Investing in People

Indicators and Definitions

Handbook Guidance – Annex 4

Guidance on HIV Indicators

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

Guidance on Health Element-Level Indicators

Many of the indicators under each Element are unique to the activities associated with the element. However, the following indicators are repeated under more than one element. In order to avoid double counting, each operating unit should determine how best to reflect targets against these indicators. This could mean counting all the targets under one program element, if appropriate, and discussing this choice in the indicator narrative box. Another option is to split the target among the most relevant program elements.

Health Governance and Finance

- Number of improvements to laws, policies, regulations or guidelines related to improve access to and use of health services drafted with USG support
- Number of health facilities rehabilitated

Investing in People

Indicator List

Program Support/ Program Design and Learning/Host Country Strategic Information Indicators

Standard Program Support indicators are associated with each Program Area. These 8 indicators are found in the FACTS system at the end of the indicator list for each Program Area.

The Program Support indicators are standard across all five Objectives. In order to avoid extensive duplicate entries, data reference sheets for these 7 standard indicators are listed here.

ELEMENT: **PROGRAM DESIGN AND LEARNING ELEMENT**	
INDICATOR TITLE: **NUMBER OF SPECIAL STUDIES**	
DEFINITION: Special Studies are undertaken to gather information relevant for a particular program or project to improve our knowledge and understanding about the study subject. Different from an assessment or an evaluation, they examine unique circumstances as opposed to an entire activity, project or program.	
RATIONALE: This indicator captures support provided by operating units for development projects and programs	
UNIT: Number of special studies	*DISAGGREGATE BY:* None
TYPE: OUTPUT/OUTCOME Output	*DIRECTION OF CHANGE:* Higher = Better
DATA SOURCE: Both qualitative and quantitative methods of data collection and analysis are used for special studies.	
MEASUREMENT NOTES:	

ELEMENT: **PROGRAM DESIGN AND LEARNING ELEMENT**	
INDICATOR TITLE: **NUMBER OF BASELINE OR FEASIBILITY STUDIES**	
DEFINITION: A "baseline study" is a study conducted to examine and record the context/situation to be addressed by the project or program. Such studies are generally carried before program activities begin or simultaneous to program start-up in order to establish a starting place from which to measure movement resulting from USG-assisted activities. A "feasibility study": is carried to examine the context in which an anticipated project or program would be implemented as well as the viability and practicality of its implementation.	
RATIONALE: Baseline and feasibility studies reflect the preparation and forethought that go into USG programming.	
UNIT: Number of Studies	*DISAGGREGATE BY:* None
TYPE: OUTPUT/OUTCOME Output	*DIRECTION OF CHANGE:* Higher = Better
DATA SOURCE: While baseline studies generally collect quantitative data, both qualitative and quantitative data are used for feasibility studies.	
MEASUREMENT NOTES:	

ELEMENT: **PROGRAM DESIGN AND LEARNING ELEMENT**

INDICATOR TITLE: **NUMBER OF EVALUATIONS**

DEFINITION: Evaluation involves a systematic collection of information on the performance and impacts of on-going or completed USG-funded projects, programs, or sub-sets of activities. Its purpose is to inform decisions about how to improve the performance to increase the prospect of achieving results and/or to inform decisions about future programming. Evaluation is a formal analytical endeavor and should not be confused with routine site visits or informal discussions about a project or program's performance. Evaluations go beyond collecting information on the extent to which planned outputs, outcomes and impacts have been achieved and focus on the collection of information that can help answer the following types of questions:

- Why have planned results not been achieved?
- What are the underlying factors and forces that appear to have impeded and/or supported the achievement of results?
- Which programs and/or activities are the most effective or efficient in achieving results?
- What types of actions should be taken to improve the performance in achieving results, including whether or not to continue funding some or all of the development activities evaluated and why.
- What are the lessons that can be learned?

RATIONALE:
This indicator captures the efforts made by an operating unit to improve the performance of on-going programs and to draw lessons for future.

UNIT:	*DISAGGREGATE BY:*
Number of Evaluations	None
TYPE: OUTPUT/OUTCOME	*DIRECTION OF CHANGE:*
Outputs	Higher = Better

DATA SOURCE:
A wide variety of data collections methods can be used. These include statistical data from secondary sources, sample surveys, structured and unstructured interviews, site visits and focus group discussions.

MEASUREMENT NOTES:

ELEMENT: **PROGRAM DESIGN AND LEARNING ELEMENT**

INDICATOR TITLE: **NUMBER OF INFORMATION GATHERING OR RESEARCH ACTIVITIES**

DEFINITION:

Information gathering or research activities" refer to efforts to gather and analyze information in a systematic fashion on a specific topic. Research falls under three categories -applied, basic and development research.

Applied Research – Applied research is defined as systematic study to gain knowledge or understanding necessary to determine the means by which a recognized and specific need may be met.

Basic Research – Basic research is defined as the systematic study directed toward fuller knowledge or understanding of a phenomenon or process and of observable facts without specific applications toward processes or products in mind.

Development Research – Development Research is defined as the systematic application of knowledge or understanding, directed toward the production of useful materials, devices, and systems or methods including design, development and improvement of prototypes and new processes to meet specific requirements.

RATIONALE: This indicator indicates the nature of support for program development undertaken by an operating unit

UNIT:	*DISAGGREGATE BY:*
Number of research activities	None
TYPE: OUTPUT/OUTCOME	*DIRECTION OF CHANGE:*
output	Higher = Better

DATA SOURCE:
Project and program documents

MEASUREMENT NOTES:

ELEMENT: **PROGRAM DESIGN AND LEARNING ELEMENT**	
INDICATOR TITLE: **NUMBER OF MONITORING PLANS**	
DEFINITION: Monitoring plans refer to the plans designed to monitor the performance of a project or program. They track the performance or situation against what was planned or expected according to pre-determined standards.	
RATIONALE: This indicator is designed to capture the Program Support provided by an operating unit.	
UNIT: Number of Monitoring Plans	*DISAGGREGATE BY:* None
TYPE: OUTPUT/OUTCOME Report	*DIRECTION OF CHANGE:* Higher = Better
DATA SOURCE: Mission/post/bureau records and documents	
MEASUREMENT NOTES:	

ELEMENT: **PROGRAM DESIGN AND LEARNING ELEMENT**	
INDICATOR TITLE: **NUMBER OF PEOPLE TRAINED IN MONITORING AND EVALUATION**	
DEFINITION: This indicator refers to the number of participants in a classroom or remote training course on any topic related to measuring performance and impacts of a project or program, including indicators, qualitative and quantitative data collection methods, data analysis and nature and purpose of evaluation.	
RATIONALE: This indicator gives an indication of the efforts made by operating unit to improve its performance	
UNIT: Number of people trained	*DISAGGREGATE BY:* Gender
TYPE: OUTPUT/OUTCOME Output	*DIRECTION OF CHANGE:* Higher = Better
DATA SOURCE: Project and program reports	
MEASUREMENT NOTES:	

ELEMENT: **PROGRAM DESIGN AND LEARNING ELEMENT**	
INDICATOR TITLE: **NUMBER OF SECTOR ASSESSMENTS**	
DEFINITION: Sector assessments are undertaken to provide comprehensive analyses of needs and opportunities in a particular sector so that informed strategic and programmatic decisions can be made. A sector is broadly defined to include gender, environment, agriculture, industry, food security, health, education, and democracy.	
RATIONALE: Sectors assessments are usually undertaken to identify problems, opportunities and promising areas for interventions.	
UNIT: Number of sector assessments	*DISAGGREGATE BY:*
TYPE: OUTPUT/OUTCOME Output	*DIRECTION OF CHANGE:* Higher = Better
DATA SOURCE: Both primary and secondary sources of data and information are used for sector assessments.	
MEASUREMENT NOTES:	

ELEMENT: **HOST COUNTRY STRATEGIC INFORMATION**	
INDICATOR TITLE: **NUMBER OF INSTITUTIONS WITH IMPROVED MANAGEMENT INFORMATION SYSTEMS, AS A RESULT OF USG ASSISTANCE**	
DEFINITION: Institutions refer to host country organizations such as a Ministry, government office, sub-national government unit, NGO, school, hospital and research organization. Management information systems are data bases, usually computerized, that allow the organization to store, analyze, report and use information.	
RATIONALE: This indicator captures the direct support provided by operating units to host country institutions.	
UNIT: Number of Institutions	*DISAGGREGATE BY:* None
TYPE: OUTPUT/OUTCOME Output	*DIRECTION OF CHANGE:* Higher = Better
DATA SOURCE: Implementing Partners/Post	
MEASUREMENT NOTES:	

Program Area: Health

ELEMENT: **IIP - 1.1 HIV/AIDS**

INDICATOR TITLE: **NUMBER OF INDIVIDUALS REACHED THROUGH COMMUNITY OUTREACH THAT PROMOTES HIV/AIDS PREVENTION THROUGH ABSTINENCE AND/OR BEING FAITHFUL**

DEFINITION:

Community outreach is defined as any effort to affect change that might include peer education, classroom, small group and/or one-on-one information, education, communication (IEC) or behavior change communication (BCC) to promote abstinence and/or being faithful.

Some programs have clear messages designed to reach a specific audience (i.e., abstinence messages to youth in school or Faithfulness messages to married men), which are fairly easy to classify in this category. Remember that this includes either Abstinence programs or Be Faithful programs or those which have a combination of these approaches as their primary message.

Abstinence and/or be faithful are defined below as any of the following:

Activities or programs that promote abstinence:

1. Importance of abstinence in reducing the prevention of HIV transmission among unmarried individuals;
2. Decision of unmarried individuals to delay sexual activity until marriage;
3. Development of skills in unmarried individuals for practicing abstinence; and
4. Adoption of social and community norms that support delaying sex until marriage and that denounce forced sexual activity among unmarried individuals

AND/OR

Activities or programs that promote being faithful:

1. Importance of being faithful in reducing the transmission of HIV among individuals in long-term sexual partnerships;Elimination of casual sex and multiple sexual partnerships;
3. Development of skills for sustaining marital fidelity;
4. Adoption of social and community norms supportive of marital fidelity and partner reduction using strategies that respect and respond to local customs and norms; and
5. Adoption of social and community norms that denounce forced sexual activity in marriage or long-term partnerships

Partners should not double count individuals within a program or service outlet. An individual will count in separate program areas, such as an OVC who may be

served separately by an OVC program, ART facility, and prevention program. However, double counting of individuals within a program area is to be avoided among USG funded partners to the extent possible. While programs should be reporting to USG managers on the number of individuals served, the USG team is responsible to the extent possible for adjusting for the overlap between multiple programs serving the same individuals within a program area. All the **prevention** and **care** indicators refer to individuals served *during the current reporting period*. If you served 100 prevention clients last year and served 120 during the current reporting period, this is reported as 120, not 220.

In order to avoid double counting, countries will need to monitor their activities by partner, programmatic area, and geographic area. This matrix is an excellent program management tool as well as helping to adjust for double counting by partners, among partners, and among USG agencies.

RATIONALE:
This indicator measures the number of individuals who attended community outreach activities focused on abstinence and/or being faithful. In any prevention campaign, the more individuals who receive the message, the higher number who may make the behavioral changes involved.

UNIT:	*DISAGGREGATE BY:*
Number of individuals	Sex
TYPE: OUTPUT/OUTCOME	*DIRECTION OF CHANGE:*
Output	Higher = better

DATA SOURCE:
Program reports

MEASUREMENT NOTES:

ELEMENT: **IIP - 1.1 HIV/AIDS**

INDICATOR TITLE: **NUMBER OF INDIVIDUALS REACHED THROUGH COMMUNITY OUTREACH THAT PROMOTES HIV/AIDS PREVENTION THROUGH ABSTINENCE**

DEFINITION:

Community outreach is defined as any effort to affect change that might include peer education, classroom, small group and/or one-on-one information, education, communication (IEC) or behavior change communication (BCC). In this case, the message will primarily focus on the promotion of abstinence.

Abstinence is defined below as any of the following:

Activities or programs that promote abstinence:

1. Importance of abstinence in reducing the prevention of HIV transmission among unmarried individuals;
2. Decision of unmarried individuals to delay sexual activity until marriage;
3. Development of skills in unmarried individuals for practicing abstinence; and
4. Adoption of social and community norms that support delaying sex until marriage and that denounce forced sexual activity among unmarried individuals

Partners should not double count individuals within a program or service outlet. An individual will count in separate program areas, such as an OVC who may be served separately by an OVC program, ART facility, and prevention program. However, double counting of individuals within a program area is to be avoided among USG funded partners to the extent possible. While programs should be reporting to USG managers on the number of individuals served, the USG team is responsible to the extent possible for adjusting for the overlap between multiple programs serving the same individuals within a program area. All the **prevention** and **care** indicators refer to individuals served *during the current reporting period*. If you served 100 prevention clients last year and served 120 during the current reporting period, this is reported as 120, not 220.

In order to avoid double counting, countries will need to monitor their activities by partner, programmatic area, and geographic area. This matrix is an excellent program management tool as well as helping to adjust for double counting by partners, among partners, and among USG agencies.

RATIONALE:

This indicator measures the number of individuals who attended community outreach activities focused on abstinence and/or being faithful. In any prevention campaign, the more individuals who receive the message, the higher number who may make the behavioral changes involved.

UNIT:	*DISAGGREGATE BY:*
Number of individuals	Sex
TYPE: OUTPUT/OUTCOME	*DIRECTION OF CHANGE:*
Output	Higher = better

DATA SOURCE: Program Reports
MEASUREMENT NOTES:

ELEMENT: **IIP - 1.1 HIV/AIDS**

INDICATOR TITLE: **NUMBER OF INDIVIDUALS TRAINED TO PROMOTE HIV/AIDS PREVENTION PROGRAMS THROUGH ABSTINENCE AND/OR BEING FAITHFUL**

DEFINITION:

Training refers to new training or retraining of individuals and assumes that training is conducted according to national or international standards when these exist.

A training must have specific learning objectives, a course outline or curriculum, and expected knowledge, skills and/or competencies to be gained by participants.

Some programs have clear messages designed to reach a specific audience (i.e., abstinence messages to youth in school or Faithfulness messages to married men), which are fairly easy to classify in this category. Remember that this includes either Abstinence programs or Be Faithful programs or those which have a combination of these approaches as their primary message. If the program is targeting sexually active young adults with condom social marketing, it will not count in the Abstinence and Be Faithful category. Abstinence and/or be faithful are defined below as any of the following:

Activities or programs that promote abstinence:

1. Importance of abstinence in reducing the prevention of HIV transmission among unmarried individuals;
2. Decision of unmarried individuals to delay sexual activity until marriage;
3. Development of skills in unmarried individuals for practicing abstinence; and
4. Adoption of social and community norms that support delaying sex until marriage and that denounce forced sexual activity among unmarried individuals

AND/OR

Activities or programs that promote being faithful:

1. Importance of being faithful in reducing the transmission of HIV among individuals in long-term sexual partnerships;Elimination of casual sex and multiple sexual partnerships;
3. Development of skills for sustaining marital fidelity;
4. Adoption of social and community norms supportive of marital fidelity and partner reduction using strategies that respect and respond to local customs and norms; and
5. Adoption of social and community norms that denounce forced sexual activity in marriage or long-term partnerships

Each USG agency and USG-funded partner counts the number of individuals trained in prevention through abstinence and/or being faithful by USG staff (HQ

or field-based) or USG-funded partners during the specified reporting period (6 months for semi-annual report/12 months for annual report).

Only participants who complete the full training course should be counted.

If a training course covers more than one prevention topic, for example abstinence and be faithful, individuals should only be counted once for that training course.

If a training course is conducted in more than one session/training event, only individuals who complete the full course should be counted. Do not sum the participants for each training event.

The USG staff responsible for compiling the semi-annual/annual reporting data should use the training log submitted by each USG agency and USG-funded partner reporting on this indicator in order to count the total number of individuals trained in prevention. Individuals trained in training courses co-funded by more than one USG agency/USG-funded partner should only be counted once within the specified reporting period (6 months for semi-annual report/12 months for annual report).

In order to avoid double counting, countries will need to monitor their activities by partner, programmatic area, and geographic area. This matrix is an excellent program management tool as well as helping to adjust for double counting by partners, among partners, and among USG agencies.

RATIONALE:
This indicator is a measure of peer or health care educators who have been trained in the delivery of prevention messages to the target audience. It measures the number of newly trained or retrained individuals who are able to deliver HIV prevention messages with primary focus on abstinence and/or being faithful. Refer to outcome indicators on training for further recommendations.

UNIT:	*DISAGGREGATE BY:*
Number of individuals	Sex
TYPE: OUTPUT/OUTCOME	*DIRECTION OF CHANGE:*
Output	Higher = better

DATA SOURCE:
Program reports.

MEASUREMENT NOTES:
USG agencies and USG-funded partners should keep a training log including the type of training, date, location, and participants.

ELEMENT: **IIP - 1.1 HIV/AIDS**

INDICATOR TITLE: **NUMBER OF TARGETED CONDOM SERVICE OUTLETS**

DEFINITION:

A targeted condom service outlet refers to fixed distribution points or mobile units with fixed schedules providing condoms for free or for sale.

Other behavior change beyond abstinence and/or being faithful includes the targeting of behaviors that increase risk for HIV transmission such as engaging in casual sexual encounters, engaging in sex in exchange for money or favors, having sex with an HIV-positive partner or one whose status is unknown, using drugs or abusing alcohol in the context of sexual interactions, and using intravenous drugs. Women, even if faithful themselves, can still be at risk of becoming infected by their spouse, regular male partner, or someone using force against them. Other high-risk persons or groups include men who have sex with men and workers who are employed away from home. This could include targeted social marketing and/or the promotion of condoms to these high risk groups.

A targeted condom service outlet refers to fixed distribution points or mobile units with fixed schedules providing condom distribution. Countries should count the number of distribution points at which condoms are available to their target population.

RATIONALE:

This indicator provides a tangible measure of the potential reach of condom distribution to a given community as an important part of a comprehensive prevention message.

UNIT:	*DISAGGREGATE BY:*
Number of target outlets	None
TYPE: OUTPUT/OUTCOME	*DIRECTION OF CHANGE:*
Output	Higher = better

DATA SOURCE:

Program Reports

MEASUREMENT NOTES:

ELEMENT: **IIP - 1.1 HIV/AIDS**

INDICATOR TITLE: **NUMBER OF INDIVIDUALS REACHED THROUGH COMMUNITY OUTREACH THAT PROMOTES HIV/AIDS PREVENTION THROUGH OTHER BEHAVIOR CHANGE BEYOND ABSTINENCE AND/OR BEING FAITHFUL**

DEFINITION:

Community outreach is defined as any effort to effect change that might include peer education, classroom, small group and/or one-on-one information, education, communication (IEC) or behavior change communication (BCC) to promote comprehensive prevention messages.

Other behavior change beyond abstinence and/or being faithful includes the targeting of behaviors that increase risk for HIV transmission such as engaging in casual sexual encounters, engaging in sex in exchange for money or favors, having sex with an HIV-positive partner or one whose status is unknown, using drugs or abusing alcohol in the context of sexual interactions, and using intravenous drugs. Women, even if faithful themselves, can still be at risk of becoming infected by their spouse, regular male partner, or someone using force against them. Other high-risk persons or groups include men who have sex with men and workers who are employed away from home. This could include targeted social marketing and/or the promotion of condoms to these high risk groups.

Partners should not double count individuals within a program or service outlet. An individual will count in separate program areas, such as an OVC who may be served separately by an OVC program, ART facility, and prevention program. However, double counting of individuals within a program area is to be avoided among USG funded partners to the extent possible. While programs should be reporting to USG managers on the number of individuals served, the USG team is responsible to the extent possible for adjusting for the overlap between multiple programs serving the same individuals within a program area. All the **prevention** and **care** indicators refer to individuals served *during the current reporting period*. If you served 100 prevention clients last year and served 120 during the current reporting period, this is reported as 120, not 220.

In order to avoid double counting, countries will need to monitor their activities by partner, programmatic area, and geographic area. This matrix is an excellent program management tool as well as helping to adjust for double counting by partners, among partners, and among USG agencies.

For concentrated/low-level epidemic settings where most at risk populations drive HIV transmission, it is recommended (but not required) that this indicator be monitored and disaggregated by the most at risk populations (MARP) as relevant to country context. Please see the example from Vietnam in the O/GAC guidance. Disaggregation for Prevention/Other Behavior Change and for Counseling and Testing.

RATIONALE: This indicator measures the number of individuals who attended community outreach activities focused on abstinence and/or being faithful. In any prevention campaign, the more individuals who receive the message, the higher number who may make the behavioral changes involved.	
UNIT: Number of individuals	*DISAGGREGATE BY:* Sex
TYPE: OUTPUT/OUTCOME Output	*DIRECTION OF CHANGE:* Higher = better
DATA SOURCE: Program reports	
MEASUREMENT NOTES:	

ELEMENT: **IIP - 1.1 HIV/AIDS**

INDICATOR TITLE: **NUMBER OF INDIVIDUALS TRAINED TO PROMOTE HIV/AIDS PREVENTION THROUGH OTHER BEHAVIOR CHANGE BEYOND ABSTINENCE AND/OR BEING FAITHFUL**

DEFINITION:

Training refers to new training or retraining of individuals and assumes that training is conducted according to national or international standards when these exist.

Other behavior change beyond abstinence and/or being faithful includes targeting those behaviors that increase risk for HIV transmission such as engaging in casual sexual encounters, engaging in sex in exchange for money or favors, having sex with an HIV-positive partner or one whose status is unknown, using drugs or abusing alcohol in the context of sexual interactions, and using intravenous drugs. Women, even if faithful themselves, can still be at risk of becoming infected by their spouse, regular male partner, or someone using force against them. Other high-risk persons or groups include men who have sex with men and workers who are employed away from home. This could include targeted social marketing and/or the promotion of condoms to these high risk groups.

Each USG agency and USG-funded partner counts the number of individuals trained in prevention through other behavior change beyond abstinence and/or being faithful by USG staff (HQ or field-based) or USG-funded partners during the specified reporting period (6 months for semi-annual report/12 months for annual report).

Only participants who complete the full training course should be counted.

If a training course covers more than one prevention topic, individuals should only be counted once for that training course.

If a training course is conducted in more than one session/training event, only individuals who complete the full course should be counted. Do not sum the participants for each training event.

The USG staff responsible for compiling the semi-annual/annual reporting data should use the training log submitted by each USG agency and USG-funded partner reporting on this indicator in order to count the total number of individuals trained in prevention. Individuals trained in training courses co-funded by more than one USG agency/USG-funded partner should only be counted once within the specified reporting period (6 months for semi-annual report/12 months for annual report).

In order to avoid double counting, countries will need to monitor their activities by partner, programmatic area, and geographic area. This matrix is an excellent

<table>
<tr><td colspan="2">program management tool as well as helping to adjust for double counting by partners, among partners, and among USG agencies.</td></tr>
<tr><td colspan="2">RATIONALE:
This indicator is a measure of peer or health care educators who have been trained in the delivery of prevention messages to the target audience. It measures the number of newly trained or retrained individuals who are able to deliver comprehensive HIV prevention messages.</td></tr>
<tr><td>UNIT:
Number of individuals</td><td>DISAGGREGATE BY:
Sex</td></tr>
<tr><td>TYPE: OUTPUT/OUTCOME
Output</td><td>DIRECTION OF CHANGE:
Higher = better</td></tr>
<tr><td colspan="2">DATA SOURCE:
Program reports.</td></tr>
<tr><td colspan="2">MEASUREMENT NOTES:
USG agencies and USG-funded partners should keep a training log including the type of training, date, location, and participants.</td></tr>
</table>

ELEMENT: **IIP - 1.1 HIV/AIDS**	
INDICATOR TITLE: **NUMBER OF SERVICE OUTLETS CARRYING OUT BLOOD SAFETY ACTIVITIES**	
DEFINITION: A service outlet refers to the lowest level of service. For example, a hospital, clinic, or mobile unit. Blood safety activities include those that support policies, infrastructure, equipment, and supplies; blood donor recruitment activities; blood collection, distribution/supply chain/logistics, testing, screening, and/or transfusion; waste management; training; and/or management to ensure a safe and adequate blood supply. The unit of measurement is the site, not the activity. A site will only count once during a reporting period regardless of the number of on-going activities at the site.	
RATIONALE: This indicator counts the number of facilities which receive USG support for blood safety activities.	
UNIT: Number of outlets	*DISAGGREGATE BY:* None
TYPE: OUTPUT/OUTCOME Output	*DIRECTION OF CHANGE:* Higher = better
DATA SOURCE: Program Reports	
MEASUREMENT NOTES:	

ELEMENT: **IIP - 1.1 HIV/AIDS**

INDICATOR TITLE: **NUMBER OF INDIVIDUALS TRAINED IN BLOOD SAFETY**

DEFINITION:

Blood safety training may address any of the following specific blood safety activities: blood safety policies, infrastructure, equipment, and supplies; blood donor recruitment; blood collection, distribution/supply chain/logistics, testing, screening, and/or transfusion; waste management; and/or management to ensure a safe and adequate blood supply.

Training refers to new training or retraining of individuals and assumes that training is conducted according to national or international standards when these exist.

The training must follow a curriculum that indicates the objectives and/or expected competencies. Training may be knowledge and/or skills and/or competency-based. Each USG agency and USG-funded partner counts the number of individuals trained in blood safety by USG staff (HQ or field-based) or USG-funded partners during the specified reporting period (6 months for semi-annual report/12 months for annual report).

Only participants who complete the full training course should be counted.

If a training course covers more than one blood safety topic, individuals should only be counted once for that training course.

If a training course is conducted in more than one session/training event, only individuals who complete the full course should be counted. Do not sum the participants for each training session.

The USG staff responsible for compiling the semi-annual/annual reporting data should use the training log submitted by each USG agency and USG-funded partner reporting on this indicator in order to count the total number of individuals trained in blood safety. Individuals trained in training courses co-funded by more than one USG agency/USG-funded partner should only be counted once within the specified reporting period (6 months for semi-annual report/12 months for annual report).

In order to avoid double counting, countries will need to monitor their activities by partner, programmatic area, and geographic area. This matrix is an excellent program management tool as well as helping to adjust for double counting by partners, among partners, and among USG agencies.

RATIONALE:

The intent of the indicator is to measure progress toward a cadre of professionals trained in blood safety activities according to national or international standards.

UNIT:	*DISAGGREGATE BY:*
Number of individuals	Sex

TYPE: OUTPUT/OUTCOME	*DIRECTION OF CHANGE:*
Output	Higher = better
DATA SOURCE: Program reports. USG agencies and USG-funded partners should keep a training log including the type of training, date, location, and participants.	
MEASUREMENT NOTES:	

ELEMENT: **IIP - 1.1 HIV/AIDS**

INDICATOR TITLE: **NUMBER OF INDIVIDUALS TRAINED IN MEDICAL INJECTION SAFETY**

DEFINITION:

Medical injection safety training may address any of the following specific medical injection safety activities: medical injection safety policies; appropriate disposal of injection equipment; waste management systems; and/or other injection safety-related distribution/supply chain/logistics.

Training refers to new training or retraining of individuals and assumes that training is conducted according to national or international standards when these exist.

A training must have specific learning objectives, a course outline or curriculum, and expected knowledge, skills and/or competencies to be gained by participants. Each USG agency and USG-funded partner counts the number of individuals trained in medical injection safety by USG staff (HQ or field-based) or USG-funded partners during the specified reporting period (6 months for semi-annual report/12 months for annual report).

Only participants who complete the full training course should be counted.

If a training course covers more than one medical injection safety topic, individuals should only be counted once for that training course.

If a training course is conducted in more than one session/training event, only individuals who complete the full course should be counted. Do not sum the participants for each training event.

The USG staff responsible for compiling the semi-annual/annual reporting data should use the training log submitted by each USG agency and USG-funded partner reporting on this indicator in order to count the total number of individuals trained in medical injection safety. Individuals trained in training courses co-funded by more than one USG agency/USG-funded partner should only be counted once within the specified reporting period (6 months for semi-annual report/12 months for annual report).

In order to avoid double counting, countries will need to monitor their activities by partner, programmatic area, and geographic area. This matrix is an excellent program management tool as well as helping to adjust for double counting by partners, among partners, and among USG agencies.

RATIONALE:

The intent of the indicator is to measure progress toward a cadre of professionals trained in medical injection safety activities according to national or international standards.

UNIT:	*DISAGGREGATE BY:*
Number of individuals	Sex

TYPE: OUTPUT/OUTCOME	*DIRECTION OF CHANGE:*
Output	Higher = better
DATA SOURCE: Program reports.	
MEASUREMENT NOTES: USG agencies and USG-funded partners should keep a training log including the type of training, date, location, and participants.	

ELEMENT: **IIP - 1.1 HIV/AIDS**

INDICATOR TITLE: **NUMBER OF SERVICE OUTLETS PROVIDING THE MINIMUM PACKAGE OF PMTCT SERVICES ACCORDING TO NATIONAL AND INTERNATIONAL STANDARDS**

DEFINITION:

A service outlet refers to the lowest level of service. For example, a hospital, clinic, or mobile unit.

The minimum package of services for preventing mother-to-child transmission (MTCT) of HIV includes at least all four of the following services:

1. Counseling and testing for pregnant women
2. ARV prophylaxis to prevent MTCT
3. Counseling and support for safe infant feeding practices
4. Family planning counseling or referral

Each USG agency and USG-funded partner counts the number of service outlets providing the minimum package of PMTCT services at the end of the specified reporting period (6 months for semi-annual report / 12 months for annual report). Count only those service outlets that provide at minimum all four services specified above (1, 2, 3, and 4).

The USG staff responsible for compiling the semi-annual / annual reporting data should use the PMTCT service outlets list submitted by each USG agency and USG-funded partner reporting on this indicator in order to count the total number of service outlets providing the minimum package of PMTCT services, avoiding any double-counting of the same PMTCT outlet supported by more than one USG agency/USG-funded partner.

RATIONALE:

This indicator provides a crude quantitative measure of the stage of PMTCT service expansion and current availability of PMTCT services supported by USG.

UNIT:	*DISAGGREGATE BY:*
Number of outlets	None
TYPE: OUTPUT/OUTCOME	*DIRECTION OF CHANGE:*
Output	Higher = better

DATA SOURCE:

Program Reports.

MEASUREMENT NOTES:

USG staff and USG-funded partners should keep an inventory of the name and location of service outlets providing PMTCT services, clearly indicating those that provide the minimum package of PMTCT services. This information should be submitted to the USG staff responsible for compiling the semi-annual / annual reporting data as evidence for the reported number of service outlets providing the minimum package of PMTCT services.

ELEMENT: **IIP - 1.1 HIV/AIDS**	
INDICATOR TITLE: **NUMBER OF PREGNANT WOMEN WHO RECEIVED HIV COUNSELING AND TESTING FOR PMTCT AND RECEIVED THEIR TEST RESULTS**	
DEFINITION: The total number of pregnant women who received both HIV counseling and testing including the provision of test results at PMTCT service outlets. Count only those pregnant women who received, at minimum, HIV counseling and testing and received results during the specified reporting period (6 months for semi-annual report / 12 months for annual report).	
RATIONALE: This indicator reflects one goal of PMTCT which is to increase the number of pregnant women who know their HIV status.	
UNIT: Number of women	*DISAGGREGATE BY:* None
TYPE: OUTPUT/OUTCOME Output	*DIRECTION OF CHANGE:* Higher = better
DATA SOURCE: Service outlet log books or HMIS.	
MEASUREMENT NOTES:	

ELEMENT: **IIP - 1.1 HIV/AIDS**	
INDICATOR TITLE: **NUMBER OF PREGNANT WOMEN PROVIDED WITH A COMPLETE COURSE OF ANTIRETROVIRAL PROPHYLAXIS IN A PMTCT SETTING**	
DEFINITION: The number of women who received a complete course of antiretroviral prophylaxis to prevent MTCT at PMTCT service outlets. ARV prophylaxis may be single dose nevirapine (SD NVP) or short-course combination prophylaxis or highly active anti-retroviral therapy (HAART). Count women who received a complete course of antiretroviral prophylaxis to prevent MTCT at PMTCT service outlets during the specified reporting period (6 months for semi-annual report / 12 months for annual report). ARV prophylaxis may be single dose nevirapine (SD NVP) or short-course combination prophylaxis or highly active anti-retroviral therapy (HAART).	
RATIONALE: This indicator is a measure of the delivery and uptake of antiretroviral prophylaxis for PMTCT.	
UNIT: Number of women	*DISAGGREGATE BY:* None
TYPE: OUTPUT/OUTCOME Output	*DIRECTION OF CHANGE:* Higher = better
DATA SOURCE: Service outlet log books or HMIS.	
MEASUREMENT NOTES:	

ELEMENT: **IIP - 1.1 HIV/AIDS**

INDICATOR TITLE: **NUMBER OF HEALTH WORKERS TRAINED IN THE PROVISION OF PMTCT SERVICES ACCORDING TO NATIONAL AND INTERNATIONAL STANDARDS**

DEFINITION:

Training refers to new training or retraining of individuals and assumes that training is conducted according to national or international standards when these exist.

A training must have specific learning objectives, a course outline or curriculum, and expected knowledge, skills and/or competencies to be gained by participants. A PMTCT the training curriculum must contain at least one of the PMTCT core elements: PMTCT-related counseling and testing, ARV prophylaxis, infant feeding counseling, and family planning counseling or referral.

Each USG agency and USG-funded partner counts the number of individuals trained in PMTCT by USG staff (HQ or field-based) or USG-funded partners during the specified reporting period (6 months for semi-annual report / 12 months for annual report).

Only participants who complete the full training course should be counted. If a training course covers more than one PMTCT topic, for example ARV prophylaxis and infant feeding, individuals should only be counted once for that training course.

If a training course is conducted in more than one session/training event, only individuals who complete the full course should be counted. Do not sum the participants for each training event.

The USG staff responsible for compiling the semi-annual/annual reporting data should use the training log submitted by each USG agency and USG-funded partner reporting on this indicator in order to count the total number of individuals trained in PMTCT. Individuals trained in training courses co-funded by more than one USG agency/USG-funded partner should only be counted once within the specified reporting period (6 months for semi-annual report/12 months for annual report).

