September 2013

Operational Guidelines for Monitoring and Evaluation of HIV Programmes for Sex Workers, Men who have Sex with Men, and Transgender People

VOLUME II FOR SERVICE DELIVERY PROVIDERS

Table of Contents

List of Tables

List of Figures

List of Boxes

Acknowledgements

This document represents the result of a large individual and multiple agency collaboration. Organizations include WHO, UNFPA, UNODC, UNDP, UNAIDS Secretariat, Global Fund, ICASO, USAID, CDC, PEPFAR, DFID. Individuals include civil society representatives, colleagues working in the field, and consultants. Current and former members of the working group include: Sharon Weir (co-chair, University of North Carolina); Keith Sabin (co-chair, WHO); Abu Abdul-Quader (CDC); Maria Au (USAID); Ludo Bok (UNDP), Jenny Butler (UNFPA); Alison Crocket (UNAIDS Secretariat); ThuVan Dinh (USAID), Sandra Kuzmanovska (Global Fund); Silvio Martinelli (Global Fund); Kevin O'Reilly (WHO); Marleen van der Ree (UNFPA); Miriam Sabin (UNAIDS); Otilia Scutelniciuc (Government of Moldova); Mary Ann Torres (ICASO); Igor Toskin (WHO); and Cheikh Traore (UNDP);. Consultants and UNC graduate students providing assistance include Matt Avery, Zulfiya Chariyeva, Laili Irani, Andrew Kerkoff, Jill Lebov, Virginia Loo, Leigh Ann Miller, William Miller, Greet Peersman and Tobi Saidel. People in Jamaica who contributed to piloting the guidelines include Peter Figueroa (University of the West Indies) and Sharlene Jarrett (Ministry of Health). We also want to thank Antonio Gerbase (WHO) and Annette Verster (WHO) for their ongoing advice and comments and Deborah Rugg for sparking this effort in 2009 as a task force reporting to the Monitoring and Evaluation Reference Group.

List of Acronyms

AIDS	acquired immunodeficiency syndrome
ART	antiretroviral therapy
BSS	behavioural surveillance system
CDC	United States Centres for Disease Control and Prevention
DFID	UK Department for International Development
FHI	FHI 360
GFATM	The Global Fund to Fight AIDS, Tuberculosis and Malaria
HIV	human immunodeficiency virus
IBBS	integrated biological and behavioural survey
M&E	monitoring and evaluation
MIS	management information system
NGO	nongovernmental organization
OI	opportunistic infections
PLACE	Priorities for Local AIDS Control Efforts
PPA	Priority Prevention Areas
PLHIV	people living with HIV
QA/QI	quality assurance and quality improvement
RDS	respondent-driven sampling
STI	sexually transmitted infection
TB	tuberculosis
TOR	terms of reference
UIC	unique identification code
UNAIDS	Joint United Nations Programme on HIV
UNDP	United Nations Development Programme
UNFPA	United Nations Population Fund
UNGASS	United Nations General Assembly Special Session
UNODC	United Nations Office on Drugs and Crime
UNICEF	United Nations Children's Fund
USAID	United States Agency for International Development
WHO	World Health Organization

A. How to Use These Guidelines: Quick Use Guide

Welcome to the second volume of the Guidelines! If you want to read about the core concepts of monitoring and evaluation, keep reading. If you already have a background in monitoring and evaluation, you may want to start with the Quick Use Guide below.

This volume is for service delivery providers and contains:

- **An Introduction to the *Guidelines* including core concepts**
- **Guidance for Each Step in the 8 Step Model**
- **An appendix of tools referenced throughout the *Guidelines*.**

Find the first volume at http://www.cpc.unc.edu/measure/publications/ms-11-49a. It covers monitoring and evaluation of programmes for key populations at the National and Sub-National Levels.

Quick Use Guide

Background Information and Core Concepts are Described in the First Section

Tools for Planning

If the focus is one of the following topics:	**And the objectives is to:**	**See Annexes/Tools:**
Setting priorities	• Identify gaps in information and indicators	Tool A
Indicators and Target Setting	• Review national indicators and select service delivery indicators	#18, 19
Methods for estimating indicators	• Develop processes and forms to collect data to estimate indicators	#6, 7, 9, 10, 11, 12, 13, 14, 15, 16, 17
Quality of services and engagement with key populations	• Monitor quality and community engagement	#5

Quick Use Guide

Tools for Specific Intervention and Service Delivery Approaches

If you use one of these service delivery approaches:	And implement these interventions or provide one of these services:	See Annexes/Tools:
Empowerment of key populations	• Community level interventions • Community mobilization	#1, 2, 3, 4, 8, 9, 10, 13, 18, 19
Outreach	• Condom distribution • Targeted education and risk reduction counselling • HIV testing and counselling	#1, 2, 3, 4, 5, 7, 8, 9, 10, 11, 12, 13, 14, 15, 16, 18, 19, 20
Clinic based including mobile clinics	• Condom distribution • Targeted education and risk reduction • HIV testing and counselling • HIV treatment, adherence and retention • Treatment for sexually transmitted infection • Psychosocial interventions • Harm reduction services • Anti-stigma and anti-discrimination programmes • Catch-up Hepatitis B Virus immunization • Community-centred services	#1, 2, 3, 4, 5, 6, 7, 8, 9, 10, 11, 12, 14, 15, 16, 17, 18, 19, 20
Drop in centres	• Condom distribution • Targeted education and risk reduction counselling • HIV testing and counselling	#1, 2, 3, 4, 7, 8, 9, 10, 11, 12, 13, 14, 15, 16, 18, 19, 20
Education of general population, health care providers and other groups and advocacy for key populations	• Anti-stigma and anti-discrimination programmes • Improving availability, accessibility and acceptability of services for key populations • Programmes to reduce violence and improve judicial redress • Programmes to improve policies that affect key populations	#1, 2, 3, 4, 5, 8, 9, 13, 18, 19
Web and mobile phone based approaches	• Targeted education and risk reduction counselling	#1, 3, 4, 5, 8, 9, 10, 13, 18, 19

B. Purpose: We Need to Strengthen Monitoring & Evaluation of Programmes!

Sex workers, men who have sex with men, and transgender people are populations at higher risk for HIV infection. HIV and AIDS are having a disproportionate impact on these populations, including in countries with generalized epidemics.

Further information on why we need to improve monitoring and evaluation of HIV programmes:

The purpose of these Guidelines is to provide operational guidance for service delivery providers to strengthen monitoring and evaluation (M&E) of HIV programmes for:

- Sex workers
- Men who have sex with men
- Transgender people

Box 1 Key population definitions

Sex workers include "female, male and transgender adults and young people (18 years of age and above) who receive money or goods in exchange for sexual services, either regularly or occasionally"(UNAIDS, 2012). Sex work is consensual sex between adults, which takes many forms, and varies between and within countries and communities. Sex work may vary in the degree to which it is formal or organized.

Men who have sex with men is an inclusive public health construct used to define the sexual behaviours of males who have sex with other males, regardless of the motivation for engaging in sex or identification with any or no particular "community". The words "man" and "sex" are interpreted differently in diverse cultures and societies, as well as by the individuals involved. As a result, the term men who have sex with men covers a large variety of settings and contexts in which male-to-male sex takes place. Perhaps the most important distinction to make is one between men who share a non-heterosexual identity (i.e. gay, homosexual, bisexual or other culture-specific concepts that equate with attraction to other men) and men who view themselves as heterosexual but who engage in sex with other males for various reasons (e.g. isolation, economic compensation, sexual desire, gender scripts) (WHO, UNDP, UNAIDS, MSMGF, 2011).

Transgender is an umbrella term for persons whose gender identity and expression does not conform to the norms and expectations traditionally associated with the sex assigned to them at birth. Transgender people may self-identify as transgender, female, male, transwoman or transman, trans-sexual, hijra, kathoey, waria or one of many other transgender identities, and may express their genders in a variety of masculine, feminine and/or androgynous ways (WHO, UNDP, UNAIDS, MSMGF, 2011).

Remember! The ultimate aim of these guidelines is to increase the ability of sex workers, men who have sex with men and transgender people to prevent HIV infection, achieve full health, and realize their human rights.

The specific objectives of the guidelines are to:

- Support monitoring and evaluation systems that are responsive to local HIV epidemics among sex workers, men who have sex with men, and transgender people;
- Function as an advocacy tool to lobby for the inclusion of monitoring and evaluation of HIV programmes for sex workers, men who have sex with men and transgender people in existing M&E systems;
- Provide guidance for monitoring and evaluation of prevention programmes at three levels: the national, sub-national, and service delivery level;
- Recommend indicators for monitoring and evaluating HIV prevention programmes at the national, sub-national and service delivery level;
- Describe methods to estimate indicators and generic forms to collect indicator data;
- Include methods that facilitate meaningful involvement of men who have sex with men, sex workers, and transgender people in monitoring and evaluation of HIV programmes;
- Incorporate experience-based and qualitative evidence as monitoring and evaluation data sources;
- Encourage timely sharing of data between national/sub-national and service delivery levels;
- Promote the use of programme impact pathways using input-output-coverage models;
- Facilitate use of the guideline with simple checklists, decision trees, and examples;
- Provide methods than can be used to identify and prioritize questions for operations and effectiveness research; and
- Provide links to relevant tools and resources.

Further information on the purpose of the *Guidelines*:

C. How do Programmes Prevent HIV Transmission?

The causal pathway below illustrates how a combination prevention programme reduces HIV transmission among key populations. An effective combination prevention programme will ultimately reduce the risk of HIV transmission and lead to fewer new infections.

Figure 1 Causal Pathway from Programmes to Prevention

Effective HIV prevention programmes for key populations must ultimately reduce exposure to HIV. Exposure to HIV refers to the amount of HIV that a person comes into contact with either through sex or sharing needles. For example, reducing the HIV viral load in a person who is infected reduces infectiousness, thereby reducing partners' HIV exposure.

The main strategies for reducing the risk of HIV transmission are to:

- reduce the number of unprotected sex acts, particularly between HIV-discordant partners
- increase the use of water-based lubricants during sex
- increase the effective treatment of sexually transmitted infections
- reduce viral load among those infected via appropriate anti-retroviral treatment
- reduce the use of non-sterile injecting equipment.

In order to evaluate whether a programme has been successful in preventing new infections among key populations, we need to monitor exposure to HIV through outcome indicators such as condom use, sexually transmitted infections, and proportion of people who receive appropriate anti-retroviral treatment.

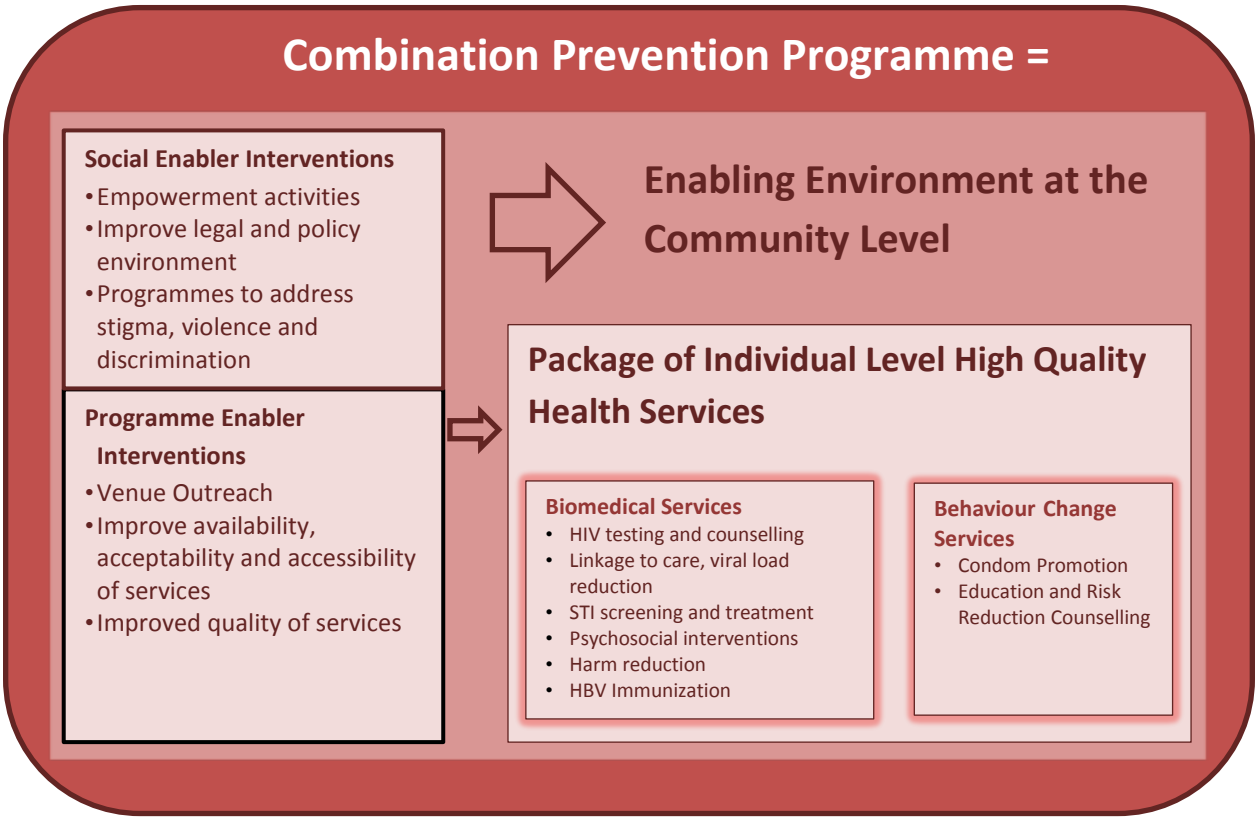
A description of the combination prevention programme is in the next section.

D. What is the Recommended National Combination Prevention Programme for Key Populations in Your Country? What Services and Interventions Do You Provide?

The recommended response for key populations is a combination HIV prevention programme. A combination HIV prevention programme seeks to achieve maximum impact on HIV transmission by strategies that are human rights-based, evidence-informed, and community-led. Programmes are tailored to local needs and conditions; focus resources on programmatic and policy actions to address both immediate risks and underlying vulnerability; and, are thoughtfully planned and managed to operate synergistically and consistently on multiple levels (i.e., individual, relationship, community and society). Combination prevention mobilizes the local community, the private sector, government and global resources in a collective undertaking (UNAIDS, 2008). The proposed Combination Prevention Programmes for sex workers, men who have sex with men and transgender individuals may change as more evidence accumulates.

A combination prevention strategy includes interventions to improve the social environment (*social enablers*) and improve the quality of programmes (*programme enablers*) as well as basic health services including clinic-based and outreach-based services (See Figure 2 and Boxes 2-5). The term "critical enablers" includes social and programme enablers and addresses factors often referred to as contributing factors or underlying determinants.

Figure 2 Combination Prevention Programme



Box 2 Recommended National Combination Prevention Programme for Sex Workers

Recommended Combination Prevention Programme for Sex Workers

The following 9 social and programme enabler interventions should be implemented based on community consultation and engagement, to achieve community-centred interventions:

- Sustained community mobilization and engagement with local sex workers to raise awareness about sex worker rights
- Safe spaces such as drop-in centres
- Venue-based delivery of services
- Collective networks and self-help groups for sex workers
- Advocacy for sex workers including advocacy to increase political commitment
- Enabling legal and policy environments in the context of HIV and sex work
- Community-centred promotion and support for programmes addressing stigma, discrimination, and violence towards sex workers
- Programmes and efforts to reduce violence through strategies that provide redressal and (judicial) services, including sex worker-led approaches
- Activities to increase the availability, accessibility and acceptability of health services for sex workers based on the principles of avoidance of stigma, non-discrimination and the right to health.

The following 8 services should be available, accessible and affordable to all sex workers:

- Targeted condom and condom-compatible lubricants promotion and distribution to increase correct and consistent condom use
- Targeted education and HIV risk reduction counselling through outreach and peer education
- STI diagnosis and treatment based on WHO guidelines for treatment of symptomatic STIs among sex workers
    - periodic screening for asymptomatic STIs to female sex workers; and
    - periodic presumptive treatment (only in high prevalence settings as a temporary measure, maximum of six months).
- Voluntary HIV testing and counselling linked to care and treatment for sex workers
- Treatment of sex workers living with HIV based on current WHO recommendations on the use of antiretroviral therapy for the general population
- Programmes to ensure adherence and retention among sex workers
- Harm reduction programmes based on the current WHO recommendations on harm reduction for sex workers who inject drugs
- Programmes to include sex workers in catch-up HBV immunization strategies in settings where infant immunization has not reached full coverage.

Adapted from: WHO, UNFPA, UNAIDS Secretariat, NSWP (2012). Prevention and treatment of HIV and other sexually transmitted infections for sex workers in low- and middle-income countries

Box 3 Recommended National Combination Prevention Programme for Men Who Have Sex with Men

The following 5 social and programme enabler interventions should be implemented based on community consultation and engagement, to achieve community-centred interventions:

- Individual-level and community level interventions including:
  - empowerment activities
  - outreach
  - small group sessions and
  - leadership activities.
- Venue-based outreach strategies to decrease risky sexual behaviour and increase uptake of HIV testing and counselling among men having sex with men
- Promote and support enabling legal and policy environments in the context of HIV and men having sex with men
- Promote and support programmes addressing stigma, discrimination, and violence towards men having sex with men
- Health services made available, accessible & acceptable to men having sex with men based on the principles of avoidance of stigma, non-discrimination and the right to health.

The following 9 services should be available, accessible & affordable to all men who have sex with men:

- Targeted condom and condom-compatible lubricants promotion and distribution to increase correct and consistent condom use during anal intercourse
- Targeted education and risk-reduction counselling through outreach and peer education
- STI prevention and treatment based on WHO guidelines for treatment of symptomatic STIs among men who have sex with men
  - periodic testing for asymptomatic urethral and rectal N. gonorrhoeae and C. trachomatis infections using NAAT and
  - periodic serological testing for asymptomatic syphilis infection.
- Community-based HIV testing and counselling linked to care and treatment
- Treatment of men who have sex with men living with HIV based on current WHO recommendations on the use of antiretroviral therapy for the general population
- Programmes to ensure adherence and retention among men who have sex with men
- Evidence-based brief psychosocial interventions involving assessment, specific feedback and advice made available to men having sex with men with harmful alcohol or other substance abuse.
- Harm reduction programmes based on the current WHO recommendations on harm reduction for men who have sex with men who inject drugs.
- Programmes to include men having sex with men in catch-up HBV immunization strategies in settings where infant immunization has not reached full coverage.

Adapted from: WHO, UNDP, UNAIDS Secretariat, MSMGF (2011). Prevention and treatment of HIV and other sexually transmitted infections among men who have sex with men and transgender people

Box 4 Recommended National Combination Prevention Programme for Transgender People

The following 5 social and programme enabler interventions should be implemented based on community consultation and engagement, to achieve community-centred interventions:

- Individual-level and community level interventions including:
  - empowerment activities
  - outreach
  - small group sessions and
  - leadership activities.
- Sex venue-based outreach strategies to decrease risky sexual behaviour and increase uptake of HIV testing and counselling among transgender people
- Promote and support enabling legal and policy environments in the context of HIV and transgender people
- Promote and support programmes addressing stigma, discrimination, and violence towards transgender people
- Health services made available, accessible and acceptable to transgender people based on the principles of avoidance of stigma, non-discrimination and the right to health.

The following 10 services should be available, accessible and affordable to all transgender people:

- Targeted condom and condom-compatible lubricants promotion and distribution to increase correct and consistent condom use during intercourse
- Targeted education and risk-reduction counselling through outreach and peer education
- STI prevention and treatment based on WHO guidelines for treatment of symptomatic STIs among transgender people
  - periodic testing for asymptomatic urethral and rectal N. gonorrhoeae and C. trachomatis infections using NAAT and
  - periodic serological testing for asymptomatic syphilis infection.
- Community-based HIV testing and counselling linked to care and treatment
- Treatment of transgender people living with HIV based on current WHO recommendations on the use of antiretroviral therapy for the general population
- Programmes to ensure adherence and retention among transgender people
- Evidence-based brief psychosocial interventions involving assessment, specific feedback and advice made available to transgender people with harmful alcohol or other substance abuse.
- Harm reduction programmes based on the current WHO recommendations on harm reduction for transgender people who inject drugs
- Promote and support programmes enabling transgender people who inject substances for gender enhancement to use sterile injecting equipment and practise safe injecting behaviours to reduce the risk of infection with bloodborne pathogens such as HIV, hepatitis B and hepatitis C
- Programmes to include transgender people in catch-up HBV immunization strategies in settings where infant immunization has not reached full coverage.

Adapted from: WHO, UNDP, UNAIDS Secretariat, MSMGF (2011). Prevention and treatment of HIV and other sexually transmitted infections among men who have sex with men and transgender people

Monitoring social and programme enable interventions is a new area for monitoring and evaluation. The types of social and programme enabler interventions you could monitor in your catchment area include social enabler interventions and programme enabler interventions.

What has been missing? Many service delivery providers have been addressing social and programme enablers but have not monitored their activities. Now is the time!

"Social enabler" interventions that address the environment such as:

- restrictive laws and policies
- stigma and discrimination
- poverty
- illiteracy
- lack of social support
- violence
- political instability
- co-morbid conditions that affect vulnerability (i.e. mental illnesses)
- lack of knowledge about methods to prevent infection.

"Programme enabler" interventions that address service quality such as:

- the lack of involvement of men who have sex with men, transgender people, and sex workers in programme planning and implementation
- poor attitudes among service delivery providers
- poor quality of services such as long waits to see providers
- lack of knowledge among providers.

Box 5 Examples of Critical Enabler Interventions for Service Delivery Providers

Note: See Tool 1, pg. 94 for illustrative activities and indicators for each social and programme enabler.

Critical enabler interventions	Rationale	Responsibility
Social Enablers		
Stigma reduction	Reduction in discrimination against people living with HIV and key populations at higher risk; enables uptake of HIV prevention and treatment services	Key populations and people living with HIV, local community leaders, activist and religious leaders; employers and workers' organizations, HIV caregivers, relevant government agencies – health, interior, criminal justice, prison administration

Critical enabler interventions	Rationale	Responsibility
Community mobilisation	Enables the mobilization and organization of groups such as sex workers and other key populations at higher risk, as their participation in HIV prevention services is essential	Community leaders, activists, local government and networks of people living with HIV, key populations at higher risk
Local responses to change the risk environment	Enable positive changes at the local level by addressing norms, values, culture and religious beliefs that negatively influence risk behaviour, such as through community conversations	Traditional leaders, local decision-makers, religious leaders and caregivers
Programme Enablers		
Community-centred design and delivery	Enables community participation and ensures the sustainability of prevention and treatment programmes	Community leaders, activists, employers and workers organizations, local government and networks of people living with HIV and key populations at higher risk
Health education	Develops healthy attitude and skills so learners and youth reduce their HIV risk; helps reduce stigma and discrimination of key populations at higher risk and people living with HIV	Ministry of education, schools, teachers, teachers, training institutions, private and public schools, formal and non-formal education providers such as religious schools, community-run schools and civil society
Gender equality and gender-based violence interventions	Enables promotion of safer sex negotiation and behaviour by transforming harmful gender norms and empowerment of women and transgender people, including key populations at higher risk such as sex workers	Community leaders, women, men, microfinance institutions, schools, police, sex workers, media

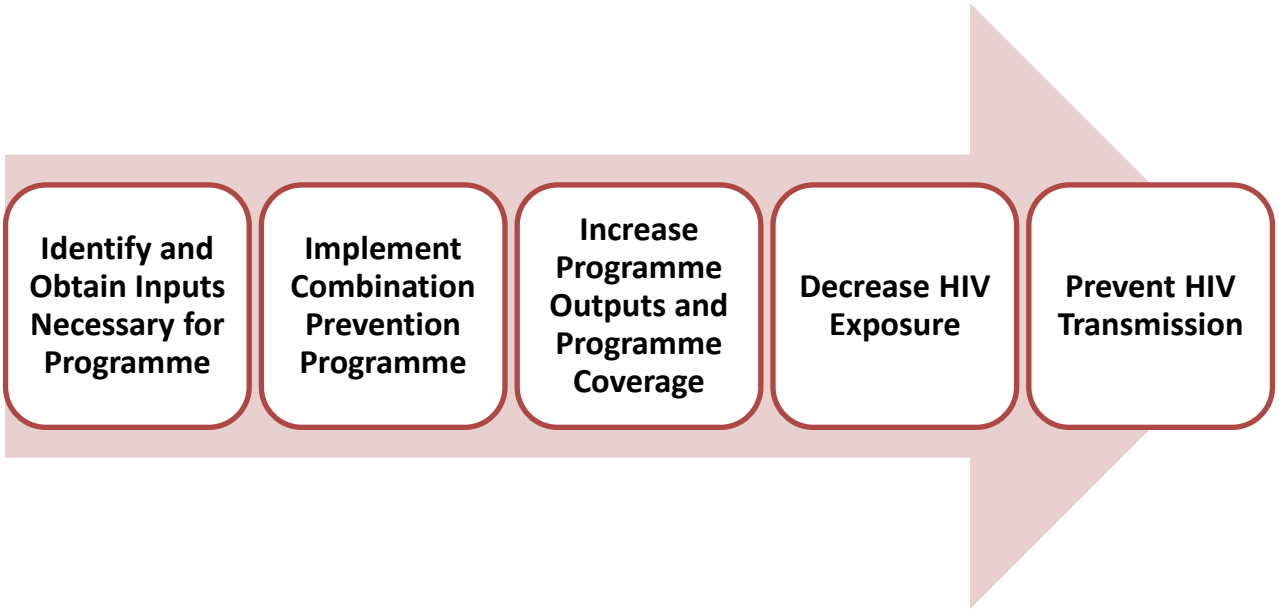
Adapted from: UNDP/UNAIDS (2012). Understanding and acting on critical enablers and development synergies for strategic investments.

E. Using a Programme Impact Pathway to Monitor a Combination Prevention Programme

A simple programme impact pathway is illustrated below. We can benefit from documenting the programme impact pathway based on the services we provide. The pathway illustrates the key activities in monitoring and evaluation:

- Input monitoring
- Service availability mapping
- Output monitoring
- Programme coverage
- Outcome monitoring of HIV exposure
- Impact monitoring of HIV infection.

Figure 3 Simple Programme Impact Pathway



Each type of monitoring and evaluation – input monitoring, output monitoring, outcome monitoring and impact monitoring – relies on quantitative indicators of programme progress. These can be supplemented with qualitative assessments. Indicator standards developed by UNAIDS (see UNAIDS Indicator Standards, 2010) include:

Standard 1. The indicator is needed and useful
Standard 2. The indicator has technical merit
Standard 3. The indicator is fully defined
Standard 4. The indicator is feasible to collect and analyse data
Standard 5. The indicators have been field tested or used in practice.
Standard 6: The indicator set is coherent and balanced overall

Useful indicators should indicate whether a service or intervention has been implemented, who has been reached, whether the service or intervention works, or where it needs to be improved. Input and output indicators are exact numbers such as numbers of condoms distributed or number of people tested and rely on routinely collected data or data from special studies. We need to verify input and output indicators though data quality audits (DQA's). See Data Quality Audit Tool (DQA): Guidelines for Implementation (Measure Evaluation, 2008).

Coverage, outcome and impact indicators such as coverage rate (based on size estimation as the denominator), percentage of consistent condom use, or HIV prevalence are usually estimated at the national or sub-national level from surveys or special studies.

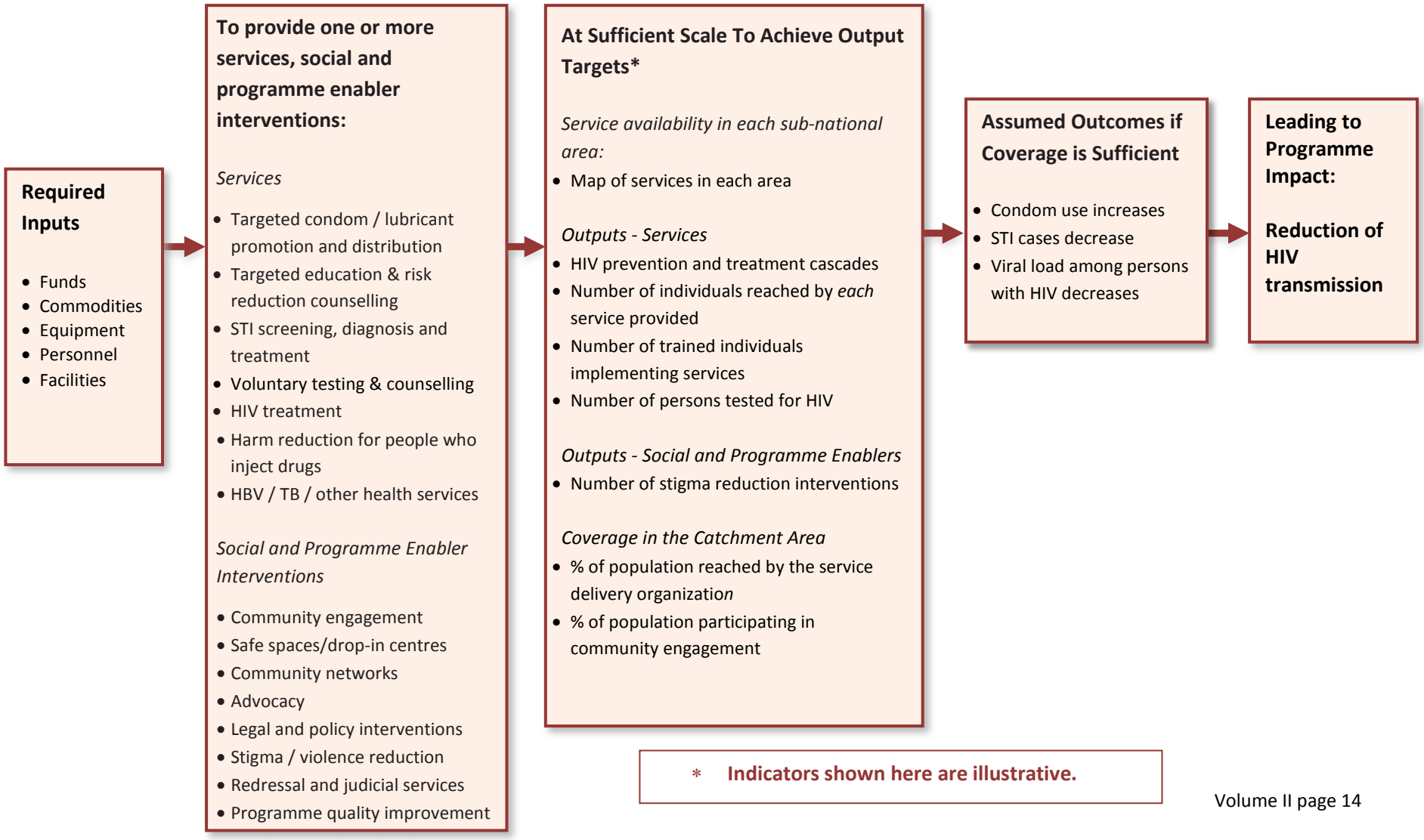
Input, output, coverage, outcome and impact indicators comprise an indicator set which measures different elements of a programme. It may be best to start with a few indicators which provide key information about the programme. Once the basics are in place, additional indicators may be added, if needed, and as resources and capacity permit. See Step 3 (pg. 41) for more information on target-setting and Step 6 (pg. 71) for defining output indicators.

Figure 4 provides a more detailed overview of the programme impact pathway for a combination HIV prevention strategy. Indicators are included for each part of the pathway. All programme impact pathways reveal the logical sequence from programme inputs to outputs to outcomes to impact on HIV incidence. Reduction in HIV transmission is always the ultimate objective. Sometimes this cannot be achieved without addressing the most important social and programme factors.

Each service delivery organization should have a written programme impact pathway. A service delivery pathway should include the entire pathway from inputs to impact in order to show the logic of its work. The pathway should identify which parts of the full pathway are addressed by the organization and which indicators it will measure. Service delivery organizations are not expected to monitor outcome or impact indicators. If capacity exists, however, the service delivery organization would benefit from monitoring 1-2 outcome indicators such as condom use or STI cases.

Figure 4 More Detailed Programme Impact Pathway for Key Populations

If the required inputs are available and a combination prevention programme of services, social and programme enabler interventions delivered at sufficient scale to achieve output and coverage targets, then outcome indicators will show a decrease in the biological determinants of HIV transmission, and fewer people will become infected.



F. 8 Step Public Health Questions Model of Monitoring and Evaluation

The 8 step public health questions model inform the programme impact pathway. The 8 steps follow a "Plan, Monitor, Evaluate" approach. The objectives for planning, monitoring and evaluation are listed below, adapted for key populations.

Steps 1-3: Plan: "What should we be doing in our catchment area to reduce HIV transmission among men who have sex with men, sex workers and transgender people?

Specific objectives are to:

- Describe **HIV prevalence** among sex workers, men who have sex with men, and transgender people within your catchment area
- Estimate the **number** of persons in each key population in your catchment area
- Estimate **baseline indicators** for increased risk of HIV infection
- Identify **social and programme enablers** that impede or support the implementation of high quality, accessible and acceptable community-led programmes
- Adapt as appropriate the recommended **combination prevention programme** for each population (See Boxes 2-4, pg. 7-9)
- Document implementation of **services, social and programme enabler interventions**
- Create a **programme impact pathway** that reflects the recommended national programme
- Set quality, output and coverage **targets** based on the programme impact pathway

Steps 4-6: Monitor: "What activities are we implementing? Are we doing them right?"

Specific objectives are to:

- Conduct **input and output monitoring** to assess whether programme inputs are adequate to meet output targets and whether output targets were achieved
- Assess the **quality** of services that are provided
- Calculate **coverage estimates** to assess the extent to which key populations are reached with services specified in the national recommended package of servicesConduct **process monitoring and evaluation**: use the programme impact pathway, HIV prevention and treatment cascades, service availability maps and "Plan-Do-Check-Act" cycles to identify where to improve programmes

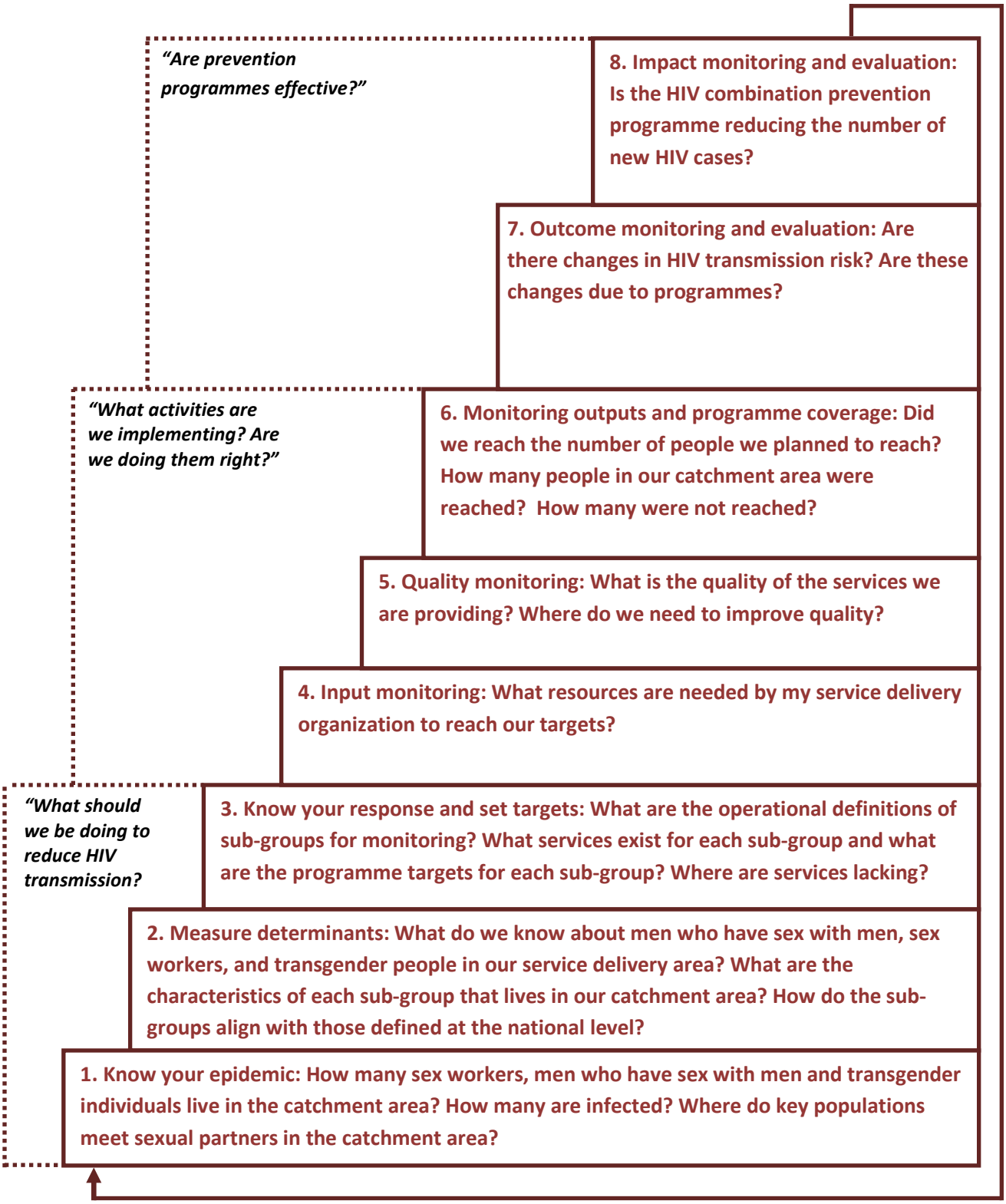
Steps 7-8: Evaluate: "Are programmes effective?"

Note: Service delivery providers often do not have the resources to conduct impact evaluations.

