Community-Based Indicators for HIV Programs

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MEASURE Evaluation

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OVERVIEW

Information from community-based health programs is important for understanding what HIV programs are doing to test, treat, and retain in care people who are living with HIV. However, until now there has been no centralized registry of community-based indicators to inform HIV programming at the community level.

To address the need for standardized monitoring and evaluation at the community level, MEASURE Evaluation developed this collection of community-based indicators for HIV programs. The collection includes detailed indicator definitions and reference details, examples of data use for selected indicators, links to additional resources, and a means to feedback and make recommendations. This collection organizes indicators into five categories: Vulnerable Children, Prevention of Mother-to-Child Transmission, Key Populations, HIV Prevention, and Home-Based Care.

Use of validated indicators allows programs to measure if the beneficiaries of community programs are being assessed and tested, are receiving needed services, and if people living with HIV are adhering to treatment. Use of indicators also increases the likelihood that programs *are* monitored and that, therefore, more community data is reported into health information systems where they may be used to inform program, management, and service delivery decisions.

Background and Methods

In 2017 and 2018, MEASURE Evaluation mapped HIV community-based data elements—for vulnerable children, key populations, prevention of mother-to-child transmission, and prevention and outreach programs—to develop indicators for community-based HIV programs.

MEASURE Evaluation gathered data collection tools from implementing and governmental partners in Nigeria, Ethiopia, South Africa, Uganda, Kenya, Côte d'Ivoire, the Democratic Republic of the Congo, and Botswana to

see what measures they use to monitor and evaluate HIV prevention, care, and treatment programs at the community level.

We examined registers, home visit and household data collection sheets, referral forms, and checklists, and recorded all data elements in Excel—by country or by source and the number of tools that included each data element. We then chose the most commonly collected data elements and sent them to those partners who had originally shared resources for feedback.

The vetted data elements were then transformed into indicators, and we conducted research to inform the definition for each. We integrated further feedback from content experts at MEASURE Evaluation into the indicator definitions. Click on the Summary List of Indicators to see the collection.

Purpose of this Collection

Community-based HIV programs or program components are usually implemented by government or nongovernmental agencies in HIV prevention or treatment interventions at the household and individual levels. Many community-based programs provide services intended to mitigate the effects of HIV and AIDS, such as those for HIV prevention, HIV care and treatment, and services for vulnerable children and their families.

The programs typically use trained community health workers to reach the general population, key populations (sex workers, transgender people, men who have sex with men, and people who inject drugs), or vulnerable children and their families. Often the key collectors of HIV information, community workers can include volunteer or paid community health extension or outreach workers, as well as agents, promoters, or distributors, traditional birth attendants or midwives, and social service or case management workers. They are often members of the communities that they support, selected by and held accountable to these communities. These health workers provide services and collect data outside the formal health sector to meet critical service delivery gaps in addressing the HIV epidemic.

Yet, many low-resource community settings do not have the guidance and tools to develop a set of core, standardized indicators to evaluate program performance. What is more typical is that countries and programs collect large quantities of information on HIV from the community level, chiefly for required reporting to their donors. They often collect these data without proper mechanisms to ensure the information is used to enhance decision making and system performance.

Community-based information systems (CBIS) collect, analyze, report, and use community-focused HIV or related social welfare information generated outside health facilities. These systems can be used to inform HIV programming and policy, direct services to populations in need, monitor the continuum of care, and address equity and access issues.

Countries and programs can use this collection of community-based indicators for HIV programs to standardize their information-generation processes and ensure that they collect the essential information to inform community-based HIV programming.

Access a printable version of this overview.

The online version of the Community-Based Indicators for HIV Programs collection is available at https://www.measureevaluation.org/community-based-indicators.

SUMMARY LIST

The indicators in this collection are categorized by areas of community-based HIV project implementation: Vulnerable Children (VC), Prevention of Mother-to-Child Transmission (PMTCT), Key Populations (KP), HIV Prevention (HIV PREV), and Home-Based Care (HBC). Click on any indicator to below see its definition, including how to use the indicator, the method of measurement, levels of disaggregation, data sources, data quality considerations, and more.

	Title	Categories
1	Number of beneficiaries served by vulnerable children programs	VC
2	Number of births to HIV-positive women attended by skilled health personnel	PMTCT, HIV PREV
3	Number of HIV-exposed infants receiving a virological test for HIV within two months of birth	VC, PMTCT, HIV PREV
4	Number of HIV-exposed infants with acute malnutrition at 12 months of age	VC
5	Number of HIV-exposed infants who are exclusively breastfed at three months of age	PMTCT, HIV PREV, VC

	Title	Categories
6	Number of HIV-positive pregnant women who received antenatal care at least four times prior to delivery	PMTCT, HIV PREV
7	Number of HIV-positive women who received antiretroviral therapy during pregnancy	HIV PREV, PMTCT
8	Number of people currently on antiretroviral therapy	KP, HBC, PMTCT, VC
9	Number of people identified to have experienced sexual, physical, or emotional violence	VC, HBC, PMTCT, KP, HIV PREV
10	Number of people known to be on treatment 12 months after initiation of antiretroviral therapy	VC, PMTCT, HIV PREV, KP
11	Number of people living with HIV who know their status	VC, PMTCT, HBC, KP
12	Number of people living with or affected by HIV provided with spiritual or psychosocial support services	KP, HBC, HIV PREV, VC
13	Number of people of reproductive age currently using a modern family planning method	KP, HIV PREV, VC
14	Number of people provided with socioeconomic strengthening services	VC, HIV PREV, KP
15	Number of people provided with referrals for services in the past three months	HBC, PMTCT, HIV PREV, KP, VC
16	Number of people provided with completed referrals for services in the past three months	HBC, PMTCT, HIV PREV, KP, VC
17	Number of people reached with individual or small group level community HIV-prevention interventions	VC, HBC, PMTCT, KP, HIV PREV

	Title	Categories
18	Number of people testing positive for tuberculosis who adhere to treatment	KP, PMTCT, HBC, VC
19	Number of people who accessed legal counsel, protection, or post-violence services	VC, HIV PREV, KP
20	Number of people who received sexually transmitted infection screening and treatment	KP, HIV PREV, VC
21	Number of people who report the use of a condom at last sex	KP, HIV PREV
22	Number of people who were nutritionally assessed and received nutrition counseling and therapeutic or supplementary food	VC, PMTCT, HBC, KP
23	Number of people who were tested for HIV and received their results	VC, PMTCT, HBC, KP
24	Number of vulnerable children who are fully immunized	VC
25	Number of vulnerable children living with HIV	VC
26	Number of vulnerable children regularly attending school	VC
27	Number of vulnerable children provided with educational support services	HBC, KP, VC, HIV PREV

INDICATORS

Number of people who were tested for HIV and received their results

How to use this indicator

This indicator monitors trends in the use of HIV testing and counseling services within a community, regardless of the location of testing, testing source, or population type. Monitoring this indicator at the community level can provide insight into populations vulnerable to or living with HIV that are not being reached by services at the facility level because of difficulties associated with access. Disaggregation for this indicator exposes the equity or lack thereof of HIV counseling and testing service access and uptake. These data allow an understanding of the number of people in a community that have accessed HIV testing services and know their status and the effectiveness of community-based interventions in linking people to testing. This information also gives community HIV program insight into resource needs, if the programs provide community-based HIV testing services, or whether they should increase efforts to motivate beneficiaries to come to testing. Although facility-based testing typically yields more HIV-positive test results, community-based testing has a positive association with retrieving people testing for the first time and adults with CD4 counts more than 350 cells/mm^3. Because combined facility and community-based testing approaches tend to increase HIV testing and counselling coverage, multiple approaches are recommended, including standalone sites, home-based testing, mobile outreach, and multi-disease campaigns.

Numerator

Number of adults and children who accessed HIV testing services and received their HIV test results during the reporting period

Unit of measure

Number

Calculation

Sum results across reporting period

Method of measurement

Data for the indicator are gathered by counting the total number of adults and children who received HIV testing services and know their test results, regardless of the source of testing (facility or community level). As part of case management, community workers should ask beneficiaries this question to assess whether those living with, or vulnerable to, HIV have been tested, are aware of their status, so that they are able to protect themselves and others and seek treatment if they tested positive.

This indicator specifically tracks HIV testing from any source, and not HIV status. If a project beneficiary has received HIV testing, regardless of source or age, they should be counted towards this indicator. HIV testing of HIV-exposed infants, however, should be counted under the early infant diagnosis indicator (see definition here).

HIV diagnosis should be confirmed per country guidelines. HIV rapid testing must be confirmed with a second test prior to enrollment in care or initiating ART. However, any person who was tested and is aware of his or her HIV serostatus should be counted for this indicator. Verification tests should be conducted prior to initiation on ART, but these tests should not be counted towards this indicator. HIV counseling and testing should adhere to WHO guidelines of informed consent, confidentiality, correct test results, and connection (linkage to care, treatment, and other services).

A mandate to do no harm must be the absolute priority whenever community programs engage in data collection and reporting of HIV status. All data must be managed with confidentiality to ensure that the identities of people living with HIV (and their key population status as applicable) are protected, to prevent stigma and discrimination. Confidentiality must be maintained especially when mapping those living with HIV. Codes and unique identifiers are recommended to protect identities, and to account for retesting and avoid double counting if electronic systems are available. Community workers should engage with utmost caution in collecting, managing, and reporting this information and should ensure confidentiality of files.

Data source

Data for this indicator are frequently collected through tools used at the community level by community workers engaged in vulnerable children (VC), key population (KP), and HIV programs. HIV testing information is collected through VC tools at the community level to report provision of comprehensive family care of households supported. Health workers regularly monitor the HIV status of the adults and children of each supported household using HIV risk assessment tools, vulnerable household summary forms, and graduation checklists.

For key population programs, this information is also frequently collected in tools such as HIV testing outreach registers and behavior-change communication activity forms. Other HIV programs typically include HIV testing in forms like HIV counseling and testing client cards, client profiles, antenatal and postnatal client appointment diaries, and family folders.

Disaggregation

- Age (<1 year, 1–4 years, 5–9 years, 10–14 years, and 15–19 years for children; 20–24 years, 25–49 years, and 50+ years for adults)
- Sex
- Pregnancy/lactation status
- Key population type (sex workers, transgender people, men who have sex with men, people who inject drugs)
- HIV testing service modality
    - Community—index, mobile, VCT, other community testing platform
    - Facility index, STI, inpatient, emergency, voluntary medical male circumcision (VMMC), voluntary counseling and testing (VCT), tuberculosis (TB), prevention of mother-to-child transmission (PMTCT), pediatric, malnutrition, other
    - Presence of partner (live-in commercial/noncommercial)

Service delivery modalities that apply specifically to the community level are detailed below. A community worker can track community-based testing specifically, by tracking the number of people tested in locations other than facilities. Community workers that cannot provide testing should refer people for facility-based testing and return later to guarantee uptake of testing services and receipt of test results—in which case they can be counted towards this indicator.

Community-based service delivery modalities:

- Community index case testing: method of testing members of social and sexual networks of people living with HIV at high risk of HIV transmission at the community level. This method can be implemented using incentivized case finding, peer-driven outreach, and partner notification services,

which means using this method to identify people for testing in the community, even if they were tested at a facility.

- Home-based testing: testing done at the household during home visits or door-to-door testing
- Mobile testing: temporary testing locations excluding VMMC
- VCT: drop-in center, wellness clinic where HIV testing is provided, site designated for key populations
- Other community platforms: ad hoc testing campaign and VC testing

If a person occupies more than one category of a key population, this information should be reported by the community worker.

The following information is recommended for data collection by community workers:

- Retesting status for HIV-positive diagnosis
- HIV test results
- Date of HIV test
- Receipt of HIV test results
- Previously tested during the reporting period
- Demographics: unique patient identifier, sex, name, age at the time of testing
- Date person tested positive and was referred to treatment
- Community service delivery modality information: name and location

Data quality considerations

The overall number reported for this indicator should be equal to the sum of the numbers of people in each disaggregation type. Recommendations call for only one type of age disaggregation to be used throughout, overlap to be avoided, and service delivery modalities be made mutually exclusive.

Note that people who have been tested and are aware of their status should only be counted once within the allotted time frame, though they may have been tested numerous times or tracked by facility and community workers. Double counting can be avoided by categorizing data by source, the community versus the facility levels, in a centralized database if community data is integrated into the national health information system. Unique patient identifiers can also track patients through the continuum of care. Note that the number of *tests* administered should not be counted towards this indicator, but rather the number of *people* tested.

Reporting frequency

Community workers should collect this information regularly, but they should monitor progress monthly with support from their supervisors. The indicator should be reported on a quarterly basis.

Data element

HIV testing

Category

Key Populations, Vulnerable Children, Home-Based Care, Prevention of Mother-to-Child Transmission

Data use case

To see a data use example for this indicator, please click below.

HIV Testing for Vulnerable Children and Their Families in Côte d'Ivoire

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The United States President's Emergency Plan for AIDS Relief. (2018). *Monitoring, evaluation, and reporting (MER 2.0) indicator reference guide updated release* (Version 2.2). Washington, DC: PEPFAR. Retrieved from https://www.pepfar.gov/documents/organization/274919.pdf

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Number of people living with HIV who know their status

How to use this indicator

This indicator aligns with the first of the United Nations' 95-95-95 targets. By 2030, UN has established the revised target that 95% of people living with HIV know their HIV status. It is essential for people living with HIV to be aware of their HIV status so that they can protect themselves and others and access treatment. This indicator is connected to HIV testing because access to testing services is a mechanism by which people living with HIV become aware of their status, receive verified diagnosis, and are linked to appropriate care and treatment services. (See the HIV testing indicator here.) Around 30 percent of people living with HIV are unaware of their serostatus. Testing is essential to ensure these people receive counselling and are linked to appropriate HIV and other clinical support services. Laboratory services must also be coordinated to ensure delivery of correct results. Knowing one's HIV status affects uptake of and compliance with antiretroviral therapies. Community interventions that involve HIV counseling and testing that are integrated into HIV-prevention packages have been shown to increase knowledge of HIV status. This indicator allows community-based programs to understand the epidemic in their communities and locate people living with HIV to provide with, or refer to, care and social services.

Numerator

Number of adults and children living with HIV who know their HIV status

Unit of measure

Number

Calculation

Sum results across reporting period

Method of measurement

At the community level, this indicator can be determined by asking beneficiaries if they know their HIV serostatus. Similar to the structure of a population-based survey, the eligible people in the household are asked whether they have been tested for HIV and (if they respond, yes) the results of their last test. The indicator would be based on the number who responded that they had been diagnosed with HIV when asked during the reporting period.

People who have never been tested for HIV can be presumed not to know their HIV status. This indicator should reveal the number of people living with HIV who have ever been tested and received their results. This indicator should not be confused with HIV diagnosis, because people may have self-tested HIV-positive.

Although questions related to HIV status are typically asked of people of reproductive age (15–49), community workers should abide by national disclosure guidelines when discussing HIV status directly with children below the age of 15. If children are younger than nine years old and HIV-positive, caregivers rarely inform them of their own HIV serostatus. Disclosure of a child's HIV status to the child has been shown to lead to positive health outcomes for the child, such as better treatment adherence and slower disease progression. It is recommended that all adolescents be made aware of their status and that this policy be considered for school-age children as well. Community workers should engage with care when discussing HIV status with those under the age of 18 and should refer to the caregiver for information in private if the child is unaware. It is important to prepare and counsel caregivers for the emotional impact of disclosure.