In order to avoid double counting, countries will need to monitor their activities by partner, programmatic area, and geographic area. This matrix is an excellent program management tool as well as helping to adjust for double counting by partners, among partners, and among USG agencies.

RATIONALE:

The intent of the indicator is to measure progress toward a cadre of professionals trained in PMTCT service delivery according to national or international standards.

UNIT: Number of people	*DISAGGREGATE BY:* Sex
TYPE: OUTPUT/OUTCOME Output	*DIRECTION OF CHANGE:* Higher = better
DATA SOURCE: Program reports.	
MEASUREMENT NOTES: USG agencies and USG-funded partners should keep a training log including the type of training, date, location, and participants.	

ELEMENT: **IIP - 1.1 HIV/AIDS**	
INDICATOR TITLE: **NUMBER OF SERVICE OUTLETS PROVIDING COUNSELING AND TESTING ACCORDING TO NATIONAL AND INTERNATIONAL STANDARDS**	
DEFINITION: A service outlet refers to the lowest level of service. For example, with regard to clinical activities, the lowest level for which data exists should be a service outlet such as a health center, hospital, clinic, stand alone VCT center, or mobile unit. Counseling and testing includes activities in which both HIV counseling and testing are provided for those who seek to know their status (as in traditional VCT) or as indicated in other contexts (e.g. STI clinics, diagnostic testing, etc.). This indicator excludes service outlets that provide counseling and testing in the context of preventing mother-to-child transmission. Please refer to Indicator 5.1 for more guidance on reporting the number of service outlets that provide services to prevent mother-to-child transmission of HIV. Outlets which provide both HIV counseling and testing, except those involved in PMTCT.	
RATIONALE: This indicator provides a gross count of the number of locations which provide basic counseling and testing for HIV. It provides a rough sense of the change in the capacity within a country to provide counseling and testing services. If there is a plan to expand the number of service outlets, this measure will track the progress of meeting that goal.	
UNIT: Number of outlets	*DISAGGREGATE BY:* None
TYPE: OUTPUT/OUTCOME Output	*DIRECTION OF CHANGE:* Higher = better
DATA SOURCE: Program reports	
MEASUREMENT NOTES:	

ELEMENT: **IIP - 1.1 HIV/AIDS**	
INDICATOR TITLE: **NUMBER OF INDIVIDUALS WHO RECEIVED COUNSELING AND TESTING FOR HIV AND RECEIVED THEIR TEST RESULTS**	
DEFINITION: This indicator requires a minimum of counseling, testing, and the provision of test results.	
RATIONALE: This indicator provides a count of those individuals who have received counseling and testing during the current reporting period and as a result are now aware of their HIV status. This is an output measure. It doesn't provide a workload count or provide any specific information about the quality of the counseling or the extent to which people are receiving follow up services. The goal is to track the number of individuals who received their test results, however, not all programs are set up to adequately distinguish between those who are tested and those who receive results. All programs should work towards being able to track individuals through pre-test counseling, testing, post-test counseling, provision of results, and subsequent interventions. This indicator also does not track where the counseling and testing is taking place. People may go more than once during the reporting period to different outlets. Refer to outcome level indicators for measurement of percent of population counseled, tested, and receiving results. This indicator does not consider the quality of service provision, which would require more in depth evaluation efforts like facility surveys. This is not a complete measure of coverage, as there is no denominator of total facilities. This does not account for non-USG supported service outlets.	
UNIT: Number of people	*DISAGGREGATE BY:* Sex
TYPE: OUTPUT/OUTCOME Output	*DIRECTION OF CHANGE:* Higher = better
DATA SOURCE: Program reports	
MEASUREMENT NOTES: Partners should not double count individuals seen multiple times within a program. An individual may count in separate program areas, such as an OVC who may be served separately by an OVC program, ART facility, and prevention program. However, double counting of individuals within a program area is to be avoided among USG funded partners to the extent possible. While programs should be reporting to USG managers on the actual number of individuals served, the USG team is responsible to the extent possible for adjusting for the overlap between multiple programs serving the same individuals within a program area. All the prevention and care indicators refer to individuals served during the current reporting period. If you reached 100 OVC last year (in the Annual Report) and now serve 120 during the current reporting period, this is reported as 120, not 220. In order to avoid double counting, countries will need	

to monitor their activities by partner, programmatic area, and geographic area. This matrix is an excellent program management tool as well as helping to adjust for double counting by partners, among partners, and among USG agencies.

For concentrated/low-level epidemic settings where most at risk populations drive HIV transmission, it is recommended (but not required) that this indicator be monitored and disaggregated by the most at risk populations (MARP) as relevant to country context. Please see the next section (Disaggregation of Most At Risk Populations (MARPs) for Program-Level Indicators on Prevention/Other and Counseling and Testing pages 76-78) -- for an example from Vietnam of MARP. Disaggregation for Prevention/Other Behavior Change and for Counseling and Testing.

ELEMENT: **IIP - 1.1 HIV/AIDS**

INDICATOR TITLE: **NUMBER OF REGISTERED TB PATIENTS WHO RECEIVED COUNSELING AND TESTING FOR HIV AND RECEIVED THEIR TEST RESULTS**

DEFINITION:

This indicator requires a minimum of counseling, testing, and the provision of test results.

Partners should not double count individuals seen multiple times within a program. An individual may count in separate program areas, such as an OVC who may be served separately by an OVC program, ART facility, and prevention program. However, double counting of individuals within a program area is to be avoided among USG funded partners to the extent possible. While programs should be reporting to USG managers on the actual number of individuals served, the USG team is responsible to the extent possible for adjusting for the overlap between multiple programs serving the same individuals within a program area. All the prevention and care indicators refer to individuals served during the current reporting period. If you reached 100 OVC last year (in the Annual Report) and now serve 120 during the current reporting period, this is reported as 120, not 220. In order to avoid double counting, countries will need to monitor their activities by partner, programmatic area, and geographic area. This matrix is an excellent program management tool as well as helping to adjust for double counting by partners, among partners, and among USG agencies.

For concentrated/low-level epidemic settings where most at risk populations drive HIV transmission, it is recommended (but not required) that this indicator be monitored and disaggregated by the most at risk populations (MARP) as relevant to country context. Please see the O/GAC section *Disaggregation of Most At Risk Populations (MARPs) for Program-Level Indicators on Prevention/Other and Counseling and Testing* -- for an example of MARP disaggregation for Prevention/Other Behavior Change and for Counseling and Testing.

RATIONALE:

This indicator provides a count of those registered TB patients who have received counseling and testing during the current reporting period and as a result are now aware of their HIV status.

It doesn't provide a workload count or provide any specific information about the quality of the counseling or the extent to which people are receiving follow up services. The goal is to track the number of individuals who received their test results, however, not all programs are set up to adequately distinguish between those who are tested and those who receive results. All programs should work towards being able to track individuals through pre-test counseling, testing, post-test counseling, provision of results, and subsequent interventions. This indicator also does not track where the counseling and testing is taking place. People may go more than once during the reporting period to different outlets. Refer to outcome level indicators for measurement of percent of population counseled, tested, and receiving results.

UNIT: Number of people	*DISAGGREGATE BY:* Sex; recommended by MARP
TYPE: OUTPUT/OUTCOME Output	*DIRECTION OF CHANGE:* Higher = better
DATA SOURCE: Program reports	
MEASUREMENT NOTES:	

ELEMENT: **IIP - 1.1 HIV/AIDS**	
INDICATOR TITLE: **NUMBER OF INDIVIDUALS TRAINED IN COUNSELING AND TESTING ACCORDING TO NATIONAL AND INTERNATIONAL STANDARDS**	
DEFINITION: Training refers to new training or retraining of individuals and assumes that training is conducted according to national or international standards when these exist. A training must have specific learning objectives, a course outline or curriculum, and expected knowledge, skills and/or competencies to be gained by participants.	
RATIONALE: This provides a means to gauge progress toward any training targets which may be incorporated into national plans. This indicator does not measure the quality of the training, nor does it measure the outcomes of the training in terms of the competencies of individuals trained, nor their job performance. This indicator simply measures number trained in counseling and testing as opposed to the percent of health facilities with trained staff, which may be measured through health facility surveys	
UNIT: Number of people	*DISAGGREGATE BY:* None
TYPE: OUTPUT/OUTCOME Output	*DIRECTION OF CHANGE:* Higher = better
DATA SOURCE: Program reports. USG agencies and USG-funded partners should keep a training log including the type of training, date, location, and participants.	
MEASUREMENT NOTES: Each USG agency and USG-funded partner counts the number of individuals trained in prevention by USG staff (HQ or field-based) or USG-funded partners during the specified reporting period (6 months for semi-annual report / 12 months for annual report). Only participants who complete the full training course should be counted. If a training course covers more than one counseling and testing topic, individuals should only be counted once for that training course. If a training course is conducted in more than one session/training event, only individuals who complete the full course should be counted. Do not sum the participants for each training event. The USG staff responsible for compiling the semi-annual/annual reporting data should use the training log submitted by each USG agency and USG-funded partner reporting on this indicator in order to count the total number of individuals trained in counseling and testing. Individuals trained in training courses co-	

funded by more than one USG agency/USG-funded partner should only be counted once within the specified reporting period (6 months for semi-annual report/12 months for annual report).

In order to avoid double counting, countries will need to monitor their activities by partner, programmatic area, and geographic area. This matrix is an excellent program management tool as well as helping to adjust for double counting by partners, among partners, and among USG agencies.

ELEMENT: **IIP - 1.1 HIV/AIDS**	
INDICATOR TITLE: **NUMBER OF SERVICE OUTLETS PROVIDING ANTIRETROVIRAL THERAPY (INCLUDES PMTCT+ SITES)**	
DEFINITION: A service outlet refers to the lowest level of service. For example, with regard to clinical activities, the lowest level for which data exists should be a service outlet such as a hospital, clinic, or mobile unit. ART services refer to activities including the provision of antiretroviral drugs and clinical monitoring for antiretroviral therapy among those with HIV infection. Antiretroviral therapy refers to long-term combination antiretroviral therapy intended primarily to improve the health of the individual on treatment, not to prevent mother-to-child transmission. PMTCT+ site is a service outlet that provides a minimum package of services which includes HIV counseling and testing for pregnant women, ARV prophylaxis to prevent mother-to-child transmission, counseling for safe infant feeding practices, family planning counseling or referral, and ARV therapy for HIV+ women, their children, and their families.	
RATIONALE: This indicator measures the progress of a program to expand the number of locations in which ART services are delivered in accordance with national or international standards. This indicator does not describe the geographic location or distribution of service outlets. This indicator does not consider the quality of service provision, which would require more in-depth evaluation efforts like facility surveys. This is not a complete measure of coverage, as there is no denominator of total facilities. This does not account for non-USG supported service outlets.	
UNIT: Number of outlets	*DISAGGREGATE BY:* None
TYPE: OUTPUT/OUTCOME Output	*DIRECTION OF CHANGE:* Higher = better
DATA SOURCE: Program Reports	
MEASUREMENT NOTES: Count all service outlets providing ART including designated PMTCT+ sites.	

ELEMENT: **IIP - 1.1 HIV/AIDS**

INDICATOR TITLE: **NUMBER OF INDIVIDUALS NEWLY INITIATING ANTIRETROVIRAL THERAPY DURING THE REPORTING PERIOD (INCLUDES PMTCT+ SITES)**

DEFINITION:

Antiretroviral therapy refers to long-term combination antiretroviral therapy intended primarily to improve the health of the individual on treatment, not to prevent mother-to-child transmission.

A "newly initiated" client is one who initiated antiretroviral therapy during the reporting period in a program directly supported by USG funds.

A PMTCT+ site is a service outlet that provides a minimum package of services which includes HIV counseling and testing for pregnant women, ARV prophylaxis to prevent mother-to-child transmission, counseling for safe infant feeding practices, family planning counseling or referral, and ARV therapy for HIV+ women, their children, and their families.

A new client is counted as pregnant if she is pregnant at the time she is initiated on antiretroviral therapy, regardless of the outcome of the pregnancy.

This indicator includes two mutually exclusive sets of individuals on ART: those who receive antiretroviral therapy at a designated PMTCT+ site and those who receive antiretroviral therapy elsewhere.

If an individual transfers in to the ART program with records from continuous ART at another facility or program, this person should NOT be counted as new.

If an individual transfers in without records or has no documented evidence of previous antiretroviral therapy, this person may be counted as new (because programs have no choice but to enroll this person as a new client).

If an individual previously on ART in the program restarts ART after an interruption in therapy, this person should NOT be counted as new.

If an individual initiated treatment during the period but died, stopped ART, or transferred out before the end of the reporting period, this person should still be counted as new (since status at the end of the period does not affect the fact that the person was still new on therapy during the period).

The USG indicators do not require reporting of transfers or restarts, but it is expected that programs will keep records of these persons and events. Clients, who transfer in, transfer out, and/or who restart after interruption of therapy will be counted in the CURRENT client load, as long as they are on ART at the end of a reporting period.

For the NEW indicator, age represents an individual's age at initiation of therapy.

RATIONALE:
There are three program indicators to count individuals receiving antiretroviral therapy at a service outlet directly supported by USG Emergency Plan funds: NEW, CUMULATIVE, and CURRENT.

NEW refers to individuals newly initiated on antiretroviral therapy during a reporting period.

UNIT:	*DISAGGREGATE BY:*
Number of people	Sex, age (<15, >=15), pregnancy status at inception of ART
TYPE: OUTPUT/OUTCOME	*DIRECTION OF CHANGE:*
Output	Higher = better

DATA SOURCE:
Program Reports

MEASUREMENT NOTES:
Disaggregation of pregnant women by age is NOT required. The number of pregnant women is to be shown as a subset of all women.

As the health of ART clients improves and ART services become available at more locations, transferring patients may account for an increasing proportion of ART client load in the health care system and at any given facility. If treatment is not adequately documented or records are not transferred with a client, clients may be newly initiated at more than one program/facility over time. At the country level, these clients will be double counted in the NEW and CUMULATIVE client indicators. Double counting of individuals within a program area is to be avoided among USG funded partners to the extent possible.

Since age and pregnancy status change over time, the comparison of NEW, CUMULATIVE, and CURRENT clients by age and pregnancy status is challenging. Because new and cumulative are states defined by beginning in a program, it is expected that the characteristics of new and cumulative clients are recorded at the time they newly initiate or transfer into a program. On the contrary, current is a state defined by vital/treatment status when last seen, so it is expected that characteristics of these clients would be updated each time they are seen by a program.

Combining all children into one age group of < 15 yrs may not be satisfactory for program managers. For children of different ages, there are different criteria for starting treatment, as well as different disease burdens, care needs, and mortality patterns. Programs may wish to further disaggregate children by age to follow programmatically and clinically meaningful differences as follows: 0-18 months, 18 months-5 years, 6-14 years.

ELEMENT: **IIP - 1.1 HIV/AIDS**

INDICATOR TITLE: **NUMBER OF INDIVIDUALS WHO EVER RECEIVED ANTIRETROVIRAL THERAPY BY THE END OF THE REPORTING PERIOD (INCLUDES PMTCT+ SITES)**

DEFINITION:

Antiretroviral therapy refers to long-term combination antiretroviral therapy intended primarily to improve the health of the individual on treatment, not to prevent mother-to-child transmission.

PMTCT+ site: A service outlet that provides a minimum package of services which includes HIV counseling and testing for pregnant women, ARV prophylaxis to prevent mother-to-child transmission, counseling for safe infant feeding practices, family planning counseling or referral, and ARV therapy for HIV+ women, their children, and their families.

Pregnant: A new client is reported as pregnant if she is pregnant at the time she is initiated on antiretroviral therapy, regardless of the outcome of the pregnancy.

RATIONALE:

Rationale: There are three program indicators to count individuals receiving antiretroviral therapy at a service outlet directly supported by USG Emergency Plan funds: NEW, CUMULATIVE, and CURRENT. Collectively, these three program indicators, when combined with the Required Outcome Indicator: Care & Treatment 5 (percentage of people still alive and on therapy at 6, 12, and 24 months after initiation of treatment) give an overview of the progress of a program in achieving targets to begin and maintain individuals on long-term, antiretroviral therapy.

What it measures: CUMULATIVE refers to the total number of individuals who were ever on ART since the start of Emergency Plan support to the service outlet.

UNIT:	*DISAGGREGATE BY:*
Number of people	Sex, age, pregnancy status at inception of ART
TYPE: OUTPUT/OUTCOME	*DIRECTION OF CHANGE:*
Output	Higher = better

DATA SOURCE:

Program reports

MEASUREMENT NOTES:

Age groups for disaggregation are: <15 years and >= 15 years.

This indicator includes two mutually exclusive sets of individuals on ART: those who receive antiretroviral therapy at a designated PMTCT+ site and those who receive antiretroviral therapy elsewhere.

The CUMULATIVE indicator is comprised of the NEW clients plus those who clients who transfer with records into a program directly supported by USG Emergency Plan funds.

The cumulative number of clients by the end of any reporting period is the sum of the cumulative number of clients at the end of the previous reporting period plus the clients who newly initiate and transfer into the program during the reporting period.

The CUMULATIVE count never declines over time, as it represents the total number of individuals who were ever on ART, regardless of whether they died or otherwise left the program.

The same individual should never be counted more than once for the CUMULATIVE indicator. (Thus If an individual previously on ART in the program restarts ART after an interruption in therapy, this person should NOT be counted again in the cumulative count as s/he was already counted once.)

For the CUMULATIVE indicator, age represents an individual's age at initiation of therapy or when s/he transfers into the program.

Disaggregation of pregnant women by age is NOT required. The number of pregnant women is to be shown as a subset of all women.

As the health of ART clients improves and ART services become available at more locations, transferring patients may account for an increasing proportion of ART client load in the health care system and at any given facility. If treatment is not adequately documented or records are not transferred with a client, clients may be newly initiated at more than one program/facility over time. At the country level, these clients will be double counted in the NEW and CUMULATIVE client indicators. Double counting of individuals within a program area is to be avoided among USG funded partners to the extent possible.

Since age and pregnancy status change over time, the comparison of NEW, CUMULATIVE, and CURRENT clients by age and pregnancy status is challenging. Because new and cumulative are states defined by beginning in a program, it is expected that the characteristics of new and cumulative clients are recorded at the time they newly initiate or transfer into a program. On the contrary, current is a state defined by vital/treatment status when last seen, so it is expected that characteristics of these clients would be updated each time they are seen by a program.

ELEMENT: **IIP - 1.1 HIV/AIDS**

INDICATOR TITLE: **NUMBER OF INDIVIDUALS RECEIVING ANTIRETROVIRAL THERAPY AT THE END OF THE REPORTING PERIOD (INCLUDES PMTCT+ SITES)**

DEFINITION:

Antiretroviral therapy: Long-term combination antiretroviral therapy intended primarily to improve the health of the individual on treatment, not to prevent mother-to-child transmission.

At the end of the reporting period: Refers to the last day of the 6-month or 12-month reporting period.

PMTCT+ site: A service outlet that provides a minimum package of services which includes HIV counseling and testing for pregnant women, ARV prophylaxis to prevent mother-to-child transmission, counseling for safe infant feeding practices, family planning counseling or referral, and ARV therapy for HIV+ women, their children, and their families.

Pregnant: A current client is pregnant if she was pregnant at any time during the reporting period, regardless of the outcome of the pregnancy.

RATIONALE:

Rationale: There are three program indicators to count individuals receiving antiretroviral therapy at a service outlet directly supported by USG Emergency Plan funds: NEW, CUMULATIVE, and CURRENT. Collectively, these three program indicators, when combined with the Required Outcome Indicator: Care & Treatment 5 (percentage of people still alive and on therapy at 6, 12, and 24 months after initiation of treatment) give an overview of the progress of a program in achieving targets to begin and maintain individuals on long-term, antiretroviral therapy.

What it measures: CURRENT refers to those individuals on antiretroviral therapy at the end of a reporting period.

UNIT:	*DISAGGREGATE BY:*
Number of individuals	Sex, age, pregnancy status during reporting period
TYPE: OUTPUT/OUTCOME	*DIRECTION OF CHANGE:*
Output	Higher = better

DATA SOURCE:

Program Reports

MEASUREMENT NOTES:

Age groups for disaggregation are: <15 years and >= 15 years.

This indicator includes two mutually exclusive sets of individuals on ART: those who receive antiretroviral therapy at a designated PMTCT+ site and those who receive antiretroviral therapy elsewhere.

A person on ART who initiated ART or transferred in during the reporting period

can be counted as a CURRENT client if s/he is on treatment at the end of the reporting period.

Individuals who died, stopped treatment, transferred out, or were otherwise lost to follow up during the reporting period are not on ART at the end of the reporting period, and thus, are NOT counted as a CURRENT client.

Note that the difference between the CUMULATIVE number ever on treatment by the end of the reporting period and the CURRENT number on treatment at the end of the reporting period should be approximately the number of individuals who died, who permanently stopped treatment or transferred out, or who were otherwise lost to follow-up by the end of the reporting period. In order to measure survival on ART and the number of CURRENT clients, all programs should collect information on the number of individuals who are no longer on treatment at the end of a reporting period and the reason (death, stop treatment, transfer out, lost to follow up).

Patients pick up ARV drugs on variable schedules, and monitoring systems are not always adequate to flag and follow up each person who misses an appointment. Thus it may not be possible to get an exact count of current clients on the last day of the reporting period. The recommended method for calculating this indicator is to count the number of individuals who were seen for ARV therapy during the last 3 months of the reporting period (i.e., the last quarter) and to subtract those who were known to have died, stopped treatment, transferred out, or been otherwise lost to follow up since the last time they were seen for a treatment appointment. Those not seen during the last 3 months are presumed lost to follow up.

For the CURRENT indicator, age represents an individual's age at the end of the reporting period, or when last seen during the reporting period for an ART appointment.

Disaggregation of pregnant women by age is NOT required. The number of pregnant women is to be shown as a subset of all women.

Monitoring systems are variable in their ability to measure exactly the client load at the end of the reporting period, thus the reported results may include some people who have recently died, dropped out, transferred out, or been lost to follow up and overestimate the true number of clients at the end of the reporting period.

Since age and pregnancy status change over time, the comparison of NEW, CUMULATIVE, and CURRENT clients by age and pregnancy status is challenging. Because new and cumulative are states defined by beginning in a program, it is expected that the characteristics of new and cumulative clients are recorded at the time they newly initiate or transfer into a program. On the

contrary, current is a state defined by vital/treatment status when last seen, so it is expected that characteristics of these clients would be updated each time they are seen by a program.

ELEMENT: **IIP - 1.1 HIV/AIDS**

INDICATOR TITLE: **NUMBER OF HEALTH WORKERS TRAINED TO DELIVER ART SERVICES, ACCORDING TO NATIONAL AND/OR INTERNATIONAL STANDARDS (INCLUDES PMTCT+)**

DEFINITION:

Health workers: This includes health workers that have been sufficiently trained to take up a direct function in support of scaling up clinical or community-based ART services.

Type of health workers include:

- Physicians and health workers with physician skills (e.g. Medical Officers)
- Nurses and other health workers with nursing skills (e.g. Midwives, Clinical Officers)
- Other health care workers and lay staff in clinical setting
- Laboratory technicians and staff
- Pharmacy/dispensing staff
- Community treatment supporters (peer educators, outreach workers, volunteers, informal caregivers)

Trained: Refers to new training or retraining of individuals and assumes that training is conducted according to national or international standards when these exist. It is assumed that in most settings such training will occur through a specialized training program that health workers attend after their regular education ("in-service" training). Only health workers who have undergone such training should be included.

A training must have specific learning objectives, a course outline, or curriculum, and expected knowledge, skills and/or competencies to be gained by participants.

ART services: Activities including the provision of antiretroviral drugs and clinical monitoring for antiretroviral therapy among those with HIV infection.

National or international standards: National guidelines and policies to promote ART training and services in a comprehensive way, linking them with HIV prevention and care and with the strengthening of health systems. National guidelines and policies are often based on existing international ones, and are generally agreed upon in a national forum. Without standards, services of unknown quality and impact can be implemented on an ad hoc basis, making it difficult to monitor and evaluate efforts.

PMTCT+ site: A service outlet that provides antiretroviral therapy (long-term triple combination antiretroviral therapy primarily intended to improve the health of the individual on treatment, not to prevent mother-to-child transmission) in the same clinic and by the same staff who provide PMTCT services.
This indicator does not measure the distribution of health workers trained to

provide ART services.

This indicator does not disaggregate by the type of health worker trained to provide ART services.

This indicator does not measure the type, content or duration of training being counted or whether the health workers counted as trained have been counted as trained in a previous period.

Only participants who complete the full training course should be counted.

If a training course covers more than one ART delivery topic, individuals should only be counted once for that training course.

If a training course is conducted in more than one session/training event, only individuals who complete the full course should be counted. Do not sum the participants for each training event.

RATIONALE:

Rationale: Building human capacity in health care delivery systems is of the utmost importance for the delivery of quality ART services.

What it measures: This indicator measures efforts to train a workforce to achieve targets in ART service delivery. Included are both certified clinical and lay health workers who contribute to the development and implementation of ART services. Health workers trained to deliver ART services at PMTCT+ sites should also be included here.

This indicator is most useful in the initial phases of a response to HIV/AIDS, when the cumulative number of trained health professionals is expected to be continuously increasing until it reaches a critical mass (or desired ceiling). At this point, the quantitative focus of the indicator on the number of health workers trained might become obsolete. The measurement could shift to capture the quality of the training, refresher training, and testing/supervision of the health care practices.

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

This indicator simply measures number trained in ART services as opposed to the percent of health facilities with trained staff, which may be measured through health facility surveys.

UNIT:	*DISAGGREGATE BY:*
Number of people	Sex
TYPE: OUTPUT/OUTCOME	*DIRECTION OF CHANGE:*
Output	Higher = better
DATA SOURCE:	

Program Reports

MEASUREMENT NOTES:

Each USG agency and USG-funded partner counts the number of individuals trained in prevention by USG staff (HQ or field-based) or USG-funded partners during the specified reporting period (6 months for semi-annual report / 12 months for annual report).

The USG staff responsible for compiling the semi-annual/annual reporting data should use the training log submitted by each USG agency and USG-funded partner reporting on this indicator in order to count the total number of individuals trained in ART delivery. Individuals trained in training courses co-funded by more than one USG agency/USG-funded partner should only be counted once within the specified reporting period (6 months for semi-annual report/12 months for annual report).

In order to avoid double counting, countries will need to monitor their activities by partner, programmatic area, and geographic area. This matrix is an excellent program management tool as well as helping to adjust for double counting by partners, among partners, and among USG agencies.

ELEMENT: **IIP - 1.1 HIV/AIDS**

INDICATOR TITLE: **TOTAL NUMBER OF SERVICE OUTLETS PROVIDING HIV-RELATED PALLIATIVE CARE (INCLUDING TB/HIV)**

DEFINITION:

A service outlet refers to the lowest level of service. For example, with regard to clinical activities, the lowest level for which data exists should be a service outlet such as a hospital, clinic, or mobile unit.

Palliative care services include A) clinical/medical, B) psychological, C) spiritual, and/or D) support care services.

Clinical care services include: prevention and treatment of TB/HIV, prevention and treatment of other opportunistic infections (OIs), alleviation of HIV-related symptoms and pain, nutritional rehabilitation for malnourished PLWHA.

Psychological care services include: interventions that address the non-physical suffering of individuals and family members, such as mental health counseling, support groups, identification and treatment of HIV-related psychiatric illnesses such as depression and related anxieties, and bereavement services.

Spiritual care services include: culturally-sensitive interventions that support individuals and families through faith and ritual, life review, assessment and counseling on hopes, fear, meaning of life, guilt, forgiveness and life completion tasks.

Supportive care services include: assisting individuals and family members in linking to care services such as child care, adherence to treatment, legal services, housing, food support and income–generating programs.

RATIONALE:

Palliative care is patient and family-centered care. It optimizes the quality of life of adults and children living with HIV through the active anticipation, prevention, and treatment of pain, symptoms and suffering from the onset of HIV diagnosis through death. Palliative care includes and goes beyond the medical management of infectious, neurological or oncological complications of HIV/AIDS to comprehensively address symptoms and suffering throughout the continuum of illness. The means by which this is achieved will vary according to stage of illness but always with the understanding that quality of life involves clinical, psychological, spiritual, and support care.

This indicator includes the total number of service outlets which provide HIV-related care.

UNIT:	*DISAGGREGATE BY:*
Number of outlets	None
TYPE: OUTPUT/OUTCOME	*DIRECTION OF CHANGE:*
Output	Higher = better

DATA SOURCE:
Program Reports

MEASUREMENT NOTES:
The number of service outlets includes those providing medical and clinical care (for opportunistic infections including TB), psychological, spiritual, and/or supportive care for HIV-infected individuals and their families.

One difficulty with this indicator is that while facility-based or community-based service outlets in fixed locations are relatively straight-forward to measure, community-based or home-based outreach activities are too difficult to define as service outlets and are not captured in this indicator. It is recommended that at country level, programs monitor which sites provide each of the key interventions: medical, psychological, spiritual and social.

This indicator does not consider the quality of service provision, which would require more in-depth evaluation efforts like facility surveys. This is not a complete measure of coverage, as there is no denominator of total facilities. This does not account for non-USG supported service outlets.

ELEMENT: **IIP - 1.1 HIV/AIDS**

INDICATOR TITLE: **NUMBER OF SERVICE OUTLETS PROVIDING TREATMENT FOR TUBERCULOSIS (TB) TO HIV-INFECTED INDIVIDUALS (DIAGNOSED OR PRESUMED) IN A PALLIATIVE CARE SETTING (A SUBSET OF ALL PALLIATIVE CARE OUTLETS)**

DEFINITION:

A service outlet refers to the lowest level of service. For example, with regard to clinical activities, the lowest level for which data exists should be a service outlet such as a hospital, clinic, or mobile unit.

A service outlet that will count in this indicator will provide treatment and/or clinical prophylaxis for tuberculosis to HIV-infected individuals (diagnosed or presumed). It is recommended that at country level, programs monitor which sites provide each of the key interventions: medical, psychological, spiritual and social.

RATIONALE:

Palliative care is patient and family-centered care. It optimizes the quality of life of adults and children living with HIV through the active anticipation, prevention, and treatment of pain, symptoms and suffering from the onset of HIV diagnosis through death. Palliative care includes and goes beyond the medical management of infectious, neurological or oncological complications of HIV/AIDS to comprehensively address symptoms and suffering throughout the continuum of illness. The means by which this is achieved will vary according to stage of illness but always with the understanding that quality of life involves clinical, psychological, spiritual, and support care.

This indicator measures the subset of service outlets providing TB/HIV care.

This indicator does not consider the quality of service provision, which would require more in-depth evaluation efforts like facility surveys. This is not a complete measure of coverage, as there is no denominator of total facilities. This does not account for non-USG supported service outlets.

UNIT:	*DISAGGREGATE BY:*
Number of outlets	None
TYPE: OUTPUT/OUTCOME	*DIRECTION OF CHANGE:*
Output	Higher = better

DATA SOURCE:

Program reports

MEASUREMENT NOTES:

This is a subset of the total number of service outlets providing general HIV-related palliative care. Outreach-only programs are counted through the number of communities served by community/home-based palliative care.

One difficulty with this indicator is that while facility-based or community-based service outlets in fixed locations are relatively straight-forward to measure, community-based or home-based outreach activities are too difficult to define as service outlets and are not captured in this indicator.

ELEMENT: **IIP - 1.1 HIV/AIDS**

INDICATOR TITLE: **TOTAL NUMBER OF INDIVIDUALS PROVIDED WITH HIV-RELATED PALLIATIVE CARE (INCLUDING TB/HIV)**

DEFINITION:

HIV-related palliative care = patient and family-centered care that optimizes the quality of life of adults and children living with HIV through the active anticipation, prevention, and treatment of pain, symptoms and suffering from the onset of HIV diagnosis through death. Palliative care includes and goes beyond the medical management of infectious, neurological or oncological complications of HIV/AIDS to comprehensively address symptoms and suffering throughout the continuum of illness. The means by which this is achieved will vary according to stage of illness but always with the understanding that quality of life involves clinical, psychological, spiritual, and supportive care.

Palliative care is a patient and family-centered service, therefore clients provided with general HIV-related palliative care/basic health care and support during the reporting period may include patients and family members. How much care is needed in order to count within the indicator is currently left to national standards – all persons served during the reporting period will be counted once by a unique program regardless of frequency. HIV-infected individuals and families have varying needs for services depending on the stage of illness, type of service, and available resources of HIV-infected persons. Quality assurance and supervision are expected by program managers to ensure that persons are receiving proper care.

This indicator is the total number of unduplicated individuals receiving palliative care from facilities and community/home-based organizations. This is not simply the sum of the individuals served by facility-based palliative care (including TB) and community/home-based palliative care partners, as adjustment for the overlap in service to the same individuals should be accounted for in this total.

RATIONALE:

This indicator is the total number of unduplicated individuals receiving palliative care from facilities and/or community/home-based organizations.

UNIT:	*DISAGGREGATE BY:*
Number of individuals	Sex, age
TYPE: OUTPUT/OUTCOME	*DIRECTION OF CHANGE:*
Output	Higher = better

DATA SOURCE:

Program reports

MEASUREMENT NOTES:

Adjusting for overlap between programs is very difficult, especially when programs are not well linked and patient confidentiality concerns must be respected.

Partners should not double count individuals within a program or service outlet. An individual will count in separate program areas, such as an OVC who may be

served separately by an OVC program, ART facility, and prevention program. However, double counting of individuals within a program area is to be avoided among USG funded partners to the extent possible. While programs should be reporting to USG managers on the number of individuals served, the USG team is responsible to the extent possible for adjusting for the overlap between multiple programs serving the same individuals within a program area. Countries will need to monitor their activities by partner, programmatic area, and geographic area. A matrix is an excellent program management tool as well as helping to avoid double counting by a partner, among partners, and among USG agencies.

