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FRAMEWORK FOR MONITORING AND EVALUATION OF HIV/AIDS PROGRAMMES IN THE CARIBBEAN

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FRAMEWORK FOR MONITORING AND EVALUATION OF HIV/AIDS PROGRAMMES IN THE CARIBBEAN

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ACRONYMS

ANC	Ante natal clinic
ARV	Antiretroviral
ART	Antiretroviral Treatment
API	AIDS Program Effort Index
AIDS	Acquired Immunodeficiency Syndrome
BCC	Behavior change communication
BSS	Behavioral Surveillance Survey
CAREC	Caribbean Epidemiological Centre
CARICOM	Caribbean Community
CDC	Center for Disease Control and Prevention (Atlanta, USA)
CHRC	Caribbean Health Research Council
CCNAPC	Caribbean Coalition of National AIDS Programs Coordinators (CCNAPC)
CIMT	Caribbean Indicators and Measurement Tools for the Evaluation of National AIDS Programmes
CRIS	Country Response Information System
CRN	Caribbean Network of People with HIV-AIDS
DOTS	Therapy of Direct Observation
FHI	Family Health International
GFATM	Global Fund against AIDS, Tuberculosis and Malaria
GAMET	World-wide Team Support Group on Monitoring and Evaluation
HIV	Human Immunodeficiency virus
IDU	Injecting drug users
IEC	Information, Education and Communication
M&E	Monitoring and Evaluation
MSM	Men who have Sex with Men
MDG	Millennium Development Goals
MTCP	Mother to child prevention
MTCT	Mother to child transmission
MOH	Ministry of Health
NAP	National AIDS Programme

NGO	Non-government organization
NSP	National Strategic Plan
OI	Opportunistic Infection
OVC	Orphan or vulnerable child
PANCAP	Pan Caribbean Partnership Against HIV-AIDS
PAHO	Pan American Health Organization
PLWHA	Persons Living with HIV/AIDS
PMTCT	Prevention of Mother to Child Transmission
STI	Sexually Transmitted Infections
SPA	Service Provision Assessment
TFG	The Futures Group
TB	Tuberculosis
TWG	Technical Working Group
UNDP	United Nations Development Program
UNGASS	United Nations General Assembly Session
USAID	Agency of the United States for the International Development
UNAIDS	Joint program of the Nations United for HIV-AIDS
UWI	University of West Indies
WB	World Bank
WHO	World Health Organization
VCT	Voluntary Counseling and Testing

EXECUTIVE SUMMARY

Currently, the countries in the Caribbean region are developing multiple actions to thwart the causes and impacts of the disease and, given the large number of efforts and resources deployed, the effectiveness level of the interventions need to be enhanced. In this respect, the most relevant stakeholders in the response to HIV/AIDS in the region recognize two critical issues: first, the need to improve M&E systems at the local and regional levels; second, the convenience of improving the level of effort coordination hence avoiding waste, duplications and overlapping.

One of the strengths of the region is the important presence of international organizations and agencies that strongly support the national efforts and participate of the results obtained. Some of them are UNAIDS, USAID, the World Bank, the European Union, among others. These institutions have established solid links with the main national stakeholders and have an important role in the future efforts to fight HIV/AIDS in the region. The Framework will also contribute to the organization and harmonization of actions in HIV/AIDS financed by institutions and cooperation agencies. In addition, it will serve to expand and reinforce the general coordination level in the region, achieving a better understanding among all parties involved.

An M&E Framework of the HIV/AIDS programs in the region is needed to address the needs mentioned above. The purposes of the framework are: to design the components of a functional M&E system to follow-up the Regional Strategic Plan; and to develop a collaborative strategy to strengthen the national M&E Systems in the Caribbean countries.

A participatory methodology was selected for the development of this proposal, responding to a strong felt demand and to the large number of stakeholders involved. This was an initiative of the Technical Working Group (TWG) for monitoring and evaluation which operates within the context of the Regional Caribbean Strategic Framework on HIV/AIDS developed by Pan Caribbean Partnership Against HIV/AIDS (PANCAP). The TWG on M&E is comprised of the following institutions:

- Caribbean Coalition of National AIDS Programs Coordinators (CCNAPC)
- World Bank (WB).
- Caribbean Office of the Joint UN Programme on AIDS (UNAIDS).
- US Government; USAID and CDC represented by someone from MEASURE.
- Caribbean Epidemiology Centre (CAREC).
- Caribbean Health Research Council (CHRC).

By mandate of the PANCAP, the M&E coordination and technical support unit is located at CHRC. This mechanism receives support from other partners working on the institutional strengthening of monitoring and evaluation efforts in the region, including UNAIDS and other international donors.

In 2004, a decision was made to develop an M&E Framework, to assist countries in the development of their own M&E systems with the coordinated support of the different participating agencies, to avoid duplication of efforts.

In view of the existence of other important stakeholders in the field of M&E in the region, it was decided that a participatory strategy for the formulation of an M&E Framework was preferred in order to have consensus regarding its purposes and content.

Following this, the Fundación Plenitud -- a research center based in the Dominican Republic -- was appointed as the facilitator to produce a consensus draft outline of the framework. A series of consultations were conducted through face-to-face interviews and teleconferences, gathering the opinion of 18 regional stakeholders.

With the results of the consultation process, a draft document of the M&E Framework was prepared and presented during a workshop that took place on 28-29 April 2005 in Port of Spain, Trinidad & Tobago. Fundación Plenitud was placed in charge of developing the proposal for the M&E Framework, based on the outcome of the workshop.

The Framework consists presents a brief overview of the general situation of M&E of HIV-AIDS Programmes in the Caribbean and some of the main regional tools are summarized, particularly, the Regional Strategic Plan and the CIMT Indicators. Then, the components of an M&E system are described. This is the conceptual framework which supports the proposal for a regional M&E system.

The main part of the Framework presents the constitutive elements of the regional M&E system for HIV-AIDS programmes in the Caribbean, including the operational processes and links among them. This is the proposal for a regional M&E system and contains three operational levels: the project level, the local or national level and the regional level. At each level, the structure, components, functions and main indicators, as well as information flows are presented. Finally, there are suggestions for the coordination of the different stakeholders that operate in the region.

The main recommendation of the Framework is the development of an Implementation Plan for the Caribbean System for HIV/AIDS Monitoring and Evaluation, covering the following areas:

- Training and Technical Assistance.
- Development of the components of the M&E System
- TWG institutional strengthening
- Implementation of an Informatics System for Indicators
- Definition of the information flows and the required reports
- Homogeneity and Standardization
- Regional Strategic Action Plan
- CIMT Indicators
- Internet website on M&E of HIV-AIDS Programmes in the Caribbean

This plan should be submitted to PANCAP with the objective of securing formal support at political level and the commitment of each country involved.

Some additional general recommendations include the following:

- Design and implement simple systems.
- Limit the collection of indicators to those that are absolutely necessary
- Incorporate UNGASS indicators, Millennium Development Goals, CIMT, etc
- Attempt to standardize the M&E systems.
- Develop an M&E system at the start of projects and programs.
- Program funds for the system
- Use a participatory approach when developing the system.

FRAMEWORK FOR MONITORING AND EVALUATION OF HIV/AIDS PROGRAMMES IN THE CARIBBEAN

I. Introduction

1.1 Rationale

After Sub-Saharan Africa, the Caribbean is the region with the highest prevalence of HIV/AIDS in the world. According to UNAIDS and WHO, of nearly 32 million people, approximately 360,000 are HIV positive.

HIV/AIDS is a complex and forceful disease that places an economic, human and social burden on the nations and the people who are infected. This situation requires organized and intelligent efforts, and monitoring and evaluation are management tools that enable higher levels of efficacy and efficiency of the actions taken in response to the epidemic.

Currently, the countries in the Caribbean region are developing multiple actions to thwart the causes and impacts of the disease and, given the large number of efforts and resources deployed, the effectiveness level of the interventions need to be enhanced. In this respect, the most relevant stakeholders in the response to HIV/AIDS in the region recognize two critical issues: first, the need to improve M&E systems at the local and regional levels; second, the convenience of improving the level of effort coordination hence avoiding waste, duplications and overlapping.

One of the strengths of the region is the important presence of international organizations and agencies that strongly support the national efforts and participate of the results obtained. Some of them are UNAIDS, USAID, the World Bank, the European Union, among others. These institutions have established solid links with the main national stakeholders and have an important role in the future efforts to fight HIV-AIDS in the region.

1.2 Purposes

An M&E Framework of the HIV/AIDS programs in the region is needed to address the needs mentioned above. A participatory methodology was selected for the development of this proposal, responding to a strong felt demand and to the large number of stakeholders involved.

OBJECTIVES OF THE FRAMEWORK
<ul style="list-style-type: none">• Design the components of a functional M&E system to follow-up the Regional Strategic Plan• Develop a collaborative strategy to strengthen the national M&E systems in the Caribbean countries

The Caribbean M&E Framework will reinforce the efforts to tackle a disease that is developing in a global and multicultural scenario. The response to HIV/AIDS must correspond to the magnitude of the epidemic, and the decisions made should increasingly be based on updated and reliable data; thus the growing importance of information and M&E systems

The Framework will also contribute to the organization and harmonization of actions in HIV/AIDS financed by institutions and cooperation agencies. In addition, it will serve to expand and reinforce the general coordination level in the region, achieving a better understanding among all parties involved.

Some of the main objectives of the Framework for Monitoring and Evaluation of the HIV/AIDS Programs in the Caribbean include:

- **Contribute to the empowerment of national programs in the implementation of local and regional processes in the response to HIV/AIDS.** Once the regional M&E objectives are defined, the national authorities at country level can identify their needs for cooperation and the potential contributions from the agencies. This way, the cooperative actions will be subject to previously identified needs, thereby counteracting possible voluntarism from the agencies and the emergence of autonomous agendas.
- **Describe the status of M&E within the HIV/AIDS programs in the Caribbean.** The Framework contains an overall diagnosis of the status and development of M&E in the region. The brief diagnosis establishes the starting point for the changes proposed.
- **Contribute to the development of a regional M&E system.** The Framework develops a general proposal for the articulation and regulation of the different institutions involved in M&E of HIV/AIDS in the region.
- **Contribute to the development of national M&E systems at country level.** Establishing the main elements required for an effective M&E system and a general inventory of the basic tools that are currently available in each country will point out which elements are missing and need to be developed in order to complete each national M&E system, and how they should be articulated in a harmonized body.
- **Highlight the importance of M&E in the implementation of HIV/AIDS programs in the region.** The Framework highlights the importance of M&E as a management tool to assess the progress of the actions and the results being achieved in the response to HIV/AIDS, suggesting adjustments to the processes that lead to an increased level of efficiency in the actions undertaken by institutions and projects.
- **Contribute to thwart dispersion and enhance the coordination and harmonization efforts in M&E.** The Framework defines a common objective for M&E in the region, and sets the basis for the development of a joint approach. With a clear and well-defined vision, the role of the stakeholders, the coordination spaces and the collaborative actions can be better established; dispersion can be reduced to the minimum and avoid duplication and overlapping of the actions.
- **Set the basis for increased exchange among the countries in the region.** The achievement of the articulation scheme proposed in the Framework would increase the exchange among the national HIV/AIDS programs in the region, hence contributing to the creation of a common M&E language and culture.

- **Identify capacity building and technical assistance requirements in the area of M&E.** Short of being a comprehensive diagnosis of the status of national human resources in the area of M&E, the Framework identifies and points out the needs for training and technical assistance required for strengthening the M&E component within HIV/AIDS programs in the region.

With the implementation of the proposal and the recommendations of this Framework, the available data on HIV/AIDS in the region will increase and the quality of this data will be improved; the number of decisions made based on objective information will increase; coordination and communication among the different institutions involved in the response to the epidemic will improve; and successful best practices will be identified and replicated in the different countries of the region. As a result, the general knowledge of the epidemic will be augmented and the effectiveness of the national and regional responses will be strengthened.

1.3 Methodological Aspects

The Technical Working Group (TWG) for monitoring and evaluation operates within the context of the Regional Caribbean Strategic Framework on HIV/AIDS developed by Pan Caribbean Partnership Against HIV-AIDS (PANCAP). It is a consultative body coordinated by CHRC, comprised of the institutions listed below, as well as other institutions invited as advisers, when appropriate.

The TWG on M&E is comprised of the following institutions:

- Caribbean Coalition of National AIDS Programs Coordinators (CCNAPC)
- World Bank (WB).
- Caribbean Office of the Joint UN Programme on AIDS (UNAIDS).
- US Government; USAID and CDC represented by someone from MEASURE.
- Caribbean Epidemiology Centre (CAREC).
- Caribbean Health Research Council (CHRC).

By mandate of the PANCAP, the M&E coordination and technical support unit is located at CHRC. This mechanism receives support from other partners working on the institutional strengthening of monitoring and evaluation efforts in the region, including UNAIDS and other international donors.

In 2004, a decision was made to develop an M&E Framework, to assist countries in the development of their own M&E systems with the coordinated support of the different participating agencies, to avoid duplication of efforts.

In view of the existence of other important stakeholders in the field of M&E in the region, it was decided that a participatory strategy for the formulation of an M&E Framework was preferred in order to have consensus regarding its purposes and content.

Following this, the Fundación Plenitud -- a research center based in the Dominican Republic -- was appointed as the facilitator to produce a consensus draft outline of the framework. A series of consultations were conducted through face-to-face interviews and teleconferences, gathering the opinion of 18 regional stakeholders (See annex I). A semi-structured interview guide was used for this purpose (See Annex II).

With the results of the consultation process, a draft document of the M&E Framework was prepared and presented during a workshop that took place on 28-29 April 2005 in Port of Spain, Trinidad & Tobago.

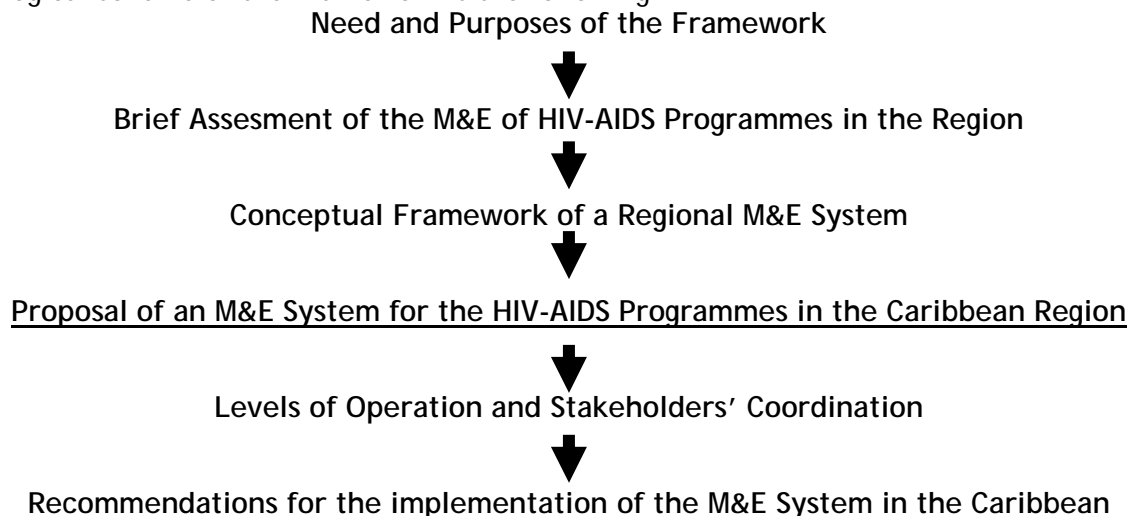
Fundación Plenitud was placed in charge of developing the proposal for the M&E Framework, based on the outcome of the workshop

Structure of the Framework

This document has the following structure:

- **Introduction.** Contains a justification on the need of an M&E Framework for HIV-AIDS Programmes in the Caribbean, and its purposes. Describes the methodology in the preparation of the Framework and its structure.
- **M&E of HIV-AIDS Programmes in the Caribbean.** Presents a brief overview of the general situation of M&E of HIV-AIDS Programmes in the Caribbean and some of the main regional tools are summarized, particularly, the Regional Strategic Plan and the CIMT Indicators.
- **Basic M&E Concepts.** The components of an M&E system are described. This is the conceptual framework which supports the proposal for a regional M&E system.
- **The M&E System for the Caribbean Region.** The constitutive parts of the regional M&E system for HIV-AIDS programmes in the Caribbean are presented, as well as the operational processes and links among them. This is the central part of the document, as it contains the proposal for a regional M&E system. The proposal contains three operational levels: the project level, the local or national level and the regional level. At each level, the structure, components, functions and main indicators, as well as information flows are presented.
- **Coordination at Operational Levels.** This contains suggestions for the coordination of the different stakeholders that operate in the region.
- **Recommendations.** A series of recommendations are included for the implementation of the proposal of a regional M&E system for HIV-AIDS programmes in the Caribbean. These should be part of a regional action plan and some of them should be part of national and local plans.

The logical scheme of the Framework is the following:



II. Monitoring & Evaluation of the HIV/AIDS Programmes in the Caribbean

A great deal of activities are currently being conducted in the Caribbean region in response to the HIV/AIDS epidemic that are not adequately monitored or evaluated, despite an increasing awareness on the importance of M&E to improve the response.

Up to now, neither a true diagnosis nor a serious assessment on the status of monitoring and evaluation of the actions in HIV/AIDS is available for the Caribbean region. There is, however, a set of common perceptions on the part of important regional stakeholders.

2.1 Status of the M&E in the region

During the consultation process for the development of the Framework, the perception on the M&E situation in the Caribbean region was obtained from the actors involved, summarized below.

- **Lack of a needs assessment on M&E.** As previously pointed out, there is no clear identification of the deficiencies and requirements in capacity building and technical assistance for M&E in the region. This often causes the provision of training and technical assistance services without a clear understanding of the actual needs and without following a work plan. In this connection, the results of an ongoing consultancy on the Evaluation of the Development of M&E Capabilities, financed by USG/MEASURE, will be an important contribution.
- **Lack of sufficient staff trained on M&E in the region.** The most sensitive aspect on the issue of M&E is the lack of trained human resources. The number of national specialists and staff dedicated to monitoring and evaluation tasks in the region is insufficient, and a large proportion of local human resources working in M&E have been trained on the field without proper formal training. International organizations, institutions and agencies often request a lot of country information, yet they have not focused on providing the countries with proper training and capacity building.
- **Increased demand for training and technical assistance in M&E.** There is a growing demand for M&E in the region due to a greater recognition of the managerial and operational importance of M&E, as well as to the ongoing information requirements on the part of agencies and international organizations.
- **A series of activities in response to the epidemic which are not being monitored or evaluated.** Given the magnitude of the epidemic, many activities addressing HIV/AIDS are conducted in the region that are not properly monitored or evaluated.
- **Presence of numerous cooperation agencies in the region with the expertise and the willingness to support M&E activities in the region, but with a low level of coordination.** There are many institutions and agencies working in the region, most of which are providing or plan to provide assistance in M&E activities. Currently, efforts are being made to coordinate the work of all the stakeholders, but a framework or a proposal to organize these efforts has been lacking. The cooperation agencies have worked with their own objectives and agendas, creating at times costly duplications. In addition, at times they operate with a limited knowledge of the national stakeholders and somehow acting in competition with similar institutions.
- **Uneven capacities in M&E.** The human and financial resources for M&E in HIV/AIDS, as well as the practices and experiences differ among the countries of the region.

- **Lack of information use in decision-making processes.** There is still a missing culture in the region for collecting and utilizing data to reinforce decision-making.
- **Inaccuracies of the M&E data in the region.** There are many inaccuracies in terms of quantity, quality and reliability of the information on HIV/AIDS produced by the countries in the region.

The Caribbean region has two important instruments for M&E: the Regional Strategic Action Framework and the CIMT Indicators. Both are valuable working tools for the regional HIV/AIDS monitoring, developed during consensual processes with the participation of important regional representatives. The implementation of the Framework is expected to contribute to put these in practice.

2.2 The Caribbean Regional Strategic Action Framework on HIV/AIDS

The Caribbean Regional Strategic Action Framework on HIV/AIDS (2002-2006) identifies the key aspects at the national level that reinforce the regional response to the disease. It was developed on the basis of the Regional Strategic Plan developed by the HIV/AIDS Task Force, which was updated to reflect the most recent policies as well as the new strategic initiatives such as PANCAP, UNGASS and the Nassau Declaration.

With the participation of key national and international stakeholders working on the issue in the region and after numerous consultative meetings, seven critical areas were identified with defined strategic objectives. The overall objective is to support the national efforts to prevent and control de epidemic and mitigate its impact at national and regional levels. Its successful implementation requires close collaboration between regional organizations and national programs. The key components already have the support of important international institutions. The priority areas of the plan are the following:

- Advocacy, policy formulation and legislation.
- Support for people living with HIV/AIDS.
- Prevention of HIV transmission, focusing on young people.
- Prevention of HIV transmission, particularly in vulnerable groups.
- Prevention of mother to child HIV transmission
- Strengthening the response capacity at national and regional levels.
- Resource mobilization.

The main priorities identified by the Regional Framework are focused on the regional level, but simultaneously serve as action framework for National Strategic Plans of PANCAP member countries.