Specific objectives are to:

- Determine whether the **risk of HIV infection** has decreased among key populations
- Determine whether the social and programme enabler interventions have **improved the environment**
- Assess whether decreases in risk are due to the programme
- Synthesize findings in recommendations useful for **planning changes**

Figure 5 Public health questions model applied to the HIV epidemic among men who have sex with men, sex workers and clients, and transgender people



TOOL A. Checklist of monitoring and evaluation products covered in each of the 8 steps

Tool A is a programme assessment form that can be used to identify M&E priorities organized according to the 8 steps. Tool A is designed to help users visualize their progress in regard to the key M&E products. This tool can also help users prioritize methods or data to be collected as it may be daunting to consider collecting all recommended data. The tool is organized based on the 8 Step Public Health Question Model (Section F, pg. 15) but the order can be modified based on institutional or national priorities.

The following describes the different columns that make up Tool A:

- Products: data collection products necessary for monitoring and evaluation of HIV programmes
- Availability: depends not only whether it exists for the geographic area of interest, but how recently it was created. Data lose relevance and become out-dated as time passes. If a particular product is more than three years old, consider revising or recollecting necessary data.
- Priority Level for M&E: based on these Guidelines' assessment regarding the importance of each product for monitoring and evaluation of HIV programmes
- Ranking: Use this column to rank the most important products based on your knowledge of the epidemic and your response. Some products should be requested from the sub-national or national level as specified in this column.

Users may find it helpful to post Tool A in a visible location and update it as necessary; it can serve as an overarching guide through the monitoring and evaluation process.

TOOL A. Checklist to set priorities for monitoring and evaluation of programmes for key populations

Country:				
Key Population:				
Name of Service Delivery Organization:				
Name of Person Preparing Checklist:				
	M&E Products **Products requested should not be completed by the service delivery organization.**	**Available (past 3 years)**	**Priority Level for M&E at the Service Delivery Level**	**Rank Your Top 5 Priorities**
	Step 1 Know Your Epidemic:			
1	Summary of evidence regarding HIV prevalence	Y N	✓✓	Request
2	Catchment area target population size	Y N	✓✓	

	M&E Products Products requested should not be completed by the service delivery organization.	Available (past 3 years)	Priority Level for M&E at the Service Delivery Level	Rank Your Top 5 Priorities
3	Maps of target populations	Y N	✓✓	
	Step 2 Measure Determinants:			
4	Programme data on condom use, STI prevalence and viral load, if available at service delivery organization	Y N	✓✓	
5	Data from national/sub-national survey of key population providing baseline estimates of behaviours, use of health services, and perceived barriers to health	Y N	✓✓✓	Request
6	Community consultation assessment covering characteristics of the population, sub-groups, social and programme enablers, issues of access, stigma, violence, policies, human rights, barriers to enabling environment, and community strengths	Y N	✓✓✓	
	Step 3 Know your Response and Set Targets:			
7	Description of services and interventions offered by service delivery organization based on national combination prevention programme	Y N	✓✓✓	
8	Definition of a person reached with a service and the criteria for adequate implementation of each social and programme enabler intervention			
9	Definitions of sub-groups	Y N	✓✓✓	
10	Map of services provided in catchment area and targets for service delivery organization	Y N	✓✓	
12	Worksheet of Indicators and targets	Y N	✓✓	

	M&E Products Products requested should not be completed by the service delivery organization.	Available (past 3 years)	Priority Level for M&E at the Service Delivery Level	Rank Your Top 5 Priorities
	Step 4 Input monitoring:			
13	Documentation monitoring inputs	Y N	✓✓	
14	Gap analysis	Y N	✓	
	Step 5 Quality monitoring:			
15	Periodic assessment of service quality	Y N	✓✓✓	
	Step 6 Monitoring Outputs and Programme Coverage:			
16	Indicator reference sheet for each indicator	Y N	✓✓	Request
17	Identified strategy to avoid double-counting	Y N	✓✓	
18	Output trends report	Y N	✓✓	
19	Service availability trend report and map	Y N	✓✓	
20	Enabling environment checklist: trends	Y N	✓✓	
21	Coverage trends report*	Y N	✓✓	
22	HIV prevention and treatment cascades/other process evaluation	Y N	✓✓✓	

*If capacity exists

G. Coordination Among National, Sub-National and Service Delivery Levels

The objectives of monitoring and evaluation at the national, sub-national and service delivery levels are described below:

- National level: To review the epidemiology of the HIV epidemic among sex workers, men who have sex with men, and transgender people; identify the sub-national areas of the country where prevention programmes are most needed; monitor the inputs, outputs and outcomes of programmes in these areas that provide services to men who have sex with men; identify the programmes that decrease transmission risk; and work strategically with partners to implement effective interventions at sufficient scale to reduce HIV transmission among sex workers, men who have sex with men, and transgender people in a manner that respects human rights;

- Sub-national level: To review the local epidemiology of the HIV epidemic among men who have sex with men, sex workers, and transgender people; monitor programme inputs, service quality, outputs, service coverage, and programme outcomes among sex workers, men who have sex with men, and transgender people in the area; and

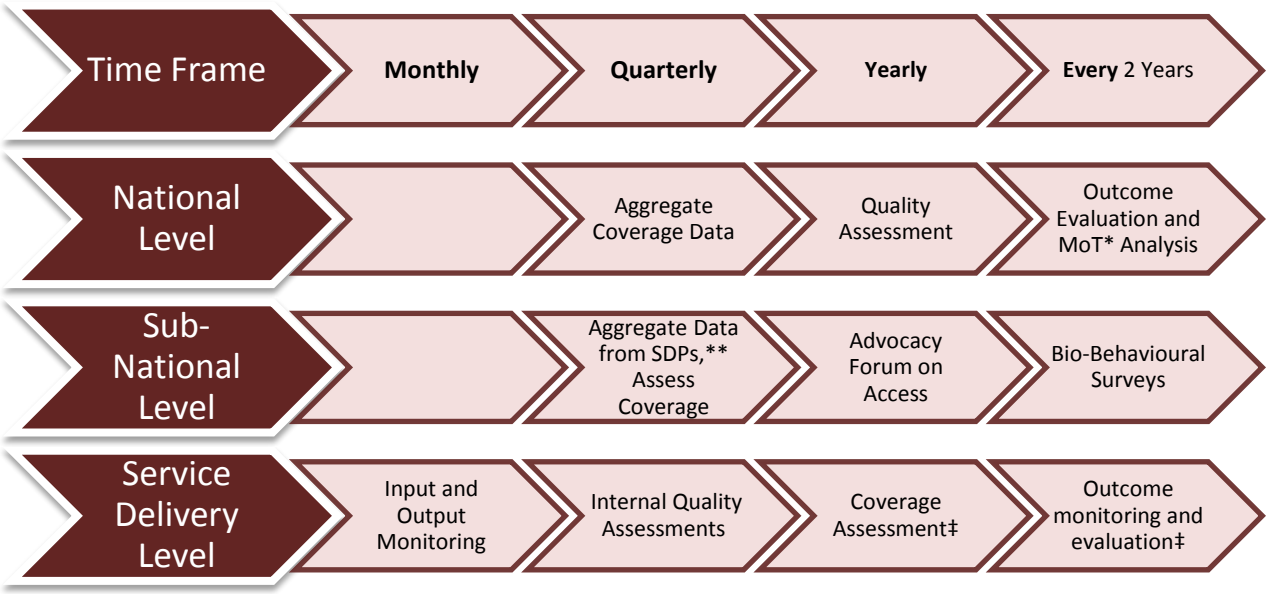
- Service delivery provider level: To monitor programme inputs at the service delivery level, monitor the quality of services, monitor service delivery outputs, and, where feasible, to monitor changes in behavioural, environmental, and disease outcomes among persons in the catchment area of the service delivery provider.

Monitoring and evaluation of combination prevention can function successfully only if it is well-coordinated among national, sub-national and service delivery levels. We need information from the national and sub-national levels about the course of the epidemic, results of special surveys and surveillance studies. National and sub-national levels need information about reach and quality of the services offered so that they can ensure a comprehensive and coordinated response.

We should be all familiar with the monitoring and evaluation system in the country where they are working and work closely with it in our efforts. Coordinating data collection, compilation of data, aggregation of service delivery statistics and ensuring that the data are used for decision making is challenging. The M&E cycle is dynamic and complex and requires ongoing communication among national, sub-national and service delivery levels.

Figure 8 illustrates one possible timeframe for the M&E cycle. The cycle should be coordinated to match decision making periods in the country planning cycle.

Figure 6 Proposed timeframe for conducting M&E activities at each level



* Modes of transmission
**Service delivery provider
‡ If capacity exists

H. Ensuring Ethical Conduct, Engagement, Mobilization As a Core

Ethical conduct and regard for the welfare of those involved in M&E activities and those affected by their results are of utmost importance. M&E must provide useful information while ensuring that data collection and use does not worsen discrimination and stigma. Sex workers, men who have sex with men and transgender people are already socially vulnerable and often marginalized for their behaviours. Data collection efforts that bring attention to these populations may place them at additional risk.

All people should be respected and treated as autonomous individuals who can and should freely make decisions regarding their participation in M&E activities. Those directing M&E efforts should maximize the benefits and minimize any potential harm from these activities. Individuals involved in planning or implementing M&E activities have ethical and legal obligations to protect the privacy of their participants. They must clearly explain to participants how they will protect and use private information. In this context, privacy refers to the control of information about an individual by that individual; and the right to control information about one's self is an aspect of autonomy.

Some common procedures that ensure that these principles are achieved when conducting outcome/impact evaluations and research include informed consent, safeguards of private information and protection of human subjects review by an institution authorized to do so, such as an institutional review board (IRB). Informed consent and human subject protections are measures to ensure that the

rights, welfare, and wellbeing of human subjects involved in **research** are documented and protected. In some cases, M&E activities may require a formal protection of human subjects review when data collection activities are classified as human subject research by qualified institutions. However, these formal documentations are generally not necessary in routine programming unless it is deemed necessary by the IRB.

However, proper procedures must be used to ensure the confidentiality and protection of private information in all programmes, regardless of whether research is being conducted. These may include conducting interviews in private spaces, using identification numbers rather than names to refer to individuals and storing private or individually identifiable information in a secure environment. These *Guidelines* recommend the use of a unique identifier code (UIC) for each individual accessing a service. This guarantees that data cannot be linked directly to a specific person and allows for better tracking of service utilization.

For key references to these guidelines:

Congratulations!

You have made it through the overview of the guidelines. Turn the page to begin the real work of step-by-step monitoring and evaluation.

See you there!

Step by Step Guidance For Service Delivery Providers:

For Monitoring and Evaluation Of HIV Programmes For Sex Workers, Men who Have Sex with Men and Transgender People

Overview of M&E at the Service Delivery Level

Planning: What strategic information do we need to plan programmes that reduce HIV transmission in our catchment area among the populations we serve?

Step 1. Know Your Epidemic:

- How many sex workers, men who have sex with men and transgender individuals live in the catchment area? How many are infected? Where can they be reached?

Step 2. Measure Determinants:

- What do we know about the social and economic situation of men who have sex with men, sex workers, and transgender people in our service delivery area?
- What are the characteristics of each population that lives in our catchment area?
- What information is available about unprotected sex and barriers to health care among each population we want to reach?
- What community and institutional factors could be changed to increase access to services or otherwise reduce transmission?

Step 3. Know your Response and Set Targets:

- What are the operational definitions of sub-groups for monitoring? How do the sub-groups align with those defined at the national level?
- What services exist for each sub-group and what are the programme targets for each sub-group?
- Based on the populations' needs, where are services lacking?
- What social and programme enabler interventions exist to make the environment more conducive to HIV programmes?
- What are the indicators and targets set at the national and sub-national levels?

Data Use Products from Steps 1-3:

- Summary of evidence regarding HIV prevalence
- Catchment area target population size
- Maps of target populations
- Programme data on condom use, STI prevalence and viral load, if available at service delivery organization
- Data from national/sub-national survey of key populations
- Community consultation assessment
- Description of services and interventions offered by service delivery organization
- Definitions of sub-groups
-
- Map of services provided in catchment area and targets for service delivery organization
- Worksheet of Indicators and targets

Overview of Volume II: M&E at the Service Delivery Level continued.

Monitoring the response: What services and interventions are we providing?

Step 4. Input Monitoring:

- What resources are needed by my service delivery organization to reach our targets?
- Do we have sufficient funding, trained personnel and other resources to implement our programmes and reach our targets?

Step 5. Quality Monitoring:

- What is the quality of the services we are providing? Where do we need to improve quality?

Step 6. Monitoring Outputs and Programme Coverage:

- Did we reach the number of people we planned to reach?
- How many people in our catchment area were reached? How many were not reached?

Data Use Products from Steps 4-6

- Documentation monitoring inputs
- Gap analysis
- Periodic assessment of service quality
- Indicator reference sheet for each indicator
- Identified strategy to avoid double-counting
- Output trends report
- Service availability trend report and map
- Enabling environment checklist: trends
- Coverage trends report*
- HIV prevention and treatment cascades/other process evaluation

If capacity exists- Evaluating effectiveness: Are our programmes effective?

Step 7. Outcome monitoring and evaluation:

- Are there changes in HIV transmission risk? Are these changes due to programmes?

Step 8. Impact monitoring and evaluation:

- Is the HIV combination prevention programme reducing the number of new HIV cases among men who have sex with men, sex workers, and transgender people?

* If capacity exists

Step 1. How many sex workers, men who have sex with men and transgender individuals live in the catchment area? How many are infected? Where do key populations meet sexual partners in the catchment area?

A. Rationale - Why this Step is Important

In this step, a local investigation of the size, scope and geographic distribution of the HIV epidemic among sex workers, men who have sex with men, and transgender people is undertaken as the first step in formulating a local response.

Welcome to Step 1. Here is where we try to understand the epidemic so our plans and interventions make sense.

Note: "Local area" refers to the "catchment area" of the service delivery provider.

B. Step 1 Flowchart and Checklist (Figure II.1.1)

The key questions for this step are presented in the flowchart.

1.1 What is the prevalence of HIV infection among sex workers, men who have sex with men, and transgender people are infected with HIV?

↓

1.2 What is the size of each of these populations in the catchment area?

Checklist: Information needed for Step 1

- ☐ Reports from bio-behavioural surveys conducted in the area
- ☐ National/sub national or local HIV/AIDS Action and M&E Plans (where available)
- ☐ Programme records and clinic records if relevant
- ☐ Any maps showing where to reach key populations and where services are provided
- ☐ List of stakeholder groups and knowledgeable persons

C. How to Answer the Key Questions and Use Data: Overview for Step 1

	Key Questions	Methods	Products	Used To
1.1	**What is the prevalence of HIV infection among sex workers, men who have sex with men, and transgender people are infected with HIV in the catchment area?**	1. Request surveillance reports from national and sub-national levels 2. Convene a meeting of knowledgeable stakeholders and service delivery providers.	Summary of Prevalence data	Inform programme efforts
1.2	**What is the size of the population of sex workers, men who have sex with men, and transgender people in the catchment area?**	1. Estimates based on Programmatic mapping 2 Estimates based on service delivery data	Size estimates Map	Set local targets in Step 3 Estimate coverage in Step 6

D. Methods and Tools

1.1 What is the prevalence of HIV infection among sex workers, men who have sex with men, and transgender people are infected with HIV in the catchment area?

1.1.1 Request information from the sub-national and national AIDS control programmes about HIV prevalence among sex workers, men who have sex with men, and transgender people

Information is often available at the national or sub-national level that is useful at the local level. Request the following information:

- Information from the national and sub-national level on HIV prevalence estimates in the country, the sub-national area and in the local area if available
- Information on HIV prevalence for men who have sex with men and transgender people younger than 25 and age 25 and older
- Information on adolescent key populations including commercial sexual exploitation of adolescents under 18
- Copies of all reports about HIV infection among sex workers, men who have sex with men, and transgender people
- Information about effective HIV prevention programmes
- Information about national HIV prevention targets for key populations

- Information about the size of men who have sex with men, sex workers and transgender populations in the sub-national area
- Important information gaps

Websites of relevant international organizations (e.g., UNAIDS, UNDP, UNFPA, WHO) are another good source of information for HIV infection among sex workers, men who have sex with men, and transgender people in the country.

1.1.2 Convene a meeting of knowledgeable stakeholders

Convening a meeting to share information is useful for community engagement. Sometimes there is fear and misunderstanding in the community about the proportion of people in the community who are likely to be infected.

Questions to address during the meeting are:

- What information is available on the number of persons tested for HIV in each population in the past year and the number that were infected? What other service delivery information is available that can be used to assess the prevalence of infection?
- To what extent are sub-national and national reports relevant for the local area?
- What proportion of each population has never been tested?

Data Use

- Prevalence data provide a key indicator about the epidemic and the need for prevention and treatment services.
- Prevalence data can be used to evaluate the effectiveness of a prevention programme (see Step 8)

1.2 What is the size of the population of sex workers, men who have sex with men, and transgender people in the catchment area?

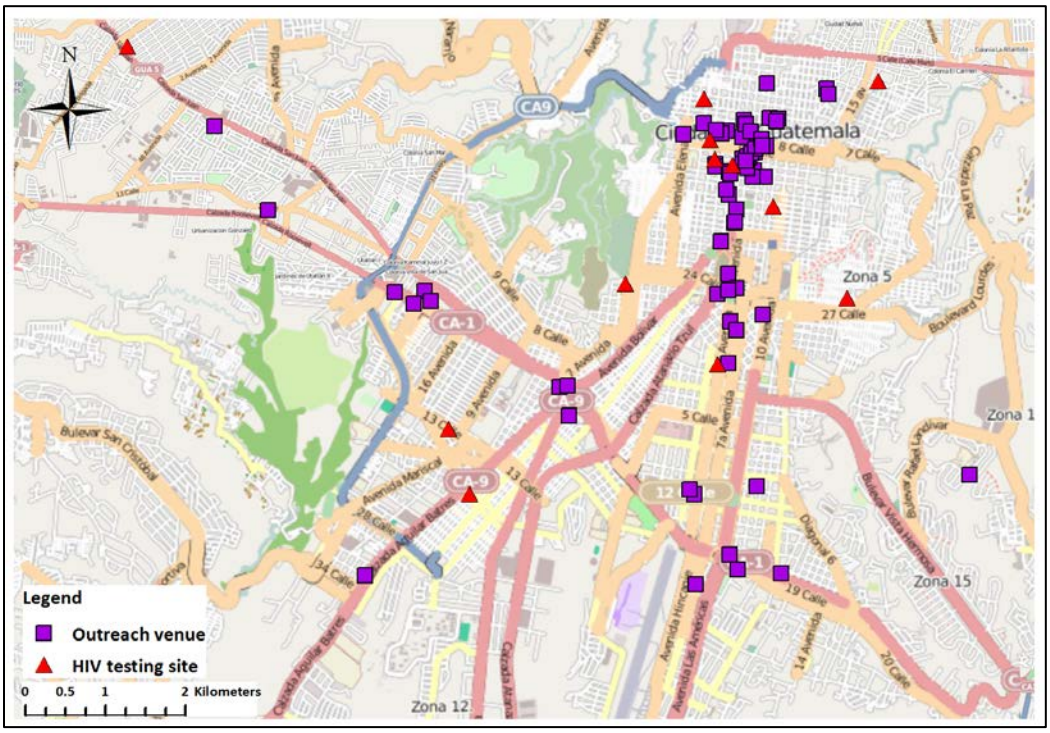
1.2.1 Estimates based on service delivery data

Size estimation based on service delivery data is usually not possible because service delivery providers often know the number of people they reach but do not know the number of people they do not reach. If a provider conducts a large outreach activity and keeps track of how many persons reached in the activity report being reached previously, it may be feasible to get a rough estimate of the size of the population. For example if a provider has reached 1000 sex workers prior to the outreach event and one third of the people who attended the outreach event reported that they had been reached previously, then the rough estimate of the number of sex workers would be three times 1000 or 3000.

1.2.2 Size estimates based on programmatic mapping

Programmatic mapping can be used at the local level to estimate the size of each population.

Figure II.1.2 Illustrative map showing outreach venues where men who have sex with men can be reached and can receive HIV testing in Guatemala City



Note: Points have been jittered to conceal the true location.
Courtesy of Tephinet Inc. and the HIV Unit, Centre for Health Studies, Del Valle University of Guatemala (2011)

Here is one strategy for creating local maps that can be used for size estimation:

- Ask 50-100 local people where sex workers, men who have sex with men, and transgender people can be reached. Ask for venues and websites and events. Ask people who are likely to know how to reach the population such as street vendors, youth, taxi drivers.
- Visit and map all places named. Visit websites and estimate the number of people profiled on the site who are linked to the catchment area.
- For each venue and event, ask knowledgeable persons at the venue how many sex workers, men who have sex with men and transgender people go to the venue or event at a busy time.
- Add up the number of persons reported at each place. Increase the estimate if information on the proportion of the population who do not visit the events or venues is known. Decrease the estimate if there is information about double counting the same people at different places.
- If possible, map the locations of each place on hand-drawn maps or use global positioning equipment and digital maps or photos. Geographic data from global positioning system (GPS) units can be displayed on free Google Earth images. Free software for reading GPS data onto images is available. These maps can be used to assess coverage. See Step 6, pg. 71.

Box II.1.1 Be Careful with Maps!

- Key populations can be made more vulnerable if the mapping exercises are not managed with appropriate controls.
- Extreme caution must be used in developing maps so that they do not unintentionally harm anyone or undermine the confidentiality of the people being served or those providing services.
- Maps can draw unwanted attention to vulnerable populations. In addition, when combined with other data, location can be a unique identifier of individuals

Data Use

- Size estimates and maps are essential for programme planning, estimating burden of disease, geographic prioritization of response, assessing coverage and evaluating effectiveness.
- Maps can describe the context of an epidemic and communicate information to people visually.

E. Summary

This step helped you to produce:

- ❑ Summary of evidence regarding HIV prevalence
- ❑ Catchment area target population size
- ❑ Maps of target populations

Further guidance on conducting size estimates can be found here.

- UNAIDS, WHO (2009) Estimation of the size of high risk groups and HIV prevalence in high risk groups in concentrated epidemics. Geneva, UNAIDS. http://www.epidem.org/Publications/Amsterdam%20Report_July%202009.pdf
- WHO, UNAIDS (2013). Guidelines for Second Generation HIV Surveillance: an update: know your epidemic. Geneva, WHO. http://www.who.int/hiv/pub/guidelines/surveillance_update/en/index.html
- UNAIDS, WHO (2010). Guidelines on Estimating the Size of Populations Most at Risk to HIV. http://www.who.int/hiv/pub/surveillance/estimating_populations_HIV_risk/en/index.html

Further information and guidance on mapping can be found here.

- MEASURE Monitoring and Evaluation Systems. http://www.cpc.unc.edu/measure/tools/monitoring-evaluation-systems/geographic-information-systems
- An Overview of Spatial Data Protocols for HIV/AIDS Activities: Why and How to Include the "Where" in Your Data. http://www.cpc.unc.edu/measure/publications/MS-11-41A
- Priorities for Local AIDS Prevention Programmes (PLACE), MEASURE Evaluation. http://www.cpc.unc.edu/measure/news/the-place-method-for-m-e-of-hiv-prevention-programmes
- PLACE Mapping and Size Estimation Module, MEASURE Evaluation. https://www.cpc.unc.edu/measure/publications/WP-11-126/at_download/document
- National Research Council (2007). Putting People on the Map: Protecting Confidentiality with Linked Social-Spatial Data. Panel on Confidentiality Issues Arising from the Integration of Remotely Sensed and Self-Identifying Data, M.P. Gutman and P.C. Stern, Eds. Washington, D.C.: The National Academies Press. http://www.nap.edu/catalog.php?record_id=11865
- VanWey, et al (2005). Confidentiality and spatially explicit data: Concerns and challenges. PNAS October 25, 2005 vol. 102 no. 43 15337-15342. http://www.pnas.org/content/102/43/15337.fll
- Guidelines on Protecting the Confidentiality and Security of HIV Information: Proceedings from a Workshop 15-17 May 2006, Geneva, Switzerland INTERIM GUIDELINES 15 May2007. http://data.unaids.org/pub/manual/2007/confidentiality_security_interim_guidelines_15may2007_en.pdf

Step 2. Measure determinants: What do we know about men who have sex with men, sex workers, and transgender people in our service delivery area? What are the characteristics of each sub-group that lives in our catchment area? How do the sub-groups align with those defined at the national level?

A. Rationale - Why this Step is Important

If you don't know how people get infected, it is tough to prevent more infections.

Why do people become infected with HIV? There are two kinds of drivers of the HIV epidemic: direct biologic determinants and indirect environmental and structural factors.

- Biologic determinants are factors directly related to biologic exposure to HIV (such as number of sexual partners) and factors related to the chance of transmitting the infection to someone else (such as whether a condom is used).

- The specific underlying environmental, social, structural and programmatic factors that affect whether a person is exposed or susceptible to HIV vary from area to area. Community engagement is essential for understanding underlying factors. Factors that weaken the environment can result in ineffective services. Social and programme enabler interventions address these factors.

The objective of Step 2 is to provide guidance for monitoring both types of determinants.

B. Step 2 Flowchart and Checklist (Figure II.2.1)

2.1 Biologic: What is the extent of multiple sexual partnerships, unprotected sex, and co-factor sexually transmitted infection among men who have sex with men, sex workers and transgender people?

2.2 Environmental: What are other individual, community and structural factors contributing to the epidemic?

Checklist: Information needed for Step 2

- ☐ Bio-behavioural survey reports for the national and sub-national levels
- ☐ Programme data
- ☐ Results from focus groups, in-depth interviews
- ☐ Summary of policy review
- ☐ National strategic plan

C. How to Answer the Key Questions and Use Data: Overview for Step 2

	Key Questions	Methods	Products	Used To
2.1	**Biologic Determinants: What is the extent of multiple sexual partnerships, unprotected sex, and co-factor sexually transmitted infection among men who have sex with men, sex workers and transgender people?**	1. Request sub-national level information and indicators 2. Use programme data if available	Synthesis of survey data and other sub-national data Synthesis of programme data	Develop programme strategies
2.2	**Environmental Determinants: What are other individual, community and structural factors contributing to the epidemic?**	• Community meetings • Focus Groups • Qualitative Studies • Analysis of Service Delivery Data	List of barriers to effective programmes and List of community strengths	-Set targets -Prioritize barriers to address -Monitor progress

D. Methods and Tools

2.1 Biologic Determinants: What is the extent of multiple sexual partnerships, unprotected sex, and co-factor sexually transmitted infection among men who have sex with men, sex workers and transgender people?

2.1.1 Request national and sub-national STI surveillance indicators, behavioural indicators and reports

Compile information from national and sub-national reports and from service delivery data if available on biologic indicators of risk of acquiring HIV and risk of transmitting HIV including:

- number of sexual partners
- extent to which partnerships are overlapping
- extent to which long term partner are sero-discordant (one is infected with HIV and the other is not)
- median age at first sex
- use of male or female condoms during vaginal and anal sex
- use of condom-compatible lubricants during anal sex
- prevalence of other sexually transmitted infections
- among people who use drugs, the extent to sterile needles are used

Surveillance and behavioural data are usually obtained through targeted surveys of men who have sex with men, sex workers and transgender people. Service providers usually do not conduct large targeted surveys, but they can request reports and conduct small scale surveys during special outreach events. They should also request that sub-national surveys are regularly conducted to obtain trend data.

2.1.2 Analyse service delivery data

Service providers routinely collect basic information from their users (see Tool 6, pg. 108 and Tool 7, pg.115). Some also have the capacity to collect more detailed information from every user at each visit including information about specific behaviours (see Tool 6, Assessment C, pg.108) and/or to gather additional information through a periodic brief survey of their users.

In the rapidly changing world of technology, service delivery providers may choose to collect data via computers, handheld computers, mobile phones or tablets. Collection of encounter form data directly into a digital database increases the availability and timeliness of service delivery data. An online server allows an organization to follow participants at multiple locations and access data from anywhere in the world. A local server allows an organization to gather information from multiple computers at the same site. Information collected from participants and entered directly into a computer eliminates the need for separate data entry or aggregation and reduces error due to illegible handwriting or missing forms. This kind of digital data collection is sometimes called eHealth for electronic health, mHealth for mobile health or electronic medical record (EMR). Software for digital data collection include open source, free platforms and expensive EMR systems. Examples of free software include Open Data Kit (ODK), Epi Info (CDC) and openXdata.

Analysis of service delivery data does not only help manage services (see Step 5, pg. 61) but also to identify sub-populations at higher risk of HIV.

Data Use

- Survey or programme data on condom use, multiple partnerships and sexually transmitted infections helps service delivery organizations focus services and interventions on specific factors that put key populations at increased risk of HIV infection
- Survey or programme data can be used to set targets for outcome indicators (See Step 3 and Step 7)

2.2 Environmental Determinants: What are other individual, community and structural factors contributing to the epidemic?

2.2 Conduct law and policy reviews, use qualitative and quantitative methods

Convening a local forum for people from a variety of disciplines, perspectives and experiences to discuss the size and characteristics of the local population of sex workers, men who have sex with men, and transgender people can be very useful. It can identify people who can help in the effort to prevention

HIV transmission. Information from the forum can be used to plan mapping venues where sex workers, men who have sex with men, and transgender people can be reached (see below).
Questions to address during the forum are:

- What information is available that sheds light on the number of sex workers, men who have sex with men, and transgender people in the area?
- What is the evidence that there is an HIV epidemic among sex workers, men who have sex with men, and transgender people in the local area?
- What information is available from community based organizations? From health care providers? Others?

Box II.2.1 Focus on Adolescents

Provision of services to adolescents (youth, age 13-19) must be adapted based on their lack of experience in negotiating use of services and, in some instances, legal barriers to use. Adolescents at higher risk may not come to static service delivery points, and services may need to be specifically targeted for them and provided on an outreach or mobile basis (where health services, information and commodities are taken to them). Thus, the essential package of targeted HIV prevention interventions for key populations should be adolescent friendly and accessible for all adolescents from key population whatever their age, legal or socio-economic status. In addition, policymakers and health care providers need to consider whether an adolescent has the capacity to consent, or 'competence' to provide consent, to medical interventions and treatment, and whether others should be involved in decision making on their behalf.

Service delivery providers may want to identify social enablers such as political commitment and advocacy, laws, legal policies, practices, community mobilisation, stigma reduction, mass media and local responses to change the risk environment. The lack of social and programme enablers can be seen as barriers to HIV prevention and can be at the community level and at the individual level. Some barriers are laws or policies that affect the entire country— for example, cultural stigma against men who have sex with men, sex workers and transgender people. The negative effects of stigma on HIV prevention efforts with these populations probably cannot be over-estimated. Stigma can affect the uptake of services, self-empowerment, self-efficacy in insisting on condom use, and the likelihood that HIV status will be disclosed. Many barriers, however, are local and include activities by police, lack of training for medical providers on issues related to working with sex workers, men who have sex with men, and transgender people and whether HIV prevention services for these populations are available and accessible. Information on barriers and strengths can be obtained using various methods including:

- Focus group discussions
- Individual in-depth interviews (structured or unstructured)
- Participant observations
- Short surveys and questionnaires

- Law and policy reviews (e.g. on criminalization of sex work or homosexuals)
- Legal redress report

Some questions that may be helpful in identifying contributing factors (i.e. social and programme enablers) that affect HIV transmission among sex workers, men who have sex with men and transgender people include:

Social enablers

- What national laws and policies restrict the rights of sex workers, men who have sex with men, and transgender people?
- What is the culture and context of sex work? of sex and relationships between men?
- What is the stance of religious leaders regarding sex between men and gay marriage?
- For men, how does having male partners in secret or non-disclosure of sexual preferences influence likelihood of condom use?
- Where do sex workers solicit? What are the main strategies used to recruit clients? What proportion of sex workers are male?
- What is the pathway into sex work? What is the pathway out of sex work?
- What characterizes the relationship between sex workers and the police?
- Are there national or local groups of sex workers, men who have sex with men, or transgender people that advocate for those populations? Who are these advocacy groups and where are they located? What are the objectives of these groups? Is HIV prevention one of their objectives?
- How common are violence, discrimination and human rights violations against sex workers, men who have sex with men, and transgender people? Have there been recent assessments of stigma or violence against these populations?
- Do sex workers, men who have sex with men, and transgender people meet new sexual partners online, in public venues such as bars, clubs, parks, malls, saunas, public toilets, train stations, and/or at private parties? What is the socialisation environment like for men who have sex with men? Is it covert? Is bisexuality culturally acceptable?
- What is the perception of risk among sex workers, men who have sex with men, and transgender people for HIV and STI?

Programme enablers

- Who are the main providers of services to sex workers, men who have sex with men, and transgender people? Who are the advocates? How is the community organized?
- Sex workers, men who have sex with men, and transgender people may resist “advice” from health educators. What are the characteristics of messages that work?
- Which international donors are involved in providing services? What are the most important restrictions if any in the provision of donor funded services?

Individual factors

- Which factors increase the vulnerability of people in each of key populations to health problems including sexually transmitted infection and drug dependence?

- What are the characteristics of sex workers, men who have sex with men, and transgender people who appear to be most at risk for acquiring or transmitting HIV? In which sub-national areas are they located? What is their age and educational level? What are the underlying causes of their increased risk?
- What are the sub-groups of sex workers, men who have sex with men, and transgender people? What issues are important to each sub-group? Which health issues are important? What prevention strategies are required for each sub-group? Which sub-groups should be monitored separately?
- To what extent are transgender people engaged in sex work?
- How does the individual's mental health influence his risk behaviour?

A report on judicial redress is another way to measure and monitor social enablers. Individuals who are discriminated against or experience violence due to their sexual orientation have the right and obligation to report offences to the corresponding law enforcement or human rights agency. To monitor the frequency and in Step 3, the response to claims made, a report for the national and sub-national areas should be maintained and tracked over time.

A checklist may be used to record key information about contributing factors (Box II.2.2) and to document each of the social and programme enablers in detail.

Box II.2.2 Checklist. Structural, community and individual factors that contribute to HIV transmission risk among sex workers

Possible structural, community and individual factors that contribute to HIV transmission risk among sex workers *	Barrier	Strength
Structural Level Social Enablers		
• Laws and policies targeting sex workers, clients and their behaviour	☐	☐
• Economic systems depriving people of meaningful employment opportunities	☐	☐
• Stigma and discrimination	☐	☐
• Migration/mobility	☐	☐
• Access to housing	☐	☐
• Public health policies and availability of comprehensive HIV services	☐	☐
• Lack of medical education and training for health professionals in health care concerns of sex workers	☐	☐
• Punitive laws, policies & practices	☐	☐
Social and Community Level Social Enablers		
• Social norms, beliefs, and values within communities with regard to sex work	☐	☐
• Availability of community-based outreach, including peer education through networks of sex workers	☐	☐
• Settings, physical environment in which sex is sold	☐	☐
• Community responses, availability of support in cases of violence, etc.	☐	☐
• Sex worker networks & organizations	☐	☐

Individual and Peer Level Factors		
• Lack of awareness about risks of unprotected intercourse and HIV transmission	☐	☐
• Lack of condom use skills	☐	☐
• Lack of safer sex communication skills (e.g. condom use negotiation skills)	☐	☐
• Education level	☐	☐
• Degree of dependence on alcohol and other substances	☐	☐
• Knowledge of HIV serostatus	☐	☐
• Mental health	☐	☐
• Social support and stability of living situation	☐	☐

* Note: Provide explanations and documentation as available.

Data Use

Analysis of contributing factors (i.e. social and programme enablers) may be used to:

- Ensure that programme response is focused on changing the contributing factors
- Monitor trends in contributing factors (See Step 7)

E. Summary

This step helped you to develop:

❑ Programme data on condom use, STI prevalence and viral load, if available at service delivery organization

❑ Data from national/sub-national survey of key population providing baseline estimates of behaviours, use of health services, and perceived barriers to health (request)

❑ Community consultation assessment covering characteristics of the population, sub-groups, social and programme enablers, issues of access, stigma, violence, policies, human rights, barriers to enabling environment, and community strengths

Further guidance on identifying social enablers can be found here.

- UNAIDS (2012). Investing for results. Results for people. http://www.unaids.org/en/media/unaids/contentassets/documents/unaidspublication/2012/JC2359_investing-for-results_en.pdf
- Poundstone KE, Strathdee SA, and Celentano DD (2004). The social epidemiology of Human Immunodeficiency Virus/Acquired Immunodeficiency Syndrome. Epidemiologic Reviews, July 2004; 26(1):22-35. http://epirev.oxfordjournals.org/content/26/1/22.full
- WHO (2004). Rapid Assessment and Response Adaptation Guide on HIV and Men who have Sex with Men. WHO, Geneva. http://www.who.int/hiv/pub/prev_care/en/msmrar.pdf
- Pan American Health Organization (2010). Blueprint for the Provision of Comprehensive Care to Gay Men and Other Men who Sex with Men (MSM) in Latin America and the Caribbean. Pan American Health Organization, Washington, D.C. http://new.paho.org/hq/dmdocuments/2010/Blueprint%20MSM%20Final%20ENGLISH.pdf
- Beardsley K (2013). Policy Analysis and Advocacy Decision Model for HIV-Related Services: Males Who Have Sex with Males, Transgender People, and Sex Workers. Washington, DC: Futures Group, Health Policy Project. http://www.healthpolicyproject.com/index.cfm?id=publications&get=pubID&pubID=79

Step 3. Know Your Response and Set Targets: What are the operational definitions of sub-groups for monitoring? What services exist for each sub-group and what are the programme targets for each sub-group? Where are services lacking?

