Prevention Indicators for the President's Emergency Plan for AIDS Relief

A Report of the CSIS Task Force on HIV/AIDS
Working Committee on Prevention

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Jennifer Kates and Phillip Nieburg

Introduction

With the second year of field operations of the U.S. President's Emergency Plan for AIDS Relief (PEPFAR) just underway, the U.S. Congress, the international community, and other key stakeholders are beginning to look toward PEPFAR's progress, particularly within the context of other international HIV/AIDS efforts. Indeed, a recent and unprecedented joint announcement by the World Health Organization (WHO), the Joint United Nations Programme on HIV/AIDS (UNAIDS), the U.S. government, and the Global Fund to Fight AIDS, Tuberculosis and Malaria (Global Fund) highlighted joint progress toward international antiretroviral treatment goals.[1] Much less attention, however, has been paid to global HIV prevention targets, which include PEPFAR's ambitious goal of preventing 7 million new HIV infections over a five-year period. Yet this is a critical moment for refocusing attention on HIV prevention and on progress toward PEPFAR and other global prevention targets. Without such attention, there is significant risk of failing in efforts to stem the tide of the pandemic.[2]

The Office of the U.S. Global AIDS Coordinator (OGAC) has identified a set of HIV prevention indicators intended to gauge progress in reaching PEPFAR's goal of preventing 7 million new infections in PEPFAR focus countries.[3] Care and treatment indicators have also been identified. Country teams in the 15

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[1] Joint media release of WHO/UNAIDS/Global Fund/U.S. Government, "700 000 People Living with AIDS in Developing Countries Now Receiving Treatment," January 26, 2005.

[2] See Global HIV Prevention Working Group reports, http://www.kff.org/hivaids/hivghpwgpackage.cfm; Daniel T. Halperin et al., "The Time has Come for Common Ground on Preventing Sexual Transmission of HIV," *The Lancet*, vol. 364 (November 2004); UNAIDS, "Intensifying HIV Prevention—Foundations for a Strategy Framework," *Report of the Sixteenth Meeting of the Programme Coordinating Board*, UNAIDS/PCB (16)/04.3, November 2004; Joshua Salomon et al., "Integrating HIV Prevention and Treatment: From Slogans to Impact," *PLOS*, vol. 2, no. 1 (January 2005).

[3] OGAC, *The President's Emergency Plan for AIDS Relief Indicators, Reporting Requirements, and Guidelines: Revised based on FY2005 Country Operation Plans* (Washington, D.C.: Department of State, September 2004), and OGAC, *Updated Appendix (Targets)* (Washington, D.C.: Department of State, October 2004).

PEPFAR focus countries—Botswana, Côte d'Ivoire, Ethiopia, Guyana, Haiti, Kenya, Mozambique, Namibia, Nigeria, Rwanda, South Africa, Tanzania, Uganda, Vietnam, and Zambia—are required to report data for these indicators in their annual reports. Preliminary FY 2004 indicator data for the 15 focus countries were presented in PEPFAR's first annual report to Congress.[4] Indicators for non-focus countries—including China, India, and Russia, considered part of the epidemic's "second wave"—are currently being developed by OGAC, and guidance is expected in 2006.[5]

This report of the CSIS Task Force on HIV/AIDS Working Committee on Prevention provides an overview of the HIV prevention indicators that are being tracked by PEPFAR in the 15 focus countries. It also compares them to indicators used by other major international initiatives. The overview is designed to inform policymakers and other experts in an area that is complex, often controversial, and one that will become increasingly important over the long haul, and to suggest some pragmatic next steps for Congress and OGAC. The overview does not, however, seek to validate the indicators chosen or analyze the preliminary data recently provided by OGAC to Congress.

The Need to Focus on Prevention and Indicators of Success

Globally, it is estimated that fewer than 1 in 5 people at risk for HIV infection have access to proven HIV prevention interventions.[6] Last year, close to 5 million people were newly infected with HIV, according to UNAIDS. At current rates of infection, millions more people will become infected with HIV by the end of the decade. There is growing concern that worldwide attention to antiretroviral treatment (ART) scale-up may be eclipsing attention to prevention—and at great cost to both prevention and treatment efforts. And, without a significant reduction in new infections, it will not be possible to keep pace with the number of people with HIV/AIDS in need of treatment. Therefore, making progress on prevention—through PEPFAR and other global efforts—is of critical importance.