2.3 CIMT Indicators

The region has an important document with indicators for the monitoring and evaluation of the actions to fight HVI/AIDS, the Caribbean Indicators and Measuring Tools (CIMT). This document contains a set of indicators including measurement tools and methodological guidelines. It considers the following strategies:

- Behavior change communication (BCC)
- Condom programming
- Voluntary Counseling and Testing (VCT)
- Prevention of Mother To Child Transmission (PMTCT)
- Blood safety
- Care, support, and treatment
- Training and capacity building
- Advocacy and policy
- Human rights, stigma and discrimination
- Socio-economic impact

The indicators are classified by programmatic area and present suggestions on recollection methods, periodicity, and international standards, as is shown in the following table:

PROGRAM AREA	RECOMMENDED INDICATORS	METHOD	PERIODICITY	INTERNATIONAL STANDARD
Prevention/Behaviour change	Percent of young people aged 15-24 who both correctly identify ways of preventing the sexual transmission of HIV and who reject major misconceptions about HIV transmission	Population-based survey	Baseline and then every 2-3 years	UNGASS 2003
	Percent of never-married young people aged 15-24 who never had penetrative sex	Population-based survey	Baseline and then every 2-3 years	WHO YPG 2004
	Proportion of young women aged 15-24 who have had sex in the last 12 months with a partner who is 10 or more years older than themselves	Population-based survey	Baseline and then every 2-3 years	WHO YPG 2004
	Percent of women and men aged 15-49 who had sex with more than one partner in the last 12 months	Population-based survey	Baseline and then every 2-3 years	Adapted from UNAIDS 2000
	Percentage of young people age 15 - 24 reporting the use of condoms during sexual intercourse with a non-regular sexual partner	Population-based survey	Baseline and then every 2 - 3 years	UNGASS 2003
	Percent of women and men aged 15-49 who say they used a condom the last time they had sex with a non-marital, non-cohabiting partner, of those who have had sex with such a partner in the last 12 months	Population-based survey	Baseline and then every 2-3 years	WHO YPG 2004, UNAIDS 2000, MDG
	Percent of men reporting sex with a sex worker in the last 12 months who used a condom during last paid intercourse	Population-based survey	Baseline and then every 2-3 years	UNAIDS 2000 WHO YPG 2004

	Percent of sex workers who report using a condom with their most recent client, of sex workers surveyed having sex with any clients in the last 12 months	Targeted sample survey	Baseline and then every 2-3 years	UNAIDS 2000, WHO YPG 2004
	Percent of men who used a condom at last sex with a male partner, of those who have had sex with a male partner in the last 6 months	Targeted sample survey	Baseline and then every 2-3 years	UNAIDS 2000 WHO YPG 2004
	Percentage of young people 15-24 who know of at least one formal source of condoms	Population-based or targeted sample survey	Baseline and then every 2-3 years	WHO YPG 2004
	Condoms available for nationwide distribution	Special study	Annual	UNAIDS 2000
	Percent of patients with sexually transmitted infections (STIs) at health care facilities who are appropriately diagnosed, treated and counselled	Special survey	Baseline and then every 2-3 years	UNGASS 2003, GFATM 2004
	Percentage of Intravenous Drug Users (IDU) who have adopted behaviours that reduce transmission of HIV	Special Survey	Biennial	UNGASS 2003
Blood safety	Percent of blood units transfused in the last 12 months that have been adequately screened for HIV according to national or regional standards	Special study	Annual	UNAIDS 2000, GFATM 2004
Prevention impact	Percent of young people aged 15-24 that are HIV infected	Sentinel Surveillance among pregnant women in ANC sites or Survey with biomarkers	Annual	UNGASS 2003, MDG 2003
Counselling and testing	Percent of the general population aged 15-49 receiving HIV test results in the last 12 months	Program reports/ Modeling or Population-based survey	Annual or Baseline and then every 2-3 years	UNAIDS 2000, WHO C&S 2004
PMTCT	Percent of all pregnant women attending at least one Antenatal Clinic (ANC) visit who received an HIV test result and post-test counselling	Program reports/ Modeling	Annual	WHO PMTCT 2004

	Percent of HIV-infected pregnant women receiving a complete course of antiretroviral prophylaxis to reduce the risk of mother to child transmission	Program reports/ Modeling	Annual	UNGASS 2003, GFATM 2004, WHO PMTCT 2004
	HIV prevalence among pregnant women ages 15 - 24	Sentinel Surveillance among pregnant women	Annual	MDG 2003
PMTCT impact	Percent HIV-infected Infants born to HIV-infected Mothers	Program reports/ Modeling	Annual	UNGASS 2003, WHO PMTCT 2004
	Ratio of current school attendance among orphans to that of non-orphans aged 10-14	Survey or program reports	Baseline and then every 2-3 years	UNGASS 2003
Care, support, and treatment	Percent of people with advanced HIV infection receiving Anti-Retroviral Treatment (ART)	Program reports/ Modeling	Annual	UNGASS 2003, GFATM 2004
	Percent of health care facilities that have the capacity and conditions to provide basic-level HIV testing and HIV/AIDS clinical management	Health facility survey	Baseline and then every 2-3 years	UNAIDS 2000, WHO C&S 2004, GFATM 2004
	Percent of health care facilities that have the capacity and conditions to provide advanced-level HIV/AIDS care and support services, including provision of ART	Health facility survey	Baseline and then every 2-3 years	UNAIDS 2000, WHO C&S 2004, GFATM 2004
	Percent of adults aged 18-59 who were chronically ill for 3 or more months during the past 12 months whose households have received free basic external support in caring for the ill person	Special study	Baseline and then every 2-3 years	WHO C&S 2004
Orphans and vulnerable children	Percent of orphans and vulnerable children under 18 whose households have received, free of user charges, basic external support in caring for the child	Special study	Baseline and then every 2-3 years	UNAIDS 2000, WHO C&S 2004, GFATM 2004
Care, support, and treatment impact	Percentage of people living with AIDS still alive at 6, 12, and 24 months after initiation of ART	Program reports/ cohort analysis	Annual	WHO 3 by 5 2004
Training and Capacity Building	Percentage of schools with teachers who have been trained in life-skills based education and who taught it during the last academic year	School-based survey and education programme review	Biennial	UNGASS 2003

Policy	AIDS Program Effort Index (API)	Special study	Baseline and then every 2-3 years	UNAIDS 2000
	National Composite Policy Index	Special study	Biennial	UNGASS 2003
	Amount of national funds spent by governments on HIV/AIDS	Survey of financial resource flows	Annual	UNGASS 2003
	Percentage of large enterprises/companies that have HIV/AIDS workplace policies and programmes	Workplace Survey	Biennial	UNGASS 2003
Human rights, stigma, and, discrimination	Percent of the general population with accepting attitudes towards those living with HIV/AIDS	Population-based survey	Baseline and then every 2-3 years	UNAIDS 2000
	Percent of health care facilities that protect against discrimination (e.g., HIV tests with informed consent)	Health facility survey	Baseline and then every 2-3 years	WHO C&S 2004
Socio-economic impact	Impact of HIV/AIDS on key socio-economic variables.	Institution-based and non-institution based costing studies	As required	HEU, UWI
	Impact of HIV/AIDS/STI on key macroeconomic indicators.	Institution-based and non-institution based costing studies	Annually or consistent with national surveys	HEU, UWI
	Impact of HIV/AIDS on key health outcomes	Institution-based and non-institution based costing studies	Annually or consistent with national surveys	HEU, UWI

Both the Regional Strategic Framework and the CIMT indicators are quality working tools that have been developed in ample participatory processes and which must be implemented and integrated into a regional M&E system. Annex III includes the definition of each indicator, its measurement tools and some comments on its interpretation.

III. Basic Concepts on M&E

This section includes several basic concepts on M&E, with the purpose of placing in context the proposal for an M&E system for the Caribbean region, which is outlined ahead.

3.1 A Monitoring and Evaluation System

A Monitoring and Evaluation system for the efforts against HIV/AIDS may be defined as the set of practices, resources and tools that are used to follow-up and assess the actions taken to tackle HIV/AIDS epidemic.

A System for Monitoring and Evaluation of the HIV/AIDS Programs allows to determine if the initiatives to tackle the epidemic are achieving the intended impact or changes

The creation of a national M&E system for HIV/AIDS allows the clarification of particular efforts, decreases duplication of efforts and the inadequacy in the use of resources, increases cooperation and exchange between projects and institutions, enhancing the efficacy of the national response to the epidemic. In addition, a good system of monitoring and evaluation:

- Allows for a precise vision, through quantitative and qualitative data, of the magnitude and quality of the gradual changes that modify a given situation and lead to a final one which was contemplated as the objective or target.
- Identifies deviations towards of the desired objectives, facilitating corrections to improve the focus of the actions involved.

BASIC COMPONENTS OF A GOOD M&E SYSTEM	
Trained Human Resources	Human resources are the driving force of every system. Monitoring and Evaluation are specialized activities requiring human resources with specific technical skills.
Work methodologies	The broad procedures to organize actions and activities in a consecutive manner in order to obtain the expected results.
A M&E Unit or Team	The organizational structure or the technical team responsible for the M&E actions.
Strategic and Operational Plans	Planning determines in advance the activities that will be implemented and the results to be obtained. Monitoring and Evaluation is done on the basis of these activities and the foreseen results. The plans are part of the planning system but are a prerequisite needed for the operation of a good M&E system.
M&E Budget	The financial resources deliberately set aside to support monitoring and evaluation activities.
Indicators and matrix	Indicators are the variables taken to measure the impact of the interventions in terms of the outlined goals and objectives.
Data Base	The informatics system that groups, organizes and makes manageable the data collected.
Systems for Data Collection, Processing and Analysis	The procedures involved in the collection of data, their combined management and subsequent study and inference with the real facts and actual processes.
Information Dissemination System	A set of practices and instruments used for disseminating the information produced by the M&E system.
Researches	The specialized efforts deployed to obtain specific data.
Surveillance System	A series of resources used to establish the HIV/AIDS epidemiological situation. Currently, it is required to have available biological, behavioral and social impact surveillance.

The components of an M&E system are organized and interact dynamically, and their put in motion may be classified under the following key moments:

- **Data generation.** The implementation of the activities generates results which in abstract may be converted into data.
- **Data collection.** The implementation of activities that allows converting facts and results into data.
- **Data entry.** Entering the data into the M&E information systems.
- **Data processing.** The information is mixed and organized for the purpose of converting the results of this operation into data.
- **Information analysis.** Revision of the processed data and development of the inference with the reality they represent.
- **Information dissemination and exchange.** The processed data is analyzed and made available at policy, managerial and operational levels to create inputs for decision-making.

It is very important that the efforts in M&E are integrated into the daily activities of institutions and projects so they are not considered as something additional and overlapping.

SEVEN KEY INFORMATION CATEGORIES OF A M&E SYSTEM
What is the status of the epidemic? <i>The most basic data must include the estimated number of persons currently infected, determine the number of new infections and if the transmission rates are decreasing, increasing or stabilizing.</i>
Do people have the theoretical and practical knowledge and the means to protect themselves and avoid contracting or transmitting the HIV infection, and are these interventions having an impact on risk behaviors? <i>The efficacy of the prevention interventions must be evaluated on a regular basis. Today we have multiple means to measure the levels of HIV/AIDS awareness and knowledge, as well as to assess the current levels of at risk behaviors.</i>
Are the people infected receiving quality care and treatment? <i>Not only should we evaluate the number of persons that have initiated treatment, but also watch closely the key pertinent procedures. Strict control of the treatment and drugs prescribed is highly important, both to improve the quality of the care services provided and to avoid the occurrence of drug resistance. System surveillance should provide early signals of possible stock shortages before they occur and determine if therapeutic failures are increasing. The effects of the treatment should be watched. Can the patients go back to work? Is their quality of life improving?</i>
Are the family members of those infected receiving services, particularly vulnerable children whose parents are sick, dying or deceased? <i>We must determine the number of children receiving basic support services and the number of those who are in need of them. At the same time, we need to know if the services being provided are having any kind of impact. Are the children being provided adequate nutrition? Are they attending school?</i>
Are pregnant women receiving services to reduce the transmission of HIV to their newborn children? <i>Data is needed to estimate the number of women that should be receiving these services; how many women are really being tested; and more importantly, how many mothers and newborns are provided with basic antiretroviral drugs required to prevent transmission.</i>
Are resources being spent in the right places and in the most efficient activities in order to achieve the goals we have established? <i>International financial resources need to be tracked from the sources (bilateral, Global Fund, foundations, World Bank) to the country level and project. At the same time, we need to determine the level of national resources, whether from the public sector or common disbursement, to assess the ratios of funding variables, and ensure the efficient allocation of such resources.</i>
What is happening to the health sector and other social sectors as a result of the response to the epidemic? <i>The contribution of a significantly greater volume of resources for the national responses can have both negative and positive repercussions on the health sector and other social services. The donors and the countries will need to track key information, such as changes in the staff recruitment models, the distribution of medical supplies and the costs of services and basic commodities through time. Are other basic health services, such as child immunization and malaria treatment, being improved or hindered? We need to know if the expansion of AIDS programs is improving the provision of health care services, and if not, how we can minimize the damage.</i>

Source: UNAIDS, *Clearing the Common Ground for the "Three Ones"*.

3.2 Monitoring, Evaluation and Surveillance

The concepts of monitoring, evaluation and surveillance are often confused and overlap. **Monitoring**, or sometimes referred to as process evaluation, is the follow up on a continuous basis of the factors which describe the performance of a given project. It is a constant revision that allows verification if the correct steps are being taken in the chosen direction, or if a change in the course of action is needed.

Monitoring	Evaluation
<ul style="list-style-type: none"> ▪ <i>Systematically tracks down the key elements in the performance of a given program</i> ▪ <i>Focuses on activities and products</i> ▪ <i>Generally an internal activity</i> ▪ <i>Basis for evaluation</i> 	<ul style="list-style-type: none"> ▪ <i>Sequential valorization of change in the results proposed that may be attributed to the program</i> ▪ <i>Focuses on results and impact</i> ▪ <i>Generally an external activity</i> ▪ <i>Requires more resources and time</i>

Evaluation refers to subsequent stages of the Project when results are being obtained. Evaluations are done periodically, and particularly important are those conducted during mid-term and final stage of the project in order to determine if the proposed objectives have been achieved.

Monitoring	What are we doing?	➤ <i>Systematic activity</i>
Evaluation	What have we achieved?	➤ <i>Episodic activity</i>

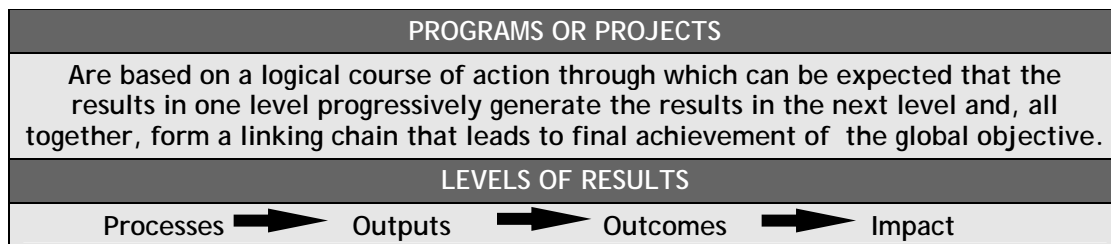
Although many times the term *surveillance* is employed when referring to monitoring, it is important to avoid its use which originates confusions of terminology.

Surveillance is the follow up of the course and trends of the epidemic. When behavior variables are introduced in surveillance, a qualitative level is scaled. This is known as second generation surveillance.

3.3 Ranking the results of a program or project

Project implementation consists of developing a logical line of activities that yield results, transforming an initial situation into the final situation expected. In this respect, monitoring and evaluation become the proper tools to identify and value the progressive results that lead to the achievement of the proposed objectives. Therefore, it is convenient to identify during the implementation of projects and programs specific scaled results which, linked together like a pyramid, will achieve the wanted objectives.

To differentiate results by level, these are classified by: processes, outputs, outcomes and impact.



Inputs. The individuals, financial resources, equipment and supplies used and spent during project activities.

Processes. The series of actions logically articulated which use the inputs and yield products.

Outputs. The result of process implementation and contributes to achieve the program or project results.

Outcomes. Intermediate effects which result from the achievement and interaction of various outcomes. In HIV/AIDS programs, outcomes are seen as changes in behavior and attitudes associated with the epidemic.

Impact. The complex long-term results that show as sustainable changes in the trends of the epidemic and mitigation of the effects.

3.4 Indicators

Indicators are variables taken to measure different aspects of project implementation. They are a fundamental reference for measuring the success of the interventions in terms of goals and objectives, providing a clear idea of the performance of an institution or project at a given moment.

One of the most critical steps during the design and implementation of a Project in HIV/AIDS, is the selection of adequate indicators, which depends on several factors, such as: the status and characteristics of the epidemic, the nature of the stakeholders and the actions undertaken, the needs and potential use of information, the type and quality of the available data and the budget assigned, among others. Most indicators measure the change occurred, but do not explain the cause for such change.

LEVELS OF EVALUATION AND INDICATORS
Process Evaluation
<i>Process Indicators</i>
<i>Outcome Indicators</i>
Effectiveness Assessment
<i>Result Indicators</i>
<i>Impact Indicators</i>
<i>Global Efforts Indicators (API)</i>

3.5 The Three Ones Initiative

On 25 April 2004, UNAIDS, the United Kingdom and the United States co-hosted a high-level meeting at which key donors reaffirmed their commitment to strengthening national AIDS responses led by the affected countries themselves.

As a result of this meeting, they endorsed the "Three Ones" principles, a proposal addressed to the National HIV/AIDS programs, to achieve the most effective and efficient use of resources, and to ensure rapid action and results-based management:

- One agreed HIV/AIDS Action Framework that provides the basis for coordinating the work of all partners.
- One National AIDS Coordinating Authority, with a broad-based multisectoral mandate.
- One agreed country-level Monitoring and Evaluation System (M&E).

These principles pursue a greater coordination among the actors involved and support the countries to focus on increasing their national capacities to respond to HIV/AIDS, on a country-by-country basis. It is highly important that each country be capable of developing actions that lead to results in achieving these principles.

When referring to the implications of an M&E system, the CIMT document expresses the following:

- Development of one national multi-sectoral M&E plan, built into the national strategic plan (NSP) at the design stage, and/or reflecting a previously drafted NSP design, and endorsed by major stakeholders.
- The national M&E plan should include:
 - A set of standardized indicators to track scale-up of programme areas, and improvements in the programming environment, reflecting country needs and with targets reflecting local capacities;
 - A sub-set of indicators allowing for global comparative tracking of UNGASS targets, using the Declaration of Commitment measurement tools and guidelines;
 - A budget for implementation based on a detailed M&E operational [action plan] for developing systems to collect, analyze and use data and;
 - A data dissemination and use strategy.

IV. M&E System for the Caribbean Region

This section covers the principles, structure, components and some aspects of the function of the HIV/AIDS Monitoring and Evaluation System in the Caribbean. The System is a complex series of interrelated elements which, once in motion, slowly generate a regional culture on the issue. It incorporates all the actions in HIV/AIDS, organized programmatically in three operational levels: health institutions and projects, local and regional.

OPERATIONAL LEVELS	Health Institutions and projects	Actions to address HIV/AIDS conducted by health institutions, programs or projects in the country.
	National or Local	The series of organized actions in a specific country
	Regional	The interaction of different stakeholders in response to the epidemic in the region.

Each level involves its own system of monitoring and evaluation, designed for its specific needs in a basic yet comprehensive manner. The systems are linked together in a hierarchic relationship wherein specific actions undertaken by the institutions and projects at the first level contribute to achieving the national and regional M&E objectives. In general, the system is a functional, consistent and homogeneous structure. It is functional, because its operational design is simple and feasible; it is consistent, because it responds to a logical arrangement that allows achieving the expected results; and it is homogenous, because of the existing similarity between components of different locations and levels.

4.1 Harmonization of M&E Instruments and Practices

As previously pointed out, the Caribbean M&E system is a whole with homogenous characteristics, a condition resulting primarily of the systematization, replication and generalization of a set of practices and working tools, as well as a high level of coordination and data exchange between the stakeholders, making possible its dissemination throughout the region.

The systematization, standardization, coordination and data exchange are some of the most important pillars supporting the groundwork for a regional culture in M&E. Also, the first two facilitate comparisons between results obtained in different countries in the region, assist in the reporting to international organizations and the general assessments of the Caribbean response to HIV/AIDS; the last two assume periodic and permanent actions that build and support the structure of the entire regional apparatus.

4.2 Principles for the Development of an M&E System on HIV/AIDS in the Caribbean

The principles outlined in this section represent a series of purposes that should permeate the activities carried out in the development of the M&E System on HIV/AIDS in the Caribbean region. These principles sketch some of the main characteristics that will be part of the system, and its initial acknowledgement will integrate their spirit in the definition of proposals and in the selection of the objectives and activities within the work plans. These are:

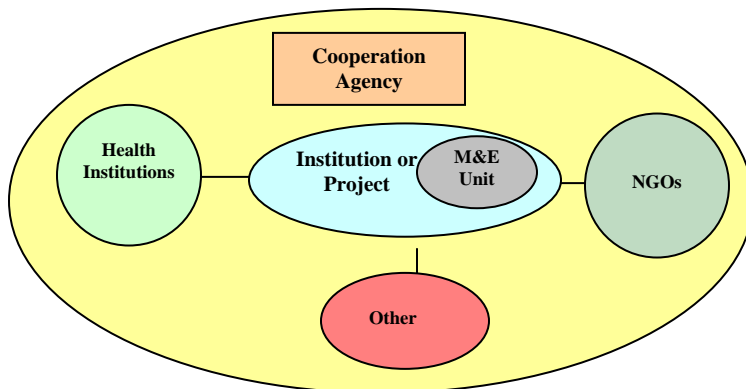
- **Prioritize on the local or national level.** The regional aspect will depend on the good operation at national level, and the activities conducted at this level will set the basis for those at the regional level. The main efforts, particularly during the initial construction stage of the system, must emphasize and pay special attention to building and strengthening the capacities of the M&E systems of each country in the region.
- **Ensure the transfer of knowledge to the national level.** In the Caribbean, there are a large number of agencies with vast experience and expertise on the subject, which are honestly and genuinely interested in the development of a good quality M&E system in the region. The cooperation activities supported by these agencies should place special emphasis on the true transfer of knowledge and on building local capacities, so that specific systems can become self sustainable in the shortest time possible. The goal will be that each country becomes independent and self-sufficient in its M&E without jeopardizing the articulation and regional coordination.
- **Develop practical and dynamic M&E Systems.** The systems to be developed will be as simple as possible, so as to allow their routine and generalized use. They will be dynamic systems so they may evolve according to time changes and shifts of the epidemic. The systems will not be sophisticated and static instruments of low use, but rather tools that will provide information for action.
- **Develop horizontal and democratic M&E Systems.** The systems supported will be horizontal, and the information will not flow into the centralized bodies to resurface already processed in the shape of decisions. The information will be accessible and useful to all the stakeholders involved in the response to the epidemic. The systems will not be bureaucratic or controlled by a privileged few. Once processed and analyzed, the information will serve for taking immediate actions at the local level.
- **Develop systems that are integrated into daily activities.** Monitoring and evaluation should be daily tasks and not solely a responsibility of the experts. The M&E activities should be incorporated into day-to-day work, and efforts will be made to avoid their becoming additional work load. They should be understood and assumed as part of the natural cycle within the processes of institutions and projects.
- **Develop homogeneous systems supported by standardized instruments.** The systems developed in the region will attempt to have homogeneous characteristics and consist of standard procedures, tools and instruments. This will encourage the development of a common culture in the region, thus facilitating the processes of coordination, data exchange, comparisons and supervision.
- **Optimize the use of existing resources.** Caribbean countries have serious constraints in the availability of resources utilized to address the vast diversity of social problems that affect them. To this effect, it is important to try and use to the maximum the informatics systems and equipment available, as long as they do not become obstacles that hinder a good operation. In addition, when new equipment and systems are purchased, it is convenient to verify their compatibility with the existing ones.

4.3 The Regional M&E System

4.3.1 First Level: *Institutions and projects*

This level includes all the structured local efforts that comprise the institutional and programmatic actions in response to the AIDS epidemic. It contains the initiatives organized in public health institutions, programs and projects with internal management systems that include planning, monitoring and evaluation of their activities.

Structure



M&E Components

Each health institution, program or project must have a feasible and reliable M&E consisting of:

- A Strategic Plan for the Institution or Project.
- Annual or Quarterly Operational Plans.
- An Indicator Database.
- Informatics Systems and Equipment (Database and Others).
- An M&E Plan.
- A Unit, Team or Person Responsible for M&E.
- Defined M&E Methodologies and Procedures.
- Regular Practices for Operational Planning, Monitoring and Evaluation.
- A Budget for M&E.
- Some may conduct Epidemiological Surveillance and Research.

Tasks

The main M&E tasks at this level are:

- Data collection:
 - Records of the institution or project.
 - Surveillance.
 - Research.
- Data registration.
- Data processing.
- Data analysis.
- Dissemination of information to internal structures.
- Dissemination of information to external organizations and agencies.
- Technical assistance and capacity building on M&E to the institutions or related projects.