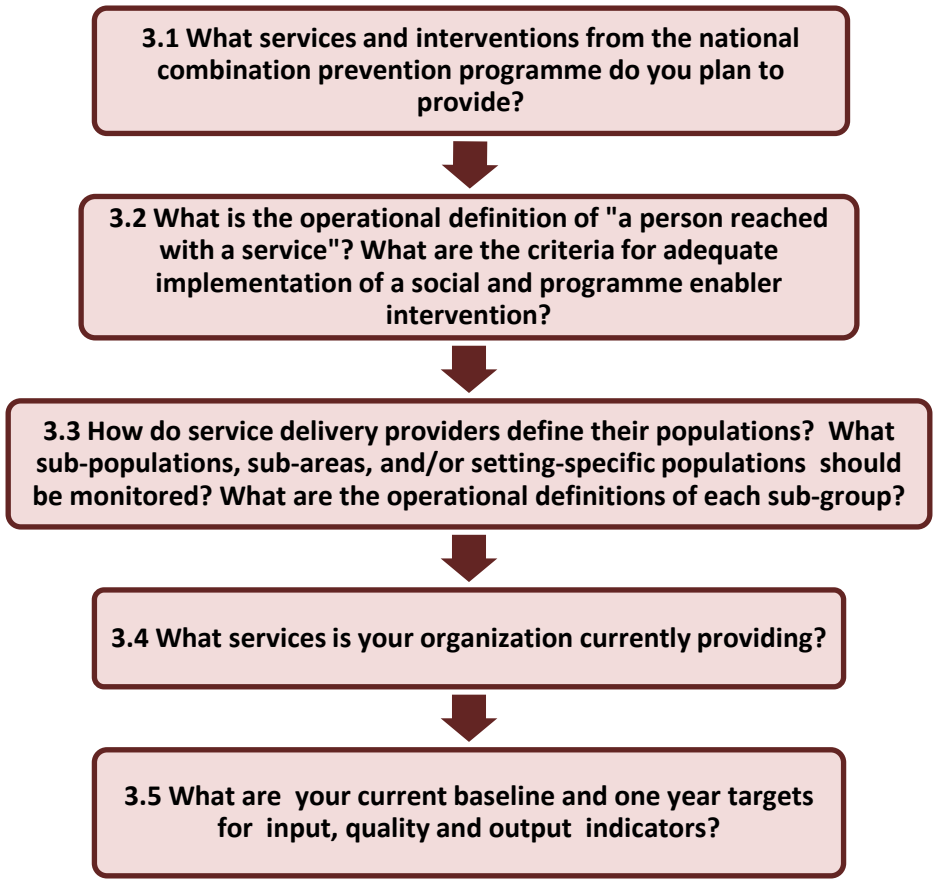
A. Rationale - Why this Step is Important

In this step, service providers put the national strategy into action at the local level by defining local service delivery targets.

The objectives of this step are for each local service delivery provider to:

- Use the national combination prevention programme to guide planning
- Identify local gaps in services
- Determine which services to provide and where
- Specify input, quality and output indicator targets for each service and for the package of services

The programme of recommended services and interventions for sex workers, men who have sex with men, and transgender people was discussed in Section D. What is the Recommended National Combination Prevention Programme for Key Populations in Your Country?, pg. 6.



B. Step 3 Flowchart and Checklist (Figure II.3.1)

See the flowchart above.

Checklist: Information needed for Step 3

- ☐ List of indicators from sub-national and national levels
- ☐ Programme records
- ☐ Clinic/hospital records (where relevant)
- ☐ Bio-behavioural survey reports conducted in the area
- ☐ National/sub national or local HIV/AIDS Action and M&E Plans (where available)

C. How to Answer the Key Questions and Use Data: Overview for Step 3

	Key Question	Methods	Products	Used To
3.1	**What services and interventions from the national combination prevention programme do you plan to provide?**	Response Planning	List of services and interventions from the national combination prevention programme that the service delivery organization plans to provide	Set priorities for a local response
3.2	**What is the operational definition of "a person reached with a service"?** **What are the criteria for adequate implementation of a social and programme enabler intervention?**	Adopt the national definition of "person reached" and intervention implemented	Definition of person reached with a service/ service package Criteria for implementation of interventions	Assess outputs and coverage
3.3	**What important sub-groups need prevention programmes? How do service delivery providers define their target populations? Is the local definition different from the national definition?**	Comparison of national definitions and local practice	An operational definition of the target population used by the service delivery provider and a strategy for reporting indicators using the national definition	Define and aggregate all M&E indicators
3.4	**What services is your organization currently providing? Where?**	Service availability mapping	Map showing availability of services	Monitor service availability and identify gaps
3.5	**What are your current baseline and one year targets for input, quality and output indicators?**	Target setting methods and target setting worksheet	Completed target setting worksheet	Assess programme implementation

D. Methods and Tools

3.1 What services and interventions from the national combination prevention programme do you plan to provide?

3.1 Conduct local response planning

In Step 3 we focus on services, interventions and targets. If we don't meet our targets how can we expect risk of infection and HIV transmission to decrease?

The recommended HIV Combination Prevention Programme of social and programme enabler interventions and health services for sex workers, men who have sex with men and transgender people are presented in Boxes 2, 3 and 4 (pg. 7-9). As not all services will be provided to each user, the national HIV package of services to be provided to each user should be agreed and clearly defined at national level and implemented at local level. This is important for planning of the service delivery but also for monitoring purposes such as data collection and reporting on who should be counted as "reached with entire HIV package of services".

Meetings with the local AIDS Control Programme will shed light on the combination prevention programme of services, social and programme enabler interventions recommended at the national level and the recommended indicators for monitoring these services and interventions. Meetings with other service delivery providers can reveal who else is providing services. Behavioural survey reports, HIV case reports, and other data sources can provide insight into the HIV epidemic. Resources from the Ministry of Health and/or the AIDS Programme can be used help co-ordinate service delivery efforts within catchment areas and identify gaps in services.

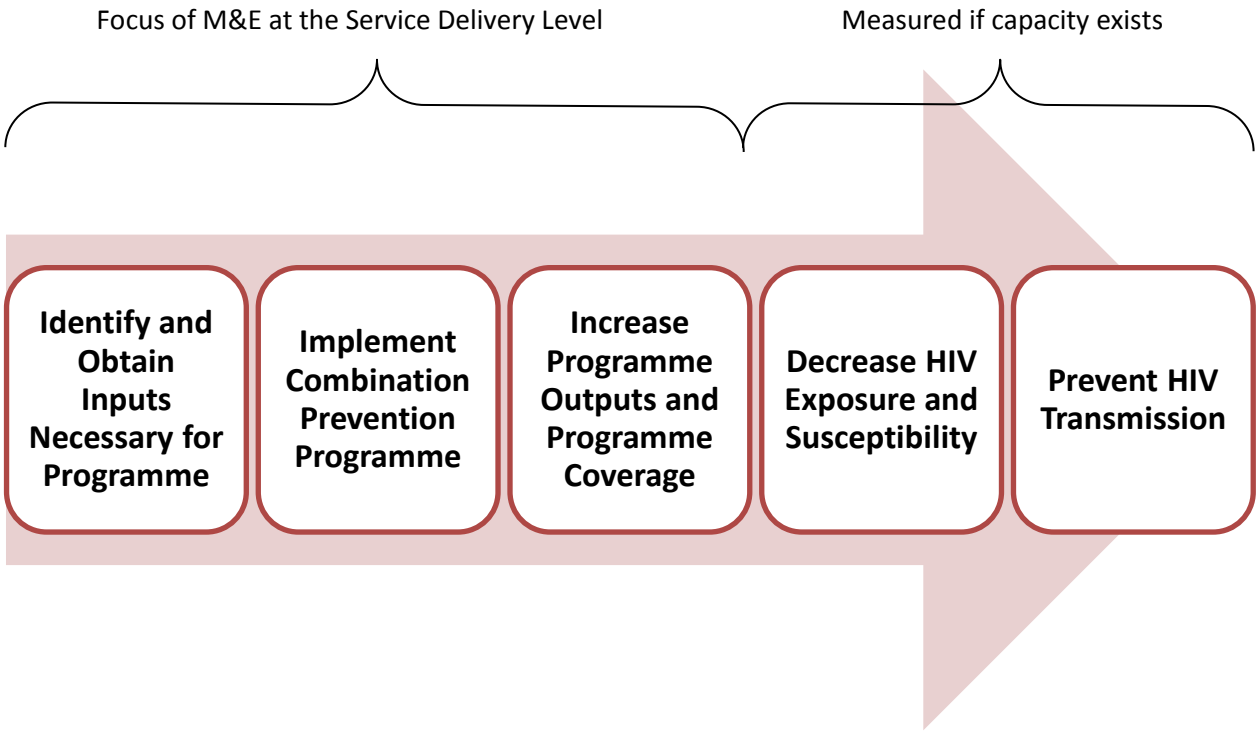
Involving members of the key population in the provision of services is essential to mobilize community support and ensure services are reflecting the needs of the population. Ways of doing this include making connections with gatekeepers to the population, hiring members of the population to provide services or facilitate linkages between the population and service providers, forming a community advisory board to guide service provision and visiting locations where men who have sex with men, and transgender people socialize, and sex workers solicit clients. In-depth interviews and focus group discussions on topics related to the welfare of the population can promote a better understanding of the population and the adequacy of the response in an area. A bibliography of references for these methods is included in Appendix 3.

Each service or intervention that is provided should be well described. The description should include how the service is defined, with what frequency the service should be provided, and what constitutes having received the service. In addition, the logic model for each service and policy/structural intervention should be specified. A logic model is a graphic that illustrates the input-output- coverage-outcome-impact pathway for the service (Figure II.3.2 and Figure II.3.3). It shows how providing the

service or conducting the intervention will prevent HIV transmission. (See Steps 4-6 for a description of process evaluation.)

Figure II.3.2 Casual pathway and a simple logic model

Figure II.3.3 Programme impact pathway



Informing the district/provincial AIDS Control Programme of your service programme goals and objectives may link you to other like-minded service programmes, data collection forms, training and gives a sense of where your programme fits into the local prevention scheme.

Data Use

- The recommended national combination prevention programme is used to prioritize specific services and interventions that your service delivery organization would like to provide for key populations in your catchment area

- The list of services and interventions provided is needed to monitor inputs (see Step 4), define output and coverage indicators and monitor trends over time (see Step 6)

3.2 What is the operational definition of "a person reached with a service"? What are the criteria for adequate implementation of a social and programme enabler intervention?

3.2 Adopt the national definition of "person reached"

One of the most important output indicators is the number of people reached with each service. A good monitoring system should clearly define the criteria that will be used to define whether or not a person has been reached with a service. The box below provides examples of simple and more complete definitions of being "reached" for each service. More complete measures include a component that measures the quality and frequency of the service. This information is useful but may not be feasible for all service delivery providers to collect. Collecting the information requires designing forms that will assess whether a person has been reached with the service. See Section 6.2.3 (pg. 76). Service delivery providers may want to adopt the national definition of being "reached" for data reporting purposes. If another definition is adopted for local use, the standard national definition should still be used in reporting.

Box II.3.1 Defining what is meant by "reached" can be problematic. For example:

- How many condoms does a person need to get in order to be reached by a condom distribution programme? Enough for a day? A week? A month?
- If one person is picking up condoms for five others, how many have been reached?
- If a person refuses to get tested for HIV, has he been reached by the testing service? What if he refuses because he knows that he is infected?
- Does seeing an HIV prevention poster on a wall meet the definition of being reached with targeted education?

Box II.3.2 Illustrative definition of what is meant by "reached with a service"

Services	Illustrative Definition of "person reached with the service" : Person has been reached with the programme if she or he….
Targeted condom and condom-compatible lubricants promotion and distribution	Accessed free male or female condoms and condom-compatible lubricant from a programme targeting members of the key population at least once during the past 12 months
Targeted education and HIV risk reduction counselling through outreach and peer education	Received tailored messages through either written or face-to-face communication about HIV risk reduction from trained outreach workers including trained peer educators at least once in the past 12 months
STI diagnosis and treatment	Was screened according to national syndromic protocol or tested for evidence of sexually transmitted infections at least once in the past 12 months and fully treated if indicated.
Voluntary HIV testing and counselling linked to care and treatment	Was tested for HIV infection using national counselling and testing protocol and linked within 1 month to appropriate assessment for treatment if the HIV test is positive
Antiretroviral treatment based on current WHO recommendations	Tested positive for HIV infection and found eligible for ART based on current WHO and National guidelines and subsequently received ART within 1 month of being found eligible
Programmes to ensure adherence and retention	Ever received ART and adhered to 90% treatment in the past month
Harm reduction programmes based on the current WHO recommendations	Was eligible for harm reduction and participated in harm reduction programme in the past month (See WHO guidelines.)
Programmes to include sex workers in catch-up HBV immunization strategies	Received HBV immunization
The entire package of services	Met the definition of being reached for each of the above services

As with the definition of a person reached, adopt the national definition of social and programme enabler intervention implemented. In the box below are some illustrative definitions of social and programme enabler interventions.

Box II.3.3 Illustrative Definitions of Social and Programme Enabler Interventions

Social and Programme Enabler Interventions	Illustrative Definition of Implementation of Social and Programme Enabler Intervention for Sex Workers In A Sub-National Area If the following conditions have been met:
Sustained community mobilization and engagement	An organization of sex workers has been established and meets at least once a year and invites all sex workers in the sub-national area to attend
Safe spaces such as drop-in centres	An identified place promoted by sex workers is available in the sub-national area where members of the population can obtain risk reduction information, information about community mobilization, and there is a system set up for responding to moments of crisis such as violence
Venue-based delivery of services	HIV testing and condom distribution are provided in at least 10% of known venues where sex workers work in addition to clinic settings
Collective networks and self-help groups for sex workers	Evidence that sex workers meet in groups in order to discuss common problems
Advocacy for sex workers including advocacy to increase political commitment	Texts of speeches, emails or pictures of protests where advocacy for sex workers has occurred
Enabling legal and policy environments in the context of HIV and sex work	Evidence of removing laws that are barriers to the uptake of HIV services in the context of sex work
Community-centred programmes addressing stigma, discrimination, and violence	Descriptions of programmes including evidence of sex worker participation in the design of the programme and evidence that the objective of the programme is reduction of stigma, discrimination or violence
Redressal and (judicial) services to address violence	Seventy-five per cent of reported violence against key populations are adequately investigated as deemed by the victim
Activities to increase the availability, accessibility and acceptability of health services	Evidence that a quality assessment of a service has been conducted and that the recommendations arising from that assessment have been implemented and improved the availability, accessibility and acceptability of services.

Data Use

- An operational definition of a “person reached with a service” and criteria for adequate implementation of social and programme enabler intervention are used to monitor outputs and coverage (See Step 6)

3.3 What important sub-groups need prevention programmes? How do service delivery providers define their target populations? Is the local definition different from the national definition?

3.3 Compare national definitions and local practice

One of the requirements of a good monitoring and evaluation system is thoughtful translation of information about the characteristics of the epidemic into strategies for reducing transmission among key populations. There are clear global definitions of sex workers, men who have sex with men and transgender people (see Section B, pg.3). Operational definitions of each population and important sub-populations are needed for monitoring and evaluation. Well-specified operational definitions of sub-groups take into account the culture and context of the epidemic. Operational definitions of sub-groups should specify measurable behaviours that define membership in each sub- population and the relevant catchment area or location. For example, an operational definition for a street-based sex worker may be a "person who has solicited money or goods on the street in X City in exchange for sex in the past 3 months". The populations of sex workers, men who have sex with men, and transgender people are not mutually exclusive and the operational definitions of sub-groups should take into account any overlaps. The operational definition of membership in a sub-population is used in surveillance, size estimation, assessment of coverage, and measuring programme effectiveness.

Operational definitions are essential for interpreting trends over time, across sub-national areas, and among service delivery providers. Operational definitions should reflect the active input of national, sub-national, service delivery levels and community-led organizations. Service delivery providers can further segment the population in order to tailor prevention efforts to the local setting. Operational definitions for M&E may focus on specific sub-populations at higher risk.

Examples of operational definitions of sub-groups that could be monitored include:

- Women aged 18 and older who work in brothels identified by a systematic mapping of all brothels meeting the national definition of an urban brothel
- Self-identified males who have had anal sex with two or more males in the past 12 months and live in a specific geographic area
- Persons in a specific geographic area who self-identify as transgender, female, male, transwoman or transman, trans-sexual, hijra, kathoey, or waria

Data Use

- Standard operational definitions coherent with national operational definitions for seamless aggregation at the national level
- Operational definitions of sub-groups are used to monitor outputs, coverage (see Step 6), outcomes (see Step 7) and impact (see Step 8)

3.4 What services is your organization currently providing? Where?

3.4 Service availability mapping

Service availability mapping can be minimally accomplished by bringing together knowledgeable people to review available information on the services provided in the area. Mapping the location of services reveals gaps in coverage and facilitates target setting.

Figure II.3.4 Map showing condom availability at venues where people meet new sexual partners in Iringa, Tanzania

Listing Exercise: List the HIV prevention services available for transgender people in your catchment area. How many of these services have data you can use to better understand the local HIV epidemic among transgender people?

Data Use

- Service availability mapping is used to identify gaps in services provided
- Service availability mapping can be used to monitor trends services provided in your catchment area (see Step 6)

3.5 What are your current baseline and one year targets for input, quality and output indicators?

3.5 Use target setting methods and target setting worksheet

Target setting is a collaborative process. It requires input from a range of stakeholders to ensure targets are set on the best available evidence, are agreed upon and understood.

The following are tips for target setting:

- Consider the indicators described in this guideline to set targets. These indicators are all measurable.
- Targets should reflect programme strategies that tailor the response to the local epidemic.
- Targets should be set based on baseline measures of the key indicators selected. Use the indicators described in Tools 18 (pg. 129) and 19 (pg. 138) as these are all feasible to measure. If baseline data are not yet available, use the best possible judgment for defining targets.
- For each indicator, it is recommended to set a monthly target based on what change from the baseline measure can be achieved over the next year with available funding and resources. The monthly target can be used to monitor progress regularly (see Step 6).
- Targets should also be set for quality of services. Service quality is typically assessed through more than just a handful of indicators (see Step 5) so targets will need to be set for the most important quality indicators.

Service delivery data are especially appropriate for:

- Estimating the number of people reached with a service
- Describing the characteristics of those reached
- For monthly, quarterly and annual reporting of activities completed
- Characterizing those routinely reached and those newly reached
- Assessing whether service delivery targets are reached

The first time that targets are set is the most difficult because there is less experience with understanding what can be accomplished over a certain time period. The box below describes some methods for setting targets.

Box II.3.4 Target setting: an overview of methods

Method	Description
International Reference Method	Determine whether the baseline estimates are "high" "medium" or "low" based on international guidelines on target setting. (As of September 2013, global target setting guidelines are forthcoming but not yet available.) Set the target at the next level higher than the baseline. For example, if the baseline is "low", set a target of "medium."
10 Years to 80% Method	Identify the baseline indicator: example: 20% and determine the gap between 20% and a target of 80%. If it takes 10 years to get to 80% from 20%, how far can you get in 2 years? The programme should aim to improve 6% each year or 12% in 2 years. At this rate, the target of 80% will be achieved in 10 years. The justification for this approach is that a target of 100% is rarely reached. Targets of 80% are more feasible. Change does not occur quickly. A ten year plan is reasonable for hard to change behaviours.
X% increase method	For each indicator, increase the target 10% from baseline. For example, if targets should increase proportionally by 20% and the baseline is 40%, then the target is 48% (i.e. 20% of 40% = 8%).
Absolute increase method	For each indicator, an absolute increase in the baseline of X amount is set as a target. For example, if targets should increase by an absolute 20% and the baseline is 40%, then the target is 60% (40% + 20%= 60%). This type of target setting is often difficult to rationalize.
Expert opinion or consensus	Some behaviours are harder to change than others and take a longer time to modify. Some programmes are newly implemented and require a longer time to gain the cooperation of the community and see results. Many factors can affect the achievement of targets. In this method, local people including members of the target population assess these factors and set reasonable targets based on their insight and knowledge.
Trends method	For service providers that can review trends in indicators, one method is to extend the trend line of each indicator (unless the trend is going the wrong direction!).

Worksheet for Setting Input, Quality and Output Targets

The worksheet in Table II.3.1 documents baseline measures and targets for quality, output and coverage indicators. Additional indicators can be included. These indicators are numbered using the same system

for the list of indicators in Tool 18 (pg. 129) and Tool 19 (pg.138) that identifies the source of the data for the indicator and the reference for the indicator. In addition to the target for each indicator it is useful to state whether the target was met (see Tool 3, pg. 99 and Tool 8, pg. 118).

Table II.3.1 Examples of targets for quality,output and coverage indicators

Indicator type	Indicator	2010 (baseline)	2011		2012	
		Baseline estimate, % or N	% change from baseline	Target % or N	% change from baseline	Target % or N
Quality	5.3 Percentage of providers testing and treating for STIs who have been trained to provide STI services to sex workers	**60%**	**+10%**	**66%**	**+20%**	**72%**
Output	4.2 Number of sex workers provided with male or female condoms by HIV prevention programmes for sex workers	**60**	**+20%**	**72**	**+40%**	**84**
Coverage	3.6 Percentage of sex workers reached by condom promotion and distribution programmes the past 12 months	**50%**	**+20%**	**60%**	**+40%**	**70%**

NOTE: Not all possible indicators are included here. Numbers and percentages in the table are examples for illustrative purposes only.

Data Use

- Target setting and monitoring progress towards targets can help an organization explain change or lack thereof in transmission risk (see Step 7) or HIV prevalence or incidence (see Step 8)
- Input, output, quality and coverage indicators and targets for each service provided will be used for Process Evaluation in Step 4-6

E. Summary

This step helped you to develop:

❑	Description of services and interventions offered by service delivery organization based on national combination prevention programme (request)
❑	Definition of a person reached with a service and the criteria for adequate implementation of each social and programme enabler intervention
❑	Definitions of sub-groups
❑	Map of services provided in catchment area and targets for service delivery organization
❑	Worksheet of Indicators and targets

Further guidance on strategic response planning can be found here:

- Volume I Step 3 of these *Guidelines*. http://www.cpc.unc.edu/measure/publications/ms-11-49a

Further guidance on service availability mapping can be found here:

- District Health Information Software http://dhis2.org/
- WHO Service Availability and Readiness Assessment (SARA) http://www.who.int/healthinfo/systems/sara_introduction/en/index.html
- WHO Monitoring the building blocks of health systems: a handbook of indicators and their measurement strategies http://www.who.int/healthinfo/systems/monitoring/en/index.html

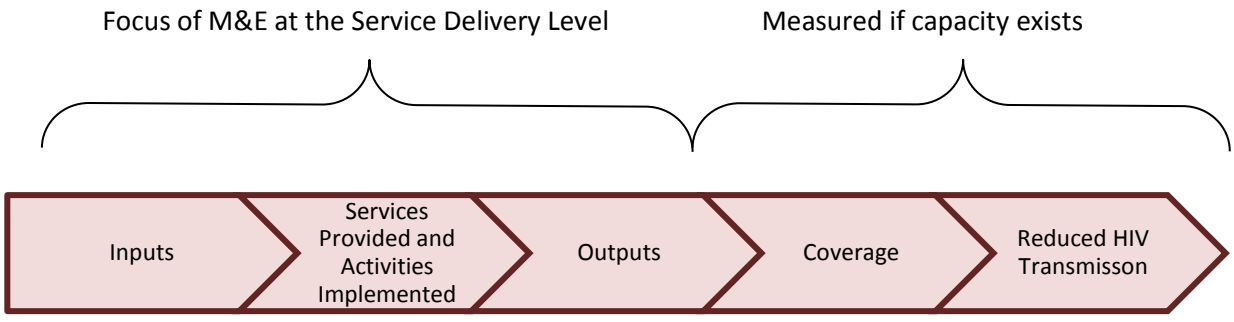
Steps 4-6: Overview of input, quality and output monitoring and process evaluation

By the end of Step 3, targets have been set to monitor the response and results. In Steps 4-6, monitoring determines whether the services and interventions developed as part of the planned response are being implemented on time, with sufficient quality and at the scale required to achieve the set targets. Steps 4-6 collect data to answer the questions: *"What interventions/services are we implementing? Are we doing them right?"*

Input, quality and output monitoring are closely linked to process evaluation. *Typically, process evaluation collects more detailed information about the way the programme is implemented and received by the target population than can be collected through routine monitoring.* Process evaluation can build upon the monitoring data and collect additional information on: access to services, whether the services reach the intended population, how the services are delivered, user satisfaction and perceptions about their needs, and management practices. This detailed information is collected at the service delivery sites for making timely corrections in service provision. Steps 4-6 focus on routine monitoring data relevant to service delivery level.

As described in Section C. How do Programmes Prevent HIV Transmission? and Section E. Using a Programme Impact Pathway to Monitor a Combination Prevention Programme, logic models are a useful way to identify the logic behind programme activities. For example, the goal may be to reduce transmission risk by reducing the frequency of unprotected anal intercourse among sex workers. In order to achieve that objective, there is a logical pathway that begins with identifying the inputs needed to provide a service aimed at increasing condom usage. (See logic model below.) It is a useful exercise to describe the logic model for each service provided. Service delivery providers rarely measure the effect of their programmes on HIV transmission, however, all service delivery providers should understand how their programmes contribute to the ultimate goal of reducing HIV transmission.

The Focus of Monitoring at the Service Delivery Level



Step 4. Input Monitoring: What resources are needed by my service delivery organization to reach our targets?

A. Rationale - Why this Step is Important

This step helps service providers assess the resources needed to reach the targets set in Step 3, determine what resources are available and whether there is a resource gap.

This information can then be used to mobilize additional resources, if needed.

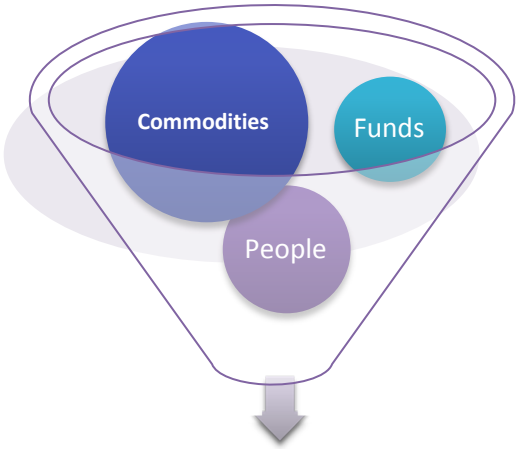


Figure II.4.2 Inputs

B. Step 4 Flowchart and Checklist (Figure II.4.1)

4.1 What is the gap between the amount of funds needed to meet targets and the amount available?

4.2 What is the gap between other resources needed to meet targets and resources available?

In this Step, we estimate the financial and other resources needed to provide the services agreed on in Step 3.

Checklist: Information needed for Step 4

Create an inventory of inputs (resources) required to monitor your programme

- ☐ Staff (e.g., managers, trainers, outreach workers, etc)
- ☐ Commodities, (e.g. condoms, drugs, etc)
- ☐ Materials (educational and risk reduction , guidelines, Operational manuals, etc)
- ☐ Facilities (STC clinics, etc)
- ☐ Funds needed, funds spent, funds still available

C. How to Answer the Key Questions and Use Data: Overview for Step 4

	Key Questions	Methods	Products	Used To
4.1	**What is the gap between the amount of funds needed to meet targets and the amount available?**	Spreadsheet	Funding gaps identified	Assess adequacy of funding and justify additional funds if necessary
4.2	**What is the gap between other resources needed to meet targets and resources available?**	Spreadsheet	Input gaps identified	Assess adequacy of resources and justify additional resources if necessary

D. Methods and Tools

Input monitoring measures whether inputs required for implementing a programme are available. Often service delivery providers neglect to identify the resources needed for monitoring and evaluation. Every organization will have different resource requirements. Here is a checklist that covers resources typically required for monitoring and evaluation.

Box II.4.1 Illustrative Description of Inputs Needed for Monitoring and Evaluation of HIV Programmes for Key Populations

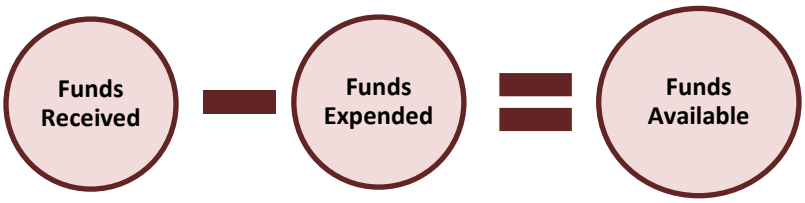
Resource	Service Delivery Level
Personnel	1 person
Supplies / Equipment / Data	1-2 computers Internet access Spreadsheet software Email Access to training equipment This operational guideline
Skills / Training	Management Data management Basic mapping Basic qualitative analysis
Funding	5-10% of service delivery programme budge

4.1 What is the gap between the amount of funds needed to meet targets and the amount available?

4.1. Use spreadsheets to conduct financial resource needs analysis

Funding Gaps

Figure II.4.3 Funds available equation



The gap in funds is the difference between the funds needed and the funds received. Estimating the funds needed to meet targets can be difficult if the services have not been provided previously. The spreadsheet below shows the funds needed and the funding gap. The source of the funds, the amounts expended and amount needed are used to estimate gaps in inputs.

Table II.4.1 Example of a Spreadsheet to Monitor Funding Gaps for Targeted Education and Risk Reduction Programmes

Service	Date/ Year	Funds Needed		Input Monitoring (Funding): Funds Received From:		Gap
		US$	Government US$	Donor 1 US$	Total US$	US$
Education and Risk Reduction	2011	50,000	50,000	0	50,000	0

Costs monitoring. Costs must be monitored. Procurement and/or budget officers know the quantities and costs of these items. Key commodities purchased, for which the programme cannot tolerate stock shortages, should be totalled monthly. Costs of other items can be totalled annually. The data can be maintained in a simple Excel spreadsheet or ledger book. Inputs monitoring is an ongoing activity and should be integrated into routine service management functions and undertaken by a service delivery and field staff member. This example shows a simple example of routine monthly tracking of commodities for a service delivery programme.

Table II.4.2 Monthly tracking of Cost of Commodities

Month/Year _____ Service Delivery Programme _____

Commodities	Number Procured	Price Per Item, $	Total Monthly Cost, $
Male or female condoms	1000	0.05	50
Lubricant	100	0.25	25
Education and risk reduction materials	1000	0.04	40
Total			115

Exercise: Does your programme keep an inventory of purchased commodities? Which ones? Is the inventory updated on a monthly basis? If not, how often is it updated? Does your programme have an itemized budget for staff, space, consultants, etc?

Data Use

- Information on gaps is used to look for and acquire more funds, or to modify the intervention package and targets.

4.2 What is the gap between other resources needed to meet targets and resources available?

4.2 Use spreadsheets to conduct other resource needs analysis (non-financial)

The gap in inputs other than funding is the difference between those inputs needed and the inputs received. The example below is simple and could be expanded to track categories of human resources, commodities, and equipment.

Table II.4.3 Example: Spreadsheet to monitor inputs other than funding at service delivery level

Inputs	Needed	Available	Gap
Human Resources (Staff, volunteers, consultants)	20	10	10
Equipment (Computers, etc)	20	20	0
Commodities (Male or female condoms, drugs for sexually transmitted infection)	10,000	5,000	5,000
Best Practices Materials	10	10	0

Data Use

- Information on gaps is used to look for and acquire more human and material resources, or to modify the intervention package and targets.

Box II.4.2 Example of determining required inputs using a simplified programme impact pathway

- *Output target:* Population coverage of 50% with commodities and services by the outreach team.
- [Estimated size of target population is 600 based on information from a survey conducted at the sub-national level. Consequently, coverage of 50% means reaching 300 sex workers]
- *Expected activities:* Each outreach worker reaches 60 sex workers per week for one month and provides weekly supply of male or female condoms and condom-compatible lubricant, educational and risk reduction materials. Each outreach worker assesses commitment to using condoms. Each outreach worker provides HIV testing to those who have not been tested in the past 12 months and provides appropriate referrals to other services.
- *Inputs needed:* 5 trained outreach workers and 1 month supply of commodities for 300 people:
  - Number of education and risk reduction materials for one month: 300 x 4 per month = 1,200 education and risk reduction brochures
  - Number of male or female condoms for one month: 300 x 20 per week x 4 weeks = 24,000 condoms

E. Summary

This step helped you to develop:

- ❑ Documentation monitoring inputs
- ❑ Gap analysis

Further information on resource allocation and planning can be found here

- UNAIDS (2000). Costing Guidelines for HIV/AIDS Intervention Strategies. UNAIDS, Geneva. http://data.unaids.org/Publications/IRC-pub05/jc412-costguidel_en.pdf
- Costing Worksheets: http://www.hivtools.lshtm.ac.uk/models.htm

Step 5. Quality Monitoring: What is the quality of the services we are providing? Where do we need to improve quality?

A. Rationale - Why this Step is Important

One of the most important strategies for improving programme effectiveness is to improve the quality of services delivered. Even if the programmes are implemented, programme effectiveness will suffer if people do not feel welcome, if the service is not provided in an accessible setting, if supplies run out, or if providers are not well trained. There may be high staff turnover among service delivery providers that requires frequent training and re-training. Measurable standards of quality are necessary in order to monitor quality. Standards should be set at the national level with input from experts, providers, and the population being served.

It's not enough to offer the services and interventions. Quality is a huge part of service delivery. We need a way to give ourselves a grade on quality and make improvements as needed. There are many ways to evaluate the quality of our services and we use multiple methods to make sure we're doing a good job. Look ahead to find out how!

Monitoring quality of the services provided to sex workers, men who have sex with men and transgender people aims to ensure availability, accessibility, and acceptability of services. Quality encompasses the scope, completeness, safety, user satisfaction, consistency of services delivered, and appropriateness to population targeted and setting in which it is delivered.

To ensure that output targets *can* be reached, it is important to assess whether the services are implemented according to plan. This allows for timely corrections as needed. The objective of Step 5 is to assess the quality of services provided based on national standards so that programmes can be improved.

B. Step 5 Flowchart and Checklist (Figure II.5.1)

5.1 Are the services implemented as planned?

↓

5.2 What is the quality of each service?

Checklist: Information needed for Step 5

- ☐ International/National standards and protocols for providing services
- ☐ Data from users, staff or focus group interviews, observation and facility audits
- ☐ User feedback/satisfaction surveys from programme level

C. How to Answer the Key Questions and Use Data: Overview for Step 5

	Key Question	Methods	Products	Used To
5.1	**Are the services implemented as planned?**	Interviews, Observations, Focus Groups, Facility Audits	Identified implementation problems and recommendations for improvement	Assess quality of services provided
5.2	**What is the quality of each service being provided?**	Quality assessment tools	Quality indicators measured	Improve the quality of programmes

D. Methods and Tools

5.1 Are the services implemented as planned?

5.1 Conduct a process evaluation

Periodically conduct a process evaluation to provide detailed information (in addition to routine monitoring data) on programme implementation and quality of the programme. This information may include: access to services, whether services reach the intended population, how services are delivered, user satisfaction and perceptions about needs and services, and management practices. Process evaluation assesses whether the programme was implemented according to quality standards. It also assesses what the intensity of the programme exposure was for participants. In addition, a process evaluation might provide an understanding of cultural, socio-political, legal and economic contexts that affect implementation of the programme. Typical methods used in process evaluation are:

• *User interviews*

Interviews with users (using an interview guide or brief survey instrument such as Tool 16, pg. 127, or Tool 17, pg. 128) can provide information on their experience, perceptions and satisfaction with the services received. This includes interactions with service providers (e.g., welcoming, respectful) and referral sites, access and acceptability of service delivery sites (e.g., location, comfort of space provided), quality of materials (e.g., user-friendly educational pamphlets) and appropriateness of services. The interviews can also assess the intensity of exposure to services and whether referral systems intended to provide a continuum of care are working effectively.

• *Staff interviews*

Interviews with management and service providers can provide information on perceived strengths, weaknesses and needs related to service delivery, management processes, staff and management

structures, capacity and communications methods. Medical care providers' attitudes toward the programme can hint at potential barriers such as stigma. Staff perceptions of service implementation can provide useful input for improving service quality and enhancing staff satisfaction.

• *Observation*

Observing the user-staff interaction provides an opportunity to assess the completeness and accuracy of information provided to users, adherence to standards and protocols, interpersonal communication skills of the staff and whether the appropriate referrals are made. (See Tool 15, pg. 126)

• *Facility audits*

Facility or service audits provide information on the availability of required staff (number and qualifications), adequacy of infrastructure, equipment, support materials, technical and operational guidelines, etc. They can also assess programme support functions, including procurement and material storage and availability, record keeping and documentation.

• *Interviews with complementary service providers*

This type of interview can address the adequacy of referral linkages by focusing on collaboration with service delivery sites that provide complementary services and can include an assessment of referral experiences, including follow-up and perceptions about referrals.

• *In-depth interviews and focus groups with non-users and community members*

Qualitative research methods such as focus group discussions or in-depth interviews with non-service users can help identify barriers and biases in access to services and gaps in service provision. The attitudes of other community members who engage with men who have sex with men, sex workers and transgender people, such as the police, can be informative.

Some of these methods may overlap with those used in Step 2 and with specific quality assessment checklists as explained below. As mentioned in the analyse service delivery data section of Step 2.1.2 (pg. 35), it can be advantageous to record data collected through the above methods using mobile phones, tablets or some other kind of computer, sometimes referred to as mHealth, eHealth or digital data collection. Data collected digitally can be analysed and used more readily and broadly than when paper forms are used.

Data Use

- Process evaluations are used to identify barriers to access and strengths (i.e. programme enablers) for key populations in relation to your organization.

5.2 What is the quality of each service?

5.2 Promote quality standards, conduct staff observations and surveys

Standards are set at the national level with input from experts, providers, and the population being served. Some universal standards that apply to the delivery of all health programmes to key populations are listed in Box II.5.1 below. This box could be developed into a poster to display in the service delivery organization.

In-service surveys of staff asking for knowledge of national standards regarding the interventions being used could be administered annually. In the case of active engagement with users, such as counselling sessions, observations of real counselling sessions or mock sessions should be conducted periodically to assure adherence to standards. The observer should be familiar with the national standards and develop a check list to assure the staffs are meeting all important elements.