To monitor progress toward reaching PEPFAR's prevention goals, OGAC has selected a set of prevention indicators to be tracked by the 15 focus countries. These indicators warrant special attention by policymakers and others, given that they:

- Form the basis of PEPFAR's monitoring and evaluation (M&E) efforts and therefore its performance, over time;
- Determine, to a large extent, how PEPFAR-supported prevention programs are designed and how resources are spent in the field, since the choice of a particular indicator signals what activities must be undertaken and measured;

[4] OGAC, *Engendering Bold Leadership: The President's Emergency Plan for AIDS Relief, First Annual Report to Congress* (Washington, D.C.: Department of State, March 2005).
[5] Personal Communication, OGAC, April 12, 2005.
[6] UNAIDS, *AIDS Epidemic Update, 2004* (New York: UNAIDS, November 2004).

- Will be used for accountability to Congress and to federal agencies by U.S. country teams, in-country partners, contractors, grantees, and others involved in carrying out aspects of the program;
- Should be compared to those used by other international donors to assess the extent to which they support the harmonization of M&E systems as agreed to by major donors under the donor harmonization and coordination principles of the "Three Ones";[7] and
- Will contribute to a broader understanding and dialogue about HIV prevention globally and at the country level, as data become available over time.

Challenges to Measuring HIV Prevention

The field of HIV prevention, and its measurement, is complex, and it is important to note the very real challenges to measuring HIV prevention that could inhibit efforts to accurately monitor progress by OGAC and others.[8] These include:

- *Lack of a uniform definition:* While averting and/or reducing new HIV infections is the ultimate goal of HIV prevention efforts, there is no uniform definition of HIV prevention, and it is often defined differently across programs and initiatives;
- *Measuring what did not happen*: It is quite difficult to measure events that did *not* occur (e.g., HIV infections averted) compared to measuring, for example, the number of people receiving ART. Because of this difficulty, models are often used to predict or project progress on prevention (derived primarily by extrapolating from proven strategies at an individual or small group level), as are interim or proxy measures of inputs and outputs, such as changes in attitudes, knowledge, and behavior, that are expected to effect outcomes and impacts, such as HIV incidence;
- *No single model of success:* In the more than 15 to 20 years of research on and evidence of HIV prevention effectiveness, no single model of success has emerged, and the few select cases of developing country success and even reversal (e.g., Uganda, Senegal, Thailand, and Brazil[9]) are due to

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[7] UNAIDS, *The Three Ones: Principles for the Coordination of National AIDS Responses* (New York, UNAIDS, April 2004), http://www.unaids.org/en/about+unaids/what+is+unaids/unaids+at+country+level/the+three+ones.asp.

[8] See, for example, WHO, "Steady…Ready…Go," information brief of the Talloires Consultation to Review the Evidence for Policies to Achieve the Global Goals on Young People and HIV/AIDS, Talloires, France, May 2004, http://www.who.int/child-adolescent-health/New_Publications/ADH/ IB_SRG.pdf; Judith Auerbach et al., "Overview of Effective and Promising HIV Prevention Interventions," paper presented at the Talloires Consultation, May 2004; "Towards an HIV-Free Generation: Lessons and Experiences From Large-Scale Youth HIV/AIDS Prevention Programming Research," XV International AIDS Conference, Satellite Session, July 13, 2004.

[9] UNAIDS, *HIV Prevention Needs and Successes: A Tale of Three Countries. An Update on HIV Prevention Success in Senegal, Thailand and Uganda* (New York: UNAIDS, 2001); National

multiple interventions and are themselves subject to much discussion and debate over the contributions of different factors.[10] Prevention strategies, and their measures of success, will need to vary in different contexts, taking into account such factors as prevalence rates, "maturity" of the epidemic, the populations affected, and trends in new infections;

- *Time required to show impact:* While reducing HIV incidence is an ultimate goal of HIV prevention efforts, it takes years to see such an impact at the population level, and policymakers and program managers need to be aware of this. Again, interim or proxy measures may be needed.
- *Urgent need to scale up*: Despite the body of evidence of what works in HIV prevention[11] it has, with few exceptions, largely been demonstrated at the individual, small group, or community level, not the population (national) level. This is because most HIV prevention interventions have not been implemented widely enough, or for long enough, to be able to show this level of impact. Even if they were scaled up and sustained, it would take a long time to show population-level reduction in HIV incidence. Yet, as with ART efforts, it is important not to wait years to document population-level impacts before scaling up proven prevention interventions. Furthermore, as efforts are scaled up, the need for operational research will be critical.
- *Complexity of behavior change and its measurement:* HIV prevention usually involves behavioral change, which is complex to measure since it is influenced by numerous individual and social factors.