RECOMMENDED REGULARITY FOR PLANNING, M&E AND SURVEILLANCE Level of Health Institution or Project	
Activity	Regularity/ Duration
Strategic Planning	Institutions: <i>3-5 years.</i> Projects: <i>implementation period foreseen.</i>
Operational Planning	Institutions: <i>Annual.</i> Projects: <i>quarterly.</i>
Monitoring	Institutions: <i>Permanent. Annually for their indicator database.</i> Projects: <i>Permanent. Annually for their indicator database.</i>
Evaluation	Institutions: <i>Annual.</i> Projects: <i>annual and at project end.</i>
Surveillance	Institutions: <i>Permanent. If the activity is conducted.</i> Projects: <i>Permanent. If the activity is conducted.</i>

Main Indicators

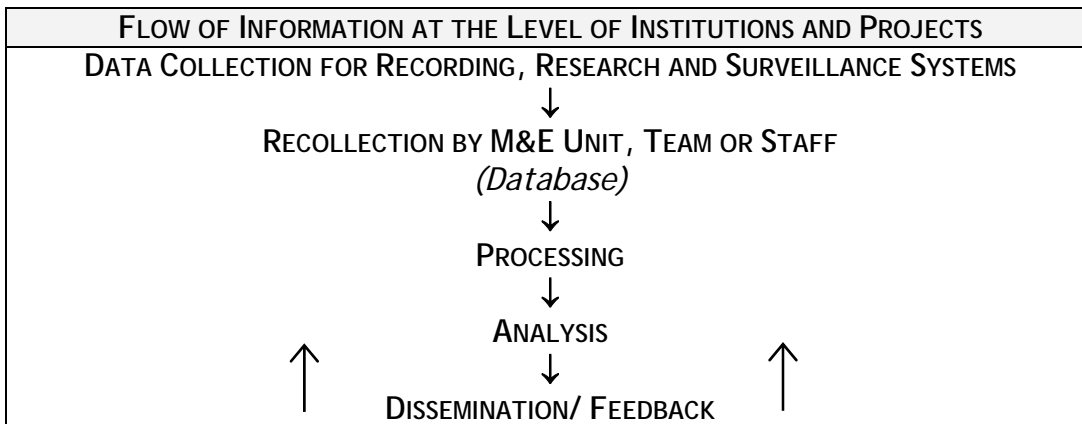
At the level of Institutions and Projects, the main indicators to be monitored and evaluated are:

- Inputs.
- Processes.
- Outcomes.

Dissemination of Information and Reporting

The M&E units, team or staff at this level distributes information periodically to various institutions:

- Their own internal operational structures.
- Health institutions and HIV/AIDS projects.
- Unit, team or national staff responsible for the HIV/AIDS M&E.
- Cooperation Agencies.

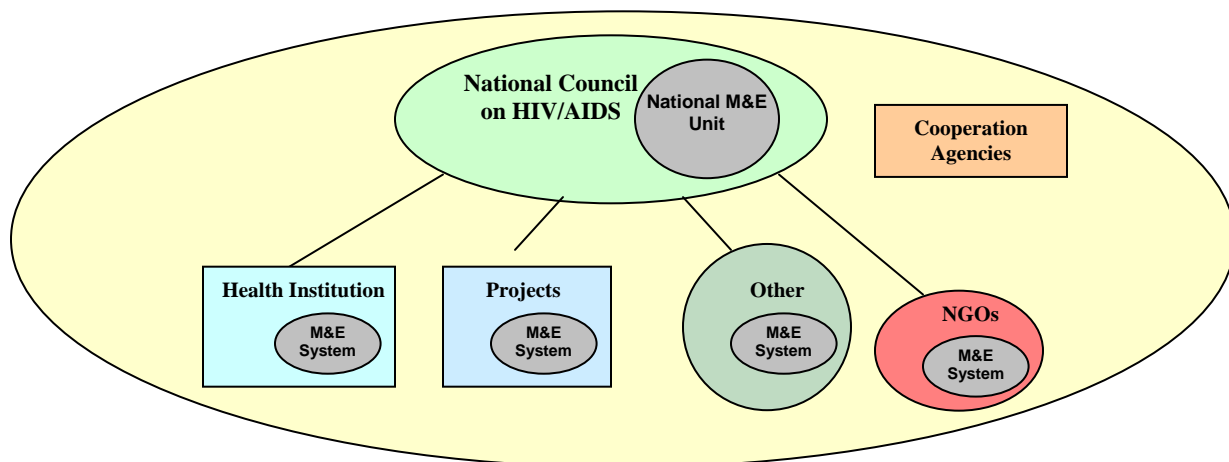


4.3.2 Second Level: *National or Local*

The joining and coordination of various national initiatives organized in the form of institutions or projects.

Each country will have a National Council responsible for the overall coordination of the National HIV/AIDS Program. The Program will have an M&E system for the national AIDS response and a Unit in charge. The national M&E system will be compatible with and linked to the specific systems of the institutions and projects.

Structure



M&E Components

The national M&E system will consist of:

- A National Strategic Plan.
- Operational Plans.
- An indicator database.
- Informatics Systems and Equipment (Database and Others).
- An M&E Plan of the National Strategic Plan.
- A Unit, Team or Person Responsible for M&E.
- Defined M&E Methodologies and Procedures.
- Regular Practices for Monitoring and Evaluation and Surveillance, and periodically in Strategic Planning.
- A Budget for M&E.
- National Surveillance System

Tasks

The main M&E tasks at this level are:

- Programmatic and epidemiological data collection, for the following sources:
 - Health Ministry and/or other health institutions.
 - National Surveillance System.
 - Programs and Projects.
 - Own research.
- Data registration.
- Data processing.
- Data analysis.
- Dissemination of information to institutions, projects and internal stakeholders.
- Dissemination of information to external organizations and agencies.
- Technical assistance and capacity building on M&E to the national M&E unit and to institutions or related projects.

RECOMMENDED REGULARITY FOR THE PLANNING, M&E AND SURVEILLANCE Local or national level	
Activity	Regularity/ Duration
Strategic Planning	<i>3-5 years.</i>
Operational Planning	<i>Quarterly/ Annual.</i>
Monitoring	<i>Permanent. Quarterly or Annual of the indicators on database.</i>
Evaluation	<i>Annual.</i>
Surveillance	<i>Permanent.</i>

Main Indicators

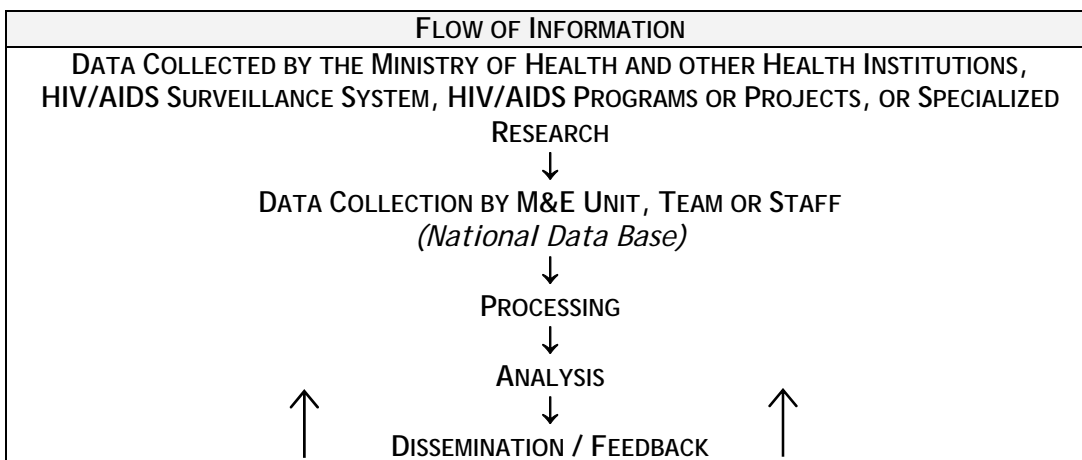
At the level of Programs and Projects, the main indicators to be monitored and evaluated are:

- Result
- Impact

Dissemination of Information and Reporting

The national level M&E will distribute information on a regular basis to:

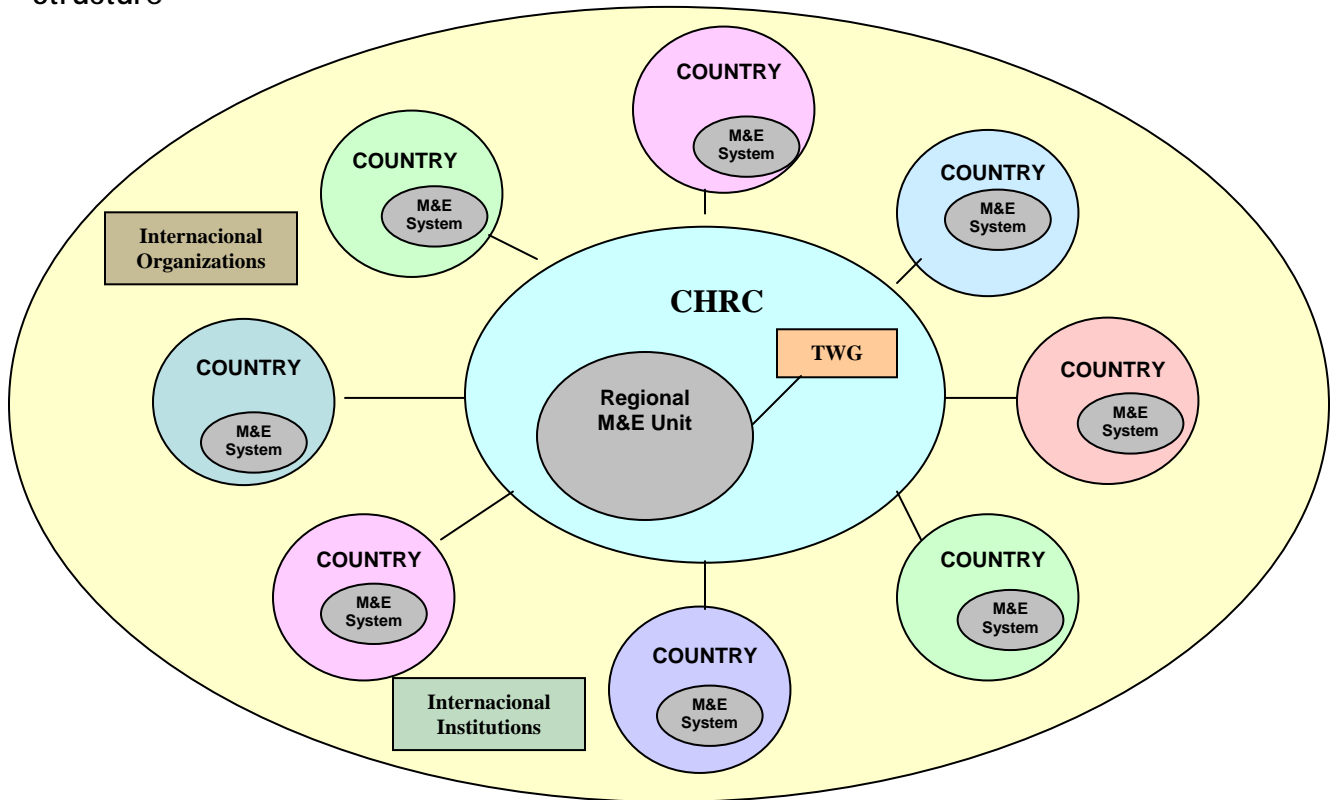
- Health institutions and HIV/AIDS projects.
- Regional M&E Unit.
- International organizations and institutions (UNAIDS, PAHO, etc.)
- Cooperation Agencies.



4.3.3. Third Level: *Regional*

Includes National Programs and is responsible for the coordination of the response to HIV/AIDS in the region.

Structure



Description

Significant steps have been taken at regional level for the creation of a Regional M&E System in the Caribbean, such as: the development of a Regional Strategic Action Framework and the CIMT Indicators. Also, it is important that CHRC has been selected by PANCAP as the regional institution responsible for monitoring and evaluation of the HIV/AIDS program in the region. Similarly important has been the establishment of a Regional M&E Technical Working Group (TWG) coordinated by CHRC. The TWG in M&E is comprised of representatives from donors and cooperation agencies which provide free training and technical assistance on M&E in the region. Their main tasks include:

- The creation of a forum for data exchange and coordination of the activities carried out by the agencies working on M&E in the Caribbean region.
- To operate as a registry of all activities associated with M&E in the region.
- Advocate for the adoption of a series of key indicators in the region (UNGASS and CIMT).
- Coordinate the provision of technical assistance on M&E in the region.
- Assist the developing countries, through the participating agencies, in the development of a broad regional M&E system.

M&E Components

A system will be available at the regional level including the following:

- A Regional Strategic Framework.
- A Regional Indicator Database.
- Informatics Systems and Equipment (Database and Others).
- An M&E Plan of the Regional Strategic Framework.
- A Unit, Team or Person Responsible for M&E.
- Defined M&E Methodologies and Procedures.
- A Budget for M&E.

Tasks

The main tasks in M&E at this level are:

- Data collection. Occasionally and in coordination with the National Programs.
- Data registration.
- Data processing.
- Data analysis.
- Dissemination of regional information to National Programs and external organizations and agencies.
- Technical assistance and capacity building to the regional M&E unit and to national HIV/AIDS programmes.

RECOMMENDED REGULARITY FOR THE PLANNING, M&E AND SURVEILLANCE Regional Level	
Activity	Regularity/ Duration
Strategic Planning	<i>5 years.</i>
Operational Planning	<i>Quarterly/ Annual.</i>
Monitoring	<i>Quarterly/ Annual.</i>
Evaluation	<i>Annual.</i>
Surveillance	<i>Permanent.</i>

Main Indicators

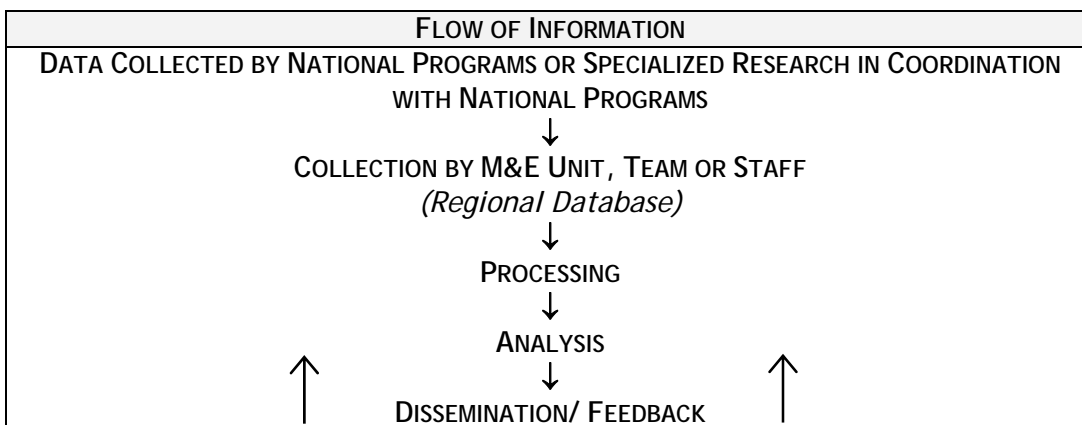
At the regional level, the main indicators are:

- Result.
- Impact.

Dissemination of Information and Reporting

The regional level should distribute information to:

- National HIV/AIDS Programs.
- International organizations (UNAIDS, PAHO, etc.).
- Cooperation Agencies.
- Regional institutions (CCNAPC, PANCAP, CAREC, UWI, CARICOM, etc.)



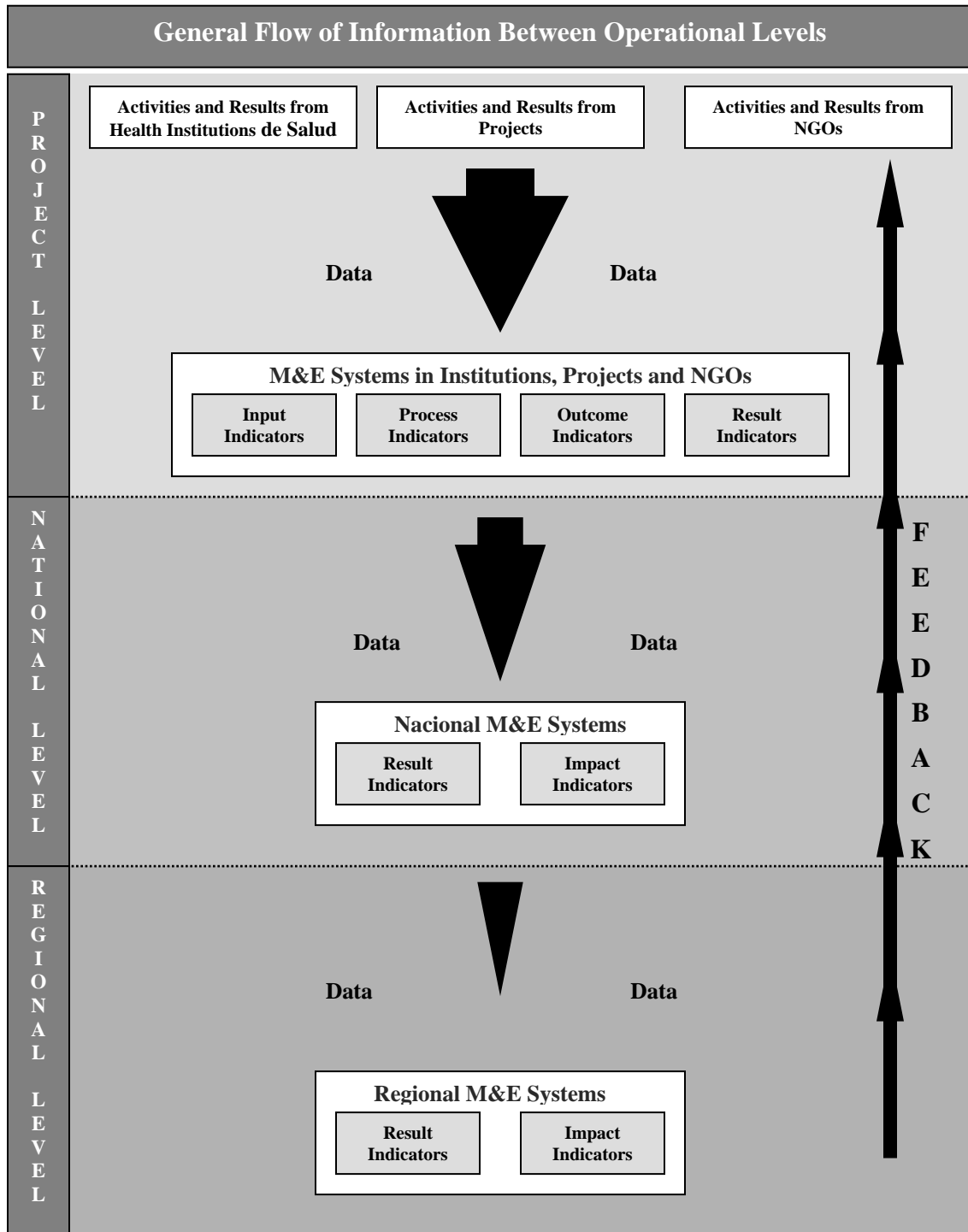
The information system at the regional level will be fed with data originated by the different countries; hence there should be some similarity among them. However, the national information provided by each country individually to organizations such as UNAIDS and others will be done directly by the country without the intervention of the regional system.

4.4 Language of the Regional System

Most of the countries and territories participating of this proposal are English speaking, as well as CHRC personnel and TWG participants. English is also the most international language and second language of many technical people in the region. In that connection, it is suggested that English is the official language of the Regional M&E System of HIV/AIDS Programmes in the Caribbean. The non English speaking countries should appoint English speaking representatives at the meetings. At the same time, CHRC should guarantee that the main documents of the system are produced in all the Caribbean languages apart from English, such as French, Spanish and Dutch. CHRC should also try to employ personnel with knowledge of the four languages.

4.5 Information Requested by Level

LEVEL	GENERAL INFORMATION
Institution and Project	<ul style="list-style-type: none"> • Information on financial and operational implementation of all bodies and stakeholders carrying out actions in response to HIV/AIDS with resources from the institutions or project. • Epidemiological information if the institution or project is implementing surveillance activities directly or through another institution.
National o Local	<ul style="list-style-type: none"> • Information on all programmatic and institutional activities in response to the epidemic. • National information on HIV/AIDS epidemiological surveillance.
Regional	<ul style="list-style-type: none"> • Partial information on in-country activities in response to HIV/AIDS in the region, based on identified key indicators. • Partial in-country epidemiological data in the region, based on certain identified variables.



4.6 The CRIS

The regional M&E system in the Caribbean is built upon a set of wide-range indicators that begin with inputs and conclude at the level of impact. To interconnect this set of indicators at different levels, the use of common software is recommended. In this respect, the implementation of the Country Response Information System (CRIS) is worth evaluating.

The CRIS is a database developed by UNAIDS that provides the ability to connect and data exchange with numerous institutions. Also, it works as an electronic tool for the submission of UNGASS indicators to UNAIDS. CRIS has many advantages, namely:

- A tool provided by UNAIDS to the countries free of charge. UNAIDS provides regular training on its use.
- Allows countries to load all global data and provides the ability to share indicator definitions in all the levels of operation considered in this proposal: health institutions or projects, local or regional levels.
- Contributes to strengthening the national response through M&E of national strategic indicators on HIV/AIDS. The system facilitates the use of UNGASS indicators, and allows the inclusion of additional indicators, with a large information capacity.
- Rapid installation and does not require advanced or sophisticated equipment.