Quality assessment tools:

a. "Five A's" Approach and Checklist

The briefest version of a quality checklist is the "Five A's" checklist. Each service can be assessed according to the **FIVE *A's***:

- ☐ **A**dherence to national standards
- ☐ **A**vailability of service
- ☐ **A**ccessibility of service
- ☐ **A**cceptability of service
- ☐ **A**ttitudes of service delivery providers towards users are positive

b. Other Quality Checklists

Information on protocols to assess quality is included in the "Further Information" section at the end of Step 5. In addition, a full checklist of quality standards designed for use at the service delivery level is provided in Tool 5 (pg. 103) for each service provided as well as for assessing the quality of the monitoring and evaluation system. This checklist is a draft document that was developed for this guideline in recognition that no easy-to-use checklist existed. A section of the quality checklist is shown below in Box II.5.2.

Box II.5.1 Quality Checklist: Universal Standards (short version)

Universal Quality Standards

Universal standards that should be applied across all services provided to key populations include:

Standards on involving key populations:
☐ The populations identified for targeted prevention services are included in needs assessment, planning, delivery, and evaluation of HIV prevention services

Standards on users' rights:
☐ Users are fully informed of the nature and content of the services as well as the risks and benefits to be expected
☐ Confidentiality and privacy of users is maintained at all times
☐ Guarantee of human rights; removal of legal barriers to access prevention and care
☐ Access to medical and legal assistance for key populations who experience sexual coercion or violence

Standards on providing combination prevention programme of health services, social and programme enabler interventions to key populations:
☐ Ensure awareness and easy access to all components of the national combination prevention programme
☐ Ensure protocols corresponding to each component of the combination prevention programme are updated periodically, disseminated to and followed at all service delivery levels

Standards on staffing:
☐ Staff has regular supervision by senior staff to maintain quality of service delivery
☐ Training and sensitization of health-care providers to avoid discriminating against key populations

Standards on availability and accessibility:
☐ Services are available irrespective of age, ethnicity, sexual identity, citizenship, religion, employment status, health insurance status, substance use status of all potential users
☐ Services are easily accessible with regard to location, travelling time, cost and transportation
☐ Services are equitable and non-discriminatory
☐ Availability of safe virtual or physical spaces (for example telephone hotlines, or drop-in centres, respectively) for key populations to seek information and referrals for care and support
☐ Communication plan to make community aware of services in place

Box II.5.2 Quality Checklist for Services Provided (short version)

Quality Checklist by Service:

Prevention services and risk reduction materials provided to key populations are:
☐ Culturally sensitive and competent
☐ Appropriate to the age, education level, language and other needs of consumers
☐ Accurate and up-to-date
☐ In the case of materials, in formats which are most appropriate for reaching populations served
☐ Provided by key populations
☐ Available and advertised for key population

Provision of condoms and lubricants
☐ Condoms are available to consumers at the right time, place and price
☐ All condoms are of reliable quality by the time they reach the consumer
☐ The condom is provided in a respectful manner, with adequate information on how to use the condom
☐ Lubricants are provided at the same time with a condom
☐ Community is aware of condom distribution points
(Drawn from: UNFPA, WHO, PATH (2005). Condom programming for HIV prevention: a manual for service providers. UNFPA, New York, USA)

Prevention and treatment of sexually transmitted infections (STIs)
☐ People diagnosed with STI receive appropriate treatment
☐ The STI case management guidelines delivered with the quality specified in the national guidelines
☐ Counselling services provided when people come to receive STI treatment
☐ Accepting attitudes (not stigmatizing) among people providing STI care
☐ Target population participates in provision of services
☐ Community is aware of STI diagnostic and treatment services
☐ Adherence to treatment is ensured

Antiretroviral therapy (ART)
☐ Having sex with men, involvement in sex work, being a transgender person does not exclude a person from accessing ART services
☐ Target population participates in provision of ART services
☐ Patients are linked to complementary health and psychological services as needed
☐ Population knows ART services exist and how to access them

All Services
<u>Also while providing services:</u>
☐ System that ensures no stockouts
☐ UIC or other system to count number of unique users versus number of contacts
☐ Established referral system including a follow-up mechanism
☐ Provide education and risk reduction counselling
☐ Conduct risk assessment
☐ Provide condoms and lubricants for key populations while providing any other HIV prevention services

c. Monitoring availability of services from programme records
Availability of services is monitored by:
1) recording any stock outs for specific commodities in the last 12 months
2) recording an inventory supply that will typically last for the next thirty days
3) recording number of days/shifts with insufficient staffing.

d. Qualitative methods to assess quality
Qualitative methods should be used monitoring the quality of services for men who have sex with men, sex workers and transgender people. Lessons can be learned from gathering feedback directly from key populations through periodic open-ended discussions, either with small groups or individuals. The following are examples of some qualitative methods that can be utilized to monitor indicators on quality:

- In-depth interviews with service providers and users
- Focus group discussions with service providers and users
- Direct observations of interaction between users and providers (Tool 15, pg. 126)
- Direct observation by mystery users
- User exit interviews (Tool 16, pg. 127, and Tool 17, pg. 128)
- User or participant feedback tools

Users should be periodically interviewed or surveyed to ascertain their experiences using the service. This can be accomplished through face-to-face in-depth interviews using an interview guide or brief survey instruments seeking feedback. Questions about their peers who do not use the service should be included. Seeking out such peers for interviews can provide rich data on barriers to uptake of the service. Elements of acceptability to explore include site factors, (good location, pleasant space), staff factors, (welcoming and respectful), and materials' quality (educational pamphlets).

In addition to users, the attitudes of other community partners can be informative. Area medical providers' attitudes toward the programme can hint at potential barriers, e.g., from stigma or homophobia. Further, perceptions of the staff on the implementation of the programme can provide useful input to improving quality of services and enhancing staff satisfaction.

Exercise: List potential community partners whose attitude toward your programme could be important to programme success. Speculate on why they might be important. What questions would you ask them?

e. Plan-Do-Check-Act (PDCA) problem solving
Plan-Do-Check-Act is a pragmatic approach that can be used to monitor and improve programme quality. It is a collaborative process where problems are identified, analysed, solutions developed and implemented, then evaluated. If the goal is achieved, the process ends. If the problem is not solved, the process repeats until a solution is found. The approach is easily used by teams and ensures that each person in the team understands how the solution is meant to solve a specific problem.

f. Monitoring key indicators on service quality

Box II.5.3 lists a sub-set of the quality indicators presented in Tool 18 and Tool 19

Quality Indicators Adapted for Service Delivery Provider	
5.2	Percentage of HIV testing and counselling sites that conduct outreach to men who have sex with men
5.3	Percentage of providers testing and treating for STIs who have been trained to provide STI services to men who have sex with men
5.4	Percentage of men who have sex with men diagnosed with STI who received treatment
5.5	Whether men who have sex with men participate in quality audits
5.6	Whether men who have sex with men participate in service delivery

Data Use

- Internal audit results are used to assess quality of services provided and to improve performance
- Meetings with members of the target population can increase the acceptability of services
- Staff morale will increase as the quality of services increases
- Service delivery providers with problems or successes in quality can help other providers by sharing their problems and solutions

E. Summary

This step helped you to conduct:

❑ Periodic assessment of service quality

Further information on universal standards of quality can be found in:

- UNAIDS Practical Guidelines for Intensifying HIV Prevention: Towards Universal Access. http://data.unaids.org/pub/Manual/2008/jc1581_big_card_en.pdf
- Clinical Facility and Services Assessment Field Guide: Quality Assurance (QA) and Quality Improvement (QI) Quality Assurance Resource Pack for Voluntary Counselling and Testing Service Providers. Contains very useful training materials for implementing quality assurance, including examples of checklists. http://www.fhi.org/NR/rdonlyres/eajjgyypire3jwyjxtequ7eb2rrehgliyrvnwl6dksu7vld4pwymiwhlxajifbtvjag3bwiiygzjck/QAQIHealthFacilitiesHV.pdf

Information on the standards for providing testing and counselling services can be found at:

- WHO Service Delivery Minimum Standards
  http://www.who.int/hiv/topics/vct/toolkit/components/service/en/index1.html
- World Bank. Are You Being Served? New Tools for Measuring Service Delivery. This volume provides an overview of a range of tools for measuring service delivery and offers valuable lessons on the opportunities and constraints practitioners face in measuring performance. Information on methods to assess health care quality is provided on pages 30-34.
  http://www-wds.worldbank.org/external/default/WDSContentServer/WDSP/IB/2008/02/15/000333038_20080215064605/Rendered/PDF/424820PUB0ISBN1LIC0disclosed0Feb131.pdf

Other guidelines related to providing basic package of services:

- UNFPA. Condom programming for HIV prevention. An operations manual for programme managers
  http://www.unfpa.org/upload/lib_pub_file/423_filename_condom_prog2.pdf
- UNFPA Condom programming for HIV prevention. A manual for service providers
  http://www.unfpa.org/upload/lib_pub_file/422_filename_condom_prog.pdf
- WHO. Consolidated guidelines on the use of antiretroviral drugs for treating and preventing HIV infection. 2013
  http://www.who.int/hiv/pub/guidelines/arv2013/en/index.html
- WHO guidelines for the management of sexually transmitted infections 2003
  http://www.who.int/hiv/pub/sti/en/STIGuidelines2003.pdf

More information about how this problem solving process Plan-Do-Check-Act can be used to improve quality is found here:

- North Carolina Department of Environment and Natural Resources (2002). Plan-Do-Check-Act: A problem-solving process.
  http://quality.enr.state.nc.us/tools/pdca.htm
- Deming, W. (1986). Out of the crisis. Cambridge, Mass.: Massachusetts Institute of Technology, Center for Advanced Engineering Study

Further guidance and information on qualitative research methods can be found at:

- Qualitative Research Methods: A Data Collector's Field Guide; Source: Family Health International
  http://www.fhi.org/NR/rdonlyres/emgox4xpcoyrysqspsgy5ww6mq7v4e44etd6toiejyxalhbmk5sdnef7fqlr3q6hlwa2ttj5524xbn/datacollectorguideenrh.pdf

Further guidance and information on using mystery users for monitoring of site improvements can be found here:

- Using Mystery Clients: A Guide to Using Mystery Clients; for Evaluation Input; Source: Pathfinder International
  http://www.pathfind.org/site/DocServer/m_e_tool_series_mystery_clients.pdf?docID=6303

A very detailed exit interview questionnaire on Voluntary Counselling and Testing for Youth can be found at:

- Population Council. HIV Research Domains: Topic N Voluntary Counseling and Testing: Services, attitudes and disclosure questionnaire:
  http://www.popcouncil.org/Horizons/ORToolkit/AIDSQuest/topics/vct.html

For more information on measures of user satisfaction and programme improvement:

- WHO/UNDCP/EMCDDA Evaluation Workbook on Client Satisfaction Evaluation
  http://www.unodc.org/docs/treatment/client_staisfaction_evaluation.pdf

An example of HIV stigma scale can be found here:

- Population Council. Measuring stigma: HIV stigma scale.
  http://www.popcouncil.org/Horizons/ORToolkit/AIDSQuest/instruments/oct00/hivstigmascale.doc

Step 6. Monitoring Outputs and Programme Coverage: Did we reach the number of people we planned to reach? How many people in our catchment area were reached? How many were not reached?

A. Rationale - Why this Step is Important

Output indicators monitor who has been reached and what services are being provided. Coverage indicators monitor the proportion of the target population reached with services.

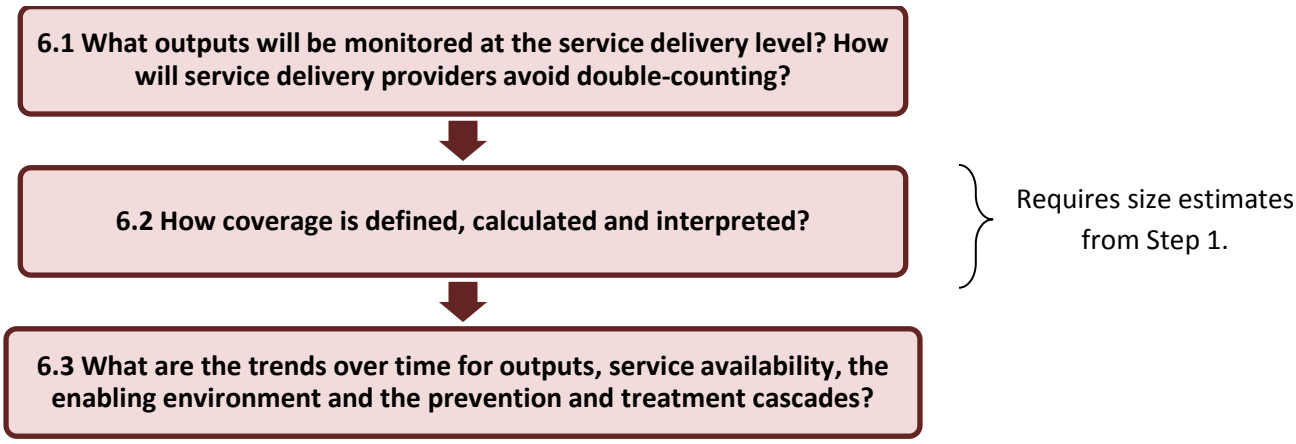
It's time to check our progress in terms of meeting the targets we set in Step 3. Using information from Step 1 and 3, we can show how visits and coverage have increased over time. We are on the way to monitoring the impact of our programme!

Output monitoring is the heart of monitoring at the service delivery level. The most common explanation for why programmes fail to prevention HIV transmission is that the services were never delivered according to the plan. Output indicators are used to:

- determine whether services were actually provided
- estimate the number of people reached with each service or intervention
- assess whether output targets are being reached
- identify quality improvement possibilities
- monitor changes in service usage
-justify programme funding to donors.

Coverage indicators monitor the proportion of the target population reached with services.

B. Step 6 Flowchart and Checklist (Figure II.6.1)



Checklist: Information needed to monitor outputs Information needed for Step 6

- ☐ Targets for each of the services provided
- ☐ Forms for output monitoring
- ☐ Reporting frequency
- ☐ Registers at clinics and drop-in-centres
- ☐ Log books
- ☐ Record keeping forms

C. How to Answer the Key Questions and Use Data: Overview for Step 6

	Key Questions	Methods	Products	Used To
6.1	What outputs will be monitored at the service delivery level? How will service delivery providers avoid double-counting?	1. Define output indicators 2. Identify a strategy to avoid double-counting 3. Develop forms that address double-counting and measure output indicators 4. HIV prevention and treatment cascades	- Set of defined output indicators for use in catchment area - Data entry programmes - Data reporting schedule and analysis plans including templates for tables & graphs	Conduct process evaluations and identify strategies for programme improvement
6.2	How is coverage defined, calculated and interpreted?	• Review forms to ensure that coverage indicators can be calculated and reported • Divide output indicator by size estimate to obtain coverage indicator	- Coverage indicators - Data analysis plans including table templates and graphs for presenting indicator trends	Identify gaps in coverage and inform the response
6.3	What are the trends over time for outputs, service availability, the enabling environment and the prevention and treatment cascades?	Tabulate and graph indicators from Steps 6.1 and 6.2 for each period collected.	Output and coverage indicator data as collected over time.	Monitor trends in outputs over time

D. Methods and Tools

Process monitoring reveals whether the activities and strategies developed as part of the planned response are being implemented on time, at the scale required by the targets, and with sufficient quality. Process monitoring can occur at the national, sub-national or service delivery level. Process monitoring compares the planned activities, timeframe, inputs, and outputs with what actually occurred. Process monitoring identifies bottlenecks, duplications and inefficiencies and can reveal practical solutions to problems. Examples of process monitoring are the HIV prevention and treatment cascades.

6.1 What outputs will be monitored at the service delivery level? How will service delivery providers avoid double-counting?

6.1.1 Define output indicators

Service delivery providers may identify many outputs to monitor. An output is an intermediate result from a programme or intervention action that can be counted. Counting outputs provides evidence that activities have occurred. Downward trends in outputs can signal a problem.

The outputs that are frequently monitored at the service delivery level include:

- Number of people reached with a service, e.g. number of people reached by a condom distribution programme
- Number of male or female condoms and condom-compatible lubricant distributed to the key population in the catchment area by a service delivery provider
- Number of men who have sex with men, sex workers, transgender people at each stage of the HIV testing and treatment cascade (more information can be found later in this step)
    - Number estimated to be infected with HIV
    - Number diagnosed with HIV
    - Number linked to HIV care
    - Number retained in HIV care
    - Number that need ART
    - Number receiving ART
    - Number adherent or with undetectable viral load
- Number of health care delivery providers trained in issues related to sex work, men who have sex with men, transgender people including how to counsel these populations, and how to detect and treat for STIs.

Outputs that are less frequently monitored include outputs achieved to reduce the barriers to access of services. Output that could be monitored in this area include:

- Meetings held with officials to address legal barriers
- Number of participants in community mobilization activities
- Number of physical safe spots organized in the community for men who have sex with men, sex workers and transgender people

Box II.6.1 lists key requirements for specifying and monitoring output indicators.

Box II.6.1 Requirements for specifying and monitoring output indicators

	Requirements for a good output indicator	Clarifications/examples
1	A fully specified indicator reference sheet	This should include the following information: - Indicator definition - Rationale/purpose for the indicator - Numerator - Denominator (if applicable) - How to calculate the indicator - Measurement Tool - Method of measurement - Data collection frequency - How to interpret indicator data - Strengths and limitations of the indicator - References to sources for further information
2	A well-defined activity that can be counted	For example: number of persons reached with a service or package of services; number of commodities (male or female condoms and condom-compatible lubricant or posters) distributed; and/or number of people trained
3	The time period during which the activity occurred	For example: - Number of condoms distributed each calendar month - Number of persons reached by a condom promotion and distribution programme in the past month
4	For output indicators that measure the number of people "reached with a service", an operational definition of what it means to be "reached"	For example: Number of persons who received at least one free condom with instructions on its use
5	For output indicators that measure the number of people "reached with a package of services", an operational definition of the content of the package	For example: Number of persons reached by: - Condom promotion and distribution programme; and, - HIV testing and counselling; and, - antiretroviral therapy.
6	The output indicator meets the *Indicator Standards*	Standard 1. Is needed and useful Standard 2. Has technical merit Standard 3. Is fully defined Standard 4. It is feasible to collect and analyse data Standard 5. Has been field tested or used in practise Each Standard is further defined by specific criteria (see *UNAIDS Indicator Standards, 2010*)
7	A standardized data collection form to collect the indicator data	An encounter form for recording which services were provided to the user (see Tools 6, 7, and 20)
8	A baseline measurement of the indicator and a realistic target	For example: - Baseline in 2010: 60,000 condoms distributed to 500 users (10 condoms per user per month) - Target for 2011: 72,000 condoms to be distributed to 600 users (same assumption of 10 condoms per user per month)

6.1.2 Identify a strategy to avoid double-counting

The "double-counting" problem is that service delivery providers do not know how many *unique* individuals they have contacted if they only record the number of contacts with the population or number of commodities provided. Knowing the number of unique individuals is a more accurate measure of coverage. The number of contacts is vague measure because the contacts include individuals reached multiple times and unique individuals.

Each service delivery provider must determine what method will be used to translate number of contacts with the population into the number of unique individuals reached with a service. Figure II.6.2 summarizes 3 different strategies to estimate the number of people reached with a service.

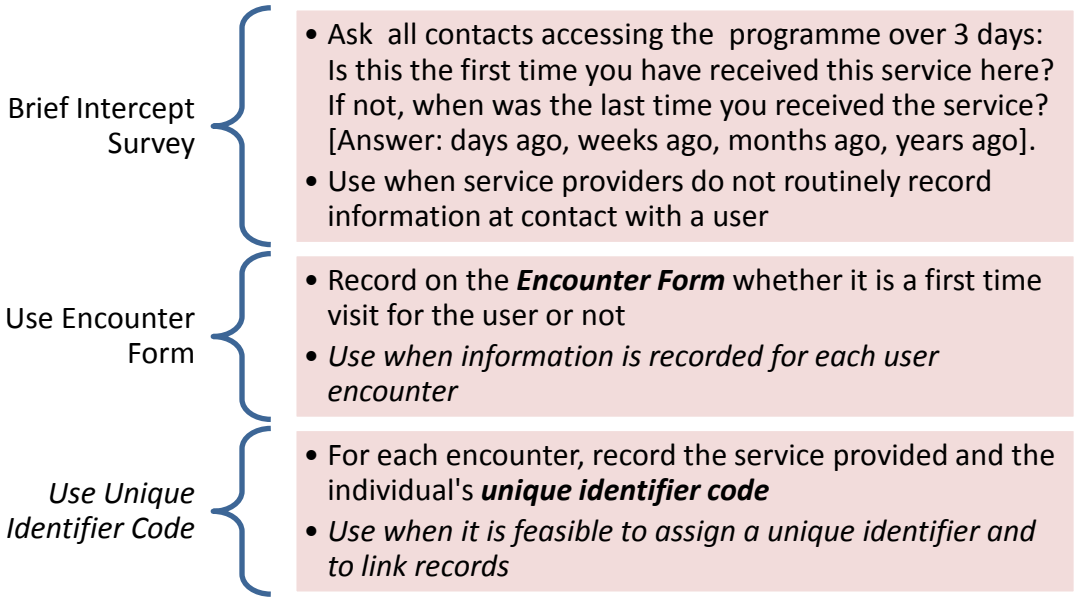
Service delivery providers that adopt the use of a unique identifier code (UIC) for users will be able to track the user's participation in the programme, the services each user receives and whether referrals to services have been followed-up. Unique identification codes can provide accurate information on the number of users reached with services and the number of contacts with each user.

In order to use a UIC, a service delivery provider must develop a data storage system that protects the privacy of users. For example, UICs should ***not*** be based on government-issued ID numbers or other unique identifiers that can readily be linked to the user. An example of a "safe" unique identifier code developed by Population Services International (Gray, Hoffman, 2008) is a 7-digit code composed of:

- First two letters of mother's first name
- First two letters of father's first name
- Gender (single letter M/F or number)
- Year of birth (last two digits).

Source : WHO, UNODC, UNAIDS Technical Guide for countries to set targets for universal access to HIV prevention, treatment and care for injecting drug users

Figure II.6.2 Strategies to avoid double-counting and a brief description of method



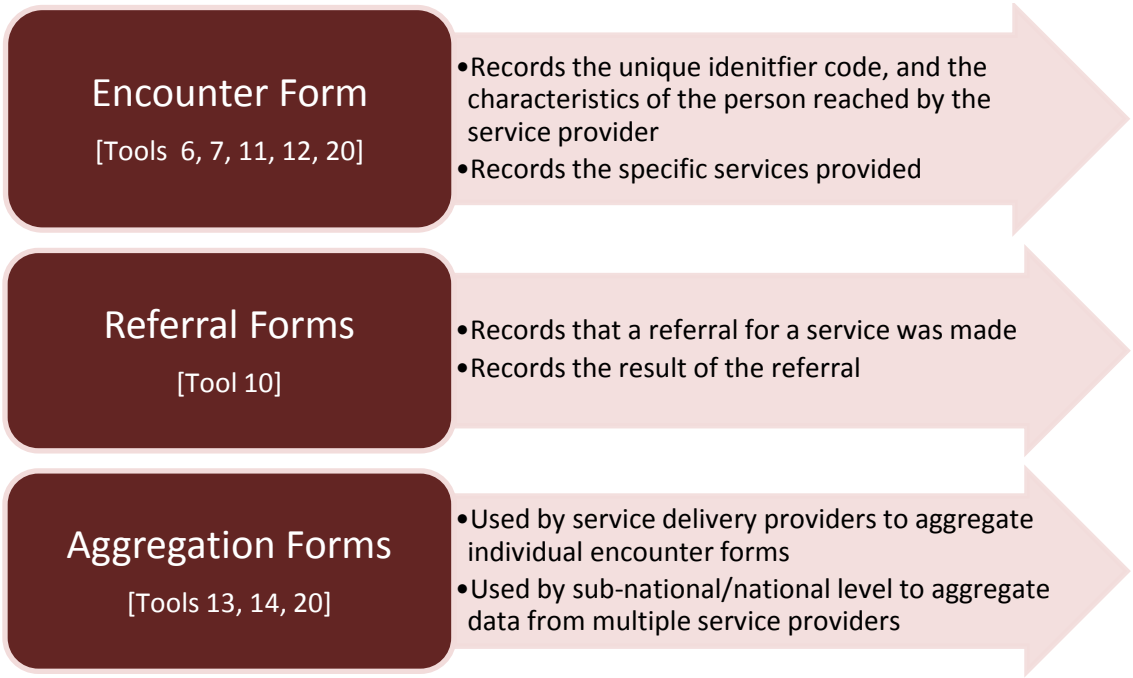
6.1.3 Use standardized forms that address double-counting and measure output indicators

Standardized data collection forms for recording whether a service has been provided are typically developed at national level to ensure that all service providers collect data in a standardized manner. The most important forms are shown in Figure II.6.3 and examples are included in the Tools Section (see Tools 6, 7, 9, 10, 11, 12, 13, 14, 15, 20).

Creating electronic versions of the tools mentioned above, collecting data using computers or mobile phones and compiling data in a local or online database is a more efficient way to monitor outputs in comparison with paper forms. The option of collecting data digitally will depend on an organization's infrastructure and resources though technology is ever more accessible through the decreasing price of electronic devices and the growth of open source software. Digital data collection allows for analysis and dissemination of data in a more timely manner and can reduce human error. See Step 2.1.2 for information on digital data collection.

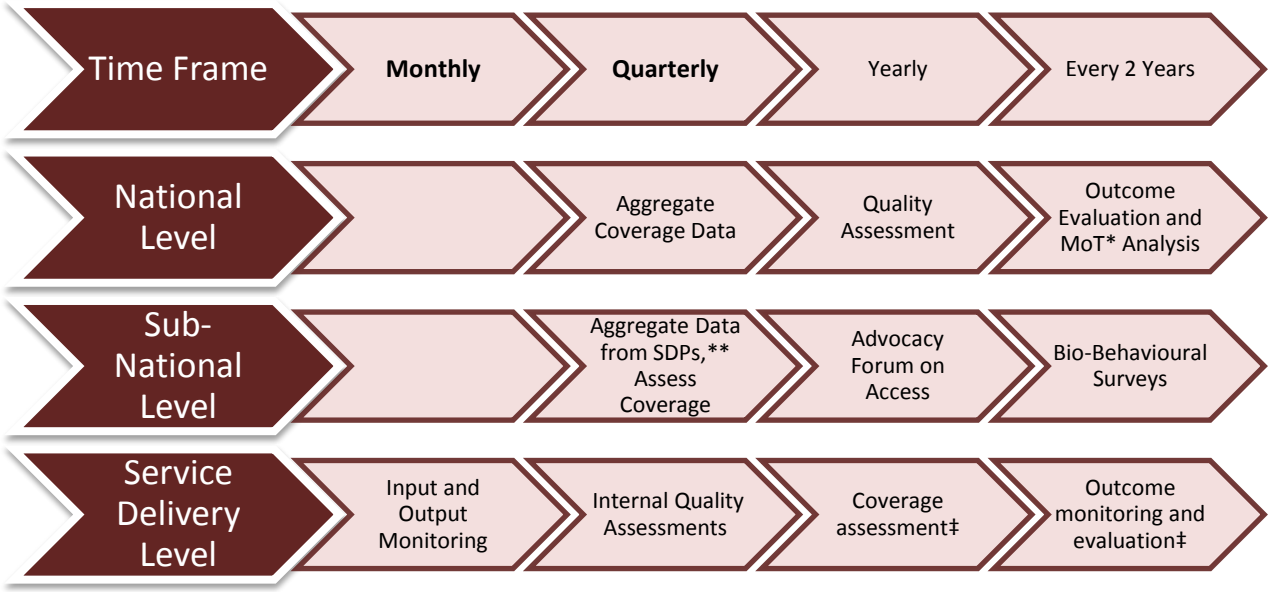
Service delivery organizations may need to conduct M&E using symbols and pictorial encounter forms. Forms like those in Tool 20, pg. 147, can be used by outreach workers who cannot read or write to record which of four services in the combination prevention programme were delivered during a given week and any risk or vulnerability factors that directly impact individuals' ability to access HIV services. Each person reached is assigned a unique identifier code using numbers, colours and dots.

Figure II.6.3 Types of forms to measure output indicators



A recommended data collection and reporting schedule for all levels is the following:

Figure II.6.4 Proposed timeframe for conducing M&E activities at each level



* Modes of transmission
**Service delivery provider
‡ If capacity exists

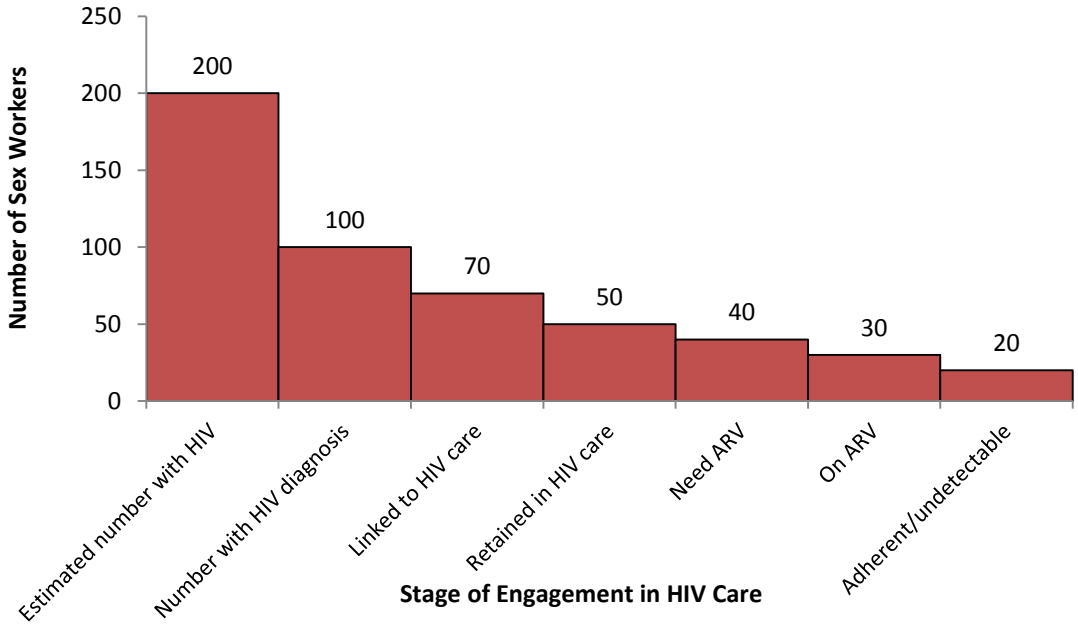
Service providers routinely collect data on outputs and tally these numbers monthly. Share these data with the sub-national level every quarter. At the national level, information from all service providers in each of the sub-national areas must be aggregated. There are specific tools available that help with aggregating data at the sub-national level (by hand or using software). For example, the UNAIDS Country Response Information System (CRIS) allows service delivery providers to enter data directly online. Further software development is ongoing to provide automatic calculation of indicator values as well as graphs to look at trends in the data over time. If service providers do not have access to computers or the internet, data can be aggregated by hand and entered onto hard copies of spreadsheets/forms. These can be shared with the sub-national or national level and entered into the Country Response Information System or other computerized system at that stage.

Exercise: Determine who are the important organizations and individuals collecting and using data within your service programme. Set a schedule for how often data reporting will be conducted and who will be responsible for each duty. Review your plan quarterly to assess how effectively your service programme is managing data. Especially work to develop fluid communication between site aggregators and multi-site aggregators since they are likely not based within the same programme.

6.1.4 Develop HIV prevention and treatment cascades

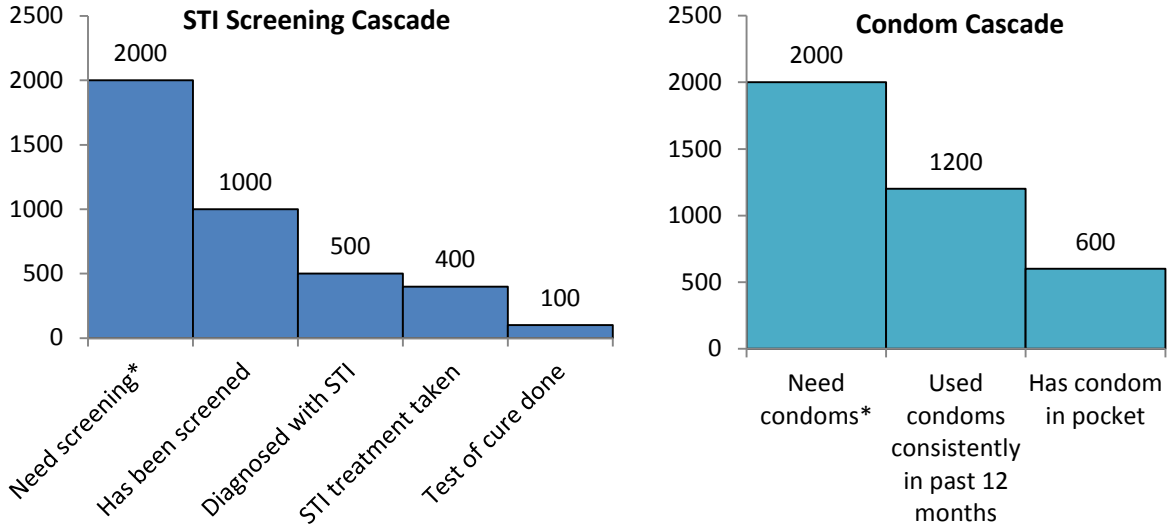
HIV prevention and treatment cascades summarize the gaps in access to services or interventions such as STI screening, male or female condom and condom-compatible lubricant distribution, HIV testing and antiretroviral therapy. In order to develop a prevention and treatment cascade, the number of persons in the population who are in need of a service must be estimated. For example, to estimate the number of people with HIV, use the prevalence of infection and the estimated size of the population in your catchment area (See Step 1, pg. 27). To estimate the number of sexually active people in your catchment area, use a survey that captures the proportion that has had sex in the past 12 months and apply it to the size of your catchment population. To accurately portray the cascade, service delivery organizations assign unique identifiers to individuals served and monitor referrals to other service delivery organizations.

Figure II.6.5 Illustrative HIV testing and treatment cascade in a catchment area with 1,000 sex workers and estimated HIV prevalence of 20%



Adapted from Gardner EM, McLees MP, Steiner JF, Del Rio C, Burman WJ. The spectrum of engagement in HIV care and its relevance to test-and-treat strategies for prevention of HIV infection. Clin Infect Dis 2011;52:793-800.

Figure II.6.6 Illustrative STI screening and condom cascades



***** Use sexually active population

Data Use

- Output indicator data are used to determine whether targets are met (see Step 3) and to monitor trends in outputs (see Step 6.3) or outcomes (see Step 7.1) over time.

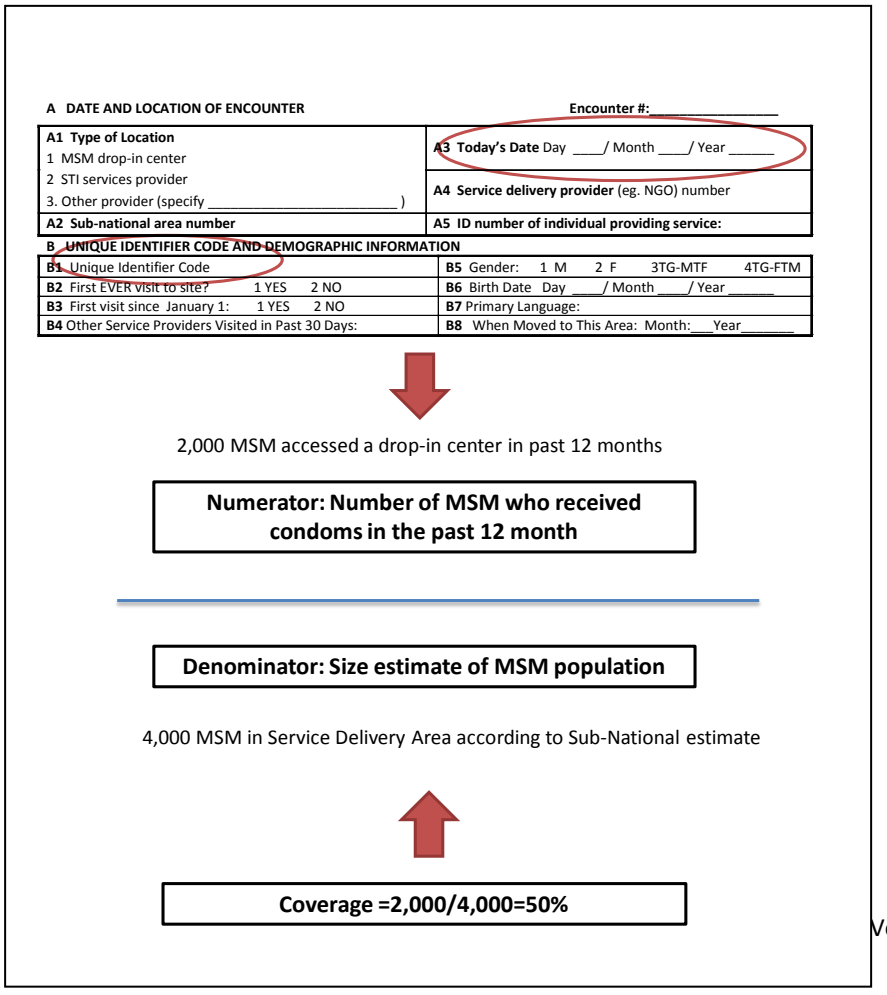
6.2 How is coverage defined, calculated and interpreted?

6.2 Calculate coverage indicators from service delivery data

Coverage indicators measure what proportion of the target population is receiving services. Estimating coverage requires knowing the size of the target population and how many of those have been reached with programme service. The national and sub-national level HIV prevention programme should estimate the proportion reached by each service. If the information is not available, however, service delivery providers may want to assess the adequacy of coverage in their service delivery area using information obtained from the user encounter form and available estimates of the size of the target population. See Figure II.6.7.

Figure II.6.7 Coverage monitoring of men who have sex with men reached by HIV prevention programmes

Indicator: Percentage of men who have sex with men reached with condom distribution service in the past 12 months



Calculating population coverage for a service or package of services using service delivery data requires:

- A clear definition of the service or package of services (see Step 3)
- A strategy to avoid double-counting of users (see Step 6.1.2)
- Estimates of the size of the target population (see Step 1.2)
- Measurement of the number of people reached with each service and with a package of services (see Step 6.1.3)

Figure II.6.8 shows how to calculate coverage from service delivery data and a size estimate of the population.