A mandate to do no harm must be the absolute priority whenever community programs engage in data collection and reporting of HIV status. All data must be managed with confidentiality to ensure that the identities of people living with HIV (and their key population status as applicable) are protected, to prevent stigma and discrimination. Confidentiality must be maintained, especially when mapping those living with HIV. Codes and unique identifiers are recommended to protect identities, and to account for retesting and avoid double counting if electronic systems are available. Community workers should engage with utmost caution in collecting, managing, and reporting this information and should ensure files remain confidential.

Data source

This indicator is tracked by vulnerable children programs in service provision, comprehensive family care, vulnerability assessment, risk assessment, enrollment, and follow-up forms. Community workers gather information on the HIV status of both children and the adults in the household. Key population programs typically determine the HIV status of participants in their behavior change communication and outreach activities. Other HIV programs collect the information necessary to profile members of the household through community family folders.

Disaggregation

- Age (5–9 years, 10–14 years, and 15–19 years for children; 20–24 years, 25–49 years, and 50+ years for adults)
- Sex
- Pregnancy/lactation status
- Key population type (sex workers, transgender people, men who have sex with men, people who inject drugs)

Data quality considerations

The overall number reported for this indicator should be equal to the sum of the numbers of people in each disaggregation type. Only one type of age disaggregation should be used throughout, and overlap should be avoided.

Reporting frequency

Community workers should collect this information regularly but should monitor progress monthly with support from their supervisors. The indicator should be reported on a semiannual basis.

Data element

HIV status

Category

Vulnerable Children, Key Populations, Prevention of Mother-to-Child Transmission, Home-Based Care

References

The United States President's Emergency Plan for AIDS Relief (PEPFAR). (2018). *Monitoring, evaluation, and reporting (MER 2.0) indicator reference guide updated release* (Version 2.2). Washington, DC: PEPFAR. Retrieved from https://www.pepfar.gov/documents/organization/274919.pdf

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Number of people who were nutritionally assessed and received nutrition counseling and therapeutic or supplementary food

How to use this indicator

This indicator can used by vulnerable children (VC), key population (KP), and HIV programs to track nutritional support provided to those vulnerable to, affected by, or who test positive for HIV. Nutritional assessment from anthropometric measurement provides the necessary information to identify those at higher risk of mortality and for whom nutrition counseling and therapeutic or supplementary feeding support is required. These data provide information on the nutritional status of people living with and at risk of acquiring HIV and should inform strategies to address nutritional care and support needs.

Although this indicator is typically reported solely for people living with HIV, it is essential for programs to consider those affected by HIV as well for nutritional assessment and support. This indicator is also typically split into three separate indicators: nutrition assessment, nutrition counseling, and provision of therapeutic or supplementary food. Although this indicator requires tracking all the above information, combining it into one indicator helps ensure adequate nutrition support service provision to those identified as malnourished.

Nutritional assessment is an essential component of care and treatment for HIV-infected and affected people; it allows monitoring of individual nutritional status and enables health workers to understand dietary habits, nutritional problems, and gauge progress. All assessments should be followed by nutrition counseling. Both should occur regularly to ensure that beneficiaries are aware of feasible dietary actions to maintain the nutritional status of themselves and their families. Nutritional status is of particular importance for those living with HIV and on treatment, because some antiretrovirals should be taken with food and others do not metabolize as well with food. The WHO recommendations state that optimal ART requires a balanced diet and good nutrition to ensure effect. Therapeutic food should be provided to those found to be severely malnourished, and supplementary food products should be provided for those found to be moderately

malnourished. Programs should track provision of food products to detail scale and coverage of food security services.

Numerator

Number of people who received a nutritional assessment, nutritional counseling, and therapeutic or supplementary food, based on their level of malnutrition (moderate or severe), at any point during the reporting period

Note: Number of households is alternative language for this indicator, especially for vulnerable children programs, but tracking the number of people is ideal given the potential for variation of nutritional intake among the various members in each household (e.g., boy infants being fed more food than girl infants).

Unit of measure

Number

Calculation

Sum results across reporting period

Method of measurement

To be counted for this indicator, beneficiaries must have received a nutrition assessment, followed by nutrition counseling, and then provided with therapeutic or supplementary food. Every person who received these three services at least once during the reporting period should be counted.

For those who are not pregnant, or who are within six months postpartum and above the age of 18, BMI is the suggested method of anthropometric measurement, which is calculated by dividing weight in kilograms by height in meters squared (BMI= kg/m2). For children ages 5–18 who are not pregnant, BMI-for-age z-score is the recommended method.

Measuring middle-upper arm circumference of the left upper arm (MUAC), is recommended for children ages 6–59 months. (See the related indicator here for more information on calculating MUAC.) MUAC can also be used to assess pregnant and lactating women (up to six months) and people who are not pregnant (or are postpartum) whose height and weight cannot be measured (because equipment is not available or the person cannot stand). Equipment necessary for measurement may include MUAC measurement tapes, stadiometers/height-measuring devices, and recumbent length devices.

It is recommended that community workers be equipped with MUAC tapes, ready-to-use therapeutic foods (RUTF), and scales. Community workers should refer moderately malnourished children, lactating mothers with infants under six months of age with middle-upper arm circumference less than 21 cm, and pregnant women with middle-upper arm circumference less than 21 cm to link them to an appropriate supplementary feeding program for screening and treatment before medical complications arise.

If a community worker is unable to conduct the nutrition assessment, counseling, and/or provide food, they can ask this question directly to determine the number of people in the household who received the three components from another source, when they follow-up post-referral to ensure completed referral. Referrals should not be counted in this indicator, because it measures service uptake.

Note that an alternative for MUAC, if a community worker does not have adequate tools or training, is the adapted FANTA hunger scale from the MEASURE Evaluation Orphans and vulnerable children (OVC) toolkit. With consent from the caregiver, a community worker can ask the caregiver the following questions in relation to their children ages 0–9, and directly to a child age 10 or above, to assess food security, following

consent of the caregiver. This is an indicator of nutritional status and a step in the theory of change for malnutrition.

1	**In the past four weeks, did you have to eat a smaller meal than you felt you needed because there was not enough food?**	**Yes** **No**	**1** **2**	**If No: 3**
2	**If yes –** How many times did this happen? **Read out responses.**	Rarely (1–2 times in past 4 weeks) Sometimes (3–10 times in past 4 weeks) Often (more than 10 times in past 4 weeks)	1 2 3	
3	In the past four weeks, did you have to skip a meal because there was not enough food?	Yes No	1 2	**If No: 5**
4	**If yes –** How many times did this happen? **Read out responses.**	Rarely (1–2 times in past 4 weeks) Sometimes (3–10 times in past 4 weeks) Often (more than 10 times in past 4 weeks)	1 2 3	
5	In the past four weeks did you go to sleep at night hungry because there was not enough food to eat?	Yes No	1 2	**If No: 7**
6	**If yes –** How many times did this happen? **Read out responses.**	Rarely (1–2 times in past 4 weeks) Sometimes (3–10 times in past 4 weeks) Often (more than 10 times in past 4 weeks)	1 2 3	
7	In the past four weeks did you go a whole day and night without eating anything because there was not enough food to eat?	Yes No	1 2	**If No: 9**
8	**If yes –** How many times did this happen? **Read out responses.**	Rarely (1–2 times in past 4 weeks) Sometimes (3–10 times in past 4 weeks)	1 2	

		Often (more than 10 times in past 4 weeks)	3	

Data source

These data are often found in one of the following forms: OVC program child/adult status, vulnerable child, and service provision tools which track nutrition and growth scores, nutrition and growth status, and whether food and nutrition services were received by OVC and their families. Community workers are asked to complete this information at the household level as they conduct case management, but they use forms that also track referrals and follow-ups required for nutrition education, counseling, and food. Key population programs usually track nutritional information, counseling, and support provided during behavior change communication and outreach activities and corresponding forms. HIV programs collect information on the number of people living with HIV (including pregnant women) provided with nutritional assessments, nutritional counseling, nutritional services, and referral for malnutrition.
Data source

Disaggregation

- Age (<1 year, 1–4 years, 5–9 years, 10–14 years, and 15–19 years for children; 20–24 years, 25–49 years, and 50+ years for adults)
- Sex
- Pregnancy/lactation status
- Key population type (sex workers, transgender people, men who have sex with men, people who inject drugs)
- Service delivery modality
- Nutritional status (severe acute malnutrition [SAM], moderate acute malnutrition [MAM])
- HIV status

Data quality considerations

This indicator, by itself, cannot track coverage of nutrition assessment and counseling, but it supports better understanding of coverage of all three services. Additionally, this indicator does not track the quality of assessment and counseling provided. Quality assurance and supportive supervision strategies should be put in place at the community level to ensure quality provision of these services. It is recommended that the country provide guidelines on the advised anthropometric measurements, by age and demographic, to be implemented universally throughout the country, to ensure comparability of data between programs. This indicator does not incorporate the impact of food support, quality of the foods, duration of food support, or adherence or dropout rates of food programs. The overall number reported for this indicator should be equal to the sum of the numbers of people in each disaggregation type. Only one type of age disaggregation should be used throughout, and overlap should be avoided.

Reporting frequency

Community workers should collect this information regularly, but they should monitor progress monthly with support from their supervisors. The indicator should be reported on a semiannual basis.

Data element

Nutritional assessment, counseling, and food received

Category

Vulnerable Children, Home-Based Care, Key Populations, Prevention of Mother-to-Child Transmission

Related content

CORE Group Essential Nutrition Actions

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Number of HIV-exposed infants with acute malnutrition at 12 months of age

How to use this indicator

Twelve months of age is a critical point in an infant's development. Malnutrition can be caused by inadequate nutrition and/or management of infection. This indicator tracks the number of infants who are acutely malnourished, demonstrated by their mid-upper arm circumference (MUAC) at 12 months of age. This is a critical time to establish the nutritional status of infants, because it is when most mothers transition from breastfeeding to replacement and complementary feeding. As a result, infants are at greater risk of growth faltering and childhood infection at this age. Community workers can use this information to support mothers, helping them ensure the nutrition and growth of their infants. Anthropometric data can inform community-based strategies to intervene with nutrition care and support services or HIV testing and treatment, in the event of growth faltering and infection or extreme wasting. Community supervisors can use this data to determine whether nutritional care and support programs are effective and the extent of malnutrition among infants of patients receiving prevention of mother-to-child transmission services. Monitoring the child's growth status at this age can confirm whether he or she should be admitted into a supplementary feeding program. Locating households where HIV-exposed infants are malnourished can assist in decision making regarding geographic targeting for planning care and support to address needs.

Numerator

Number of HIV-exposed infants who have a MUAC reading in the yellow, orange, or red categories

Unit of measure

Number

Calculation

Sum results across reporting period

Method of measurement

MUAC, or middle-upper arm circumference of the left upper arm, assesses nutrition status and is measured at the midpoint between the shoulder and the tip of the elbow. Community workers need minimal training to conduct the measurement; it requires little equipment and is easy to perform. This method for measuring malnutrition has been shown to be less susceptible to errors than other methods for active case finding. This measurement can be used for children between the ages of six and fifty-nine months; it can also measure acute energy deficiency among famished adults.

To measure MUAC, a flexible measuring tape should be wrapped around the middle-upper arm between the shoulder and the elbow. The child's left arm should be bent and loosely hanging. A string can be used to find the midpoint between the shoulder and the tip of the elbow. The MUAC tapes are often supplied from The United Nations Children's Fund (UNICEF) directly; one version is numbered, and the other is colored. For the numbered tapes, the end of the tape should be placed down through the first opening and up through the third opening. The measurement is read through the middle window where the arrows point.

On the colored version, the colors on the tape indicate the level of malnutrition, and different tapes use different readings and colors (green/yellow/orange/red versus green/yellow/red). The tape is placed down through the first opening and then through the second opening, and the reading is provided through the window where the arrows point. Regardless of the tape used, green signifies that the child is well nourished, and red signifies that the child is suffering from severe acute malnutrition. The yellow in the three-colored tape signifies moderate acute malnutrition. In the tape with the four-color scale, orange signifies moderate acute malnutrition, and yellow means that the child is at risk of acute malnutrition and should be counseled on growth promotion and monitoring.

These data can be collected by an appropriately trained community worker, but they should be collected when an infant is brought to the 12-month follow-up visit at a health facility, and results should be recorded on the child's health card. The HIV-exposed child will also be tested at this time, if not already confirmed HIV-positive. Therefore, it is essential for community workers to motivate HIV-positive mothers to bring their infants for this visit, if there are insufficient resources for community workers to conduct the measurement in the field. To track this information at the community level, community workers can ask to see the child's health card, or they can ask the caregiver for this information after the visit or referral.

Data must be treated with utmost care; identification of HIV-exposed infants versus non-exposed infants can lead to discrimination and stigma, both against the HIV-exposed infant and his or her mother.

Disaggregation

- Sex
- HIV status

Data quality considerations

This indicator is often underreported because it is difficult to capture all children who have been exposed to HIV whose exposure status is unknown. It is recommended that community workers be trained how to conduct MUAC, so they can collect these data at the community level. The overall number reported for this indicator should be equal to the sum of the numbers of people in each disaggregation type. Only one type of age disaggregation should be used throughout, and overlap should be avoided.

Reporting frequency

Community workers should collect this information regularly and monitor progress monthly with support from their supervisors. The indicator should be reported on a regular basis as required by national guidelines (monthly, quarterly, semiannually, or annually).

Data element

HIV-exposed infant nutritional status

Category

Vulnerable Children

Additional resources

UNICEF MUAC Lesson

Mother and Child Nutrition MUAC Details

References

The United Nations Children's Fund. (2005). HIV and Infant Feeding. Retrieved from https://www.unicef.org/nutrition/index_24827.html

The United Nations Children's Fund. (2016, August 22). HIV and nutrition. Retrieved from https://www.unicef.org/nutrition/index_HIV.html

MUAC Tape - Mid-Upper Arm Circumference [MUAC] - Mother, Infant and Young Child Nutrition & Malnutrition - Feeding practices including micronutrient deficiencies prevention, control of wasting, stunting and underweight. (n.d.). Retrieved from http://motherchildnutrition.org/early-malnutrition-detection/detection-referral-children-with-acute-malnutrition/muac.htm

The United Nations Children's Fund. (n.d.). Lesson list Assessment Mini-lesson 3.1.3. Retrieved from https://www.unicef.org/nutrition/training/3.1.3/6.html

Number of people reached with individual or small group level community HIV-prevention interventions

How to use this indicator

HIV prevention interventions at the community level are designed to improve HIV-related knowledge and decrease risk behaviors. These interventions can change HIV-related knowledge and attitudes and reduce sexual risk-taking behaviors, especially if the behaviors are relevant to the specific health problems and the interventions have beneficial outcomes for the populations targeted. This indicator derives from the PEPFAR indicator KP_PREV but extends beyond key populations to include vulnerable children, their families, and others vulnerable to HIV (i.e., adolescents and pregnant and lactating women). These data provide information on the total number of people that have received individual-level and/or small group interventions during the reporting period. This indicator does not track HIV testing services or referral to HIV testing services, because these two data elements were crafted into distinct indicators in this collection (see HIV testing here and referral to HIV testing here) and are essential, distinct components that HIV programs incorporating community approaches must monitor.