Despite these challenges, the process of assessing HIV prevention and developing indicators has been underway for 15 to 20 years. Early efforts began, for example, in the work of the WHO's Global Programme on AIDS (the precursor to UNAIDS).[12] UNAIDS has expanded and adapted these indicators over time,[13] and as part of the United Nation's General Assembly on HIV/AIDS (UNGASS), global prevention targets and indicators were specified and adopted

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Intelligence Council, *The Next Wave of HIV/AIDS: Nigeria, Ethiopia, Russia, India, and China*, ICA 2002-04 D (Washington, D.C.: National Intelligence Council, November 2002).

[10] Janice A. Hogel, ed., *What Happened in Uganda? Declining HIV Prevalence, Behavior Change, and the National Response* (Washington, D.C.: U.S. Agency for International Development, September 2002); Daniel Low-Beer and Rand L. Stoneburner, "Behaviour and Communication Change in Reducing HIV: Is Uganda Unique?" *African Journal of AIDS Research*, vol. 2, no. 1 (2003).

[11] See, for example, Global HIV Prevention Working Group reports, and Halperin et al., "The Time Has Come for Common Ground."

[12] Personal communication with Dr. Michael Merson, Yale University, January 11 and 12, 2005, and February 4, 2005; Thierry Mertens et al., "Prevention Indicators for Evaluating the Progress of National AIDS Programmes, *AIDS*, vol. 8, no. 10 (1994); Mehret Mandfredo et al., "Baseline for the Evaluation of an AIDS Programme Using Prevention Indicators: A Case Study in Ethiopia," *WHO Bulletin*, vol. 74, no. 5 (1996); Thierry Mertens and Michel Carael, "Evaluation of HIV/STD Prevention, Care and Support: An Update on WHO's Approaches," *AIDS Education and Prevention*, vol. 9, no. 2 (1997).

[13] UNAIDS, *National AIDS Programmes: A Guide to Monitoring and Evaluation* (New York: UNAIDS, June 2000).

by member nations.[14] The international community also agreed to a set of global targets for addressing poverty, including some HIV prevention targets, in the Millennium Development Goals (MDGs).[15] More recently, the Global Fund, the U.S. government, UNAIDS, WHO, and other partners, developed a comprehensive toolkit for the monitoring and evaluation of HIV/AIDS, TB, and malaria efforts that includes prevention indicators for HIV.[16] The purpose of the collaborative toolkit is to "gather a selection of standard indicators and best practice in M&E, by applying a common M&E framework for the three diseases and providing users with references to key materials and resources."[17] Other, more targeted, international monitoring tools and guidelines have also been developed through collaborative efforts by UNAIDS, WHO, the United States, and others.

In the United States, the Centers for Disease Control and Prevention (CDC) and U.S. Agency for International Development (USAID) have included the use of prevention indicators in their global HIV/AIDS efforts for several years.[18] And, as noted above, last year, major donors agreed on the principles of the "Three Ones," an effort to harmonize and coordinate their efforts at the country level; efforts are also underway by donors to jointly develop and identify additional indicators.[19] Together, these efforts have led to the identification of a set of HIV prevention indicators, many of which are widely accepted by international donors, national AIDS programs, and others.

The PEPFAR Prevention Indicators for Focus Countries

Building on prior international and U.S. government efforts, OGAC developed guidance on indicators and reporting requirements for the PEPFAR program in the 15 focus countries, incorporated in *The President's Emergency Plan for AIDS Relief Indicators, Reporting Requirements, and Guidelines: Revised based on FY2005 Country Operation Plans.* This document has been provided to country teams and is intended to be a working document that is revised as data and other program information become available. Other guidance documents are also being developed by OGAC. For example, OGAC recently provided country teams with further guidance on defining and implementing the "ABC"—Abstinence, Be

