AIDS Action Europe
Reader Monitoring & Evaluation Seminar
23-25 November 2006, Amsterdam

Content

1. Introduction

AIDS Action Europe has prepared this backgrounder report for the European Seminar *'Monitoring and evaluation'* that will take place in Amsterdam, the Netherlands on November 23-25, 2006. This event is hosted by STI AIDS Netherlands, as main partner of AIDS Action Europe, the Pan European NGO Partnership on HIV and AIDS.

We know that monitoring and evaluation are important, but see it often as a burden imposed on NGOs by demanding sponsors. With a lot of problems to solve and too little money and staff it is however important for NGOs to be as effective and efficient as possible. Monitoring answers the question 'Did we do what we said we were going to do?' while evaluation looks into 'Did we make a difference?'. The challenge is to develop a good monitoring and evaluation system that helps us redirect, adapt and improve the quality and impact of our programmes. We need good monitoring and evaluation systems because:
- we care about transparency and accountability
- we want to know and show our impact
- we want to share lessons learned with others
- we want to improve the effectiveness of our programmes
- sponsors have a right to know the results of their sponsoring

The European Seminar '**Monitoring and evaluation**' is part of a series of European best practice seminars that we are organising under the project 'European Partners in Action on AIDS'. This project aims to strengthen knowledge, capacities, discussion and exchange among AIDS-related NGOs in Western and Eastern Europe in order to encourage concerted action and the acceleration of innovation in their approaches in the fight against HIV and AIDS. The best practice seminars will provide a forum for exchange, sharing of information and experiences and creation of European consensus on strategies for acceleration of innovative approaches.

Please visit www.aidsactioneurope.org if you wish to learn more about AIDS Action Europe and the other European best practice seminars. The report of this seminar on monitoring and evaluation will also become available at our website.

We hope that this report and the outcomes of the seminar will contribute to the strengthening of NGO capacities to develop effective but at the same time simple and clear monitoring and evaluation systems that allow NGOs to measure the impact of their activities in the fight against HIV and AIDS.

Martine de Schutter

Coordinator project European Partners in Action on AIDS
AIDS Action Europe

The seminar is made possible with the financial contributions of the European Commission, GlaxoSmithKline's Positive Action Programme, STI AIDS Netherlands and AIDS Action Europe.

2. Information Speakers

Wieger Bakker
Is associate professor at the Utrecht School of Governance and organizer and teacher of international courses in Central and Eastern Europe on 'Policymaking in European Context' and on 'In- and exclusion in contemporary European Societies' .

Bram van Ojik
Is the Director of the Policy and Operations Evaluation Department of the ministry of Foreign Affairs of the Netherlands. Before that he was ambassador in general service entrusted with the contacts within and outside of the Netherlands for the minister of Development Cooperation. He will talk about how evaluation can contribute to achieving results.

Lilianne Ploumen
Worked in different functions for Plan. After leading Mama Cash, an organisation that gives small subsidies to women, she started working for Cordaid. Last year she became director International Programmes. She has a lot of experience in the field of development aids and monitoring and evaluation.

Nataliya Salabaj
Has been working for the Ukrainian Network of People Living With HIV/Aids since 2005. She has a long history in sociological research and is still active on sociological research, counseling on Projects' and Organization management as a self-employer. She will tell how the Ukrainian Network of PLWHA developed very fast into a professional organisation with M&E.

Irina Berezhnova
Is a Senior Researcher at the Department of Monitoring and Evaluation and Research within AIDS Foundation East-West. In her presentation she will describe what are the purposes and values of M&E as well as the tools that are used within her organization. Also, she will be giving a practical example on that. Irina has been working in the field of HIV/AIDS prevention for more than 4 years. Her expertise includes significant research experience in the field of HIV/AIDS epidemiology in different risk groups (quantitative and qualitative studies as well as field work coordination), conducting assessments, developing project concept papers, monitoring projects, tracking project indicators.

Jadranka Mimica
Is the Program Coordinator of The Knowledge Hub on HIV Surveillance of UNDP. She wants to talk about use of surveillance data for M&E, issues and challenges in the region. She will start with the definition and linkages between M&E and surveillance systems, M&E Framework, lessons learned from selection and definition of key program indicators, and current recommendations

Ulrich Laukamm-Josten
Is 'Coordinator' and the technical focal point in the Sexually Transmitted Infections/ HIV/AIDS Programme of the WHO for grants management and fundraising, EU relations, Monitoring and

Evaluation, Capacity building and the Backup Initiative, and STI. Apart from that he is the geographic focal point for Central Europe, Baltic States, and Ukraine. He will talk about the Dublin Declaration and about monitoring Universal Access.

Gerjo Kok
Was appointed Professor in Applied Psychology of the School of Psychology at Maastricht University in 1998, where he was dean from 1998-2006. His main topic of interest is the application of social psychological theories to solve or reduce social problems.

Olga Varetska
Is the Programme Manager of Programmatic M&E within the ICF International HIV/AIDS Alliance of Ukraine. Currently she is working on a manual for NGO's on monitoring and evaluation. The manual will be sent to the participants on forehand in order to give the opportunity to read it and to enable the participants to give feedback during the seminar.

Richard South
Has worldwide responsibility for HIV and malaria community partnership programs at GlaxoSmithKline, determining grant-making strategies and working with selected nonprofit partners to implement projects, oversee their execution and evaluation and ensure that lessons learned are shared widely. A graduate in medicine, South studied at the University of Liverpool, UK, and then worked as a physician within the UK National Health Service before joining the research-based pharmaceutical industry.

Martine de Schutter
Is the coordinator of the western office of AIDS Action Europe. She coordinates, among others, the 3-year project European Partners on Action in AIDS. The seminar on monitoring and evaluation is organised as part of a series of seminars under this project.

3. List of Partcipants

Ankierszteijn-Bartczak	Magdalena	F	Foundation of Social Education	Poland
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Smirnov	Sergey	M	Community of PLHIV	Russian Federation
Solinc	Miran	M	SKUC	Slovenia
Oprea	Adriana	F	ARAS	Romania
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Zhelyazkova	Kristina	F	Initiative for Health Foundation	Bulgaria
Meneri	Rezarta	F	Association for prevention from AIDS	Albania
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Hovhannisyan	Ruben	M	Armenian National AIDS Foundation	Austria
Gancheva	Rumyana	F	"Dose of Love" Association	Bulgaria
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Ngobi	Eddie-Kool	M	Nordic Minority Group	Denmark
Varetska	Olga	F	ICF "International HIV/AIDS Alliance, Ukraine"	
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Stojanovic	Dragana	F	Youth of Jazas	Yugoslavia
Frazão	Filomena	F	SIDA, Portugal	Portugal
South	Richard	M.	Glaxo Smith Kline	United Kingdom
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Mimica	Jadranca	F	UNDP	Croatia
Laukamm-Josten	Ulrich	M	WHO	Denmark
Wieger	Bakker	M	University of Utrecht	The Netherlands
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Van der Meulen	Martine	F	AIDS Action Europe	The Netherlands
Voermans	Floor	F	AIDS Action Europe, Soa Aids Nederland	The Netherlands
Keizer	Irene	F	Soa Aids Nederland	The Netherlands

4. Links for more information

Guidelines for effective use of data from HIV surveillance systems (2004)
http://data.unaids.org/Publications/IRC-pub06/JC1010-UsingData_en.pdf

Guidelines for Second Generation HIV Surveillance
http://data.unaids.org/Publications/IRC-pub01/JC370-2ndGeneration_en.pdf

Guidelines on construction of core indicators (2005)
http://data.unaids.org/publications/irc-pub06/jc1126-constrcoreindic-ungass_en.pdf

Intervention mapping
www.interventionmapping.nl

Strategic Information/ Monitoring and Evaluation Field Officer Website
http://www.globalhivevaluation.org/

The “Three Ones” in action: where we are and where we go from here
http://data.unaids.org/publications/irc-pub06/jc935-3onesinaction_en.pdf

Fulfilling reproductive rights for women affected by HIV/AIDS
A tool for monitoring
http://www.ipas.org/publications/en/MDGHIV_E06_en.pdf

“There’s nothing you could do if your rights were being violated”, Monitoring Millennium Development Goals in relation to HIV-positive women’s rights
http://www.ipas.org/publications/en/MDGMON_E06_en.pdf

5. M&E – Global Fund

World Health Organization

THE WORLD BANK

unicef

UNAIDS
JOINT UNITED NATIONS PROGRAMME ON HIV/AIDS

Investing in our future
The Global Fund
To Fight AIDS, Tuberculosis and Malaria

MEASURE Evaluation

MONITORING AND EVALUATION TOOLKIT

HIV/AIDS, TUBERCULOSIS AND MALARIA

Second Edition
January 2006

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Monitoring and Evaluation Toolkit: HIV/AIDS, Tuberculosis, and Malaria

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This document was based on a collaboration between WHO, UNAIDS, The Global Fund to Fight AIDS, Tuberculosis & Malaria, USAID, US Department of State, OGAC, CDC, UNICEF, MEASURE Evaluation and the World Bank.

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List of terms and abbreviations used

AIS	AIDS Indicator Survey
ARV	Antiretroviral therapy
BSS	Behavioral surveillance survey
CBO	Community Based Organisations
CDC	Centers for Disease Control and Prevention, DHSS (USA)
CPT	Co-trimoxazole prophylactic treatment
CSW	Commercial sex worker
CTBC	Community tuberculosis care
DHS	Demographic health survey
DOTS	The internationally recommended strategy for TB control
GFATM	Global Fund to Fight AIDS, Tuberculosis and Malaria
HBC	High-burden country (used in reference to tuberculosis disease burden)
H(M)IS	Health (Management) Information System
IDU	Injecting drug user
IEC	Information, education, communication
IPT	Intermittent preventive treatment
IRS	Indoor residual spraying
ITN	Insecticide-treated (bed) net
KAP	Knowledge, Attitude and Practice
LLIN	Long-lasting insecticide treated net
M&E	Monitoring and evaluation
MARP	Most-at-risk population (female sex workers, clients of female sex workers, injecting drug users and men who have sex with men)
MDG	Millennium Development Goal
MDR-TB	Multidrug-resistant tuberculosis
METAT	Monitoring and Evaluation Technical Assistance and Training
MICS	Multiple Indicator Cluster Surveys
MIS	Malaria Indicator Survey
MSM	Men who have sex with men
NAC	National AIDS Council
NGO	Non-governmental organization
NTP	National Tuberculosis Program
OGAC	The President's Emergency Plan for AIDS Relief: Office of the Global AIDS Coordinator
OVC	Orphans and vulnerable children
PEPFAR	President's Emergency Plan for AIDS Relief (USA)
PLWHA	People living with HIV/AIDS
PMTCT	Prevention of Mother-to-Child Transmission (of HIV)
PPM	Public-private mix
RBM	Roll Back Malaria
SDA	Service delivery area
SSA	Sub-Saharian Africa
STB	StopTB (Tuberculosis)
STI	Sexually transmitted infections
SW	Sex Workers
TB	Tuberculosis
UNGASS	UN General Assembly Special Session
UNDP	United Nations Development Programme

I. How to use the M&E Toolkit

Why this toolkit?

With the global momentum to scale up the response to the three main infectious diseases, HIV/AIDS, tuberculosis (TB) and malaria, public health practitioners need to provide various levels of accountability for their activities to several constituencies. It is becoming increasingly important for countries to be able to report accurate, timely and comparable data to national authorities and donors in order to secure continued funding for expanding health programs. Most importantly, they need to be able to utilize this information locally to strengthen evolving programs. It is particularly important for national program implementers and managers to have access to the quality information they need to make adjustments and programmatic and technical decisions.

Existing M&E guidelines and materials have been developed through the collaborative work of many partnership constituents, such as UNAIDS, WHO, UNICEF, the President's Emergency Plan for AIDS Relief: Office of the Global AIDS Coordinator (OGAC), USAID and HHS/CDC, other bilateral agencies, non-governmental organizations (NGOs) including MEASURE Evaluation and Family Health International (FHI), and global disease partnerships such as HIV/AIDS 3 by 5 Initiative, Stop TB and Roll Back Malaria. In addition, country M&E officers have been deployed by many agencies, for example UNAIDS and the Emergency Plan. They have an important role to work with country M&E systems to harmonize reporting around common measures and ensure different stakeholders coordinate closely to develop M&E systems.

Developed with the support of international technical agencies and M&E experts, the purpose of the M&E Toolkit is to gather a selection of standard indicators and provide users with references to key materials and resources.

The M&E Toolkit aims to assist countries in achieving the following:

- Coordinate reporting in line with international partners and national systems, thereby encouraging the use of existing, widely agreed and accurate measures
- Select simple indicators, measure, report, and use good quality health and health-related information in a manner that meets both donor and country needs
- Clearly define the standard services that are delivered by a program, and establish both routine and longer term measures of progress
- Formulate a participatory national M&E strategy by providing an overview of key issues to consider
- Evaluate, review and improve M&E systems over time as the scale up of interventions to prevent and reduce morbidity and mortality associated with HIV/AIDS, TB and malaria occurs

The M&E Toolkit focuses mainly on the routine high level reporting of a restricted set of measures of progress (**programmatic and outcome/impact indicators**). Indicators for "supportive environments" are presented in an attempt to address each disease within a broader context. However, most indicators are focused on the health sector.

Who is it for?

This information package aims to provide those working at the country level on M&E systems linked to expanded HIV/AIDS, TB and/or malaria programs with rapid access to key resources and standard guidelines. Users include national disease program managers and project leaders, donor agencies, technical and implementing agencies and NGOs so as to better harmonize information demands. While the guide is written with this specific audience in mind, it does not intend to exclude the wider cadre of individuals and groups working in these disease areas including, for example, professionals working in education, gender issues, and legal reform.

What are its contents?

The M&E Toolkit is meant to provide a framework in which to present a selection of standard and essential indicators in the areas of HIV/AIDS, TB, and malaria:

1. General M&E concepts, guidelines, and responses to frequently asked questions are outlined in the first part of the document.

2. The second half of the toolkit is divided into disease-specific sections, with summary tables of selected programmatic indicators organized by service delivery areas. Outcome and impact measures are also shown in a second summary table and approaches to measurement are presented. Further resources and links to more specialized indicator manuals related to that disease are discussed in each section.
3. The Annexes to the M&E toolkit provide an overview of indicator definitions, measurement, and reporting.

How do you use this toolkit?

The indicators presented have been developed for reporting at the national level, although many of them can also be used at various levels. National level users should design or modify their health information collection system keeping in mind that different types of data need to be collected for use at each level.

Users should aim to simplify their monitoring and evaluation and reporting, and aim to report internationally only a restricted set of indicators. The M&E Toolkit is not meant to contain a comprehensive list of indicators, but rather is limited to a selection of standard indicators that are likely to be part of routine data collection in disease programs, and useful for international reporting. As noted above, this toolkit is a work in progress, and modifications will be made periodically to assure that user needs are met and technical developments incorporated.

How was the toolkit developed?

The M&E Toolkit is the outcome of a collaborative process of international partners, bilateral agencies and NGOs. Harmonization and wider partner buy-in is seen as important for coordination of reporting from international to national and local levels, particularly as resources for these activities are frequently limited. The toolkit aims to encourage the use of common measures in order to minimize parallel reporting systems.

The indicators in this toolkit were selected in consultation with technical M&E experts in each of the three diseases and with donors such as the Global Fund. Consultations were held with staff from the HIV/AIDS, TB, and malaria departments at WHO. Additionally, inputs from other members of the UN (particularly from UNAIDS and UNICEF) as well as the World Bank, Measure Evaluation and the Emergency Plan: OGAC, USAID, and the HHS/CDC were sought in order to ensure that the recommended indicators were in-line with those used across organizations. It is important to note that generally no new indicators have been developed for the purposes of this toolkit, but rather, existing indicators which are already being used are presented. This toolkit therefore builds upon already existing and accepted indicators used in a wide range of programs.

To make specific suggestions regarding improvements to the toolkit, users are encouraged to write to: toolkit@who.int

Recent update

This new edition of the M&E Toolkit is *not* a new reporting framework but rather a fine tuning and enhancement of the previous M&E Toolkit.

The toolkit uses the same measurement framework as developed in the first edition of the toolkit. M&E reporting based on the first edition can continue to be used (and results reported, for example to the Global Fund). This update represents developments in M&E which may improve measurement.

New technologies and developments have resulted in the need to revise and update the indicators presented in the first edition (published in June 2004). This updated edition of the toolkit has been revised according to the latest technical resources of the three diseases. Resources relating to impact and measurement approaches have been expanded, based on feedback from users. Since it is recognized that the three diseases are classified by different indicators, and that the aim is to provide a common framework, both versions of the toolkit attempt to move closer to an internationally agreed upon M&E system of indicators. The toolkit includes the following updates:

- Refinement and update of indicators and service delivery areas for the three diseases.
- Expansion of impact measures for the three diseases (which was limited in the first toolkit).
- Collaborative HIV/TB activities incorporated into HIV and TB components.
- Inclusion of a transversal "Health Systems Strengthening" section and relevant service delivery areas and indicators. Health System Strengthening service delivery areas and indicators can be included in each disease component. The details and rules for each round of Global Fund funding should be consulted to assess the best strategy.

- Additional information on data collection methods and evaluation (including measuring quality, limited in the first toolkit).
- Additional information on the M&E toolkit and Global Fund reporting, including the "top 10" indicators for Global Fund programmatic and outcome/impact reporting.

The Monitoring and Evaluation Toolkit is available electronically at http://www.theglobalfund.org .

II. Basic Elements of M&E

Establishing and strengthening a M&E program

While significant progress has been made in country M&E, much disease-specific M&E has been done in a vertical, isolated fashion that is often not linked or triangulated with other sources. Extensive evaluation of a donor-sponsored project may have been carried out in an important area of programming, without the results ever being shared in the field. In short, the utility of much of the disease-related measurement efforts in a country may be lost because there is often no coherent M&E system for users that can capture information on multiple diseases at different levels.

1. Harmonizing country reporting, data standards and reporting systems

There is a danger that separate disease and donor driven M&E systems do not have common data standards, compatible IT systems or reporting platforms. Coordination of the overall M&E system across country and donor requirements (e.g. the Emergency Plan, the Global Fund and World Bank) is an important first step in building a common M&E system which can meet a variety of needs. In addition, many countries rely on surveys such as the Demographic and Health Surveys (DHS) or AIDS Indicator Surveys (AIS), Multiple Indicator Cluster Surveys (MICS) and/or Behavioral Surveillance Surveys (BSS) that are funded through external donors. This produces data that may be valuable in the broader M&E context, but may not be well integrated with traditional sources of health information, such as national health information and surveillance systems.

This toolkit aims to provide common indicators in support of implementing the "Three Ones" (described below). Although developed for AIDS, the principles have general relevance for M&E. By bringing together indicators for the three diseases, the aim is to extend the "Three Ones" beyond HIV to all three diseases.

The "Three Ones"

On 25 April 2004, the representatives of major donor organizations and of many developing countries adopted three principles as the overarching framework to better coordinate the scale-up of National AIDS Programs and related responses to the HIV/AIDS epidemic. The "Three Ones" are:

- ***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*.

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 program leaders and managers at each level of the program and health care system; 2) selected quality data can be reported to national leaders; and 3) the national program is able to meet donor and international reporting requirements under a unified global effort to contain the HIV/AIDS pandemic.

A common, comprehensive and coherent M&E system has several advantages. It contributes to more efficient use of data and resources by ensuring, for example, that indicators and sampling methodologies are comparable over time and by reducing duplication of effort. As data collection resources are limited, this is an important asset as countries may pool donor funds in order to produce a limited number of large-scale, high quality studies rather than a myriad of ad hoc assessments that are not comparable. Data generated by a comprehensive M&E system ought to serve the needs of many constituents, including program or project managers, researchers and donors, eliminating the need for each to repeat baseline surveys or evaluation studies when they might easily use existing data. It is equally important that the basic data is made available as transparently as possible and placed in the public domain.

2. What is the difference between national and sub-national M&E?

From the point of view of the national program, a coherent M&E system helps ensure that donor-funded M&E efforts best contribute to national needs. These needs go beyond disease-focused M&E, to strengthen the overall health information system. A further advantage is that it encourages coordination and communication between different groups involved in the national response to HIV/AIDS, TB, and malaria. These may include ministries working on social welfare or child welfare and the ministries of statistics and planning. Agreement among the major donor, technical and implementing agencies on the basic core M&E framework will reduce the burden of requests for data from different agencies.

Shared planning, execution, analysis and dissemination of data collection can reduce overlap in programming and increase cooperation between different groups, many of whom may work more efficiently together than in isolation.

In view of scarce M&E resources at sub-national level, emphasis is placed on monitoring program inputs and outputs and assessing whether or not implementation progresses according to a sub-national plan. A facility assessment as part of routine supervision serves to provide information on the quality of care or the availability and utilization of services. At all levels, both monitoring and evaluation are required.

Sub-national data is extremely relevant for national level M&E provided that national guidelines are followed to make aggregation possible. Information gathered from the sub-national level is helpful in guiding policy discussions and in validating results at higher levels. In some cases, data from the sub-national level provides a better indication of trends and issues of equity than from a country-level perspective.

Building or strengthening **Health Management Information Systems (HMIS)** is a pre-requisite for proper monitoring of the three diseases and the response to them. Increased funding in the three disease areas creates an opportunity to strengthen not only program or project specific health information, but also the health information and surveillance systems as a whole. HIV/AIDS, TB and malaria have different strengths related to data collection, dissemination, and use; opportunities exist for the three diseases to leverage each other's strengths.

An effective HMIS provides a solid basis for evaluations of large-scale programs, ultimately leading to improved planning and decision-making. Based on these findings, urgent decisions such as how to allocate new resources to achieve the best overall results will become easier to make.

3. What are the features of a good M&E system?

Countries have different M&E needs, dictated in part by the state of their HIV/AIDS, TB, and/or malaria disease burdens and country health structure. Yet successful M&E systems will share common elements, as demonstrated by successful programs in several countries. A list of some of these elements is given in Table 1.

Table 1: Features of a good M&E system

M&E UNIT	• An established M&E unit within the Ministry of Health with designated technical and data management staff. This unit should, among other things, coordinate M&E efforts across the three disease areas, irrespective of where individual disease-specific M&E is managed, and be integrated within the broader statistical needs of the country. • Guidelines and guidance to sub national districts, regions and provinces for M&E. • Guidelines for linking M&E to other sectors such as education, labor, and military. • A budget for M&E that is between five to ten percent of the combined national HIV/AIDS, TB, and malaria budgets from all sources. On average, seven percent should be used as the reference. • A significant national contribution to the national M&E budget (not total reliance on external funding resources). • A formalized M&E link, particularly with appropriate line Ministries, NGOs and donors, and national research institutions aimed at enhancing operations research efforts. • A multi-sectoral working group to provide input and achieve consensus on indicator selection and various aspects of M&E design and implementation. • Expertise in the M&E unit or affiliated with the unit to cover: epidemiology, behavioral/social science, data processing and statistical, data dissemination, resource tracking (both financial and commodity resources).
CLEAR GOALS	• Well-defined national program or project plans with clear goals, targets and operational plans. National M&E plans should be revised every 3-5 years, and M&E operational plans updated yearly. • Regular reviews/evaluations of the progress of the implementation of the national program or project plans against targets. • Coordination of national and donor M&E needs.
INDICATORS	• A set of priority indicators and additional indicators at different levels of M&E. • Consistent indicators that are comparable over time and with clear targets. • Selection of a number of key indicators that are comparable with other countries.

DATA COLLECTION & ANALYSIS	• An overall national level data collection and analysis plan, including data quality assurance. • A plan to collect data and periodically analyze indicators and associated data sets at different jurisdictional levels of M&E (including geographical). • Second generation surveillance, where behavioral data are linked to disease surveillance data.
DATA DISSEMINATION	• An overall national level data dissemination plan, with basic data sets freely and transparently available in a timely manner. Transparency is essential for real accountability. • A well-disseminated, informative annual report. • Annual meetings to disseminate and discuss M&E and research findings with policy makers, planners and implementers. • A clearinghouse for generation and dissemination of findings. • A centralized database or library of all HIV/AIDS, TB, and malaria-related data collection, including ongoing research which is transparently and publicly available. • Coordination of national and donor M&E dissemination needs.
SPECIAL STUDIES	• Select priority outcome/evaluation studies. • Include qualitative studies as needed. • Include operational research studies.

4. What is the difference between program and project M&E?

For the purposes of the Toolkit, *program* refers to an overarching national or sub-national response to the disease. Within a national program, there are typically a number of different areas of programming. For example, the HIV/AIDS program has a number of "sub-programs or projects" such as blood safety, sexually transmitted infection (STI) control, or HIV prevention for young people.

Project refers to a time-limited set of activities and objectives supported by resources that aim at a specific population defined geographically or otherwise. It should be noted that projects and programs can also be defined by timeframes – projects are usually short term where as programs are usually longer term in scope.

In view of its wider scope (thematic, geographic, target population), *program* monitoring tends to be more complex than *project* monitoring and therefore requires strong coordination among all implementing agencies. For impact and outcome evaluations to be conducted, the design of the program/project must include its own baseline and follow-up assessments measuring not only specific outcomes but also the level of exposure to the program/project and its activities.

III. General concepts in M&E

1. What is the difference between monitoring and evaluation?

Monitoring is the *routine* tracking of the key elements of program/project performance (usually inputs and outputs) through record-keeping, regular reporting and surveillance systems, as well as health facility observation and surveys. Monitoring helps program or project managers determine which areas require greater effort and identify areas which might contribute to an improved response. In a well-designed monitoring and evaluation system, monitoring contributes greatly towards evaluation. Indicators selected for monitoring will be different, depending on the reporting level within the health system. It is very important to select a limited number of indicators that will actually be used by program implementers and managers. There is a tendency to collect information on many indicators and report this information to levels where it will not and cannot be used for effective decision-making. In addition, monitoring is used for measuring trends over time, thus the methods used need to be consistent and rigorous to ensure an appropriate comparison. More information is needed for project management than is needed at national or international levels. The number of indicators reported should decrease substantially from the sub-national to the national and international levels.

In contrast, **evaluation** is the *episodic* assessment of the change in targeted results related to the program or project intervention. In other words, evaluation attempts to *link* a particular output or outcome directly to an intervention after a period of time has passed. Evaluation thus helps program or project managers determine the value or worth of a specific program or project. Cost-effectiveness and cost-benefit evaluations are useful in determining the added value of a particular program or project. In addition, evaluation should also relate the outputs of a project/program to wider national trends in behavior and other outcomes, and the impact of diseases. This type of evaluation is important even if the project/program is only one part of a collective effort to impact the disease.

The objectives and the methodology used in monitoring and evaluation are different. In general, evaluations are more difficult in view of the methodological rigor needed: without such rigor, wrong conclusions on the value of a program or project can be drawn. They are also more costly, especially outcome and impact evaluations which often require population-based surveys or other rigorous research designs. However, evaluation should leverage data and surveys that are nationally available and regularly undertaken, e.g. DHS surveys, vital registration or sentinel site disease data.

2. Generalized Monitoring and Evaluation framework

There are varying frameworks applied to the selection of M&E indicators. Indicators are used at different levels to measure what goes into a program or project and what comes out of it. Over the past few years, one largely agreed upon framework has commonly been used, the input-process-output-outcome-impact framework. For a program or project to achieve its goals, **inputs** such as money and staff time must result in **outputs** such as new or improved services, trained staff, persons reached with services, etc. These outputs are the result of specific **processes**, such as training for staff, that should be included as key **activities** aimed at achieving the outputs. If these outputs are well designed and reach the populations for which they were intended, the program or project is likely to have positive short-term **effects** or **outcomes**, for example increased condom use with casual partners, increased use of insecticide-treated nets (ITNs), adherence to TB drugs, or later age at first sex among young people. These positive short-term outcomes should lead to changes in the longer-term **impact** of programs, measured in fewer new cases of HIV/AIDS, TB, or malaria and related burden of disease among those infected and affected (such as orphans and vulnerable children or widows). In the case of HIV, a desired impact among those infected includes quality of life and life expectancy. For additional information on M&E frameworks, readers can visit the following sites:

UNDP: http://www.undp.org/gef/undp-gef_monitoring_evaluation

MEASURE: http://www.cpc.unc.edu/measure

USG: http://www.globalHIVevaluation.org

UNAIDS: http://www.unaids.org/en/default.asp

Assessing the impact of a program requires extensive investment in monitoring and evaluation efforts, and it is often difficult to ascertain the extent to which individual programs, or individual program components, contribute to overall reduction in cases and increased survival. In order to establish a cause-effect relationship for a given intervention, studies with experimental or quasi-experimental designs may be necessary to demonstrate the impact. Monitoring of output or outcome indicators can also identify such relationships and give a general indication of programs progress according to agreed upon goals and targets. National surveys and datasets should also be leveraged in evaluation.

Different types of indicators are not equal but *linked* to each other to reach the intended goals and objectives of a specific program. Inputs such as money and staff time result in outputs such as delivery systems for drugs or other essential commodities, new or improved services, trained staff, informational materials, etc. If these outputs are well designed and reach the populations for which they were intended, the program is likely to have positive outcomes – depending on the context in which it operates. These positive outcomes should lead to changes in the longer-term impact of programs on target populations or systems.

The use of **standard indicators** provides the National Program with valuable measures of the same indicator in different populations, permitting analysis of trends (triangulation). This helps to direct resources to regions or sub-populations with greater needs and to identify areas for intensification or reduction of effort at the national level, ultimately improving the overall effectiveness of the national response. Over time, the use of standard indicators also ensures comparability of information across countries. When data from different sources are combined for analysis, this "triangulation" of data allows national, regional, or local evaluation of program efforts.

A note on target populations and denominators: In many cases, it may be difficult to determine the denominator, or population, to use when assessing, for example, coverage. We have therefore focused on **numerators**, or the subset of the population that is affected or benefits from interventions. Denominators should also be included where possible (if percentages are given, **numerators should also always be reported** to allow assessment of coverage over time and across populations). The publications *Estimating the Size of Populations at Risk for HIV (UNAIDS/IMPACT/FHI, 2002)* and *Guidelines for Sampling Orphans and other Vulnerable Children (UNICEF, 2003)*, as well as the *Guide to Monitoring and Evaluation National HIV Prevention Programs for Most-at-risk Population in Low Level and Concentrated Settings* (currently under review), may help readers in addressing the challenges faced in determining denominators when working with hidden populations or low and concentrated epidemics.

In this toolkit, the term target population refers to the group of people who are in need of an intervention. The target population can be the total population or a smaller, specific group such as young people. In designing interventions, efforts should be made to clearly define the target population. The description of services provided should specify which populations and geographic areas are covered. Definition of these is usually based on knowing whom diseases affect most, directly and indirectly. For example, the definition of a target population for HIV/AIDS interventions is often based on the epidemic state. In generalized epidemics where HIV prevalence is consistently over one per cent in pregnant women, the target population could very well be the general population. However, in concentrated and low-level epidemics where HIV prevalence is concentrated within groups with specific risk behaviors, the target group may be defined as a sub-group of the general population that shares these same behaviors – for example, men who have sex with men (MSM), people who use intravenous drugs (IDUs), or commercial sex workers (CSWs). For malaria in high endemic areas such as in Sub-Saharan Africa, important target groups are pregnant women and children under the age of five.

Finally, it is very important to **clearly define the services provided** to a population: these services are defined in terms of standard service delivery areas (SDAs) in this toolkit. The package of services needs to be specified carefully by target population group.

Methods of data collection

Methods of data collection are provided in the disease specific sections, an overview is given here. The frequency of reporting will depend on the level of the indicators within the M&E conceptual framework – taking into account both a reasonable time-frame for an expected change and program capacity for M&E. It is particularly important to include routine data collection which is monitored regularly (quarterly, six months, annually) and plan at an early stage for longer term 1-3 year monitoring and evaluation surveys with clear baselines. The following reporting schedules are suggested:

Table 2: Suggested reporting schedules

Level of indicator	Recommended frequency of reporting	Examples of data collection methods used
Input/Process	Continuously	• Health services statistics • Health facility surveys • Program monitoring
Output	Quarterly, semi-annually, or annually	• Health services statistics • Health facility surveys • Program monitoring
Outcome	1 to 3 years	• Population-based surveys • Health facility surveys • Special studies
Impact	2 to 5 years	• Surveillance • Population-based surveys • Special studies

Table 3: Measurement tools

Measurement tools	Main characteristics	Examples of measurement methods used
Health services statistics	Routine data collection at health facilities. Program monitoring.	• Data registered from various health facility registers
Health facility survey	Survey targeting health facilities to gather information on the availability of human resources, equipment, commodities and drugs and the type of services delivered.	• Site based facility surveys (e.g. HIV/AIDS Service Provision Assessment) • SAMS (Service Availability Mapping Surveys)
Qualitative methods	Determine "what exists" and "why it exists" rather than "how much of it is there". Through allowing the people to voice their opinions, views and experiences in the way they want, qualitative methods aim at understanding reality as it is defined by the group to be studied without imposing a pre/formulated questionnaire or structure (always developed by the researchers) on the population *(Maier B. Gorgen, R et at 1995)*.	• In-depth Interview (individuals, focus groups, key informants) • Direct observation • Interactive or projective technique (comments on posters, open-ended story/comment on story, role-play)

Operational research	Operational research (OR), also called targeted evaluation, complements M&E systems. The main objective of OR is to provide program managers with the required information to develop, improve or scale-up programs. If evaluation focuses on whether a change in results can be attributed to a program, OR focuses on whether the program is the right, or best, program to achieve the desired results. It can be thought of as a practical, systematic process for identifying and solving program-related problems.	• Examples of OR:
		  • Adherence
		  • Equitable access
		  • Costs
		  • Linking prevention-treatment
		  • Different models of intervention

Sentinel site surveillance	Collect prevalence information from populations that are more or less representative of the general population (such as pregnant women) or / as well as populations considered to be at high risk of infection and transmission. Can be linked or unlinked anonymous testing, with or without informed consent.	• HIV sero surveillance in pregnant women or in identified groups at high risk
Population-based surveys	A survey based on sampling of the target or general population, generally aiming to represent the characteristics, behaviors and practices of that population. It requires sufficient sample size to represent the larger population and to be analyzed in sub-groups, by age, sex, region and target populations.	• MICS, DHS and DHS+, AIS, BSS, PLACE, SAVVY

Much of the information contained in this toolkit is centered on the collection of *quantitative* data. It is important to emphasize however, the value and use of *qualitative* data in complementing, validating and providing a richer understanding of quantitative findings. Although qualitative approaches are not intended to be generalized to broader populations, and cannot measure trends, such data does put quantitative data into context and allows for a more expansive interpretation of quantitative indicators. Qualitative data is also useful in addressing contextual responses to behavior change, information that can prove valuable in designing more effective communication campaigns, giving voice to the poor and vulnerable populations and providing better services to target groups.

Various methodologies are used in the collection of qualitative data including, among others, patient satisfaction surveys, desk reviews, patient/staff observation, mapping exercises, key informant interviews, focus groups, participatory rural appraisals, and rapid ethnographic studies. For more information on these methodologies, refer to: http://www.fhi.org/en/hivaids/pub/archive/evalchap/inex.htm.

Ideally, a mixed qualitative and quantitative approach should be utilized when collecting and analyzing information. The mixed methodological approach will contribute to a more substantial understanding of program progress, ensure triangulation of data sources and reduce biases in the data.

Technical assistance

A significant development in the areas of technical assistance has been the deployment of country M&E staff by some agencies such as UNAIDS and the Emergency Plan. They have an important role in coordinating M&E efforts among partners and countries. Information on technical assistance with links and resources is provided in the individual disease component sections (HIV/AIDS, TB/HIV, TB, Malaria, Health Systems Strenghtening).

In 2005, the UNAIDS Monitoring and Evaluation Technical Assistance System (METAT) was established and supported by a number of partners including the Global Fund, the Emergency Plan and WHO. METAT aims to broker requests for M&E technical assistance from countries and programs with the supply of expertise from technical partners. The main purpose of the system is to take requests and distribute them to relevant partners and track M&E technical assistance and the outcome of such requests. This aims to broker the request for technical assistance with local needs. With the "Task List/Work Order" feature, users are able to follow the course and deal with requests from the initial phase to the last step, i.e., when the request has been responded to appropriately. An analysis of the type of technical requests received through METAT is done on a regular basis to identify gaps and proactive solutions. This system is in its early stages of implementation.

To join METAT as a member or for more information on the system, please contact UNAIDS Secretariat at helpME@unaids.org. The service is also being extended to M&E technical assistance in relation to malaria and TB through the relevant partners for each disease.

Technical assistance and links to technical resources and websites for each disease are presented in the disease specific sections.

IV. Frequently asked questions

Operational questions

1. How to select indicators from the core list provided in this toolkit?

In deciding on a set of indicators, countries are *not* limited to the core list presented in this toolkit and should report *only on a limited set of indicators* from this toolkit. The choice of indicators should be driven by the goals and objectives of the national program or project. Where indicators fit needs, national programs are encouraged to use the core indicators proposed in this toolkit to ensure standardization of information over time. The core indicators have been tried and tested and have proved to provide useful and reliable information. Countries should aim to simplify M&E and report a limited and standardized set of indicators internationally.

The following guiding principles help in choosing the most appropriate set of indicators and associated data collection instruments:

- Use a conceptual framework for M&E for proper interpretation of the results.
- Ensure that the indicators are linked to the goals and objectives, and that they are able to measure change over the program time period.
- Ensure that standard indicators are used to the extent possible for comparability over time or between population groups.
- Ensure that indicators relate to defined services which are delivered by the program. Attempt to define the standard package of services provided by the program and the groups targeted.
- Consider the cost and feasibility of data collection and analysis.
- For HIV/AIDS, take into account the stage of the epidemic.
- **Keep the number of indicators to the minimum needed**, with specific reference to the level of the system that requires and will use indicators to make programming and management decisions.

Additional indicators can always be identified later or may be collected for project management. For international reporting, a small set of indicators which are standard and comparable internationally is recommended. They do not need to capture the initial stages of the framework, e.g. inputs and process, but do need to focus on the outputs and outcomes of services delivered.

2. Does planning of data collection require different strategies for different indicators?

The cost, difficulty, and capacity required for collecting information usually increase as indicators shift from input to output, outcome and impact. It should be possible to collect data for *input* and *output* indicators centrally from routine health information systems, provided that such systems exist and are functional. Program planners should take strategic advantage of the increased attention to HIV/AIDS, TB, and malaria programs and request funding for strengthening national health information and surveillance systems that can be used to report on all these as well as other disease-specific programs.