This indicator tracks people who are HIV-positive and negative who have received at least one of the prevention activities listed below, at the community level. The goals of prevention activities are to keep HIV-positive people mentally and physically healthy; prevent further transmission of HIV; and involve people living with HIV in prevention, leadership, and advocacy activities.

Prevention Interventions can include, but are not limited to the following:

- Targeted information, education, and communication
- Outreach
- Empowerment
- Condoms, lubricant accompanying individual/group counseling/sensitization activities
- HIV risk reduction support
- Behavior change communication messaging (sketch, play, film, chat, or interview)

Numerator

Number of adults and children provided with any individual and/or small group-level HIV-prevention intervention designed for the target population at the community level

Note: Number of households is alternative language for this indicator, especially for OVC programs, although tracking the number of people is ideal given the potential for variation of targeted messaging required to address needs of the various members in each household (e.g., adolescent-friendly messaging).

Unit of measure

Number

Calculation

Sum results across reporting period

Method of measurement

This indicator tracks the number of people who have received any kind of individual or small group prevention intervention at the community level. It should exclude people who have received a pamphlet or flyer during outreach activities, unless they also received counseling or targeted information, education, and communication. This indicator should include people who have received counseling from a community worker at a household as well as community sensitization activities provided by community-based organizations, or even health providers, if the activity occurred outside of the facility level. Although referrals are often made after sensitization or outreach activities, referrals for HIV testing and other services should not be counted towards this indicator.

People should not be included in interventions if they are not old enough to understand messaging or if messaging conflicts with what is accepted by their caregiver; messaging and activities should be age appropriate and should only be provided with caregiver consent. Community workers should be trained to provide counseling and messaging that are both age-appropriate and friendly, and they should be trained to discuss sensitive topics in the context of cultural and religious norms.

Data source

This information is often tracked during behavior change communication activities at the community level. Counseling is typically provided at the community level, on a broad range of topics, to increase knowledge on HIV and HIV-related topics, such as HIV, PMTCT, tuberculosis (TB), safe sex, antenatal care (ANC), nutrition, male circumcision, health facility delivery, family planning, condom use, gender-based violence, STIs, child education, early childhood development, child wellbeing, children's rights, agricultural information, and household sanitation and hygiene. Forms used to collect this information include vulnerable children or

household/caregiver service forms, HIV activity reports for CBOs, household assessment and monitoring forms, and adult/child counseling session forms.

Disaggregation

- Age (<1 year, 1–4 years, 5–9 years, 10–14 years, and 15–19 years for children; 20–24 years, 25–49 years, and 50+ years for adults)
- Sex
- Pregnancy/lactation status
- Key population type (sex workers, transgender people, men who have sex with men, people who inject drugs)
- HIV status
- Intervention type as applicable (outreach, sensitization, group counseling, one-on-one counseling, behavior change communication, peer volunteer counseling, information, film/interview/chat/sketch, and informed flyer/brochure distribution)
- Intervention topic (HIV, PMTCT, TB, safe sex, ANC, nutrition, male circumcision, health facility delivery, family planning, condom use, GBV, STDs, child education, early childhood development, child wellbeing, children's rights, agricultural information, household sanitation and hygiene)

Data quality considerations

A person who received interventions multiple times during the reporting period should only be counted once for this indicator. It is important to pay attention to the reporting period to avoid double counting people (quarterly versus annual reporting). If resources allow, everyone can be provided with a unique identifier to help programs track the frequency, diversity, and reach of contact with people over time. The total number of people reached with HIV prevention interventions should be equal to the sum of each type of disaggregate. People who fall into more than one category of key population or pregnancy/lactation status should only count a person in one category for the total. This indicator does not track the quality or intensity of messaging and activities, or knowledge gained, or behavior changed owing to messaging and activities. Programs may also consider tracking the number of times specific people are exposed to messaging to ensure that beneficiaries are provided with enough information to make informed decisions.

Reporting frequency

Community workers should collect this information regularly but monitor progress monthly with support from their supervisors. The indicator should be reported on a semiannual basis.

Data element

Reach of community level HIV-prevention interventions

Category

HIV Prevention, Key Populations, Home-Based Care, Prevention of Mother-to-Child Transmission, Vulnerable Children

References

The United States President's Emergency Plan for AIDS Relief (PEPFAR) (2018). *Monitoring, evaluation, and reporting (MER 2.0) indicator reference guide updated release* (Version 2.2). Washington, DC: PEPFAR. Retrieved from https://www.pepfar.gov/documents/organization/263233.pdf

Ibrahim, S., & Sidani, S. (2014). Community-based HIV prevention intervention in developing countries: A Systematic review. Retrieved from https://www.hindawi.com/journals/anurs/2014/174960/

Kennedy, C., Medley, A., Sweat, M., & O'Reilly, K. (2011). Behavioural interventions for HIV-positive prevention in developing countries: A systematic review and meta-analysis. Retrieved from http://www.who.int/bulletin/volumes/88/8/09-068213/en/

Number of people currently on antiretroviral therapy

How to use this indicator

There is evidence to suggest that HIV is best managed through community-based care and that the most effective programs ensure decentralization of ART services and long-term retention of patients in care. Models of service delivery engage community workers in the delivery of medicine, provision of social support and education, and linkage of patients to the facility level. ART should be provided to people living with HIV whose CD4+ counts are less than 500 cells per μL, HIV-infected pregnant women, HIV-discordant partners, people with certain medical conditions such as active tuberculosis and active hepatitis B, and people with severe or advanced HIV clinical disease. This indicator monitors the ongoing scale-up and uptake of ART programs and provides insight on the number of people currently on antiretroviral treatment for HIV at the community level. This allows tracking of progress in the HIV response and monitoring of the HIV services cascade—between when diagnosis is made and treatment is initiated at the community level.

Numerator

Number of adults and children currently receiving antiretroviral therapy (ART) during the reporting period

Unit of measure

Number

Calculation

Sum results across reporting period

Method of measurement

This indicator can be calculated by counting the number of adults and children who are currently taking ART in accordance with treatment protocols. The information can be collected through community monitoring tools and determined by asking members during community worker household visits for adherence counseling and management. People who stopped treatment temporarily and then started again at the time of inquiry should be counted as current users. People who start short term ART for prevention purposes (PREP) or an ART starter pack should not be counted for this indicator. People who should be counted towards this indicator include those who:

- Initiated or transferred into treatment during the reporting period
- HIV-positive pregnant women who newly initiated ART during pregnancy or were already taking ART before pregnancy for their own treatment during the reporting period (This indicator is also defined separately here.)

People should not be included if they died, stopped treatment, transferred out of care, or were lost to follow-up during the reporting period. Those lost to follow-up are people who have not received antiretroviral in the past 90 days after their most recent missed appointment or missed drug pickup. Current should be defined as the treatment status the last time the community worker visited the household during the reporting period.

Data source

Programs usually track this information using service provision forms, vulnerable children/adult service forms, vulnerable children enrollment registers, family folder profiles, and home visit tools.

Disaggregation

- Age (<1 year, 1–4 years, 5–9 years, 10–14 years, and 15–19 years for children; 20–24 years, 25–49 years, and 50+ years for adults)
- Sex
- Key population type (sex workers, transgender people, men who have sex with men, people who inject drugs)
- HIV status
- Pregnancy/lactation status

Data quality considerations

Only one age disaggregation should be used for all types of disaggregation. If full age and sex disaggregations are not possible, then coarse disaggregate should be used (<1, <15 M, <15 F, 15+ M, 15+ F). The total number of people currently using ART should not be greater than the sum of each type of disaggregation. Age should be defined as the age of the person counted the last time he or she was visited during the reporting period.

Reporting frequency

Community workers should collect this information regularly but should monitor progress monthly with support from their supervisors. The indicator should be reported on a quarterly basis.

Data element

Current ART use

Category

Vulnerable Children, Key Populations, Home-Based Care, Prevention of Mother-to-Child Transmission

References

The United States President's Emergency Plan for AIDS Relief (PEPFAR). (2018). *Monitoring, evaluation, and reporting (MER 2.0) indicator reference guide updated release* (Version 2.2). Washington, DC: PEPFAR. Retrieved from https://www.pepfar.gov/documents/organization/263233.pdf

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Mukherjee, J. S., Barry, D., Weatherford, R. D., Desai, I. K., & Farmer, P. E. (2016). Community-based ART programs: Sustaining adherence and follow-up. Retrieved from https://www.ncbi.nlm.nih.gov/pmc/articles/PMC5106499/

Number of people who received sexually transmitted infection screening and treatment

How to use this indicator

Countries that have managed to successfully control sexually transmitted infections have experienced reversals or reductions in their HIV epidemics. Sexually transmitted infection (STI) services should target and provide outreach to populations of highest risk, promote and provide condoms, and provide case management of STIs for people and their partners. Programs usually treat STIs and prevent their recurrence by promoting condom use and encouraging partners to be tested and treated to avoid reinfection. Provision of clinical services in health facilities alone has proven inadequate to control STIs, because many people do not go to clinics. Continuous access to STI services has been shown to reduce HIV transmission, making outreach and community-based STI services very important. STI care is also seen as an entry point for HIV testing, which is important because patients suffering from STIs may have acute HIV infection, given the increased risk of HIV transmission STI imparts. This indicator provides insight into the reach of HIV programs to provide functional STI screening and treatment services. It tracks the uptake and use of services as well as whether those tested and identified as positive for an STI have actually received treatment. Community and outreach workers are essential for effective targeting of key populations and bridge populations by identifying locations of higher STI prevalence and mapping them.

To ensure quality of care, all people regardless of HIV status or key population status should receive STI treatment if diagnosed. However, this indicator also tracks provision of both STI testing and treatment services among those who test HIV-positive. Infants may be at risk of STIs in the event of mother-to-child transmission during delivery as well as children who are exposed to sexual exploitation and/or violence. Vulnerable children who are exposed to HIV may also be at heightened risk for acquiring STIs because of earlier sexual debut and sexual risk-taking behaviors. Adolescents who benefit from HIV-prevention programs should also receive STI testing and treatment services, especially if they are sexually active.

Numerator

Number of adults and children who were tested for any STI and were treated for an STI during the reporting period

Unit of measure

Number

Calculation

Sum results across reporting period

Method of measurement

Data for the indicator should be determined by counting the total number of adults and children who received STI testing and treatment services, regardless of testing source (facility or community levels). Community workers can ask beneficiaries this question to determine whether the beneficiaries have been tested and the location of testing within a certain time frame, regardless of whether testing occurred at the facility or community level. However, the service delivery modalities that apply specifically to the community level are listed below. A community worker can track community-based testing specifically by recording the number of people tested in locations other than facilities.

Community-based service delivery modalities:

- Mobile testing: temporary testing locations excluding voluntary medical male circumcision
- VCT: drop-in center, wellness clinic where STI testing is provided, or site designated for key populations
- Other community platforms: ad hoc testing campaign

This indicator specifically tracks STI testing and treatment from any source. It does not track STI status. A project beneficiary who has received STI testing, as well as treatment, regardless of source, should be counted towards this indicator.

A mandate to do no harm must be the absolute priority whenever community programs engage in data collection and reporting of STI status. All data must be managed with confidentiality to ensure that the identities of people living with STIs (and their key population status as applicable) are protected, to prevent stigma and discrimination. Community workers should engage with utmost caution in collecting, managing, and reporting this information and ensure confidentiality of files.

Data source

This indicator is often found in peer outreach forms and behavior change communication forms for key population programs.

Disaggregation

- Age (<1 year, 1–4 years, 5–9 years, 10–14 years, and 15–19 years for children; 20–24 years, 25–49 years, and 50+ years for adults)
- Sex
- Pregnancy/lactation status
- Key population type (sex workers, transgender people, men who have sex with men, people who inject drugs)
- Service delivery modality
- Type of STI
- Partner type (one time paying, regular paying and non-paying)

Disaggregation should be based on whether the person tested occupies one of the key population categories. If a person occupies more than one category, this information should be reported by the community health or outreach worker. Given the sensitivity of this information, and the possible ramifications of disclosure for people who occupy these categories, community workers should engage with utmost caution in collecting, managing, and reporting this information. Community workers should also keep the files secure, to ensure confidentiality and to ensure that they do no harm.

Data quality considerations

The overall number reported for this indicator should be equal to the sum of people in each disaggregation type. Use one type of age disaggregation throughout is recommended; overlap should be avoided. Service delivery modalities should be mutually exclusive. It is important to pay attention to the reporting period to avoid double counting of people (quarterly versus annual reporting). People who have been tested should only be counted once within the allotted time frame, though some may have been tested and treated numerous times or tracked by both facility and community workers. This indicator does not track the number of people who have a STI, because some people, especially those at higher risk, may have been screened and treated for more than one STI during the reporting period, or may not have accessed testing and treatment services. This indicator also does not include HIV, because although HIV can be transmitted sexually, it can also be transmitted through other modalities and should be tracked distinctly. The number of *tests* administered should not be counted towards this indicator, but rather the number of *people* tested.

Reporting frequency

Community workers should collect this information regularly but monitor progress monthly with support from their supervisors. The indicator should be reported on a semiannual basis.

Data element

STI diagnosis and treatment

Category

Vulnerable Children, Key Populations, HIV Prevention

References

Centers for Disease Control and Prevention (1998). STD treatment to prevent HIV Infection: Implications of recent community-level studies. Retrieved from https://www.cdc.gov/std/hiv/facts_treatment_prevent_hiv_infection.htm

Steen, R., Wi, T. E., Kamali, A., & Ndowa, F. (2009). Control of sexually transmitted infections and prevention of HIV transmission: Mending a fractured paradigm. Retrieved from https://www.ncbi.nlm.nih.gov/pmc/articles/PMC2770276/

Number of people living with or affected by HIV provided with spiritual or psychosocial support services

How to use this indicator

This indicator tracks the psychosocial support services provided to people living with or affected by HIV. Psychosocial support deals with the ongoing psychological and social problems faced by people living with and affected by HIV. HIV has a serious impact on the lives of people living with the virus and their families. Previous research has shown that people living with HIV tend to suffer from fatigue, pain, fever, headache, and mental health issues. Acquiring HIV can result in stigma and discrimination against those who live with the virus and their families, and can lead to decline in socioeconomic status, employment, income, housing, healthcare, and mobility. Psychological support can help these individuals cope more effectively with their situation and enhance their quality of life. Support services such as mental health, case management, and counseling services have been associated with improved CD4 counts in patients receiving antiretroviral therapy (ART). This support has also been shown to affect the level of stress and the severity of mental problems that can develop as a result of diagnosis.

It has been shown that community health workers can provide psychosocial and psychological interventions as part of primary and secondary prevention of mental, neurological, and substance use disorders in low-resource settings. Interventions involving community health workers in promotion of health among people living with HIV have historically focused on reducing depression or stigma associated with HIV and promoting quality of life, social support, and self-efficacy. The efforts of community health workers to address psychosocial outcomes of people living with HIV have demonstrated positive changes in improving quality of life and self-efficacy in some contexts. Community workers are ideally positioned to provide psychosocial support, because of they often have the highest level of interaction with people living with HIV and, therefore, the greatest chances of understanding their needs.