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[14] "UN General Assembly's Special Session on HIV/AIDS," June 2001, http://www.un.org/ga/aids/coverage/.
[15] "UN Millennium Development Goals (MDG)," http://www.un.org/millenniumgoals.
[16] WHO et al., *Monitoring and Evaluation Toolkit: HIV/AIDS, Tuberculosis and Malaria* (Geneva: WHO, June 2004), http://www.who.int/hiv/pub/epidemiology/en/me_toolkit_en.pdf.
[17] Ibid., p. 5.
[18] CDC, *Monitoring the Global AIDS Program: Indicator Guide for Annual Reporting* 2003; USAID, *Expanded Response Guide to Core Indicators for Monitoring and Reporting on HIV/AIDS Programs* (Washington, D.C.: USAID, January 2003); USAID, *Handbook of Indicators for HIV/AIDS/STI Programs* (Washington, D.C.: USAID, March 2002).
[19] For example, UNAIDS, WHO, the Global Fund, and the U.S. Government are jointly working to revise the "Most at Risk Population" indicators, and OGAC reports that these indicators will be included as part of the PEPFAR indicators (source: personal communication, OGAC, February 15, 2005).

Faithful, and correct and consistent Condom use—approach to HIV/AIDS prevention.[20]

The PEPFAR indicator guidance identifies two types of data to be reported by country teams: **program** indicators and **national** indicators:

- PEPFAR **program** indicators measure *inputs* (e.g., people trained, equipment purchased) and *outputs* (e.g., activities or services delivered, people reached). They are specifically designed to assess U.S. government-supported activities, and were developed by OGAC for this purpose. In most, but not all, cases, these data will include: number of service outlets/programs; number of clients served (disaggregated by sex); and number of health workers trained in the service.
- PEPFAR **national** indicators measure *outcomes* (e.g., changes in behaviors, skills) and *impacts* (e.g., changes in HIV infection rates). These indicators were chosen to assess joint progress with other international donors, as part of the principles of the "Three Ones," and are drawn from and aligned with international standards and measurement tools where possible.

The "input-output-outcome-impact" framework is the standard framework used by most M&E efforts.[21] These stages represent the flow of interventions over time and are intended to capture the relationship between them: for example, a program input (such as staff or materials) leads to an output (such as number of people reached using these inputs), then an outcome (the response of those reached, such as a change in behavior), and finally an impact (such as the effect on morbidity or mortality).

Most PEPFAR indicators are categorized by OGAC into the broad areas represented by each major PEPFAR overall goal: prevention, treatment (ART), care (non-ART), and orphans and vulnerable children. Some indicators are more general, such as those designed to measure policy analysis and systems strengthening that apply broadly across PEPFAR goals.

Tables 1 and 2 in the appendix include all indicators specified as "HIV prevention" in the OGAC guidance. Also included are those indicators categorized under other program areas but generally considered to be part of HIV prevention: HIV counseling and testing (categorized under care) and laboratory infrastructure related to HIV testing (categorized under treatment). Not included are indicators related to the provision of prophylaxis for opportunistic infections, which are categorized by OGAC under care. Also not included are indicators that measure stigma and discrimination reduction activities, which are categorized by

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[20] OGAC, *ABC Guidance #1 For United States Government In-Country Staff and Implementing Partners Applying the ABC Approach To Preventing Sexually-Transmitted HIV Infections Within The President's Emergency Plan for AIDS Relief* (Washington, D.C.: Department of State, 2005).

[21] See UNAIDS, [M&E] Conceptual Framework, http://www.unaids.org/EN/in+focus/monitoringevaluation/m_e+library/m_e+guidelines/conceptual+framework.asp; UNAIDS, *National AIDS Programmes: A Guide to Monitoring and Evaluation* (Geneva: UNAIDS, June 2000); and WHO et al., *Monitoring and Evaluation Toolkit*.

OGAC in other, more cross-cutting areas (e.g., policy analysis and system strengthening), since such activities serve to facilitate HIV prevention, care, and treatment efforts. Table 1 includes program indicators (input and output). Table 2 includes national indicators (outcome and impact).

Tables 1 and 2 also indicate whether the PEPFAR indicators are used or recommended for use as a monitoring tool by UNGASS, the Global Fund's Joint M&E Toolkit, and the MDGs.[22] While these three efforts are not meant to be inclusive of all indicators generally agreed upon by the international community, they represent the major and recent global community efforts to identify common indicators. It is important to note that some of the indicators chosen by OGAC, particularly the outcome and impact indicators, were drawn from other, more targeted, international monitoring tools and guidelines outside of these three efforts, such as those focused specifically on young people.[23]

Finally, table 3 provides select FY 2004 prevention indicator data (totals across the 15 focus countries) included in PEPFAR's first annual report to Congress.

