sex

Definition: The percent of respondents (15-49) who report using 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 year. (USAID Handbook, page 43)

Standard Indicator: Median age at first sex among young men and women (age of sexual debut)

Definition: The age by which one half of young men or young women aged 15-24 have had penetrative sex (median age), of all young people (15-24) surveyed. (UNAIDS Handbook, page 90)

Implementation Mechanisms: The Demographic & Health Survey (DHS+) Project and the CDC Reproductive Health Survey both implement national health surveys on a routine basis. Future DHS surveys should in most cases include an HIV/AIDS module. Alternately, MEASURE/Evaluation has developed a less expensive standard national risk reduction behavior survey that can be implemented by several organizations (DHS+, CDC, FHI/IMPACT) in place of a DHS. In many cases, depending upon the severity of the national epidemic and the focus of the USAID program, it will also be important to periodically implement subnational behavioral surveillance surveys (BSSs), which monitor changes in sexual risk reduction behavior in groups who practice "high-risk" behaviors. Behavioral surveillance surveys can be implemented by FHI/IMPACT or CDC.

Please note that it may not be appropriate to conduct a national, general population survey, such as the DHS, in countries with low HIV prevalence. In these countries, it may be most appropriate, instead, to survey groups who practice "high risk" behaviors such as STI patients, commercial sex workers (CSWs), injecting drug users (IDUs), and men-who-have-sex-with-men (MSM). **USAID/W is available to consult with field missions to determine the most appropriate type and frequency of surveys depending upon the stage of the epidemic and the mix of prevention/mitigation interventions supported by USAID and the national program.**

- **Progress on implementing all five USAID program areas and population covered:** Missions must report annually on progress toward implementing their HIV/AIDS strategy and increasing the proportion of the target population(s) covered by both prevention and

care/support programs. Much of this information is already routinely collected by program managers, but this system will have to be expanded to include the several new program areas in the Expanded Response such as orphans and other vulnerable children (OVC), prevention of mother-to-child transmission (PMTCT), care & support and multisectoral responses.

Standard Program Progress & Coverage Indicators (by Program Area):

Note: Missions will <u>only</u> be required to report in the areas where they support programs. But, whenever appropriate, Missions are <u>encouraged</u> to establish or expand programs in these areas.

<u>Condom Social Marketing Programs</u>

- Total condoms sold

<u>Sexually Transmitted Infections (STI) Services</u>

- Number of clients provided services at STI clinics
- Number of STI clinics with USAID assistance

<u>Orphans and vulnerable Children (OVC) Programs</u>

- Number of orphans and other vulnerable children receiving care/support
- Number of OVC programs with USAID assistance
- Number of community initiatives or community organizations receiving support to care for orphans and other vulnerable children

<u>Prevention of Mother-to-Child Transmission (PMTCT) Programs</u>

- Number of USAID-supported health facilities offering PMTCT services
- Number of women who attended PMTCT sites for a new pregnancy in the past 12 months
- Number of women with known HIV infection among those seen at PMTCT sites within the past year.
- Percentage of HIV-positive women attending antenatal clinics receiving a complete course of ARV therapy to prevent MTCT (UNGASS National Programme & Behavior Indicator #4)

<u>Care, Support, and Treatment Programs</u>

Community, Home-based and Clinic Care

- Number of individuals reached by community and home-based care programs in the past 12 months
- Number of USAID-assisted community and home-based care programs

VCT Programs

- Number of clients seen at VCT centers
- Number of VCT centers with USAID assistance

ARV Treatment Programs

- Number of HIV-infected persons receiving ARV treatment
- Number of USAID-assisted ARV treatment programs

Note: (1) The number of people served by each HIV/AIDS program is an estimate since some individuals will received services from more than one program and thus be "double-counted." (2) Additional indicators may be proposed.

Early in the Expanded Response, many missions and regional programs will be in the design rather than the implementation stage in some of these new program areas and will not be able to report on the numbers of people reached by these services. In these cases, the mission should provide a brief description of the status of its new programs and when it plans to begin service provision.