Data from this indicator can assist programs in tracking any efforts to improve the mental health of those living with and affected by the virus, help them to develop coping strategies, improve their adherence to treatment, build resilience among children and guardians, and prevent further HIV transmission. World Health Organization guidelines include psychosocial support as an essential component of HIV care and management.

Numerator

Number of adults and children living with or affected by HIV who have been provided with spiritual or psychosocial support services during the reporting period

Note: number of households is alternative language for this indicator, especially for vulnerable children programs, but tracking the number of individuals is recommended because each household member will require individual care planning based on individual-level needs for case management.

Unit of measure

Number

Calculation

Sum results across reporting period

Method of measurement

Community workers can ask project beneficiaries whether they have participated in or are receiving psychosocial or spiritual support services during the reporting period, regardless of source, to determine whether they should be counted towards this indicator. Psychosocial support provided by community workers themselves, or by community-based organizations, can be tracked directly by the community worker.

Psychosocial or spiritual support services can include participation in self-help groups; peer counseling related to fears, hopes, meaning, and guilt; succession planning; and preparing for and coping with the process of dying. Counseling on HIV care and treatment adherence (ART pickup clubs and support groups) should also be included when counting individuals for this indicator.

Community workers can be trained to develop competency to provide psychosocial support and positive parenting at the household level and during outreach activities, as well as to targeted groups, but should receive sensitivity training on how to interact with and protect people living with, vulnerable to, or affected by HIV. They can be trained on how to recognize signs of distress and use supportive listening techniques, provide education about stress reduction, and make a referral to a specialist as needed, if a specialist is available. A training curriculum for health providers and community workers should be mandated at the national level. Counseling should be provided to caregivers and their children to prevent separation of children from families suffering from the vulnerabilities caused by HIV. This counseling should cover parenting skills and best practices for childcare.

Beneficiaries should not be included in counseling if they are not old enough to understand counseling messages or if messaging conflicts with what is approved by their caregiver; counseling should be age appropriate and should only be provided following consent of the caregiver. Counseling should also be tailored to the individual's target population, and messaging should account for that population's vulnerabilities.

Data source

These data are often tracked using quarterly report forms, community-level care-and-support-service forms, beneficiary support forms, monthly registration forms, adult counseling session forms, behavior-change communication activity forms, and vulnerable children monthly registration forms.

Disaggregation

- Age (5–9 years, 10–14 years, and 15–17 years for children; 18–24 years, 25–49 years, and 50+ years for adults)
- Sex

- Pregnancy/lactation status
- Key population type (sex workers, men who have sex with men, people who inject drugs, transgender people)
- Service delivery modality

Data quality considerations

This indicator does not track the quality or the intensity of the psychosocial support provided. It is essential for community workers and community-based organizations providing support to be adequately trained in line with national guidance if deployed by programs to provide this type of support. Supportive supervision and coaching of community workers should ensure that they are providing quality and appropriate counseling. This indicator includes individuals who have received one counseling session as well as those who received numerous sessions throughout the reporting period. Programs may consider also tracking individual participation rates in counseling, to ensure that beneficiaries are provided with comprehensive psychosocial support.

Reporting frequency

Community workers should collect this information regularly, but they should monitor progress monthly with support from their supervisors. The indicator should be reported on a quarterly basis.

Data element

HIV-related psychosocial support

Category

Vulnerable Children, Key Populations, Home-Based Care, HIV Prevention

References

World Health Organization. (2006). Psychosocial support. Retrieved from http://www.who.int/hiv/topics/psychosocial/support/en/

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Han, H., Kim, K., Murphy, J., Cudjoe, J., Wilson, P., Sharps, P., & Farley, J. (2018). Community health worker interventions to promote psychosocial outcomes among people living with HIV—A systematic review. PLoS ONE 13(4):e0194928. https://doi.org/10.1371/journal.pone.0194928

Walker, P., McGrath, M., & Schafer, A. (n.d.). CHWs and mental health: Equipping community health workers with essential skills for addressing mental health and violence in the home. CHWCentral. Retrieved from http://www.chwcentral.org/blog/chws-and-mental-health-equipping-community-health-workers-essential-skills-addressing-mental

Number of vulnerable children provided with educational support services

How to use this indicator

Given the unique vulnerabilities their households face, children who are living with HIV, or who have caregivers living with HIV, often require educational support services if they are to stay in school. This support provides incentive for caregivers to keep their children in school, because school attendance can reduce the risk of acquiring HIV. Adolescent girls who stay in high school, for instance, have been shown to be at lower risk of HIV infection and engage in fewer higher-risk sexual behaviors than those who drop out. Data from this indicator monitor the number of children who receive free basic support to allow them to attend school and provide insight into whether these children are attending school. The information will also give the education sector the ability to track the role that schools are playing to support enrolled vulnerable children. Schools are important partners of HIV programs because they are often used by community-based organizations (CBOs), nongovernmental organizations (NGOs), and faith-based organizations (FBOs) to access and provide support to children affected by or living with HIV. Schools, vulnerable children programs, key population programs, CBOs, NGOs, or FBOs often provide children with educational support, and it is important to track children who receive these services to ensure that they are staying in school.

Numerator

Number of vulnerable children provided with educational support services during the reporting period

Unit of measure

Number

Calculation

Sum results across reporting period

Method of measurement

Depending on country context, vulnerable children may be defined as follows: a child below the age of 18, who because of circumstances, lacks access to the basic needs and resources in the areas of safety or protection, stability, education, and health that are necessary for optimal growth and development. This category can also include the following subpopulations of children, depending on the population a project targets: children who have lost one or both parents; children with chronically ill parent(s); children of members of key populations; child victims of abuse and exploitation; abandoned children; children living on the street; children born out of wedlock; unaccompanied and separated children; internally displaced and refugee children; children of migrant workers; children of asylum-seekers; children in labor camps; child victims of sexual exploitation; children in armed forces; children in residential care facilities; children in alternative care; or children who engage in illegal behavior, are stigmatized, or under the control of others.

Children must be attending and enrolled in school to be counted for this indicator. Community workers should count the number of children in their catchment area who have received educational support services, regardless of source, during the reporting period. They should coordinate with CBOs, NGOs, and schools to obtain accurate counts for this indicator. They can also confirm this count by asking caregivers at households whether services were received in reference to the school-age children living in their household that are supported by the program. Each child who received any form of educational support service, such as those listed below, should be counted towards this indicator.

Education support services can include the following: school feeding, take-home ration cards, contribution to school materials, school registration, tuition support, contribution to expenses related to schooling, school supervision, school reinforcement, moral support, support for resolution of relationship problems, and death management assistance.

Data source

This information is often collected by programs for vulnerable children on forms such as service provision tools, vulnerable children comprehensive family care tools, household vulnerability assessment forms, referral forms, enrollment registers, and school monitoring forms.

Disaggregation

- Age (4 years and below, 5–9 years, 10–14 years, 15–17 years, 18–24 years, 25+ years)
- Sex
- Grade in school
- Type of support provided (school feeding, take-home ration cards, contribution to school materials, school registration, tuition support, contribution to expenses related to schooling, school supervision, school reinforcement, moral support, support for resolution of relationship problems, and death management assistance)
- Level of schooling (early childhood development, primary, secondary)

Depending on the official entrance age to primary education, primary school can start for children between the ages of 5–7, with the entrance age for most countries falling into the range of 6–7 years old. Preprimary school can begin as early as age three, depending on the country, although worldwide only half of children ages 3–6 years old have access to preprimary education. Therefore, age disaggregations for this indicator should depend on the country context and the ages of vulnerable children being supported for schooling and vocational training by vulnerable children programs.

Data quality considerations

The number reported for this indicator should be equal to the sum of individuals in each disaggregation type. It is recommended that only one type of age disaggregation be used throughout; overlap should be avoided.

Reporting frequency

Community workers should collect this information regularly, but they should monitor progress monthly with support from supervisors. The indicator should be reported on a biannual basis.

Data element

Education support to vulnerable children

Category

Vulnerable Children, Key Populations, HIV Prevention

References

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Number of people provided with socioeconomic strengthening services

How to use this indicator

HIV and AIDS interact with poverty on a national level, strain community safety nets and coping mechanisms, and destroy individual income and assets. Living with HIV makes it difficult for people to maintain regular employment, because the virus affects their physical and mental functioning as well as their ability to seek out appropriate care. HIV/AIDS can lead to poverty for the entire family owing to weakened family and societal support systems and depleted family income. Children are often required to pick up the slack of incapacitated caregivers, which could lead them to drop out of formal education.

Programs that aim to reduce the burden of HIV/AIDS, or reduce risks of acquiring HIV/AIDS, can use this indicator to monitor any socioeconomic strengthening activity provided to households and individuals. Economic strengthening includes numerous types of interventions to reduce the economic vulnerability of individuals and empower them to make better choices for themselves and their families, including members of key populations who are at heightened risk. Activities include saving, obtaining credit, income-generating activities, jobs, cash transfers, savings groups, and vocational training. Information can be used to identify the poorest individuals and households, though economic support should be provided to vulnerable individuals, regardless of their status in relation to other beneficiaries, unless they are able to financially sustain themselves and their families and their treatment.

Numerator

Number of adults and children who received socioeconomic strengthening services during the reporting period

Note: number of households is alternative language for this indicator, especially for vulnerable children programs. Although some countries track this information by counting the number of households that received services, it is advisable to track the total number of individuals who received support, because people living with HIV who do not have children could also be eligible for support. Key populations would also be eligible for this support, regardless of HIV status, depending on level of economic instability.

Unit of measure

Number

Calculation

Sum results across reporting period

Method of measurement

This indicator should count the total number of individuals, regardless of age, who have received some form of economic strengthening at least once during the reporting period. See the list of eligible forms of interventions below:

- Cash transfer (conditional or nonconditional)
- Vocational or business skills training
- Loan
- Bond
- Savings group
- Credit
- Microfinance
- Apprenticeship
- Business incentives
- Income generation in cash or kind (agricultural inputs)
- Material or financial support for shelter
- Other form of economic support

Funding or support services for food and education should be counted towards respective indicators defined here for food and here for education. Household eligibility for external support should be determined based on the severity of poverty and vulnerability. Community workers can conduct household vulnerability assessments to ascertain levels of household economic instability. The information for this indicator is obtained by asking beneficiaries directly whether they received any cash, goods, or vocational training of any kind during the reporting period and then clarifying which services were received. Community workers can track community-based services provided to individuals by counting the number of participants in savings groups, for instance, who are either vulnerable to, affected by, or living with HIV.

Data sources

This information is mainly tracked by vulnerable children programs through vulnerable children service forms, graduation checklists, beneficiary support forms, and household assessment and monitoring forms. Key population programs often track those individuals who have received some form of vocational training, loan, savings, or cash transfer as a result of program funds.

Disaggregation

- Age (<1 year, 1–4 years, 5–9 years, 10–14 years, and 15–17 years for children; 18–24 years, 25–49 years, and 50+ years for adults)
- Sex
- Type of support provided (see list above)

- Key population type (sex workers, men who have sex with men, people who inject drugs, transgender people)

Data quality considerations

This information should be tracked regularly, because household economic status of individuals living with, affected by, and vulnerable to HIV can change frequently and drastically. This indicator does not account for frequency, intensity, or quality of support services provided, and supervision should ensure services sustainably improve the financial security of households. Double counting should be avoided (such as of people receiving services more than once or from numerous sources).

Reporting frequency

Community workers should collect this information regularly, but they should monitor progress monthly with support from their supervisors. The indicator should be reported on a quarterly basis.

Data element

Socioeconomic strengthening services

Category

Vulnerable Children, Key Populations, HIV Prevention

References

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Number of people provided with referrals for services in the past three months

How to use this indicator

Referral is an essential component of any community-based HIV program, whether it serves the general population, vulnerable children and their families, or key populations. Health and social service systems rely on community workers to ensure that individuals at risk of acquiring HIV (or in need of treatment, care, or support services) are linked to services as soon as possible. Timely referral and linkage to care are crucial factors in HIV prevention, treatment, and care, and are important parts of ensuring nationwide access and equity to those living with and affected by HIV, as well as those with a serious risk of acquiring HIV. These individuals require a wide range of comprehensive care and support services and need to know where they can receive services when necessary. This indicator verifies the existence of a referral system, but it also provides details on the demand of services in line with their supply.

Numerator

Number of adults and children who received a referral for a service of any kind during the reporting period from a community worker

Unit of measure

Number

Calculation

Sum results across reporting period

Method of measurement

Community-based organizations and community workers can collaborate with providers of care and support to ensure that individuals are linked to care and receive services according to their needs. Community workers can refer beneficiaries to the following services:

Health services (health facility, clinic, mobile unit, or drop-in center)

- HIV testing and counseling
- Sexually transmitted infection screening, prevention, and treatment
- Antiretroviral therapy
- Prevention, diagnosis, and treatment of tuberculosis
- Screening and vaccination for viral hepatitis
- Reproductive health (family planning, prevention of mother-to-child transmission)
- Medication-assisted therapy
- Needle syringe program
- Post-violence care

Psychological services (health facility, clinic, drop-in center, community-based organization [CBO], nongovernmental organization [NGO], or faith-based organization [FBO]):

- Emotional support and follow-up counseling
- Support groups and/or post-test clubs for people living with HIV/AIDS, people affected by HIV/AIDS, spiritual support groups
- Post-violence counseling

Legal support services (NGO, CBO, FBO, legal agency, probation office, police, local authorities, social institutions, or health facility):

- Child or adult protection services (protection against violence, abuse, exploitation, or trafficking)
- Protection of succession rights
- Training and orientation on protection of the child
- Inheritance support
- Will writing support
- Removal from dangerous situations
- Assistance to report child abuse and neglect
- Assistance to resolve child abuse and neglect cases

- Fostering and adoption
- Child rights education
- Vital registration
- Succession planning (making of a will and memory book)
- Education of individual on legal rights
- Post-violence clinical services
- Legal counsel
- Police services
- Psychosocial support for sexual, physical, and/or emotional violence

Nutrition services (school, health facility, NGO, CBO, and FBO):

- Nutrition assessment, counseling, and support
- Food and nutritional supplements
- Nutrition education

Socioeconomic strengthening services (NGO, CBO, and FBO):

- Cash transfer (conditional/nonconditional)
- Vocational/business skills training
- Loan
- Bond
- Savings group
- Credit
- Microfinance
- Apprenticeship
- Business incentives
- Income generation in cash or kind (agricultural inputs)
- Material or financial support for shelter
- Other form of economic support

Education services (school, CBO, NGO, and FBO):

- School feeding
- Take home ration cards
- Contribution to school materials
- School registration and tuition support

- Contribution to expenses related to schooling
- School supervision
- School reinforcement
- Moral support: support for resolution of relationship problems
- Death management assistance

Data will be collected from community workers who track the number of referrals that they make during the reporting period. Community workers can provide detail to the service delivery point on the individuals to be expected, and details on their vulnerabilities, especially if they are at high risk of acquiring HIV or are living with HIV. Community workers should coordinate with the service delivery point to confirm in person or via phone, text message, or mobile app that the referral was completed (see the completed referral indicator defined here).