Key Findings

A review of PEPFAR prevention indicators indicates the following:

- Twenty-four program-level prevention indicators are included in the guidance (see table 1).[24] Two of the 24 program-level indicators are tracked by central databases at USAID and do not need to be tracked by country teams. Fourteen national-level prevention indicators are included in the guidance, one of which is recommended but not required at this point (see table 2).
- The majority of prevention indicators developed or chosen by PEPFAR, therefore, are designed to track PEPFAR program inputs and outputs versus national-level outcomes and impacts. This focus may reflect the relatively early stage of program implementation, the direct control of PEPFAR over its own inputs and outputs (in contrast to outcomes and impacts), and the need for greater coordination with and reliance on external partners to determine and monitor national-level outcomes and impacts over time.

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[22] An indicator was considered to also be used by another initiative if it generally measured the same type of information as PEPFAR, even if its wording differed slightly. Differences are noted where appropriate.

[23] See in particular: WHO, *National AIDS Programmes: A Guide to Indicators for Monitoring and Evaluating National HIV/AIDS Prevention Programmes for Young People* (Geneva: WHO, 2004); WHO, "Injection Safety: Toolbox: Resources to Assist in the Management of National Safe and Appropriate Use of Injection Policies," http://www.who.int/injection_safety/toolbox/en/.

[24] Note: indicators that are subsets of others are not included in this total; for example, "number of community outreach HIV/AIDS prevention programs that promote being faithful" is a subset of "number of community outreach HIV/AIDS prevention programs that promote abstinence and/or being faithful."

- There is consistency and overlap between many of the PEPFAR indicators and those used by other international initiatives, particularly those identified by the Global Fund's Joint M&E Toolkit. Most consistency is found in the choice of outcome and impact indicators, since they are drawn from internationally agreed upon measures, but there also is overlap between several of the input and output indicators and those identified by the Joint M&E Toolkit. In general, there is less overlap with UNGASS and the MDGs, in part because those two efforts are focused primarily on outcomes and impacts and because they include fewer HIV prevention indicators overall.
- PEPFAR program-level indicators are disaggregated according to the "ABC" approach, with a major emphasis on measuring activities focused on abstinence and/or faithfulness. All other activities, including those related to condom use, are classified as "other behavior change." The indicators used by the other three initiatives examined do not specify program content at this level.
- The PEPFAR prevention program indicators include several indicators of training activities (e.g., number of individuals trained). The importance of including training indicators is emphasized in the Global Fund Joint M&E Toolkit as a key component for assessing overall "coverage" of prevention (and other) interventions, although the indicators themselves do not explicitly include training variables. Prevention training indicators are not specified by UNGASS or the MDGs, most likely a reflection of the fact that these efforts are primarily focused on outcomes and impacts.
- There are currently no PEPFAR prevention indicators that specifically measure prevention interventions designed to address nonmedical injecting drug transmission (e.g., referral of injecting drug users to addiction treatment). Both UNGASS and the Joint M&E Toolkit have measures that address this area of HIV prevention. OGAC indicates that future versions of guidance will include such measures, particularly in light of the recent addition of Vietnam to the set of PEPFAR focus countries, given that drug use has played such a significant role in that country's epidemic.[25]
- Several of the indicators are to be disaggregated by sex, age, and other key demographic variables when reported by country teams to OGAC.

Policy Implications and Next Steps

This review of the initial indicator guidance developed by OGAC demonstrates that much has already been done to identify prevention indicators and that many of these indicators are used and recommended by other major international efforts. Moving forward, there are several policy implications and pragmatic steps

[25] Personal communication, OGAC, April 12, 2005.

that could be considered by OGAC and Congress to further progress in this area. These include the importance of:

- *Monitoring and assessing the capacity* of focus countries to report data for all indicators, including training and technical assistance needs, data quality, and the level of burden posed by reporting requirements. To the extent that there is consistency with other major M&E initiatives, reporting requirements will be less cumbersome for implementing agencies and host-country governments.
- *Demonstrating how PEPFAR inputs and outputs relate to outcomes and impacts*. This will help convey to Congress and others how the PEPFAR prevention indicators monitored over time contribute to PEPFAR's overall goal of preventing 7 million new HIV infections and to other international prevention goals.
- *Investing in targeted evaluation/operational research* on prevention activities. PEPFAR's ongoing implementation poses a tremendous current opportunity for such research to be undertaken, particularly where interventions are newly introduced and/or scaled up. This research should go beyond the analysis of data reported by countries.
- *Assessing the reach of prevention activities for women and girls*. OGAC's requirement that many of the prevention indicators be disaggregated by sex provides an important opportunity for tracking the reach of PEPFAR prevention activities to women and girls. Given the epidemic's increasing impact on women and girls globally and in the focus countries, such analyses promise to offer critical new information. PEPFAR's first annual report to Congress has begun to provide data on women reached.
- *Emphasizing prevention in non-focus countries*. Even though guidance on prevention indicators for non-focus countries will not be available until 2006 (midway through PEPFAR's authorization), it will be critical for OGAC and Congress not to lose sight of the importance of assessing prevention efforts in these countries. This is particularly urgent in the case of the second-wave nations of China, India, and Russia, where prevention today is critical for stemming the tide of the epidemic tomorrow.[26]
- *Working toward a global HIV prevention target across donors*. Finally, given concerns about the need for more global attention to HIV prevention, and in line with the principles of "Three Ones," OGAC should consider replicating the recent coordination of global antiretroviral treatment progress by WHO, UNAIDS, the U.S. government, and the Global Fund for global HIV prevention, working with these other donors toward identifying a shared prevention target, against which current global efforts could be measured over time. This could result in a joint donor assessment and statement of shared progress on prevention, similar to that announced for treatment in January. Such an effort could bring renewed

[26] See, for example, Jennifer G. Cooke, *The Second Wave of the HIV/AIDS Pandemic: China, India, Russia, Ethiopia, Nigeria* (Washington, D.C.: CSIS, December 2002).

energy and focus to the importance of HIV prevention to the global community.

Appendix

Table 1: PEPFAR Prevention Indicators: Program Level (Input & Output)

Program Input & Output Indicators	UNGASS	Global Fund Joint M&E Toolkit[1]	MDGs
Abstinence[2] and/or Being Faithful[3] (abstinence counts are subset of each indicator)			
1. Number of community outreach HIV/AIDS prevention programs that promote abstinence and/or being faithful			
2. Number of mass media HIV/AIDS prevention programs that promote abstinence and/or being faithful		x[4]	
3. Number of individuals reached with community outreach HIV/AIDS prevention programs that promote abstinence and/or being faithful			
4. Estimated number of individuals reached with mass media HIV/AIDS prevention programs that promote abstinence and/or being faithful			
5. Number of individuals trained to provide HIV/AIDS prevention programs that promote abstinence and/or being faithful		x	
Other Behavior Change[5]			
6. Number of community outreach HIV/AIDS prevention programs that are not focused on abstinence and/or being faithful			
7. Number of mass media HIV/AIDS prevention programs that are not focused on abstinence and/or being faithful		x[4]	
8. Number of individuals reached with community outreach HIV/AIDS prevention programs that are not focused on abstinence and/or being faithful			
9. Estimated number of individuals reached with mass media HIV/AIDS prevention programs that are not focused on abstinence and/or being faithful			
10. Number of individuals trained to provide HIV/AIDS prevention programs that are not focused on abstinence and/or being faithful		x	
11. Number of targeted condom service outlets		x	
12. Number of condoms purchased/shipped for social marketing campaigns[6]			

Program Input & Output Indicators	UNGASS	Global Fund Joint M&E Toolkit[7]	MDGs
13. Number of condoms sold/distributed through social marketing campaigns[6]		x	
Number of condoms sold/distributed through targeted outlets[6] (subset)		x	
Counseling and Testing[8]			
14. Number of service outlets providing counseling and testing		x	
15. Number of individuals who received counseling and testing		x	
16. Number of individuals trained in counseling and testing		x	
PMTCT[9]			
17. Number of service outlets providing the minimum package of PMTCT services		x	
18. Number of pregnant women provided with PMTCT services, including counseling and testing		x	
Number of pregnant women provided with a complete course of antiretroviral prophylaxis in a PMTCT setting (subset)	x	x	
19. Number of health workers newly trained or retrained in the provision of PMTCT services		x	
Medical Transmission/Blood Safety[10]			
20. Number of service outlets/programs carrying out blood safety activities		x	
21. Number of individuals trained in blood safety		x	
Medical Transmission/Injection Safety[11]			
22. Number of individuals trained in injection safety		x	
Laboratory Infrastructure[12]			
23. Number of laboratories with capacity to perform HIV tests			
24. Number of individuals trained in the provision of lab-related activities		x	

[1] The Global Fund M&E Toolkit specifies the importance of measuring training for assessing coverage, but does not specifically include training in indicator language.