Implementation Mechanisms: USAID missions and bureaus can request additional technical assistance from USAID/W to establish an on-going system to collect this information and report on overall USAID program progress (number of programs and number of people served) at the country level. USAID/W has allocated limited additional resources to the Synergy Project, Measure/Evaluation and FHI/IMPACT to support these efforts.

Working with Partners. In many countries, USAID will collaborate closely with CDC, other USG agencies, the host country government, other donors, including the World Bank/MAP program and the Global Fund to fight AIDS, Tuberculosis and Malaria, and UNAIDS to ensure that, to the extent possible, this monitoring and reporting system meets the reporting requirements of all participating agencies. This approach will allow each agency to fund a portion of the system at the country level and provide complementary technical assistance. Within this context, however, USAID's priority will be to establish an improved, comprehensive system to report on its Expanded Response program.

References:
UNAIDS: National AIDS Programmes: A Guide to Monitoring and Evaluation (June, 2000)
USAID: Handbook of Indicators for HIV/AIDS/STI Programs (March, 2000)
United Nations General Assembly Special Session (UNGASS) on HIV/AIDS: Guidelines on Construction of Core Indicators (August, 2002)
USAID: Expanded Response Core Indicators for Monitoring and Reporting on HIV/AIDS Programs (October, 2002)

III. USAID/Washington Technical Database

The Agency has established a coordinated technical database at USAID/Washington which will be managed by the Office of HIV-AIDS, Bureau of Global Health (GH/OHA). This Database has three components, operated by the following organizations:

- The International Office of the Census Bureau (BuCen) **collects data from national sentinel surveillance systems and maintains the global HIV/AIDS Surveillance Database,** which UNAIDS uses to generate its regional and country-level seroprevalence estimates. BuCen both monitors the spread of HIV and models the potential effect of the AIDS pandemic on development.

- The Demographic and Health Survey (DHS+) Project **has established a database to collect national level HIV/AIDS sexual behavior survey data.** This survey database will also maintain information from surveys conducted by UNICEF, UNAIDS, CDC and WHO. The database provides an easily accessible comprehensive source of information on HIV/AIDS indicators from these surveys. The database allows the user to produce tables for specific countries by select background characteristics.

  The indicators included are derived from the both the USAID Handbook of Indicators for HIV/AIDS/STI Programs and the UNAIDS National AIDS Programmes: Guide to Monitoring and Evaluation. These guides provide standardized indicators for measuring the progress of HIV/AIDS programs. Some of the UN General Assembly Special Session on HIV/AIDS (UNGASS) indicators are also included here.

  Currently, the main sources of HIV/AIDS indicators in the database are the Demographic and Health Surveys (DHS), the UNICEF Multiple Indicator Cluster Surveys (MICS), the CDC Reproductive Health Surveys (RHS), the Sexual Behavior Surveys (SBS) designed by MEASURE/Evaluation, and the FHI/IMPACT Behavioral Surveillance Surveys (BSS). The database is designed to be global in scope, eventually covering all countries for which indicators are available. (Website: www.measuredhs.com/hivdata)

- The SYNERGY Project has developed a program database (PDB) to monitor the implementation of all Bureau of Global Health (GH) managed HIV/AIDS programs. The PDB is being expanded to also **collect USAID program progress & coverage data from field missions and regional programs**. This data will be collected for the first time from the FY02 mission reports (due early in FY03) and entered into this database.

Please note that information from these three technical databases is available to field missions and regional bureaus. (Point of contact: John Novak, 202-712-4814, jnovak@usaid.gov)

IV. Finalizing the Expanded Response M&E Indicators

The Expanded Response Handbook for Monitoring and Reporting on HIV/AIDS Programs which defines each of the new standard Expanded Response indicators and its recommended data collection/analysis methodology will be distributed to all missions and regional bureaus in October, 2002. Please note that a UNAIDS indicator working group has developed the definitions and data collection procedures for the 19 indicators to report global progress toward achieving the targets in the Declaration of Commitment approved by the United Nations General Assembly Special Session on HIV/AIDS. This guidance on UNGASS indicators will distributed to missions and regional bureaus along with the USAID Expanded Response Handbook. To the extent possible, the indicator definitions and data collection/analysis methodologies in the USAID Expanded Response Handbook will be compatible with these new UNGASS reporting standards as well as the Millennium Development Goals (MDGs), Goal 6, Target 7.for HIV/AIDS.