In addition, if projects are setting up their own M&E components, **one of the first steps should initially be to coordinate with other projects in the country** (e.g. PEPFAR, World Bank, the Global Fund, major NGOs and government activities) in order to reduce overlap and use common data standards, software, systems, and indicators where possible.

Data for many *outcome* and *impact* indicators are collected through more costly and difficult population-based or health facility surveys, requiring some expertise in research methods. Outcome measurement is usually more difficult in view of the sensitivity and specificity of each indicator. However, programs can often leverage ongoing surveys and baselines already undertaken in the country.

3. How can we capitalize on existing data collection efforts?

In devising their data collection plans, countries should take into account to the extent possible:

- The existence of data already collected by agencies not directly involved in one of the three specific diseases, but that can help in monitoring;
- The timing of costly population-based surveys such as DHS in which modules can be included to obtain data on a number of indicators relevant to the three diseases; and

- The activities of other major programs in the country (e.g. PEPFAR, World Bank, Global Fund, major NGOs and government activities) to reduce overlap and use common data standards, software, systems, and indicators where possible.

4. What resources should be allocated to M&E from the total national program budget?

Ensuring that resources are well used requires a coherent M&E system. It is therefore recommended that about 5-10 percent of the national program budget is used for M&E; 7% is generally accepted. The same rule should be applied at sub-national level. This percentage should be based on the total of all resources, including external donor and national funding together. Between 3 percent and 5 percent of regional and district (where appropriate) financial resources should be devoted to M&E activities at regional and district levels.

Funders are increasingly realizing that project funds should be allocated to the development of an M&E system so that information related to the project can be collected, reported, and used. As a result, additional resources have become available as part of larger grants. This allows for the development of coherent systems rather than ad hoc efforts. These should provide standard indicators so that data for a number of projects, departments and donors can be provided. Resources from any one donor should be used to fill gaps in the M&E system in a coordinated way.

5. What is the best way to optimize the use of M&E funds?

The following recommendations help ensure that M&E funds are properly invested:

- Develop coordinated systems rather than implement ad hoc data collection efforts. The initial investment cost is to be seen in light of the incremental benefit of more regular or more extensive data collection, ultimately resulting in a less costly exercise.
- Consider both short and long-term needs to ensure smooth continuity of national programs.
- Mobilize key M&E players at country level through a M&E support group to avoid duplication of efforts.
- Use commonly agreed upon M&E frameworks for comparability purposes.
- Ensure that large surveys collect data that will address relevant indicators.

6. How to optimize the use of data?

The ultimate goal of data collection is to ensure that data are fed back into the decision-making process. Data are powerful tools for advocacy, generating resources, accountability, program design and improvement, and attributing changes to specific interventions and programming (or reorientation of programs). Based on lessons learnt over the past years, the following steps help optimize the use of data:

- Produce quality data. This requires serious investment throughout the data collection process.
- Assess how data will be used, and make it as transparent and widely available as possible.
- Identify the different end-users, and present and package the data according to their needs, focusing on a minimal number of indicators at each level.
- Set up mechanisms for an efficient data-use system, including feedback through supervision at all levels, and assurances that data at a given level is relevant and actionable at that level.
- Ensure ownership throughout the data collection exercise, which means that national and local M&E capacities must be strengthened to guarantee uniform and quality data within a sustainable framework.
- Ensure that an M&E support group with strong presence of key stakeholders such as the government, donor agencies, NGOs, civil society and academic institutions is established to guide the government throughout the development and implementation of national M&E strategies. This will improve the credibility of the data generated by the government.
- Allocate sufficient resources for the development and implementation of a data-use plan.
- Ensure that data are used as widely as possible and made transparently available in the public domain.

7. How can we avoid donor demands driving health information investments?

To ensure that donor demands do not drive health information investments – with the risk of having different competing demands – the following steps are recommended:

- Establish a platform under country leadership with strong donor involvement, such as M&E country coordinating committee with high level support.
- Advocate for building a health information system that provides quality and timely information.

- Use – to the extent possible – commonly agreed upon M&E frameworks and standard indicators.
- In cases where two or more donors have multiple demands, a consensus should be reached through in-country coordination mechanisms.
- Before establishing M&E systems, check with other projects/programs and national focal points in the country to reduce parallel systems and reporting.

8. What are the key lessons learnt from successful M&E systems?

Most importantly, data should be used -for management and funding decisions- to sustain any M&E reporting system. Below is an illustrative list of key lessons:

- M&E systems must be as simple as possible. Most programs and projects collect far more data than they use. The more complex a M&E system, the more likely it will fail. It is important that data is used as a basis for ongoing decision making.
- M&E systems must include a standardized core set of tools to collect and analyze data. If each implementing partner uses different systems or tools, the data cannot be analyzed or summarized effectively. The need for a standardized core set of tools does not preclude individual implementing partners from collecting additional situation-specific M&E data.
- Good M&E requires both internal self-assessment and external verification. Thus, while implementing partners should collect and verify their own internal data, an external agency should verify the completeness and accuracy of the data collected by those implementing partners. Supervisory visits should be based on the analysis of internal self-assessment and externally verified primary data.
- A specialized entity is required to collect, verify, enter and analyze primary M&E data from each partner. Without such an entity, reliable data collection, verification and analysis are unlikely to occur as Ministries and other public agencies are seldom equipped to manage such a process. Increased resources devoted to HIV/AIDS, TB and malaria should be used to build local capacity within such a national organization.
- M&E must be built into the design of a program and must be operational when grant implementation begins, not added later. It is much harder and less effective to "retrofit" M&E after grant implementation is underway.
- Sub national data are important for the national level data collection as they can be aggregated up to this level. However, sub national data are more relevant to program managers in making day to day decisions.
- Data should be made available as widely and transparently as possible, and wherever possible placed in the public domain. M&E is about promoting the use of data.

No matter how sound an M&E system may be, it will fail without widespread stakeholders "buy-in." Thus, a large-scale, participatory process in the development and implementation of M&E strategies is essential to build ownership and "buy-in" from the start.

Common questions on the toolkit and Global Fund reporting

1. How is the M&E toolkit used by the Global Fund?

The Global Fund raises money, allocates funds to programs, and shows these funds help fight HIV/AIDS, tuberculosis and malaria. In brief, it aims to "**raise funds, spend them and help prove their contribution to fight the diseases**" in partnership with other international and national organizations, and crucially with the projects which implement the grants.

The Global Fund is a **financing mechanism** rather than a technical agency. The Global Fund does not develop new or its own indicators, but builds on indicators already used by partners and countries (agreed in this toolkit). It has therefore brought together technical agencies to agree on a core set of indicators across the three diseases which are presented in this toolkit. Standardization is important, to simplify monitoring and evaluation efforts. Furthermore, it allows the Global Fund to describe progress and coverage across its whole portfolio of grants for very varied projects and settings.

Performance-based Funding is central to the Global Fund mechanism, to ensure raising, spending and proving the contribution of funds are closely related. Funds are released when progress against agreed targets is met. This requires that:

- Overall **goals** are clearly formulated
- Services are clearly defined, grouped into **service delivery areas**, and related to goals

- **Indicators are chosen, targets set** and progress reported regularly

The Global Fund relies on a **minimal set of indicators** which are agreed by a wide range of partners and used in countries as captured in this toolkit. Reporting should draw as much as possible from existing M&E systems and not provide an additional reporting burden. The Global Fund wants to increase the coverage of quality services, and therefore for each service it is important to report regularly on people reached, service points supported and people trained in providing the service.

Routine reporting	Medium-term reporting (one to five years)
• People reached by services (numerators)	• Impact on the three diseases
• Number of service points supported	• Behavior changes
• Number of providers trained in service	• Percentage of target groups reached by services (numerators and denominators)

In addition, over the medium term (1-5 years), the Global Fund wants to ensure that **evaluation** of the impact on the three diseases, changes in behaviors, and the percentage of target groups reached (numerators and denominators) are measured. These are seen as the outcome of collective efforts, should leverage national data sources, and are not necessarily directly attributable to the specific program.

Performance will be based on how well different indicators can be measured, documented and verified against agreed targets to achieve the goals of the proposal. There are therefore very strong incentives to have clear, simple, measurable and well communicated results on a regular basis. Wider measures of progress should also be reported, but **core performance will rely on a few clear and meaningful targets**.

Performance-based Funding helps ensure that money is well spent relative to project goals, and ultimately services are provided to those affected by disease. Funds raised do not belong to the Global Fund nor to the programs supported, but to the people who need services with urgency. Performance-based Funding also develops an evidence base and platform to advocate sustained and dependable funding.

Performance-based Funding framework

The Global Fund's system for **Performance-based Funding** aims to:

- **Ensure money is spent on services for people in need**
- Relate disbursements to achievement of targets
- Provide incentives to focus on results and timely implementation
- Free up committed resources from non-performing programs for re-allocation to programs where results can be achieved

2. At what stages do grants report on results?

The Global Fund has developed a set of tools in collaboration with technical partners to facilitate grant management and Performance-based Funding throughout the lifecycle of a grant. These tools track relevant performance targets and achievements by using a clear set of indicators and targets taken from the original proposal and built into the Grant Agreement. They ensure reported data are used, and used for decisions at each stage.

The information collected is used at three main stages of performance evaluation:

- **Regular Disbursements (6 monthly as the default):** Agreement on a few indicators of progress is used for regular Financial Release on a quarterly or 6 monthly basis. Finances are released based on disbursement requests accompanied by progress updates of results against targets with an explanation or self assessment from the program. Grants do not need to set targets and report results for every indicator in every reporting period. Reporting periods should be aligned with the National information system. Grantees need to explain reasons for deviation of results from targets.
- **Annual reviews (every 12 months):** These collect the results for all indicators for the year and include a self-assessment of progress, barriers, successes and failures. The Global Fund uses these updates to report on progress in program implementation across its portfolio, and as a key source of contextual information to interpret the minimal performance focus of results against targets. The Global Fund does not request a specific report and can use existing annual reviews or yearly program reports.

- **Phase 2 evaluation (from 18 to 20 months):** Funding is committed for a first period of two years. After 18 months the program makes a submission for Phase 2 funding to cover up to an additional three years (a total of 5 years of funding). An overall review of performance is used as a basis for the Secretariat of the Global Fund to recommend further funding into Phase 2. This includes a comprehensive report on results against targets, against the goals of the proposal, and of the delivery of key services relevant to fighting the three diseases. Self assessment by the program is an important element, including the possibility to suggest changes in the program from experience. Although targets should not be changed, explanations of deviance of results from targets are taken into account in rating performance. A ***Grant Scorecard*** is prepared combining the aggregate results with independent verification and assessment of data on the grant's performance. The Grant Scorecard becomes the basis for the Phase 2 funding decisions taken by the Board.

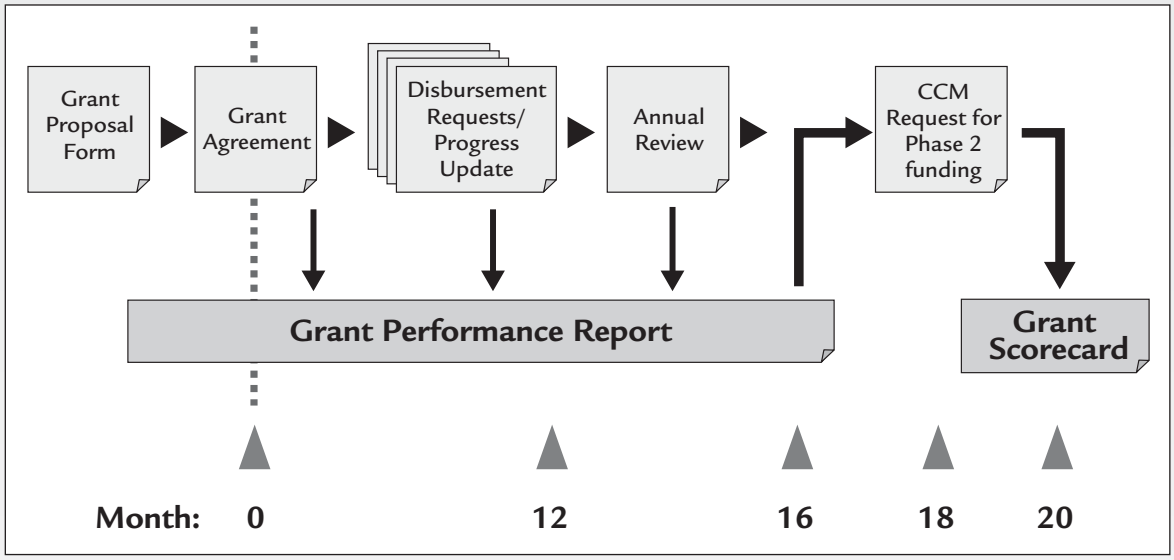
While Performance-based Funding of grants reaches a critical milestone at the Phase 2 funding stage, the measurement and evaluation system starts at the beginning of a grant when indicators and targets are agreed by recipients and the Global Fund and made part of the first grant agreement.

Targets are tracked at every stage in the process (as shown in the figure below): defined in the grant proposal, incorporated into the grant agreement (in M&E grant attachment), progress reported before each disbursement (progress update), in annual reviews, and consolidated in the CCM request for continued funding for Phase 2, and beyond into Phase 2 reporting. Performance-based Funding occurs continuously throughout the grant's life.

It is important to note that the aim of Performance-based Funding is to use reported results actively, as the basis for self assessment and decisions in programs and at the Global Fund. Results against targets are only the basis of a performance rating. As important are the self assessment and explanation of progress by the program, and corrective measures proposed to ensure rapid learning and scale up of programs. Overall performance incorporates both the hard quantitative elements of results against targets and the qualitative assessment of progress and important contextual factors.

Finally, **country ownership** provides the basis for Performance-based Funding. Targets should be derived from country proposals, and agreed by both sides in the Grant Agreement.

Figure 1: Stages of a Global Fund grant and reporting on results



3. How to use the toolkit for a Global Fund grant?

The M&E toolkit should be used to guide the proposal application, finalize the M&E grant attachment where indicators and targets are incorporated, and to guide reporting throughout the grant lifecycle. There should be an M&E plan which can, if relevant, be a plan which already exists in the country. The toolkit is then used to choose the limited set of indicators to be used from the more extensive M&E plan and system and those for which targets are set as a basis of reporting to the Global Fund. It is important to distinguish between levels of M&E, the more **extensive set of indicators needed to manage a program**, and the **few indicators needed for donor and international reporting**.

The Global Fund aims to reach people with quality services to impact the control of three diseases. As the program becomes established, reporting shifts to information regarding increased number of people reached, and then outcome and impact indicators. The Global Fund aims to simplify reporting focusing on:

- **Capacity building (from grant start):** people trained and service points supported
- **People reached by services (within 12 months):** for prevention, treatment, care
- **Fighting the diseases (1 to 5 years):** behavioral change and disease impacts

The Global Fund recognizes that this requires strengthening of health systems, and therefore the toolkit also includes indicators and service delivery areas related to the strengthening of health systems. These can be included in disease components for HIV/AIDS, TB and Malaria directly.

A central aim is to increase coverage of prevention, treatment and care of HIV/AIDS, TB and malaria and to be able to measure the coverage. To show this internationally across many countries and programs, a few high level standard indicators that are provided by grant recipients of people reached by services, are highly valued.

In addition, changes to population behaviors and disease impacts are reported over time, in collaboration with country partners. Alongside traditional stages of M&E, increased delivery of services is emphasized (training, service delivery points supported and people reached) to evaluate whether more people are being reached by more quality services. The following table is a tentative approach to link the international framework with the different levels of reporting to the Global Fund.

Table 4: Tentative approach to link the international framework with the different levels of reporting to the Global Fund

International Framework	Global Fund reporting Framework	Examples of Areas
Input indicators	**Capacity building** (people trained, service points supported)	• Human Resources • Policy formulation • Financial inputs • Infrastructure building and rehabilitation
Process indicators		• **People trained** • Drugs procured • Basic needs and commodities procured • Coordination ensured
Output indicators		• Service delivery points supported (**Number of service points supported**)
	People reached by services (and services delivered)	• People benefiting from interventions (**Number of people reached by the services**)
Outcome/ Impact indicators	**Fighting the three diseases** (behavior change and impact)	• Change of behavior, reduced morbidity and mortality

4. How to simplify M&E and reporting to the Global Fund?

At the country level, there are various systems for data collection and mechanisms to distribute resource flows that feed into the day to day management of grants. The Global Fund focuses only on a small set of indicators (the "tip of the iceberg") to ensure that grant programs reach more people with the vital services they need.

Grants should only report on a **few indicators for defined service delivery areas in line with achieving its goals and objectives**. In general, a grant should report on a very few indicators per service delivery area (to show people reached by services, service points supported, and people trained). Performance-based Funding is usually undertaken with a focus on *5-10 key indicators* per grant, with 15 reported in total.

In addition, grants should **leverage existing national M&E systems** in countries. These systems are fundamental for reporting to the Global Fund. There is a clear distinction to be made between the information that will be collected for program management and M&E purposes at the country level (many more indicators) and what is submitted to the Global Fund to assess programmatic performance (focused on 5-10 key indicators, with 15 indicators reported in

total). The indicators reported to the Global Fund should be a simplified set from the overall M&E plan. The reporting to the Global Fund needs to capture a small subset of information. However, in order to provide that information, the country needs to have a strong base on which data can be captured. Core performance will be based on how well different indicators can be measured, documented and verified against agreed targets for each service delivery area.

Not only does performance evaluation serve to ensure that funds are allocated correctly, but it also provides a **platform for programs to communicate evidence of progress internally and externally, and make the case for sustained funding**.

The M&E plan should build on existing national programs and policies wherever possible. The M&E plan is a central part of grant applications, the grant agreement signed by both sides, and the basis for ongoing "Performance-based Funding". Whenever an M&E plan exists for a national program, the M&E reporting framework for the Global Fund should be drawn from it. Many of the indicators covered in the toolkit are therefore only the "tip of the iceberg" of the full monitoring and evaluation plan and they need to be interpreted in this wider context.

5. How to choose indicators and targets to report to the Global Fund?

Programs or projects should have clear defined goals and objectives. This is the starting point of reporting to the Global Fund. To achieve these, service delivery areas should be defined, from which indicators are selected. These indicators need to be reliable and measurable on a regular basis. The consistency of goals and services delivered is important so as to be able to evaluate over the medium term, progress in fighting the three diseases in terms of impact and behavior change.

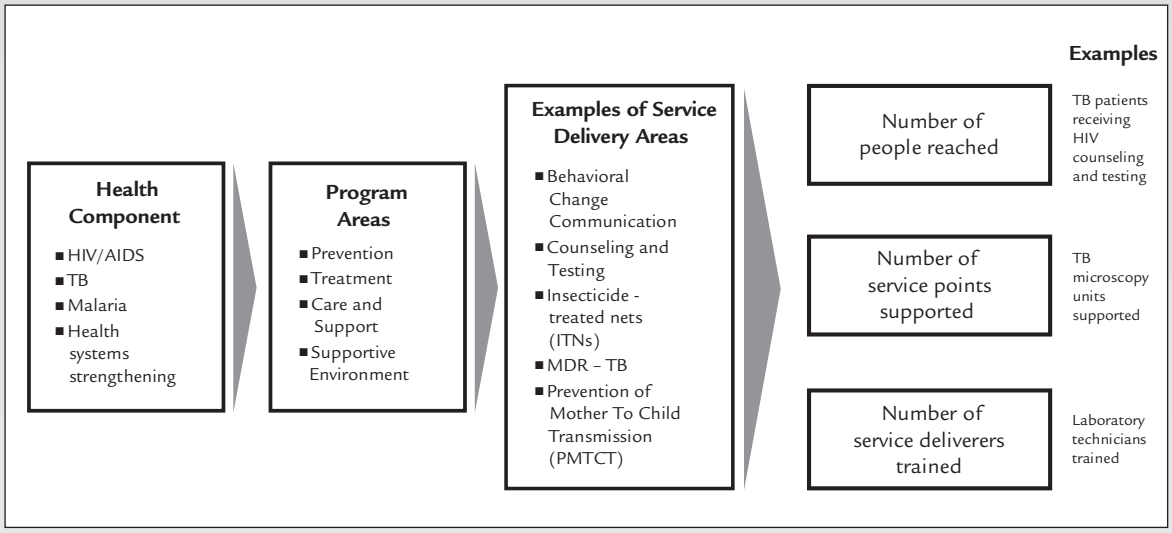
Overall Goals are broad and overarching, for example "*reduced HIV-related mortality*", "*reduced burden of tuberculosis", "reduced transmission of malaria*". For each goal, **impact indicators** must be chosen.

Objectives need to be clearly described for each goal. An objective describes the intention of the programs for which funding is sought and provides a framework under which services are delivered. Examples of objectives include "*improving survival rates in people with advanced HIV infection in four provinces*", *"to reduce transmission of tuberculosis among prisoners in the ten largest prisons*", "*to reduce malaria-related morbidity among pregnant women in seven rural districts*".

The next step, and the core of regular Performance-based Funding is to identify key **services to be delivered**, and provide, for each of them, **indicators with targets** that can be measured and can show regular programmatic progress. Under each objective, indicators are therefore grouped under their respective **Service Delivery Areas** (a service delivery area corresponds to a specific service that is provided).

A program has one or two goals. Each goal has an objective, each objective includes several Service Delivery Areas, and each SDA is evaluated on one or more indicators.

Figure 2: The relationship between disease components, service delivery areas and indicators



The Global Fund **puts particular value on reporting of a set of "top ten" indicators** measuring people reached with services that it can report on internationally and regularly across the entire portfolio. These are standard services which can be reported on at the international level. They are for frequent routine reporting, for regular disbursements of money. **These indicators should be incorporated into grant reporting wherever the services are provided**.

Table 5: Top Ten Indicators for routine Global Fund reporting

	Top Ten Indicators for routine Global Fund reporting	Disease
1	Number of people with advanced HIV infection currently receiving **anti-retroviral combination therapy** (ARV)	*HIV*
2	Number of a. **new smear positive TB cases detected,** b. new smear positive TB cases that **successfully complete treatment** and c. TB cases enrolled to begin **second line treatment for multi-drug-resistant TB**	*TB*
3	Number of **ITNs** (including retreatment kits for existing nets) distributed to people at risk (or, where appropriate, number of houses receiving indoor residual spraying according to national policy)	*Malaria*
4	Number of people with uncomplicated or severe malaria receiving **anti-malarial treatment** as per national guidelines (specify ACT/non-ACT)	*Malaria*
5	Number of people **counseled and tested for HIV** including provision of test results	*HIV*
6	Number of HIV-positive pregnant women receiving a complete course of anti-retroviral prophylaxis to reduce mother to child transmission **(PMTCT)**	*HIV*
7	Number of **condoms** distributed to people	*HIV*
8	Number of people benefiting from **community-based programs** (specify, a. Prevention b. Orphan support c. Care and support)	*HIV/TB/Malaria*
9	Number of cases treated for **infections associated with HIV** (specify, a. Preventive therapy for TB/HIV, b. STIs with counseling)	*HIV/TB*
10	Number of **service deliverers trained** according to documented guidelines (specify a. Health services b. Peer and community programs)	*HIV/TB/Malaria*

In the **medium to long-term (1-5 years), outcome and impact indicators** that show decreases in disease incidence or prevalence and behavior change should be selected. Please note that **planning for these indicators should begin at the start of the grant**, and that they require clear baseline values. These indicators are usually more difficult and costly to collect and correspond to the contribution of all stakeholder efforts and programs in-country. Existing surveys should be leveraged, and data analyzed as part of a national collective effort. Programs should draw as far as possible from existing surveillance information, including impact and evaluation studies implemented in-country. If these surveys do not exist the Global Fund encourages the country to develop and implement such studies in partnership with other

technical partners in-country. Global Fund program funds should be used to fill in gaps, and investments in both monitoring and evaluation are strongly encouraged.

Table 6: Top Ten Indicators for medium term outcome and impact

	Top Ten Outcome and Impact Indicators	Disease	Source
1	Percentage of young women and men aged 15-24 who are HIV infected (**HIV prevalence**) (applicable to most-at-risk populations in concentrated/lower epidemics)	HIV	UNGASS
2	Percentage of adults and children with HIV still alive 12 months after initiation of anti-retroviral therapy (extend to 2, 3, 5 years as program matures) **(Reduced mortality)**	HIV	UNGASS
3	Percentage of infants born to HIV infected mothers who are HIV infected (**Reduced mother to child HIV transmission**)	HIV	UNGASS
4	Percentage of young people aged 15-24 who had sex with more than one partner in the last year (**Multiple Partners**)	HIV	WHO/ UNAIDS
5	Percentage of 15-19 year olds who never had sex **(Primary abstinence)** and percentage of 15-24 year olds who never had sex in last year of those who ever had sex (**Secondary abstinence)**	HIV	WHO/ UNAIDS
6	Percentage of young people aged 15-24 reporting the **consistent use of condoms** with non-regular partners	HIV	WHO/ UNAIDS
7	**TB case detection** rate and **treatment success** rate	TB	WHO StopTB
8	Estimated number of all active TB cases per 100,000 population (**TB prevalence rate**)	TB	WHO StopTB
9	**Death rates associated with malaria:** all cause under-5 mortality in highly endemic areas	Malaria	WHO RBM
10	**Incidence of clinical malaria cases** (estimated and/or reported)	Malaria	WHO RBM

Baselines are determined and targets are set for successive regular measurement over five years. The timing of the measurement of these regular targets should, as far as possible, be aligned with existing data collection and reporting systems. Please note that all indicators do not need to be reported on for each disbursement period, but results should be consolidated on a yearly basis in the annual review. These targets are generally the aims of a variety of activities, national programs and collaborators working together, not just an individual project.

It is important to remember:

- To extract indicators from existing M&E plans, in line with national strategies, wherever possible.
- Select simple indicators (which have already been tested) with existing tools to collect them.
- Ensure a good balance between periodic surveys and routine health statistics data. Surveys can complement information gaps in HMIS, in particular for outcome and impact indicators. However, the surveys generally do not provide results as regularly as routine systems to report on six monthly disbursements.
- **Set baselines for each main indicator**. Results reported should be cumulative over each phase of funding, and generally should exclude baselines. The exception is if people are carried forward into the program, e.g. people on an ARV pilot program are treated under the grant.
- If results are in **percentages, there is a need to provide numerators and denominators**.
- Avoid double-counting the same individual within one program/service area during each reporting period. However, it is acceptable to count the same person in multiple program/service areas (for example ARV and Palliative Care).
- Training refers to either new training or retraining of individuals and assumes that it is conducted according to national or international standards when these exist. It is very important that the recognized standards of training are recorded (including objectives, duration, follow-up), and that follow up is undertaken to ensure that these individuals become active and practice service delivery.

V. Component-specific reporting framework

This section of the toolkit presents selected (1) programmatic and (2) outcome and impact indicators for HIV/AIDS, TB, and malaria. In addition, indicators for Health Systems Strengthening are provided. Summary tables show an overview of selected indicators, the annexes provide more detailed supporting descriptions. These indicators have been developed, discussed and agreed upon by a wide range of international and national experts and donors. They have been developed for the specific purpose of minimizing information demands on countries. The indicator development process was guided by six major principles:

- Building on existing indicators
- Minimizing the number of indicators to be collected
- Selection of indicators that are collected regularly through health information systems or acknowledged population-based surveys (MICS, DHS, DHS+)
- Coordinating national and donor M&E needs
- Harmonizing with other international frameworks such as UNGASS and the Millennium Development Goals (MDGs)
- Covering a wide range of program areas and sectors related to HIV/AIDS, TB, and malaria

For each disease, general program areas have been defined. In the case of HIV/AIDS, for example, these include prevention, treatment, care and support, and supportive environments. The **Toolkit Annexes** give information regarding:

- Rationale for use
- Definition, including numerator and denominator
- Measurement – i.e. details on instrument and process, comprising:
    - Measurement tools: health services statistics, health facility surveys, qualitative methods, sentinel sites surveillance, population-based surveys
    - Recommended periodicity of data collection
- Resources – i.e. reference groups, technical assistance sources, guidelines

Remember

- **Tables presented for each component do not aim to provide a comprehensive overview of all indicators.** Rather, they aim to provide users with a set of the most common indicators used for specific activity areas. For a complete listing of all existing indicators, readers are referred to the guidelines section for each component. These sections list all available M&E guides including program indicators.
- Generic input and output process indicators that refer to counts (such as number of people trained) are usually not defined in the Toolkit Annex.[1] Grants can include the number of people trained and service points supported as generic indicators with the relevant programmatic definitions, e.g. of clear training standards.
- In order to facilitate the referencing of indicators from the summary tables to the related annexes, indicators have been named according to their activity area (i.e., prevention, care and support, treatment and outcome indicator) and a number (i.e., 1, 2, 3, etc.). Therefore, the first prevention indicator is named PI (prevention indicator) 1, and so on. The references do not relate to any categorization of the same indicators in other publications.
- **Health Systems Strengthening (HSS) is included as a separate section in this toolkit. However any HSS service delivery area can also be built into disease specific grants. The details and rules for each round of Global Fund funding should be consulted to assess the best strategy**.

[1] *These are generally common from a medical/public health perspective across the three disease areas and are therefore not specified for each. While there are some differences across the three diseases, these indicators generally take on the following forms: (1)* ***Generic input indicator****: Existence of national policies, guidelines, or strategies. This is a "yes" / "no" question. Reporting of overall budget allocation is included as an input. (2)* ***Generic output indicator****: Number of persons trained, number of drugs shipped/ordered, etc.*

VI. HIV/AIDS

This section of the toolkit provides an overview of indicators at the output, outcome and impact levels and general M&E resources for HIV/AIDS. Most indicators listed are extracted from international M&E guidelines which have been developed jointly by key international partners to avoid duplication of efforts and to minimize country burden. For this reason, although some indicators may inevitably be revised over time, the use of the agreed upon indicators is strongly encouraged where appropriate.

Most of the HIV/AIDS indicators are *applicable* to most settings, the main exception being indicators covering injecting drug users (IDUs) and HIV prevalence. The IDU indicator is applicable to countries where injecting drug use is an established, significant mode of HIV transmission. Likewise, the indicator for orphans and vulnerable children (OVCs) will be less relevant in low level/concentrated epidemics. Countries with low HIV prevalence or concentrated epidemics should report on an alternative indicator of HIV prevalence among high-risk behavior groups, as well as prevalence among young people obtained from antenatal clinic sentinel surveillance.

Details of the most recent indicators for the different programs or initiatives can be found in the original sources referenced at the end of this section. The field has been moving rapidly but key partners have reached consensus on a number of indicators for the various programs or initiatives. The recent scaling-up of ARV therapy, under the 3 by 5 Initiative of WHO, the Emergency Plan, World Bank, the Global Fund and other partners, has led to a number of international M&E guidelines addressing prevention, care and treatment. Additional and alternative indicators may be found in other documents referred to in the section entitled "Guidelines and essential references".

A number of high level goals have been defined as part of the Millennium Development Goals (MDGs), UNGASS targets, and G8 leaders' commitment:

Key HIV/AIDS Goals and Targets

Millennium Development Goals (MDGs):

Goal 6: Combat HIV/AIDS, Malaria and other diseases

Target 7: Have halted by 2015 and begun to reverse the spread of HIV/AIDS

UNGASS targets – Universal access to ARV programs by year 2010:

- By 2010, 95% of young women and men aged 15-24 both correctly identify ways of preventing the sexual transmission of HIV and reject major misconceptions about HIV transmission
- By 2010, 25% of reduction globally of young women and men aged 15-24 who are HIV infected
- By 2010, 50% reduction of infants born to HIV infected mothers who are infected

G8 leaders' commitment:

"To provide as close as possible universal access to treatment for AIDS by 2010"

WHO, together with UNAIDS, have defined a package of interventions for HIV/AIDS. Some or all of these interventions can be applied to the different target groups under consideration in the programs:

- General population
- Population sub-groups (youth, women, men, pregnant women, others)
- Most-at-risk population (MARP) – (IDU, MSM, CSWs and their clients)
- Orphans and Vulnerable Children (OVCs)

Each country/program defines the specific package that is to be applied for the target population.

Measurement tools and data sources

The primary measurement tools are:

- Health facility-based statistics
- Community-based program reports
- Surveillance studies

- National representatives, population/based sample surveys such as Demographic and Health Survey (DHS and DHS+, AIS, Multiple Indicator Cluster Surveys (MICS))
- Schools, health facility and workplace surveys
- Specially designed surveys and questionnaires, including surveys of specific groups (e.g., targeted surveys of most-at-risk populations and specific service coverage surveys (SAM and the National Composite Policy Index questionnaire)).

Existing monitoring resources, including records and program reviews from health facilities and schools, as well as specific information from HIV&AIDS and sexually transmitted infections (STI) surveillance activities and control programs, should supplement the primary measurement tools. Civil society is also a valuable source of data for many indicators, especially those that relate to interventions where non-government, faith-based and community-based organizations play an active role, including work with young people, most-at-risk populations and pregnant women.[2]

Ensuring Quality Services

The quality of activities and services being implemented are crucial to achieve desired results. If interventions being implemented are of poor quality, the results of the activities will not be optimal even if the intervention was able to attain high coverage. Thus it is important to monitor the *quality* of activities and services to ensure effective progress. These should be built into any M&E plan in support of the output indicators reported.

Although many of the indicators listed in the toolkit ultimately count the number of facilities providing services or the number of people reached, the quality component of these indicators should be carefully documented with reference to national and international standards of service delivery. For example, the number of people trained on ARV does not aim to solely capture everyone trained on ARV, regardless of the content of the training; the intent is to capture the number of people who are trained according to a *specific criteria* or meeting an acceptable standard. Likewise, the number of facilities providing a particular service tries to capture the facilities which have systems and items meeting a *certain criteria*. In line with the "Three Ones," it may be useful for countries to introduce an accreditation process for facilities[3] or a certification process for those trained in certain service delivery areas[4] in order to have a standardized way of ensuring that quality of services are provided.

Changes from the first version of the M&E Toolkit: The same measurement framework is used, which is compatible with reporting outlined in the initial toolkit. Significant changes are: TB/HIV is included in both the HIV and the TB section, community outreach activities are expanded and MARP prevention is included in the HIV section. Where specific services are provided to MARP or population subgroups (e.g. Counseling and Testing), they should be specified under these services with an indicator related to the specific groups. Youth education is now included in Behavior Change Communication. From experience, precise services were often not well defined, when youth and MARP were taken as separate SDAs rather than captured with precise indicators for standard service delivery areas.

2 *Text extracted from UNGASS Guidelines on Construction of Core indicators, 2006.*

3 *WHO is currently in the process of producing a guide for an HIV care accreditation program which will provide an overview of the various components and minimum requirements of an accreditation program as well as how to set up such a program. In conjunction, WHO will also produce an operational guide for accreditation processes.*

4 *WHO is currently in the process of developing certification tools and procedures for the IMAI (integrated management of Adult and Adolescent Illnesses) Basic ART guide as well as for PMTCT training materials.*

Table 7: Selected Programmatic Indicators for HIV/AIDS

Most of these indicators can be collected through monthly health statistics and the annual program review. However, some may be best collected through surveys, such as school based surveys. Generic indicators measuring ***number of people trained*** and ***service points supported*** can be used for service delivery areas where these are not specifically defined.