ELEMENT: **IIP - 1.1 HIV/AIDS**	
INDICATOR TITLE: **NUMBER OF HIV-INFECTED CLIENTS ATTENDING HIV CARE/TREATMENT SERVICES THAT ARE RECEIVING TREATMENT FOR TB DISEASE (A SUBSET OF ALL SERVED WITH PALLIATIVE CARE)**	
DEFINITION: The number of HIV-positive clients accessing HIV care/treatment services HIV (HIV care centers, PMTCT) that are documented to be receiving treatment for TB disease. This treatment should be in-line with National TB Program treatment guidelines. As TB treatment lasts approximately 9 months, this indicator does not measure the outcome of the TB treatment. [Source: WHO: Policy Statement on Preventive Therapy against TB in People Living with HIV: Report of a Meeting held in Geneva 18-20 Feb. 1998]. This indicator does not measure the duration of therapy.	
RATIONALE: Evidence has shown that previously undiagnosed tuberculosis was detected in a significant proportion (up to 11%) of HIV-infected clients through routinely TB screening at HIV counseling and testing services. HIV-infected patients with tuberculosis should be identified and placed on appropriate TB treatment in order interrupt TB transmission, and reduce the burden of TB among HIV-infected clients. This indicator will measure the implementation of the recommended activity to integrate TB and HIV activity and reduce the burden of TB in HIV-infected clients.	
UNIT: Number of people	*DISAGGREGATE BY:* Sex, age
TYPE: OUTPUT/OUTCOME Output	*DIRECTION OF CHANGE:* Higher = better
DATA SOURCE: Program registries, reports	
MEASUREMENT NOTES: The data for this indicator can be located in health records service outlets that provide HIV care/treatment (Home/community-based care, PMTCT sites, HIV care centers, general health services that manage HIV/AIDS patients).	

ELEMENT: **IIP - 1.1 HIV/AIDS**

INDICATOR TITLE: **TOTAL NUMBER OF INDIVIDUALS TRAINED TO PROVIDE HIV PALLIATIVE CARE (INCLUDING TB/HIV)**

DEFINITION:

Training refers to new training or retraining of individuals and assumes that training is conducted according to national or international standards when these exist.

A training must have specific learning objectives, a course outline or curriculum, and expected knowledge, skills and/or competencies to be gained by participants.

Training on HIV-related palliative care services may include: A) clinical/medical including TB/HIV, B) psychological, C) spiritual, and/or D) support care services for HIV-infected individuals and family members.

Clinical care services include: prevention and treatment of TB/HIV, prevention and treatment of other opportunistic infections (OIs), alleviation of HIV-related symptoms and pain, nutritional rehabilitation for malnourished PLWHA.
Psychological care services include: interventions that address the non-physical suffering of individuals and family members, such as mental health counseling, support groups, identification and treatment of HIV-related psychiatric illnesses such as depression and related anxieties, and bereavement services.
Spiritual care services include: culturally-sensitive interventions that support individuals and families through faith and ritual, life review, assessment and counseling on hopes, fear, meaning of life, guilt, forgiveness and life completion tasks.

Supportive care services include: assisting individuals and family members in linking to care services such as child care, adherence to treatment, legal services, housing, food support and income–generating programs.

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

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

Each USG agency and USG-funded partner counts the number of individuals trained in HIV-related palliative care by USG staff (HQ or field-based) or USG-funded partners during the specified reporting period (6 months for semi-annual report / 12 months for annual report).

Only participants who complete the full training course should be counted.
If a training course covers more than one palliative care topic, for example clinical care and psychological care, individuals should only be counted once for that training course.

If a training course is conducted in more than one session/training event, only individuals who complete the full course should be counted. Do not sum the participants for each training event.

Individuals trained in training courses co-funded by more than one USG agency/USG-funded partner should only be counted once within the specified reporting period (6 months for semi-annual report/12 months for annual report).

RATIONALE:
This indicator measures the total number trained for HIV-related palliative care

UNIT:	*DISAGGREGATE BY:*
Number of individuals	Sex
TYPE: OUTPUT/OUTCOME	*DIRECTION OF CHANGE:*
Output	Higher = better

DATA SOURCE:
Program reports. USG agencies and USG-funded partners should keep a training log including the type of training, date, location, and participants.

MEASUREMENT NOTES:
This indicator is the total number of individuals receiving training for facility-based palliative care (including those trained in TB/HIV)

The USG staff responsible for compiling the semi-annual / annual reporting data should use the training log submitted by each USG agency and USG-funded partner reporting on this indicator in order to count the total number of individuals trained in HIV-related palliative care.

In order to avoid double counting, countries will need to monitor their activities by partner, programmatic area, and geographic area. This matrix is an excellent program management tool as well as helping to adjust for double counting by partners, among partners, and among USG agencies.

ELEMENT: **IIP - 1.1 HIV/AIDS**

INDICATOR TITLE: **NUMBER OF INDIVIDUALS TRAINED TO PROVIDE CLINICAL TREATMENT FOR TB TO HIV-INFECTED INDIVIDUALS (DIAGNOSED OR PRESUMED) (A SUBSET ALL TRAINED)**

DEFINITION:

Training refers to new training or retraining of individuals and assumes that training is conducted according to national or international standards when these exist.

TB/HIV training refers to trainings designed to enhance participants' knowledge of or ability to deliver clinical prophylaxis and/or treatment for TB.

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

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

This is a subset of the total number trained for HIV-related palliative care who had specific training on TB/HIV including clinical prophylaxis and/or treatment to HIV-infected individuals (diagnosed or presumed).

Each USG agency and USG-funded partner counts the number of individuals trained in TB/HIV by USG staff (HQ or field-based) or USG-funded partners during the specified reporting period (6 months for semi-annual report/12 months for annual report).

Only participants who complete the full training course should be counted.
If a training course covers more than one TB/HIV topic, individuals should only be counted once for that training course.

If a training course is conducted in more than one session/training event, only individuals who complete the full course should be counted. Do not sum the participants for each training event.

Individuals trained in training courses co-funded by more than one USG agency/USG-funded partner should only be counted once within the specified reporting period (6 months for semi-annual report/12 months for annual report).

RATIONALE:

This is a subset of the total number trained for HIV-related palliative care who had specific training on TB/HIV

UNIT:	*DISAGGREGATE BY:*
Number of individuals	Sex
TYPE: OUTPUT/OUTCOME	*DIRECTION OF CHANGE:*

Output	Higher = better

DATA SOURCE:
Program reports. USG agencies and USG-funded partners should keep a training log including the type of training, date, location, and participants.

MEASUREMENT NOTES:
The USG staff responsible for compiling the semi-annual/annual reporting data should use the training log submitted by each USG agency and USG-funded partner reporting on this indicator in order to count the total number of individuals trained in TB/HIV.

In order to avoid double counting, countries will need to monitor their activities by partner, programmatic area, and geographic area. This matrix is an excellent program management tool as well as helping to adjust for double counting by partners, among partners, and among USG agencies.

ELEMENT: **IIP - 1.1 HIV/AIDS**

INDICATOR TITLE: **NUMBER OF OVC SERVED BY OVC PROGRAMS**

DEFINITION:

Orphans are defined as children under 18 who have lost either a mother or father.

Vulnerable children are those that reside in households affected by HIV/AIDS, for example a household in which a parent or principle caretaker is HIV infected.

This indicator captures the reach of Emergency Plan funded services, but not the quality or content of those services. In the absence of policy guidance for Emergency Plan funded OVC interventions, the USG team in country may require that certain conditions be met before an OVC can be reported as "served".

While programs for OVC are likely to work with family members, reporting on this indicator is restricted to orphans and vulnerable children; other (non-OVC) family members should not be counted in this indicator. The number of contacts and the extent of services an OVC receives in order to count in this indicator is to be determined by each country based on standards agreed upon by USG and its implementing partners. However, all OVC served during the reporting period will be counted once by a program, regardless of the number of contacts with that OVC during the period. Quality assurance, supervision, and follow-up are expected by program managers to ensure that OVC are receiving quality care.

Count the number of OVC reached during the reporting period that is October through March for the semi-annual report and October through September for the annual report. This is NOT the cumulative number of OVC reached over the life of the Emergency Plan. Although the same OVC may be counted in different fiscal years, you should not add OVC reached from one fiscal year to the next. For example, if you reached 1000 OVC in FY04 and you continue to serve 900 of them in FY05 plus an additional 500 new OVC, you would report 1400 OVC reached in FY05.

RATIONALE:

The goal of OVC activities is to provide support aimed at improving the lives of children and families directly affected by AIDS-related morbidity and/or mortality. The emphasis is on strengthening communities to meet the needs of orphans and vulnerable children affected by HIV/AIDS, supporting community-based responses, helping children and adolescents meet their own needs, creating a supportive social environment. This indicator will measure OVC who are receiving: access to education; economic support; targeted food and nutrition support; legal aid; medical, psychological, or emotional care; and/or other social and material support. Institutional responses would also be included.

The impact of services on the children served is not captured through routinely collected program indicators. National-level outcome and impact indicators will

be collected periodically via population-based surveys, and special studies.

This indicator does not consider the quality of service provision, which would require more in-depth evaluation efforts like facility surveys. This is not a complete measure of coverage, as there is no denominator of total facilities. This does not account for non-USG supported service outlets.

UNIT:	*DISAGGREGATE BY:*
Number of people	Sex, primary direct, supplemental direct
TYPE: OUTPUT/OUTCOME	*DIRECTION OF CHANGE:*
Output	Higher = better
DATA SOURCE:	
Program reports	

MEASUREMENT NOTES:

Partners should not double count individuals within a program or service outlet. An individual will count in separate program areas, such as an OVC who may be served separately by an OVC program, ART facility, and prevention program. However, double counting of individuals within a program area is to be avoided among USG funded partners to the extent possible. While programs should be reporting to USG managers on the number of individuals served, the USG team is responsible to the extent possible for adjusting for the overlap between multiple programs serving the same individuals within a program area.

OVC policy guidance is under development and this indicator may evolve along with the policy.

ELEMENT: **IIP - 1.1 HIV/AIDS**

INDICATOR TITLE: **NUMBER OF PROVIDERS/CARETAKERS TRAINED IN CARING FOR OVC**

DEFINITION:

Providers/caretakers = anyone who ensures care for OVC, including those who provide, make referrals to, and/or oversee social services. This may include parents, guardians, other caregivers, extended family, neighbors, community leaders, police officers, social workers, national, district, and/or local social welfare ministry staff, as well as health care workers, teachers, or community workers who receive training on how to address the needs of OVC.

Training refers to new training or retraining of individuals and assumes that training is conducted according to national or international standards when these exist.

A training must have specific learning objectives, a course outline or curriculum, and expected knowledge, skills and/or competencies to be gained by participants.

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

Each USG agency and USG-funded partner counts the number of individuals trained in OVC care by USG staff (HQ or field-based) or USG-funded partners during the specified reporting period (6 months for semi-annual report/12 months for annual report).

Only participants who complete the full training course should be counted.
If a training course covers more than one OVC care topic, for example abstinence and be faithful, individuals should only be counted once for that training course.

If a training course is conducted in more than one session/training event, only individuals who complete the full course should be counted. Do not sum the participants for each training event.

Individuals trained in training courses co-funded by more than one USG agency / USG-funded partner should only be counted once within the specified reporting period (6 months for semi-annual report/12 months for annual report).

RATIONALE:

The goal of OVC activities is to provide support aimed at improving the lives of children and families directly affected by AIDS-related morbidity and/or mortality. The emphasis is on strengthening communities to meet the needs of orphans and vulnerable children affected by HIV/AIDS, supporting community-based responses, helping children and adolescents meet their own needs, creating a supportive social environment. Activities could include training to increase

capacity of families, community members, government staff, and staff of NGOs/CBOs/FBOs to provide: increasing access to education; economic support; targeted food and nutrition support; legal aid; medical, psychological, or emotional care; and/or other social and material support. Institutional responses would also be included.	
UNIT: Number of people	*DISAGGREGATE BY:* Sex
TYPE: OUTPUT/OUTCOME Output	*DIRECTION OF CHANGE:* Higher = better
DATA SOURCE: Program reports. USG agencies and USG-funded partners should keep a training log including the type of training, date, location, and participants.	
MEASUREMENT NOTES: The USG staff responsible for compiling the semi-annual/annual reporting data should use the training log submitted by each USG agency and USG-funded partner reporting on this indicator in order to count the total number of individuals trained in OVC care. In order to avoid double counting, countries will need to monitor their activities by partner, programmatic area, and geographic area. This matrix is an excellent program management tool as well as helping to adjust for double counting by partners, among partners, and among USG agencies.	

ELEMENT: **IIP - 1.1 HIV/AIDS**

INDICATOR TITLE: **NUMBER OF LABORATORIES WITH CAPACITY TO PERFORM 1) HIV TESTS AND 2) CD4 TESTS AND/OR LYMPHOCYTE TESTS**

DEFINITION:

Laboratory capacity is defined as the ability to perform (1) HIV tests and (2) CD4 tests or lymphocyte tests. This refers to both the equipment and personnel necessary to carry out testing.

Each USG agency and USG-funded partner counts the number of laboratory sites that have at minimum the capacity to perform the specified testing at the end of the specified reporting period (6 months for semi-annual report / 12 months for annual report). Count only those laboratory sites that are able to perform both HIV tests and [CD4 tests and/or lymphocyte tests].

This indicator does not measure whether the sites are actually performing the specified tests. This indicator also does not consider the quality of service provision, which would require more in-depth evaluation efforts like facility surveys. This is not a complete measure of coverage, as there is no denominator of total facilities. This does not account for non-USG supported service outlets.

RATIONALE:

This indicator reflects USG efforts to strengthen capacities of laboratories to perform HIV/AIDS related tests, diagnostics and monitoring tasks.

UNIT:	*DISAGGREGATE BY:*
Number of laboratory sites	None
TYPE: OUTPUT/OUTCOME	*DIRECTION OF CHANGE:*
Outcome	Higher = better

DATA SOURCE:

Program reports. To assess whether the laboratory sites have the capacity to perform the specified testing, special studies using observation techniques may be necessary.

METHOD FOR AGGREGATING ACROSS COUNTRIES:

MEASUREMENT NOTES:

The USG staff responsible for compiling the semi-annual / annual reporting data should use the laboratory sites list submitted by each USG agency and USG-funded partner reporting on this indicator in order to count the total number of laboratory sites that have the stated capacity, avoiding any double-counting of the same laboratory site supported by more than one USG agency/USG-funded partner.

USG staff and USG-funded partners should keep an inventory of the name and location of laboratory sites that are able to perform the specified testing. This information should be submitted to the USG staff responsible for compiling the semi-annual / annual reporting data as evidence for the reported number of laboratories with the capacity to perform the specified tests.

ELEMENT: **IIP - 1.1 HIV/AIDS**	
INDICATOR TITLE: **NUMBER OF INDIVIDUALS TRAINED IN THE PROVISION OF LABORATORY-RELATED ACTIVITIES**	
DEFINITION: Training refers to new training or retraining of individuals and assumes that training is conducted according to national or international standards when these exist. A training must have specific learning objectives, a course outline or curriculum, and expected knowledge, skills and/or competencies to be gained by participants. This indicator does not measure the quality of the training, nor does it measure the outcomes of the training in terms of the competencies of individuals trained, nor their job performance. This indicator simply measures number trained in laboratory-related activities as opposed to the percent of health facilities with trained staff, which may be measured through health facility surveys. Each USG agency and USG-funded partner counts the number of individuals trained in laboratory-related activities by USG staff (HQ or field-based) or USG-funded partners during the specified reporting period (6 months for semi-annual report / 12 months for annual report). Only participants who complete the full training course should be counted. If a training course covers more than one laboratory-related activities topic, individuals should only be counted once for that training course. If a training course is conducted in more than one session / training event, only individuals who complete the full course should be counted. Do not sum the participants for each training event.	
RATIONALE: The intent of the indicator is to measure progress toward developing and/or maintaining the skills of a cadre of professionals such that they are able to provide laboratory services according to national or international standards.	
UNIT: Number of individuals	*DISAGGREGATE BY:* Sex
TYPE: OUTPUT/OUTCOME Output	*DIRECTION OF CHANGE:* Higher = better
DATA SOURCE: Program reports. USG agencies and USG-funded partners should keep a training log including the type of training, date, location, and participants.	
MEASUREMENT NOTES: The USG staff responsible for compiling the semi-annual / annual reporting data should use the training log submitted by each USG agency and USG-funded	

partner reporting on this indicator in order to count the total number of individuals trained in laboratory-related activities. Individuals trained in training courses co-funded by more than one USG agency/USG-funded partner should only be counted once within the specified reporting period (6 months for semi-annual report/12 months for annual report).

In order to avoid double counting, countries will need to monitor their activities by partner, programmatic area, and geographic area. This matrix is an excellent program management tool as well as helping to adjust for double counting by partners, among partners, and among USG agencies.

ELEMENT: **IIP - 1.1 HIV/AIDS**

INDICATOR TITLE: **NUMBER OF TESTS PERFORMED AT USG-SUPPORTED LABORATORIES DURING THE REPORTING PERIOD: 1) HIV TESTING, 2) TB DIAGNOSTICS, 3) SYPHILIS TESTING, AND 4) HIV DISEASE MONITORING**

DEFINITION:

The number of tests performed at USG-supported laboratories during the reporting period (6 months/ 12 months)

- HIV testing: Examples include ELISA and simple rapid tests for serology and polymerase chain reaction (PCR) for infant diagnostics;
- TB diagnostics: Acid fast (Ziehl-Neelsen) staining of sputum.
- Syphilis testing: Rapid Plasma Reagent (RPR), simple syphilis, Treponema pallidum hemagglutination assay (TPHA), Include both screening and confirmation; and
- HIV disease monitoring: CD4, viral load, Alanin transaminase (ALT), and Creatinine.

This measure should reflect the number of tests performed, not the number of kits or reagents purchased.

Measurement of this indicator is undertaken by systematically reviewing laboratory records maintained at each site, as well as USG project records and documents, to count the number of USG-supported laboratories performing tests within each of the categories listed above. The number of tests should be added within each category. For example, the number of HIV tests should reflect the sum of ELISAs, rapid tests, and PCRs.

Systematic review of project documents and records; laboratory records. Data collection must be ongoing and aggregated over the 6-month and 12 month reporting period. The USG team in country should aggregate data across all USG-supported laboratories.

This indicator should be interpreted along with the indicator “Number of service outlets providing ART services according to national or international standards “

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

This indicator does not measure the unique contribution of USG, since other donors or countries may also be providing support. This indicator should not be used as a measure of the number of people tested or receiving services since the unit of analysis is the test not the person.

RATIONALE:

This indicator measures the extent to which USG-supported laboratories are expanding laboratory services to support HIV/AIDS care and treatment services.

This indicator is an output indicator of direct support provided to strengthen laboratories in a given country and for the Emergency Plan as a whole. Different sub-categories of HIV monitoring provide an overall picture of USG support. For management purposes, laboratories may want more detailed information about the tests performed.	
UNIT: Number of tests	*DISAGGREGATE BY:* Type of test
TYPE: OUTPUT/OUTCOME Output	*DIRECTION OF CHANGE:* Higher = better
DATA SOURCE: Implementers and/or operating units	
MEASUREMENT NOTES: When interpreting this indicator, consideration must be given to factors within and beyond USG manageable interests. For example, reagent stock outages and logistical problems greatly reduce the number of tests performed in labs. Often procurement and logistics are being managed independently. The ability of laboratories to report this information may lag behind their capacity to perform these tests. As a result, counts may underestimate laboratory performance. As record keeping and reporting capacity of laboratories improves, so will the quality and accuracy of the indicator estimate.	

ELEMENT: **IIP - 1.1 HIV/AIDS**

INDICATOR TITLE: **NUMBER OF LOCAL ORGANIZATIONS PROVIDED WITH TECHNICAL ASSISTANCE FOR STRATEGIC INFORMATION ACTIVITIES**

DEFINITION:

A local organization is defined as any entity whose headquarters is in a country or region served by the Emergency Plan. As such, the majority of the entity's staff (senior, mid-level, support) is comprised of host country and/or regional nationals. "Local organizations" refers to both governmental and non-governmental (NGOs, FBOs, and community-based) organizations.

Technical assistance (TA) is defined as the identification of need for and delivery of practical program and technical support. TA is intended to assist local organizations in building capacity to design, implement and evaluate HIV prevention, care and treatment programs.

TA should include regular technical communications and information dissemination sustained over a period of time. TA can be provided through a combination of strategic approaches and dissemination strategies including individualized and on-site peer and expert consultation, site visits, ongoing consultative relationships, national and/or regional meetings, consultative meetings and conferences, conference calls and web-casts, development and implementation of training curricula.

Provision of technical assistance for strategic information refers to activities that aim to strengthen HIV/AIDS surveillance, HMIS and M&E. Examples include providing local organizations with technical assistance in the following areas: developing or improving M&E models, methods and tools for collecting, analyzing, disseminating and using data; establishing or improving information systems; developing or improving program monitoring, planning and or conducting targeted program evaluations including operations research; monitoring and disseminating best practices to improve program efficiency and effectiveness; and/or improving data quality.

Strategic information includes HIV/AIDS surveillance, health management information systems, and monitoring and evaluation.

This indicator does not capture the quality of the technical support provided, nor does it capture changes in the capacity of the organization/agency in collecting, analyzing, disseminating and using HIV/AIDS data.

Each USG agency and USG-funded partner counts the number of organizations that received technical assistance for SI activities from USG staff (HQ or field-based) or USG-funded partners during the specified reporting period (6 months for semi-annual report / 12 months for annual report).

RATIONALE: The intent of the indicator is to capture support provided to enhance the capacity of local organizations to collect, analyze, disseminate and use HIV/AIDS-related data.	
UNIT: Number of organizations	*DISAGGREGATE BY:* None
TYPE: OUTPUT/OUTCOME Output	*DIRECTION OF CHANGE:* Higher = better
DATA SOURCE: Program reports.	
MEASUREMENT NOTES: USG staff and USG-funded partners should keep an inventory of name of organization to which the technical assistance is provided, the type of technical assistance provided, name of technical assistance provider, and date / time period of technical assistance provision. This information should be submitted to the USG staff responsible for compiling the semi-annual / annual reporting data as evidence for the reported number of organizations supported with SI technical assistance. The USG staff responsible for compiling the semi-annual / annual reporting data should use the technical assistance inventory submitted by each USG agency and USG-funded partner reporting on this indicator in order to count the total number of organizations / agencies that received technical assistance for SI activities from USG staff (HQ or field-based) or USG-funded partners during the reporting period. Organizations may only be counted once within the specified reporting period (6 months for semi-annual report / 12 months for annual report).	

ELEMENT: **IIP - 1.1 HIV/AIDS**

INDICATOR TITLE: **NUMBER OF INDIVIDUALS TRAINED IN STRATEGIC INFORMATION (INCLUDES M&E, SURVEILLANCE, AND/OR HMIS)**

DEFINITION:

Training refers to new training or retraining of individuals and assumes that training is conducted according to national or international standards when these exist.

A training must have specific learning objectives, a course outline or curriculum, and expected knowledge, skills and/or competencies to be gained by participants.

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

Only participants who complete the full training course should be counted.

If a training course is conducted in several sessions or covers more than one SI topic, for example M&E and surveillance, individuals should only be counted once for that training course.

If a training spans more than 1 programmatic area with separate and specific objectives and curricula for each program (for instance OVC and SI), individuals trained may count in each program area.

Individuals trained in training courses co-funded by more than one USG agency / USG-funded partner should only be counted once within the specified reporting period.

RATIONALE:

The intent of the indicator is to measure progress toward creating a cadre of professionals trained in the collection, analysis, dissemination and use of strategic information for HIV/AIDS programming.

UNIT:	*DISAGGREGATE BY:*
Number of individuals	Sex
TYPE: OUTPUT/OUTCOME	*DIRECTION OF CHANGE:*
Output	Higher = better

DATA SOURCE:

Program reports. USG agencies and USG-funded partners should keep a training log including the type of training, date, location, and participants.

MEASUREMENT NOTES:

Count the number of individuals trained in SI during the specified reporting period (6 months for semi-annual report / 12 months for annual report).

Each USG agency and USG-funded partner counts the number of individuals trained in SI by USG staff (HQ or field-based) or USG-funded partners during the

specified reporting period (6 months for semi-annual report/12 months for annual report).

The USG staff responsible for compiling the semi-annual / annual reporting data should use the training log submitted by each USG agency and USG-funded partner reporting on this indicator in order to count the total number of individuals trained in SI. Individuals trained in training courses co-funded by more than one USG agency / USG-funded partner should only be counted once within the specified reporting period (6 months for semi-annual report / 12 months for annual report).

ELEMENT: **IIP - 1.1 HIV/AIDS**

INDICATOR TITLE: **NUMBER OF LOCAL ORGANIZATIONS PROVIDED WITH TECHNICAL ASSISTANCE FOR HIV-RELATED POLICY DEVELOPMENT**

DEFINITION:

A local organization is defined as any entity whose headquarters is in a country or region served by the Emergency Plan. As such, the majority of the entity's staff (senior, mid-level, support) is comprised of host country and/or regional nationals. "Local organizations" refers to both governmental and non-governmental (NGOs, FBOs, and community-based) organizations.

Technical assistance (TA) is defined as the identification of need for and delivery of practical program and technical support. TA is intended to assist local organizations in building capacity to design, implement and evaluate HIV prevention, care and treatment programs.

TA should include regular technical communications and information dissemination sustained over a period of time. TA can be provided through a combination of strategic approaches and dissemination strategies including individualized and on-site peer and expert consultation, site visits, ongoing consultative relationships, national and/or regional meetings, consultative meetings and conferences, conference calls and web-casts, development and implementation of training curricula.

TA for policy development activities aim to:

- Broaden and strengthen political and popular support for HIV/AIDS policies and programs;
- Improve the operational environment for these programs, including better planning and financing;
- Ensure that accurate, up-to-date information informs policy decisions; and
- Build in-country and regional capacity to participate in policy development.

This indicator does not measure amount and quality of TA and only indicates the number of organizations that received any TA.

RATIONALE:

This indicator measures the degree to which local organizations receive technical assistance in support of policy development, a priority area of the Emergency Plan.

UNIT:	*DISAGGREGATE BY:*
Number of organizations	None
TYPE: OUTPUT/OUTCOME	*DIRECTION OF CHANGE:*
Output	Higher = better

DATA SOURCE:

Program reports

MEASUREMENT NOTES:

Organizations that received TA for Strategic Information (M&E, HMIS, and Surveillance) or Quality Assurance should be counted under the indicator "Number of laboratories with the capacity to perform (1) HIV tests and (2) CD4 tests and/or lymphocyte tests". Organizations that received TA for institutional capacity building should be reported under the indicator "Number of individuals trained in strategic information (M&E and/or surveillance and/or HMIS)".

ELEMENT: **IIP - 1.1 HIV/AIDS**

INDICATOR TITLE: **NUMBER OF LOCAL ORGANIZATIONS PROVIDED WITH TECHNICAL ASSISTANCE FOR HIV-RELATED INSTITUTIONAL CAPACITY BUILDING**

DEFINITION:

A local organization is defined as any entity whose headquarters is in a country or region served by the Emergency Plan. As such, the majority of the entity's staff (senior, mid-level, support) is comprised of host country and/or regional nationals. "Local organizations" refers to both governmental and non-governmental (NGOs, FBOs, and community-based) organizations.

Technical assistance (TA) is defined as the identification of need for and delivery of practical program and technical support. TA is intended to assist local organizations in building capacity to design, implement and evaluate HIV prevention, care and treatment programs.

TA should include regular technical communications and information dissemination sustained over a period of time. TA can be provided through a combination of strategic approaches and dissemination strategies including individualized and on-site peer and expert consultation, site visits, ongoing consultative relationships, national and/or regional meetings, consultative meetings and conferences, conference calls and web-casts, development and implementation of training curricula.

TA for institutional capacity building may cover the following:

- Strategic Planning: organizations that have a Board of Directors, mission statement, and strategies for the short and long-term (5 -10 years), including diversification of funding sources and ability to write their own grant proposals;
- Registration: organizations that are officially registered as legal entities;
- Financial Management: organizations that have a practical accounting system in place and are able to account for all expenditures in accordance with USG and in-country audit requirements, analyze unit costs, make financial projections, and track expenditures against budgets;
- Human Resource Management: organizations with an established personnel system with checks and balances, for recruiting, paying, retaining, training, and supervising adequate numbers of staff at all levels of the organization;
- Networks Development: local networks established/strengthened that deliver prevention, care and treatment services, monitor implementation, and report results;
- Commodities, Equipment and Logistics Management: organizations that have established a system to assess commodity needs, account for donated product, ensure adequate drug supply at all times, and eventually procure and purchase supplies, equipment, and drugs for HIV/AIDS prevention, care and treatment services; and

- Infrastructure Development: laboratories, clinics, and classrooms improved or renovated to provide HIV/AIDS training or services.

This indicator does not measure amount and quality of TA and only indicates the number of organizations that received any TA.

RATIONALE:
This indicator measures the degree to which organizations receive technical assistance in support of institutional capacity development, a priority area of The Emergency Plan.

UNIT:	*DISAGGREGATE BY:*
Number of organizations	None
TYPE: OUTPUT/OUTCOME	*DIRECTION OF CHANGE:*
output	Higher = better

DATA SOURCE:
Program reports

MEASUREMENT NOTES:
Organizations that received TA for Strategic Information (M&E, HMIS, and Surveillance) or Quality Assurance should be counted under the indicator "Number of laboratories with the capacity to perform (1) HIV tests and (2) CD4 tests and/or lymphocyte tests". Organizations that received TA for institutional capacity building should be reported under the indicator "Number of individuals trained in strategic information (M&E and/or surveillance and/or HMIS)".

ELEMENT: **IIP - 1.1 HIV/AIDS**

INDICATOR TITLE: **NUMBER OF INDIVIDUALS TRAINED IN HIV-RELATED POLICY DEVELOPMENT**

DEFINITION:

Training refers to new training or retraining of individuals and assumes that training is conducted according to national or international standards when these exist. Count all individuals trained, from local organizations or otherwise, during the reporting period.

A training must have specific learning objectives, a course outline or curriculum, and expected knowledge, skills and/or competencies to be gained by participants.

Policy activities aim to:

- Broaden and strengthen political and popular support for HIV/AIDS policies and programs;
- Improve the operational environment for these programs, including better planning and financing;
- Ensure that accurate, up-to-date information informs policy decisions; and
- Build in-country and regional capacity to participate in policy development.

Each USG agency and USG-funded partner counts the number of individuals trained in policy development by USG staff (HQ or field-based) or USG-funded partners during the specified reporting period (6 months for semi-annual report/12 months for annual report).

Only participants who complete the full training course should be counted.
If a training course covers more than one policy development topic, individuals should only be counted once for that training course.

If a training course is conducted in more than one session / training event, only individuals who complete the full course should be counted. Do not sum the participants for each training event.

Individuals trained in training courses co-funded by more than one USG agency/USG-funded partner should only be counted once within the specified reporting period (6 months for semi-annual report/12 months for annual report).

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

This indicator simply measures number trained in HIV-related policy development as opposed to the percent of organizations with trained staff.

RATIONALE:

Supportive Interventions strengthen HIV prevention, care and treatment

programs. This indicator measures the number of individuals trained in policy for HIV/AIDS programs.	
UNIT: Number of individuals	*DISAGGREGATE BY:* Sex
TYPE: OUTPUT/OUTCOME Output	*DIRECTION OF CHANGE:* Higher = better
DATA SOURCE: Program reports. USG agencies and USG-funded partners should keep a training log including the type of training, date, location, and participants.	
MEASUREMENT NOTES: The USG staff responsible for compiling the semi-annual / annual reporting data should use the training log submitted by each USG agency and USG-funded partner reporting on this indicator in order to count the total number of individuals trained in policy development. In order to avoid double counting, countries will need to monitor their activities by partner, programmatic area, and geographic area. This matrix is an excellent program management tool as well as helping to adjust for double counting by partners, among partners, and among USG agencies.	

ELEMENT: **IIP - 1.1 HIV/AIDS**

INDICATOR TITLE: **NUMBER OF INDIVIDUALS TRAINED IN HIV-RELATED INSTITUTIONAL CAPACITY BUILDING**

DEFINITION:

Training refers to new training or retraining of individuals and assumes that training is conducted according to national or international standards when these exist. Count all individuals trained, from local organizations or otherwise, during the reporting period.

A training must have specific learning objectives, a course outline or curriculum, and expected knowledge, skills and/or competencies to be gained by participants.

Institutional capacity building activities may include:

- Strategic Planning: organizations that have a Board of Directors, mission statement, and strategies for the short and long-term (5 -10 years), including diversification of funding sources and ability to write their own grant proposals;
- Registration: organizations that are officially registered as legal entities;
- Financial Management: organizations that have a practical accounting system in place and are able to account for all expenditures in accordance with USG and in-country audit requirements, analyze unit costs, make financial projections, and track expenditures against budgets;
- Human Resource Management: organizations with an established personnel system with checks and balances, for recruiting, paying, retaining, training, and supervising adequate numbers of staff at all levels of the organization;
- Networks Development: local networks established/strengthened that deliver prevention, care and treatment services, monitor implementation, and report results;
- Commodities, Equipment and Logistics Management: organizations that have established a system to assess commodity needs, account for donated product, ensure adequate drug supply at all times, and eventually procure and purchase supplies, equipment, and drugs for HIV/AIDS prevention, care and treatment services; and
- Infrastructure Development: laboratories, clinics, and classrooms improved or renovated to provide HIV/AIDS training or services.

Each USG agency and USG-funded partner counts the number of individuals trained in institutional capacity building by USG staff (HQ or field-based) or USG-funded partners during the specified reporting period (6 months for semi-annual report/12 months for annual report).

Only participants who complete the full training course should be counted.
If a training course covers more than one institutional capacity building topic,

individuals should only be counted once for that training course.

If a training course is conducted in more than one session/training event, only individuals who complete the full course should be counted. Do not sum the participants for each training event.

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

This indicator simply measures number trained in institutional capacity building as opposed to the percent of organizations with trained staff.

RATIONALE:
This indicator measures the number of individuals trained in institutional capacity building. As more and more individuals are trained in the different capacity building domains, more individuals can be reached with HIV/AIDS services. In conjunction with indicator 12.2, this gives a picture of the reach of capacity building programs.

