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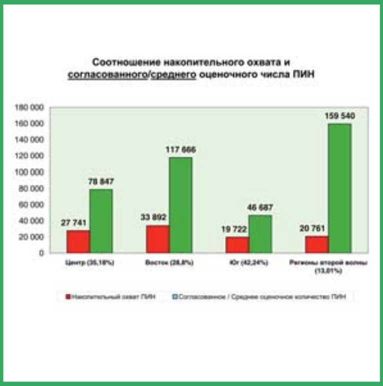
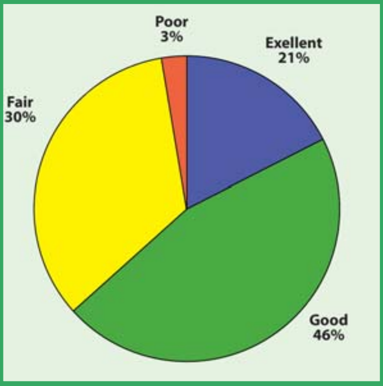


PROGRAMME MONITORING AND EVALUATION

PRACTICAL MANUAL

for Organizations Coordinating and Implementing Prevention Projects among Injecting Drug Users, Commercial Sex Workers, Men who have Sex with Men, Prisoners and Care and Support Projects for People Living with HIV/AIDS



WITH A LIST OF KEY SELECTED INDICATORS

KYIV, 2008

Programme Monitoring and Evaluation

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for Organizations Coordinating and Implementing
Prevention Projects among Injecting Drug Users, Commercial Sex
Workers, Men who have Sex with Men, Prisoners
and Care and Support Projects for People Living with HIV/AIDS

Kyiv, 2008

ББК 55-1
М -77

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Programme Monitoring and Evaluation. Practical Manual / Olga Morozova, Olga Varetska, Daniel Jones, Pepukai Chikukwa, Tetyana Salyuk. Kyiv: Oranta, 2008. 142 pages.

ISBN 966-8754-21-2

This manual provides practical recommendations on the development and support of programme monitoring and evaluation systems for programmes and projects providing HIV/AIDS prevention among most-at-risk populations and care and support for people living with HIV/AIDS.

This manual is an easy-to-follow practical guide targeted at government and non-government organizations managing and/or implementing prevention projects and services for populations at high risk of HIV infection, as well as care and support projects and services for PLHA. It is aimed primarily at personnel within organizations who are responsible for developing and managing M&E systems for monitoring programme and project coverage. This manual may also be useful for managers of organizations, as well as other staff responsible for planning and implementing programmes in HIV prevention, care and support. The manual is also intended to serve as a resource for decision-makers at all levels in understanding and selecting the tools and resources available to better monitor the uptake and coverage of HIV/AIDS programmes, and to use data from these programmes to further improve their efficacy and efficiency.

This publication is supported by the Global Fund to fight HIV/AIDS, Tuberculosis and Malaria™

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Any citation from or reference to this manual must be cited as **Programme Monitoring and Evaluation. Practical Manual** / Olga Morozova, Olga Varetska, Daniel Jones, Pepukai Chikukwa, Tetyana Salyuk. Kyiv: Oranta, 2008.

ISBN 966-8754-21-2

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ACKNOWLEDGEMENTS

The working group which prepared this manual is deeply grateful to members of the National HIV/AIDS Monitoring and Evaluation working group under the National Tuberculosis and HIV/AIDS Coordination Council for their invaluable contributions to this publication.

The working group would also like to recognize the contributions of the following colleagues, whose work in the area of monitoring and evaluation of HIV/AIDS in Ukraine helped to make this manual possible:

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Joost Hoppenbrouwer, HIV/AIDS & public health consultant
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Yuriy Kruglov, Ukrainian AIDS Centre
Violeta Martsinovska, Ukrainian AIDS Centre
Yuriy Kobyscha, World Health Organization
Vinay P. Saldanha, Joint United Nations Programme on HIV/AIDS (UNAIDS)
Lyudmyla Husak, International HIV/AIDS Alliance in Ukraine
Vyacheslav Kushakov, International HIV/AIDS Alliance
Pavlo Smyrnov, International HIV/AIDS Alliance in Ukraine
Vasyl Borschev, software development consultant

Important contributions to the development of this manual were made by Ukrainian NGOs implementing prevention projects among most-at-risk populations, as well as care and support projects for people living with HIV/AIDS. Through implementation of the 'Overcoming the HIV/AIDS Epidemic in Ukraine' national programme supported by the Global Fund to Fight HIV/AIDS, Tuberculosis and Malaria, the International HIV/AIDS Alliance in Ukraine was able to develop, systematize and implement the programmatic monitoring and evaluation system described in this document.
The authors of this manual express their gratitude to members of the Alliance monitoring and evaluation team Julia Skoropatska and Lesya Khmel, for their help and contribution to the preparation of this manual.

The publication of this manual was made possible with support from the International HIV/AIDS Alliance in Ukraine, with financial support from the Global Fund to Fight HIV/AIDS, Tuberculosis and Malaria in the framework of the National Programme "Overcoming the HIV/AIDS Epidemic in Ukraine".

PREFACE

This practical manual was developed by the M&E team at the International HIV/AIDS Alliance in Ukraine, in cooperation with International HIV/AIDS Alliance head office (based in Brighton, UK) and various partners working in the field of monitoring and evaluation of HIV/AIDS in Ukraine. This volume represents the first attempt to compile different resources and references in the area of programme-based monitoring and evaluation of HIV/AIDS programmes and activities. The publication aims to serve as an easy-to-follow practical manual targeted at government and non-government organizations managing and/or implementing prevention projects and services for IDUs, CSWs, MSM, prisoners, and well as care and support projects and services for PLHA. It is aimed primarily at personnel within organizations who are responsible for developing and managing M&E systems for monitoring programme and project coverage. It may also be useful for managers of organizations, as well as other staff responsible for planning and implementing programmes in HIV prevention, care and support. The manual is also intended to serve as a resource for decision-makers at all levels in understanding and selecting the tools and resources available to better monitor the uptake and coverage of HIV/AIDS programmes, and to use data from these programmes to further improve their efficacy and efficiency. Regardless of at what stage of programme implementation readers find themselves – initial planning, monitoring implementation, or reprogramming activities in accordance with achieved results – they will find this manual a useful tool for strengthening practical monitoring of their HIV/AIDS programmes and activities.

As such, this version of the manual is being distributed as an initial framework, to be used in various field settings and tested for feasibility and applicability in coming years. The International HIV/AIDS Alliance in Ukraine, its implementing partners and collaborating organizations plan to continue to apply at field level the tools and methods described herein. The experience of users in the practical application of this manual, and any lessons learnt, will be collected regularly to form the basis of future revisions to this manual. Subsequent revisions will reflect practical suggestions from readers on how to strengthen the publication, and will include practical examples of how the manual is being applied in monitoring and evaluation of HIV/AIDS programmes and activities.

In this regard, all comments and feedback are welcome and should be addressed to the International HIV/AIDS Alliance in Ukraine.

For any specific requests and suggestions concerning the content of this manual, please contact Olga Morozova, programme manager: Programmatic M&E, at the International HIV/AIDS Alliance in Ukraine **(morozova@aidsalliance.org.ua)**, 5 Dymytrova St., building 10A, 9th floor, 03680 Kyiv, Ukraine.

ACRONYMS

Alliance – International HIV/AIDS Alliance in Ukraine

ART – antiretroviral therapy

CSW, SW – commercial sex worker, sex worker

CDC – Center for Disease Control (USA)

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

HIV/AIDS – Human Immunodeficiency Virus/Acquired Immune Deficiency Syndrome

IDU – injecting drug user

IPs – implementing partners of funding organizations

M&E – monitoring and evaluation

MARPs – most-at-risk populations

MIS – management information system

MRS – monitoring reporting system

MSM – men who have sex with men

NGO – non-governmental organization

PEPFAR – President's Emergency Plan for AIDS Relief (US Government)

PLHA – people living with HIV/AIDS

PSA – participatory site assessment

SyrEx – syringe exchange management information system used by Alliance sub-grantees working in the sphere of HIV prevention

SDA – service delivery area

SDP – service delivery point

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 and Malaria, USAID, US Department of State, OGAC, CDC, UNICEF, MEASURE Evaluation and the World Bank

TOR – terms of reference

UNAIDS – Joint United Nations Programme on HIV/AIDS

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

USAID – United States Agency for International Development

VCT – voluntary counselling and testing

WHO – World Health Organization

GLOSSARY

- **Evaluation** is a rigorous, scientifically–based collection of information about programme activities, characteristics, and outcomes that determine the merit or worth of a specific programme. Evaluation studies are used to improve programmes and inform decisions about future resource allocations.

- **Funding organizations** are organizations working on either national or regional level (usually national), whose primary focus is coordination of programme implementation. They do not usually provide services to target groups themselves, but contract implementing organizations to perform this work. Funding organizations usually perform the function of intermediary between donor and implementing organizations.

- **Impact evaluation** looks at the rise and fall of disease incidence and prevalence as a function of AIDS programmes. The effects (impact) on entire populations can seldom be attributed to a single programme or even several programmes; therefore, evaluations of impact on populations usually entail a rigorous evaluation design that includes the combined effects of a number of programmes among at–risk populations.

- **Implementing organizations** are organizations working on either national or regional level (usually regional), whose major activity focus is direct provision of services to target groups. Implementing organisations usually receive funding from either state or donor organizations (referred to in this manual as funding organizations) to perform service provision.

- **Intervention** is a specific set of activities implemented by a project or providers and can be focused at various levels such as the individual, small or large group, community or societal levels.

- **Monitoring** is the routine tracking of key elements of a programme or project and its intended outcomes. It usually includes information from record keeping and surveys, both population and client–based.

- **Outcome evaluation** is a type of evaluation that is concerned with determining if, and by how much, programme activities or services have achieved their intended outcomes. Whereas outcome monitoring is helpful and necessary to know whether outcomes have been attained, outcome evaluation attempts to attribute observed change to the intervention tested, describe the extent or scope of programme outcomes, and indicate what might have happened in the absence of the programme. It is methodologically rigorous and requires a comparative element in design, such as a control or comparison group.

- **Outcome monitoring** is the basic tracking of variables that have been adopted as measures or 'indicators' of the desired programme outcomes. It may also track information directly related to programme clients, such as change in knowledge, attitudes, beliefs, skills, behaviours, access to services, policies, and environmental conditions.

- **Outputs** are the results of programme activities; the direct products or deliverables of programme activities, such as the number of counselling sessions completed, the number of people reached, and the number of materials distributed.

- **Outreach services** are those that take health information and services into the communities where most–at–risk populations live, or places where they congregate (such as shooting galleries or sexual pick–up spots). Outreach health services, information and commodities can be provided by health workers in a variety of venues such as storefronts, street corners, and mobile buses.

- **Process evaluation** is a type of evaluation that focuses on programme implementation and uses largely qualitative methods to describe programme activities and perceptions, especially during the developmental stages and early implementation of a programme. It may also include some quantitative approaches, such as surveys about client satisfaction and perceptions about needs and services. In addition, it might provide understanding about the cultural, socio-political, legal, and economic contexts that affect a programme.

- **Process monitoring** is the routine gathering of information on all aspects of a project or programme to check how project activities are progressing. It provides information for planning and feedback on the progress of the project to donors, implementers, and beneficiaries of the project.

- **Programme** in the field of HIV/AIDS generally refers to an overarching national or sub-national systematic response to the epidemic and may include a number of projects and interventions.

- **Surveillance** is the ongoing, systematic collection, analysis, interpretation, and dissemination of data regarding a health-related event for use in public health action to reduce morbidity and mortality and to improve health.

- **Triangulation** refers to the analysis and use of data from multiple sources obtained by different methods. Findings can be corroborated and the weakness (or bias) of any one method or data source can be compensated for by the strengths of another, thereby increasing the validity and reliability of the results.

- **Vulnerability** refers to those factors that contribute to people engaging in risky behaviours. A person vulnerable to HIV can be defined as one who is susceptible to, or unable to protect himself from, significant harm or exploitation linked with HIV infection.

Chapter I

INTRODUCTION: KEY ISSUES ON PROGRAMMATIC MONITORING AND EVALUATION AND THIS MANUAL

What is Programmatic Monitoring and Evaluation?

Programmatic monitoring and evaluation (M&E) is an inherent part of the overall M&E system, which is performed at different levels and by different means. The overall M&E framework is presented more broadly in *Chapter II*. The task of programmatic M&E is to assess the progress and results of a particular project and/or programme to the greatest possible extent, aiming to separate the results achieved by the project/programme from other factors contributing to the ultimate goal of the implemented activities and interventions. While other parts of the overall M&E system serve different tasks, programmatic M&E provides programme staff and decision-makers with an operational assessment tool used during the planning and implementation stages, particularly when selecting implementing partners, comparing achieved results to set targets, and correcting activities implementation through an ongoing process.

What is the Difference Between Programme and Project M&E?[1]

Although this manual targets a wide audience of organizations and agencies involved at different levels in fighting the epidemic, it is nevertheless important to distinguish between programme and project M&E.

For the purposes of this manual, *programme* refers to an overarching national or sub-national response to the disease, which usually has a relatively long time frame. For example, the National Programme for HIV Prevention, Care and Treatment of People Living with HIV/AIDS for years 2004–2008 is a programme, as is the "Overcoming the HIV/AIDS Epidemic in Ukraine" national programme supported by the Global Fund to Fight HIV/AIDS, Tuberculosis and Malaria. Within a national programme there are typically a number of different areas of programming, such as blood safety, sexually transmitted infection (STI) control, and HIV prevention among young people.

In contrast, *project* refers to a time-limited set of activities and objectives supported by resources that are aimed at a specific population defined geographically or otherwise. In view of its wider scope (thematic, geographic, target population), programme monitoring tends to be more complex than project monitoring and therefore requires extensive coordination among all implementing agencies.

However, for the purposes of this manual, the term "programme monitoring" will be used universally to describe monitoring of programmes and projects implemented to fight the HIV/AIDS epidemic. It is left to readers to adapt the information to better fit the scale of their interventions.

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[1] – Abstracted from the *M&E Toolkit: HIV/AIDS, Tuberculosis and Malaria*, January 2006 (Second Edition), p. 10

Why Do We Need a Single Unified National Programmatic M&E System?

Programmatic M&E is an integral part of the national M&E system, and, according to the Three Ones principles (UNAIDS), countries need (besides other elements) 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 and Malaria*, January 2006 (Second Edition): "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.[2] 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 which 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. A single national programmatic M&E system means that all players involved in fighting HIV/AIDS at national, regional or sub-regional level use the same basic instruments, tools and resources which comply with international requirements to conduct their programmatic M&E. More specifically, this means using the same sets of core programme-level indicators, data gathering techniques and counting methods throughout the country. This brings us to the second question of why using a single national programmatic M&E system is so important. There are several reasons: first of all, from a 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, as they can use previously developed and determined sets of internationally-accepted instruments and guidelines. As already noted in the preface, this manual was created with the aim of summarizing these resources and providing an easy-to-follow list of steps and instruments that will enable national players to employ a common programmatic M&E system. Another reason for creating a single system of programmatic M&E is that national authorities need to see the full picture of activities carried out in the sphere of HIV/AIDS and the results achieved at national level in order to make timely decisions and reprogram activities in case initially set targets are not met. If different national players are using different sets of indicators, gathering them with different periodicity, or using different data gathering techniques, this task becomes 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 an example of this below).

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[2] – *Monitoring and Evaluation Toolkit: HIV/AIDS, Tuberculosis and Malaria*, January 2006 (Second Edition), p. 8

Example:

Organization X is implementing a harm reduction project in one of the cities of Ukraine. The project is supported by the International HIV/AIDS Alliance in Ukraine within the Global Fund-supported programme and reaches 200 clients. Organization Y is also implementing a harm reduction project in the same city which reaches 150 clients, but the project is supported by the Ministry of Family, Youth and Sport of Ukraine.

How many clients are reached in this city through both projects? Are clients intersecting? Without a coordinated programmatic M&E system it is impossible to answer these questions.

Why Do Organizations Need a Programmatic Monitoring System?

There are numerous reasons to set up an effective programmatic monitoring system. Some of them include:

– to systematically track results of individual HIV/AIDS projects, analyze process and output-level data, reprogram the activities in order to achieve set goals, and produce reports for funding organizations. If the programmatic M&E system is functioning properly, it will help programme managers detect problems in activity implementation and 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 it for improvement in policy;

– to identify gaps in nationwide access to and coverage with services, and attract additional funding to cover them;

– to be able to analyze the cost-benefit and cost-effectiveness of particular projects and interventions;

– to provide a basis for evidence-based decision-making and strategic planning;

– to provide donors and stakeholders with accurate and reliable reports; etc.

What Resources are Needed to Build a Programmatic M&E System?

It is recommended that about 5–10 percent of national programme budgets, and around 3–5 percent of regional or district programme budgets devoted to HIV/AIDS, should be allocated for M&E activities. Although this may seem a large proportion, programmatic M&E is much less expensive than research and surveillance (also an inherent part of the M&E system), while being nevertheless a valuable source of data. It is also strongly recommended that there is a designated specialist, or for large programmes, a team of specialists in the organization to deal specifically with M&E. Such specialists/teams should be responsible for all M&E activities within an organization, their key tasks being to ensure proper gathering, analysis, usage and dissemination of data. They are also responsible for maintaining M&E management information systems and task-specific databases, if such are used, and for producing reports. In small NGOs whose primary goal is to provide services, it is recommended to have one devoted team member responsible for implementation of M&E activities; however, the existence of simple and clear internal M&E procedures and regulations, and usage of a registration management information system, would be a necessary requirement even in this case, as will be discussed later.

In order to ensure optimal and proper use of funds, it is important to develop a single coordinated system, including tools, procedures and training of relevant staff. The initial investment cost will later be seen in the light of the incremental benefit of data which has been collected and analyzed, and is infinitely less costly than having a number of different systems functioning.

Why This Manual?

As already mentioned in the preface, this manual was created as a first attempt to build a coordinated programmatic M&E system in Ukraine. It will also be useful for players in other countries who are developing their systems of programmatic M&E, since it builds extensively on internationally–accepted principles and resources, such as the *Monitoring and Evaluation Toolkit: HIV/AIDS, Tuberculosis and Malaria* [3] (endorsed by the Global Fund to Fight HIV/AIDS, TB and Malaria, WHO, The World Bank, UNAIDS, USAID and other stakeholders), *A Framework for Monitoring and Evaluating HIV Prevention Programmes for Most–At–Risk Populations* [4] developed by UNAIDS and endorsed by WHO, USAID, CDC, MEASURE Evaluations, and others.

Although there are individual organizations creating and successfully maintaining effective programmatic M&E systems for monitoring and evaluating their activities, numerous donors, state bodies and NGOs see programme/project monitoring as just a tool of accountability to their funding organizations and a means of producing reports. There is a lack of understanding of how programme and project M&E data can be used at the national level; at the same time, there is increasing demand within state bodies scaling up HIV/AIDS–related funding, as well as within non–government organizations both in Ukraine and abroad, for 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 programmes and projects are on track, and, if not, amend performance in a timely manner. In this manual the International HIV/AIDS Alliance in Ukraine has tried to accumulate the experience and best practices developed through its implementation of the GF–supported programme.

Who is it For?

The main target audience of the manual is 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 receiving funding for implementation of particular activities and facing the need to establish a project monitoring and evaluation system. The list of indicators attached to this manual can be used both by programmes at national/sub–national level, and by individual projects. As mentioned earlier, the manual builds extensively on internationally–accepted principles and resources, thus making it a useful tool for different countries.

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[3] – *Monitoring and Evaluation Toolkit: HIV/AIDS, Tuberculosis and Malaria,* January 2006 (Second Edition)

[4] – *A Framework for Monitoring and Evaluating HIV Prevention Programmes for Most–At–Risk Populations,* April 2007.

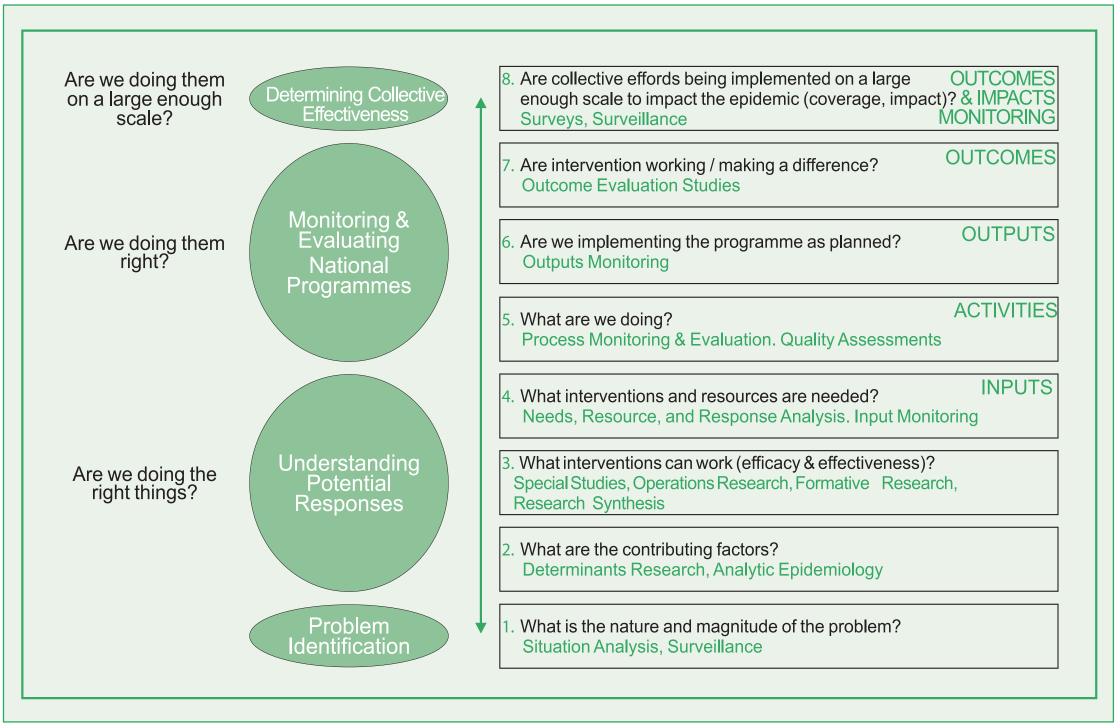
How is it Different From Other M&E Books and Resources?

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 diagrams, illustrations, examples and practical case studies. Although some basic M&E knowledge is desirable, it should be perfectly understandable to non-M&E specialists. Additional M&E resources and tools can be found on the attached CD. Apart from the two sources mentioned above (*Monitoring and Evaluation Toolkit: HIV/AIDS, Tuberculosis and Malaria* and *A Framework for Monitoring and Evaluating HIV Prevention Programmes for Most-At-Risk Populations* developed by UNAIDS), the CD also contains *Monitoring and Evaluation Methodological Recommendations* developed by the International HIV/AIDS Alliance, Ukraine in 2004. The major difference between the Methodological Recommendations and this manual is that while the former provides a comprehensive summary of all different methods and tools used for data gathering, analysis and usage, with detailed description and examples, the latter proposes a practical list of steps required from an organization desiring to build a system of programmatic M&E. It will not provide the reader with all necessary background information or all possible tools and methods that exist in this sphere; however, it will assist in carrying out concrete steps aimed at building an M&E system in a practical and cost-effective manner.

Manual Structure

The investigation of any problem begins by asking pertinent questions that serve to initiate and organize the response. Such questions might include: what is the problem? What are the contributing factors? What can be done about the problem? Once answers are found, we move on to the stage of planning activities, and their implementation and evaluation. Each of these stages requires specific M&E activities to be carried out as part of a well-functioning M&E system. The overall approach to planning and organizing M&E activities along with planning and implementing adequate interventions in the response to HIV is presented in *Diagram 1*. The structure of this manual is designed in such a way as to capture the steps and necessary arrangements to plan, monitor, and evaluate HIV prevention programmes for most-at-risk populations and care and support projects for PLHA. It provides a step-by-step sequence for planning data collection, analysis and usage over time, serving as a road map where the answers to questions at one step provide the basis for the questions and information needed at the next step. It also allows everyone involved to identify their role and contribution to the M&E system.

Diagram 1. ***Approach to Planning and Organizing M&E Activities*** [5]



8. Are collective effords being implemented on a large enough scale to impact the epidemic (coverage, impact)? Surveys, Surveillance

7. Are intervention working / making a difference? Outcome Evaluation Studies

6. Are we implementing the programme as planned? Outputs Monitoring

5. What are we doing? Process Monitoring & Evaluation. Quality Assessments

4. What interventions and resources are needed? Needs, Resource, and Response Analysis. Input Monitoring

3. What interventions can work (efficacy & effectiveness)? Special Studies, Operations Research, Formative Research, Research Synthesis

2. What are the contributing factors? Determinants Research, Analytic Epidemiology

1. What is the nature and magnitude of the problem? Situation Analysis, Surveillance

Chapter II briefly describes major conceptual and theoretical issues of the M&E system, aimed at providing a basis for better understanding of the context for non-M&E specialists.

Chapters III to IX provide an overview of the necessary steps on the way to building and maintaining a system of programmatic M&E. The steps have been structured in such a way as to address both the needs of large national or sub-national programmes providing grants/budgetary subventions to their implementing partners (later in the text referred to as funding organizations), as well as smaller organizations which are themselves recipients of budgetary or donor funding (implementing organizations). 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 the activities of those organizations they fund, some of the steps will be relevant only for this type of organization. Smaller organizations and projects will be able to skip them, as will be indicated.

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[5] – Abstracted from *A Framework for Monitoring and Evaluating HIV Prevention Programmes for Most-At-Risk Populations*, April 2007, p. 8 (Source: Rugg et al. (2004). *Global advances in HIV/AIDS monitoring and evaluation. New Directions for Evaluation*. Hoboken, NJ, Wiley Periodicals, Inc.)

The seven steps towards building and maintaining an effective M&E system are as follows:

Step One:	Planning activities and interventions (defining goals, objectives, service delivery areas, target groups and scope of work)
Step Two:	Defining the indicators framework: selection of indicators, determining baselines, setting targets
Step Three:	Selection of implementing partners, conducting capacity assessment, development of reporting formats
Step Four:	Monitoring service quantity and quality: keeping programme records
Step Five:	Collection and analysis of data, ensuring data quality
Step Six:	Projects and interventions evaluation
Step Seven:	Translation of M&E results into managerial decisions, data usage

Each of these steps is presented using the following structure for ease of reference:

- **What does this step mean? What is it for?**
- **How and when is it done?**
- **What are the anticipated challenges and possible solutions?**
- **Practical case example**

Each of these questions will be addressed separately for the funding and implementing organization where relevant (please refer to the Glossary for definitions of these terms).

Chapter X reviews the monitoring and evaluation cycle as a broader national M&E process.

The manual also refers to the list of **Annexes:**

Annex 1:	Data Measurement Tools and Methods
Annex 2:	Service Delivery Areas and Examples of Output Indicators
Annex 3:	List of National Indicators on Monitoring and Evaluation of HIV/AIDS Control Activities Efficiency
Annex 4:	Sample Programme Reporting Format (Focused Prevention Project for MARPs)
Annex 5:	Sample Primary Registration Forms
Annex 6:	Sample Monitoring Visit Report Form used by the International HIV/AIDS Alliance in Ukraine to Monitor Focused Prevention Projects
Annex 7:	Sample Indicators Framework
Annex 8:	Sample Project Performance Summary Form
Annex 9:	National Behavioural Surveillance Study of Early Seroconversion
Annex 10:	Sample Brief Description of Possible Operational Research Option

and

What Are Some "Tips And Tricks" of Building a Successful Programmatic M&E System?[6]

- M&E systems must be as simple as possible. Most programmes and projects collect far more data than they use. The more complex an M&E system, the more likely it is to fail. It is important that data are 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 analysis of the internal self-assessment and externally verified primary data.

- M&E must be built into the design of a programme 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 national-level data collection as they can be aggregated up to this level. However, sub-national data are more relevant to programme 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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[6] – Abstracted from the *M&E Toolkit: HIV/AIDS, Tuberculosis and Malaria*, January 2006 (Second Edition), p. 17

Chapter II

PROGRAMMATIC MONITORING AS AN INHERENT PART OF THE OVERALL M&E FRAMEWORK

There are varying frameworks applied to monitoring and evaluation in any sphere. Indicators are used at different levels to measure what goes into a programme 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 programme 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 programme or project is likely to have positive short-term **effects** or **outcomes,** for example increased condom use with casual partners, increased use of sterile injecting equipment, adherence to ARV therapy, etc. These positive short-term outcomes should lead to longer-term **impact**, measured in fewer new cases of HIV/AIDS, decreased mortality and related disease burden among those infected and affected (such as orphans and vulnerable children). The desired impact also includes improvement in quality of life and life expectancy among those infected.[7] 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
US Government: http://www.globalHIVevaluation.org
UNAIDS: http://www.unaids.org/en/default.asp

This framework is often visualised in the form of the M&E levels pyramid presented in *Diagram 2*. It describes all levels at which monitoring and evaluation can take place and provides a logical way of organizing the data collection process: at the **input level**, an organization tracks all inputs and resources that are invested into a certain process (usually financial resources); at the **process level**, the activities implemented are tracked, e.g. trainings conducted, materials distributed, or counselling sessions conducted; at the **output level** the organization tracks the direct results of the activities carried out at the process level: coverage of vulnerable groups' representatives with services, numbers of students educated, etc. The basic instrument of data collection at these three levels is programme 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 latter can be carried out by means of analyzing existing programme monitoring data, as well as conducting special studies, as will be discussed later. **Programmatic M&E** is usually defined as the **process** and **output** parts of this pyramid, measuring those indicators which can be attributed to the results of activities of a certain programme or project per se. **Input** level monitoring usually deals with financial reporting, and thus will be touched upon only slightly in this manual.

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). In the diagram, these two blocks are shaded a different colour in order to emphasise their difference from the first three levels of M&E.

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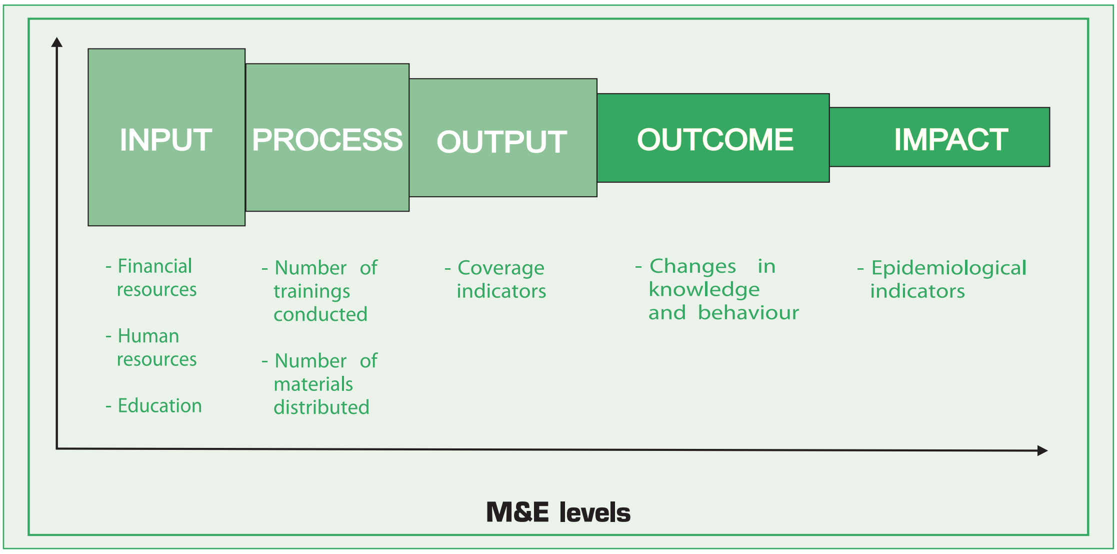
[7] – Abstracted from the *M&E Toolkit: HIV/AIDS, Tuberculosis and Malaria*, January 2006 (Second Edition), p. 11

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, but 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. Assessing the impact of a programme requires extensive investment in monitoring and evaluation, and it is often difficult to ascertain the extent to which individual programmes or programme 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 programmes' progress according to agreed-upon goals and targets. National surveys and datasets should also be leveraged in evaluation.

The narrowing character of this pipeline, where each consecutive box is of a smaller size than the one before, illustrates the number of indicators to be collected and the number of agencies involved in the process of data collection and analysis at each level.