	Service Delivery Area	Output Indicators	Examples of Outcome Indicators
	Behavioral Change Communication – Mass media	• HIV/AIDS information, education, communication (IEC) material broadcasted or distributed (radio & television programs / newspapers) (number)	• People (by age and sex) who had sex with more than one partner in the last year (percentage) (**Multiple Partners**) (HIV-OI 1) (can be applied for MARP or population sub-groups) • IDU who have adopted behaviors that reduce transmission of HIV (percentage) UNGASS (HIV-OI 5) *See Table 8 for further behavior indicators*
Prevention	**Behavioral Change communication – community outreach**	• Young people reached by life-based HIV/AIDS education in schools (number and percentage) • Schools with at least one teacher who has been trained in participatory life skills-based HIV/AIDS education and who taught it during the last academic year (number and percentage) UNGASS (HIV-PI 1) • Young people reached by HIV/AIDS education in out-of-school settings (number and percentage) • Young people 15-24 who both correctly identify ways of preventing the sexual transmission of HIV and who reject the major misconceptions about HIV transmission (percentage) UNGASS (HIV-PI 3) • Individuals (i.e., peer educators) trained (specify if trained for specific MARP sub-groups) (number) • People reached by BCC prevention outreach and peer education (number) UNGASS (can be applied for MARP or population sub-groups) • IDUs reached by HIV/AIDS prevention programs* (number and percentage) (HIV-PI 2) • MSM reached by HIV/AIDS prevention programs* (number and percentage) (HIV-PI 2) • Sex workers & clients reached by HIV/AIDS prevention programs* (number and percentage) (HIV-PI 2)	
	Condom distribution	• Condoms sold through the private sector (number) • Condoms distributed for free (number) • Retail outlets and service delivery points with condoms in stock (number) (HIV-PI 4) (can specify between public and private) • Key intervention areas covered with targeted condom outlets (areas with concentration of MARP) (number)	• Young people reporting the use of condoms the last time they had sex with a non-regular sexual partner (percentage) • Young people aged 15-24 reporting **the consistent use of a condom** with non-regular sexual partners in the last year (percentage) (HIV-OI 4) *See Table 8 for further behavior indicators*
	Testing and Counseling	• People who receive HIV testing and counseling (including provision of test result) (number) (HIV-PI 5) • Service outlets providing counseling and testing according to national standards (number) • MARP who received HIV testing in the last 12 months and who know the results (number and percentage) UNGASS • PLWHA who have tested positive who have received counseling for positive prevention (number and percentage)	

	Service Delivery Area	Output Indicators	Examples of Outcome Indicators
	PMTCT	• Health facilities providing the minimum package of PMTCT services (number and percentage) (HIV-PI 6) • HIV-positive pregnant women receiving a complete course of antiretroviral prophylaxis to reduce the risk of mother-to-child transmission (number and percentage) UNGASS (HIV-PI 7) • HIV-exposed infants seen within 2 months of birth for check-up (number and percentage) • HIV-exposed infants and children receiving co-trimoxazole prophylaxis treatment (number and percentage)	
	Post-exposure prophylaxis	• People receiving post-exposure prophylaxis (number)	
	STI diagnosis and treatment	• Patients with STIs at health care facilities who are appropriately diagnosed, treated and counseled (can be applied for MARP or population sub-groups) (number and percentage) (HIV-PI 8)	
	Blood safety and universal precaution	• Districts with access to donor recruitment and blood transfusion (number and percentage) (HIV-PI 9) • Transfused blood units screened for HIV according to national guidelines (number and percentage) UNGASS (HIV-PI 10)	
Treatment	**Antiretroviral treatment and monitoring**	• People with advanced HIV infection receiving antiretroviral combination therapy (number and percentage) UNGASS (HIV-TI 1) • Health facilities that have the capacity and conditions to provide advanced HIV/AIDS clinical care and psychosocial support services, including providing and monitoring ARV (number and percentage) (HIV-TI 2)	• Adults and children who are still on treatment after 6 months, 1, 2, 3, 5 years from the initiation of treatment (percentage)
	Prophylaxis and treatment for opportunistic infections	• PLWHA receiving diagnosis and treatment for opportunistic infections (number and percentage)	
Care and Support	**Care and support for the chronically ill**	• Adults aged 18-59 years who have been chronically ill for 3 or more months in the past 12 months due to HIV/AIDS, whose households received basic external support in caring for chronically ill adults (number and percentage) • Community organizations that received support to assist PLWHA (number)	
	Support for orphans and vulnerable children	• Orphans and other children made vulnerable by HIV/AIDS (OVC) whose households received free basic external support in caring for the child (number and percentage) UNGASS (HIV-CS 1) • Community organizations that received support to assist OVC (number)	• Orphaned children compared to non-orphaned children aged 10-14 who are currently attending school (percentage) (HIV-OI 6)

	Service Delivery Area	Output Indicators	Examples of Outcome Indicators
TB/HIV collaborative activities	**Intensified case-finding among PLWHA**	• PLWHA receiving HIV testing and counseling or HIV treatment and care services who were screened for TB symptoms** (number and percentage) (TB/HIV 1)	
	Prevention of TB disease in PLWHA	• Newly diagnosed HIV positive clients given treatment for latent TB infection (number and percentage) (TB/HIV 3)	
	Prevention of HIV in TB patients	• Registered TB patients who receive HIV counseling and testing*** (number and percentage) (TB/HIV 4)	
	Prevention of opportunistic infections in PLWHA with TB	• HIV positive TB patients who receive co-trimoxazole preventive therapy (number and percentage) (TB/HIV 6)	
	HIV care and support for HIV-positive TB patients	• HIV-positive TB patients referred to HIV care and support services during TB treatment (number and percentage) (TB/HIV 7)	
	Provision of antiretroviral treatment for TB patients during TB treatment	• HIV positive registered TB patients who have begun or are continuing ARV, during or at the end of TB treatment (number and percentage) (TB/HIV 8)	
Supportive environment	**Policy development including workplace policy**	• Large enterprises / companies that have HIV/AIDS workplace policies and programs (number and percentage) UNGASS (HIV-SE 1) • Local organizations provided with technical assistance for HIV-related policy development (number)	
	Strengthening of civil society and institutional capacity building	• NGOs providing HIV/AIDS prevention, treatment, care and support services according to national guidelines (number) • NGOs actively involved in planning, budgeting, monitoring and evaluation of HIV and HIV/TB activities (number) • National Composite Policy Index (UNGASS)	
	Stigma reduction in all settings	• Policy makers attending sensitization workshops on HIV/AIDS and HIV/TB (number)	

* *For each of these sub-groups, the prevention package to apply must be clearly defined: outreach and peer education, exposure to targeted mass media, STI screening and/or treatment, HIV counseling and testing, substitution therapy and safer injection practice for IDUs, or others.*

** *For this indicator, the number of new cases of TB diagnosed should also be reported. (TB/HIV 2)*

*** *For this indicator, the number of registered TB patients who were found to be HIV positive should also be reported. (TB/HIV 5)*

Detailed descriptions of the indicators listed above are provided in Annex A of the Toolkit Annexes and the defining guidelines are listed in the following section under "Guidelines and essential references". It should be noted that the indicators presented above and in the annex are not comprehensive, and readers should refer to the individual indicator guidelines for a more complete listing of all core and additional indicators in this area.

Table 8: Selected HIV /AIDS Impact and Outcome Indicators

	Impact Indicators	Reporting schedule	Measurement	Reference
Impact Indicators	• Young women and men aged 15-24 who are HIV infected (percentage) (**HIV prevalence**) (applicable to most-at-risk populations in concentrated/lower epidemics)	Annual	HIV sentinel surveillance and population-based survey	UNGASS
	• Adults aged 15-49 who are HIV infected (percentage)	Annual	HIV sentinel surveillance and population-based survey	WHO/UNAIDS
	• Adults and children with HIV still alive 12 months after initiation of antiretroviral therapy (extend to 2, 3, 5 years as program matures) (percentage) (**Reduced mortality**)	Annual	Program monitoring	UNGASS
	• Infants born to HIV infected mothers who are HIV infected (percentage) (**Reduced mother to child HIV transmission**)	Annual	Estimate based on program coverage	UNGASS
	• **HIV seroprevalence** among all newly registered TB patients (percentage) (TB/HIV 9)	Annual	Routine HIV testing, sentinel surveillance, periodic special survey	WHO TB/HIV

	Outcome Indicators	Reporting schedule	Measurement	Reference
Outcome Indicators*	• **Multiple partners**: Young people aged 15-24 who had sex with more than one partner in the last year (percentage) (HIV-OI 1) (applicable for MARP or population subgroups)	Every 2-3 years	Population-based survey	WHO/UNAIDS
	• **Primary abstinence**: Young people aged 15-19 who have never had sex (percentage) (HIV-OI 2)	Every 2-3 years	Population-based survey	WHO/UNAIDS
	• **Secondary abstinence**: Young people aged 15-24 who never had sex in the last year of those who ever had sex (percentage) (HIV-OI 3)	Every 2-3 years	Population-based survey	WHO/UNAIDS
	• **Consistent condom use**: Young people aged 15-24 reporting the **consistent use of a condom** with non-regular sexual partners in the last year (percentage) (HIV-OI 4)	Every 2-3 years	Population-based survey	WHO/UNAIDS
	• Young women and men who had sex before the age of 15 (age can be adapted - see guidelines) (percentage)	Every 2-3 years	Population-based survey	UNGASS
	• Adults and children who are still on treatment after 6 months, 1, 2, 3, 5 years from the initiation of treatment (percentage)	Annual	Program monitoring	WHO/UNAIDS
	• Injecting drug users who have adopted behaviors that reduce transmission of HIV. (i.e. who both avoid sharing non sterile injecting equipment and use condoms,) in the last 12 months (for countries where injecting drug use is an established mode of transmission) (percentage) (HIV-OI 5)	Every 2-3 years	Special survey	UNGASS
	• Orphaned children compared to non-orphaned children aged 10-14 who are currently attending school (percentage) (HIV-OI 6)	Every 2-3 years	Population-based survey	UNAIDS/UNICEF
	• Young people aged 15-24 reporting the use of a condom the last time they had sex with a non-regular sexual partner (percentage)	Every 2-3 years	Population-based survey	Adapted from UNAIDS Youth Guide, 2004

	Outcome Indicators	Reporting schedule	Measurement	Reference
Outcome Indicators*	• People expressing accepting attitudes towards PLWHA, of all people surveyed aged 15-49 (percentage)	Every 2-3 years	Population-based survey	WHO/UNAIDS
	• Female sex workers reporting the use of a condom with every client in the last month (percentage)	Every 2-3 years	Special survey	UNGASS
	• Men who have had sex with a female sex worker in the last year (percentage)	Every 2-3 years	Special survey	UNGASS
	• Men reporting the use of condom the last time they had anal sex with a male partner in the last 6 months (percentage)	Every 2-3 years	Special survey	UNGASS

* *HIV sexual behavior indicators should be analyzed together to assess behavior change (as important interactions can occur). Non-regular sexual partners: cohabitation may not be a good measure of non-regular partners in youth..*

The following table provides a summary of some of the measurement tools available to support the reporting of indicators. It shows the indicator area, data available, limitations and recommendations. Wherever possible such existing sources of data should be leveraged and used in reporting.

Table 9: Example of data measurement tools:

Area	Data Available	Limitations	Recommendations
Impact related to HIV prevalence	• HIV sentinel site surveillance • Population-based surveys which collect specimens for HIV testing	• Difficulty to accurately measure or estimate risk population size • Sample biases in both approaches	• Prevalence estimates should have ranges • Use WHO/UNAIDS guidelines for conducting HIV sentinel serosurveys and for measuring national HIV prevalence in population-based surveys
Impact related to survival on ARV	• Patient records from facilities aggregated	• Tracking clients lost to follow-up is not easy • Records do not usually include mobile populations • Cohort analyses can be complex	• Set-up a standardized patient monitoring and reporting system according to WHO recommendations
Knowledge and Behavior among general population	• Population-based surveys (BSS, KAP, DHS, MICS)	• Self reporting biases • Household surveys tend to under-sample MARP • Conducted only every several years	• Review timing of DHS and MICS scheduled in a country to plan when survey results will be available
Knowledge and Behavior among MARP	• Special surveys of MARP in country	• Difficult to find a representative sample • Response biases	• Plan for surveys targeting MARPs, especially in concentrated epidemics • Refer to M&E guide on MARP
National Commitment, policies and strategies	• Questionnaire • Key informant survey	• Quality is not always captured	• For composite indicators / indexes, adapt standardized questions
People trained in various areas related to HIV prevention, treatment and care and support	• Training records • Certification records	• Training is not always standardized • Those attending training may not be delivering the services	• Countries may want to implement certification processes to ensure that those trained meet national minimum standards set on the training topic

Area	Data Available	Limitations	Recommendations
Coverage of various service provision (e.g. districts with services, number of facilities with services)	• Ministry of Health reports • Program reports • Health facility surveys • Facility accreditation records • NGO records	• Range in quality of services provided – some may be below standards • May be difficult to capture services provision outside of the public sector	• Adapt standardized definition of indicators which list criteria for health facilities to be considered suitable to provide a particular service • Set-up a system in place to keep track of various providers of services within a district or country
Number of people reached by services	• Routine health information system • Client records / registers • NGO records	• May be difficult to capture service provision outside of the public sector • Client registers or a system to maintain records must exist	• Try to standardize data collection for various services so that information could be collated easily
TB/HIV services	• Client records / registers	• Current TB and HIV related registers may not capture this information	• Registers may need to be modified to capture this information; if necessary, modify registers according to WHO recommendations
Cross-cutting indicator services where data is not easily extracted from existing registers	• Client records / registers / special studies	• Existing registers and reporting forms may not capture some of this information	• Current practices and data collection forms should be reviewed to see how this information could be captured • Referral links may need to be systematized and strengthened
Information on community-level programs and activities	• Record-keeping forms • Special surveys	• May be difficult to capture service provision outside of the public sector • Where multiple organizations are operating, different record keeping systems may be in place	• Set-up a system in place to keep track of various providers of services within a district or country • Partners working in communities may want to coordinate some basic data elements to be collected so that information can be collated and reported
Indicators related to Most-at-risk Populations – e.g. SW, IDU, migrant population, etc.	• Special surveys and studies • NGO records	• Difficult to accurately measure the size of at-risk populations • Due to their mobile nature, there is a need to be careful with duplication in counting and whether trends can be captured over time	• Refer to recommendation in international guide on M&E of most-at-risk populations • Align reporting requirements among those working with specific populations and GFATM reporting needs

General resources

At WHO, the HIV/AIDS department (http://www.who.int/hiv/en) can provide a wide range of assistance, including the latest publications related to M&E in the health sector. In addition to guidelines and general resources in the area, the web site of the WHO HIV/AIDS department provides the latest information on WHO's 3 by 5 Initiative, including the most facts and figures.

Since the creation of the UNAIDS Secretariat, a number of M&E structures and resource groups – mainly at the global level – were established to improve coordination among key M&E players.

The M&E structures include:

- The UNAIDS Monitoring and Evaluation Unit – composed of UNAIDS Secretariat staff – assists in the development of generic M&E systems for strategic information sharing.
- The Strategic Information and Research Unit (SIR) of the HIV Department at WHO – that develops normative guidelines and provides country support in the areas of monitoring & evaluation, operational research, drug resistance, and policy.

The M&E resource groups include:

- The UNAIDS Monitoring and Evaluation Reference Group (MERG) – composed of co-sponsors/Secretariat M&E focal points, bilateral agencies, research institutes, and individual experts – assists in harmonizing M&E approaches and improving methods.
- The UNAIDS Estimates, Modeling and Projections Reference Group and UNAIDS/WHO working group on surveillance and estimates for HIV transmission and mortality.
- The Global Monitoring and Evaluation Support Team (GAMET) – composed of World Bank personnel and staff seconded from technical agencies – focuses on M&E country support in World Bank-supported countries.
- The Taskforce on M&E of HIV/AIDS – composed of representatives of WHO Departments involved with M&E, UNAIDS, and the Global Fund – periodically discusses and reviews issues related to the monitoring of HIV treatment and prevention scale up.

Members of the various resource groups have contributed to the development of the indicators presented in the toolkit.

At country level, UNAIDS Secretariat and partners have been encouraging national authorities to set up a national level M&E reference/support group to provide advice on national M&E strategies, and to assist in mobilizing resources for M&E and optimizing the use of data. Where those groups exist, coordination among partners has improved tremendously.

Technical assistance

At UNAIDS, the Monitoring and Evaluation Unit is setting up a global system for technical assistance: the Monitoring and Evaluation Assistance System (METAT). Additional assistance can also be sought from the Evaluation Unit at the UNAIDS Secretariat for specific questions on the UNGASS Declaration of Commitment (UNGASS DoC) indicators at UNGASSindicators@unaids.org, or at M-E@unaids.org for general M&E questions.

Technical support to governments is available through the Strategic Information and Research (SIR) Unit of WHO's HIV/AIDS department (http://www.who.int/hiv/strategic/en) and M&E technical support groups in some countries. For specific questions related to the M&E of HIV/AIDS, in particular related to the scaling-up of ARV treatment assistance can be sought at hivmoniteva@who.int .

Other sources of support for all the diseases include: the Emergency Plan: USAID, CDC, Measure Evaluation, Partners for Health Reform Plus (USA), Institute for Health Systems Development (UK). Further support for HIV/AIDS includes Measure DHS, Family Health International, and The Synergy Project. Many countries now have UNAIDS M&E Field Officers or US Government Strategic Information and Monitoring and Evaluation Field Officers (see website www.globalHIVevaluation.org) .

Software products

UNAIDS has developed a useful tool for countries – the *Country Response Information System* (CRIS) – that has the potential to house all national data obtained on core and additional indicators and generate reports on the indicators. The CRIS includes two additional functions: resource tracking and research inventory.

To learn more about the process of indicator development and the suggested actions to implement the UNGASS DoC M&E framework, readers are encouraged to consult the *Guidelines on Construction of Core Indicators* that exist in four languages (English, French, Spanish and Russian) and which can be downloaded from the UNAIDS web site. More information on the CRIS, can also be found on the UNAIDS web site.

Guidelines and essential references

The major sources for guidelines cited below are UNAIDS, WHO, UNICEF, Emergency Plan, USAID, CDC, MEASURE Evaluation and FHI, and some of their partners.

Upcoming M&E Guidelines from WHO and partners, in addition to those below, will address Testing and Counseling (voluntary), Most-At-Risk-Populations (MARP) and monitoring tools related to home-based care as well as paediatric considerations for some of the existing guides and indicators will be proposed.

Versions of the various guidelines may be found on the Internet in the UNAIDS M&E library at:

http://www.unaids.org/EN/in+focus/monitoringevaluation/m_e+library.asp

Alternatively, readers may also want to access the following partner sites for more detailed information in specific areas:

http://www.who.int

http://www.unicef.org

http://www.child.orgp

http://www.cpc.unc.edu/measure

http://www.fhi.org

http://www.cdc.gov

http://www.globalHIVevaluation.org

Centers for Disease Control and Prevention (2002). *Strategic Monitoring and Evaluation: A Draft Planning Guide and Related Tools for CDC GAP Country Programs.* Centers for Disease Control and Prevention, Atlanta. (no URL available).

Family Health International (2002). *Evaluating Programs for HIV/AIDS Prevention and Care in Developing Countries: A Handbook for Program Managers and Decision Makers.* Family Health International, Arlington.
http://www.fhi.org/en/hivaids/pub/archive/evalchap/index.htm

Family Health International (2000). *Behavioral Surveillance Surveys (BSS): Guidelines for Repeated Behavioral Surveys in Populations at Risk for HIV.* Family Health International, Arlington.
http://www.fhi.org/en/topics/bss.htm

UNAIDS (2005). *Monitoring the Declaration of Commitment on HIV/AIDS Guidelines on the construction of core indicators*
http://www.unaids.org/html/pub/Publications/IRC-pub02/JC894-CoreIndicators_en_pdf.pdf

UNAIDS/UNICEF (2005) Guide to Monitoring and Evaluation of the National Response for Children Orphaned and Made Vulnerable by HIV/AIDS.

UNAIDS/MEASURE (2000). *National AIDS Programs: A Guide to Monitoring and Evaluation.* UNAIDS, Geneva.
http://www.cpc.unc.edu/measure

USAID/UNAIDS/WHO/Policy Project (2003). *The Level of Effort in the National Response to HIV/AIDS: The AIDS Program Effort Index (API) 2003 Round.*

USAID/UNAIDS/WHO/CDC/Policy Project (2004). *Coverage for Selected Services for HIV/AIDS Prevention and Care in Low and Middle Income Countries in 2003*

UNAIDS/World Bank (2002). *National AIDS Councils (NACs) Monitoring and Evaluation Operations Manual*. UNAIDS/World Bank, Geneva. http://www.worldbank.org

WHO (2003). The Monitoring and Evaluation (M&E) of the 3 by 5 Initiative. WHO, Geneva. http://www.who.int/3by5/publications/briefs/monitoring/en

WHO (2003). Guidelines for surveillance of HIV drug resistance. WHO, Geneva. http://www.who.int/3by5/publications/documents/hivdrugsurveillance/en

WHO (2003). Integrated Management of Adolescent and Adult Illness (IMAI) modules. WHO, Geneva.

WHO (2003). Monitoring and evaluating of national ARV programs in the rapid scale-up to 3 by 5. WHO, Geneva. http://www.who.int/3by5/publications/documents/artindicators/en

WHO/UNAIDS (2004). *National AIDS Programs: A guide to monitoring and evaluating HIV/AIDS care and support.* WHO, Geneva. http://www.who.int/hiv/pub/epidemiology/pubnapcs/en

WHO/UNAIDS (2000). *Second Generation Surveillance for HIV: The Next Decade.* UNAIDS, Geneva. http://www.who.int/hiv/pub/surveillance/en/cds_edc_2000_5.pdf

WHO/UNAIDS/Measure DHS/The World Bank/ UNICEF/UNESCO/FHI/USAID. (2004) Guide to Monitoring and Evaluating National HIV/AIDS Prevention Programs for Young People (10 to 24 years old). WHO, Geneva. http://www.who.int/hiv/pub/me/en/me_prev_intro.pdf

WHO/UNAIDS/USAID/UNICEF/CDC/UNFPA (2004). National Guide to Monitoring and Evaluating Programs for the Prevention of HIV in Infants and Young Children. WHO, Geneva.

WHO/UNAIDS/GFATM/USAID/MEASURE Evaluation/FHI (2005). National AIDS Programs- A guide to indicators for monitoring and evaluation national antiretroviral programs. WHO, Geneva. http://www.who.int/hiv/pub/prev_care/youngchildren/en/

Data for some of these indicators are available at www.measuredhs.com/hivdata/

UNAIDS/USAID/UNICEF/CDC/WHO Draft to be published in 2006. Guide to Monitoring and Evaluating HIV prevention programs for Most-at-risk Populations in low-level and concentrated settings.

WHO (2004). Guide to monitoring and evaluation for collaborative TB/HIV activities. (WHO/HTM/TB/2004.342) http://www.who.int/hiv/pub/prev_care/tb_hiv/en/

ANNEX A:
Description of HIV/AIDS Indicators

PREVENTION INDICATOR (HIV-PI 1):

BEHAVIOUR CHANGE COMMUNICATION
Provision of life-skills-based HIV/AIDS education in schools

Percentage of schools with at least one teacher who has been trained in participatory life-skills-based HIV/AIDS education and who taught it during the last academic year.

RATIONALE

This indicator is a measure of the progress in implementing life-skills-based HIV/AIDS education in schools. It is a measure of coverage by schools – that is, estimating the proportion of schools that report having such programs. It is not a measure of the quality of such programs. For this indicator to be most meaningful, it should be combined with measures of quality.

DEFINITION OF INDICATOR

Numerator: Number of schools with at least one teacher trained in, and regularly teaching, life-skills-based HIV/AIDS education

Denominator: Number of schools

Note: The target population for this indicator is primary and secondary schools.

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

1. Does your school have at least one qualified teacher who has been trained in participatory life-skills-based HIV/AIDS education in the last five years?
2. If the answer to question 1 is "yes": Did this person teach life-skills-based HIV/AIDS education on a regular basis in your school *throughout* the last academic year? ("*throughout*" meaning at least 5–15 hours of life-skills-based HIV/AIDS education programming per year per grade of pupil)

A ***qualified teacher*** is one that has participated in, and successfully completed, a training course focusing on the skills required to conduct participatory learning experiences that aim to develop knowledge, positive attitudes and skills (e.g., interpersonal communication, negotiation, decision-making and critical-thinking skills and coping strategies) that assist young people in maintaining safe lifestyles.

The criteria of ***teaching on a regular basis*** is grounded in research findings that show that high-quality programs can produce good outcomes with five to 15 hours of life-skills-based HIV/AIDS education programming per year per grade of pupil.

The time dimension of ***the last academic year*** will be, in each country, defined according to the educational calendar (usually nine to 10 months within one calendar year, designed to allow students to complete one educational level, or grade).

If the sample was selected to represent different strata, the results can be disaggregated by school type (i.e., female and male, large and small, urban and rural, private or public, and primary or secondary). Where a school is both primary and secondary, information should be collected and reported separately for each level.

In addition, primary and secondary school attendance rates for the most recent academic year available should be stated.

Resources permitting, the following additional four questions can also be included (in the case of the answer to question 1 above being "yes"):

3. How many teachers at your school have received training in participatory life-skills-based HIV/AIDS education in the last five years?
4. How many of these teachers taught life-skills-based HIV/AIDS education program in your school during the last academic year?
5. How many classes and students in each grade in your school received life-skills-based HIV/AIDS education last year?
6. How long was the program/course for each grade in hours?

With information on the overall school-age population and on the above questions, it is possible to estimate the proportion of all young people, as well as the proportion of school-going young people, who actually receive life-skills-based HIV/AIDS education.

For a guide to ***quality*** aspects of a life-skills-based HIV/AIDS education, refer to UNICEF website: www.unicef.org/lifeskills/

Platform: School-based survey

Frequency: Biennial

REFERENCES

- *WHO-UNAIDS (2004) Guide to Monitoring and Evaluating National HIV/AIDS Prevention Programs for Young People. Geneva. www.who.int/hiv/pub/epidemiologu/me_prev_yp/en*

PREVENTION INDICATOR (HIV-PI 2):

BEHAVIOUR CHANGE COMMUNICATION
Most-at-risk populations: prevention programs

Percentage of [most-at-risk population(s)] reached with HIV/AIDS prevention programs.

RATIONALE

Most-at-risk populations are often difficult to reach with HIV/AIDS prevention programs. However, in order to prevent the spread of HIV/AIDS among these populations as well as into the general population, it is important that they access these services. This indicator is to assess progress in implementing HIV/AIDS prevention programs for most-at-risk populations and should be calculated separately for each population that is considered most-at-risk in a given country, e.g., sex workers, injecting drug users, men who have sex with men.

Note: Countries with generalized epidemics may also have a concentrated sub-epidemic among one or more most-at-risk populations. If so, it would be valuable for them to calculate and report on this indicator for those populations.

DEFINITION OF INDICATOR

Numerator: Number of [most-at-risk population] respondents who have accessed HIV/AIDS prevention programs during the last 12 months

Denominator: Number of most-at-risk population included in the survey sample or prevalence estimation methods for the size of the most-at-risk population for the denominator (if the data is being collected through program monitoring records)

Note: Data collected for this indicator should be disaggregated by gender and age (<25/25+).

Whenever possible, data for most-at-risk populations should be collected through civil society organizations that have worked closely with this population in the field.

Access to survey respondents as well as the data collected from them must remain confidential.

MEASUREMENT

The data can be collected through special surveys and program monitoring records.

Surveys: Respondents are asked a series of questions about the exposure/use of key HIV prevention services. Depending on local contexts, the list would include (1) outreach and peer education; (2) exposure to targeted mass media; (3) STI screening and/or treatment; (4) HIV counseling and testing; (5) substitution therapy and safer injection practices for IDU.

Accessing and/or surveying most-at-risk populations can be challenging. Consequently, data obtained may not be based on a representative sample of the national most-at-risk population being surveyed. If there are concerns that the data is not based on a representative sample, these concerns should be reflected in the interpretation of the survey data. Where different sources of data exist, the best available estimate should be used. Information on the sample size, the quality/reliability of the data and any related issues should be included in the report submitted with this indicator.

Program monitoring: records of programs providing the above-mentioned services are compiled and aggregated to obtain an overall measure of the reach of prevention programs.

When the indicator is based on program data, an attempt to address the issue of double counting during the reference period should be made. There is a need to ensure that clients served (as opposed to clients-visits) for the same service or across services are counted.

Different types of services will all count the same in estimating overall service coverage.

Platform: The data can be collected through special surveys and program monitoring records

Frequency: Biennial

REFERENCES

- *UNAIDS (2005) Monitoring the Declaration of Commitment on HIV/AIDS: Guidelines on construction of core indicators-2006 reporting, UNGASS, Geneva*
- *WHO-UNAIDS (2005) A guide to monitoring and evaluating national HIV prevention programs for most-at-risk populations in low-level and concentrated epidemic settings (draft)*

PREVENTION INDICATOR (HIV-PI 3):

BEHAVIOR CHANGE COMMUNICATION

Knowledge of HIV prevention among young people

Percentage of young people who both correctly identify ways of preventing the sexual transmission of HIV and who reject major misconceptions about HIV.

RATIONALE

This indicator combines the measures of knowledge of HIV transmission and prevention with the prevalence of most common misconceptions about HIV.

DEFINITION OF INDICATOR

Numerator: Number of young men and young women who gave correct answers to all five questions relating to transmission of HIV and misconceptions about HIV

Denominator: All young men and young women surveyed

Note: Analysis and reporting in percentage broken down by males and females according to urban/rural residence.

MEASUREMENT

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

1. Can the risk of HIV transmission be reduced by having sex with only one faithful, uninfected partner?
2. Can the risk of HIV transmission be reduced by using condoms?
3. Can a healthy-looking person have HIV infection?
4. Can a person get HIV infection from mosquito bites?
5. Can a person get HIV infection by sharing a meal with someone who is infected?

Items 4 and 5 may be replaced with the two most common local (national) misconceptions about HIV transmission or prevention. For example, "Can HIV in an infected man be cured if he has sex with a virgin girl?" or "Can people get HIV by getting injections with a needle that was already used by someone else?"

Items 1 and 2 measure the correct knowledge for preventing HIV transmission. Item 3 measures a common misconception that healthy-looking people do not have HIV infection. This is a widespread misconception among young people, and it can result in unprotected sex with an infected partner. Items 4 and 5 refer to two other misconceptions about HIV transmission.

Together the indicator provides program managers with a measure of the overall knowledge that young people have about avoiding HIV. Previous knowledge indicators have included abstinence as a "correct" method of prevention used in this indicator. Abstinence is an extremely important prevention option for young people.

Research in many settings shows that already sexually active people rarely use abstinence as a primary HIV-prevention method. However, young people in particular may be practicing "secondary abstinence" – that is, a prolonged voluntary period of sexual inactivity following sexual initiation. Negative responses on this item may therefore result from people believing that abstinence is not feasible, rather than from belief that abstinence does not provide effective protection. In surveys among adolescents, however, questions about abstinence continue to be important. Programs focusing on delaying age at first sex among adolescents (ages 10–19) may choose to add a knowledge indicator that includes correct responses to a question about abstinence as a prevention method in the numerator. A suggested question on abstinence might be: "Can the risk of HIV transmission be reduced by abstaining from sexual intercourse?"

This indicator should be presented as a percentage separately for men and women, disaggregated by age in the following groups: 10–14 (if available) 15–19, 20–24, 15-24, and 10–24 (again, if available). This indicator should be reported for the 15-24 age group for the Millennium Development Goal and the UNGASS HIV Goal indicators.

The indicator can also be disaggregated by question to show gaps in knowledge and prevalence of misconceptions.

Platform: Nationally representative general population survey

Frequency: Every 2-4 years

REFERENCES

- *WHO-UNAIDS (2004) Guide to Monitoring and Evaluating National HIV/AIDS Prevention Programs for Young People. Geneva. www.who.int/hiv/pub/epidemiologu/me_prev_yp/en*
- *UNAIDS (2005) Monitoring the Declaration of Commitment on HIV/AIDS: Guidelines on construction of core indicators-2006 reporting, UNGASS, Geneva*

PREVENTION INDICATOR (HIV-PI 4):

CONDOM DISTRIBUTION

Retail outlets and service delivery points with condoms in stock

The proportion of randomly-selected retail outlets and service delivery points that have condoms in stock at the time of a survey, of all retail outlets and service delivery points selected for survey.

RATIONALE

This indicator reflects the success of attempts to broaden the distribution of condoms so that they are more widely available to people at locations and times when people are likely to need them. It measures actual distribution of condoms at designated points at any one point in time.

DEFINITION OF INDICATOR

Numerator: Number of retail outlets and service delivery points that have condoms in stock at the time of a survey

Denominator: Total number of retail outlets and service delivery points that have been selected for the survey

Note: Sites in both urban and rural areas should be selected.

MEASUREMENT

A number of sites of different types (i.e. pharmacies, clinics, bars and clubs) are randomly selected for a retail survey from a standard checklist of venues where condoms should be accessible, including bars and nightclubs, different classes of retail shops, STI clinics and other service provision points. While the indicator gives a single summary figure, the data can also be disaggregated by outlet type.

Platform: Retail surveys (PSI protocol to evaluate social marketing programs, WHO/GPA prevention indicator 3)

Frequency: Quarterly/annually

REFERENCES

- *UNAIDS/MEASURE (2000) National AIDS Programs: A guide to monitoring and evaluation. Geneva: UNAIDS. www.cpc.unc.edu/measure/guide/guide.html*

PREVENTION INDICATOR (HIV-PI 5):

TESTING AND COUNSELING
People receiving counseling and testing

The percentage of the general population receiving an HIV test, the results, and post-test counseling.

RATIONALE

HIV testing and counseling are important entry points for prevention and care needs. It is therefore important to measure the number of people who access these services, as an indicator of the number of people who could potentially benefit from prevention and care.

This indicator is designed to show how many people have been tested and received post-test counseling services.

For the program manager, this indicator would be a cascade that would be able to identify the following:

1. Number of individuals who received pre-test counseling and/or pre-test information sufficient to ensure informed consent
2. Percent of those tested who received pre-test counseling and actually tested
3. Percent of those tested who received their results
4. Percent of those tested who received post-test counseling

DEFINITION OF INDICATOR

Numerator: The number of people who have received HIV test results and post-test counseling

Denominator: Number of people surveyed or total population, depending on method of data collection

Note: Analysis and reporting by component and gender is recommended. It is suggested that data also be collected on those requesting an HIV test, receiving the test and receiving their results. It is also recommended that data be disaggregated for those under 25 as follows: 15-19 and 20-24.

MEASUREMENT

The following methodologies are recommended:

1. Household survey: By asking respondents whether they have ever been tested and if so whether they have received the results. This indicator can be captured in a nationally-representative manner.
2. Health Management Information Systems (HMIS): Ideally, information for this indicator can be collected by reviewing data collected at the local level(s) and available through the HMIS at the national level.
3. Health Facility Survey.

Where HMIS are not fully operational, the use of health facility surveys with a testing and counseling component in all relevant units/departments may be necessary.

It is necessary to stratify the indicator by how these services are delivered. Specifically, whether by integrated (i.e. testing for diagnostic purposes) or vertical (i.e. stand alone VCT) service delivery.

The denominator, total population, can be obtained from the latest census data.

Platform: UNAIDS general population survey; DHS AIDS module; FHI adult BSS; youth BSS

Frequency: Annually

REFERENCES

- *UNAIDS/MEASURE (2000) National AIDS Programs: A guide to monitoring and evaluation. Geneva: UNAIDS. www.cpc.unc.edu/measure/guide/guide.html*
- *UNAIDS-WHO (2004) National AIDS Programs. A guide to monitoring and evaluating HIV/AIDS care and support. Geneva: UNAIDS*

PREVENTION INDICATOR (HIV-PI 6):

PREVENTION OF MOTHER TO CHILD TRANSMISSION
Health facilities offering minimum package of PMTCT

The percentage of public, missionary, and workplace venues (family planning and primary health care clinics, ANC/MCH, and maternity hospitals) offering the minimum package of services to prevent HIV infection in infants and young children in the past 12 months.

RATIONALE

This indicator provides critical information on the national availability of prevention and care efforts for women and infants. It is useful to program planners in determining where services may be needed, or where facilities are providing the full spectrum of services to prevent HIV infection in women and infants.

DEFINITION OF INDICATOR

Numerator: Number of public, missionary, and workplace venues (family planning and primary health care clinics, ANC/MCH, and maternity hospitals) offering the minimum package of services to prevent HIV infection in infants and young children in the past 12 months

Denominator: All public, missionary, and workplace venues (family planning and primary health care clinics, ANC/MCH, and maternity hospitals)

Note: Analysis and reporting by type of service is recommended.

MEASUREMENT

The information required for this indicator can be collected through a variety of different methods, and depends on resource availability as well as the amount of detail sought. It focuses on the minimum package of services which is defined by the type of clinical setting (see reference below). One option is to send a questionnaire to all public, missionary and workplace health facilities offering family planning and primary health care clinics, ANC/MCH, and maternity services. Another way to collect the relevant information is by adapting other instruments that already exist.

Platform: Health facility surveys

Frequency: Every 2-3 years

REFERENCES

- *UNAIDS-WHO (2004) National guide to monitoring and evaluating programs for the prevention of HIV in infants and young children. Geneva*

PREVENTION INDICATOR (HIV-PI 7):

PREVENTION OF MOTHER TO CHILD TRANSMISSION

HIV-infected pregnant women receiving a complete course of antiretroviral prophylaxis to reduce the risk of mother to child transmission (MTCT)

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

RATIONALE

This indicator assesses the progress in preventing mother-to-child HIV transmission through the provision of ARV prophylaxis.

DEFINITION OF INDICATOR

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

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

Note: Breakdown by type of service is recommended and if possible by women by age group: 15-19, 20-24, 25-34, 35-49.

MEASUREMENT

The number of HIV-infected pregnant women provided with antiretroviral prophylaxis to reduce the risk of MTCT in the last 12 months is obtained from program monitoring records. Only those women who completed the full course should be included. The number of HIV-infected pregnant women to whom antiretroviral prophylaxis to reduce the risk of MTCT *could potentially have been given* is estimated by multiplying the total number of women who gave birth in the last 12 months (Central Statistics Office estimates of births) by the most recent national estimate of HIV prevalence in pregnant women (HIV sentinel surveillance antenatal clinic estimates).

Platform: Program monitoring records / Central Statistics Office estimates of births

Frequency: Every 2-3 years

REFERENCES

- *UNAIDS-WHO (2004) National guide to monitoring and evaluating programs for the prevention of HIV in infants and young children, Geneva*
- *UNAIDS (2005) Monitoring the Declaration of Commitment on HIV/AIDS: Guidelines on construction of core indicators-2006 reporting, UNGASS, Geneva*

PREVENTION INDICATOR (HIV-PI 8):

SEXUALLY TRANSMITTED INFECTION (STI) DIAGNOSIS AND TREATMENT

STI comprehensive case management

Percentage of patients with STIs at health care facilities who are appropriately diagnosed, treated and counseled.

RATIONALE

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

DEFINITION OF INDICATOR

Numerator: Number of STI patients for whom the correct procedures were followed on: (1) history taking; (2) examination; (3) diagnosis and treatment; and (4) effective counseling on partner notification, condom use and HIV testing

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

Note: Disaggregation by gender and for patients under and over 25 years of age is recommended. Ideally, ages under 25 would be disaggregated as follows: 15-19 and 20-24.

Scores for each component of the indicator (i.e., history taking, examination, diagnosis and treatment, and counseling) must be reported as well as the overall indicator score.

MEASUREMENT

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

Platform: Health facility survey – based on WHO/UNAIDS revised guidelines on evaluating STI services and/or MEASURE service provision assessment (SPA)

Frequency: Biennial

REFERENCES

- *UNAIDS (2005) Monitoring the Declaration of Commitment on HIV/AIDS: Guidelines on construction of core indicators-2006 reporting, UNGASS, Geneva*

PREVENTION INDICATOR (HIV-PI 9):

BLOOD SAFETY AND UNIVERSAL PRECAUTIONS
Districts with access to donor recruitment and blood transfusion

Percent of districts or regions with access to blood transfusion services which do not pay blood donors, and do not recruit donors from among relatives of the patient.

RATIONALE

Many countries working to improve access to safe blood have established blood transfusion services including blood banks at the regional or district level, and are working systematically to enhance the recruitment of voluntary donors as well as reducing or eliminating reliance on blood donations from relatives and paid donors. This indicator assesses to what extent this has been implemented at the level dictated by national policy.

DEFINITION OF INDICATOR

Numerator: Number of districts or regions with access to blood transfusion services which do not pay blood donors, and do not recruit donors from among relatives of the patient

Denominator: Total number of districts or regions

MEASUREMENT

A district or region is considered to score positively on this indicator if at least 95 percent of blood transfused is supplied by a regional or provincial blood transfusion service that screens donors for risk behaviors and excludes donations from relatives and paid donors.

Platform: MEASURE Evaluation Draft Blood Safety Protocol

Frequency: Quarterly

REFERENCES

- *UNAIDS/MEASURE (2000) National AIDS Programs: A guide to monitoring and evaluation. Geneva: UNAIDS. www.cpc.unc.edu/measure/guide/guide.html*

PREVENTION INDICATOR (HIV-PI 10):

BLOOD SAFETY AND UNIVERSAL PRECAUTIONS

Transfused blood units screened for HIV

The percentage of blood units transfused in the last 12 months that have been adequately screened for HIV according to national or WHO guidelines.

RATIONALE

Blood safety programs aim to ensure that the overwhelming majority (ideally 100 percent) of blood units are screened for HIV, and those that are included in the national blood supply are indeed uninfected. This indicator gives an idea of the overall percentage of blood units that have been screened to sufficiently high standards that can be confidently declared as HIV free.

DEFINITION OF INDICATOR

Numerator: Number of blood units screened for HIV in the previous 12 months, and among those, the number screened up to WHO or national standards

Denominator: Total number of blood units transfused in the previous 12 months

Note: Breakdown by components of the indicator is recommended.