Figure II.6.8 Method to calculate coverage based on service delivery data

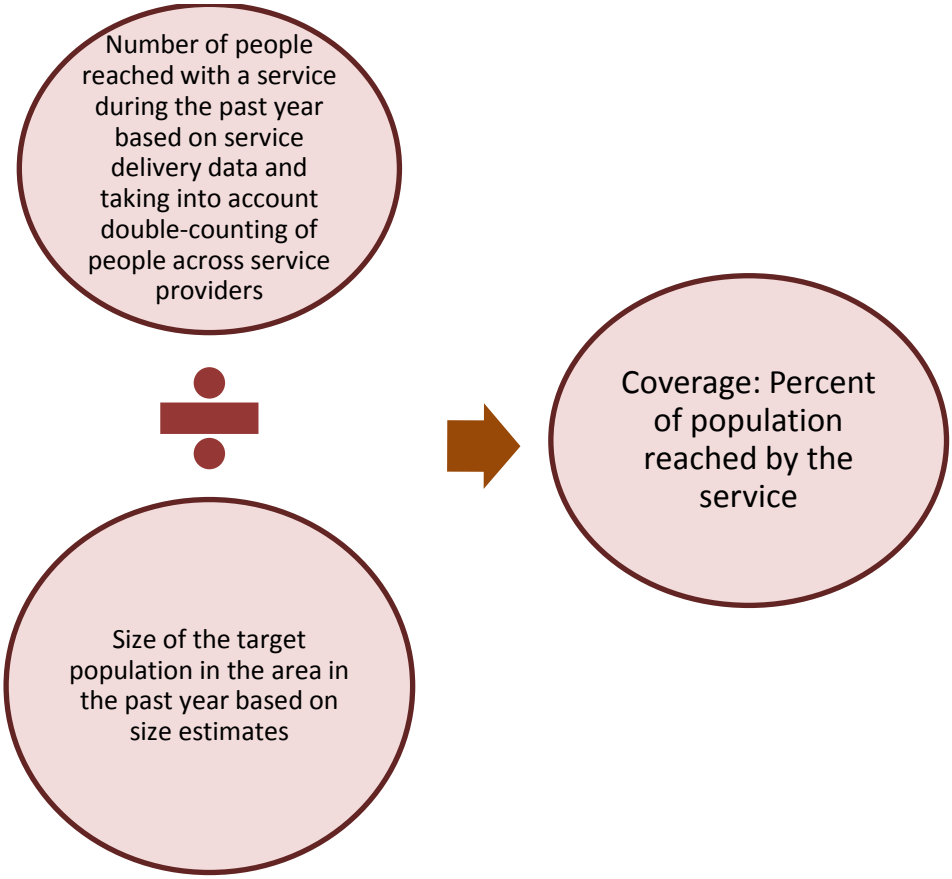
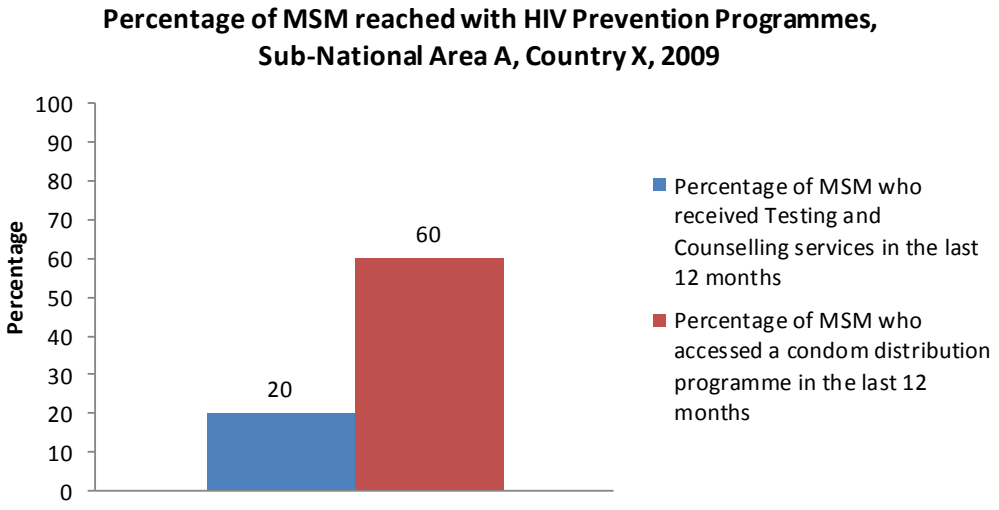


Figure II.6.9 provides an example of coverage indicators for two service elements of the HIV prevention package of services for men who have sex with men.

Figure II.6.9 Example of coverage monitoring of services provided for men who have sex with men



Data Use

- Coverage indicators measure what proportion of the target population is receiving services, important for target setting (Step 3.5), monitoring coverage over time and making improvements to programmes as needed (Step 6.3).

6.3 What are the trends over time for outputs, service availability, the enabling environment and the prevention and treatment cascades?

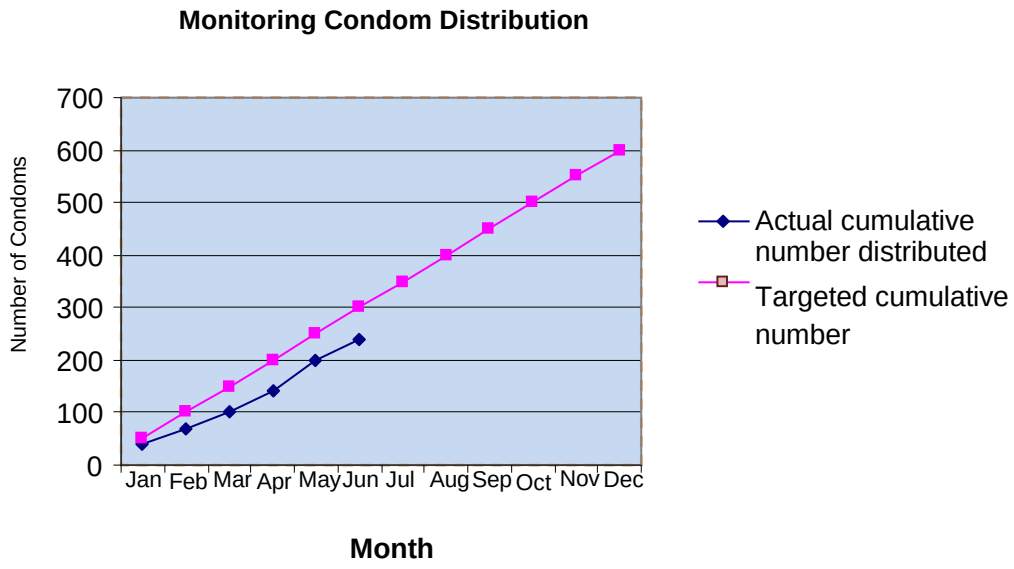
6.3 Trend Analysis

The example below illustrates how output trend analysis can improve services at the service delivery level. Trend analysis compares actual outputs to output targets over time. To analyse how well the outputs meeting the target:

-Take output data from programme records

-Assess whether outputs are meeting the targets using tables or graphs

Figure II.6.10 Monitoring condoms distribution



Example of monitoring condom distribution trends

Let's assume that in the previous steps the service delivery provider set a target of 600 000 male or female condoms to be distributed during one year. In order to reach this target, the target number to be distributed every month is approximately 600 000/12=50 000. This graphic show how well a programme is doing meeting the targets for the first six months. Tracking this information monthly is a good way of showing how programmes may need to scale up to respond to targets.

The results of the output monitoring allow assessing whether targets are being reached, take actions to improve the situation when needed, and share the lessons learned with other service delivery providers in the area. These are several ways to use the output monitoring information to improve the programme:
-Keep doing what you are doing if the outputs are reaching the targets.
-Areas of underperformance are identified and can be addressed
-Reasons for the underperformance can be explored (including internal quality assurance/quality improvement). In addition, underperformance should be discussed with the key population and relevant partners in order to identify reasons for underperformance, look for potential solutions, and determine steps to take.

Using coverage information help to improve performance

Achieving high coverage is an intermediate step in promoting healthy sexual behaviours among men who have sex with men, sex workers and transgender people. ***The programme is unlikely to result in behavioural changes if it is not reaching its target audience.*** It is important to monitor coverage to ensure that these targets are being reached. Efforts need to be made to provide better individual

coverage. This depends on resources available, how programmes are received by community partners including sex workers, men who have sex with men and transgender people, the quality of services provided by the programme, sensitization of programme staff, etc. Timely feedback from the national to sub-national level and from the sub-national level to service delivery level may result in better coverage. In a situation when the areas of underperformance are identified, it is necessary to examine data more carefully, analyse the reasons of the current situation, identify potential solutions, determine steps to take, and implement changes needed to improve performance.

Data Use

- Trend analysis of output and coverage indicators is used to determine whether programmes are reaching a portion of the population that is sufficient for the programme to be effective

E. Summary

This step helped you to develop:

❑	(request)
❑	Identified strategy to avoid double-counting
❑	Output trends report
❑	Service availability trend report and map
❑	Enabling environment checklist: trends
❑	Coverage trends report*
❑	HIV prevention and treatment cascades/other process evaluation

*If capacity exists

More information on collecting, analysing and using monitoring data, entering data into the global spreadsheet, doing basic analysis and creating charts can be found here:

- FHI. Monitoring HIV/AIDS Programmes: Participant Guide(2004). http://www.fhi.org/NR/rdonlyres/epjwoqeky4zmoliungcpnchi3v3cnrqxgsdiaione2ct3jeyguv3nsnqrbjt5oha7oihw5huwo7e3k/ParticipantCoreModule2.pdf

More information on pictorial encounter forms can be found here:

- Bill & Melinda Gates Foundation (2009). Peer Led Outreach at Scale: A Guide to Implementation. http://docs.gatesfoundation.org/avahan/Documents/Avahan_PeerLedOutreach

Step 7. Outcome Monitoring and Evaluation: Are there changes in HIV transmission risk? Are these changes due to programmes?

A. Why this Step is Especially Challenging for Service Delivery Providers

Service delivery providers usually do not have the capacity to either monitor outcomes or evaluate whether their particular programmes are responsible for changes in these outcomes. The difference between outcome monitoring and outcome evaluation is often misunderstood:

- *Outcome monitoring* tracks changes in outcomes without determining whether a specific programme caused any changes observed.
- *Outcome evaluation*, on the other hand, determines whether changes in outcome indicators are directly caused by exposure to a prevention programme rather than (or over and above) other causes. Outcome evaluation requires a comparison group. Outcomes among the group or in the area exposed to a programme are compared to a group/area without the programme.

Here's where we want to know whether the people we reach are using condoms more often or having sex with few partners. Are the people with HIV taking their medications and going to their check-ups? Are they aware of their viral load and is it supressed? Only then can new infections be prevented. Over time we can get an idea of whether risk of HIV transmission is going up or down. Some organization can track these data and others lack the resources – try it!

For service delivery programmes that have the capacity to implement outcome monitoring or outcome evaluation, this step explains how to monitor outcomes at the service delivery level and how they can be used to evaluate the effectiveness of the programme. Outcomes measure the risk of getting infected or infecting someone else such as unprotected sex. Targets for these outcomes were set in Step 3. Service providers who want to monitor outcomes must either have the capacity to survey the target population or to capture outcome indicators on the User Encounter Forms (see Tool 6 and Tool 7) and use a unique identifier code for each user. Not all service providers need to collect outcome data or have the capacity to do so. See Step 6.1.2.

Figure II.7.1 shows how providing the service or conducting the intervention may prevent HIV transmission. The objective of this step is to show how to use service delivery data to find out whether the programme is reducing the chance that people will get infected.

Figure II.7.1 Programme impact pathway

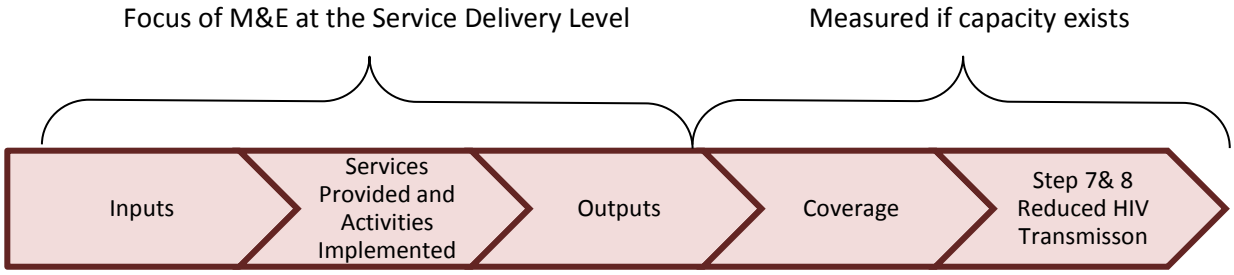
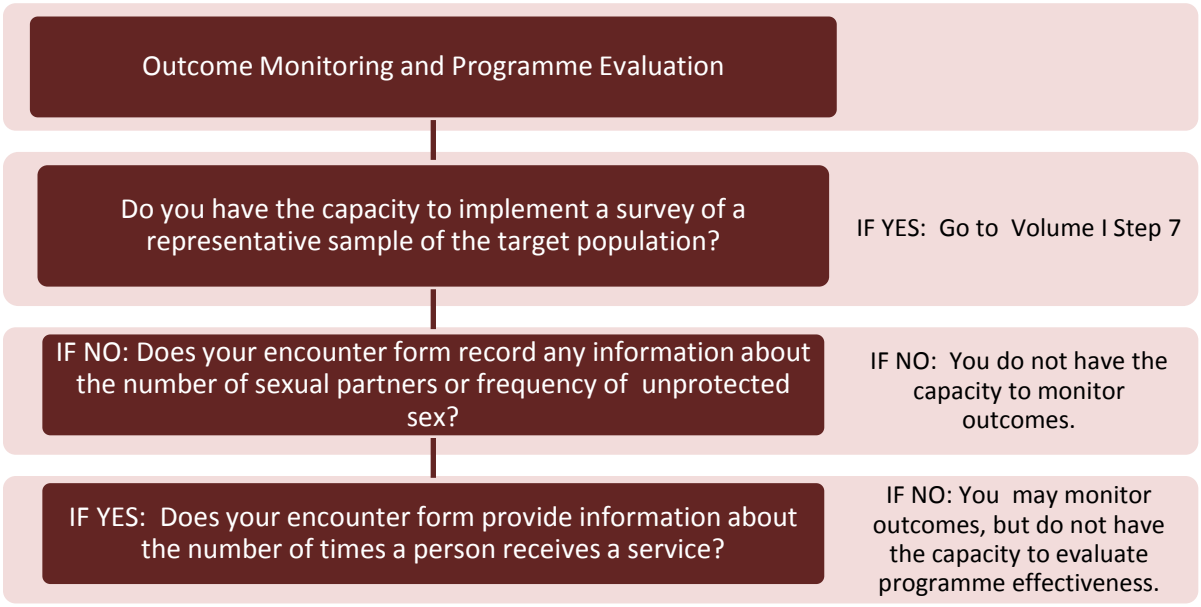
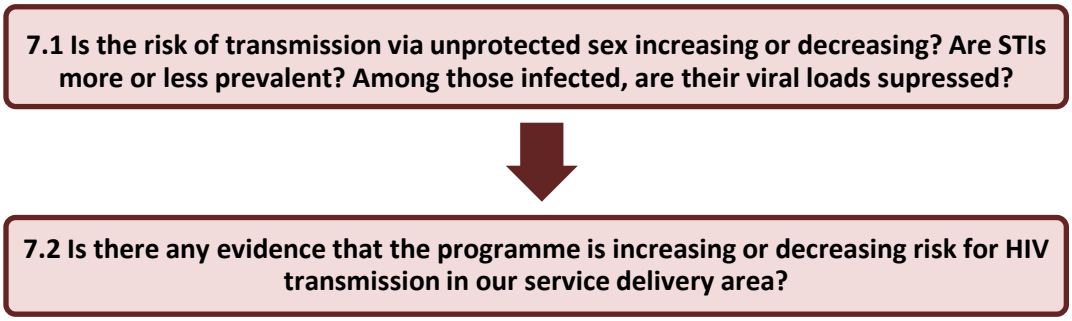


Figure II.7.2 Questions to Assess Whether Step 7 Is Appropriate or Additional Information Is Needed



B. Step 7 Flowchart (Figure II.7.3)



Checklist: Information needed to monitor outputs Information needed for Step 7

- ☐ Encounter form data (See Step 6.1.3)
- ☐ User survey data
- ☐ Bio-behavioural survey reports conducted in the area (See Step 2.1)

C. How to Answer the Key Questions and Use Data: Overview for Step 7

	Key Question	Methods	Products	Used To
7.1	**Is the risk of transmission via unprotected sex increasing or decreasing? Are STIs more or less prevalent? Among those infected, are their viral loads supressed?**	1. Analysis of information from Encounter Forms 2. Brief surveys of users	Trends in condom use, number of partners, STIs and viral load	Assess whether there are any changes in the specified outcome indicators over time
7.2	**Is there any evidence that the programme is increasing or decreasing risk for HIV transmission our service delivery area?**	Use an outcome evaluation design to determine if any changes in outcomes are due to the programme	Report of outcome evaluation	Identify strengths and weaknesses of a programme in order to improve its effectiveness

D. Methods and Tools

7.1 Is the risk of transmission via unprotected sex increasing or decreasing? Are STIs more or less prevalent?

7.1.1 Monitor outcomes using Encounter Form data

Service delivery data are a valuable source of information about the people receiving services. For example, if the Encounter Form records whether a condom was used at last sex, it would be possible to aggregate monthly the number of people who reported using a condom at last sex and the number who did not. Trends in the number who reported using a condom could be monitored over time.
Interpretation of this trend is difficult, however, because information on people who did not use the service is not taken into account. Programme data may show an increase in the number of sex workers using condoms, however, the problem may not be improving in the service delivery area if few sex workers are accessing condoms or the number of sex workers is increasing in the area.
See Volume I Step 7 for further guidance on analysing and interpreting trends in outcome data.

7.1.2 Monitor outcomes using surveys

Surveys can be used for assessing changes in outcome measures. Survey participants are asked about their utilization of specific services, about any facilitators or barriers to service use, as well as the quality of the services received. Obtaining information on the use of services—both the quantity and intensity, as well as on HIV-related risk behaviours, can be used to determine whether there is evidence of a decrease in risk behaviours among users accessing services. See Tools 18 (pg. 129) and 19 (pg. 138) for a list of illustrative survey questions and the corresponding indicators that can be obtained.
Surveys are typically repeated every two years to collect outcome indicators. They require additional expertise and resources to do them well and are therefore mostly conducted by the sub-national and/or national level. Other data collection methods are also used to interpret the findings from surveys. See Volume I section 7.1 for more information about the range of methods which should ideally be used.

Data Use

- Trend analysis is used to assess whether there are any changes in the specified outcome indicators over time.
- A change in outcome indicators can signal an increase or decrease in new HIV infections.

7.2 Is there any evidence that the programme is increasing or decreasing risk for HIV transmission our service delivery area?

7.2 Conduct an outcome evaluation

There is a difference between outcome monitoring and outcome evaluation:
Review definitions on page 85.

Deciding whether an evaluation is needed requires a clear understanding of what it is already known about the programme. Research studies have found condoms to be effective in preventing HIV transmission. Consequently there is no need to conduct an evaluation to determine if condoms are effective. What is more important is to conduct an evaluation to assess whether your programme has increased condom use or not. It is important to select appropriate evaluation methods and a skilled evaluation team to ensure that valid results can be obtained which will allow for improvement of the programme where needed. Detailed information about outcome evaluation methods is provided in Volume I section 7.2.

Data Use

- An outcome evaluation is used to determine whether services or interventions provided by your organization were responsible for changes in outcome indicators such as condom use, STI prevalence or viral load.
- Outcome evaluations are useful in identifying strengths and weaknesses in programmes and making improvements.

E. Summary

See Volume I Step 7 for more information on outcome monitoring and evaluation.

Appendices

Step 8. Impact Monitoring and Evaluation: Is the HIV combination prevention programme reducing the number of new HIV cases?

A. Why this step is especially challenging for service delivery providers

Service delivery providers rarely have the capacity to monitor HIV prevalence or incidence among the persons in their catchment area or to assess whether their programmes are responsible for change in HIV prevalence or incidence among persons in their catchment area. The difference between impact monitoring and impact evaluation is often misunderstood. *Impact monitoring* describes trends in HIV prevalence or incidence, while *impact evaluation* assesses whether changes in HIV prevalence or incidence can be attributed to a specific programme.

We all want the best for the people we serve and following these 8 steps is the way to make sure we're making a difference. We need to know the population we aim to help, the services they need, the resources needed to provide those services, the quality of the services provided and the number of people served to do the best job possible. Steps 7 and 8 are more technically challenging but get at the heart of the problem: are new HIV cases prevented? Though, it's really hard to say whether the changes over time are due to chance alone or are impacted by the services we provide.

Most service providers do not conduct impact monitoring or impact evaluation for several reasons. Changes in HIV prevalence or incidence are often small, hard to measure in a short period of time, and difficult to attribute to a specific programme. Few, if any, service providers have the capacity to evaluate their programmes in this way and it is also not needed. Impact is most likely to be the combined effect of several services/programmes (i.e., high service coverage in all/most areas in need), not the effect of a single programme or service. Thus, impact monitoring and evaluation is typically conducted at the national/sub-national level to understand the effects of the overall HIV prevention response in the country/sub-national area. The service delivery level plays a critical role in impact assessments since aggregated service delivery data are analysed and used to understand the results of the overall response. Moreover, service staff and programme managers may be asked to participate in reviews of service records and regular reporting systems; key informant interviews; population-based surveys, longitudinal studies, review of secondary data, etc. Methods for impact monitoring and impact evaluation are described in Volume I Step 8.

Appendices

Appendices

Appendix 1. Tools

TOOL 1. Topics to address in a rapid assessment for men who have sex with men, transgender people and sex workers

TOOL 2. Overview of Size Estimation Methods

TOOL 3. Worksheet for setting impact, outcome, and coverage targets at sub-national or national level. Example for sex workers

TOOL 4. Topics to address in a rapid assessment for sex workers, men who have sex with men, and transgender people

TOOL 5. Quality/Programme Enabler checklist.

TOOL 6. Comprehensive Encounter Form

TOOL 7. Short Encounter Form

TOOL 8. Target setting worksheet for quality and output measures at the service delivery level

TOOL 9. Output Form: Training log

TOOL 10. Referral card and referral monitoring form

TOOL 11. Form for monitoring distribution of male or female condoms and condom-compatible lubricant

TOOL 12. Form for monitoring HIV testing and counselling interventions

TOOL 13. Form to calculate the number of people reached by outreach programmes

TOOL 14. Form to monitor outputs across outreach workers

TOOL 15. Checklist for post-service user-centred approach for provision of condoms and condom-compatible lubricants

TOOL 16. Tool for participant feedback to assess distribution of condoms and condom-compatible lubricants

TOOL 17. User satisfaction survey for HIV testing and counselling

TOOL 18. Worksheet to Select Measures at National, Sub-National and Service Delivery Levels to Monitor and Evaluate Programmes for Men who Have Sex with Men and Transgender People

TOOL 19. Worksheet to Select Measures at National, Sub-National and Service Delivery Levels to Monitor and Evaluate Programmes for Sex Workers

TOOL 20. Pictorial Encounter Forms for outreach workers in low education settings

Appendix 2. HIV/AIDS Monitoring and Evaluation Glossary

Appendix 3. References

Appendix 1. Tools

TOOL 1 Illustrative Critical Enabler Activities and Indicators

Critical Enabler Intervention	Activities- Examples	Indicators – Examples
Social Enablers:		
Stigma reduction	Increasing knowledge about HIV transmission and its causes and impact; engaging community, religious and political leaders to challenge stereotypes and norms, values and culture that fuel stigma	Output: Number of stigma reduction sessions held with religious leaders Outcome: Percentage of sex workers that experience stigma
Community mobilisation	Identification of key populations at higher risk that need HIV services and key hotspots through which information and services will be disseminated; establishing networks of people living with HIV and other key populations for sharing information, education and communication; engaging the family members of key populations at higher risk and wider community to support information, education and communication initiatives; community empowerment and violence reduction strategies among key populations at higher risk	Output: Number of sex worker networks Outcome: Percentage of sex workers reached by networks/community empowerment interventions
Local responses to change the risk environment	Data about local HIV prevalence and mapping of local HIV service providers; engagement of local government, religious and traditional leaders and networks of people living with HIV and key populations at higher risk; engagement of local government, religious and traditional leaders to promote gender equality and reduce harmful gender norms	Output: Number of local government, religious and traditional leaders that participate in gender equality interventions Outcome: Percentage of local government, religious or traditional leaders that report stigma towards key populations

Programme Enablers:		
Community-centred design and delivery	Participatory needs assessments and planning of the programme activities to identify key high-risk behaviour and its causes and consequences; Participatory monitoring of programme activities to identify bottlenecks, lessons learned and corrective actions	Output: Number of needs assessments in which individuals from key populations participated.
Health education	Incorporating skills-based activities for HIV into information, education and communication and curricula; train and support teachers; regular assessment of knowledge, attitudes, skills and behaviour	Output: Number of schools that that include skills-based activities for HIV in curricula Outcome: Percentage of teachers reporting stigma towards key populations Percentage of youth with skills-based HIV knowledge, attitudes and behaviours
Gender equality and gender-based violence interventions	Empowerment of women and transgender people through gender equality and HIV training; community mobilization, peer-based participatory education challenging harmful gender norms, particularly among men, boys and girls	Output: Number of transgender individuals that participate in gender equality and HIV training Outcome: Percentage of transgender individuals reached by gender equality and HIV training Percentage of transgender individuals reached by peer-based participatory education challenging harmful gender norms

TOOL 2. Overview of size estimation methods

Method name	Description	Advantages	Disadvantages
Census/ Enumeration	-Census methods count all members of the population. -Enumeration methods develop a sampling frame and count all members of the population at a sample of places listed in the sampling frame.	-Census methods are the gold standard as it is a full count of the population - Use in programme planning, implementation, evaluation	-Key populations are often hidden and it is likely that any census or enumeration methods will miss members of the population. -Stigma against key populations may preclude self-identification as population member -Time consuming and expensive to conduct
Capture-recapture	-Uses mathematical formula to calculate total size of population based on two independent captures of population members 1) Capture 1: 'tag' and count number tagged 2) Capture 2: 'tag' and keep track of who is 'retagged' & who is 'first time tagged'	- When applying a simple two-sample capture-recapture model the method: is relatively easy to use; does not require much data; the effect of violating assumptions is easy to understand (e.g. samples not independent); does not require considerable degree of statistical expertise	Relies on four conditions that are hard to meet: 1) two samples must be independent & not correlated 2) each population member should have equal chance of selection 3) correctly identify 'capture' & 'recapture' persons 4) no major in/out migration
Multiplier	-Compares two independent sources of data for key populations -Source 1: count/listing of key population who accessed a service/object -Source 2: survey with representative sample that gives % of key population that accessed service /object	-Uses data sources already available - Flexible in terms of a sampling method, such as random sampling or nomination (snowball) sampling methods; - Useful in many circumstances - Easy when already doing a BSS	-Two sources of data must be independent -Data sources must define key population in the same way -Time periods, age ranges and geographic areas must be aligned -Inaccuracy of programme data used as a benchmark

Method name	Description	Advantages	Disadvantages
Nomination method **(also called 'snowball' 'respondent driven' or 'chain' sampling methods)**	-Begins with a few known members of key population -Asks them to nominate/contact peers who share same behaviours	-With key population members helping to make introductions method can be easy to conduct -Does not require much field work/site visits since key population members recruit peers	**-Not** recommended for size estimation Reasons why: 1) Populations often engage in behaviours that are illegal or stigmatized making it difficult to collect identifying information to help with de-duplication. 2) Begins with visible members of key population who may not represent complete population at risk 3) Depends on key population being networked 4) Sophisticated statistical methods necessary to analyse
Population survey methods	- Include questions relevant to behaviours of interest (male-male sex, sex work, etc.) in population based surveys	-Surveys are common and familiar -Easy to implement if survey is underway -Straightforward to analyse - Sampling is easy to defend scientifically ("gold standard")	-Low precision when behaviours are rare -Only reaches people residing in households -Respondents unlikely to admit to high risk or stigmatized behaviours within household where others can hear (privacy, confidentiality, risk to subjects)

Method name	Description	Advantages	Disadvantages
Network Scale-up Method	-Based on idea that people's social networks reflect the general population -Ask random sample in general population to estimate number of people they know who have a characteristic of interest -Uses maximum likelihood estimation for an unbiased estimate of how many people each respondent knows -These estimates allow for estimating size of population of interest	-Can generate estimates from general population rather than hard-to-reach populations -Does not require asking detailed sensitive questions or lengthy behavioural survey	-Dependent on having clear definition of what is to 'know' someone -Average personal network size is difficult to estimate -Accuracy of responses is unknown -Some subgroups may not associate with members of general population -Respondent may be unaware someone in his/her network engages in behaviour of interest -Biases (i.e. social desirability) may arise by types of questions asked
Extrapolation	-Creating an estimate for where data does not exist -Simple version: apply a standardized formula/% to all areas (men who have sex with men=4% of adult men) -Complex version: Apply a formula that takes into account context & geography	-Uses existing data sources -Provides way to get an estimate when little data are available about key populations	-Must consider geographic variability. Does same % hold for the key population in urban and rural areas? -Must know how generalizable local data sources are? Can they be extrapolated to other areas? -Definitions from data must match your population definition

TOOL 3. Worksheet for setting impact, outcome, and coverage targets at sub-national or national level. Example for sex workers

NOTE: Not all possible measures are included here. See list of measures in Tools 18 and 19.

	Measure	Year	Estimate	Target	Target met? No / Yes
Impact measures					
G1	HIV prevalence among sex workers				
1.4	HIV incidence among sex workers				
Outcome measures — Biological determinants					
G2	Percentage of female and male sex workers reporting the use of a condom with their most recent client				
2.1	Percentage of sex workers reporting symptoms of an STI in the past 12 months				
Outcome measures — Contributing factors and enabling environment					
2.9	Percentage of sex workers who report experiencing stigma in the last 12 months				
2.10	Percentage of sex workers reporting physical violence within last 12 months				
Coverage measures					
G4	Percentage of sex workers that have received an HIV test in the last 12 months and who know their results				
3.4	Percentage of sex workers reached by condom promotion and distribution programmes the past 12 months				
3.6	Percentage of sex workers screened for STI in the past 12 months				

TOOL 4. Topics to address in a rapid assessment for sex workers, men who have sex with men, and transgender people

Topics to address in a rapid assessment of sex workers can include:

Social enablers

- What national laws and policies restrict the rights of sex workers?
- What is the culture and context of sex work?
- Where do female sex workers solicit? Where do male sex workers solicit? What are the main strategies used to recruit clients? What proportion of sex workers are male?
- What is the pathway into sex work? What is the pathway out of sex work?
- What characterizes the relationship between sex workers and the police?

Programme enablers

- Which international donors are involved in providing services? What are the most important restrictions if any in the provision of donor funded services?
- In which sub-national areas are sex workers located? What is their age and educational level?
- Who are the main providers of services to sex workers? Who are the advocates? How is the community organized?

Individual factors

- Which factors increase the vulnerability of people in each of these populations to health problems including sexually transmitted infection and drug dependence?
- What are the characteristics of sex workers who appear to be most at risk for acquiring or transmitting HIV?
- Are there identifiable sub-groups that require different prevention approaches?
- What issues are perceived as important by sex workers?
- Which health issues are important?
- To what extent are transgender people engaged in sex work?

Note: Further information can be found in the WHO rapid assessment tool for MSM (2004): http://www.who.int/hiv/pub/prev_care/en/msmrar.pdf

Topics to address in a rapid assessment of men who have sex with men can include:

Social enablers:

- What national laws and policies restrict the rights of men who have sex with men?
- How do newspapers portray men who have sex with men?
- What is the stance of religious leaders regarding sex between men and gay marriage?
- What is the culture, sociological and historical context of sex and relationships between men?
- What is the pathway into sex work for young men who have sex with men who engage in sex work? What is the pathway out of sex work?
- Are there national or local groups of MSM that advocate for MSM? Who are these groups and where are they located? What are the objectives of these groups? Is HIV prevention one of their objectives?
- What is the role of beauty within the gay culture? Can values around beauty be tapped for increasing the acceptance of an HIV positive test result?
- How common are violence, discrimination and human rights violations against men who have sex with men? Have there been recent assessments of stigma or violence against men who have sex with men?

Programme enablers:

- Which international donors are involved in providing services? What are the most important restrictions if any in the provision of donor funded services?
- What are the sub-groups of men who have sex with men? What issues are important to each sub-group? Which health issues are important? What prevention strategies are required for each sub-group? Which sub-groups of men who have sex with men should be monitored separately?
- Who are the main providers of services to men who have sex with men?
- Are MSM who are well-educated and self-sufficient financially in need of additional targeted prevention programmes or are their needs served by current programmes or the private sector?
- Men who have sex with men may resist “advice” from health educators. What are the characteristics of messages that work?

Individual factors:

- Do men meet new sexual partners online, in public venues such as bars, clubs, parks, malls, saunas, public toilets, train stations, and/or at private parties? What is the socialisation environment like for men who have sex with men? Is it covert? Is bisexuality culturally acceptable?
- How does having male partners in secret or non-disclosure of sexual preferences influence likelihood of condom use?
- What is the perception of risk among men who have sex with men for HIV and STI?
- What are the characteristics of men who have sex with men who appear to be most at risk for acquiring or transmitting HIV? In which sub-national areas are they located? What is their age and educational level? What are the underlying causes of their increased risk?
- How does the individual’s mental health influence his risk behaviour?
- Which factors increase the vulnerability of MSM to health problems including sexually transmitted infection and drug dependence?

Topics to address in a rapid assessment of transgender people can include:

Social enablers

- What is the culture and context of sexual relationships among transgender people?
- What national laws and policies restrict the rights of transgender people?
- How do newspapers portray transgender people?
- Who are the people who speak out about transgender issues? Are there national or local groups that advocate for transgender people? Who are these groups and where are they located? What are the objectives of these groups? Is HIV prevention one of their objectives?
- What is the role of beauty within the gay culture? Can values around beauty be tapped for increasing the acceptance of an HIV positive test result?
- What is the pathway into sex work for transgender people who engage in sex work?
- How common are violence, discrimination, human rights violations against transgender people? Have there been recent assessments of stigma or violence?

Programme enablers

- Which international donors are involved in providing services? What are the most important restrictions if any in the provision of donor funded services?
- Are there identifiable sub-groups that require different prevention approaches?
- Who provides services to transgender people?

Individual factors

- Where do transgender people meet sexual partners?
- To what extent are transgender people engaged in sex work?
- To what extent are transgender people at risk for HIV acquisition and transmission? What is the perception of risk among the population?
- What are the characteristics of transgender people who appear to be most at risk for acquiring or transmitting HIV? In which sub-national areas are they located?
- What issues are perceived as important by transgender people? Which health issues are important including psychological issues?
- Which factors increase the vulnerability of transgender people to health problems including sexually transmitted infection and drug dependence?

TOOL 5 Quality/Programme enabler checklist.

The intervention quality encompasses the scope, completeness, safety, user satisfaction, consistency of services delivered and appropriateness to population targeted and setting in which it is delivered. High quality services with attention to programme enablers will ensure demand for services is high.