In summary, USAID is moving ahead to establish an improved system to report on the Agency's progress toward achieving our program objectives. While this system will require that a few new indicators be collected, **most of the required information is already being collected by USAID field missions.** This improved reporting system will ensure that select information from the field is routinely reported to USAID/Washington, thus enabling the Agency to better report on the progress of its global HIV/AIDS program.

For further information, contact: John Novak GH/HIV-AIDS (202) 712-4814
Harriett Destler GH/HIV-AIDS (202) 712-4908

V. Annual Report on USAID's HIV/AIDS Program (Draft)

GH and PPC, in consultation with senior Agency management and Congress, have developed a proposed outline for the Agency's Annual Report on HIV/AIDS. Missions are requested to submit the required information on their HIV/AIDS programs as a section of their Annual Report to PPC. Please note that there is no maximum page limit to the HIV/AIDS section of the Annual Report. USAID/W encourages missions and regional programs to provide sufficient information to adequately describe program progress and results including, at a minimum, the "core" indicators outlined in this guidance which correspond to the country or regional program.

This outline identifies the priority topics, principal data sources and suggested USAID Operating Unit (OU) reporting responsibilities. (See Appendix A) Our objective is to produce one comprehensive annual report on the Agency's HIV/AIDS program. In the design of this report we have tried to limit mission reporting requirements. **Please note that USAID/W encourages missions and regional programs, including those in Basic countries, to provide <u>additional</u> information on program progress and results beyond what is recommended in this outline. This additional reporting is <u>optional,</u> but it will enable the Agency to provide the most comprehensive program report possible.**

Appendix A

Annual Report on USAID's HIV/AIDS Program for Congress

Outline
(DRAFT)

Chapter One: Status of the Global Epidemic (Understanding What's Going On)

1.1 Introduction to Global Trends: prevalence levels, spread of the disease

1.2 Regional Trends: prevalence levels, spread of the disease in each region
Sub-Saharan Africa

B. Latin American/Caribbean

Asia/Near East
Europe & Eurasia

1.3 HIV/AIDS Burden on social-economic development and potential impacts:

Health effects such as: life expectancy, population growth, child mortality and socioeconomic effects such as decrease in labor supply, cost of AIDS care as portion of national budgets, resulting declines in GDP, socioeconomic consequences of a "lost generation"/orphans & vulnerable children (OVC), etc.

Data needs: This chapter will be based upon Bureau of the Census (BuCen) and UNAIDS data and reports.

Data Source: Mission Under the Expanded Response, missions will be requested to facilitate the annual reporting of national sentinel surveillance data to the BuCen. Presently, national governments do report this sentinel surveillance data directly to BuCen, but USAID should support the more routine and timely reporting of this data to the extent feasible.

BuCen will use these data to update the status of the epidemic at the national, regional and global levels – the data would then be used to produce the Annual UNAIDS Report on the Global HIV/AIDS Epidemic and also to produce the sections in the USAID report on global and regional trends (see above).

Chapter Two: The USAID Response in Preventing the Further Spread of HIV/AIDS (Reporting on Results)

2.1 Behavior Change/Safer Sex: This section will report on USAID's worldwide program to promote the "A,B,Cs": abstinence, be faithful to one partner and increase condom use. These programs are usually targeted at youth and "at risk" groups.

Data needs: Results from national (or regional) surveys on sexual risk reduction behavior – specifically condom use, number of sexual partners and age at first sex.

Data Source: Mission-supported surveys: The new Expanded Response M&E reporting guidance requires missions to implement a national (or regional) survey every 3-5 years to collect the data. Most countries are already implementing these surveys every 3-5 years.

2.2 Condom Social Marketing: This section would report on USAID's efforts to prevent the spread of HIV/AIDS through condom social marketing programs worldwide.

Data needs: USAID program/country and total condom sales

Data Source: USAID/Washington PSI/AIDSMark, the USAID-supported social marketing project, currently provides this information annually for almost all USAID funded programs. Missions are not required to report this information directly, although they have the option to provide additional information for use in the annual report.