MEASUREMENT

The number of units transfused and the number screened for HIV should be available from health information systems. Quality of screening may be determined from a special study that re-tests a sample of blood previously screened, or from an assessment of the conditions under which screening occurred. In situations where this approach is not feasible, data on the percentage of facilities with good screening and transfusion records and no stockouts of test kits may be used to estimate adequately screened blood for this indicator.

Platform: MEASURE Evaluation Draft Blood Safety Protocol

Frequency: Every 2-3 years

REFERENCES

- *UNAIDS/MEASURE (2000) National AIDS Programs: A guide to monitoring and evaluation. Geneva: UNAIDS. www.cpc.unc.edu/measure/guide/guide.html*
- *UNAIDS (2005) Monitoring the Declaration of Commitment on HIV/AIDS: Guidelines on construction of core indicators-2006 reporting, UNGASS, Geneva*

TREATMENT INDICATOR (HIV-TI 1):

ANTIRETROVIRAL TREATMENT AND MONITORING

People with advanced HIV infection receiving antiretroviral combination therapy

Percentage of people with advanced HIV infection receiving antiretroviral combination therapy.

RATIONALE

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

DEFINITION OF INDICATOR

Numerator: Number of people with advanced HIV infection who receive antiretroviral combination treatment according to the nationally approved treatment protocol (or WHO/UNAIDS standards)

Denominator: Number of people with advanced HIV infection

Note: This indicator should be disaggregated by public/private services and by age group and gender. Age groups should be 0-2, 3-4, 5-9, 10-14, 15-34, 35-49, 50+.

MEASUREMENT

The numerator of this indicator consists of the number of people receiving treatment at start of year plus the number of people who commenced treatment in the last 12 months minus the number of people for whom treatment was terminated in the last 12 months (including those who died). The number of people with advanced HIV infection is assumed to be 15 percent of the total number of people currently infected (for the purposes of this indicator). The latter is estimated using the most recent national sentinel surveillance data. The start and end dates of the period for which the number of people are given antiretroviral therapy should be stated. Overlaps between reporting periods should be avoided wherever possible.

Platform: Program monitoring records

Frequency: Biennial

REFERENCES

- *UNAIDS-WHO (2004) National AIDS Programs: A guide to indicators for monitoring and evaluating national antiretroviral programs, Geneva*
- *UNAIDS (2005) Monitoring the Declaration of Commitment on HIV/AIDS: Guidelines on construction of core indicators-2006 reporting, UNGASS, Geneva*

TREATMENT INDICATOR (HIV-TI 2):

ANTIRETROVIRAL TREATMENT AND MONITORING

Health facilities capable of providing advanced HIV clinical care and psychosocial support services for HIV-infected persons

Percentage of health facilities that have the capacity and conditions to provide advanced HIV/AIDS clinical care and psychosocial support services, including providing and monitoring antiretroviral combination therapy.

RATIONALE

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

The ability to provide advanced HIV/AIDS care is defined as:

(a) systems and items to support the management of opportunistic infections and the provision of palliative care (symptomatic treatment) for the advanced care of people living with HIV/AIDS;

(b) systems and items to support advanced services for the care of people living with HIV/AIDS;

(c) systems and items to support antiretroviral combination therapy;

(d) conditions to provide advanced inpatient care for people living with HIV/AIDS;

(e) conditions to support home care services; and

(f) post exposure prophylaxis.

DEFINITION OF INDICATOR

Numerator:

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

Denominator:

For 1: the total number of health facilities surveyed

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

MEASUREMENT

This information should be collected through a health facility survey with observation in all relevant service areas. Like core indicator 6, interviews of HIV/AIDS service providers would also be needed.

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

Platform: Health facility surveys

Frequency: Every 2-4 years

REFERENCES

- *UNAIDS (2004) National AIDS Programs. A guide to monitoring and evaluating HIV/AIDS care and support. Geneva: UNAIDS*

SUPPORT FOR ORPHANS

Orphans and other children made vulnerable by HIV/AIDS whose households received free basic external support

Percentage of orphans and vulnerable children whose households received free basic external support in caring for the child.

RATIONALE

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

DEFINITION OF INDICATOR

Numerator: Number of orphans and vulnerable children residing in households that received at least one of the following services for the child:

- medical care support within the past 12 months;
- emotional support within the past 3 months;
- school-related assistance within the past 12 months; and
- other social support, including material support, within the past 3 months.

Denominator: Total number of orphans and vulnerable children

Note: If sample sizes permit, data should be analyzed and reported by age (0–5, 6–9, and 10–17 years) and by sex.

MEASUREMENT

As part of a household survey, household rosters can be used to identify all eligible orphans and vulnerable children (under 18 years of age). For each household with orphans and vulnerable children, a series of questions is asked about the **types** and **frequency** of support received and the primary source of the help. This survey tool may also be used in low-prevalence settings or targeted populations with similar but adapted methods.

Platform: Household surveys

Frequency: Every 2-4 years

REFERENCES

- *UNAIDS/UNICEF (2005). Guide to monitoring and evaluation of the national response for children orphaned and made vulnerable by HIV/AIDS. New York: UNICEF. www.unaids.org/EN/in+focus/monitoringevaluation/m_e+library.asp*
- *UNAIDS-WHO (2004) National AIDS Programs. A guide to monitoring and evaluating HIV/AIDS care and support. Geneva: UNAIDS www.unaids.org/EN/in+focus/monitoringevaluation/m_e+library.asp*
- *UNAIDS (2005) Monitoring the Declaration of Commitment on HIV/AIDS: Guidelines on construction of core indicators-2006 reporting, UNGASS, Geneva*

SUPPORTIVE ENVIRONMENT (HIV-SE 1):

WORKPLACE POLICY
Companies with HIV/AIDS workplace policies and programs

Percentage of large enterprises/companies which have HIV/AIDS workplace policies and programs.

RATIONALE

The workplace is often a highly convenient and conducive setting for HIV control activities and workplace-based interventions have been proven to be effective. The indicator is useful even in countries where HIV prevalence is low because early action in educating workers on HIV prevention is essential if the serious economic and social consequences of HIV/AIDS are to be avoided.

DEFINITION OF INDICATOR

Numerator: Number of employers with HIV/AIDS policies and regulations that meet all criteria

Denominator: Number of employers surveyed

Note: Analysis and reporting both individually by private/public sectors and by both combined is recommended

MEASUREMENT

Private sector employers are selected on the basis of the size of the labor force. Public sector employers should be the ministries of transport, labor, tourism, education and health. Employers are asked to state whether they are currently implementing personnel policies and procedures that cover a minimum of specified aspects (see reference for details). Copies of written personnel policies and regulations should be obtained and assessed wherever possible.

Platform: Survey of the 30 largest employers – 25 private sector; 5 public sector

Frequency: Biennial

REFERENCES

- *UNAIDS (2005) Monitoring the Declaration of Commitment on HIV/AIDS: Guidelines on construction of core indicators-2006 reporting, UNGASS, Geneva*

HIV OUTCOME INDICATOR (HIV-OI 1):

MULTIPLE PARTNERS

Women and men aged 15-49 who had sex with more than one partner in the last twelve months

Percentage of women and men aged 15-49 who had sex with more than one partner in the last twelve months, of all people surveyed aged 15-49 who report being sexually active in the last twelve months.

RATIONALE

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

DEFINITION OF INDICATOR

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

Denominator: Number of women and men aged 15-49 who report being sexually active in the last twelve months

MEASUREMENT

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

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

To cope with the measurement challenge of men in polygamous societies who may have multiple partners within marriage, it is necessary to disaggregate this indicator by marital status including polygamy. Furthermore, given that the likelihood of HIV transmission during recent (acute) infection may be an order of magnitude greater than during chronic infection, it may be desirable to conduct analyses to asses the percentage of sexually active individuals who had two or more partners during the previous two months. Quantifying the prevalence of overlapping or concurrent partnerships may provide a useful proxy for quantifying possible exposures to HIV during the period of acute infection.

Platform: Population based surveys such as UNAIDS general population survey, DHS/AIS, BSS (youth), RHS

Frequency: Baseline, then every 2-3 years

REFERENCES

- *WHO-UNAIDS (2004) Guide to Monitoring and Evaluating National HIV/AIDS Prevention Programs for Young People. Geneva. www.who.int/hiv/pub/epidemiologu/me_prev_yp/en*

HIV OUTCOME INDICATOR (HIV-OI 2):

ABSTINENCE

Primary abstinence

Percentage of young women and men aged 15-19 who never had sex.

RATIONALE

This indicator provides information on important aspects of sexual behavior. It describes the proportion of young people surveyed who never had sex, thus the prevalence of virginity among young people. Looking at this prevalence within narrow age ranges (15-16, 17-19, for example, or ideally, by single ages) across time allows program managers to see if the age at first sex is changing.

DEFINITION OF INDICATOR

Numerator: Number of young women and men aged 15-19 who never had sex

Denominator: Number of young women and men aged 15-19 surveyed

MEASUREMENT

Respondents (15-19 year olds) are asked if they have ever had sex.

The indicator should be reported separately for men and women.

If the indicator is calculated for groups of ages larger than the period of change in abstinence, the indicator will not reflect changes e.g. change in abstinence among 15-19 year old, will not reflect change over a 2-3 year period. It is therefore recommended that this indicator be reported by single age.

Platform: Population based surveys such as DHS/AIS, RHS

Frequency: Baseline, then every 2-3 years

REFERENCES

- *Adapted from UNAIDS (2004)*

HIV OUTCOME INDICATOR (HIV-OI 3):

ABSTINENCE

Secondary abstinence

Percentage of young women and men aged 15-24 who never had sex in the last year of those who ever had sex.

RATIONALE

This indicator is a measure of sex among young people. A high score on this indicator reflects a failure of prevention messages stressing abstinence. Given that young people should be the focus of education and prevention programs, deciding to abstain from sex after having precocious sexual activity would be a desired program outcome. This indicator measures changes in what may be culturally and socially ascribed norms for early sexual activity. Where programs are advocating a delay of first sex or abstinence, the indicator should show a decrease.

DEFINITION OF INDICATOR

Numerator: Number of women and men aged 15-24 who never had sex in the last 12 months

Denominator: Number of women and men aged 15-24 who ever had sex

MEASUREMENT

In a survey among people aged 15-24, respondents are asked about their sexual partnerships in the last twelve months and before.

The indicator should be reported separately for men and women.

Platform: Population based surveys such as UNAIDS general population survey, DHS/AIS, BSS (youth), RHS

Frequency: Baseline, then every 2-3 years

REFERENCES

- *Adapted from UNAIDS (2000)*

HIV OUTCOME INDICATOR (HIV-OI 4):

CONSISTENT CONDOM USE

Young people's condom use with non-regular partners

Percentage of young people aged 15-24 reporting the consistent use of a condom with non-regular sexual partners in the last year.

RATIONALE

This indicator shows the extent to which condoms are used by young people who engage in sexual relationships with non-regular partners.

When interpreting trends in this indicator, it should be noted that changes might reflect variations in the numbers of persons having sex with non-regular partners and not necessarily variation in condom use. Thus, this indicator should be analyzed carefully considering the changes in proportion of young people having sex with a non-regular partner to understand the programmatic implications.

DEFINITION OF INDICATOR

Numerator: The number of young men and young women aged 15-24 years who had sex with non-regular partners in the last 12 months and consistently used a condom

Denominator: Young men and young women aged 15-24 years who had sex with non-regular partners in the last 12 months

Note: The target population for this indicator is 15- to 24-year-olds. Data should always be reported separately for males and females. When sample sizes permit, it is also useful to report for age groups 15-19 and 20-24.

MEASUREMENT

Respondents are first asked if they have ever had sex. Among those who have, questions are asked about the consistent use of condom with all the partners in the last year and information on the type of partner (such as spouse, live-in partner, boyfriend/girlfriend, acquaintance, commercial sex worker).

This indicator should be presented as a percentage, separately for males and females, in three age groups: 15–19, 20-24 and 15–24.

Platform: Nationally representative general population survey

Frequency: Preferably biennial; at a minimum every 4-5 years

REFERENCES

- *Adapted from UNAIDS (2000)*

PREVENTION INDICATOR (HIV-OI 5):

BEHAVIOR CHANGE COMMUNICATION
Intravenous drug users: safe injecting and sexual practices

Percentage of IDUs who have adopted behaviors that reduce transmission of HIV, i.e. who both avoid sharing non-sterile injecting equipment and use condoms.

RATIONALE

Safe injecting and sexual practices among injecting drug users (IDUs) are essential, even in countries where other modes of HIV transmission predominate, because: (1) the risk of HIV transmission among IDUs using contaminated injecting equipment is extremely high; and (2) IDUs can provide a reservoir of infection from which HIV spreads (e.g., through sexual transmission) to the wider population.

DEFINITION OF INDICATOR

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

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

Note: Analysis and reporting disaggregated by age (those less than 25 and those over 25) is recommended.

MEASUREMENT

Survey respondents are asked the following sequence of questions:

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

Platform: Time-location cluster sample survey or targeted snowball sample survey (see behavioral surveillance survey (BSS) manual)

Frequency: Biennial

REFERENCES

- *FHI (2000) Behavioral Surveillance Surveys (BSS): guidelines for the repeated behavioral surveys in Populations at risk of HIV*
- *UNAIDS (2005) Monitoring the Declaration of Commitment on HIV/AIDS: Guidelines on construction of core indicators-2006 reporting, UNGASS, Geneva*

SUPPORT FOR ORPHANS
Orphans' school attendance

Ratio of orphaned children compared to non-orphaned children aged 10-14 who are currently attending school.

RATIONALE

HIV/AIDS is claiming lives of ever-growing numbers of adults just as they are forming families and bringing up children. As a result, orphan prevalence is rising steadily in many countries. Fewer relatives within the prime adult ages means that orphaned children face an increasingly uncertain future. Orphanhood is frequently accompanied by prejudice and increased poverty – factors that can further jeopardize children's chances of completing school education, which may lead to the adoption of survival strategies that increase vulnerability to HIV. It is important, therefore, to monitor the extent to which AIDS-support programs succeed in securing the educational opportunities of orphaned children.

DEFINITION OF INDICATOR

Orphans' school attendance (1):

Numerator: Number of children (10-14 years old) who have lost both parents and are still in school

Denominator: Number of children (10-14 years old) who have lost both parents

Non-orphans' school attendance (2):

Numerator: Number of children (10-14 years old) both of whose parents are still alive, who live with at least one parent and who are still in school

Denominator: Number of children (10-14 years old) whose parents are both still alive and who live with at least one parent

Calculate the ration of (1) to (2)

Note: Indicator scores are required for all children aged 10-14 years and for boys and girls separately. Where possible, the indicator should also be calculated by single year of age. The minimum number of orphaned 10-14 year old children needed to calculate this indicator is 50.

MEASUREMENT

In a population-based survey respondents are asked whether they are currently attending school. The indicator is the ratio of the current school attendance rate of children aged 10–14 both of whose biological parents have died to the current school attendance rate of children aged 10–14 whose parents are both still alive and who currently live with at least one biological parent.

Countries are also strongly encouraged to report the ratio of OVC attending school versus non-OVC attending school. In countries where the number of children who are orphans is relatively low (less than 5–8 percent of the population under age 18), this indicator will overcome the problem of low numbers of double orphans.

Platform: Population-based surveys such as DHS, UNICEF MICS, or other representative survey

Frequency: Every 2-4 years

REFERENCES

- *UNAIDS/UNICEF (2005). Guide to monitoring and evaluation of the national response for children orphaned and made vulnerable by HIV/AIDS. New York: UNICEF. www.unaids.org/EN/in+focus/monitoringevaluation/m_e+library.asp*
- *UNAIDS (2005) Monitoring the Declaration of Commitment on HIV/AIDS: Guidelines on construction of core indicators-2006 reporting, UNGASS, Geneva*

6. M&E - MSF

MONITORING
in
MSF Holland

INTRODUCTION

AND

TOOLS

Monitoring and Evaluation Unit
Médecins Sans Frontières, Amsterdam
April 1999

INDEX

1.1. PREFACE

This is the second edition of the MSF-Holland Monitoring Manual. New insights have been developed as a result of ongoing feed back from the field and the Amsterdam office.

This manual provides MSF-Holland staff with a conceptual framework and the tools for monitoring project performance and the project environment. Monitoring borders conceptually on a number of related processes, manuals and papers to which references are made. An important consideration is that effective monitoring requires familiarity with the logical framework approach, the basis for (project) planning.

The two manuals, Central and Operational Monitoring are now combined. This will contribute to a better integrated system in which information is consistently collected and recorded at the various management levels.

The interaction between project environment and project implementation has been further developed. Monitoring and reporting of the qualitative aspects of our work has been made more explicit with evaluation criteria. The link between advocacy and medical aid in our work and how this translates in the monitoring system is further explored. Some of the tools were adjusted accordingly.

We will continue to develop new insights as the tools are used in the organisation and we will continue to rely on your feedback to ensure that the MSF-Holland monitoring system remains a useful aid to your daily work.

Monitoring and Evaluation Unit, April 1999

1.2. THE CONCEPTUAL FRAMEWORKS

MSF Holland is a complex organisation with differentiated information needs. We need a common and consistent basis for information collection, analysis, documentation and dissemination throughout the project cycle. Not only for internal but also for external communication purposes.

Two closely related frameworks are being widely used in the humanitarian aid community for this purpose.

1) The *logical framework* is a planning tool, stating a project's objectives, activities, indicators, anticipated results, assumptions and preconditions[1].

2) The *evaluation criteria* for development aid were developed by the OECD-DAC [2]. They were adjusted further to characteristics of humanitarian assistance via the Relief and Rehabilitation Network at ODI[3]. Evaluation criteria take into account the most important aspects of our work: the appropriateness, effectiveness/impact, cost-effectiveness/efficiency, connectedness, coverage, and coherence.[4]

The principles of these frameworks relate to each phase of the project cycle: the needs assessment, problem analysis, project planning, monitoring and evaluation. When monitoring, we apply the evaluation criteria to the project planning and its environment.

Monitoring integrates the following frameworks:

- **The Logical Framework: defining objectives, activities, indicators, anticipated results, assumptions and preconditions.**
- **The Evaluation Framework: defining the appropriateness, effectiveness/impact, cost-effectiveness/efficiency, connectedness, coverage, and coherence of our work.**

MSF information systems and the underlying conceptual frameworks provide analytical tools to help us think about content issues, performance and accountability. They are not straight-jackets smothering initiatives for innovative and creative programming. They are meant to be the basis for collecting, analysing and recording information about our work. This enables us to reflect on fundamental issues and allows for appropriate adjustments.

[1] Manual for Project Planning, MSF-Holland. November 1995
[2] OECD Development Assistance Committee (1991), *Principles for Evaluation of Development Assistance.*
[3] RRN,ODI 1998. Good practice Review 7. Evaluating Humanitarian Assistance in Complex Emergencies. A. Hallam
[4] For definitions, please consult chapter 1.4.3.

1.3. MONITORING: DEFINITION AND GUIDING PRINCIPLES

THE DEFINITION OF MONITORING[5]:

- **A continuous and systematic process of recording, collecting, measuring, analysing and communicating information to support line management responsibilities.**

Monitoring is an essential management process and takes place at every management level in MSF, each level requiring specific information[6]. This information is exchanged formally or informally, written or verbal. Multiple formats and sources are important in order to allow managers to cross-check information.

Reporting, as part of the MSF monitoring tools, has a dual function:

1. It supports management by documenting information in a systematic way and provides a basis for **improving performance** and for **learning** from experience. This also contributes to the institutional memory of the organisation.

2. It serves as an **accountability** tool to all stakeholders of the project; private and institutional donors, beneficiaries, peer and partner organisations etc., as well as to internal stakeholders like national staff, the country management team, support departments and line management

Managers require information, generated by monitoring, to fulfil their responsibilities for planning, decision making and strategic support to the field. Receiving information also creates an obligation for managers to take responsibility for the strategic implications of what has been received: e.g. initiate policy development and strategic plans.

GUIDING PRINCIPLES FOR MONITORING:

- **It focuses on *minimal information required* for *each level* of responsibility.**
- **It includes *all* forms of communication: verbal and written, formal and informal, creating the potential for cross-checking information.**
- **It is essential to enhance the *quality* of our interventions through *learning* and *accountability*.**
- **Receiving information creates an *obligation to act on operational and strategic implications.***

[5] OECD definition

[6] Managers referred to in this document include Operational Directors, Country Managers and Project Co-ordinators.

1.4. MONITORING PROJECT IMPLEMENTATION AND ENVIRONMENT

The monitoring system provides tools for managers to collect and provide information on:

1. Progress of **project implementation**, including the use of resources, measured by the indicators of the project planning, using the LogFrame.

2. Developments in the **project environment,** described in the assumptions and preconditions of the logical framework and defined in the overall objective, using the observation process.

3. The analysis of the **interaction between the project and its environment**, applying the evaluation criteria.

1.4.1. Monitoring Project Implementation

Monitoring progress of project implementation is based on the logical framework defined in the Country Annual Plans and Project Proposals. We may need to adapt planned objectives, activities or indicators from time to time as a result of findings during the monitoring process.

Indicators are instruments for measuring the extent to which objectives are being realised. On project implementation level, indicators describe our direct results: they define the outcome of the activities for which we are solely responsible. Apart from the LogFrame, we also need to consider project phasing when monitoring. Activities may not have taken place yet, results may not show until later.

There is a general tendency to select quantitative indicators as they appear to be more objective and easier to verify. However, many objectives are qualitative (e.g. proximity, capacity building, collaboration with counterparts, participation[7] of beneficiaries, advocacy objectives). The same basic rule applies to both quantitative and qualitative indicators: we need to be able substantiate their value: For instance if our objective is a 'well functioning hospital management team', our indicators can be 'job descriptions agreed on', 'weekly meetings taking place' and/or 'decisions are being taken'.

The primary process of MSF is defined as medical aid linked to advocacy (témoignage)[8]. This should be reflected in the planning. Objectives, activities and indicators for advocacy need to be made explicit in the logical framework, as part of a project or as a 'project' by itself. Progress towards achieving them should be monitored and reported accordingly.

We also monitor human and financial resources and their relation to the outputs and results. This may assist us in identifying the need for budget adjustments or changing human resource requirements.

[7] S.Rifkin Primary Health Care: On measuring participation, 1988.
[8] Chantilly, charter, mission statement; MSF International

1.4.2. Monitoring Project Environment

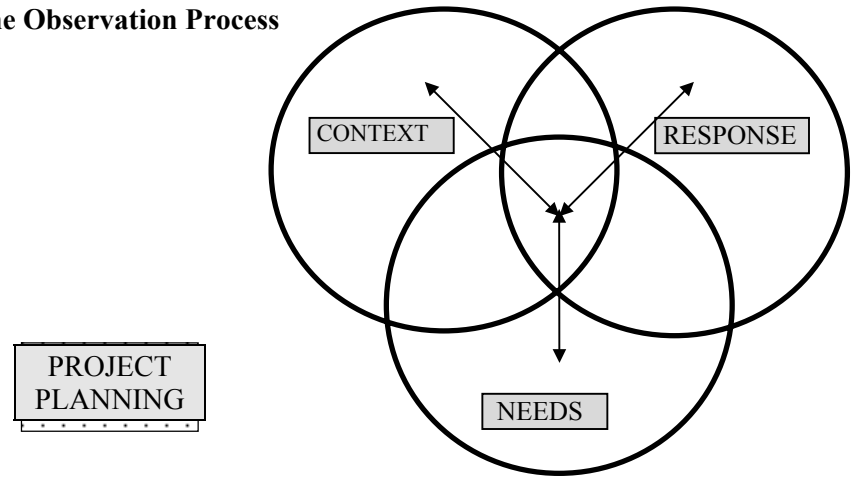
The project environment is monitored through the observation process. This relates to the ***assumptions, preconditions and overall objective*** sections of the logical framework. Developments need to be monitored in order to anticipate adjustments in project planning. Three broad domains are defined:

1) The **context** of the project, which consists of the political, social, cultural, climatological, geographical, demographic and economic environment of the project. It provides the project with opportunities and constraints in reaching its objectives. The context also includes human rights issues if they are a cause of public health problems. Context information includes security issues, determining our 'humanitarian space'[9].

2) The **needs** of the target population, divided into a) needs perceived or expressed by the target population, b) the needs identified by MSF-Holland and/or c) the needs as identified by others. Most of the information in this domain comes from our health surveillance. Mortality rates, morbidity incidence patterns and malnutrition rates are examples of quantitative data giving insight into the changes of the health situation of our target population[10]. Beneficiaries can also have advocacy needs, for instance when their rights are being violated.

3) The **response** domain includes: a) the capacity of the target population to address its own needs, b) all actions undertaken by other actors in response to these needs, and c) MSF's organisational capacity (including our expertise and policies).

Fig.1: The Observation Process



1.4.3. Interaction between project implementation and project environment

[9] Humanitarian Space refers to issues determining access to people in need (for example security, permission from local authority, etc.). For a more comprehensive elaboration, please refer to the report of the MSF-H regional meeting in Kampala of January, 1999.

[10] It is important to distinguish these rates from project purpose indicators. For further reading see 'Do objectives of health-aid programmes impair their effectiveness? Lancet 1997; 349: 722-23; P. Garner'

Humanitarian assistance is often provided in changing environments. The MSF monitoring system incorporates the changes in the environment and the developments in our projects. We need to describe and analyse these contextual dynamics and specify the consequences they have on our projects as well as the effects our projects have on this environment. This analysis needs to be reflected in the four-monthly report and in the monthly project report. Major changes in the project implementation may require approval from higher management levels.

The analysis is based on the following criteria:

1. **Appropriateness:** refers to the need to tailor the activities to the local needs, to address them in a culturally acceptable manner and in line with MSF policies.

2. **Connectedness:** refers to the need to ensure that activities of a short-term emergency nature are carried out in a context which takes longer-term problems into account.

3. **Effectiveness:** measures the extent to which the project achieves its purpose, and whether this can be expected to happen on the basis of the outputs of the project.

4. **Impact:** looks at the wider project effects on the target population or the country in general, intended or unintended, positive and negative, both in the short and long term.

5. **Coherence:** assesses whether the activities are carried out with an effective division of labour among the actors, maximising the comparative advantage of each.

6. **Coverage:** concerns the extent to which project activities are reaching the specific target population of the project .

7. **Efficiency:** (managerial), measures the outputs - qualitative and quantitative - in relation to the inputs (human, material and financial resources).

For a more elaborate discussion on these criteria, please refer to the Evaluation Manual.

1.4.4. The Status Descriptor

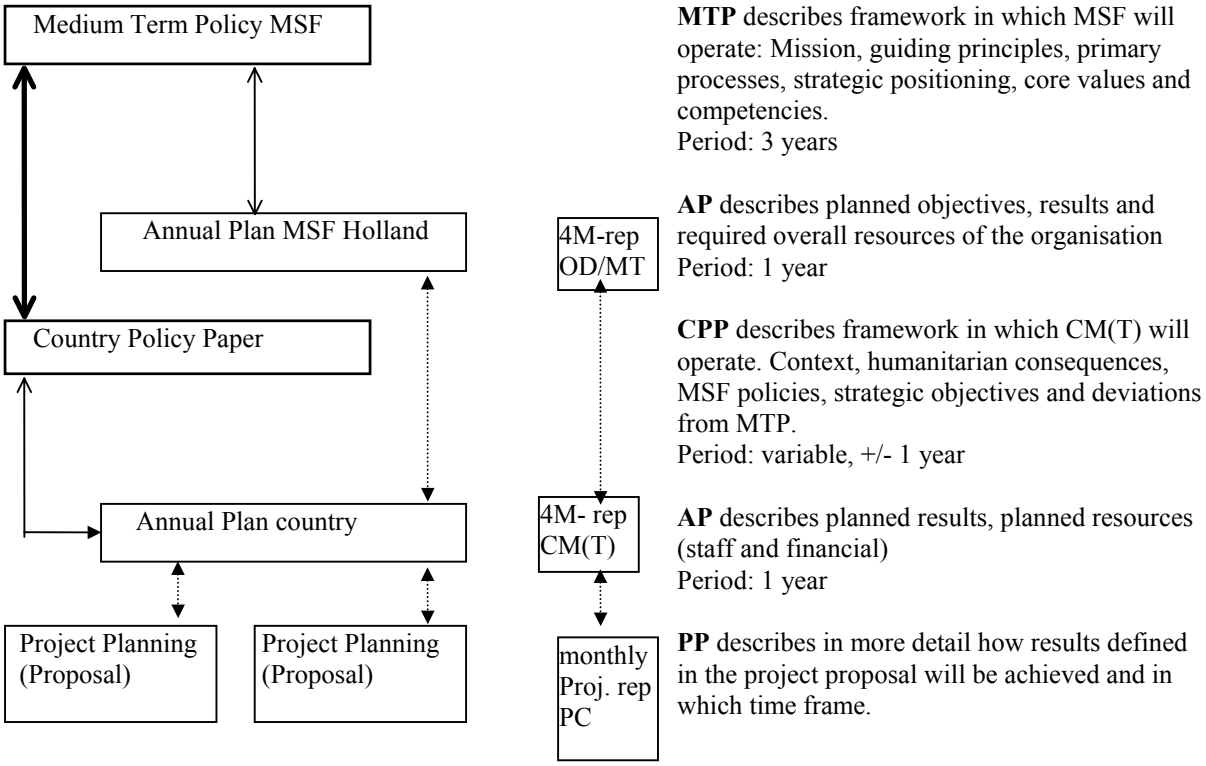
The conclusion of this analysis culminates in the **status descriptor** of the project as used in the four monthly report. In 'one word' it describes the overall status of the project in relation to its environment. As such, it briefly indicates whether there is a need for further adjustments or not. The status can be defined as:

- Ahead of planning : objectives will be achieved **prior** to planned time-frames and project still considered to be appropriate, effective, coherent etc.;
- OK : objectives will be achieved and project still considered to be appropriate, effective, coherent etc.;
- Problems : objectives will still be achieved, still considered appropriate, effective etc. but **delayed**
- Major problems : objectives can either **no longer** be achieved or are **no longer** considered appropriate, effective, etc. or both.

1.5. MONITORING AS INPUT FOR POLICY DEVELOPMENT

Country Managers are responsible for developing country policies. Operational Directors have similar responsibilities towards the Medium Term Policy. These policies form the frameworks on which annual planning and project planning are based and to which they should comply. New insights gained during the monitoring process may lead to adjustments in these plans as then documented in the project and/or four-monthly reports. When monitoring indicates that a project does not comply with MSF policy, either the project or the policy requires adjustments.

Fig 2: Links between the various policies & planning tools within MSF-Holland



1.6. EPILOGUE: THE LIMITATIONS OF MONITORING

The model presented in this manual is based on the logical framework and incorporates some of the problems associated with it. Reality is more complex than linear and causal relationships assumed in the LogFrame. MSF activities have important qualitative characteristics. How we work is often just as important as the results we seek to achieve, for instance in the area of coherence and connectedness (collaboration with MoH, phasing out, capacity building etc.).

Monitoring takes place during the implementation of the project, when project management is heavily preoccupied with operational issues. Time constraints, operational priorities and insecurity all limit information collection and the depth of analysis of this information, especially when we consider qualitative results.

While monitoring reflects on intermediate results, we also need to collect and analyse information at the end of the project cycle to reflect on the overall achievements of the intervention. We can do this during evaluation, when we analyse monitoring information collected during the entire period of project implementation, with the advantage of hindsight.

As evaluations require time and resources (e.g. staff time, transport, external evaluators) it is important to include them in the original project planning. This ensures the availability of resources and create opportunities for deeper analysis. This will strengthen the validity of our findings and allows a broadening the scope of our reflections. It will also allow us to study more than one project (e.g. country programme), a policy or a particular theme in several projects.

For more comprehensive information on evaluations, please refer to the Evaluation Manual.

MONITORING

Part 2

TOOLS

2. MONITORING TOOLS

This document describes various monitoring instruments and reporting formats referred to in part 1. The instruments are divided in those that provide the minimal information required by the Operational Director (Central Monitoring) and those required by the Country Manager (Operational Monitoring).

The combined instruments provide the insight required by the various managers. Some complement each other, some overlap or address similar topics but are provided by different people with different responsibilities and expertise. This way a system is developed which allows for cross-checking.

2.1. MONITORING INSTRUMENTS

2.1.1. Four Monthly (4M) Progress Report

Monitoring information is reported four-monthly to the Operational Director (OD). Country Managers indicate the outcomes of exploratory missions, progress and present status of the projects and the use of the allocated human and financial resources, as planned in the Country Annual Plan[11]. Deviations from the original planning, either in content or resources, should be reported. When these changes have been approved and are documented in the 4M report, this becomes the adjusted Annual Plan.

The second 4M report is also an important input for the following Annual Plan. The third 4M report gives account of the entire previous year.

The 4M has 3 sections:
1. Narrative : see annex 1
2. Human resources : see annex 2
3. Financial resources : see annex 3

2.1.2. Sitrep

Situation reports provide more in-depth information about the project environment. Particularly in the very acute stages of complex emergencies, when the circumstances change too rapidly to allow for adequate and elaborate planning, sitreps become the main tool for communication. Because of the rapid chances in the context, internal sitreps do not have a specified format. Nevertheless, sitreps should include information about:

1. OBSERVATION PROCESS:
- Main changes in the context
- Main changes in the needs
- Main changes in the overall response

2. ANALYSIS:
- What are the humanitarian (health and advocacy) implications ?
- Direct consequences for the MSF Mission and projects
- Consequences for the future, forecast

[11] Explanation to the Annual Plan (AP) of a country: content and format for 1999

3. KEY DECISIONS MADE:

2.1.3. Trip report operational directors

For the sake of transparency and clarity, Operational Directors report important decisions made during field trips. This will also allow the MT, the relevant support departments and the field to comment or ask for clarification. The format is based on the Public Health Department Trip report format (see annex 4). It includes a ToR, main conclusions, main recommendation and, when indicated, specific information and/or request for support from support departments.

2.1.4. Trip report support departments

An important perspective on the projects is provided by internal advisors from the support departments. The advisors will provide a summary and full report. The format for the summary report has been developed in the Public Health Department, see annex 4. A modified format can be used by other support departments.

2.1.5. Context reports

These are currently made by the Context Unit in support of the Country Manager and the Operational Director. Context reports provide in-depth analysis of national or regional developments relevant to MSF operations and policies.

2.1.6. Ad hoc communications

Fax, e-mail, phone, casual conversation, etc. to complement formal reporting.

2.1.7. Debriefing Country Managers

In order to facilitate hand-over to the new CM and in order to comply with standard exit requirements.

2.2. OPERATIONAL MONITORING INSTRUMENTS

2.2.1. Exploratory Missions, Rapid Assessments and Transparent Intervention Approach

Exploratory missions and (rapid) assessments are important tools for the Country Manager to collect new information. They contain the base-line information on the context, needs and response (observation process).

Explo/assessment reports and other information collected during the observation process at national or regional level, support Country Managers in decision making. The manual 'Towards a Transparent Approach of Emergency Interventions' has been developed to analyse the *necessity*, *possibility* and the *willingness* to intervene. Conclusions lead to recommendations to intervene or not.

For more information, see **'Médecins Sans Frontières, Amsterdam; Manual for Exploratory Missions and Rapid Assessments, September 1995' and 'Médecins Sans Frontières, Amsterdam; Towards a Transparent Approach of emergency Interventions, February 1995'.**

2.2.2. Project Proposal and Planning

Intervention decisions lead to a project proposal and planning (logical frame-work), a time frame in which objectives are to be accomplished and the resources required.

For more information, see '**Médecins Sans Frontières, Amsterdam: Manual for Project Planning, November 1995'.**

2.2.3. Project Report (Monthly)

A project report describes progress of achieving the results as planned in the projects' logical frame-work. This is the responsibility of the Project Co-ordinator. The overviews need to be concise and structured in a way which allows the Country Manager to quickly identify priorities. The status descriptor plays an important role in the identification of action points. See annex 5 for format.

2.2.4. Updates on human resources and finances at project level

Sections on human resources and finances are included in the monthly project reports, required by Country Manager. Human Resources and Finances information is only needed on actual versus planned numbers of staff and actual versus planned expenses. Short narrative sections can be added by the PC to give explanations of deviations and to outline actions undertaken in response.

Human resources format (see annex 2):

The format for human resources (planned positions and projected changes) allows contract monitoring and HRM planning (replacements, job profiles and job descriptions to the HRM department in Amsterdam). For explanation of annex 2, please contact HRM field.

Finances (annex 3A and 3B):

The Budget Control Report gives an updated overview of the project finances. The Budget Overview report gives an overview of total income and expenses at country level. For further details please contact Project Finance and Administration.

2.2.5. Trip reports Support Department

Trip reports from support department staff are a valuable source of information for the Country Management and Project Teams to get feedback on the functioning of the projects.

2.2.6. Field Visits Country Management Team members

Field visit reports allow CMT members to be accountable to each other and to the project teams. The accumulated information allows Country Managers to cross-check information from (monthly) progress reports. The trip report format (annex 4) can be adapted for this purpose.

2.2.7. Debriefing Project Staff

Country Managers collect additional project information by debriefing project staff (expat and national).

2.2.8. Ad Hoc Communication

Regular meetings between the CM and project co-ordinators, CMT meetings, feed-back through fax, standard-C, E-mail, phone, etc. and coaching will complement information from written reports. Ad-hoc communications also facilitate verification and cross-checking of reports.

ANNEX 1A: FOUR MONTHLY PROGRESS REPORT NARRATIVE

Country: X
Name Country Manager:
Progress report period from [date] **till** [date+4 months]**:**

	Name (and cost centre)	*Situation type*	*Planned or unplanned*	*Phase*	*Status*
Observation process: Incl. Exploratory and Assessment missions	*List them here, provide details in separate sheets*				
Projects	*List them here, provide details in separate sheets*				
Country visits	Name/position	Organisation / Department			ToR or Trip Report Received?