Universal standards that should be applied across all health services, social and programme enabler interventions provided to key populations include:

Standards on involving key populations

- ☐ The populations identified for targeted prevention services are included in needs assessment, planning, delivery, and evaluation of HIV prevention services, social and programme enabler interventions

Standards on users' rights

- ☐ Users are fully informed of the nature and content of the services as well as the risks and benefits to be expected
- ☐ Confidentiality and privacy of users is maintained at all times
- ☐ Guarantee of human rights; removal of legal barriers to access prevention and care
- ☐ Access to medical and legal assistance for key populations who experience sexual coercion or violence

Standards on providing entire package of services to key populations

- ☐ Ensure awareness and easy access to all services in the package
- ☐ Ensure protocols corresponding to each service in the package are updated periodically, disseminated to and followed at all service delivery levels

Standards on staffing

- ☐ Staff has regular supervision by senior staff to maintain quality of service delivery
- ☐ Training and sensitization of health-care providers to avoid discriminating key populations

Standards on availability and accessibility

- ☐ Services are available irrespective of age, ethnicity, sexual identity, citizenship, religion, employment status, health insurance status, substance use status of all potential users
- ☐ Services are easily accessible with regard to location, travelling time, cost and transportation
- ☐ Services are equitable and non-discriminatory
- ☐ Availability of safe virtual or physical spaces (for example telephone hotlines, or drop-in centres, respectively) for key populations to seek information and referrals for care and support
- ☐ Communication plan to make community aware of services in place

<u>For all services **FIVE *A's*** approach:</u>
-Adherence to national standards
-Availability of service
-Accessibility of service
-Acceptability of service
-Attitudes of service delivery providers towards users are positive

<u>Also while providing services:</u>

☐ System that ensures no stockouts
☐ UIC or other system to count number of unique users versus number of contacts
☐ Established referral system including a follow-up mechanism
☐ Provide targeted education and risk reduction counselling
☐ Conduct risk assessment
☐ Provide male or female condoms and condom-compatible lubricants for key populations while providing any other HIV prevention services

Quality Check list by Service:

Provision of male or female condoms and condom-compatible lubricants

☐ Male and female condoms and condom-compatible lubricant are consistently available within a country
☐ Male and female condoms and condom-compatible lubricant are available to consumers at the right time, place and price
☐ All condoms and condom-compatible lubricant are of reliable quality by the time they reach the consumer
☐ The condom is provided in a respectful manner, with adequate information on how to use the condom
☐ Condom-compatible lubricants are provided at the same time with a condom
☐ Community is aware of condom distribution points
(Drawn from: UNFPA, WHO, PATH (2005). Condom programming for HIV prevention: a manual for service providers. UNFPA, New York, USA)

Prevention and treatment of sexually transmitted infections (STIs)

☐ People diagnosed with STI receive appropriate treatment
☐ The STI case management guidelines delivered with the quality specified in the national guidelines
☐ The national STI management guidelines periodically reviewed at the national level to ensure their continued correspondence to the latest treatment methods
☐ Counselling services provided when people come to receive STI treatment
☐ Accepting attitudes (not stigmatizing) among people providing STI care
☐ Population participates in provision of services
☐ Community is aware of STI diagnostic and treatment services
☐ Adherence to treatment is ensured

Targeted education and risk reduction counselling for key populations and their sexual partners

Prevention services and materials provided to key populations are:

- ☐ Culturally sensitive and competent
- ☐ Appropriate to the age, education level, language and other needs of consumers
- ☐ Accurate and up-to-date
- ☐ In the case of materials, in formats which are most appropriate for reaching populations served
- ☐ Provided by key populations
- ☐ Available and advertised for key population

Outreach workers possess the following attributes:

- ☐ Experience working with and the ability to speak the same language as the target population(s)
- ☐ Possession of knowledge about available resources and the ability to refer consumers to those resources
- ☐ The capacity to maintain appropriate documentation
- ☐ Possession of knowledge about issues related to safety, consumer engagement, ethics, and professionalism

☐ Each Outreach Worker receives appropriate supervision and oversight

☐ Each Provider delivers Outreach Services that access at-risk individuals in settings where members of the target population are likely to be located and at times when members of the target population are likely to be present

☐ Each Provider delivers Outreach based on sound prevention theory that is appropriate to their target population and outcome objectives. Outreach services strive to help consumers develop skills and motivation to adopt and maintain safer behaviours over time

☐ Interventions Delivered to Groups consist of sessions with a maximum of 15 participants that build on each other and that include skill-building components

(The education and risk reduction standards are drawn from: Standards of HIV/AIDS Care & Services and HIV/AIDS Prevention & Education, Pennsylvania Department of Health, Division of HIV/AIDS http://www.aidsnetpa.org/Documents/Subgrantee/prevention%20standards.pdf)

HIV Testing and Counselling

☐ HIV Testing and Counselling provided in accordance with the pre-determined national protocol
☐ The counsellors deliver the pre-determined protocol
☐ The counsellors provide users with opportunities for questions
☐ People receiving testing and counselling feel that their confidentiality is protected
☐ Waiting time to receive the test results is not long from the users' point of view
☐ Population participates in provision of HIV testing and counselling
☐ Patients are linked to ART or other services as needed
☐ Population knows where to go HIV testing and counselling services

Necessary information prior to testing

"Prior to administering an HIV test, providers should explain:
☐ the rationale for testing, the type of test to be used, and the meaning of a positive/negative result;
☐ that if managed with antiretroviral therapy (ART) and quality clinical care, HIV infection may be controlled as a chronic condition;
☐ that the test result is confidential and that disclosure of a positive result is needed to enrol in treatment;
☐ that users are encouraged to ask questions regarding the test process; and
☐ that users may opt out of testing without repercussion to other care services."

Source: Pan American Health Organization (2010). Blueprint for the Provision of Comprehensive Care to Men Who Have Sex with Men (MSM) in Latin America and the Caribbean. Pan American Health Organization, Washington, D.C.:

Minimum standards

The minimum acceptable standards for approaches to HIV testing and counselling require that all models of service delivery respect the following principles.

- ☐ HIV testing and counselling should be voluntary
- ☐ Individuals should have sufficient information, understanding and freedom of choice to be able to give informed consent to testing
- ☐ Pre-test information (for PITC) and pre-test counselling for user-initiated testing and counselling) are fundamental to informed consent to testing
- ☐ There should be appropriate post-test information, counselling and/or referral
- ☐ There should be consistent commitment and ethical support to encourage partner participation and disclosure to significant others
- ☐ Persons whose test results are positive should receive counselling and referral to care, support and treatment, where available
- ☐ HIV test results and counselling records should be treated confidentially and only those health-care workers with a direct role in the management of patients should have access to this information
- ☐ Persons whose test results are negative should receive counselling to enable them to remain free of HIV

(more information on strategies to improve user return rated for receiving HIV test results: http://www.michigan.gov/documents/mdch/FTR.Strat.May.07.FINAL_197486_7.pdf)

Antiretroviral therapy (ART)

☐ Being a member of a key populations does not exclude a person from accessing ART services
☐ Population participates in provision of ART services
☐ Patients are linked to complementary health and psychological services as needed
☐ Population knows ART services exist and how to access them

Health care providers should:

☐ learn how to listen to patients more openly and without judgment
☐ become better educated about current recommendations for the care of key populations .

In health care facility:

☐ Service signage, photographs, and other visual elements are welcoming and key populations inclusive
☐ Protocol for the collection of personal information allows discretion and does not require disclosure of sensitive personal information
☐ Clinical services do not focus exclusively on sexual behaviour risk factors but provide opportunities for counselling and psychological assessment and care
☐ The environment in the clinic allows users to feel safe, accepted, and valued

☐ The health care facility is safe, clean, inviting, and appropriately designed and equipped to care for patients. It is located in a place that is easily reached by the target population, whether urban, semi-urban or rural. It is on or near public transportation lines and has adequate parking. Access to the facility is well lit, well maintained, and users are required to wait in, or pass through isolated or unsafe areas to reach the clinic. The entry to the facility is secure and allows for a locked door, a security guard, and/or a double-door entry, as appropriate.

Source**:** Pan American Health Organization (2010). Blueprint for the Provision of Comprehensive Care to Men Who Have Sex with Men (MSM) in Latin America and the Caribbean. Pan American Health Organization, Washington, D.C.:

Methods to improve quality of programme management

- Make use of improvements in data collection technology
- Use process evaluation results to improve programme performance
- Staff training
- Improve staff supervision
- Minimize start turnover
- PDCA (plan-do-check-act) cycle

M&E System Quality Check list

The importance of creating, implementing and strengthening a unified and coherent M&E system at the country level cannot be overemphasized. A strong unified M&E system ensures that: 1) relevant, timely and accurate data are made available to national programme leaders and managers at each level of the programme and health care system; 2) selected quality data can be reported to national leaders; and 3) the national programme is able to meet donor and international reporting requirements under a unified global effort to contain the HIV epidemic (Global Fund.)

☐ Reporting forms are available at all levels
☐ Programme data are collected and submitted for reporting with the established frequency
☐ Datasets are maintained electronically and appropriately safeguarded
☐ Standardized Recording and Reporting Form at service delivery level
☐ Continuous Capacity building
☐ Clear Indicator Definition
☐ Timely feedback of indicators and reports to service delivery providers
☐ System that facilitates an "evidence-informed approach" to decision making
☐ Adherence to the principles of the Three Ones (see below. Source: http://www.measuredhs.com/hivdata/guides/GlobalFund_pp_me_toolkitJan2006.pdf)

> ***-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 multi-sector mandate; and
> ***-One*** agreed-upon country-level *monitoring and evaluation system*.

TOOL 6. Comprehensive Encounter Form

A DATE AND LOCATION OF ENCOUNTER **Encounter #:_____**

A1 Type of Location 1 Drop-in centre 2 STI services provider 3. Other provider (specify _____)	**A3 Today's Date** Day ____/ Month ____/ Year _____ **A4 Service delivery provider** (e.g. NGO) number
A2 Sub-national area number	**A5 ID number of individual providing service:**

B UNIQUE IDENTIFIER CODE AND DEMOGRAPHIC INFORMATION

B1 Unique Identifier Code	**B5** Gender: 1 M 2 F 3TG-MTF 4TG-FTM
B2 First EVER visit to site? 1 YES 2 NO	**B6** Birth Date Day ____/ Month ____/ Year _____
B3 First visit since January 1: 1 YES 2 NO	**B7** Primary Language:
B4 Other Service Providers Visited in Past 30 Days:	**B8** When Moved to This Area: Month:___Year_____

C ASSESSMENT

1 Received Money for Sex in Past 30 days	2 Paid Money for Sex in Past 30 days	3 Number of Partners in Past 7 days		4 Last time, Used Condom?	5 Times Unprotected Receptive Anal Intercourse Past 30 Days	6 User Stage for Condom Use (Use codes below)	7 Experienced Violence in Past 12 Months?	
							Physical	Emotional
Y N	Y N	Male:		Y N			Y N	Y N
		Female:		Y N				

User Stage for Condom Use

1 Did not consider 2 Thought about it 3 Tried First Time 4 Inconsistent Use 5 Consistent Use

D HIV TESTING AND COUNSELLING

D1 HIV Status?	D2 Counselled?	D3 Tested?	D4 Results provided?	D5 Test result?	D6 ART?
1 Positive 2 Negative 3 Unknown/Refused	1 Yes 2 No	1 Yes 2 No	1 Yes 2 No	1 Positive 2 Negative	1 Provided here 2 Provided elsewhere 3 Referred 4 Not Eligible

E SUMMARY OF SERVICES PROVIDED or REFERRED DURING THIS VISIT (Circle all that apply)

		A	B	C	D	E	F	G	H	I
		Assessed	Counselled	Tested	Vaccination Completed	Treatment Started	Treatment Ongoing	Treatment Completed	Referral Made	Referral Outstanding
	Health Services									
1	STI Services	**1**	**2**	**3**		**5**	**6**	**7**	**8**	**9**
2	Hepatitis B Services	**1**	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9**
3	Hepatitis C Services	**1**	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9**
4	TB Services	**1**	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9**
5	Primary health care	**1**	**2**	**3**		**5**	**6**	**7**	**8**	**9**
6	Mental health services	**1**	**2**	**3**		**5**	**6**	**7**	**8**	**9**
7	Drug/ Alcohol addiction	**1**	**2**			**5**	**6**	**7**	**8**	**9**
	Commodities Provided	**Yes**	**No**							
8	Condoms	**1**	**2**	**Number:**						
9	Lubricants	**1**	**2**	**Number:**						
10	education and risk reduction Materials	**1**	**2**	**Number:**						
11	Needles/Syringes	**1**	**2**	**Number:**						

Instructions for the Comprehensive Encounter Form

Ref code	Indicator	Sub-indicators	Definition
A DATE AND LOCATION OF ENCOUNTER			
	Encounter #		Each encounter with a man who has sex with men, sex worker or transgender person should have a unique encounter number. This will be used to track number of encounters total and number of encounters per man who has sex with other men, sex worker or transgender person.
A1	**Type of Location:**		
		1 Drop-in centre	
		2 STI Services provider	
		3 Other provider (specify_____	A site that does not fall into one of the above categories

A2	**Sub-national area number**		Each sub-national area should have an associated code number. Enter it here.
A3	**Today's Date**	Day / Month / Year	dd/mm/yyyy
A4	**Service delivery provider**		The service delivery provider is the NGO or other organization that is responsible for the site's functioning. Each service delivery provider should have an associated code number. Enter it in the box.
A5	**ID number of individual providing service:**		Each outreach coordinator, peer educator or clinician should have an ID number. Enter it in the box.
B UNIQUE IDENTIFIER CODE AND DEMOGRAPHIC INFORMATION			
B1	**Unique Identifier Code**		An example of the unique identifier code developed by Population Services International is a simple 7-digit code composed of: • First two letters of mother's first name • First two letters of father's first name • Gender (single letter M/F or number) • Year of birth (last two digits).
B2	**First EVER visit to site?**	1 YES 2 NO	Record if the person has ever visited the site in which you are filling out the encounter form
B3	**First visit since January 1**	1 YES 2 NO	Record if the person has been to the site in which you are filling out the encounter form this year
B4	**Other Service Providers Visited in the Past 30 days**		Write in the code or standardized name of each facility that the person has visited in the last month. Keep a list of facility reference codes handy so that you can fill this in easily during the encounter.
B5	**Gender**		
		1 M	Male
		2 F	Female
		3TG-MTF	Transgendered – Male to Female
		4TG-FTM	Transgendered – Female to Male
B6	**Birth Date**	Day / Month / Year	dd/mm/yyyy
B7	**Primary Language**		Write in the primary language
B8	**When Moved to This Area**	Month/ Year	The month and year of when the person moved to the catchment area of the site
C ASSESSMENT			
The indicators in this section aim to gather information about the person's receipt of money for sex, frequency of sexual acts, number of partners, and behaviours and attitudes regarding condom use. --- Ask if the person has engaged in a sexual act in the last 30 days. If the answer is 'yes', proceed to questions C1-C6. If the answer is 'no', move on to the next section of the Encounter Form.			

C1	**Sex for Money in Past 30 days**			If the person has engaged in a sexual act for payment in the past 30 days, circle Y. If the person has not engaged in a sexual act for payment in the last 30 days, circle N. If neither Y nor N is circled, it means that the person refused to answer, does not know, or the data is missing.
C2	**Paid Money for Sex in Past 30 days**			If the person has paid for sex in the past 30 days, circle Y. If the person has not paid for sex in the last 30 days, circle N. If neither Y nor N is circled, it means that the person refused to answer, does not know, or the data is missing.
C3	**Number of Partners in Past 7 Days**	**Male** **Female**		Write in the number of male and/or female sexual partners the person has had in the past 7 days. For sex workers, write in the number of male and/or female clients the person has had in the past 30 days. If the person has not had any sexual partners/clients in the last 7 days, input 0 and skip C4, C5, and C6.
C4	**Last time, Used Condom?**			Circle Y if the person used a condom the last time he engaged in a sexual act. Circle N if he did not use a condom the last time he engaged in a sexual act. If neither Y nor N is circled, it means that the person refused to answer, does not know, or the data is missing.
C5	**Times Unprotected Receptive Anal Intercourse in Past 30 Days**			Write in the number of times the person has had unprotected receptive anal intercourse in the past 30 days. You may change the wording of this question to use more colloquial terms that are culturally relevant.
C6	**User Stage for Condom Use in Past 7 Days**			If the person has engaged in one or more sexual acts in the past 7 days, assess the person's attitudes and behaviours regarding condom use. Use the following codes to indicate stage.
		1	Did not consider	Input 1 in the box if the person has not thought about using condoms in the past 7 days.
		2	Thought about it	Input 2 in the box if the person has seriously contemplated using condoms within the past 7 days.
		3	Tried First Time	Input 3 if the person has tried to use or successfully used a condom for the first time in the past 7 days.
		4	Inconsistent Use	Input 4 if the person has used condoms in the past 7 days, but has not used them for *all* sexual acts in the past 7 days.
		5	Consistent Use	Input 5 if the person used condoms for *all* sexual acts in the past 7 days.
C7	**Experienced**	**Physical**		Ask the person if he has experienced physical violence or

	Violence in Past 12 Months	**Emotional**	emotional abuse in the past 12 months. Physical violence includes sexual assault. Emotional abuse includes verbal abuse, harassment, and neglect.
D HIV TESTING AND COUNSELLING (circle response)			
If you have a confidential way to inquire about and record the person's HIV status, proceed to fill out this section. However, if there is a possibility that confidentiality could be compromised (e.g. unsecured database, someone might overhear the conversation, etc), then DO NOT ask the questions in section F.			
D1	**HIV Status?**		
		1 Positive	Circle Positive if the person reports that he/she has received results indicating that he/she is HIV positive. Skip D3, D4, and D5.
		2 Negative	Circle Negative if the person has received results *in the last 12 months* indicating that he is HIV negative.
		3 Unknown/Refused	Circle Unknown/Refused if the person does not know his status, refused to answer, or received a negative test result more than 12 months ago.
D2	**Counselled?**	1 Yes 2 No	Indicate if the person was counselled about HIV transmission prevention, HIV testing and treatment. All people should be counselled about these topics during an encounter.
D3	**Tested?**	1 Yes 2 No	Indicate whether the person was tested for HIV during this encounter
D4	**Results provided?**	1 Yes 2 No	Indicate whether results were provided to the person during this encounter. This indicator can be used to record the results of an HIV test done today or an HIV
D5	**Test result?**	1 Positive 2 Negative	If the person received his results, indicate if the result was positive or negative
D6	**ART?**		
		1 Provided here	
		2 Provided elsewhere	
		3 Referred	
		4 Not Eligible	
E SUMMARY OF SERVICES PROVIDED or REFERRED DURING THIS VISIT (Circle all that apply)			
	Definitions of service provision codes		The codes listed below are suggested codes that cover various outcomes of an encounter with a member of key population. The form can be easily modified to accommodate other or fewer outcomes. For example, if your site captures more specific information about treatment status, you may want to modify the form to include various phases of treatment specific to each condition. For those services that your site does not provide, a referral should be made.
1		**Assessed**	Circle 1 if the person was assessed for the need or usefulness of each service

2		**Counselled**	Circle 2 if the person was counselled about the service
3		**Tested**	Circle 3 if the person was tested (when relevant)
4		**Vaccination Completed**	For Hepatitis B, STI, and TB services categories, indicate if the person has completed vaccination by circling 5
Treatment includes antiretroviral drugs, mental health counselling and related pharmacotherapy, drugs to treat Hepatitis B, anti-TB agents, etc.			
5		**Treatment Started**	Circle 6 if the person has started treatment
6		**Treatment Ongoing**	Circle 7 if the person is currently on treatment
7		**Treatment Completed**	Circle 8 if the person has completed treatment
8		**Referral Made**	Circle 8 if the person was referred for the service because the service is not provided at this site
9		**Referral Outstanding**	Circle 9 if the person was previously referred for a service, but has not yet gone to the referral site
	Definitions of services		The following is a list of services that ought to be provided to men who have sex with men, sex workers and transgender people. You may modify this list based on national guidelines for the comprehensive package of services for men who have sex with men, sex workers and transgender people.
E1		**STI Services**	Refer to national guidelines for the effective management of STIs. Can include: case management of STI, syndromic management of STI, assessment for STI risk factors, STI treatment, etc.
E2		**Hepatitis B Services**	Refer to national guidelines Can include: immunization, education about transmission and vaccination schemes, screening of blood and blood products, etc.
E3		**Hepatitis C Services**	Refer to national guidelines Can include: Diagnosis, treatment, education, etc.
E4		**TB Services**	All services should have a case-finding protocol for TB and HIV so that personnel are aware of the symptoms of TB and HIV and can ensure that drug users have access to appropriate TB and HIV testing and counselling, preferably at the service where they initially present.
E5		**Primary health care**	As defined by national guidelines

E6		**Mental health services**	Any non-pharmacological intervention carried out in a therapeutic context at an individual, family or group level. Psychosocial interventions may include structured, professionally administered interventions (e.g. cognitive behaviour therapy or insight oriented psychotherapy) or non-professional interventions (e.g. self-help groups and non-pharmacological interventions from traditional healers).
E7		**Drug/ Alcohol addiction**	Refer to national guidelines
	Commodities Provided	This section is used to record commodities provided to the person *during this visit.* If 'Yes' is circled for any of the commodities, be sure to write the number of commodities provided in the appropriate cells.	
E8		**Condoms**	If no male and female condoms were provided to the person during this encounter, circle 2 for 'No' and move on to the next line. If condoms were provided to the person today, circle 1 for 'Yes' and write in the number that were provided.
E9		**Condom-compatible lubricants**	If no condom-compatible lubricants were provided to the person during this encounter, circle 2 for 'No' and move on to the next line. If lubricants were provided to the person today, circle 1 for 'Yes' and write in the number that were provided.
E10		**Education and Risk Reduction Materials**	Educational and risk reduction materials consist of pamphlets, flyers, or other information, education and communication materials. If no educational and risk reduction materials were provided to the person during this encounter, circle 2 for 'No'. If educational and risk reduction materials were provided to the person today, circle 1 for 'Yes' and write in the number that were provided.
E11		**Needles/ Syringes**	If no needles or syringes were provided to the person during this encounter, circle 2 for 'No' and move on to the next line. If needles or syringes were provided to the person today, circle 1 for 'Yes' and write in the number that were provided.

TOOL 7. Short Encounter Form

Service Delivery Provider Number: ___________________ Type of Site: ____________ Sub-National Area: ____________________________

Unique Identification Code (UIC)				Date of encounter mm/dd/yy	Contact with Service Provider		Number Provided			Number of Partners in last 7 days		Last time sex – used condom?	Times sex in the past 7 days	Of those times, how many with condom?	Test and Treatment Provided (insert code in each box)									
Gender	Date of Birth mm/dd/yy	First 2 letters of mother's name	First 2 letters of father's name		First ever?	First since Jan1?	Lubricants	Condoms	Educational materials	Male	Female				*HIV*		*HEPB*		*HEPC*		*STI*		*TB*	
															Test	Treatment	Test	Treatment	Test	Treatment	Test	Treatment	Test	Treatment
M F TG-MTF TG-FTM	___/___/___	____	____	___/__/___	Yes No	Yes No	___	___	___	___	___	Yes No	___	___										
M F TG-MTF TG-FTM	___/___/___	____	____	___/__/___	Yes No	Yes No	___	___	___	___	___	Yes No	___	___										
M F TG-MTF TG-FTM	___/___/___	____	____	___/__/___	Yes No	Yes No	___	___	___	___	___	Yes No	___	___										

Codes		
Gender codes:	**Test codes:**	**Treatment codes:**
M= Male F=Female TG-MTF = Transgendered – male to female TG-FTM =Transgendered -- female to male	1 =Test offered and accepted 2 = Test offered and refused 3= Test not applicable because user already tested positive 4= Test not offered	1 = Treatment provided 2= Referred for Treatment 3= Treatment not provided and user not referred

Instructions for the Short Encounter Form

Ref code Indicator	Sub-indicators	Definition
Unique Identification code		
An example of the unique identifier code developed by Population Services International is a simple 7-digit code composed of: • First two letters of mother's first name • First two letters of father's first name • Gender • Year of birth (last two digits).		
Gender	M	Male
	F	Female
	TG-MTF	Transgendered – male to female
	TG-FTM	Transgendered – female to male
Date of Birth		Input two digits for month, two digits for day, and two digits for year
First 2 letters of mother's name		Input first two letters of mother's name
First 2 letters of father's name		Input first two letters of father's name
Date of encounter		Input two digits for month, two digits for day, and two digits for year
Contact with Service Provider		
	First ever?	Circle Yes if this is the person's first visit to this site. Circle No if the person has visited the site before
	First since Jan 1?	Circle Yes if this is the person's first visit since the beginning of the year. Circle No if the person has visited the site at least once already this year
Number Provided	Condom-compatible lubricants	Input the number of condom-compatible lubricants provided during this encounter. If no lubricants were provided, input 0.

		Condoms	Input the number of male and female condoms provided during this encounter. If no condoms were provided, input 0.
		Educational and risk reduction materials	Educational and risk reduction materials consist of pamphlets, flyers, or other information, education and communication materials. If no educational and risk reduction materials were provided to the person during this encounter, input 0. If educational and risk reduction materials were provided to the person today, input the number of materials provided
Number of Partners in Past 7 Days		Male	Write in the number of male and/or female sexual partners the person has had in the past 7 days. If the person has not had any sexual partners in the last 7 days, input 0 and skip other questions related to sexual acts
		Female	
Last time sex -used condom?			Circle Yes if the person used a condom the last time he engaged in a sexual act. Circle No if he did not use a condom the last time he engaged in a sexual act. If neither Y nor N is circled, it means that the person refused to answer, does not know, or the data is missing.
Times Sex in Past 7 days			Write in the number of times the person has engaged in a sexual act in the past 7 days. If the answer is 0, skip the next question.
Of those times, how many with condom?			If the person engaged in a sexual act in the last 7 days, ask how many times a condom was used. Write the number in the box.
Test and Treatment Provided (insert code in each box)			
Test codes	1	Test offered and accepted	Input 1 in the Test box if a test was offered to the person and he agreed to be tested.
	2	Test offered and refused	Input 2 in the Test box if a test was offered to the person and he refused to be tested.
	3	Test not applicable because user already tested positive	Input 3 in the Test box if a test was not applicable because the person is positive for the outcome in question. For example, if the person is HIV positive, he will not be offered an HIV test unless he wants to be tested for verification purposes.
	4	Test not offered	Input 4 in the Test box if the test was not offered. Reasons for this include test stockouts, person who does the testing or the counselling is unavailable, etc.
Treatment codes	1	Treatment provided	Input 1 in the Treatment box if treatment to the person during this encounter.
	2	Referred for treatment	Input 2 in the Treatment box if the person was referred to another site for treatment.
	3	Treatment not provided and user not referred	Input 3 if the person was not given treatment and was not referred for treatment. Use this code if the site normally provides treatment to users, but currently has a stockout of medicine. Also use this code if the person is not eligible for treatment (e.g. person's CD4 count has not yet reached the level at which treatment is recommended).

TOOL 8. Target setting worksheet for quality and output measures at the service delivery level

NOTE: Not all possible measures are included here; additional measures may be added as appropriate. The measures are numbered as per the list of measures in Tools 18 and 19 and including the data source and full references.

	Measure	Baseline Estimate or No/Yes	Target	Follow-Up Estimate	At Follow-Up Target Met? No Yes
Quality measures					
6.2	Percentage of HIV testing and counselling sites that conduct outreach to men who have sex with men	n/n =%	%	n/n =%	0 1
6.3	Percentage of providers testing and treating for STIs who have been trained to provide STI services to men who have sex with men	n/n =%	%	n/n =%	0 1
6.4	Percentage of men who have sex with men diagnosed with STI who received treatment	n/n =%	%	n/n =%	0 1
6.5	Whether men who have sex with men participate in quality audits	N/Y	Y	N/Y	0 1
6.6	Whether men who have sex with men participate in service delivery	N/Y	Y	N/Y	0 1
Output measures					
4.1	Number of unique medical providers receiving training on providing treatment to men who have sex with men	n	n	n	0 1
4.2	Number of men who have sex with men provided with condoms and condom-compatible lubricant by HIV prevention programmes for men who have sex with men	n	n	n	0 1
4.3	Number of condoms and condom-compatible lubricant distributed by HIV prevention programmes for men who have sex with men	n	n	n	0 1
4.4	Number of coordinated mass media campaigns, segmented by audience, that address high-risk sexual norms, reduce multiple and concurrent partnerships, reduce stigma towards men who have sex with men	n	n	n	0 1

TOOL 9. Output Form: Training log

This form can be used by service providers to monitor number of people trained.

Service location: _____

Service provider ID: _____

Name of the training:_____

ID	Name of student	Date	Type of training	Training is completed (Yes/No)	Final exam is passed (Yes/No)
1					
2					

TOOL 10. Referral card and referral monitoring form

Referral card

Date referred:			
UIC	**Referred by (A4)**	**Referred to (code)**	**Service requested (E)**

Monthly monitoring form for referrals

Date referred	**UIC**	**Service requested (code from E):**
Referral results (check one):	□ Person never came to referral site □ Person came to referral site – doesn't need to return □ Person came to referral site – needs to return □ Person came –referred elsewhere	Date seen: _____ Date referred: _____

Instructions for referral card and referral monitoring form

Referral card	
This form is used to track a person who has been referred. The referred person should provide this card to the referral site upon arrival.	
UIC	Write in unique identifier code for referred person: See B1.
Referred by (A4)	Write in the service delivery provider code.
Referred to (code)	Write in the code for the site to which the person is referred.
Service requested (E)	Write in the code of the service requested from section E. For example, if the person is being referred for legal counselling, write "E17."
Monthly referral monitoring form	
This form is used report on the outcome of a referral on a monthly basis.	
Date referred	Write in the date when the person was referred to your site.
UIC	Write in unique identifier code for referred person: See B1.
Service requested (code from E):	Write in the code of the service requested from section E. For example, if the person has been referred for legal counselling, write "E17."
Referral results:	Check one of the following options to record what happened to the person who was referred for a service.
Person never came to referral site	Check this box if the referred person never came to the site.
Person came to referral site – doesn't need to return (Date seen):	Check this box if the person came and received services. This box should be checked in a situation where the person only needed to come to the referral site one time. For example, if the person came for abscess care and prevention (E3), received treatment, and does not need to return – check this box. Additionally, write in the date the referred person was seen.
Person came to referral site – needs to return	Check this box if the person came and received services, but needs to return to complete the referral. For example, if the person was referred to the site for mental health counselling, it is likely that he/she will need to come back for subsequent sessions. In that case, check this box.
Person came –referred elsewhere (Date referred):	Check this box if the person came to the referral site, but the services he/she was referred for were not available at that time. Check this box if it was necessary to refer the person elsewhere so that he/she could get the services sought. Write in the date the person was referrfed.

Reference:http://www.searo.who.int/LinkFiles/Publications_Module_02_Treatment_&_Care_for_HIV_positive_IDUs.pdf

TOOL 11. Form for monitoring distribution of male or female and condom-compatible lubricant

This form can be used by service providers to monitor programme outputs.
Location of the services: _____
Service provider ID: _____
Reported time period: _____

Unique identifier code of programme participant	Date	Number of condoms given	Number of condom compatible lubricant sachets given	Information materials given (Yes/No)	Referrals for other services made (Yes/No), if yes, to what services

TOOL 12. Form for monitoring HIV testing and counselling interventions

This form can be used by service providers to monitor programme outputs.

Location of the services: _____

Service provider ID: _____

Reported time period: _____

Number	Unique identifier code of programme participant	Date of testing and counselling	Information materials given (Yes/No)	Condoms/lubricants are given (Yes/No)	Referrals for other services made (Yes/No), if yes, to what services	A person came back to receive results (Yes/No)
1						
2						
3						

TOOL 13. Form to calculate the number of people reached by outreach programmes

This form can be used by peer educators/outreach workers to monitor programme outputs.

Name and location of the service delivery point _____

Peer educator ID:__

Date: Week of _____

Instructions: Please enter information in each of the rows daily and submit the form to your supervisor by Monday of the following week.

Day of the week/services provided	**Mon**	**Tues**	**Wed**	**Thurs**	**Fri**	**Sat**	**Sun**	**Total**
Number of unique contacts made								
Number people reached for the first time								
Number of educational and risk reduction materials distributed								
Number of condoms/lubricants distributed								

Comments _____

TOOL 14. Form to monitor outputs across outreach workers

This form can be used by service providers to monitor programme outputs.

Name and location of service delivery point _____

Peer educator's code	Date: Week of_____	Number of contacts made	Weekly target	Number of people reached for the first time	Number of male or female condoms distributed	Number educational and risk reduction materials distributed

TOOL 15. Checklist for post-service user-centred approach for provision of male or female condoms and condom-compatible lubricants

This form can be used by both non-programme staff members to conduct direct observations and by staff members to determine if all necessary events within one interaction have occurred

☐ User was welcomed in a friendly manner

☐ User was asked whether he needs any information on use of male or female condoms and condom-compatible lubricant

☐ User was asked if he was clear about the use of the male or female condoms and condom-compatible lubricants

☐ User was encouraged to come back before he is out of condoms or condom-compatible lubricants

☐ User was encouraged to tell friends about this condom and condom-compatible lubricant distribution service

☐ User was asked if he has any other questions or needs

☐ User was encouraged to fill in a user/participant feedback tool to improve quality of services

☐ Services were provided in a respectful, professional manner

TOOL 16. Tool for participant feedback to assess distribution of condoms and condom-compatible lubricants

Are you satisfied with the services provided to you today? (Very satisfied, satisfied, not satisfied, very unsatisfied)

Do you feel that your needs for male or female condoms and lubricants were met? (Yes, No)

How much in your opinion, was the staff attentive and responsive to your needs? (Very much, moderate, not at all)

How friendly was the staff to you today? (Very friendly, friendly, not friendly, not friendly at all)

If applicable, do you feel that all your questions on condoms and condom-compatible lubricants use were answered? (Yes, No)

Did you feel comfortable asking a staff member questions on condom and lubricant use? (Very comfortable, comfortable, not comfortable, not comfortable at all)

Please suggest any ways we could improve our services to better serve you in the future.

TOOL 17. User satisfaction survey for HIV testing and counselling

Please help us improve our services by taking a few minutes to answer this survey.
Do not put your name on this form.

For each question mark the one answer that best describes what you think.

Did the counselling help you? ☐ Helped a lot ☐ Helped some ☐ Did not help

Did you get helpful information? ☐ A lot of information ☐ A little information ☐ No information

When you saw the counsellor . . .

Who talked the most? ☐ Me ☐ The counsellor ☐ We talked the same amount

Who listened the most? ☐ Me ☐ The counsellor ☐ We listened the same amount

For each of these mark only one: A lot, Some, or Not at all:	A lot	Some	Not at all
4. Did the counsellor answer your questions and concerns about HIV?	☐	☐	☐
5. Did the counsellor help you think about what you were doing that puts you at risk for getting HIV?	☐	☐	☐
6. Did the counsellor help you make a plan to protect yourself from HIV?	☐	☐	☐
7. Did the counsellor help you come up with small steps you can take to make your plan work?	☐	☐	☐
8. Did the counsellor tell you about other places you could go for help?	☐	☐	☐

For each of these mark only one: ***Yes, No, or I don't know:***	Yes	No	Don't know
9. I have no risk of getting HIV.	☐	☐	☐
10. I am at risk of getting HIV.	☐	☐	☐
11. I want to reduce my risk of getting HIV.	☐	☐	☐
12. I know the ways to reduce my risk.	☐	☐	☐
13. I have a plan for how I will reduce my risk.	☐	☐	☐
14. I like my plan.	☐	☐	☐
15. I'm sure I can follow my plan.	☐	☐	☐

16. In your plan to reduce your risk, who came up with what you will do? ☐ I did ☐ The counsellor

17. How much did the counsellor help you? ☐ More than enough ☐ Enough ☐ Not enough

18. How much did you help the counsellor? ☐ More than enough ☐ Enough ☐ Not enough

19. How much did you tell the counsellor about your sex life and use of drugs?

☐ All of it ☐ Some of it ☐ None of it

What else would you like to tell us about your experience with the counsellor?_____

_____

Thank You!

Source for the HIV Test Counselling Client Satisfaction Survey: www.doh.wa.gov *website (http://www.doh.wa.gov/concon/FmsReptTitlePage/titlepage.htm).*

TOOL 18. Worksheet to Select Measures at National, Sub-National and Service Delivery Levels to Monitor and Evaluate Programmes for Men who Have Sex with Men and Transgender People

The worksheet below can be used to select global, national, sub-national and service delivery measures for monitoring and evaluating HIV prevention programmes for men who have sex with men and for programmes for transgender people.

In general, measures should be monitored for important sub-groups such as bisexual men, men who have sex with men only, men who have sex with men and inject drugs, and men who have sex with men or women in exchange for money. The list below includes measures relevant to most of these sub-groups.

The worksheet below includes indicators recommended at the global level for Global AIDS Response Progress Reporting (GARPR) and Universal Access (UA) reporting and presents other measures to monitor progress in implementing programmes based on programme impact pathways. Consistent monitoring of these measures can identify bottlenecks and where additional attention is needed. Programme impact pathways should be developed in collaboration with implementing partners including members of the key populations. These pathways will differ from country to country and consequently the measures may also vary. The highest priority is to monitor measures at the sub-national level in areas most in need of HIV prevention programmes for men who have sex with men and transgender people, based on the size of the population and an understanding of the local epidemic.

Usually national-level measures are aggregated measures based on sub-national estimates from bio-behavioural surveys or service delivery data.

Service delivery providers focus on input and output measures but may estimate coverage and outcome measures if they collect the appropriate data. Service delivery providers are encouraged to review the forms provided in these operational guidelines in order to obtain measures described below and to consider using unique identifiers to accurately estimate the number of persons reached by interventions and to provide an independent assessment of prevention programme coverage.

The list of measures below is primarily written for monitoring and evaluation of programmes for men who have sex with men. The list for monitoring programmes for transgender people is identical except that there is one additional measure for transgender people (See measure 2.7). The list for transgender people is not repeated here.

This list does not include indicator reference sheets. Indicator reference sheets fully describe each indicator including its purpose, how it is defined, how often it should be collected, and what are its strengths and weaknesses. After a period of consultation, we anticipate that reference sheets will be developed for each measure below and available on UNAIDS, UNDP, UNFPA, and Global Fund websites.

Abbreviations:
GARPR-Global AIDS Response Progress Reporting
UA-Universal Access indicators
UNGASS-United Nations General Assembly Special Session
DHS-Demographic Health Survey
AIS-AIDS Indicator Survey

References:
1-Global AIDS Response Progress Reporting (GARPR) (2012). Guidelines: Construction of Core Indicators for Monitoring the 2011 Political Declaration on HIV/AIDS (2011). UNAIDS, Geneva.
2- UNAIDS (2008). Practical guidelines for intensifying HIV prevention: towards universal access. UNAIDS, Geneva.
3-At the National level: Aggregated Annually from Sub-national level Annual Reports
4-At the Sub-National level: Aggregated Quarterly from Monthly Programme data
5-Repeated Cross-Sectional Bio-Behavioural Surveys of Men who Have Sex with Men Conducted Every 2 years in sub-national areas
6-M&E Operational Guidelines for Monitoring and Evaluation of HIV Prevention for Sex Work, Men who have Sex with Men, and Transgender People (M&E Operational Guidelines)
7-GARPR Most-at-Risk Populations indicator applied to men who have sex with men
8-The measures are used for gap analysis (amount needed minus amount available)
9-Universal Access (UA) indicators (2011). A Guide on Indicators for Monitoring and Reporting on the Health Sector Response to HIV/AIDS.
10-The President's Emergency Plan for AIDS Relief (2009). Next Generation Indicators Reference Guide. Verson 1.1. PEPFAR, Washington, D.C.
11-The Global Fund to Fight AIDS, Tuberculosis and Malaria (GFATM) (2011). Monitoring and Evaluation Toolkit. Part 2. 4th ed. GFATM, Geneva.
12-Global UNGASS Indicator (2009). Monitoring the Declaration of Commitment on HIV/AIDS: guidelines on construction of core indicators : 2010 reporting. UNAIDS, Geneva.
13-UNDP (2012). UBRAF Indictaors.

Note: All measures need to be compared with the targets set in Step 3.