2.3 Voluntary Counseling & Testing (VCT) services: This section will report on USAID's support for the provision of VCT services.

Data needs: (1) number of clients seen at USAID-assisted VCT centers and (2) number of USAID-assisted VCT centers.

Data source: Missions will be required to report these two indicators annually.

2.4 Sexually Transmitted Infection (STI) Services: This section will report on USAID's efforts to protect youth and other vulnerable groups from STIs.

Data needs: (1) number of clients seen at USAID-assisted STI clinics and (2) number of USAID-assisted STI clinics.

Data Source: Missions will be required to report this indicator annually.

2.5 Preventing Mother-to-Child-Transmission (PMTCT): This section will report on USAID's program to protect infants and young children from becoming infected with HIV from their mothers.

Data needs: (1) Number of USAID-supported health facilities offering PMTCT services (2) Number of USAID-supported health facilities offering PMTCT services (3) Number of women who attended PMTCT sites for a new pregnancy in the past 12 months (4) Number of women with known HIV infection among those seen at PMTCT sites within the past year (5) Percentage of HIV-positive women attending antenatal clinics receiving a complete course of ARV therapy to prevent MTCT (UNGASS National Programme & Behavior Indicator #4)

Data Source: Mission Missions will be required to report these indicators annually.

2.6 USAID Leadership and Response to the Pandemic in Improving Prevention & Care and Support Programs

This section will report on USAID's research results and best practices that will improve the design and implementation of Agency and other donor sponsored programs and maintain USAID's global leadership role.

Data Needs: Research results will be collected from the HORIZONS (operations research) Project and best practices will be collected from program evaluations and other sources within the Agency. Missions are not required to report this information directly although they have the option to provide additional information for use in the Agency's annual report.

Data Source: USAID/Washington Missions are not required to report this information directly although they have the option to provide additional information for use in the Agency's annual report.

Chapter Three: The USAID Response in Caring for the Sick and Those Most Vulnerable (Reporting on Results)

3.1 Community and Home-Based Care Programs: This section will report on USAID's efforts to provide care & support to HIV-infected people and their families.

Data needs: (1) Number of individuals served by community and home-based care programs assisted by USAID and (2) number of USAID-assisted community and home-based care programs (3)

Data Source: Missions will be required to report these indicators annually.

3.2 Pilot Anti-Retroviral (ARV) Treatment Programs: This section will report on USAID's innovative efforts to provide ARV treatment to HIV-infected people in low-resource settings.

Data needs: In FY02, the number of pilot projects with short descriptions of results/success. Beginning in FY03, (1) number of HIV-infected persons receiving ARV treatment from USAID-assisted programs and (2) number of USAID-assisted ARV treatment programs.

Data Source: Missions will be required to report these indicators annually.

3.3 Orphans, Vulnerable Children (OVC) Programs: This section will report on USAID's efforts to provide care & support to orphans and vulnerable children, including PL480 Title II food aid.

Data needs: (1) Number of orphans and other vulnerable children receiving care/support, including those reached with food aid through USAID-assisted programs and (2) number of USAID-assisted basic care and psychosocial support programs.

Data Source: Missions will be required to report these indicators annually.

Chapter Four: USAID Global Leadership: Building Political Commitment to Address the Pandemic

4.1 Building Local and Community Support to Fight HIV/AIDS

Data needs: The International HIV/AIDS Alliance, the Peace Corps, the Community REACH Project and the CORE Project report to the Bureau for Global Health on these efforts annually. Missions are not required to report this information directly although they have the option to provide additional information for use in the annual report.

Data Source: USAID/Washington with mission contributions (optional)

4.2 Building National Responses to HIV/AIDS

Data needs: Matrix of countries classified by level of political commitment as measured by the AIDS Program Effort Index (API). In addition, our main central contract, the POLICY Project,

already provides success stories on an annual basis, including new laws, policies, regulations, increased budgets, and an increasing number of multisectoral approaches from the countries where it works (15-25 USAID countries).