4.7 Information System

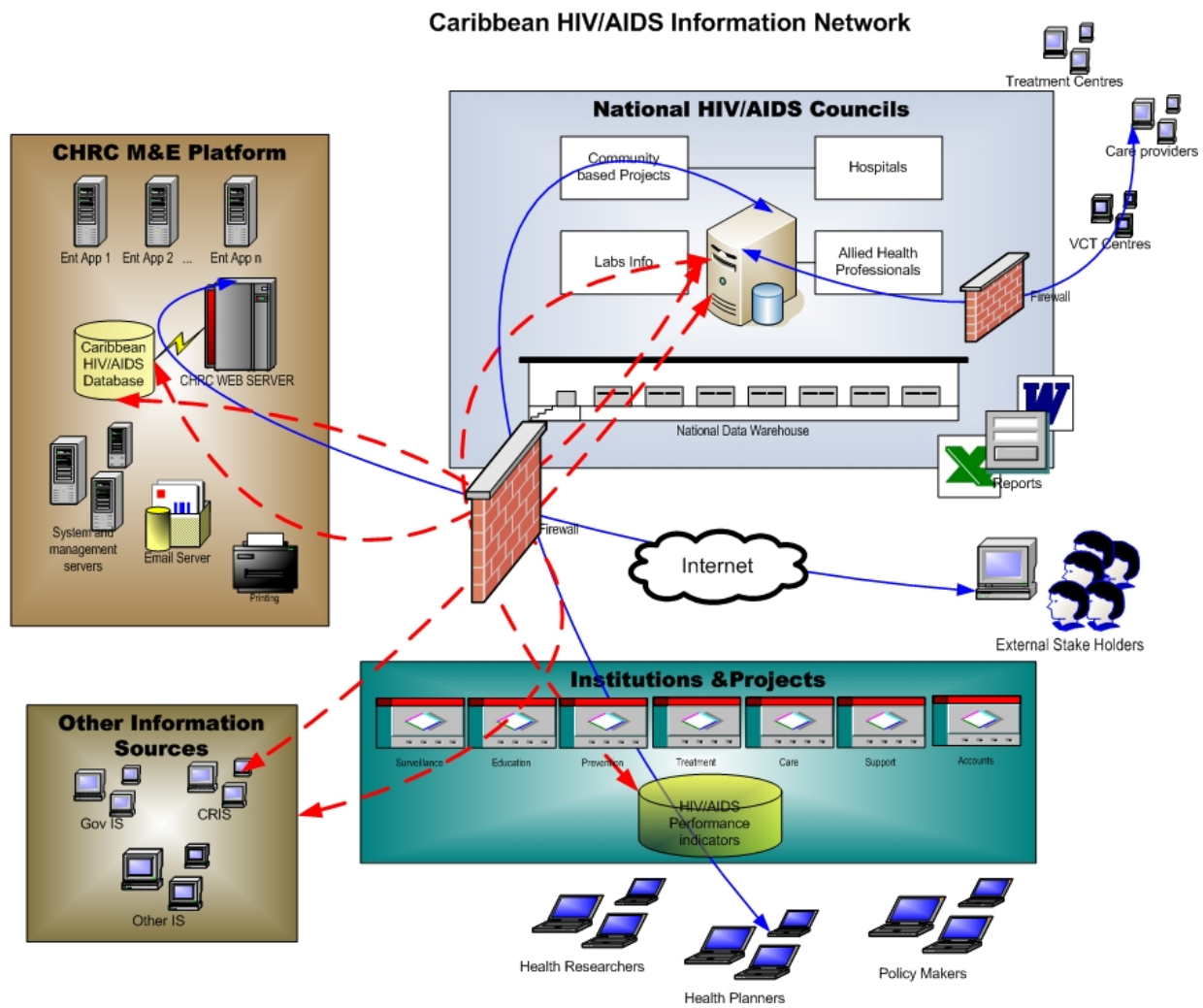
One of the main aspects of an M&E system is the establishment of a structure which allows the exchange of information among stakeholders, particularly national HIV/AIDS authorities and institutions, health care providers, projects, donors, international organizations. This should be done in a way that is reliable, timely and at a reasonable cost.

The information technology structure should have the following components:

- **Clinical information system on HIV/AIDS.** They intend to increase the efficiency and effectiveness of HIV/AIDS health care services. They are used both for ambulatory and inpatient services, and include counselling and HIV/AIDS testing. In cases where there is no access to computer infrastructure, it is imperative that this information is produced with manual registries.
- **National databases from institutions and projects.** Each project or institution working with HIV-AIDS should collect information, capture and register it in a database which allows interchange with other databases and information centres. At the national level, the main information on the fight against the epidemic will be stored and would be accessed through previously defined protocols. It is advisable that this database is located in the M&E Unit of the HIV-AIDS National Council or a similar institution.
- **Regional Database.** A regional database with all the relevant information on HIV-AIDS in the Caribbean submitted by the National Programmes will be developed in the Regional Unit in CHRC.

- **Communication and Information Exchange Network.** The different information systems at the project, national and regional level would be connected with an exchange network, protected with high security technology. This network could be private or Internet based, using manual or automated transmission methods. The information specialists should evaluate the pertinence of using CRIS as the software to exchange indicators information.

The following scheme of the network was proposed by Ato Wilson.



OPERATIONAL LEVELS OF THE CARIBBEAN REGIONAL M&E SYSTEM		
HEALTH INSTITUTIONS, PROGRAMS AND PROJECTS		
Institution Responsible: <i>Health institutions and projects</i>		
Components	Tasks	Indicators
<ul style="list-style-type: none"> • A Strategic Plan for the Institution, Program or Project. • Annual or Quarterly Operational Plans. • An indicator database. • Informatics Systems and Equipment (Database and Others). • An M&E Plan. • A unit, team or staff responsible for M&E. • Defined M&E methodologies and procedures. • Regular planning and M&E practices. • Budget for M&E • Some may conduct: Epidemiological Surveillance and Research. 	<ul style="list-style-type: none"> • Data collection: <ul style="list-style-type: none"> ▪ Project records. ▪ Surveillance. ▪ Research. • Data registration. • Data processing. • Data analysis. • Dissemination of information to internal structures. • Dissemination of information to external organizations and agencies. 	<ul style="list-style-type: none"> • Inputs. • Processes. • Outputs. • Outcomes.
NATIONAL OR LOCAL		
Institution Responsible: <i>National HIV/AIDS Councils</i>		
Components	Tasks	Indicators
<ul style="list-style-type: none"> • A National Strategic Plan. • An indicator database. • Informatics Systems and Equipment (National Database and Others). • A M&E Plan in the National Strategic Plan. • A unit, team or staff responsible for M&E. • Defined M&E methodologies and procedures. • Regular planning and M&E practices and surveillance, and periodical practices in Strategic Planning. • Budget for M&E • National Surveillance System. 	<ul style="list-style-type: none"> • Programmatic and epidemiological data collection originating from: <ul style="list-style-type: none"> ▪ MOH and/or other health institutions. ▪ National Surveillance System. ▪ Programs and Projects. ▪ Own research studies. • Data registration. • Data analysis. • Dissemination of internal information. • Dissemination of information to external organizations and agencies. 	<ul style="list-style-type: none"> • Outcomes. • Impact.
REGIONAL		
Institution Responsible: <i>Caribbean Health Research Council (CHRC)</i>		
Components	Tasks	Indicators
<ul style="list-style-type: none"> • A Regional Strategic Framework. • A Regional Indicator Database. • Informatics Systems and Equipment (Regional Database and Others). • A M&E Plan in the Regional Strategic Framework. • A unit, team or staff responsible for M&E • Defined M&E methodologies and procedures. • Budget for M&E 	<ul style="list-style-type: none"> • Data collection. Occasionally and in coordination with the National Programs to obtain some specific information. • Data registration. • Data processing. • Data analysis. • Dissemination of regional information to National Programs and external organizations and agencies. 	<ul style="list-style-type: none"> • Outcomes. • Impact

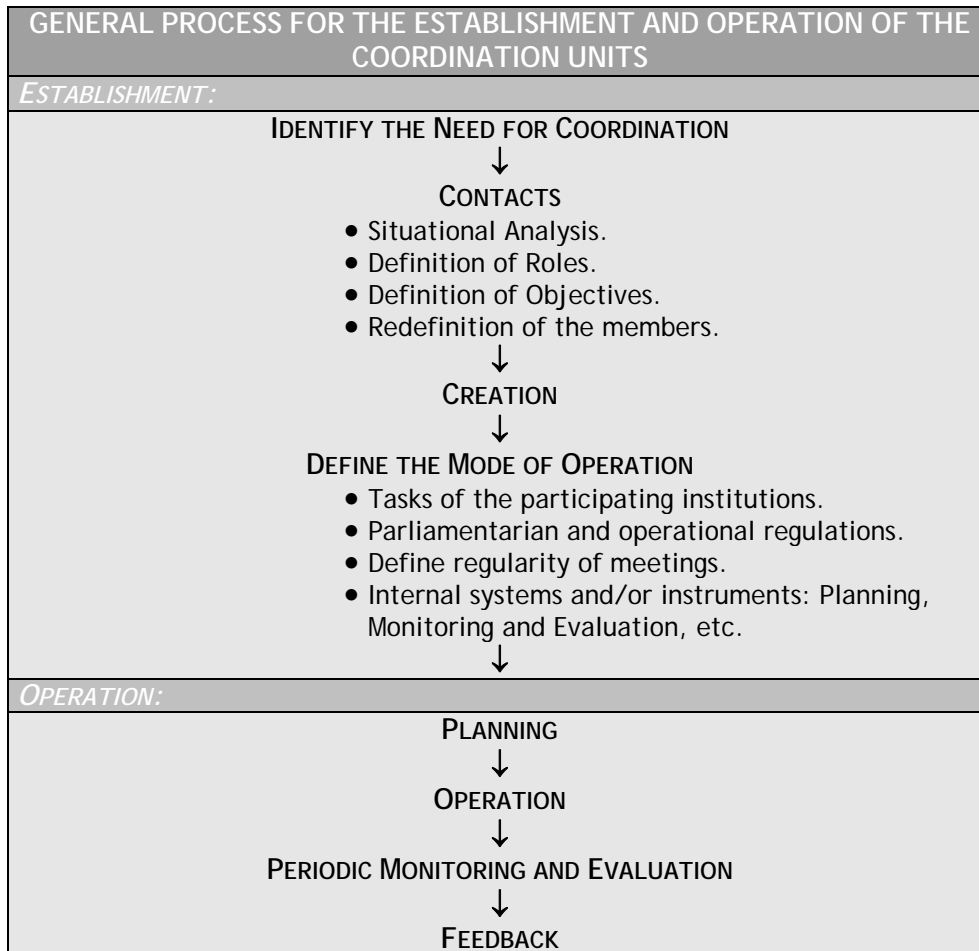
V. Coordination by Operational Levels

5.1 Basic Requirements for Establishing a Good Coordination in the Region

Good coordination is an essential element for the adequate functioning of a system as broad as the one proposed, which depends on the participation of the acting institutions, legitimizes the system and contributes to organizing the use of available resources. Coordination is understood as all those actions of contact and agreement between the parties contributing to a joint operation of the system.

Below is an outline of a series of basic requirements and recommendations for different forms of coordination at the three operational levels that have been suggested.

- **The coordination must respond to real working needs.** To be functional and effective, coordination spaces must respond to the real needs that are perceived along the construction and operation of the system.
- **The establishment of coordination spaces with common objectives.** Coordination is a joint exercise that must occur in order to achieve common objectives previously defined between the parties that make up the coordination units.
- **A clear definition of the roles and tasks between the main stakeholders.** When developing the coordination units, the roles and responsibilities of all the acting parties must be clearly defined.
- **Integrating empowered representatives in the coordination units.** The inclusion of national and institutional representatives without real decision-making power has proven to be a totally ineffective exercise and a waste of time. It is important that the coordination units are comprised of representatives with real authority and power so that the agreements made may subsequently be enforced.
- **Clear game rules.** Coordination units must clearly define their internal rules from the very beginning. These rules should be as simple and feasible as possible to avoid hampering the operation or increasing the bureaucracy.
- **Defining the regularity of the meetings.** Defining the regularity of the meetings contributes to formalizing the coordination units and ensures better attendance of the members.
- **Establishment of and formal compliance with commitments.** The decisions made in the coordination units must be documented, with clearly defined responsibilities.

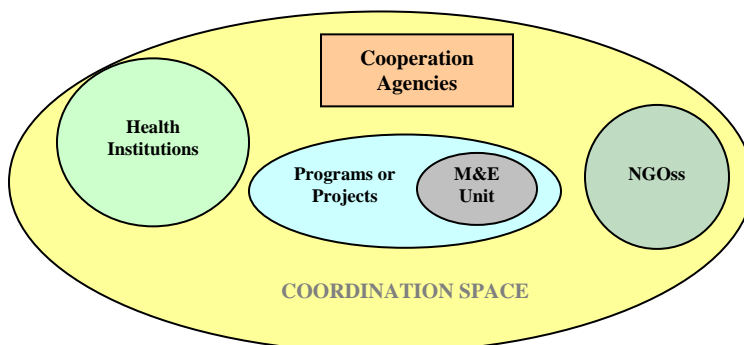


5.2 Coordination by Levels of Operation

5.2.1 First Level: *Institutions or Projects*

This level includes the coordination actions between the institutions and projects which have related bodies for implementing activities of mutual interest.

Structure



Operation

- The coordination at this level is often done directly with the institutions and stakeholders working in HIV-AIDS with common interests.
- Neither a formal agreement nor a special coordination unit is necessarily required. This type of coordination is regularly informal and sometimes even personal.
- The regularity in the number of meetings will be determined by the degree of intensity throughout the processes and the actions.

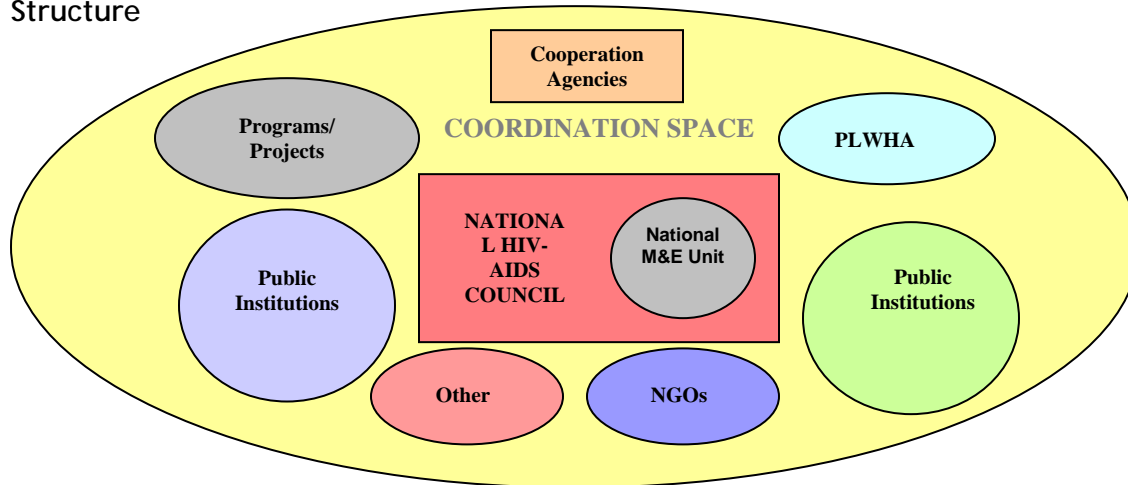
M&E Coordination

- Coordination is required among the members of the M&E Unit in each project or institution as well as with the different entities with which the project works.
- The objective of this is to follow-up the M&E activities of the project.
- Meetings should be scheduled at a defined periodicity, and do not need to follow a very formal structure.

5.2.2 Second Level: *National or Local*

The national or local level is a broad space consisting of several institutions working on the response to the epidemic at the national level. The central institution responsible for the coordination is the National Council on HIV/AIDS.

Structure



Operation

- Given the complexity of the epidemic and the different areas it impacts, this coordination level should be multisectoral and include representatives of the highest-level authorities in the country, and rely on their political support.
- All the stakeholders affected by and involved in the national response should be represented in this level of the cooperation efforts.
- The National Council on HIV/AIDS is the central coordinating institution but it should encourage a democratic and participatory approach throughout the process.
- This coordination space requires a formal procedure in its establishment and operation.

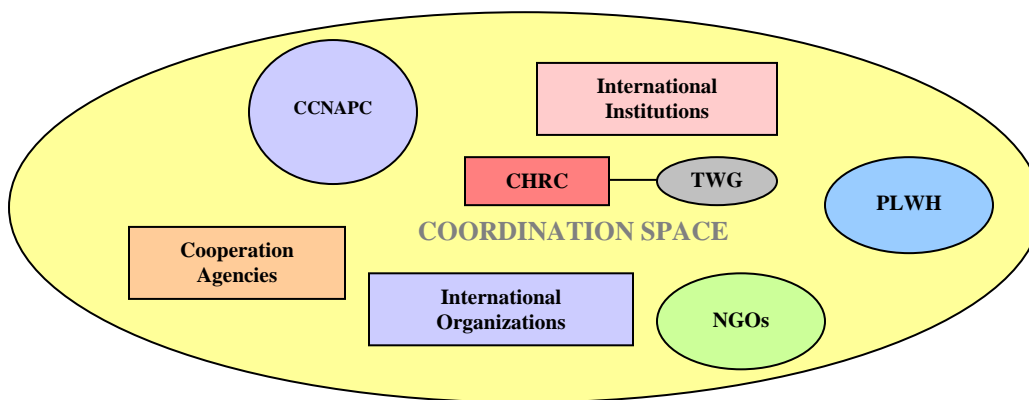
M&E Coordination

- It is very convenient to constitute an M&E working group which would be in charge of the design, planning and following up of the national HIV-AIDS actions of the National Programme. This group should be integrated by the M&E representatives of the most important initiatives in the country.
- The coordination of this M&E working group should be responsibility of the National HIV-AIDS Council.
- The M&E working group should meet regularly, with a pre-defined periodicity.

5.2.3 Third Level: *Regional*

This level brings together representatives of the key organizations, institutions and agencies involved in the regional response to the epidemic. It has been developed recently and is currently in an advanced management stage.

Structure



Operation

The TWG in M&E is a space provided by CHRC for coordinating the main agencies and institutions that support the M&E of HIV/AIDS in the region.

- The TWG in M&E includes all the relevant stakeholders in the regional response to HIV/AIDS.
- The TWG in M&E is basically operational in nature, harmonizing interests and providing solutions to all parties involved.
- The TWG consists of the following institutions:
 - Caribbean Community (CARICOM).
 - Caribbean Health Research Council (CHRC);
 - Caribbean Epidemiology Centre (CAREC);
 - Caribbean Network of People with HIV-AIDS (CRN);
 - Caribbean Office of the Joint UN Program on HIV/AIDS (UNAIDS).
 - University of West Indies (UWI).
 - Caribbean Coalition on National Aids Program Coordinators (CCNAPC)
 - Pan Caribbean Partnership Against HIV/AIDS (PANCAP)
 - World Bank/GAMET

The Caribbean Health Research Council (CHRC) is the regional organization responsible for coordinating and promoting health research in the Caribbean region.

In order for this coordination space to function properly, the TWG must:

- Guarantee the integration and active participation in the TWG of the key institutions and agencies collaborating in M&E activities in the region. The members of the TWG should be empowered.
- Define a series of management tools for the organization and internal operation as well as for decision-making.
- Take minutes and keep record of the meetings, including written record of the agreements made. A good level of formality should be ensured, particularly when commitments are made.
- With the participation of regional stakeholders, identify joint annual objectives and develop operational plans based on these. A margin of flexibility should be considered for introducing certain priority actions identified along the process and not included in the original operational plans.
- Monitor on a permanent basis the implementation of the activities proposed in the operational plans.
- Evaluate periodically the results accomplished.
- Present to the TWG in M&E every initiative on M&E to be undertaken by any of the participating institutions or agencies so that all the participants are informed and it is registered in the database.

Coordination of Capacity Building and Technical Assistance

The region has great needs for training and technical assistance in M&E, and at the same time, many available institutions and cooperation agencies capable of providing them.

Capacity building in each country is an indispensable requisite for the creation and subsequent operation of a regional M&E system, hence the need for improving the coordination between the participating institutions and agencies so that efforts are harmonized and enhanced. In this respect, the CHRC and the TWG play a key role in adapting the needs for training and technical assistance with the initiatives of the different institutions and cooperation agencies.

In addition to the absence of a regional coordination space, another factor which has not contributed to the organization is the absence of a formal procedure for requesting the required training and assistance. Below is a proposal for a formal request procedure that has been prepared based on suggestions provided by key regional stakeholders.

PROCESS FOR REQUESTING TRAINING AND TECHNICAL ASSISTANCE	
STEPS	INSTITUTION OR ACTING STAFF
NEED PERCEPTION ↓	STAFF FROM HEALTH INSTITUTIONS, PROGRAM, PROJECT, NGO, NAP, ETC.
IDENTIFY THE NEED ↓	STAFF FROM HEALTH INSTITUTIONS, PROGRAM, PROJECT, NGO, NAP, PLHAs, ETC.
PREPARE A REQUEST FOR TRAINING OR TECHNICAL ASSISTANCE ↓	MOH, NAC, PROGRAM, PROJECT, NGO, PLHAs, ETC.
SUBMIT TO CHRC ↓	MOH, NAC, PROGRAM, PROJECT, NGO, PLHAs, ETC.
SUBMIT TO INSTITUTION OR COOPERATION AGENCY ↓	
	CHRC
↑ RESPONSE: TRAINING AND/OR TA ↑	INSTITUTION OR COOPERATION AGENCY
<i>THE INSTITUTION OR COOPERATION AGENCY INFORMS CHRC ON THE BENEFICIARY AND TYPE OF TRAINING OR TECHNICAL ASSISTANCE THAT WILL BE PROVIDED</i>	<i>CHRC REGISTERS IN DATABASE THE INFORMATION ON THE TRAINING AND TECHNICAL ASSISTANCE PROVIDED AND INFORMS THE INSTITUTION OR COOPERATION AGENCY ON SIMILAR SESSIONS PREVIOUSLY RECEIVED IN THE COUNTRY</i>

There are numerous institutions and cooperation agencies in the region providing training and technical assistance in the area of HIV/AIDS monitoring and evaluation. The following chart shows the type of activity and the level of operation.