Community workers should provide beneficiaries with referral forms that they can keep so that they are aware of the name and details of the service delivery point, including the service that they are being referred for. Community workers may collect sensitive information, but information that could lead to disclosure of HIV or sexually transmitted infection status should not be indicated on the referral form given to the client.

It is also recommended that beneficiaries be provided with referral by text or mobile application, if they have their own phone. These methods are considered more dependable, because paper forms can be easily damaged or lost. Text alerts can also be a dependable mechanism to follow up with individuals who have not completed their referrals. Tracking completed referral tends to be extremely difficult for national programs and national health management information systems. It is advised to use some sort of technology that allows for tracking of referrals. Some projects are piloting electronic referral systems that allow data of completed referrals to be sent back to the community health worker (CHW) via text, whereby the information about referral completion is stored in the national health information system.

Data source

Vulnerable children, key population, and HIV programs all rely on their community workers engaged in supporting beneficiaries at the community level to track this information. The following types of forms usually include this information: service provision tools, graduation checklists, vulnerable children service forms, caregiver/household head service forms, referral forms for vulnerable households, sensitization activity forms, people living with HIV support activity forms, HIV activity reports for community organizations, CHW reports, and outreach peer calendars, among others.

Disaggregation

- Age (<1 year, 1–4 years, 5–9 years, 10–14 years, and 15–17 years for children; 18–24 years, 25–49 years, and 50+ years for adults)
- Sex
- Pregnancy/lactation status
- Key population type (sex workers, men who have sex with men, people who inject drugs, transgender people)
- Type of service (see list by category above)
- HIV status

Some countries aggregate the counts of referrals based on the category of services provided, and this could be an alternative to tracking referral to all types of services, especially if community workers are trained on where the services fall in each category.

Data quality considerations

Although this indicator can be used to look at the quantity of referrals from the community level, it cannot be used to determine whether referrals were completed during the reporting period—whether people follow through on the referral and receive the service at the service delivery point. This indicator also does not indicate the quality of the referral or whether it was provided in a timely manner, with complete information per country guidance, or to the appropriate and most accessible service delivery point for the client. Double counting should be avoided, such as of people receiving referrals more than once or from numerous sources.

Reporting frequency

Community workers should collect this information regularly, but they should monitor progress monthly with support from their supervisors. The indicator should be reported on a quarterly basis.

Data element

Referral

Category

Vulnerable Children, Key Populations, Prevention of Mother-to-Child Transmission, Home-Based Care, HIV Prevention

References

National AIDS programmes. (2004). A guide to monitoring and evaluating HIV/AIDS care and support (Rep.). (2004). Geneva, Switzerland: World Health Organization. Retrieved from http://apps.who.int/iris/bitstream/handle/10665/42895/9241591439.pdf;jsessionid=10A5A38CBC9163B77825FA9D6022970D?sequence=1

Tumilowicz, A. (2010). Guide to screening for food and nutrition services among adolescents and adults living with HIV. Washington, DC: Food and Nutrition Technical Assistance II Project (FANTA-2), Academy for Educational Development. Retrieved from https://www.fantaproject.org/sites/default/files/resources/Nutrition_Interventions_Screening_Guide_Final.pdf

Number of people provided with completed referrals for services in the past three months

How to use this indicator

An effective referral system should include the following components: a group of organizations providing a range of comprehensive services, a directory of those services, referral protocols, processes to ensure referral completion, information exchanges and feedback loops among providers and community workers, tracking of referrals, and a coordinating unit responsible for the referral system. Effective linkage and communication mechanisms between structures and stakeholders that provide HIV care and support are essential to ensure that clients in desperate need of services can access care and support. An effective referral system should be able to adapt to different and evolving programs and services and should be easy for community workers and service delivery providers to use. The completed referral indicator can be used to track individuals who receive appropriate services based on the referral provided during the reporting period. Programs can use this indicator to determine the effectiveness of the community referral system, because the end goal should be uptake of

service by individuals who are vulnerable to and living with or affected by HIV. This indicator can provide insight into demand for and access to services, and the effectiveness of community worker referral, whether they are provided in a timely manner, and to the appropriate and most accessible service delivery point for the client's needs.

Numerator

Number of adults and children who received the service for which they were referred, regardless of service, by a community worker during the reporting period

Unit of measure

Number

Calculation

Sum results across reporting period

Method of measurement

This information can be gathered by a community worker through adequate follow-up and communication with service delivery providers, governmental agencies, and community-based organizations. It is recommended that national-level governmental agencies mandate standard operating procedures for referral systems. Many programs or health systems allow the referral process to happen organically. This leads to poor quality data on referral and referral system effectiveness. Ideally, community workers should coordinate with the service delivery point to confirm (in person or via phone, text message, or mobile app) that the referral was completed by their beneficiary and count the total number of beneficiaries with verified completed referrals during the reporting period. An individual should be counted only one time if they received care for the services they were referred for during the reporting period. Although calling or asking the client directly, to ascertain whether they completed the referral, is an option, it is not recommended, because verbal assent is not proof of completion. Community workers can also wait for news to return to them via counter referral form, but this approach is also not recommended, owing to a lack of timeliness and the possibility of losing the form. In some projects, clinics have a liaison to the community health worker (CHW), and this liaison brings information on clients seen at the clinic that week or month back to the CHW on a regular basis. Some projects are piloting electronic referral systems that allow data on completed referrals to be sent back to the CHW via text, whereby the information about referral completion is stored in the national health information system. Participation of community workers is vital in tracking HIV patients lost to follow-up and completed referral back to antiretroviral therapy (ART) services is crucial to ensure patients are brought back to care as soon as possible. Therefore, community workers are an important asset in controlling the HIV/AIDS epidemic.

Data source

This information is tracked primarily by programs for vulnerable children, to determine the state of referrals provided to households participating in their programs. The forms that are used to collect this information usually include child care monitoring forms, monthly registration forms, household assessment tools, and referral forms for vulnerable households. HIV programs typically also track completed referrals for ART.

Disaggregation

- Age (<1 year, 1–4 years, 5–9 years, 10–14 years, and 15–17 years for children; 18–24 years, 25–49 years, and 50+ years for adults)
- Sex
- Pregnancy/lactation status

- Key population type (sex workers, men who have sex with men, people who inject drugs, transgender people)
- Type of service (see list here)
- Service category (health, psychological, legal, nutrition, education, or economic strengthening)
- HIV status

Some countries tend to aggregate the counts of completed referrals based on the category of the type of services provided, and this could be an alternative to tracking referral to all types of services, especially if community workers are trained on where the services fall in each category.

Data quality considerations

Although this indicator can be used to examine the quantity of referrals from the community level, it cannot be used to determine the quality of services provided upon uptake of services for which referral was made. Referrals can be provided in one reporting period and then completed in another, but only completed referrals should be counted, which means a person has received services on the basis of that referral.

Reporting frequency

Community workers should collect this information regularly, but they should monitor progress monthly with support from their supervisors. The indicator should be reported on a quarterly basis.

Data element

Completed referral

Category

Vulnerable Children, Key Populations, Prevention of Mother-to-Child Transmission, HIV Prevention, Home-Based Care

References

de la Torre, C. (2013). Monitoring referrals to strengthen service integration. Retrieved from https://www.slideshare.net/measureevaluation/monitoring-referrals-presentation-webinar-final

Number of beneficiaries served by vulnerable children programs

How to use this indicator

This indicator is based on the United States President's Emergency Plan for AIDS Relief (PEPFAR) OVC_SERV indicator that is mandated for any program that provides support to children made vulnerable by HIV (including, but not limited to, children living with HIV) but extends to programs that are not supported by PEPFAR. Having a caregiver who is living with HIV or AIDS can negatively affect the emotional and physical development of children, but a number of services can mitigate these effects. Living with HIV produces ripple effects on the psychological, health, education, legal, and poverty status of children, and programs for these children provide a variety of services to protect and support them that extend beyond their physical health. Vulnerable children programs can seek ways to build the stability and resiliency of children and families exposed to, living with, or affected by HIV/AIDS through rigorous case management and provision and linkage to health and socioeconomic interventions. Collecting data on the total number of beneficiaries, including those who are active, graduated, transferred, and exited, measures how successful a program for vulnerable children is

in building the resiliency of children and their families. This indicator measures the number of children and families vulnerable to and affected by HIV/AIDS who receive program support services.

Numerator

Number of adults and children provided with vulnerable children program support during the reporting period

Unit of measure

Number

Calculation

Sum results across reporting period

Method of measurement

Depending on country context, vulnerable children may be defined as follows: a child below the age of 18, who because of circumstances, lacks access to the basic needs and resources in the areas of safety or protection, stability, education, and health that are necessary for optimal growth and development. This category can also include the following subpopulations of children, depending on the population a project targets: children who have lost one or both parents; children with chronically ill parent(s); children of members of key populations; child victims of abuse and exploitation; abandoned children; children living on the street; children born out of wedlock; unaccompanied and separated children; internally displaced and refugee children; children of migrant workers; children of asylum-seekers; children in labor camps; child victims of sexual exploitation; children in armed forces; children in residential care facilities; children in alternative care; or children who engage in illegal behavior, are stigmatized, or under the control of others.

This indicator is the sum of active and graduated beneficiaries of program services for vulnerable children during the reporting period. Beneficiaries should have received service at least once from a range of available program services, including education, nutrition, psychosocial, legal/protection, socioeconomic, and/or health services. Community workers can track this information by asking the caregiver of each supported household directly whether family members have received services, and, if they have, the type, location, and date of receipt of services. The community workers should record names of those who received services (active) or graduated from program support during the reporting period. The recommended reporting period for this indicator is six months. They should determine when the services were received, to ensure that service provision occurred during the reporting period. Community workers can also count those to whom they provided services directly and follow up with community-based organizations to verify service delivery to specific beneficiaries in their caseload.

Data source

This indicator is tracked by programs for vulnerable children through service provision and family care tools, graduation checklists, child care monitoring forms, monthly registration forms, and home visit tools.

Disaggregation

- Type of beneficiary (active, transferred, exited, or graduated)
- Age (<1 year, 1–4 years, 5–9 years, 10–14 years, and 15–17 years for children; 18–24 years, 25+ years)
- Sex
- Type of service (education support, parenting or caregiver support, social protection, economic strengthening, other service areas)

Per PEPFAR guidelines, "transferred" and "exited without graduation" should be used as levels of disaggregation, but these should not be counted towards the overall sum reported for this indicator during the reporting period.

"Active beneficiaries" are individuals who received a service in the past six months. Beneficiaries who were recently registered, during the past six months, should also be counted as active, even if they have yet to receive services.

"Graduated beneficiaries" are those who are determined stable and no longer in urgent need of externally supported services during the reporting period. This also includes children who have reached the age of 18 and have a transition plan for exiting the program successfully. Criteria for graduation are established by each country's guidelines for case management, which should be designed to ensure children are healthy, stable, safe, and schooled.

"Transferred" is defined as any beneficiary who was transitioned to any forms of program support other than those provided through the original vulnerable children program, including other donor-funded or country-led programs, during the reporting period. Transferred can be disaggregated into two separate categories: "transferred out to a PEPFAR-supported partner" and transferred out to a "non-PEPFAR supported partner."

"Exited without graduation" is defined as any child who was lost to follow-up, is older than 18 years and lacks a graduation plan, relocated, or died during the reporting period.

Data quality considerations

This indicator does not track the quality or the intensity of the support services provided; it categorizes individuals who received one service the same as those who received numerous services throughout the reporting period. Programs may consider also tracking individual participation rates in services to ensure that they are providing beneficiaries with comprehensive support.

The number reported for this indicator should equal the sum of individuals in each disaggregation category. Only one type of age disaggregation should be used throughout, and overlap should be avoided.

Reporting frequency

Community workers should collect this information regularly, but they should monitor progress monthly with support from their supervisors. The indicator should be reported on a semiannual basis.

Data element

Beneficiaries served by vulnerable children programs

Category

Vulnerable Children

Data use case

To see a data use example for this indicator, please click below.

Active Versus Graduated Beneficiaries of an Orphans and Vulnerable Children Program in Uganda

References

Bachman, G. (2017). Core, near core and non-core activities: How PEPFAR countries prioritize activities, implement priorities, and determine future plans for transition. Retrieved from http://www.urc-chs.com/resources/core-near-core-and-non%E2%80%90core-activities-how-pepfar-countries-prioritize-activities

The United States President's Emergency Plan for AIDS Relief (PEPFAR) (2018). *Monitoring, Evaluation, and Reporting (MER 2.0) Indicator Reference Guide Updated Release* (Version 2.2). Washington, DC: PEPFAR. Retrieved from https://www.pepfar.gov/documents/organization/274919.pdf

Number of vulnerable children who are fully immunized

How to use this indicator

Immunization programs are one of the most cost-effective ways to reduce child mortality. They aim to reduce vaccine-preventable diseases among children. Immunization coverage is more likely to occur in children during their first year of life when the child's biological parents are alive and living with the child, making children orphaned by HIV particularly vulnerable to preventable diseases. This indicator tracks vaccination coverage among children vulnerable to or affected by HIV and tracks vulnerable children program efforts to link children to immunization services. Programs can ensure that immunization services are accessible to those at heightened vulnerability to HIV, and this information can inform questions of access at the community level. Vaccination services for children under one year old are an essential component of maternal and child healthcare provision and should be incorporated into child-focused activities by programs for vulnerable children. Community presence is necessary to ensure children have access to routine vaccinations, because certain vaccinations can be administered by community workers themselves, and vaccination health events are mechanisms by which coverage can be achieved.

Numerator

Number of vulnerable children ages 12–23 months supported during the reporting period who received all vaccinations before their first birthday

Unit of measure

Number

Calculation

Sum results across reporting period

Method of measurement

Depending on country context, vulnerable children may be defined as follows: a child below the age of 18, who because of circumstances, lacks access to the basic needs and resources in the areas of safety or protection, stability, education, and health that are necessary for optimal growth and development. This category can also include the following subpopulations of children, depending on the population a project targets: children who have lost one or both parents; children with chronically ill parent(s); children of members of key populations; child victims of abuse and exploitation; abandoned children; children living on the street; children born out of wedlock; unaccompanied and separated children; internally displaced and refugee children; children of migrant workers; children of asylum-seekers; children in labor camps; child victims of sexual exploitation; children in armed forces; children in residential care facilities; children in alternative care; or children who engage in illegal behavior, are stigmatized, or under the control of others.

A child can be defined as fully immunized if they have received a Bacillus Calmette-Guerin (BCG) vaccination; three doses of the Diphtheria, Pertussis, and Tetanus (DPT) vaccine; three doses of the polio vaccine; and a measles vaccine, and should be fully immunized within the first year of life. Full immunization during the first year should be based on the national schedule.

Community workers can track this information by asking the caregiver to present the child's health card, including their immunization record. If the health card is filled out incorrectly, the community worker should ask the caregiver questions about each vaccination, because it has been shown that a mother's recall of her child's immunization history can be quite accurate. However, mothers may not recall the names of the vaccines, or the number of doses received, nor the exact dates of those vaccinations. This could lead to a biasing of results, so it is best for community workers to work with vulnerable children households to ensure that their vaccination information is adequately filled out on their health card.