FOUR MONTHLY PROGRESS REPORT ON RESULTS

- ***For assistance whilst filling out the section of projects, consult Chapter 4 of the introduction part of this manual.***
- ***For a concrete example, please consult the Manual for Project Planning.***

Observation process: incl. Exploratory and Assessment missions **Area Assessed:** **Assessment Period:**	
	Present the main conclusion of the analysis of the following questions for each explo: 1. the necessity for an intervention from outside? 2. the necessity for MSF to intervene? 3. MSF willingness to intervene? 4. the possibility for MSF to intervene?
Conclusions:	

For each project:

Project X:	*Name and cost centre*
Project Purpose (PP): describes the objective of the project.	
PP indicator (=Planned result): *target group, quantity, quality, time and place*	
Current Value of PP indicator:	
Value the interaction between project implementation and its environment by discussing: 1. Are the activities and outcomes still **appropriate**? 2. Is project still reaching its purpose on the basis of project outputs? Are activities **effective?** 3. Is the project still having **impact** on the wider context and needs? 4. Are the used inputs still the most **efficient** way of generating outputs? 5. Is the project still taking place in a co-ordinated and **coherent** manner? 6. **Connectedness:** Are long term problems taken into account? 7. Is the project still **covering** the projected target population?	
Status	
Constraints/opportunities (Observations CM)	
Corrective action/Planning next quarter	

ANNEX 1B: EXPLANATION OF THE FOUR MONTHLY PROGRESS REPORT

- *NAME (AND COST CENTRE): PROJECTS AND EXPLO MISSIONS :* Description of exploratory missions or projects and their respective cost centre(s), if available.

- *SITUATION TYPE:* Description of the situation type as stated in the Medium Term Policy. We would require monitoring of allocation of resources in the following way:

* Africa (60%)	* A
* Continent (40%)	* C
* War related intervention (65%)	* W
* Unplanned emergencies (10%)	* U
* Other (25%)	* O

Possible codes for this section are than: AW, AU, AO ; or CW, CU, CO. This will allow us to monitor the resources allocations set out in the MTP.

- *PLANNED OR UNPLANNED:* Refer to the Annual Plan of the country

- *PHASE:* Description of the phase of the exploratory mission or project, at the moment of reporting. The following descriptors are suggested: Under preparation, being implemented, suspended, being handed over, handed over, completed.

- *COUNTRY VISITS* : List visits HQ staff or non-MSF visitors. Give name, date, if visit was planned, whether there was a ToR, and date the trip report was or will be ready.

- *OBSERVATION PROCESS: INCL. EXPLORATORY AND ASSESSMENT MISSIONS*: Discuss the four questions from the Transparent Intervention Approach and give main conclusions here.

- *PROJECT:* Description of the project, consistent with the description of the Annual Plan or proposal.

- *PROJECT PURPOSE* (PP): Give PP as defined in logical framework. Consult Manual for Project Planning and section 1.4.1 of the Introduction of the Monitoring Manual.

- *PLANNED RESULT:* Give value of PP indicator, including target group, quantity, quality, time and place. Measures the PP, see section 1.4.1 of the introduction.

- *CURRENT VALUE OF PP INDICATOR:* Give present value of indicator, which is the interim result at PP level. Consult section 1.4.1 of the introduction of this manual.

- *VALUE THE INTERACTION BETWEEN PROJECT IMPLEMENTATION AND ITS ENVIRONMENT*: Use the evaluation criteria to discuss the influence of the project on context, response and needs (and vice versa). Consult section 1.4.2 and 1.4.3 of this Manual.

- *STATUS:* Use Status indicator as described in 1.4.4 of the introduction.

- *CONSTRAINTS /OPPORTUNITIES:* Main constraints and/or opportunities related to project implementation and changes in its environment.

- *OBSERVATIONS CM:* CM can add his/her personal observations on the status of the project.

- *RESPONSE:* Briefly present the actions undertaken to overcome the problems mentioned. Examples: medicines ordered, recruitment of local staff intensified, CMT requested to provide additional staff etc. This may require an adjusted LogFrame.

- *PLANNING NEXT QUARTER:* Briefly describe activities not referred to in the original planning. Document any changes to LogFrame for the coming phase.

ANNEX 2: FOUR MONTHLY REPORT ON HUMAN RESOURCES

COUNTRY:
MATRIX FIELD STAFF
June 1997

Please fill in Yes or No

PROJECT	POST	NAME / medical background	1ST MISSION	1ST X COORD PC/CM/MC	TRAINEE	FROM	JAN	FEB	MAR	APR	May	JUN	JUL	AUG	SEP	OCT	NOV	DEC	UNTIL
1 Capital	Country Manager	John/MD				010696	-------	-------	-------	-------	-------	-------	-------	-------	-------	VAC	0111	-------	
	Medical Coord.	Marie/Nurse		Y		010397	-------	VAC	0503	-------	-------	-------	-------	-------	-------	-------	-------	-------	
	Financial Coord.	Bert				050597	-------	-------	-------	VAC	2005	-------	-------	-------	-------	-------	-------	-------	
	Logistic Coord.	Andre				011196	-------	-------	-------	-------	-------	-------	-------	-------	-------	VAC	0111	-------	
2 Project X	Project Coord.	Frans				011196	-------	-------	-------	-------	-------	-------	-------	-------	-------	VAC	0111	-------	
	Medical Doctor	Gunilda/MD				011196	-------	-------	-------	-------	-------	-------	-------	VAC	1509	-------	-------	-------	
	Log/admin	George	Y			010197	-------	-------	-------	-------	VAC	1506	-------	-------	-------	-------	-------	-------	
	WatSan	Linda			Y	011196	-------	-------	-------	-------	-------	-------	-------	-------	-------	-------	VAC	1512	
	Nutritionist	Saskia/Nutr.				011196	-------	-------	-------	-------	-------	-------	EOP						
	Logistician	Koert	Y				NP01	-------	-------	-------	-------	-------	EOP						
3 Project Y	Co-ordinator	?							NP01	-------	-------	-------	-------	------	------	------	------	-------	
	Medical Doctor	?/MD							NP01	------	------	------	------	------	------	------	------	------	
TOTAL NO. OF EXPATS PRESENT			2	1	1		10	10	12	12	12	12							
PLANNED POSTS ACCORD. TO ANNUAL PLAN							11	11	11	11	11	11	11	11	11	11	11	11	
DEVIATION (+/-)							-1	-1	+1	+1	+1	+1							
																			TOTALS
VACANCIES	(VAC + NP)						1	0	3	0	1	1	0	0	1	0	3	1	11
NEW POSTS	(NP)						1	0	2	0	0	0	0	0	0	0	0	0	3
END OF POSTS	(EOP)						0	0	0	0	0	0	2	0	0	0	0	0	2
CHANGE IN NO.OF POSTS	(NP - EOP)						1	0	2	0	0	0	-2	0	0	0	0	0	1

1.B Explanation of deviation

1.C Response CM

ANNEX 3A: FOUR MONTHLY FINANCIAL OVERVIEW

TOTAL OVERVIEW OF PROJECTS PER COUNTRY(In Dfl. x 1.000)

Year Operational Director Country Country Manager Financial Controller		1st Trimester 2nd Trimester 3rd Trimester	Change in funding situation and/or expected expenses Date	Category /Situation

CC	Projectname	Date from	Date until	Annual plan 1 Tot.exp.	Annual plan 2 External	Annual plan 3=1-2 MSF	Last financial overview (as a revision of the annual plan) 4 Tot.exp.	Last financial overview (as a revision of the annual plan) 5 External	Last financial overview (as a revision of the annual plan) 6=4-5 MSF	Total expected this bookyear 7 Tot.exp.	Total expected this bookyear 8 External	Total expected this bookyear 9=7-8 MSF	Deviation last Fin Overview-total expected this bookyear 10=7-4 Tot.exp.	Deviation last Fin Overview-total expected this bookyear 11=8-5 External	Deviation last Fin Overview-total expected this bookyear 12=9-6 MSF	Deviation Annual Plan-total expected this bookyear 13=7-1 Tot.exp.	Deviation Annual Plan-total expected this bookyear 14=8-2 External	Deviation Annual Plan-total expected this bookyear 15=9-3 MSF
Closed Costcentres (reported)																		
						0			0			0	0	0	0	0	0	0
Running Costcentres																		
						0			0			0	0	0	0	0	0	0
Planned New Costcentres																		
						0			0			0	0	0	0	0	0	0
Grandtotal				0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Percentage Internal/External financing					0%	0%		0%	0%		0%	0%						
Volume *Category* 1				0	0	0	0	0	0	0	0	0						
Volume *Category* 2				0	0	0	0	0	0	0	0	0						
Volume *Category* 3				0	0	0	0	0	0	0	0	0						
Volume *Category* 4 (data c*ategories* exclude eventual Explo's)				0	0	0	0	0	0	0	0	0						

ANNEX 3B: MONTHLY BUDGET CONTROL REPORT

PROJECT BUDGET CONTROL REPORT				
Date	: **17-May-99**			
Project country	:			
Name of project	:			
Cost centre	:			
Starting date budget	:			
End date budget	:			
Length in months	: **0**			
Expenses until	:			
Country Manager	:			
Administrator/controller	:			
OD Amsterdam	:			
Internal Financing	HFL	:		(latest approved Fin.Overview)
External Financing	HFL	:		(latest approved Fin.Overview)
Total Budget	HFL	:	0	

COMPARISON TOTAL BUDGET AND ACTUAL ACCUMULATED EXPENSES					% Time passed	
Nr.	Breakdown		BUDGET HFL	EXPENSES HFL	BALANCE HFL	% Realised Budget	Notes
1	EXPATRIATE STAFF			-	-		1
2	CONSULTANTS			-	-		2
3	LOCAL STAFF			-	-		3
4	FUNCT./OFFICE COSTS			-	-		4
5	TRANSPORTATION			-	-		5
6	DRUGS/MED. MATERIAL			-	-		6
7	NON-MEDICAL MATERIAL			-	-		7
8	TRANSPORT/STORAGE			-	-		8
9	TRAINING/STORAGE			-	-		9
10							
	PLANNED BUDGET		-				
-/-	FINANCING SHORTAGE		0				
	ACTUAL BUDGET		0	0	0		

Explanations:

1
2
3
4
5
6
7
8
9
10

ANNEX 4: TRIP REPORT PUBLIC HEALTH DEPARTMENT

By: (name)

Country	:	**Project(s)**	:
From	:	**To**	:

Purpose of trip (T.O.R):

1)

2)

3)

Main conclusions:

1)

2)

3)

Main recommendations:

1)

2)

3)

Proposed next visit :

Project activities (focus on info for Public Health Department colleagues):

Training :
Nutritional Issues :
Mental Health :
Surveillance :
MedCo potential :
Watsan :
HAD :
Other :

ANNEX 5: (MONTHLY) PROJECT REPORT

Country: X **Name PC:** Ms. Clever **Progress report last period from** [date] **till** [date+1 months]**:**

Project:	*Name and cost centre*
Project Purpose (PP): describes the objective of the project . (manual for project planning and section 1.4.1 of the introduction of the monitoring manual)	
PP indicator (=Planned result): *target group, quantity, quality, time and place* measures the PP (section 1.4.1 of the introduction)	
Current "Value" of PP indicator: Interim result at PP level (section 1.4.1 of the introduction)	
Value the interaction between project implementation and its environment by discussing: (section 1.4.2 and 1.4.3 of the introduction) 1. Are the activities and outcomes still **appropriate**? 2. Is project still reaching its purpose on the basis of project outputs? Are activities **effective?** 3. Is the project still having **impact** on the wider context and needs? 4. Are the used inputs still the most **efficient** way of generating outputs? 5. Is the project still taking place in a co-ordinated and **coherent** manner? 6. **Connectedness:** Are long term problems taken into account? 7. Is the project still **covering** the projected target population?	
Status Use Status indicator (as described in 1.4.4 of the introduction)	
Constraints/opportunities (Observations CM)	
Response/Planning next quarter Adjustment of project planning (LogFrame) for the coming phase	

For each Specific Objective, use the following format:

Specific Objective (SO) 1
SO indicator
Interim "value" of SO indicator(s)
Constraints/opportunities
Response

ANNEXES (Contact relevant support department for content and formats):

1. monthly health update
2. monthly watsan update
3. monthly advocacy update
4. monthly technical support update
5. monthly logistics update
6. monthly Human Resources Update (includes overview national staff per project activity)
7. monthly Financial Update (Project Budget Control Report):

7. M&E - AFEW

AIDS Foundation East West
СПИД Фонд Восток Запад

Monitoring & Evaluation at *AFEW*

A toolkit for M&E practitioners

August 2006

Content

Background

AIDS Foundation East-West (AFEW) is a Dutch non-governmental humanitarian public health organisation whose mission is to make a major contribution to the reduction of the impact of HIV/AIDS in Eastern Europe and Central Asia (EECA)[1] by:

- Taking an innovative and pro-active approach to developing, implementing and promoting tools for effective HIV/AIDS prevention, treatment, care and support, designed for and appropriate to the specific conditions of EECA;
- Targeting the younger generation of the region, in particular those engaging in risky behaviour;
- Co-operating closely with national governmental and non-governmental structures to boost local coping capacities and to advocate for appropriate action;
- Strengthening East-West engagement by exchanging knowledge and people via programme activities and stimulating a committed response.

AFEW Projects:

- Mass Media Campaigns (Russia, Ukraine, Moldova),
- HIV prevention and health promotion in prisons (Russia and CAR),
- Harm Reduction Training Programmes (Russia),
- HIV Prevention and Health Promotion among Sex Workers (CAR),
- Pre- and post-HIV test counseling (Russia, Ukraine and CAR),
- Client Management for HIV/AIDS services (CAR),
- Preventing Mother-to-Child Transmission of HIV (Russia), and
- Men who have sex with men: HIV/STI prevention and support project (Ukraine).

The purpose/values of M&E at *AFEW*

- To implement programmes and projects on behalf of donors;

- To ensure the organisation learns from its experiences and is able to continually improve the quality of its activities;

- To advocate for a more significant and effective response from others (governments, donors, other NGOs etc).

M&E fundamental questions

- What is required in this particular situation?
- What is working and why?
- What is not working and why?
- What could be done differently?
- What adjustments and changes are required?

M&E tools in the past

In the past, *AFEW* had a general approach of establishing a baseline at the beginning of the project and then not gathering significant monitoring and evaluation information until a follow-up study either mid-way through or at the end of the project.

The main data collection tools that were used for this are outlined below. Essentially this did not provide enough ongoing data throughout the project to actively assist in project implementation and reporting.

Impact Evaluation:

- Baseline/RAR studies (HR projects – Russia, Ukraine, Moldova, CAR and SW projects – CAR);
- Follow up studies amongst MARA (Mass Media Campaigns on Safer sex, PSP, SW projects in CAR).

Output and Outcome Evaluation:

- Qualitative and quantitative studies;
- Site visits;
- Reports from the projects' staff; and
- External evaluations of the projects.

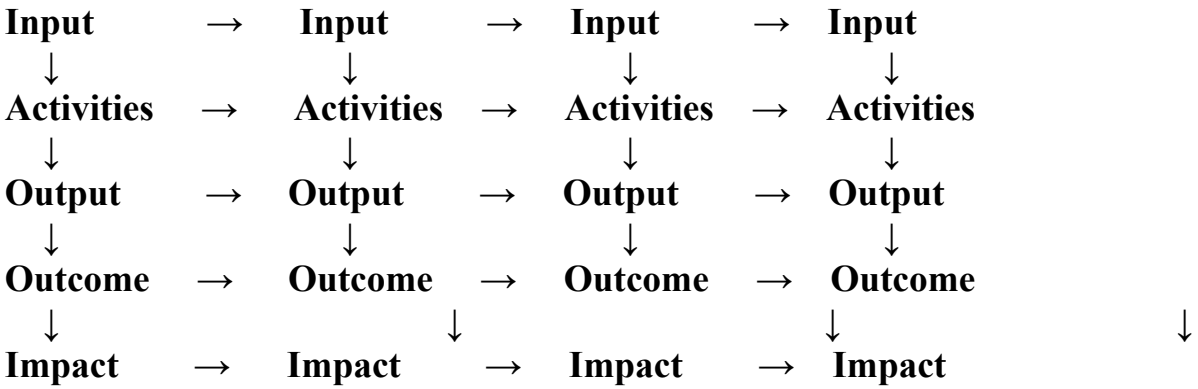
How we do it now?

The M&E Matrix. Comprehensive and Integrated.

At *AFEW* we view all projects as progressing through several lifecycle stages.

Plan → Build → Implement → Close → Realise

Based on this and the project objectives we aim to ensure that we have data collection systems in place to monitor every stage of the project lifecycle, through inputs, activities, outputs, outcomes and impacts.



Logical Frameworks are the main planning tool used to establish links between impacts, outcomes, outputs, activities and inputs. They are also used to form the basis of risk assessment of projects and specify the assumptions that underlie the project approach.

How does it all work?

Plan → Identify desired inputs, outputs, outcomes and impact/s of each activity and/or conduct a risk analysis on the project approach and model to identify indicators and broader data collection measures;

Build → Develop and test data collection tools, develop and test the project in The *AFEW Information Resource (The AIR), our online project management system*;

Implement → Implement tools and system, conduct ongoing monitoring and periodic evaluation and update The *AIR*;

Close → Conduct final evaluation, review all existing data; and

Realise → Transfer lessons learnt, publish results.

Planning Phase

The main output of the planning phase of the project in relation to M&E is the M&E Strategy. This is the what, who, why, when and how of M&E for a project. The M&E Strategy:

- Is based on the logical framework or project plan for the project;
- Might be based on a Risk Analysis for the project if one has been done, which identifies key risk points for project success;
- Identifies desired outputs and outcomes for each activity as a minimum;
- Identifies data collection methods and reporting approaches and timeframes; and
- Identifies indicators.

Importantly, indicators at *AFEW* are seen as only one element of a broader M&E Strategy for monitoring project performance. They serve as a useful way of identifying major issues early and meeting donor requirements for transparency, however, *AFEW* believes strongly in monitoring project performance through a comprehensive range of measures, including reference to complex data sets and matching quantitative data with qualitative information sources.

Build Phase

In the build phase the M&E and project team aim to do the following:

- Develop and test M&E tools;
- Set up The *AIR*; and
- Conduct trainings on tools.

Implementation Phase

The implementation phase involves:

- Implementing the M&E strategy, including conducting regular reviews of project performance; and
- Maintaining data in The *AIR*.

Close/Evaluation Phase

At the end of the project the M&E plans a key role in pulling all the data collected together and conducting a final review of the project, this can involve:

- Collecting all information required to conduct the final evaluation (eg. Conduct follow-up surveys);
- Analyse all data; and
- Evaluate the programme/project effectiveness, impact and sustainability, and develop evaluation report.

Realisation Phase

The realisation phase of the project begins when the project ends and is the final legacy of the project. In some cases it may be possible and desirable to conduct a post implementation review of the project to evaluate its ongoing impact but in most cases this phase will focus on:

- Transfer of lessons learnt internally; and
- Publish data where possible.

Core M&E Tools

Main **Output** and **Outcome** measurement tools:

- Training Evaluations (eg. Pre- and Post -Training Evaluation);
- Service Utilisation Surveillance (eg. Treatment Surveillance);
- Site Visits, including checklists and guides;
- Regular project reporting;
- Qualitative studies (in-depth interviews, key informants, direct observations, focus groups discussions);
- Operational research;
- Official statistics and epidemiological data;
- Workshop feedback reports; and
- External evaluations.

Operations Research is a rigorous type of evaluation that complements M&E systems.
The process has five key steps:

1. Problem identification and diagnosis
2. Selection of a programme strategy
3. Strategy testing and evaluation
4. Information dissemination
5. Information utilization and scaling-up

Main **Impact** Measurement Tools:

- Baseline and Follow-up Evaluation Studies (in some cases could be considered outcome measurement); and

- Official statistics, epidemiological data and routine statistical data collection at health facilities (eg. incidence rates).

The benefits of effective M&E

- Improved management of activities and quality of outcomes;
- Improved accountability: it helps to identify the successful strategies for extension/expansion/replication and modify unsuccessful strategies; and
- Learning and development. It helps to measure effects/benefits of programmes and interventions.

M&E helps to improve performance and achieve results. It is also provides important information for advocacy and helping others improve their activities.

How do we manage all of this information?

The central data repository at *AFEW* is *The AIR,* an online, restricted-access project management system.

Description

The AIR's primary purpose is to serve as an online resource for managing, monitoring and evaluating projects. All *AFEW* staff have access to *The AIR* site.

Purpose

- Facilitate the management, monitoring and evaluation of projects by making it easier to plan and share information.
- Bring *AFEW* staff together in a common informational space.
- Allow information to be viewed and modified online.
- Document the project development process so that it can be improved over time.
- Collect and store, in a single database, information on project activities, indicators, aims and tasks that can be used for communication and advocacy purposes.
- Provide access to the organisation's information resources through the library.

The *AFEW* Information Resource (**The *AIR***) key functions:

- Project Management Information;
- Project Monitoring Reports;
- Project Evaluation Data;
- Department Management Information;
- Department Monitoring Reports; and
- Programme Development Information Management.

Project Logical Framework structure.

Purpose – overall result of all the activities during the project cycle (www.pmi.org).
Example: «To extend and increase the effectiveness of VCCT service».

Objective – an achievement of one of the expected results. It includes a number of activities and tasks aimed at achievement of the overall project purpose.
Example: «To train the Health Care specialists on HIV Counseling».

Activities – groups of tasks that need to be completed in order to achieve project objectives. For each of the activities there are some expected results determined (outputs and outcomes).
Example: «To conduct three trainings on VCCT».

The expected output— number of people trained; expected outcome is increased level of knowledge in VCCT amongst the target group.

Tasks – basic project management unit. Each activity (eg. conduct a VCCT training) could consist of a few tasks (eg. develop training materials, send invitations, etc) aimed at achievement of a certain objectives.

Example of AFEW Project Logical Framework (presentation from The AIR):

Objective: Support existing VCT services

Summary:

Sort Method: by number

Activity 1.1	**Assess VCT service needs in # of CTCs and regions.**	(01.01.2005 - 17.11.2005)
	Task 1.1.1 M&E Baseline study	
Activity 1.2	**Build team of experts on Counselling issues who will be housed within each of the three Counselling Training Centres**	(01.05.2005 - 30.09.2005)
	Task 1.2.1 Staff development	
	Task 1.2.2 Hire Counselling Training Center (CTC) staff	
	Task 1.2.3 Introductory Workshop for new Counselling Training Center (CTC) staff	
	Task 1.2.4 Agreement	
	Task 1.2.5 Post-Test Counselling Training	
	Task 1.2.6 Create Counselling Training Center (CTC)	
	Task 1.2.7 Post-Test Counselling Training	
	Task 1.2.8 Counselling training	
	Task 1.2.9 Trainings on Counselling for peer trainers	
	Task 1.2.10 Counselling training	
	Task 1.2.11 Counselling training	
Activity 1.3	**Develop quarterly bulletins and a web-site on Counselling in coordination with AFEW projects on Health Promotion in Penal System, pMTCT, Prevention of HIV among Injecting Drug Users, and other projects of the consortium.**	(14.07.2005 - 14.07.2005)
Activity 1.4	**Build patients referral system in cooperation with all the consortium members and their regional partners**	(01.04.2005 - 29.10.2005)
Activity 1.5	**Provide healthcare professionals in VCT services in 10 regions with a set of IEC materials on HIV/AIDS related issues.**	(01.03.2005 - 17.09.2005)
	Task 1.5.1 Training and infromational materials	
	Task 1.5.2 Training agendas and materials	
	Task 1.5.3 Develop recommendations	

Summary

To ensure adequate, accurate and timely information is available to facilitate donor reporting, project performance management, programme development and advocacy".

Our Method:

1. Ensure a comprehensive M&E strategy is in place across the entire project lifecycle (the M&E Matrix);

2. Employ a standardised core set of tools (plus others if required); and

3. Monitor the implementation of the project and the M&E strategy using 'The *AIR*'.

Attachment A: A practical example of M&E at *AFEW*

Conducting rigorous evaluation of trainings is particularly important for *AFEW* as the delivery of trainings has traditionally been a significant component of many of the projects being implemented. Looking to the future, the routine collection of data relating to clients being served through *AFEW* projects is becoming more and more necessary.

The following provides an outline of how *AFEW* evaluates trainings and briefly illustrates some of the routine client-level data collection systems the *AFEW* works with.

Training Evaluation

Key Questions

1. What is overall goal (desired impact) of the training?
2. What are the desired outcomes (eg. specific learning objectives)?
3. What are the desired outputs of the training (eg. the number and type of people to be trained)?
4. How can we tell if the outputs have been delivered?
5. How can we tell if the outcomes have been achieved?
6. How can we tell if the overall goal has been achieved?

An Example

1. Overall Goal/Impact: To increase the capacity of relevant health professionals in a certain region to provide VCT.
2. Learning Objectives/Outcomes: To increase the knowledge of relevant health professionals on certain issues relating to VCT.
3. Desired Outputs: Relevant health professionals have been trained on these certain issues.

Output Measure 1: We record the training topics covered through trainer's report.
Output Measure 2: We record the number of people trained from particular groups through pre and post training evaluation (PPTE) questionnaire.

Outcome Measure: We measure improvements in knowledge and changes in attitude in relation to certain issues through PPTE.

Impact Measure: We conduct baseline and follow-up surveys within the region to monitor changes in the overall population of relevant professionals.

The following is an example of a graph that might be produced from the training evaluation data. The blue bars represent the percentage of respondents who recorded correct answer against the particular question prior to the training. The red represents the same figure after the training has been implemented.

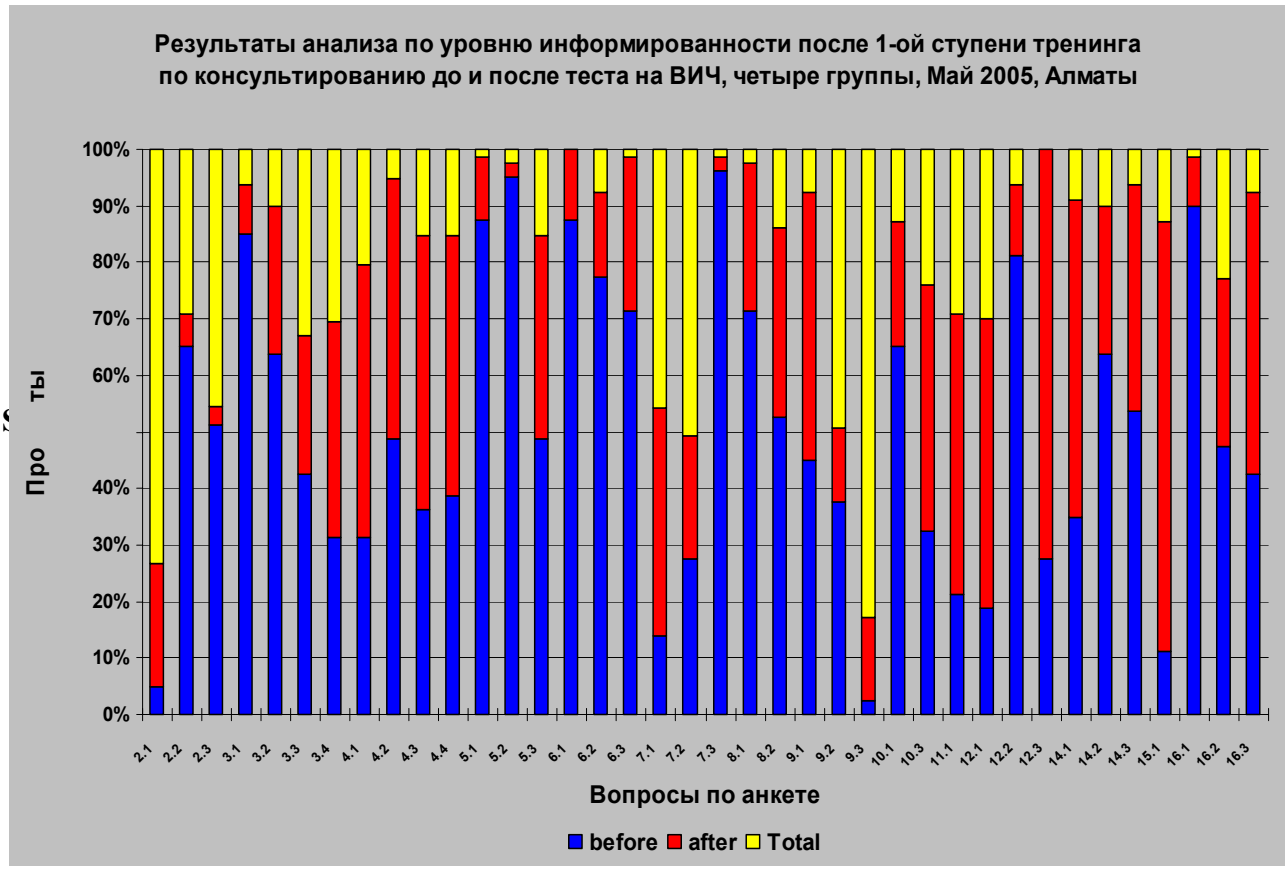


Figure 1: Training evaluation data.

Drug Monitoring Information System (DMIS)

Description

DMIS is a patient-level data collection system used in the GLOBUS project in the Russian Federation. As such, it records pertinent information relevant for each time a patient on ARV therapy sees a member of the multi-disciplinary team and/or is provided medications.

Purpose Monitoring of ARV-therapy in the framework of GLOBUS project.

Elements in the System

- Procurement;
- Patient's monitoring system;
- Registering (individual code);
- Disease History;
- Specialist examination;
- Laboratory assessment;
- Evaluation of readiness of a patient to receive ART and treatment regimen (in progress); and
- Demonstration of adherence.

Case Management Monitoring System (CMMS)

Description

CMMS is a client-level data collection system used in the Client Management project *AFEW* is currently implementing in Central Asia. This database is used by client managers to track the progress of clients through the HIV/AIDS service network as well as, more broadly, to monitor and evaluate the project.

Purpose Monitoring of information relating to clients and the services they are referred to.

Elements in the System

- Unique ID of Client;
- Main target category (SW, IDU, Prisoner)
- Nature of first contact (eg. outreach, drop-in, etc)
- Assessment of health status
- Recommended treatment plan (select from range of possible services) and control of the execution
- Where referred to and when
- Outcome of referral:
  - Did the person attend and when?
  - What service was provided?
  - How successful was it (rating scale)?
  - What further recommendations?

8. INDICATORS

By Irina Berezhnova

Indicators are used to guide project monitoring and evaluation activities. The need for indicators arises out of the practical reality of not being able to simultaneously monitor all relevant project data. As such, they are used to indicate or highlight specific trends or events that are relevant to the achievement of project outcomes and that may deserve further, more detailed, investigation relating to project performance.

Indicators are best used as one part of a broader set of monitoring and evaluation tools and, in particular, they are best combined with periodic or routine targeted evaluation or reviews that use indicator data as a starting point but which look beyond this information to a more comprehensive evaluation of the project.

Measures that indicators can be based on include:

Quantitative, e.g. number of people trained; or
Qualitative, e.g. training curricula developed.

There are no absolute principles about what makes a good indicator of achievement, however, the SMART characteristics listed below are useful.

A good OUTCOME indicator is:

Specific. Key indicators need to relate to the conditions the project seeks to change.

Measurable. Both quantifiable and qualitative indicators can be measurable and useful as long as they are precise, in terms of what is measured and how and they can be independently verified.

Attainable. The indicator must be attainable at reasonable cost using an appropriate data collection method.

Relevant. Indicators should be relevant to the management information needs of the people who will use data. Information must be sorted, screened, aggregated and summarized in different ways to meet different managers' needs.

Timely. An indicator needs to be collected and reported at the right time to influence many management decisions.

It is also vitally important that the indicators selected match the activities planned to be implemented in the project. Often it is best to identify the indicators based on the objectives of the project but before conducting detailed planning. This allows project managers to tailor the project plan to ensure that they have the best chance of meeting the targets.

In other cases it is necessary to conduct the detailed project planning before meaningful indicators can be identified.

Either cases the planned activities should match the targets specified.

Furthermore, when specifying targets for indicators it is preferable to select measures with targets that provide ongoing feedback regarding project success throughout the project. Targets which are only measured at a single point within a project and are essentially 'hit or miss' do not adequately serve the function of providing early warning to project implementers regarding project performance or allow them to modify the project approach in time to meet targets.

Another toolset that can assist in the development of indicators is risk management. Generally indicators focus on whether or not the project is achieving a particular output or outcome. In many cases, however, the achievement of project success is dictated by the successful combination of multiple factors. In particular, the delivery of most projects requires not only successfully conducting planned activities but also having in place effective risk management strategies to mitigate the negative effect of risks on the project.

Focusing only achievement or non-achievement with indicators in this context may not provide enough information to the project manager regarding specifically what needs to be delivered or modified throughout a project for it to be successful. It may also be advisable to monitor certain identified risks or contributing factors to the project through the use of indicators. For example, in implementing an ARV treatment project focused on the provision of medications to achieve a reduction in HIV transmission, risks that might be identified could include the possibility that relevant medical staff may not have adequate expertise or experience and/or that potential clients are unwilling to engage with the required medical institions. It may be necessary, therefore, to not only monitor more standard indicators related to the provision of medications as an output and ultimately the HIV transmission rate but also to monitor issues such as the knowledge levels of staff or the attitudes of clients. These can be important indicators of the project's likely success even though they may not be directly related to the activites of the project.

Methods of data collection

The possible methods for data collection are numerous. Some examples of potential data collection methods include:

- Extracting data from written records (eg. client files);
- Surveys of individuals or households, including:
    - Self-administered questionnaire;
    - Interviewer administered questionnaire; and
    - Qualitative studies (eg. interviews, FGDs).
- Have a trained observer rate behaviour, environments or organisations;
- Take physical measurements (eg. health status);
- Reports from project staff or stakeholders; and
- Identified outcomes and records from meetings.

Key issues in Data Collection Procedures

Some of the key questions relevant for identifying data collection measures include:

- When to collect?
- Who is a participant?
- All participants or only a sample?
- Who will collect the data?
- How to protect confidentiality?

- How to inform participants?

What to monitor in your measurement system?

- Time spent;
- Former participant not located;
- Data frequently missing in records;
- Response rates;
- Refusal rates;
- Planned observations not completed;
- Data collection errors;
- Data needed but unavailable; and
- Costs beyond staff time.

Some Indicator Examples

Indicator definition – the need for operational definition consistent over time

Example #1

Percentage of IDUs who have adopted behaviors that reduce HIV transmission

Numerator: Not having shared needles in the last month and used condoms at last sex

Denominator: Number of respondents who report both injecting drugs and having sex in the last month.

Measurement tool: Time location cluster sample or targeted snowball sample.
How many questions you need in your questionnaire? How do you compute value?

Indicator definition

- N= total sample of your respondents
- # those who did not share equipment last month and used condom A
- # those reporting having injected and had sex last month B (B is lower than N)

- Indicator value formula: A/B*100

Indicator definition

- % of young people 14-18 who use condoms regularly (always, sometimes, never)
- % of young people 14-25, who used condom at last sex with non-cohabitating parter (non-regular)
- The average duration of regular relationship among secondary school students range between 2-6 months
- Condom use at first and last month

Example #2. **Number of individuals trained in counseling and testing according to national or international standards**

Rationale/What It Measures: This provides a means to gauge progress toward any training targets which may be incorporated into national plans.

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

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

Measurement Tool:
Program reports. agencies and partners should keep a training log including the type of training, date, location, and participants.

How To Measure It:
Each agency and /or partner counts the number of individuals trained in prevention by staff or during the specified reporting period (6 months for semi-annual report / 12 months for annual report).

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

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

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

Interpretation/Strengths and Weaknesses:
This indicator does not measure the quality of the training, nor does it measure the outcomes of the training in terms of the competencies of individuals trained, nor their job performance.

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

9. Practical Manual for NGOs by the HIV/AIDS Alliance

Альянс
Міжнародний Альянс з ВІЛ/СНІД в Україні

UNAIDS
JOINT UNITED NATIONS PROGRAMME ON HIV/AIDS
UNHCR UNICEF WFP UNDP UNFPA UNODC ILO UNESCO WHO WORLD BANK

Program Monitoring and Evaluation

Practical Manual

for Organizations Coordinating and Implementing Prevention Projects among IDUs, CSWs, MSM, Prisoners and Care and Support Projects for PLHA

with attached list of selected indicators

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Table of Contents

List of Annexes

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Introduction

This Practical Manual was developed by the M&E team at the International HIV/AIDS Alliance, Ukraine, in cooperation with UNAIDS, as a first attempt to pull together different sources and documents in programmatic M&E, in order to come up with a single simple and easy-to-follow practical manual targeted at both government and non-government organizations coordinating and / or implementing prevention projects for IDUs, CSWs, MSM, prisoners, and care and support projects for PLHA. This manual will be useful for organization managers, as well as other staff, responsible for planning, implementing, monitoring and evaluating programs in HIV prevention, care and support. It is also meant to assist decision makers at all levels in amending programs and activities in order to better address the challenge of fighting the epidemic. Readers will find this manual a useful tool, regardless at what stage of program implementation they are right now: initial planning, implementation, or reprogramming of activities in accordance with the results achieved at the initial stage of implementation.

This version of the Manual being a working document, the authors would like to kindly ask everybody who would like to contribute to its final version to send their comments and suggestions to Olga Varetska, PM: Programmatic M&E, at the International HIV/AIDS Alliance, Ukraine (varetska@aidsalliance.org.ua) till October 30th, 2006. If you would like to order this Manual once it is finalized and published, please send your request to: ICF "International HIV/AIDS Alliance, Ukraine", 5 Dymytrova St., build 10A, 6th floor, 03680 Kyiv, Ukraine; E-mail: varetska@aidsalliance.org.ua.

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Glossary

Alliance – International HIV/AIDS Alliance, Ukraine

CSW, SW – commercial sex workers

GF, GFATM – Global Fund to to Fight HIV/AIDS, Tuberculosis and Malaria

IDUs – injecting drug users

IPs – implementing partners of funding organizations

M&E – monitoring and evaluation

MSM – men who have sex with men

SyrEx - Syringe Exchange database used by the Alliance sub-grantees working in the sphere of HIV prevention record keeping

SDA – service delivery area

SGS - second generation surveillance for HIV/AIDS

STI – sexually transmitted infections

Toolkit – Monitoring and Evaluation Toolkit for HIV/AIDS, Tuberculosis and Malaria, January 2006, based on a collaboration between WHO, UNAIDS The Global Fund to Fight AIDS, Tuberculosis & Malaria, USAID, US Department of State, OGAC, CDC, UNICEF, MEASURE Evaluation and the World Bank

UNGASS – United Nations General Assembly Special Session on HIV/AIDS

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Chapter I: Before we start: Frequently asked questions on programmatic monitoring and this Manual

Why do organizations need a system of programmatic monitoring?

There are numerous reasons to set up an effective programmatic monitoring system. A list of a number of them follows:

- to systematically track results of individual HIV/AIDS projects; analyze output-level data, reprogram the activities in order to achieve the set goals, and produce reports to funding organizations. If programmatic M&E system is functioning properly, it will help program managers to detect problems in activities implementation and to correct them in a timely manner;
- to set particular goals and objectives at the national level; aggregate results achieved by the numerous players; determine whether the targets were reached; analyze the data and use information for policy-making improvement;
- to identify gaps in nation-wide access to and coverage with services, and attract additional funding to cover them;
- to be able to analyze cost-effectiveness of particular projects and interventions.