[2] FROM OGAC: "Abstinence: activities or programs that promote the: Importance of abstinence in reducing the prevention of HIV transmission among unmarried individuals; Decision of unmarried individuals to delay sexual activity until marriage; Development of skills in unmarried individuals for practicing abstinence; and Adoption of social and community norms that support delaying sex until marriage and that denounce forced sexual activity among unmarried individuals. Activities and programs may include: mass media programs, including national and/or sub-national programs that involve radio and/or television addresses, and/or any other mass-scale dissemination of IEC and BCC messages to promote abstinence. Community outreach programs could include community mobilization, peer education, classroom, small group and/or one-on-one information, education, and communication (IEC) and behavior change communication (BCC) messages/programs to promote abstinence. The programs counted here are a

subset of Abstinence and/or Being Faithful totals."

[3] FROM OGAC: "Abstinence and Being Faithful: Activities or programs that promote abstinence combined with the: Importance of being faithful in reducing the transmission of HIV among individuals in long-term sexual partnerships; Elimination of casual sex and multiple sexual partnerships; Development of skills for sustaining marital fidelity; Adoption of social and community norms supportive of marital fidelity and partner reduction using strategies that respect and respond to local customs and norms; and Adoption of social and community norms that denounce forced sexual activity in marriage or long-term partnerships. Activities and programs may include: mass media programs, including national and/or sub-national programs that involve radio and/or television addresses, and/or any other mass-scale dissemination of IEC and BCC messages to promote abstinence and/or being faithful. Community outreach programs could include community mobilization, peer education, classroom, small group and/or one-on-one information, education, and communication (IEC) and behavior change communication (BCC) messages/programs to promote abstinence and/or being faithful. If program content primarily addresses being faithful messages (i.e., a program for married men) it would count here."

[4] FROM OGAC: "Includes other behavior change activities outside of those promoting abstinence and being faithful that are aimed at preventing HIV transmission. Could include mass media and targeted community outreach programs to promote avoidance of or reduction of HIV risk behaviors, community mobilization for HIV testing, and the social marketing and/or promotion of condoms. This includes work with high-risk groups such as intravenous drug users (IDUs), men who have sex with men (MSM), commercial sex workers (CSWs) and their clients, and people living with HIV and/or AIDS (PLWHA)."

[5] FROM OGAC: "Includes other behavior change activities outside of those promoting abstinence and being faithful that are aimed at preventing HIV transmission. Could include mass media and targeted community outreach programs to promote avoidance of or reduction of HIV risk behaviors, community mobilization for HIV testing, and the social marketing and/or promotion of condoms. This includes work with high-risk groups such as intravenous drug users (IDUs), men who have sex with men (MSM), commercial sex workers (CSWs) and their clients, and people living with HIV and/or AIDS (PLWHA)."

[6] Collected by USAID, not focus countries.

[7] The Global Fund M&E Toolkit specifies the importance of measuring training for assessing coverage, but does not specifically include training in indicator language.

[8] FROM OGAC: "Activities in which both HIV counseling and testing are provided for those who want to know their HIV status (as in traditional VCT) or as indicated in other contexts (e.g., STI clinics or TB centers, where HIV diagnosis is confirmed). Counseling and testing in the context of PMTCT is coded under PMTCT."

[9] FROM OGAC: "Activities aimed at providing the minimum package of services for preventing mother-to-child transmission including: counseling and testing for pregnant women; ARV prophylaxis to prevent MTCT; counseling and support for safe infant feeding practices; family planning counseling or referral."

[10] FROM OGAC: "Activities supporting a national coordinated blood program that includes policies, infrastructure, equipment, and supplies; donor recruitment activities; blood collection, distribution/supply chain/logistics, testing, screening, and transfusion; waste management; training; and management to ensure a safe and adequate blood supply."

[11] FROM OGAC: "Policies, training, waste management systems, advocacy, and other activities to promote (medical) injection safety, including distribution/supply chain/logistics, cost, and appropriate disposal of injection equipment, and other related equipment and supplies."

[12] FROM OGAC: "Development and strengthening of laboratory facilities to support HIV/AIDS-related activities, including the purchase of equipment and/or commodities, the provision of quality assurance, staff training, and other technical assistance."