CAPACITY BUILDING AND TECHNICAL ASSISTANCE BY REGIONAL STAKEHOLDERS			
Institutions	Project Level	National Level	Regional Level
CHRC			<ul style="list-style-type: none"> • Conduct NAP assessments • Provide M&E technical assistance to NAPs • Produce a guide for M&E for the assessment of NAPs in the region • Collaborate on the development of a harmonized set of M&E indicators and data collection tools. • Provide training an monitoring & evaluation • Co-ordinate and chair the work of the M&E Technical Working Group • Ensure the collaborative approach to regional M&E capacity building efforts to strengthen M&E systems • To guide the development of a regional M&E framework fro the region • Strengthen country and institution's ability to track and report on their GF grants.
UNAIDS		<ul style="list-style-type: none"> • Support to national M&E units re. Defining TOR of M&E officer, clarity around what a national M&E system/s is; development of national M&E frameworks; defining data flow systems; next steps and use of tools; integrating multiple donor reporting needs into national frameworks, rationalizing indicators across donors etc. Support for installation and use 	<ul style="list-style-type: none"> • Input to development of harmonized tools for national M&E frameworks and data flow mapping/data collection; support to GFATM grant recipient countries; strengthening of overall national M&E systems including informatics support such as CRIS; resource mobilization and sourcing of additional M&E consultants/technical support to participate in joint country missions. Full participation and support to the regional M&E TWG process.

		of CRIS and brokering support for other IT platform design.	
WB		<ul style="list-style-type: none"> • Ditto – see also UNAIDS above. Also particular expertise with working at the district and sub-national level to support data collection at the level of implementation; collection of baseline data. Particular focus on WB loan/credit reporting, but within nationally developed systems. 	<ul style="list-style-type: none"> • Ex-sitio participation in regional M&E TWG; see also UNAIDS above.
US-GOV	<ul style="list-style-type: none"> • Data collection systems and tools development • Database/IT • Capacity Building in above • General M&E • Operations Research 	<ul style="list-style-type: none"> • M&E systems development • Training/Capacity Building in all areas of comprehensive information systems • Survey design and implementation • Operations Research 	<ul style="list-style-type: none"> • M&E systems development • Training/Capacity Building in all areas of comprehensive information systems
CCNAPC		<ul style="list-style-type: none"> • Can work through the NAPCs to achieve consensus on the regional M&E framework and the way forward. • identify needs, facilitate horizontal cooperation and build the capacity of countries to respond to the AIDS epidemic 	<ul style="list-style-type: none"> • Capacity to disseminate information to 35 regional NAPCs. • Conducted preliminary assessments of capacity needs of NAPs among members. • Sub-recipient of GFATM grants CRN+ and PANCAP.
PAHO/CAREC	<ul style="list-style-type: none"> • Participate in the TWG activities – core data set • Assist with general M&E activities • In-country capacity building. 	<ul style="list-style-type: none"> • Facilitate in-country M&E activities • Assist the process with respect to MDG and PAHO/Countries' core data sets • Facilitate the implementation process with in-country TA • Advocacy for the unified M&E framework at the country level. 	<ul style="list-style-type: none"> • Assist with the dissemination of regional framework and action plans • Collaborate with other partners in the development of M&E guidelines. • Advocacy at the regional level
CHART			<ul style="list-style-type: none"> • Establish training centers for the Caribbean that utilize the cost-effective mechanisms, institutions and concepts for the ongoing training and development of healthcare workers • Ensure that transfer of knowledge and technologies
PANCAP		<ul style="list-style-type: none"> • Resource mobilization, coordination, advocacy for the unified M&E framework at the country level • Develop and revise national policies to promote human rights and non-discrimination practices for persons infected • Monitor the impact of programmes in member countries 	<ul style="list-style-type: none"> • Resource mobilization in M&E • Build the capacity of partners in M&E • Monitor the impact of programmes in member organizations • Assist in streamlining programmes and projects

UWI		<ul style="list-style-type: none"> • Research • Knowledge creation, information technology in M&E • Training and capacity building 	<ul style="list-style-type: none"> • UWI, through the Health Economics Unit (HEU), gather and analyze data for action on AIDS-related issues • Provide technical expertise and support to regional initiatives
CRN+		<ul style="list-style-type: none"> • Share information, • Build capacity among PLHA • Advocacy 	<ul style="list-style-type: none"> • Share information, • Build capacity among PLHA • Advocacy

VI. Recommendations

6.1 Implementation Plan

The main recommendation is the development of an Implementation Plan for the Caribbean System for HIV/AIDS Monitoring and Evaluation, covering the following areas:

- Training and Technical Assistance.
- Development of the components of the M&E System
- TWG institutional strengthening
- Implementation of an Informatics System for Indicators
- Definition of the information flows and the required reports
- Homogeneity and Standardization
- Regional Strategic Action Plan
- CIMT Indicators
- Internet website on M&E of HIV-AIDS Programmes in the Caribbean

This plan should be submitted to PANCAP with the objective of securing formal support at political level and the commitment of each country involved.

6.1.1 Training and Technical Assistance

Activities:

- Identify the needs for M&E training and technical assistance in the region. As the needs are similar and easily identifiable, a detailed needs assessment for each country is not required. The needs should be identified according to the level of priority. The training needs assessment should consider the appropriateness of training on first and second generation surveillance as well and HIV/AIDS research studies. The consultancy on the Assessment of the M&E Development of Capacities, which USG/MEASURE is supporting, would probably deliver the required information on the technical assistance and training needs on M&E in the region.
- During a meeting held with important stakeholders from the region, various capacity building needs were identified and are outlined below. It is important to point out that although useful, the list does not replace in any way the needs assessment that must be conducted in the region.
 - An assessment of the existing and potential offer from the M&E training and technical assistance providers in the region.
 - An agreed specific regional M&E training plan that answers to the common needs identified and in line with the capacities of the providers. The plan must contemplate actions that benefit all the stakeholders: public, private and NGOs:
 - What is an M&E System and what is its use.
 - Management of basic software, the existing information systems and the CRIS.
 - What is the M&E Framework M&E and its implementation.
 - Specialized research.
 - Data assessment, processing and analysis.
 - How to use the data in the decision-making.

- Implementation of a Regional Training and Technical Assistance Plan in M&E. Will start with actions that respond to priority needs. National and regional modalities will be enforced according to the requirements and resource availability. If considered adequate, regional training sessions could be conducted through the use of the Internet and teleconferences, which would allow the implementation of regional programs without the need to transfer participants to any specific location.
- Coordination will be done with the institutions and cooperation agencies to assign responsibilities and ensure that activities from the regional framework are incorporated into individual plans.
- Definition, consensus and dissemination of the M&E training and technical assistance request procedures in the region. This paper includes a proposal that should be circulated for its understanding and further consideration.
- Dissemination of the Reference Framework for Monitoring and Evaluation of the HIV/AIDS Programs in the Caribbean, and provide training on its understanding and use.
- Development of a simple Database for CHRC to register the training and technical assistance on M&E provided in the region. This will include: Country (ies) Beneficiary (is), Institution or Cooperation Agency, Topic, Modality (workshop, seminar, consultant, etc.), Date, Place or venue, etc.

The training sessions must not necessarily be formal, and a combination of theory and practice is recommended. The training can be regional or national. Important regional stakeholders pointed out that in most cases, a greater number of persons from different levels can benefit from local training sessions. It is important to highlight that regional trainings can be provided without having to mobilize people from their countries and workplaces through the use of technology resources such as the Internet and videoconferences. The information exchange that takes place during regional training sessions contributes to generating a common language and a common culture.

6.1.2 Components of the M&E System M&E

- Every country in the region must develop an inventory and a descriptive assessment of the main components of an M&E System.

COMPONENTS				COMMENTS
1	<i>One National Council or Authority on HIV/AIDS</i>	Yes	No	
2	<i>HIV/AIDS M&E Unit</i>	Yes	No	
3	<i>National Strategic Plan on HIV/AIDS</i>	Yes	No	
4	<i>Indicator Database of the Strategic Plan</i>	Yes	No	
5	<i>Annual Operational Plans</i>	Yes	No	
6	<i>M&E Database</i>	Yes	No	
7	<i>Budget for M&E</i>	Yes	No	
8	<i>HIV/AIDS Epidemiological Surveillance System</i>	Yes	No	

After concluding the inventory, a work plan must be developed and implemented in order to create and put in place the missing components, as well as overcoming the main short backs identified in the existing components. A similar exercise is needed for key institutions and important HIV/AIDS projects in each country.

6.1.3 TWG institutional strengthening

- Development of a specific plan for capacity building in HIV/AIDS M&E for CHRC and the TWG. This foresees the consolidation of the TWG and increases its legitimacy and acknowledgment by the local authorities. The TWG is expected to:
 - Increase the number of member institutions and cooperation agencies.
 - Establish internal operational regulations.
 - Define frequency and regularity of its meetings.

6.1.4 Implementation of an Informatics Indicator Database

- Preparation of a specific plan for the design and development of an informatics system for the exchange of indicator data among the different regional levels. The design and plan would include:
 - Supporting institutional framework.
 - Basic software.
 - Hardware requirements.
 - Training needs.

We recommend considering and analyzing the advantages in the implementation of the CRIS.

6.1.5 Definition of the information flows and reports required

- Identify the variables of specific information required by different levels and develop standard reporting tools for the region.
- Design general information flow for the regional M&E system.

The TWG will identify the reports and indicators required by the institutions and cooperation agencies and the regularity. The countries will be informed and given support so they are capable of providing the required information.

6.1.6 Homogeneity and Standardization

- Prepare an inventory for the identification, collection and assessment of key working tools used for M&E in countries of the region.
- Regional dissemination of the best tools and instruments classified during previous assessments and subsequent training.
- Develop harmonized data collection instruments that can be adapted at the national level and which include basic indicators.

6.1.7 Regional Strategic Plan

Evaluate the relevancy of the current Regional Strategic Action Framework for HIV/AIDS. If outdated, a new plan should be developed for a 4 to 5-year period.

- If the Plan is up to date:
 - Dissemination and training on its contents.
 - Implementation with firm support of the institutions and cooperation agencies.
 - Design and implementation of a M&E strategic plan that includes indicators, annual targets, data collection tools, regularity, responsibilities, among other issues.

6.1.8 CIMT Indicators

- Joint revision of CIMT indicators to eliminate some and/or introduce new ones. Prepare a timetable for CIMT indicator reports synchronized with the UNGASS reports.

6.1.9 Internet website on M&E of HIV-AIDS Programmes in the Caribbean

- Development of an Internet Website in CHRC which will include all the basic documents and data on HIV-AIDS M&E in the Caribbean. All the information will be presented in English, Spanish, French and Dutch. From the website, documents could be downloaded, there will be links to other related sites, dissemination of data and events and it will allow communication with the M&E personnel in CHRC and other expert teams.

6.2 Overall Recommendations

- **Design and implement simple systems.** Complex monitoring and evaluation systems have greater difficulties for implementation and have high probabilities of failure. The greater the country's institutional weakness and its difficulties to generate updated and reliable data, the simpler the systems should be, both in content and operation.
- **Limit the collection of indicators to those that are absolutely necessary.** Many projects and programs select more indicators than they really need to collect. Also, some collect more data than they use. The selection of indicators must be balanced, as unuseful data is a squander of both efforts and financial resources.
- **Incorporate UNGASS indicators, Millennium Development Goals, CIMT, etc.** During the design of M&E systems for HIV/AIDS, it is convenient to include indicators such as the UNGASS, MDGs and CIMT. This facilitates comparison of program performance between countries and the data construction at regional and global levels.
- **Attempt to standardize the M&E systems.** Standard systems facilitate the generation of a common culture for monitoring and evaluation, and allow data exchange and integration.
- **Develop an M&E system at the start of projects and programs.** It is convenient that an M&E system in every program and project is created from the very beginning of the implementation. This way the system becomes a management tool that can contribute to recurring adjustments in the direction of efforts.
- **Program funds for the system.** Sufficient funds should be allocated during program and project design for the implementation of an M&E system UNAIDS recommends 10% of the general budget should be allocated for this purpose.
- **Use a participatory approach when developing the system.** The M&E system is not the sole property of a group of specialized technical staff. The system is a common asset that should be accessible to all parties involved. Its use will depend greatly on the degree of participation and ownership of the related staff.

ANNEX I

SCHEDULE INTERVIEWS				
	NAME	ORGANISATION	TEL./EMAIL	DATE
1	<i>Elizabeth Lloyd</i>	Monitoring and evaluation CHRC	868- 645-3769	Tuesday 15 10:00 am
2	<i>Dr. Donald Simeon</i>	Director CHRC 25a Warner Street St. Augustine Trinidad	868-645-3769 645-7421 dtsimeon@tstt.net.tt	Tuesday 15 1:30 pm
3	<i>Joe Valadez</i>	GAMET	jvaladez@worldbank.org 202-473-7847	Friday, 1 April 10:00am
4	<i>Dr. Bilali Camara</i>	Head SPSTI Division TRINIDAD	868-628-6435	Friday 18 9 :00 am
5	<i>Hilary Hughes</i>	M&E Advisor UNAIDS Caribbean Team #3 Chancery Lane, Port Spain, Trinidad hilary.hughes@undp.org.tt	Tel.1-868-623-7056 ext.279 868-637-3996 home 868-733-5545 cel.	Thursday 17 4:00
6	<i>Ms. Yolanda Simon</i>	Coordinator Caribbean Regional Network PLWHA (CRN+)	868-622-0176 622-8045 yolanda.simon@crnplus.org coordinator@crnplus.org communications@crnplus.org	Friday 4:00pm
7	<i>Dr. Antonio De Moya</i>	Consultant COPRESIDA, D.R.	COPRESIDA 809-732-7772	Wednesday 16 5:30pm
8	<i>Angela Trenton-Mbonde</i>	Team Leader UNAIDS Caribbean Team #3 Chancery Lane Port-of-Spain Trinidad	623-7056 ext. 221 625-4922 868-624-0468	Thursday 17 9:00am
9	<i>Mary Ann Seday</i>	Resident Advisor Measure Evaluation/USAID TRINIDAD	868-735-0604	Thursday 17 11:00am
10	<i>Robert Brohim</i>	Programme Manager Health Sector Development CARICOM 57 High street, Kingston, Georgetown, Guyana	rbrohim@ 592-2-226-4914 Guyana	Wednesday 23 10:30am RD: 10:00
11	<i>Ms. Alies Jordan</i>	Director National HIV/AIDS Commission BARBADOS	246-436-7790/92 ajordan@hiv-aids.gov.bb 246-421-8568	Monday 21 2:00pm
12	<i>Mrs. Rosa Mae-Bain</i>	Director Department of AIDS Ministry of Health BAHAMAS	medicineid@batelnet.bs 242 325 5120 - 1	Wednesday 23 4:00m (RD:5:00)
13	<i>Dr. Bonnie Richardson-Lake</i>	Primary Health Care Manager	264-497-3042/3930 bonnie.lake@gov.do Anguilla	Monday 4 9:30am
14	<i>Mr. Elvis Newton</i>	Permanent Secretary Ministry of Health	869-466-6978 Saint-KittsNavy 869-465-2521 ext 1108 jamnew23@yahoo.com pshande@caribsurf.com	Tuesday 22 8:00 am

15	<i>Mrs. Annegret Spelleken</i>	Proyecto Supra-Regional Juventus Y SIDA En Latino-America y el Caribe	juventud.sida@internet.net.do 809) 532-9532 (809) 535-1652 / 9655	Wednesday 23 3:00pm
16	<i>Judith Timyan</i>	CONNECTA/FHI/USAID	jtimyan@fhidr.org	Tuesday 22 march 5:00pm
17	<i>Jacob Gayle</i>	CDC/UNAIDS	jgayle@unaid jgayle@cdc.gov 41-22-791-4430	Wednesday 23 3:00pm Suiza RD9:00am
18	<i>Angel Almanzar,</i>	ITS /VIH/SIDA Dominican Republic Director DIGECITSS		Wednesday 6 april 10:00am

ANNEX II

CARIBBEAN HIV/AIDS M&E FRAMEWORK

Interview guide for regional stakeholders

A core team comprised by the Caribbean Health Research Council (CHRC), the Caribbean Epidemiology Centre (CAREC), the Joint UN Programme on HIV-AIDS, and the Caribbean Coalition of National AIDS Programme Coordinators (CCNAPC), is charged with the responsibility of the development of a *Framework for Monitoring and Evaluating National HIV-AIDS Programmes in the Caribbean*. In this connection, a team of consultants from Fundación Plenitud, a firm from the Dominican Republic, was hired to facilitate the development of the Framework, with funding from the European Union through the project *Strengthening the Institutional Response to HIV-AIDS/STIs in the Caribbean (SIRHASC)*, which is being administrated by CARICOM.

The following questions intend to serve as a semi structured guide to interview the major regional stakeholders (regional and international organizations, including donors, lending institutions, technical assistance organizations, national institutions, etc.).

1. Roles and responsibilities of main stakeholders on HIV-AIDS M&E

- Purpose of the Regional M&E Framework
- Main stakeholders in the region and their strengths

2. Regional Strategic Plan

- Opinion on the existing Regional Strategic Plan
- Areas of improvement
- General suggestions for operationalization

3. Regional M&E Framework

- General suggestions on the *Regional M&E Framework*
- Areas or components that it would need to address

4. UNGASS and CIMT indicators

- If the CIMT indicators reflect the priorities of the fight against HIV-AIDS in the Caribbean and if there is consensus around them.
- Key points for a good monitoring system of these indicators.
- How the data collection reporting system could be improved both at the national and the regional level
- At the national level: Which institution should be responsible of data collection and with which mechanism?
- At the regional level: Which institution should be responsible of data collection and with which mechanism?
- Recommendations at the regional level to build a complete regional M&E system

5. Coordination and standardization mechanisms

- Which collecting tools should be standardizing to facilitate the regional M&E system and to obtain internationally comparable data?
- Specific tools already developed that could be of standard use at the national and regional level
- Opinion on regional M&E training programmes.

6. Capacity building

- Weaknesses confronting the Caribbean countries to collect M&E data
- How could the reporting systems of the countries be improved?
- How could the reports to donor, lending institutions, and regional institutions be standardized and unified, in order to lessen the paper work burden at the country level?
- Suggestions for the dissemination of the information, in order that it is useful for policy making
- Priority areas in training and capacity building, by country.

7. Technical assistance

- Request of a table with TA by country and programmatic area for 2005.
- TA beneficiaries and process of TA requests.
- TA strengths.
- How to organize adequately a collaborative TA process.

ANNEX III

Program level output matrix (Table 2)

Definition

Counts of persons trained by service/program area, service outlets/programs and clients/area.

Measurement tools

Program reports (aggregate)

Rationale/What it measures

These program level counts aggregated at the national level are a crude measure of the availability and use of services and training activities. When the client counts are combined with census-derived or estimated population figures, these data provide measures of service coverage.

How to measure it

A National AIDS Programme should promote the standardization of program categories in line with international definitions. Secondly the NAP must establish a system for collecting and aggregating the three types of basic output counts:

1. number of people trained
2. number of service outlets or programs
3. number of clients served

Double-counting the same client within one service/program area during a single reporting period should be avoided. Thus, if one orphan or vulnerable child (OVC) is receiving school-related expenses from a program and also receives periodic nutritional support and counselling from the same program, this child is only counted once within the reporting period under OVC. It is the responsibility of the NAP to ensure that while program-level summary counts only count the number of persons served once, each person served should be given the appropriate quality package of services, according to national/international standards.

It is acceptable to count the same person in multiple service/program areas (e.g., OVC and prevention of mother-to-child prevention plus (PMTCT+), antiretroviral therapy (ART) and Palliative Care) but not to count a person for the same service multiple times. Persons receiving services in multiple reporting cycles, however, will be counted again in the next cycle if they are still receiving services (e.g., a person on ART served in one annual period will also be counted if he/she is served in the next reporting period). Thus, reports show the total number of persons currently being served within each reporting period.

The same applies to counting numbers of people trained. A person trained more than once within a given period is only counted as one person trained; however, if this person is trained in a different area then he/she can also be counted for that area.

Interpretation/Strengths and limitations

Estimated availability and use of programs and services allows for an assessment of whether or not prevention and care targets are being reached. They also potentially stimulate further investment, by giving donors easily accessible output results to compare with stated goals.

Double counting of clients and person trained, in particular, is an issue. Measures should be taken by the National AIDS Programme to minimize double counting, through promotion of case-based program monitoring systems and systems for the aggregation of the data generated.

Source: GAC (2004). The President's Emergency Plan for AIDS Relief, Indicators, Reporting Requirements, and Guidelines.

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

Definition

Percentage of young women and men aged 15-24 who, in response to prompted questions, say that people can protect themselves from contracting HIV by having sex with only one faithful, uninfected partner, and using condoms, who know that a healthy-looking person can have the AIDS virus, and who correctly reject the two most common local misconceptions about AIDS transmission.

Measurement tools

Population-based survey such as Behavioural Surveillance Surveys (BSS) focusing on youth.

Rationale/What it measures

Assesses progress in achieving universal knowledge of the essential facts about HIV transmission.

How to measure it

This indicator is constructed from responses to the following set of prompted questions:

1. Can the risk of HIV transmission be reduced by having sex with only one faithful, uninfected partner?
2. Can the risk of HIV transmission be reduced by using condoms?
3. Can a healthy-looking person have HIV?
4. *Can a person get HIV from mosquito bites?* (this is an example, local misconceptions should be questioned here)
5. *Can a person get HIV by sharing a meal with someone who is infected?* (this is an example, local misconceptions should be questioned here)

Those who have never heard of HIV/AIDS should be excluded from the numerator but included in the denominator.

Indicator scores are required for all respondents aged 15-24 years and should be reported separately for males and females, according to urban/rural residence.

Scores for each of the individual questions (based on the same denominator) are required in addition to the score for the composite indicator.

Numerator

Number of young women and men aged 15-24 who, in response to prompted questions, say that people can protect themselves from contracting HIV by having sex with only one faithful, uninfected partner, and using condoms and know that a healthy-looking person can have the AIDS virus, and who correctly reject the two most common local misconceptions about AIDS transmission.

Denominator

Number of young women and men aged 15-24 surveyed

Interpretation/Strengths and limitations

The belief that a healthy-looking person cannot be infected with HIV is a common misconception that can result in unprotected sexual intercourse with infected partners.

Correct knowledge of false modes of HIV transmission is as important as correct knowledge of true modes of transmission. For example, the belief that HIV is transmitted through mosquito bites can weaken motivation to adopt safe sexual behavior, while the belief that HIV can be transmitted through sharing food reinforces the stigma faced by people living with AIDS.

This indicator is particularly useful in countries where knowledge about HIV/AIDS is poor because it allows for easy measurement of incremental improvements over time. However, it is also important in other countries because it can be used to ensure that pre-existing high levels of knowledge are maintained.

The "two most common misconceptions about AIDS transmission" will vary not only from country to country, but from survey to survey in the same country over time. This should be kept in mind when comparing this indicator across countries and over time.

Source: UNGASS (2002)

Percent of never-married young people aged 15-24 who never had penetrative sex

Definition

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

Measurement tools

Population-based surveys such as DHS/AIS, RHS, BSS (youth)

Rationale/What it measures

This indicator is Part 1 of a composite indicator that provides information on important aspects of sexual behavior. This particular indicator describes the proportion of never married young people surveyed who have never had sex, thus the prevalence of virginity among young people. Looking at this prevalence within narrow age ranges (15-16, 17-18, 19-20, 21-22, and 23-24, for example, or better yet, in single ages) across time allows program managers to see if the age at first sex is moving.

How to measure it

Respondents (15-24 year olds) are asked if they have ever had penetrative sex.

The indicator should be reported separately for men and women.

If the indicator is calculated for groupings of ages that are broader than the period of time that has passed, the indicator will not be able to reflect changes that may in fact be occurring. It is therefore recommended that this indicator be reported by single age.

Numerator

Number of never married young women and men who have never had sex

Denominator

Number of never married young women and men aged 15-24 surveyed

Interpretation/Strengths and limitations

Abstinence from sex, being faithful to one partner, and using condoms are the ways of preventing HIV infection that form the central message of USG programs. This indicator describes the extent to which abstinence is practiced among youth.

In some settings, the proportion of those aged 20-24 who are never married will be very low, at least among women, and it may not be appropriate to construct the indicator for this age group in these cases.

The other parts of the ABC composite should be considered as additional indicators as the composite shows movement of youth among the different behaviours if collected across time. Considering all six aspects of behaviour together makes sense, as each component affects the other and each component is of progressively riskier behaviour.

Source: Adapted from *UNAIDS YPG (2004)*

Proportion of young women aged 15 - 24 who have had sex in the last 12 months with a partner who is 10 or more years older than themselves

Definition

Proportion of young women who have had sex in the last 12 months with a partner who is 10 or more years older than themselves

Measurement tools

Population-based surveys such as DHS/AIS, RHS, BSS (youth)

Rationale/What it measures

This indicator measures the progress made towards reducing the proportion of young women having sex with older men.

Sex between young women and older men is often risky because young women lack the power in the relationship to negotiate safe sex. It is also an efficient means of spreading HIV infection, since, for physiological reasons, younger women are more likely to get infected. Each sexual act with an infected man carries a higher risk of infection for a young girl, and older men are more likely than younger men to be infected. AIDS programmes sometimes try to address this issue through behaviour change campaigns aimed at making sex with younger women socially unacceptable among older men, and through initiatives to increase girls' negotiating power.