UNIT:	*DISAGGREGATE BY:*
Number of individuals	Sex
TYPE: OUTPUT/OUTCOME	*DIRECTION OF CHANGE:*
Output	Higher = better

DATA SOURCE:
Program reports. USG agencies and USG-funded partners should keep a training log including the type of training, date, location, and participants.

MEASUREMENT NOTES:
The USG staff responsible for compiling the semi-annual/annual reporting data should use the training log submitted by each USG agency and USG-funded partner reporting on this indicator in order to count the total number of individuals trained in institutional capacity building. Individuals trained in training courses co-funded by more than one USG agency / USG-funded partner should only be counted once within the specified reporting period (6 months for semi-annual report/12 months for annual report).

In order to avoid double counting, countries will need to monitor their activities by partner, programmatic area, and geographic area. This matrix is an excellent program management tool as well as helping to adjust for double counting by partners, among partners, and among USG agencies.

ELEMENT: **IIP - 1.1 HIV/AIDS**

INDICATOR TITLE: **NUMBER OF INDIVIDUALS TRAINED IN HIV-RELATED STIGMA AND DISCRIMINATION REDUCTION**

DEFINITION:

Training refers to new training or retraining of individuals and assumes that training is conducted according to national or international standards when these exist. Count all individuals trained, from local organizations or otherwise, during the reporting period.

A training must have specific learning objectives, a course outline or curriculum, and expected knowledge, skills and/or competencies to be gained by participants.

HIV/AIDS-related stigma can be described as a "process of devaluation" of people either living with or associated with HIV and AIDS. This stigma often stems from the underlying stigmatization of sex and intravenous drug use—two of the primary routes of HIV infection. Discrimination follows stigma and is the unfair and unjust treatment of an individual based on his or her real or perceived HIV status or being perceived to belong to a particular group.

Stigma and discrimination reduction activities may include:

- Enhancing practical knowledge to reduce fear of casual transmission;
- Providing a safe forum to discuss sensitive topics (sex, death, drug use, inequity);
- Finding a common language to talk about stigma;
- Strengthening the capacity of people living with HIV and AIDS to challenge stigma in their lives;
- Providing a process to determine appropriate and feasible individual and community responses to stigma;
- Providing comprehensive, flexible tools for organizations to strengthen staff skills and develop or strengthen interventions to reduce HIV-related stigma; and
- Developing a system to compile and address reported acts of discrimination.

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

This indicator simply measures number trained in stigma and discrimination reduction as opposed to the percent of organizations with trained staff.

Only participants who complete the full training course should be counted.

If a training course covers more than one stigma and discrimination reduction

topic, individuals should only be counted once for that training course.

If a training course is conducted in more than one session/training event, only individuals who complete the full course should be counted. Do not sum the participants for each training event.

Individuals trained in training courses co-funded by more than one USG agency/USG-funded partner should only be counted once within the specified reporting period (6 months for semi-annual report/12 months for annual report).

RATIONALE:
Supportive Interventions strengthen HIV prevention, care and treatment programs. This indicator measures the number of individuals trained in HIV-related stigma and discrimination reduction.

UNIT:	*DISAGGREGATE BY:*
Number of individuals	None
TYPE: OUTPUT/OUTCOME	*DIRECTION OF CHANGE:*
Output	Higher = better

DATA SOURCE:
Program reports. USG agencies and USG-funded partners should keep a training log including the type of training, date, location, and participants.

MEASUREMENT NOTES:
Each USG agency and USG-funded partner counts the number of individuals trained in stigma and discrimination reduction by USG staff (HQ or field-based) or USG-funded partners during the specified reporting period (6 months for semi-annual report/12 months for annual report).

The USG staff responsible for compiling the semi-annual/annual reporting data should use the training log submitted by each USG agency and USG-funded partner reporting on this indicator in order to count the total number of individuals trained in stigma and discrimination reduction.

In order to avoid double counting, countries will need to monitor their activities by partner, programmatic area, and geographic area. This matrix is an excellent program management tool as well as helping to adjust for double counting by partners, among partners, and among USG agencies.

ELEMENT: **IIP - 1.1 HIV/AIDS**

INDICATOR TITLE: **NUMBER OF INDIVIDUALS TRAINED IN HIV-RELATED COMMUNITY MOBILIZATION FOR PREVENTION CARE AND/OR TREATMENT**

DEFINITION:

Training refers to new training or retraining of individuals and assumes that training is conducted according to national or international standards when these exist. Count all individuals trained, from local organizations or otherwise, during the reporting period.

A training must have specific learning objectives, a course outline or curriculum, and expected knowledge, skills and/or competencies to be gained by participants.

Community mobilization activities include:

- Identifying social groups and mapping existing formal structures or networks in order to encourage or promote HIV prevention, care and/or treatment interventions and services, such as counseling and testing, PMTCT, HIV care and antiretroviral treatment
  Building trust with the community by providing a forum to discuss their perceived needs for HIV prevention, care and/or treatment interventions and services,
- Developing communication around social networks to engage in dialogue with the community which encourages or promotes HIV prevention, care and/or treatment interventions and services,
- Creating media and events that expose community members to new ideas, involving them in problem solving, and encouraging innovations which promote HIV prevention, care and/or treatment interventions and services.

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

This indicator simply measures number trained in stigma and discrimination reduction as opposed to the percent of organizations with trained staff.

Each USG agency and USG-funded partner counts the number of individuals trained in community mobilization by USG staff (HQ or field-based) or USG-funded partners during the specified reporting period (6 months for semi-annual report/12 months for annual report).

Only participants who complete the full training course should be counted.
If a training course covers more than one community mobilization topic, individuals should only be counted once for that training course.

If a training course is conducted in more than one session/training event, only individuals who complete the full course should be counted. Do not sum the participants for each training event.

Individuals trained in training courses co-funded by more than one USG agency/USG-funded partner should only be counted once within the specified reporting period (6 months for semi-annual report/12 months for annual report).

RATIONALE:
Supportive Interventions strengthen HIV prevention, care and treatment programs. This indicator measures the number of individuals trained in HIV-related community mobilization for prevention, care and/or treatment.

UNIT:	*DISAGGREGATE BY:*
Number of individuals	None
TYPE: OUTPUT/OUTCOME	*DIRECTION OF CHANGE:*
Output	Higher = better

DATA SOURCE:
Program reports. USG agencies and USG-funded partners should keep a training log including the type of training, date, location, and participants.

MEASUREMENT NOTES:
The USG staff responsible for compiling the semi-annual/annual reporting data should use the training log submitted by each USG agency and USG-funded partner reporting on this indicator in order to count the total number of individuals trained in community mobilization.

In order to avoid double counting, countries will need to monitor their activities by partner, programmatic area, and geographic area. This matrix is an excellent program management tool as well as helping to adjust for double counting by partners, among partners, and among USG agencies.

ELEMENT: **IIP - 1.1 HIV/AIDS**	
INDICATOR TITLE: **NUMBER OF MISSIONS ACCESSING CENTRALLY-DESIGNED OR MANAGED MECHANISMS USING THEIR OWN FUNDING**	
DEFINITION: To avoid double-counting, this indicator is only to be used by Functional Bureaus. Centrally-designed or managed mechanisms are defined as contracts, grants, and cooperative agreements designed or managed in a Functional Bureau. Missions may access these mechanisms through task orders under IQCs, field support, MAARDs or Associate Awards under centrally-managed Leader with Associate Award cooperative agreements.	
RATIONALE: One of the primary functions of Functional Bureaus is to provide technical support to missions. One way to accomplish this is through centrally-designed and managed mechanisms. This indicator is a measure of the breadth of use of central mechanisms by missions.	
UNIT: Number	*DISAGGREGATE BY:* None
TYPE: OUTPUT/OUTCOME Output	*DIRECTION OF CHANGE:* Higher=better
DATA SOURCE: Field Support Database	
MEASUREMENT NOTES:	

ELEMENT: **IIP - 1.1 HIV/AIDS**	
INDICATOR TITLE: **RATIO OF MISSION FUNDING TO CORE FUNDING IN CENTRALLY-MANAGED MECHANISMS DESIGNED TO SUPPORT THE FIELD**	
DEFINITION: To avoid double-counting, this indicator is only to be used by Functional Bureaus. Numerator: Sum of element-specific mission funding obligated to eligible mechanisms in the FY. Denominator: Sum of element-specific core funding obligated to eligible projects in the FY. Eligible mechanisms include all those that are centrally-managed and for which it was expected at the time of design that a portion of the funding would come from non-core sources; i.e., most mechanisms that provide training or technical assistance, some research mechanisms, and some international partnerships. Mission funding is defined as mission OYB obligated through the field support system into centrally-managed mechanisms (field support), mission OYB sub-obligated from mission SOAGs into centrally-managed mechanisms (through MAARDS), and mission-allocated funding deposited into the Working Capital Fund and subsequently obligated into centrally-managed mechanisms.	
RATIONALE: One of the primary functions of Functional Bureaus is to provide technical support to missions. One way to accomplish this is through centrally-managed mechanisms. This indicator is a measure of the extent to which projects designed to meet mission needs are doing so.	
UNIT: Ratio	*DISAGGREGATE BY:* None
TYPE: OUTPUT/OUTCOME Output	*DIRECTION OF CHANGE:* Higher=better
DATA SOURCE: Field Support Database and core budgets	
MEASUREMENT NOTES: Mission-issued Task Order and Associate Award funding is not included in this measure because those funds are not centrally managed	

ELEMENT: **IIP - 1.1 HIV/AIDS**	
INDICATOR TITLE: **PERSON-DAYS OF TECHNICAL SUPPORT PROVIDED TO MISSIONS THROUGH TDYS**	
DEFINITION: To avoid double counting, this indicator is only to be used by Functional Bureaus and Regional Platforms. Total number of days spent in travel status to USAID-supported field programs where primary purpose of travel as noted on the travel request form is "direct support to mission" or "direct support to GH-managed CAs, projects, etc."	
RATIONALE: One of the primary functions of Functional Bureaus is to provide technical support to missions. One way to accomplish this is to provide in-person expert support for program design, implementation, and evaluation. This indicator is a measure of the quantity of in-person technical support provided to missions.	
UNIT: Number of person days	*DISAGGREGATE BY:* Country
TYPE: OUTPUT/OUTCOME Output	*DIRECTION OF CHANGE:* Higher=better
DATA SOURCE: GH travel worksheet	
MEASUREMENT NOTES:	

ELEMENT: **IIP - 1.1 HIV/AIDS**	
INDICATOR TITLE: **NUMBER OF TECHNOLOGIES UNDER DEVELOPMENT**	
DEFINITION: To avoid double-counting, this indicator is *only* to be used by Functional Bureaus. Any new technology (e.g., contraceptive, vaccine, drug) or new use of an existing technology (e.g., community-based treatment of pneumonia with amoxicillin) undergoing Phase II or III clinical trials or field-based operations research.	
RATIONALE: One of the primary functions of Functional Bureaus is to conduct applied and operations research. This indicator is a measure of the volume and progress of that research.	
UNIT: Number of technologies	*DISAGGREGATE BY:* None
TYPE: OUTPUT/OUTCOME Output	*DIRECTION OF CHANGE:* Higher = better
DATA SOURCE Data collected from implementing partners by Functional Bureaus	
MEASUREMENT NOTES:	

ELEMENT: **IIP - 1.2 TUBERCULOSIS**	
INDICATOR TITLE: **PERCENT OF THE ESTIMATED NUMBER OF NEW SMEAR-POSITIVE PULMONARY TB CASES THAT WERE DETECTED UNDER DOTS (I.E. CASE DETECTION RATE)**	
DEFINITION: The percentage of new smear positive TB cases detected (diagnosed and reported to the national authorities) among the total number of TB cases estimated to occur countrywide each year. Numerator: Number of new smear positive TB cases detected under DOTS programs Denominator: Estimate number of new smear positive TB cases country wide (x 100)	
RATIONALE: Internationally recognized indicator that measures changes in the DOTS program's capacity to detect TB cases. An upward trend in case detection can reflect improvement in program performance or, in some cases, the impact of HIV/AIDS. This indicator should be reported for any TB program at the national level. Corresponding sub element: 1.2.1 – DOTS expansion and enhancement	
UNIT: Percent	*DISAGGREGATE BY:* This indicator can also be used to calculate case detection for all forms of TB, and for new smear positive TB cases from all sources.
TYPE: OUTPUT/OUTCOME Outcome	*DIRECTION OF CHANGE:* Higher=better
DATA SOURCE: USG Partners	
MEASUREMENT NOTES: Collected and Available. Most recent year collected – 2005.	

Element: **IIP - 1.2 Tuberculosis**	
INDICATOR TITLE: **CASE NOTIFICATION RATE IN NEW SPUTUM SMEAR POSITIVE PULMONARY TB CASES PER 100,000 POPULATION IN USG-SUPPORTED AREAS**	
DEFINITION: Case notification rate in new sputum smear positive pulmonary TB cases reported by DOTS programs in a specified geographic area Numerator: Number of new sputum smear positive pulmonary TB cases reported in the past year Denominator: Total population in the specified geographic area (x 100,000)	
RATIONALE: Internationally recognized indicator that measures changes in the TB program's capacity to detect TB cases. An upward trend in case notification can reflect improvement in program performance or, in some cases, the impact of HIV/AIDS. Can be measured at the sub-national level.	
UNIT: Cases reported/population (x 100,000)	*DISAGGREGATE BY:*
TYPE: OUTPUT/OUTCOME Outcome	*DIRECTION OF CHANGE:* Higher = better
DATA SOURCE: Implementing partners	
MEASUREMENT NOTES:	

Element: **IIP - 1.2 Tuberculosis**

INDICATOR TITLE: **PERCENT OF REGISTERED NEW SMEAR-POSITIVE PULMONARY TB CASES THAT WERE CURED AND COMPLETED TREATMENT UNDER DOTS (I.E. TREATMENT SUCCESS RATE) IN USG-SUPPORTED AREAS**

DEFINITION:
Percent of registered new smear-positive pulmonary TB cases that were cured and completed treatment under DOTS (i.e. treatment success rate)

Numerator: Number of new sputum smear positive pulmonary TB cases registered in a specified time period that were cured plus the number that completed treatment in the same specified time period

Denominator: Total number of new smear positive TB cases registered in the same specified time period (x 100)

RATIONALE:
Internationally recognized indicator that measures a program's capacity to retain patients through a complete course of TB treatment with favorable clinical results. There is a direct link between the treatment success rate and the impact of reduced TB mortality. This indicator should be reported at the national level and should at the sub-national level in USG supported areas (such as districts, provinces, states, etc.).

Corresponding sub element: 1.2.1 – DOTS expansion and enhancement

UNIT:	*DISAGGREGATE BY:*
Percent	None
TYPE: OUTPUT/OUTCOME	*DIRECTION OF CHANGE:*
Outcome	Higher=better

DATA SOURCE:

MEASUREMENT NOTES:

ELEMENT: **IIP-1.2 TUBERCULOSIS**	
INDICATOR TITLE: **NUMBER OF PEOPLE TRAINED IN DOTS WITH USG FUNDING**	
DEFINITION: Number of people (medical personnel, laboratory technicians, health workers, community workers, etc.) trained in the components of the DOTS strategy	
RATIONALE: This indicator will be used to quantify USG support for building local capacity for delivering DOTS. Corresponding sub elements: 1.2.1 – DOTS expansion and enhancement	
UNIT: Number of people	*DISAGGREGATE BY:* Gender
TYPE: OUTPUT/OUTCOME Output	*DIRECTION OF CHANGE:* Higher = better
DATA SOURCE: USG partners	
MEASUREMENT NOTES: Data collected and available. Most recent year collected – 2007.	

ELEMENT: **IIP-1.2 TUBERCULOSIS**	
INDICATOR TITLE: **NUMBER OF PEOPLE TRAINED IN TB SUB-ELEMENTS WITH USG FUNDING**	
DEFINITION: Number of people (medical personnel, laboratory technicians, health workers, community workers, etc.) trained in any of the TB sub-elements	
RATIONALE: This indicator will be used to quantify USG support for building local capacity for delivering the various components of the TB element. Corresponding sub elements: 1.2.1 – DOTS expansion and enhancement; 1.2.3 - Improve management of TB/HIV; 1.2.4 – Multi Drug Resistant TB; 1.2.5 – TB Care and Support.	
UNIT: Number of people	*DISAGGREGATE BY:* Gender
TYPE: OUTPUT/OUTCOME Output	*DIRECTION OF CHANGE:* Higher=better
DATA SOURCE: USG Partners	
MEASUREMENT NOTES: Data collected and available. Most recent year collected – 2007.	

ELEMENT: **IIP - 1.2 TUBERCULOSIS**	
INDICATOR TITLE: **TB MICROSCOPY LABORATORY COVERAGE IN USG-SUPPORTED AREAS**	
DEFINITION: Average population per TB microscopy unit Numerator: Total Population Denominator: Total number of TB microscopy units	
RATIONALE: Internationally recognized indicator that measures the coverage of smear microscopy in the laboratory network. (50,000 – 100,000 people/microscopy unit is the internationally recommended standard depending on the geographic setting and workload of the lab) Corresponding sub element: 1.2.1 – DOTS expansion and enhancement	
UNIT: People per laboratory	*DISAGGREGATE BY:* None
TYPE: OUTPUT/OUTCOME Output	*DIRECTION OF CHANGE:* Lower=Better
DATA SOURCE: Implementing partners	
MEASUREMENT NOTES:	

ELEMENT: **IIP - 1.2 TUBERCULOSIS**	
INDICATOR TITLE: **TB LABORATORY QUALITY ASSURANCE FOR SMEAR MICROSCOPY IN USG-SUPPORTED AREAS**	
DEFINITION: Percent of laboratories performing TB microscopy with over 95% correct microscopy results Numerator: Number of laboratories with over 95% correct microscopy results as compared to external quality assurance checking by reference lab Denominator: Total number of laboratories performing TB microscopy	
RATIONALE: A quantitative indicator that measures the performance (quality) of laboratory smear microscopy services. It is expected that laboratories performing TB microscopy should provide over 95% correct results when compared to the external quality assurance performed by the reference lab. Corresponding sub element: 1.2.1 – DOTS expansion and enhancement	
UNIT: Percent	*DISAGGREGATE BY:* None
TYPE: OUTPUT/OUTCOME Output	*DIRECTION OF CHANGE:* Higher=better
DATA SOURCE: USG Partners	
MEASUREMENT NOTES: Collected and Available. Most recent year collected – 2007.	

ELEMENT: **IIP - 1.2 TUBERCULOSIS**	
INDICATOR TITLE: **PERCENT OF USG-SUPPORTED LABORATORIES PERFORMING TB MICROSCOPY WITH OVER 95% CORRECT MICROSCOPY RESULTS**	
DEFINITION: Percent of laboratories performing TB microscopy with over 95% correct microscopy results Numerator: Number of laboratories with over 95% correct microscopy results as compared to external quality assurance checking by reference lab Denominator: Total number of laboratories performing TB microscopy	
RATIONALE: A quantitative indicator that measures the performance (quality) of laboratory smear microscopy services. It is expected that laboratories performing TB microscopy should provide over 95% correct results when compared to the external quality assurance performed by the reference lab.	
UNIT: Percent	*DISAGGREGATE BY:* None
TYPE: OUTPUT/OUTCOME Output	*DIRECTION OF CHANGE:* Higher=better
DATA SOURCE: Implementing partners	
MEASUREMENT NOTES:	

ELEMENT: **IIP - 1.2 TUBERCULOSIS**	
INDICATOR TITLE: **PERCENT OF ALL REGISTERED TB PATIENTS WHO ARE TESTED FOR HIV THROUGH USG-SUPPORTED PROGRAMS**	
DEFINITION: Percent of all registered TB patients (over a given time period) who are tested for HIV Numerator: Number of registered TB patients (over a given time period) who are tested for HIV Denominator: Total number of registered TB patients (over the same time period)	
RATIONALE: This is an internationally recognized indicator to measure the performance of TB program in terms of testing for HIV.	
UNIT: Percent	*DISAGGREGATE BY:* Sex
TYPE: OUTPUT/OUTCOME Output	*DIRECTION OF CHANGE:* Higher = better
DATA SOURCE: Implementing partners	
MEASUREMENT NOTES:	

PROGRAM AREA: **IIP - 1.2 TUBERCULOSIS**	
INDICATOR TITLE: **EXISTENCE OF A MULTI-DRUG RESISTANT TB QUALITY CONTROL STANDARD AT THE NATIONAL LEVEL**	
DEFINITION: The existence of a MDR quality control standard at the national level A qualitative indicator measures on a scale of 0 – 3 whether a country's MDR TB program meets the technically recommended multi-drug resistance quality control standard at the national level. There are <u>three</u> quality criteria that a country needs to meet: • A policy supporting MDR-TB diagnosis and treatment • Existence of a functioning surveillance (or survey) system • At least one laboratory in the public sector performing culture & Drug sensitivity testing Each component is rated as 1=Yes and 0=No. Total score of 3 indicates that the country meets the quality criteria.	
RATIONALE: This is an internationally recognized indicator to measure the policy, surveillance and diagnosis for MDR-TB.	
UNIT: Rating on a scale of 0-3	*DISAGGREGATE BY:* None
TYPE: OUTPUT/OUTCOME Output	*DIRECTION OF CHANGE:* Higher = better
DATA SOURCE: Implementing partners	
MEASUREMENT NOTES:	

ELEMENT: **IIP - 1.2 TUBERCULOSIS**	
INDICATOR TITLE: **TREATMENT SUCCESS RATE IN USG-ASSISTED DOTS PLUS PROGRAMS TO TREAT MDR TB PATIENTS**	
DEFINITION: Percent of registered category IV TB patients that were cured and completed treatment under DOTS Plus programs with second line anti-TB drugs (i.e. treatment success rate). Numerator: Number of category IV TB patients registered in a specified time period that were cured plus the number that completed treatment in the same specified time period. Denominator: Total number of category IV TB cases registered in the same specified time period (x 100).	
RATIONALE:	
UNIT: Percent	*DISAGGREGATE BY:* None
TYPE: OUTPUT/OUTCOME Outcome	*DIRECTION OF CHANGE:* Higher = better
DATA SOURCE: Implementing partners	
MEASUREMENT NOTES:	

ELEMENT: **IIP - 1.2 TUBERCULOSIS**	
INDICATOR TITLE: **NUMBER OF TB CASES REPORTED TO NTP BY USG-ASSISTED NON-MOH SECTOR**	
DEFINITION: Number of TB cases reported to NTP by non-MOH sector. Non-MOH sector can include prisons, social security, private sector clinics and hospitals, clinics and hospitals for military and police, and faith based clinics and hospitals.	
RATIONALE: This is an internationally recognized indicator that measures the contribution of all providers outside of the MOH National TB Program (NTP) to TB case notification.	
UNIT: Number of cases	*DISAGGREGATE BY:* Sex
TYPE: OUTPUT/OUTCOME Output	*DIRECTION OF CHANGE:* Higher = better
DATA SOURCE: Implementing partners	
MEASUREMENT NOTES:	

ELEMENT: **IIP - 1.2 TUBERCULOSIS**	
INDICATOR TITLE: **NUMBER OF IMPROVEMENTS TO LAWS, POLICIES, REGULATIONS OR GUIDELINES RELATED TO IMPROVE ACCESS TO AND USE OF HEALTH SERVICES DRAFTED WITH USG SUPPORT**	
DEFINITION: Number of improvements to laws, policies, regulations or guidelines related to improve access to and use of health services drafted with USG support	
RATIONALE: Policies are important for the sustainability of programs and for use and access of services	
UNIT: Number of policies drafted	*DISAGGREGATE BY:* Policy improvements informed by National Health Accounts/Other USG input
TYPE: OUTPUT/OUTCOME Output	*DIRECTION OF CHANGE:* Higher = better
DATA SOURCE: Implementing partners	
MEASUREMENT NOTES: More changes are not necessarily better than fewer. What is important is that a supportive policy environment exists. This could be the result of a single policy change. This indicator can be used within or across health elements. If used within an element, it must be measured for and relate specifically to that element.	

ELEMENT: **IIP-1.2 TUBERCULOSIS**	
INDICATOR TITLE: **NUMBER OF PEOPLE COVERED BY USG-SUPPORTED HEALTH FINANCING ARRANGEMENTS**	
DEFINITION: Number of people covered by USG-supported health insurance or subsidies (to avoid double counting, individuals receiving both insurance and subsidies are to be counted only once)	
RATIONALE: Financing arrangements remove barriers to access and use of health services	
UNIT: Number of people	*DISAGGREGATE BY:* None
TYPE: OUTPUT/OUTCOME Output	*DIRECTION OF CHANGE:* Higher = better
DATA SOURCE: Implementing partners	
MEASUREMENT NOTES:	

ELEMENT: **IIP-1.2 TUBERCULOSIS**	
INDICATOR TITLE: **NUMBER OF USG-ASSISTED SERVICE DELIVERY POINTS EXPERIENCING STOCK-OUTS OF SPECIFIC TRACER DRUGS**	
DEFINITION: Number of USG-assisted service delivery points (SDPs) experiencing stock-outs at any time during the defined reporting period of specific tracer drugs offered by the SDP. Drugs should be included based on locally developed list (e.g., oral contraceptives, artemisinin-based combination therapies, oral rehydration salts)	
RATIONALE: Provides a measure of the ability of the procurement and distribution system to maintain a constant supply of drugs.	
UNIT: Number of SDPs	*DISAGGREGATE BY:* None
TYPE: OUTPUT/OUTCOME Output	*DIRECTION OF CHANGE:* Lower = better
DATA SOURCE: Implementing partners	
MEASUREMENT NOTES:	

ELEMENT: **IIP-1.2 TUBERCULOSIS**	
INDICATOR TITLE: **VALUE OF PHARMACEUTICALS AND HEALTH COMMODITIES PURCHASED BY USG-ASSISTED GOVERNMENTAL ENTITIES THROUGH COMPETITIVE TENDERS**	
DEFINITION: Value of pharmaceuticals and health commodities from all funding sources purchased by USG-assisted governmental entities using sealed bids and a transparent and accountable procurement process.	
RATIONALE: Over time, an increase in this indicator reflects an improvement in the use of available resources and provides an indication of the commitment to cost-efficient purchases and ethical practices.	
UNIT: US dollars	*DISAGGREGATE BY:* Central level and other
TYPE: OUTPUT/OUTCOME Output	*DIRECTION OF CHANGE:* Higher = better
DATA SOURCE: Implementing partners	

ELEMENT: **IIP-1.2 TUBERCULOSIS**	
INDICATOR TITLE: **ASSESSMENT OF USG-ASSISTED CLINIC FACILITIES' COMPLIANCE WITH CLINICAL STANDARDS**	
DEFINITION: Of a random sample of at least 3 clinical facilities receiving USG assistance, the per cent of providers by major category (e.g., graduate nurse, clinical officer), for which documentation is provided of an independent assessment of compliance with at least one clinical standard issued by a national authority, during the previous 12 months. Sampling frame comprises the facilities where USG provided assistance on health systems improvement and which are feasible to visit.	
RATIONALE: Required to assure technical quality of services	
UNIT: Percent of providers	*DISAGGREGATE BY:* None
TYPE: OUTPUT/OUTCOME Output	*DIRECTION OF CHANGE:* Higher = better
DATA SOURCE: Implementing partners	
MEASUREMENT NOTES:	

ELEMENT: **IIP-1.2 TUBERCULOSIS**	
INDICATOR TITLE: **NUMBER OF MISSIONS ACCESSING CENTRALLY-DESIGNED OR MANAGED MECHANISMS USING THEIR OWN FUNDING**	
DEFINITION: To avoid double-counting, this indicator is only to be used by Functional Bureaus. Centrally-designed or managed mechanisms are defined as contracts, grants, and cooperative agreements designed or managed in a Functional Bureau. Missions may access these mechanisms through task orders under IQCs, field support, MAARDs or Associate Awards under centrally-managed Leader with Associate Award cooperative agreements.	
RATIONALE: One of the primary functions of Functional Bureaus is to provide technical support to missions. One way to accomplish this is through centrally-designed and managed mechanisms. This indicator is a measure of the breadth of use of central mechanisms by missions.	
UNIT: Number	*DISAGGREGATE BY:* None
TYPE: OUTPUT/OUTCOME Output	*DIRECTION OF CHANGE:* Higher=better
DATA SOURCE: Field Support Database	
MEASUREMENT NOTES:	

ELEMENT: **IIP-1.2 TUBERCULOSIS**	
INDICATOR TITLE: **NUMBER OF TECHNOLOGIES UNDER DEVELOPMENT**	
DEFINITION: To avoid double-counting, this indicator is *only* to be used by Functional Bureaus. Any new technology (e.g., contraceptive, vaccine, drug) or new use of an existing technology (e.g., community-based treatment of pneumonia with amoxicillin) undergoing Phase II or III clinical trials or field-based operations research.	
RATIONALE: One of the primary functions of Functional Bureaus is to conduct applied and operations research. This indicator is a measure of the volume and progress of that research.	
UNIT: Number of technologies	*DISAGGREGATE BY:* None
TYPE: OUTPUT/OUTCOME Output	*DIRECTION OF CHANGE:* Higher = Better
DATA SOURCE:	
MEASUREMENT NOTES:	

ELEMENT: **IIP-1.2 TUBERCULOSIS**

INDICATOR TITLE: **RATIO OF MISSION FUNDING TO CORE FUNDING IN CENTRALLY-MANAGED MECHANISMS DESIGNED TO SUPPORT THE FIELD**

DEFINITION:

To avoid double-counting, this indicator is only to be used by Functional Bureaus.

Numerator: Sum of element-specific mission funding obligated to eligible mechanisms in the FY.

Denominator: Sum of element-specific core funding obligated to eligible projects in the FY.

Eligible mechanisms include all those that are centrally-managed and for which it was expected at the time of design that a portion of the funding would come from non-core sources; i.e., most mechanisms that provide training or technical assistance, some research mechanisms, and some international partnerships.

Mission funding is defined as mission OYB obligated through the field support system into centrally-managed mechanisms (field support), mission OYB sub-obligated from mission SOAGs into centrally-managed mechanisms (through MAARDS), and mission-allocated funding deposited into the Working Capital Fund and subsequently obligated into centrally-managed mechanisms.

RATIONALE:

One of the primary functions of Functional Bureaus is to provide technical support to missions. One way to accomplish this is through centrally-managed mechanisms. This indicator is a measure of the extent to which projects designed to meet mission needs are doing so.

UNIT:	*DISAGGREGATE BY:*
Ratio	None
TYPE: OUTPUT/OUTCOME	*DIRECTION OF CHANGE:*
Output	Higher=better

DATA SOURCE:

Field Support Database and core budgets

MEASUREMENT NOTES:

Mission-issued Task Order and Associate Award funding is not included in this measure because those funds are not centrally managed

ELEMENT: **IIP-1.2 TUBERCULOSIS**	
INDICATOR TITLE: **PERSON-DAYS OF TECHNICAL SUPPORT PROVIDED TO MISSIONS THROUGH TDYS**	
DEFINITION: To avoid double-counting, this indicator is *only* to be used by Functional Bureaus and Regional Platforms. Total number of days spent in travel status to USAID-supported field programs where primary purpose of travel as noted on the travel request form is "direct support to mission" or "direct support to GH-managed CAs, projects, etc."	
RATIONALE: One of the primary functions of Functional Bureaus is to provide technical support to missions. One way to accomplish this is to provide in-person expert support for program design, implementation, and evaluation. This indicator is a measure of the quantity of in-person technical support provided to missions.	
UNIT: Number of person days	*DISAGGREGATE BY:* None
TYPE: OUTPUT/OUTCOME Output	*DIRECTION OF CHANGE:* Higher = better
DATA SOURCE: GH travel worksheet	
MEASUREMENT NOTES: None	

ELEMENT: **IIP-1.2 TUBERCULOSIS**	
INDICATOR TITLE: **NUMBER OF MEDICAL AND PARA-MEDICAL PRACTITIONERS TRAINED IN EVIDENCE-BASED CLINICAL GUIDELINES**	
DEFINITION: Number of medical and paramedical practitioners trained in evidence-based clinical guidelines, where guidelines are based on at least one clinical standard issued by a national authority. Training refers to new training or retraining of individuals and assumes that training is conducted according to national or international standards when these exist. A training must have specific learning objectives, a course outline or curriculum, and expected knowledge, skills and/or competencies to be gained by participants.	
RATIONALE: Required to assure technical quality of services	
UNIT: Number of people	*DISAGGREGATE BY:* None
TYPE: OUTPUT/OUTCOME Output	*DIRECTION OF CHANGE:* Higher = better
DATA SOURCE: Implementing partners	
MEASUREMENT NOTES: This indicator can be used within or across health elements. If used within an element, it must be measured for and relate specifically to that element.	