Data Source: USAID/Washington with mission contributions (optional)

4.3 Increasing International Cooperation and Supporting UNAIDS

Data needs: The Global Bureau/HIV-AIDS Office reports annually on USAID collaboration with the Japan/JICA, UK/DIFD, EU, and on USAID support to UNAIDS and USAID/UNAIDS joint leadership to develop global standards and priorities.

Data Source: USAID/Washington with mission contributions (optional)

SUBJECT: **MONITORING AND REPORTING ON HIV/AIDS PROGRAMS**
FROM: **USAID ADMINISTRATOR ANDREW NATSIOS**
TO: **ALL USAID BUREAUS, MISSIONS, AND REGIONAL OFFICES**
REF: **A) STATE 097109, B) STATE 208062**
NEW HIV/AIDS MONITORING AND REPORTING SYSTEM (UNCLASSIFIED)
DATE: **11 MARCH 2002**

Excerpt

USAID HAS BEEN ENTRUSTED WITH INCREASED RESOURCES TO LEAD THE INTERNATIONAL WAR AGAINST HIV/AIDS AND TO ASSIST IN MEETING THE 2007 INTERNATIONAL TARGETS SET BY THE GLOBAL HIV/AIDS COMMUNITY. WITH THESE INCREASED RESOURCES HAS COME INCREASED SCRUTINY.

WE ARE COMMITTED TO WORKING WITH YOU TO DEVELOP AND IMPLEMENT AN EXPANDED HIV/AIDS SURVEILLANCE, MONITORING, AND REPORTING SYSTEM THAT RESPONDS TO THE NEED TO TRACK THE PANDEMIC, MANAGE RESOURCES, AND REPORT ON PROGRESS TO KEY CONSTITUENCIES AND AT THE SAME TIME IS PRACTICAL AND MANAGEABLE AT THE FIELD LEVEL. THE SYSTEM, WHICH INCLUDES DATA, WHICH MOST OF YOU ARE ALREADY COLLECTING, HAS THREE ELEMENTS:

(1) THE ANNUAL AND PERIODIC COLLECTION OF DATA: (I)HIV SEROPREVALENCE RATES, (II) CHANGES IN RISK REDUCTION, AND (III) PROGRESS ON USAID PROGRAM IMPLEMENTATION AND COVERAGE OF TARGET POPULATIONS;
(2) THE USE OF STANDARD INDICATORS; AND
(3) THE REPORTING OF DATA TO CENTRAL REPOSITORIES.

AS PART OF THE NEW ANNUAL REPORTING SYSTEM, MISSIONS WILL REPORT EACH YEAR ON THEIR PROGRESS TOWARD IMPLEMENTING THEIR EXPANDED HIV/AIDS PROGRAMS AND INCREASING THE PROPORTION OF THE TARGETED POPULATION(S) COVERED BY THESE PROGRAMS.

MISSIONS ALREADY ROUTINELY COLLECT SOME OF THIS INFORMATION USING THE STANDARD INDICATORS IN THE USAID AND UNAIDS HANDBOOKS. BUT SOME ADDITIONAL INDICATORS ARE NEEDED FOR THE NEWER PROGRAM AREAS. WITH OTHER DONORS AND U.S. AGENCIES, WE ARE DEVELOPING SOME NEW INDICATORS FOR MTCT, ORPHANS AND OTHER VULNERABLE CHILDREN AND BASIC CARE AND SUPPORT FOR HIV-POSITIVE PERSONS. SOME BEHAVIOR INDICATORS ARE STILL BEING REFINED AND FIELD-TESTED. WE ARE FURTHER ALONG WITH SOME OF THESE INDICATORS THAN OTHERS. GH IS FIELD TESTING THESE NEW INDICATORS WITH THE HELP OF SEVERAL AFRICAN MISSIONS.

THE FINAL ELEMENT OF THE NEW SYSTEM IS THE CENTRAL TECHNICAL DATABASE MANAGED BY USAID/WASHINGTON. GH IS DESIGNING THE DATABASE TO BE USEFUL FOR USAID IN WASHINGTON AND IN THE FIELD AND FOR OUR OTHER U.S. GOVERNMENT, HOST COUNTRY, AND UNITED NATIONS PARTNERS.