How to measure it

In a general population survey, respondents are first asked whether they have had sex in the past 12 months. Of those who said they had, respondents are then asked about the ages of the last three partners within the past 12 months. The numerator includes all those respondents who had sex with a man who is at least 10 years older than themselves of the last three partners in the last 12 months.

This indicator should be reported as a percentage presented separately for age into three groups: 15-19, 20-24 and 15-24. It should be further disaggregated by current marital status, where possible.

Numerator

Number of female respondents aged 15-24 years who have had sex in the last 12 months with a partner who is 10 years or more older than themselves

Denominator

Female respondents aged 15-24 years who have had sex in the last 12 months

Interpretation/Strengths and limitations

This measure has two major limitations. The first is that people often do not know the exact age of their sex partners. This is more likely to be true of casual partners than of spouses. The second is that it is not clear exactly what age difference constitutes an elevated risk of exposure to HIV.

When uncertain about a partner's age, respondents frequently give numbers that "heap" around numbers such as 20 or 30. This may well distort the indicator. It should be noted, however, that the biases introduced through age heaping or age misreporting are unlikely to change greatly over time, so this may be of little consequence when looking at trends.

This measure will not give an exact picture of patterns of age mixing, and it will not capture small shifts in the age gap between partners. But it should capture the substantial changes in age mixing that HIV prevention and life-skills programmes promote, since women are unlikely to mistake a peer for a man much older than themselves. If women increasingly choose to have sex with their peers rather than with older men, or if older men become less likely to seek out substantially younger partners, these changes will be reflected in the indicator, regardless of errors in age reporting.

Source: UNAIDS YPG (2004)

Percent of women and men aged 15-49 who had sex with more than one partner in the last 12 months

Definition

Percent of women and men aged 15-49 who have had sex with more than one partner in the last 12 months, of all people aged 15-49 surveyed.

Measurement tools

Population-based surveys such as UNAIDS general population survey, DHS/AIS, RHS

Rationale/What it measures

Prevention messages should focus on abstinence and also on mutual monogamy. But because sexual relationships, particularly among young people, can be frequently unstable, relationships that were intended to be mutually monogamous may break up and be replaced by other relationships in which similar intentions prevail. Particularly in high HIV prevalence epidemics, serial monogamy is not greatly protective against HIV infection. This indicator measures the proportion of people that have been exposed to more than one partner in the last year.

How to measure it

In a survey among people aged 15-49, respondents are asked about their sexual partnerships in the last year.

The indicator should be reported separately for men and women. It should also be constructed separately for those aged 15-19, and 20-24, 15-24, and 15-49.

To cope with the measurement challenge posed by men in polygamous societies, who may have multiple partners within marriage, it may be necessary to disaggregate this indicator by marital status including polygamy.

Numerator

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

Denominator

Number of women and men aged 15-49 surveyed who report being sexually active in last 12 months

Interpretation/Strengths and limitations

This indicator does not distinguish between marital and non-marital partners. It tracks all multiple partnerships, regardless of their relative levels of risk. The indicator also suffers from the expected respondent and social desirability bias. For people saturated with prevention messages, there will be high motivation to under-report partners. Likewise, social pressure for women to give untruthful answers may be strong.

Source: Adapted from *National AIDS Programs: A Guide to Monitoring and Evaluation* (UNAIDS, 2000). The President's Emergency Plan for AIDS Relief (USAID 2004)

Percentage of young people age 15 - 24 reporting the use of condom during sexual intercourse with a non-regular sexual partner

Definition

This indicator assesses progress in preventing early-age exposure to HIV through unprotected sex with non-regular partners

Measurement tools

Population-based survey such as DHS, UNICEF MICS, BSS (youth)

Rationale/What it measures

Consistent correct use of condoms within non-regular sexual partnerships substantially reduces the risk of sexual HIV transmission. This is especially important for young people who often experience the highest rates of HIV acquisition because they have low prior exposure to infection and sometimes relatively high numbers of non-regular sexual partnerships. Consistent condom use with non-regular sexual partners is important even in countries where HIV prevalence is low because it can prevent the spread of HIV in circumstances where non-regular relationships are common. Condom use is one measure of protection against HIV/AIDS; delaying age at first sex, reducing the number of non-regular sexual partners, and being faithful to one uninfected partner are equally important.

How to measure it

Survey respondents aged 15 - 24 years are asked whether they have commenced sexual activity (or this is inferred from responses to a question on age at first sex). Those who report sexual activity (whether currently married or unmarried) are then asked the following questions:

1. In the last 12 months, have you has sexual intercourse with a non-regular partner who was neither your spouse nor someone you were living with?
2. If the answer to question 1 is "yes". How many non-regular partners have you had sex with in the last 12 months?
3. If the answer to question 1 is "yes": Did you (or your partner) use a condom the last time you had sex with your most recent non-regular partner?

Numerator

Number of the respondents (aged 15-24) who reported having had a non-regular (i.e. non-marital and non-cohabiting) sexual partner in the last 12 months who also reported that a condom was used the last time they had sex with this partner.

Denominator

Number of respondents (15 - 24) who reported having has a non-regular sexual partner in the last 12 months.

Interpretation/Strengths and limitations

This indicator shows the extent to which condoms are used by young people who engage in non-regular sexual relationships. However, the broader significance of any indicator score will depend upon the extent to which young people engage in such relationships. Thus, levels and trends should be interpreted carefully using the data obtained on percentages of young people who have started having sex and (of those) that have engaged in a non-regular partnership within the last year.

Condom use is just one measure of protection against HIV/AIDS. Delaying first sex, reducing the number of non-regular sexual partner, and remaining faithful to one's non-infected partners are equally important. Thus, countries are strongly advised to report on the suggested additional indicators on median age at first sex and higher-risk sex in the last year, using data form the same survey instrument as the one proposed for calculating the core indicator.

Source: UNGASS 2004.

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

Definition

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

Measurement tools

Population-based surveys such as UNAIDS general population survey, DHS/AIS, BSS (adult), RHS.

Rationale/What it measures

If everyone used a condom every time they had sex with a non-marital or non-cohabiting partner, a heterosexually transmitted HIV epidemic would be almost impossible to sustain. While AIDS programs may try to reduce casual partnerships, they must also, if they are to succeed in curbing the epidemic, promote condom use in the casual partnerships that remain. This indicator tracks changes in condom use in these partnerships.

How to measure it

For each partner listed in the last 12 months, respondents are asked whether they used a condom the last time the couple had sex. Other questions will allow for the classification of partnerships as non-marital and non-cohabiting.

The indicator should be reported separately for men and women. It should also be constructed separately for those aged 15-24 and 15-49.

Numerator

Number of those women and men in the denominator who used a condom the last time they had sex with their *most recent* non-marital, non-cohabiting partner

Denominator

Number of women and men aged 15-49 who report at least one non-marital, non-cohabiting partner in the last 12 months

Interpretation/Strengths and limitations

A rise in this indicator is an extremely powerful indication that condom promotion campaigns are having the desired effect among those high-risk individuals with multiple partners.

Since condom promotion campaigns aim for consistent use of condoms with non-regular partners rather than simply occasional use, some surveys have tried to ask directly about consistent use, often using an always/sometimes/never question. While this may be useful in sub-population surveys, it is subject to recall bias and other biases and is not sufficiently robust for use in a general population survey. Asking about the most recent act of non-marital, non-cohabiting sex minimizes recall bias and gives a good cross-sectional picture of levels of condom use. It is recognized that consistent use of condoms is an important goal. But inevitably, if consistent use rises, this indicator will also rise.

An increase over time of this indicator does not necessarily mean an increase in "safe sex" practices; the percentage of non-marital, non-cohabiting partners may be decreasing. This indicator should be analysed in combination with an estimate of the percentage of respondents having sex with a non-marital, non-cohabiting partner.

Source: *National AIDS Programs: A Guide to Monitoring and Evaluation* (UNAIDS, 2000); MDG; YPG

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

Definition

Percent of men aged 15–49 reporting condom use the last time they had sex with a sex worker, of those who report having had sex with a sex worker in the last 12 months.

Measurement tools

Population-based surveys such as UNAIDS general population survey, DHS/AIS, BSS, RHS.

Rationale/What it measures

This indicator gives an indication of the success or failure of campaigns to increase condom use among clients of sex workers. It measures condom use by men with partners they consider to be commercial partners.

How to measure it

In general population surveys or in specialized surveys among groups of men who fit the profile of clients of sex workers (e.g., members of the military, truck drivers), men are asked if they have paid someone in exchange for sex in the last 12 months. If they reply yes, they are further asked whether they used a condom the last time they did so.

Numerator

Number of men who report that they used a condom at last sex with a commercial sex worker or when they last paid someone in exchange for sex.

Denominator

Number of men 15–49 who had sex with a commercial sex worker or paid someone in exchange for sex in the last 12 months.

Interpretation/Strengths and limitations

This indicator is invaluable in tracking the success of major programs to promote condom use in commercial sex.

Most AIDS programs aim to increase consistent use of condoms with sex workers. Surveys of clients of sex workers will almost certainly want to ask whether they use a condom always, sometimes, or never in sex with sex workers over the last 12 months. However the pressure to say “always” is strong. Asking about a

particular, and recent, act of sex may give a more robust measure of levels of condom use in commercial sex. However, it is strongly recommended that programs focusing prevention resources on increasing condom use in commercial sex also construct an indicator of consistent use of condoms in commercial sex.

Where there are several distinct populations of sex workers with different levels of perceived risk—for example, brothel-based prostitutes may be thought of as having riskier behaviour than commercial sex workers in nightclubs—data may be collected separately for separate categories of sex worker. This can provide important information for programming. For example, men may report very high levels of consistent condom use in brothels, but much lower levels with commercial sex workers working out of nightclubs. This may be a warning signal for a shift of the high prevalence from one group to another. In constructing the indicator, however, only the last commercial sex partner of any sort should be considered.

It is very difficult to define commercial sex in a way that translates from one place to another and this is the major limitation of this indicator. Once commercial sex has been described for a country, however, this is unlikely to change much over time.

An increase over time of this indicator does not necessarily mean an increase in “safe sex” in commercial sex; the percentage of men having sex with commercial sex workers may be decreasing. This indicator should be analysed in combination with an estimate of the percentage of men having sex with a commercial sex partner.

Source: *National AIDS Programs: A Guide to Monitoring and Evaluation* (UNAIDS, 2000).

Percent of sex workers who report using a condom with their most recent client, of sex workers surveyed having sex with any clients in the last 12 months

Definition

Percent of sex workers who report using a condom with their most recent client, of sex workers surveyed having sex with any clients in the last 12 months.

Measurement tools

BSS (sex workers).

Rationale/What it measures

This indicator measures the success of campaigns to promote condom use in commercial sex from reports given by sex workers. Although many surveys and the previous indicator gather data from actual clients of sex workers, this indicator looks to men and women actually working as providers of sex. Collected in conjunction with self-reported client data, this indicator will validate levels of commercial sex and condom use. In areas where patronage of commercial sex is highly stigmatised, clients may hesitate to report visits to commercial sex workers. As well, clients may desire to give the 'good' answer that they used a condom at last sex, especially in areas where programs have stressed condom use at commercial and other sex. This indicator seeks responses from sex workers, who may not have the same motivation to give socially desirable answers and who offer a different perspective.

How to measure it

In special surveys of sex workers, sex workers are asked whether they used a condom with their most recent client, divided by the total number of sex workers interviewed who report sex with clients in the last 12 months.

Numerator

Number of sex workers who used a condom with their most recent client.

Denominator

Number of sex workers who report sex with clients in the last 12 months

Interpretation/Strengths and limitations

The goal of most AIDS programmes working with sex workers is an increase in the number of sex workers who *always* use a condom and thus are protected from HIV infection. As with clients, surveys of sex workers will almost certainly want to ask whether they use a condom always, sometimes, or never with their clients. But again, the pressure to say "always" is strong. And again, asking about a recent act of sex may give a more robust measure of levels of condom use with clients. However it is strongly recommended that programmes focusing prevention resources on increasing condom use in commercial sex also construct an indicator of consistent use of condoms in commercial sex. If both questions are asked, the "last client" question should precede the "always, sometimes, never" question.

The difference between the two answers can be useful for programme purposes. What proportion of those who say they used a condom at last sex also say they are not regular condom users, for example? Do any sex workers who claim to "always" use condoms with their clients also say that they did not use one with their last client? Since a sex worker typically sees more clients than vice versa, it is unlikely that there will be an exact match between condom use reports from sex workers and from their clients. However if both data sets show trends in the same direction, confidence in this self-reported data is likely to be strengthened. It is possible to construct a similar indicator for male sex workers in special surveys of that group.

Source: *National AIDS Programs: A Guide to Monitoring and Evaluation* (UNAIDS, 2000).

Percentage of young people 15 - 24 who know at least one formal source of condoms

Percent of men who used a condom at last sex with a male partner, of those who have had sex with a male partner in the last 6 months

Definition

Percent of men (or their partners) who used a condom at last penetrative sex with a male partner, of those who have had sex with a male partner in the last 6 months.

Measurement tools

BSS (men who have sex with men).

Rationale/What it measures

The single most common intervention among men who have sex with men is the promotion of condom use during penetrative (anal) sex. This indicator measures progress towards increasing the proportion of acts of anal sex that are protected against HIV transmission. The indicator measures condom use by either partner during the last penetrative sex act.

How to measure it

This indicator is intended for use where special surveys among men who have sex with other men are possible. In a behavioural survey in a sample of men who have sex with men, respondents are asked about sexual partnerships in the preceding six months, about anal sex within those partnerships, and about condom use at last anal sex.

Numerator

The number of men reporting that a condom was used the last time they had anal sex.

Denominator

All men who reported having anal sex *at least once* in the previous six months.

Interpretation/Strengths and limitations

This measure suffers from difficulties of recall. Its most serious limitation is that it does not distinguish between regular and non-regular partners and that information about sero-status may not be known. Many couples who know their sero-status and are sero-concordant may choose not to use condoms within their regular partnership. Provided they use condoms in any sex with other partners, this represents no increased risk of transmission within the partnership. Where non-use of condoms within stable partnerships is common, the indicator will suggest higher levels of risk than actually exist.

However, defining "regular" partnerships in the context of men who have sex with men is fraught with difficulty, particularly in communities where male-male sex is clandestine. Condom use at last anal sex with any partner probably gives a good indication of overall levels and trends of protected and unprotected sex in populations surveyed.

This indicator does not give any idea of risk behaviour in sex with women, among men who have sex with both men and women. In countries where men in the sub-population surveyed are likely to have partners of both sexes, condom use with female as well as male partners should be investigated. In these cases, data on condom use should always be presented separately for male and female partners.

Source: *National AIDS Programs: A Guide to Monitoring and Evaluation* (UNAIDS, 2000).

Definition

Percentage of young people 15-24 who know of at least one formal source of condoms

This indicator should be presented as a percentage separately for men and women disaggregated by age in the following groups: 15-

Measurement tools

Population based survey such as DHS/AIS, BSS (general population, youth, etc).

Rationale/What it measures

Studies in sub-Saharan Africa have demonstrated that adolescents who know of at least one source of condoms are much more likely to use them. This indicator measures the proportion of young people who can name at least one formal source of condoms.

Note that there may be many acceptable answers to the question on sources, including health centres, pharmacies, stores, outreach clinics, vending machines, or any other formal structure or setting where condoms can be purchased or obtained free of charge. The exact range of acceptable sources is best defined in each national setting.

How to measure it

This indicator is assessed by asking respondents to name at least one source where they can obtain condoms. The question should allow for more than one source to be listed (the maximum number can be defined in each national setting, but three sources is an acceptable option). In a surveyor-administered questionnaire, the surveyor should simply record the sources listed, probing the respondent to think of another source until the set number of sources is listed, or until the respondent cannot name any additional source. In a self-administered questionnaire, a number of blank spaces should be provided into which the respondent writes his/her response. At the analysis stage, certain stated sources may be considered unacceptable, or "incorrect" (for example, "friends" or "family members" may not be considered formal sources of condoms).

19, 20-24.

Numerator

Number of young people, aged 15-24 years, who name at least one formal source of condoms.

Denominator

All young people 15-24 years surveyed.

Interpretation/Strengths and limitations

Sound knowledge of HIV transmission and prevention is a prerequisite, although alone insufficient, for adoption of behaviour that reduces the risk of HIV transmission. Correct knowledge of false modes of transmission is as important as knowing correct modes. Disaggregated data on this can provide meaningful guidance for national health-promotion programmes.

This indicator is easy to measure in a survey, and is especially informative in countries where overall knowledge of HIV/AIDS is low, because it permits easy measurement of incremental improvement over time. In countries where knowledge is high, the indicator can tell whether the high levels are maintained.

Source: WHO YPG (2004).

Condoms available for nation-wide distribution

Definition

Total number of condoms available for distribution nation-wide during the preceding 12 months, divided by the total population aged 15-49. This indicator was formerly the WHO/GPA Prevention Indicator 2.

Measurement tools

WHO/GPA protocol for estimating condom availability for distribution at the central and peripheral level

What it measures

The best distribution system in the world is not much help if there is nothing to distribute. The first challenge for national programs promoting condom use is to ensure that there are enough condoms in the country to satisfy demand. This indicator measures the number of condoms available for use by those in the most sexually active age group. Where active efforts are made to promote the availability of female condoms, these should be included, although the indicator should be disaggregated by type.

This indicator can be used together with indicators of sexual behaviour to give a picture of condom provision. For example, if a third of all men aged 15-49 say they have had non-regular sex in the past year and 20 percent of married couples say they have used condoms to avoid pregnancy, and yet there are only three condoms available per sexually active adult per year, it can be deduced that the supply of condoms nationally is not sufficient to meet the potential demand.

How to measure it

The indicator is measured by estimating the number of condoms (male and female) available for in-country use during the last 12 months. Key informants are identified and interviewed to uncover all possible sources of condom manufacture, import, distribution and storage. Next, data are collected from all manufacturers and major commercial distributors as well as major donors, condom storage facilities, and government and NGO bodies involved in acquiring and distributing condoms.

This indicator sums the condoms in stock nationally at the start of the 12-month period, plus condoms imported during the 12-month period, plus condoms manufactured in country during the same period, minus any exports of condoms over that period. The sum of all condoms available for use in the country during the past 12 months is then divided by the total population aged 15-49.

Strengths and limitations

The number of condoms available at the central level helps assess the adequacy of overall condom availability. It is important to note, however, that "availability" is not the same as "accessibility", which includes dimensions of price, location and access by sub-populations at risk for unprotected sex and HIV. It is often the case that not all available condoms are distributed, or reach the individuals that most need them to protect against the spread of HIV. This indicator by itself cannot give a picture of how many "in-stock" condoms actually get distributed or used.

Ironically, efforts at the national level to encourage condom use sometimes complicate the measurement of this indicator. Many countries have deregulated condom imports in the face of AIDS, in order to maximize the number of condoms available. This means that condoms may be imported by a wide variety of companies, NGOs, donors and government departments (the health ministry, the defense ministry, etc.) without necessarily reporting numbers imported to a central body. Traditionally, there is also a distinction between condoms distributed through family planning programs and those distributed to reduce sexually transmitted infections. It is important to take both sources into account.

Where condom promotion activities are centred around marketing condoms at subsidized prices to people likely to be engaging in risky sex (social marketing), sales of particular brands of condoms can also provide a useful indicator of program success. Organizations responsible for the social marketing of condoms typically keep very good records of condoms distributed down to the retail level. While these data tell only part of the story of condom availability, they provide a very low-cost source of information for the National AIDS Program, and can be very useful for advocacy purposes. A rise in the number of condoms manufactured or imported into a country, or of condoms sold, can be useful in supporting other indicators measuring rises in self-reported condom use, or falls in self-reported STIs and eventually HIV prevalence.

Source: *National AIDS Programs: A Guide to Monitoring and Evaluation* (UNAIDS, 2000).

Percent of patients with STIs at health care facilities who are appropriately diagnosed, treated and counselled

Definition

Percent of patients with STIs at health care facilities who are assessed and treated in an appropriate manner.

Measurement tools

Health facility survey-based on revised guidelines on evaluating STI services and/or MEASURE service provision assessment (SPA).

Rationale/What it measures

The availability and utilization of services to treat and contain the spread of STIs may help reduce the rate of HIV transmission within a population. STI services also provide opportunities to promote HIV testing. One of the corner stones of STI control is comprehensive case management of patients with symptomatic STIs. This composite indicator reflects the competence of health service providers to appropriately provide these services, and the quality of services provided.

How to measure it

Data are collected in observations of provider-client interaction at a sample of health care facilities offering STI services. Providers are assessed on history taking, examination, proper diagnosis and treatment of patients, and effective counselling including counselling on partner notification, condom use and HIV testing. Appropriate diagnosis and treatment and counselling procedures in any given country, are those specified in national STI service guidelines.

Note: Disaggregate by gender and for patients under and over 20 years of age. Scores for each component of the indicator (i.e., history taking, examination, diagnosis and treatment, and counselling) must be reported as well as the overall indicator score.

Source: *UNGASS, GFATM*.

Numerator

Number of STI patients for whom the correct procedures were followed on: (a) history-taking; (b) examination; (c) diagnosis and treatment; and (d) effective counselling on partner notification, condom use and HIV testing.

Denominator

Number of STI patients for whom provider-client interactions were observed.

Interpretation/Strengths and limitations

This composite indicator reflects the competence of health-service providers to correctly identify and treat STIs, the availability of the necessary equipment, drugs and materials, and the provision of appropriate counselling to patients. The indicator reflects the quality of services provided but not the cost or accessibility of these services. The standard for 'appropriate' care upon which the measurement of the indicator is based may vary between countries (or over time). Currently, syndromic management is seen as the most practical approach in high-prevalence, low-income countries, since there are fewer bottlenecks in diagnosis.

Percentage of IDUs who have adopted behaviours that reduce transmission of HIV

Definition

Percentage of injecting drug users (IDUs) who have adopted behaviours that reduce transmission of HIV. i.e., who both avoid sharing injecting equipment and use condoms.

Measurement tools

Time-location cluster sample survey or targeted snowball sample survey (refer to BSS manual).

Rationale/What it measures

Safe injecting and sexual practices among injecting drug users (IDUs) are essential, even in countries where other modes of HIV transmission predominate, because (i) the risk of HIV transmission among IDUs using contaminated injecting equipment is extremely high; and (ii) IDUs can provide a reservoir of infection from which HIV spreads to the wider population.

How to measure it

Survey respondents are asked the following sequence of questions:

1. Have you injected drugs at any time in the last month?
2. If the answer to question 1 is "yes": Have you shared injecting equipment at any time in the last month?
3. Have you had sexual intercourse in the last month?
4. If the answer to questions 1 & 3 are *both* "yes": Did you (or your partner) use a condom when you last had sex?

Numerator

Number of respondents who report having never shared injecting equipment during the last month *and* who also reported that a condom was used the last time they had sex.

Denominator

Number of respondents who report injecting drugs in the last month *and* having had sexual intercourse in the last month.