ELEMENT: **IIP - 1.3 MALARIA**	
INDICATOR TITLE: **NUMBER OF HOUSES SPRAYED WITH IRS WITH USG SUPPORT**	
DEFINITION: Number of occupied houses in the indoor residual spraying (IRS) program target area sprayed with a residual insecticide for malaria prevention with USG direct support.	
RATIONALE: Used to measure the number of houses reached with one of the two high impact prevention interventions for malaria attributable to USG support.	
UNIT: Number of houses	*DISAGGREGATE BY:* None
TYPE: OUTPUT/OUTCOME Output	*DIRECTION OF CHANGE:* Higher = better
DATA SOURCE: Implementing partners	
MEASUREMENT NOTES:	

ELEMENT: **IIP - 1.3 MALARIA**	
INDICATOR TITLE: **NUMBER OF PEOPLE TRAINED WITH USG FUNDS IN MALARIA TREATMENT OR PREVENTION**	
DEFINITION: Number of people (medical personnel, health workers, community workers, etc.) trained in malaria treatment or prevention	
RATIONALE: This indicator will be used to quantify one of the inputs of USG support for building local capacity for delivering malaria services.	
UNIT: Number of people	*DISAGGREGATE BY:* Sex
TYPE: OUTPUT/OUTCOME Output	*DIRECTION OF CHANGE:* Higher = better
DATA SOURCE: Implementing partners	
MEASUREMENT NOTES:	

ELEMENT: **IIP - 1.3 MALARIA**	
INDICATOR TITLE: **NUMBER OF ARTEMISININ-BASED COMBINATION TREATMENTS (ACTS) PURCHASED WITH USG-SUPPORT**	
DEFINITION: Number of treatments with artemisinin-based combination drugs purchased and distributed to malaria patients through USG support.	
RATIONALE: Used to measure the number of treatments with the highly effective artemisinin-based combination drugs that are delivered to patients with malaria	
UNIT: Number of ACTs	*DISAGGREGATE BY:* None
TYPE: OUTPUT/OUTCOME Output	*DIRECTION OF CHANGE:* Higher = better
DATA SOURCE: Implementing partners	
MEASUREMENT NOTES:	

ELEMENT: **IIP - 1.3 MALARIA**	
INDICATOR TITLE: **NUMBER OF IMPROVEMENTS TO LAWS, POLICIES, REGULATIONS OR GUIDELINES RELATED TO IMPROVE ACCESS TO AND USE OF HEALTH SERVICES DRAFTED WITH USG SUPPORT**	
DEFINITION: Number of improvements to laws, policies, regulations or guidelines related to improve access to and use of health services drafted with USG support	
RATIONALE: Policies are important for the sustainability of programs and for use and access of services	
UNIT: Number of policies	*DISAGGREGATE BY:* Policy improvements informed by National Health Accounts/Other USG input
TYPE: OUTPUT/OUTCOME Output	*DIRECTION OF CHANGE:* Higher = better
DATA SOURCE: Implementing partners	
MEASUREMENT NOTES: More changes are not necessarily better than fewer. What is important is that a supportive policy environment exists. This could be the result of a single policy change. This indicator can be used within or across health elements. If used within an element, it must be measured for and relate specifically to that element.	

ELEMENT: **IIP - 1.3 MALARIA**	
INDICATOR TITLE: **NUMBER OF PEOPLE COVERED BY USG-SUPPORTED HEALTH FINANCING ARRANGEMENTS**	
DEFINITION: Number of people covered by USG-supported health insurance or subsidies (to avoid double counting, individuals receiving both insurance and subsidies are to be counted only once)	
RATIONALE: Financing arrangements remove barriers to access and use of health services	
UNIT: Number of people	*DISAGGREGATE BY:* None
TYPE: OUTPUT/OUTCOME Output	*DIRECTION OF CHANGE:* Higher = better
DATA SOURCE: Implementing partners	
MEASUREMENT NOTES:	

ELEMENT: **IIP - 1.3 MALARIA**	
INDICATOR TITLE: **NUMBER OF USG-ASSISTED SERVICE DELIVERY POINTS EXPERIENCING STOCK-OUTS OF SPECIFIC TRACER DRUGS**	
DEFINITION: Number of USG-assisted service delivery points (SDPs) experiencing stock-outs at any time during the defined reporting period of specific tracer drugs offered by the SDP. Drugs should be included based on locally developed list (e.g., oral contraceptives, artemisinin-based combination therapies, oral rehydration salts)	
RATIONALE: Provides a measure of the ability of the procurement and distribution system to maintain a constant supply of drugs.	
UNIT: Number of SDPs	*DISAGGREGATE BY:* None
TYPE: OUTPUT/OUTCOME Output	*DIRECTION OF CHANGE:* Lower = better
DATA SOURCE: Implementing partners	
MEASUREMENT NOTES:	

ELEMENT: **IIP - 1.3 MALARIA**	
INDICATOR TITLE: **VALUE OF PHARMACEUTICALS AND HEALTH COMMODITIES PURCHASED BY USG-ASSISTED GOVERNMENTAL ENTITIES THROUGH COMPETITIVE TENDERS**	
DEFINITION: Value of pharmaceuticals and health commodities from all funding sources purchased by USG-assisted governmental entities using sealed bids and a transparent and accountable procurement process.	
RATIONALE: Over time, an increase in this indicator reflects an improvement in the use of available resources and provides an indication of the commitment to cost-efficient purchases and ethical practices.	
UNIT: US dollars	*DISAGGREGATE BY:* Central level and other
TYPE: OUTPUT/OUTCOME Output	*DIRECTION OF CHANGE:* Higher = better
DATA SOURCE: Implementing partners	
MEASUREMENT NOTES:	

ELEMENT: **IIP - 1.3 MALARIA**	
INDICATOR TITLE: **USG-ASSISTED FACILITIES' PROVIDER STAFF WITH A WRITTEN PERFORMANCE APPRAISAL**	
DEFINITION: Of a random sample of at least 3 USG-assisted facilities, the per cent of provider staff with a written performance appraisal in the past 12 months. A performance appraisal must refer to the duties and actual performance of a specific provider, and be available on site. Sampling frame comprises the facilities where USG provided assistance on health systems improvement and which are feasible to visit.	
RATIONALE: Fundamental feature of human resource management	
UNIT: Percent of providers	*DISAGGREGATE BY:* None
TYPE: OUTPUT/OUTCOME Output	*DIRECTION OF CHANGE:* Higher = better
DATA SOURCE: Implementing partners	
MEASUREMENT NOTES:	

ELEMENT: **IIP - 1.3 MALARIA**	
INDICATOR TITLE: **ASSESSMENT OF USG-ASSISTED CLINIC FACILITIES' COMPLIANCE WITH CLINICAL STANDARDS**	
DEFINITION: Of a random sample of at least 3 clinical facilities receiving USG assistance, the per cent of providers by major category (e.g., graduate nurse, clinical officer), for which documentation is provided of an independent assessment of compliance with at least one clinical standard issued by a national authority, during the previous 12 months. Sampling frame comprises the facilities where USG provided assistance on health systems improvement and which are feasible to visit.	
RATIONALE: Required to assure technical quality of services	
UNIT: Percent of providers	*DISAGGREGATE BY:* None
TYPE: OUTPUT/OUTCOME Output	*DIRECTION OF CHANGE:* Higher = better
DATA SOURCE: Implementing partners	
MEASUREMENT NOTES:	

ELEMENT: **IIP - 1.3 MALARIA**	
INDICATOR TITLE: **NUMBER OF HEALTH FACILITIES REHABILITATED**	
DEFINITION: "Rehabilitated" ranges from cosmetic upgrades such as whitewashing walls, to structural improvements (replacing broken windows, fixing leaky roofs, rebuilding damaged walls or roofs), and mending broken furniture.	
RATIONALE: Health facilities in flagrant disrepair are frequently unsafe and inadequate for providing health care.	
UNIT: Number of facilities	*DISAGGREGATE BY:* None
TYPE: OUTPUT/OUTCOME Output	*DIRECTION OF CHANGE:* Higher = better
DATA SOURCE: Implementing partners	
MEASUREMENT NOTES:	

ELEMENT: **IIP - 1.3 MALARIA**	
INDICATOR TITLE: **PROPORTION OF ITNS DISTRIBUTED ACCORDING TO PLAN**	
DEFINITION: Numerator: Number of long-lasting insecticide-treated nets (ITNs) distributed or sold Denominator: Number of ITNs planned to be distributed or sold	
RATIONALE: Used to measure the number of ITNs distributed with USG funds. Distribution of ITNs is one of the two high-impact prevention interventions for malaria.	
UNIT: Number of ITNs	*DISAGGREGATE BY:* None
TYPE: OUTPUT/OUTCOME Output	*DIRECTION OF CHANGE:* Higher=better
DATA SOURCE: Implementing partners	
MEASUREMENT NOTES:	

ELEMENT: **IIP - 1.3 MALARIA**	
INDICATOR TITLE: **NUMBER OF SP TABLETS DELIVERED TO ANC CLINICS**	
DEFINITION: Number of Sulfadoxine-Pyrimethamine (SP) tablets purchased with USG funds and delivered to ANC clinics.	
RATIONALE: Used to measure the number of SP tablets distributed for use at ANC clinics for intermittent preventive treatment in pregnancy (IPTp).	
UNIT: Number of SP tablets	*DISAGGREGATE BY:* None
TYPE: OUTPUT/OUTCOME Output	*DIRECTION OF CHANGE:* Higher=better
DATA SOURCE: Implementing partners	
MEASUREMENT NOTES:	

ELEMENT: **IIP - 1.3 MALARIA**	
INDICATOR TITLE: **NUMBER OF RDTS PURCHASED AND DISTRIBUTED THROUGH USG SUPPORT**	
DEFINITION: Number of Rapid Diagnostic Tests (RDTs) purchased with USG funds and distributed to health facilities.	
RATIONALE: Used to measure the number of RDTs distributed to health facilities for use in diagnosing malaria, one of 2 major methods for diagnosis.	
UNIT: Number of RDTs	*DISAGGREGATE BY:* None
TYPE: OUTPUT/OUTCOME Output	*DIRECTION OF CHANGE:* Higher=better
DATA SOURCE: Implementing partners	
MEASUREMENT NOTES:	

ELEMENT: **IIP - 1.3 MALARIA**	
INDICATOR TITLE: **NUMBER OF PEOPLE TRAINED WITH USG FUNDS TO DELIVER IRS**	
DEFINITION: Number of spray personnel and supervisors who have been trained to deliver Indoor Residual Spraying (IRS) according to protocol with USG funds.	
RATIONALE: Trained people to deliver IRS is essential for the correct spraying of houses.	
UNIT: Number of people	*DISAGGREGATE BY:* None
TYPE: OUTPUT/OUTCOME Output	*DIRECTION OF CHANGE:* Higher = better
DATA SOURCE: Implementing partners	
MEASUREMENT NOTES:	

ELEMENT: **IIP - 1.3 MALARIA**	
INDICATOR TITLE: **NUMBER OF MISSIONS ACCESSING CENTRALLY-DESIGNED OR MANAGED MECHANISMS USING THEIR OWN FUNDING**	
DEFINITION: To avoid double-counting, this indicator is only to be used by Functional Bureaus. Centrally-designed or managed mechanisms are defined as contracts, grants, and cooperative agreements designed or managed in a Functional Bureau. Missions may access these mechanisms through task orders under IQCs, field support, MAARDs or Associate Awards under centrally-managed Leader with Associate Award cooperative agreements.	
RATIONALE: One of the primary functions of Functional Bureaus is to provide technical support to missions. One way to accomplish this is through centrally-designed and managed mechanisms. This indicator is a measure of the breadth of use of central mechanisms by missions.	
UNIT: Number	*DISAGGREGATE BY:* None
TYPE: OUTPUT/OUTCOME Output	*DIRECTION OF CHANGE:* Higher=better
DATA SOURCE: Field Support Database	
MEASUREMENT NOTES:	

ELEMENT: **IIP - 1.3 MALARIA**	
INDICATOR TITLE: **NUMBER OF INSECTICIDE TREATED NETS PURCHASED WITH USG FUNDS**	
DEFINITION: Number of ITNs purchased (procured) with USG funds	
RATIONALE: Used to measure the number of ITNs procured with USG funds. Use of ITNs is one of the two high impact prevention interventions for malaria.	
UNIT: Number of ITNs	*DISAGGREGATE BY:* None
TYPE: OUTPUT/OUTCOME Output	*DIRECTION OF CHANGE:* Higher = Better
DATA SOURCE: Implementing Partners	
MEASUREMENT NOTES:	

ELEMENT: **IIP - 1.3 MALARIA**	
INDICATOR TITLE: **NUMBER OF INSECTICIDE TREATED NETS DISTRIBUTED OR SOLD WITH USG FUNDS**	
DEFINITION: Number of ITNs distributed or sold with USG funds. This includes ITNs that were not procured with USG funds in addition to those that were procured with USG funds	
RATIONALE: Used to measure the number of ITNs distributed with USG funds. Distribution of ITNs is one of the two high impact prevention interventions for malaria	
UNIT: Number of ITNs	*DISAGGREGATE BY:* None
TYPE: OUTPUT/OUTCOME Output	*DIRECTION OF CHANGE:* Higher = Better
DATA SOURCE: Implementing Mechanism	
MEASUREMENT NOTES:	

ELEMENT: **IIP - 1.3 MALARIA**	
INDICATOR TITLE: **NUMBER OF MISSION BUY-INS INTO CENTRALLY-DESIGNED OR MANAGED MECHANISMS FOR PROGRAM IMPLEMENTATION IN MALARIA**	
DEFINITION: To avoid double-counting, this indicator is *only* to be used by Functional Bureaus. Number of mission buy-ins into centrally-designed or managed mechanisms for malaria assistance. Each buy-in is counted distinctly; one mission may have more than one buy-in, all of which would contribute to the total. Centrally-designed or managed mechanisms are defined as contracts, grants, and cooperative agreements designed or managed in an AID/W functional bureau. Missions may access these mechanisms through task orders under IQCs, field support, MAARDs or Associate Awards under centrally-managed Leader with Associate Award cooperative agreements.	
RATIONALE: One of the primary functions of Functional Bureaus is to provide technical support to Operating Units in the field. One way to accomplish this is to design and manage central mechanisms for use by the field. Such mechanisms can reduce management burden and increase economies of scale. This indicator is a measure of the use of central mechanisms by Operating Units in the field.	
UNIT: Number of mission buy-ins	*DISAGGREGATE BY:* None
TYPE: OUTPUT/OUTCOME Output	*DIRECTION OF CHANGE:* Higher = better
DATA SOURCE: Field Support Database	
MEASUREMENT NOTES: None	

ELEMENT: **IIP - 1.3 MALARIA**	
INDICATOR TITLE: **RATIO OF MISSION FUNDING TO CORE FUNDING IN CENTRALLY-MANAGED MECHANISMS DESIGNED TO SUPPORT THE FIELD**	
DEFINITION: To avoid double-counting, this indicator is only to be used by Functional Bureaus. Numerator: Sum of element-specific mission funding obligated to eligible mechanisms in the FY. Denominator: Sum of element-specific core funding obligated to eligible projects in the FY. Eligible mechanisms include all those that are centrally-managed and for which it was expected at the time of design that a portion of the funding would come from non-core sources; i.e., most mechanisms that provide training or technical assistance, some research mechanisms, and some international partnerships. Mission funding is defined as mission OYB obligated through the field support system into centrally-managed mechanisms (field support), mission OYB sub-obligated from mission SOAGs into centrally-managed mechanisms (through MAARDS), and mission-allocated funding deposited into the Working Capital Fund and subsequently obligated into centrally-managed mechanisms.	
RATIONALE: One of the primary functions of Functional Bureaus is to provide technical support to missions. One way to accomplish this is through centrally-managed mechanisms. This indicator is a measure of the extent to which projects designed to meet mission needs are doing so.	
UNIT: Ratio	*DISAGGREGATE BY:* None
TYPE: OUTPUT/OUTCOME Output	*DIRECTION OF CHANGE:* Higher=better
DATA SOURCE: Field Support Database and core budgets	
MEASUREMENT NOTES: Mission-issued Task Order and Associate Award funding is not included in this measure because those funds are not centrally managed	

ELEMENT: **IIP - 1.3 MALARIA**	
INDICATOR TITLE: **PERSON-DAYS OF TECHNICAL SUPPORT PROVIDED TO MISSIONS THROUGH TDYS**	
DEFINITION: To avoid double counting, this indicator is *only* to be used by Functional Bureaus and Regional Platforms. Total number of days spent in travel status to USAID-supported field programs where primary purpose of travel as noted on the travel request form is "direct support to mission" or "direct support to GH-managed CAs, projects, etc."	
RATIONALE: One of the primary functions of Functional Bureaus is to provide technical support to missions. One way to accomplish this is to provide in-person expert support for program design, implementation, and evaluation. This indicator is a measure of the quantity of in-person technical support provided to missions.	
UNIT: Number of person days	*DISAGGREGATE BY:* None
TYPE: OUTPUT/OUTCOME Output	*DIRECTION OF CHANGE:* Higher = better
DATA SOURCE: GH travel worksheet	
METHOD FOR AGGREGATING ACROSS COUNTRIES: None	
MEASUREMENT NOTES: None	

ELEMENT: **IIP - 1.3 MALARIA**	
INDICATOR TITLE: **NUMBER OF INSTANCES OF INTERVENTIONS BEING INTRODUCED OR EXPANDED IN COUNTRIES (FUNCTIONAL/PILLAR BUREAU USE ONLY)**	
DEFINITION: To avoid double-counting, this indicator is *only* to be used by Functional Bureaus. The total number of country instances in which an Element's evidence-based interventions (any tools, technologies or approaches) are being introduced (used in a very limited number of program sites or by a very limited number of partners) or expanded (used at at least the district level or by a broad array of partners). A country should be counted more than once if more than one intervention is being introduced or expanded in it. For example, intervention X is being introduced in 4 countries and expanded in 2 countries and, within the same Element, intervention Y is being introduced in 7 countries and expanded in 3 countries (some of which overlap with intervention X). The result for this Element would be 16.	
RATIONALE: One of the primary functions of Functional Bureaus is to provide support to missions and host countries for introducing and expanding new tools, technologies and approaches. This indicator is a measure of the volume and progress of that support.	
UNIT: Number of instances	*DISAGGREGATE BY:* None
TYPE: OUTPUT/OUTCOME Output	*DIRECTION OF CHANGE:* Higher = Better
DATA SOURCE: Data collected from implementing partners by Functional Bureaus	
MEASUREMENT NOTES:	

ELEMENT: **IIP - 1.3 MALARIA**	
INDICATOR TITLE: **NUMBER OF TECHNOLOGIES UNDER DEVELOPMENT**	
DEFINITION: To avoid double-counting, this indicator is *only* to be used by Functional Bureaus. Any new technology (e.g., contraceptive, vaccine, drug) or new use of an existing technology (e.g., community-based treatment of pneumonia with amoxicillin) undergoing Phase II or III clinical trials or field-based operations research.	
RATIONALE: One of the primary functions of Functional Bureaus is to conduct applied and operations research. This indicator is a measure of the volume and progress of that research	
UNIT: Number of technologies	*DISAGGREGATE BY:* None
TYPE: OUTPUT/OUTCOME Output	*DIRECTION OF CHANGE:* Higher is Better
DATA SOURCE: Data collected from implementing partners by Functional Bureaus	
MEASUREMENT NOTES:	

ELEMENT: **IIP - 1.3 MALARIA**	
INDICATOR TITLE: **NUMBER OF MEDICAL AND PARA-MEDICAL PRACTITIONERS TRAINED IN EVIDENCE-BASED CLINICAL GUIDELINES**	
DEFINITION: Number of medical and paramedical practitioners trained in evidence-based clinical guidelines, where guidelines are based on at least one clinical standard issued by a national authority. Training refers to new training or retraining of individuals and assumes that training is conducted according to national or international standards when these exist. A training must have specific learning objectives, a course outline or curriculum, and expected knowledge, skills and/or competencies to be gained by participants.	
RATIONALE: *Required to assure technical quality of services*	
UNIT: Number of people	*DISAGGREGATE BY:* None
TYPE: OUTPUT/OUTCOME Output	*DIRECTION OF CHANGE:* Higher = better
DATA SOURCE: Implementing partners	
MEASUREMENT NOTES: This indicator can be used within or across health elements. If used within an element, it must be measured for and relate specifically to that element.	

ELEMENT: **IIP - 1.4 AVIAN INFLUENZA**	
INDICATOR TITLE: **NUMBER OF INSTANCES OF INTERVENTIONS BEING INTRODUCED OR EXPANDED IN COUNTRIES (FUNCTIONAL/PILLAR BUREAU USE ONLY)**	
DEFINITION: To avoid double-counting, this indicator is *only* to be used by Functional Bureaus. The total number of country instances in which an Element's evidence-based interventions (any tools, technologies or approaches) are being introduced (used in a very limited number of program sites or by a very limited number of partners) or expanded (used at at least the district level or by a broad array of partners). A country should be counted more than once if more than one intervention is being introduced or expanded in it. For example, intervention X is being introduced in 4 countries and expanded in 2 countries and, within the same Element, intervention Y is being introduced in 7 countries and expanded in 3 countries (some of which overlap with intervention X). The result for this Element would be 16.	
RATIONALE: One of the primary functions of Functional Bureaus is to provide support to missions and host countries for introducing and expanding new tools, technologies and approaches. This indicator is a measure of the volume and progress of that support.	
UNIT: Number of instances	*DISAGGREGATE BY:* None
TYPE: OUTPUT/OUTCOME Output	*DIRECTION OF CHANGE:* Higher = Better
DATA SOURCE: Data collected from implementing partners by Functional Bureaus	
MEASUREMENT NOTES:	

ELEMENT: **IIP - 1.4 AVIAN INFLUENZA**	
INDICATOR TITLE: **NUMBER OF USG-PROVIDED PPE KITS DELIVERED TO REQUESTING COUNTRY**	
DEFINITION: The number of PPE kits delivered to Ministries of Agriculture, Ministries of Health, and other organizations conducting Avian and Pandemic Influenza - related surveillance and response activities.	
RATIONALE: It tracks the USG investment towards ensuring surveillance and response activities are conducted in a safe manner and limit human exposure to the H5N1 virus in high risk activities.	
UNIT: Number of PPE Units	*DISAGGREGATE BY:* None
TYPE: OUTPUT/OUTCOME Output	*DIRECTION OF CHANGE:* Higher = better.
DATA SOURCE: USAID Missions	
MEASUREMENT NOTES:	

ELEMENT: **IIP - 1.4 AVIAN INFLUENZA**	
INDICATOR TITLE: **NUMBER OF PEOPLE TRAINED IN AVIAN AND PANDEMIC INFLUENZA-RELATED KNOWLEDGE AND SKILLS WITH USG FUNDS**	
DEFINITION: Number of people trained in Avian and Pandemic Influenza- related surveillance, response and behavior change-communications	
RATIONALE: It tracks the number of people in-countries with knowledge about how to do animal and human surveillance, how to contain an outbreak in animals and humans and how to message to specific audiences about key behaviors related to limiting exposure to and spread of the H5N1 virus.	
UNIT: Number of people trained	*DISAGGREGATE BY:* Those trained in surveillance, containment, and behavior change communications for animal and human health.
TYPE: OUTPUT/OUTCOME Output	*DIRECTION OF CHANGE:* Higher = better
DATA SOURCE: USAID/Washington and USAID Missions	
MEASUREMENT NOTES:	

ELEMENT: **IIP - 1.4 AVIAN INFLUENZA**	
INDICATOR TITLE: **NUMBER OF PEOPLE WHO HAVE SEEN OR HEARD A USG-FUNDED AVIAN AND/OR PANDEMIC INFLUENZA- RELATED MESSAGE**	
DEFINITION: Number of people who have seen or heard an Avian and Pandemic Influenza-related message	
RATIONALE: It tracks the number of people in-countries who have been exposed to Avian and/or Pandemic related messages to provide the estimated reach of AI related communications as the first step in changing risk-behavior.	
UNIT: Number of people	*DISAGGREGATE BY:* None
TYPE: OUTPUT/OUTCOME Output	*DIRECTION OF CHANGE:* Higher = better
DATA SOURCE: Implementing partners	
MEASUREMENT NOTES:	

ELEMENT: **IIP - 1.4 AVIAN INFLUENZA**	
INDICATOR TITLE: **NUMBER OF IMPROVEMENTS TO LAWS, POLICIES, REGULATIONS OR GUIDELINES RELATED TO IMPROVE ACCESS TO AND USE OF HEALTH SERVICES DRAFTED WITH USG SUPPORT**	
DEFINITION: Number of improvements to laws, policies, regulations or guidelines related to improve access to and use of health services drafted with USG support	
RATIONALE: Policies are important for the sustainability of programs and for use and access of services	
UNIT: Number of policy improvements	*DISAGGREGATE BY:* Policy improvements informed by National Health Accounts/Other USG input
TYPE: OUTPUT/OUTCOME Output	*DIRECTION OF CHANGE:* Higher = better
DATA SOURCE: Implementing partners	
MEASUREMENT NOTES: More changes are not necessarily better than fewer. What is important is that a supportive policy environment exists. This could be the result of a single policy change. This indicator can be used within or across health elements. If used within an element, it must be measured for and relate specifically to that element.	

ELEMENT: **IIP - 1.4 AVIAN INFLUENZA**	
INDICATOR TITLE: **NUMBER OF INSTANCES OF INTERVENTIONS BEING INTRODUCED OR EXPANDED IN COUNTRIES (FUNCTIONAL/PILLAR BUREAU USE ONLY)**	
DEFINITION: To avoid double-counting, this indicator is *only* to be used by Functional Bureaus. The total number of country instances in which an Element's evidence-based interventions (any tools, technologies or approaches) are being introduced (used in a very limited number of program sites or by a very limited number of partners) or expanded (used at at least the district level or by a broad array of partners). A country should be counted more than once if more than one intervention is being introduced or expanded in it. For example, intervention X is being introduced in 4 countries and expanded in 2 countries and, within the same Element, intervention Y is being introduced in 7 countries and expanded in 3 countries (some of which overlap with intervention X). The result for this Element would be 16.	
RATIONALE: One of the primary functions of Functional Bureaus is to provide support to missions and host countries for introducing and expanding new tools, technologies and approaches. This indicator is a measure of the volume and progress of that support.	
UNIT: Number of instances	*DISAGGREGATE BY:* None
TYPE: OUTPUT/OUTCOME Output	*DIRECTION OF CHANGE:* Higher = Better
DATA SOURCE: Data collected from implementing partners by Functional Bureaus	
MEASUREMENT NOTES:	

ELEMENT: **IIP - 1.4 AVIAN INFLUENZA**	
INDICATOR TITLE: **NUMBER OF TECHNOLOGIES UNDER DEVELOPMENT**	
DEFINITION: To avoid double-counting, this indicator is *only* to be used by Functional Bureaus. Any new technology (e.g., contraceptive, vaccine, drug) or new use of an existing technology (e.g., community-based treatment of pneumonia with amoxicillin) undergoing Phase II or III clinical trials or field-based operations research.	
RATIONALE: One of the primary functions of Functional Bureaus is to conduct applied and operations research. This indicator is a measure of the volume and progress of that research	
UNIT: Number of technologies	*DISAGGREGATE BY:* None
TYPE: OUTPUT/OUTCOME Output	*DIRECTION OF CHANGE:* Higher is Better
DATA SOURCE: Data collected from implementing partners by Functional Bureaus	
MEASUREMENT NOTES:	

ELEMENT: **IIP - 1.4 AVIAN INFLUENZA**	
INDICATOR TITLE: **ASSESSMENT OF USG-ASSISTED CLINIC FACILITIES' COMPLIANCE WITH CLINICAL STANDARDS**	
DEFINITION: Of a random sample of at least 3 clinical facilities receiving USG assistance, the per cent of providers by major category (e.g., graduate nurse, clinical officer), for which documentation is provided of an independent assessment of compliance with at least one clinical standard issued by a national authority, during the previous 12 months. Sampling frame comprises the facilities where USG provided assistance on health systems improvement and which are feasible to visit.	
RATIONALE: Required to assure technical quality of services	
UNIT: Percent of providers	*DISAGGREGATE BY:* None
TYPE: OUTPUT/OUTCOME Output	*DIRECTION OF CHANGE:* Higher = better
DATA SOURCE: Implementing partners	
MEASUREMENT NOTES:	

ELEMENT: **IIP – 1.4 AVIAN INFLUENZA**	
INDICATOR TITLE: **NUMBER OF MISSIONS ACCESSING CENTRALLY-DESIGNED OR MANAGED MECHANISMS USING THEIR OWN FUNDING**	
DEFINITION: To avoid double-counting, this indicator is *only* to be used by Functional Bureaus. Centrally-designed or managed mechanisms are defined as contracts, grants, and cooperative agreements designed or managed in a Functional Bureau. Missions may access these mechanisms through task orders under IQCs, field support, MAARDs or Associate Awards under centrally-managed Leader with Associate Award cooperative agreements.	
RATIONALE: One of the primary functions of Functional Bureaus is to provide technical support to missions. One way to accomplish this is through centrally-designed and managed mechanisms. This indicator is a measure of the breadth of use of central mechanisms by missions.	
UNIT: Number	*DISAGGREGATE BY:* None
TYPE: OUTPUT/OUTCOME Output	*DIRECTION OF CHANGE:* Higher = better
DATA SOURCE: Field Support Database	
MEASUREMENT NOTES: None	

ELEMENT: **IIP - 1.4 AVIAN INFLUENZA**	
INDICATOR TITLE: **RATIO OF MISSION FUNDING TO CORE FUNDING IN CENTRALLY-MANAGED MECHANISMS DESIGNED TO SUPPORT THE FIELD**	
DEFINITION: To avoid double-counting, this indicator is *only* to be used by Functional Bureaus. Numerator: Sum of element-specific mission funding obligated to eligible mechanisms in the FY. Denominator: Sum of element-specific core funding obligated to eligible projects in the FY. Eligible mechanisms include all those that are centrally-managed and for which it was expected at the time of design that a portion of the funding would come from non-core sources; i.e., most mechanisms that provide training or technical assistance, some research mechanisms, and some international partnerships. Mission funding is defined as mission OYB obligated through the field support system into centrally-managed mechanisms (field support), mission OYB sub-obligated from mission SOAGs into centrally-managed mechanisms (through MAARDS), and mission-allocated funding deposited into the Working Capital Fund and subsequently obligated into centrally-managed mechanisms.	
RATIONALE: One of the primary functions of Functional Bureaus is to provide technical support to missions. One way to accomplish this is through centrally-managed mechanisms. This indicator is a measure of the extent to which projects designed to meet mission needs are doing so.	
UNIT: Ratio	*DISAGGREGATE BY:* None
TYPE: OUTPUT/OUTCOME Output	*DIRECTION OF CHANGE:* Higher = better
DATA SOURCE: Field Support Database and core budgets	
MEASUREMENT NOTES: Mission-issued Task Order and Associate Award funding is not included in this measure because those funds are not centrally managed.	

ELEMENT: **IIP - 1.4 AVIAN INFLUENZA**	
INDICATOR TITLE: **PERSON-DAYS OF TECHNICAL SUPPORT PROVIDED TO MISSIONS THROUGH TDYS**	
DEFINITION: To avoid double-counting, this indicator is *only* to be used by Functional Bureaus and Regional Platforms. Total number of days spent in travel status to USAID-supported field programs where primary purpose of travel as noted on the travel request form is "direct support to mission" or "direct support to GH-managed CAs, projects, etc."	
RATIONALE: One of the primary functions of Functional Bureaus is to provide technical support to missions. One way to accomplish this is to provide in-person expert support for program design, implementation, and evaluation. This indicator is a measure of the quantity of in-person technical support provided to missions.	
UNIT: Number of person days	*DISAGGREGATE BY:* None
TYPE: OUTPUT/OUTCOME Output	*DIRECTION OF CHANGE:* Higher = better
DATA SOURCE: GH travel worksheet	
METHOD FOR AGGREGATING ACROSS COUNTRIES: None	
MEASUREMENT NOTES: None	

ELEMENT: **IIP - 1.4 AVIAN INFLUENZA**	
INDICATOR TITLE: **NUMBER OF MEDICAL AND PARA-MEDICAL PRACTITIONERS TRAINED IN EVIDENCE-BASED CLINICAL GUIDELINES**	
DEFINITION: Number of medical and paramedical practitioners trained in evidence-based clinical guidelines, where guidelines are based on at least one clinical standard issued by a national authority. Training refers to new training or retraining of individuals and assumes that training is conducted according to national or international standards when these exist. A training must have specific learning objectives, a course outline or curriculum, and expected knowledge, skills and/or competencies to be gained by participants.	
RATIONALE: *Required to assure technical quality of services*	
UNIT: Number of people	*DISAGGREGATE BY:* None
TYPE: OUTPUT/OUTCOME Output	*DIRECTION OF CHANGE:* Higher = better
DATA SOURCE: Implementing partners	
MEASUREMENT NOTES: This indicator can be used within or across health elements. If used within an element, it must be measured for and relate specifically to that element.	

ELEMENT: **IIP - 1.5 OTHER PUBLIC HEALTH THREATS**	
INDICATOR TITLE: **NUMBER OF PEOPLE WHO RECEIVE MEDICATION OR OTHER SERVICES FROM USG-FUNDED PROGRAMS TO CONTROL AND REDUCE NEGLECTED TROPICAL DISEASES**	
DEFINITION: Number of people who receive medication or other services to control and reduce neglected tropical diseases (specifically onchocerciasis, schistosomiasis, lymphatic filariasis, soil-based helminthes and trachoma) and other infectious diseases of public health importance (e.g. cholera and dengue).	
RATIONALE: This indicator will be used to monitor the key output results of programs to reduce infectious diseases. In the case of neglected diseases, it is the output measure for the primary intervention used for an integrated mass drug administration program.	
UNIT: Number of people	*DISAGGREGATE BY:* None
TYPE: OUTPUT/OUTCOME Output	*DIRECTION OF CHANGE:* Higher = better
DATA SOURCE: USG and partners	
MEASUREMENT NOTES:	

ELEMENT: **IIP - 1.5 OTHER PUBLIC HEALTH THREATS**	
INDICATOR TITLE: **NUMBER OF BENEFICIARIES OF USG-FUNDED SERVICE-ORIENTED PROGRAMS TO REDUCE NON-COMMUNICABLE DISEASES**	
DEFINITION: Number of beneficiaries of service-oriented programs to reduce non-communicable diseases	
RATIONALE: Used to measure the progress for inputs for programs to reduce non-communicable diseases.	
UNIT: Number of beneficiaries	*DISAGGREGATE BY:* Sex
TYPE: OUTPUT/OUTCOME Output	*DIRECTION OF CHANGE:* Higher = better
DATA SOURCE: Implementing partners	
MEASUREMENT NOTES:	

ELEMENT: **IIP - 1.5 OTHER PUBLIC HEALTH THREATS**	
INDICATOR TITLE: **NUMBER OF IMPROVEMENTS TO LAWS, POLICIES, REGULATIONS OR GUIDELINES RELATED TO IMPROVE ACCESS TO AND USE OF HEALTH SERVICES DRAFTED WITH USG SUPPORT**	
DEFINITION: Number of improvements to laws, policies, regulations or guidelines related to improve access to and use of health services drafted with USG support	
RATIONALE: Policies are important for the sustainability of programs and for use and access of services	
UNIT: Number of policies	*DISAGGREGATE BY:* Policy improvements informed by National Health Accounts/Other USG input
TYPE: OUTPUT/OUTCOME Output	*DIRECTION OF CHANGE:* Higher = better
DATA SOURCE: Implementing partners	
MEASUREMENT NOTES: More changes are not necessarily better than fewer. What is important is that a supportive policy environment exists. This could be the result of a single policy change. This indicator can be used within or across health elements. If used within an element, it must be measured for and relate specifically to that element.	