Diagram 2. ***Levels of Monitoring and Evaluation***

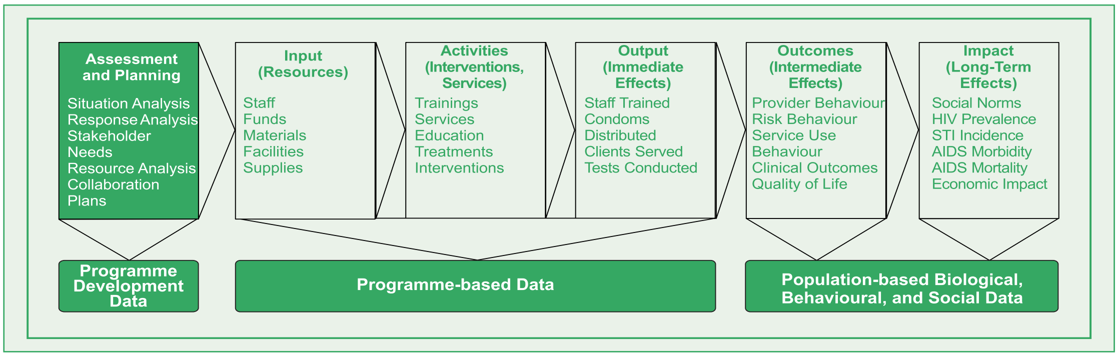


As mentioned earlier, process and output-level results can in most cases be directly attributed to the specific projects or programmes that financed and implemented them, while outcome and impact results usually show the nationwide (or sometimes regional) effects of all activities aimed at fighting HIV/AIDS that are being implemented, as well as the natural epidemic trends. Thus, it might quite possibly be the case that output-level monitoring and evaluation indicates that the programme is on track, the set targets are reached and the quality of services is adequate, while the impact level shows evidence of increased incidence and mortality rates.

We will touch only slightly on national-level surveys and second generation surveillance within this manual, as its major focus is to describe the processes of programmatic M&E carried out by organizations with their own means, and thus the following text will focus mainly 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.

More specifically the M&E framework is illustrated in *Diagram 3*.

Diagram 3. **Global AIDS Monitoring and Evaluation Framework and Illustrative Data Types.**[8]



To truly determine the merit or value of a programme, evaluation studies must supplement monitoring data, which is gathered on a routine basis, as will be discussed later in this guide.

The following are the key parameters by which programmatic M&E data differ from outcome and impact-level data:

- **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 every 2–5 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 a full description of data collection and measurement tools and methods.

The methodology used to obtain data at all M&E levels should remain consistent over time. This is relevant for all further addressed data collection-related issues, as only under this condition can data be made comparable over years. As the major purpose of all M&E activities is measurement of trends in response to certain interventions, data has to be comparable over time periods, which basically means using the same data collection methodology.

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[8] – Abstracted from *A Framework for Monitoring and Evaluating HIV Prevention Programmes for Most-At-Risk Population*, April 2007, p. 5 (Source: Rugg et al. (2004). *Global advances in HIV/AIDS monitoring and evaluation. New Directions for Evaluation*. Hoboken, NJ, Wiley Periodicals, Inc.)

Table 1. ***Recommended Reporting Frequencies and Data Collection Methods for Different Levels of Indicators***[9]

Level of indicator	Recommended frequency of reporting	Examples of data collection methods*
Input/process	Continuously	– Health services statistics – Programmatic M&E records
Output	Quarterly, biannually or annually	– Health services statistics – Programmatic M&E records – Operational research
Outcome	Once in 1–3 years	– Population–based surveys – Health facilities surveys – Special studies
Impact	Once in 2–5 years	– Population–based surveys – Epidemiological surveillance – Special studies

* Most of these data collection methods will be described in greater detail later in this manual with the emphasis on programmatic M&E data collection methods (process and output level)

- **Number of entities** which should conduct data collection, analysis and reporting. While programmatic M&E should be conducted by all entities implementing relevant programmes, data on outcome and impact indicators should be collected nationally (or regionally) by specially designated or selected agencies. Since data collection and analysis for outcome and impact indicators requires rigorous scientific methodology and is expensive, only a few agencies in the country can usually conduct such work.

- **Costs.** Routine collection and analysis of programmatic M&E data is less expensive than conducting behavioural and epidemiological researches and surveys.

Much of the information contained in this manual is focused 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 behaviour change, information that can prove valuable in designing more effective communication campaigns, giving voice to poor and vulnerable populations and providing better services to target groups.

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 programme progress, ensure triangulation of data sources and reduce biases in the data.

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[9] – Adapted from the *M&E Toolkit: HIV/AIDS, Tuberculosis and Malaria*, January 2006 (Second Edition), p. 13

Difference Between Monitoring and Evaluation[10]

Monitoring is the routine tracking of the key elements of programme/project performance (usually inputs, process and outputs) through record keeping, regular reporting and surveillance systems, as well as health facility observation and surveys. Monitoring helps programme 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 differ, 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 programme 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 programme 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 programme or project managers determine the value or worth of a specific programme or project. Cost-effectiveness and cost-benefit evaluations are useful in determining the added value of a particular programme or project. In addition, evaluation should also relate the outputs of a project/programme to wider national trends in behaviour and other outcomes, and the impact on diseases. This type of evaluation is important even if the project/programme 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 rigour needed; without such rigour, wrong conclusions on the value of a programme 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.

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[10] – Abstracted from the *M&E Toolkit: HIV/AIDS, Tuberculosis and Malaria*, January 2006 (Second Edition), p. 11

Chapter III

STEP ONE:

PLANNING ACTIVITIES AND INTERVENTIONS (DEFINING GOALS, OBJECTIVES, SERVICE DELIVERY AREAS, TARGET GROUPS AND SCOPE OF WORK)

■ What does this step mean? What is it for?

Programmes or projects should have clearly defined goals and objectives of their work. This is the starting point of the usual project management cycle and consequently the process of setting up a programmatic M&E system. Unless there is a specific objective which a programme intends to achieve, it is impossible to say whether adequate interventions are being implemented and whether the achieved results correspond to the initial intentions or not. Service delivery areas (SDAs) represent further detailed breakdown of objectives, linking indicators to specific areas of work and activities allowing for comparison of 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. incidence and prevalence rates among IDUs) in the future. Along with defining goals, objectives and SDAs, specific attention should also be paid to defining the target groups and scope of work of the planned interventions. This will have direct implications on the development of the project work plan and budget. The process of defining the scope of work should find a balance between the recommended scale of interventions in order to have an impact on the epidemics, and the capacity of a particular organization to implement certain activities.

At this stage *funding agencies* should define the broader contextual framework of the programme to be implemented, thus limiting and specifying the context, planned interventions and means of implementation, scope of the overall programme, and funding priorities. This would provide a basis for *implementing organizations* to plan their work within the overall programme–defined frames and priorities. When preparing their proposals, they would further narrow down interventions, activities and scope of work to be done at the field level.

At this stage the programme or project management team would define and clarify the logical structure and expected results of the work to be done.

■ How and when is it done?

The described work should be done prior to programme or project implementation, as part of the broader strategic planning process usually performed by senior management of either *funding* or *implementing organizations*. However, as project management is a cyclical process, the data and evidence obtained at later stages will enhance implementation during future periods.

A programme has one or two goals. Each goal has a series of objectives, each objective includes several SDAs, and performance within each SDA is monitored and evaluated by means of one or more indicators.

Overall Goals – are broad and overarching, defining the ultimate impact of intended work, for example *"Reduced HIV–related mortality"*, *"Reduced transmission of HIV"*, *"Improved quality of life of people living with HIV/AIDS"*, etc.

Objectives need to be clearly described for each goal. An objective describes the intention of the programmes for which funding is sought and provides a framework within which services are delivered which aim to achieve the set goals. Examples of objectives include *"Improving survival rates among people with advanced HIV infection in four oblasts", "Reaching 60 percent coverage with prevention services in two regions", "Reduction of mother–to–child transmission of HIV in Kyiv"*, etc.

Under each objective **service delivery areas (SDAs)** 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, but to other areas as well, with examples of indicators, can be found in *Annex 2*. Examples of SDAs may be: *"Provision of voluntary counselling and testing to vulnerable groups", "Provision of sterile injecting equipment to IDUs", "Home–based care provision to chronically ill PLHA"*, etc. The list of SDAs constitutes a basis for the development of a work plan (the list of specific activities to be implemented with corresponding timelines). Each SDA should have corresponding process and output–level indicators, which will be discussed further. Some output–level indicators may reflect the progress achieved by implementing the specific activities within several SDAs. For example, *"Number of people reached with comprehensive prevention services"* might include those receiving VCT, condoms and syringes, behaviour change materials and counselling, etc. which each represent a separate SDA.

Objectives and SDAs are usually formulated with regard to a certain **target population**, referring to the group of people who are in need of an intervention, and **geographic coverage.** The target population can be the total population or a smaller, specific group defined by age limits or behaviour patterns; definition is usually based on knowing who is most affected by diseases both directly and indirectly. For example, the definition of a target population for HIV/AIDS interventions is often based on the epidemic situation. In *generalized epidemics* where HIV prevalence is consistently over 1 percent 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 behaviours, the target group may be defined as a sub–group of the general population that shares these same behaviours – for example, *men who have sex with men (MSM), people who use intravenous drugs (IDUs), or commercial sex workers (CSWs).*[11] *Male prisoners* are of particular concern in many settings due to the risk of having unprotected and often coercive sex, and due to the sharing of injection equipment; thus they are also often defined as a target population.

The exact definition of IDU, CSW and MSM populations refers to the time period during which an individual has been practicing a particular risk behaviour. Although these time periods should be defined by national consensus, it is recommended to follow standard internationally accepted definitions.

Injecting Drug Users (IDUs)

Based on UNGASS guidelines, it is recommended that a person is classified as an injecting drug user if they report having injected drugs within the last month.

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[11] – Abstracted from the *M&E Toolkit: HIV/AIDS, Tuberculosis and Malaria*, January 2006 (Second Edition), p. 12

Men who have Sex with Men (MSM)

Based on UNGASS guidelines, it is recommended that a person is classified as a man who has sex with men if they report having had anal sex with a male partner in the last six months.

Commercial Sex Workers (CSWs)

Based on UNGASS guidelines, it is recommended that a person is classified as a sex worker if they report having had commercial sex in the last 12 months.

Sometimes it is worth splitting these groups into sub-groups, i.e. female IDUs who sell sex, or young IDUs (25 and younger). This is usually done when the decision is made to target specific interventions at these sub-groups which would differ from overall approaches taken to work with the population as a whole. In such cases these decisions would have implications for the design of a programmatic M&E system, specifically for indicators disaggregation and data collection tools.

The target population of **care and support projects** for people living with and/or affected by HIV/AIDS is self-explanatory, although the group considered to be affected by HIV/AIDS should be clearly defined. It usually includes children born to HIV-positive mothers (including orphans) and other relatives of PLHA; however for consistency purposes this should be specified on the national level, or the level of any large-scale programme implemented in the country.

Individual projects should follow agreements reached on the national level selecting one or several target populations to work with.

Once goals, objectives, SDAs and target groups have been defined, it is time to make a decision on the scope of work to be done. The scale at which interventions will be implemented and reach target populations is usually defined by funding availability, feasibility considerations and international recommendations. **For example, WHO recommends that at least 60 percent of IDUs should be regularly reached with prevention services in order to influence epidemic trends.**[12] On the other hand, there are always certain limitations which should be taken into account at this stage. Apart from the level of funding, these are political context, and in the case of *funding agencies* the level of development of implementing organization networks, or the organizational capacity and regional peculiarities of high risk group behaviours in the case of *implementing organizations.*

The scope of work to be implemented is usually put in the form of figures, showing the intended percentage of target group coverage with a description of assumptions and limitations. In order to calculate the percentage, both numerator and denominator should be defined. The issue of setting targets as an absolute value (numerator) will be discussed in the following chapter, while here we will address the issue of **how to define the denominator, or in other words, how to estimate the size of the target population** both on the national and regional level.

An estimate of the size of the target population, rather than **official statistics**, is recommended to be used for defining the scope of work both on the national and regional levels. The main reason for this is the well-known fact that official statistics usually show much lower numbers of all target populations because of the hidden character of the latter.

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[12] – *A Framework for Monitoring and Evaluating HIV Prevention Programmes for Most-At-Risk Populations*, April 2007

Official statistics on the number of IDUs can be obtained from Ministry of Health statistics on the number of patients with mental and behavioural disorders due to consumption of psychoactive substances, and the official number of CSWs can be obtained from Ministry of Interior statistics on arrests for prostitution. Obviously, these numbers are much lower than the actual number of IDUs and CSWs. The situation is the same concerning the number of PLHA, as the number of individuals registered with HIV infection in the AIDS Centre is much lower that the actual number.

Some MARPs such as MSM are not included in any statistical records, which basically means there is no available official information on the size of this group.

Thus, estimation of target population size is one of the key issues for strategic planning, as it informs resource needs, measures to be taken and forecast of the expected level of impact. At the same time, official statistics are still an essential component of the estimation process. The usage of statistical data in the estimation process will be addressed further.

There are several MARPs such as **the prison population** where official statistics provide exhaustive information on the size of the group. These populations are not considered hidden, while still being at high risk of HIV–infection.

How to Estimate the Size of IDU, CSW and MSM Populations

In order to conduct size estimation the following issues have to be addressed:

- Target group identification
- Selection of a proper method

Identification of Target Groups

As mentioned previously, there is no single approach to identifying an individual as an IDU, CSW or MSM. In the context of response to the HIV/AIDS epidemic, identification of target groups should include the level of potential risk to become infected or to infect another person.

IDUs – injecting drug users. In the context of the HIV epidemic, strategic planners are interested in individuals who use drugs regularly and thus represent a risk group. In order to identify this group, it is recommended to control two major indicators: the duration of drug use (in a lifetime): during one year, or during the last six months; and the regularity of drug use – for example, those who use drugs at least weekly.

CSWs – commercial sex workers. This group includes women (and men) who use sex as a source of income (permanent or temporary). It can also include women who provide sexual services to achieve certain goals (career development). However, in terms of the epidemic, it is important to consider the group of CSWs who are involved in sexual services for a certain period of time (but not for a single occasion): during the year or the last six months. Another criterion to be taken into account is whether commercial sex services are the primary (or one of the primary) sources of income.

MSM – men who have sex with men. This group includes men having sex with men during the previous 12 months. The issue of duration and frequency of such relations, as well as whether it is voluntary or forced, is still controversial.

Commonly Used Methods

A decision on the method of estimation to be used as the most relevant and reliable should be based on several options: available statistical data and previous estimations, level of estimation (national or regional) and level of stigmatization of the target group.

Most widely used are the following methods:

General Population Survey/Poll

Also called national household survey (NHS) – standardized mass representative polls of research subjects. This survey can provide information on minimal indicators of the size of a population which practices socially disapproved behaviours. This method is usually effective on the national level. It was used as the only option to estimate the size of the MSM population in Ukraine. The questionnaire for a survey of this type may include a block of questions on sexual behaviour, including sexual relations of men with other representatives of their gender. As a sub-method, school surveys can cover part of the target population; for example, if the size of the population of young drug users (under 18) has to be estimated.

There are several limitations to this method. First of all, risky behaviour is not widely represented among the general population. Secondly, respondents can refuse to give true answers. Thirdly, people who represent a potential target group usually do not belong to a household; in other words, they usually live in other places than ordinary houses or apartments (streets, brothels, etc.) where they cannot be reached by researchers. It is important to mention that this most marginalized part of the target group is most vulnerable to HIV and needs prevention interventions first of all. This method does not usually work to estimate IDU population size.

Capture-recapture Method

The essence of this method is performing the poll twice. After the first poll respondents are marked as those people who have participated in polling. Different marking methods can be used, e.g. some memorable present (for example, a set of cosmetics), which the interviewer gives to the respondent after first polling. During the second poll the interviewer "captures" those respondents who participated in the first polling and who report having been given a present (being marked). This method assumes that after returning to their groups respondents will get "mixed up" to homogeneity. Thus the share of those who participate in the second polling will be equal to the share in a fully investigated aggregate. To calculate the size of the target group (TG) the following formula is used:

$$\text{Total estimated number of TG (N)} = \frac{n1 \times n2}{m} \qquad \text{(formula 1)}$$

Where: n 1 — the number of TG in the sampling of the first capture

n 2 — the number of TG in the sampling of the second capture

m — the number of TG from the first "capture" in the sampling of the second capture

Below is an example of the practical application of this method:

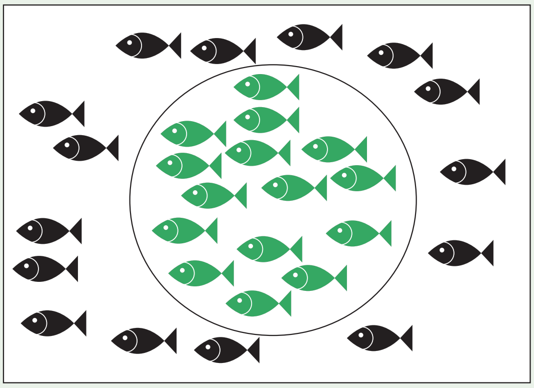


Figure 1

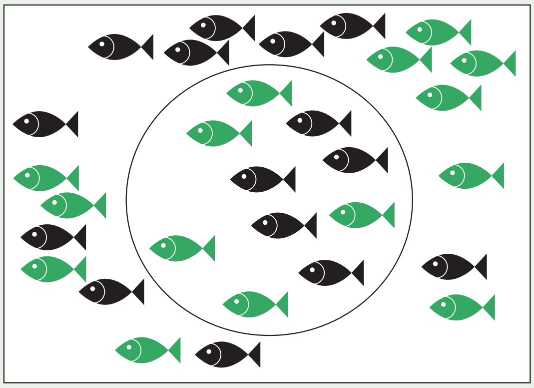


Figure 2

Example:

An ecologist wants to estimate the number of fish in a lake: therefore a sample of fish are caught, counted, marked in some way and then released. As shown in Figure 1, a sample of 15 fish have been caught and marked. At a later date the ecologist returns to catch another sample, and by checking for marks (as demonstrated in the second figure), the number of fish present in both samples is discovered; it is five. The total number caught the second time is ten.

Applying the formula described above, the result will be as follows: **15 x 10/5=30**

One of the fundamental requirements for this method to be applied is the capacity to ensure independence of the first and second sampling – in other words, a theoretically similar probability exists for each representative of the group to be covered by sampling during the first and the second poll.

This method is rather complicated and sensitive to migration processes or the political situation, which is why it can be used **only on the regional or even site level.**

In Ukraine this method was used to estimate the number of CSWs on the regional level.

Quasi Capture-recapture

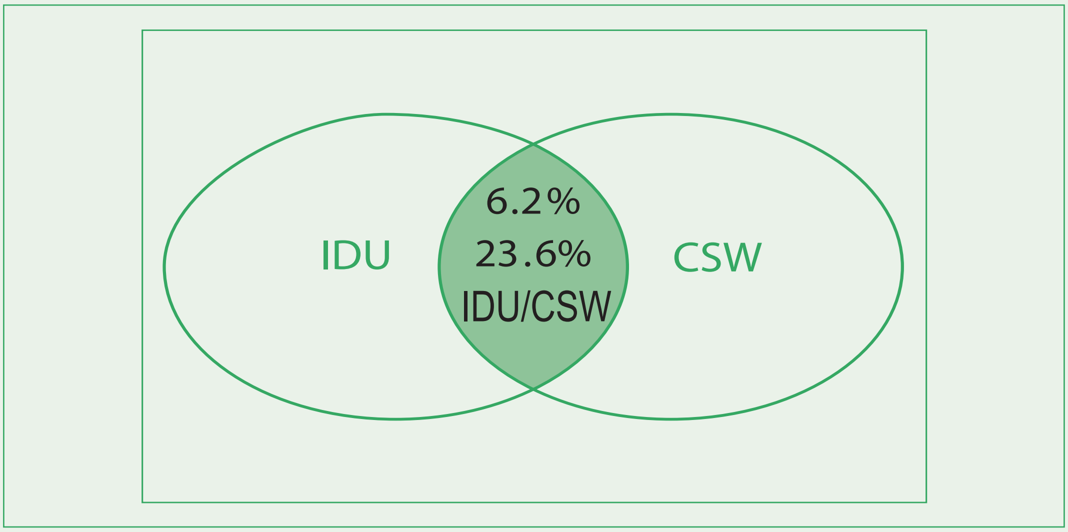
This method is based on the same principle of homogeneity as the original capture-recapture, but is simplified. Instead of two polls, the researcher can use two or more lists of official records or survey databases, assuming that the same people are mentioned in these lists or participated in these surveys. In other words, quasi capture-recapture is used as a secondary analysis of existing or obtained data. As far as statistical or survey data can be obtained both on a regional and national level, this method allows for making estimations on different levels, in contrast to capture-recapture. This method also has some requirements. First of all, working with officially registered data (list of participants) requires that these lists were created independently. The second necessary condition is that data should be obtained in the same time period and location.

Below are two examples of application of this method. The first is based on use of data from two behavioural surveys. The second is based on use of a list of official records.

Example 1:

This example shows a calculation of CSW population size.
Two different surveys among IDUs and among CSWs were conducted. It was assumed that the same individuals might participate in both surveys. This assumption was based on the fact that female drug users could also be female sex workers. In this case, the two surveys can be considered as first and second captures. The first capture was a poll of IDUs, where CSWs were present as a sub-set of the whole sample. The second capture was a poll of CSWs, where a part of the sampling was IDUs.

Graphically this can be shown in the following way:



As a result of the behavioural survey among IDUs, a percentage of female IDUs was determined (6.2 percent), who answered that they had provided commercial sexual services during the last 12 months. They are marked as caught in the first capture. Assuming that the estimated number of IDUs is known and is equal to 120'000, then the number of CSWs caught in the first capture is

120'000 x 6.2/100 = **7'440**.

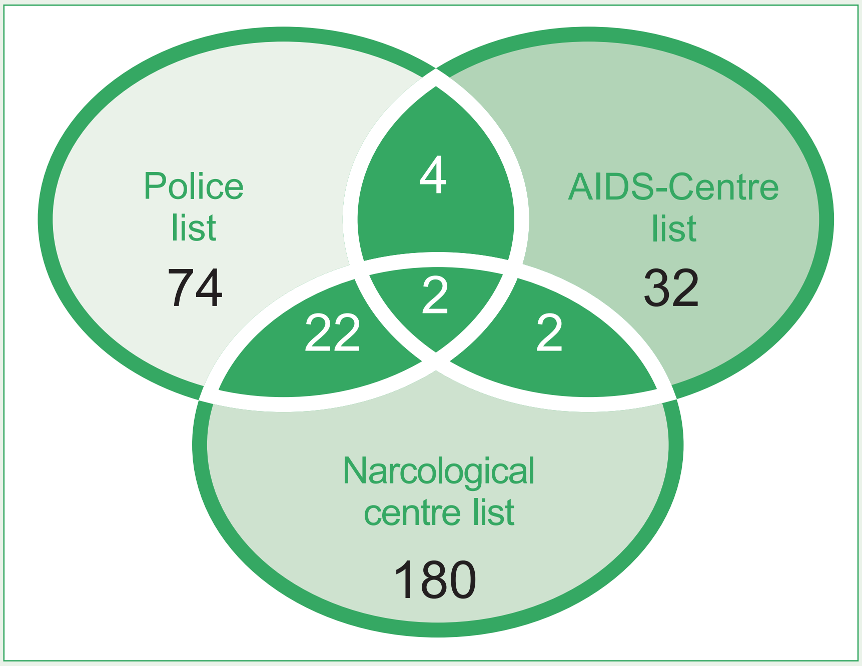
As a result of the behavioural survey among CSWs, it was determined that each fourth woman (23.6 percent) had used injecting drugs during the last 12 months. In our case they are marked as individuals in the second capture.

In other words, the 7'440 CSW/IDU constitute 23.6 percent of the total number of CSWs. So, the total estimated number of CSWs is

7'440 x 100/23.6 = **31'757**.

Example 2:

An organization wants to estimate the actual size of the IDU population in city A. Only a few statistical records are available: drug users registered by the police, drug users registered in the narcological centre and drug users registered in the AIDS centre (all data were obtained within one year). In this case the organization has three lists of drug users with names. Some individuals were found on two lists, some of them on three.



In the case of two available lists, formula 1 can be applied. In case of three or more lists a rather complicated software tool has to be used.
This software tool is called PEPI for Windows (WinPepi), which can be downloaded from:
http://www.healthcarefreeware.com/calc.htm

Coefficient (Multiplier) Method

The method of coefficients can be applied if quantitative information from at least two sources is available, and if it is known that estimated groups overlap, and the size of this overlap is also known. The first source may be statistics from any institution which is in contact with a target group (for example, registration in a substance dependency facility). The second source may be direct information received from the target group within a behavioural survey (for example, a positive answer to a question concerning registration at the narcological dispensary). In this particular case official statistics can help in obtaining an estimate number. In order to apply this method several steps have to be taken:

1. Identify sources of input data.
2. Receive necessary statistical information.
3. Develop questions and include them into the questionnaire for polling.
4. After polling, calculate the percentage of respondents who gave a positive answer to your question.
5. Apply the formula to all received data and calculate the number of the estimated group in the city/region. This method can also be used nationwide.

Example:

- 1'500 IDUs received treatment in city A during 2004.
- According to survey results, 20 percent of IDUs received treatment.
- Coefficient for the calculation of the size: 100% : 20% = 5
- **Total estimated number of IDUs = 1'500 x 5 = 7'500**

This method was used to estimate the number of IDUs in Ukraine on the national level. The so-called "hospitalization coefficient" was applied in this case. In several countries where good/reliable data of officially-registered overdose cases exists, another coefficient can be used based on overdose data.

Regarding CSWs, the only official data available from the Department to Combat Human Trafficking Crimes at the Ministry of Internal Affairs of Ukraine is of CSWs registered as arrested for prostitution. In this case during a behavioural survey respondents have to be asked whether they have been arrested for prostitution during the defined time period. Putting these two data sources into the above formula, the total number of CSWs can be estimated.

Two requirements are essential: the official data must be reliable, and all data from both sources have to be obtained within the same time period.

It is recommended that national estimations of MARP size are conducted once every 5 years, while regional estimations can be updated every 2–3 years. The following table summarizes the applicability of described methods for different populations and levels.

Table 2. ***MARPs Estimation Methods Applicability Table***

Method	National level	Regional level
General population survey (household survey)	MSM, CSW	–
Capture-recapture	–	IDU, CSW, MSM
Quasi capture-recapture	CSW, IDU, MSM	CSW, IDU, MSM
Coefficient (multiplier) method	CSW, IDU	CSW, IDU

Estimating Numbers of People Living with HIV/AIDS

Since the beginning of the AIDS epidemic, the methods and results for generating estimates of numbers of people living with HIV and AIDS have been regularly revised and improved. Several methods exist for conducting such estimates, not all of which are consistent or scientifically based. In order to encourage consistency in the use of reliable and scientifically-valid methods, the UNAIDS Reference Group on Estimates, Modelling and Projections was established. The Reference Group provides impartial scientific advice to UNAIDS and the World Health Organization (WHO) on global estimations and projections of the prevalence, incidence and impact of HIV/AIDS.[13] UNAIDS/WHO recommend the following methods to obtain national HIV and AIDS estimates.

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[13] – For more information about the reference group, visit their website at www.epidem.org

- **Generalized Epidemic:**

In countries with a **generalized epidemic**, national estimates of HIV prevalence are based on data generated by surveillance systems that focus on pregnant women who attend a selected number of sentinel antenatal clinics, and in an increasing number of countries on nationally representative serosurveys. This data is entered into the **Estimation and Projection Package (EPP)** software which fits a simple epidemiological model to find the best fitting curve that describes the evolution of adult HIV prevalence over time, and calibrates that curve to the prevalence found in the national survey.

- **Low Level or Concentrated Epidemic:**[14]

In countries with a low level or **concentrated epidemic** national estimates of HIV prevalence are primarily based on surveillance data collected from populations at high risk (commercial sex workers, men who have sex with men, injecting drug users) and estimates of the size of populations at high and low risk. This information is entered into point prevalence and projection spreadsheet models (**the Workbook Method**) to find the best fitting curve that describes the evolution of adult HIV prevalence over time.

The Workbook approach to making HIV prevalence estimates and building future scenarios of HIV/AIDS prevalence was developed for use in countries with low–level and concentrated epidemics. There is no set of representative data that can be used to estimate adult prevalence in these countries, unlike countries where the epidemic has become generalized and data from pregnant women is used as a proxy for adult prevalence.

In concentrated epidemics, HIV has spread rapidly in a defined sub–population, but is not well–established in the general population. This epidemic state suggests active networks of risk within the sub–population. The future course of the epidemic is determined by the frequency and nature of links between highly infected sub–populations and the general population. For concentrated and low–level epidemics, the approach has been to:

- develop estimates for populations who are most exposed to HIV/AIDS, and then
- combine those estimates to produce an overall estimate of adult prevalence.

Most of the work of preparing a national estimate consists of the initial data collection and planning. Some of the data required to complete a projection curve estimate in Workbook include:

- Geographical regions
- The groups in the country who are at higher risk of HIV infection
- The groups in the country who are at lower risk of HIV infection

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[14] – *Using the Workbook Method to Make HIV/AIDS Estimates in Countries with Low–Level or Concentrated Epidemics*. Manual. UNAIDS and WHO, 2007.

- Data for population sizes of groups at higher risk of HIV
- Current HIV prevalence data for these population groups

Workbook also requires users to decide how to handle missing or incomplete data.

Once users have generated national HIV estimates for a series of years, Workbook allows users to use these estimates to plot an epidemic curve that shows the course of the epidemic over time. The Epidemic Curve sheets allow users to:

- fit an epidemic curve to the data points so as to assess the trend over time;
- determine doubling time of the epidemic, rate of growth of the epidemic and the current prevalence level.

This adult prevalence curve, along with national population estimates and epidemiological assumptions, is then entered into the **Spectrum software program** to calculate the number of people infected, new infections and deaths.

SPECTRUM is a suite of policy models (DemProj, FamPlan, AIM, RAPID, Ben-Cost, NewGen, PMTCT, ProTrain, and SupplyPlan). Each model includes a detailed user manual that not only describes how to use the software but also includes sections on data sources, interpreting and using the results, a tutorial, and a description of the methodology.

The program and manuals can be downloaded from the UNAIDS website at: http://www.unaids.org/en/HIV_data/Epidemiology/epi_software2007.asp.

Program and manuals are available free of charge.

The Role of NGOs in the Estimation Process

Individual prevention projects among IDUs, CSWs and MSM document their activities using various forms and standards. In 2005 the International HIV/AIDS Alliance in Ukraine designed and introduced a single electronic management information system (MIS) of clients of various HIV prevention projects for IDUs, CSWs and MSM, which makes it possible to identify former and present regular clients (this issue will be addressed further in detail). The MIS can be used as an additional source of information with application of quasi capture-recapture or coefficient (multiplier) methods.

Up till now the majority of behavioural surveys within these closed groups were conducted with the active involvement of social workers, volunteers and clients of NGOs which provide services and maintain daily contact with representatives of these groups. Organizations and projects which deal with prevention among IDUs in large and the most affected cities are developing rapidly. At the same time, access to IDUs in smaller towns and regions with low HIV prevalence can be achieved only through official institutions, as prevention projects run by NGOs are of a very limited scale and number.

In order to provide a comprehensive background for planning interventions and activities, a situation analysis is recommended, which would aim to assess environmental, structural, community and individual factors contributing to the creation and maintenance of risk behaviours. *Funding agencies* usually have a certain budget line devoted to this activity; however such analysis is usually done on the regional level, and thus its implementation is a task of *implementing organizations*, which would use it in order to adapt standard approaches to their local context.

Time frames and methodology for conducting a situation analysis derive from the availability of resources and time. It would usually combine qualitative and quantitative methods and typically employ observation of the community, visits to sites where drugs or sex are purchased and used, and interviews with key informants in the community. Specific methods may include mapping locations where high–risk behaviours occur, mapping prevention services to assess availability and physical barriers to use, in–depth interviews, and focus group discussions with community members and key informants to understand the effects of the community and environment on risk behaviours. This method is also used to estimate the size of MARPs on the site level in those cases when there are limited or no resources and time for more rigorous estimations. The case example at the end of this section illustrates this approach. Please refer to the list of references at the end of this manual for further reading on this topic.

■ What are the anticipated challenges and possible solutions?

The process of strategic and operational planning is likely to encounter a number of challenges of both technical and institutional character.

Funding organisations usually in charge of the overall programme design need the broad participation and commitment of different stakeholders at this stage. The decisions made at this point should take into account the political context and possible limitations, or, on the contrary, facilitate and advocate necessary political changes and decisions to be made by the government.

It is also recommended that *implementing organizations* coordinate the planning process with other AIDS–service organizations and state authorities in their locality, since there is a risk that individual planning might result in duplication of efforts or make impossible the implementation of certain activities due to resistance from local stakeholders.

In general, any programme will always benefit from the broad participation of different parties at the planning stage, as it provides additional incentives to view the problem from different angles and thus design a comprehensive response.