What resources are needed to build a programmatic M&E system?

It is recommended that about 5-10 percent of the national program budgets, and around 3-5 percent of regional or district program budgets devoted to HIV/AIDS should be used for M&E activities. Although this might seem as a large fraction to some managers, programmatic M&E is much less expensive than researches and surveillance, nevertheless being a valuable source of data. It is also strongly recommended that there is a designated specialist, or for the large programmes – a team of specialists in the organization, dealing specifically with M&E. Such specialists / teams should be responsible for all M&E activities within organization; their key tasks should be to ensure proper gathering, analysis, usage and dissemination of data. They are also responsible for maintaining M&E databases, if such are used, and producing reports. In small NGOs, the primarily goal of which is to provide services, it is recommend to have one devoted team member, responsible for the implementation of the M&E activities, however programmatic M&E database usage would be a necessary requirement even in this case, as will be discussed later.

Why do we need one national programmatic M&E system?

Programmatic M&E is an integral part of the National M&E system, and according to Three One's principles, countries need One national M&E system for building an effective response to the HIV/AIDS epidemic. According to the Monitoring and Evaluation Toolkit: HIV/AIDS, Tuberculosis, Malaria, "*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 program leaders and managers at each level of the program and health care system; 2) selected quality data can be reported to national leaders; and 3) the national program is able to meet donor and international reporting requirements under a unified global effort to contain the HIV/AIDS pandemic*"[1]. Since programmatic M&E is an integral part of the National M&E system, a single national system of programmatic monitoring is also a necessary element from the Three Ones perspective. Two important questions that need to be answered at this point are: 1) What is meant by a single national programmatic M&E system? and 2) Why is it important for all national players to use the same programmatic M&E system?

Let us start by answering the first question. Having a single national programmatic M&E system basically means that all players at the national, regional or sub-regional level within the country

[1] Monitoring and Evaluation Toolkit: HIV/AIDS, Tuberculosis, Malaria, p.8

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involved in fighting HIV/AIDS are using the same basic instruments, tools and resources for conducting their programmatic M&E that comply with the international requirements. More specifically, this would mean using the same sets of core program-level indicators, data gathering techniques and counting methods throughout the nation. This brings us to the second question of the importance of one single national programmatic M&E system. There are several reasons for this: first of all, from the practical point of view, employing the same methods and techniques for data gathering and analysis allows both national and sub-national players to analyze data over time and between regions / geographical locations; it also allows field-level organizations to economize resources, both financial and human, on the development of a system of programmatic M&E; all they have to do is use previously developed and determined sets of internationally-accepted instruments and guides. And, as was already noted in the introduction, this Manual was created with an aim to summarize these resources and provide an easy to follow list of steps and instruments that would enable national players to employ a common programmatic M&E system. Another reason for creating a single system of programmatic M&E lies in the need of the national authorities in the sphere of HIV/AIDS to "see the full picture" of activities carried out and results achieved at the national level, in order to make timely decisions and reprogram the activities in case if the initially set targets were not met. If different national players are using different sets of indicators, are gathering them with different periodicity, or use different data gathering techniques, this task would become impossible. Moreover, a coordinated M&E system is needed in order to avoid double-counting or other kinds of data misinterpretation when aggregating field-level data at a higher level (please see Box 1 for an example of this).

Box 1
Example: Organization X implements harm reduction project in Katsapetovka, Ukraine. Project is supported by the International HIV/AIDS Alliance, Ukraine within the Global Fund supported Program and reaches 200 clients. Organization Y also implements harm reduction project in Katsapetovka and reaches 150 clients, but the project is supported by the Ministry of Family, Youth and Sport of Ukraine. How many clients do we reach in Katsapetovka through both projects? Are clients intersecting? Without coordinated programmatic M&E system it is impossible to answer these questions.

What is the difference between program and project M&E?[2]

Although this Manual is targeting a wide audience of different level organizations and agencies involved in fighting the epidemic, it is still important to distinguish program and project M&E. For the purposes of this Manual, program refers to an overarching national or sub-national response to the disease, which usually has a relatively long time frame. For example, the National Program for HIV Prevention, Care and Treatment of People Living with HIV/AIDS for years 2004 - 2008 is a program, as well as the 'Overcoming the HIV/AIDS Epidemics in Ukraine' national program supported by the Global Fund to Fight HIV/AIDS, tuberculosis and malaria. Within a national program, there is typically a number of different areas of programming, such as, for example, blood safety, sexually transmitted infection (STI) control, HIV prevention among young people.

On the other hand, project refers to a time-limited set of activities and objectives supported by resources that aim at a specific population defined geographically or otherwise. In view of its wider scope (thematic, geographic, target population), program monitoring tends to be more complex than project monitoring and therefore requires strong coordination among all implementing agencies. However, for the purposes of this Manual, the term 'program monitoring' will be used universally to describe monitoring of programs and projects implemented to fight the HIV/AIDS epidemic, and it is left to the readers to adapt the information to better fit the scale of their interventions.

Why this Manual?

[2] Abstracted from the M&E Toolkit: HIV/AIDS, Tuberculosis and Malaria

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As was already mentioned in the introduction, this manual was created as a first attempt to build a coordinated programmatic M&E system in Ukraine. It would also be useful for other countries' players struggling at building their systems of programmatic M&E, since it builds extensively on internationally-accepted principles and resources, such as Monitoring and Evaluation Toolkit: HIV/AIDS, Tuberculosis, Malaria[3], M&E of HIV Prevention Programmes for Most-At-Risk Populations Guide developed by UNAIDS[4].

Although there are individual organizations that do create and successfully maintain effective programmatic M&E systems for monitoring and evaluating their activities, still, numerous donors, state structures, and NGOs see program/project monitoring just as a tool of accountability to their funding organizations and as a means of producing reports. There is lack of understanding of how program and project M&E data can be used at the national level, and, at the same time, there is an increasing demand within state structures, which scale up HIV/AIDS related funding, as well as within non-government organizations, both in Ukraine and abroad, to have a practical instrument, which would help build an effective programmatic M&E system in coordination with other stakeholders in order to determine whether national / sub-national programs and projects are on track, and, if not, amend performance in a timely manner. In this Manual, the International HIV/AIDS Alliance, Ukraine also tried to accumulate all the experience and best practice examples that we developed through implementation of the GF supported program. As mentioned previously, the Manual uses extensively the concepts of the Monitoring and Evaluation Toolkit: HIV/AIDS, Tuberculosis, Malaria, as well as refers to the M&E of HIV Prevention Programmes for Most-At-Risk Populations Guide developed by UNAIDS (a working document).

Who is it for?

The main target audience for the Manual will be organizations, both government and non-government, which provide funding (state/regional budgetary funding, grants, subventions) to other organizations at the national, regional and local levels, as well as small NGOs, local level government structures and individual projects, which receive funding and face the need of establishing a project monitoring and evaluation system. The list of indicators in the Attachment to this Manual can be used both by programs at national / sub-national level, as well as individual projects. And, as mentioned before, this Manual builds extensively on internationally-accepted principles and resources, thus making it a useful tool for different countries.

How is it different from other M&E books and resources?

While compiling this Manual, we tried not to repeat theoretical M&E knowledge described elsewhere. The Manual is rather a practical handbook, which adds concrete M&E tools (indicators, forms, databases) to theoretical M&E concepts and frameworks. The Manual is written in a user-friendly format with schemes, pictures, examples and practical exercises. Although some basic M&E knowledge is desirable, the Manual will be perfectly understood by non-M&E specialists. Apart from the two sources mentioned above (*Monitoring and Evaluation Toolkit: HIV/AIDS,* Tuberculosis, Malaria and *M&E of HIV Prevention Programmes for Most-At-Risk Populations Guide* developed by UNAIDS), it also contains *Monitoring and Evaluation Methodological Recommendations*, developed by International HIV/AIDS Alliance, Ukraine in 2004. The major difference between the Methodological Recommendations and this Manual is that while the first one provides a comprehensive summary of all different methods and tools used for data gathering, analysis and usage, with detailed description and examples of such, the second proposes a practical list of steps that are required from an organization that desires to build a system of programmatic M&E. It will not provide the reader with all the necessary background information, all possible

[3] Monitoring and Evaluation Toolkit: HIV/AIDS, Tuberculosis, Malaria

[4] This guide to monitoring and evaluating national HIV prevention programmes for Most-At-Risk Populations in low-level and concentrated epidemic settings; with applications for generalized epidemics is a working document for feed-back, the final version of the document is expected to be available in December 2006.

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tools and methods that exist in the sphere; however it will assist in carrying out concrete steps aimed at building the M&E system in a practical and cost-effective manner.

What are some "tips and tricks" of building successful programmatic M&E system? (from the Toolkit)[5]

- M&E systems must be as simple as possible. Most programs and projects collect far more data than they use. The more complex an M&E system, the more likely it will fail. It is important that data is used as a basis for ongoing decision making.
- M&E systems must include a standardized core set of tools to collect and analyze data. If each agency within a country uses different systems or tools, the data cannot be analyzed or summarized effectively. The need for a standardized core set of tools does not preclude individual entities from collecting additional situation-specific M&E data.
- Good M&E requires both internal self-assessment and external verification. Thus, while organizations should collect and verify their own internal data, an external agency, usually represented by the funding organization, should verify the completeness and accuracy of the data collected. Monitoring visits carried out by these external agencies should be based on the analysis of internal self-assessment and externally verified primary data.
- M&E must be built into the design of a program and must be operational when implementation begins, not added later. It is much harder and less effective to "retrofit" M&E after grant implementation is underway.
- Sub national data are important for the national level data collection as they can be aggregated up to this level. However, sub national data are more relevant to program managers in making day to day decisions.
- Data should be made available as widely and transparently as possible, and wherever possible placed in the public domain. M&E is about promoting the use of data.

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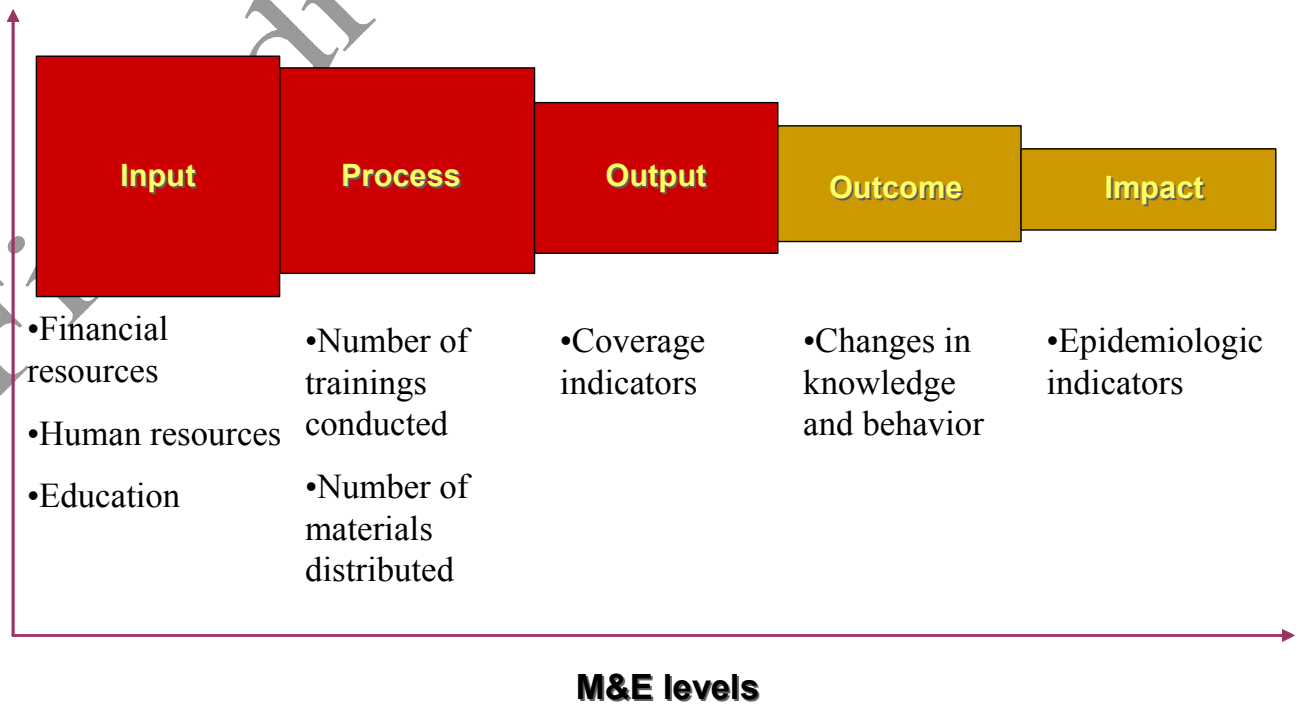
[5] Abstracted from the M&E Toolkit: HIV/AIDS, Tuberculosis and Malaria

Chapter II: Programmatic monitoring as an integral part of the National M&E system

In order to start building a programmatic M&E system, it is first of all important to locate programmatic M&E within the usual pyramid of M&E levels provided in the majority of text books on M&E (diagram 1). Diagram 1 describes all levels at which monitoring and evaluation efforts can take place and provides a logical way of organizing data collection process: at the input level, an organization tracks all inputs and resources that are invested into a certain process, at the process level, the activities implemented are tracked, e.g. counselling sessions provided and materials distributed, or trainings provided, at the output level the organization tracks direct results of the activities carried out at the process level: coverage of vulnerable groups' representatives with services, numbers of students taught, etc. The basic instrument of data collection at these three levels is program record keeping. Apart from this, it is also suggested that organizations conduct evaluation studies, aimed more at measuring the qualitative part of service provision. The later could be carried out by means of analyzing existing program monitoring data, as well as conducting special studies, as will be discussed later.

Outcome and impact levels of monitoring and evaluation in their turn measure the changes in knowledge and behaviour (outcome level) and changes in the epidemic trends (impact level). On the diagram, these two blocks are shaded in a different colour, in order to emphasise the difference between the first three levels of M&E and these two. While at the first three levels data are routinely gathered by means of accurate record keeping at the field level and reported to higher authorities and/or funding entities, outcome and impact levels of M&E data require national behavioural surveys and surveillance activities to be conducted. Thus, in simple words, all organizations working in the sphere of HIV/AIDS at sub-national, regional, district or local levels will be employed in monitoring (and, possibly, evaluation) at the input, process and output level, and only national players will be involved in obtaining outcome level data (conducting behavioural surveys within the general public or among specific groups) and implementing surveillance activities (both routine and sentinel) in order to assess the impact of the activities being carried out on prevalence (within the general population and among vulnerable groups), HIV/AIDS morbidity and mortality. Other possible social and economic impacts of the epidemic also belong to the impact part of the diagram.

Diagram 1. Levels of monitoring and evaluation



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One more important aspect that needs to be underlined at this point is the issue of attributing the achieved results to different projects and programs. While process and output level results could be, in most cases, directly attributed to the specific projects or programs that financed and implemented them, outcome and impact results usually show nation-wide effects of all activities aimed at fighting HIV/AIDS that are being implemented in the country, as well as the natural epidemic trends. Thus, it could quite possibly be the case that output level monitoring and evaluation indicates that the program is on track, the set targets are reached, the quality of services is of an adequate level, while at the same time at the impact level their would be evidence of increased prevalence rates, higher mortality and, as a result, morbidity rates.

Although we will touch slightly on national level surveys and second generation surveillance within this Manual, in general its basic aim is to describe the processes of programmatic M&E carried out by organizations with their own means, and thus the following text will focus basically around the three levels of M&E related to programmatic monitoring and marked red in the diagram: input, process, and output, with most emphasis on process and output monitoring and evaluation.

The following are the key parameters, by which programmatic M&E is different from outcome and impact level evaluations:

- Indicators. While programmatic M&E enables us to obtain data on input, process and output level indicators, outcome and impact level evaluations provide data on outcome and impact level indicators accordingly.
- Frequency of data collection and reporting. While programmatic M&E data should be collected continuously, outcome and impact indicators should be measured less frequently – once in 2 – 5 years.

Table 1. Recommended reporting frequencies for different levels of indicators[6]

Level of indicator	Recommended frequency of reporting
Input/process	Continuously
Output	Quarterly, semi-annually or annually
Outcome	Once in 1 to 3 years
Impact	Once in 2 to 5 years

- Methods of data collection. For programmatic M&E accurate record keeping and reporting by field level service providers is the basic source of data, while for gathering data on outcome and impact indicators special studies are required (behavioural, epidemiological). Please refer to Annex 1 for full description of measurement tools and methods.
- Number of entities, which should conduct data collection, analysis and reporting. While programmatic M&E should be conducted by all entities implementing relevant programs, data on outcome and impact indicators should be collected nationally by specially designated or selected agencies. Since data collection and analysis for outcome and impact indicators require rigorous scientific methodology and is expensive, only few agencies in the country can usually conduct them.
- Costs. Collection and analysis of programmatic M&E data is less expensive than conducting behavioural and epidemiological researches and surveys.

[6] Adopted from the M&E Toolkit: HIV/AIDS, Tuberculosis and Malaria

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Chapter III: Seven steps to establish and maintain an effective programmatic M&E system

This chapter provides an overview of the necessary steps on the way of building and maintaining a system of programmatic M&E. The steps were structured in such a way as to address both the needs of large national or sub-national programs that provide grants / budgetary subventions to their implementing partners, as well as smaller organizations, which are themselves recipients of budgetary or donor funding. Since monitoring of programmes/organizations working with implementing partners / sub-recipients is usually more complex than project monitoring, in that they have to monitor their own activities as well as activities of the organizations they fund, some of the steps would be relevant only for this type of organizations. Smaller organizations and projects would be able to skip those, as will be indicated below.

Step One:	**Define goals, objectives, service delivery areas and activities**
Step Two:	**Select indicators, set targets**
Step Three:	**Select implementing partners, conduct capacity assessment**
Step Four:	**Monitor service quality and quantity, keep program records while implementing activities**
Step Five:	**Develop reporting formats, collect and analyze data**
Step Six:	**Ensure data quality**
Step Seven:	**Translate M&E results into managerial decisions**

Step One: Define goals, objectives, service delivery areas and activities

Programs or projects should have clear defined goals and objectives. This is the starting point of setting up a programmatic M&E system. Unless there is a specific objective of what a program intends to achieve, it is impossible to say whether the right interventions are being implemented and whether the achieved results correspond to the initial intentions or not. Service delivery areas are a necessary part of the structure, since linking indicators to specific service delivery areas would allow comparing output level results achieved at the national level (e.g. IDU coverage) with the progress achieved in terms of impact and behaviour change (e.g. prevalence rates among IDUs) in the future.

Overall Goals are broad and overarching, for example "*reduced HIV-related mortality*", "*reduced transmission of HIV", improved quality of life of people living with HIV/AIDS*".

Objectives need to be clearly described for each goal. An objective describes the intention of the programs for which funding is sought and provides a framework under which services are delivered. Examples of objectives include "*improving survival rates among people with advanced HIV infection in four oblast*", *"to reach 60% coverage with prevention services in two regions*", "*to reduce mother-to-child transmission of HIV in Kyiv"*.

Under each objective, **Service Delivery Areas (SDA)** are specified (a service delivery area corresponds to a specific service that is provided). A broad list of service delivery areas that are not only pertinent to prevention and care and support with examples of indicators can be found in Annex 2.

A program has one or two goals. Each goal has an objective, each objective includes several SDA, and performance within each SDA is monitored and evaluated by means of one or more indicators.

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Example: In Ukraine the National Program, supported by the Global Fund to Fight HIV/AIDS, tuberculosis and malaria and Implemented by the International HIV/AIDS Alliance, Ukraine, as the PR of the grant, has the following goal and objectives:

Goal: The HIV prevalence, HIV-infection morbidity and AIDS mortality in Ukraine is reduced

Programme Objective: Country response to HIV/AIDS epidemic is strengthened

Specific Component objectives:

1. Complementary HIV/AIDS treatment is scaled up, needed health products are procured and supplied
2. Vulnerable groups have increased access to the good quality services and information on prevention, care and support at the community level
3. Creation of enabling environment through information, education and advocacy is facilitated
4. Improvements in the national surveillance and evaluation system are supported

Step Two: Select indicators, set targets.

The following guiding principles help in choosing the most appropriate set of indicators and associated data collection instruments:

● Ensure that the indicators are linked to the goals and objectives, and that they are able to measure change over the program time period.

● The set of chosen indicators should be representative of the proportion of funds spent for this or that activity. The simple rule of the thumb would be as follows: if about 30% of the total budget is spent for prevention among vulnerable groups, and 70% - for general prevention, the split of indicators between the two objectives should be similar. However, this does not always work. For example, if 30% of the total organization's budget is spent on prevention work among IDUs, and 70% - on prevention work among CSWs, this does not necessarily mean that the number of indicators should be split accordingly. Rather, the higher targets related to CSW coverage in comparison to IDU coverage would indicate that the majority of efforts of the given project are aimed at CSWs.

● Ensure that standard indicators are used to the extent possible for comparability over time or between population groups. In the attached ***Selected Indicators*** you can find a list of recommended core output level indicators, with indicator descriptions, suggested measurement tools and periodicity of data collection. This list was developed on the basis of internationally-accepted indicators, as outlined in the M&E Toolkit: HIV/AIDS, Tuberculosis and Malaria, with some 'country-specific' indicators, added by the authors on the basis of their experience in programmatic M&E. Outcome, impact and partially output indicators , should be taken from the UNGASS list of core indicators for countries with concentrated epidemics. In Ukraine the List of national indicators (Annex 3) should be used for this purpose, since these indicators were tested, approved, and have baseline values.

● Ensure that indicators relate to defined services which are delivered by the program. Attempt to define the standard package of services provided by the program and the groups targeted.

● Consider the cost and feasibility of data collection and analysis. Ensure a good balance between periodic surveys and data obtained by means of routine record-keeping. Surveys can complement information gaps in routine statistics, in particular for outcome and impact indicators. However, surveys generally do not provide results as regularly as routine systems and are more costly. Moreover, survey results are usually subject to selection bias, as will be discussed later on. Thus, in this Manual it is recommended that programs and projects do not use surveys for the purposes of obtaining output level data, but rather enhance their record-keeping procedures.

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● Take into account the stage of the epidemic. In the context of a concentrated epidemic, more services should be aimed at targeting most-at-risk populations, and, as a result, indicators should also reflect this tendency.

● Set a baseline for each core indicator. The difference between core and additional indicators will be described further.

● **Keep the number of indicators to the minimum needed**, with specific reference to the level of the system that requires and will use indicators to make programming and management decisions.

Additional indicators can always be identified later or may be collected simply for project management purposes (without reporting them further). In terms of aggregating purposes, a small nationally-accepted set of indicators which are standard and comparable internationally is recommended (please see attached ***Selected Indicators*** for a list of suggested core indicators). Those indicators from the list that correspond to the activities that are planned within the program or project to be implemented, will constitute your **core** indicators. You might find that this list does not address all your needs in data gathering; in this case we suggest using some additional indicators from the existing M&E guides (the Toolkit, the UNAIDS working document previously referred to), or, if they also do not fully address you needs, develop additional indicators, but of a limited quantity and to be used mostly for management purposes. All other indicators, apart from the core ones, that are added to better reflect the needs of you program, are called **additional** indicators.

Different levels of indicators

As was already mentioned, all indicators could be assigned to a certain level (please refer to diagram 1 for M&E levels). The following table depicts examples of different level indicators:

Indicator levels:	Input	Process	Output	Outcome	Impact
Examples of indicators	Number of staff members hired; Number of service delivery points established; Number of condoms procured; Number of trainings conducted for service deliverers; Number of service deliverers trained; Etc	Number of trainings conducted for vulnerable groups' representatives; Number of syringes distributed; Number of information materials distributed; Number of condoms distributed; Etc.	Number of IDUs reached with prevention services; Number of sex workers reached with prevention services; Number of MSM reached with prevention services; Number of prisoners reached with prevention services; Number of PLHA reached with care and support	Percentage of MARPs, who both correctly identify ways of preventing the sexual transmission of HIV and who reject major misconceptions about HIV transmission; Percentage of injecting drug users who have adopted behaviors that reduce transmission of HIV; Percentage of sex workers, who reported the use of a condom with their most recent client;	HIV prevalence according to surveillance data among injecting drug users; HIV prevalence among sex workers; HIV prevalence among men having sex with men; Etc.

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			services; Etc.	Etc.	

Although examples of outcome and impact indicators relevant to the sphere of prevention and care and support are also provided in the table, please keep in mind that the data for those are obtained through national level behavioural and epidemiologic surveys. The wording of outcome and impact indicators comes directly from the list of Ukrainian National Indicators On Monitoring and Evaluation of Efficiency of Activities to Control HIV/AIDS Epidemic (Annex 3), which is in its turn based on the UNAIDS list of recommended indicators for countries with a concentrated epidemic.

While organizations might choose to gather data at all levels of M&E for internal purposes, for programmatic reporting they usually do not need to capture the initial stages of the framework, e.g. input level of indicators (e.g. numbers of disposables procured, numbers of service deliverers trained, etc.), but do need to focus more on the process and, mainly, outputs of services delivered with a major focus on coverage indicators.

Coverage indicators

Coverage indicators are a special focus of the Manual. We strongly encourage all government and non-government organizations working in the sphere of service provision to vulnerable population groups to gather data and report on coverage of the groups they work with. Coverage is the most important output indicator; obtaining and aggregating data from all national players on coverage of most-at-risk-population groups would result in a national level absolute number and percentage of IDUs, SWs and other groups reached with services. Without this information it is almost impossible to plan an effective response to HIV/AIDS epidemic in the country, determine the necessary resources and implement prevention activities.

According to the Toolkit, three levels of coverage indicators are distinguished:

Level one: Number of people trained (in prevention, care and support, etc.)

Level two: Number of service points established (number of syringe exchange points operating, number of care and support projects established; etc.)

Level three: Number of people reached with services (covered by prevention programs, receiving care and support services, etc).

As the programs establish, indicators should shift from numbers of people trained and service delivery points established to numbers of people reached.

For the purposes of this Manual, we will mostly focus at level three indicators (***number of people reached***). On the one hand, these indicators are most difficult to measure, they are usually the most challenging ones for program managers to plan and collect data on; on the other hand, those are the indicators that usually mostly interest the funding agencies; and they are the ones that contribute to obtaining the national level picture of coverage. Thus, when speaking about coverage indicators in the Manual, we will be basically speaking about numbers (and percentage) of people reached. Indicators #1.1 – 1.4, 2.1, 2.2 in the attached ***Selected Indicators*** are examples of core coverage indicators.

Defining coverage

The concept of coverage is a key one in public health and programme management. Achieving certain levels of coverage is an intermediate step before changing behaviour and impacting the epidemic. It can essentially be defined as the number of people who receive a service expressed as a percentage of those who need the service. Thus for coverage calculations, the number of people receiving the service is the 'numerator' and those needing the service is the 'denominator'.

Numerator definition

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In order to define level 3 coverage indicators, it is important first to determine people who received a service or, in other word, 'were reached'. In order to measure people reached, it is essential that unique individuals can be identified[7][8]. This may be difficult when services are provided anonymously, e.g. hotlines, some VCT services; when numbers reached are very large, e.g. mass youth events; and when confidentiality considerations preclude the collection and storage of personal data, e.g. many programmes with IDUs and sex workers. Although the latter issue can be largely overcome by the use of identifying codes, as will be discussed later, in situations where unique individuals can not be identified, programme activity can be measured in terms of 'contacts' or 'person times'. However, true coverage calculations are not possible under such circumstances.

Secondly, there is need to define what services a person needs to receive in order to be considered being covered. Definitions for suggested core indicators (#1.1 – 1.4, 2.1, 2.2 in the attached ***Selected Indicators***) outline commonly used worldwide composition of the '**package of services**' that should be given by a social worker to a vulnerable group representative, in order for the later to be considered reached. Minimal exposure to services which would be extremely unlikely to have any significant effect on a person should not be counted as people covered[9].

Thirdly, people reached, or clients may be defined in a number of different ways:

1. *Cumulative number of clients* – People who received a service at least once during the entire period of time, since the counting began (e.g. since the beginning of the project). In other word, cumulative means that data from previous periods is included. Data from ongoing and one-off services are cumulated slightly differently. For example, if 100 people receive VCT this quarter and previously the cumulated total was 1100, the new cumulative total is 1200. However, for ART, if 100 people receive ART this quarter and the previously cumulated total was 90, the new cumulative total is 100. Thus, for prevention and care and support projects, the cumulative number of clients is simply obtained by adding 'new clients', that is people who received services for the first time during the reporting period, to the cumulative number of people reached by the beginning of the same reporting period. When using cumulative figures, it is important to specify if figures include or exclude baselines (baseline values that were reached by the time the project started its activities / began counting against a particular indicator). An electronic database is not required for obtaining cumulative numbers of people reached; however, accurate record keeping and a coding system that enables to identify truly 'new' individuals are required;
2. *Current clients* – People who receive services at least once during a specified period. If numbers of clients are considerable, an electronic database would be needed to gather data on this indicator (please see more on this in Step 4).
3. *Regular client* - People who receive services at a specified frequency. An electronic database would be needed to gather data on this indicator (please see more on this in Step 4).

It is basically left to the discretion of funding organizations or field level projects themselves, which way to count 'people reached'. Some would choose to use several methods at the same time in order to see all the different dimensions of coverage: for example, number of people reached during a certain time period does not give any clue as to how many people use project services with a certain periodicity and could be considered to be 'regular client', and how many came just once. However, for the purposes of this Manual, we suggest programs and projects to count people who received services ***at least once during the last 12 months*** (please see #1.1 – 1.4, 2.1, 2.2 in the attached ***Selected Indicators*** for specific definitions). The choice of this time period is again based on internationally accepted practices: both the Toolkit and the UNAIDS list of core indicators for

[7] This is needed in order to be able to distinguish between one person attending twice and two people attending once.
[8] For small numbers of clients, e.g. children with HIV, these may be known individually by project staff. However, in most cases, this will require some form of documentation.
[9] Examples include glancing at a poster, hearing a radio broadcast and being given a brochure

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concentrated epidemics, suggest using this time frame for reporting on key coverage indicators. Again, for the purposes of internal data collection, organizations can use several alternative ways of counting numbers of people reached; however, they need to make sure they clearly identify the selected method in the indicator definition (or add an explanation to it), so that it is clear to both, field level services providers and funding organizations, what exactly is being meant under each indicator.

Denominator levels

It is suggested that countries make a separate effort to estimate the population sizes for major vulnerable groups that are, according to the sentinel surveillance data, the major driving force of the epidemic. Obtaining such data would enable calculation of national coverage at a certain point in time; allow target setting in order to achieve certain levels of coverage in the future and tracking performance in accordance to these targets. Particular methods of estimating key population sizes are provided in the ***M&E of HIV Prevention Programmes for Most-At-Risk Populations Guide*** developed by UNAIDS (a working document),

New data is now available on estimated size of vulnerable populations in Ukraine (Alliance, 2005h; UISR et al., 2005). This puts population sizes as:

- IDUs – 325 000 to 425 000
- Sex workers - 110 000 to 250 000
- MSM – 177 000 to 430 000

These figures are currently used for setting the baseline and target values for key output indicators at the national level. Figures are also available at the oblast level (Alliance, 2005e/f).

Example of coverage calculation: In the city A, the total estimated number of IDUs is 580. Number of IDUs, which use prevention services is 120. Coverage of IDUs in the city A is therefore: 120:580 x 100% = 21%

Coverage of IDUs in Ukraine as of July 1, 2006

- Covered with services (cumulatively) – **91 974**
- Estimated number of IDU in the country - **325 000 – 425 000**
- Percentage of IDU covered – **22 – 23%**

After indicators are selected, **targets** need to be set for them. Simply tracking the achieved results of projects and programs is not enough; targets are needed in order to monitoring with time whether the programs are on track and whether, as a result, the set objectives will be achieved. The periods, for which targets are set, depend on the regularity with which data on each particular indicator is gathered. That is, it is possible that targets for different indicators are set with different periodicity. The actual procedure of target setting is more an art than a science, thus no specific rules are provided on this. However, since, as previously discussed, coverage indicators are the main focus, it is suggested to start by setting targets for those. For example, for harm reduction activities among injecting drug users, it has been estimated that reaching at least 60% of IDU population is necessary in order to impact the epidemic within this target group *(M&E of HIV Prevention Programmes for Most-At-Risk Populations, UNAIDS)*. Thus, it is suggested that target setting is carried out in such a way as to reach 60% level of coverage within a particular geographical area. The targets for all other related indicators could be set on the basis of the targets for coverage: e.g. if a project plans to reach a set number of IDUs that would constitute 60% of the estimated IDU population size, the numbers of condoms and syringes to be distributed should be planned accordingly, assuming that every individual receives X condoms/syringes per week/month. Obviously, for the purposes of setting targets for coverage indicators, it is of primary importance to obtain data on the estimated number of key population group's representatives in a given area / site where the organization or its implementing partners work.

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Step Three: Select implementing partners, conduct capacity assessment

As mentioned before, this section is irrelevant for field level organizations that directly provide services and do not fund activities carried out by other organizations. It will be relevant for those organizations that select implementing partners (IPs) for implementing particular sets of activities.

Selection of implementing partners, is an important and complex process, which includes a number of programmatic and financial procedures. Apart from competitive selection of implementing partners on an open and transparent basis, an important part of IPs selection process is their capacity assessment – financial and M&E. This assessment could be carried out before provision of funding, then its positive result could be a prerequisite for funding the IP, or it can be also conducted separately, if needed. The suggested questions for the M&E capacity assessment are in the following table.

Table 2 Monitoring and Evaluation Capacity Assessment Form

Monitoring and Evaluation Policies and Procedures						
			Control documents	Weight (1-5)	Score (1-6)	Total (weight*score)
1		**Dedicated officer and/or programme staff with adequate experience responsible for project monitoring and evaluation**	Job descriptions, resume of M&E specialists, project proposals	**5**		
2		**Experience in regular reporting on project results and accomplishments**	Last quarterly reports	**3**		
3		**Past experience in monitoring and evaluation:**	3.1 – 3.2	**3**		
	3.1	Past experience in periodical monitoring of project performance	M&E plan, donor requirements to reporting			
	2.2	Use of standard indicators in periodical monitoring of project performance	List of indicators			
4		**Monitoring tools used:**	4.1 – 4.4	**3**		
	4.1	Periodical reports on project performance and activities	Last quarterly reports			
	4.2	Databases	Demonstration of databases			
	4.3	Periodical publications, bulletins, electronic lists	Demonstration of materials			
	4.4	Current monitoring forms and approved documents	Demonstration of forms			**Total**

Evaluation of the total score:

70 – 84	Exceeds expectations
56 – 69	Fully satisfies requirements
42 – 55	Minimal risks

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28 – 41	Manageable risks
14 – 27	High risks, potential exists
0 – 13	High risk, no potential

If the M&E capacity assessment determines that a particular organization does not comply with the monitoring and reporting requirements, a decision could be made to either assist the organization in building its M&E capacity or not to fund the particular potential IP altogether.

Step Four: Monitor service quantity and quality; keep program records while implementing activities

As soon as organizations start implementing certain types of activities, it is important to monitor quality and quantity of services they provide. Program monitoring is usually carried out both by the organization that itself implements activities, and by the funding organization. There are two components of program monitoring: qualitative and quantitative. In general, application and adherence to service quality standards, as well as the use of the monitoring visits instrument to check how the standards are adhered to constitute the basis of monitoring service quality. The main source of information for monitoring service quantity is data obtained from day-to-day program records, which are periodically aggregated into reports (quarterly, semi-annual and/or annual) and checked during monitoring visits for consistency against the reported figures. It is expected that organizations' managers regularly analyze program data against the targets, make conclusions and improve their projects implementation. Usual recording documents include card of client, journals of social workers, lists of training participants, lists of distributed materials, books, etc.

Although the organizations usually themselves decide what type of registration documents they need, it is suggested that the following paper-based documentation would be useful: (i) registration log-book that contains the list of all clients of the project and their basic details, new individuals are added to the log-book once they become project clients; (ii) daily record-keeping journals that contain the list of all clients who obtained project services during a specific day; these should be usually filled in by social workers of the program directly at the points of service provision, right during the contact with the client; at the end of the day or once a week the data entered into daily journals are aggregated and entered into an electronic database, if used; (iii) it is also suggested that project clients receive a "membership card", which states that the person is a client of a particular project, and contains his/her personal code on it; for confidentiality purposes, the client's name is not shown on the card.

Thus, prevention and care and support projects need to use a coding system in order to keep track of the number of people reached and identify individual clients (instead of simply counting visits to the points of service provision). The coding system may vary from organization to organization depending on the individual organization's practices and other factors. However, the coding system needs to be based on the following principles:

- One person should be assigned a single code regardless of the points of service provision at which he/she receives the services;
- The code has to comply with the principles of anonymity; however, it should be based on the client's personal information in order to be easily restored in case if the client looses his / her card. For example: code IPS120178 is based on the following information: Ivanov Petr Sergeevich, born on January 12, 1978.

If it is possible to implement a single coding system within a particular geographical area, or, best of all, within a country, it would enable to avoid double-counting when aggregating nationwide data on numbers of people reached with services, as will be discussed in the next section.

Avoiding 'double counting'

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When recording and reporting data, it is important to avoid counting the same data twice.

In order to avoid counting the same person more than once, in the case of loss of card, social workers should try to restore the code under which the person was previously registered (usage of coding systems that are based on personal information of the client is very useful for this purpose; otherwise the code is reconstructed according to the daily records, on the basis of approximate dates of previous visits and other relevant information).

In order to avoid registration of the same person at two different points of service provision / two different organizations, during the first contact the social worker should ask the client whether he/she was previously registered with any organization working in the sphere of HIV-prevention / care and support. If the answer to this question is positive, the person is registered under the code that was provided to him/her previously (and when personal data are entered into the MySQL database discussed further, a separate checkbox titled "previously received services at another organization" is checked in this case by the project employees).