ELEMENT: **IIP - 1.5 OTHER PUBLIC HEALTH THREATS**	
INDICATOR TITLE: **NUMBER OF PEOPLE COVERED BY USG-SUPPORTED HEALTH FINANCING ARRANGEMENTS**	
DEFINITION: Number of people covered by USG-supported health insurance or subsidies (to avoid double counting, individuals receiving both insurance and subsidies are to be counted only once)	
RATIONALE: Financing arrangements remove barriers to access and use of health services	
UNIT: Number of people	*DISAGGREGATE BY:* None
TYPE: OUTPUT/OUTCOME Output	*DIRECTION OF CHANGE:* Higher = better
DATA SOURCE: Implementing partners	
MEASUREMENT NOTES:	

ELEMENT: **IIP - 1.5 OTHER PUBLIC HEALTH THREATS**	
INDICATOR TITLE: **NUMBER OF USG-ASSISTED SERVICE DELIVERY POINTS EXPERIENCING STOCK-OUTS OF SPECIFIC TRACER DRUGS**	
DEFINITION: Number of USG-assisted service delivery points (SDPs) experiencing stock-outs at any time during the defined reporting period of specific tracer drugs offered by the SDP. Drugs should be included based on locally developed list (e.g., oral contraceptives, artemisinin-based combination therapies, oral rehydration salts)	
RATIONALE: Provides a measure of the ability of the procurement and distribution system to maintain a constant supply of drugs.	
UNIT: Number of SDPs	*DISAGGREGATE BY:* None
TYPE: OUTPUT/OUTCOME Output	*DIRECTION OF CHANGE:* Lower = better
DATA SOURCE: Implementing partners	
MEASUREMENT NOTES:	

ELEMENT: **IIP - 1.5 OTHER PUBLIC HEALTH THREATS**	
INDICATOR TITLE: **ASSESSMENT OF USG-ASSISTED CLINIC FACILITIES' COMPLIANCE WITH CLINICAL STANDARDS**	
DEFINITION: Of a random sample of at least 3 clinical facilities receiving USG assistance, the per cent of providers by major category (e.g., graduate nurse, clinical officer), for which documentation is provided of an independent assessment of compliance with at least one clinical standard issued by a national authority, during the previous 12 months. Sampling frame comprises the facilities where USG provided assistance on health systems improvement and which are feasible to visit.	
RATIONALE: Required to assure technical quality of services	
UNIT: Percent of providers	*DISAGGREGATE BY:* None
TYPE: OUTPUT/OUTCOME Output	*DIRECTION OF CHANGE:* Higher = better
DATA SOURCE: Implementing partners	
MEASUREMENT NOTES:	

ELEMENT: **IIP - 1.5 OTHER PUBLIC HEALTH THREATS**	
INDICATOR TITLE: **NUMBER OF MISSIONS ACCESSING CENTRALLY-DESIGNED OR MANAGED MECHANISMS USING THEIR OWN FUNDING**	
DEFINITION: To avoid double-counting, this indicator is *only* to be used by Functional Bureaus. Centrally-designed or managed mechanisms are defined as contracts, grants, and cooperative agreements designed or managed in a Functional Bureau. Missions may access these mechanisms through task orders under IQCs, field support, MAARDs or Associate Awards under centrally-managed Leader with Associate Award cooperative agreements.	
RATIONALE: One of the primary functions of Functional Bureaus is to provide technical support to missions. One way to accomplish this is through centrally-designed and managed mechanisms. This indicator is a measure of the breadth of use of central mechanisms by missions.	
UNIT: Number	*DISAGGREGATE BY:* None
TYPE: OUTPUT/OUTCOME Output	*DIRECTION OF CHANGE:* Higher=better
DATA SOURCE: Field Support Database	
MEASUREMENT NOTES:	

ELEMENT: **IIP - 1.5 OTHER PUBLIC HEALTH THREATS**	
INDICATOR TITLE: **NUMBER OF INSTANCES OF INTERVENTIONS BEING INTRODUCED OR EXPANDED IN COUNTRIES (FUNCTIONAL/PILLAR BUREAU USE ONLY)**	
DEFINITION: To avoid double-counting, this indicator is *only* to be used by Functional Bureaus. The total number of country instances in which an Element's evidence-based interventions (any tools, technologies or approaches) are being introduced (used in a very limited number of program sites or by a very limited number of partners) or expanded (used at least the district level or by a broad array of partners). A country should be counted more than once if more than one intervention is being introduced or expanded in it. For example, intervention X is being introduced in 4 countries and expanded in 2 countries and, within the same Element, intervention Y is being introduced in 7 countries and expanded in 3 countries (some of which overlap with intervention X). The result for this Element would be 16.	
RATIONALE: One of the primary functions of Functional Bureaus is to provide support to missions and host countries for introducing and expanding new tools, technologies and approaches. This indicator is a measure of the volume and progress of that support.	
UNIT: Number of instances	*DISAGGREGATE BY:* None
TYPE: OUTPUT/OUTCOME Output	*DIRECTION OF CHANGE:* Higher = Better
DATA SOURCE: Data collected from implementing partners by Functional Bureaus	
MEASUREMENT NOTES:	

ELEMENT: **IIP - 1.5 OTHER PUBLIC HEALTH THREATS**	
INDICATOR TITLE: **NUMBER OF TECHNOLOGIES UNDER DEVELOPMENT**	
DEFINITION: To avoid double-counting, this indicator is *only* to be used by Functional Bureaus. Any new technology (e.g., contraceptive, vaccine, drug) or new use of an existing technology (e.g., community-based treatment of pneumonia with amoxicillin) undergoing Phase II or III clinical trials or field-based operations research	
RATIONALE: One of the primary functions of Functional Bureaus is to conduct applied and operations research. This indicator is a measure of the volume and progress of that research	
UNIT: Number of technologies	*DISAGGREGATE BY:* None
TYPE: OUTPUT/OUTCOME Output	*DIRECTION OF CHANGE:* Higher = Better
DATA SOURCE: Data collected from implementing partners by Functional Bureaus	
MEASUREMENT NOTES:	

ELEMENT: **IIP – 1.5 OTHER PUBLIC HEALTH THREATS**	
INDICATOR TITLE: **RATIO OF MISSION FUNDING TO CORE FUNDING IN CENTRALLY-MANAGED MECHANISMS DESIGNED TO SUPPORT THE FIELD**	
DEFINITION: To avoid double-counting, this indicator is *only* to be used by Functional Bureaus. Numerator: Sum of element-specific mission funding obligated to eligible mechanisms in the FY. Denominator: Sum of element-specific core funding obligated to eligible projects in the FY. Eligible mechanisms include all those that are centrally-managed and for which it was expected at the time of design that a portion of the funding would come from non-core sources; i.e., most mechanisms that provide training or technical assistance, some research mechanisms, and some international partnerships. Mission funding is defined as mission OYB obligated through the field support system into centrally-managed mechanisms (field support), mission OYB sub-obligated from mission SOAGs into centrally-managed mechanisms (through MAARDS), and mission-allocated funding deposited into the Working Capital Fund and subsequently obligated into centrally-managed mechanisms.	
RATIONALE: One of the primary functions of Functional Bureaus is to provide technical support to missions. One way to accomplish this is through centrally-managed mechanisms. This indicator is a measure of the extent to which projects designed to meet mission needs are doing so.	
UNIT: Ratio	*DISAGGREGATE BY:* None
TYPE: OUTPUT/OUTCOME Output	*DIRECTION OF CHANGE:* Higher = better
DATA SOURCE: Field Support Database and core budgets	
MEASUREMENT NOTES: Mission-issued Task Order and Associate Award funding is not included in this measure because those funds are not centrally managed.	

ELEMENT: **IIP - 1.5 OTHER PUBLIC HEALTH THREATS**	
INDICATOR TITLE: **PERSON-DAYS OF TECHNICAL SUPPORT PROVIDED TO MISSIONS THROUGH TDYS**	
DEFINITION: To avoid double-counting, this indicator is *only* to be used by Functional Bureaus and Regional Platforms. Total number of days spent in travel status to USAID-supported field programs where primary purpose of travel as noted on the travel request form is "direct support to mission" or "direct support to GH-managed CAs, projects, etc."	
RATIONALE: One of the primary functions of Functional Bureaus is to provide technical support to missions. One way to accomplish this is to provide in-person expert support for program design, implementation, and evaluation. This indicator is a measure of the quantity of in-person technical support provided to missions.	
UNIT: Number of person days	*DISAGGREGATE BY:* None
TYPE: OUTPUT/OUTCOME Output	*DIRECTION OF CHANGE:* Higher = better
DATA SOURCE: GH travel worksheet	
METHOD FOR AGGREGATING ACROSS COUNTRIES: None	
MEASUREMENT NOTES: None	

ELEMENT: **IIP - 1.5 OTHER PUBLIC HEALTH THREATS**	
INDICATOR TITLE: **NUMBER OF MEDICAL AND PARA-MEDICAL PRACTITIONERS TRAINED IN EVIDENCE-BASED CLINICAL GUIDELINES**	
DEFINITION: Number of medical and paramedical practitioners trained in evidence-based clinical guidelines, where guidelines are based on at least one clinical standard issued by a national authority. Training refers to new training or retraining of individuals and assumes that training is conducted according to national or international standards when these exist. A training must have specific learning objectives, a course outline or curriculum, and expected knowledge, skills and/or competencies to be gained by participants.	
RATIONALE: *Required to assure technical quality of services*	
UNIT: Number of people	*DISAGGREGATE BY:* None
TYPE: OUTPUT/OUTCOME Output	*DIRECTION OF CHANGE:* Higher = better
DATA SOURCE: Implementing partners	
MEASUREMENT NOTES: This indicator can be used within or across health elements. If used within an element, it must be measured for and relate specifically to that element.	

ELEMENT: **IIP - 1.6 MATERNAL AND CHILD HEALTH**	
INDICATOR TITLE: **NUMBER OF POSTPARTUM/NEWBORN VISITS WITHIN 3 DAYS OF BIRTH IN USG-ASSISTED PROGRAMS**	
DEFINITION: Number of postpartum/newborn visits within 3 days of birth (Includes all skilled attendant deliveries plus facility or outreach postpartum/newborn visits for mothers/newborns who did not have SBA delivery)	
RATIONALE: After birth is a time of great vulnerability for postpartum mother and newborn.	
UNIT: Number of visits	*DISAGGREGATE BY:* None
TYPE: OUTPUT/OUTCOME Output	*DIRECTION OF CHANGE:* Higher = better
DATA SOURCE: Implementing partners; service statistics from USAID projects	
MEASUREMENT NOTES:	

ELEMENT: **IIP - 1.6 MATERNAL AND CHILD HEALTH**	
INDICATOR TITLE: **NUMBER OF ANTENATAL CARE (ANC) VISITS BY SKILLED PROVIDERS FROM USG-ASSISTED FACILITIES**	
DEFINITION: Number of antenatal care (ANC) visits provided by skilled providers from USG-assisted facilities. Skilled provider includes: medically trained doctor, nurse, or midwife. It does NOT include traditional birth attendants (TBA).	
RATIONALE: This indicator is based on evidence that ANC visits are required to provide preventive and curative care to promote healthy birth outcomes.	
UNIT: Number of visits	*DISAGGREGATE BY:* None
TYPE: OUTPUT/OUTCOME Output	*DIRECTION OF CHANGE:* Higher = better
DATA SOURCE: Implementing partners; service statistics from USAID projects	
MEASUREMENT NOTES:	

ELEMENT: **IIP - 1.6 MATERNAL AND CHILD HEALTH**	
INDICATOR TITLE: **NUMBER OF PEOPLE TRAINED IN MATERNAL/NEWBORN HEALTH THROUGH USG-SUPPORTED PROGRAMS**	
DEFINITION: Number of people (health professionals, primary health care workers, community health workers, volunteers, non-health personnel) trained in maternal and/or newborn health and nutrition care through USG-supported programs.	
RATIONALE: Development of human capacity through training is a major component of USG-supported health area programs in this element.	
UNIT: Number of people	*DISAGGREGATE BY:* Sex
TYPE: OUTPUT/OUTCOME Output	*DIRECTION OF CHANGE:* Higher = better
DATA SOURCE: Implementing partners; service statistics from USAID projects	
MEASUREMENT NOTES:	

ELEMENT: **IIP - 1.6 MATERNAL AND CHILD HEALTH**	
INDICATOR TITLE: **NUMBER OF DELIVERIES WITH A SKILLED BIRTH ATTENDANT (SBA) IN USG-ASSISTED PROGRAMS**	
DEFINITION: Number of deliveries with a skilled birth attendant (SBA). SBA includes: medically trained doctor, nurse, or midwife. It does NOT include traditional birth attendants (TBA).	
RATIONALE: Attendance at birth by a medically trained professional provides the opportunity to administer life-saving preventive and curative care at the time of greatest vulnerability for the mother and the newborn.	
UNIT: Output	*DISAGGREGATE BY:* None
TYPE: OUTPUT/OUTCOME Number of deliveries	*DIRECTION OF CHANGE:* Higher = better
DATA SOURCE: Implementing partners; service statistics from USAID projects	
MEASUREMENT NOTES:	

ELEMENT: **IIP - 1.6 MATERNAL AND CHILD HEALTH**	
INDICATOR TITLE: **NUMBER OF PEOPLE TRAINED IN CHILD HEALTH AND NUTRITION THROUGH USG-SUPPORTED HEALTH AREA PROGRAMS**	
DEFINITION: Number of people (health professionals, primary health care workers, community health workers, volunteers, non-health personnel) trained in child health care and child nutrition through USG-supported programs	
RATIONALE: Development of human capacity through training is a major component of USG-supported health area programs in this element	
UNIT: Individuals	*DISAGGREGATE BY:* Sex
TYPE: OUTPUT/OUTCOME Output	*DIRECTION OF CHANGE:* Higher = better
DATA SOURCE: Implementing partners; service statistics from USAID projects	
MEASUREMENT NOTES:	

ELEMENT: **IIP - 1.6 MATERNAL AND CHILD HEALTH**	
INDICATOR TITLE: **NUMBER OF WOMEN RECEIVING ACTIVE MANAGEMENT OF THE THIRD STAGE OF LABOR (AMTSL) THROUGH USG-SUPPORTED PROGRAMS**	
DEFINITION: Number of women giving birth who received Active Management of the Third Stage of Labor (AMTSL) through USG-supported programs.	
RATIONALE: AMTSL is a key component of USAID programs aimed at preventing and managing post-partum hemorrhage, a major cause of maternal mortality	
UNIT: Number of women	*DISAGGREGATE BY:* None
TYPE: OUTPUT/OUTCOME Output	*DIRECTION OF CHANGE:* Higher = better
DATA SOURCE: Implementing partners; service statistics from USAID projects	
MEASUREMENT NOTES:	

ELEMENT: **IIP - 1.6 MATERNAL AND CHILD HEALTH**	
INDICATOR TITLE: **NUMBER OF NEWBORNS RECEIVING ANTIBIOTIC TREATMENT FOR INFECTION FROM APPROPRIATE HEALTH WORKERS THROUGH USG-SUPPORTED PROGRAMS**	
DEFINITION: Number of newborn infants identified as having possible infection who receive antibiotic treatment from appropriate trained facility, outreach or community health workers through USG-supported programs. A newborn is a live-born infant less than or equal to 28 days old.	
RATIONALE: Antibiotic treatment of newborns who have signs and symptoms of infection is the second major approach of USAID programs aimed at reducing the newborn component of infant mortality.	
UNIT: Number of newborns	*DISAGGREGATE BY:* None
TYPE: OUTPUT/OUTCOME Output	*DIRECTION OF CHANGE:* Higher = better
DATA SOURCE: Implementing partners; service statistics from USAID projects	
MEASUREMENT NOTES:	

ELEMENT: **IIP - 1.6 MATERNAL AND CHILD HEALTH**	
INDICATOR TITLE: **NUMBER OF NEWBORNS RECEIVING ESSENTIAL NEWBORN CARE THROUGH USG-SUPPORTED PROGRAMS**	
DEFINITION: Number of newborn infants who receive essential newborn care (clean cord care, drying and wrapping, immediate breastfeeding) from trained facility, outreach or community health workers through USG-supported programs	
RATIONALE: Basic essential care for all newborns is a cornerstone component of USAID programs aimed at reducing the newborn component of infant mortality	
UNIT: Number of newborns	*DISAGGREGATE BY:* None
TYPE: OUTPUT/OUTCOME Output	*DIRECTION OF CHANGE:* Higher = better
DATA SOURCE: Implementing partners; service statistics from USAID projects	
MEASUREMENT NOTES:	

ELEMENT: **IIP - 1.6 MATERNAL AND CHILD HEALTH**	
INDICATOR TITLE: **NUMBER OF CHILDREN REACHED BY USG-SUPPORTED NUTRITION PROGRAMS**	
DEFINITION: Number of children reached by programs that promote good infant and young child feeding and/or growth promotion programs	
RATIONALE: Promotion of good infant and young child feeding (IYCF) practices, including breastfeeding, and participation in community based growth monitoring and promotion (GMP), are essential in preventing malnutrition and improving child survival.	
UNIT: Number of children	*DISAGGREGATE BY:* None
TYPE: OUTPUT/OUTCOME Output	*DIRECTION OF CHANGE:* Higher = better
DATA SOURCE: Implementing partners; service statistics from USAID projects	
MEASUREMENT NOTES:	

ELEMENT: **IIP - 1.6 MATERNAL AND CHILD HEALTH**	
INDICATOR TITLE: **NUMBER OF CASES OF CHILD PNEUMONIA TREATED WITH ANTIBIOTICS BY TRAINED FACILITY OR COMMUNITY HEALTH WORKERS IN USG-SUPPORTED PROGRAMS**	
DEFINITION: Number of cases of child pneumonia treated with antibiotics by trained facility or community health workers in USAID supported programs.	
RATIONALE: Pneumonia is the leading cause of preventable mortality among infants and young children; this indicator provides a measure of the number of children with pneumonia symptoms receiving required treatment.	
UNIT: Number of treated cases	*DISAGGREGATE BY:* None
TYPE: OUTPUT/OUTCOME Output	*DIRECTION OF CHANGE:* Higher = better
DATA SOURCE: Implementing partners; service statistics from USAID projects	
MEASUREMENT NOTES:	

ELEMENT: **IIP - 1.6 MATERNAL AND CHILD HEALTH**	
INDICATOR TITLE: **NUMBER OF CHILDREN LESS THAN 12 MONTHS OF AGE WHO RECEIVED DPT3 FROM USG-SUPPORTED PROGRAMS**	
DEFINITION: Number of children less than 12 months who received DPT3 in a given year from USG supported programs.	
RATIONALE: DPT3 coverage can be used as a proxy for full immunization coverage in countries with established immunization programs. Child immunization is one of the most cost-effective program interventions to reduce under-five mortality.	
UNIT: Number of children	*DISAGGREGATE BY:* None
TYPE: OUTPUT/OUTCOME Output	*DIRECTION OF CHANGE:* Higher = better
DATA SOURCE: Implementing partners; service statistics from USAID projects	
MEASUREMENT NOTES:	

ELEMENT: **IIP - 1.6 MATERNAL AND CHILD HEALTH**	
INDICATOR TITLE: **NUMBER OF CHILDREN UNDER 5 YEARS OF AGE WHO RECEIVED VITAMIN A FROM USG-SUPPORTED PROGRAMS**	
DEFINITION: Number of children under 5 years of age who received Vitamin A from USG-supported programs.	
RATIONALE: Vitamin A supplementation reduces risk of under-five mortality by about one-fourth among the millions of children deficient in this micronutrient	
UNIT: Number of children	*DISAGGREGATE BY:* None
TYPE: OUTPUT/OUTCOME Output	*DIRECTION OF CHANGE:* Higher = better
DATA SOURCE: Implementing partners; service statistics from USAID projects	
MEASUREMENT NOTES:	

ELEMENT: **IIP - 1.6 MATERNAL AND CHILD HEALTH**	
INDICATOR TITLE: **LITERS OF DRINKING WATER DISINFECTED WITH USG-SUPPORTED POINT-OF-USE TREATMENT PRODUCTS**	
DEFINITION: Liters of drinking water treated with one or more USG-supported proven methods* for point-of-use disinfection. Calculation: Number of products sold times liters of water treated per product, for each product type * methods currently supported by USG programs proven to reduce diarrheal disease, include: chlorination, combined flocculation/chlorination	
RATIONALE: Disinfecting and properly storing drinking water at the household level is associated with a 34% reduction in diarrheal disease prevalence among young children. It is among the most cost-effective water supply, sanitation, and hygiene interventions from a public health perspective.	
UNIT: Liters	*DISAGGREGATE BY:* None
TYPE: OUTPUT/OUTCOME Output	*DIRECTION OF CHANGE:* Higher = better
DATA SOURCE: Implementing partners; cooperating public, commercial, and not-for-profit agencies	
MEASUREMENT NOTES:	

ELEMENT: **IIP - 1.6 MATERNAL AND CHILD HEALTH**	
INDICATOR TITLE: **NUMBER OF CASES OF CHILD DIARRHEA TREATED IN USAID-ASSISTED PROGRAMS**	
DEFINITION: Number of cases of child diarrhea treated through USG-supported programs with: a) oral rehydration therapy (ORT), b) zinc supplements	
RATIONALE: Diarrheal illness is a major cause of preventable mortality among infants and young children; this indicator provides a measure of the number of children with diarrheal illness receiving required treatment.	
UNIT: Number of treated cases	*DISAGGREGATE BY:* None
TYPE: OUTPUT/OUTCOME Outcome	*DIRECTION OF CHANGE:* Higher = better
DATA SOURCE: Implementing partners; service statistics from USAID projects	
MEASUREMENT NOTES:	

ELEMENT: **IIP - 1.6 MATERNAL AND CHILD HEALTH**	
INDICATOR TITLE: **NUMBER OF HEALTH FACILITIES REHABILITATED**	
DEFINITION: "Rehabilitated" ranges from cosmetic upgrades such as whitewashing walls, to structural improvements (replacing broken windows, fixing leaky roofs, rebuilding damaged walls or roofs), and mending broken furniture.	
RATIONALE: Health facilities in flagrant disrepair are frequently unsafe and inadequate for providing health care.	
UNIT: Number of facilities	*DISAGGREGATE BY:* None
TYPE: OUTPUT/OUTCOME Output	*DIRECTION OF CHANGE:* Higher = better
DATA SOURCE: Implementing partners	
MEASUREMENT NOTES:	

ELEMENT: **IIP - 1.6 MATERNAL AND CHILD HEALTH**	
INDICATOR TITLE: **NUMBER OF IMPROVEMENTS TO LAWS, POLICIES, REGULATIONS OR GUIDELINES RELATED TO IMPROVE ACCESS TO AND USE OF HEALTH SERVICES DRAFTED WITH USG SUPPORT**	
DEFINITION: Number of improvements to laws, policies, regulations or guidelines related to improve access to and use of health services drafted with USG support	
RATIONALE: Policies are important for the sustainability of programs and for use and access of services	
UNIT: Number of policies	*DISAGGREGATE BY:* Policy improvements informed by National Health Accounts/Other USG input
TYPE: OUTPUT/OUTCOME Output	*DIRECTION OF CHANGE:* Higher = better
DATA SOURCE: Implementing partners	
MEASUREMENT NOTES: More changes are not necessarily better than fewer. What is important is that a supportive policy environment exists. This could be the result of a single policy change. This indicator can be used within or across health elements. If used within an element, it must be measured for and relate specifically to that element.	

ELEMENT: **IIP - 1.6 MATERNAL AND CHILD HEALTH**	
INDICATOR TITLE: **NUMBER OF PEOPLE COVERED BY USG-SUPPORTED HEALTH FINANCING ARRANGEMENTS**	
DEFINITION: Number of people covered by USG-supported health insurance or subsidies (to avoid double counting, individuals receiving both insurance and subsidies are to be counted only once)	
RATIONALE: Financing arrangements remove barriers to access and use of health services	
UNIT: Number of people	*DISAGGREGATE BY:* None
TYPE: OUTPUT/OUTCOME Output	*DIRECTION OF CHANGE:* Higher = better
DATA SOURCE: Implementing partners	
MEASUREMENT NOTES:	

ELEMENT: **IIP - 1.6 MATERNAL AND CHILD HEALTH**	
INDICATOR TITLE: **NUMBER OF USG-ASSISTED SERVICE DELIVERY POINTS EXPERIENCING STOCK-OUTS OF SPECIFIC TRACER DRUGS**	
DEFINITION: Number of USG-assisted service delivery points (SDPs) experiencing stock-outs at any time during the defined reporting period of specific tracer drugs offered by the SDP. Drugs should be included based on locally developed list (e.g., oral contraceptives, artemisinin-based combination therapies, oral rehydration salts)	
RATIONALE: Provides a measure of the ability of the procurement and distribution system to maintain a constant supply of drugs.	
UNIT: Number of SDPs	*DISAGGREGATE BY:* None
TYPE: OUTPUT/OUTCOME Output	*DIRECTION OF CHANGE:* Lower = better
DATA SOURCE: Implementing partners	
MEASUREMENT NOTES:	

ELEMENT: **IIP - 1.6 MATERNAL AND CHILD HEALTH**	
INDICATOR TITLE: **USG-ASSISTED FACILITIES' PROVIDER STAFF WITH A WRITTEN PERFORMANCE APPRAISAL**	
DEFINITION: Of a random sample of at least 3 USG-assisted facilities, the per cent of provider staff with a written performance appraisal in the past 12 months. A performance appraisal must refer to the duties and actual performance of a specific provider, and be available on site. Sampling frame comprises the facilities where USG provided assistance on health systems improvement and which are feasible to visit.	
RATIONALE: Fundamental feature of human resource management	
UNIT: Percent of providers	*DISAGGREGATE BY:* None
TYPE: OUTPUT/OUTCOME Output	*DIRECTION OF CHANGE:* Higher = better
DATA SOURCE: Implementing partners	
MEASUREMENT NOTES:	

ELEMENT: **IIP - 1.6 MATERNAL AND CHILD HEALTH**	
INDICATOR TITLE: **ASSESSMENT OF USG-ASSISTED CLINIC FACILITIES' COMPLIANCE WITH CLINICAL STANDARDS**	
DEFINITION: Of a random sample of at least 3 clinical facilities receiving USG assistance, the per cent of providers by major category (e.g., graduate nurse, clinical officer), for which documentation is provided of an independent assessment of compliance with at least one clinical standard issued by a national authority, during the previous 12 months. Sampling frame comprises the facilities where USG provided assistance on health systems improvement and which are feasible to visit.	
RATIONALE: Required to assure technical quality of services	
UNIT: Percent of providers	*DISAGGREGATE BY:* None
TYPE: OUTPUT/OUTCOME Output	*DIRECTION OF CHANGE:* Higher = better
DATA SOURCE: Implementing partners	
MEASUREMENT NOTES:	

ELEMENT: **IIP - 1.6 MATERNAL AND CHILD HEALTH**	
INDICATOR TITLE: **AMOUNT OF PRIVATE FINANCING MOBILIZED WITH A DCA GUARANTEE**	
DEFINITION: The amount of financing in US dollars or US dollar equivalent from the private sector that is guaranteed by the Development Credit Authority guarantee AND has been provided to a targeted borrower(s).	
RATIONALE: This indicator measures the increased amount of private financing that supports the availability and use of proven life-saving procedures. Without the DCA guarantee, this amount of private financing would not have been made available and fewer life-saving interventions would have been possible.	
UNIT: US Dollars or equivalent	*DISAGGREGATE BY:* None
TYPE: OUTPUT/OUTCOME Outcome	*DIRECTION OF CHANGE:* Higher = better
DATA SOURCE: DCA guarantee recipient	
MEASUREMENT NOTES:	

ELEMENT: **IIP - 1.6 MATERNAL AND CHILD HEALTH**	
INDICATOR TITLE: **NUMBER OF MEDICAL AND PARA-MEDICAL PRACTITIONERS TRAINED IN EVIDENCE-BASED CLINICAL GUIDELINES**	
DEFINITION: Number of medical and paramedical practitioners trained in evidence-based clinical guidelines, where guidelines are based on at least one clinical standard issued by a national authority. Training refers to new training or retraining of individuals and assumes that training is conducted according to national or international standards when these exist. A training must have specific learning objectives, a course outline or curriculum, and expected knowledge, skills and/or competencies to be gained by participants.	
RATIONALE: *Required to assure technical quality of services*	
UNIT: Number of people	*DISAGGREGATE BY:* None
TYPE: OUTPUT/OUTCOME Output	*DIRECTION OF CHANGE:* Higher = better
DATA SOURCE: Implementing partners	
MEASUREMENT NOTES: This indicator can be used within or across health elements. If used within an element, it must be measured for and relate specifically to that element.	

ELEMENT: **IIP - 1.6 MATERNAL AND CHILD HEALTH**	
INDICATOR TITLE: **NUMBER OF INSTANCES OF INTERVENTIONS BEING INTRODUCED OR EXPANDED IN COUNTRIES (FUNCTIONAL/PILLAR BUREAU USE ONLY)**	
DEFINITION: To avoid double-counting, this indicator is *only* to be used by Functional Bureaus. The total number of country instances in which an Element's evidence-based interventions (any tools, technologies or approaches) are being introduced (used in a very limited number of program sites or by a very limited number of partners) or expanded (used at least the district level or by a broad array of partners). A country should be counted more than once if more than one intervention is being introduced or expanded in it. For example, intervention X is being introduced in 4 countries and expanded in 2 countries and, within the same Element, intervention Y is being introduced in 7 countries and expanded in 3 countries (some of which overlap with intervention X). The result for this Element would be 16.	
RATIONALE: One of the primary functions of Functional Bureaus is to provide support to missions and host countries for introducing and expanding new tools, technologies and approaches. This indicator is a measure of the volume and progress of that support	
UNIT: Number of instances	*DISAGGREGATE BY:* None
TYPE: OUTPUT/OUTCOME Output	*DIRECTION OF CHANGE:* Higher = Better
DATA SOURCE: Data collected from implementing partners by Functional Bureaus	
MEASUREMENT NOTES:	

ELEMENT: **IIP - 1.6 MATERNAL AND CHILD HEALTH**	
INDICATOR TITLE: **NUMBER OF TECHNOLOGIES UNDER DEVELOPMENT**	
DEFINITION: To avoid double-counting, this indicator is *only* to be used by Functional Bureaus. Any new technology (e.g., contraceptive, vaccine, drug) or new use of an existing technology (e.g., community-based treatment of pneumonia with amoxicillin) undergoing Phase II or III clinical trials or field-based operations research	
RATIONALE: One of the primary functions of Functional Bureaus is to conduct applied and operations research. This indicator is a measure of the volume and progress of that research.	
UNIT: Number of Technologies	*DISAGGREGATE BY:* None
TYPE: OUTPUT/OUTCOME Output	*DIRECTION OF CHANGE:* Higher = Better
DATA SOURCE: Data collected from implementing partners by Functional Bureaus	
Measurement Notes:	

ELEMENT: **IIP - 1.6 MATERNAL AND CHILD HEALTH**	
INDICATOR TITLE:: **RATE OF NON-POLIO ACUTE FLACCID PARALYSIS (AFP) CASES OCCURRING PER 100,000 CHILDREN LESS THAN 15 YEARS OF AGE (NON-POLIO AFP RATE).**	
DEFINITION: The rate of non-polio acute flaccid paralysis cases occurring per 100,000 children less than 15 years of age. **Numerator:** Number non-polio cases (number of acute flaccid paralysis cases reported, detected, investigated, samples collected and analyzed in a WHO accredited laboratory and determined to be caused by something [virus, condition, disease]other than the polio virus.) **Denominator:** per 100,000 children under age 15	
RATIONALE: This indicator is used to determine the sensitivity of the polio surveillance system at the national level. The surveillance system should find a minimum of 2 non-polio AFP cases per 100,000 children less than 15 years of age. This is the key indicator for global certification of polio-free status.	
UNIT: Rate	*DISAGGREGATE BY:* None
TYPE: OUTPUT/OUTCOME Outcome	*DIRECTION OF CHANGE:* 2 or higher = better
DATA SOURCE: WHO	
MEASUREMENT NOTES: None	

ELEMENT: **1.6 MATERNAL AND CHILD HEALTH**	
INDICATOR TITLE: **NUMBER OF MISSIONS ACCESSING CENTRALLY-DESIGNED OR MANAGED MECHANISMS USING THEIR OWN FUNDING**	
DEFINITION: To avoid double-counting, this indicator is *only* to be used by Functional Bureaus. Centrally-designed or managed mechanisms are defined as contracts, grants, and cooperative agreements designed or managed in a Functional Bureau. Missions may access these mechanisms through task orders under IQCs, field support, MAARDs or Associate Awards under centrally-managed Leader with Associate Award cooperative agreements.	
RATIONALE: One of the primary functions of Functional Bureaus is to provide technical support to missions. One way to accomplish this is through centrally-designed and managed mechanisms. This indicator is a measure of the breadth of use of central mechanisms by missions.	
UNIT: Number	*DISAGGREGATE BY:* None
TYPE: OUTPUT/OUTCOME Output	*DIRECTION OF CHANGE:* Higher = better
DATA SOURCE: Field Support Database	
MEASUREMENT NOTES: None	

ELEMENT: **IIP – 1.6 MATERNAL AND CHILD HEALTH**

INDICATOR TITLE: **RATIO OF MISSION FUNDING TO CORE FUNDING IN CENTRALLY-MANAGED MECHANISMS DESIGNED TO SUPPORT THE FIELD**

DEFINITION:

To avoid double-counting, this indicator is *only* to be used by Functional Bureaus.

Numerator: Sum of element-specific mission funding obligated to eligible mechanisms in the FY.

Denominator: Sum of element-specific core funding obligated to eligible projects in the FY.

Eligible mechanisms include all those that are centrally-managed and for which it was expected at the time of design that a portion of the funding would come from non-core sources; i.e., most mechanisms that provide training or technical assistance, some research mechanisms, and some international partnerships.