Note: National measures are based on sub-national estimates aggregated to national level.

Note: For input, output and coverage measures, sub-national measures are based on service delivery data aggregated to the sub-national level.

Note: UNGASS indicators are no longer reported as UNGASS was a 10 year agreement that ended in 2011. The Global AIDS Response Progress Reporting (GARPR) indicators replaced the UNGASS indicators and while all GARPR indicators were formerly part of UNGASS not all UNGASS indicators were carried forward as GARPR. If your organization routinely collects data on UNGASS indicators that were not carried forward into GARPR, you can decide whether to continue collecting data for those indicators or abandon them and focus on GARPR, national and other indicators of your choice.

Worksheet for Selecting Measures

Number	Indicator	Method	Reference	Relevant Steps	Selected Y / N
Section 1. Indicators for Global Reporting					
G1	HIV prevalence among men who have sex with men	Bio-Behavioural Surveys [5]	GARPR[1]#1.14, UA[9] #C6c, PEPFAR[10]#9.17N, GFATM[11]#HIV-I4, (formerly UNGASS#23[12,7])	1 & 8	
G2	Percentage of men reporting the use of a condom the last time they had anal sex with a male partner	Bio-Behavioural Surveys [5]	GARPR[1]#1.12, UA[9] #C5d, PEPFAR[10]#9.4N, GFATM[11]#HIV-O5, (formerly UNGASS [12]#19	2 & 7	
G3	Percentage of men who have sex with men who both correctly identify ways of preventing the sexual of HIV and who reject major misconceptions about HIV	Bio-Behavioural Surveys [5]	(formerly UNGASS[12,7]#14)	2 & 7	
G4	Percentage of men who have sex with men that have received an HIV test in the last 12 months and who know their results	Bio-Behavioural Surveys [5]	GARPR[1]#1.13, PEPFAR[10]#P9.10N, GFATM[11]#HIV-C-P6, (formerly UNGASS[12,7]#8)	6	
G5	Percentage of men who have sex with men reached with HIV Prevention Programmes	Bio-Behavioural Surveys [5]	GARPR[1]#1.11, GFATM11#HIV-C-P3, (formerly UNGASS[12,7] #9)	6	
G6	Percentage of eligible men who have sex with men currently receiving ART	Routine Programme data	UA[9] # G2a, (formerly UNGASS [12]#4)	6	
G7	Whether or not the national M&E plan includes all of the components for M&E of HIV prevention programmes for men who have sex with men	Desk review and key informant interviews conducted as part of the NCPI	(formerly UNGASS [12]: Appendix 4 NCPI Part A Section V Number 2 adapted to focus on men who have sex with men)	4	
G8	Total funds expended on programmes for men who have sex with men	National AIDS Spending Assessment for a calendar or fiscal year & Financial Resource Flows	GARPR[1]#6.1, (formerly UNGASS [12]: Appendix 3 National Funding Matrix 1.09)	4	

Number	Indicator	Method	Reference	Relevant Steps	Selected Y / N
Section 2. Other National-Level Indicators from UNAIDS Indicator Registry, Universal Access Reporting (UA), PEPFAR and Global Fund (GFATM) indicator guidelines					
U1	Number of MARP* reached with individual and/or small group level HIV preventive interventions that are based on evidence and/or meet the minimum standards required Note: * Indicator reference uses "MARP".	Service Delivery data	PEPFAR[10]#P8.3D, GFATM[11]#HIV-P4, UNAIDS Indicator Registry # 536	6	
U2	Number and percentage of key populations reached with a basic (minimum) package of HIV prevention services (Indicator should be used when the basic package of services is defined)	Routine Programme data	GFATM[11]#HIV-P5, UNAIDS Indicator Registry # 760	6	
U3	Percentage of men who have sex with men with active syphilis	Bio-Behavioural Surveys [5]	UA[9] # F5	2&7	
U4	Enabling Environment Index for men who have sex with men (Scale 1-10, see below)	Document and Policy Review	GARPR1#7.1 National Commitments and Policy Instrument (NCPI) (formerly UNGASS-National Composite Policy Index (NCPI))	2 & 7	

Indicator U3 Enabling Environment Index for Men who Have Sex with Men (Contributing Factor Outcome Indicator)		**Yes No**
U3.1	Has the country developed national multisectoral strategy to respond to HIV that addresses men who have sex with men? (NCPI, Part A, Section I, 1.3)	Y N
U3.2	Has the country ensured "full involvement and participation" of civil society [including men who have sex with men] in the development of the multisectoral strategy? (NCPI, Part A, Section I, 1.7)	Y N
U3.3	Does the country have a mechanism to promote interaction between government, civil society organizations [including organizations of men who have sex with men], and the private sector for implementing HIV strategies/programmes? (NCPI, Part A, Section II, 3)	Y N
U3.4	Does the country have non-discrimination laws or regulations which specify protections for men who have sex with men? (NCPI, Part A, Section III, 1.1)	Y N
U3.5	[Is the] country [free of] laws, regulations or policies that present obstacles to effective HIV prevention, treatment, care and support for men who have sex with men? (NCPI, Part A, Section III, 2)	Y N
U3.6	Does the country have a policy or strategy to promote information, education and	Y N

	communication and other preventive health interventions for key or other vulnerable sub-populations [such as men who have sex with men]? (NCPI, Part A, Section IV, 3)	
U3.7	Does the [country have a] policy or strategy policy/strategy that addresses condom promotion for men who have sex with men? (NCPI, Part A, Section IV, 3.1)	Y N
U3.8	Does the [country have a] policy or strategy policy/strategy that addresses HIV testing and counselling for men who have sex with men? (NCPI, Part A, Section IV, 3.1)	Y N
U3.9	Does the [country have a] policy or strategy policy/strategy that addresses stigma and discrimination reduction for men who have sex with men? (NCPI, Part A, Section IV, 3.1)	Y N
U3.10	Does the [country have a] policy or strategy policy/strategy that addresses targeted information on risk reduction and HIV education for men who have sex with men? (NCPI, Part A, Section IV, 3.1)	Y N
U3.11	Does the [country have a] policy or strategy policy/strategy that addresses vulnerability reduction (e.g. income generation) for men who have sex with men? (NCPI, Part A, Section IV, 3.1)	Y N
U3.12	Has the country has identified the specific needs for HIV prevention programmes [for men who have sex with men] (NCPI, Part A, Section IV, 4)	Y N
U3.13	To what extent has HIV prevention been implemented? Do the majority of [men who have sex with men] in need have access to risk reduction? (NCPI, Part A, Section IV, 4.1)	Y N
U3.14	Is there a central national database with HIV-related data on key populations [such as men who have sex with men]? (NCPI, Part A, Section V, 6.1)	Y N
U3.15	Does the country a policy to ensure equal access for men who have sex with men to HIV prevention, treatment, care and support? (NCPI, Part B, Section II, 8)	Y N
U3.16	Does the country have municipal level comprehensive HIV prevention, treatment and care programmes implemented for and with men who have sex with men or transgender people? (UBRAF UNDP Indicator A1.2.1a)[13]	Y N
Index: Sum of "Yes"		

Section 3. Other measures in the Guidelines[6] that may be useful

Number	Measures	Method	Relevant Steps	Selected Y / N
National Level and Selected Sub-National Area Measures				
Impact Measures including Size of Population				
1.1	Number of men who have sex with men	DHS or AIS survey, Size estimation methods	1 & 8	
1.2	Number of men who have sex with men who are HIV positive	Modelling (Spectrum /MOT)	1 & 8	
1.3	HIV prevalence among men who have sex with men age 15-24 as a proxy for HIV incidence	Bio-Behavioural Surveys [5]	1 & 8	
1.4	HIV incidence among men who have sex with men	Modelling (Spectrum /MOT)	1 & 8	

Outcome Measures for Direct / Biological Determinants of HIV Transmission				
2.1	Average number of new male sex partners per year among men who have sex with men	Bio-Behavioural Surveys [5]	2&7	
2.2	Percentage of men who have sex with men who report having sex for the first time younger than age 15	Bio-Behavioural Surveys [5]	2&7	
2.3	Percentage of men who have sex with men reporting unprotected receptive anal sex at last time they had sex with a male partner	Bio-Behavioural Surveys [5]	2&7	
2.4	Percentage of men who have sex with men who are circumcised	Bio-Behavioural Surveys [5]	2&7	
2.5	Percentage of men who have sex with men reporting use of injecting drugs in last 12 months	Bio-Behavioural Surveys [5]	2&7	
2.6	Percentage of men who have sex with men who inject drugs reporting use of clean needle the last time injected	Bio-Behavioural Surveys [5]	2&7	
2.7	Percentage of transgender people who inject drugs or other substances (e.g. silicone) for gender enhancement reporting use of clean needle the last time they injected	Bio-Behavioural Surveys [5]	2&7	
Outcome Measures for Enabling Environment and Contributing Factors				
2.8	Percentage of people in general population with high score on homophobia scale (See for example, Wright, L. W., Adams, H. E., & Bernat, J. (1999)).	Population-based household surveys	2&7	
2.9	Percentage men who have sex with men who report experiencing stigma within last 12 months	Culturally appropriate stigma scale within surveys[5]	2&7	
2.10	Percentage of men who have sex with men reporting physical violence within last 12 months	Bio-Behavioural Surveys [5]	2&7	
2.11	Percentage of men who have sex with men reporting verbal abuse within last 12 months	Bio-Behavioural Surveys [5]	2&7	
2.12	Percentage of men who have sex with men reporting getting paid in exchange for having sexual intercourse in last 12 months	Bio-Behavioural Surveys [5]	2&7	
2.13	Percentage of men who have sex with men who report at last sexual intercourse use of alcohol by himself or partner (*See AIDS Indicator Survey, March 2006*)	Bio-Behavioural Surveys [5]	2&7	
2.14	Percentage of men who have sex with men reporting symptoms of an STI in the past 12 months	Bio-Behavioural Surveys [5]	2&7	
Coverage Measures				
3.1	Percentage of men who have sex with men receiving no HIV prevention services in the past 12 months	Bio-Behavioural Surveys [5]	6	
3.2	Percentage of men who have sex with men receiving the country-defined minimum package of services in the	Bio-Behavioural Surveys [5]	6	

	past 12 months			
3.3	Percentage of men who have sex with men reporting that they could get condoms on their own if they wanted *(Adapted from UNAIDS Indicator Registry #400)*	Bio-Behavioural Surveys [5]	6	
Sub-National Level and Service Delivery Providers				
Coverage Measures				
For each service in the nationally defined package of services, percentage of men who have sex with men who received the service in the past 12 months (or ever for vaccination) (sub-national only):				
3.4	Percentage of men who have sex with men reached by condom promotion and distribution programmes the past 12 months	Bio-Behavioural Surveys [5]	6	
3.5	Percentage of men who have sex with men reached by lubricants promotion and distribution programmes the past 12 months	Bio-Behavioural Surveys [5]	6	
3.6	Percentage of men who have sex with men screened for STI in the past 12 months	Bio-Behavioural Surveys [5]	6	
3.7	Percentage of men who have sex with men reached by HIV testing and counselling programme in the past 12 months and know their result (same as G4)	Bio-Behavioural Surveys [5]	6	
3.8	Percentage of men who have sex with men who have received specific and targeted information on prevention and risk reduction strategies designed to appeal to and meet the needs of men who have sex with men	Bio-Behavioural Surveys [5]	6	
3.9	Percentage of men who have sex with men who have completed the course of HBV vaccination	Bio-Behavioural Surveys [5]	6	
Note: Service delivery providers that know the size of the men who have sex with men population in their catchment area and can estimate the unique number of persons reached may estimate coverage measures 3.4-3.9.				
Geographic Coverage (for Each Sub-National Area Monitored)				
3.10	Whether HIV prevention programme providing comprehensive package is available for men who have sex with men in sub-national area (Y/N)	Programme data[4]	6	
Services				
3.11	Availability of condom promotion and distribution programmes for men who have sex with men in sub-national area (Y/N)	Programme data[4]	6	
3.12	Availability of lubricants distribution programmes for men who have sex with men in sub-national area (Y/N)	Programme data[4]	6	
3.13	Availability of quality treatment for sexually transmitted infections in sub-national area (Y/N)	Programme data[4]	6	
3.14	Availability of voluntary testing and counselling in sub-national area (Y/N)	Programme data[4]	6	

3.15	Availability of information and prevention and care services for female partners of men who have sex with men in sub-national area (Y/N)	Programme data[4]	6	
3.16	Availability of HIV treatment and care programmes for men who have sex with men in sub-national area (Y/N)	Programme data[4]	6	
3.17	Availability and promotion of hepatitis immunization in sub-national area (Y/N)	Programme data[4]	6	
3.18	Number of service delivery providers offering the country defined minimum package of services to men who have sex with men in sub-national area	Programme data[4]	6	
Enabling environments- Geographic Availability				
3.19	Availability of medical and legal assistance for boys and men who experience sexual coercion and violence in sub-national area (Y/N)	Document Review, Stakeholders' meetings	6	
3.20	Availability of safe virtual and physical spaces (e.g. telephone hotlines, drop-in centres) for men who have sex with men to seek information and referrals for care and support in sub-national area (Y/N) *(See UNAIDS Practical Guidelines for Intensifying HIV Prevention[2])*	Stakeholders' meetings	6	
Output Measures				
4.1	Number of unique medical providers receiving training on providing treatment to men who have sex with men compiled quarterly	Programme data[4]	6	
4.2	Number of men who have sex with men provided with condoms and lubricants by HIV prevention programmes for men who have sex with men compiled quarterly	Programme data[4]	6	
4.3	Number of condoms and lubricant sachets distributed by HIV prevention programmes for men who have sex with men compiled quarterly	Programme data[4]	6	
4.4	Number of coordinated mass media campaigns, segmented by audience, that address high-risk sexual norms, reduce multiple and concurrent partnerships, reduce stigma towards men who have sex with men compiled quarterly *(See UNAIDS Practical Guidelines for Intensifying HIV Prevention[2])*	Programme data[4]	6	
Input Measures - The measures are used for gap analysis (amount needed minus amount available)				
5.1	Funds available	Programme data[4]	4	
5.2	Human Resources available	Programme data[4]	4	
5.3	Equipment available	Programme data[4]	4	
National, Sub-National Level and Service Delivery Providers				
Quality Measures				
6.1	Percentage of safe spots that meet quality standards	Quality Audit	5	

6.2	Percentage of HIV testing and counselling sites that conduct outreach to men who have sex with men	Programme data[3,4]	5	
6.3	Percentage of providers testing and treating for STIs who have been trained to provide STI services to men who have sex with men	Programme data[3,4]	5	
6.4	Percentage of men who have sex with men diagnosed with STI who received treatment	Surveys[5], Programme data[3,4]	5	
6.5	Whether men who have sex with men participate in quality audits	Quality Checklist	5	
6.6	Whether men who have sex with men participate in service delivery	Quality Checklist	5	
6.7	Among men who have sex with men diagnosed with HBV in the past 12 months, percentage of men who have sex with men receiving treatment for HBV	Programme data[3,4]	5	
6.8	Among men who have sex with men who were due to complete HBV treatment in the past 12 months, percentage of men who have sex with men completing treatment for HBV	Programme data[3,4]	5	
6.9	Among men who have sex with men diagnosed with TB in the past 12 months, percentage of men who have sex with men who started treatment	Programme data[3,4]	5	
6.10	Number of condoms and lubricant sachets available for distribution nationwide *(See HIV/AIDS Survey Indicators Database, Indicator # 2.1.)*	Condom data from condom manufacturers, distributors, major donors, storage facilities, governments and NGOs	5	
6.11	Percentage of retail outlets and services with condoms and condom-compatible lubricant in stock *(See HIV/AIDS Survey Indicators Database, Indicator # 2.2.)*	A number of sites of different types are randomly selected for a retail survey.	5	
6.12	Percentage of condoms that meet quality control measures *(See HIV/AIDS Survey Indicators Database, Indicator # 2.3.)*	The sampling frame for retail outlets used in Condom Availability Indicator 2, Retail outlets and services with condoms in stock, can be used for the retail portion of this indicator; condoms may be sampled from retail outlets during the retail survey.	5	

TOOL 19. Worksheet to Select Measures at National, Sub-National and Service Delivery Levels to Monitor and Evaluate Programmes for Sex Workers

The worksheet below can be used to select global, national, sub-national and service delivery measures for monitoring and evaluating HIV prevention programmes for sex workers (male and female).

By definition, people younger than 18 who exchange sex for money are not sex workers. Measures for this group have not yet been developed, but countries who want to monitor programmes among these persons can draw on the measures below.

The worksheet below includes indicators recommended at the global level for The Global AIDS Response Progress Reporting (GARPR) and Universal Access (UA) reporting and presents other measures to monitor progress in implementing programmes based on programme impact pathways. Consistent monitoring of these measures can identify where there are bottlenecks and where additional attention is needed. Programme impact pathways should be developed in collaboration with implementing partners including members of the key populations. These pathways will differ from country to country and consequently the measures may also vary. The highest priority is to monitor measures at the sub-national level in areas most in need of HIV prevention programmes for sex workers, based on the size of the population and an understanding of the local epidemic.

Usually national-level measures are aggregated measures based on sub-national estimates from bio-behavioural surveys or service delivery data.

Service delivery providers focus on input and output measures but may estimate coverage and outcome measures if they collect the appropriate data. Service delivery providers are encouraged to review the forms provided in these operational guidelines in order to obtain measures described below and to consider using unique identifiers to accurately estimate the number of persons reached by interventions and to provide an independent assessment of prevention programme coverage.

This list does not include indicator reference sheets. Indicator reference sheets fully describe each indicator including its purpose, how it is defined, how often it should be collected, and what are its strengths and weaknesses. After a period of consultation, we anticipate that reference sheets will be developed for each measure below and available on UNAIDS, UNDP, UNFPA, and Global Fund websites.

Abbreviations:
GARPR-Global AIDS Response Progress Reporting
UA-Universal Access indicators
UNGASS-United Nations General Assembly Special Session
DHS-Demographic Health Survey
AIS-AIDS Indicator Survey

References:
1-Global AIDS Response Progress Reporting (GARPR) (2012). Guidelines: Construction of Core Indicators for Monitoring the 2011 Political Declaration on HIV/AIDS (2011). UNAIDS, Geneva.
2-UNAIDS (2008). Practical guidelines for intensifying HIV prevention: towards universal access. UNAIDS, Geneva.
3-At the National level: Aggregated Annually from Sub-national level Annual Reports
4-At the Sub-National level: Aggregated Quarterly from Monthly Programme data
5-Repeated Cross-Sectional Bio-Behavioural Surveys of sex workers Conducted Every 2 years in sub-national areas
6-M&E Operational Guidelines for Monitoring and Evaluation of HIV Prevention for Sex Work, Men who have Sex with Men, and Transgender People (M&E Operational Guidelines)
7-UNGASS Most-at-Risk Populations indicator applied to sex workers
8-The measures are used for gap analysis (amount needed minus amount available)
9-Universal Access (UA) indicators (2011). A Guide on Indicators for Monitoring and Reporting on the Health Sector Response to HIV/AIDS.
10-The President's Emergency Plan for AIDS Relief (2009). Next Generation Indicators Reference Guide. Verson 1.1. PEPFAR, Washington, D.C.
11-The Global Fund to Fight AIDS, Tuberculosis and Malaria (GFATM) (2011). Monitoring and Evaluation Toolkit. Part 2. 4th ed. GFATM, Geneva.
12-Global UNGASS Indicator (2009). Monitoring the Declaration of Commitment on HIV/AIDS: guidelines on construction of core indicators : 2010 reporting. UNAIDS, Geneva
13-UNDP (2012). UBRAF Indictaors.

Note: All measures need to be compared with the targets set in Step 3.

Note: National measures are based on sub-national estimates aggregated to national level.

Note: For input, output and coverage measures, sub-national measures are based on service delivery data aggregated to the sub-national level.

Note: UNGASS indicators are no longer reported as UNGASS was a 10 year agreement that ended in 2011. The Global AIDS Response Progress Reporting (GARPR) indicators replaced the UNGASS indicators and while all GARPR indicators were formerly part of UNGASS not all UNGASS indicators were carried forward as GARPR. If your organization routinely collects data on UNGASS indicators that were not carried forward into GARPR, you can decide whether to continue collecting data for those indicators or abandon them and focus on GARPR, national and other indicators of your choice.

Worksheet for Selecting Measures

Number	Indicator	Method	Reference	Relevant Steps	Selected Y / N
Section 1. Indicators for Global Reporting					
G1	HIV prevalence among sex workers	Bio-Behavioural Surveys [5]	GARPR[1]#1.10, UA[9] #C6b, PEPFAR[10]#9.17N, GFATM[11]#HIV-I3, (formerly UNGASS#23[12,7])	1 & 8	
G2	Percentage of female and male sex workers reporting the use of a condom with their most recent client	Bio-Behavioural Surveys [5]	GARPR[1]#1.8, UA[9] #C5c, PEPFAR[10]#P9.2.N, GFATM[11]#HIV-O4, (formerly UNGASS [12]#18)	2 & 7	
G3	Percentage of sex workers who both correctly identify ways of preventing the sexual of HIV and who reject major misconceptions about HIV	Bio-Behavioural Surveys [5]	(formerly UNGASS[12,7]#14)	2 & 7	
G4	Percentage of sex workers that have received an HIV test in the last 12 months and who know their results	Bio-Behavioural Surveys [5]	GARPR[1]#1.9, PEPFAR[10]#P9.10N, GFATM[11]#HIV-C-P5, (formerly UNGASS[12,7]#8)	6	
G5	Percentage of sex workers reached with HIV Prevention Programmes	Bio-Behavioural Surveys [5]	GARPR[1]#1.7, GFATM11#HIV-C-P2, (formerly UNGASS[12,7] #9)	6	
G6	Percentage of eligible sex workers currently receiving ART	Routine Programme data	UA[9] # G2a, (formerly UNGASS [12]#4)	6	
G7	Whether or not the national M&E plan includes all of the components for M&E of HIV prevention programmes for sex workers	Desk review and key informant interviews conducted as part of the NCPI	(formerly UNGASS [12]: Appendix 4 NCPI Part A Section V Number 2 adapted to focus on sex workers)	4	
G8	Total funds expended on programmes for sex workers	National AIDS Spending Assessment for a calendar or fiscal year & Financial Resource Flows	GARPR[1]#6.1, (formerly UNGASS [12]: Appendix 3 National Funding Matrix 1.09)	4	

Number	Indicator	Method	Reference	Relevant Steps	Selected Y / N
Section 2. Other National-Level Indicators from UNAIDS Indicator Registry, Universal Access Reporting (UA), PEPFAR and Global Fund (GFATM) indicator guidelines					
U1	Number of MARP* reached with individual and/or small group level HIV preventive interventions that are based on evidence and/or meet the minimum standards required Note: * Indicator reference uses "MARP".	Service Delivery data	PEPFAR[10]#P8.3D, GFATM[11]#HIV-P4, UNAIDS Indicator Registry # 536	6	
U2	Number and percentage of key populations reached with a basic (minimum) package of HIV prevention services (Indicator should be used when the basic package of services is defined)	Routine Programme data	GFATM[11]#HIV-P5, UNAIDS Indicator Registry # 760	6	
U3	Percentage of sex workers with active syphilis	Bio-Behavioural Surveys [5]	UA[9] # F4	2&7	
U4	Enabling Environment Index for sex workers (Scale 1-10, see below)	Document and Policy Review	UNGASS-National Composite Policy Index (NCPI)	2 & 7	

	Indicator U3 Enabling Environment Index for sex workers (Contributing Factor Outcome Indicator)	**Yes No**
U3.1	Has the country developed national multisectoral strategy to respond to HIV that addresses sex workers? (NCPI, Part A, Section I, 1.3)	Y N
U3.2	Has the country ensured "full involvement and participation" of civil society [including sex workers] in the development of the multisectoral strategy? (NCPI, Part A, Section I, 1.7)	Y N
U3.3	Does the country have a mechanism to promote interaction between government, civil society organizations [including organizations of sex workers], and the private sector for implementing HIV strategies/programmes? (NCPI, Part A, Section II, 3)	Y N
U3.4	Does the country have non-discrimination laws or regulations which specify protections for sex workers? (NCPI, Part A, Section III, 1.1)	Y N
U3.5	[Is the] country [free of] laws, regulations or policies that present obstacles to effective HIV prevention, treatment, care and support for sex workers? (NCPI, Part A, Section III, 2)	Y N
U3.6	Does the country have a policy or strategy to promote information, education and communication and other preventive health interventions for key or other vulnerable sub-populations [such as sex workers]? (NCPI, Part A, Section IV, 3)	Y N
U3.7	Does the [country have a] policy or strategy policy/strategy that addresses condom promotion for sex workers? (NCPI, Part A, Section IV, 3.1)	Y N
U3.8	Does the [country have a] policy or strategy policy/strategy that addresses HIV testing and counselling for sex workers? (NCPI, Part A, Section IV, 3.1)	Y N

U3.9	Does the [country have a] policy or strategy policy/strategy that addresses stigma and discrimination reduction for sex workers? (NCPI, Part A, Section IV, 3.1)	Y N
U3.10	Does the [country have a] policy or strategy policy/strategy that addresses targeted information on risk reduction and HIV education for sex workers? (NCPI, Part A, Section IV, 3.1)	Y N
U3.11	Does the [country have a] policy or strategy policy/strategy that addresses vulnerability reduction (e.g. income generation) for sex workers? (NCPI, Part A, Section IV, 3.1)	Y N
U3.12	Has the country has identified the specific needs for HIV prevention programmes [for sex workers] (NCPI, Part A, Section IV, 4)	Y N
U3.13	To what extent has HIV prevention been implemented? Do the majority of [sex workers] in need have access to risk reduction? (NCPI, Part A, Section IV, 4.1)	Y N
U3.14	Is there a central national database with HIV-related data on key populations [such as sex workers]? (NCPI, Part A, Section V, 6.1)	Y N
U3.15	Does the country a policy to ensure equal access for sex workers to HIV prevention, treatment, care and support? (NCPI, Part B, Section II, 8)	Y N
U3.16	Does the country have municipal level comprehensive HIV prevention, treatment and care programmes implemented for and with sex workers? (UBRAF UNDP Indicator A1.2.1a)[13]	Y N
Index: Sum of "Yes"		

Section 3. Other measures in the Guidelines[6] that may be useful

Number	Measures	Method	Relevant Steps	Selected Y / N
National Level and Selected Sub-National Area Measures				
Impact Measures including Size of Population				
1.1	Number of sex workers age 18+	DHS or AIS survey, Size estimation methods	1&8	
1.2	Number of sex workers age 18+ who are HIV positive	Modelling (Spectrum /MOT)	1&8	
1.3	HIV prevalence among sex workers age 15-24 as a proxy for HIV incidence	Bio-Behavioural Surveys [5]	1&8	
1.4	HIV incidence among sex workers age 18 and older	Modelling (Spectrum /MOT)	1&8	
1.5	HIV prevalence among minors age 15-17 who exchange sex for money	Survey	1&8	
Outcome Measures for Direct / Biological Determinants of HIV Transmission				
2.1	Percentage of sex workers reporting symptoms of an STI in the past 12 months	Bio-Behavioural Surveys [5]	2&7	
2.2	Percentage of sex workers who report having sex for the first time younger than age 15	Bio-Behavioural Surveys [5]	2&7	
2.3	Percentage of sex workers reporting unprotected receptive anal sex at last time they had sex with a male partner	Bio-Behavioural Surveys [5]	2&7	
2.4	Age at first sex	Bio-Behavioural Surveys [5]	2&7	

2.5	Percentage of sex workers reporting use of injecting drugs in last 12 months	Bio-Behavioural Surveys [5]	2&7	
2.6	Percentage of sex workers who inject drugs reporting use of clean needle the last time injected	Bio-Behavioural Surveys [5]	2&7	
2.7	Percentage of protected sex acts in the last week	Bio-Behavioural Surveys [5]	2&7	
Outcome Measures for Enabling Environment and Contributing Factors				
2.8	Percentage of sex workers reporting sexual violence within last 12 months	Sub-National Bio-Behavioural Surveys [5]	2&7	
2.9	Percentage sex workers who report experiencing stigma within last 12 months	Culturally appropriate stigma scale within surveys[5]	2&7	
2.10	Percentage of sex workers reporting physical violence within last 12 months	Bio-Behavioural Surveys [5]	2&7	
2.11	Percentage of sex workers reporting verbal abuse within last 12 months	Bio-Behavioural Surveys [5]	2&7	
2.13 *	Percentage of sex workers who report use of alcohol by themselves or partner at last sexual intercourse (*See AIDS Indicator Survey, March 2006*)	Bio-Behavioural Surveys [5]	2&7	
Coverage Measures				
3.1	Percentage of sex workers receiving no HIV prevention services in the past 12 months	Bio-Behavioural Surveys [5]	6	
3.2	Percentage of sex workers receiving the country-defined minimum package of services in the past 12 months	Bio-Behavioural Surveys [5]	6	
3.3	Percentage of sex workers reporting that they could get condoms on their own if they wanted *(Adapted from UNAIDS Indicator Registry #400)*	Bio-Behavioural Surveys [5]	6	
Sub-National Level and Service Delivery Providers				
Coverage Measures				
For each service in the nationally defined package of services, percentage of sex workers who received the service in the past 12 months (or ever for vaccination) (sub-national only):				
3.4	Percentage of sex workers reached by condom promotion and distribution programmes the past 12 months	Bio-Behavioural Surveys [5]	6	
3.6*	Percentage of sex workers screened for STI in the past 12 months	Bio-Behavioural Surveys [5]	6	
3.7	Percentage of sex workers reached by HIV testing and counselling programme in the past 12 months and know their result (same as G4 / UNGASS 8)	Bio-Behavioural Surveys [5]	6	
3.8	Percentage of sex workers who have received specific and targeted information on prevention and risk reduction strategies designed to appeal to and meet the needs of sex workers	Bio-Behavioural Surveys [5]	6	
3.9	Percentage of sex workers who have completed the	Bio-Behavioural Surveys [5]	6	

	course of HBV vaccination			
Note: Service delivery providers that know the size of the sex workers population in their catchment area and can estimate the unique number of persons reached may estimate coverage measures 3.4-3.9.				
Geographic Coverage (for Each Sub-National Area Monitored)				
3.10	Whether HIV prevention programme providing comprehensive package is available for sex workers in sub-national area (Y/N)	Programme data[4]	6	
Services				
3.11	Availability of condom promotion and distribution programmes for sex workers in sub-national area (Y/N)	Programme data[4]	6	
3.12	Availability of lubricants distribution programmes for sex workers in sub-national area (Y/N)	Programme data[4]	6	
3.13	Availability of quality treatment for sexually transmitted infections in sub-national area (Y/N)	Programme data[4]	6	
3.14	Availability of voluntary testing and counselling in sub-national area (Y/N)	Programme data[4]	6	
3.15	Availability of information and prevention and care services for clients of sex workers in sub-national area (Y/N)	Programme data[4]	6	
3.16	Availability of HIV treatment and care programmes for sex workers in sub-national area (Y/N)	Programme data[4]	6	
3.17	Availability and promotion of hepatitis immunization in sub-national area (Y/N)	Programme data[4]	6	
3.18	Number of service delivery providers offering the country defined minimum package of services to sex workers in sub-national area	Programme data[4]	6	
Enabling environments- Geographic Availability				
3.19	Availability of medical and legal assistance for sex workers who experience sexual coercion and violence in sub-national area (Y/N)	Document Review, Stakeholders' meetings	6	
3.20	Availability of safe virtual and physical spaces (e.g. telephone hotlines, drop-in centres) for sex workers to seek information and referrals for care and support in sub-national area (Y/N) *(See UNAIDS Practical Guidelines for Intensifying HIV Prevention[2])*	Stakeholders' meetings	6	
3.21	Availability of adult literacy programmes for sex workers	Stakeholders' meetings	6	
3.22	Number of economic empowerment initiatives for sex workers operating in a country	Stakeholders' meetings	6	
3.23	Number of sex work organizations supported in a country	Stakeholders' meetings	6	
3.24	Number of workplace programmes for male employees implemented to reach potential clients of sex workers	Stakeholders' meetings	6	
Output Measures				

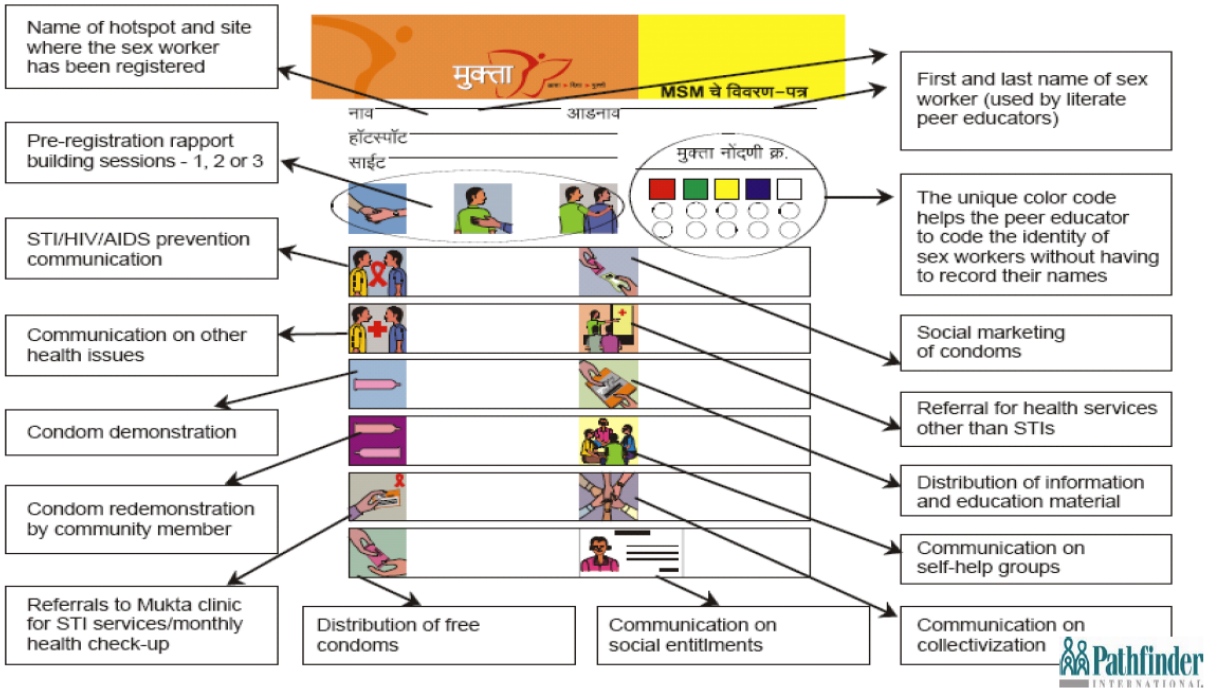
4.1	Number of unique medical providers receiving training on providing treatment to sex workers compiled quarterly	Programme data[4]	6	
4.2	Number of sex workers provided with male or female condoms and condom-compatible lubricant by HIV prevention programmes for sex workers compiled quarterly	Programme data[4]	6	
4.3	Number of male or female condoms and condom-compatible lubricant sachets distributed by HIV prevention programmes for sex workers compiled quarterly	Programme data[4]	6	
4.4	Number of coordinated mass media campaigns, segmented by audience, that address high-risk sexual norms, reduce multiple and concurrent partnerships, reduce stigma towards sex workers compiled quarterly *(See UNAIDS Practical Guidelines for Intensifying HIV Prevention[2])*	Programme data[4]	6	
4.5	Number of sex workers who visited a clinic at least once	Programme data[4]	6	
Input Measures - The measures are used for gap analysis (amount needed minus amount available)				
5.1	Funds available	Programme data[4]	4	
5.2	Human Resources available	Programme data[4]	4	
5.3	Equipment available	Programme data[4]	4	
National, Sub-National Level and Service Delivery Providers				
Quality Measures				
6.1	Percentage of safe spots that meet quality standards	Quality Audit	5	
6.2	Percentage of HIV testing and counselling sites that conduct outreach to sex workers	Programme data[3,4]	5	
6.3	Percentage of providers testing and treating for STIs who have been trained to provide STI services to sex workers	Programme data[3,4]	5	
6.4	Percentage of sex workers diagnosed with STI who received treatment	Surveys[5], Programme data[3,4]	5	
6.5	Whether sex workers participate in quality audits	Quality Checklist	5	
6.6	Whether sex workers participate in service delivery	Quality Checklist	5	
6.7	Among sex workers diagnosed with HBV in the past 12 months, percentage of sex workers receiving treatment for HBV	Programme data[3,4]	5	
6.8	Among sex workers who were due to complete HBV treatment in the past 12 months, percentage of sex workers completing treatment for HBV	Programme data[3,4]	5	
6.9	Among sex workers diagnosed with TB in the past 12 months, percentage of sex workers who started treatment	Programme data[3,4]	5	
6.10	Number of male or female condoms and condom-	Condom data from	5	

	compatible lubricant sachets available for distribution nationwide *(See HIV/AIDS Survey Indicators Database, Indicator # 2.1.)*	condom manufacturers, distributors, major donors, storage facilities, governments and NGOs		
6.11	Percentage of retail outlets and services with condoms in stock *(See HIV/AIDS Survey Indicators Database, Indicator # 2.2.)*	A number of sites of different types are randomly selected for a retail survey.	5	
6.12	Percentage of condoms that meet quality control measures *(See HIV/AIDS Survey Indicators Database, Indicator # 2.3.)*	The sampling frame for retail outlets used in Condom Availability Indicator 2, Retail outlets and services with condoms in stock can be used for the retail portion of this indicator; condoms may be sampled from retail outlets during the retail survey.	5	

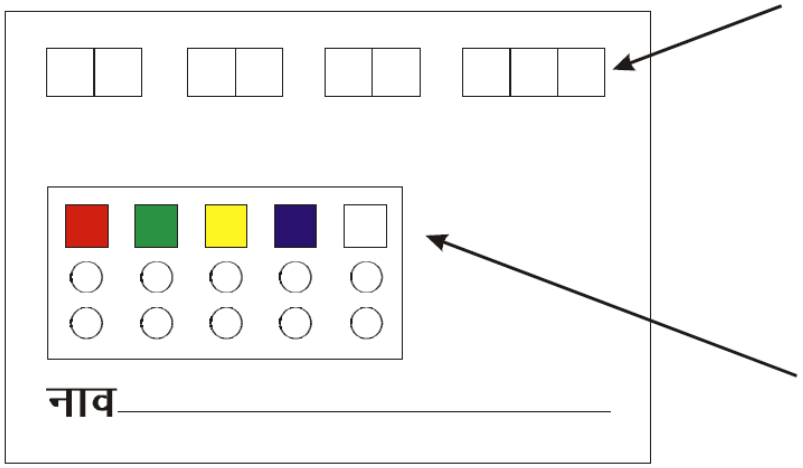
*the measure prior this is missed intentionally to ensure consistency across all measures for men who have sex with men, sex workers and transgender people.