The suggested question for this indicator is as follows:

Do you have a card where [NAME's] vaccinations are written down?

If YES — May I see it, please?

Record immunizations from vaccination card and probe about any missing records.

• Has [NAME] received a vaccine against tuberculosis, that is, an injection in the arm or shoulder, that usually causes a scar? (BCG)

• Has [NAME] received the polio vaccine, that is, drops in the mouth?

• Has the child received OPV0, that is the first polio vaccine normally received in the first two weeks after birth?

• Has the child received OPV1, that is the second polio vaccine?

• Has the child received OPV2, that is the third polio vaccine?

• Has the child received OPV3, that is the fourth polio vaccine?

• Has the child received the DPT vaccination, that is, an injection given in the thigh or buttocks, sometimes at the same time as polio drops?

• How many times was the DPT vaccine received?

• Has the child received a measles injection, that is, a shot in the arm at the age of 9 months or older – to prevent him or her from getting measles?

Data source

This information is often tracked in forms for child care monitoring, monthly registration, evaluation of the child's index, and community family folders.

Disaggregation

- Age (<1 year, 1–4 years, 5–9 years, 10–14 years, and 15–17 years for children; 18–24 years, 25+ years)
- Sex

Data quality considerations

Mother recall of the child's vaccination history can be a source of bias and inaccuracy in regular monitoring of immunization coverage by community workers. No child should be counted if the child did not receive all necessary vaccinations as dictated by national protocol before his or her first birthday. The number reported for this indicator should equal the sum of individuals in each disaggregation category. Only one type of age disaggregation should be used throughout, and overlap should be avoided.

Reporting frequency

Community workers should collect this information regularly, but they should monitor progress monthly with support from their supervisors. The indicator should be reported on a quarterly basis.

Data element

Vulnerable children fully immunized

Category

Vulnerable Children

References and resources

Chapman, J. (2014). Core OVC program impact indicators. Retrieved from https://www.measureevaluation.org/resources/publications/ms-13-61

Vinod, M., & Bignami-Van Assche, S. (2008). Orphans and vulnerable children in high HIV-prevalence countries in sub-Saharan Africa (English). Calverton, Maryland, USA: Macro International Retrieved from https://www.dhsprogram.com/publications/publication-AS15-Analytical-Studies.cfm

Number of vulnerable children regularly attending school

How to use this indicator

Vulnerability caused by HIV and AIDS has negative effects on school attendance among children because they correspond with an increased likelihood of prejudice and poverty, which can jeopardize a child's chance of completing a school education. Failure to complete school can lead to increased chance of higher-risk sexual behaviors and increased vulnerability to HIV. Children in school are less likely to acquire HIV. This indicator tracks the effectiveness of programs for vulnerable children in ensuring both children affected by and living with HIV stay in school. Data for this indicator should be analyzed in conjunction with the numbers of vulnerable children receiving education support services (see the indicator definition here). It is important for schools and community-based organizations to collaborate with community workers to ensure that children stay in school and are identified for education support or parenting skills counseling if there are barriers to attendance.

Numerator

Number of vulnerable children who are currently attending school during the reporting period

Unit of measure

Number

Calculation

Sum results across reporting period

Method of measurement

Depending on country context, vulnerable children may be defined as follows: a child below the age of 18, who because of circumstances, lacks access to the basic needs and resources in the areas of safety or protection, stability, education, and health that are necessary for optimal growth and development. This category can also include the following subpopulations of children, depending on the population a project targets: children who have lost one or both parents; children with chronically ill parent(s); children of members of key populations; child victims of abuse and exploitation; abandoned children; children living on the street; children born out of

wedlock; unaccompanied and separated children; internally displaced and refugee children; children of migrant workers; children of asylum-seekers; children in labor camps; child victims of sexual exploitation; children in armed forces; children in residential care facilities; children in alternative care; or children who engage in illegal behavior, are stigmatized, or under the control of others.

Community workers should ask caregivers this question directly and verify with children ages 10–18, following consent from their caregivers. Community workers should ask whether the child is currently attending school, when visiting during the reporting period. The community worker can clarify the regularity of attendance by asking whether the child has missed any days of school in the past month. A child who misses 20 percent of school days during the past month should not be defined as regularly attending school.

Data source

This information is regularly tracked by vulnerable children programs through comprehensive family care tools, graduation checklists, vulnerability assessment and household/child service forms, child counseling forms, enrollment registers, infant indexes, and school monitoring forms. Information also gathered included reasons for missing school, regular attendance, and current enrollment.

Disaggregation

- Sex
- Age (4 years and below, 5–9 years, 10–14 years, 15–17 years, 18-24 years, 25+ years)

Depending on the official entrance age to primary education, primary school can start for children between the ages of 5–7, with the entrance age for most countries falling into the range of 6–7 years old. Preprimary school can begin as early as age three, depending on the country, although worldwide only half of children ages 3–6 years old have access to preprimary education. Therefore, age disaggregations for this indicator should depend on the country context and the ages of vulnerable children being supported for schooling and vocational training by vulnerable children programs.

Vulnerable children programs typically support children under 18 years of age, but there are other initiatives, such as Determined, Resilient, Empowered, AIDS-Free, Mentored, and Safe Women (DREAMS) (which focuses on adolescent girls and young women ages 10–24) and Linkages across the Continuum of HIV Services for Key Populations Affected by HIV (LINKAGES) (which focuses on sex workers, men who have sex with men, people who inject drugs, and transgender people 18 years and above) that provide services to young adults.

Data quality considerations

This indicator does not consider the extent of school attendance, or whether the child has been absent from school for prolonged periods during the reporting period. It is important to verify with the child but to do so with caution and following consent from the caregiver and the child. The number reported for this indicator should equal the sum of individuals in each disaggregation category. Only one type of age disaggregation should be used throughout, and overlap should be avoided.

Reporting frequency

Community workers should collect this information regularly, but they should monitor progress monthly with support from their supervisors. The indicator should be reported on a quarterly basis.

Data element

Vulnerable children school attendance

Category

Vulnerable Children

References

United Nations Educational, Scientific and Cultural Organization (UNESCO) (2013). Core Indicators for the monitoring and evaluation of education sector responses to HIV and AIDS in countries with a generalized epidemic. In *Measuring the education sector response to HIV and AIDS Guideline for the construction and use of core indicators*. Paris, France: UNESCO. Retrieved from http://unesdoc.unesco.org/images/0022/002230/223028e.pdf

Chapman, J., & Parker, L. (2015). *MER Essential Survey Indicators - MEASURE Evaluation*. Presentation. Retrieved from https://www.measureevaluation.org/our-work/ovc/pepfar-ovc-forum-presentations/mer-essential-survey-indicators

Number of vulnerable children living with HIV

How to use this indicator

There is elevated risk of HIV among children affected by and vulnerable to HIV. Implementing partners of the United States President's Emergency Plan for AIDS Relief (PEPFAR) track this indicator through the numerator of OVC_HIVSTAT, but they do so solely among project specific beneficiaries, whereas this indicator tracks HIV status of vulnerable children supported by any community-based program. When there is awareness of the HIV status of vulnerable children, programs and governments can ensure that children are linked to appropriate care and treatment and that their households are provided with support, such as psychosocial, health, education, nutrition, legal, and household economic strengthening services. Of the 2.1 million children living with HIV globally, only 43 percent were on antiretroviral therapy (ART) as of 2017, and without treatment, half will die by their second birthday. This indicator is essential to the identification of children living with HIV, because identification allows them to get on treatment as early as possible.

Governmental and implementing organizations should assess HIV risk of supported vulnerable children and can do so through reporting for this indicator. Results should guide provision of HIV counseling and testing services to those most at risk and ensure those who test positive for HIV are enrolled and retained in care.

Numerator

Number of vulnerable children living with HIV

Unit of measure

Number

Calculation

Sum results across reporting period

Method of measurement

Depending on country context, vulnerable children may be defined as follows: a child below the age of 18, who because of circumstances, lacks access to the basic needs and resources in the areas of safety or protection, stability, education, and health that are necessary for optimal growth and development. This category can also include the following subpopulations of children, depending on the population a project targets: children who have lost one or both parents; children with chronically ill parent(s); children of members of key populations; child victims of abuse and exploitation; abandoned children; children living on the street; children born out of wedlock; unaccompanied and separated children; internally displaced and refugee children; children of migrant

workers; children of asylum-seekers; children in labor camps; child victims of sexual exploitation; children in armed forces; children in residential care facilities; children in alternative care; or children who engage in illegal behavior, are stigmatized, or under the control of others.

This information is gathered, through self-reporting, when a caregiver is asked whether his or her child has been tested for HIV and the results of that test. Children may be aware of this information, but the community worker should engage with caution because disclosure should be family centered. If the child is reported to be HIV-positive, then the community worker should count the child towards this indicator.

Community workers first register vulnerable children and determine their HIV status, and if their status is unknown, the community workers should conduct an HIV risk assessment. If identified to be at risk, the child is then referred to testing. The community worker can then count this child as HIV-positive if the child was tested and received a positive result.

HIV risk assessments should be administered by community workers, to determine the child's risk of acquiring HIV, if status is unknown, and those at heightened risk should be referred for HIV testing. This will save resources, reduce costs, and ensure quicker identification of those living with HIV. Community workers should also track the numbers of HIV testing referrals, completed referrals, and children who refuse to self-report following testing, but this information should not be counted towards this indicator.

Data source

This indicator is sourced from risk assessments, registers, client records, referral forms, and case management tools used by community workers to monitor vulnerable children in their communities. This indicator is tracked by vulnerable children (VC) programs in service provision, comprehensive family care, vulnerability assessment, risk assessment, enrollment, and follow-up forms. Community workers gather information on the HIV status of both the children and the adults in the household. In some country contexts, key population and VC programs work in collaboration to ensure HIV-positive members of key populations who are caregivers are linked to VC program support services. Some VC programs have an even larger mandate and provide support to children of key populations who are HIV-negative as well.

Disaggregation

- Status type
    - Reporting HIV-positive to implementing partner
    - Reporting HIV-negative to implementing partner
    - No HIV status reported to implementing partner
        - Test not indicated
        - Other reasons

While all of the above information is suggested for data collection by community workers engaged in supporting vulnerable children, only reporting HIV-positive to implementing partner should be counted towards this indicator.

Data quality considerations

The overall number reported for this indicator should be equal to the sum of individuals in each disaggregation type. This indicator does not imply that all vulnerable children should be tested for HIV, nor does it suggest a calculation to yield the number of new HIV-positive diagnoses.

HIV risk assessments should not be overly complicated but should be created in line with the average educational level of the community workers completing the assessments. Community workers should not be asked to sum a series of risk factors before they can establish whether a child is eligible for HIV testing referral, because this can lead to confusion. Outcomes for children at risk and children not at risk should be clearly labeled on the form. And next steps with guidance and instructions for referral to HIV testing should always be included. Note that community workers should be allowed to report on self-reported HIV-positive test results, which is necessary for effective case management. Case management tools also should always include HIV-negative test result as a field, and community workers should be trained to not leave this blank but mark this field accurately. Enrollment and case management forms may also include fields for whether HIV-positive children are either currently or not currently on ART, and should do so for PEPFAR-funded programs, but this information should not inform the calculation for this indicator.

Reporting frequency

Community workers should collect this information regularly, but they should monitor progress monthly with support from their supervisors. The indicator should be reported on a semiannual basis.

Data element

HIV status of vulnerable children

Category

Vulnerable Children

Data use case

To see a data use example for this indicator, please click below.

HIV Status of Vulnerable Children in the Democratic Republic of the Congo

Additional Resources

Listen to the MEASURE Evaluation webinar on OVC_HIVSTAT and linkages to care for strengthened collection, analysis, and use of routine health data here: https://www.measureevaluation.org/resources/webinars/strengthening-the-collection-analysis-and-use-of-ovc_hivstat-data

References

The United States President's Emergency Plan for AIDS Relief (PEPFAR). (2018). *Monitoring, Evaluation, and Reporting (MER 2.0) Indicator Reference Guide Updated Release* (Version 2.2). Washington, DC: PEPFAR. Retrieved from https://www.pepfar.gov/documents/organization/263233.pdf

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Number of people testing positive for tuberculosis who adhere to treatment

Background

High-quality treatment and care of tuberculosis (TB) relies on the following: laboratories and X-rays, input from skilled clinicians, a reliable supply of drugs, adequate health education, provision of care, and good follow-up and information systems for disease surveillance—in other words, an effectively operating health system. Ensuring adherence to treatment for TB is very important because it prevents transmission to others. Models that involve the family and community members can address barriers to adherence among those suffering with TB. These barriers include medical expenses; stigma associate with the illness; communication breakdowns between providers and patients; and limited health literacy, health workforce, and drug procurement. Community, family, and patient organizations all play a key role in improving adherence to TB treatment. Participation in patient organizations supported by community health workers has been shown to affect self-management of chronic diseases and the creation and maintenance of healthy habits. Community-based organizations and community workers should use this indicator to monitor progress towards managing TB within communities by motivating adherence to treatment, regardless of HIV status. TB is the leading cause of morbidity and mortality among people living with HIV. Community workers can support the health system by tracing TB patients lost to follow-up, referring those suspected to screening, referring TB patients to treatment, and following up to ensure adherence. This indicator can be used to track progress of these activities because these activities lead to improved adherence to treatment.

Numerator

Number of adults and children diagnosed with TB who have kept all TB appointments and taken all pills as prescribed during the reporting period

Unit of measure

Number

Calculation

Sum results across reporting period

Method of measurement

Community workers can improve adherence by accompanying TB patients to their appointments, and they can also motivate treatment uptake by counting pills. The community worker can ask the patient to self-report whether they attended all appointments as required for treatment and then follow up with the facility workers to ensure that these patients have indeed come for treatment services and prescriptions. The community worker can also refer to the prescription to ascertain whether the patient has been taking drugs as instructed, based on the date that the pills were prescribed. This approach can be invasive, so community workers should engage with caution and obtain consent before checking pill bottles; community workers should never force treatment uptake. They should also be trained on which symptoms to look for in patients who may have TB, so they may refer patients for screening. Patients should have decision-making power over whether to take their medication three times or once daily. However, it should be noted that those who choose to take their medication three times daily, versus once a day, tend to have better treatment adherence.

There is no ideal method for measuring adherence behavior, but a variety of strategies have proven effective in approximating true adherence rates. Another measurement approach is to ask patients to rate their adherence to TB treatment, or the adherence of their TB-positive children on a scale. Adherence methods provide only an estimate of a patient's true behavior. Community workers should engage with caution when handling and gathering this information, because TB status has been shown to lead to discrimination and stigma. Confidentiality should be maintained at all costs. Questions related to child treatment adherence should be directed to caregivers.

Data source

Community extension workers employed by programs for vulnerable children collect information related to TB through graduation checklists, vulnerable children service forms, caregiver/household head service forms, referral forms for the vulnerable household, and child counseling session forms. Community health workers collect this information in forms that manage the health status of mothers and their children, including disaggregation for HIV-positive mothers. TB cases are also managed through monthly community health worker (CHW) reports and HIV care and antiretroviral treatment (ART) transfer and referral forms by community health workers of HIV programs.