Table 2: PEPFAR Prevention Indicators: National Level (Outcome and Impact)

National Outcome Indicators[1]	UNGASS	Global Fund Joint M&E Toolkit	MDGs
1. Percent of young people aged 15–24 who both correctly identify ways of preventing the sexual transmission of HIV and who reject major misconceptions about HIV transmission	X	X	X
2. Percent of never-married young people aged 15–24 who have never had sex			
3. Percent of never-married women and men aged 15–24 who had sex in the last 12 months, of all never-married women and men (aged 15–24) surveyed			
4. Percent of women and men aged 15–49 who had sex with more than one partner in the last 12 months			
5. Percent of women and men aged 15–49 who say they used a condom the last time they had sex with a non-marital, non-cohabiting partner, of those who have had sex with such a partner in the last 12 months	X[2]	X[2]	X[2]
6. Percent of men reporting sex with a sex worker in the last 12 months who used a condom during last paid intercourse			
7. Percent of blood units transfused in the last 12 months that have been adequately screened for HIV according to national or WHO guidelines		X	
8. Average number of medical injections per person per year			
9. Proportion of women and men age 15-49 reporting that the last health care injection was given with a syringe and needle set from a new, unopened package			
10. Percent of HIV-infected pregnant women receiving a complete course of antiretroviral prophylaxis to reduce the risk of MTCT	X	X	
11. Percent of the general population aged 15–49 receiving HIV test results in the last 12 months		X	
12. Percent of patients with STIs at health care facilities who are appropriately diagnosed, treated and counseled (recommended only, not required)	X	X	
National Impact Indicators			
13. Percent of young people aged 15–24 that are HIV infected	X		X[3]
14. Percent of HIV-infected infants born to HIV-infected mothers	X		

[1] In many cases, these indicators are drawn or adapted from other international tools and guidelines, other than the three examined here.

[2] Indicator tracks for 15-24 year olds.

[3] Indicator tracks for 15–24 year-old pregnant women as method for estimating adult prevalence.

Table 3: Select Prevention Indicator Data for 15 Focus Countries, FY 2004

Indicator	Results[1]
Number of community outreach HIV/AIDS prevention programs that promote abstinence and/or being faithful	1,032
Number of community outreach HIV/AIDS prevention programs that promote abstinence (subset)	*184*
Number of mass media HIV/AIDS prevention programs that promote abstinence and/or being faithful	135
Number of mass media HIV/AIDS prevention programs that promote abstinence (subset)	*25*
Number of individuals reached with community outreach HIV/AIDS prevention programs that promote abstinence and/or being faithful	24,041,800
Number of individuals reached with community outreach HIV/AIDS prevention programs that promote abstinence (subset)	*11,530,400*
Estimated number of individuals reached with mass media HIV/AIDS prevention programs that promote abstinence and/or being faithful	120,073,400
Estimated number of individuals reached with mass media HIV/AIDS prevention programs that promote abstinence (subset)	*32,154,400*
Number of individuals trained to provide HIV/AIDS prevention programs that promote abstinence and/or being faithful	116,600
Number of individuals trained to provide HIV/AIDS prevention programs that promote abstinence (subset)	*79,580*
Number of community outreach HIV/AIDS prevention programs that are not focused on abstinence and/or being faithful	498
Number of mass media HIV/AIDS prevention programs that are not focused on abstinence and/or being faithful	155
Number of individuals reached with community outreach HIV/AIDS prevention programs that are not focused on abstinence and/or being faithful	11,899,900
Estimated number of individuals reached with mass media HIV/AIDS prevention programs that are not focused on abstinence and/or being faithful	76,620,600
Number of individuals trained to provide HIV/AIDS prevention programs that are not focused on abstinence and/or being faithful	51,205
Number of service outlets providing counseling and testing	2,126
Number of individuals who received counseling and testing	1,791,900
Number of individuals trained in counseling and testing	14,089
Number of service outlets providing the minimum package of PMTCT services	2,154
Number of pregnant women provided with PMTCT services, including counseling and testing	1,271,300
Number of health workers newly trained or retrained in the provision of PMTCT services	23,500
Number of service outlets/programs carrying out blood safety activities	249
Number of individuals trained in blood safety	2,184
Number of individuals trained in injection safety	4,343

[1] Data in the PEPFAR Annual Report to Congress are rounded to the nearest 100; data used here are not rounded. Abstinence data are subsets of abstinence and faithfulness data.