Wherever possible, data for IDUs should be collected through service organizations that traditionally work with these populations. Access to IDU survey participants as well as the data collected from them must remain confidential.

Interpretation/Strengths and limitations

Gaining access to IDUs poses a significant challenge. Thus, data obtained may not be based on a representative sample of the national IDU population. This will need to be borne in mind when interpreting results and especially when cross-country comparisons are made.

The extent of IDU-associated HIV transmission within a country depends upon: (i) the size, stage and pattern of dissemination of the national HIV epidemic; (ii) the extent of injecting drug use; (iii) the degree to which IDUs use contaminated injecting equipment; and (iv) the patterns of sexual mixing and condom use among IDUs and between IDUs and the wider population. This indicator provides information on the third of these factors and partial information on the fourth.

Source: UNGASS 2004

Screening of blood units for transfusion

Definition

The percent of blood units transfused in the last 12 months that have been adequately screened for HIV according to national or regional standards.

Measurement tools

MEASURE *Evaluation* blood safety protocol.

Rationale/What it measures

Blood safety programs aim to ensure that the overwhelming majority (ideally 100 percent) of blood units are screened for HIV, and those that are included in the national blood supply are indeed uninfected. This is demonstrably not the case in many countries. Some blood units are not screened at all, others are screened by poorly trained personnel using outdated equipment or insufficient inputs. What's more, poor blood testing facilities mean that some blood is screened using antibody tests at a time after the donor has become infected with HIV but before they have developed antibodies to the virus. Together, these factors mean that a significant proportion of blood units may be classified as safe even though they are infected. This indicator gives an idea of the overall percentage of blood units that have been screened to high enough standards that they can confidently be declared free of HIV.

How to measure it

Three pieces of information are needed for this indicator: the number of blood units transfused in the previous 12 months, the number of blood units screened for HIV in the previous 12 months, and among the units screened, the number screened up to WHO or national standards. The number of units transfused and the number screened for HIV should be available from health information systems. Quality of screening may be determined from a special study that retests a sample of blood previously

screened, or from an assessment of the conditions under which screening occurred. In situations where this approach is not feasible, data on the percentage of facilities with good screening and transfusion records and no stock-outs of test kits may be used to estimate adequately screened blood or this indicator.

Numerator

See above.

Denominator

See above.

Interpretation/Strengths and limitations

Where sufficient information exists to construct it, this measure is a strong indicator of the overall safety of the blood supply. However changes in the indicator could reflect changes in the proportion of blood units screened or changes in the quality of the screening process. A successful campaign to reduce unnecessary transfusions may also be reflected in the indicator, since the overall number of transfused units would fall and the proportion of those screened to WHO/national standards should rise in consequence. However, the different elements of the indicator should therefore be reported separately for programmatic purposes.

Where health systems are decentralized, or where the private sector is involved in blood screening and blood banking, it may be difficult to obtain good enough information to construct robust indicator on a national scale. In this case, it will probably be necessary to select sentinel hospitals and laboratories in both the public and the private sector for facility-based surveys of blood transfusion and screening quality.

Source: *National AIDS Programs: A Guide to Monitoring and Evaluation* (UNAIDS, 2000); GFATM

Percent of young people aged 15-24 that are HIV infected

Definition

Percent of young people aged 15-24 that are HIV-infected.

city, in other urban areas and in rural areas should be provided so that national estimates can be calculated, where possible.

Measurement tools

1. *HIV sentinel surveillance*: it is recommended that this indicator is measured through use of existing ANC-based sentinel surveillance data (15-24 year old pregnant women) and epidemiological models (EPP). WHO guidelines.
2. *Targeted sample survey*: in concentrated epidemics this indicator may best be measured through targeted sample surveys (such as the BSS) of MSM and/or FSW with biomarkers.
3. *General Population Survey*: Where feasible, the indicator should be periodically measured directly through serological survey of the general population (women and men age 15-24), during DHS-type or AIS-type surveys. This allows sex-specific, age-specific estimates to be produced.

Or

This indicator is calculated using data from HIV tests conducted among members of chosen population groups in the capital city.

This indicator should be reported for the capital city only, to avoid biases in trends over time. In recent years, many countries have expanded the number of sentinel sites to include more rural ones, leading to biased trends resulting from aggregation of data from these sites.

Numerator

Number of ANC attendees (aged 15-24) tested whose HIV test results are positive.

Or

Number of members of population groups tested whose HIV test results are positive.

Denominator

Number of ANC attendees (15-24) tested for their HIV infection status.

Or

Number of members of population groups tested for their HIV infection.

Interpretation/Strengths and limitations (general population)

HIV prevalence at any given age is the difference between the cumulative numbers of people who have become infected with HIV up to this age and the number who died expressed as a percentage of the total number alive at this age. At older ages, changes in HIV prevalence are slow to reflect changes in the rate of new infections (HIV incidence) because the average duration of infection is long. Furthermore, declines in HIV prevalence can reflect saturation of infection among those individuals most vulnerable and rising mortality rather than behavioural change. At young ages, trends in HIV prevalence are a better indication of recent trends in HIV incidence and risk behaviour. Thus, reductions in HIV incidence

NOTE: Methodologies presented below refer to the ANC and the targeted sample survey measurement approach.

Rationale/What it measures

The ultimate goal in the fight against HIV/AIDS is to eradicate HIV infection. Because HIV infections among youth are likely to have been more recently acquired, this indicator is a proxy for the number of new infections that are occurring and can be used as marker of progress towards this goal.

How to measure it

This indicator is calculated using data from pregnant women attending ANCs in HIV sentinel surveillance sites in the capital city, other urban areas and rural areas.

Median figures should be used for other urban and rural areas. Indicator scores should be given for the whole age range (15-24 years) and disaggregated by five-year age group (i.e.,

15-19-year olds and 20-24-year-olds). The genuine behavioural change should first become detectable in HIV prevalence figures for the 15-19-year-old age group. Where available, parallel behavioural surveillance survey (BSS) data should be used to aid interpretation of trends in HIV prevalence.

associated with

In countries where first sexual intercourse occurs at an older age and/or levels of contraception are high, HIV prevalence among pregnant 15-24-year-old women will differ from that among women in the age group.

This indicator gives a fairly good estimate of relatively recent trends in HIV infection in locations where the epidemic is heterosexually driven. It is less reliable as an indicator of HIV epidemic trends in locations where most infections remain temporarily confined to subpopulations with high-risk behaviours.

Source: *UNGASS, MDG*

Percentage of the general population aged 15 - 49 receiving HIV test results in the last 12 months

Definition

Percentage of the general population aged 15-49 years receiving HIV test results in the past 12 months

Measurement tools

1. Program monitoring records/health management information systems.
2. A population-based survey.

Rationale/What it measures

HIV testing and counselling are important entry points for prevention and care needs. Measuring the number of people who access these services is therefore important to indicate the number of people who could potentially benefit from prevention and care. In addition, over time this indicator provides information on the number of new people tested.

This indicator is designed to show how many people have been tested and received results through post-test counselling. This indicator can be used as a proxy for the coverage of HIV counselling and testing services.

How to measure it

1. Program reports/health management information systems. Ideally, information for this indicator can be collected by reviewing data collected at the local program level and making them available through the health management information system at the national level.
2. A household survey. The indicator is asked through a population-based survey and should be stratified by age.

Numerator

Number of people aged 15-49 years who have received HIV test results and post-test counselling in the past 12 months.

Denominator

Total population aged 15-49 years.

Interpretation/Strengths and limitations

When considering coverage for counseling and testing, traditional stand-alone voluntary counselling and testing units are insufficient. Because testing and counselling services are often performed in diagnostic clinical settings where monitoring information is not well tracked, it is important to build capacity for this information. Similarly, testing is not always performed within discrete units (that is, outpatient or inpatient departments), therefore, reports can potentially be duplicated for the same individual being tested in multiple units or those being tested multiple times during the 12-month period.

In other cases such as preventing the mother-to-child transmission of HIV and other HIV testing and counselling, services are performed in the same place. This too will lead to double reporting in the number of people tested.

Collecting this information at the national level through a health management information system may not yet be possible in some settings. Alternative methods for collecting this information such as population-based surveys are resource-intensive processes that make the annual collection of these data difficult in some areas. If a population-based survey is used, double counting can be minimized.

Source: *UNAIDS 2000, WHO C&S 2004*

Percent of all pregnant women attending at least one ANC visit who received an HIV test result and post-test counselling

Definition

The percent of all pregnant women attending at least one ANC visit who received an HIV test result and post-test counselling.

Measurement tool

Program reports/estimation.

Rationale/What it measures

For PMTCT to be effective, it is necessary to know a woman's sero-status in order to tailor prevention and care to her needs. A successful PMTCT program will reach as many pregnant women as possible to ensure knowledge of sero-status. This indicator provides a broad measure of program coverage in the country. However, issues related to poor access to services, as well as to poor uptake, result in a small percentage of women knowing their status. Therefore, it is important to refer to the program-level indicator described in the footnote below.

How to measure it

This indicator requires that program records be reviewed in order to count how many women complete the counselling and testing process (received their test results and post-test counselling). The number of women who attended at least one ANC visit is estimated by multiplying the number of births in the past 12 months by the rate of ANC attendance using census or best source of available data for the estimation..

The numerator may be available through national level records. If these are not available at the national level, they will most likely be available at the district level, where they can be collected directly from facilities where these services are provided.

In some cases, the denominator may be available through the national level ANC registry. If the number is not available or reliable, the estimate of the number of pregnant women described above can be used.

This indicator should be measured every year.

Numerator

Number of all pregnant women who receive an HIV test result and post-test counselling in the last 12 months.

Denominator

Estimated number of all pregnant women giving birth in the last 12 months who attended at least one ANC visit.

Interpretation/Strengths and limitations

As stated in the document *National AIDS Programmes: A guide to monitoring and evaluation* (UNAIDS, 2000), this indicator is a broad measure of service provision and gives an idea of coverage in ANC settings where PMTCT interventions are available. This indicator does not attempt to inform service providers about where in the counselling and testing cycle women are lost.

A series of lower-level indicators to determine loss to follow-up is an important indicator that must be used by program managers. Additionally, because the quality of services is not being measured, the information on dropouts and the points at which these occur is of limited use if it is not followed up with operations research to discover why women are failing to complete the cycle.

Note: An important program-level counselling and testing indicator must be considered when managing a PMTCT program. The indicator measures the points in the provision of counselling and testing for pregnant women at which women are lost, or "drop out". Information on where this dropout occurs can be used to further investigate why women are lost at specific points, and ultimately to decreasing that loss. Such information is therefore important for program planning. The indicator includes three components.

- a) *Number of pregnant women who attend at least one ANC visit and were counseled in a PMTCT site/all pregnant women.*
- b) *Number of pregnant women accepting testing for HIV/ all pregnant women who attend at least one ANC visit and were counseled in a PMTCT site.*
- c) *Number of women receiving post-test counselling and HIV results/ all pregnant women who attend at least one ANC visit and were counseled in a PMTCT site.*

Source: WHO PMTCT 2004

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

Definition

The percent of women testing positive at selected antenatal clinics in the last year who are provided with a complete course of antiretroviral therapy to prevent mother to child transmission according to national / international guidelines.

Measurement tools

Program monitoring and estimation.

Rationale/What it measures

In the absence of preventative interventions, infants born to, and breastfed by, HIV-infected women have roughly a one-in-three chance of acquiring infection themselves. This can happen during pregnancy, during labour and delivery, or after delivery through breastfeeding. The risk of MTCT can be reduced through the complementary approaches of antiretroviral prophylaxis for the mother, with or without prophylaxis to the infant, implementation of safe delivery practices, and use of safe alternatives to breastfeeding.

How to measure it

The number of HIV-infected pregnant women provided with antiretroviral prophylaxis to reduce the risk of MTCT in the last 12 months is obtained from program monitoring records. Only those women who completed the full course should be included. The definition of a 'full course' of antiretroviral prophylaxis will depend on the country's policy on antiretroviral prophylaxis to reduce the risk of MTCT and may or may not include a dose for newborns. Details of the definition used should be provided.

The number of HIV-infected pregnant women to whom antiretroviral prophylaxis to reduce the risk of MTCT *could potentially have been given* is estimated by multiplying the total number of women who gave birth in the last 12 months (Central Statistics Office estimates of births) by the most recent national estimate of HIV prevalence in pregnant women (HIV sentinel surveillance antenatal clinic estimates).

The decision as to whether or not to include women who receive treatment from private-sector and NGO clinics in the calculation of the indicator is left to the discretion of the country concerned. However, the decision taken should be noted and applied consistently in both the numerator and denominator. Private-sector and NGO clinics that provide prescriptions

for antiretrovirals but assume that the drugs will be acquired by the individuals elsewhere are not included in this indicator, even though such clinics may be major providers of MTCT-reduction services.

Separate estimates of the numbers of pregnant women provided with antiretroviral prophylaxis at public- and private-sector clinics should be given.

The indicator should be constructed separately for those aged 15-24 and 15-49.

Numerator

Number of HIV positive pregnant women receiving a complete course of ARV prophylaxis to reduce the likelihood of MTCT in accordance with nationally approved treatment protocol (or WHO/UNAIDS standards) in last 12 months.

Denominator

Estimated number of HIV-infected pregnant women giving birth in last 12 months.

Interpretation/Strengths and limitations

In many countries, the estimate of HIV prevalence among pregnant women used in the calculation of this indicator will be based on antenatal clinic (ANC)-based HIV surveillance data. In some of these countries, large numbers of pregnant women do not have access to ANC services or choose not to make use of them. Pregnant women with HIV may be more or less likely to use ANC services (or public rather than private ANC services) than those who are not infected, particularly where antiretroviral prophylaxis can be accessed via such services. In such circumstances, this indicator should be interpreted with reference to recent estimates of utilization of national ANC services.

Countries will apply different definitions as to what constitutes a 'full course' of antiretroviral prophylaxis. Thus, inter-country comparisons may not be entirely valid and should be interpreted with reference to details of the different definitions used in each case. This indicator does not measure compliance with the antiretroviral treatment regime because it is not possible to monitor drug compliance, unless direct supervision is undertaken.

Source: UNGASS 2002, GFATM 2004, WHO PMTCT 2004

HIV prevalence among pregnant women aged 15 - 24

Definition

HIV prevalence among 15 - 24 year-old pregnant women is the percentage of pregnant women aged 15 - 24 whose blood samples test positive for HIV.

Rationale/What it measures

HIV infection leads to AIDS. Without treatment, average survival from the time of infection is about nine years. Access to treatment is uneven, and no vaccine is currently available.

About half of all new HIV cases are among people 24 years of age or younger. In generalized epidemics (with prevalence consistently at more than 1 per cent among pregnant women), the infection rate for pregnant women is similar to the overall rate for the adult population. Therefore, the indicator is a measure of the spread of the epidemic. In low-level and concentrated epidemics, HIV prevalence is monitored in groups with high-risk behaviour because prevalence among pregnant women is low.

How to measure it

The number of pregnant women whose blood samples test positive for HIV expressed as a percentage of all pregnant women in that age group whose blood is tested.

Data Collection and Source

Data on HIV in pregnant women come from tests on leftover blood samples taken for other reasons during pregnancy. The samples come from selected antenatal clinics during routine sentinel surveillance, chosen to reflect urban, rural and other socio-geographic divisions in a country. HIV prevalence data in groups with high-risk behaviour are collected in serosurveys that are part of the surveillance system or in ad hoc prevalence surveys.

Only the results of unlinked, anonymous screening of blood taken for other purposes should be used in calculating this indicator of HIV prevalence. Refusal and other forms of participation bias are considerably reduced in unlinked, anonymous HIV testing compared with other programmes that offer counselling and voluntary HIV testing for pregnant women to reduce mother-to-child transmission.

The data are gathered by the World Health Organization and the Joint United Nations Programme on HIV/AIDS.

Periodicity of Measurement

The data are collated annually in many developing countries.

Interpretation/Strengths and limitations

The indicator gives a fairly good idea of relatively recent trends in HIV infection nationwide in countries where the epidemic is generalized. In areas where most HIV infections are confined to subpopulations with high-risk behaviours, trends should be assessed in those populations.

In most countries, serosurveillance sites have not been selected as representative samples of the country. Logistical, feasibility and cost issues guide the selection of these sites. In addition, in many countries, the sites included in the surveillance system have changed over time, making interpretation of trends more difficult.

Percent HIV-infected Infants Born to HIV-infected Mothers

Percent HIV-infected infants born to HIV-infected mothers.

Definition

Percent of HIV-infected infants born to HIV-infected mothers.

Measurement tool

Program reports/estimation.

Rationale/What it measures

Assesses progress toward eliminating mother-to-child HIV transmission. In high-income countries, strategies such as antiretroviral treatment during pregnancy and following birth and use of breastfeeding substitutes have greatly reduced the rate of mother-to-child HIV transmission. In developing countries, significant difficulties exist in implementing these strategies due to constraints in accessing, affording and using VCT and reproductive health and maternal- and child-health services that offer MTCT prevention support. Nevertheless, substantial reductions in MTCT can be achieved in these settings through approaches such as short-course antiretroviral prophylaxis.

How to measure it

The indicator is calculated by taking the weighted average of the probabilities of MTCT for pregnant women receiving and not receiving antiretroviral, the weights being the proportions of women receiving and not receiving ARV, respectively. Expressed as a simple mathematical formula:

$$\text{Indicator score} = \{ T*(1-e) + (1-T) \} * v$$

where:

T = proportion of HIV-infected pregnant women provided with antiretroviral treatment
v = MTCT rate in the absence of any treatment
e = efficacy of treatment provided
T = the value for PMTCT Indicator 1

Default values of 25% and 50%, respectively, can be used for v and e. However, where scientific estimates of the efficacy of the specific forms of antiretroviral treatment (e.g., nevirapine) used in the country are available, these can be used in applying the formula. When this is done, the values of these estimates should be recorded. The most common forms of treatment provided during the last 12 months should be noted.

Numerator

See above.

Denominator

See above.

Interpretation/Strengths and limitations

This indicator focuses on prevention of MTCT of HIV through increased provision of antiretroviral prophylaxis. Thus, the effect of breastfeeding on MTCT of HIV is ignored and the indicator may yield underestimates of true rates of MTCT in countries where long periods of breastfeeding are common. Similarly, in countries where other forms of prevention of MTCT of HIV (e.g., caesarean section) are widely practiced, the indicator will typically provide overestimates of MTCT. For these reasons, trends in this indicator may not reflect overall trends in MTCT of HIV.

This PMTCT indicator may provide a poor estimate for the proportion of HIV infected pregnant women provided with antiretroviral treatment (T) in circumstances where usage of antenatal clinic services is low.

Source: UNGASS (2002), *UNAIDS PMTCT (2004)*

Ratio of current school attendance among orphans to that of non-orphans aged 10 - 14

Definition

Ratio of current school attendance among orphans to that among non-orphans aged 10 - 14.

Measurement tool

Population-based survey such as DHS, Cluster surveys or other representative survey.

Rationale/What it measures

HIV is claiming the lives of ever-growing numbers of adults just when they are forming families and bringing up children. As a result, orphan prevalence is rising in many countries, while fewer relatives within the prime adult ages mean that orphaned children face an increasingly uncertain future. It is important therefore to monitor the extent to which AIDS support programmes succeed in securing the educational opportunities of orphaned children.

How to measure it

Ratio of the current school attendance rate of children aged 10 - 14 both of whose *biological* parents have died to the current school attendance rate of children aged 10 - 14 whose parents are both still alive and who currently live with at least one biological parent.

Orphans' schools attendance (1)

Numerator

Number of children who have lost both parents and are still in school.

Denominator

Number of children who have lost both parents.

Non orphans' school attendance 2

Numerator

Number of children, both of whose parents are still alive, who live with at least one parent and who are still in school.

Denominator

Number of children whose parents are both still alive and who live with at least one parent.

Calculate the ration of (1) to (2)

Indicator scores are required for all children aged 10 - 14 years and for boys *and* girls, separately> Where possible, the indicator should also be calculated by single year of age (see section on interpretation).

The minimum number of orphaned 10-14-year-old children needed to calculate this indicator is 50 (see section on interpretation).

Interpretation/Strengths and limitations

The definitions of an orphan and non-orphan used here, i.e., child aged 10 - 14 years at last birthday, both of whose parents are still alive, have died respectively, are chosen so that the maximum effect of disadvantage resulting from orphanhood can be identified and tracked over time. The age range of 10 -14 years is used because younger orphans are more likely to have only recently lost their parents, so any detrimental effect on their education will have had little time to materialize. However, orphaned children are typically older than non-orphaned children because the parents of younger children have had less time to die and older children are more likely to have left school. Thus, the value of this indicator will tend to be slightly greater than 1, even when orphans suffer no relative disadvantage.

Typically, the data used to measure this indicator will be taken from household-based surveys. Children not recorded in such surveys, e.g., those living in institutions or on the street, generally are more disadvantaged and are more likely to be orphans. Thus, the indicator will tend to understate the relative disadvantage in educational attendance experienced by orphaned children.

Source: UNGASS 2004.

Percent of people with advanced HIV infection receiving ART

Definition

Percent of people with advanced HIV infection receiving ART

Measurement tool

Program monitoring (Program reports+ modelling, HMIS)

Rationale/What it measures

As the HIV pandemic matures, increasing numbers of people are reaching advanced stages of HIV infection. Antiretroviral combination therapy has been shown to reduce mortality among those infected and efforts are being made to make it more affordable even within less developed countries. Antiretroviral combination therapy should be provided in conjunction with broader care and support services, including counselling for family caregivers.

Assesses progress in providing antiretroviral combination therapy to all people with advanced HIV infection.

How to measure it

The number of people (i.e., adults and children) with advanced HIV infection who currently receive antiretroviral combination therapy can be calculated as follows:

A: Number of people receiving treatment at start of year

+

B: Number of people who commenced treatment in the last 12 months

-

C: Number of people for whom treatment was terminated in the last 12 months (including those who died).

For the purpose of this indicator, the number of people with advanced HIV infection is taken to be 15% of the total number of people currently infected. The latter is estimated using the most recent national sentinel surveillance data.

Private-sector antiretroviral provision should be included in the calculation of the indicator wherever possible, and the extent of such provision should be recorded separately.

Interpretation/Strengths and limitations

The indicator permits monitoring of trends in coverage, but does not attempt to distinguish between different forms of antiretroviral therapy, or to measure the cost, quality, or effectiveness of treatment provided. These will each vary within and between countries and are liable to change over time.

The proportion of people with advanced stages of HIV infection will vary according to the stage of the HIV epidemic and the cumulative coverage and effectiveness of antiretroviral therapy among adults and children. The proportion currently recommended for use in calculating this indicator (15%) is a crude estimate and may be subject to revision. This figure is particularly relevant in situations where the current coverage of antiretroviral combination therapy is low.

The degree of utilization of antiretroviral therapy will depend on cost relative to local incomes, service delivery infrastructure and quality, availability and uptake of VCT services, perceptions of effectiveness, and possible side effects of treatment.

Preventative antiretroviral therapy for the purpose of prevention of MTCT and post-exposure prophylaxis are not included in this indicator.

Source: UNGASS 2002, GFATM 2004, WHO 3 by 5

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

Definition

Percentage of health facilities that have the capacity and conditions to provide basic HIV counselling and testing and to manage HIV/AIDS clinical services.