Disaggregation

- Age (<1 year, 1–4 years, 5–9 years, 10–14 years, and 15–19 years for children; 20–24 years, 25–49 years, and 50+ years for adults)
- Sex
- Pregnancy/lactation status
- Key population type (sex workers, men who have sex with men, people who inject drugs, transgender people)

Data quality considerations

The overall number reported for this indicator should be equal to the sum of the numbers of people in each disaggregation type. Only one type of age disaggregation should be used throughout, and overlap should be avoided.

Reporting frequency

Community workers should collect this information regularly, but they should monitor progress monthly with support from their supervisors. The indicator should be reported on a quarterly basis.

Data element

TB treatment adherence

Category

Vulnerable Children, Home-Based Care, Key Populations, Prevention of Mother-to-Child Transmission

References

Garner, P., Smith, H., Munro, S., & Volmink, J. (2011). Promoting adherence to tuberculosis treatment. Retrieved from http://www.who.int/bulletin/volumes/85/5/06-035568/en/

Sabate, E. (2015, December 21). Adherence to Long-Term Therapies: Evidence for Action. Retrieved from http://www.who.int/chp/knowledge/publications/adherence_report/en/

Number of births to HIV-positive women attended by skilled health personnel

Background

The presence of a skilled birth attendant at delivery has been associated with a 20-percent reduction in the risk of death or stillbirth caused by intrapartum complications. The United Nations estimated in 2015 that 17.8 million women in the world are living with HIV, and in sub-Saharan Africa (SSA) alone, women constituted 56 percent of all new HIV infections among adults. And, although there has been a global reduction in the maternal mortality ratio, 216 mothers still die per 100,000 live births, and this number reaches as high as 546 deaths in SSA. Coexisting high levels of both maternal mortality and HIV in these contexts make the fact that an estimated 90 percent of deliveries still occur at home—which equates to 60 million women delivering without assistance from a skilled birth attendant—quite concerning. This is a key indicator to measure improvement in women's health. The proportion of deliveries that involve skilled birth attendance has stagnated at 40 percent in SSA, and many deliveries take place outside of the formal health care system, with support from trained and untrained traditional birth attendants or family members. Global goals call for a reduction in the number of new HIV infections in infants from 40,000 to 20,000 by 2020 and call for 95 percent of pregnant women to have access to lifelong treatment.

Rural residency, delivery at home, failure to uptake antiretrovirals at birth, and mixed feeding are factors associated with mother-to-child transmission (MTCT) of HIV. Women from rural areas are less likely to attend antenatal care (ANC) clinics, and ANC clinics in rural areas equipped with prevention of mother-to-child transmission (PMTCT) services are limited. Skilled birth attendance at a health facility reduces risk of MTCT, owing to increased likelihood of appropriate administration of antiretroviral prophylaxis to the mother during delivery and infant at birth, but many women do not have access to this option. Community programs are essential to ensure that HIV-positive pregnant women are mobilized and educated to increase uptake of PMTCT interventions, institutional delivery, and proper follow-up for infants. It has also been demonstrated that, when trained adequately, traditional birth attendants should participate in PMTCT and ANC service provision and can contribute to increased uptake and coverage for services. Community programs that provide transport to clinics and recruit and train volunteers to provide counseling and increase awareness to pregnant and breastfeeding women with HIV have been shown to increase antiretroviral therapy enrolments.

Numerator

Number of HIV-positive pregnant women who were assisted by a nurse, doctor, or midwife during a delivery that occurred during the reporting period

Unit of measure

Number

Calculation

Sum results across reporting period

Method of measurement

Skilled health personnel can be defined as an accredited health professional, including a midwife, doctor, nurse, or auxiliary nurse/midwife who has been educated and trained to a certain skill level required to manage uncomplicated pregnancies, childbirth, and the immediate postnatal period, and manage and refer complicated pregnancies. Traditional birth attendants and community health workers cannot be counted as skilled health personnel.

Traditional birth attendants and community workers can gather these data by tracking the number of pregnant women in their communities, ensuring that they are linked to ANC services, educating them on PMTCT and HIV, and linking them to testing for HIV through the opt-out strategy. The opt-out strategy allows women to opt out of HIV testing after being given HIV counseling and information by a service provider; it has been shown to be effective in getting women to agree to HIV testing HIV. Poor monitoring of PMTCT services has been shown to lead to poor retention of HIV-positive mothers in treatment, which is why effective community and facility-based monitoring of this indicator is essential. Community workers are essential to efforts to retain and link HIV-positive pregnant women and HIV-exposed infants to care; their primary contributions can include reducing HIV-related stigma and helping women disclose their status to families and partners to seek support. When a community worker has linked the HIV-positive pregnant women to a skilled birth attendant and PMTCT services for delivery, the community worker can count a woman towards this indicator. If this information is unknown, community workers can also ask HIV-positive pregnant women if they delivered their child during the reporting period and whether that birth was assisted by a nurse, midwife, or doctor.

Data source

This information is most often tracked by community workers through their community folders, monthly reports, and registers.

Disaggregation

- Age (15–49)
- Sex
- Location of delivery
- Key population type (female sex workers, trans men, and women who inject drugs)

Data quality considerations

This indicator only measures whether births were attended during the reporting period but does not look at whether providers were successful in preventing mother-to-child transmission or preventing maternal or infant death. Service delivery sites may not be equipped to provide PMTCT services, especially in rural areas, and community workers should ensure that they locate a facility that offers the service, which should be done at the time when ANC services are needed. The overall number reported for this indicator should be equal to the sum of the numbers of people in each disaggregation type. Only one type of age disaggregation should be used throughout, and overlap should be avoided.

Reporting frequency

Community workers should collect this information regularly, but they should monitor progress monthly with support from their supervisors. The indicator should be reported on a quarterly basis.

Data element

HIV-exposed births attended by skilled personnel

Category

Prevention of Mother-to-Child Transmission, HIV Prevention

References

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Facts and figures: HIV and AIDS. (n.d.). Retrieved from http://www.unwomen.org/en/what-we-do/hiv-and-aids/facts-and-figures

Maternal Mortality. (n.d.). Retrieved from https://data.unicef.org/topic/maternal-health/maternal-mortality/

Perez, F., Aung, K. D., Ndoro, T., Engelsmann, B., & Dabis, F. (2008). Participation of traditional birth attendants in prevention of mother-to-child transmission of HIV services in two rural districts in Zimbabwe: A feasibility study. Retrieved from https://www.ncbi.nlm.nih.gov/pubmed/19061506

Prevention of mother-to-child transmission (PMTCT) of HIV. (2018). Retrieved from https://www.avert.org/professionals/hiv-programming/prevention/prevention-mother-child#footnoteref14_8xwktnq

Wudineh, F., & Damtew, B. (2016). Mother-to-child transmission of HIV infection and its determinants among exposed infants on care and follow-up in Dire Dawa City, Eastern Ethiopia. Retrieved from https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4771871/

Number of HIV-positive women who received antiretroviral therapy during pregnancy

Background

Given human resource constraints, community health workers can play a key role in ensuring enrollment in, adherence to, and retention of antiretroviral treatment for HIV. Prevention of mother-to-child transmission (PMTCT) programs must provide antiretroviral therapy (ART) to HIV-positive pregnant women, ensure early infant diagnosis at 4–6 weeks, and provide ART to infants exposed by 12 weeks to reduce the risk of vertical transmission to under 5 percent. In 2015, the World Health Organization recommended that all HIV-positive pregnant women be provided lifelong treatment, regardless of their CD4 count. (This strategy is called the Option B+ approach.) According to the Joint United Nations Programme on HIV/AIDS Global Plan of 2016, AIDS-related deaths decreased by 43 percent between 2009 and 2015 in the six priority countries where Option B+ was employed. Increased knowledge of HIV, mother-to-child transmission (MTCT), and PMTCT have led to increased uptake of PMTCT services, one area that community health workers have demonstrated influence. This information can be used by community HIV programs to assess progress in attempts to prevent mother-to-child transmission of HIV and inform strategic planning around resource allocation and coverage.

Numerator

Number of HIV-positive pregnant women who delivered and received ART to reduce the risk of mother-child-transmission during pregnancy or delivery during the reporting period

Unit of measure

Number

Calculation

Sum results across reporting period

Method of measurement

This information can be obtained through coordination with community-based organizations supporting HIV-positive pregnant women, to prevent vertical transmission of the virus. It can also be obtained by tracking HIV-positive pregnant women throughout the course of their pregnancy. Community workers are key to ensuring that pregnant women vulnerable to HIV are linked to HIV counseling and testing services to ensure that appropriate treatment is provided before and during delivery. This indicator includes HIV-positive pregnant

women who were newly initiated on treatment during the current pregnancy or during labor, including maternal triple antiretroviral prophylaxis, and those already on ART before becoming pregnant. Even if a woman intends to discontinue therapy after breastfeeding, she can still be counted towards this indicator if she meets the above criteria.

Data source

This information can be collected through the antenatal client appointment diary, forms, or client and antenatal profiles and is often collected by programs that place particular emphasis on supporting pregnant women and mothers.

Disaggregation

- Age
- Category
    - Newly initiated on ART during current pregnancy
    - Already on ART before the pregnancy
    - Other
        - Maternal zidovudine (AZT)
        - Single dose nevirapine
        - Any other regimen not listed
        - Linked from ART

Data quality considerations

This indicator does not measure the quality of treatment services provided to the woman at facilities. This indicator also does not track adherence and whether women discontinued treatment because of side effects or other reasons. This indicator should not be used as a true measure of mother-to-child transmission. The overall number reported for this indicator should be equal to the sum of individuals in each disaggregation type. Only one type of age disaggregation should be used throughout; overlap should be avoided. Categories should be mutually exclusive.

Reporting frequency

Community workers should collect this information regularly, but they should monitor progress monthly with support from their supervisors. The indicator should be reported on a quarterly basis.

Data element

HIV-positive women on ART during pregnancy

Category

Prevention of Mother-to-Child Transmission, HIV Prevention

References

Prevention of mother-to-child transmission (PMTCT) of HIV. (2018). Retrieved from https://www.avert.org/professionals/hiv-programming/prevention/prevention-mother-child#footnoteref14_8xwktnq

The United States President's Emergency Plan for AIDS Relief (PEPFAR). (2018). *Monitoring, evaluation, and reporting (MER 2.0) indicator reference guide updated release* (Version 2.2). Washington, DC: PEPFAR. Retrieved from https://www.pepfar.gov/documents/organization/263233.pdf

Number of HIV-positive pregnant women who received antenatal care at least four times prior to delivery

Background

The decision to go to a facility for antenatal care has been linked with the decision to deliver at a health facility, where medications can be provided to prevent mother-to-child transmission. Women are less likely to deliver in a health facility if they have not received at least one antenatal care visit. Involvement of community workers is crucial to the effort to link pregnant women to antenatal care and encourage use of antenatal care services. It has been shown to significantly improve attendance, where HIV testing, counseling, and pregnancy services can be provided, and a birth plan put in place. Antenatal care is part of the cascade of interventions required to prevent mother-to-child transmission, along with HIV testing in pregnancy, use of antiretroviral therapy among HIV-positive pregnant women, safe childbirth and feeding practices, uptake of infant HIV testing, and other postnatal health services. Community workers have been shown to be effective in identifying pregnant women early in their pregnancy and improving uptake of antenatal care services. This indicator tracks progress to increase attendance at all antenatal care visits prior to delivery, to ensure that pregnant women living with HIV have all the tools in place to prevent transmission to their infants.

Numerator

Number of HIV-positive pregnant women who delivered and received at least four antenatal care visits prior to delivery during the reporting period

Unit of measure

Number

Calculation

Sum results across reporting period

Method of measurement

This information can be obtained through coordination with facilities and community-based organizations supporting HIV-positive pregnant women, to prevent vertical transmission of the virus. It can also be obtained by tracking HIV-positive pregnant women throughout the course of their pregnancy. Community workers are key to ensuring that pregnant women vulnerable to HIV are linked to HIV counseling and testing services, to ensure that appropriate treatment is provided before and during delivery. This indicator includes HIV-positive pregnant women who delivered during the reporting period and received at least four antenatal care visits at facilities prior to delivery. Community workers can ask new mothers whether they received all visits, during pregnancy and prior to delivery, to count towards this indicator.

Data source

This information can be collected through community worker monthly community reports, client and antenatal profiles, and client appointment diaries and is often collected by programs that place particular emphasis on supporting pregnant women and mothers.

Disaggregation

- Youth female (15–24), adult female (25 years and above)

Data quality considerations

This indicator does not track the quality of care provided but the intensity of antenatal care for HIV-positive pregnant women. Recall bias may be a factor if new mothers are not asked within a year of when they delivered their infants. The overall number reported for this indicator equal the sum of individuals in each disaggregation type. Only one type of age disaggregation should be used throughout, and overlap should be avoided.

Reporting frequency

Community workers should collect this information regularly but monitor progress monthly with support from their supervisors. The indicator should be reported on a quarterly basis.

Data element

4+ antenatal care attendance by HIV-positive pregnant women

Category

Prevention of Mother-to-Child Transmission, HIV Prevention

Data use case

To see a data use example for this indicator, please click below.

Uptake of Antenatal Care and Community-Based Data for Decision Making in Ethiopia

References

Perez, F., Aung, K. D., Ndoro, T., Engelsmann, B., & Dabis, F. (2008). Participation of traditional birth attendants in prevention of mother-to-child transmission of HIV services in two rural districts in Zimbabwe: A feasibility study. Retrieved from https://www.ncbi.nlm.nih.gov/pubmed/19061506

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Gunn, J. K., Asaolu, I. O., Center, K. E., Gibson, S. J., Wightman, P., Ezeanolue, E. E., & Ehiri, J. E. (2016). Antenatal care and uptake of HIV testing among pregnant women in sub-Saharan Africa: A cross-sectional study. Retrieved from https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4718968/

Number of HIV-exposed infants receiving a virological test for HIV within two months of birth

Background

Infants born to mothers that are HIV-positive should be tested within four to six months of birth, per World Health Organization (WHO) recommendation, to ensure that antiretroviral therapy (ART) can be provided—ART has been shown to reduce risks of death by AIDS-related illness by 75 percent. Earlier initiation of ART in infants is effective in preventing death and disease progression, but about half of those infected perinatally, and a quarter infected through breastfeeding, will die before their first birthday without treatment. Identification of infants that are exposed to HIV is a crucial element of early infant diagnosis, but identifying infants exposed

postnatally, for testing and services, has been proven to be a challenge. HIV DNA polymerase chain reaction testing on dried blood spots has significantly improved early infant diagnosis (EID) services. The WHO has recommended that EID be provided during the six-week immunization visit postpartum for all infants, given the high rate of coverage for vaccination in resource-poor settings, but the WHO recommendation has yet to translate to high EID rates. Barriers to prevention of mother-to-child transmission services in developing countries have been linked to ineffective communication and continuity between antenatal, delivery, and postnatal facilities and poor information systems.