Another potential risk relates to defining target populations for particular programmes and projects. HIV prevention interventions are usually designed to target IDUs, CSWs, MSM and prison populations. While these behavioural groupings are useful for targeting prevention interventions, not all high–risk individuals fit neatly into one category, and not all individuals in a given category are at high risk of HIV. For example, MSM in a mutually monogamous relationship with an HIV–negative partner, or IDUs who decrease injecting drug use and do not use non–sterile equipment, are at a much lower risk of HIV infection. And as previously noted, there is overlapping risk between these groupings and some people may be practicing multiple risk behaviours, for example, many CSWs are also IDUs, and likewise, IDUs may buy or sell sex in exchange for drugs. This overlap in risk behaviours must be considered in planning and reporting on M&E efforts.

It is also important to take into account other groups at increased risk of infection in a given region or country, depending on the particular epidemiological context. The level of effort directed at reaching these other populations will depend on the level of the epidemic and available resources. Most of these populations are vulnerable because of their partners' risk behaviours, e.g. *sexual partners of IDUs, female partners of MSM, clients of sex workers and their partners.* In some settings, they make up a substantial proportion of new infections.

Whatever the strength of the linkages between populations, it must also be noted that there is often overlapping risk between these populations. Unfortunately, sexual partners of most-at-risk populations are not necessarily aware that they are at increased risk and often do not take preventive measures. These populations are difficult to monitor with regard to HIV prevalence or sexual risk behaviour as they are less likely to self-identify or to congregate in locations where they can be reached using standard data collection methods.[15]

All MARPs (IDUs, CSWs and MSM) are rather closed and difficult to access. This is preconditioned by two key factors: first, stigmatizing attitudes of the majority of the general population towards them; second, fear and concerns of IDUs, CSWs and MSM about possible repressive measures initiated by law enforcement agencies.

Special Considerations in Developing Population Size Estimates[16]

In order to generate reliable estimates of the number of people living with HIV/AIDS, it is essential that the same definition of each most-at-risk population is used when assessing the number of people in that group and the prevalence of HIV within the group. Unfortunately this is often not the case, resulting in unreliable estimates. It is important that HIV prevalence estimates are representative of the groups to which they are applied: often it is the most-at-risk individuals who are surveyed, and the prevalence of HIV amongst them applied to the whole group, thus overestimating the total number of HIV infections.

Another important consideration is that the overlap between most-at-risk populations (e.g. sex workers who are also injecting drug users) needs to be quantified. Double counting the same people who engage in both behaviours can overestimate the number of individuals at risk. Individuals who belong to more than one risk group can also be at very high risk of HIV infection, and thus can also be an important conduit between risk groups, facilitating rapid transmission of HIV. A major difficulty when planning studies, and when comparing results from different studies, is that definitions of population groups often differ. To some extent this reflects the particular local social context. Nevertheless, it is recommended that the following guidelines be used in order to increase the comparability and rigour of definitions of most-at-risk populations. These guidelines focus on those aspects of behaviour that are most associated with current risk of HIV acquisition and transmission.

Official statistics (governmental and sector-specific) on IDUs do not reflect real numbers of injecting drug users. Statistical reporting and registration of drug users performed by substance dependence facilities (narcological dispensaries) and law enforcement agencies covers users of all psychotropic substances, without specification of the drug use mode (injecting, smoking, oral, etc). Medical statistics register only IDUs, however the data on

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[15] – Adapted from *A Framework for Monitoring and Evaluating HIV Prevention Programmes for Most-At-Risk Populations*, April 2007

[16] – Adapted from *Development of the software packages, EPP v2 and Spectrum*, and *Measuring and tracking the epidemic in countries where HIV is concentrated among populations at high risk of HIV*. Report of a meeting of the UNAIDS Reference Group for Estimates, Modelling and Projections held in Sintra, December 8–10, 2004. UNAIDS.

hepatitis and STI incidence among IDUs is not fully complete and trustworthy. There are no medical statistics on overdoses, abscesses, or IDU mortality as a result of overdose. In some cities the statistical data of healthcare authorities and of law enforcement agencies do not match because, in accordance with current requirements, no comparison of lists of those registered is performed. In different locations the number of IDUs registered by healthcare facilities and police considerably depends on the activity of law enforcers and IDU access to medical services.

Access of IDUs to medical services in large cities is much easier than in small ones; this affects the completeness of IDU medical registration and consequently the level of reliability of statistical data. In contrast, registration in law enforcement agencies in small towns can be more complete than in large cities, in connection to small local population size and a high level of contact between police and local residents. However, some experts believe that the opposite situation may also occur, when drug users are not registered on the request of their relatives. It should also be noted that the CSW group is criminalized by current legislation in Ukraine, which creates additional obstacles.

Challenges which emerge while estimating PLHA group size are primarily linked to receiving reliable data on MARPs size and HIV prevalence among these groups (both on the national and regional level). Because PLHA population size estimation requires a huge amount of different data which may be available only as national estimates, regional PLHA group size estimations are usually impossible to make.

As for the national and regional cross–section, there are also considerable problems in generalization, consolidation, analysis and strategic application of available information. In order to harmonize this process there should be a single institution ready to accept full responsibility for unification of definitions, evaluation of the size of IDU, CSW and MSM populations, analysis of trends and comparison of regional characteristics, methodological support in data collection, and authority to perform this task. For this reason, NGOs can take a leading role in the dissemination process and in reaching agreement on estimated data and their further application on the national and regional level.

A situation analysis will be informative only if it is planned and implemented with the involvement of members of the communities and populations under study. People conducting formative research need to be sensitive to the culture that they are entering, non–judgmental, and understanding of cultural norms and behaviours. Community engagement is essential at all steps of the process. In addition, because these are populations practicing behaviours that are often highly stigmatized and sometimes illegal, measures must be taken to prevent harming them. For example, information and maps of locations where most–at–risk behaviours occur may need to be kept confidential if they are likely to be subjected to action by local authorities. Special training and supervision of field work may also be needed to ensure adherence to good research practices, including informed consent, voluntary participation, confidentiality and anonymity.[17]

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[17] – Adapted from *A Framework for Monitoring and Evaluating HIV Prevention Programmes for Most–At–Risk Populations*, April 2007

Practical Case Example:

In Ukraine the "Overcoming the HIV/AIDS Epidemic in Ukraine" national programme, supported by the Global Fund to Fight HIV/AIDS, Tuberculosis and Malaria and implemented by the International HIV/AIDS Alliance in Ukraine as principal recipient of the grant, has the following goal, objectives and SDAs:

Goal: HIV prevalence, HIV morbidity and AIDS mortality in Ukraine is reduced.

Specific component objectives and SDAs:

- Improved and scaled up treatment for individuals with HIV infection:
    - ARV treatment and monitoring;
    - prevention of mother–to–child vertical transmission.
- Increased HIV prevention activities for vulnerable groups:
    - increased access to VCT services for vulnerable groups;
    - provision of drug substitution therapy;
    - behaviour change communication and condom (syringes) distribution.
- Care and support for people living with or affected by HIVAIDS:
    - development of adherence to ART among PLHA;
    - home–based care and support for chronically ill PLHA;
    - support to development of the self–help movement for PLHA.
- Support to development of the National HIV/AIDS M&E System.

Based on the results of sentinel and routine surveillance, the HIV epidemic in Ukraine can be defined as concentrated, where HIV prevalence among pregnant women is less than 1 percent, while HIV prevalence among IDUs varies from 5 to 60 percent in different regions, and among CSWs from 2 to 30 percent with the major proportion of positive cases among CSWs who inject drugs. There is no evidence on HIV prevalence among MSM, but based on international experience this group is also considered to be at higher risk; however the HIV–epidemic in Ukraine can definitely be described as IDU–driven.

New data is now available on the estimated size of vulnerable populations in Ukraine. This puts population sizes as:

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

Based on these and additional data and using Workbook and Spectrum software, the number of PLHA in Ukraine has been estimated at **377’000** individuals.

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, 2006). Please refer to the *Analytical Report on Most–at–risk Populations Size Estimation in Ukraine*, ICF "International HIV/AIDS Alliance in Ukraine" et al., 2006 (available on the Alliance web–site).

During 2005–2006 in the framework of the USAID–funded project "Scaling up the National Response to HIV/AIDS through Information and Services" (SUNRISE) several Ukrainian sites conducted a situation analysis in the form of a Participatory Site Assessment (PSA). **The aim of the PSA was to combine in–depth needs assessment and planning processes with mobilization of vulnerable communities for the response to the HIV/AIDS epidemic.**

More specifically the objectives of this assessment were to:

- identify different sub–groups of IDUs, CSWs and MSM;
- identify areas of high concentration of IDUs, CSWs and MSM;
- map mobility of IDUs and CSWs in each site;
- identify the general and specific factors that influence HIV/STI transmission and AIDS care for different sub–groups in each site;
- find out which interventions are currently present in the site and generate ideas for how best to scale up coverage;
- identify intervention gaps in each site and generate ideas for how they could best be implemented;
- mobilize representatives of MARPs to share risk reduction, care and support techniques and information about support and services;
- work with government, NGOs, MARPs and other key stakeholders in the sites to provide feedback on and verify PSA findings.

Overall, 13,723 people were contacted, interviewed and informed in the course of the PSA process.

The main findings of the PSA included:

- Different sub–groups of IDUs and CSWs were identified. In particular, it was determined that:
    - IDUs can generally be divided into three major groups that differ by the type of narcotic substance used, and, correspondingly, by the type of risky behaviour typical for them. These are the opiate group, ephedrine group, and poly–drug users group. For example, while the opiate group is more vulnerable to infection during injection, the ephedrine group is at higher risk of infection during sexual intercourse.
    - Sub–groups of CSWs consist of the highway group, street group, call group, and entertainment group. It was clarified that women who sell sex on highways and streets are more likely to be simultaneously drug users.
    - A group of MSM who sell sex was also identified in some sites.
- Areas of high concentration of IDUs, CSWs and MSM were identified in each site. Knowledge of the location of "hot spots" allowed service providers to correctly define geographic priorities and concentrate prevention interventions in the most appropriate locations.
- Maps of the mobility of IDUs and CSWs were created for each site. Information on mobility allowed on one hand to better plan activities geographically, and on the other

hand, to avoid double counting those project beneficiaries who are engaged in intensive migration within sites.

- Intervention gaps in each site were identified. Ideas for how to address these gaps were used for development of a comprehensive intervention package. The comprehensive intervention package was developed and agreed upon by the implementation group and PSA teams.

- The general and specific factors that influence HIV/STI transmission and AIDS care for different sub-groups of key populations in each site were identified during PSA interviews, focus groups and monitoring visits. These factors include but are not limited to the following:

  - Female IDUs are more likely to be vulnerable to HIV than male IDUs. They are less mobile and more likely to practice unprotected sex under the influence of drugs.

  - They are also more stigmatized and less willing to disclose their HIV status, while they are usually the first who find it out.

These factors make female partners of IDUs a hard-to-reach population and cause difficulties in promoting positive prevention among them.

  - Some of the MARPs, CSWs in particular, mentioned difficulties in access to STI diagnostics and treatment. Improper, often self-treatment, of STIs causes higher vulnerability to HIV among members of the target groups.

  - Due to changes in the drug scene, such as the transformation of drug spots from stationary to mobile, IDUs are more likely to practice unsafe behaviour, such as buying large amounts of drugs in a common syringe and injecting the drug on the spot, and so often not having clean equipment available, etc.

  - There are some "new" site-specific misconceptions about HIV transmission, such as that a syringe used for muscular injection is "clean from HIV" compared to a syringe used for intravenous injection.

Chapter IV

STEP TWO:

DEFINING THE INDICATORS FRAMEWORK: SELECTION OF INDICATORS, DETERMINING BASELINES, SETTING TARGETS

■ What does this step mean? What is it for?

At this point both *funding* and *implementing organisations* will transform the output and results of Step 1 into a specific list of indicators to be tracked over the period of implementation and sometimes afterwards. Each indicator should be meaningful in the context of future use of the obtained results in planning and decision making. Therefore, at this stage programme and project managers should clearly define the future implications and use of data to be collected for each indicator.

Each selected indicator should have a specific outline and framework, including but not limited to the following: indicator description, disaggregation, source of data, instrument of data collection, frequency of data collection, responsible entity/person and quality assurance mechanism, baseline value and targets (each of these elements will be discussed in detail later in the chapter). The framework must be as detailed as possible and at the same time straightforward enough to avoid misinterpretation and consequent deterioration of data quality. For consistency purposes, *funding agencies* would usually define a unified indicators framework for all sub-recipients implementing the programme. The following sub-section provides one possible indicators framework outline, and Annex 7 provides a sample indicators framework with a sample list of parameters (which is however not exhaustive, and shows only some of the parameters).

Among other parameters defined for each indicator, one should try to assess the corresponding *baseline value*, in other words, the progress that has already been achieved in the country or region by a given point in time (usually the beginning of planned activities). The baselines are usually defined or estimated regardless of the funding source, with the aim of showing the starting point of the project or programme to be implemented. While *funding organizations* usually define nationwide baselines, *implementing organizations* put their efforts into determining baselines on the level of their regions, reflecting the results of their own or other agencies' activities prior to the beginning of the new project.

Baseline figures and estimations of target population sizes (discussed in the previous chapter) form the basis for setting targets against selected indicators. The overall (usually national) targets set by *funding organizations* should be in line with the corresponding targets set by their *implementing partners*. Targets and estimated unit costs form a basis for budget calculations.

■ How and when is it done?

As the targets set against selected indicators inform budget preparation, this work should be done as early as possible, before budgeting and obviously before the beginning of programme/project implementation.

The following simple guiding principles help in choosing the most appropriate set of indicators and associated framework:

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

- The selection of how many indicators are appropriate and which indicators are most appropriate for use should reflect the focus of activities in the programme or project and be consistent with the allocation of resources. For example, if approximately 30 percent of the total budget is spent on prevention services for most at-risk populations, and 70 percent is allocated for prevention among the general population, there should be a proportionate division of indicators between these two areas, with more indicators that monitor prevention activities among the general population. However, this approach should not be simply repeated as a rule within programmatic areas. For example, within the area of prevention services for most-at-risk populations, if there is a priority focus on IDUs, and only a marginal focus on prevention among sex workers, there should not be inconsistency between the numbers of indicators for these different populations, particularly at the level of outputs (coverage). On the contrary, it is advised to use the same basic indicator formulation, such as coverage with specific prevention services within a specified period of time, for both populations. The only difference between the indicators for different populations may be in the targets (higher numerical and percentage targets for IDUs coverage), the frequency of measuring coverage, and the definition of a minimum package of services (the package of IDUs would include a syringe, which might not be a minimal requirement for sex workers).

- 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 and process level indicators, with indicator descriptions, suggested measurement tools and regularity 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 to some extent output-level indicators should be taken from the UNGASS list of core indicators for countries with concentrated epidemics.[18] In Ukraine the List of National Indicators (*Annex 3*) should be used for this purpose, since these indicators have been tested and approved, have baseline values, and are measured according to unified methodology. ***Funding organizations should select indicators representing all M&E levels, while implementing organizations should rather focus on process and output level indicators to monitor their activities.***

- Ensure that indicators relate to defined services which are delivered by the programme or project. Attempt to define the standard package of services provided for each target group in order to set the criteria for coverage calculation, in other words, what an individual should be provided with in order to be counted as reached or covered. This issue will be further discussed later on.

- 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 *implementing organizations* do not use surveys for the purposes of obtaining output level data, but rather enhance their record keeping procedures.

- 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 reflect this tendency.

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[18] – UNAIDS. *Monitoring the declaration of commitment on HIV/AIDS. Guidelines on construction of core indicators.* UNAIDS, Geneva (2007). http://data.unaids.org/pub/Manual/2007/20070411_ungass_core_indicators_manual_en.pdf

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

- **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 and 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 planned within the programme 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 international M&E guides (please refer to the list of reference materials at the end of this manual), or, if they also do not fully address your 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 your programme are called **additional** indicators.

Each subsequent level of the data collection system should use fewer indicators for aggregation and analysis. The largest number of indicators capturing all the different aspects of project implementation is tracked by implementing organizations; at the same time they would usually report to the funding agency only the aforementioned list of core and additional indicators. A limited selection of these indicators would usually be reported by the funding organisations to international donor organizations or national funding agencies and stakeholders, in accordance to the reporting requirements of the latter. In general, the simple rule that should be followed in determining the number of indicators to be tracked and reported, regardless of the level of data collection, is that **not a single indicator should be tracked without use of collected data.**

As already mentioned above, a specific framework should be defined for each selected indicator. A possible way of organizing this might be the one presented in *Table 3*. The framework is usually organized in the form of a table (where some columns can be further split) with possible additional columns, such as tools of data collection, tools and procedures for data quality control, data dissemination strategy, etc.

Table 3. ***Sample Indicators Framework***

Objective / SDA(s)	Indicator formulation	Level of indicator	Baseline	Directly tied to project funding?	Frequency of data collection	Source of data	Method of data collection	Disaggregation	Targets	Data use / Other comments

Examples of indicators for each M&E level are given in *Diagram 3 (Chapter II)*.

A description of the elements of the indicators framework follows.

- **Objective/SDA(s) to which an indicator corresponds**

Please refer to step 1 for a discussion of objectives and SDAs.

- **Indicator formulation**

It is recommended to use the standardized formulations of core and additional indicators, where possible, for consistency and comparison purposes. Please refer to Selected Indicators given in the annex and the existing M&E guides when defining your indicators.

- **Level of indicator (Input–Process–Output–Outcome–Impact)**

It should be kept in mind that data on outcome and impact indicators are obtained through national level behavioural and epidemiological surveys. The wording of outcome and impact indicators comes directly from the list of Ukrainian National Indicators on Monitoring and Evaluation of the Efficiency of Activities to Control the 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 may 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, i.e. input level indicators (e.g. numbers of disposables procured, number of staff hired, etc.), but need to focus more on the **process** and in particular the **outputs** of services delivered, with emphasis on **coverage indicators** which are the major focus of this manual, as will be discussed further on.

- **Baseline (value, source and date of baseline)**

The level of effort necessary to determine the baseline may differ and very much depends on the particular indicator and the existing M&E systems in the country. Wherever statistical data are available or there is one central body collecting and analyzing data (i.e. a national M&E unit), the baseline is defined by a simple request for data from either the funding or implementing organization. However, very often additional efforts are required for obtaining baseline values. Those might be conducting a separate assessment survey, conducting an expert consensus meeting, direct observation, etc. Sometimes, in the case of limited time and resources, it is possible to leave out the baseline value and identify a time frame for data collection.

While setting targets one should also consider and specify whether the baseline value is included in the target figure.

- **Whether achieved progress under the indicator is directly tied to project funding or not**

The higher the level of indicator, the more difficult it is to attribute the achieved results to any specific funding source. While input and process–level indicators are naturally directly tied to a specific funding source, output–level indicators may be directly tied to specific funding only if the implementing organization has a single funding source. For example, if an organization has multiple funding sources all aimed at provision of prevention services to IDUs, then it is next to impossible, and unnecessary, to split the overall coverage based on funding. Outcome and impact indicators are not tied to any funding source exclusively, but rather indicate the effects of all activities carried out in a certain geographical area, as well as the natural epidemic trends.

- **Frequency of data collection**

As already mentioned in *Table 1 (Chapter II)*: the recommended frequency of data collection for input/process indicators is continuous, for output – quarterly, biannual or annual, for outcome – once every 1–3 years, and impact – once every 2–5 years.

- **Data sources and responsibility for data collection**

For each indicator specific data sources and who will be responsible for data collection and analysis should be defined. Those might be programmatic records of implementing organizations (either paper-based or entered in a special management information system or MIS), special surveys, state statistics, regular surveillance, etc.

Implementing organizations should in their turn have internal registration regulations describing procedures and responsibilities of data flow within the organization.

- **Method of data collection**

This column directly follows from the previous one, and again there are some standard approaches to gathering data depending on indicator levels. Input and process indicators are collected in the form of standardized programmatic records showing, for example, numbers of trainings conducted, materials distributed and services provided. There are two possible ways of obtaining output level indicators (i.e. coverage indicators): analysis of programmatic records of implementing organizations and conducting special surveys. The first method requires usage of a special software tool (MIS) in order to keep registries of people provided with services, thus enabling precise calculation of coverage. The second method (surveys) assesses the percentage of people reached by composing a sample of vulnerable population representatives and asking them whether they have received specific services. But in spite of the seeming ease of obtaining coverage data with this method, it has several serious limitations. This method does not give an absolute coverage figure as it assesses the percentage; obtained results cannot be attributed to a specific project (unless there is only one operating in the region); and, most importantly, there is an inevitable selection bias when dealing with marginalized populations. In other words, the sample for such surveys would usually be formed through AIDS-service projects, thus increasing the likelihood of project clients being selected compared to non-clients. Although it is still recommended to include a question on coverage with services into knowledge and behaviour surveys among MARPs for cross-checking purposes, it is strongly recommended that all *funding* and *implementing organizations* use the programmatic approach for measuring coverage indicators.

As mentioned earlier, outcome and impact indicators are measured by special surveys, sentinel and routine surveillance.

Please refer to Annex 1 for a detailed list of possible data sources and data collection methods.

- **Possible indicator disaggregation**

For certain indicators it may be worth defining disaggregation categories. These are usually age, sex, population, type of service, etc.

- **Targets for future periods**

Simply tracking the achieved results of projects and programmes is not enough; targets are needed in order to monitor with time whether the programmes 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 regularity. The actual procedure of target setting is rather an art than a science, thus no specific rules are provided. However, since, as previously discussed, coverage indicators are the main focus, it is suggested to start by setting targets for these. For example, for harm reduction activities among injecting drug users, it has been estimated that reaching at least 60 percent of the IDU population is necessary in order to impact the epidemic within this target group (UNAIDS, WHO).[19] Thus it is suggested that target setting is carried out in such a way as to reach a 60 percent 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 percent of the estimated IDU population, 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 representatives in a given area/site where the organization or its implementing partners work (as has already been discussed in the previous chapter).

While *funding agencies* define a single (usually national) coverage target, *implementing organizations* will consider both the desired percentage of coverage within their region (which can possibly be achieved by a number of organizations working in the region) and their own capacity and possibility to access target groups (which is usually a limiting factor). By referring to historical project performance data (on the number of people reached, variety of consumables and services provided, attraction of new clients and client turnover), implementing organizations can define more well-grounded, reasonable and realistic targets for both process and output indicators. An example of a possible approach to this is given at the end of this chapter.

- **Data usage/other comments**

It is usually worth indicating some related issues which would add information to all the previously described categories. Those might include a short description of data collection tools and approaches, coverage criteria and other qualifying context information.

Coverage Indicators

For the purpose of clarity it should be noted that different terms are used in international literature to reflect the number of people reached with a specific package of services during a certain time period. It is often referred to as either *coverage* or *uptake*.[20] Sometimes the term *coverage* is used to define which geographical areas have prevention or care and support projects, thus showing a potential possibility for representatives of vulnerable groups to become project clients and receive services, while the term *uptake* is used to define the actual contact of client and service provider. **In this manual, we use the term coverage to describe actual numbers of people reached.**

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[19] – *A Framework for Monitoring and Evaluating HIV Prevention Programmes for Most-At-Risk Populations*, April 2007

[20] – *A Framework for Monitoring and Evaluating HIV Prevention Programmes for Most-At-Risk Populations,* April 2007, Chapter 6

Coverage indicators are a special focus of this 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 agencies on coverage of most–at–risk population groups would result in a national level absolute number and percentage of IDUs, CSWs and other groups reached with services. Without this information it is almost impossible to plan an effective response to the HIV/AIDS epidemic in the country, determine the necessary resources and evaluate the effectiveness of interventions.

For the purposes of this manual, when speaking about coverage we are basically speaking about the **numbers (and percentage) of people reached**. On one hand, these indicators are the most difficult to measure and are usually the most challenging ones for programme managers to plan and collect data on; on the other hand, these are the indicators that usually most interest funding agencies, and they are the ones that contribute to obtaining a national level picture of coverage. Indicators 1.1–1.4 and 2.1–2.3 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. Coverage 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 the number needing the service is the *denominator* (already addressed in the previous chapter).

Numerator Definition

In order to define coverage indicators, it is important first to separate individuals who received a service or, in other words, were reached, from those who were not. In order to measure people reached, it is essential that a system be in place so that **unique individuals can be identified** (this is needed in order to be able to distinguish between one person attending twice and two people attending once).[21] 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 serving 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 cannot be identified, programme activity can be measured in terms of "person contacts" or "visits". However, **true coverage calculations are not possible under such circumstances**.

Secondly, there is a need to define what services a person should receive in order to be considered covered **(coverage criterion)**. Definitions for suggested core indicators (1.1–1.4, 2.1–2.3 in the attached **Selected Indicators** outline the composition of the **"package of services"** commonly used worldwide that should be given by a social worker

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[21] – 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.

to a vulnerable group representative, in order for the latter 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.[22]

Thirdly, the time period of exposure to services should be defined. The number of people reached may be defined in a number of different ways:

- ***Cumulative number of clients:*** people who received a package of services at least once during the entire period of time since counting began (e.g. since the beginning of the programme/project). In other words, 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 received VCT this quarter and previously the cumulated total was 1100, the new cumulative total is 1200. However, for ART, if 100 people received 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). A special software tool is desirable but not necessary for obtaining cumulative numbers of people reached; however, accurate record keeping and a coding system that enables identification of truly "new" individuals are required.

- ***Current clients:*** people who receive services at least once during a specified period (usually 4, 6 or 12 months). If numbers of clients are considerable, a special client registration software tool (MIS) would be needed to obtain data on this indicator (please see more on this in *Chapter VI*).

- ***Regular clients:*** people who receive services at a specified frequency during a certain time period (e.g. quarterly or annually). The registration and record keeping MIS is required for obtaining this figure (please see more on this in *Chapter VI*).

It is basically left to the discretion of funding organizations or field level projects themselves how to count the "number of people reached". Some choose to use several methods at the same time in order to see all the different dimensions of coverage: for example, the number of people reached during a certain time period does not give any indication as to how many people use project services with regularity and could be considered "regular clients", and how many came just once. However, for the purposes of this manual, we suggest programmes and projects 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 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 meant under each indicator. Procedures for coverage data collection are addressed in detail in *Chapter VI*.

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[22] – Examples include glancing at a poster, hearing a radio broadcast and being given a brochure.

It is highly desirable that a unified nationwide approach to counting coverage is agreed among all stakeholders working in AIDS-service organisations.

Denominator Definition

As has already been addressed in the previous chapter, it is suggested that countries make a separate effort to estimate the population sizes for major vulnerable groups that are, according to sentinel surveillance data, the major driving force of the epidemic. Obtaining such data would enable calculation of national coverage at a given point in time, allow target setting in order to achieve certain levels of coverage in the future, and permit tracking performance in accordance to these targets. Particular methods of estimating key population sizes are provided in *Chapter III* of this manual and in the *Framework for Monitoring and Evaluating HIV Prevention Programmes for Most-At-Risk Populations*, (UNAIDS, April 2007).

It is assumed that all IDUs, CSWs, PLHA and other vulnerable groups are in need of prevention and/or care and support services, thus the size estimations of these populations are used as the denominators for coverage calculation.

■ What are the anticipated challenges and possible solutions?

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 management information systems, provided that such systems exist and are functional. Programme planners should take strategic advantage of the increased attention to HIV/AIDS programmes 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 programmes.

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

As planning is usually done in very limited time frames, it is usually hard to bring together all stakeholders and define unified approaches, tools and systems for data collection and analysis. However, responsible senior management staff of *funding agencies* should not economize on this consensus-reaching process, as this would ultimately result in loss of data usefulness in decision making and planning, thus rendering useless the whole difficult process of data collection. Once overall agreements between key national stakeholders are achieved, *implementing organizations* should regard it as a green light for taking a proactive approach to coordinating implementation of a common indicators framework and M&E plan development on the level of their regions, capitalizing on the efforts of all regional stakeholders in M&E activities implementation.

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, programmes can often leverage ongoing surveys and baselines already undertaken in the country.

Setting targets for outcome and impact indicators is a very tricky task, as it is hard to make a prognosis about the influence of planned interventions on knowledge and behaviour, and even harder on the epidemic trends. Moreover, international donor organizations usually require setting yearly targets reported during the period of programme implementation against outcome and impact indicators, while it is known that a certain time lag exists between implementation and actual impact of prevention interventions.

Implementing organisations usually face challenges in setting targets for output level indicators in the case of absence of historical data on which future projections could be based, especially taking into consideration all the different dimensions of measuring coverage (cumulative, current, regular). In this case, it would be useful to use the results of a situation analysis to at least assess the access of vulnerable groups to services in the region, evaluate the existing organisational capacity (trained staff, partnerships with other organisations, etc.) and try to seek technical support from other more experienced AIDS-service organizations.

Funding organizations should advocate setting targets for output indicators that are not directly tied to the given source of funding, in case of various similar initiatives operating in the country or region.

It is important to make sure that there is a system in place to be able to collect and report on coverage indicators at the point of selecting indicators and setting targets, especially if the selected indicators include numbers of current and regular clients. This issue is further addressed in detail in *Chapter VI*.

Practical Case Example

Within the Round 6 grant signed between the Global Fund and Ukraine, the following indic-tors framework was outlined (only a selection of four indicators is provided here; please refer to Annex 7 for the whole list of indicators for Years 1 and 2 of Round 6 grant implementation.

Please keep in mind that not all, but only several parameters are listed in the sample framework given in the Annex):

Objective / SDA(s)	**Indicator formulation**	**Level of indicator**	**Baseline**	**Directly tied to GF funding?**	**Frequency of data collection**	**Source of data**	**Method of data collection**	**Disaggregation**	**Targets (1st year of grant implementation)**
Ensure sufficient access to HIV prevention, treatment and care for marginalized populations	Number of VCTs for HIV with rapid test among vulnerable groups	Process	**7'861** 31 Dec, 2006, programmatic reports of Alliance sub-recipients	Yes	Quarterly	Programmatic reports of Alliance sub-recipients	Routine data collection	By vulnerable group (IDUs, CSWs, MSM)	46'040
	IDUs reached by HIV/AIDS prevention programmes*	Output	**110'407** 31 Dec, 2006, programmatic reports of Alliance sub-recipients	Yes**	Quarterly	Programmatic reports of Alliance sub-recipients	Routine data collection	–	150'000 / 325'000 (46%)
	IDUs: safe injecting and sexual practices	Outcome	**20%** UNGASS report, 2004	No	Every 2 years	Behavioural sampling survey	Survey	Age groups	50 % (Target for Year 3)
	HIV prevalence among IDUs	Impact	**35%** UNGASS report, 2004	No	Every 2 years	Sentinel surveillance	Surveillance	Age groups	31% (Target for Year 3)

* Cumulative number of IDUs benefiting from prevention projects are accounted for under this indicator, e.g. those who have received a basic package of services and have continued access to those services in the subsequent periods.

** Overall IDU coverage by organizations receiving GF–funded grants exclusively or among other sources are accounted for under this indicator.

The criterion for IDUs being covered with prevention services is receiving at least the minimum package of services, which include:

- provision of syringes and condoms;
- provision of BCC material aimed at promoting safer behaviour;
- counselling with a social worker or other relevant specialist;
- referral to other services depending on the clients' needs.

The criteria for a prevention project client to be considered regular may be defined in different ways. For example:

- receiving services at least once a week;
- receiving services at least once a month;
- receiving services at least 10 times during the quarter, while not less than twice during each of three months, etc.

This should be defined for the whole programme on the national level and followed by all implementing partners.

As of December 31, 2006 a total of **110'407 IDUs** were **cumulatively** reached with prevention services all over Ukraine (programmatic reports of Alliance Ukraine implementing partners). Given the recent estimations of the number of IDUs in the country **(325'000 – 425'000),** the **cumulative coverage of IDUs as of the end of 2006 was *26 – 34 percent.***

In 2006 a regular behavioural survey was conducted in order to assess knowledge and behaviour of vulnerable groups. Results of this survey show that ***61 percent* of IDUs were reached with prevention services during the previous 12 months.**

The difference in the above figures illustrates the necessity to collect output–level indicators data on a routine basis using programmatic monitoring data collection tools and procedures.

Setting targets for coverage indicators by implementing organizations.
Organization X has been working as an AIDS–service NGO in city Y during the previous three years. Estimated number of IDUs in city Y is **8'100 – 9'300.**

By the end of 2006 this organization reached cumulatively **3'837 IDUs** (41–47 percent), while its coverage during the previous 12 months constituted **2'612 IDUs** (28–32 percent).

Analysis of data from the previous periods shows that the NGO was attracting **240** new clients quarterly (on average), while average annual turnover was about **600** clients.