Mission funding is defined as mission OYB obligated through the field support system into centrally-managed mechanisms (field support), mission OYB sub-obligated from mission SOAGs into centrally-managed mechanisms (through MAARDS), and mission-allocated funding deposited into the Working Capital Fund and subsequently obligated into centrally-managed mechanisms.

RATIONALE:

One of the primary functions of Functional Bureaus is to provide technical support to missions. One way to accomplish this is through centrally-managed mechanisms. This indicator is a measure of the extent to which projects designed to meet mission needs are doing so.

UNIT:	*DISAGGREGATE BY:*
Ratio	None
TYPE: OUTPUT/OUTCOME	*DIRECTION OF CHANGE:*
Output	Higher = better

DATA SOURCE:

Field Support Database and core budgets

MEASUREMENT NOTES: Mission-issued Task Order and Associate Award funding is not included in this measure because those funds are not centrally managed.

ELEMENT: **IIP – 1.6 MATERNAL AND CHILD HEALTH**	
INDICATOR TITLE: **PERSON-DAYS OF SUPPORT PROVIDED TO MISSIONS TRHOUGH TDYS**	
DEFINITION: To avoid double counting, this indicator is *only* to be used by Functional Bureaus and Regional Platforms. Total number of days spent in travel status to USAID-supported field programs where primary purpose of travel as noted on the travel request form is "direct support to mission" or "direct support to GH-managed CAs, projects, etc."	
RATIONALE: One of the primary functions of Functional Bureaus is to provide technical support to missions. One way to accomplish this is to provide in-person expert support for program design, implementation, and evaluation. This indicator is a measure of the quantity of in-person technical support provided to missions.	
UNIT: Number of person days	*DISAGGREGATE BY:* None
TYPE: OUTPUT/OUTCOME Output	*DIRECTION OF CHANGE:* Higher = better
DATA SOURCE: GH travel worksheet	
METHOD FOR AGGREGATING ACROSS COUNTRIES: None	
MEASUREMENT NOTES: None	

ELEMENT: **IIP - 1.7 FAMILY PLANNING AND REPRODUCTIVE HEALTH**	
INDICATOR TITLE: **COUPLE YEARS OF PROTECTION (CYP) IN USG-SUPPORTED PROGRAMS**	
DEFINITION: The estimated protection provided by family planning services during a one-year period, based upon the volume of all contraceptives provided to clients during that period. The CYP is calculated by multiplying the quantity of each method distributed to clients by a conversion factor, to yield an estimate of the duration of contraceptive protection provided per unit of that method. The CYPs for each method are then summed over all methods to obtain a total CYP figure. N.B. Goals for CYP may be appropriate at the level of the service delivery site or higher (e.g., district or national program level) for the purposes of planning or budgeting. However, they must not be translated into targets for numbers of acceptors or acceptors of a particular method provided by individual service provider, referral agents, or program personnel.	
RATIONALE:	
UNIT: Couple-years	*DISAGGREGATE BY:* Public and private sector
TYPE: OUTPUT/OUTCOME Output	*DIRECTION OF CHANGE:* Higher = better
DATA SOURCE: Implementing partners	
MEASUREMENT NOTES:	

ELEMENT: **IIP - 1.7 FAMILY PLANNING AND REPRODUCTIVE HEALTH**	
INDICATOR TITLE: **NUMBER OF PEOPLE TRAINED IN FP/RH WITH USG FUNDS**	
DEFINITION: Number of people (health professionals, primary health care workers, community health workers, volunteers, non-health personnel) trained in FP/RH (including training in service delivery, communication, policy and systems, research, etc.). Training refers to new training or retraining of individuals and assumes that training is conducted according to national or international standards when these exist. A training must have specific learning objectives, a course outline or curriculum, and expected knowledge, skills and/or competencies to be gained by participants.	
RATIONALE:	
UNIT: Number of people	*DISAGGREGATE BY:* Sex
TYPE: OUTPUT/OUTCOME Output	*DIRECTION OF CHANGE:* Higher = better
DATA SOURCE: Implementing partners	
MEASUREMENT NOTES:	

ELEMENT: **IIP - 1.7 FAMILY PLANNING AND REPRODUCTIVE HEALTH**	
INDICATOR TITLE: **NUMBER OF MEDICAL AND PARA-MEDICAL PRACTITIONERS TRAINED IN EVIDENCE-BASED CLINICAL GUIDELINES**	
DEFINITION: Number of medical and paramedical practitioners trained in evidence-based clinical guidelines, where guidelines are based on at least one clinical standard issued by a national authority. Training refers to new training or retraining of individuals and assumes that training is conducted according to national or international standards when these exist. A training must have specific learning objectives, a course outline or curriculum, and expected knowledge, skills and/or competencies to be gained by participants.	
RATIONALE: *Required to assure technical quality of services*	
UNIT: Number of people	*DISAGGREGATE BY:* None
TYPE: OUTPUT/OUTCOME Output	*DIRECTION OF CHANGE:* Higher = better
DATA SOURCE: Implementing partners	
MEASUREMENT NOTES: This indicator can be used within or across health elements. If used within an element, it must be measured for and relate specifically to that element.	

ELEMENT: **IIP - 1.7 FAMILY PLANNING AND REPRODUCTIVE HEALTH**	
INDICATOR TITLE: **NUMBER OF COUNSELING VISITS FOR FP/RH AS A RESULT OF USG ASSISTANCE**	
DEFINITION: Number of visits that include counseling on FP/RH. Can include clinic visits as well as contacts with CBD agents.	
RATIONALE:	
UNIT: Number of visits	*DISAGGREGATE BY:* 5-year age group, post-partum women
TYPE: OUTPUT/OUTCOME Output	*DIRECTION OF CHANGE:* Higher = better
DATA SOURCE: Implementing partners	
MEASUREMENT NOTES: For this indicator, the post-partum period is defined as up to one year after the birth.	

ELEMENT: **IIP - 1.7 FAMILY PLANNING AND REPRODUCTIVE HEALTH**	
INDICATOR TITLE: **NUMBER OF PEOPLE THAT HAVE SEEN OR HEARD A SPECIFIC USG-SUPPORTED FP/RH MESSAGE**	
DEFINITION: Size of target population that has seen or heard a specific FP/RH message	
RATIONALE:	
UNIT: Number of people	*DISAGGREGATE BY:* None
TYPE: OUTPUT/OUTCOME Output	*DIRECTION OF CHANGE:* Higher = better
DATA SOURCE: Implementing partners	
MEASUREMENT NOTES:	

ELEMENT: **IIP - 1.7 FAMILY PLANNING AND REPRODUCTIVE HEALTH**	
INDICATOR TITLE: **NUMBER OF NEW APPROACHES SUCCESSFULLY INTRODUCED THROUGH USG-SUPPORTED PROGRAMS**	
DEFINITION: Number of new approaches (e.g., tools, technologies, operational procedures, information systems, etc.) successfully introduced into recipient or country programs	
RATIONALE:	
UNIT: Number of new approaches	*DISAGGREGATE BY:* None
TYPE: OUTPUT/OUTCOME Output	*DIRECTION OF CHANGE:* Higher = better
DATA SOURCE: Implementing partners	
METHOD FOR AGGREGATING ACROSS COUNTRIES:	
MEASUREMENT NOTES:	

ELEMENT: **IIP - 1.7 FAMILY PLANNING AND REPRODUCTIVE HEALTH**	
INDICATOR TITLE: **NUMBER OF USG-ASSISTED SERVICE DELIVERY POINTS PROVIDING FP COUNSELING OR SERVICES**	
DEFINITION: Number of service delivery points (excluding door-to-door CBD) providing FP counseling or services, disaggregated, as appropriate, by type of service: vertical FP/RH; HIV, incl. PMTCT; pre-natal/post-natal or other MCH; sites offering long-acting and permanent methods (IUD, implants, voluntary sterilization)	
RATIONALE:	
UNIT: Number of service delivery points	*DISAGGREGATE BY:* Type of service: vertical FP/RH; HIV, incl. PMTCT; pre-natal/post-natal or other MCH; sites offering long-acting and permanent methods (IUD, implants, voluntary sterilization)
TYPE: OUTPUT/OUTCOME Output	*DIRECTION OF CHANGE:* Higher = better
DATA SOURCE: Implementing partners	
METHOD FOR AGGREGATING ACROSS COUNTRIES:	
MEASUREMENT NOTES:	

ELEMENT: **IIP - 1.7 FAMILY PLANNING AND REPRODUCTIVE HEALTH**	
INDICATOR TITLE: **AMOUNT OF IN-COUNTRY PUBLIC AND PRIVATE FINANCIAL RESOURCES LEVERAGED BY USG PROGRAMS FOR FP/RH**	
DEFINITION: Amount of in-country public and private financial resources leveraged for FP/RH	
RATIONALE:	
UNIT: Dollars Leveraged	*DISAGGREGATE BY:* Public Resources, Private Resources
TYPE: OUTPUT/OUTCOME Outcome	*DIRECTION OF CHANGE:* Higher = better
DATA SOURCE: Implementing Partners	
MEASUREMENT NOTES:	

ELEMENT: **IIP - 1.7 FAMILY PLANNING AND REPRODUCTIVE HEALTH**

INDICATOR TITLE: **NUMBER OF USG PROGRAM INTERVENTIONS PROVIDING SERVICES, COUNSELING, AND/OR COMMUNITY-BASED AWARENESS ACTIVITIES INTENDED TO RESPOND TO AND/OR REDUCE RATES OF GENDER-BASED VIOLENCE**

DEFINITION:

Number of interventions providing services, counseling, and/or community-based awareness activities intended to respond to and/or reduce rates of gender-based violence (GBV)

GBV is defined as: Violence involving men and women, in which the female is usually the victim; and which is derived from unequal power relationships between men and women. Violence is directed specifically against a woman because she is a woman, or affects women disproportionately. It includes, but is not limited to, physical, sexual, and psychological harm… It includes that violence which is perpetuated or condoned by the state. This may include, but is not limited to, sexual assault, rape, marital rape, intimate partner violence, childhood sexual abuse (including incest), FGC/FGM, trafficking of girls and women, sexual violence against displaced women/girls, bride burning, acid throwing, honor killing, and other harmful traditional practices.

"Intervention" is defined as the specific type of activity addressing gender-based violence. Types of interventions are: policy/advocacy, service delivery, community mobilization, behavior change communication, research/data collection, monitoring and evaluation. For example, a project in country X could have a reproductive health mass media campaign nationally that includes anti-GBV messages (which equals 1 intervention: behavior change communication); could organize stakeholder meetings with MOH officials and civil society groups to disseminate national data on GBV (which equals 1 intervention: policy/advocacy); and carry out training for health care providers in 10 FP clinics throughout the country (which equals 1 intervention: service delivery). In total, this project would report 3 interventions under this indicator.

RATIONALE:

Women who have experienced intimate partner violence and/or sexual violence are more likely to: use FP clandestinely; have partner stop them from using FP; have a partner refuse to use a condom; experience a higher rate of unintended pregnancies; and become pregnant in adolescence. By addressing GBV, FP/RH programs may be able to enhance their effectiveness, may enable women who have experienced to benefit from existing programs, and may prevent such violence

UNIT:	*DISAGGREGATE BY:*
Number of interventions	Type of intervention
TYPE: OUTPUT/OUTCOME	*DIRECTION OF CHANGE:*
Output	Higher = better

DATA SOURCE:

Implementing Partners; statistics from USAID projects

MEASUREMENT NOTES:

ELEMENT: **IIP - 1.7 FAMILY PLANNING AND REPRODUCTIVE HEALTH**	
INDICATOR TITLE: **NUMBER OF HEALTH FACILITIES REHABILITATED**	
DEFINITION: "Rehabilitated" ranges from cosmetic upgrades such as whitewashing walls, to structural improvements (replacing broken windows, fixing leaky roofs, rebuilding damaged walls or roofs), and mending broken furniture.	
RATIONALE: Health facilities in flagrant disrepair are frequently unsafe and inadequate for providing health care.	
UNIT: Number of facilities	*DISAGGREGATE BY::* None
TYPE: OUTPUT/OUTCOME Output	*DIRECTION OF CHANGE:* Higher = better
DATA SOURCE: Implementing partners	
MEASUREMENT NOTES:	

ELEMENT: **IIP - 1.7 FAMILY PLANNING AND REPRODUCTIVE HEALTH**	
INDICATOR TITLE: **NUMBER OF IMPROVEMENTS TO LAWS, POLICIES, REGULATIONS OR GUIDELINES RELATED TO IMPROVE ACCESS TO AND USE OF HEALTH SERVICES DRAFTED WITH USG SUPPORT**	
DEFINITION: Number of improvements to laws, policies, regulations or guidelines related to improve access to and use of health services drafted with USG support	
RATIONALE: Policies are important for the sustainability of programs and for use and access of services	
UNIT: Number of policy improvements	*DISAGGREGATE BY:* Policy improvements informed by National Health Accounts/Other USG input
TYPE: OUTPUT/OUTCOME Output	*DIRECTION OF CHANGE:* Higher = better
DATA SOURCE: Implementing partners	
MEASUREMENT NOTES: More changes are not necessarily better than fewer. What is important is that a supportive policy environment exists. This could be the result of a single policy change. This indicator can be used within or across health elements. If used within an element, it must be measured for and relate specifically to that element.	

ELEMENT: **IIP - 1.7 FAMILY PLANNING AND REPRODUCTIVE HEALTH**	
INDICATOR TITLE: **NUMBER OF PEOPLE COVERED BY USG-SUPPORTED HEALTH FINANCING ARRANGEMENTS**	
DEFINITION: Number of people covered by USG-supported health insurance or subsidies (to avoid double counting, individuals receiving both insurance and subsidies are to be counted only once)	
RATIONALE: Financing arrangements remove barriers to access and use of health services	
UNIT: Number of people	*DISAGGREGATE BY:* None
TYPE: OUTPUT/OUTCOME Output	*DIRECTION OF CHANGE:* Higher = better
DATA SOURCE: Implementing partners	
MEASUREMENT NOTES:	

ELEMENT: **IIP - 1.7 FAMILY PLANNING AND REPRODUCTIVE HEALTH**	
INDICATOR TITLE: **NUMBER OF USG-ASSISTED SERVICE DELIVERY POINTS EXPERIENCING STOCK-OUTS OF SPECIFIC TRACER DRUGS**	
DEFINITION: Number of USG-assisted service delivery points (SDPs) experiencing stock-outs at any time during the defined reporting period of specific tracer drugs offered by the SDP. Drugs should be included based on locally developed list (e.g., oral contraceptives, artemisinin-based combination therapies, oral rehydration salts)	
RATIONALE: Provides a measure of the ability of the procurement and distribution system to maintain a constant supply of drugs.	
UNIT: Number of SDPs	*DISAGGREGATE BY:* None
TYPE: OUTPUT/OUTCOME Output	*DIRECTION OF CHANGE:* Lower = better
DATA SOURCE: Implementing partners	
MEASUREMENT NOTES:	

ELEMENT: **IIP - 1.7 FAMILY PLANNING AND REPRODUCTIVE HEALTH**	
INDICATOR TITLE: **VALUE OF PHARMACEUTICALS AND HEALTH COMMODITIES PURCHASED BY USG-ASSISTED GOVERNMENTAL ENTITIES THROUGH COMPETITIVE TENDERS**	
DEFINITION: Value of pharmaceuticals and health commodities from all funding sources purchased by USG-assisted governmental entities using sealed bids and a transparent and accountable procurement process.	
RATIONALE: Over time, an increase in this indicator reflects an improvement in the use of available resources and provides an indication of the commitment to cost-efficient purchases and ethical practices.	
UNIT: US dollars	*DISAGGREGATE BY:* Central level and other
TYPE: OUTPUT/OUTCOME Output	*DIRECTION OF CHANGE:* Higher = better
DATA SOURCE: Implementing partners	
MEASUREMENT NOTES:	

ELEMENT: **IIP - 1.7 FAMILY PLANNING AND REPRODUCTIVE HEALTH**	
INDICATOR TITLE: **USG-ASSISTED FACILITIES' PROVIDER STAFF WITH A WRITTEN PERFORMANCE APPRAISAL**	
DEFINITION: Of a random sample of at least 3 USG-assisted facilities, the per cent of provider staff with a written performance appraisal in the past 12 months. A performance appraisal must refer to the duties and actual performance of a specific provider, and be available on site. Sampling frame comprises the facilities where USG provided assistance on health systems improvement and which are feasible to visit.	
RATIONALE: Fundamental feature of human resource management	
UNIT: Percent of providers	*DISAGGREGATE BY:* None
TYPE: OUTPUT/OUTCOME Output	*DIRECTION OF CHANGE:* Higher = better
DATA SOURCE: Implementing partners	
MEASUREMENT NOTES:	

ELEMENT: **IIP - 1.7 FAMILY PLANNING AND REPRODUCTIVE HEALTH**	
INDICATOR TITLE: **ASSESSMENT OF USG-ASSISTED CLINIC FACILITIES' COMPLIANCE WITH CLINICAL STANDARDS**	
DEFINITION: Of a random sample of at least 3 clinical facilities receiving USG assistance, the per cent of providers by major category (e.g., graduate nurse, clinical officer), for which documentation is provided of an independent assessment of compliance with at least one clinical standard issued by a national authority, during the previous 12 months. Sampling frame comprises the facilities where USG provided assistance on health systems improvement and which are feasible to visit.	
RATIONALE: Required to assure technical quality of services	
UNIT: Percent of providers	*DISAGGREGATE BY:* None
TYPE: OUTPUT/OUTCOME Output	*DIRECTION OF CHANGE:* Higher = better
DATA SOURCE: Implementing partners	
MEASUREMENT NOTES:	

ELEMENT: **IIP - 1.7 FAMILY PLANNING AND REPRODUCTIVE HEALTH**	
INDICATOR TITLE: **NUMBER OF TECHNOLOGIES UNDER DEVELOPMENT**	
DEFINITION: To avoid double-counting, this indicator is *only* to be used by Functional Bureaus. Any new technology (e.g., contraceptive, vaccine, drug) or new use of an existing technology (e.g., community-based treatment of pneumonia with amoxicillin) undergoing Phase II or III clinical trials or field-based operations research	
RATIONALE: One of the primary functions of Functional Bureaus is to conduct applied and operations research. This indicator is a measure of the volume and progress of that research	
UNIT: Number of Technologies	*DISAGGREGATE BY:* None
TYPE: OUTPUT/OUTCOME Output	*DIRECTION OF CHANGE:* Higher = Better
DATA SOURCE:	
MEASUREMENT NOTES:	

ELEMENT: **IIP - 1.7 FAMILY PLANNING AND REPRODUCTIVE HEALTH**

INDICATOR TITLE: **NUMBER OF INSTANCES OF INTERVENTIONS BEING INTRODUCED OR EXPANDED IN COUNTRIES (FUNCTIONAL/PILLAR BUREAU USE ONLY)**

DEFINITION:

To avoid double-counting, this indicator is *only* to be used by Functional Bureaus.

The total number of country instances in which an Element's evidence-based interventions (any tools, technologies or approaches) are being introduced (used in a very limited number of program sites or by a very limited number of partners) or expanded (used at least the district level or by a broad array of partners).

A country should be counted more than once if more than one intervention is being introduced or expanded in it. For example, intervention X is being introduced in 4 countries and expanded in 2 countries and, within the same Element, intervention Y is being introduced in 7 countries and expanded in 3 countries (some of which overlap with intervention X). The result for this Element would be 16.

RATIONALE:

One of the primary functions of Functional Bureaus is to provide support to missions and host countries for introducing and expanding new tools, technologies and approaches. This indicator is a measure of the volume and progress of that support.

UNIT:	*DISAGGREGATE BY:*
Number of Instances	None
TYPE: OUTPUT/OUTCOME	*DIRECTION OF CHANGE:*
Output	Higher = Better

DATA SOURCE:

Data collected from implementing partners by Functional Bureaus

MEASUREMENT NOTES:

ELEMENT: **IIP – 1.7 FAMILY PLANNING AND REPRODUCTIVE HEALTH**	
INDICATOR TITLE: **NUMBER OF MISSIONS ACCESSING CENTRALLY-DESIGNED OR MANAGED MECHANISMS USING THEIR OWN FUNDING**	
DEFINITION: To avoid double-counting, this indicator is *only* to be used by Functional Bureaus. Centrally-designed or managed mechanisms are defined as contracts, grants, and cooperative agreements designed or managed in a Functional Bureau. Missions may access these mechanisms through task orders under IQCs, field support, MAARDs or Associate Awards under centrally-managed Leader with Associate Award cooperative agreements.	
RATIONALE: One of the primary functions of Functional Bureaus is to provide technical support to missions. One way to accomplish this is through centrally-designed and managed mechanisms. This indicator is a measure of the breadth of use of central mechanisms by missions.	
UNIT: Number	*DISAGGREGATE BY:* None
TYPE: OUTPUT/OUTCOME Output	*DIRECTION OF CHANGE:* Higher = better
DATA SOURCE: Field Support Database	
MEASUREMENT NOTES: None	

ELEMENT: **IIP –1.7 FAMILY PLANNING AND REPRODUCTIVE HEALTH**

INDICATOR TITLE: **RATIO OF MISSION FUNDING TO CORE FUNDING IN CENTRALLY-MANAGED MECHANISMS DESIGNED TO SUPPORT THE FIELD**

DEFINITION:

To avoid double-counting, this indicator is *only* to be used by Functional Bureaus.

Numerator: Sum of element-specific mission funding obligated to eligible mechanisms in the FY.

Denominator: Sum of element-specific core funding obligated to eligible projects in the FY.

Eligible mechanisms include all those that are centrally-managed and for which it was expected at the time of design that a portion of the funding would come from non-core sources; i.e., most mechanisms that provide training or technical assistance, some research mechanisms, and some international partnerships.

Mission funding is defined as mission OYB obligated through the field support system into centrally-managed mechanisms (field support), mission OYB sub-obligated from mission SOAGs into centrally-managed mechanisms (through MAARDS), and mission-allocated funding deposited into the Working Capital Fund and subsequently obligated into centrally-managed mechanisms.

RATIONALE:

One of the primary functions of Functional Bureaus is to provide technical support to missions. One way to accomplish this is through centrally-managed mechanisms. This indicator is a measure of the extent to which projects designed to meet mission needs are doing so.

UNIT:	*DISAGGREGATE BY:*
Ratio	None
TYPE: OUTPUT/OUTCOME	*DIRECTION OF CHANGE:*
Output	Higher = better

DATA SOURCE:

Field Support Database and core budgets

MEASUREMENT NOTES: Mission-issued Task Order and Associate Award funding is not included in this measure because those funds are not centrally managed.

ELEMENT: **IIP –1.7 FAMILY PLANNING AND REPRODUCTIVE HEALTH**	
INDICATOR TITLE: **PERSON-DAYS OF SUPPORT PROVIDED TO MISSIONS TRHOUGH TDYS**	
DEFINITION: To avoid double counting, this indicator is *only* to be used by Functional Bureaus and Regional Platforms. Total number of days spent in travel status to USAID-supported field programs where primary purpose of travel as noted on the travel request form is "direct support to mission" or "direct support to GH-managed CAs, projects, etc."	
RATIONALE: One of the primary functions of Functional Bureaus is to provide technical support to missions. One way to accomplish this is to provide in-person expert support for program design, implementation, and evaluation. This indicator is a measure of the quantity of in-person technical support provided to missions.	
UNIT: Number of person days	*DISAGGREGATE BY:* None
TYPE: OUTPUT/OUTCOME Output	*DIRECTION OF CHANGE:* Higher = better
DATA SOURCE: GH travel worksheet	
METHOD FOR AGGREGATING ACROSS COUNTRIES: None	
MEASUREMENT NOTES: None	

ELEMENT: **IIP –1.7 FAMILY PLANNING AND REPRODUCTIVE HEALTH**	
INDICATOR TITLE: **AMOUNT OF PRIVATE FINANCING MOBILIZED WITH A DCA GUARANTEE**	
DEFINITION: The amount of financing in US dollars or US dollar equivalent from the private sector that is guaranteed by the Development Credit Authority guarantee AND has been provided to a targeted borrower(s).	
RATIONALE: This indicator measures the increased amount of private financing that supports increased access to reliable water and sanitation services. Without the DCA guarantee, the private financing would not have been made available.	
UNIT: US Dollars or equivalent	*DISAGGREGATE BY:* None
TYPE: OUTPUT/OUTCOME Outcome	*DIRECTION OF CHANGE:* Higher = better
DATA SOURCE: DCA guarantee recipient	
MEASUREMENT NOTES:	

ELEMENT: **IIP - 1.8 CLEAN WATER AND SANITATION SERVICES**

INDICATOR TITLE: **NUMBER OF PEOPLE IN TARGET AREAS WITH ACCESS TO IMPROVED DRINKING WATER SUPPLY AS A RESULT OF USG ASSISTANCE**

DEFINITION:

Improved drinking water technologies are those more likely to provide safe drinking water than those characterized as unimproved. Extensive research in rural areas has found that people satisfy their basic needs for water if the source can be reached in a round trip of 30 minutes or less. When it takes more than 30 minutes to get to the water source and back, people typically haul less water than they need to meet their basic requirements.

Improved sources may still contain harmful substances, and water can be contaminated during transport and storage.

Improved drinking water sources = Water supply technologies including household water connection, public standpipe, borehole, protected dug well, protected spring, rainwater collection and bottled water (if a secondary source is also improved).

Unimproved drinking water sources (not counted here) = Unprotected well, unprotected spring, rivers or ponds, vendor-provided water, and tanker truck water.

RATIONALE:

This indicator accurately measures delivery of a basic human service, using definitions that are completely consistent with internationally endorsed WHO/UNICEF indicators.

UNIT:	*DISAGGREGATE BY:*
Number of people	Sex, urban/rural
TYPE: OUTPUT/OUTCOME	*DIRECTION OF CHANGE:*
Output	Higher = better

DATA SOURCE:

Implementing partners

MEASUREMENT NOTES:

ELEMENT: **IIP - 1.8 CLEAN WATER AND SANITATION SERVICES**	
INDICATOR TITLE: **PERSON-DAYS OF TECHNICAL SUPPORT PROVIDED TO MISSIONS THROUGH TDYS**	
DEFINITION: To avoid double counting, this indicator is only to be used by Functional Bureaus and Regional Platforms. Total number of days spent in travel status to USAID-supported field programs where primary purpose of travel as noted on the travel request form is "direct support to mission" or "direct support to GH-managed CAs, projects, etc."	
RATIONALE: One of the primary functions of Functional Bureaus is to provide technical support to missions. One way to accomplish this is to provide in-person expert support for program design, implementation, and evaluation. This indicator is a measure of the quantity of in-person technical support provided to missions.	
UNIT: Number of person days	*DISAGGREGATE BY:* Country
TYPE: OUTPUT/OUTCOME Output	*DIRECTION OF CHANGE:* Higher=better
DATA SOURCE: GH travel worksheet	
MEASUREMENT NOTES:	

ELEMENT: **IIP - 1.8 CLEAN WATER AND SANITATION SERVICES**	
INDICATOR TITLE: **NUMBER OF PEOPLE IN TARGET AREAS WITH ACCESS TO IMPROVED SANITATION FACILITIES AS A RESULT OF USG ASSISTANCE**	
DEFINITION: Improved sanitation facilities = Technologies more likely to ensure privacy and hygienic use, i.e., connection to a public sewer, connection to a septic system, pour-flush latrine, simple pit latrine, and ventilated improved pit (VIP) latrine. Unimproved sanitation facilities (not counted here) = public or shared latrines, open pit latrines, and bucket latrines.	
RATIONALE: This indicator accurately measures delivery of a basic human service, using definitions that are completely consistent with internationally endorsed WHO/UNICEF indicators	
UNIT: Number of people	*DISAGGREGATE BY:* Sex, urban/rural
TYPE: OUTPUT/OUTCOME Output	*DIRECTION OF CHANGE:* Higher = better
DATA SOURCE: Implementing partners	
MEASUREMENT NOTES:	

ELEMENT: **IIP - 1.8 CLEAN WATER AND SANITATION SERVICES**	
INDICATOR TITLE: **NUMBER OF HOURS PER DAY THAT HOUSEHOLDS IN AREAS ASSISTED BY USG PROGRAMS HAVE POTABLE WATER SERVICES**	
DEFINITION: Average number of hours per day that households in areas assisted by USG programs have potable water service	
RATIONALE:	
UNIT: Average number of hours	*DISAGGREGATE BY:* None
TYPE: OUTPUT/OUTCOME Output	*DIRECTION OF CHANGE:* Higher = better
DATA SOURCE: Implementing partners	
MEASUREMENT NOTES:	

ELEMENT: **IIP - 1.8 CLEAN WATER AND SANITATION SERVICES**	
INDICATOR TITLE: **AMOUNT OF PRIVATE FINANCING MOBILIZED WITH A DCA GUARANTEE**	
DEFINITION: The amount of financing in US dollars or US dollar equivalent from the private sector that is guaranteed by the Development Credit Authority guarantee AND has been provided to a targeted borrower(s).	
RATIONALE: This indicator measures the increased amount of private financing that supports increased access to reliable water and sanitation services. Without the DCA guarantee, the private financing would not have been made available.	
UNIT: US Dollars or equivalent	*DISAGGREGATE BY:* None
TYPE: OUTPUT/OUTCOME Outcome	*DIRECTION OF CHANGE:* Higher = better
DATA SOURCE: DCA guarantee recipient	
MEASUREMENT NOTES:	

ELEMENT: **IIP – 1.8 CLEAN WATER AND SANITATION SERVICES**	
INDICATOR TITLE: **NUMBER OF MISSIONS ACCESSING CENTRALLY-DESIGNED OR MANAGED MECHANISMS USING THEIR OWN FUNDING**	
DEFINITION: To avoid double-counting, this indicator is *only* to be used by Functional Bureaus. Centrally-designed or managed mechanisms are defined as contracts, grants, and cooperative agreements designed or managed in a Functional Bureau. Missions may access these mechanisms through task orders under IQCs, field support, MAARDs or Associate Awards under centrally-managed Leader with Associate Award cooperative agreements.	
RATIONALE: One of the primary functions of Functional Bureaus is to provide technical support to missions. One way to accomplish this is through centrally-designed and managed mechanisms. This indicator is a measure of the breadth of use of central mechanisms by missions.	
UNIT: Number	*DISAGGREGATE BY:* None
TYPE: OUTPUT/OUTCOME Output	*DIRECTION OF CHANGE:* Higher = better
DATA SOURCE: Field Support Database	
MEASUREMENT NOTES: None	

ELEMENT: **IIP – 1.8 CLEAN WATER AND SANITATION SERVICES**

INDICATOR TITLE: **RATIO OF MISSION FUNDING TO CORE FUNDING IN CENTRALLY-MANAGED MECHANISMS DESIGNED TO SUPPORT THE FIELD**

DEFINITION:
To avoid double-counting, this indicator is *only* to be used by Functional Bureaus.

Numerator: Sum of element-specific mission funding obligated to eligible mechanisms in the FY.

Denominator: Sum of element-specific core funding obligated to eligible projects in the FY.

Eligible mechanisms include all those that are centrally-managed and for which it was expected at the time of design that a portion of the funding would come from non-core sources; i.e., most mechanisms that provide training or technical assistance, some research mechanisms, and some international partnerships.

Mission funding is defined as mission OYB obligated through the field support system into centrally-managed mechanisms (field support), mission OYB sub-obligated from mission SOAGs into centrally-managed mechanisms (through MAARDS), and mission-allocated funding deposited into the Working Capital Fund and subsequently obligated into centrally-managed mechanisms.

RATIONALE:
One of the primary functions of Functional Bureaus is to provide technical support to missions. One way to accomplish this is through centrally-managed mechanisms. This indicator is a measure of the extent to which projects designed to meet mission needs are doing so.

UNIT:	*DISAGGREGATE BY:*
Ratio	None
TYPE: OUTPUT/OUTCOME	*DIRECTION OF CHANGE:*
Output	Higher = better

DATA SOURCE:
Field Support Database and core budgets

MEASUREMENT NOTES: Mission-issued Task Order and Associate Award funding is not included in this measure because those funds are not centrally managed.