Capacity to provide basic HIV counselling and testing and health services is defined as:

- a. a system for testing and providing results for HIV infection;
- b. systems and qualified staff for pre- and post-test counselling;
- c. specific health services relevant to HIV/AIDS, including resources and supplies for providing these services;
- d. elements for preventing nosocomial infections; and
- e. trained staff and resources providing basic interventions for prevention and treatment for people living with HIV/AIDS.

Numerator

1. Number of facilities at which the individual items for each service or item listed above exist
2. Number of facilities at which all components for each individual service or item (a, b, c, d or e) exist
3. Number of facilities at which all components for all individual services and items (a, b, c, d and e) exist

Denominator

For 1, the total number of health facilities surveyed

For 2 and 3, the total number of health facilities at which HIV/AIDS services in each of the areas identified in the definition are offered or relevant

Measurement tool

This information should be collected through a health facility survey. The recommended tool is the piloted Service Provision Assessment covering all relevant service areas. HIV/AIDS service providers should also be interviewed.

Rationale/What it measures

Many facilities that provide general curative care are also providing services related to HIV/AIDS and are caring for people living with HIV/AIDS. This may occur in settings that have no specific HIV/AIDS program. For facilities that are providing these services, evaluating the degree to which capacity exists to carry out these HIV services is therefore important. The HIV/AIDS specific services and components identified and defined by this indicator are those that both support HIV/AIDS services and can reasonably be expected to exist in almost any health facility.

How to measure it

This information should be collected through a health facility survey in all relevant service areas. HIV/AIDS service providers should also be interviewed.

See Annex 1 of the UNAIDS C&S M&E Guide for details of the individual items identified for each of these, including detailed measurement instructions.

Source: WHO C&S 2004

Interpretation/Strengths and limitations

Although the objective is to determine the percentage of facilities that have all items within all service and item areas (a, b, c, d and e), few, if any, facilities will have this level of services. In many settings, facilities do not have all items for each service. The specific items to support each service should therefore be presented individually.

This indicator does not provide individual information for voluntary counselling and testing services or for services for preventing the mother-to-child transmission of HIV except if: 1) the services are integrated within the health facility; and 2) the components of these services are relevant to the areas assessed.

The list of components (for Part a) also excludes facilities that only conduct or refer for pre-employment HIV tests, excludes testing blood prior to transfusion, and excludes facilities that refer people living with HIV/AIDS to another facility for assessment and testing if the referral facility is responsible for further services.

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

Definition

Capacity to provide advanced HIV/AIDS care is defined as:

- a. systems and items to support the management of opportunistic infections and the provision of palliative care (symptomatic treatment) for the advanced care of people living with HIV/AIDS;
- b. systems and items to support advanced services for the care of people living with HIV/AIDS;
- c. systems and items to support antiretroviral combination therapy (including security measures for the ARVs);
- d. conditions to provide advanced inpatient care for people living with HIV/AIDS;
- e. conditions to support home-care services; and post-exposure prophylaxis.

Measurement tool

This information should be collected through a health facility survey with observation in all relevant service areas and interviews of HIV/AIDS service providers would also be needed.

Rationale/What it measures

This indicator measures the availability of advanced services specific to people living with HIV/AIDS. It is assumed that the services and items measured in this indicator require substantial input and personnel training beyond what is routine for most health systems.

How to measure it

The specific items for each service should be presented individually and at a first level of aggregation (all components of each service or item). When a reasonable proportion of facilities begin to have all first-level aggregated components, a second-level aggregation can be presented when appropriate.

See Annex 1 of the WHO C&S 2004 for details of the individual items identified for each of these, including detailed measurement instructions.

Numerator

1. Number of facilities at which the individual items for each service or item listed above exist.
2. Number of facilities at which all components for each individual service or item (a, b, c, d, e, or f) exist.
3. Number of facilities at which all components for all individual services and items (a, b, c, d, e, and f) exist.

Denominator

For 1, the total number of health facilities surveyed.

For 2 and 3, the total number of health facilities at which HIV/AIDS services in each of the areas identified in the definition are offered or relevant.

Interpretation/Strengths and limitations

This indicator examines advanced HIV/AIDS services among all health facilities. In some settings, facilities will not have all items for each item or component, and countries may have different strategies for providing select advanced services at only certain levels of the health care system (that is, referral hospitals may offer a wider range of advanced care than health centres). Although this indicator does not stratify by level of health care facility, managers of national AIDS programs can analyse this information if desired.

Source: WHO C&S 2004

Percent of adults aged 18-59 who were chronically ill for 3 or more months during the past year whose households received free basic external support in caring for the ill person

Definition

Percentage of adults aged 18-59 who have been chronically ill for 3 or more months in the past 12 months, including those ill for 3 or more months before death, whose households received, free of user charges, basic external support in caring for chronically ill people, including health, psychological, or emotional, and other social and material support

External support for chronically ill adults is defined as:

- Medical support;
- Emotional and psychological: counselling from a trained counsellor, companionship, and emotional or spiritual support;
- Material including socio-economic (clothing, extra food or financial support); and
- Other social support or instrumental (help with household work, training for a caregiver or legal services).

External support is defined here as help free of user charges coming from a source other than friends, family or neighbours unless they are working for a community-based group or organization. The definition of chronically ill is defined here as bed-ridden, down, unable to function in one's normal daily role.

Measurement tool

Population-based survey. In low prevalence settings a special study of networks of PLWHA, facility-based samples of PLWHA or other targeted sampling may be optimal.

Rationale/What it measures

This indicator attempts to quantify the extent of professional/institutional support services.

How to measure it

The following methods are recommended:

- A population-based household survey can be used in high-prevalence settings. As part of a household survey, household rosters can be used to identify all eligible chronically ill people aged 15-59. For each household with a chronically ill member, a series of questions is asked about the types and frequency of support received and primary source of the help.
- A special study: the survey tool may be used in low-prevalence settings or targeted populations

with similar but adapted methods sampling networks of people living with HIV/AIDS and/or recipients of services from care and support programs.

Data should be analysed and reported by gender and age categories when sample size allows (15-24, 25-39, and 40+ years).

Each component on type of support will also be reported on separately, i.e., percentage whose households received medical support, percentage whose households received emotional support, and so on.

Numerator

Women and men aged 18-59 who have been ill for 3 or more months during the past 12 months and whose household received the following support:

1. Medical support at least once a month during illness
AND
2. Emotional support in the last 30 days
AND
3. Material support in the last 30 days
AND
4. Social support in the last 30 days.

OR

Women and men who died in the past 12 months, age 18-59 when they died, and who had been chronically ill for 3 months before death and whose household received the support listed above.

Denominator

All adults aged 18-59 who were ill for 3 or more months during the past 12 months, including those ill for 3 or more months before death.

Interpretation/Strengths and limitations

Household-based samples of chronically ill people are not nationally representative of all chronically ill people because they exclude those who are hospitalised, institutionalised, or homeless. As a result, the proportion of the population "missed" varies. Other targeted sampling among groups such as facility clients, home-based care recipients, or PLWHA network members (as discussed above in "How To Measure It") should be done to address this problem.

Source: Adapted from WHO *C&S 2004*

Percent of orphans and vulnerable children under 18 whose households have received, free of user charges, basic external support in caring for the child

Definition

Percent of orphans and vulnerable children under 18 living in a household whose households have received, free of user charges, basic external support in caring for the child. Orphan is defined as a child under 18 who has lost either a mother or father or both. A vulnerable child is defined as a child with a chronically ill parent (mother or father).

Measurement tool

Population-based survey

Rationale/What it measures

This indicator measures support coming from a source other than friends, family, or neighbours (unless they are working for a community-based group or organization) given free of user charges to households with orphans and vulnerable children.

How to measure it

As part of a household survey, household rosters can be used to identify all eligible orphans and vulnerable children (under 18 years of age). For each household with orphans and vulnerable children, a series of questions is asked about the types and frequency of support received and the primary source of the help.

The following methods are recommended:

- A population-based household survey can be used in high-prevalence settings. As part of a household survey, household rosters can be used to identify all eligible chronically ill people 15-59 years old. For each household with a chronically ill member, a series of questions is asked about the types and frequency of support received and primary source of the help.
- A special study: the survey tool may be used in low-prevalence settings or targeted populations with similar but adapted methods sampling networks of people living with HIV/AIDS and/or recipients of services from OVC and/or care and support programs.

Data should be analysed and reported by age (0-5, 6-9, 10-14, and 15-17 years) and gender when possible. Depending on the epidemiological situation and available resources, program managers may decide to aggregate age data into larger ranges.

Each component of type of support will also be reported on separately, i.e., percentage whose households received medical support, percentage whose households

Numerator

Number of orphans and vulnerable children residing in households that received:

- a. health care support within the past 12 months;
- b. emotional support within the past 3 months;
- c. school-related assistance within the past 12 months;
- d. other social support, including material support, within the past 3 months; and
- e. all four types of support.

Orphan (at least one dead parent) AND/OR vulnerable child (at least one chronically ill parent) whose household has received:

1. Medical support within the last 12 months;
AND
2. Emotional/psychological support within the last 3 months
AND
3. Material support within the last 3 months
AND
4. Social support within the last 3 months
AND
5. School-related assistance within the past 12 months.

Denominator

ORPHANS: All children under 18 who have at least one dead parent (mother or father)
AND VULNERABLE CHILDREN: All children under 18 who have a chronically ill parent (mother or father) defined as a parent who has been very sick for 3 or more months during the last 12 months, regardless of whether or not the ill parent lives in the household.

Interpretation/Strengths and limitations

The greatest limitation of this indicator is its inability to distinguish whether needs are being met. Not all households caring for orphans need help. The needs of households with multiple orphans may be greater than those with a single orphan, but this will not be captured in this measure. Unfortunately, needs assessment is beyond the scope of a regular population-based survey. Experience shows that response rates are very high when people are asked whether they need extra support, though more qualitative work distinguishes large differences in actual coping

received emotional support, and so on.
Orphans are a very mobile population. Those most in need of care may be in child-headed households that do not even qualify for inclusion in a household survey. Street children and others who live outside regular households will also be missed; in some urban areas these children may make up a substantial fraction of orphans in greatest need of care.

Source: Adapted from *UNAIDS 2000, WHO C&S 2004, GFATM 2004*

Percentage of people living with AIDS still alive at 6, 12, and 24 months after initiation of ART

Definition

Percentage of people living with HIV/AIDS still alive at 6, 12, and 24 months after initiation of ART.

Measurement tool

Patient records/cohort analysis.

Rationale/What it measures

One of the goals of any ART program should be to increase survival among infected individuals. This indicator measures the degree to which treatment can prolong a person's life by assessing how many individuals survived after 6, 12, and 24 months of receiving treatment.

How to measure it

Information on survival beyond specific points in time can be collected in patient registers. This indicator will require that a cohort of patients be followed up.

Data should be analysed by sex and age.

Numerator

Number of individuals living with HIV/AIDS still alive after initiating ART after 6, 12, and 24 months.

Denominator

Number of individuals living with HIV/AIDS initiating ART at a given point in time

Interpretation/Strengths and limitations

The strengths of this indicator lay in the ease of data collection, as any ART program should monitor patients on treatment and determine the number of individuals who survive beyond specific periods in time. For some patients, follow-up information may not be available as a result of migration, complete treatment failure, or even death. Programs may deal with this loss by including only those individuals for whom they have full information in the numerator and denominator.

Interpretation of trends in this indicator is enhanced when information on health status at treatment initiation is also available. Health outcomes, including survival rate, quality of life measures, weight gain etc. It should be noted that start-up ART program may have higher mortality due to enrollment of the sickest PLWHA. Over time, this effect will level out. Clinical staging or mean CD4 count is helpful information for interpretation of trends.

Source: *WHO 3 by 5 (draft 2004)*

Percent of schools with teachers who have been trained in life skills based education and who taught it during the last academic year

Definition

Percentage of schools with teachers who have been trained in life-skills-based HIV/AIDS education and who taught it during the last academic year.

Measurement tool

School-based or education programme review.

Rationale/What it measures

School-based HIV prevention programmes have the potential to reach vast numbers of young people. Those programmes that offer participatory and interactive life-skills training on individual, social and environmental factors that affect the risks of HIV transmission have proved to be more effective in bringing about behavioural change - delayed age at first sex, condom use, reduced number of sexual partners, etc. - than more formal approaches that concentrate on providing information.

How to measure it

Principals/heads of a nationally representative sample of schools (to include both private and public schools) are briefed on the meaning of life-skills-based HIV/AIDS education and are then asked the following questions:

1. Does your school have at least one qualified teacher who has received training in participatory life-skills-based HIV/AIDS education in the last five years?
2. If the answer to question 1 is "yes". Did this person teach life-skills-based HIV/AIDS education on a regular basis to each grade in your school throughout the last academic year?

The teacher training must have included time dedicated to mastering facilitation of participatory learning experiences that aim to develop knowledge, positive attitudes and skills that assist young people in maintaining safe lifestyles.

Numerator

Number of schools with staff members trained in, and regularly teaching, life-skills-based HIV/AIDS education

Denominator

Number of schools surveyed

Interpretation/Strengths and limitations

It is important that life-skills-based HIV/AIDS education be initiated in the early grades of primary schools and then continued throughout schooling, with content and methods being adapted to the age and experience of the students. Where schools provide both primary and secondary education, at least one teacher should have been trained to teach life-skills-based HIV/AIDS education at each of these levels. This indicator is a measure of coverage.

Source: *UNGASS 2004*)

AIDS Program Effort Index

Definition

The average score given to a national program by a defined group of knowledgeable individuals asked about progress in over 90 individual areas of programming, grouped into 10 major components.

Measurement tools

The AIDS Program Effort Index (API) questionnaire and protocol.

Interpretation/Strengths and limitations

The major concern surrounding the API is its subjectivity and its reliability. The outcome depends entirely on the choice of informants and informants will likely change from year to year. Since the indicator is still under development, the choice of informants has not yet been standardized.

Questions have also been raised about the

Rationale/What it measures

The AIDS Program Effort Index is a composite index designed to measure political commitment and program effort in the areas of HIV prevention and care. It tries to capture many of the inputs and outputs of a national HIV/AIDS program. The score is made up of 10 main components of an effective national response: political support, policy formulation, organizational structure, program resources, evaluation and research, legal and regulatory aspects, human rights, prevention programs, care programs and service availability.

How to measure it

The API uses key informants from a designated mix of institutions to give opinions about central areas of commitment and programming, compiling an index out of scores given in various areas. The score, which is calculated as a percentage with zero indicating no program effort and 100 indicating maximum effort, may be converted into a grade to minimize informant variation. Suggested grades range from very weak and weak through moderate and strong to very strong, depending on the range in which the numerical scores fall.

utility of a single composite score, in which improvements in some areas may be masked by deterioration in other areas. For diagnostic as well as monitoring purposes, it may be more useful simply to publish the indices separately by category. The separate category scores may stand alone as indicators, although for several areas of program effort this document proposes alternatives which are based on measured parameters rather than expert opinion and may therefore be more useful in tracking trends over time.

One area in which the API process may yield a particularly useful indicator is in the area of policy formulation (Section 20 of the API protocol).

Source: *UNAIDS, 2000, UNGASS 2002*

National Composite Policy Index

Definition

The average score given to national level HIV/AIDS policies and strategies grouped into four areas: strategic plan, prevention, human rights, and care and support.

Measurement tool

Special study (Country assessment questionnaire -see Appendix 3 of UNGASS).

Rationale/What it measures

This indicator allows assessment of progress in the development of national-level HIV/AIDS policies and strategies.

How to measure it

The composite index covers four broad areas of policy:

Interpretation/Strengths and limitations

The simple quantitative nature of the National Composite Policy Index means that it does not give information on the effectiveness of national policies and strategies. Therefore, a separate AIDS Programme Effort Survey will be conducted in selected countries to assess the effective-ness of national policies and strategies.

- A. Strategic plan
- B. Prevention
- C. Human rights
- D. Care and support

A number of specific policy indicators have been identified for each of these policy areas (see list on page 22). A separate index is calculated for each policy area by adding up the scores (yes = 1, no = 0) for the relevant specific policy indicators and calculating the overall percentage score. The composite index is calculated by taking the average of the scores for the four components.

Where appropriate, the score for a specific policy indicator should be assessed with reference to the standards and criteria provided (see Appendix 3 of UNGASS).

Source: *UNGASS 2002*

Spending on HIV/AIDS programs

Definition

The amount of money allocated in national accounts for spending on HIV prevention and care programmes.

Measurement tool

Special study (UNAIDS/UNFPA/NIDI survey on financial resource flows)

Rationale/What it measures

This indicator allows monitoring of the flow of national funding for HIV/AIDS as a measure of national government's economic commitment to fight HIV/AIDS

How to measure it

Survey of national government expenditure on HIV/AIDS programmes. The costs of any multilateral or bilateral international donor-funded government programmes should be excluded. Similarly, all local NGO programmes should be excluded, except for programmes (or parts of programmes) that are

Interpretation/Strengths and limitations

This indicator is a measure of economic commitment to enhancing the national response to HIV/AIDS. It is not intended to be used as a measure of resource availability.

In larger and more decentralized countries, national expenditures at lower levels may not be captured fully in a centrally-administered survey so the total amount of national expenditure on combating HIV/AIDS may be underreported

Percentage of large enterprises/companies that have HIV/AIDS workplace policies and programmes

funded by the national government.

Definition

Allocated national funds comprise expenditure on the

following four categories of programme, totals for each of which should be specified separately:

Percentage of transnational companies that are present in developing countries and that have HIV/AIDS

workplace policies and programmes.

1. STD control activities

2. HIV prevention

3. HIV/AIDS clinical care and treatment

4. HIV/AIDS impact mitigation

Measurement post

Numerator

Number of employers with HIV/AIDS policies and regulations that meet all of the above criteria.

Denominator

Source: *Adapted from UNGASS 2002*

Percent of the general population with accepting attitudes toward PLWHA

Desk review and key informant interviews.

Number of employers surveyed.

Rationale/What it measures

To assess progress in implementing workplace policies and programmes to combat HIV/AIDS in transnational companies.

Copies of written personnel policies and regulations should be obtained and assessed wherever possible.

How to measure it

Companies are asked to state whether they currently implement personnel policies and procedures that cover, as a minimum, all of the following aspects:

1. Prevention of stigmatization and discrimination on the basis of HIV infection status in: (a) staff recruitment and promotion; and (b) employment, sickness and termination benefits.
2. Workplace-based HIV/AIDS prevention, control and care programmes that cover: (a) the basic facts on HIV/AIDS; (b) specific work-related HIV transmission hazards and safeguards; (c) condom promotion; (d) voluntary counselling and testing (VCT); (e) sexually transmitted infection (STI) diagnosis and treatment; and (f) provision of HIV/AIDS-related drugs.

Source: *UNGASS 2004*

Definition

The percent of people expressing accepting attitudes towards people with HIV, of all people surveyed aged 15-49.

Measurement tool

UNAIDS general population survey; DHS/AIS; BSS (adult and youth).

Rationale/What it measures

This is an indicator based on answers to a series of hypothetical questions about men and women with HIV. It reflects what people are prepared to say they feel or would do when confronted with various situations involving people living with HIV.

How to measure it

Respondents in a general population survey are asked a series of questions about people with HIV, as follows:

- If a member of your family became sick with the AIDS virus, would you be willing to care for him or her in your household?
- If you knew that a shopkeeper or food seller had the AIDS virus, would you buy fresh vegetables from them?
- If a female teacher has the AIDS virus but is not sick, should she be allowed to continue teaching in school?
- If a member of your family became infected with the AIDS virus, would you want it to remain a secret?

Only a respondent who reports an accepting or supportive attitude on all four of these questions enters the numerator. The denominator is all people surveyed who have heard of HIV/AIDS.

Numerator

Number of women and men who report an accepting attitude on all four of these questions.

Denominator

Number of all women and men aged 15-49 surveyed who have heard of HIV/AIDS.

Interpretation/Strengths and limitations

Methodologically, this is a relatively easy way to construct an indicator of attitudes to people with HIV. A low score on the indicator is a fairly sound indication of high levels of stigma, and for that reason alone it is worth measuring.

There are, however, difficulties in interpreting indicators based on hypothetical questions, and a high score on the indicator is harder to understand. It could mean there is little real stigma attached to HIV. Or it could mean that people know they should not discriminate, and therefore report accepting attitudes. This may not change their behaviour, which may continue to be discriminatory towards people with HIV. Changes in the indicator could therefore reflect a reduction in stigma or simply a growing awareness that it is not nice to own up to one's prejudices. That in itself may, however, constitute the first step in program success. High scores may also reflect the respondent's limited personal experience with someone who is HIV-infected.

This indicator is similar to an earlier measure developed by WHO, but questions have been changed following field testing to better reflect situations in which people with HIV actually suffer from stigma. Field tests revealed that responses are greatly affected by the exact wording of the indicator. When the gender of the teacher was not specified, for example, one country registered very high levels of "discriminatory" attitudes on that question, for example. Further investigation showed that the negative attitudes were related to recent news reports of male teachers infecting female pupils with HIV.

On-going pilot testing of indicators of stigma and discrimination have identified two additional domains, shame and blame, that should be addressed by future versions of this indicator. Questions and indicators to address shame and blame are currently being pilot tested. These findings should be considered in future updates to this indicator.

Source: UNAIDS, 2000

Adaptations to this indicator are currently being pilot tested by the USAID Stigma and Discrimination Working Group.

Percent of health care facilities that protect against discrimination (e.g., HIV tests with informed consent, persons living with HIV/AIDS not segregated, etc.)

Definition

The percent of health care facilities that protect against discrimination against PLWHA and those seeking HIV tests.

Measurement Tool

Health facility survey.

Rationale/What it measures

This indicator measures the policies and practices of health care facilities that reflect the level of discrimination and stigmatisation felt by PLWHA and those seeking HIV tests in seeking care.

How to measure it

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

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

- Care for persons living with HIV/AIDS is not denied or delayed, or they are not referred elsewhere for services available within the facility.
- Care for patients awaiting HIV tests results is not denied or delayed, or they are not referred elsewhere for services available within the facility.
- Persons living with HIV/AIDS are not segregated or isolated.
- Care for persons living with HIV/AIDS is of the same quality as the care provided to other patients
- Confidentiality of HIV status is respected.

Data should be disaggregated by type and level of facility (e.g., hospital and clinic).

Interpretation/Strengths and limitations:

This indicator is newly developed and has yet to be thoroughly tested in diverse settings. It is anticipated that health facilities at different levels of the health care system will have different policies and procedures in providing care to those who are HIV infected, and to those seeking HIV testing.

In some settings this indicator will reflect the level of training of staff in providing HIV/AIDS related care, and in that sense this indicator will overlap with the indicator "Health facilities with the capacity to deliver appropriate care to HIV-infected patients" presented previously. In other countries where care for patients infected with HIV is highly segregated this indicator will only measure the *de facto* policy and not the facility-level practice of discrimination.

Further development and refinement of this indicator is expected.

Source: Adapted from: Expanded Response Guide to Core Indicators for Monitoring and Reporting on HIV/AIDS Programs. (USAID, 2002)

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