In its proposal for the following year the NGO sets targets for cumulative and annual coverage. The NGO is planning to increase the number of new clients attracted quarterly to **280** on average, while the estimated turnover remains the same. Thus:

- planned number of new clients reached during the following 12 months is **280 x 4 = 1'120**;

- out of the **2'612** current clients about **600** will drop out, thus the number of current clients who will still be receiving services in the following year is **2'612 – 600 = 2'012** (will round down to **2'000**);

- planned coverage during the following 12 months is the number of clients "remaining from the previous year" plus newly attracted clients, which in our case would be **2'000 + 1'120 = 3'120, which is 34–39 percent in percentage terms;**

- planned cumulative coverage by the end of the following year will be previous cumulative coverage plus newly attracted clients, which in our case would be **3'837 + 1'120 = 4'957 (**will round up to **5'000), which is 54–62 percent in percentage terms.**

However, there are two other organizations in the city providing prevention services to IDUs. One is an NGO and the other is a division of the State Social Service for Family and Youth.

The question of true coverage figures in the city achieved by the joint efforts of these three agencies remains unanswered at this point; however, various ways to obtain joint coverage figures will be addressed further in *Chapter VI*.

Chapter V

STEP THREE:

SELECTION OF IMPLEMENTING PARTNERS, CONDUCTING CAPACITY ASSESSMENT, DEVELOPMENT OF REPORTING FORMATS

▪ What does this step mean? What is it for?

After defining goals and objectives and working out the indicators framework, it is time for *funding agencies* to launch programme implementation. As in the majority of cases they would not act as service providers themselves, but rather select and fund *implementing partners,* this step addresses some major issues of this process. Thus, this chapter is not relevant for field level organizations that directly provide services and do not fund activities carried out by other organizations. **It will be relevant for those funding organizations that select implementing partners (IPs) for carrying out particular sets of activities.**

Selection of implementing partners is an important and complex process, which includes a number of programmatic and financial procedures. Without going deeply into all the aspects of competitive selection of implementing partners and development of corresponding policies and procedures, we would like to focus mainly on the role of **capacity assessment** in the IPs selection process – programmatic, financial and M&E.

Selection and funding of implementing partners of course requires development of financial and **programmatic reporting formats** and requirements as part of the overall onward granting procedures, as well as corresponding legal documentation. While financial reporting is not the issue to be covered in this manual, we will address the topic of **programmatic reporting format development** further in this chapter.

▪ How and when is it done?

Selection of implementing partners starts right after the planning stage is over, when all legal issues are resolved and funding is guaranteed, representing the launch of the programme implementation phase. Selection of IPs is usually done on a competitive basis, by announcing an open call for proposals with an independent proposal review committee to determine winners.

IPs capacity assessment could be carried out before the decision on provision of funding is made. In this case its positive result could be a prerequisite for funding the IP. This issue should be specifically addressed in granting procedures, indicating whether formal assessment is a necessary step to be carried out in all cases prior to provision of funding, or if there are certain exceptions, i.e. previous funding, tender review committee recommendations, etc. Interim capacity assessment can also be conducted separately during the project implementation phase if needed. The procedure and documentation format of the formal capacity assessment should be prepared and approved at this point. An example of an M&E capacity assessment form is provided further on.

Capacity assessment would usually be performed during a field visit to the implementing organization by relevant staff members or consultants of the funding organization, and would result in completion of a formal feedback form. The format of the capacity assessment visit form must be a separate approved document, which would usually address financial and programmatic issues, as well as a list of questions for M&E capacity assessment, such as the ones given in *Table 4*.

Table 4. ***Monitoring and Evaluation Capacity Assessment Form***

№		**Category**	**Control documents**	**Weight** (1–5)	**Score** (1–6)	**Total** (weight x 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**	Any available donor reports	**3**		
3		**Past experience in monitoring and evaluation:**	**3.1 – 3.2**	**3**		
	3.1	Past experience in routine monitoring of project performance	M&E plan, internal M&E regulations			
	3.2	Use of standard indicators in routine 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	Latest reports			
	4.2	Management information systems (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:	

Interpretation of the total score:

70 — 84	Exceeds expectations
56 — 69	Fully satisfies requirements
42 — 55	Minimal risks
28 — 41	Manageable risks
14 — 27	High risks, potential exists
0 — 13	High risks, no potential

If the M&E capacity assessment determines that a particular organization does not comply with the monitoring and reporting requirements, a decision may be made to either assist the organization in building its M&E capacity or not to fund the particular organization altogether (however, this would unquestionably be a decision based on the joint results of programmatic, financial and M&E capacity assessments).

Reporting is one of the most important stages of programmatic M&E. It is usually regulated by an organization's policies and procedures or set forth as the funding organization's requirements.

As the *reporting format* and requirements on its completion should form a part of the formal grant agreement, it is necessary to develop these before the actual signing of the agreements takes place. The reporting format must be formally and logically linked to the developed indicators framework (addressed in the previous chapter). 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 containing a list of indicators with set targets and cells to be filled in with actual results against these targets (this part derives from the indicators' framework), and a narrative section where reporting organizations can describe all results achieved during the reporting period, with their successes and failures. Please refer to *Annex 4* for a sample reporting format.

When designing the format of the reporting form to be used by implementing partners, it is of primary importance to take two factors into account:

- The requirements of the donor organizations/entities to which funding agencies have to report in their turn. If the data received from IPs does not allow for easy reporting to donor(s) and additional information is requested every reporting period, than probably the reporting format (or list of indicators on which the IPs have to report) has not been correctly developed.
- The data that is needed internally to make informed optimal managerial decisions.

It is recommended that the reporting format is developed in such a way that:

- it is *unified* for all IPs regardless of areas of activity (with different lists of indicators for each). IPs with similar activities should submit reports with the *same list of indicators*;
- all indicators are clearly formulated and *unified* instructions are developed on how to collect and report data against each of them (including possible disaggregation);
- it is clearly defined whether indicators can be accumulated over the periods or not. In other words, would the sum of two figures for two subsequent periods (e.g. quarters) give the corresponding figure for the overall period (e.g. half a year)? For indicators like "Number of condoms distributed" it would be possible to add these numbers for, say, quarters 1 and 2, and this would give the number of condoms distributed during half the year. However, for indicators like "Number of people reached during the quarter", a simple summing up of figures indicating the number of people reached during quarters 1 and 2 will not result in the number of people reached during half the year since the same people will definitely be reached in both quarter 1 and 2;
- there is a separate section to report on work plan implementation, which should indicate major planned activities for the period and the status of their implementation;

- there is a separate section for free–format narrative explanations;
- timelines for report submission and verification procedure should be very clearly and specifically defined;
- recommendations should be provided on the requested list of supporting documents for each area of activity to be submitted together with the report.

Ideally, the reporting process should be computerised in the form of a special software tool aimed at data collection, storage and analysis. One attempt to introduce such a reporting format is described in the example section of this chapter.

What are the anticipated challenges and possible solutions?

The process of ***IPs selection*** is rather a managerial and procedural issue than M&E. However, in general it should be mentioned that successful implementation of IPs selection is determined by observing all rules and procedures regulating the selection process, as well as by the level of expertise of the proposal review committee members responsible for choosing the most sound proposals. The entire process should be thoroughly planned, giving enough time for all stages and procedures to be followed.

There is usually limited time for the process of IPs selection and ***capacity assessment***. Moreover, as capacity assessment requires conducting a field visit, which is very time–consuming in itself, staff workload should be planned accordingly. In most cases it would be useless and unnecessary to conduct capacity assessment of all IPs. Regulations on this issue should be developed and observed, indicating which organizations selected as winners by the proposal review committee should pass this procedure. These might include organizations previously not funded, organizations recommended by the committee as subject to assessment, etc. And, of course, the procedure of capacity assessment must be formally and accurately documented according to a unified format.

In aiming to collect a lot of varied data and contextual information from IPs, funding organizations sometimes develop very complicated and extensive ***reporting formats***, which appear to be hard and time–consuming to prepare. As a result, aggregated data will be of low quality, and therefore of very little use.

It is highly recommended to develop a reporting format which is as simple and straight–forward as possible while at the same time meeting the data needs of decision–makers and donor reporting requirements. Very detailed instructions on report preparation and submission must be developed and articulated in order to avoid data biases.

Practical Case Example

In 2005 the International HIV/AIDS Alliance in Ukraine launched usage of the reporting and planning software tool Monitoring Reporting System (MRS), developed by the International HIV/AIDS Alliance (Brighton, UK).

The MRS database is a software program that allows entering, storing and analyzing planning and progress data on Alliance-funded HIV/AIDS interventions and activities. The data is received from implementing organizations in electronic or paper form; once it has been input into the database, it can be used for analysis at various levels.

The database includes details about all Alliance-funded implementing partners and all subsequent planning and progress data is linked to the organization from which it came and to a particular planning and reporting period.

The database can produce planning forms for manual capture of data from the work plans of all Alliance-funded organizations, covering information regarding intervention types, activities to be implemented and indicator targets for core as well as user-defined indicators. Progress reporting forms can also be generated for manual or electronic capture of data regarding progress against planned intervention types, indicator targets and planned activities with narratives to comment on achievements and challenges both past and anticipated.

Reports are produced for progress analysis by one or more variables, including organization, time period, intervention type, etc.

The MRS provides the possibility to generate unified format Excel spreadsheets in order to capture data in electronic format and automatically upload into the database. Reporting forms are sent quarterly to each implementing partner, which they complete according to the specified format. The reporting form has several sections that enable IPs to provide detailed information about their performance. These include: list of quantitative indicators with set targets, where relevant, and actual results; list of implemented activities; and a narrative part.

Please refer to *Annex 4* for the sample MRS reporting format.

Chapter VI

STEP FOUR:

MONITORING SERVICE QUANTITY AND QUALITY: KEEPING PROGRAMME RECORDS

What does this step mean? What is it for?

As soon as all preparatory steps have been made, organisations can proceed with the actual implementation phase of the programme/project. If all previous steps have been taken correctly, at this point both *funding* and *implementing organisations* will have clear implications for the design of an effective record keeping system. Every project or programme, no matter how small, needs a simple monitoring and evaluation strategy that is put into place at the design stage. In this chapter we address the major steps and procedures taken by *implementing organisations* in order to organise routine (daily) gathering of information on key aspects of programme/project implementation in order to inform understanding of how project activities are progressing. It is this step that enables provision of information about project progress to donors, implementers and beneficiaries which can be used for planning and feedback. Here *implementing organizations* collect data on previously selected **process** and **output** indicators. Programme monitoring is often seen as the most important type of monitoring and evaluation activity for programme managers, as it helps identify successful aspects which can be continued or expanded, as well as deficiencies and the means of addressing them. This information should be communicated periodically to staff to ensure they are aware of successes, deficiencies and changes in direction. Programme monitoring also provides an opportunity for most-at-risk populations to contribute to programme development and strengthens the relationships and collaboration between members of affected communities and project stakeholders.

There are two components of programme monitoring: ***qualitative*** and ***quantitative***.

The *quality* of activities and services being implemented is crucial to achieving 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. A quality assurance system should be built into any M&E plan in support of the output indicators. Although many of the indicators on which this manual focuses 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 and continuously monitored.

Tracking the number of clients served and other quantitative indicators (*quantitative* monitoring) is a basic component of programme monitoring at the project level. Project staff may also use these data to calculate individual coverage estimates in order to assess whether interventions are reaching a sufficient proportion of the target population, or if changes to strategies or additional resources are needed.

At this point, it is the main task of the *funding agency* to develop a unified record keeping system and tools (including software), while the task of i*mplementing organizations* is to observe correctly, accurately developed procedures and organize internal data collection processes accordingly. Another task of *funding agencies* during the implementation phase is to conduct regular monitoring visits to *implementing partners*, primarily to check if quality standards are being observed and if the record keeping and reporting system is working properly.

While setting up the system, the *funding agency* should be in constant consultation with the *implementing organizations* who will use the system, in order to take into account their opinions and experience.

Besides the above-mentioned implications, programme monitoring results constitute the basis for any project or programme evaluation. If coverage data are not taken into account, results of outcome and impact evaluations may be misleading. Taking this level of data into account might reveal, for example, whether in a particular situation little or no impact was observed because the intervention was ineffective, or, on the other hand, because it did not reach a sufficient percentage of the target population.

The following sub-sections are divided into **Part A: Monitoring service quantity,** and **Part B: Monitoring service quality.**

Part A: Monitoring Service Quantity

■ How and when it is done?

Programme monitoring should start at programme inception, with routine data being collected and used to monitor the services that are provided during the whole period of programme/project implementation. These routine data, which include key service output indicators, should be analyzed on a regular basis to provide information on progress against targets and provide feedback to programme staff and other key stakeholders.

As already addressed in *Chapter IV*, one limitation of using behavioural surveys as the only source of data on coverage is that coverage data obtained through sampling surveys cannot provide information on the coverage of each individual project. Thus in this chapter we describe programme monitoring procedures (with special focus on obtaining coverage figures) using programme records and target population size estimates.

Data on clients served or reached should be collected as part of a **routine monitoring system** at the project level and implemented at project start-up, then analyzed on a regular basis. As an ongoing activity, programme monitoring should be integrated into routine programme management functions and undertaken by field staff on a day to day basis. Aggregation of project-level data for overall programme monitoring purposes may occur on a quarterly, biannual or annual basis. Data on aggregated coverage must be combined with estimates of the population size (discussed in *Chapters III* and *IV*) to determine programme coverage as a percentage of overall need.

Data on process-level indicators can be collected and aggregated using paper-based or simple electronic tools (i.e. Excel tables), although utilization of the special **management information system (MIS)** would undoubtedly simplify this process. Development and implementation of a MIS for programme monitoring would enable projects to obtain all the different dimensions of coverage (described in *Chapter IV*), and, at a minimum, to capture each individual client reached as well as basic information on project activities and services provided. **As it is usually difficult to record the number of clients rather than client visits or contacts, a system needs to be put in place to allow the tracking of individual clients.**

Basically, a **routine data collection system** consists of:

- registration forms and tools (paper–based and electronic);
- regulations and procedures of their usage and data flows;
- regular aggregation and analysis of data.

Although organizations usually themselves decide how they will adapt registration documents and tools to match their needs, it is strongly advised that the **following paper–based documentation is in place:**

- a registration logbook containing a list of all project clients with their basic details: new individuals are added to the logbook once they become project clients. The level of details collected from each new client is usually defined by project staff based on data requirements and its availability (please see an example of a logbook in *Annex 5*);
- daily record keeping registries that contain a list of all clients who obtained project services during a specific day, indicating the specific materials and services provided (please see an example of a registry in *Annex 5*). These should usually be filled in by front–line project staff directly at the points of service provision, during contact with the client. At the end of the day or once a week the data entered into daily registries are aggregated and entered into the MIS if one is in place;
- it is also advisable that project clients receive a "client card", which states that the person is a client of a particular project, and contains his/her personal code; for confidentiality purposes, the client's name is not shown on the card.

Development and implementation of a **coding system** is a central issue of a programme monitoring system's effective functioning, as it provides **the possibility to track an individual rather than client visits or contacts.** Because people in most–at–risk and affected populations are often marginalized and face stigma and discrimination, it is crucial to develop a system which meets confidentiality requirements; otherwise it would endanger the quality and extent of services provided.

The coding system may vary from organization to organization depending on the individual organization's practices, traditions and other factors, or can be set up on a unified basis across the country. In any case, the coding system needs to be based on the following principles:

- one person should be assigned a single code regardless of the number of points of service provision at which he/she receives the services;
- the code must comply with the principles of confidentiality.

Preferably the client's code should be based on the client's personal information, in order to be easily restored in case of loss of a client card. For example: code **IPS120178** is based on the following information: **I**vanov **P**etr **S**ergeyevich, born on **January 12**, 19**78**. Another way to organize the system would be to use an identification code (usually a simple record number with a letter indicating the service provision point which issued the card, i.e. **00178–K**). This allows individual clients to sign in for services without divulging personal information; however, as will be discussed later, this increases the probability of double counting.

In case of the first coding system option, an organization might decide not to use cards, as each client is able to remember his/her code. A social worker would only ask a client if this is the first or subsequent episode of service provision to him/her. However, very often client cards have a broader significance and usage than simple registration needs; therefore it is still recommended to use cards.

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

With certain variations, procedures of data collection and analysis within an organization can be summarized as follows:

- **At the point of service provision** (stationary or outreach): front–line service providers record all necessary information about the client during the first contact, and all consumables and services provided to the client against his/her code during each contact. Registration at this point should be organized with respect to previously determined coverage criteria (discussed in *Chapter IV*).

- **At the level of the project:** data collected by front–line staff is regularly aggregated and entered into the MIS (if one is in place). Primary paper–based documentation should be organized and stored in the project office. It is strongly recommended that there is a staff–member fully dedicated to internal project monitoring. It is his/her responsibility to collect data and provide project managers with regular data analysis.

A number of issues have been pointed out in this and previous chapters which should be kept in mind when preparing a TOR for project monitoring MIS development which describes requirements for functionality. These include a specific framework for each indicator to be tracked (including disaggregation), a coding system in place, reporting, etc.

Before launching the MIS development process, the following issues should be considered and incorporated into the development and implementation plan:

- the MIS should be as simple as possible while meeting data collection requirements (every part of it should have clear implications which do not create an additional data collection burden);

- the level of details to be collected and analyzed should be determined by the size of the programme/project and reflect the country/regional context;

- a list of MIS usage limitations should be clearly stated and communicated to end users;

- the MIS should cover maximum needs in data collection in order to avoid duplication in data collection efforts and tools;

- before scaling up implementation of the MIS, a certain time period should be devoted to piloting;

- a separate section in the implementation plan should be devoted to building the capacity of end users, including training, technical assistance visits, etc.

- A user guide should accompany the MIS.

In 2005 the International HIV/AIDS Alliance in Ukraine launched implementation of SyrEx, a special MIS software tool for internal programme monitoring of focused HIV prevention projects. The following pages provide an overview of its functions.

SyrEx MIS for Registration of Focused Prevention Project Clients

The SyrEx database was developed by the International HIV/AIDS Alliance in Ukraine with financial support from the Global Fund to Fight HIV/AIDS, TB and Malaria in the framework of the national programme 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. The 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 providing prevention services in penitentiary institutions.

As already mentioned, the key requirement for effective utilization of SyrEx is a well–functioning client coding system. Because the issue of confidentiality is so sensitive for target groups, they cannot be registered using names, last names and passport data. A good solution to this problem is client coding, when an individual is given a card with a code on it, which will be further used as ID information for this individual. Another important element of an effective registration system is the accurate and timely completion of daily registration forms directly at service provision points.

SyrEx functions

- Client 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.). In addition, at the time of first contact an individual is asked whether (s)he has ever been registered and received services from another organization. In case of a positive answer, a corresponding mark is made to avoid double counting at the data aggregation stage, and this individual is registered with his/her old code.
- Adding organization–specific data:
  - each MIS user (organization) has its own list of materials and services provided to clients. SyrEx allows users to compile this list, which is used to track distribution of materials and provision of services among clients (i.e. how many items of material X were given to client Y and when; this represents an electronic version of the daily registration form);
  - a unique list of social workers and service provision points is compiled in order to track the work of each point and staff member providing services;
  - the database also provides the option to add a list of typical training modules conducted by the organization, which is used for tracking trainings.
- Keeping track of daily records:
  - social workers fill in daily registration records at service delivery points. Generally, these contain information on the number of materials given out, counselling sessions and other services provided, etc. to each client (i.e. code) visiting the point during a given day;
  - these daily registries are regularly copied to the MIS (transferred from paper–based to electronic form).
- Compilation of reports (see below for further details)
- Data export to MS Excel for further analysis
- Database back–up and restoration (a necessary function, as PC work is very unstable and data may be lost)

- Data transfer and consolidated analysis:
    - SyrEx provides the option 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 create a general picture of several (all) organizations at the 'regional' (lower) level.

Compilation of reports

The database allows analysis of data in different ways and different levels, namely:

- extraction of the cumulative number of clients reached starting at a given point in time (i.e. project start up) with basic information on each client (number of visits, age, sex, target group, etc.);
- extraction of 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 list of **Selected Indicators**);
- extraction of the list (number) of people reached during any user–defined time period (day/week/month/quarter/...);
- extraction of the list (number) of regular clients of the programme (according to preset criteria);
- extraction of general information on the number of materials given out and counselling sessions provided during a user–defined time period;
- extraction of the list of clients who received one particular material or service or a defined package of services during a user–defined time period;
- analysis of data on regularity of visits during a given time period;
- extraction of all above–mentioned data either for the whole organization or for a user–defined list of service provision points or social workers (one or several);
- extraction of information on the number of trainings conducted and people trained, split by training modules and target groups;
- creation of additional user–defined reports.

Figure 1. ***Main Page of the SyrEx MIS***

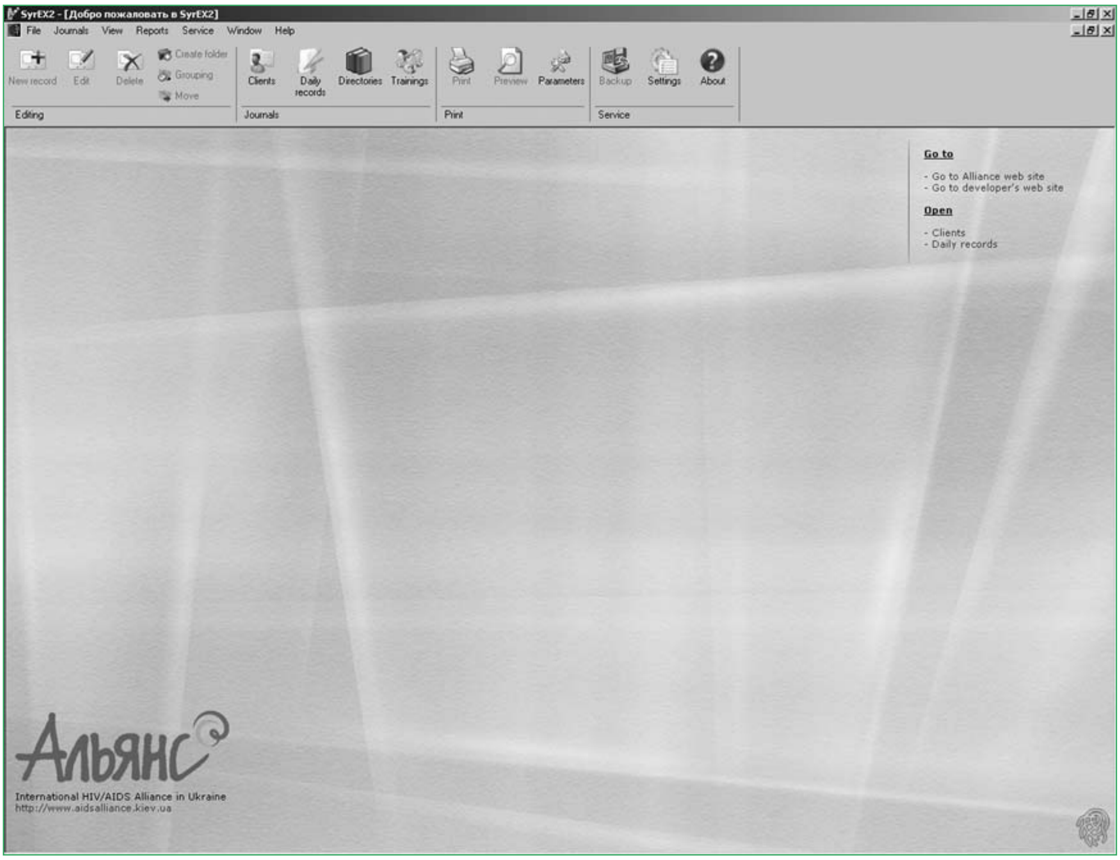
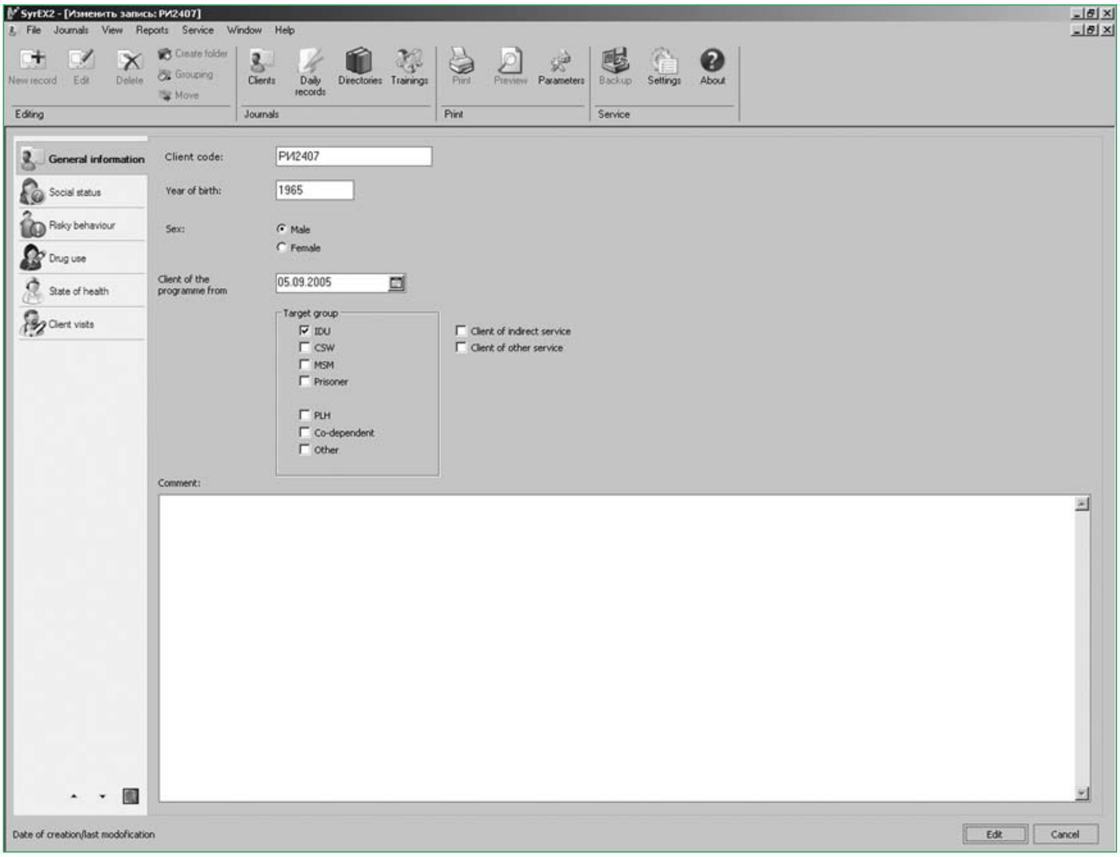


Figure 2. ***Client Profile – Basic Information***



Client code: РИ2407

Year of birth: 1965

Sex: ● Male ○ Female

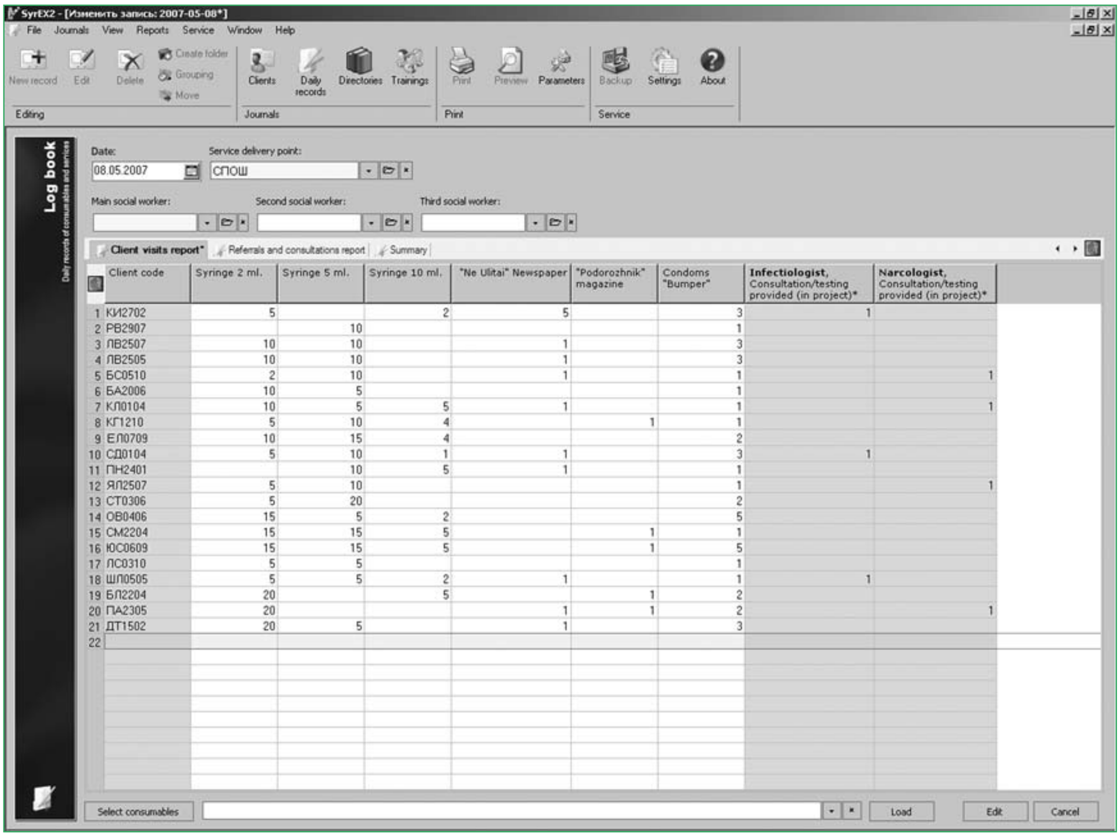
Client of the programme from 05.09.2005

Target group

☑ IDU
☐ CSW
☐ MSM
☐ Prisoner
☐ PLH
☐ Co-dependent
☐ Other

☐ Client of indirect service
☐ Client of other service

Figure 3. **Daily Registration Form**



Date: 08.05.2007

Service delivery point: СПОШ

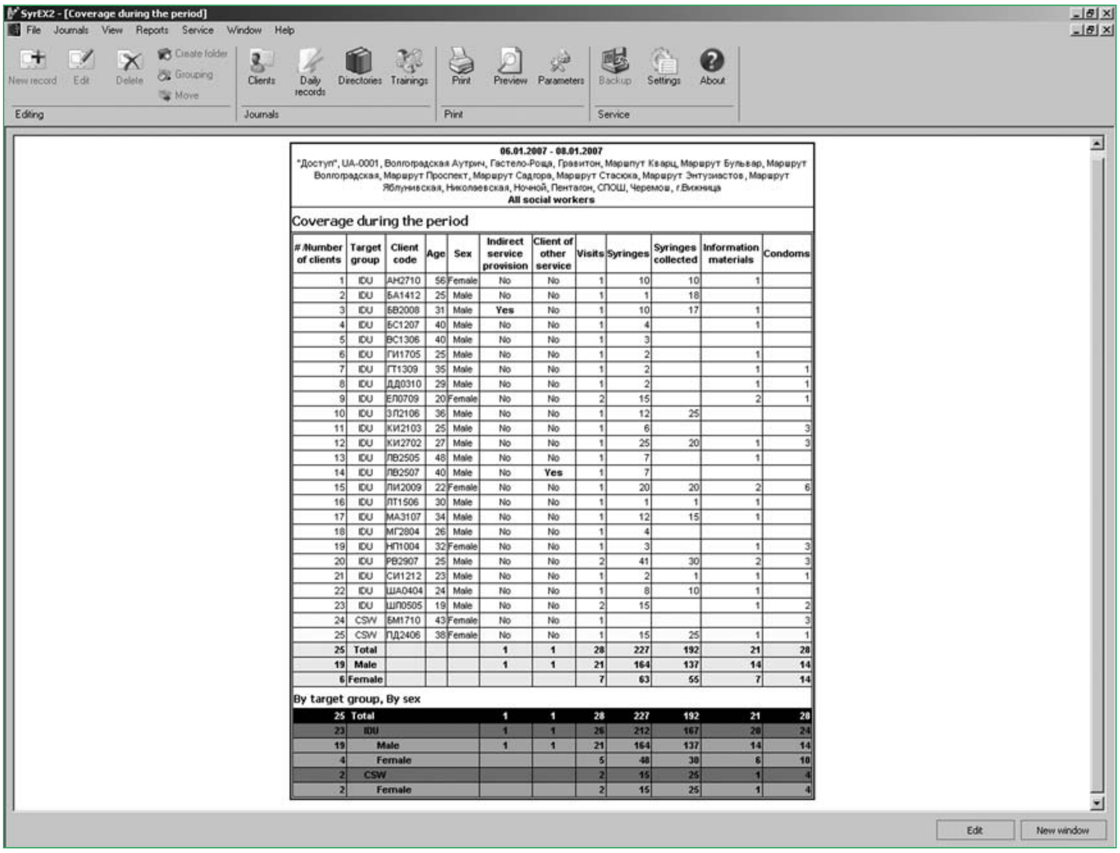
Main social worker:

Second social worker:

Third social worker:

	Client code	Syringe 2 ml.	Syringe 5 ml.	Syringe 10 ml.	"Ne Ulitai" Newspaper	"Podorozhnik" magazine	Condoms "Bumper"	**Infectiologist,** Consultation/testing provided (in project)*	**Narcologist,** Consultation/testing provided (in project)*
1	КИ2702	5		2	5		3	1	
2	РВ2907		10				1		
3	ЛВ2507	10	10		1		3		
4	ЛВ2505	10	10		1		3		
5	БС0510	2	10		1		1		1
6	БА2006	10	5				1		
7	КЛ0104	10	5	5	1		1		1
8	КГ1210	5	10	4		1	1		
9	ЕЛ0709	10	15	4			2		
10	СД0104	5	10	1	1		3	1	
11	ПН2401		10	5	1		1		
12	ЯЛ2507	5	10				1		1
13	СТ0306	5	20				2		
14	ОВ0406	15	5	2			5		
15	СМ2204	15	15	5		1	1		
16	ЮС0609	15	15	5		1	5		
17	ЛС0310	5	5				1		
18	ШЛ0505	5	5	2	1		1	1	
19	БЛ2204	20		5		1	2		
20	ПА2305	20			1	1	2		1
21	ДТ1502	20	5		1		3		
22									

Figure 4. **Sample Report on Coverage During the Period**



06.01.2007 - 08.01.2007

"Доступ", UA-0001, Волгоградская Аутрич, Гастело-Роща, Гравитон, Маршрут Кварц, Маршрут Бульвар, Маршрут Волгоградская, Маршрут Проспект, Маршрут Садгора, Маршрут Стасюка, Маршрут Энтузиастов, Маршрут Яблунивская, Николаевская, Ночной, Пентагон, СПОШ, Черемош, г.Винница

All social workers

Coverage during the period

# /Number of clients	Target group	Client code	Age	Sex	Indirect service provision	Client of other service	Visits	Syringes	Syringes collected	Information materials	Condoms
1	IDU	АН2710	56	Female	No	No	1	10	10	1	
2	IDU	БА1412	25	Male	No	No	1	1	18		
3	IDU	БВ2008	31	Male	**Yes**	No	1	10	17	1	
4	IDU	БС1207	40	Male	No	No	1	4		1	
5	IDU	ВС1306	40	Male	No	No	1	3			
6	IDU	ГИ1705	25	Male	No	No	1	2		1	
7	IDU	ГТ1309	35	Male	No	No	1	2		1	1
8	IDU	ДД0310	29	Male	No	No	1	2		1	1
9	IDU	ЕЛ0709	20	Female	No	No	2	15		2	1
10	IDU	ЗЛ2106	36	Male	No	No	1	12	25		
11	IDU	КИ2103	25	Male	No	No	1	6			3
12	IDU	КИ2702	27	Male	No	No	1	25	20	1	3
13	IDU	ЛВ2505	48	Male	No	No	1	7		1	
14	IDU	ЛВ2507	40	Male	No	**Yes**	1	7			
15	IDU	ЛИ2009	22	Female	No	No	1	20	20	2	6
16	IDU	ЛТ1506	30	Male	No	No	1	1	1	1	
17	IDU	МА3107	34	Male	No	No	1	12	15	1	
18	IDU	МГ2804	26	Male	No	No	1	4			
19	IDU	НП1004	32	Female	No	No	1	3		1	3
20	IDU	РВ2907	25	Male	No	No	2	41	30	2	3
21	IDU	СИ1212	23	Male	No	No	1	2	1	1	1
22	IDU	ША0404	24	Male	No	No	1	8	10	1	
23	IDU	ШЛ0505	19	Male	No	No	2	15		1	2
24	CSW	БМ1710	43	Female	No	No	1				3
25	CSW	ПД2406	38	Female	No	No	1	15	25	1	1
25	**Total**				**1**	**1**	**28**	**227**	**192**	**21**	**28**
19	**Male**				**1**	**1**	**21**	**164**	**137**	**14**	**14**
6	**Female**						**7**	**63**	**55**	**7**	**14**

By target group, By sex

25	**Total**	**1**	**1**	**28**	**227**	**192**	**21**	**28**
23	**IDU**	**1**	**1**	**26**	**212**	**167**	**20**	**24**
19	**Male**	**1**	**1**	**21**	**164**	**137**	**14**	**14**
4	**Female**			**5**	**48**	**30**	**6**	**10**
2	**CSW**			**2**	**15**	**25**	**1**	**4**
2	**Female**			**2**	**15**	**25**	**1**	**4**

■ What are the anticipated challenges and possible solutions?