However, there are a number of instances where apparent 'double counting' may be almost inevitable or where avoiding 'double counting' may create a misleading impression. A few relevant examples are included here:

- In some situations, an individual is a member of two vulnerable populations, for example, where a woman is both a sex worker and injects drugs. Current practice is to avoid 'double counting' by counting such individuals as sex workers reached, if they are served by organizations whose main target audience is SWs, and as an IDU, if it is a project aimed at IDUs (in Ukraine those two types of projects are usually separate; in other countries where this is not the case, this approach might not work and double counting will be occur)
- When training in one topic, the service provider is expected to identify people who have received training more than once and only count them as one person. On the other hand, if the same person is trained in HIV prevention and in capacity building, they are recorded as two people in both settings (for this to be true, two separate indicators should be used for people trained in prevention and in capacity building; the same person should not be counted more than once under the same indicator)
- *In the same organisation*, particularly where different services are provided to members of the same population, e.g. peer counselling and material support for PLWHA. This can be avoided in a number of different ways and is essentially the responsibility of the NGO in question. If the number of people receiving services is small, this can probably be achieved based on personal knowledge of staff. If the number is larger, some kind of record system may be required, ultimately perhaps requiring some sort of electronic database. In this case efforts should be made to avoid double counting
- *Between different organisations*, this is particularly likely to occur when more than one organisation is providing the same or related services to the same vulnerable population; where different services are provided to overlapping vulnerable populations; or when populations are highly mobile. It is unlikely that double counting can fully be eliminated in these circumstances[10].
- *Between 'unrelated' services,* for example PLWHA receiving ART and those receiving other forms of support. It is probably not necessary or desirable to seek to avoid 'double counting' under these circumstances
- *When services are provided in different time periods*, for example if someone receives initial services one year and then maybe only returns again after a long period, say 2 years. In this situation, there is a possibility that the person may be counted as a new client and counted

[10] Without introducing a national coding system and shared database which is unlikely to be justified if this is the sole purpose of doing so. Even if such systems are introduced, double counting would occur if someone gave incorrect, code-critical personal information

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twice. Avoiding double counting in these situations relies on clients to provide accurate and honest information and for organizations to have good records of services provided. However, if a client provided inaccurate or untrue identifying information, it will be virtually impossible to avoid double counting

"SyrEx" – database for registration of clients of focused prevention projects.

"SyrEx" database was developed by International HIV/AIDS Alliance Ukraine with financial support of the Global Fund to fight HIV/AIDS, TB and Malaria in the framework of National Program "Overcoming the HIV/AIDS epidemic in Ukraine".

"SyrEx" provides a user-friendly instrument for tracking numbers of clients reached by focused prevention services as well as the regularity of services provided to them. "SyrEx" database was developed primarily for harm reduction projects working with IDUs and CSWs. However, it can also be effectively used by projects working with MSM and those, which provide prevention services in penitentiary institutions.

The key requirement for effective "SyrEx" utilization is well-functioning clients coding system. Because the issue of confidentiality is rather sensitive for target groups, they can not be registered using names, last names and passport data. Good solution to this problem is clients coding, when an individual is given a card with a code on it, which will be further used as ID information for this individual. Besides this, another important element of effective registration system is accurate and timely completion of daily registration forms directly at service provision points.

"SyrEx" basic functions:

- Clients registration:
    - Once an individual becomes a project client, a new data entry is added to the *list of clients*, which contains information about the person (code, date of birth, target group, sex, social status, injecting and sexual practices, etc.). Besides that, it's preferable to indicate whether a person is a secondary exchange client, and whether s/he had ever been a client of another organization.
- Adding organization-specific data:
    - Each database user (organization) has their own list of materials and other expendables, which are distributed among clients. Database provides the possibility to compile this list, which is used to track distribution of materials among clients (how many items of material "X" were given to client "Y" and when);
    - The unique list of social workers and service provision points is compiled in order to track the work of each point and staff, which provides services;
    - The database also provides the possibility to add the list of typical training modules conducted by the organization, which is used for tracking trainings.
- Keep track of daily records:
    - The social workers are filling daily records at service delivery points. Generally, they contain information on the number of materials given out, consultations provided, etc. to each client (i.e. code) visiting the point during certain day;
    - These daily records are regularly copied to the database (transferred from paper-based to electronic form).
- Compilation of reports (see below further details);
- Database back-up and restoring (necessary function, as PC work is very unstable and data might be lost);
- Data transfer and consolidated analysis:

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- The database provides the possibility to transfer data to the "central unit" (upper level);
- At the "central" (upper) level all data-files can be consolidated and analyzed in order to see the general picture over several (all) organization of "regional" (lower) level.

Compilation of reports:

The database provides the possibility to analyze data in different ways and different levels, namely:

- Extract the cumulative number of clients reached starting certain time point (i.e. project start) with basic information on each client (number of visits, age, target group, etc.);
- Extract the list (number) of people reached during the previous 12 months (corresponds to suggested core indicators #1.1 – 1.4, 2.1, 2.2 in the attached ***Selected Indicators***);
- Extract the list (number) of people reached during any user-defined time period (day / week / month / quarter /…);
- Extract the list (number) of regular clients of the program (according to preset criterion);
- Extract general information on the number of materials and provided consultations during the user-defined time period;
- Analyze data on visits regularity during a certain time-period;
- Extract all above mentioned data either for the whole organization or for user-defined list of service provision points (one or several);
- Extract information on the number of trainings conducted and people trained, split by training modules and target groups.

"SyrEx" additional functions:

- Enter and update regional epidemiological information;
- Design and analysis of polls (questionnaire design, responses entry, analysis of results).

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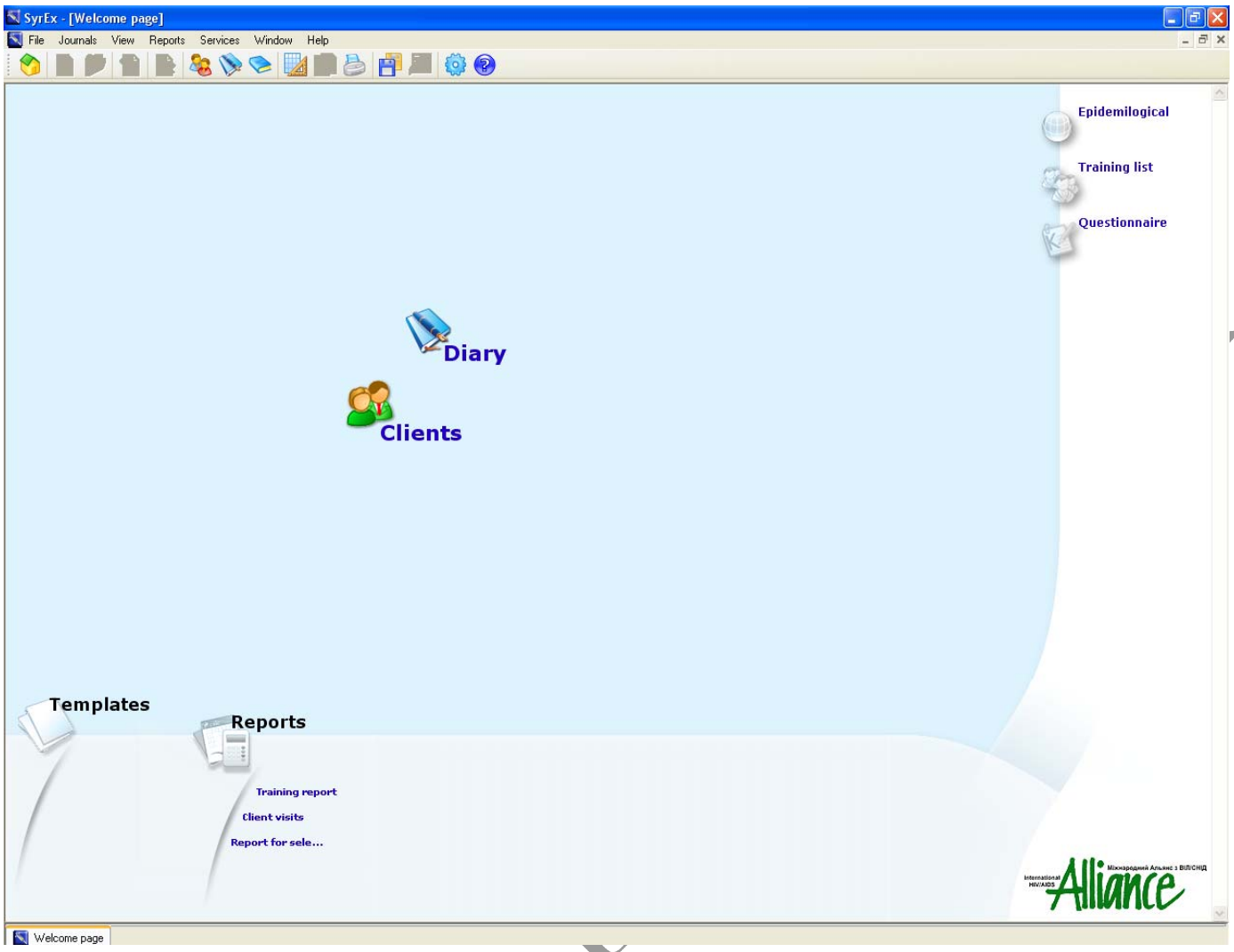

Pic. 1 Main page of the SyrEx database

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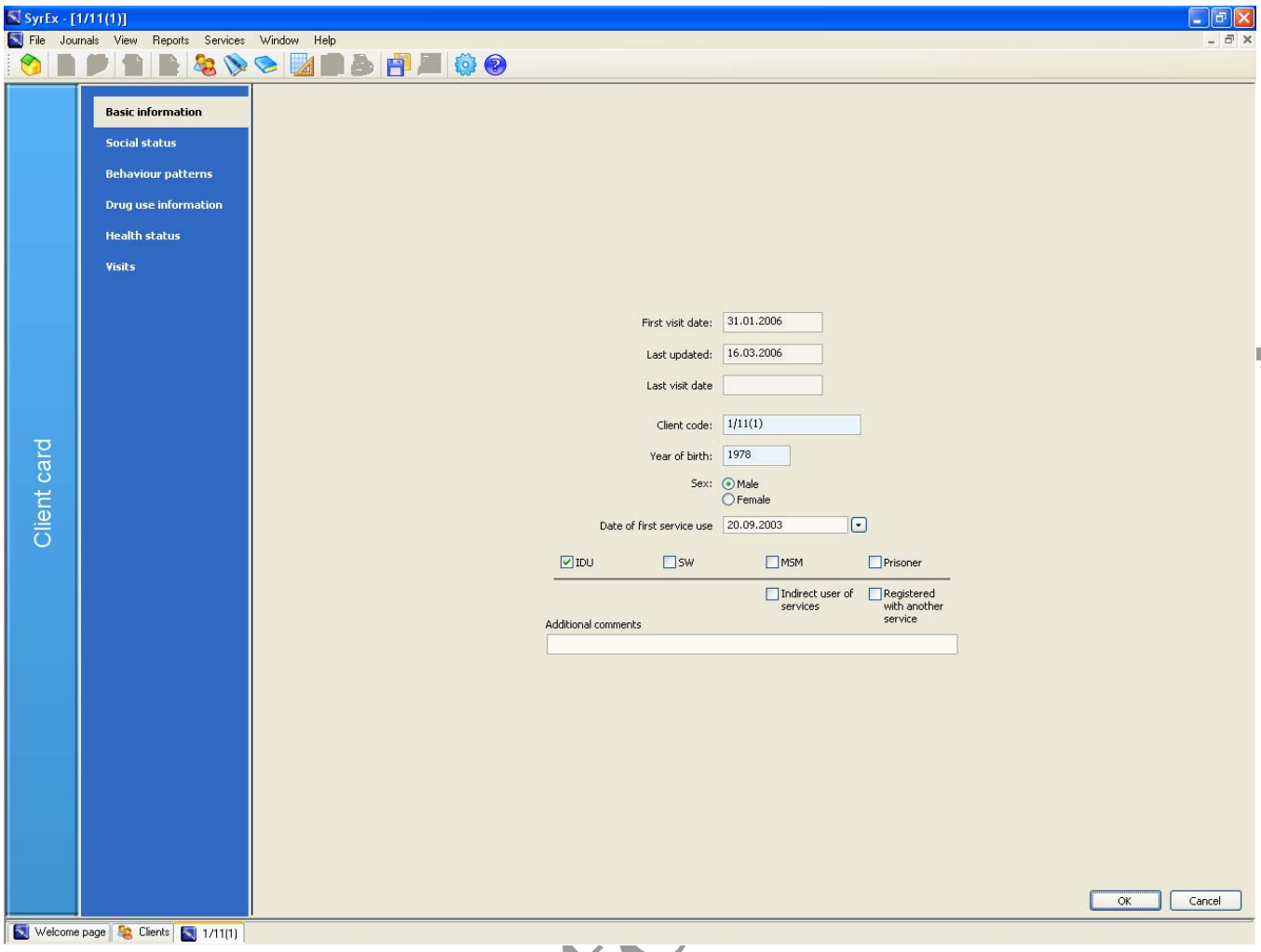

Pic. 2 Client profile. Basic information

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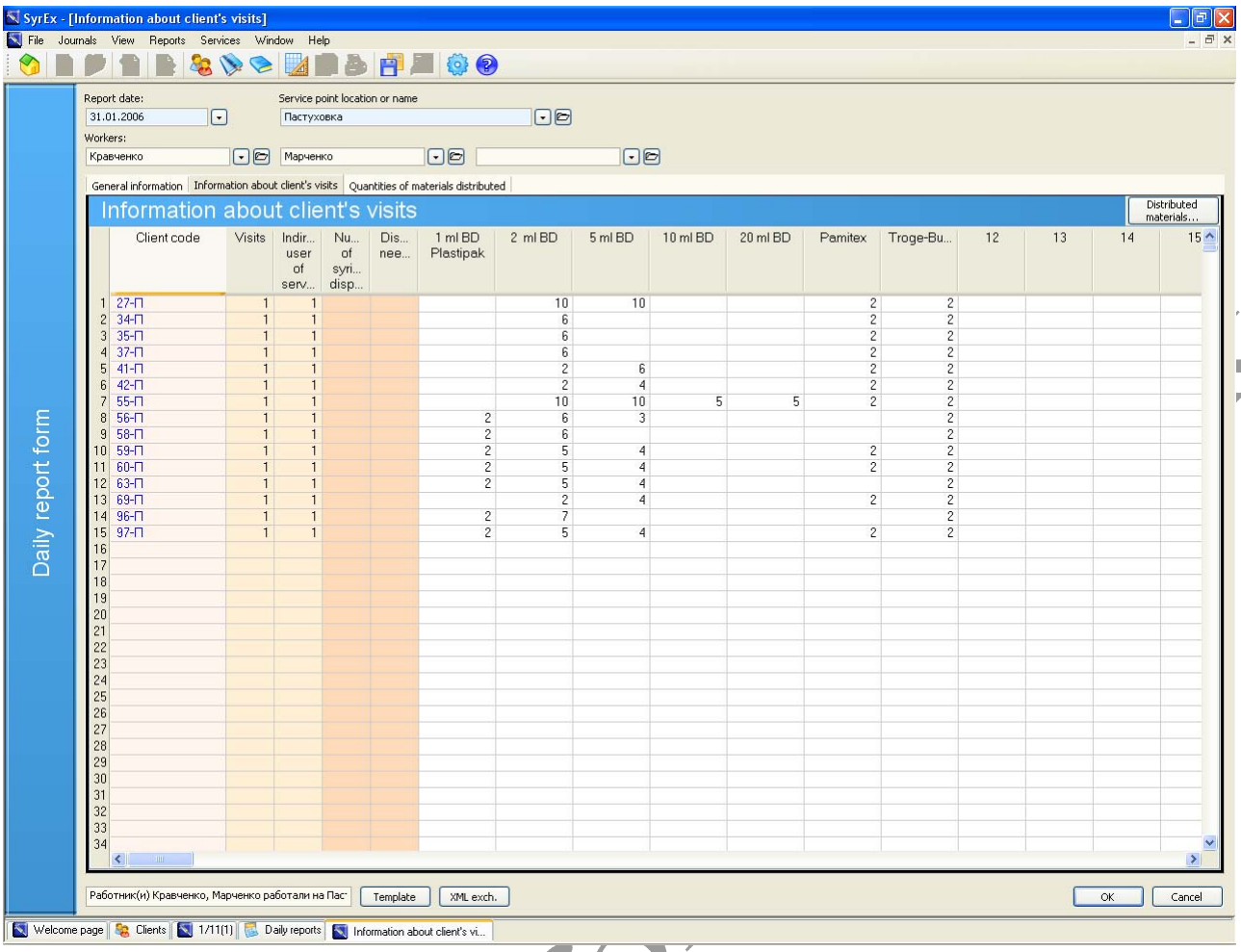

Pic. 3 Daily registration form

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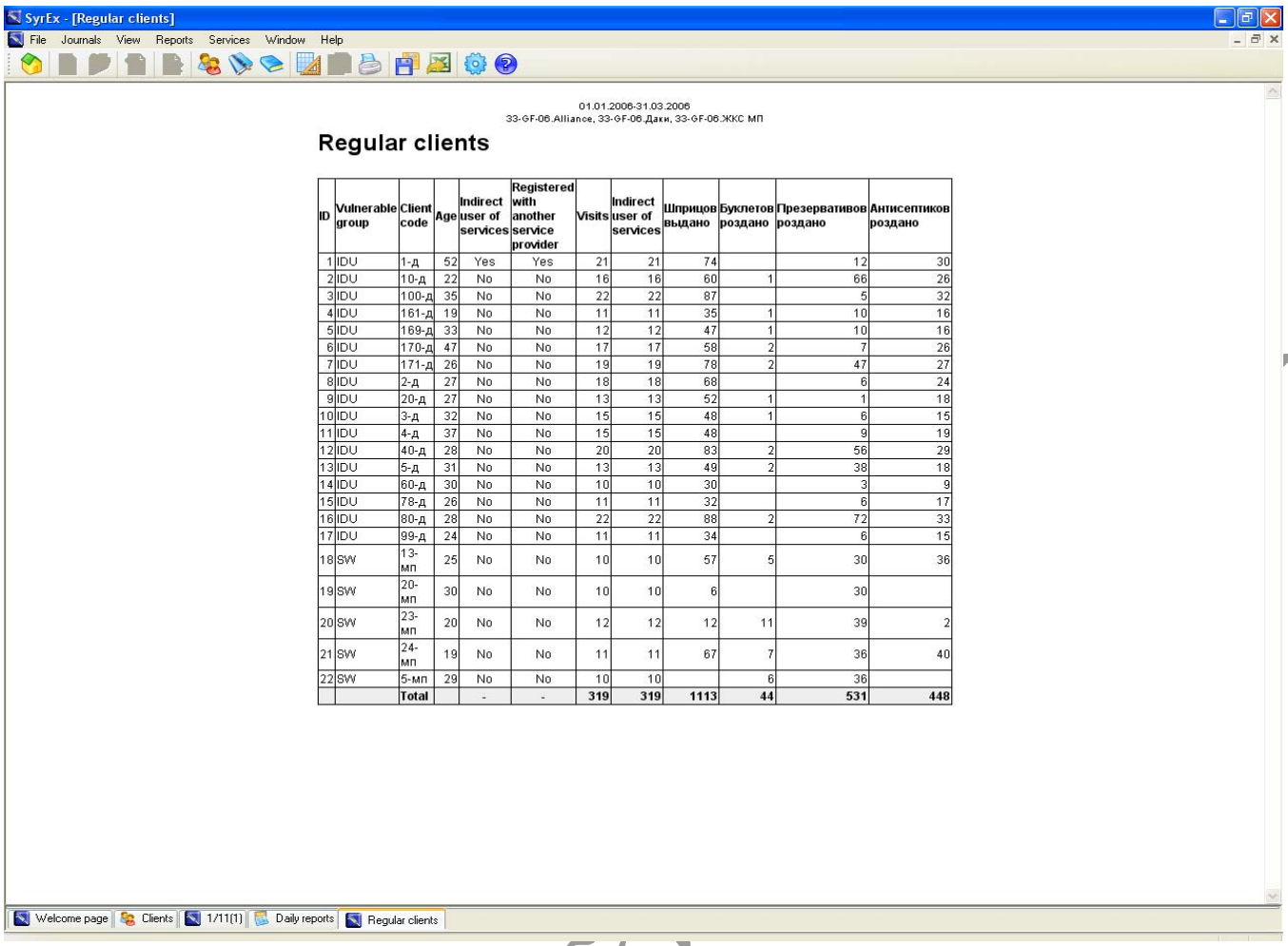

ID	Vulnerable group	Client code	Age	Indirect user of services	Registered with another service provider	Visits	Indirect user of services	Шприцов выдано	Буклетов роздано	Презервативов роздано	Антисептиков роздано
1	IDU	1-д	52	Yes	Yes	21	21	74		12	30
2	IDU	10-д	22	No	No	16	16	60	1	66	26
3	IDU	100-д	35	No	No	22	22	87		5	32
4	IDU	161-д	19	No	No	11	11	35	1	10	16
5	IDU	169-д	33	No	No	12	12	47	1	10	16
6	IDU	170-д	47	No	No	17	17	58	2	7	26
7	IDU	171-д	26	No	No	19	19	78	2	47	27
8	IDU	2-д	27	No	No	18	18	68		6	24
9	IDU	20-д	27	No	No	13	13	52	1	1	18
10	IDU	3-д	32	No	No	15	15	48	1	6	15
11	IDU	4-д	37	No	No	15	15	48		9	19
12	IDU	40-д	28	No	No	20	20	83	2	56	29
13	IDU	5-д	31	No	No	13	13	49	2	38	18
14	IDU	60-д	30	No	No	10	10	30		3	9
15	IDU	78-д	26	No	No	11	11	32		6	17
16	IDU	80-д	28	No	No	22	22	88	2	72	33
17	IDU	99-д	24	No	No	11	11	34		6	15
18	SW	13-мп	25	No	No	10	10	57	5	30	36
19	SW	20-мп	30	No	No	10	10	6		30	
20	SW	23-мп	20	No	No	12	12	12	11	39	2
21	SW	24-мп	19	No	No	11	11	67	7	36	40
22	SW	5-мп	29	No	No	10	10		6	36	
		Total		-	-	**319**	**319**	**1113**	**44**	**531**	**448**

Pic. 4 Regular clients report

Ensuring Quality Services[11]

The quality of activities and services being implemented is crucial to achieve desired results. If interventions being implemented are of poor quality, the results of the activities will not be optimal even if the intervention was able to attain high coverage. Thus, it is important to monitor the quality of activities and services to ensure effective progress.

Quality standards

Quality assurance standards constitute the basic instrument of monitoring performance in a particular service delivery area. These standards can be considered as analogous to indicators, but they often also include a target element, either implicitly or explicitly, within them. Standards may include quantitative aspects but often have a strong focus on quality, hence the term quality standards. Minimum acceptable standards are often used, also referred to as benchmarks.

How can standards be set?

First, the areas in which standards are required need to be identified. For a programme, this is likely to include all major areas in which services are provided. It may be advisable to start with services where there are known or suspected to be problems with the quality of services provided.

Secondly, look at the existing standards in the sphere. The ideal situation would be that there are national standards for all services being delivered by a programme and these could be used as the basis for programme standards. Unfortunately, such standards are often absent. In such settings, a

[11] Abstracted from the M&E Toolkit: HIV/AIDS, Tuberculosis and Malaria

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programme might adopt international standards (WHO or EU), if available and suitable, might modify these for its own setting, or might need to develop its own programme standards.

If a programme has to set performance standards for all or some of its services, it might start by considering the availability of international and national standards for that service. This should then be supplemented by consulting users and providers of services regarding what they consider a good quality service. For example, a simple consultation with a group of people attending a drug rehabilitation centre revealed that they considered that a rehabilitation centre to be good if it:

- Had sufficient scheduled activities to fill each day
- Included a programme of physical activity, such as sport
- Had well-trained, well-qualified, professional staff
- Had literature available
- Respected people's views and did not impose their own views
- Did not seek to convert people to a particular religion

These criteria could be used as the basis for further consultation with other groups of service providers and users with the aim of expanding this to a list of service standards and quality assessment tools.

How can standards be used?

The overarching aim of having service standards is to improve the quality of services provided. For this purpose, first, service providers should be trained to deliver services according to these standards. Second, standards should be used as appraisal criteria for monitoring activities, such as site visits, user surveys etc.

In the area of medical treatment, official standards do exist in the form of protocols. However in the spheres of HIV/AIDS prevention, care and support, Ukraine at present is still at a very initial stage of defining and implementing service quality standards.

Step Five: Ensuring the reporting process (developing reporting forms, collecting and analyzing reports)

Reporting is one of the most important stages of programmatic M&E. It is usually regulated by organization's policies and procedures or set forth as funding organization's requirements.

The reporting forms usually have several sections that enable the reporting organizations to provide detailed information about their performance. These usually include: a quantitative section with a list of indicators with set targets and cells to be filled in with actual results against these targets, and a narrative part, where the reporting organizations verbally describe all results achieved during the reporting period, their successes and failures.

When designing the format of the reporting form to be used by implementing partners of your organization, it is of primary importance to take to factors into account:

- The requirements of the funding organization / entities, to which you have to report in your turn. If the data that you receive from your IPs does not allow you to easily report to your funding organization and you have to request additional information every reporting period, than probably the reporting format (or list of indicators on which the IPs have to report) were not developed right.
- The data that your organization needs in order to make optimal managerial decisions. For example, if your organization needs to know how many syringes were distributed during the reporting period by your IPs in order to make an adequate decision on next periods' funding, this indicator needs to be included into the reporting form.

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As noted previously, individual organizations mostly report on output level indicators. In order to ensure consistency and comparability of data provided and in order to minimize the number of errors, it is suggested that all implementing partners of the funding organization submit their reports using the same format. Program reporting usually occurs on quarterly basis, but other reporting periods are also possible. All reports provided by field level organizations need to be reviewed and approved by managers of the funding organizations; afterwards, they are usually analysed and aggregated for further reporting. Data analysis is carried out in accordance with the following parameters: the data are compared to the set targets at the project level, the data are checked for consistency against the backup documentation; aggregate data are compared to the national / program targets set. Key stakeholders are usually regularly updated on the key programme achievements at meetings or upon request.

Step Six: Ensure quality of data

After collecting the reports, it is important to ensure that the data provided in the reports correspond to the activities conducted in the reporting period. Although all previous steps, such as IP's capacity assessment, maintaining program records, regular reporting, etc. contribute to the collection of quality data, specific actions should be conducted to verify consistency of the data. The most simple and effective method of such verification is conduction of monitoring visits.

Monitoring Visits

Monitoring visits are the basic instrument of assuring the quality of data provided by the IPs. Monitoring visits can be conducted by the staff of the organization or/and by specially hired organizations. The frequency of visits depends on the nature of the grant recipients, the services provided by them, etc., as well as the composition of the teams that conduct the visits to different IPs. Naturally, more complex grants with bigger funding require more frequent monitoring visits comparing to smaller projects with little financing. At the same time, monitoring visit is also the instrument of provision of technical support; therefore less experienced, new organizations might require more attention and more frequent visiting. Composition of teams, which visit organization, also depends on the criteria mentioned above, as well as on the problems the organizations are experiencing: if problems are related to databases, recording or reporting issues, it is worthwhile for M&E specialist to visit the project, while if the problems are related to service provision, usually a person from the "programme-specific" team would visit the project more frequently.

A monitoring visit should result in the completion of the Monitoring Visit Report Form, which should serve the following purposes:

- provide a summary of the organization's performance,
- verify the organizations' achievements declared in the reports on the basis of reviewing project's primary documentation, as well as by means of direct observation, and
- track follow-up on remedial actions taken in accordance with recommendations provided to the organization during the previous visit.

The data obtained from the monitoring visit form are used to:

- provide feedback to the IP on its overall performance and attainment of the set targets,
- suggest corrective measures to be taken, if necessary, by the IP in order to improve service provision,
- assist managerial decision making within the funding organization regarding a particular grant / IP,
- enable follow-up on the implementation of remedial actions by the IPs in relation to recommendations provided during the monitoring visit,
- assist the IP in improving its monitoring and reporting practices in order to provide accurate and up to date data.

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The results of the site visits, together with IP's quarterly reports and/or ad-hoc requests from organizations constitute the basis for providing corresponding technical assistance to the IPs. An example of the Monitoring Visit Report Form that is used to monitor the performance of needle exchange projects and provides a summary of both programmatic and M&E information is provided in ***Annex 4***.

Monitoring visits to the implementing partners thus serve as the means of verification of the data provided by the IPs in the reports, as well as an instrument for verifying the implementation of the remedial actions identified as necessary and communicated to the IP in case if the planned targets were not reached.

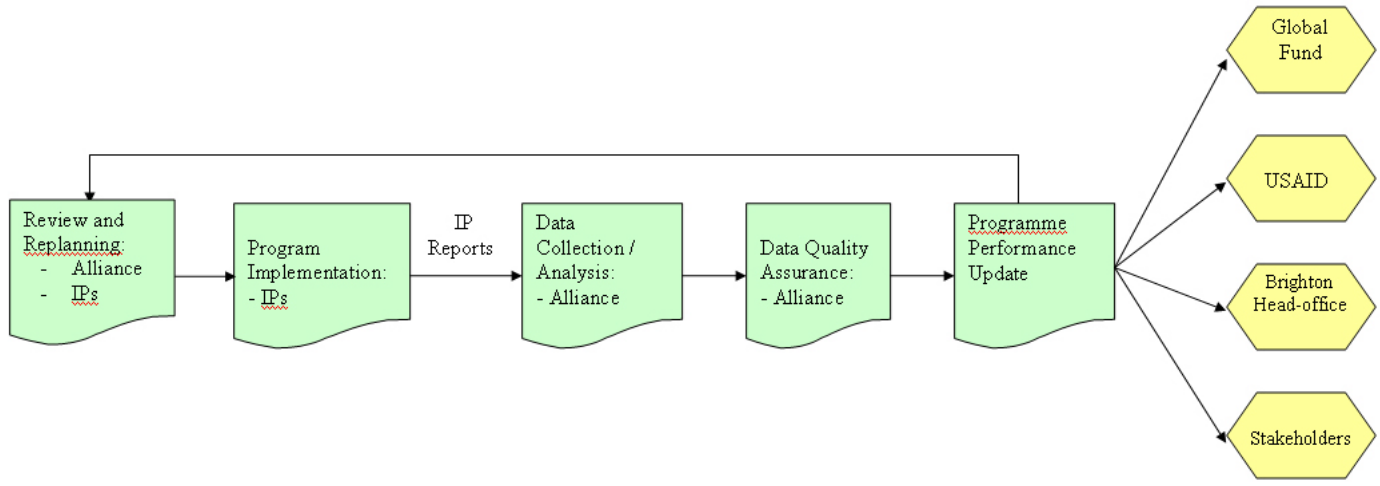
Step Seven: Translate M&E results into managerial decisions

The data from programme monitoring are used for:

- Providing an authoritative and quantitative record of the implementation of projects, detailing what has been spent, what activities have been undertaken, and how many beneficiaries have been reached;
- Informing decision makers of the progress of the programmes in a timely manner;
- Assessing the performance of the overall programme as well as thematic components and individual projects by comparing the planned figures with actual results and evaluating whether interventions and activities are on track towards achieving the objectives and goals at output, as well as outcome and impact levels;
- Correcting and fine-tuning service delivery in order to achieve or improve the intended impact;
- Using the records for future planning processes on project, regional and organisational level.
- Promoting a standardized approach to programme monitoring at the national level to enable the aggregation and analysis of data from programmes implemented all over the country;

Example: The information flow cycle in the Alliance, Ukraine is presented at the Reporting, Data Quality Assurance and Information Sharing Process diagram

Diagram 2: Information Flow Cycle in the Alliance



Programme monitoring thus indicates whether and to what extent the obtained results correspond to the targets set at the planning stage. If there is overall consistency with targets and results achieved, activities are implemented further according to the plan, with only minor recommendations/corrective actions, as required. If there are any deviations from the set targets, corrective actions are carried out before implementation continues. These corrective actions can

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include special measures to strengthen the capacity in certain areas, reallocation of financial resources, opening new points of service provision in new geographical locations to attract new clients, etc.

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Chapter IV: M&E Cycle

As it was said in the Chapter 2, Programmatic monitoring is a part of a broader national M&E processes. After the M&E system is established, the entire M&E process is functioning as a loop that links the overall programme goal, planning, implementation, programme monitoring, internal and external programme evaluations.

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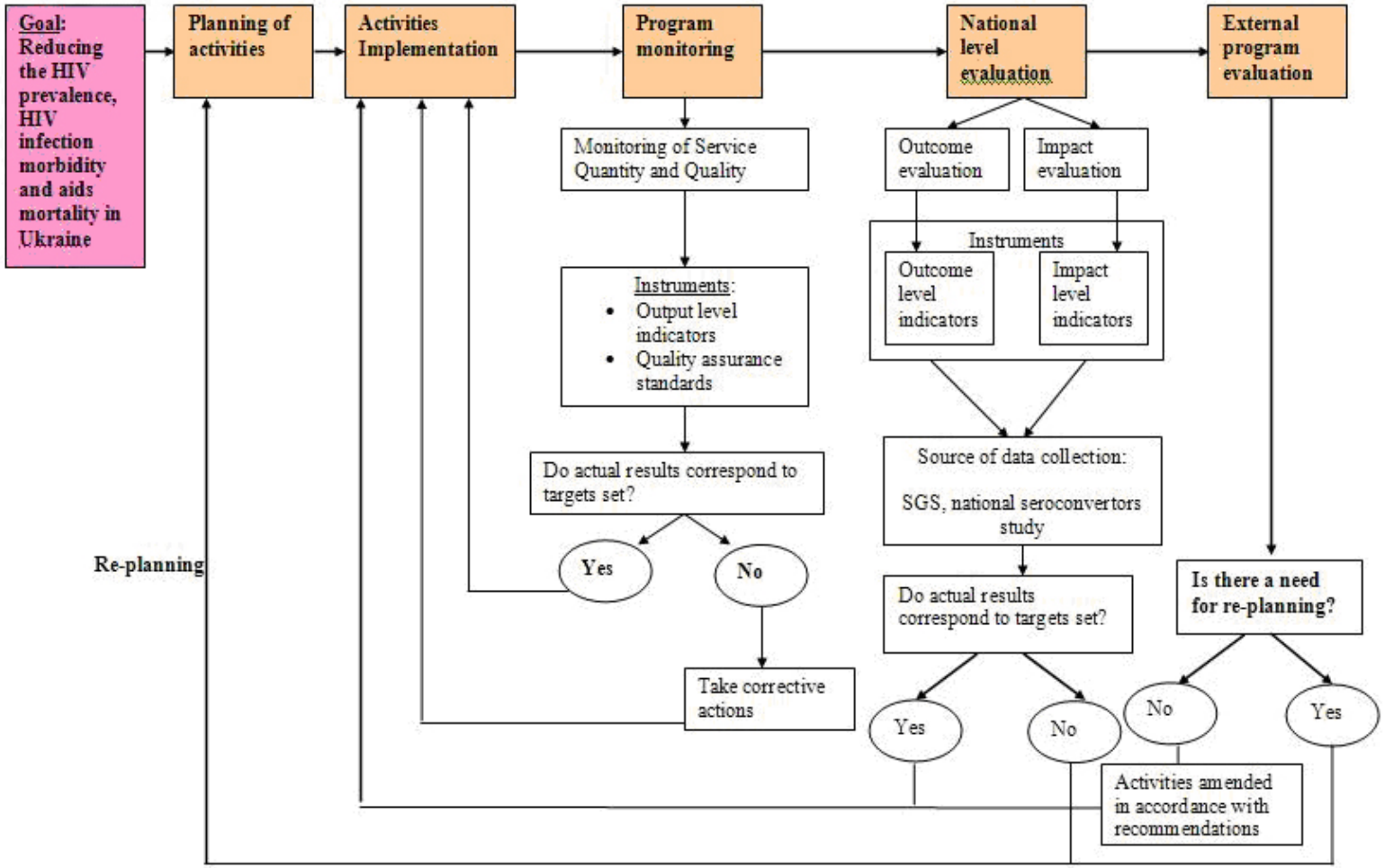

Diagram 3 M&E cycle

First

While programmatic M&E processes were described in details above (you can now see the position of programmatic M&E in the whole cycle of the National M&E system), below are brief description of National level evaluations and external evaluations.

National Level Evaluation

National level evaluation box (Diagram 3) consists of outcome and impact evaluation. As was outlined before, the instruments used for these are outcome and impact level indicators correspondingly. The data for these indicators are collected through the behavioural and epidemiological parts of SGS, as well as through the national behavioural surveillance study of seroconvertors, as in the case of Ukraine.

If actual results correspond to the set targets, services continue to be provided according to the plan or minor corrective actions are taken, as required. If not, the re-planning phase takes place. Re-planning can consist of reconsidering the quantity / quality part of services provision (adjusting them so that they are capable of providing the intended impact) or changing the overall programme strategy (e.g. redistributing resources between projects aimed at covering different vulnerable groups if there is evidence that the epidemic is more IDU-driven vs. FSW-driven, or vice versa, etc.) within the framework of the work-plan.

External Programme Evaluations

External evaluations are carried out for large-scale programs and look into the efficiency and effectiveness of their key components, as well as assess their overall impact on the national response to HIV/AIDS. This is achieved through the use of external evaluations of the key components of the programme, and the systematic implementation of the findings and recommendations of the evaluations in the ongoing reprogramming and enhancement of the programmes' activities and quality of services. The evaluations are usually divided into two principal categories: i. mid-term evaluations, and ii. programme-end evaluations. Each of these types of evaluation will have specific aims and outputs.

a. Mid-term Evaluations

The specific aims of the mid-term evaluations include: to analyze the strengths and weaknesses of specific components of the programme, provide specific assessment of shortcomings / programme improvements that need to be addressed in order to enhance outcomes, coverage and quality of services, and generate recommendations on specifying ways of strengthening the programme activities for the remainder of implementation.

b. Programme-End Evaluations

Programme-end evaluations are conducted at the end of the program. The specific aims of the programme-end evaluations include: analysis of the overall contribution of the programme to the national response to HIV/AIDS in the country, clear documentation of the achievements of the programme, and assessment of the sustainability and continuity of services covered under the programme beyond its end.

The results of the evaluations should be disseminated publicly, reviewed with stakeholders, and be used in reprogramming. And, as can be seen from Diagram 3, the activities are amended / re-planned on the basis of the recommendations obtained as a result of the external evaluations.

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Conclusion

We tried to develop this Manual in such a way, as to assist individual organizations, as well as larger national / sub-national projects and programs working in the sphere of HIV prevention among vulnerable groups and/or care and support for PLHA in developing a system of programmatic monitoring and evaluation and maintaining it. The authors of this Manual believe that a sound M&E system is needed in order to effectively implement interventions aimed at fighting the HIV/AIDS epidemic, keeping individual programs and projects on track, and making a notable contribution at the impact level. Since this is a working document, all comments and suggestions on its improvement are very welcome.

To conclude, we would like to emphasise that M&E needs to be simple. People usually artificially overcomplicate it. Everything that is needed to develop a good M&E system is common sense and good management.