ELEMENT: **IIP – 1.8 CLEAN WATER AND SANITATION SERVICES**	
INDICATOR TITLE: **NUMBER OF INSTANCES OF INTERVENTIONS BEING INTRODUCED OR EXPANDED IN COUNTRIES (FUNCTIONAL/PILLAR BUREAU USE ONLY)**	
DEFINITION: To avoid double-counting, this indicator is *only* to be used by Functional Bureaus. The total number of country instances in which an Element's evidence-based interventions (any tools, technologies or approaches) are being introduced (used in a very limited number of program sites or by a very limited number of partners) or expanded (used at least the district level or by a broad array of partners). A country should be counted more than once if more than one intervention is being introduced or expanded in it. For example, intervention X is being introduced in 4 countries and expanded in 2 countries and, within the same Element, intervention Y is being introduced in 7 countries and expanded in 3 countries (some of which overlap with intervention X). The result for this Element would be 16.	
RATIONALE: One of the primary functions of Functional Bureaus is to provide support to missions and host countries for introducing and expanding new tools, technologies and approaches. This indicator is a measure of the volume and progress of that support	
UNIT: Number of instances	*DISAGGREGATE BY:* None
TYPE: OUTPUT/OUTCOME Output	*DIRECTION OF CHANGE:* Higher = Better
DATA SOURCE: Data collected from implementing partners by Functional Bureaus	
MEASUREMENT NOTES:	

ELEMENT: **IIP – 1.8 CLEAN WATER AND SANITATION SERVICES**	
INDICATOR TITLE: **NUMBER OF TECHNOLOGIES UNDER DEVELOPMENT**	
DEFINITION: To avoid double-counting, this indicator is *only* to be used by Functional Bureaus. Any new technology (e.g., contraceptive, vaccine, drug) or new use of an existing technology (e.g., community-based treatment of pneumonia with amoxicillin) undergoing Phase II or III clinical trials or field-based operations research.	
RATIONALE: One of the primary functions of Functional Bureaus is to conduct applied and operations research. This indicator is a measure of the volume and progress of that research.	
UNIT: Number of technologies	*DISAGGREGATE BY:* None
TYPE: OUTPUT/OUTCOME Output	*DIRECTION OF CHANGE:* Higher = Better
DATA SOURCE: Data collected from implementing partners by Functional Bureaus	
MEASUREMENT NOTES:	

Program Area:
Education

ELEMENT: **IIP 2.1-BASIC EDUCATION**	
INDICATOR TITLE: **NUMBER OF ADMINISTRATORS AND OFFICIALS TRAINED**	
DEFINITION: Number of education officials (public or private) or administrators of education programs, funds or institutions who receive training in aspects of their current positions, including areas such as finance, management (e.g., logistics, monitoring, personnel use and support), governance (e.g., legislation, communication, enforcement) or infrastructure (e.g. building, supplies). Successful completion requires that trainees meet the completion requirements of the structured training program as defined by the program offered. Training should be at least three working days (24 hours) in duration (based on the ADS standard for in-country training). Note also that an individual trainee, even if he/she is trained in more than one area or instance of training that year, should be counted only once.	
RATIONALE: USG training supports capacity building for host country education administrators and officials – and their institutions. Counting the number of trainees provides an overall sense of scope. However, because the depth and duration of USG supported interventions varies, this is a limited indicator, meant to help 'tell the story' by giving an overall sense of the number of administrators/officials affected by USAID-supported efforts.	
UNIT: Number	*DISAGGREGATE BY:* Sex
TYPE: OUTPUT/OUTCOME Output	*DIRECTION OF CHANGE:* Higher = better
DATA SOURCE: Implementing partners, USG and partners	
MEASUREMENT NOTES:	

ELEMENT: **IIP 2.1 - BASIC EDUCATION**	
INDICATOR TITLE: **NUMBER OF LEARNERS ENROLLED IN USG-SUPPORTED PRE-PRIMARY SCHOOLS OR EQUIVALENT NON-SCHOOL-BASED SETTINGS**	
DEFINITION: Number of individuals formally enrolled in USG-supported pre-primary schools or equivalent non-school based settings for the purpose of acquiring academic basic education skills or knowledge. This may include individuals receiving USG-supported educational radio and/or TV programs. However, this indicator is intended to capture direct rather than indirect beneficiaries.	
RATIONALE: Counting the number of learners provides an overall sense of scope. However, the depth and duration of USG supported interventions varies. Also, it is easier to reach learners in urban areas, whereas USG efforts often on the hardest to reach populations. Thus, this is a limited indicator, meant to help 'tell the story' by counting the annual, overall number of direct beneficiaries of USG basic education programs.	
UNIT: Number of learners	*DISAGGREGATE BY:* Sex
TYPE: OUTPUT/OUTCOME Output	*DIRECTION OF CHANGE:* Higher = better
DATA SOURCE: Implementing partners, USG and partners	
MEASUREMENT NOTES:	

ELEMENT: **IIP 2.1 - BASIC EDUCATION**	
INDICATOR TITLE: **NUMBER OF LEARNERS ENROLLED IN USG-SUPPORTED PRIMARY SCHOOLS OR EQUIVALENT NON-SCHOOL-BASED SETTINGS**	
DEFINITION: Number of individuals formally enrolled in USG-supported primary schools or equivalent non-school based settings for the purpose of acquiring academic basic education skills or knowledge. This may include individuals receiving USG-supported educational radio and/or TV programs. However, this indicator is intended to capture direct rather than indirect beneficiaries.	
RATIONALE: Counting the number of learners provides an overall sense of scope. However, the depth and duration of USG supported interventions varies. Also, it is easier to reach learners in urban areas, whereas USG efforts often on the hardest to reach populations. Thus, this is a limited indicator, meant to help 'tell the story' by counting the annual, overall number of direct beneficiaries of USG basic education programs.	
UNIT: Number of learners	*DISAGGREGATE BY:* Sex
TYPE: OUTPUT/OUTCOME Output	*DIRECTION OF CHANGE:* Higher = better
DATA SOURCE: Implementing partners, USG and partners	
MEASUREMENT NOTES:	

ELEMENT: **IIP 2.1 - BASIC EDUCATION**	
INDICATOR TITLE: **NUMBER OF LEARNERS ENROLLED IN USG-SUPPORTED SECONDARY SCHOOLS OR EQUIVALENT NON-SCHOOL-BASED SETTINGS**	
DEFINITION: Number of individuals formally enrolled in USG-supported schools or equivalent non-school based settings for the purpose of acquiring academic basic education skills or knowledge. This may include individuals receiving USG-supported educational radio and/or TV programs. However, this indicator is intended to capture direct rather than indirect beneficiaries.	
RATIONALE: Counting the number of learners provides an overall sense of scope. However, the depth and duration of USG supported interventions varies. Also, it is easier to reach learners in urban areas, whereas USG efforts often on the hardest to reach populations. Thus, this is a limited indicator, meant to help 'tell the story' by counting the annual, overall number of direct beneficiaries of USG basic education programs.	
UNIT: Number of learners	*DISAGGREGATE BY:* Sex
TYPE: OUTPUT/OUTCOME Output	*DIRECTION OF CHANGE:* Higher = better
DATA SOURCE: Implementing partners, USG and partners	
MEASUREMENT NOTES:	

ELEMENT: **IIP 2.1 - BASIC EDUCATION**	
INDICATOR TITLE: **NUMBER OF ADULT LEARNERS ENROLLED IN USG-SUPPORTED SCHOOLS OR EQUIVALENT NON-SCHOOL-BASED SETTINGS**	
DEFINITION: Number of adult learners formally enrolled in USG-supported schools or equivalent non-school based settings for the purpose of acquiring academic basic education skills or knowledge. This may include individuals receiving USG-supported educational radio and/or TV programs. However, it excludes individuals who are enrolled in technical and vocational education programs and workforce readiness programs. This indicator is intended to capture direct rather than indirect beneficiaries.	
RATIONALE: Counting the number of learners provides an overall sense of scope. However, the depth and duration of USG supported interventions varies. Also, it is easier to reach learners in urban areas, whereas USG efforts often on the hardest to reach populations. Thus, this is a limited indicator, meant to help 'tell the story' by counting the annual, overall number of direct beneficiaries of USG basic education programs.	
UNIT: Number of adult learners	*DISAGGREGATE BY:* Sex
TYPE: OUTPUT/OUTCOME Output	*DIRECTION OF CHANGE:* Higher = better
DATA SOURCE: Implementing partners, USG and partners	
MEASUREMENT NOTES:	

ELEMENT: **IIP 2.1- BASIC EDUCATION**	
INDICATOR TITLE: **NUMBER OF TEACHERS/EDUCATORS TRAINED WITH USG SUPPORT**	
DEFINITION: Number of individuals who have successfully completed a pre- or in-service training program to teach in schools or equivalent non-school-based settings (pre-primary; primary; lower-secondary; upper-secondary; adult literacy), with USG support (e.g. scholarships or a training program funded in whole or in part by USG). Successful completion requires that trainees meet the completion requirements of the structured training program as defined by the program offered. Training should be at least three working days (24 hours) in duration (based on the ADS standard for in-country training). Note also that an individual trainee, even if he/she is trained in more than one area or instance of training that year, should be counted only once. People trained under Fulbright or in sectors other than education who will be/are teaching in pre-primary, primary, lower-secondary, upper-secondary, adult literacy should be counted here.	
RATIONALE: Training teachers and/or educators supports individual and institutional capacity building in countries. This indicator provides an overall sense of scope by giving a count of the total number of teachers/educators trained. However, because the depth of USAID supporting interventions varies (e.g. this includes both short term and long term training), this is a limited indicator, meant to help 'tell the story'.	
UNIT: Number of teachers/educators	*DISAGGREGATE BY:* Sex
TYPE: OUTPUT/OUTCOME Output	*DIRECTION OF CHANGE:* Higher = better
DATA SOURCE: Implementing partners, USG and partners	
MEASUREMENT NOTES:	

ELEMENT: **IIP 2.1-BASIC EDUCATION**	
INDICATOR TITLE: **NUMBER OF PARENT-TEACHER ASSOCIATION OR SIMILAR 'SCHOOL' GOVERNANCE STRUCTURES SUPPORTED**	
DEFINITION: A count of PTA, School Management Committee (SMC), or other similar governance bodies for an individual school (or equivalent non-school setting) supported by USG to organize, meet regularly, participate more fully in education activities, contribute to school governance, or in any other way be more supportive of the school or non-school equivalent education setting. USG support includes, but is not limited to, direct financial support (grants) and training in skills related to serving on a PTA, SMC, or equivalent governance body.	
RATIONALE: Support for PTA or other school governance structures are an important way to promote capacity building at the grassroots, local level. Such structures promote opportunities for democracy in action as well as improved local ownership, accountability, and educational quality. This indicator provides an overall sense of scope. Because the depth of USG supporting interventions varies, this is a limited indicator, meant to help 'tell the story' by giving an overall sense of the number of such structures affected by USG-supported efforts.	
UNIT: Number of PTAs, SMCs, or other governing bodies	*DISAGGREGATE BY:* None
TYPE: OUTPUT/OUTCOME Output	*DIRECTION OF CHANGE:* Higher = better
DATA SOURCE: Implementing partners, USG and partners	
MEASUREMENT NOTES:	

ELEMENT: **IIP 2.1-BASIC EDUCATION**	
INDICATOR TITLE: **NUMBER OF CLASSROOMS REPAIRED WITH USG ASSISTANCE**	
DEFINITION: "Repair" ranges from cosmetic upgrades such as whitewashing walls, to structural improvements (replacing broken windows, fixing leaky roofs, rebuilding damaged walls or roofs), and mending broken furniture. If a classroom block is repaired, the number of classrooms in that block affected by the repairs should be counted.	
RATIONALE: Schools in flagrant disrepair are a deterrent to attendance, especially for girls, a distraction from instruction, and frequently unsafe and inadequate for teaching and learning in inclement weather.	
UNIT: Number of classrooms	*DISAGGREGATE BY:* None
TYPE: OUTPUT/OUTCOME Output	*DIRECTION OF CHANGE:* Higher = better
DATA SOURCE: Implementing partners, USG and partners	
MEASUREMENT NOTES:	

ELEMENT: **IIP 2.1-BASIC EDUCATION**	
INDICATOR TITLE: **NUMBER OF CLASSROOMS CONSTRUCTED WITH USG ASSISTANCE**	
DEFINITION: "Classrooms" are safe and secure spaces in which organized group learning takes place. Classrooms range from environmentally-appropriate, roofed structures without walls, to traditional four-walled structures with a roof and windows. This indicator does not include temporary classrooms (such as tents, open spaces set aside for instruction) frequently found in refugee settings. Individual classrooms should be counted if a whole classroom block is built.	
RATIONALE: Classrooms of acceptable quality are an essential component of education, making instruction possible and encouraging parents to send their children to school.	
UNIT: Number of discrete classrooms	*DISAGGREGATE BY:* None
TYPE: OUTPUT/OUTCOME Output	*DIRECTION OF CHANGE:* Higher = better
DATA SOURCE: Implementing partners, USG and partners	
MEASUREMENT NOTES:	

ELEMENT: **IIP 2.1-BASIC EDUCATION**

INDICATOR TITLE: **NUMBER OF TEXTBOOKS AND OTHER TEACHING AND LEARNING MATERIALS PROVIDED WITH USG ASSISTANCE**

DEFINITION:

The number of teaching and learning materials provided with USG assistance (funded in whole or in part by USG). This may represent a range of final 'products', including materials that are designed and then printed and published, or documents that are purchased and distributed. For the purposes of this indicator, however, the same material should only be counted once: in its final stage of USG support. Teaching and learning materials may include textbooks, student workbooks, supplementary reading books, educational tapes and CDs, and reference material in hard or electronic copies for use in preschool, primary, secondary, adult education, and/or teacher training classes. Library books or materials, and support materials for educational radio, cassette, CD or TV broadcasts should be counted. Small materials and supplies (e.g. pencils, small materials produced as hand-outs in training etc.), even if paid for by USG funds should not to be counted.

RATIONALE:

Learning materials, including an adequate amount of materials per student, is critical to supporting educational quality. This measure provides an overall sense of the scope of products resulting from investments in this area. However, because the depth of USG supporting interventions varies, this is a limited indicator that is meant to help 'tell the story'.

UNIT:	*DISAGGREGATE BY:*
Number of textbooks and materials	None
TYPE: OUTPUT/OUTCOME	*DIRECTION OF CHANGE:*
Output	Higher = better

DATA SOURCE:

Implementing partners, USG and partners

MEASUREMENT NOTES:

ELEMENT: **IIP 2.1 - BASIC EDUCATION**	
INDICATOR TITLE: **DOES YOUR PROGRAM SUPPORT EDUCATION SYSTEMS/POLICY REFORM? IF YES, PLEASE DESCRIBE THE CONTRIBUTIONS OF YOUR PROGRAM, INCLUDING PROGRESS AGAINST ANY MISSION-LEVEL OUTCOME OR IMPACT INDICATORS.**	
DEFINITION: This question requests a narrative description, if applicable, of the contributions of USG funded policy and systems support efforts to larger efforts and progress within the sector. For example, this may include activities in the area of decentralization, finance, support for the development of sector plans and analyses, etc.	
RATIONALE: Indicators on annual USG funded outputs, and annual national level statistics do not tell the full story of USG's involvement in education in most countries. There is a companion indicator that does capture outputs related to policy/systems, but this indicator captures important narrative information that addresses the critical middle ground between basic annual outputs and national level data. Unless there are enormous budgets, noteworthy changes in national level data, even over a period of several years, is rarely within the USG's manageable interest. This indicator helps address this middle ground by commenting on how output indicator results are strategically contributing to larger level outcomes, capacity building and systems strengthening. This is particularly important for education, where most programs are operating in a context of close donor and host country coordination, including Sector Wide Approach (SWAP) environments.	
UNIT: Yes/No	*DISAGGREGATE BY:* None
TYPE: OUTPUT/OUTCOME Outcome	*DIRECTION OF CHANGE:* Yes = better
DATA SOURCE: Implementing partners, USG and partners	
MEASUREMENT NOTES:	

ELEMENT: **IIP 2.1 - BASIC EDUCATION**	
INDICATOR TITLE: **NUMBER OF LAWS, POLICIES, REGULATIONS, OR GUIDELINES DEVELOPED OR MODIFIED TO IMPROVE EQUITABLE ACCESS TO OR THE QUALITY OF EDUCATION SERVICES**	
DEFINITION: This indicator captures information on quantifiable systems and policy level activities. Examples of actions that may be counted include the development or modification of laws, policies, regulations or guidelines in areas such as school finance, assessment, teacher recruitment and selection, etc. To be counted, actions must have, as their ultimate purpose, improving equitable access to or the quality of education services.	
RATIONALE: This indicator is a quantitative complement to the qualitative narrative indicator on policy/systems level support activities.	
UNIT: Number of laws, policies, regulations or guidelines	*DISAGGREGATE BY:* None
TYPE: OUTPUT/OUTCOME Output	*DIRECTION OF CHANGE:* Higher = better
DATA SOURCE: Implementing partners, USG and partners	
MEASUREMENT NOTES:	

ELEMENT: **IIP – 2.1 BASIC EDUCATION**	
INDICATOR TITLE: **AMOUNT OF PRIVATE FINANCING MOBILIZED WITH A DCA GUARANTEE**	
DEFINITION: The amount of financing in US dollars or US dollar equivalent from the private sector that is guaranteed by the Development Credit Authority guarantee AND has been provided to a targeted borrower(s).	
RATIONALE: This indicator measures the amount of private financing made available to formal and non-formal education systems to strengthen effectiveness and sustainability. Without the DCA guarantee, the private financing would not have been made available.	
UNIT: US Dollars or equivalent	*DISAGGREGATE BY:* None
TYPE: OUTPUT/OUTCOME Outcome	*DIRECTION OF CHANGE:* Higher = better
DATA SOURCE: DCA guarantee recipient	
MEASUREMENT NOTES:	

ELEMENT: **IIP 2.2 - HIGHER EDUCATION**	
INDICATOR TITLE: **NUMBER OF HIGHER EDUCATION PARTNERSHIPS BETWEEN US AND HOST COUNTRY HIGHER EDUCATION INSTITUTIONS THAT ADDRESS REGIONAL, NATIONAL, AND/OR LOCAL DEVELOPMENT NEEDS.**	
DEFINITION: Higher education institutions include research institutes, teacher-training colleges and institutes, universities, community colleges, and post-secondary professional skills colleges. Activities include requests from regional, national, and local organizations (public and private) and concrete active efforts by higher education to apply research and technology, policy and institutional development, community service, and technical assistance to defined development needs.	
RATIONALE: Used to measure institutional relationships between US and host-country higher education institutions as channels of effective development assistance and public diplomacy.	
UNIT: Number	*DISAGGREGATE BY:* Sector
TYPE: OUTPUT/OUTCOME Output	*DIRECTION OF CHANGE:* Higher = better
DATA SOURCE: Implementing partners	
MEASUREMENT NOTES:	

ELEMENT: **IIP 2.2 - HIGHER EDUCATION**	
INDICATOR TITLE: **NUMBER OF USG-FUNDED SCHOLARSHIP AND EXCHANGE PROGRAMS CONDUCTED THROUGH HIGHER EDUCATION INSTITUTIONS**	
DEFINITION: Number of USG-funded scholarship and exchange programs conducted through higher education institutions (US/host-country/third-country). Exchange programs include long- and short-term degrees, visitor and cultural exchanges, and study tours. Higher education institutions include research institutes, teacher-training colleges and institutes, universities, community colleges, and post-secondary professional skills colleges.	
RATIONALE: Used to measure the number of scholarship and exchange programs that provide access to higher education opportunities.	
UNIT: Number of programs	*DISAGGREGATE BY:* None
TYPE: OUTPUT/OUTCOME Output	*DIRECTION OF CHANGE:* Higher = better
DATA SOURCE: Implementing partners	
MEASUREMENT NOTES:	

ELEMENT: **IIP 2.2 - HIGHER EDUCATION**	
INDICATOR TITLE: **NUMBER OF HOST-COUNTRY INDIVIDUALS RECEIVING USG-FUNDED SCHOLARSHIPS TO ATTEND HIGHER EDUCATION INSTITUTIONS**	
DEFINITION: Number of host-country individuals receiving scholarships through USG-funded partnerships, scholarship programs or exchange programs (such as Fulbright and other fellowship programs) to attend higher education institutions (US/host-country/third-country). Higher education institutions include research institutes, teacher-training colleges and institutes, universities, community colleges, and post-secondary professional skills colleges.	
RATIONALE: Used to measure the number of individuals with access to higher education as a result of USG funding.	
UNIT: Number of individuals	*DISAGGREGATE BY:* Sex; sector; country; receiving institution (US/host-country/third-country)
TYPE: OUTPUT/OUTCOME Output	*DIRECTION OF CHANGE:* Higher = better
DATA SOURCE: Implementing partners and TraiNet for USAID participants	
MEASUREMENT NOTES:	

ELEMENT: **IIP 2.2 – HIGHER EDUCATION**	
INDICATOR TITLE: **NUMBER OF HOST-COUNTRY INDIVIDUALS COMPLETING USG-FUNDED EXCHANGE PROGRAMS CONDUCTED THROUGH HIGHER EDUCATION INSTITUTIONS**	
DEFINITION: Number of host-country individuals completing exchange programs conducted through higher education institutions (US/host-country/third-country). Exchange programs include long- and short-term degree and certificate programs, visitor and cultural exchanges, and study tours. Higher education institutions include research institutes, teacher-training colleges and institutes, universities, community colleges, and post-secondary professional skills colleges.	
RATIONALE: Used to measure the number of individuals benefiting from exchange programs through higher education institutions.	
UNIT: Number of individuals	*DISAGGREGATE BY:* Sex; sector; country; receiving institution (US/host-country/third-country)
TYPE: OUTPUT/OUTCOME Output	*DIRECTION OF CHANGE:* Higher = better
DATA SOURCE: Implementing partners and TraiNet for USAID participants	
MEASUREMENT NOTES:	

ELEMENT: **IIP 2.2 - HIGHER EDUCATION**	
INDICATOR TITLE: **NUMBER OF HOST-COUNTRY INDIVIDUALS TRAINED AS A RESULT OF USG INVESTMENTS INVOLVING HIGHER EDUCATION INSTITUTIONS**	
DEFINITION: Number of host-country individuals trained as a result of USG investments involving higher education institutions (US/host-country/third-country). Individuals trained include all individuals participating in activities meant to enhance their knowledge or skills. (Activities might include courses, explicit formal or informal training, research, or coaching and mentoring.) USG investments involving higher education institutions include but are not limited to research and training programs, scholarships, exchanges and partnerships. Higher education institutions include research institutes, teacher-training colleges and institutes, universities, community colleges, and post-secondary professional skills colleges.	
RATIONALE: Used to measure USG efforts towards human capacity building that utilizes higher education institutions.	
UNIT: Number of individuals	*DISAGGREGATE BY:* Sex; location of higher education institution; type of higher education institution; sector
TYPE: OUTPUT/OUTCOME Output	*DIRECTION OF CHANGE:* Higher = better
DATA SOURCE: Implementing partners	
MEASUREMENT NOTES:	

ELEMENT: **IIP 2.2 – HIGHER EDUCATION**	
INDICATOR TITLE: **NUMBER OF USG-SUPPORTED ORGANIZATIONAL IMPROVEMENTS THAT STRENGTHEN THE INSTITUTIONAL CAPACITY OF HOST-COUNTRY HIGHER EDUCATION INSTITUTIONS**	
DEFINITION: An organizational improvement is a change in structures, systems, resources or policies that improves the performance of the institution. This includes, but is not limited to, changes in human resources (improved faculty skills, improved capacities of staff and administrators); management and administration (financial management, service delivery, fundraising, outreach, institutional linkages to the private sector, personnel policies); research capacity and methods; and academic programs (quality relevant degree programs, curricula, pedagogy). Higher education institutions include research institutes, teacher-training colleges and institutes, universities, community colleges, and post-secondary professional skills colleges.	
RATIONALE: Used to measure the number of key organizational improvements that strengthen the institutional capacity of host-country higher education institutions.	
UNIT: Number of improvements	*DISAGGREGATE BY:* None
TYPE: OUTPUT/OUTCOME Outcome	*DIRECTION OF CHANGE:* Higher = better
DATA SOURCE: Implementing partners	
MEASUREMENT NOTES:	

ELEMENT: **IIP 2.2 - HIGHER EDUCATION**	
INDICATOR TITLE: **NUMBER OF HOST-COUNTRY INSTITUTIONS WITH INCREASED MANAGEMENT OR INSTITUTIONAL CAPACITY AS A RESULT OF USG INVESTMENTS INVOLVING HIGHER EDUCATION INSTITUTIONS**	
DEFINITION: Increased management or institutional capacity includes improved administration, financial management, human resources, strategic planning and service delivery. Higher education institutions include research institutes, teacher-training colleges and institutes, universities, community colleges, and post-secondary professional skills colleges.	
RATIONALE: Used to measure the number of host-country institutions with increased management and institutional capacity as a result of USG investments involving higher education institutions.	
UNIT: Number of institutions	*DISAGGREGATE BY:* Non-profit, government, and private sector
TYPE: OUTPUT/OUTCOME Outcome	*DIRECTION OF CHANGE:* Higher = better
DATA SOURCE: Implementing partners	
MEASUREMENT NOTES:	

ELEMENT: **IIP 2.2 – HIGHER EDUCATION**	
INDICATOR TITLE: **NUMBER OF USG-ASSISTED HOST-COUNTRY POLICY DEVELOPMENT AND REFORM ACTIVITIES UTILIZING HOST-COUNTRY HIGHER EDUCATION INSTITUTIONS**	
DEFINITION: Policy development and reform activities include but are not limited to policy analyses, policy dialogues, policy designs, policy research, and legislative testimony, regardless of sector. Higher education institutions include research institutes, teacher-training colleges and institutes, universities, community colleges, and post-secondary professional skills colleges.	
RATIONALE: Used to measure the ability of host-country higher education institutions to engage in policy development and reform activities to contribute to development.	
UNIT: Number of activities	*DISAGGREGATE BY:* Sector
TYPE: OUTPUT/OUTCOME Output	*DIRECTION OF CHANGE:* Higher = better
DATA SOURCE: Implementing partners	
MEASUREMENT NOTES:	

ELEMENT: **IIP 2.2 - HIGHER EDUCATION**	
INDICATOR TITLE: **NUMBER OF USG-ASSISTED HIGHER EDUCATION INSTITUTIONS' ACTIVITIES THAT ADDRESS REGIONAL, NATIONAL, AND LOCAL DEVELOPMENT NEEDS**	
DEFINITION: Activities include concrete active efforts by higher education institutions to conduct or apply research and technology, policy analysis, institutional development, training, community service, or technical assistance in order to address development needs. Higher education institutions include research institutes, teacher-training colleges and institutes, universities, community colleges, and post-secondary professional skills colleges.	
RATIONALE: Used to measure the extent to which higher education institutions contribute to development.	
UNIT: Number of institutions	*DISAGGREGATE BY:* Foreign assistance framework objective; sector; higher education institution (host-country or U.S.)
TYPE: OUTPUT/OUTCOME Outcome	*DIRECTION OF CHANGE:* Higher = better
DATA SOURCE: Implementing partners	
MEASUREMENT NOTES:	

Program Area: Social Services and Protection for Vulnerable Populations

ELEMENT: **IIP 3.1 - POLICIES, REGULATIONS AND SYSTEMS**	
INDICATOR TITLE: **NUMBER OF SOCIAL PROTECTION POLICY REFORMS DRAFTED, ADOPTED OR IMPLEMENTED WITH USG SUPPORT**	
DEFINITION: Number of Missions engaged in social protection policy reform issues, by result. Missions report policies drafted, adopted, and/or implemented as a result of USG technical support/input.	
RATIONALE: Provides information about progress in the development of a country's social protection policies (policies drafted). It also provides proxy measures for social protection regulations (policies adopted) and for systems (policies implemented).	
UNIT: Number of reforms	*DISAGGREGATE BY:* Result: Policies drafted, policies adopted, policies implemented
TYPE: OUTPUT/OUTCOME Output	*DIRECTION OF CHANGE:* Higher = better
DATA SOURCE: Missions, implementing partners	
MEASUREMENT NOTES:	

ELEMENT: **IIP 3.1 - POLICIES, REGULATIONS AND SYSTEMS**	
INDICATOR TITLE: **NUMBER OF NATIONWIDE POVERTY/VULNERABILITY MAPPING EFFORTS BEING SUPPORTED**	
DEFINITION: Number of Missions assisting in nationwide poverty/vulnerability mapping efforts by result. Missions report development of systems capable of mapping/tracking poverty, food insecurity and/or other vulnerability.	
RATIONALE: Effective and responsive social policy and social protection regulations and systems can only be built on a sound knowledge base. Poverty or vulnerability mapping can provide this base. Greater complexity will broaden the base.	
UNIT: Number of mapping efforts	*DISAGGREGATE BY:* Complexity defined by number of variables considered (gender, rural/urban, livelihood/food economy, seasonality, etc.) Level 1 (1-5 variables); Level 2 (6-10 variables) Level 3 (11 +)
TYPE: OUTPUT/OUTCOME Output	*DIRECTION OF CHANGE:* Higher = better
DATA SOURCE: National Ministries, Implementing Partners, WB, UN	
MEASUREMENT NOTES:	

ELEMENT: **IIP 3.2 – SOCIAL SERVICES**	
INDICATOR TITLE: **NUMBER OF PEOPLE BENEFITING FROM USG-SUPPORTED SOCIAL SERVICES**	
DEFINITION: Number of vulnerable people receiving services from programs funded in whole or in part by the USG.	
RATIONALE: Simple output measure to enable the roll up of vulnerable people assisted through USG resources.	
UNIT: Number of people	*DISAGGREGATE BY:* Sex, Group (Displaced Children and Orphans; War Victims, Victims of Torture; Other Vulnerable)
TYPE: OUTPUT/OUTCOME Output	*DIRECTION OF CHANGE:* Higher = better
DATA SOURCE: Implementing partners	
MEASUREMENT NOTES:	

ELEMENT: **IIP 3.2 – SOCIAL SERVICES**	
INDICATOR TITLE: **NUMBER OF SERVICE PROVIDERS TRAINED WHO SERVE VULNERABLE PERSONS**	
DEFINITION: Number of service providers trained who serve Vulnerable Persons	
RATIONALE: Tracks improvement in the capacity to provide social assistance and social service programs. Also serves as an indicator of a government's commitment and capacity to protect its vulnerable populations.	
UNIT: Number of service providers	*DISAGGREGATE BY:* Sex
TYPE: OUTPUT/OUTCOME Output	*DIRECTION OF CHANGE:* Higher = better
DATA SOURCE: Implementing partners, Government Ministries, United Nations, World Bank, NGOs	
MEASUREMENT NOTES:	

ELEMENT: **IIP 3.2 – SOCIAL SERVICES**	
INDICATOR TITLE: **NUMBER OF USG ASSISTED ORGANIZATIONS AND/OR SERVICE DELIVERY SYSTEMS STRENGTHENED WHO SERVE VULNERABLE POPULATIONS**	
DEFINITION: Number of organizations or service delivery systems strengthened (providing better or more efficient services) with USG resources.	
RATIONALE: Tracks improvement in the capacity to provide social assistance and social service programs. Also serves as an indicator of a government's commitment and capacity to protect its vulnerable populations.	
UNIT: Number of organizations and/or service delivery systems	*DISAGGREGATE BY:* None
TYPE: OUTPUT/OUTCOME Output	*DIRECTION OF CHANGE:* Higher = better
DATA SOURCE: Implementing partners, Government Ministries, United Nations, World Bank, NGOs	
MEASUREMENT NOTES:	

ELEMENT: **IIP 3.3 – SOCIAL ASSISTANCE**	
INDICATOR TITLE: **NUMBER OF PEOPLE BENEFITTING FROM USG-SUPPORTED SOCIAL ASSISTANCE PROGRAMMING**	
DEFINITION: Number of people receiving assistance (cash, food, or other in-kind) from programs supported in whole or in part through USG resources.	
RATIONALE: Simple output measure to enable the roll up of USG-supported programming addressing social assistance needs.	
UNIT: Number of people	*DISAGGREGATE BY:* Sex, Target group (e.g. HIV affected; food-insecure; female-headed household, etc)
TYPE: OUTPUT/OUTCOME Output	*DIRECTION OF CHANGE:* Higher = better
DATA SOURCE: Implementing partners	
MEASUREMENT NOTES:	

ELEMENT: **IIP 3.3 – SOCIAL ASSISTANCE**	
INDICATOR TITLE: **PERCENT OF TOTAL ELIGIBLE PERSONS RECEIVING ASSISTANCE THROUGH USG-SUPPORTED SOCIAL ASSISTANCE PROGRAMMING**	
DEFINITION: The number of USG beneficiaries as a percentage of the estimated total number of people in a target population	
RATIONALE: By comparing needs met to total need we have a greater understanding of what USG assistance is achieving.	
UNIT: Percent of eligible persons	*DISAGGREGATE BY:* Sex, Target group (e.g. HIV affected; food-insecure; female-headed household, etc)
TYPE: OUTPUT/OUTCOME Output	*DIRECTION OF CHANGE:* Contextual
DATA SOURCE: Implementing partners	
MEASUREMENT NOTES:	

ELEMENT: **IIP 3.3 – SOCIAL ASSISTANCE**	
INDICATOR TITLE: **NUMBER OF USG SOCIAL ASSISTANCE BENEFICIARIES PARTICIPATING IN PRODUCTIVE SAFETY NETS**	
DEFINITION: The number of people participating in USG-supported social assistance programming with productive components aimed at increasing community assets, household assets, or strengthening human capital.	
RATIONALE: Provides information on the amount of USG assistance aimed at increasing self-sufficiency in vulnerable populations.	
UNIT: Number of beneficiaries	*DISAGGREGATE BY:* Sex, Target group (e.g. HIV affected; food-insecure; female-headed household, etc) and/or type of asset built: community assets, household assets, or human capital
TYPE: OUTPUT/OUTCOME Output	*DIRECTION OF CHANGE:* Higher = better
DATA SOURCE: Implementing partners	
MEASUREMENT NOTES:	

ELEMENT: **IIP 3.3 – SOCIAL ASSISTANCE**	
INDICATOR TITLE: **PERCENT OF USG SOCIAL ASSISTANCE BENEFICIARIES PARTICIPATING IN PRODUCTIVE SAFETY NETS**	
DEFINITION: The number of people participating in productive components of USG-supported social assistance programming as a percentage of the total number of social assistance beneficiaries.	
RATIONALE: Provides information about the proportion of USG social assistance which is "conditional"-- that is, directly linked to programming aimed at increasing the self-reliance of vulnerable households and communities.	
UNIT: Percent of beneficiaries	*DISAGGREGATE BY:* Sex, Target group (e.g. HIV affected; food-insecure; female-headed household, etc) and/or type of asset built: community assets, household assets, or human capital
TYPE: OUTPUT/OUTCOME Output	*DIRECTION OF CHANGE:* Higher = better
DATA SOURCE: Implementing partners	
MEASUREMENT NOTES:	

ELEMENT: **IIP 3.3 – SOCIAL ASSISTANCE**	
INDICATOR TITLE: **AVERAGE NUMBER OF MONTHS THAT HOUSEHOLDS BENEFITING FROM USG SUPPORTED SOCIAL ASSISTANCE HAVE ENOUGH FOOD**	
DEFINITION: The average number of months beneficiaries in USG-supported social assistance programs are able to meet their basic food needs.	
RATIONALE: For particular use in Title II supported programming aimed at improving the food security of chronically vulnerable populations. As an output indicator, this measure provides information about the adequacy and immediate impact of program support. Measured over time as an outcome indicator, it can provide information about sustainable reductions in overall household food insecurity.	
UNIT: Average number of months	*DISAGGREGATE BY:* Sex, Target group (e.g. HIV affected; food-insecure; female-headed household, etc)
TYPE: OUTPUT/OUTCOME Outcome	*DIRECTION OF CHANGE:* Higher = better
DATA SOURCE: Implementing partners	
MEASUREMENT NOTES:	