There are a number of challenges which both *funding* and *implementing organizations* face when developing and especially implementing routine data collection practices. These are more or less all about finding the balance between collecting good quality data and observing anonymity and confidentiality requirements, i.e. not compromising on quality of services provided.

The same ethical considerations associated with research involving human subjects need to be applied when undertaking programme monitoring in client communities. Values including respect for privacy, confidentiality, anonymity, and the principle of "do no harm" must guide the approach to data collection, analysis, and release of findings. Ethical research practices must be strictly adhered to when accessing project records to maintain confidentiality of client information.

Because members of most–at–risk populations may want to remain anonymous when accessing services or when contacted by outreach workers, it can be difficult for projects to keep track of individual clients reached. First of all, clients may be unwilling to provide personal identifying information that could be used to identify them during subsequent visits altogether. Further, as outreach activities sometimes occur in public places, project staff might not be able to record information about the client immediately after the first visit. In this case it is suggested that the provision of a client card occurs during one of the subsequent contacts when the client feels safe and realizes that it would not harm him.

An important element of nearly all HIV–related interventions is advocacy work and tolerance–raising campaigns. Apart from their direct benefits for the most vulnerable groups, these interventions would also ultimately improve the quality of programme data, because a major proportion of the data collected by *implementing organizations* is self–reported by clients. An overall supportive environment would encourage project clients to provide true information.

As mentioned in the previous sub–section, one of the key issues to be considered at the design and implementation phase is avoiding or at least minimizing the double counting of clients.

Avoiding Double Counting

Double counting may occur either within one organization (when a single person is recorded twice) or between organizations (when a single person is a client of two different AIDS–service organizations).

In order to avoid counting the same person more than once within one organization, in the case of card loss social workers should try to restore the code under which the person was previously registered (usage of coding systems based on personal client information is very useful for this purpose; otherwise the code is reconstructed according to daily records, on the basis of approximate dates of previous visits and other relevant information). Obviously, it is much easier to restore a code which is based on personal information (please refer to the first way of organizing the coding system described in the previous sub–section), thus using this approach would reduce the chance of double counting within one organization.

In order to avoid registration of the same person at two different points of service provision or 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 MIS a separate checkbox titled "previously received services at another organization" is checked by the project employee).

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

- In some situations, an individual is a *representative of two vulnerable populations*, for example a woman could be both a sex worker and an injecting drug user. 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 CSWs, and as IDUs if it is a project aimed at IDUs (in Ukraine these two types of projects are usually separate; in other countries where this is not the case this approach might not work and double counting could occur). As long as IDUs and CSWs reached are not added together to form an overall number of "IDUs and CSWs reached", double counting does not occur and projects can use this approach to calculate coverage. Whichever approach is used, corresponding registrations rules should be developed at project level, agreed, made clear to all relevant staff and adhered to.

- A similar situation can occur when aggregating numbers of *people trained*. Training providers are expected to identify individuals trained in a certain topic and count every person once in order to avoid double counting. However, if the same person is trained in two different topics, e.g. in HIV prevention and in capacity building, he would usually be recorded as two people. This does not constitute a problem if two separate indicators are used to record people trained in two different topics, i.e. numbers of people trained in HIV prevention and in capacity building are not added together; however the same person should not be counted more than once under the same indicator.

- *Within one organisation,* particularly where different services are provided to the same people, e.g. peer–counselling and humanitarian aid for PLHA. Double counting 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 the staff's personal knowledge. Otherwise this issue is easily resolved by usage of the MIS.

- *Between different organisations*. Double counting is particularly likely to occur when more than one organisation is providing similar services to the same vulnerable population in one geographical location, where different services are provided to overlapping vulnerable populations, or when populations are highly mobile. It is unlikely that double counting can be fully eliminated in these circumstances unless a ***unified coding system*** is introduced and utilized, meaning that an individual may access similar services at every point in the country and he/she will still be registered under the same unique code. However, this would require introduction and full utilization of a ***shared online registration MIS*** *used by* **all** *parties*, which would require a considerable amount of human and financial resources; and still would not eliminate double counting if someone has given incorrect code–critical personal information. If the sole purpose of unified coding system introduction is to avoid double counting, it is not necessarily justified; however, there might be other reasons for its implementation. For example, in some cases (examples are available from outside of Ukraine) an individual may be assigned a regional or nationwide code, unique throughout all HIV–related services that he/she might access: needle–exchange programmes, drug–treatment facilities, AIDS centre services, care and support projects, STI clinics, etc. This approach facilitates keeping track of all services provided to a particular individual, regardless of service provider, and enables each agency to observe the entire history of service provision up to a given point in time.

- *When services are provided in different time periods*, for example if someone receives initial services and then returns again after a long period, say in two years. In this situation, there is a chance that the person may be registered as a new client and thus counted twice. Avoiding double counting in these situations relies on clients providing accurate and honest information and organizations having good records of services provided. However, if a client provides inaccurate or untrue identifying information, it is virtually impossible to avoid double counting in this case.

As mentioned above, for consistency purposes programme monitoring systems should be designed by *funding agencies* (preferably on the national level). However, it is the task of *implementing organizations* to use the system properly. Very often it appears that front–line and other project staff involved in the process of data collection do not understand the purpose of M&E–related work and are not familiar with basic registration procedures. Therefore it is of crucial importance that *funding agencies* devote enough time to training relevant *project staff* (usually project managers and M&E personnel), who in turn ensure that internal data collection procedures are developed, understood and observed by all staff involved in the process.

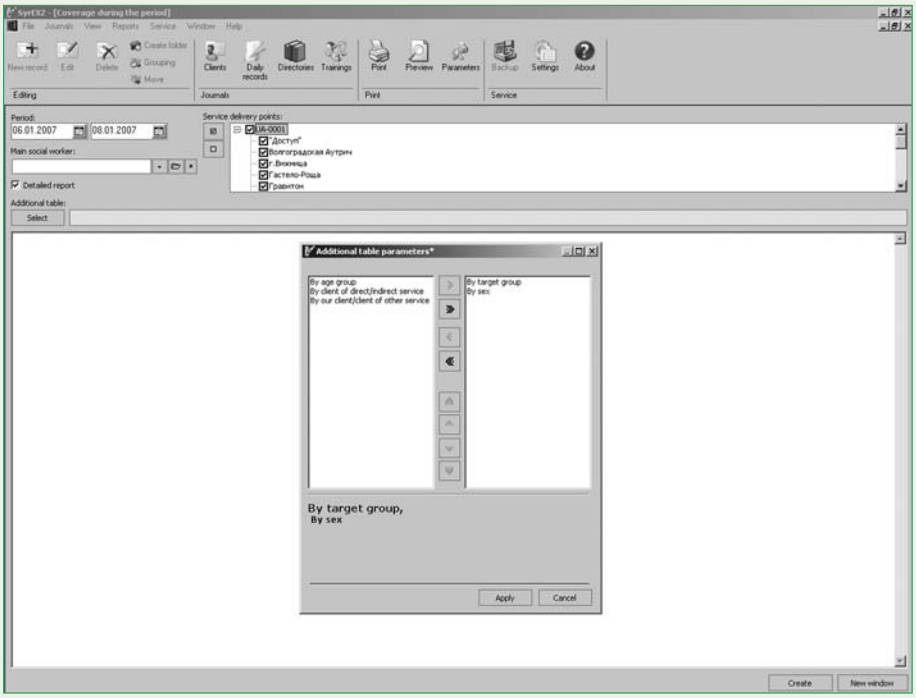
It is usually impossible to foresee all possible issues which might arise after reporting and registration systems are designed. Moreover, even those projects working in the same sphere (i.e. harm reduction among IDUs) might be quite different in terms of services provided, activities implemented and approaches taken. Thus it is very important for *funding agencies* to find a proper balance between necessary standardization and flexibility when developing the system of programme monitoring, and coordinate this process with other national stakeholders.

Practical Case Example

Please refer to *Annex 5* for sample logbook and daily registration form.

Based on SyrEx MIS data it is possible to generate different kinds of reports and make detailed programme–level data analysis. Several examples are given below.

Sample Report Compilation Template



Period: 06.01.2007 08.01.2007

Main social worker:

☑ Detailed report

Additional table:

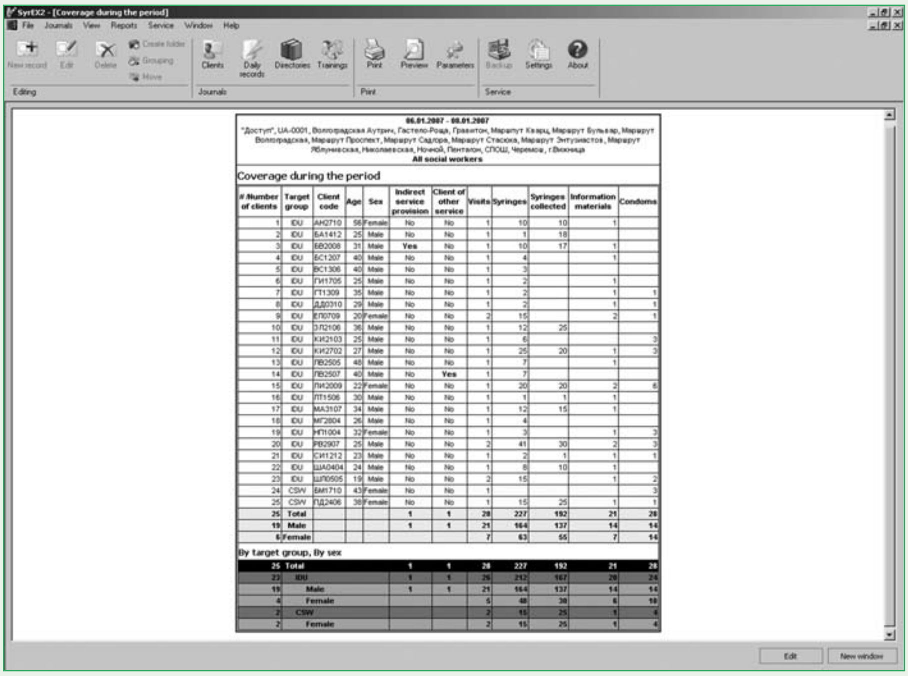
Service delivery points:
- ☑ UA-0001
  - ☑ "Доступ"
  - ☑ Волгоградская Аутрич
  - ☑ г.Винница
  - ☑ Гастело-Роща
  - ☑ Гравитон

By age group
By client of direct/indirect service
By our client/client of other service

By target group
By sex

By target group,
By sex

Sample Report on Coverage During the Period



06.01.2007 - 08.01.2007
"Доступ", UA-0001, Волгоградская Аутрич, Гастело-Роща, Гравитон, Маршрут Кварц, Маршрут Бульвар, Маршрут Волгоградская, Маршрут Проспект, Маршрут Садова, Маршрут Стасюка, Маршрут Энтузиастов, Маршрут Яблунівская, Николаевская, Ночной, Пентагон, СПОШ, Черемош, г.Винница
All social workers

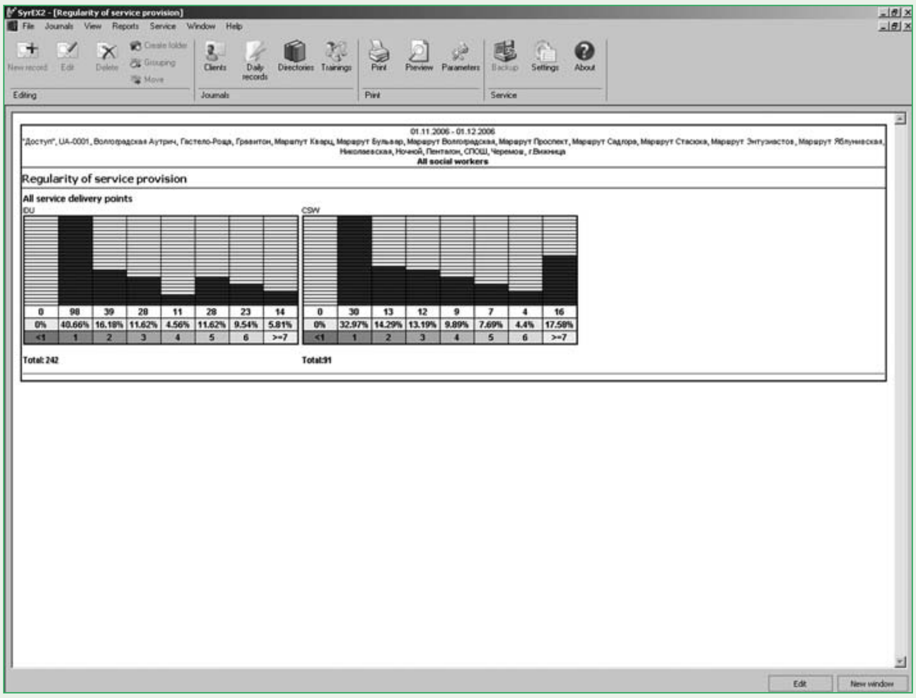
Coverage during the period

# Number of clients	Target group	Client code	Age	Sex	Indirect service provision	Client of other service	Visits	Syringes	Syringes collected	Information materials	Condoms
1	IDU	АН2710	56	Female	No	No	1	10	10	1	
2	IDU	БА1412	25	Male	No	No	1	1	18		
3	IDU	БВ2008	31	Male	**Yes**	No	1	10	17	1	
4	IDU	БС1207	40	Male	No	No	1	4		1	
5	IDU	ВС1306	40	Male	No	No	1	3			
6	IDU	ГИ1705	25	Male	No	No	1	2		1	
7	IDU	ГТ1309	35	Male	No	No	1	2		1	1
8	IDU	ДД0310	29	Male	No	No	1	2		1	1
9	IDU	ЕП0709	20	Female	No	No	2	15		2	1
10	IDU	ЗЛ2106	36	Male	No	No	1	12	25		
11	IDU	КИ2103	25	Male	No	No	1	6			3
12	IDU	КИ2702	27	Male	No	No	1	25	20	1	3
13	IDU	ЛВ2505	48	Male	No	No	1	7		1	
14	IDU	ЛВ2507	40	Male	No	**Yes**	1	7			
15	IDU	ЛИ2009	22	Female	No	No	1	20	20	2	6
16	IDU	ЛТ1506	30	Male	No	No	1	1	1	1	
17	IDU	МА3107	34	Male	No	No	1	12	15	1	
18	IDU	МГ2604	26	Male	No	No	1	4			
19	IDU	НП1004	32	Female	No	No	1	3		1	3
20	IDU	РВ2907	25	Male	No	No	2	41	30	2	3
21	IDU	СИ1212	23	Male	No	No	1	2	1	1	1
22	IDU	ША0404	24	Male	No	No	1	8	10	1	
23	IDU	ШП0505	19	Male	No	No	2	15		1	2
24	CSW	БМ1710	43	Female	No	No	1				3
25	CSW	ПД2406	38	Female	No	No	1	15	25	1	1
25	**Total**				**1**	**1**	**28**	**227**	**192**	**21**	**28**
19	**Male**				**1**	**1**	**21**	**164**	**137**	**14**	**14**
6	**Female**						**7**	**63**	**55**	**7**	**14**

By target group, By sex

25	**Total**	**1**	**1**	**28**	**227**	**192**	**21**	**28**
23	**IDU**	**1**	**1**	**26**	**212**	**167**	**20**	**24**
19	**Male**	**1**	**1**	**21**	**164**	**137**	**14**	**14**
4	**Female**			**5**	**48**	**30**	**6**	**10**
2	**CSW**			**2**	**15**	**25**	**1**	**4**
2	**Female**			**2**	**15**	**25**	**1**	**4**

Sample Report on the Regularity of Service Provision



01.11.2006 - 01.12.2006
"Доступ", UA-0001, Волгоградская Аутрич, Гастело-Роща, Гравитон, Маршрут Кварц, Маршрут Бульвар, Маршрут Волгоградская, Маршрут Проспект, Маршрут Садгора, Маршрут Стасюка, Маршрут Энтузиастов, Маршрут Яблунівская, Николаевская, Ночной, Пентагон, СПОШ, Черемош, г.Винница
All social workers

Regularity of service provision

All service delivery points

IDU

0	98	39	28	11	28	23	14
0%	40.66%	16.18%	11.62%	4.56%	11.62%	9.54%	5.81%
<1	1	2	3	4	5	6	>=7

Total: 242

CSW

0	30	13	12	9	7	4	16
0%	32.97%	14.29%	13.19%	9.89%	7.69%	4.4%	17.58%
<1	1	2	3	4	5	6	>=7

Total:91

Part B: Monitoring Service Quality

■ How and when it is done?

Monitoring the quality of services should be done throughout the whole period of programme/project implementation on an ongoing basis. Assessments of the quality of services should be done by both *organisations providing services* directly and by the *organisations giving funding* to other organisations to provide services. They can also be carried out by an external agency contracted to conduct a service quality assessment.

Various methodologies are used in collection of qualitative data, including, among others, client satisfaction surveys, desk reviews, client/staff observation, mapping exercises, key informant interviews, focus groups, participatory appraisals, etc. Please refer to the list of references and resources at the end of this manual for additional information on utilization of these methodologies.

Activities aimed at determining programme implementation quality range from rapid assessments that can be accomplished cost-effectively and relatively quickly, to special data collection activities that employ rigorous research methods, detailed assessment tools and in-depth programme analyses. Methods of implementation quality data collection may include:

- *Client interviews*

Interviews with clients provide information on their experience, perceptions and satisfaction with services they have received. This includes interactions with project staff and referral agencies, access to and convenience of project sites, and appropriateness of provided services. They can also assess the intensity of exposure to interventions and whether referral systems intended to provide a continuum of care are working effectively.

- *Staff interviews*

Interviews with project management and staff can provide information on perceived strengths, weaknesses and needs related to service delivery, programme processes, staff and management structures, capacity, and communications methods.

- *Observation*

Observation of the client–staff interaction provides an opportunity to assess the completeness and accuracy of information provided to clients, adherence to protocols, and interpersonal communication skills of the staff, and whether the appropriate referrals are made.

- *Facility audits*

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

- *Interviews with Complementary Service Providers*

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

- *In–depth interviews and focus groups with non–users*

Qualitative research methods such as focus groups or in–depth interviews with non service users can help identify barriers and biases in access to services and gaps in service provision.[23]

Quality standards constitute the basic instrument of monitoring performance in a particular service delivery area. Definition and application of quality standards is the basis of monitoring service quality. Ideally, minimum quality standards should be set by the state at the national level and constitute a benchmark according to which service–providing organizations are licensed. However, in the absence of nationwide unified standards *funding organizations* are encouraged to set their own quality standards with maximum involvement of all stakeholders, which will be used by all their *implementing partners*. The quality of services provided by an organization should be regularly monitored and assessed to ensure that clients are receiving the quality of services that is guaranteed by the standards. Quality 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.

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[23] – Abstracted from *A Framework for Monitoring and Evaluating HIV Prevention Programmes for Most–At–Risk Populations*, April 2007, Chapter 5

The overarching **aim of having service quality standards** is to improve the quality of services provided. For this purpose, as soon as standards have been developed and approved, service providers should be trained to deliver services in accordance with them. Standards should also be publicised for service users to be aware of the level of services they can expect to receive. Standards should also be used as appraisal criteria during monitoring activities, such as site visits, client surveys, etc. This can best be done through inclusion of quality standards in instruments used for appraisals. In this way, the **monitoring visit report** form (further discussed in the following chapter) should, among other elements, have a section devoted to documenting the quality of services provided.

How Can Standards be Set?

The following are the basic steps for defining and setting quality standards:

1. 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.

2. Search for any quality standards that have already been developed for the service areas of interest. The starting point for this search should be national standards, if available. If national standards are not available, then international standards developed by international agencies e.g. WHO, UNAIDS and others, can be adapted, if available and suitable (please refer to the list of recommended resources at the end of this manual).

3. If national or international standards are not available, the next step is to develop new programme standards relating to the services being provided (see an example of one attempt to develop such standards below).

4. The final step is to test the developed standards by consulting service users, providers, and other stakeholders before further approval and implementation.

The following provides a list of possible ways in which quality can be assessed by means of different appraisal instruments, after standards have been defined:

- service users: by asking service users what they think about the services being provided, using an instrument developed to capture the quality of services;
- observation: by observing services being provided, using an instrument or checklist to record how services are provided and with what quality, as long as there is no breach of client confidentiality;
- service providers: by asking service providers some key questions relating to different aspects of service provision;
- record verification: through checking records for services provided, as long as there is no breach of client confidentiality;
- key stakeholders: through consulting with key stakeholders in the locality about their perceptions of the services being provided by the organisation or the service provider (these may be, for example, state service providers or other NGOs).

What are the anticipated challenges and possible solutions?

While all programmes, regardless of target population and type of intervention, should conduct monitoring and evaluation of service quality, there are several issues to which programmes targeting most–at–risk populations should pay particular attention in terms of ensuring maximum quality of services. These issues are also candidates for inclusion in quality standards. A description of some of them follows:

- *Acceptability of services by clients* – this could be influenced by associated stigma and discrimination, clients' perception of privacy and confidentiality, appropriateness and relevance of interpersonal communication, client involvement in programme planning and implementation, related positive and negative experiences and overall satisfaction.

- *Access to programme services* – including distance to and location of project sites, opening hours, waiting time, cost if any and police presence.

- *Targeting of most–at–risk populations by programmes* – whether programmes are reaching particular networks of most–at–risk populations and excluding others that may be less visible or more highly affected by HIV.

- *Linkages with other services* – as individual programmes cannot be expected to meet all the needs of most–at–risk populations, organizations need to link effectively with others providing complementary services. These include other prevention services as well as treatment, care, support services, human rights, and life or vocational skills training.

- *Involvement of community stakeholders* – programmes targeting most–at–risk populations are unlikely to be successful without the simultaneous involvement of those individuals who also influence their vulnerability to HIV. These are specific to local contexts and can include sex industry gatekeepers, sexual partners, police and local authorities, or other influential individuals. These individuals directly influence the success of interventions.

One of the quality components which should be considered in order to ensure maximum effectiveness of implemented interventions is the front–line staff approach to **first time contact with a client**. Besides provision of information and services and motivating clients for future visits, it is important to assess the vulnerability of each new client by asking several screening questions aimed at filtering occasional irrelevant individuals and paying maximum attention to most vulnerable representatives.

Naturally, quality of services is very much determined by individual personal perceptions and beliefs, thus making the process of quality assurance quite subjective. Attempts to develop standards and procedures to verify adherence to standards (e.g. checklists) are intended to make this process as objective as possible; however, they may compromise flexibility. Thus, while developing standards and monitoring tools, a balance should be kept between ensuring maximum flexibility and objectiveness.

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Practical Case Examples

Development of Quality Standards for Rehabilitation Services: First Steps

A simple consultation with a group of people attending a drug rehabilitation centre revealed that they considered 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 its 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 them to a list of service standards and quality assessment tools.[24]

State Quality Standard of the Minimum Package of HIV/STI Prevention Social Services for IDUs

The State Quality Standard of the Minimum Package of HIV/STI Prevention Social Services is a basic document developed in 2007 by an expert group comprised of Ukrainian state social service providers (State Social Service for Family, Children and Youth), AIDS–service NGOs (including the Coalition of AIDS–service Organizations), and international organizations. Without going deeply into the details of each particular service (covered in separate protocols yet to be developed), the standard provides a good framework by determining the minimum guaranteed package of social services for IDUs, including a description of types of services provided (social counselling, psychological counselling, information services, syringe distribution, etc.). It is anticipated that in future the given document (together with relevant protocols) will constitute the basis for licensing AIDS–service organizations, both government and non–government.

Verification of the Quality of Services Provided to Clients of Prevention Projects For MARPs: Experience of the Alliance In Ukraine

As part of monitoring visits procedure, the Alliance Ukraine has developed a checklist aimed at verification of the quality of services provided to clients of prevention projects for MARPs. This checklist has been incorporated into the monitoring visit report form, which will be discussed in the following chapter, and is given as an example on the attached CD and in *Annex 6*.

In order to formalize the service quality assurance procedure, the following **quality–crucial components** of service provision were identified:

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[24] – Derived from the *Monitoring the Work of International Charitable Foundation "International HIV/AIDS Alliance in Ukraine"* report prepared by R. Drew, Health and Development Consultant, January 2006

- Comprehensiveness of services provided to clients
- Confidentiality, safety and respect towards clients
- Overall client satisfaction
- Staff professionalism

In other words, these four components represent different dimensions of quality service provision, and are evaluated separately in order to formalize assessment and create an overall picture.

The service quality monitoring process for all four dimensions is performed by Alliance Ukraine staff members through the following means:

- Direct observation of service provision
- Interviews with clients
- Interviews with staff members

Based on the answers to all questions listed for each quality component, a corresponding integral rank is calculated per project/organization. Mathematical methodology and formulas used to calculate the integral rank can be found in the Excel file containing the monitoring visit report form on the CD attached to this manual.

Chapter VII

STEP FIVE:

COLLECTION AND ANALYSIS OF DATA, ENSURING DATA QUALITY

■ What does this step mean? What is it for?

The process of data collection and analysis, as well as verification of data quality, constitutes a part of routine monitoring procedures along with monitoring service quantity and quality addressed in the previous chapter. While *implementing organizations* are responsible for accurate routine record keeping described in detail in the previous chapter, at this point it is the task of *funding organizations* to collect and analyse data reported with a given regularity (usually quarterly or biannually) by *implementing organizations*. The process of developing reporting format and requirements has already been described in detail in *Chapter V*, thus at this point *funding organizations* will collect data submitted in a single unified format. Data obtained from *implementing partners* serves a number of functions, including further reporting to donor organizations, internal managerial decision-making processes both about overall programme performance and the performance of each individual IP, data usage for advocacy and PR purposes, etc.

Measuring the success and improving the management of AIDS-service organizations is predicated on strong monitoring systems that produce quality data. The data collected and submitted by IPs and managed within any information system (or manually) must be validated for completeness, accuracy and consistency. Unless quality of data is assured, it will not be reliable, and thus will not be useful for planning and decision-making. The process of data quality assurance is also an opportunity to identify areas for building the capacity of IPs. Therefore, after collecting reports, it is important to ensure that the data provided correspond to the activities conducted in the reporting period. Although all previous steps, such as IP capacity assessment, maintaining programme records, regular reporting, etc. contribute to the collection of quality data, specific actions should be taken to verify the consistency and accuracy of reported data. It is the responsibility of both *funding* and *implementing organisations* to maintain the system of data quality assurance; however it is clear that the ultimate responsibility for gathering quality data lies with *funding organizations.*

Thus the content of this chapter is written primarily for *funding agencies* (as is *Chapter V*), but will also be useful for *implementing organizations*.

■ How and when is it done?

Data collection, analysis and quality checks are performed with a given regularity (usually once a quarter or half-year) on a routine basis during the whole period of programme/project implementation. *Funding organizations* should develop an algorithm for data quality assurance, which among other components would regulate the timelines and regularity for quality controls to be performed.

As noted previously, *implementing organisations* submit reports using the same unified format which has been developed at the planning stage and communicated to them. All reports provided by *field level organizations* need to be reviewed and approved by relevant staff of the *funding organizations*; afterwards, they are usually analysed and aggregated for further reporting (to donors and stakeholders). The number of staff members involved in the verification and analysis of reports depends on the scale of the programme and the number of implementing partners, but it is advisable to have one dedicated staff member within any funding agency who would be responsible for data aggregation, summary analysis and production of further reports. Aggregate data are compared to national/programme targets set in order to check whether the programme is on track.

M&E programme staff at national or sub–national levels should be responsible for aggregating data on coverage with certain services across projects targeting most–at–risk populations in order to assess the collective coverage of services. Challenges related to double counting and possible ways to avoid it at the point of aggregating coverage data are addressed in *Chapter VI*. It is also at this level that geographic coverage should be monitored to identify gaps in programming and allocate resources more strategically. Both these activities require capacity at the national or sub–national level to compile and analyse data and produce a clear picture on intervention availability and use.

Reported data analysis and verification for each individual *implementing organisation* can be done either by the same staff member who is responsible for data aggregation and analysis, or by a different staff member or group of people depending on the scale of the programme implemented. At this point reports are verified according to, among other parameters, their compliance with:

- Targets
- Previously reported figures
- Budget utilization report
- Activities implemented
- Back–up supporting documentation
- Common sense (for instance, the number of regular clients should be less than or equal to the number of current clients reached during the same period, as regular clients are a subset of all people reached).