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Annexes

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Annex 1. Measurement tools and methods[12]

Measurement tools	Main characteristics	Examples of measurement methods used
Health services statistics	Routine data collection at health facilities. Program monitoring.	• Data registered from various health facility registers
Health facility survey	Survey targeting health facilities to gather information on the availability of human resources, equipment, commodities and drugs and the type of services delivered.	• Site based facility surveys (e.g. HIV/AIDS Service Provision Assessment) • SAMS (Service Availability Mapping Surveys)
Qualitative methods	Determine "what exists" and "why it exists" rather than "how much of it is there". Through allowing the people to voice their opinions, views and experiences in the way they want, qualitative methods aim at understanding reality as it is defined by the group to be studied without imposing a pre/formulated questionnaire or structure (always developed by the researchers) on the population *(Maier B. Gorgen, R et at 1995).*	• In-depth Interview (individuals, focus groups, key informants) • Direct observation • Interactive or projective technique (comments on posters, open-ended story/comment on story, role-play)
Operational research	Operational research (OR), also called targeted evaluation, complements M&E systems. The main objective of OR is to provide program managers with the required information to develop, improve or scale-up programs. If evaluation focuses on whether a change in results can be attributed to a program, OR focuses on whether the program is the right, or best, program to achieve the desired results. It can be thought of as a practical, systematic process for identifying and solving program-related problems.	Examples of OR: • Adherence • Equitable access • Costs • Linking prevention-treatment • Different models of intervention
Sentinel site surveillance	Collect prevalence information from populations that are more or less representative of the general population (such as pregnant women) or / as well as populations considered to be at high risk of infection and transmission. Can be linked or unlinked anonymous testing, with or without informed consent.	• HIV sero surveillance in pregnant women or in identified groups at high risk
Population-based surveys	A survey based on sampling of the target or general population, generally aiming to represent the characteristics, behaviors and practices of that population. It requires sufficient sample size to represent the larger population and to be analyzed in sub-groups, by age, sex, region and target populations.	• MICS, DHS and DHS+, AIS, BSS, PLACE, SAVVY

[12] Abstracted from the M&E Toolkit

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Annex 2. Service Delivery Areas and examples of output indicators[13]

Objective	Service Delivery Area	Examples of Output Indicators
Prevention	**Behavioral Change Communication – Mass media**	HIV/AIDS information, education, communication (IEC) material broadcasted or distributed (radio & television programs / newspapers) (number)
	Behavioral Change communication – community outreach	Young people reached by life-based HIV/AIDS education in schools (number and percentage)
		Individuals (i.e., peer educators) trained (specify if trained for specific MARP sub-groups) (number)
		IDUs reached by HIV/AIDS prevention programs* (number and percentage)
		MSM reached by HIV/AIDS prevention programs* (number and percentage)
		Sex workers & clients reached by HIV/AIDS prevention programs* (number and percentage)
	Condom distribution	Condoms distributed for free (number)
		Condoms sold through the private sector (number)
	Testing and Counseling	People who receive HIV testing and counselling (including provision of test result) (number)
		MARP who received HIV testing in the last 12 months and who know the results (number and percentage)
		PLWHA who have tested positive who have received counseling for positive prevention (number and percentage)
	PMTCT	Health facilities providing the minimum package of PMTCT services (number and percentage)
		HIV-positive pregnant women receiving a complete course of antiretroviral prophylaxis to reduce the risk of mother-to-child transmission (number and percentage)
	Post-exposure prophylaxis	People receiving post-exposure prophylaxis (number)
	STI diagnosis and treatment	Patients with STIs at health care facilities who are appropriately diagnosed, treated and counselled (can be applied for MARP or population subgroups) (number and percentage)
	Blood safety and universal precaution	Transfused blood units screened for HIV according to national guidelines (number and percentage)
Treatment	**Antiretroviral treatment and monitoring**	People with advanced HIV infection receiving antiretroviral combination therapy (number and percentage)
		Health facilities that have the capacity and conditions to provide advanced HIV/AIDS clinical care and psychosocial support services, including providing and monitoring ARV
	Prophylaxis and treatment for opportunistic infections	PLWHA receiving diagnosis and treatment for opportunistic infections (number and percentage)
Care and support	**Care and support for the chronically ill**	Adults aged 18-59 years who have been chronically ill for 3 or more months in the past 12 months due to HIV/AIDS, whose households received basic external support in caring for chronically ill adults (number and percentage)

[13] Adapted from the M&E Toolkit (please refer to the M&E Toolkit for complete list of indicators)

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		Community organizations that received support to assist PLWHA (number)
	Support for orphans and vulnerable children	Orphans and other children made vulnerable by HIV/AIDS (OVC) whose households received free basic external support in caring for the child (number and percentage) Community organizations that received support to assist OVC (number)
TB/HIV collaborative activities	**Intensified case finding among PLWHA**	PLWHA receiving HIV testing and counseling or HIV treatment and care services who were screened for TB symptoms
	Prevention of TB disease in PLWHA	Newly diagnosed HIV positive clients given treatment for latent TB infection (number and percentage)
	Prevention of HIV in TB patients	Registered TB patients who receive HIV counselling and testing (number and percentage)
	Prevention of opportunistic infections in PLWHA with TB	HIV positive TB patients who receive co-trimoxazole preventive therapy (number and percentage)
	HIV care and support for HIV positive TB patients	HIV-positive TB patients referred to HIV care and support services during TB treatment (number and percentage)
	Provision of antiretroviral treatment for TB patients during TB treatment	HIV positive registered TB patients who have begun or are continuing ARV, during or at the end of TB treatment (number and percentage)
Supportive environment	**Policy development including workplace policy**	Large enterprises / companies that have HIV/AIDS workplace policies and programs (number and percentage) Local organizations provided with technical assistance for HIV-related policy development(number)
	Strengthening of civil society and institutional capacity building	NGOs providing HIV/AIDS prevention, care and support services according to national guidelines (number)
	Stigma reduction in all settings	Policy makers attending sensitization workshops on HIV/AIDS and HIV/TB (number)

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Annex 3.

List

of National Indicators On Monitoring and Evaluation of Efficiency of Activities to Control HIV/AIDS Epidemic

№	Indicators	Responsible CEA	Method of Data Collection
National Commitment & Action			
Expenditures			
1.	Amount of national funds spent by the Cabinet of Ministers of Ukraine on HIV/AIDS response	Ministry of Finance	Reporting of CEA
Policy Development and Implementation Status			
2.	National Composite Policy Index	Part A. MOH Part B. Nongovernmental organizations	Desk review and key informant interviews
National Programs: HIV testing and prevention programs for most-at-risk populations			
3.	Percentage of persons, who received HIV testing in the last 12 months and know the results: a. Among injecting drug users; b. Among commercial sex workers; c. Among men, who have sex with men; d. Among prisoners; e. Among young people aged 15-24.	Ministry of youth, family and sport , State penalty department	Special surveys
4.	Percentage of persons, reached by prevention programs: a. Among injecting drug users; b. Among commercial sex workers; c. Among young people aged 15-24.	Ministry of youth, family and sport , State penalty department	Special surveys
National Programs: Education, workplace policies, STI case management, blood safety, prevention of mother-to-child transmission coverage, antiretroviral combination therapy coverage			
5.	Percentage of schools with teachers who have been trained in life-skills-based HIV/AIDS education and who taught it during the last academic year.	Ministry of education and science	Special surveys
6.	Percentage of pupils and students of secondary schools, vocational training schools and post-secondary educational institutions of I-IV levels of accreditation were covered by HIV/AIDS prevention programs	Ministry of education and science	Special surveys
7.	The quantity and volume of information materials about HIV/AIDS on state-owned TV and radio	State committee on television and radio	Reporting
8.	Percentage of large enterprises/companies that have HIV/AIDS workplace policies and programs	Ministry of labor and social policy	Special surveys

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№	Indicators	Responsible CEA	Method of Data Collection
9.	Percentage of patients with sexually transmitted infections at state-owned and communal health care facilities, who were appropriately diagnosed, treated and counseled	MOH	Special surveys
10.	Percentage of HIV-infected pregnant women receiving a complete course of ARV prophylaxis to reduce the risk of MTCT	MOH	Reporting
11.	Number and percentage of women and men with advanced HIV infection receiving antiretroviral combination therapy	MOH	Reporting
12.	Percentage of transfused blood units screened for HIV during the last 12 months	MOH	Reporting
13.	Percentage of potential blood donors with diagnosed HIV	MOH	Reporting
Knowledge and behavior indicators			
14.	Percentage of persons, who both correctly identify ways of preventing the sexual transmission of HIV and who reject major misconceptions about HIV transmission: a. Among injecting drug users; b. Among commercial sex workers; c. Among men, who have sex with men; d. Among convicted and prisoners; e. Among uniformed personnel.	Ministry of youth, family and sport , State penalty department, Ministry of defense	Special surveys
15.	Percentage of young people aged 15-24 who both correctly identify ways of preventing the sexual transmission of HIV and who reject major misconceptions about HIV transmission	Ministry of youth, family and sport	Special surveys
16.	Percentage of female and male sex workers among respondents, who provided commercial sex services during the last 12 months and reported the use of a condom with their most recent client	Ministry of youth, family and sport	Special surveys
17.	Percentage of men reporting the use of a condom the last time they had anal sex with a male partner	Ministry of youth, family and sport	Special surveys
18.	Percentage of injecting drug users who have adopted behaviors that reduce transmission of HIV	Ministry of youth, family and sport	Special surveys
19.	Percentage of young people aged 15-24 years reporting the use of a condom during sexual intercourse with a non-regular sexual partner	Ministry of youth, family and sport	Special surveys
20.	Percentage of military personnel reporting the use of a condom during sexual intercourse with non-regular partners	Ministry of defense	Special surveys.
21.	Percentage of people who have tolerant attitudes towards HIV-infected	Ministry of youth, family and sport	Special surveys
Impact indicators			

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№	Indicators	Responsible CEA	Method of Data Collection
22.	HIV prevalence according to surveillance data among: a. Injecting drug users; b. Commercial sex workers; c. Men having sex with men	MOH	SGS survey
23.	Percentage of adults and children with HIV/AIDS still alive 12 months after initiation of antiretroviral therapy	MOH	reporting
24.	Percentage of infants born to HIV-infected mothers who are infected	MOH	reporting

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Annex 4.

Sample Monitoring Visit Form
Used by International HIV/AIDS Alliance, Ukraine to monitor Needle Exchange Programs

International HIV/AIDS Alliance, Ukraine
Project Monitoring Form (Needle Exchange Programs)

Date: _____

NGO Name: _____

NGO Address: _____

Telephone : _____

Fax: _____

E-mail: _____

Grand Number _____

Project Name

Accomplished by _____

***Every section of the form has to be filled. Please explain the reason in case if you do not have information for some sections. Please fill in the section "Comments" on what basic the conclusion was done.

I. Project Implementation

1. Work Plan Implementation

Activities	Implementation Status			Comments
	yes	*no*	*partly*	

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2. Project target groups.

Which target groups are served by the project?

	Primary documents data	data from the last project report	Comments
1. Cumulative number of people covered with services			
2. Number of people covered by project's services in the last quarter			
3. Number of regular clients			

Number of clients at the visited Syringe Exchange Points

Address/place of Syringe Exchange Point	Number	Comments

The number of clients at all syringe exchange points for the last day (data of the clients register keeping by Social Workers)

Address/place of Syringe Exchange Point	Number of Clients

3. Clients response about the quality of provided services/ quantity of distributed consumables.

How many syringes do the social workers distributed to one client?

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How many condoms do the social workers distributed to one client?

What additional services are provided to the clients of the project?

II. Project Documentation.

1. How the project clients are calculated?

2. Accounting for distributed consumables.

	Data form the Social Workers Log	data from the last project report	Comments:
Number of the distributed syringes for the last quarter			
Number of the distributed condoms for the last quarter			
Number of the distributed informational materials for the last quarter			

Supplies left:

Syringes
Informational Materials
Condoms

III. Project staff

Disbursed money and the list of staff meet the requirements of the budget (yes/no)

Comments:

IV. Equipment

The equipment obtained as required in the budget and available to use (yes/no)

Comments:

Inventory numbers are on the equipment (yes/no)

Comments:

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V. Project Success

VI. Project Problems

VII. The necessity of Alliance technical assistance.

VIII. Response to the note from the last visit.

Notes from the last visit	Response to the notes

IX. Notes and comments.

Notes	Recommendations

X. Reporting

Primary documents confirmation of the reports		
Primary Documents	***yes***	***no***
1. Timetable of the SEP		
2. Social Workers statements of clients services		
3. Project clients registration logs.		

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4. Informational materials logs.		
5. Reports on trainings, round table discussions, working meeting, and other.		
6. Agreement on syringe utilization		
7. List of consumables		
8. Discarding acts of consumables		
9. Consultant's statements (copies)		

	yes	***no***	***Comments (Name and Position):***
Responsible person for warehouse is present			

	yes	***no***	***Comments (Name and Position):***
Responsible person for monitoring and evaluation is present			

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Selected Indicators for

Prevention Projects among IDUs, CSWs, MSM, prisoners

and Care and Support Projects for PLHA

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1. Selected Indicators for

Prevention among IDUs, CSWs, MSM, prisoners

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1.1 IDUs reached with prevention services during the previous 12 months (number and %)

What it measures

Indicator measures number (and %) of IDUs reached (at least once) with prevention services during the previous 12 months. An IDU is "reached with prevention services" if he/she is a client of a project, i.e. received an essential package of services. It is suggested that the essential package of services for IDUs should consist of an information booklet, syringes, condoms, counselling with a social worker and a referral to another specialist, in accordance with individual's needs. This list of services determines the minimum requirement of services that a person needs to receive in order to be 'reached' and by no means diminishes the importance of other relevant services provided at service delivery points.

How to measure it

The numerator of this indicator is the number of IDUs, who received essential package of services at least once during the previous 12 months. The denominator is the estimated number of IDUs in the area.

The numerator can be obtained from clients registration database. Registration records are updated upon provision of services (usually, daily). Count each individual once regardless of number of services provided. Avoid double counting, where possible.

Reporting Frequency: Annually

Responsibility: individual government and non-government organizations working in the sphere of prevention among IDUs; ministries responsible for prevention among IDUs (e.g. Ministry of Family, Youth and Sport);
National M&E Unit

Data Source: program records of organizations working in prevention at the field level

First draft for feed-back

1.2 Sex workers reached with prevention services during the previous 12 months (number and %)

What it measures

Indicator measures number (and %) of sex workers reached (at least once) with prevention services during the previous 12 months. Sex worker is considered to be "reached with prevention services" if he/she is a client of a project, i.e. came to the point of condom provision and received an essential package of services. It is suggested that the essential package of services for sex workers should consist of an information booklet, condoms, syringes (if he/she is also an IDU), counseling with a social worker, and a referral to another specialist, in accordance with individual's needs. This list of services determines the minimum requirement of services that a person needs to receive in order to be 'reached' and by no means diminishes the importance of other relevant services provided at service delivery points.

How to measure it

The numerator of this indicator is the number of SWs, who received essential package of services at least once during the previous 12 months. The denominator is the estimated number of SWs in the area.

The numerator can be obtained from clients registration database. Registration records are updated upon provision of services (usually, daily). Count each individual once regardless of number of services provided. Avoid double counting, where possible.

Reporting Frequency: Annually

Responsibility: individual government and non-government organizations working in the sphere of prevention among SWs; ministries responsible for prevention among SWs (if there are such); National M&E Unit

Data Source: program records of organizations working in prevention at the field level

First draft for feed-back

1.3 MSM reached with prevention services during the previous 12 months (number and %)

What it measures

Indicator measures number (and %) of MSM reached (at least once) with prevention services during the previous 12 months. MSM is considered to be "reached with prevention services" if he is a client of a project, i.e. received an essential package of services. It is suggested that the essential package of services for MSM should consist of an information booklet, condoms, syringes (if he is also an IDU), counseling with a social worker, and a referral to another specialist, in accordance with individual's needs. This list of services determines the minimum requirement of services that a person needs to receive in order to be 'reached' and by no means diminishes the importance of other relevant services provided at service delivery points.

How to measure it

The numerator of this indicator is the number of MSM, who received essential package of services at least once during the previous 12 months. The denominator is the estimated number of MSM in the area.

The numerator can be obtained from clients registration database. Registration records are updated upon provision of services (usually, daily). Count each individual once regardless of number of services provided. Avoid double counting, where possible.

Reporting Frequency: Annually

Responsibility: individual government and non-government organizations working in the sphere of prevention among MSM; ministries responsible for prevention among MSM (if there are such); National M&E Unit

Data Source: program records of organizations working in prevention at the field level

First draft for feed-back

1.4 Imprisoned individuals reached with prevention services during the previous 12 months (number and %)

What it measures

Indicator measures number (and %) of imprisoned individuals reached (at least once) with prevention services during the previous 12 months. A prisoner is considered to be "reached with prevention services" if he/she received an essential package of services. It is suggested that the essential package of services for prisoners consists of counseling with a social worker and information booklet; condoms and syringes should be provided, if needed. This list of services determines the minimum requirement of services that a person needs to receive in order to be 'reached' and by no means diminishes the importance of other relevant services provided at service delivery points.

How to measure it

The numerator of this indicator is the number of prisoners, who received essential package of services at least once during the previous 12 months. The denominator is the total number of imprisoned individuals in those penitentiary institutions, where such services are allowed.

The numerator can be obtained from clients registration database. Registration records are updated upon provision of services (usually, daily). Count each individual once regardless of number of services provided.

Reporting Frequency: Annually

Responsibility: individual government and non-government organizations working in the sphere of prevention among prisoners; ministries responsible for prevention among prisoners (e.g. State Penitentiary Department); National M&E Unit

Data Source: program records of organizations working in prevention at the field level.

First draft for feed-back

1.5 Number of condoms distributed for free

What it measures

This indicator measures the total number of condoms distributed through prevention programmes and projects to representatives of vulnerable groups, i.e. IDUs, sex workers, MSM and prisoners.

Number of condoms distributed should include both male and female condoms.

How to measure it

Count as one each condom distributed. So, for example, a strip/packet of three condoms is counted as 3.

Disaggregation

Disaggregate this indicator by male and female condoms.

Reporting Frequency: Quarterly

Responsibility: individual organizations working in the sphere of prevention among vulnerable groups; ministries responsible for prevention among vulnerable groups; National M&E Unit

Data Source: program records of organizations working in prevention at the field level.

First draft for feed-back

1.6 Number of syringes distributed

What it measures

This indicator measures the total number of syringes distributed through prevention programmes and projects to IDUs.

How to measure it

Count each syringe given out

Reporting Frequency: Quarterly

Responsibility: individual organizations working in the sphere of prevention among vulnerable groups; ministries responsible for prevention among vulnerable groups; National M&E Unit

Data Source: program records of organizations working in prevention at the field level.

First draft for feed-back

1.7 Number of service providers trained in HIV prevention

What it measures
This indicator measures the number of people trained in HIV prevention strategies for direct activity implementation with the community. Service providers could be peer educators, outreach workers, community based workers, health workers, etc. This training could be for peer outreach activities, participatory prevention, interactive sexuality and lifeskills education, counselling and all other community-based prevention work.
If the training is part of another training course which is not only focussed on HIV prevention, then the course must be recognised by the organisation as having a sufficient prevention focus. The reporting organisation must take responsibility for checking that the course is of a suitable standard. The training must give participants the skills to implement directly prevention activities with the community.

Example Activities
This training can include skills for

- Education/interpersonal communication/small group communication/participatory prevention strategies for prevention of HIV.
- The training can include sexual and reproductive health education, promotion of STI health seeking behaviours, condom use promotion, improving sex negotiation skills.

How to measure it
Count the number of individuals trained in prevention. Count every person trained as one individual, even if he/she attends more than one training course in prevention within the same reporting period. Do not count health care professionals trained in STI diagnosis or treatment.

Reporting Frequency: Quarterly

Responsibility: government and non-government agencies that conduct trainings for service providers; ministries responsible for prevention services (e.g. Ministry of Family, Youth and Sport); National M&E Unit

Data Source: program reports of agencies conducting trainings for prevention service providers

First draft for feed-back

1.8 Number of service delivery points established and functioning

What it measures

This indicator measures the number of service delivery points established and functioning, i.e. providing prevention services to most-at-risk-populations.

How to measure it

Count each established point once.

Disaggregation

This indicator can be disaggregated by the type of service delivery point (i.e. stationary, mobile outreach, outdoor, secondary exchange)

Reporting Frequency: Annually

Responsibility: individual organizations working in the sphere of prevention among vulnerable groups; National M&E Unit

Data Source: program reports of organizations working in prevention at the field level

First draft for feed-back

2. Selected Indicators for

Care and Support Projects for PLHA

First draft for feed-back

2.1 People living with HIV/AIDS (PLHA) reached with care and support services during the previous 12 months (number and %)

What it measures

Indicator measures number (and %) of PLHAs reached (at least once) with care and support services during the previous 12 months.

The indicator measures the number of adult PLHA (15 years old and elder) benefiting from care and support services. According to the All-Ukrainian Network of People Living with HIV/AIDS, a person is considered to be "reached" if he/she received psychological support (peer counselling and/or participation in self-help groups and/or consultation by a professional) and/or socioeconomic support.

More broadly, care and support programmes can cover external support, including counselling, medical care, help with household work, companionship, financial support, legal services, care, support for schooling, access to shelter or other medical or social services. Some of these services will be provided at household level and some at community level, and this indicator measures for both.

How to measure it

The numerator of this indicator is the number of PLHAs, who received essential package of services at least once during the previous 12 months. The denominator is estimated number of PLHAs in the area. If there are no such data, the number of officially registered HIV+ people in the area could be used as the denominator.

The numerator can be obtained from clients registration database maintained at organizations that provide services. Registration records are updated upon provision of services (usually, daily). Count each individual once regardless of number of services provided. Avoid double counting, where possible.

Disaggregation

Disaggregate by gender and age group

Reporting Frequency: Annually (quarterly data could also be gathered by organizations)

Responsibility: individual government and non-government organizations working in the sphere of care and support of PLHA; ministries responsible for provision of care and support services to PLHA; National M&E Unit

Data Source: program records of government and non-government organizations providing care and support services to PLHA at the field level.

First draft for feed-back

2.2 Number of children living with and/or affected by HIV/AIDS reached with care and support services

What it measures

Indicator measures number of children living with and/or affected by HIV/AIDS reached (at least once) with care and support services during the previous 12 months.

This indicator is related to the number of children (people under 15 years of age) benefiting from a package of care and support services. For children the package of services consists of: 1) infants: medical and social patronage, care, hygiene, nutrition and supportive environment, medical rehabilitation, provision of humanitarian aid (nutrition - milk formula, vitamins, basic medicines, toiletries, toys, etc.); 2) 18 month - 15 year old: medical and psychosocial support, education and development, social and legal support, assistance in granting disability pension and allowance, medical rehabilitation, family support, treatment adherence and positive prevention, vocational guidance, etc.

How to measure it

Count the number of children (people under 15 years of age) benefiting from a package of care and support services during the previous 12 months.
Count each individual once regardless of number of services provided. Avoid double counting, where possible.

Reporting Frequency: Annually (quarterly data could also be gathered by organizations)

Responsibility: individual government and non-government organizations working in the sphere of care and support of children living with and/or affected by HIV/AIDS; ministries responsible for provision of care and support services to children living with and/or affected by HIV/AIDS; National M&E Unit

Data Source: program records of government and non-government organizations providing care and support services to children living with and/or affected by HIV/AIDS at the field level.

First draft for feed-back

2.3 Number of PLHA receiving palliative care

What it measures

Indicator measures number of PLHA, who received palliative care in hospices / out-patient departments (clinics) during the previous 12 months.

How to measure it

Count each individual who received palliative care during the previous 12 months. Avoid double-counting.

Reporting Frequency: Annually

Responsibility: individual government and non-government organizations providing palliative care to PLHA; ministries responsible for provision of palliative care to PLHA (e.g. Ministry of Health of Ukraine); National M&E Unit

Data Source: program records individual government and non-government organizations providing palliative care to PLHA.

First draft for feed-back

2.4 Number of care and support service delivery points established and functioning

What it measures

Number of service delivery points established and functioning in the area of care and support services to PLHA. Count every project as one service delivery point if it operated in one locality. Service delivery points that do not report any coverage of PLHA should not be reported.

How to measure it

Count each service delivery point established and functioning. Count only those service delivery points that are supported by means of funding provided by your organization.

Reporting Frequency: Annually

Responsibility: government and non-government organizations that fund activities of field-level organizations providing care and support services to PLHA (Ministries, donor organizations, etc.)

Data Source: reports of government and non-government organizations that fund activities of field-level organizations providing care and support services to PLHA.

First draft for feed-back

10. Learning as an organisation by Mag. Frank M. Amort [1]

Your organisation has knowledge. Very often knowledge is linked to a person. But for an organisation it is very important that knowledge is made available for every staff member. Only shared information enables an organisation to learn. This can be e.g. information on organisational standards, how to make work sequences more efficient or simply contacts, which are important for your work.

In order to learn, which means to gain more knowledge, firstly, internal procedures must be made transparent. Secondly, an organisation must create ways to standardise and evaluate the knowledge and experience of the individual employee. This makes it possible to compare the results of different projects, to create standards, to organise workflows more efficiently, etc.

A major point for NGOs is the efficient organisation of workflows. When you organise your activities and make data available as well as comparable you will save time and avoid confusion and frustration among your staff.

There are some techniques which can help you to improve the work of your organisation, to plan activities more efficiently and to prepare for future challenges. For example, keeping all information on a project available for all who are involved can be very difficult, but a Concept Card will help you to keep your project members informed. To analyse the strengths and weaknesses of your organisation regularly is crucial for your work, so have a look at this technique as well. The ABC-analysis can help you to organise your tasks more efficiently by identifying and eliminating those which only consume time but are not important for your work. Last but not least, you should prepare for whatever the future holds in store. In “Scenarios of the Future” you will find a tool that helps you to take a look at realistic possibilities.

1. The Concept Card

Much time is lost when information on your projects are not easily available for those who are involved or the responsibilities are not clear. When planning a project use a concept card, which accompanies you through the project. It makes information readily available, clarifies structures and might show weaknesses in your concept. The Concept Card must include the following points:

[1] Mag. Frank M. Amort, Leiter der Präventionsabteilung, Aids Hilfe Wien

- **Brief description of the project**

  This template should allow you to structure ‘wild plans’ into a more controllable process. It can be used for designing projects, campaigns, publications or new services… The concept card is a work in progress, that grows and evolves as your idea becomes clearer. Start by giving a brief description of the project or publication.

- **Main responsibilities**

  Describe here who takes up which responsibility within the organisation. A green light for printing, for example, ought to be given by the one who has the final responsibility of the project. Depending on the project, other responsibilities may be relevant, e.g.: final responsibility, responsibility content, responsibility product design, responsibility for other aspects...

- **Contextualisation**

  In this initial paragraph, you briefly describe which problem or challenge you want to address by means of a campaign, product or service. Make it **evidence based**: Frame the issue summarily in its larger, social context. Indicate epidemiological and social scientific data with regard to behavioural determinants and societal factors to the degree that these are known and described. Make it **value based**: Refer to the organisation’s operational goals and core values. Your coordinator may assist you here.

- **Target group**

  Describe as precisely as possible which group you want to target, both **qualitatively** (demographic, socio-economic, cultural and other characteristics, to the degree relevant, of course) and **quantitatively** (population description; how big is your target group?).

- **Goals**

  Distinguish, if possible, between end goals and operational goals.

  1. **End goals**: what we want to obtain, e.g.: *Gay men assess accurately how severe the problem of syphilis really is.*
  2. **Operational goals** are more concrete and should be able to be expressed in numbers, e.g.:*Gay men know that the incidence of syphilis among themselves has been rising for the last years and that an infection with syphilis may facilitate an infection with hiv; seropositive gay men know that an infection with syphilis is harder to treat successfully if one has hiv. How many gay and how many seropositive men can be reached by this project?*

- **Strategy and Method**

  In this paragraph, you describe as precisely as possible how you want to reach the goals

proposed. Examples, resulting from the above inventory of operational goals:
Gay men and syphilis: we launch a poster campaign annex short performance (max. 5 min.), emphasizing that it is much easier to get infected with hiv if one has syphilis (for seronegative persons) and that treatment of syphilis is at times very hazardous for seropositive gay men. The strategy is a straightforward information and sensibilisation campaign; the methods are: distribution of posters and community theatre. We adopt the strategy of empowerment and opt for the method of workshops, training Central and West African women on the level of communication and negotiation skills taylorised according to their own specific cultural background.

- **Concrete planning and implementation**

  Here you describe clearly and summarily how you wish to realise the project (implementation): what budgetary means are needed? with whom do you want to cooperate? Who is responsible for what? How will things develop time wise? How do the subsequent phases of the process need to be timed?

  1. **Parties involved and partners**: A successful implementation (execution/application) of a project implies also that you think carefully about the internal (Departments and collaborators) and external partners (target group, intermediaries, policy makers, other, …) with whom you intend to cooperate. Briefly describe the tasks of everyone involved.
  2. **Distribution**: The distribution of products (posters, gadgets, beer mats, brochures, etc.) is a task on its own. Plan this carefully, so that it becomes possible to accurately estimate a realistic circulation figure and assure that no problems will show up, that you can't resolve comfortably.
  3. **Timing**: Here you briefly describe how the project will be developed through time. How much time is needed to develop, implement and evaluate your project? Which subsequent deadlines are implied by this? Take into account that some phases might be more time consuming than expected. Explore and discuss these issues with relevant colleagues and partners.
  4. **Production data**: In due course, practical data are filled out, that are relevant in view of the actual production. Depending on the product, these data may diverge, but for brochures or posters one has to at least consider the following:

- **Budget**

  Keep all relevant cost factors in mind! Try to anticipate all aspects of development, production, implementation and evaluation in order to inventorise all budgetary means necessary for a successful campaign. Expenses might be: preparatory work, development, production, potential cost of personnel, external expertise, promotion, cost of distribution (mailing, ...), evaluation costs...If possible, indicate also how potential new revenue can be attracted for the campaign initiative. Possible revenues are: organisational budget, cooperative agreement with

…, gouvernment subsidizing, sponsoring by …, sale (if applicable). Make sure your budget planning is sound and balanced!

- **Evaluation**

  At the same time you write up this concept card, think also about how you would like to evaluate your project: make sure that you can do more than just a process evaluation. Describe briefly how you might want to measure the campaign's effect or outcome. Pre-tests and post-test also belong here and need to be included in the developing process. They are not to be set up separately afterwards.

  For all projects, we set up at least a minimal pre-test. 'Minimal' here means that a concrete draft of a brochure is presented to some 10 readers, who do belong to the target group, yet have no specific affiliation or connection to the field of sexual health promotion.

  For campaigns, new websites or new prevention messages, the pre-test gets expanded to a group of 30 to 100 members of the target group, who are invited to comment upon the product-in-the-making.

  For all projects, we set up at least a minimal post-test. How is the information or campaign received by the target audience? What are the questions you are going to ask?

  The larger the budget, the more elaborate the proposed evaluation procedure will have to be.

- **Communication plan**

  How are you going to assure that the target group, intermediaries… will get informed about your initiative? At least consider the following steps:

  1. **Internal collaborators**:

     First of all, it is indispensable to inform colleagues within the organisation itself **in time**: personnel and the board of administration (via weekly report), volunteers of the helpline, for initiatives with a large impact (direct mail system, new campaign) all volunteers. In case your project implies the dissemination of new messages, special care ought to be given to a proper preparation of the internal collaborators. A specific presentation or training might have to be set up and provided for volunteers of the helpline as well as for the colleagues at the Reception Desk.

  2. **Partners**:

     Depending on the type or nature of the project, you must inform relevant partner organisations in time.

  3. **Target group**

     Find more information on channels and opportunities to inform the target group. Some possibilities are: the organisation's newsletter, the website, presentation folders and texts, press release or press map and Journals of external organisations

Ask for help to mobilise the right means of communication. If you decide to address the press, the Management ought to be consulted at all times.
Large reforms might call for a stepwise development of a communication plan, both with regard to the precise message content as with regard to the communication channels chosen as to the ones, involved in the communication process. A detailed, stepwise timing ought to be set up in this context as well.

4. **The website:**
   Check how your initiative relates towards the organisation's website. Does it have to be announced on the website? Must the current information be adapted or completed by elements from the new initiative? Discuss these issues in time with the webmaster.

2. Analyse the strengths and weaknesses of your Organisation

This tool gives you the opportunity to find out your staff´s opinion about your organisation. It helps to see your organisation realistically and to indicate those areas where improvements might be necessary. In order to get an "outside view", this analysis can be repeated among your clients.
First of all, a catalogue of criteria is drafted, which might include the following:

- Management: management style, aims, decision process, working atmosphere, cooperation, delegation, motivation, planing, cost control, supervision, finances, financial power, financial planing
- Service: quality of service, intensity of service, variety of service and regularity of service
- Communication: with clients, with sponsors, with other NGOs, with the government/governmental organisations, with media

These criteria should be assessed with either a three point scale (1 = weak performance, 2 = medium performance, 3 = maximum performance) or a ten point scale form 1 (weak) to 10 (perfect). To ensure a realistic picture of the organisation every participant should give his opinion anonymously.

After the evaluation the positive as well as the negative scores should be discussed and measures can be taken to eliminate the weaknesses.

3. ABC-Analysis

The beneficence of time management can be most easily shown when you regard your way you organise your tasks. Some are very important for your organisation, some are just necessary and some only consume your time and your energy. You should reflect your everyday workload and think about your priorities. It would be best, if you wrote a list with the things you do on a regular basis. Then you can sort the tasks according to the classification mentioned below:

- **A rating**: These tasks are most important with a high urgency but bring a high benefit for your work and should be taken care of personally.
- **B rating**: Tasks rated as B are important as well, but not urgent. They can be delegated if there is no time do deal with them in order to keep the workflow alive.
- **C rating**: Those are urgent but not important for your work. They should be delegated, so that they can be dealt with quickly.

This ABC-Analysis can not only be used for your everyday work, but also for projects and even for your contacts. Just keep in mind what is important, what is urgent and what can be done by someone else.

4. Scenarios of the Future

The daily work of a NGO is very often ruled by routine on one hand and emergency recovery on the other hand. However, it is very important to keep in mind that part of our activities have to tackle the future. For the wellbeing of an organisation it is very important to develop regularly plausible paths for the future. The technique of developing scenarios can help to structure such a process. A group of qualified and experienced team members will develop descriptions of conceivable positive and negative developments of the organisation in the future. We would like to show you step by step how such scenarios could be developed.

First of all a group of 6-8 persons is formed. The group members should be qualified and experienced team members that have strong communication skills and should be able to discuss their work in an abstract but yet pragmatical way. First all group members are given the same level of information of the process to follow. The selected group members meet for one or two days and work interactively within the group. In the beginning two smaller groups are formed. If it is possible for you to organise an external person to moderate the process it will be benefiting, but it has been shown by practice that the work can also be done without an external moderator. The seminar will discuss the following topics point by point:

1. Defining the object

What is the object of your interest: the whole organisation, a department or only a selected service? Whether you decide to choose a small object or a big object – define it very exactly as it helps you to keep a clear focal point in your process. A short written definition will remind you in the further steps on what your focus is.

2. Description of the present situation

   A key element of this technique is the description of the present situation. All available quantitative and qualitative data as well as the informal knowledge of the group members is presented and discussed. It is very important to play with open cards and to collect all arising questions without any taboo. An example: *In quantitative numbers you are able to say that there are 2000 HIV-positive people living in your city and a certain service of your organisation is used by 100 clients which are 5% of the possible service users. What do those numbers mean? That 95% don't need our service and that you serve a minority, or does it mean that 95% are not aware this service exists*. This part of the process will need quite some time, but you should always ask yourself: Are we still discussing the chosen object of interest or is the group loosing its clear focus of interest.

3. Determination of influences

   Following the discussion on the present situation the group will brainstorm on possible positive or negative influences: *More donations might mean that you are able to serve more meals to service users in a drop-in-centre but might cause logistic problems as your kitchen is not big enough.* It is important to collect all conceivable and somehow realistic positive and negative events but still you should have finally not more than 3-5 positive or negative influences.

4. Development of Scenarios

   Now comes the most important part of your process. Finally your group splits in those two groups that where formed in the early beginning. Keeping the definition of the chosen object of interest in mind and the shared views of the current situation within the two groups we will shift the time perspective: So far we were mostly interested in what is going on now and partly had a look into the past. Starting from now our focus is only in the future as we finally develop scenarios of the next year, or any other chosen time unit in the future. One group will develop a positive scenario and the other a negative one. Once again: Keep it realistic and conceivable! Every group member should share the perspective that this scenario should be possible. By using the 3-5 determinants of influence that the group has defined some dramaturgical elements can be included in the story telling of the scenario. It is important to develop this scenario in the form of a story.

   The positive perspective might read such as: *Our organisation will receive for the next 12 months extra food donations that will allow us to serve 25% more clients on a long-term perspective. For the first 3 months we anticipate a small increase of 10% clients as we have to adjust our opening hours and the training of 3 missing volunteers. In the meantime we inform our clients about this changes. Finally we get started and can see*

that our clients adjusted to different service operation hours as we are still lacking a bigger kitchen. Even we still have not accomplished to get funding for a bigger kitchen we are able to accept all the food donations and through more information we had an increase of 20% new clients.

5. Discussion and Formulation of new Strategies
   Finally the two groups present their scenarios. The scenario should be presented as a story and include as many details as possible. It helps very often to support the presentation with a poster or other creative methods such as role play. Try to be as creative as possible and avoid any standardised forms of presentations such as PowerPoints. Tell a story and argue why you found this is a good example for a positive or negative scenario. Later the group should discuss the two scenarios: Did anyone find an element of a scenario unrealistic and why? What are the elements of the both scenarios most group members find realistic? An finally: What conclusions and strategies can the group identify for a strategic planning? What are the steps that should follow immediately and what processes should be anticipated.

The big benefit of this strategy is that it is developed in a very participative way and not only the management was involved. Therefor people involved in the development identify stronger with it and adhere to decisions made. As it was several times mention that all steps of the process have to be found realistic and conceivable also the final conclusions and recommendations for further action should pass this pragmatic reality check. Of course not everything will happen as anticipated, but in any case: It is always better to act with a clear vision of the future than just to react.

5. Checklist for a learning organisation

	Yes	No
1. Do you plan your projects and activities thoroughly and do you know at every step of a project all details?		
2. Are you evaluating your strengths and weaknesses regularly?		
3. Do you reflect the priorities in your work on a regular basis?		
4. Does your organisation have a strategic plan for the future?		

If you answered one or more questions with “No”, then please refer to the methods described.