IT IS CRITICAL THAT WE ALL MOVE QUICKLY TO IMPLEMENT THIS SYSTEM. ALL RAPID SCALE-UP AND INTENSIVE FOCUS MISSIONS SHOULD IMPLEMENT THIS NEW SYSTEM IN FY 2002 AND ESTABLISH PROGRAMS FOR BASELINES, AND OUTER-YEAR TARGETS FOR NATIONAL SEROPREVALENCE AMONG 15- TO 24-YEAR-OLDS AND THE RELATED

BEHAVIOR AND PROGRAM CHANGES INCLUDING, WHERE APPROPRIATE, ACCESS TO SERVICES FOR HIV-POSITIVE PREGNANT WOMEN. IN HIGH SEROPREVALENCE COUNTRIES, IT IS IMPORTANT TO SET BASELINES AND CARE TARGETS FOR THOSE INFECTED AND SUPPORT FOR ORPHANS AND VULNERABLE CHILDREN. REGIONAL BUREAUS MAY REQUIRE THAT OTHER MISSION IN THEIR RESPECTIVE REGIONS ALSO FOLLOW THESE EXPANDED REPORTING REQUIREMENTS.

Required Core Indicators – USAID and UNAIDS

Annual Report PPC/USAID 2002	**Expanded Response** GHB/USAID 2002	**UNGASS DoC**[10] UNAIDS 2002	**Global Standard**[11] USAID/UNAIDS 2000
Primary Prevention			
Condom use with last non-regular partner	Condom use with last non-regular partner	% of young people aged 15-24 reporting the use of a condom with a non-regular sex partner	Risky sex and condom use at last sex for adults, CSWs, MSM and youth
	# of sexual partners in the past 12 months		
	Median age of sexual debut		
Condom sales			Condom accessibility and quality
Care, Support and Treatment			
# of individuals reached by community and home-based care programs	# of individuals that reached by community and home-based care programs in the past 12 moths		Households receiving help in caring for chronically ill adults aged 15-49
# of individuals reached by antiretroviral treatment programs	#of USAID-assisted community and home-based care programs		
	# of clients seen at VCT centers		% of people aged 15-49 who have voluntarily requested an HIV test and received the results
	# of VCT centers with USAID assistance		
	# of HIV-infected persons receiving ARV treatment	% of people with advanced HIV infection receiving ARV therapy	
	# of USAID-assisted ARV treatment programs		
Mother–to–Child Transmission of HIV			
# of individuals covered by Maternal-to-Child Treatment programs* *(see note below)*	% of HIV-positive women attending antenatal clinics receiving a complete course of ARV therapy to prevent mother-to-child transmission	% of HIV-positive women attending antenatal clinics receiving a complete course of ARV therapy to prevent mother-to-child transmission	Provision of antiretroviral therapy during pregnancy
	# of health facilities offering PMTCT of HIV services		
	# & % of women with known HIV infection among those seen at PTMCT of HIV sites in the last 12 months		

[10] *Declaration of Commitment* – UN General Assembly Special Session on HIV/AIDS (June 2001)
[11] *USAID Handbook of Indicators for HIV/AIDS/STI Programs* (First Edition March 2000)
UNAIDS Guide for Monitoring & Evaluation of National AIDS Programmes (June 2000)

	# of women who attend PMTCT of HIV sites for a new pregnancy in the last 12 months		

Orphans and Vulnerable Children			
% of target population of orphans and vulnerable children reached	# of orphans and other vulnerable children receiving care and support in the past 12 months		Households receiving help from outside the family with orphan care
	# of community initiatives or community organizations receiving support to care for orphans and other vulnerable children in past 12 months		
	Total # of orphans and other vulnerable children programs supported by USAID in FY__		
		Ratio of orphaned to non-orphaned children aged 10-14 who are currently attending school	

Notes:

***** This indicator will measure all individuals covered by prevention of mother-to-child of HIV treatment programs, including "HIV positive women attending antenatal clinics receiving a complete course of ARV therapy to prevent mother-to-child transmission" (*Expanded Response & UNGASS core indicators)*