Besides the data quality checks which are performed during reports verification, the major part of the data quality assurance process is performed during **monitoring visits** to *implementing organisations*, which should be conducted regularly by responsible staff of the *funding organisation.*

Monitoring Visits

Monitoring visits are the basic instrument of assuring the quality of data provided by IPs. Monitoring visits can be conducted by staff of the *funding organization* and/or 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 which conduct the visits to different IPs. Naturally, more complex grants with bigger funding require more frequent monitoring visits compared to smaller projects with less financing. At the same time, monitoring visits are also an instrument of technical support provision and identification of areas for improvement; therefore less experienced, new organizations might require more attention and more frequent visits. The composition of the teams visiting organizations also depends on the criteria mentioned above, as well as on the problems experienced by the organization: if problems are related to databases, recording or reporting issues, it is relevant for an M&E specialist to visit the project, while if 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 completion of a monitoring visit report form (please refer to *Annex 6* for the sample), which serves the following purposes:

- provide a summary of the organization's performance;
- verify that appropriate data collection procedures and systems are in place;
- verify the organization's achievements (as declared in reports) on the basis of reviewing the project's primary documentation, as well as by direct observation;
- assess the quality of services provided to clients (discussed in the previous chapter);
- 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 report form are used to:

- provide feedback to the IP on its overall performance and attainment of set targets;
- communicate 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.

Quality controls during the monitoring visit will be performed chronologically in four phases:

Phase 1: The first phase of data quality control occurs prior to the monitoring visit (emphasizing the cyclical and successive nature of the monitoring visit process). At this phase the monitoring team selects indicators, activities and time period to be verified, and reviews the latest programme report and latest monitoring visit report form (in order to check the list of previous remarks and recommendations).

Phase 2: The second phase is conducted at the office of the IP that is being monitored. During this phase the monitoring team assesses data registration, collection and analysis systems and procedures in the organisation (in order to identify potential risks to data quality created by absence of unified procedures and neglect of set rules), as well as analyzes paper and electronic registration documentation (including information systems). At this point the following controls are performed:

- Is there a dedicated person responsible for M&E?
- Has the organisation clearly documented what is reported to whom, and how and when reporting is required?
- Are there clearly defined internal data flow (collection and aggregation) regulations and procedures (including instructions for front-line staff on completing primary registration documentation?

- Do all staff members involved in the data collection process understand their roles and responsibilities?

- Are there standard data registration and collection forms and tools (including information systems) that are systematically used, kept and made available?

- Are there any discrepancies between primary and aggregated documentation, which occurred during the internal data flow process?

Before the visit to service delivery points, the monitoring team will select and study the primary source documentation of these points for the previous period (usually, a month or a couple of weeks).

At this phase the monitoring team also checks if the recommendations from the previous monitoring visit have been met.

Phase 3: The third phase of this process takes place at the selected service delivery points. During this phase the monitoring team assesses data registration systems and practices at the points, and traces and verifies reported numbers from source documents for the selected indicators. The purpose of this part of the quality assurance process is to assess on a limited scale if service delivery sites are collecting data accurately and on time. To do this, the monitoring team will determine how accurately front-line staff have recorded the activity that contributes to the selected indicators, and how similar the monitoring day data appears to be in comparison with average previous period data. At this point the monitoring team will:

- observe the correspondence between the delivery of services/commodities and the completion of the source document (daily register) that records that service delivery;

- compare the observed numbers of people reached, commodities distributed, etc. to the numbers reported (for the given service delivery point);

- check if quality and coverage criteria defined previously are observed;

- check if the right people are being targeted and are receiving the services;

- interview clients and front-line staff in order to determine the actual quality of services provided.

However, because there are significant differences between certain types of service delivery areas (outreach information and education, mobile clinics, home-based care, etc), the data quality assurance should include specific protocols to perform these standard data-verifications for each particular service delivery area.

Phase 4: The last phase of the quality assurance process takes place back in the *funding organization*. To document the quality assurance process, the monitoring team collects and documents: 1) evidence related to the review of data flow systems; 2) evidence related to data verification. During this phase the monitoring team completes a monitoring visit report form (sample provided in Annex 6) and initiates follow-up procedures to ensure that agreed-upon corrective measures are implemented by the organisation. The results of the site visits, together with IP quarterly reports and/or ad-hoc requests from organizations constitute the basis for providing corresponding technical assistance to IPs, and other managerial decisions.

Monitoring visits to implementing partners thus serve as a means of verification of data provided by IPs in their reports, as well as an instrument for verifying the implementation of remedial actions identified as necessary and communicated to the IP in case planned targets were not reached.

When there is more than one data aggregation level (for example, there are a number of intermediary implementing partners), quality controls of data collection and aggregation systems should be performed at each of these levels. In this case, the number of phases would increase.

What are the anticipated challenges and possible solutions?

The major challenge of the data collection and analysis process performed by the funding organisation is ensuring timely and accurate collection of reports. It appears easy at first glance, but in practice it seems to be very hard to collect and verify all reports within specific deadlines without compromising on data quality. Therefore, all procedures to be taken by responsible staff at this stage should be clearly defined and kept as simple as possible.

The procedure of monitoring visits described above is in practice rather complicated and time–consuming, requiring a lot of human resources to ensure the regularity and accuracy of the whole process. Moreover, one of the most important features of this process is its cyclical nature, wherein remarks and recommendations from previous visits should form the basis of the next. All this requires attention and a consistent approach to this process. Otherwise, no improvements will occur within any particular implementing organisation.

The whole visit should be conducted in a positive manner, underscoring the supportive attitude of the monitoring team towards the implementing organization, as another basic aim of the visit is provision of technical assistance to IP staff. It is not always easy to find a balance between the supportive character of the visit and the need to document objectively all evidence found during the visit.

The part of the process that takes place at the service delivery point is the most challenging for the monitoring team. First of all, as prevention and care and support projects are mostly working with highly marginalized and stigmatized populations, some service delivery points might be closed for "external visitors". For instance, if service provision occurs at a client's home, it might be unethical to perform "spot–checks". As noted above, the procedure to be carried out at the service delivery point includes interviews with clients, which again might cause difficulties if clients are not willing to communicate with people they don't know, or simply do not wish to answer questions. In this case, the monitoring team should try to collect and document as much information as possible, adding a necessary commentary on any limitations that occurred.

When speaking about the number of clients served at the service delivery point, another aspect should be noted. Because of the sensitivity of the work done by focused prevention and care and support projects, there are a number of different factors which may influence daily coverage, such as time of year, weather, law enforcement activity, etc. Thus, a lower number of clients compared to the average might be due both to data manipulation and to objective factors. In this case, it is the task of follow–up visits to find more evidence to support one of the possible scenarios.

Practical Case Example

The International HIV/AIDS Alliance in Ukraine utilises the above-described procedure for conducting monitoring visits to focused prevention projects. The monitoring visit report form currently used by the Alliance is given in *Annex 6*. More specifically, the major components of the monitoring visit process are (verification of fulfilment of previous visit recommendations is performed at each of the following stages where relevant):

- Review of the last quarterly report and the last completed monitoring visit report form.
- At the IP office:
    - verification of data collection procedures (availability of data flow regulations, standard registration forms; SyrEx MIS, dedicated M&E staff member, etc.);
    - availability of all primary source documentation;
    - correspondence of reported figures against key indicators with those generated from the SyrEx MIS;
    - correspondence of primary registration documentation to data in the SyrEx MIS (several registration forms are selected randomly from the folder of primary paper-based documentation and compared to the corresponding electronic registries in SyrEx for the purpose of complete compliance);
    - the average number of clients served during the previous month at service delivery points selected for visit is calculated based on primary registration documentation.
- At the service delivery points:
    - verification of actual data registration procedure performed by front-line staff;
    - verification of package of services/commodities provided to a client (whether it matches coverage criteria);
    - documentation of the number of clients served at this point during the day of visit (it should not differ dramatically from the average number calculated based on previous records);
    - interviewing clients and front-line staff.
- Other site-visits:
    - interviews with local partners (state bodies, other AIDS-service organizations);
    - interviews with AIDS centre representatives;
    - interviews with local law enforcement representatives; etc.
- Follow-up procedure:
    - monitoring visit report form is completed;
    - corresponding recommendations are sent to the IP;
    - an action plan identifying next steps and required technical assistance is developed in partnership with the IP;
    - subsequent control of recommendations fulfilment is done during the following visit.

Chapter VIII

STEP SIX:

PROJECTS AND INTERVENTIONS EVALUATION[25]

What does this step mean? What is it for?

Activities conducted at this stage are aimed at providing a broad and complex picture of the project or intervention under study. They represent the later stages of the M&E framework described in *Chapter II*, and constitute on one hand a part of programme M&E which aims to assess the effectiveness of a particular project or intervention, and on the other hand, a part of the overall evaluation process which is not classically considered to be programme M&E at all.

Such evaluation can be done either to assess the work of each individual project in order to conduct a comparative analysis of similar projects and identify success factors and constraints that hinder the given project in achieving its objectives, or else an outcome evaluation can be conducted in order to assess the effectiveness of an intervention (which may be implemented by several projects) compared to intended results.

As mentioned earlier in *Chapter II*, in contrast to monitoring, which is done on a routine basis, evaluation represents *episodic* assessment of the change in targeted results and outcomes related to the project or intervention. In other words, evaluation attempts to link a particular output or outcome directly to an intervention after a period of time has passed. Project or intervention level evaluations are different from national level evaluations primarily in their aims and interpretation of results. Project level evaluations aim to assess the effect and value of a specific project, trying to isolate it from other influencing factors to the greatest possible extent. National-level evaluations provide evidence on wider trends in behaviour, knowledge and epidemiological indicators, where projects or programmes are only one component of a collective effort. National-level evaluations would not usually attempt to isolate the individual influence of any contributing factor.

Project or intervention evaluation determines if, and by how much, implemented activities are achieving their intended effects on the target population. It answers two questions:

- Are the desired outcomes observed in the target population?
- Are these changes likely to be the result of the intervention or project?

The first question involves the collection of data on selected outcomes, such as HIV-related knowledge and risk behaviour, over time. The second question requires the use of methods that provide sufficient evidence to support a link between the observed changes and the intervention activities. Intended users of the findings from an outcome evaluation, such as programme planners, need to determine up-front the expected magnitude of the effect and the level of evidence that is needed to conclude that the intervention is indeed effective. These factors will affect decisions about the programme, such as whether funding should be continued and whether the intervention should be expanded or replicated.

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[25] – Based on *A Framework for Monitoring and Evaluating HIV Prevention Programmes* for Most-At-Risk Populations, April 2007, Chapter 7

A good outcome evaluation examines outcomes at multiple levels:

a) individual, client-based outcomes (e.g., in terms of changes in clients' circumstances, status, quality of life or functioning, knowledge, attitude and behaviour);

b) programme and system-level outcomes (e.g. improved access to case management, expanded job placement alternatives, strengthened project partnerships);

c) broader family or community outcomes (e.g. increased civil society participation, decreased violence).

One of the common errors in conducting outcome evaluations is not allowing adequate time for the intervention to have an effect before assessing it. HIV behavioural interventions require time to impact personal behaviour, community social norms and HIV incidence itself. Prematurely evaluating programme outcomes may show no change or show short-term improvements that are not sustained.

Such evaluations can be conducted either by project staff (internal evaluations) or by an external agency, which is hired specifically for this activity (external evaluations). In case of "self-evaluation", it is strongly recommended that the *funding organisation* provides the *implementing partner* with the methodology and protocol for such evaluation, because an individual evaluation design would have a very limited use and be a waste of resources. Thus it is very much recommended that external research agencies both develop the evaluation protocol and implement the study, because usually conducting a good evaluation requires skilled staff dedicated to the task.

Perhaps the most important step in the outcome evaluation process is the effective use and dissemination of data. Because outcome evaluations will provide information on intervention effectiveness, this information is critical for policy-makers and programme planners locally, but also elsewhere. Among the many uses of evaluation results, the most critical is refining and improving HIV interventions. Outcome evaluations can be used by programme planners to better design programmes tailored to the specific needs of the populations they serve. In addition, the programme's framework and content may be replicable (with adjustments) to other most-at-risk populations or in other geographical areas. Evaluation results can inform resource distribution among different programmes and provide the necessary data to convince policy-makers of the importance of scaling up HIV prevention and care programmes for people vulnerable to or living with HIV.

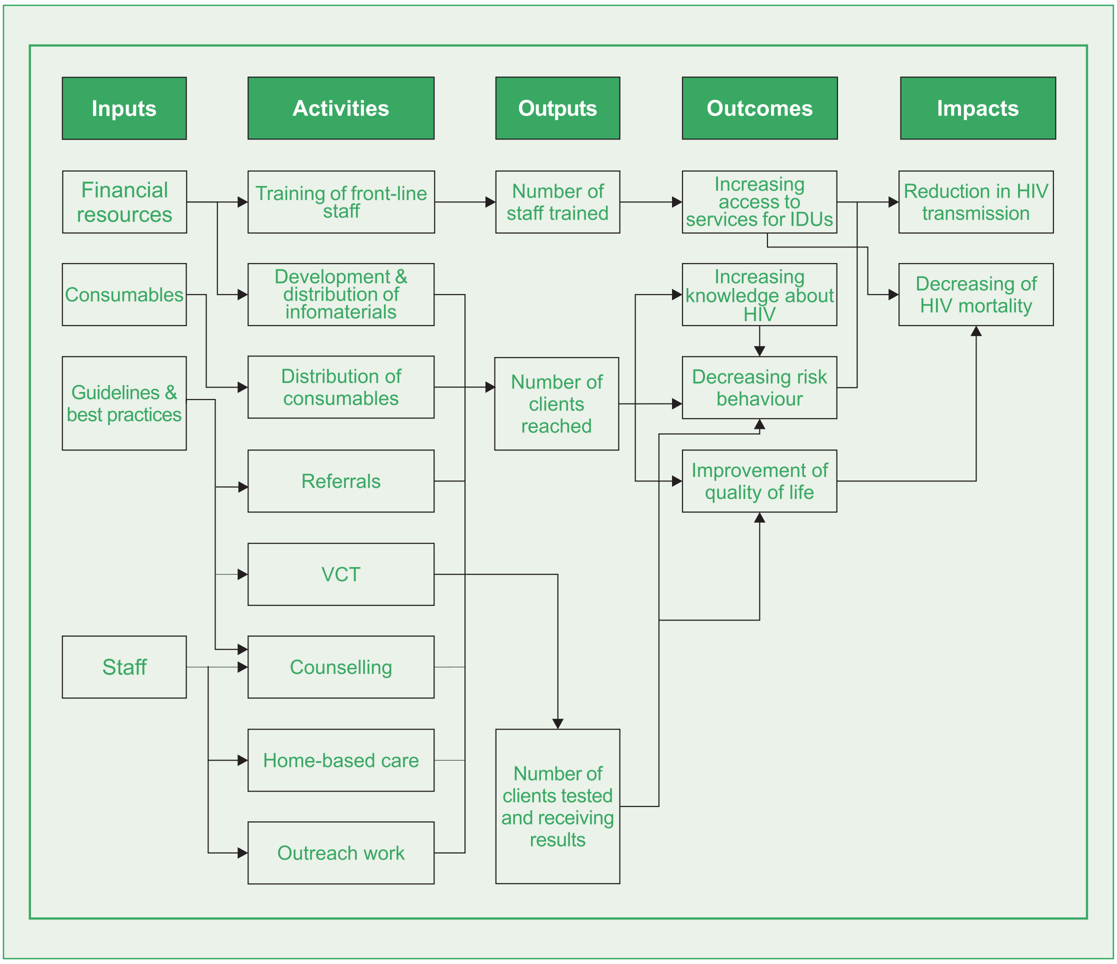
■ How and when it is done?

Whether or not an outcome evaluation is warranted and which methods should be used will vary by intervention and intervention context. The extent and cost of M&E activities should be commensurate to the size, reach and cost of programmes. In addition, not all M&E activities are appropriate for a given programme or the stage of development of a programme. Generally speaking, this step would not necessarily be implemented in all cases. One should consider conducting an outcome evaluation after the introduction of a new intervention or when the effectiveness of an intervention is not known, to establish its efficacy. As already mentioned, another purpose of outcome evaluation may be conducting comparative analysis of similar projects in order to identify areas for improvement. Evaluating *efficacy* typically refers to determining whether an intervention could work if it were implemented optimally (a more research-based approach for which generally the most rigorous methods are used). Evaluating *effectiveness* typically refers to determining whether an intervention does work as implemented, usually under less than optimal or real-world conditions (a more pragmatic programmatic approach).

The planning for an outcome evaluation should begin at the early stages of programme formulation. One effective method for planning an evaluation is through the development of a logic model (see *Diagram 4* for an example of a logic model. Note: only some logical linkages between programme elements are indicated). A logic model provides a road map for the programme, highlighting what activities need to come before others and how it is intended to achieve desired outputs and outcomes. By including explicit connections between short–term, intermediate and long–term outcomes, programme staff will be better able to evaluate progress and programme success, and locate weaknesses in programme operations. It can be used to decide which of the elements of the programme to study systematically in order to determine whether or not underlying programme assumptions were correct or where the model is failing to perform as originally conceptualized. In other words, it helps to link activities to desired outcomes and helps to focus the evaluation on key events to see what happens, what works, what does not work, and for whom.

Before actually conducting the outcome evaluation, it is important to determine through routine qualitative and quantitative monitoring whether the activities are being implemented as planned and whether they are reaching their intended beneficiaries. In addition, a fledgling project needs to establish its ability to serve a large enough number of clients with an appro–priate intensity of service. If a programme is not ready for evaluation, limited funds, time and other resources may be wasted and programme staff may be discouraged from conducting and/or permitting any evaluations at all.

Diagram 4. **Example of a Harm Reduction Project among IDUs Logic Model**



Conducting an outcome evaluation requires systematic and well-grounded methods. Some of the methods described in *Annex 1* are widely used for project and intervention evaluation purposes. Among others, those include different methods of qualitative analysis described in *Chapter VI*; operational researches (usually focused on assessment of whether there is a change in certain parameters, and if so, whether this change can be attributed to certain activity); cohort studies (uncontrolled and case-control), etc. In most cases evaluation design using either of these methods requires the special expertise of research agencies, individual researchers or evaluation consultants. More information about the methodologies used for project and intervention evaluations can be found in the reference materials listed at the end of this manual.

The choice of an appropriate study design should begin early on in project implementation or, even better, at the planning stage, as it usually requires baseline data to be collected in order to hold further comparative analysis. When planning an outcome evaluation, quantitative data or a combination of both quantitative and qualitative data may be used to provide the most comprehensive picture of the intervention's effectiveness.

- **Quantitative methods:** these are essential in most outcome evaluations for quantifying the extent to which programme objectives were achieved. They analyze relationships between variables such as an individual's background characteristics and HIV-related risk behaviour. Instruments include surveys and questionnaires to systematically collect and compare information for a selected sample of individuals (cohort studies).

- **Qualitative methods:** these are important for gaining a more complete understanding of the behaviour of most-at-risk populations, factors affecting the success of an HIV intervention, and interpreting quantitative results. Examples of qualitative methods include interviews, focus groups and direct observations.

One of the primary methods for assessing effectiveness is surveying to assess the perceptions, behaviours, knowledge and attitudes of most-at-risk populations targeted by an HIV prevention and care project or intervention. Good surveys utilize well-tested and validated instruments (usually questionnaires) administered to representative samples of the population targeted by the intervention.

When an evaluation is conducted by an external agency, project staff and service providers should be involved in the process and appreciate the importance of evaluation research for project improvement, sustainability and replication, while evaluators must recognize that most organizations need information to address HIV prevention needs. Increased cooperation between programme staff and evaluators will improve the quality and relevance of outcome evaluations.

What are the anticipated challenges and possible solutions?

Conducting effective outcome evaluations for HIV-related interventions is inherently challenging due to the skills and resources needed and even more challenging for studies involving most-at-risk populations. It is important to pay attention to the specific barriers in the evaluation planning process. Overcoming discrimination and marginalization within the research and policy arenas presents the first challenge to outcome evaluations specific to HIV-related activities among most-at-risk populations. Some policy-makers, and even programme managers and evaluators, consider high-risk populations unworthy of the resources needed to implement and evaluate interventions. Such marginalized groups, although most at risk, therefore receive less focus. Programme planners, evaluators and HIV advocates must convince other stakeholders of the continued need for HIV prevention and care interventions and evaluations.

Another challenge is that of survey design and implementation. Most–at–risk populations are often mobile and hard to reach, which creates difficulties when the time comes to do follow–up assessments. Therefore, specialized sampling and surveys should be administered to capture the most reliable estimates of behaviour following an intervention. These may require more time, effort and resources, but the utility of the information generally outweighs the cost.

Obtaining and maintaining behaviour change is another main challenge. Designing effective behaviour change programmes for high–risk populations is difficult, and many programmes fail to have a behavioural impact. That does not mean interventions should be stopped. Rather, outcome evaluations can illustrate where intervention improvements could be made.

One of the major challenges of project and intervention evaluations is that in real life in most cases it is impossible or very difficult to isolate the effect of a particular intervention project from other contributing factors. Sometimes study design requires usage of a very sophisticated methodology in order to answer questions about the effect of particular activities. Often, information users will be satisfied with evidence that is "good enough", in other words, evidence that supports a plausible link between the programme's operations and the desired outcomes. While non–experimental methods have been used regularly in behavioural outcome evaluations, they do not necessarily deliver the information necessary for stakeholders to make informed decisions. Where there is a high degree of uncertainty or the decision stakes are particularly high, more rigorous methods may be needed to provide solid evidence that the intervention, over and above other factors, caused the observed outcomes. The need for a rigorous study design, however, must be balanced with issues of cost and feasibility. It should also be noted that while experimental studies can ascertain the efficacy of an intervention under controlled conditions, they cannot in most instances imply effectiveness of the same intervention once it has been introduced into routine practice.

Effective use and dissemination of evaluation results is of particular importance. Since evaluations are usually quite costly, maximum use should be made of their results.

Possible uses of outcome evaluation findings are:

- Assisting strategic programme planning for the future
- Informing capacity–building plans and activities
- Directing programme staffing plans and decisions
- Influencing funding efforts and decisions
- Affecting development of and changes to organizational policy
- Providing valuable information about lessons learnt for agencies planning to implement similar programmes
- Influencing government policy and procedures

It is important that the findings from outcome evaluations are interpreted and integrated with information and lessons learned from other M&E activities, especially routine data collection. Process and output data will assist in understanding why and how interventions have achieved their results or not, and may illustrate what is actually causing the behaviour changes. Use of M&E data will be further addressed in the following chapter.

To increase the likelihood of data use, evaluators and programme planners should include data–use planning prior to and during the intervention evaluation process. Before deciding on the evaluation design, evaluators should generate a list of all relevant stakeholders, such as policy–makers, donors, programme staff, etc. and consider who is most likely to use the data collected from the outcome evaluation and how they might utilize that information. Any barriers to using the data should be identified at this stage and strategies for overcoming them should be discussed. This could include, for example, developing early buy–in from stakeholders and generating evaluation questions meaningful to intended users.

Evaluation findings should be made available to target populations, and these populations should be involved in the wider dissemination of data. Evaluation findings should be disseminated in an audience friendly and timely manner through:

- formal and informal networks in the high–risk community via meetings, newsletters and other forums;
- professional conferences related to HIV and M&E via discussion papers or posters;
- journals (professional or lay);
- electronic media, such as web pages, electronic newspapers and e–mail.

It is important, especially when publicizing results to the community at risk, that results be tailored to the audience. Overly technical and scientific language should be avoided and important concepts paraphrased and made as practical as possible. Presentations should include reasons why the audience should care about the results and how the results affect them and the entire community.

Practical Case Example

In 2006–2007 the International HIV/AIDS Alliance in Ukraine initiated a project–based survey among focused prevention project clients. A simple questionnaire was developed in order to collect data on HIV–related knowledge and behaviour among high–risk groups. Unified UNAIDS methodology was used to assess HIV–related knowledge and behaviour (refer to *Guidelines on Construction of Care Indicators*, UNAIDS, March 2007).

The same short questionnaire was applied to a sample of "old" project clients (those who have been receiving project services for a while) and "new" clients who were interviewed during their first contact with project staff. The hypothesis behind the survey was that old clients should report better knowledge and safer behaviour than new clients.

The hypothesis was mostly supported, although in some cases the difference between the knowledge and behaviour of old and new clients turned out to be insignificant. For example, the survey among IDUs indicated the following results: despite project efforts, the respondents who were clients of prevention programmes continue to practice unsafe behaviours that put them at risk of HIV infection. A total of 18 percent of respondents are still using already–used syringes. Among new clients, 23 percent used somebody else's syringes or needles for their most recent injection; among old clients the proportion was 16 percent. The study also indicated that a significant proportion (38 percent) of respondents are aware of safe behaviour, but do not apply their knowledge in practice.

There were several limitations to this study. First of all, it was carried out by project staff who were not professional sociologists. As a result, the methodology was not always observed; the data are not comparable among organizations, and an incentive to cheat over the project's results was obviously present in many cases. Also, as discussed above, the obtained results cannot be attributed solely to project activities, because there are a number of contributing factors which should be taken into account in order to conduct a more sophisticated analysis.

Please refer to *Annex 10* for sample brief description of one of the possible options of operational research.

Chapter IX

STEP SEVEN:

TRANSLATION OF M&E RESULTS INTO MANAGERIAL DECISIONS, DATA USAGE

What does this step mean? What is it for?

The ultimate goal of data collection is to ensure that data are fed back into the decision–making process. Data constitute a powerful tool for advocacy, generation and distribution of resources, accountability, programme design and improvement, and attribution of changes to specific interventions and programming (or reorientation of programmes). Both *funding* and *implementing organisations* perform this exercise; however the scale of this analysis will differ in each cases.

In this chapter we address two levels of data analysis and usage. The first level is analysis and usage of programme monitoring and evaluation data only, and the second is broader M&E data analysis using different data sources, where programme M&E data is only one of the elements.

Programme monitoring provides quantitative and qualitative data on progress and performance, including:

- Whether the results obtained correspond to the targets set at the planning stage
- Whether the quality of programme implementation and service delivery is appropriate
- Whether the programme is on track to achieve its objectives and goals

Managers should use this information on a regular basis to make operational decisions, identify necessary corrective actions and allocate resources. This is one of the most important steps in the whole M&E process, as it makes the link back to programme implementation and ensures that monitoring is used to improve performance.

The utility of findings from programme M&E will be enhanced if they are integrated into routine programme management, and key findings are frequently made available to stakeholders. In turn, this will facilitate timely programmatic adjustments to meet changing epidemic dynamics and priorities. This requires dissemination strategies that present information in an easily digestible form for stakeholders and that promote the use of findings for programme improvement.

Many countries are scaling up to expand the delivery of HIV interventions to most–at–risk populations. Monitoring this effort helps to ensure that a comprehensive range of interventions is being delivered to these populations and that the scale of the interventions is sufficient to meet the need. With expanded resources being made available, programmes are being held accountable for effectively providing these services and are often obliged to report to national governments, donors and the international community on the number of clients reached as part of the process of generating coverage estimates. Analyzing progress in achieving coverage can be a useful tool for demonstrating results and advocating for additional resources.

Besides the separate use of programme M&E data, it is also used to perform broader analysis, where programme data is only one of the sources. To increase the reliability and validity of data analysis, quantitative and qualitative programme data should be analyzed together with relevant behavioural, biological, and epidemiological data (obtained through routine or sentinel surveillance) to provide a more comprehensive picture of the context where risk behaviour occurs and indicate whether collective efforts are being implemented on a large enough scale to have an impact on the epidemic. Such integrated analysis is called triangulation as it uses multiple data sets perspectives or methods to interpret a particular situation. In the absence of rigorous controlled trials, data triangulation, under certain circumstances, can be used to link the intervention being evaluated and any observed behaviour and epidemiological changes.

The goal of triangulation is to increase the validity and reliability of programme evaluation by using and analyzing data from multiple sources, often obtained from different methods. In this way, findings can be corroborated and the strengths of any one method or data source can compensate for the weakness (or bias) of another in assessing programme effectiveness, either individually or collectively in aggregate. Referring to the M&E framework (See *Chapter II*), triangulation can be used to address the following questions about effectiveness at both the outcome and impact levels:

- Are interventions working and are they making a difference?
- What changes in population–level outcome and impact indicators have been observed and what do they mean?
- Can the observed changes in outcomes and impact indicators be attributed to programme outputs?
- Are the collective efforts being implemented on a large enough scale to impact the course of the epidemic?

In most routine HIV programme intervention contexts, data are obtained from a variety of sources. As was described in the organizing framework, a comprehensive M&E approach includes a sequential and cyclical process in which different methods are used to answer different questions. While each of the data collection methods on its own has particular limitations, their combined and complementary use helps to overcome them. From this perspective, there is no single hierarchy of research methods, and knowledge is gained by sequential use of complementary research methods.[26]

■ How and when is it done?

Programme data analysis for decision–making purposes can be done on an ad hoc basis, which has certain implications on operational management decision–making. However, as a rule, programme data analysis should be integrated into the usual project cycle of *funding organizations*, and thus performed according to given rules on a yearly basis (as this is the usual project cycle) to inform decisions made at the stage of planning and budgeting of individual *implementing organizations* for the following programme year.

Funding organisations use programme monitoring data to assess and manage performance at two different levels:

- Individual implementing organisations
- Overall programme

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[26] – *A Framework for Monitoring and Evaluating HIV Prevention Programmes for Most–At–Risk Populations*, April 2007, Chapter 9

The *funding organisation* reviews routine reports and other monitoring data from **each individual IP** to assess performance and the need for any further support/corrective action. This review is the basis of approval/decision–making for future disbursements and technical support plans.

Routine reports provided by *implementing organizations* to the *funding organization* contain key programme M&E data for managers to review on an ongoing basis. The following are the basic decision–making options to respond to this monitoring data:

- If there is overall consistency between targets and results achieved, and service provision is of the required quality, the next quarter's activities are implemented according to plan, with only minor corrective actions as required.

- If performance is much better than expected, managers should first confirm that the data is accurate (see *Chapter VII*). If the programme (or one specific service point or component) is really exceeding its targets, the reasons for this should be documented so that other services, components or organisations can learn from this success. A successful organisation may also be able to support others, or use its success to gain additional funding.

- If monitoring data reveals a risk of missing some targets (especially coverage targets), or some concerns about programme quality, appropriate improvements/changes in response are made over the next period. As well as specific management attention to address the identified problems, there may also be a need for reallocation of resources to strengthen weaker areas, and/or for additional technical support or training.

- If there are substantial deviations from the set targets and/or more serious quality concerns, corrective actions are carried out urgently, before implementation continues. These corrective actions can include special measures to strengthen capacity or staff skills in certain areas, reallocation of financial resources, opening new service provision points in new geographical locations to attract new clients, etc.

Funding organisations also synthesise and collate monitoring data from all implementing organisations and projects to assess the performance of **the overall programme** and its thematic components. Again, based on this data, they can assess overall progress against targets/objectives and quality standards, and identify lessons, improvements, corrective actions and resource allocations for the programme as a whole. Documenting best practices is an intrinsic and very important part of this process as it provides the basis for replicating most successful activities, interventions and approaches.

At this level, it is also important to consider whether the programme is on track to achieve its objectives and goals at outcome and impact level, based on monitoring data and internal and external evaluations (see *Chapter VIII*). As well as ongoing adjustments, there should be an opportunity from time to time to revise the overall programme strategy (e.g. redistributing resources between projects aimed at different vulnerable groups if there is evidence that the epidemic is more IDU–driven than CSW–driven, or vice versa, etc).

The strategic decisions that would not be relevant for every routine report (monthly/quarterly), but perhaps only once a year when the organisation considers its annual plan (see *Chapters III–V*) are:

- Considering trends in performance over time. For example, is current coverage increasing, staying the same or decreasing? Even if an organisation is reaching its targets, there is still a problem if current coverage is going down. Similarly, an organisation may miss its targets but consistently increase its coverage, which may mean that the targets are too high and in fact performance is good, or that there is an opportunity to increase coverage even more.

- Looking at the wider context and considering whether activities will actually make a contribution at outcome or impact level. For example, an organisation may meet its planned target of reaching 100 IDUs, but if there are 1000 IDUs in its geographical area, this target is probably too low to have an impact in terms of behaviour change and rates of infection.

Implementing organisations should use the data from programme monitoring to assess their own performance on a quarterly basis, and to check whether they are on track and/or whether they need any additional support in order to improve performance. Project managers of *implementing organizations* are also encouraged to perform in–depth programme data analysis on a yearly basis before submitting an annual proposal with activities, targets and budget for the next year. This is a key opportunity to make programme decisions based on M&E and performance information. The annual proposal should consider programme performance over the previous year, and address the questions of trends and context mentioned above. This analysis may include performance indicators of each service provision point/front–line staff, client feedback, situation analysis, data on average consumables and services consumption, needs assessments, etc.