TOOL 20. Pictorial Encounter Forms for outreach workers in low education settings

Daily Individual Encounter Form



Unique Identifier Code



The following basis is used to form the registration code:

Boxes 1 & 2: District code (e.g., 01 for Ahmednagar)

Boxes 3 & 4: Hotspot code (e.g., 01 for Ahmednagar city)

Boxes 5 & 6: PE code (e.g., A0 for Shobha)

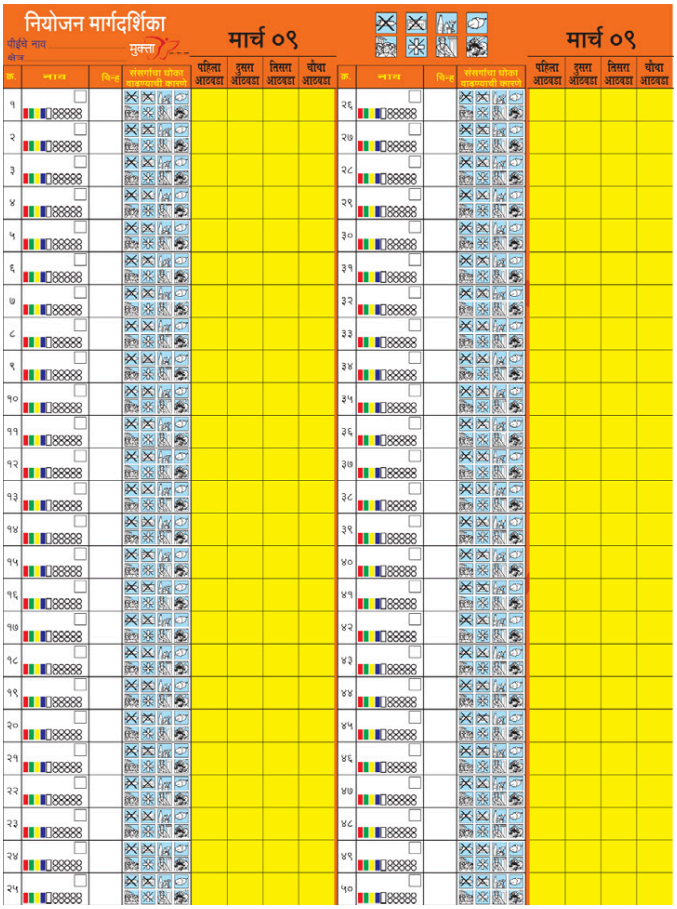
Boxes 7, 8 & 9: Unique sex worker code (e.g., 001)

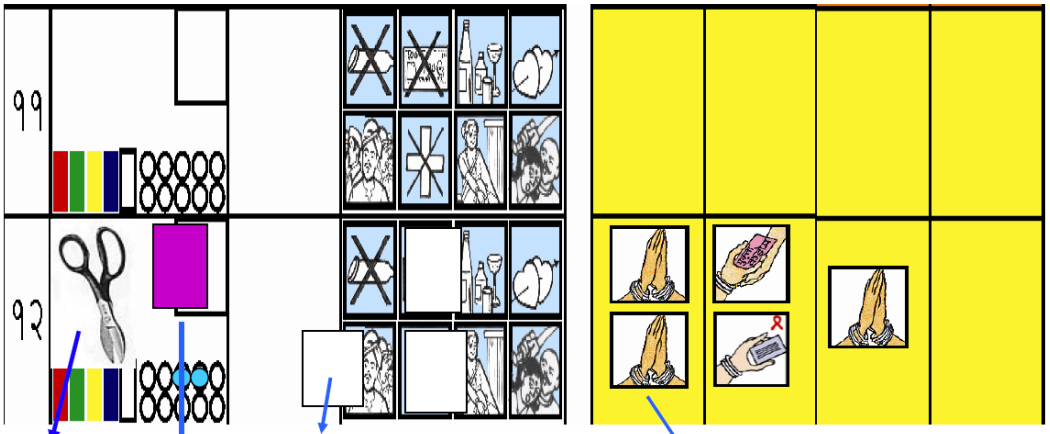
A color code system consisting of five colors and 10 dots covers up to 50 high-risk individuals for each peer. The color code corresponds to the unique ID (e.g., sex worker 001 would be coded as red-1 dot or 022 would be yellow-2 dots).

Source: Mukta Project, Pathfinder International

Source: Peer Led Outreach at Scale: A Guide to Implementation. New Delhi: Bill & Melinda Gates Foundation, 2009

Monthly Aggregate Form





Appendices

Appendix 2. HIV/AIDS Monitoring and Evaluation Glossary

Accountability—responsibility for the use of resources and the decisions made, as well as the obligation to demonstrate that work has been done in compliance with agreed-upon rules and standards and to report fairly and accurately on performance results.

Activity—actions taken to produce specific outputs from inputs such as funds, technical assistance, and other resources.

Adequacy evaluation—measures how well programme activities have met the expected objectives, but does not causally link programme activities to observed changes. Adequacy evaluation often can be carried out by cross-sectional, one-time surveys among beneficiaries.

Assumptions—hypotheses about factors that could affect the progress or success of an intervention. Achieving results depends on whether or not the assumptions made prove to be true. Incorrect assumptions at any stage can become an obstacle to the validity of the expected result or achieving it.

Attribution—the causal link of one event with another, or the ascription of a causal link between observed changes and a specific intervention.

Baseline—the status of services and outcome-related measures, such as knowledge, attitudes, norms, behaviours, and conditions before intervention.

Benchmark—a reference point or standard against which progress or achievements can be assessed. A benchmark refers to the performance that has been achieved in the recent past by other comparable organizations, or what can be reasonably inferred to have been achieved in similar circumstances.

Capacity—the knowledge, organization, and resources needed to perform a function.

Case study—a methodological approach that describes a situation, individual, or the like and that typically incorporates the data-gathering activities (e.g., interviews, observations, questionnaires) at selected sites or programmes. Case studies are characterized by purposive selection of sites, or small samples, and the expectation of generalizability is less than that in many other forms of research. The findings are used to report to stakeholders, make recommendations for programme improvement, and share lessons with other countries.

Catchment Area – A geographic area defined and served by a health programme or institution, such as a hospital or community health centre, which is delineated on the basis of such factors as population distribution, natural geographic boundaries and transportation accessibility.

Combination Prevention- involves choosing the right mix of behavioural, biomedical and structural HIV prevention actions and tactics to suit a country's actual epidemic and the needs of those most at risk.

Conclusion—a sound judgment deducted from empirical findings or factual statements corresponding to a specific circumstance.

Country response information system (CRIS)—an information system for monitoring and evaluating national responses to HIV/AIDS. CRIS includes integrated indicator, project/resources tracking, and research modules. It facilitates the development of a clearinghouse for indicator data to enable indicator exchange between the United Nations and other partner applications.

Coverage—the extent to which a programme reaches its intended target population, institution, or geographical area.

Data—specific quantitative and qualitative information or facts that are collected.

Effectiveness—the extent to which a programme or project has achieved its objectives under normal conditions in a field setting.

Efficacy— the extent to which an intervention produces the expected results under ideal implementation conditions in a controlled environment.

Efficiency—a measure of how well inputs (resources such as funds, expertise, and time) are converted into outputs. This term is also used more specifically in economic evaluation to mean the cost value of producing a given product or service.

Epidemic—an infectious disease's rapid spread through a demographic segment of a population. In the context of HIV, a generalized epidemic is characterized by an HIV prevalence higher than 1 percent in the total population; in a concentrated epidemic, the HIV prevalence is higher than 5 percent in any subpopulation at higher risk of HIV infection, but less than 1 percent in the total population.

Epidemiology—the study of how often diseases occur in different groups of people and why. Epidemiological information is used to plan and evaluate strategies to prevent illness.

Evaluability assessment—a study to determine whether or not a programme or project can be evaluated.

Evaluation—the systematic collection and analysis of information about programme activities, characteristics, and outcomes that determines the merit or worth of a specific programme. Evaluation studies provide credible information for use in improving programmes, identifying lessons learned, and informing decisions about future resource allocation. An evaluation can use a quantitative approach (e.g., structured or standardized approaches for collecting numeric or categorical data, such as surveys, questionnaires, and checklists, using experimental or quasi-experimental design), a qualitative approach (e.g., semi structured data collection, such as interviews, focus groups, and observation), or a mix of both approaches.

Exploratory study—a preliminary study to provide information on the topic of the intervention to understand the problem better.

Facility survey—a survey of a representative sample of facilities that generally aims to assess the readiness of all elements required to provide services and other aspects of quality of care (e.g., basic infrastructure, drugs, equipment, test kits, registers, staff trained in the delivery of services). The units of observation are facilities of various types and levels in the same health system. The exact content of the survey can vary, but it typically includes a facility inventory and, sometimes, health worker interviews, user exit interviews, and user-provider observation. Depending on the objective of the survey, both public and private facilities may be included in the sample frame of sites; the Service Provision Assessment is one example. The term "health facility assessment" is sometimes used as a broader term than "facility survey." A health facility assessment includes facility surveys, but it also includes facility censuses, such as the World Health Organization's Service Availability Mapping.

Feasibility—the coherence and quality of a programme or project strategy that makes successful implementation likely.

Formative evaluation—an evaluation intended to improve the performance of a programme or project. A formative evaluation is usually undertaken during the design and pretesting of the project or programme, but it can also be conducted early in the implementation phase, particularly if implementation activities are not going as expected.

Generalizability—the extent to which findings can be assumed to be true for the entire target population, not just the sample. To ensure generalizability, the sample procedure and the data need to meet certain methodological standards.

Goals—the higher order aims of the programme or project, to which the intervention is intended to contribute.

Health information systems (HIS)—a data system, usually computerized, that routinely collects and reports information about the delivery of services, costs, demographic and health information, and results status. The terms "routine health information systems" (RHIS) and "health management information systems" (HMIS) are also sometimes used.

HIV Prevention and Treatment Cascade – The cascade is a way of thinking about HIV prevention and treatment as a continuum with defined stages that helps identify gaps in the completeness our service provision and prevention efforts. Each bar represents a stage in the continuum of care, the first being the most inclusive and the last, the most exclusive. Ideally, all bars should reach the same level indicating that all persons have accessed all desired stages in the continuum of care.

Impact—the longer range, cumulative effect of programmes over time on what they ultimately aim to change. Often, this effect will be a population-level health outcome, such as a change in HIV infection, morbidity, and mortality. Impacts are rarely, if ever, attributable to a single programme, but a

programme may, with other programmes, contribute to impacts on a population. Impact can also be used in the context of a specific programme. In this case, it implies a much closer link to attribution of the programme and a conceptual model underlying it.

Impact evaluation—a scientifically rigorous methodology to establish a causal association between programmes and what they aimed to achieve beyond the outcomes on individuals targeted by the programme(s). Impact evaluation looks at the rise and fall of impacts, such as disease incidence and prevalence or quality of life as a function of HIV/AIDS programmes. The effects (impacts) on the entire populations seldom can be attributed to a single programme or even several programmes; therefore evaluations of impact on populations usually entail an evaluation design that includes the combined effects of a number of programmes for at-risk populations.

Impact monitoring—in the field of public health, a process that is usually referred to as "disease surveillance" (defined above) and is concerned with the monitoring of disease prevalence or incidence. With this type of monitoring, data are collected at the jurisdictional, regional, and national levels.

Incidence—the number of new cases of a disease that occur in a specified population during a specified time period.

Indicator—a quantitative or qualitative variable that provides simple and reliable means to measure achievement, monitor performance, or to reflect changes connected to an intervention.

Input—a resource used in a programme, including monetary and personnel resources from a variety of sources, as well as curricula and materials.

Inputs and outputs monitoring—the basic tracking of information about programme inputs, or resources that go into a programme, and about outputs of the programme activities. Data sources for monitoring inputs and outputs usually exist in programme documentation (e.g., activity reports, logs) and user records, which offer details about the time, place, and amount of services delivered, as well as the types of users receiving services.

Internal evaluation—an evaluation of the intervention conducted by a unit reporting to the donors, partners, and/or implementing organization.

Intervention—a specific activity (or set of activities) intended to bring about change in some aspect of the status of the target population (e.g., HIV risk reduction, improving the quality of services) using a common strategy. An intervention has distinct process and outcome objectives and a protocol outlining the steps of the intervention.

Joint evaluation—an evaluation of programme or project where different partners or donors participate.

Lessons learned—learning from experience that is applicable to a generic situation, not just to a specific situation. Generalizations are based on evaluation experiences from programmes, projects or policies.

Meta-evaluation—an evaluation that aggregates findings from a series of evaluations. A meta-evaluation can also be an evaluation of an evaluation to assess the performance of the evaluators.

Monitoring—routine tracking and reporting of priority information about a programme and its intended outputs and outcomes.

Monitoring and evaluation (M&E) plan—a comprehensive planning document for all M&E activities. An M&E plan documents the key M&E questions to be addressed, including what indicators are collected; how, how often, from where, and why they will be collected; what baselines, targets, and assumptions will be included; how the indicators are going to be analysed or interpreted; and how or how often reports will be developed and distributed on these indicators.

Objective—a statement of desired programme results. A good objective meets the criteria of being specific, measurable, achievable, realistic, and time based (SMART).

Operational research—the application of systematic research and evaluation techniques to improve programmes and service delivery. This application analyses only factors that are under the control of programme managers, including indicators of programme success, such as improving the quality of services, increasing training and supervision of staff members, and adding new service components. It is designed to assess the accessibility, availability, quality, and sustainability of programmes.

Outcome—the changes that a programme aims to effect on target audiences or populations, such as change in knowledge, attitudes, beliefs, skills, behaviours, access to services, policies, and environmental conditions.

Outcome evaluation—a type of evaluation that is concerned with determining if, and by how much, programme activities or services achieved their intended outcomes among the targeted population. Whereas outcome monitoring is helpful and necessary in knowing whether outcomes were attained, outcome evaluation attempts to attribute observed changes among the targeted population to the intervention tested, describe the extent or scope of programme outcomes, and indicate what might happen in the absence of the programme. An outcome evaluation is methodologically rigorous and generally requires a comparative element in design, such as a control or comparison group, although it is possible to use statistical techniques in some instances when control groups are not available (e.g., for a national programme).

Outcome monitoring—the basic tracking of variables that have been adopted as measures or "indicators" of the desired programme outcomes. Outcome monitoring does not infer causality; changes in outcome could be attributable to multiple factors, not just the programme. With national AIDS programmes, outcome monitoring is typically conducted through population-based surveys (representative of the target population, not necessarily the general population) to track whether

desired outcomes have been reached; it may also track information directly related to programme users, such as change in knowledge, attitudes, beliefs, skills, behaviours, access to services, policies, and environmental conditions.

Outputs—the results of programme activities. This term relates to the direct products or deliverables of programme activities, such as the number of counselling sessions completed, the number of people reached, and the number of materials distributed.

Performance—the degree to which an intervention operates according to specific criteria, standards, or guidelines, or achieves results in accordance with stated plans.

Plausibility evaluation—a way to demonstrate with a certain level of certainty that impact is due to an intervention programme. Plausibility evaluation includes the use of control groups and requires baseline and post-intervention statistics, as well as multivariate analyses.

Population-based surveys—large-scale national health surveys, such as Demographic and Health Surveys. Population-based surveys are statistically representative of their target populations. Usually, surveys that are population based imply representation of the general population of a given age and sex in a given geographic area, but they do not have to be national in scope or even of a large scale. National surveys can also be conducted in such a way so that they are not population based.

Prevalence—the total number of people living with a specific disease or condition during a given time period.

Process—the multiple activities that are carried out to achieve the objectives of a programme. The process includes what is done and how well it is done.

Process evaluation—a type of evaluation that focuses on programme implementation, including, but not limited to how services are delivered, differences between the intended population and the population served, access to the programme, management practices. In addition, process evaluation might provide understanding about a programme's cultural, sociopolitical, legal, and economic contexts that affect implementation.

Process monitoring—the routine gathering of information on all aspects of programme or project implementation, to check on how activities are progressing. An example of process monitoring is the routine documentation of characteristics describing the targeted population served, the services provided, and the resources used to deliver those services. It provides information for planning and feedback on the progress of the project or programme to the donors, implementers, and beneficiaries of the activities.

Programme—an overarching national or subnational response to a disease. A programme generally includes a number of projects.

Programme evaluation—a systematic assessment of the means and the ends of some or all stages of a programme, including planning, implementation, and outcome, to determine the value of and to improve the programme.

Programme records—various sources of information that are used to describe programme inputs and programme-related, project-level activities. Examples include budget and expenditure records and logs of commodities.

Project—a time-bound intervention that consists of a set of planned, interrelated activities aimed at achieving defined outputs. A project usually has a shorter timeframe than a programme.

Qualitative data—data collected from qualitative methods, such as interviews, focus groups, observation, and key informant interviews. Qualitative data can provide an understanding of social situations and interaction, as well as people's values, perceptions, motivations, and reactions. Qualitative data are generally expressed in narrative form, not numerically.

Quantitative data—data presented in numerical form, such as survey data and epidemiological data.

Recommendations—proposals aimed at improving the effectiveness, quality, or efficiency of an intervention that should be linked to findings based on monitoring and evaluation data.

Relevance—the degree to which the outputs, outcomes, or goals of the intervention are consistent with the needs of the target group, as well as global, national, partners', and donors' policies and priorities.

Reliability—consistency of the data collected through the repeated use of a scientific instrument or a data collection procedure used under the same conditions. Reliability is not the same as data validity; that is, a data collection method may produce consistent data but not measure what is intended to be measured.

Research—activity that focuses primarily on hypothesis testing, aiming to contribute to generalizable knowledge. Research typically attempts to make statements about relationships among specific variables under controlled circumstances and at a given point in time.

Research design—a plan that defines the research question, hypotheses to be examined, and the number and type of variables to be studied. It also assesses the relationship between the variables by using well-developed principles of scientific inquiry.

Results—the output, outcome, or impact of an intervention.

Second-generation surveillance—HIV surveillance that is tailored to meet the specific pattern of the epidemic in a country. It not only tracks HIV prevalence but also uses additional sources of data to increase understanding of trends of the epidemic over time. It includes biological surveillance of HIV and other sexually transmitted infections as well as systematic surveillance of the behaviours that spread them.

Sentinel surveillance—systematic, ongoing collection and analysis of data from certain sites (e.g., hospitals, health centres, antenatal clinics) selected for their geographic location, medical specialty, and populations served, and considered to have the potential to provide an early indication in the changes in the level of disease.

Stakeholders—a person, group, or entity that has a role and interest in the goals or objectives and implementation of a programme.

Summative evaluation—an evaluation designed to present conclusions about the merit of an intervention and recommendations of whether it should be retained, altered, or eliminated.

Surveillance—the ongoing, systematic collection, analysis, interpretation, and dissemination of data regarding a health-related event for use in public health action to reduce morbidity and mortality and to improve health. These data can help predict future trends and target needed prevention and treatment programmes.

Sustainability (of a programme)—the likelihood that political and financial support will last.

Target populations—groups of people who are to benefit from the result of the intervention.

Triangulation—the analysis and use of data from three or more sources obtained by different methods. Findings can be corroborated, and the weakness or bias of any of the methods or data sources can be compensated for by the strengths of another, thereby increasing the validity and reliability of the result.

Validity— the extent to which a measurement or test accurately measures what is intended to be measured

Appendices

Appendix 3. References

These *Guidelines* are a companion document to:

UNAIDS Guidance Note on HIV and Sex Work (UNAIDS April 2012)
http://www.unaids.org/en/media/unaids/contentassets/documents/unaidspublication/2009/JC2306_UNAIDS-guidance-note-HIV-sex-work_en.pdf

Prevention and treatment of HIV and other sexually transmitted infections among men who have sex with men and transgender people. Recommendations for a public health approach (WHO, UNDP, UNAIDS Secretariat, MSMGF 2011)
http://whqlibdoc.who.int/publications/2011/9789241501750_eng.pdf

Prevention and Treatment of HIV and other Sexually Transmitted Infections for Sex Workers in Low- and Middle-income Countries. Recommendations for a public health approach (WHO, UNFPA, UNAIDS Secretariat, NSWP 2012)
http://apps.who.int/iris/bitstream/10665/77745/1/9789241504744_eng.pdf

Investing for results. Results for people (UNAIDS 2012)
http://www.unaids.org/en/media/unaids/contentassets/documents/unaidspublication/2012/JC2359_investing-for-results_en.pdf

UNAIDS Action Framework: Universal Access for Men who Have Sex with Men and Transgender People (UNAIDS 2009)
http://data.unaids.org/pub/report/2009/jc1720_action_framework_msm_en.pdf

A Framework for Monitoring and Evaluating HIV Prevention Programmes for Most-At-Risk Populations (UNAIDS 2008)
http://www.unaids.org/en/media/unaids/contentassets/dataimport/pub/manual/2008/jc1519_framework_for_me_en.pdf

U.S. President's Emergency Plan for AIDS Relief (PEPFAR) Technical Guidance on Combination HIV Prevention for Men Who Have Sex with Men (PEPFAR May 2011)
http://www.pepfar.gov/documents/organization/164010.pdf

Monitoring and Evaluation Toolkit Part I and 2 (Global Fund 2011)
http://www.theglobalfund.org/en/me/documents/toolkit/

Operational Guidelines for Monitoring and Evaluation of HIV Programmes for People who Inject Drugs (UNAIDS in press)
http://www.cpc.unc.edu/measure/tools/hiv-aids/operational-guidelines-for-m-e-of-hiv-programmes-for-people-who-inject-drugs

Further information on why we need to improve monitoring and evaluation of HIV programmes:

Baral, S., Sifakis, F., Cleghorn, F et al.. (2007), Elevated risk for HIV infection among MSM in low- and middle-income countries: A systematic review. PLOS Medicine.

Baral S, Beyrer C., Muessig K,et al., (2012), Burden of HIV among female sex workers in low-income and middle-income countries: a systematic review and meta-analysis; The Lancet.

Baral, S, Poteat T, Strömdahl S, et al., (2013), Worldwide burden of HIV in transgender women: a systematic review and meta-analysis. Lancet Infect Dis.

UNAIDS, (2012), Together we will end AIDS.

UNAIDS, (2012), Investing for results. Results for people.

UNDP, UNAIDS, (2012), Understanding and acting on critical enablers and development synergies. Supplementary guidance to the UNAIDS Investment Framework.

The World Bank, (2011), The Global HIV Epidemics among MSM.

Further information on the purpose of the *Guidelines*:

UNAIDS (April 2012). Guidance Note on HIV and Sex Work.
http://www.unaids.org/en/media/unaids/contentassets/documents/unaidspublication/2009/JC2306_UNAIDS-guidance-note-HIV-sex-work_en.pdf

WHO, UNDP, UNAIDS Secretariat, MSMGF (2011). Prevention and treatment of HIV and other sexually transmitted infections among men who have sex with men and transgender people. Recommendations for a public health approach
http://whqlibdoc.who.int/publications/2011/9789241501750_eng.pdf

Key References for the Guidelines:

Measure Evaluation (2008). Data Quality Audit Tool: Guidelines for Implementation. Measure Evaluation, USAID, Chapel Hill, NC, USA.
http://www.cpc.unc.edu/measure/tools/monitoring-evaluation-systems/data-quality-assurance-tools

Pan American Health Organization (2010). Blueprint for the Provision of Comprehensive Care to Men Who Have Sex with Men (MSM) in Latin America and the Caribbean. Pan American Health Organization, Washington, D.C.
http://new.paho.org/hq/index.php?option=com_content&task=view&id=2449&Itemid=259

PEPFAR (2011). Technical Guidance on Combination HIV Prevention for Men Who Have Sex with Men. PEPFAR, Washington, DC, USA.
http://www.pepfar.gov/guidance/combinationprevention/combprevmsm/index.htm

UNAIDS (2010). Report on the Global AIDS Epidemic. UNAIDS, Geneva.
http://www.unaids.org/globalreport/Global_report.htm

UNAIDS (2007). Practical guidelines for intensifying HIV prevention: towards universal access. UNAIDS, Geneva.
http://data.unaids.org/pub/Manual/2007/20070306_prevention_guidelines_towards_universal_access_en.pdf

UNAIDS (2008). A Framework for Monitoring and Evaluating HIV Prevention Programmes for Most-At-Risk Populations. UNAIDS, Geneva.
http://www.unaids.org/en/media/unaids/contentassets/documents/document/2010/17_Framework_ME_Prevention_Prog_MARP_E.pdf

UNAIDS (2008). Organizing framework for a functional national HIV monitoring and evaluation system. UNAIDS, Geneva.
http://data.unaids.org/pub/BaseDocument/2008/20090305_organizingframeworkforhivmesystem_en.pdf

UNAIDS, UNDP (2009). UNAIDS Action Framework: Universal Access for Men who have Sex with Men and Transgender People. UNAIDS, Geneva.
http://data.unaids.org/pub/report/2009/jc1720_action_framework_msm_en.pdf

UNAIDS (2010). Strategic Guidance for Evaluating HIV Prevention Programmes, UNAIDS, Geneva,
http://www.unaids.org/en/media/unaids/contentassets/documents/document/2010/12_7_MERG_Guidance_Evaluating%20HIV_PreventionProgrammes.pdf

UNAIDS (2011). UNAIDS Terminology Guidelines, UNAIDS, Geneva,
http://www.unaids.org/en/media/unaids/contentassets/documents/unaidspublication/2011/JC2118_terminology-guidelines_en.pdf

UNAIDS (2011). Supporting community based responses to AIDS, TB and malaria: A guidance tool for including Community Systems Strengthening in Global Fund Proposals, UNAIDS, Geneva
https://www.unaids.org/en/media/unaids/contentassets/dataimport/pub/manual/2009/20090218_jc1667_css_guidance_tool_en.pdf

UNAIDS (2012). Investing for results. Results for people
http://www.unaids.org/en/media/unaids/contentassets/documents/unaidspublication/2012/JC2359_investing-for-results_en.pdf

UNAIDS (in press). Operational Guidelines for Monitoring and Evaluation of HIV Programmes for People who Inject Drugs, UNAIDS, Geneva
http://www.cpc.unc.edu/measure/tools/hiv-aids/operational-guidelines-for-m-e-of-hiv-programmes-for-people-who-inject-drugs

WHO (2004). Rapid Assessment and Response Adaptation Guide on HIV and Men who have Sex with Men. WHO, Geneva.
http://www.who.int/hiv/pub/prev_care/en/msmrar.pdf or
http://www.who.int/hiv/pub/prev_care/rar/en/

WHO, UNAIDS, UNICEF (2009). Towards universal access: scaling up priority HIV/AIDS interventions in the health sector. WHO, Geneva.
http://www.who.int/hiv/pub/2009progressreport/en/

Other references:

Beardsley K. (2013). Policy Analysis and Advocacy Decision Model for HIV-Related Services: Males Who Have Sex with Males, Transgender People, and Sex Workers. Washington, DC: Futures Group, Health Policy Project.

Bill & Melinda Gates Foundation (2009). Peer Led Outreach at Scale: A Guide to Implementation. New Delhi: Bill & Melinda Gates Foundation.

Craig P, Dieppe P, Macintyre S, Mitchie S, Nazareth I, Petticrew M (2008). Developing and evaluating complex interventions: the new Medical Research Council guidance. BMJ 337:979-983.

De Lay P, Manda V (2004). Politics of monitoring and evaluation : lessons from the AIDS epidemic. In: Rugg D, Peersman G, Carael M (eds). Global Advances in HIV/AIDS Monitoring and Evaluation. New Directions for Evaluation 103:13-31.

FHI (2000). Behavioural surveillance surveys: guidelines for repeated behavioural surveys in populations at risk for HIV. Research Triangle Park, NC, FHI.

FHI (2001). Evaluating Programmes for HIV/AIDS Prevention and Care in Developing Countries. Research Triangle Park, NC, FHI.

FHI (2001). HIV/AIDS rapid assessment guide. Triangle Park, NC, FHI and USAID, USA.

FHI (2004). Monitoring HIV/AIDS programmes: participant guide. Research Triangle Park, NC, FHI.

FHI (2004). Monitoring HIV/AIDS programmes: a facilitator's training guide. Research Triangle Park, NC, FHI.

FHI (2005). Qualitative Research Methods: A Data Collector's Field Guide. Research Triangle Park, NC, FHI.

FHI (2007). Clinical facility and services assessment field guide: Quality Assurance (QA) and Quality Improvement (QI). Research Triangle Park, NC, FHI.

Futures Group International (2003). Goals model for estimating the effects of resource allocation decisions on the achievement of the goals of the HIV/AIDS strategic plan. Futures Group International, Washington DC, USA.

Gray R, Hoffman L (2008). Tracking coverage on the silk road: Time to turn theory into practice. International Journal of Drug Policy 19(S):S15-S24.

Habicht JP, Victoria C, Vaughan J. Evaluation designs for adequacy, plausibility and probability of public health programme performance and impact. *International Journal of Epidemiology* 1999; 28:10-18.

International HIV/AIDS Alliance (2009). All together now! International HIV/AIDS Alliance, UK.

Mahy M, Chhea C, Saliuk T, Varetska O, Lyerla R (2010). A Proxy Measure for HIV Incidence among Populations at Increased Risk to HIV. In: New Strategies and Methods for HIV/AIDS Surveillance in Low and Middle Income Countries. jHASE Special Issue 2(1): http://www.ieph.org/HASE/j-gateway.htm

Michigan Department of Community Health Division of Health, Wellness & Disease Control HIV/AIDS Prevention & Intervention Section (2007). Strategies to improve client return rates for receiving HIV test results.

North Carolina Department of Environment and Natural Resources (2009). Plan-Do-Check-Act. A problem solving process. North Carolina Department of Environment and Natural Resources, NC, USA. http://quality.enr.state.nc.us/tools/pdca.htm

Pacheco AG, Tuboi SH, et al. (2009). Temporal changes in causes of death among HIV-infected patients in the HAART era in Rio de Janeiro, Brazil. J Acquired Immune Deficiecy Syndrome 51(5):624-30.

Pathfinder International (2006). Using mystery clients: a guide to using mystery clients for evaluation input. Pathfinder International, Washington DC, USA.PEPFAR (2011). Technical Guidance on Combination HIV Prevention for Men Who Have Sex with Men. PEPFAR, Washington, DC, USA.

PLACE (2005). Priorities for local AIDS control efforts (PLACE): a manual for implementing the PLACE Method. Carolina Population Centre. Chapel Hill, University of North Carolina at Chapel Hill.

Poundstone KE, Strathdee SA, and Celentano DD (2004). The social epidemiology of Human Immunodeficiency Virus/Acquired Immunodeficiency Syndrome. Epidemiologic Reviews 26(1):22-35.

Population Council (nd). Developing high-quality VCT service delivery strategies for youth. Population Council, Washington DC, USA.

SEARO (2009). Monitoring & evaluation toolkit for sex worker interventions. SEARO, New Delhi, India.

Standards of HIV/AIDS Care & Services and HIV/AIDS Prevention & Education, Pennsylvania Department of Health, Division of HIV/AIDS
http://www.aidsnetpa.org/Documents/Subgrantee/prevention%20standards.pdf

UNAIDS (2004). “Three Ones” key principles: “Coordination of National Responses to HIV/AIDS” Guiding Principles for national authorities and their partners. UNAIDS, Geneva.

UNAIDS (2005). Guidelines for second generation HIV surveillance. UNAIDS, Geneva.

UNAIDS (2006). HIV and sexually transmitted infection prevention among sex workers in Eastern Europe and Central Asia. UNAIDS best practice collection. UNAIDS, Geneva.

UNAIDS (2007). Modelling the expected short-term distribution of incidence of HIV infections by exposure group. UNAIDS, Geneva.

UNAIDS (2008). Combination prevention in Eastern and Southern Africa. UNAIDS, Geneva.

UNAIDS (2008). Modes of transmission study guidelines for country teams. UNAIDS, Geneva.

UNAIDS (2008). Practical guidelines for intensifying HIV prevention: towards universal access. UNAIDS, Geneva.

UNAIDS and GAMET (2009). Analysis of HIV prevention response and modes of HIV transmission: the UNAIDS-GAMET supported synthesis process. UNAIDS, Geneva.

UNAIDS (2009). UNAIDS Guidance Note on HIV and Sex Work. UNAIDS, Geneva.

UNAIDS (2009). Estimating national adult prevalence of HIV-1 in concentrated epidemics. UNAIDS, Geneva.

UNAIDS (2009). Estimating national adult prevalence of HIV-1 in generalized epidemics. UNAIDS, Geneva.

UNAIDS (2009). United Nations General Assembly Special Session on HIV/AIDS (UNGASS). Monitoring the Declaration of Commitment on HIV/AIDS. Guidelines on Construction of Core Indicators. 2010 Reporting. UNAIDS, Geneva. Refer to www.unaids.org for any updates in the UNGASS indicator set.

UNAIDS (2009). HIV Triangulation Resource Guide. UNAIDS, Geneva

UNAIDS (2009). National AIDS spending assessments resource tracking system user guide. UNAIDS, Geneva.

UNAIDS (2009). Surveillance in populations at risk for HIV infection as a result of high risk behaviour. UNAIDS, Geneva.

UNFPA, WHO, PATH (2005). Condom programming for HIV prevention: a manual for service providers. UNFPA, New York, USA.

UNFPA, WHO, PATH (2005). Condom programming for HIV prevention: an operations manual for programme managers. UNFPA, New York, USA.

USAID (2000). Handbook of Indicators for HIV/ AIDS/ STI Programmes.USAID, USA.

Washington State Department of State. HIV Test Counselling Client Satisfaction Survey. Retrived on March 2011 from http://www.doh.wa.gov/concon/FmsReptTitlePage/titlepage.htm

Weir SS, Pailman C, Mahlalela X et al. (2003). From people to places: focusing AIDS prevention efforts where it matters most. AIDS 17(6):895-903.

WHO and UNODC (2000). Client satisfaction evaluations. WHO, Geneva.

WHO (2003). Guidelines for the management of sexually transmitted infections. WHO, Geneva.

WHO (2003). Quality assurance resource pack for voluntary counselling and testing service providers. WHO, Geneva.

World Health Organization (2004). National AIDS Programmes: A guide to monitoring and evaluating HIV/AIDS Care and Support. WHO, Geneva.

WHO (2005). Policy and programming guide for HIV/AIDS prevention and care among people who inject drugs. WHO, Geneva.

WHO, UNODC, UNAIDS (2006). Technical guide for countries to set targets for universal access to HIV prevention, treatment and care for people who inject drugs. WHO, Geneva.

WHO, UNAIDS, Global Fund (2006). Monitoring and Evaluation Toolkit: HIV/AIDS, Tuberculosis, and Malaria

WHO and UNAIDS (2007). Guidance on provider-initiated HIV testing and counselling in health facilities. WHO, Geneva.

WHO/UNAIDS (2010). When and how to use assays for recent infection to estimate HIV incidence at a population level. WHO, Geneva.

WHO/UNAIDS (2010). Guidelines on estimating the size of populations most at risk to HIV. WHO, Geneva.

WHO/UNAIDS (2011). Guidelines on surveillance among populations most at risk for HIV. WHO, Geneva.

WHO/UNAIDS (2013). Guidelines for Second Generation HIV Surveillance: an update: know your epidemic. Geneva, WHO.

WHO (2009). Toolkit for monitoring and evaluation of interventions for sex workers. WHO, Geneva.

WHO (2011). Improving HIV Testing and Counselling Services: Technical Brief. http://www.who.int/hiv/pub/vct/WHO_HIV_11_01/en/index.html

WHO (2013). Consolidated guidelines on the use of antiretroviral drugs for treating and preventing HIV infection: Recommendations for a public health approach. WHO, Geneva.

Wilson D (2005). A Monitoring and Evaluation Framework for Concentrated Epidemics and Vulnerable Populations. Global HIV/AIDS Monitoring Team (GAMET), Global HIV/AIDS Program (GHAP).

World Bank (2008). Are you being served? New tools for measuring service delivery. World Bank, Washington DC, USA.

World Bank (2009). Institutionalizing impact evaluation within the framework of a monitoring and evaluation system. World Bank, Washington DC, USA.

World Bank and UNAIDS (2009). Kenya: HIV prevention response and modes of transmission analysis. World Bank, Washington DC, USA.

World Bank and UNAIDS (2009). Lesotho: HIV prevention response and modes of transmission analysis. World Bank, Washington DC, USA.

World Bank and UNAIDS (2009). Swaziland: HIV prevention response and modes of transmission analysis. World Bank, Washington DC, USA.

World Bank and UNAIDS (2009). Uganda: HIV prevention response and modes of transmission analysis. World Bank, Washington DC, USA.

Wright L, Adams H, & Bernat J (1999). Development and Validation of the Homophobia Scale. Journal of Psychopathology and Behavioral Assessment; 21(4): 337-47.

Zhang F, Dou Z et al. (2009). Five-year outcomes of the China National Free Antiretroviral Treatment Program. Ann Intern Med 151(4):241-51, W-52.

This publication was made possible with support from the U.S. Agency for International Development (USAID) through MEASURE Evaluation cooperative agreement GHA-A-00-08-00003-00. The views expressed in this publication do not necessarily reflect the views of USAID or the U.S. government.

September 2013 **MS-11-49b**