Triangulated analysis for effectiveness evaluation should only be conducted in specific limited circumstances. Listed below are some criteria to determine whether it makes sense to conduct a triangulated analysis:

- When interventions have been in place for a sufficient duration of time to reasonably expect that changes at the population level may be attributable to programme interventions. For behaviour change, this period should be roughly 2—3 years. For HIV prevalence, ideally 5—7 years is needed to attribute changes in HIV prevalence to a prevention programme.

- When interventions have been implemented with sufficient intensity and with high enough coverage to reasonably expect effects to be observed in the target population.

- When programme–level data including programme outputs, coverage estimates, and the quality of programme implementation are available, complete, of high quality and accessible for analysis.

- If the results of programme evaluations indicate that programme activities are being realized as planned. If this is not the case, it does not make sense to conduct a triangulated effectiveness evaluation.

Cross–sectional behavioural and biological outcome and impact data are generally the primary data sources of interest for triangulated analyses. These data sources have the advantage of being generalizable to the populations targeted by the prevention programme, so that inferences can be made from the results of these surveys. When combined with programme–level data from programmes targeting the same population, they can help link changes in population–level measures with programme effort. In addition to these quantitative data, the incorporation of qualitative data into these analyses can provide contextual information and aid in interpretation of the findings.

Common sources of triangulation data for programme evaluation:

- repeated HIV prevalence and behavioural surveys;
- routine programme service delivery process outputs;
- quality of service assurance and quality improvement assessments;
- qualitative research such as in–depth interviews, focus group discussions, key informant interviews or rapid assessments.

Methods and tools to collect data on HIV knowledge, behaviour, prevalence and other key indicators used in triangulation analysis are not a focus of this manual. However, there are multiple manuals and guidelines devoted specifically to these issues. Please refer to the list of resources at the end of this manual for further reading.

Triangulation is generally used to determine the effectiveness of a specific programme or the collective effectiveness of multiple programmes. It will not, however, yield precise quantitative estimates of a programme's effect, as this requires more rigorous controlled experimental approaches. Still, in the absence of such approaches typical for routine HIV programming, triangulation is a useful approach for making use of available data to assess programme effectiveness to the extent possible.

There is no standardized triangulation methodology that can be applied for integrated triangulated analysis, nor should there be. The specific methodological approaches that are used must be customized to the context of the programme implementation and the sources and quality of data available.[27]

■ What are the anticipated challenges and possible solutions?

The process of data analysis for decision-making is predetermined by the availability of quality data in the first place, thus depending on the whole functioning M&E system addressed at each previous step. The following simple rules 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 minimum 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 are 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.
- 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.

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[27] – Refer to *A Framework for Monitoring and Evaluating HIV Prevention Programmes for Most-At-Risk Populations*, April 2007, Chapter 9 for further reading

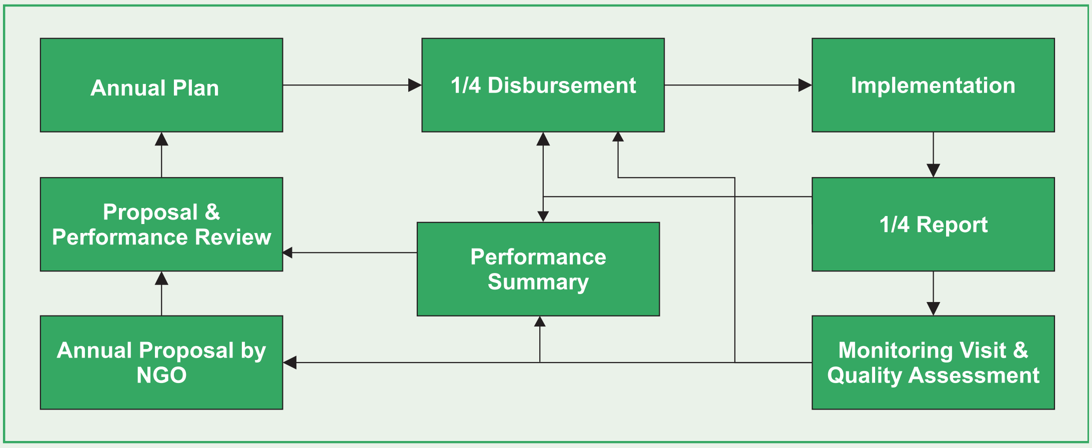
Given the diverse methods and data sources involved in performing triangulation analysis, a participatory team approach is strongly advocated. One of the strengths of triangulation is that multiple investigators should be involved to minimize the bias associated with any one investigator's technical and experiential background. Researchers with strong quantitative and qualitative backgrounds should be involved in assessing data availability and quality, as well as the methods and approaches for integrating and synthesizing the data. Programme managers, relevant stakeholders and representatives of most–at–risk populations should be involved in framing and defining the questions to be answered and the scope of the effectiveness evaluation so that the findings have the greatest value. In order to minimize any biases associated with framing the results in a "desirable" way, it is also recommended that the lead investigators not be directly involved in the programme's design or implementation. Although this is not always possible, it does help to maintain objectivity.

It is crucial that members of most–at–risk populations participate in the evaluation process to ensure that those communities receive feedback on the findings, and about the behaviours that have changed, as well as those that have not. In addition, participation is needed to ensure that the results will not have any negative repercussions on the populations being targeted by the interventions. Rather, the results should be used constructively to best inform the design and implementation of future interventions targeting high–risk populations. At the collective level, determining the effectiveness of the national response to the epidemic is critical for policy and advocacy, programme planning and M&E.

Practical Case Example

Because funding organisations deal with large programmes and a number of implementing organisations, they need more summarised information on IP performance. For example, the Alliance Ukraine is using a performance summary form for each IP, which includes key quantitative performance indicators and a quality assessment based on quarterly reports and monitoring visits. This summary is used to inform decisions on NGO funding proposals for the following year.

Example: Annual NGO Planning, Implementation and Monitoring Cycle – Alliance Ukraine



Please also see *Annex 8* for a sample performance summary form

Chapter X

MONITORING AND EVALUATION CYCLE

As stated in *Chapter II*, programmatic monitoring is part of broader national M&E processes. Countries have different M&E needs, dictated in part by the state of their HIV/AIDS disease burden and country health structure. Yet successful M&E systems will share common elements, as demonstrated by successful programmes in several countries. A list of some of these elements is given in Table 5.

Table 5. ***Features of a Good M&E System***[28]

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 country and be integrated within the broader statistical needs of the country. ■ Guidelines and guidance to sub-national districts, regions and provinces for M&E. ■ A budget for M&E that is between 5 and 10 percent of the combined national HIV/AIDS budget from all sources. On average, 7 percent should be used as a reference. ■ A significant national contribution to the national M&E budget (not total reliance on external funding resources). ■ 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, behavioural/social science, data processing and statistical data dissemination, and resource tracking (both financial and commodity resources).
CLEAR GOALS	■ Well-defined national programme 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 implementation of the national programme 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 dissemination plan, with basic data sets freely and transparently available in a timely manner. Transparency is essential for real accountability. ■ A plan to collect data and periodically analyze indicators and associated data sets at different levels of M&E (including geographical). ■ Second generation surveillance, where behavioural data are linked to disease surveillance data.

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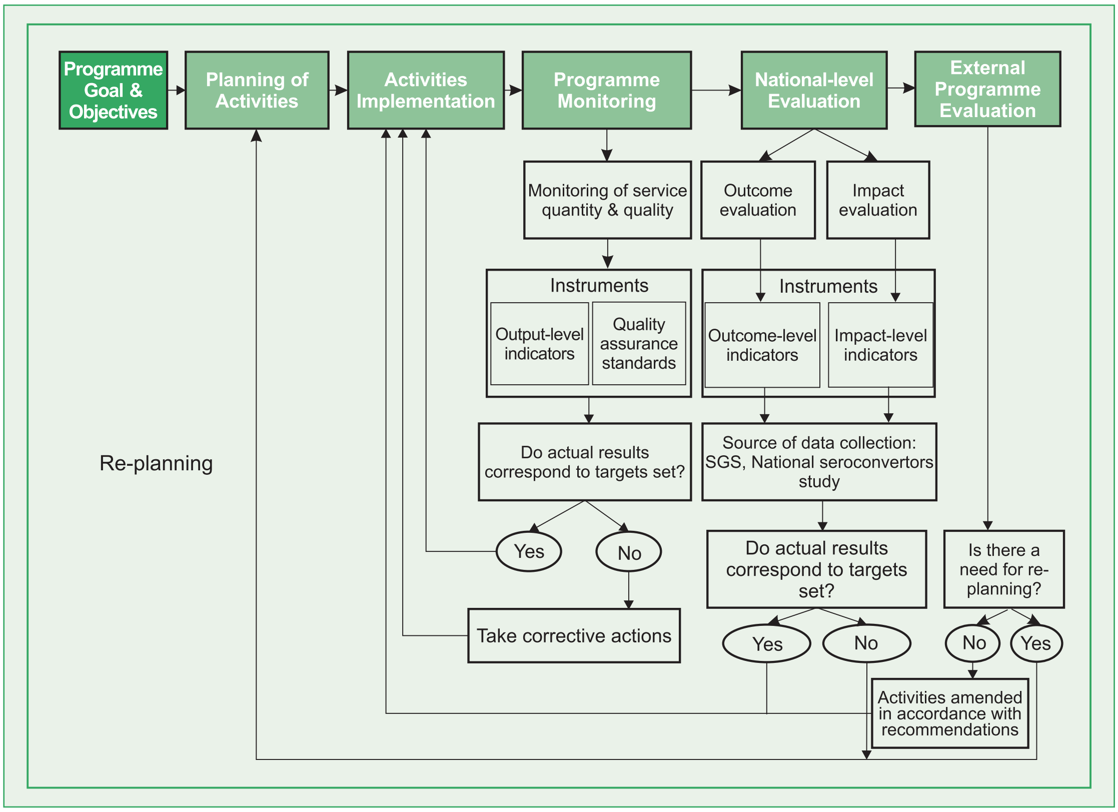
[28] – Adapted from the *M&E Toolkit: HIV/AIDS, Tuberculosis and Malaria*, January 2006 (Second Edition), p. 9–10

DATA DISSEMI-NATION	▪ 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. ▪ Annual meetings to disseminate and discuss M&E and research findings with policy–makers, planners and implementers. ▪ A clearing house for generation and dissemination of findings. ▪ A centralized database or library of all HIV/AIDS 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.

After the M&E system is established, the entire M&E process functions as a cycle that links the overall programme goal, planning, implementation, programme monitoring, and internal and external programme evaluations. *Diagram 5* depicts the **Monitoring and Evaluation Cycle.**

Diagram 5. ***Monitoring and Evaluation Cycle***



While programmatic M&E processes are described in detail above (you can now see the position of programmatic M&E in the whole cycle of the national M&E system), below is a brief description of national–level evaluations and external evaluations.

National-level Evaluation

The national-level evaluation box (*Diagram 5*) consists of outcome and impact evaluation. As outlined earlier, the instruments used for these are outcome and impact level indicators respectively. The data for these indicators are collected through the behavioural and epidemiological parts of second generation sentinel surveillance (which links together behavioural and epidemiological researches), as well as through the national behavioural surveillance study of seroconvertors (please see *Annex 9* for a description of this study in Ukraine).

Sociological surveys for national data collection are divided into three different types:

1. Surveys on behavioural monitoring in most-at-risk populations (IDUs, CSWs, prisoners, MSM, youth, military personnel). These surveys are conducted using a unified methodology and questionnaires consistent with international guidelines.
2. Special surveys on coverage of target groups by different prevention interventions (coverage of schoolchildren, workplace policies, STI patients' coverage, etc.). For national indicators collected on a regular basis, a standardized methodology is used, while the methodology for one-off surveys will be designed in accordance with survey tasks.
3. Other special surveys needed for evaluation of specific initiatives or programmes. These needs are defined in close consultation with the UN Technical Working Group on UNGASS.

Sentinel epidemiological surveillance is the basic source of data on HIV prevalence levels among most-at-risk populations in Ukraine. Thus, when speaking about prevention interventions, the ultimate effectiveness of projects is measured by means of sentinel epidemiological surveillance data.

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, a replanning phase takes place. Replanning can consist of reconsidering the quantity/quality aspect of service 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 than CSW-driven, or vice versa, etc.) within the framework of the work plan.

External Programme Evaluations

External evaluations are carried out for large-scale programmes 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 key programme components, and the systematic implementation of the evaluation findings and recommendations into the ongoing reprogramming and enhancement of the programmes' activities and quality of services. The evaluations are usually divided into two principal categories: a. mid-term evaluations, and b. programme-end evaluations. Each of these types of evaluation has specific aims and outputs.

a. *Mid-term evaluations*

The aims of mid-term evaluations include analyzing the strengths and weaknesses of specific programme components, providing specific assessment of shortcomings/programme improvements that need to be addressed in order to enhance outcomes, coverage and quality of services, and generating recommendations on ways to strengthen programme activities for the remainder of implementation.

b. *Programme–end evaluations*

Programme–end evaluations are conducted at the end of the programme. Their specific aims include analysis of the programme's overall contribution to the country's national response to HIV/AIDS, clear documentation of the programme's achievements, and assessment of the sustainability and continuity of services covered under the programme beyond its end.

The evaluation results should be disseminated publicly, reviewed by stakeholders, and used in reprogramming. As can be seen from *Diagram 5*, activities are amended/replanned on the basis of recommendations obtained as a result of external evaluations.

CONCLUSION

We have tried to develop this manual in such a way as to assist individual organizations, as well as larger national/sub–national projects and programmes working in the sphere of HIV prevention among vulnerable groups and/or care and support for PLHA, in developing and maintaining a system of programmatic monitoring and evaluation. The authors believe that a sound monitoring and evaluation system is needed in order to effectively implement interventions aimed at fighting the HIV/AIDS epidemic, keeping individual programmes and projects on track, and making a notable contribution at the impact level.

To conclude, we would like to emphasise that monitoring and evaluation systems need to be simple. People tend to artificially overcomplicate the issue, when in fact all that is needed to develop and maintain a good monitoring and evaluation system is common sense and good management.

Annexes

ANNEX 1[1]

DATA MEASUREMENT TOOLS AND METHODS

Measurement Tools	Main Characteristics	Examples of Measurement Methods Used
Health services statistics	Routine data collection at health facilities. Programme monitoring.	▪ Data registered in 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 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 programme managers with the required information to develop, improve or scale up programmes. If evaluation focuses on whether a change in results can be attributed to a programme, OR focuses on whether the programme is the right, or best, programme to achieve the desired results. It can be thought of as a practical, systematic process for identifying and solving programme-related problems.	Examples of OR: ▪ Adherence ▪ Equitable access ▪ Costs ▪ Linking prevention-treatment ▪ Different models of intervention
Sentinel site surveillance	A survey based on sampling of the target or general population, generally aiming to represent the characteristics, behaviours and practices of that population. It requires a sufficient sample size to represent the larger population and to be analyzed in sub-groups, by age, sex, region and target populations. Usually conducted by specialized research agencies.	▪ HIV sero-surveillance in pregnant women or in identified groups at high risk.

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[1] – Abstracted from the *M&E Toolkit: HIV/AIDS, Tuberculosis and Malaria,* January 2006 (Second Edition)

Measurement Tools	Main Characteristics	Examples of Measurement Methods Used
Population-based surveys	A survey based on sampling of the target or general population, generally aiming to represent the characteristics, behaviours and practices of that population. It requires a sufficient sample size to represent the larger population and to be analyzed in sub-groups, by age, sex, region and target populations. Usually conducted by specialized research agencies.	▪ MICS (multiple indicator cluster survey), DHS (demographic health survey) and DHS+, AIS (AIDS indicator survey), BSS (behavioural surveillance survey), etc.

Application of Data Measurement Tools and Methods Examples

Area of Application	Data Measurement Tools and Methods	Limitations	Recommendations
Impact related to HIV prevalence	▪ HIV sentinel site surveillance ▪ Population-based surveys which collect specimens for HIV testing	▪ Difficult 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 sero-surveys and for measuring national HIV prevalence in population-based surveys
Knowledge and Behaviour among general population	▪ Population-based surveys (BSS -behavioural surveillance survey, KAP - knowledge, attitude and practice, DHS - demographic health survey, MICS - multiple indicator cluster survey)	▪ Self reporting biases ▪ Household surveys tend to under-sample MARP ▪ Conducted only every several years	▪ Review timing of DHS (demographic health survey) and MICS (multiple indicator cluster survey) scheduled in a country to plan when survey results will be available
Knowledge and Behaviour among most-at-risk populations	▪ 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 international best practices on surveys among MARPs to minimize the sample and response bias
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 for the training topic ▪ A decision has to be made on how to count a single person trained in several topics

Area of Application	Data Measurement Tools and Methods	Limitations	Recommendations
Access to various service provision (e.g. areas with services, facilities providing services)	▪ Ministry of Health reports ▪ Programme 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 and community facilities to be considered suitable to provide a particular service ▪ Set up a system to keep track of various providers of services within a district or country
Coverage indicators (number of people reached with 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 ▪ Where multiple organizations are operating, different record-keeping systems may be in place ▪ Difficult to accurately measure the size of at-risk populations ▪ Due to mobile nature, there is a need to be careful about double counting	▪ Try to standardize data collection for various services on the national level so that information can be collated easily

ANNEX 2

SERVICE DELIVERY AREAS AND EXAMPLES OF OUTPUT INDICATORS[2]

Objective	Service Delivery Area	Examples of Output Indicators
Prevention	**Behavioural change communication – mass media**	HIV/AIDS information, education, communication (IEC) material broadcast or distributed (radio and television programmes/newspapers) (number)
	Behavioural change communication – community outreach	Young people reached by life skills-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 programmes* (number and percentage)
		MSM reached by HIV/AIDS prevention programmes* (number and percentage)
		Sex workers and clients reached by HIV/AIDS prevention programmes* (number and percentage)
	Condom distribution	Condoms distributed for free (number)
		Condoms sold through the private sector (number)
	Testing and Counselling	People who received HIV testing and counselling (including provision of test result) (number)
		MARPs who received HIV testing in the last 12 months and who know the results (number and percentage)
		PLHA who tested positive who have received counselling for positive prevention (number and percentage)
	PMTCT (prevention of mother-to-child transmission)	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 to MARP or population sub-groups) (number and percentage)
	Blood safety and universal precaution	Transfused blood units screened for HIV according to national guidelines (number and percentage)

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[2] – Adapted from *the M&E Toolkit: HIV/AIDS, Tuberculosis and Malaria*, January 2006 (Second Edition) (please refer to the M&E Toolkit for a complete list of indicators)

Objective	Service Delivery Area	Examples of Output Indicators
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	PLHA 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 three 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 PLHA (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 PLHA**	PLHA receiving HIV testing and counselling or HIV treatment and care services who were screened for TB symptoms
	Prevention of TB disease in PLHA	Newly diagnosed HIV-positive clients given treatment for latent TB infection (number and percentage)
	Prevention of HIV in TB patients	Registered TB patients who received HIV counselling and testing (number and percentage)
	Prevention of opportunistic infections in PLHA with TB	HIV-positive TB patients who received 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 programmes (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)

* 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 counselling and testing, substitution therapy and safer injection practice for IDUs, or others.

ANNEX 3

LIST OF NATIONAL INDICATORS ON MONITORING AND EVALUATION OF HIV/AIDS CONTROL ACTIVITIES EFFICIENCY

Note: Please refer to *Guidelines on Construction of Core Indicators* (UNAIDS, 2007)

№	Indicators	Responsible Central Executive Authority (CEA)	Method of Data Collection
National Commitment & Action			
Expenditures			
1.	Domestic and international AIDS spending by categories and financing sources	Ministry of Finance and other involved CEAs	National AIDS spending assessments or financial resource flow surveys
Policy Development and Implementation Status			
2.	National Composite Policy Index (areas covered: gender, workplace programmes, stigma and discrimination, prevention, care and support, human rights, civil society involvement, and monitoring and evaluation)	Part A. Ministry of Health Part B. Non-governmental organizations	Desk review and key informant interviews
National programmes: blood safety, antiretroviral therapy coverage, prevention of mother-to-child transmission, co-management of TB and HIV treatment, HIV testing, prevention programmes, services for orphans and vulnerable children, and education			
3.	Percentage of donated blood units screened for HIV in a quality-assured manner	Ministry of Health	Programme monitoring
4.	Percentage of adults and children with advanced HIV infection receiving antiretroviral therapy	Ministry of Health	Programme monitoring and estimates
5.	Percentage of HIV-positive pregnant women who received antiretrovirals to reduce the risk of mother-to-child transmission	Ministry of Health	Programme monitoring and estimates
6.	Percentage of HIV-positive incident TB cases that received treatment for TB and HIV	Ministry of Health	Programme monitoring
7.	Percentage of women and men aged 15-49 who received an HIV test in the last 12 months and who know their results	Ministry of Youth, Family and Sport	Population-based survey
8.	Percentage of individuals who received an HIV test in the last 12 months and who know their 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 Penitentiary Department	Behavioural survey

№	Indicators	Responsible Central Executive Authority (CEA)	Method of Data Collection
9.	Percentage of individuals reached with HIV prevention programmes: **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 Penitentiary Department	Behavioural survey
10.	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	School-based survey
Knowledge and Behaviour Indicators			
11.	Percentage of young women and men aged 15–24 who both correctly identify ways of preventing sexual transmission of HIV and who reject major misconceptions about HIV transmission	Ministry of Youth, Family and Sport	Population-based survey
12.	Percentage of most-at-risk populations who both correctly identify ways of preventing 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 Penitentiary Department, Ministry of Defence	Behavioural survey
13.	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	Population-based survey
14.	Percentage of military personnel reporting the use of a condom during sexual intercourse with a non-regular partner	Ministry of Defence	Behavioural survey
15.	Percentage of women and men aged 15-49 who had more than one sexual partner in the past 12 months reporting the use of a condom during their last sexual intercourse	Ministry of Youth, Family and Sport	Population-based survey
16.	Percentage of female and male sex workers reporting the use of a condom with their most recent client	Ministry of Youth, Family and Sport	Behavioural survey
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	Behavioural survey

№	Indicators	Responsible Central Executive Authority (CEA)	Method of Data Collection
18.	Percentage of injecting drug users reporting the use of a condom the last time they had sexual intercourse	Ministry of Youth, Family and Sport	Behavioural survey
19.	Percentage of injecting drug users reporting the use of sterile injecting equipment the last time they injected	Ministry of Youth, Family and Sport	Behavioural survey
	Impact Indicators		
20.	Percentage of young women and men aged 15–24 who are HIV–positive	Ministry of Health	HIV sentinel surveillanc and population–based survey
21.	Percentage of most–at–risk populations who are HIV–positive among: **a.** injecting drug users; **b.** commercial sex workers; **c.** men having sex with men.	Ministry of Health	HIV sentinel surveillance
22.	Percentage of adults and children with HIV known to be on treatment 12 months after initiation of antiretroviral therapy	Ministry of Health	Programme monitoring
23.	Percentage of infants born to HIV–positive mothers who are infected	Ministry of Health	Treatment protocols and efficacy studies, programme monitoring

ANNEX 4

SAMPLE PROGRAMME REPORTING FORMAT (FOCUSED PREVENTION PROJECT FOR MARPS)

Note: the reporting form is used in Excel format, where each section is put on a separate worksheet.

Ind. Code	Indicator	Total over the previous periods	Plan Quarter	Actual Quarter	Total by the end of quarter
1.12	Number of people who received HIV prevention services during the reporting period*	N/A			N/A
11.02	Among them, number of newly reached clients who received HIV prevention services during the reporting period*	0			0
11.06	Number of regular project clients over the reporting period*	N/A			N/A
1.13	Number of condoms distributed during the period	0			0
11.24	Number of syringes distributed during the period	0			0
11.35	Number of used syringes collected during the period	0			0
11.07	Number of BCC materials developed (items)	0			0
11.08	Number of BCC materials disseminated (copies)	0			0
11.26	Number of trainings conducted for prevention service providers during the reporting period	0			0
1.11	Number of service providers trained in HIV prevention during the reporting period	0			0
11.68	Number of trainings conducted for project clients during the reporting period	0			0
11.69	Number of project clients trained during the reporting period	0			0
11.28	Number of VCTs for HIV with rapid test conducted during the reporting period	0			0
11.36	Among them, number of positive HIV rapid test results	0			0
11.33	Number of counselling provision cases during the reporting period (disaggregated by specialist)	0			0
11.42	Number of service delivery points functioning (disaggregated by type)	N/A			N/A

*Disaggregated by MARPs (IDUs, CSWs, MSM, prisoners)

№	Activities conducted during the reporting period (according to work plan)	Result * *
1.		
2.		
3.		
4.		
5.		

* * The following coding is used: F – fully implemented; P – partially implemented; N – not implemented

Narrative Section

Describe your achievements
Describe corresponding challenges
What activities will you undertake to improve project implementation?
What kind of assistance could be provided by the Alliance?
Alliance staff comments
Additional comments on current activities performance

Additional detailed information on trainings conducted and BCC materials distributed is requested to be provided as supporting documents to the report.

ANNEX 5

SAMPLE PRIMARY REGISTRATION FORMS

Client Registration Logbook							
Service delivery point							
Social worker							
№	**Date**	**Client ID**	**Gender**	**Date of birth**	**Vulnerable group**	**Ever received services (in another agency)?**	**Other comments**
1							
2							
3							
4							
5							
6							
7							

Daily register for focused prevention projects (sample)																		
Organization																		
Service delivery point																		
Service providers																		
Client info				**Provision of services and commodities**														
№	**№ ID card**	**New client (Y/N)**	**For new clients – ref № to Registr. Logbook**	**Syringes returned**	**Syringes provided**			**Condoms provided**	**BCC materials provided**			**Counselling and other services provided**			**Referrals provided**			**Other comments**
					1 ml	2 ml	5 ml		№1 (Safe injecting)	№2 (Safe sex)	№3 (ARV treatment)	№1 (Child care)	№2 (Rapid test)	№3 (Accomp. to AIDS Cent.)	№1 (VCT)	№2 (C&S)	№3 (physician)	
1																		
2																		
3																		
4																		
5																		
6																		
7																		
Total																		
Total # of people served								Date										

ANNEX 6

SAMPLE MONITORING VISIT REPORT FORM USED BY THE INTERNATIONAL HIV/AIDS ALLIANCE IN UKRAINE TO MONITOR FOCUSED PREVENTION PROJECTS

ICF "International HIV/AIDS Alliance in Ukraine"

Sample Monitoring Visit Report Form – Focused Prevention	
Date	
NGO Name	
NGO Address	
Telephone	
Fax	
E-mail	
Grant Number	
Project Name	
Completed by	

Every section of the form must be filled in. Please explain the reason if you do not have information for some sections. Please write in the Comments section on what basis the conclusion was drawn.

I. Project(s)/work plan implementation					
Activities (planned for the period being monitored)		**Implementation Status**			**Comments**
		Yes	***No***	***Partly***	
II. Project(s) staff					
The list of project staff is as requested (in the grant agreement and other agreed documents) (Yes/No)					
Comments:					
III. Project successes (please briefly describe the main successes)					

IV. Project challenges and possible solutions

V. Finance and technical support needed from the Alliance (including FSF, M&E, HR&Admin)

VI. Monitoring

Are there acting procedures of internal monitoring (registration, data flow, reporting) (Yes/No)	

Comments:

Responsible person for warehouse is available	***Yes***	***No***	**Comments (name and position):**
Responsible person for monitoring and evaluation is available	***Yes***	***No***	**Comments (name and position):**

VII. Response to the notes and recommendations from the last visit

Notes and recommendations from the last visit	**Response**

VIII. Remarks, comments and further action plan

Remarks	**Recommendations**

IX. Technical assistance provided by Alliance representative(s) during the monitoring visit

Project target groups

Which target groups are served by the project?

Keeping project registration documents/MIS

Is the SyrEx database in use? (Yes/No)

If yes: Do data from SyrEx correspond to data from primary registration documents?

(cross-check at least 5 random records from different dates/service delivery points)

In the SyrEx database 5 records in the Diary section are selected at random (it is better to use records from different SDPs and dates). Complete data compliance in the Client Visits section of the Diary to data in the primary registry should be checked. **(Yes/No)**

Comments:

If the SyrEx database is in operation, check data compliance from the last quarterly report with data in the SyrEx database (where needed),if not, check data compliance from the last quarterly report with data from primary documents.

	Data from SyrEx database and/or primary documents data	Data from the last project report	Comments:
1. Cumulative number of people reached with services; number of new people among them (separately by target groups)			
2. Number of people reached by project services in the last quarter (separately by target groups)			
3. Number of regular clients (separately by target groups)			
4. Number of distributed condoms in the last quarter			
5. Number of distributed syringes in the last quarter			
6. Number of distributed BCC materials in the last quarter			
7. Number of trainings conducted in the last quarter (including trainings for project clients)			
8. Number of people trained (training participants) in the last quarter (including project clients)			
9. Number of acting service delivery points (by types)			

Availability of primary documents			
Primary Documents	***Yes***	***No***	***Comments:***
1. Timetable of SDPs/consultants/community centre			
2. Social workers' daily registers			
3. Project clients registration logs (primary questionnaire/project client cards)			
4. Information materials and other consumables logs			
5. Reports on trainings, round table discussions, working meetings, and other (lists of participants and programmes)			
6. Agreement on syringe utilization			
7. Documentation of written-off consumables			
8. Consultants' registers (copies)			
9. VCT and/or STI diagnostics/treatment log			
10. Other (indicate the document name)			

Field work

Address/place/name of service delivery point	**Number of clients at the point on the day of visit**	**Average number of clients at the point for the last week/month (according to social workers' daily registers)**	**Comments**

Consumables available in the warehouse and their quality

Consumables	**Available in the warehouse (Yes/No)**	**Comments (name (type), use-by date, sufficient number, etc.)**

Signature of the person(s) who conducted the monitoring visit	

Services Quality Monitoring

Direct Observation (overall result of observations during the visit to one or several SDPs)				
**** Put either Yes or No depending on observations (sum in the line should be = 1)***				
Comprehensiveness of services		***YES (0–1)***	***NO (0–1)***	***Comments***
1.1	Clients receive syringes, condoms and other commodities available in the project upon and in accordance with request			
1.2	Clients receive BCC materials			
1.3	Clients receive counselling on safe behaviour and other questions they are interested in			
1.4	Clients are offered VCT within the project (rapid test) or are referred to the AIDS centre for VCT (indicate in comments field the way VCT is provided)			
1.5	Clients are offered counselling from different specialists either within the project or are referred to clinics or other organisations (indicate the list of specialists in the comments field)			
1.6	Clients can receive counselling from specialists (psychologist/lawyer/therapist...) directly at the SDP (indicate details in the comments field)			
		0	**0**	
Confidentiality, respect and safety		***YES (0–1)***	***NO (0–1)***	***Comments***
2.1	Front–line staff do not conduct confidential consultations so that they may be overheard by other people			
2.2	The communication manner of front–line staff is respectful and polite			
2.3	Relationships between clients and front–line staff can be described as trustful (i.e. social workers know clients' names, clients are open for communication, etc.)			
2.4	Front–line staff do not speak openly about the HIV status and personal life of clients			
		0	**0**	
Staff professionalism		***YES (0–1)***	***NO (0–1)***	***Comments***
4.6	Front–line staff demonstrate skills of effective communication (i.e. listen attentively, reply correctly, etc.)			
		0	**0**	
Client Feedback (at least 5 clients)				
IT IS RECOMMENDED THAT INTERVIEWS ARE NOT HEARD BY STAFF!				
Comment (indicate number of clients interviewed at each SDP)				
Number of clients interviewed		**5**		
****Indicate number of clients answering YES/NO or A/B/C/D in the Client Satisfaction section (sum in the line = number of clients interviewed)***				
Comprehensiveness of services/Client satisfaction		***# YES***	***# NO***	***Comments***
1.7	Do you receive enough commodities (syringes, condoms and others)?			
1.8*	Are you satisfied with the quality of the commodities you receive?			
1.9	Do you read BCC materials received from the project?			

Comprehensiveness of services/Client satisfaction		**# YES**	**# NO**	**Comments**
1.10*	Are you satisfied with the topics covered in these materials? (Which? Indicate in the comments field)			
1.11	Were you offered the services of other specialists?			
1.12	Did you receive social patronage services?			
1.13	Were you offered VCT recently?			
1.14	Did you receive information about ST programmes/ rehabilitation/community centres or any other information about other HIV-related services (at the discretion of interviewer – indicate in comments what services were covered)			
		0	**0**	

Confidentiality, respect and safety		**# YES**	**# NO**	**Comments**
2.5	Do you feel safe in the place where you receive project services?			
2.6	Have you ever experienced violation of confidentiality in relation to receiving project services?			
2.7	Are you always treated with respect by project staff?			
		0	**0**	

Client satisfaction		**# A**	**# B**	**# C**	**# D**	**Comments**
3.1	To what extent are you satisfied with project services? (Excellent(A)/Good(B)/Satisfactory(C)/Bad(D))					
3.2	How flexibly does the organisation react to your needs? (Excellent(A)/Good(B)/Satisfactory(C)/Bad(D))					
		0	**0**	**0**	**0**	

* – questions contribute to the Client Satisfaction section

Staff Interviews (at least 2 individuals)

Indicate # of staff members giving Correct/Not Correct answers and No Answer (sum in the line = # of staff members interviewed)

# of front-line staff members interviewed	**2**	

Staff professionalism		**# Correct**	**# Not Correct**	**# No Answer**	**Comments**
4.1	Question about HIV transmission				
4.2	Question about safe behaviour				
4.3	Question about clients' needs				
4.4	Question about referrals to other medical services (i.e. addresses, names, etc.)				
4.5	Question about referrals to other AIDS-service organisations (i.e. community centre, care and support, etc.)				
		0	**0**	**0**	

	Rank				
1	***Comprehensiveness of services***		**0**	+2 — +1.75 —A	
				+1.74 — +0.5 — B	
				+0.49 — −0.74 – C	
				−0.75 and less – D	
2	***Confidentiality, respect and safety***		**0**	+2 — +1.75 — A	
				+1.74 — +0.5 — B	
				+0.49 — −0.74 — C	
				−0.75 and less – D	
3	***Client satisfaction***		**0**	7.01–8 — A	
				+1.74 — +0.5 — B	
				3.01–5 —C	
				2–3 — D	
4	***Staff professionalism***		**+**	**–**	6 – 5.5 correct = A
			0	**0**	5.49 – 4 correct = B
					3.99 – 2.5 correct = C
					2.49 and less correct = D

ANNEX 7

SAMPLE INDICATORS FRAMEWORK

Sample Indicators Framework							
№	**Indicator description**	**Indicator level**	**Description**	**Instrument of data collection**	**Frequency of data collection**	**Responsible for data collection**	**Quality assurance mechanism**
1	Percentage of people still alive 12 months after initiation of ARV treatment	Impact	Changes in epidemic trends/AIDS mortality/economic impact	Cohort study	Every year	National AIDS Centre	Accurate record-keeping, internal checking, monitoring visits carried out by Alliance staff to the Ukrainian AIDS Centre and AIDS Centre specialists to the regions
2	Percentage of HIV-positive infants born to HIV-positive mothers			Statistics		Ministry of Health	Accurate record-keeping, internal checking
3	HIV prevalence among injecting drug users			Epidemiological part of SGS		National AIDS Centre	Monitoring visits to oblasts carried out by AIDS Centre epidemiologists and data comparison between years
4	HIV prevalence among female commercial sex workers			Epidemiological part of SGS		National AIDS Centre	
5	Safe injecting and sexual practices among IDUs	Outcome	Change in knowledge and behaviour trends	Behavioural part of SGS	Every year	Relevant ministry (and the research agency competitively selected to carry out a particular study)	Usage of internationally- accepted methodological guidelines for data collection; identification and selection of appropriate sample sizes
6	Percentage of CSWs who report using condoms						
7	Percentage of prisoners who both correctly identify ways of sexual transmission of HIV and who reject major misconceptions about HIV transmission						
8	Young people's condom use with non-regular partners						
9	Number and percentage of people receiving ARV treatment	Output	Coverage of programmes and access to services	Programme records (obtained through reports provided by grant recipients)	Quarterly programme reporting	National AIDS Centre	Accurate record-keeping, internal checking, monitoring visits carried out by Alliance staff
10	Number of service deliverers trained to provide diagnostic and treatment services to HIV-positive people composed of infectious disease specialists, narcologists and TB specialists					Knowledge Hub, Ukraine	Documentation review and monitoring visits carried out by Alliance staff
11	HIV-positive pregnant women receiving a complete course of ARV prophylaxis to reduce the risk of MTCT					National AIDS Centre	Accurate record-keeping, internal checking, monitoring visits carried out by Alliance staff to the Ukrainian AIDS Centre and AIDS Centre specialists to the regions
12	Number of patients of STI and TB facilities completing the HIV testing and counselling process					National AIDS Centre	
13	Number and percentage of HIV-positive people screened for TB					National AIDS Centre	

14	Number and percentage of IDUs reached by prevention services	Output	Coverage of programmes and access to services	Programme records (obtained through reports provided by grant recipients)	Quarterly programme reporting	International HIV/AIDS Alliance in Ukraine at the central level; NGOs working in prevention at the field level	Monitoring visits to field-level NGOs that provide prevention services for IDUs/CSW/MSM/prisoners
15	Number and percentage of sex workers and their clients exposed to outreach programmes						
16	MSM exposed to outreach programmes						
17	Number and percentage of prisoners in medium security prisons reached with prevention services						
18	Number and percentage of IDUs on ARV combination therapy reached with substitution therapy					Public Health Policy Research Institute in cooperation with State Drug Dependence Service	Monitoring visits to oblasts carried out by Public Health Policy Research Institute
19	Number and percentage of IDUs receiving substitution therapy						
20	Number of condoms distributed					International HIV/AIDS Alliance in Ukraine at the central level	Monitoring visits to field-level NGOs that provide prevention services for IDUs/CSWs/MSM/prisoners
21	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			In the absence of relevant statistics – sample survey	Annually	Ministry of Education and Science (and the research agency competitively selected to carry out the study)	Usage of internationally-accepted methodological guidelines for data collection; identification and selection of appropriate sample sizes
22	Number and percentage of schoolchildren exposed to HIV/AIDS education in school settings						
23	Number of PLHA reached by comprehensive care and support services			Programme records (obtained through reports provided by grant recipients)	Quarterly programme reporting	International HIV/AIDS Alliance, Ukraine at the central level; NGOs working in care and support at the field level	Monitoring visits to field-level NGOs that provide care and support services to PLHA
24	Number of children living with and/or affected by HIV/AIDS reached with care and support						
25	Number of hospices established to provide care and support to chronically ill PLHA					National AIDS Centre	Accurate record-keeping, internal checking, monitoring visits carried out by Alliance staff and AIDS Centre specialists
26	Number of people trained in HIV/AIDS prevention					International HIV/AIDS Alliance in Ukraine at the central level; NGOs working in prevention and care and support at the field level	Accurate record-keeping, monitoring visits to field-level NGOs
27	Number of behavioural change communication materials developed (incl. materials developed by field-level service providers) – copies						
28	Number of types of behavioural change communication materials disseminated (incl. materials developed by field-level service providers) – items						

29	Number of people receiving VCT in centres supported by the project	Output	Coverage of programmes and access to services	Programme records (obtained through reports provided by grant recipients)	Quarterly programme reporting	PATH (Program for Appropriate Technologies in Health)	Monitoring visits and documentation review carried out by PATH
30	Number of VCT centres supported by the project						
31	Number of people trained in VCT						
32	Number of key population representatives involved in PSA (participatory site assessment)					International HIV/AIDS Alliance in Ukraine at the central level; NGOs at the field level	Monitoring visits and documentation review carried out by the Alliance
33	Number of people trained in capacity building/ organizational development						

ANNEX 8

SAMPLE PROJECT PERFORMANCE SUMMARY FORM

1. Overall Organization Ranking: A/B/C/D

Depends on introduction of a standard organizational capacity assessment tool

2. Coverage Data: *updated annually*

Key population group	Total coverage achieved (during the last 12 months)	Target coverage	Coverage as % of target	Coverage as % of population
IDUs			%	%
CSWs			%	%
Total # of clients reached during the year				
Reported # verified during monitoring visits		**Yes/Partly/No**	***Comments:***	

Coverage information available from programmatic reports and SyrEx database; population estimate available from annual project proposals and national estimates

3. *Financial Data:* *updated annually*

	Annual expenditure	**Annual budget**	**Expenditure as % of budget**
Total expenditure	$	$	%
Programme expenditure	$	$	%

Programme expenditure per client reached: **$...**

Cost per client relative to Alliance Ukraine benchmarks: **Above/Within/Below**
(Upper benchmark: **$**... / Lower benchmark: **$**...)

Information available from financial reports and new Grant Management System

4. *Services Provided:* *updated annually*

Community Centre	**Y/N**	**Mobile clinics**	**Y/N**
VCT with rapid test	**Y/N**	**...**	**Y/N**
STI screening	**Y/N**	**Other (specify): ...**	**Y/N**

Information available from records and/or programme staff knowledge of organization

5. Quality Data: *updated twice a year*

Quality area	Rating 1	Rating 2	Comments
Comprehensive services (incl. information and referrals)	A/B/C/D	A/B/C/D	
Confidentiality, safety and respect	A/B/C/D	A/B/C/D	
Professional level of staff working directly with clients	A/B/C/D	A/B/C/D	
Client satisfaction	A/B/C/D	A/B/C/D	

Ratings provided by programme staff based on quality assessment during monitoring visit, using agreed standards and protocol including direct observation and interviewing staff and clients.

A: *excellent, exceeds standard*
B: *good, meets standard*
C: *ysatisfactory, partially meets standard*
D: *poor, does not meet standard/serious violation*

6. Management Capacity: *updated annually*

- Financial systems and performance (budget utilization, quality of financial reports)
- Funding (funding sources, percentage of total funding provided by Alliance)
- Monitoring and reporting systems and performance (timeliness and quality of reports)
- HR systems
- Administrative systems
- Partnerships with other organizations and profile with regional stakeholders

No standard tool – narrative summary of key management systems and strengths/weaknesses.

ANNEX 9

NATIONAL BEHAVIOURAL SURVEILLANCE STUDY OF EARLY SEROCONVERSION

Although extensive behavioural surveillance studies are already being conducted in Ukraine as part of UNGASS data collection, this data is collected on a periodic basis, either once per year or once every two years. There is an urgent need to complement prevention and support programmes with an ongoing national behavioural surveillance study that looks at the current behaviour of seroconvertors (people newly infected with HIV). The aim of the study is to assess why, despite the existence of prevention interventions, these individuals still became infected with HIV, and how existing services are addressing the treatment, care and support needs of those newly infected. The National Behavioural Surveillance Study of Seroconvertors will generate real-time data on the current trends in HIV-related knowledge and behaviour, and also provide programmes with ongoing feedback from newly infected clients as to the strengths and shortcomings of the programme's activities and services. This study will provide an ongoing source of qualitative data that will assist programmes to monitor their specific outcomes in serving the needs of clients, as well as provide a quality assessment tool to generate ongoing recommendations for improving the quality and efficacy of programmes and services.

The National Behavioural Surveillance Study of Seroconvertors will be based on similar studies known as Polaris (http://www.hivpolaris.org) developed in Canada and the Russian Federation by Professor Liviana Calzavara of the HIV Studies Unit, University of Toronto. The concept of implementing this study in Ukraine has been discussed with Professor Calzavara, who has consented to supervise the study in Ukraine on the condition of adequate resources and support being provided in-country. Professor Calzavara has agreed to supervise the process of developing/adapting the study for use in Ukraine, as well as supervise the training of project personnel in the collection and analysis of data, and also be involved in the ongoing analysis and interpretation of project data.

The study will involve identification of suitable participants through the use of a detuned assay of previous negative test results to confirm a recent case of seroconversion. Suitable candidates will be offered an opportunity to participate in the study on a voluntary basis, in return for nominal financial compensation. Recruitment will be conducted through the existing network of oblast AIDS centres, with interviews and data entry being performed by the epidemiology departments of the AIDS centres participating in the study. Additional support will be required from a domestic research institute or similar institution in Ukraine that will be responsible for the ongoing analysis of data.

The study should be governed by a steering committee in Ukraine, which includes the component managers of the relevant components of the programme, and other relevant partners. The steering committee would review the results of the study on a regular basis, and guide the project in making key decisions. The results of the study should be reviewed by the steering committee on a quarterly basis, with a comprehensive review on an annual basis. The study will generate specific, client-centred recommendations on the strengths and shortcomings of the existing services for each of the programme's components, with particularly extensive recommendations for the focused prevention, treatment, care and support components. It will be the responsibility of the steering committee to determine which of the recommendations of the study will be implemented, and to monitor their implementation in consultation with the Global Fund to Fight HIV/AIDS, TB and Malaria.

ANNEX 10

SAMPLE BRIEF DESCRIPTION OF POSSIBLE OPERATIONAL RESEARCH OPTION

Concept: Under the general heading of "harm reduction", different NGOs employ a range of different options. For example, some NGOs only provide commodities, while others also offer counselling, referral to medical, social and legal services, testing etc. Similarly, there are NGOs which are centre-based/static while others rely on outreach and mobile service provision.

This research would compare different approaches/combinations of services in terms of:

- Coverage and cost per client
- Client satisfaction and retention
- Reported risk behaviour among regular clients as compared to new clients

Research question:

- What do different "programme options" achieve in terms of coverage, cost-efficiency, client satisfaction/retention and behaviour change?
- Which options offer the best balance between these different dimensions?

Approach/methodology:

The first step is to identify the different programme options to compare, and then to choose NGOs which are good examples of each option. These choices will depend on programme staff judgement and interest. Given the emphasis on peer-driven interventions, it seems sensible to include an example of such intervention.

Once the NGOs are identified, the approach would be a combination of:

- document review (client registers, SyrEx, financial records etc) and analysis of coverage, cost per client and client retention/regularity;
- interviews/focus group discussions with clients on service quality and satisfaction;
- interviews/questionnaire with regular and new clients on risk behaviours;
- review AIDS centre data on referral and survival rates (good external indicators of effective services – number of referrals; early uptake of ART).

Each programme option would be documented by a member of the Programme & Resource Development team, based on interviews with NGO staff and clients, observation and review of documents.

Main steps:

- identify programme options and example NGOs;
- develop TOR and instruments with input from research expert;
- train research assistants and test instruments;

- conduct NGO visits, including client survey and programme documentation;
- quantitative and qualitative data entry;
- data analysis with research expert, including programme documentation;
- produce research report and revised programme documentation.

Product:

The research report will include:

- comparison of success achieved by each option, in terms of number of new and regular clients reached, cost per client, client satisfaction and risk behaviours;
- conclusion on which option or approach offers the best balance and/or which option is least likely to be successful.

There will also be a "practice note" or similar documentation for each approach so that other NGOs can replicate it (if recommended by the research).

Potential follow–up:

A follow–up study could be conducted in the following year, looking at the recommended programme options in more detail and/or exploring new options.

Recommended Output and Process Indicators for

HIV Prevention Projects among IDUs, CSWs, MSM, Prisoners,

and Care and Support Projects for PLHA

1. RECOMMENDED OUTPUT AND PROCESS INDICATORS FOR HIV PREVENTION AMONG IDUS, CSWS, MSM, PRISONERS

1.1 IDUs reached with prevention services during 12 months (number and percentage)

1.2 CSWs reached with prevention services during 12 months (number and percentage)

1.3 MSM reached with prevention services during 12 months (number and percentage)

1.4 Imprisoned individuals reached with prevention services during 12 months (number and percentage)

1.5 Number of condoms distributed for free

1.6 Number of syringes distributed

1.7 Number of BCC (behaviour change communication) materials disseminated among MARPs

1.8 Number of service providers trained in HIV prevention during 12 months

1.9 Number of service delivery points established and functioning

1.1 IDUs reached with prevention services during 12 months (number and percentage)

What it measures	Indicator measures number (and percentage) of IDUs reached (at least once) with prevention services during the 12 month period. 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 include: ■ BCC material (promoting safer behaviour); ■ consumables (syringes, condoms); ■ counselling from a social worker or other relevant specialist; ■ referral to another specialist or service based on individual client needs. This list defines the minimum number of services that an individual should receive in order to be counted as "reached" and by no means diminishes the importance of other relevant services provided at service delivery points.
How is it measured?	**Numerator** The numerator of this indicator is the number of IDUs (individual clients regardless of number of service provision episodes), who received the essential package of services at least once during the 12 month period. **Denominator** The denominator for this indicator is the estimated number of IDUs in the area of project/programme coverage.
What tools are used?	The **numerator** for this indicator can be obtained from the client registration MIS. Registration records are updated upon provision of services (usually, daily). Aggregation of data is made at the "central" level (usually, regional or national). Double counting should be avoided where possible.
Reporting frequency	Annually
Possible disaggregation	Gender, age, primary drug of use, CSW/non-CSW, MSM/non-MSM (for males).
Responsibility and data source	Data is obtained from all HIV prevention service providers in the region/country. Those might include: ■ individual NGOs; ■ individual public (governmental) organizations, i.e. Social Service within the Ministry of Family, Youth and Sports; ■ individual private organizations. There should be a single body (usually, national M&E unit) responsible for collection, aggregation, analysis and dissemination of this data.

1.2 CSWs reached with prevention services during 12 months (number and percentage)

What it measures	Indicator measures number (and percentage) of CSWs reached (at least once) with prevention services during the 12 month period. A CSW 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 CSWs should include: ■ BCC material (promoting safer behaviour); ■ consumables (syringes if client is also an IDU, condoms); ■ counselling from a social worker or other relevant specialist; and ■ referral to another specialist or service based on individual client needs. This list defines the minimum number of services that an individual should receive in order to be counted as "reached" and by no means diminishes the importance of other relevant services provided at service delivery points.
How is it measured?	**Numerator** The numerator of this indicator is the number of CSWs (individual clients regardless of number of service provision episodes) who received the essential package of services at least once during the 12 month period. **Denominator** The denominator for this indicator is the estimated number of CSWs in the area of project/programme coverage.
What tools are used?	The **numerator** for this indicator can be obtained from the client registration MIS. Registration records are updated upon provision of services (usually, daily). Aggregation of data is made at the "central" level (usually, regional or national). Double counting should be avoided where possible.
Reporting frequency	Annually
Possible disaggregation	Gender, age, IDU/non-IDU, MSM/non-MSM (for males).
Responsibility and data source	Data is obtained from all HIV prevention service providers in the region/country. Those might include: ■ individual NGOs; ■ individual public (governmental) organizations, i.e. Social Service within the Ministry of Family, Youth and Sports; ■ individual private organizations. There should be a single body (usually, national M&E unit) responsible for collection, aggregation, analysis and dissemination of this data.

1.3 MSM reached with prevention services during 12 months (number and percentage)

What it measures	Indicator measures number (and percentage) of MSM reached (at least once) with prevention services during the 12 month period. A MSM is "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 include: ▪ BCC material (promoting safer behaviour); ▪ consumables (syringes if client is also an IDU, condoms); ▪ counselling from a social worker or other relevant specialist; and ▪ referral to another specialist or service based on individual client needs. This list defines the minimum number of services that an individual should receive in order to be counted as "reached" and by no means diminishes the importance of other relevant services provided at service delivery points.
How is it measured?	**Numerator** The numerator of this indicator is the number of MSM (individual clients regardless of number of service provision episodes), who received the essential package of services at least once during the 12 month period. **Denominator** The denominator for this indicator is the estimated number of MSM in the area of project/programme coverage.
What tools are used?	The **numerator** for this indicator can be obtained from the client registration MIS. Registration records are updated upon provision of services (usually, daily). Aggregation of data is made at the "central" level (usually, regional or national). Double counting should be avoided where possible.
Reporting frequency	Annually
Possible disaggregation	Age, IDU/non-IDU, CSW/non-CSW.
Responsibility and data source	Data is obtained from all HIV prevention service providers in the region/country. Those might include: ▪ individual NGOs; ▪ individual public (governmental) organizations, i.e. Social Service within the Ministry of Family, Youth and Sports; ▪ individual private organizations. There should be a single body (usually, national M&E unit) responsible for collection, aggregation, analysis and dissemination of this data.

1.4 Imprisoned individuals reached with prevention services during 12 months (number and percentage)

What it measures	Indicator measures number (and percentage) of imprisoned individuals reached (at least once) with prevention services during the 12 month period. A prisoner is "reached with prevention services" if he/she received an **essential package of services**. It is suggested that the essential package of services for prisoners should include: ■ BCC material (promoting safer behaviour); ■ counselling from a social worker or other relevant specialist; and ■ consumables (syringes, condoms – available, but not obligatory to receive). This list defines the minimum number of services that an individual should receive in order to be counted as "reached" and by no means diminishes the importance of other relevant services provided in penitentiary institutions.
How is it measured?	**Numerator** The numerator of this indicator is the number of prisoners (individual clients regardless of number of service provision episodes) who received the essential package of services at least once during the 12 months period. **Denominator** The denominator for this indicator is the total number of individuals ever being imprisoned during the same 12 months (including those who have been imprisoned during this period for less than 12 months) in all penitentiary institutions of project/programme coverage, where such services are allowed by national legislation.
What tools are used?	The **numerator** for this indicator can be obtained from the client registration MIS. Registration records are updated upon provision of services (usually, daily). Aggregation of data is made at the "central" level (usually, regional or national). Double counting should be avoided where possible.
Reporting frequency	Annually
Possible disaggregation	Gender, age, IDU/non-IDU, MSM/non-MSM (for males).
Responsibility and data source	Data is obtained from all HIV prevention service providers working in penitentiary institutions in the region/country. Those might include: ■ individual NGOs; ■ individual public (governmental) organizations, i.e. Social Service within the State Penitentiary Department; ■ individual private organizations. There should be a single body (usually, national M&E unit) responsible for collection, aggregation, analysis and dissemination of this data.

1.5 Number of condoms distributed for free

What it measures	This indicator measures the total number of condoms distributed through focused prevention programmes and projects to MARP representatives, i.e. IDUs, CSWs, MSM and prisoners. Number of condoms distributed should include both male and female condoms.
How is it measured?	Count each condom distributed as one. For example, a strip/packet of three condoms is counted as three.
What tools are used?	Data on this indicator can be obtained from the client registration MIS, which also tracks all consumables and services provided to each client. It can also be obtained from warehouse registration documents.
Reporting frequency	Quarterly/biannually/annually
Possible disaggregation	Male/female condoms, number of condoms distributed to each of the most-at-risk groups (i.e. IDUs, CSWs, MSM, prisoners)
Responsibility and data source	Data is obtained from all HIV prevention service providers in the region/country. Those might include: ▪ individual NGOs; ▪ individual public (governmental) organizations, i.e. Social Service within the Ministry of Family, Youth and Sports, State Penitentiary Department; ▪ individual private organizations. There should be a single body (usually, national M&E unit) responsible for collection, aggregation, analysis and dissemination of this data.

1.6 Number of syringes distributed

What it measures	This indicator measures the total number of syringes distributed through focused prevention programmes and projects to IDUs.
How is it measured?	Count each syringe distributed as one. For example, a strip/packet of three syringes is counted as three.
What tools are used?	Data on this indicator can be obtained from the client registration MIS, which also tracks all consumables and services provided to each client. It can also be obtained from warehouse registration documents.
Reporting frequency	Quarterly/biannually/annually
Possible disaggregation	Type of syringe (volume), given out/exchanged syringes
Responsibility and data source	Data is obtained from all HIV prevention service providers in the region/country. Those might include: ■ Individual NGOs; ■ Individual public (governmental) organizations, i.e. Social Service within the Ministry of Family, Youth and Sports, State Penitentiary Department; ■ Individual private organizations. There should be a single body (usually, national M&E unit) responsible for collection, aggregation, analysis and dissemination of this data.

1.7 Number of BCC (behaviour change communication) materials disseminated among MARPs

What it measures	This indicator measures the total number of BCC materials disseminated through focused prevention programmes and projects to MARPs representatives, i.e. IDUs, CSWs, MSM and prisoners.
How is it measured?	Count each copy of a BCC material distributed as one. BCC materials may include booklets, leaflets, brochures, bulletins, periodicals, referral directories, etc. aimed at promoting safer behaviour. They usually do not include posters and cards.
What tools are used?	Data on this indicator can be obtained from the client registration MIS, which also tracks all consumables and services provided to each client. It can also be obtained from warehouse registration documents.
Reporting frequency	Quarterly/biannually/annually
Possible disaggregation	Type of BCC material, number of materials distributed to each of the most-at-risk groups (i.e. IDUs, CSWs, MSM, prisoners).
Responsibility and data source	Data is obtained from all HIV prevention service providers in the region/country. Those might include: ▪ individual NGOs; ▪ individual public (governmental) organizations, i.e. Social Service within the Ministry of Family, Youth and Sports, State Penitentiary Department; ▪ individual private organizations. There should be a single body (usually, national M&E unit) responsible for collection, aggregation, analysis and dissemination of this data.

1.8 Number of service providers trained in HIV prevention during 12 months

What it measures	This indicator measures the number of people trained in HIV prevention strategies for direct activity implementation with the community during the 12 month period. 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 sexual and life skills education, counselling and all other community-based prevention work. If the training is part of another training course which is not focused on HIV prevention only, then the course must be recognized by the organization as having a sufficient prevention focus. The reporting organization must take responsibility for checking that the course is of a suitable standard. The training must give participants the skills to directly implement prevention activities with the community. **Examples** of such skills may be: education/interpersonal communication/small group communication/participatory prevention strategies for prevention of HIV, sexual and reproductive health education, promotion of STI health seeking behaviours, condom use promotion, improving sex negotiation skills.
How is it measured?	Count the number of service providers trained in prevention during the 12 month period. Count each individual trained as one, even if he/she attends more than one training course in prevention within the same reporting period (12 months).
What tools are used?	Data on this indicator can be obtained from the training registration MIS (this function can either be included into the client registration MIS or a separate MIS can be developed for this purpose).
Reporting frequency	Annually
Possible disaggregation	Gender, training topic
Responsibility and data source	Data is obtained from all agencies conducting trainings in HIV prevention for service providers in the region/country. Those might include: ▪ individual NGOs; ▪ individual public (governmental) organizations, i.e. Social Service within the Ministry of Family, Youth and Sports, State Penitentiary Department; ▪ individual private organizations. There should be a single body (usually, national M&E unit) responsible for collection, aggregation, analysis and dissemination of this data.

1.9 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 at least the essential package of prevention services to most-at-risk populations at the given point of time.
How is it measured?	Count each established and functioning point once. Usually the number of functioning service delivery points is measured at a given time point (i.e. end of quarter/year) excluding those which worked during previous periods but have terminated work at this point in time.
What tools are used?	Programme records of all HIV prevention service providers.
Reporting frequency	Annually
Possible disaggregation	This indicator can be disaggregated by the type of service delivery point (i.e. stationary, mobile outreach, outdoor, etc.) or by region.
Responsibility and data source	Data is obtained from all agencies providing HIV prevention services in the region/country. Those might include: ▪ individual NGOs; ▪ individual public (governmental) organizations, i.e. Social Service within the Ministry of Family, Youth and Sports, State Penitentiary Department; ▪ individual private organizations. There should be a single body (usually, national M&E unit) responsible for collection, aggregation, analysis and dissemination of this data.

2. SELECTED OUTPUT AND PROCESS INDICATORS FOR CARE AND SUPPORT PROJECTS FOR PEOPLE LIVING WITH HIV/AIDS

2.1 Adults living with HIV/AIDS (PLHA) reached with care and support services during 12 months (number and percentage)

2.2 Children living with and/or affected by HIV/AIDS reached with care and support services during 12 months (number and percentage)

2.3 Chronically ill people living with HIV/AIDS (PLHA) receiving palliative care during 12 months

2.4 Number of comprehensive care and support centres for PLHA established and functioning

2.1 Adults living with HIV/AIDS (PLHA) reached with care and support services during 12 months (number and percentage)

What it measures	Indicator measures number (and percentage) of adult (16 and over) PLHA reached at least once with care and support services during the 12 month period. A PLHA is "reached with care and support 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 PLHA should include at least one of the following: ■ psychological support (peer counselling and/or participation in self-help groups and/or ART adherence counselling, etc.); ■ socioeconomic support (humanitarian aid, home-based care, social patronage, etc.). 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 both.
How is it measured?	**Numerator** The numerator for this indicator is the number of PLHA (individual clients regardless of number of service provision episodes), who received the essential package of services at least once during the 12 month period. **Denominator** The denominator for this indicator is the estimated number of PLHA in the area of project/programme coverage (in the absence of such estimates the number of officially registered HIV-positive people in the area can be used as the denominator).
What tools are used?	The **numerator** for this indicator can be obtained from the client registration MIS. Registration records are updated upon provision of services (usually, daily). Aggregation of data is made at the "central" level (usually, regional or national). Double counting should be avoided where possible.
Reporting frequency	Annually
Possible disaggregation	Gender, age, IDU/non-IDU, MSM/non-MSM, CSW/non-CSW.
Responsibility and data source	Data is obtained from all HIV care and support service providers in the region/country. Those might include: ■ individual NGOs; ■ individual public (governmental) organizations, i.e. Social Service within the Ministry of Family, Youth and Sports, Ministry of Health; ■ individual private organizations. There should be a single body (usually, national M&E unit) responsible for collection, aggregation, analysis and dissemination of this data.

2.2 Children living with and/or affected by HIV/AIDS reached with care and support services during 12 months (number and percentage)

What it measures	Indicator measures number (and percentage) of children (under 16) living with or affected by HIV/AIDS reached at least once with care and support services during the 12 month period. A child is "reached with care and support 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 children should include at least one of the following: ■ for infants (under 18 months): 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.); ■ 18 months–15 years: 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. Some of these services will be provided at household level and some at community level, and this indicator measures both.
How is it measured?	**Numerator** The numerator for this indicator is the number of children (under 16 years old) living with or affected by HIV/AIDS (individual clients regardless of number of service provision episodes), who received the essential package of services at least once during the 12 month period. Children affected by HIV/AIDS are those who have lost one or both parents because of AIDS, or those born to HIV-positive mothers. **Denominator** The denominator for this indicator is the estimated number of children living with and/or affected by HIV/AIDS in the area of project/programme coverage (in the absence of such estimates the number of officially registered children born to HIV-positive mothers in the area can be used as the denominator).
What tools are used?	The numerator for this indicator can be obtained from the client registration MIS. Registration records are updated upon provision of services (usually, daily). Aggregation of data is made at the "central" level (usually, regional or national). Double counting should be avoided where possible.
Reporting frequency	Annually
Possible dis-aggregation	Gender, age, HIV-positive/HIV-negative.
Responsibility and data source	Data is obtained from all HIV care and support service providers in the region/country providing services to children. Those might include: ■ individual NGOs; ■ individual public (governmental) organizations, i.e. Social Service within the Ministry of Family, Youth and Sports, Ministry of Health; ■ individual private organizations. There should be a single body (usually, national M&E unit) responsible for collection, aggregation, analysis and dissemination of this data.

2.3 Chronically ill people living with HIV/AIDS (PLHA) receiving palliative care during 12 months

What it measures	Indicator measures the number of chronically ill PLHA receiving palliative care in hospices/out-patient departments (clinics) during the previous 12 months.
How is it measured?	This indicator measures the number of PLHA (individual clients regardless of number of service provision episodes), who received palliative care during the 12 month period.
What tools are used?	Data on this indicator can be obtained from client registration MIS operating in hospices/out-patient departments (clinics). Aggregation of data is made at the "central" level (usually, regional or national). Double counting should be avoided where possible.
Reporting frequency	Annually
Possible disaggregation	Gender, age
Responsibility and data source	Data is obtained from all hospices/clinics providing palliative care to chronically ill PLHA in the region/country. There should be a single body (usually, national M&E unit) responsible for collection, aggregation, analysis and dissemination of this data.

2.4 Number of comprehensive care and support centres for PLHA established and functioning

What it measures	This indicator measures the number of comprehensive care and support centres for PLHA established and functioning, i.e. providing complex care and support services for PLHA (including children living with and/or affected by HIV/AIDS) at the given point of time. A comprehensive care and support centre usually comprises a community centre providing various services, day care for children, referral and social patronage services, etc. However, the criteria for a comprehensive care and support centre (list of services available) should be defined on the national level and followed by all country service providers.
How is it measured?	Count each established and functioning centre once. Usually the number of functioning centres is measured at a given point in time (i.e. end of quarter/year) excluding those which were working during previous periods but have terminated work at this point in time.
What tools are used?	Programme records of all PLHA care and support service providers.
Reporting frequency	Annually
Possible disaggregation	This indicator can be disaggregated by region.
Responsibility and data source	Data is obtained from all agencies providing care and support services in the region/country. Those might include: ■ individual NGOs; ■ individual public (governmental) organizations, i.e. Social Service within the Ministry of Family, Youth and Sports, Ministry of Health; ■ individual private organizations. There should be a single body (usually, national M&E unit) responsible for collection, aggregation, analysis and dissemination of this data.

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ББК 55–1
М –77

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Programme Monitoring and Evaluation. Practical Manual / Olga Morozova, Olga Varetska, Daniel Jones, Pepukai Chikukwa, Tetyana Salyuk. Kyiv: Oranta, 2008. 142 pages.

This manual provides practical recommendations on the development and support of programme monitoring and evaluation systems for programmes and projects providing HIV/AIDS prevention among most-at-risk populations and care and support for people living with HIV/AIDS.

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Copies – 1000
Distributed free of charge

Подписано в печать 28.03.2008. Формат 64x90 1/8. Бумага офсетная.
Зак. № 0328–21.1. Тираж 1000 экз.

Макет и печать:
Полиграфическая фирма «Оранта»
Украина, 03037, г Киев, ул. М. Кривоноса, 2Б
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