Community workers are essential to the effort to ensure newborns are linked to immunization visits and then also HIV testing, given the importance of motivating and counseling mothers at the household level. Using community workers for case finding and community-based HIV testing has been shown to reduce the burden on health clinics and to increase enrollment in care. This indicator measures the extent to which infants born to women living with HIV are tested within two months of birth to ascertain HIV status and eligibility for ART, and the extent to which community programs are progressing towards this aim. Early diagnosis is key to ensuring early treatment, given the intensity of disease progression among children.

Numerator

Number of infants who received an HIV test within two months of birth during the reporting period

Unit of measure

Number

Calculation

Sum results across reporting period

Method of measurement

This indicator counts the number of infants born to HIV-positive mothers in the community that were linked to testing services within two months of birth, at least once during the reporting period. Community workers should track HIV-positive pregnant women through their pregnancies and up until the point where risk of vertical transmission to their infants is eliminated. They can collect this information by coordinating with service delivery points and community programs, but also by discussing these questions with the mothers themselves, verifying the age of the infant, and determining whether testing services were received within eight weeks of birth. The community worker should be aware of the date of testing, the infant's age at testing, and the results of the test.

Data source

This information is normally collected through reporting forms given to community workers to track HIV-positive pregnant women and their infants through the continuum of care.

Disaggregation

- Infant age (3 months, 9 months, 18 months, within 2 months)
- Test result (Negative: within 2 months, between 2–12 months; Positive: within 2 months, between 2–12 months)
- Sex

Data quality considerations

Limiting the period to two months is said to eliminate the possibility of repeated tests for the same infant and prevent double counting. This indicator does not track whether infants have a definitive diagnosis of HIV or

whether appropriate services were provided to the child based on the results of testing. It also does not look at the quality of the testing services provided. Disaggregation by test result should not be used as a proxy for mother-to-child transmission rates.

Reporting frequency

Community workers should collect this information regularly, but they should monitor progress monthly with support from their supervisors. The indicator should be reported on a quarterly basis.

Data element

Early infant diagnosis

Category

Prevention of Mother-to-Child Transmission, Vulnerable Children, HIV Prevention

References

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Number of HIV-exposed infants who are exclusively breastfed at three months of age

Background

The World Health Organization recommends that women living with HIV exclusively breastfeed their infants, rather than offer mixed feeding, if they are on antiretroviral therapy (ART) and live in a resource-poor setting, given the difficulty associated with accessing clean water and formula in these settings. Mixed feeding—feeding both breastmilk and other food or liquid—has been shown to increase risk of HIV transmission in contrast to exclusive breastfeeding during the first six months postpartum. This recommendation was a response to higher rates of diarrhea, malnutrition, and other diseases in non-breastfed children. Recently, prevention of mother-to-child transmission (PMTCT) care has focused on achieving HIV-free survival with the provision of antiretrovirals (ARVs) to breastfed HIV-exposed infants. If HIV-positive women breastfeed without treatment for two years, it is estimated that their infants have a 10–20-percent chance Mixed feeding can damage the gut wall of infants, making them more susceptible to the virus. However, mixed feeding is still unfortunately common practice among children less than six months of age in many countries with high HIV prevalence. Babies who are not breastfed at all are fourteen times more likely to die from diarrhea or respiratory infections than babies who are exclusively breastfed for the first six months. Provision of ARVs has made breastfeeding dramatically safer, often reducing risk of transmission by 1 to 2 percent.

It is important for national programs to mandate which infant feeding practices and interventions will be used by all maternal and child health services, including counsel provided by community workers. Community programs are imperative to help mothers to feed their babies and take ARVs in line with national policy. This

indicator can be used by community programs to determine the extent to which HIV-positive mothers are choosing positive infant feeding practices in line with recommendations.

Numerator

Number of HIV-positive infants who are being exclusively breastfed by their mothers at three months of age during the reporting period

Unit of measure

Number

Calculation

Sum results across reporting period

Method of measurement

It is recommended that data for this indicator be collected during administration of 14-week third diphtheria, pertussis, and tetanus vaccination (DPT3) for infants, because this vaccination occurs about halfway between when infants are born and when exclusive breastfeeding should discontinue. Community workers should use this visit as a marker of when they should collect this information and ask the mother whether she is exclusively breastfeeding. Community workers can coordinate with vaccination service delivery points to link mothers and infants to services and ascertain breastfeeding status. If the mother was exclusively breastfeeding (the infant is given no formula, food, or water) during the 24 hours prior to this visit and the visit occurred during the reporting period, then she can be counted towards this indicator. Otherwise, community workers can ask HIV-positive mothers directly about infant feeding practices the previous day to determine what the infant ate or drank in the past 24 hours (during the last day or at night).

National programs that adopt policies of breastfeeding and ARVs should recommend that HIV-positive mothers breastfeed their infants for 12 months and that infants be exclusively breastfed for the first six months. Community programs should not advocate that HIV-infected mothers only breastfeed if they are on ART, although every effort should be made to accelerate access to ART for PMTCT.

Data source

This information can be collected through nutritional state monitoring forms and client appointment cards.

Disaggregation

- Age (0–5 months, 6–11 months, 12–23 months, and 0–23 months)
- Sex

Data quality considerations

Note that asking about a 24-hour recall usually tends to overestimate the number of mothers who are truly exclusively breastfeeding; mothers may have been given other liquids or foods in the many days since birth. However, this has been determined as the most effective way to determine exclusive breastfeeding. This indicator relies on accurate age assessment, and the community worker should verify the child's age, if possible, instead of relying solely on the word of the caregiver. The overall number reported for this indicator should equal the sum of individuals in each disaggregation type. It is recommended that only one type of age disaggregation be used throughout, and overlap should be avoided.

Reporting frequency

Community workers should collect this information regularly, but they should monitor progress monthly with support from their supervisors. The indicator should be reported on a quarterly basis.

Data element

Exclusive breastfeeding of HIV-exposed infants

Category

Vulnerable Children, Prevention of Mother-to-Child Transmission, HIV Prevention

References

Prevention of mother-to-child transmission (PMTCT) of HIV. (2018). Retrieved from https://www.avert.org/professionals/hiv-programming/prevention/prevention-mother-child

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Number of people who report the use of a condom at last sex

Background

This indicator is used by community HIV programs to track and monitor progress towards ensuring condom usage among those vulnerable to HIV. This indicator is collected by vulnerable children and key population programs to ensure that those living with HIV, or at risk of acquiring HIV, are engaging in safe sexual behaviors. Although this indicator can be collected for last high-risk sex, all sexual encounters among key and vulnerable populations can be perceived as high-risk, particularly because young people tend to engage in multiple concurrent sexual relationships and key populations often face the highest risk of HIV transmission from their non-commercial, non-exclusive partners. Although there are many barriers to condom use, community prevention interventions that engage communities in their design and implementation have been shown to have an impact on sexual behaviors, like condom use with noncommercial, nonexclusive clients and partners, and sexually transmitted infection (STI) and HIV prevalence. Community prevention interventions that involve peer education, improving advocacy, changing negative policies, and increasing community awareness, as well as an enabling environment (STI clinics, drop-in centers, condoms, lubricants, STI treatment) have been shown to be effective in reducing risky behavior and decreasing prevalence. This indicator can also be used by community programs engaging in community campaigns to determine the effectiveness of messaging.

Numerator

Number of adults and adolescents who report using a condom the last time they had sexual intercourse during the reporting period

Note: programs and researchers have examined condom use among program beneficiaries and target populations in numerous ways. Programs and studies involving key populations have worded this indicator, or related indicators, in many different ways. The following domains are examples:

- Consistent condom usage
- Refusal to have sex without a condom

- Charging higher fees for sex without a condom
- Using condoms for contraception
- Ability to identify one formal source of condoms
- Ever experience of condom sabotage
- Ever receipt of free condoms
- Knowledge that condom use prevents HIV transmission
- Power to negotiate condom use
- Receipt of condom-negotiation skills training
- Condom usage with the person with whom pregnancy was conceived
- Identify as the main condom use decision maker
- Always use a condom
- Risky sexual acts covered through condom

Key population programs and research have defined this indicator by various periods (such as, in the past week, in the past 6 months, in the past month/30 days, at last sex, during pregnancy) and by types of sexual partner (such as, one time paying, regular paying, and non-paying, clients, noncommercial partner, casual partner, regular partner, occasional partner). Although community programs may alternatively collect information on whether condoms were used consistently or always within a certain period with a certain type of partner, these questions may be subject to recall bias. A recommended alternative for this indicator is the number of adults and adolescents who report using condoms consistently or always during sexual intercourse in the past week.

Unit of measure

Number

Calculation

Sum results across reporting period

Method of measurement

Community workers can ask the beneficiary this question directly, to determine whether condom(s) were used the last time they engaged in sexual intercourse. Community workers should engage with caution, when discussing sexual behavior, especially with any adolescent below the age of 18. Children below the age of 13 should not be questioned. Before a minor below the age of 18 can be questioned, his or her caregiver must consent.

Data source

This information is often collected by programs for vulnerable children during adult and child counseling sessions and by key population programs during peer outreach.

Disaggregation

- Key population type (sex workers, men who have sex with men, people who inject drugs, transgender people)

- Partner type (one time paying, regular paying, and non-paying)
- Sex
- Age
- HIV status
- Pregnancy/lactation status

Data quality considerations

The overall number reported for this indicator should equal the sum of individuals in each disaggregation type. Only one type of age disaggregation should be used throughout, and overlap should be avoided. Community workers should use caution when discussing this information with any individual below the age of 18 and should be trained to communicate effectively with minors about sensitive topics.

Reporting frequency

Community workers should collect this information regularly, but they should monitor progress monthly with support from their supervisors. The indicator should be reported on a quarterly basis.

Data element

Condom use at last sex

Category

HIV Prevention, Key Populations

References

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Number of people known to be on treatment 12 months after initiation of antiretroviral therapy

Background

Community HIV programs must work to ensure adherence to the daily schedule of antiretroviral therapy (ART) and lifelong retention in care in order to achieve the best possible patient outcomes for people living with HIV. Community-based decentralized care became the international model for ART scale-up to address the multiple complex factors that impact patient's retention and adherence and influence access to quality care. The decentralization approach can be described as offering ART and related services in patient's homes and through community-based distribution points. Community participation usually translates to promotion of retention and

adherence through psychosocial support, peer support, and other prevention interventions relying on counseling and knowledge promotion. Community workers have been shown to enhance retention and adherence of ART among HIV-positive beneficiaries and are used to provide nutritional and food support, educational support, transport fees, and psychosocial support. Community programs also often institute community support groups to help beneficiaries better process their illness and develop coping strategies. Community workers have been used to distribute ART refills, provide ART and consultations at patient health clubs, establish ART distribution points run by people living with HIV, and organize patient-led community ART groups. When they engage in these activities, community workers can reduce the burden for both patients and health systems. This indicator can be used to monitor progress in their efforts to provide support to people living with HIV to adhere to treatment. The number of individuals who survived at 12 months is a very important piece of information that should be used by programs to look at ART survival over time.

Numerator

Number of adults and children who are still alive and on treatment at 12 months after initiating ART

Unit of measure

Number

Calculation

Sum results across reporting period

Method of measurement

Community workers can track this information through continuous monitoring of HIV-positive patient treatment and care and should coordinate with facilities, providers, and community programs to ensure adherence has been achieved by the end of their first year on ART. Beneficiaries do not need to have been using ART during the entire 12-month period, and this indicator includes those who may have stopped treatment at some point, as long as they are still on treatment by the twelfth month. Beneficiaries who have died, stopped treatment, or were lost to follow-up at month 12 should not be counted in the numerator. Community workers should track patients enrolled in treatment over the course of the year and check in after one year to ensure that patients are still on treatment. If the patients are on ART at one year from their initiation date, they should be counted towards this indicator. Those who transferred out of the program should not be counted towards this indicator. Those whose initiation date is unknown, but who transferred into the program, should not be counted towards this indicator.

Data source

This information can be tracked through behaviour change communication activity fact sheets, monthly community health worker reports, community monitoring forms for people living with HIV, monthly registration forms, and client, antenatal, and child profile diaries.

Disaggregation

- Age (<1, 1–4, 5–9, 10–14, 15–19, 20–24, 25–49, 50+)
- Sex
- Key population type (sex workers, men who have sex with men, people who inject drugs, transgender people)
- Pregnancy/lactation status

Data quality considerations

The overall number reported for this indicator should be equal to the sum of individuals in each disaggregation type. It is recommended to only use one type of age disaggregation throughout; overlap should be avoided.

Reporting frequency

Community workers should collect this information regularly, but they should monitor progress monthly with support from their supervisors. The indicator should be reported on a quarterly basis.

Data element

ART adherence

Category

Key Populations, Vulnerable Children, Prevention of Mother-to-Child Transmission, HIV Prevention

Data use case

To see a data use example for this indicator, please click below.

ART Retention and an mHealth Initiative in Mozambique

References

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Number of people of reproductive age currently using a modern family planning method

Background

Contraceptive use is a measure of coverage of family planning and reproductive health programs used to determine the extent of access and demand for contraceptive products and services. This indicator measures the total number of men and women of reproductive age (15–49) who are using a modern contraceptive method. Community workers are an essential component of the family planning workforce responsible for the delivery of family planning services. Certain community workers work directly with specific health facilities to care for reproductive, maternal, newborn, and child health in the community and bring clients to care. Others are involved in outreach activities on health and primarily focus on information, education, and communication. Community workers and community-based distributors of contraceptives primarily create awareness of contraceptive methods; distribute Cyclebeads, condoms, and oral contraceptive pills; and refer individuals to health facilities for clinical methods and counseling. This indicator can be used by community workers to track whether individuals in their communities have adopted a modern method based on contraceptive demand and unmet need.

This information is of particular importance for those living with HIV, because condom use is an essential practice to prevent transmission between serodiscordant couples if antiretrovirals or pre-exposure prophylaxis

are not being used. Condom use is also essential practice for HIV concordant couples, especially if either partner has engaged in sexual risk taking or has been subjected to forced sex. Condoms are the only form of modern contraception that simultaneously reduce the risk of HIV and other sexually transmitted infections and prevent unintended pregnancy. Modern contraceptive methods allow couples to decide the number and size of their families and prevent pregnancies that are mistimed or unwanted and protect themselves from sexually transmitted infections and HIV. Contraceptive use is particularly important for women living with HIV, because family planning reduces the risk of unintended pregnancy and, as a result, the number of babies who are living with HIV, especially in areas with low access to antiretrovirals.

Numerator

Number of women and men of reproductive age (15–49) who were using a modern contraceptive method during the past visit with a community worker within the reporting period

Unit of measure

Number

Calculation

Sum results across reporting period

Method of measurement

This indicator should not be confused with modern contraceptive prevalence, because additional information on the population at risk for pregnancy would be required. This information should be used by HIV programs to determine pregnancy intentions and support modern contraceptive use based on need among beneficiaries of reproductive age. Community workers should not track this information by counting the number of individuals in their communities that they distributed a contraceptive method to during the reporting period. To determine current use, community workers must ask each beneficiary directly if they are currently using a modern contraceptive method, and the list the methods they could be using. If the beneficiary indicates that he or she is using any of the modern methods below, and the last time this question was asked was during the reporting period, the beneficiary can be counted towards this indicator. If the beneficiary is using more than one modern method at the time of the visit, this information should be recorded. The community worker should define current use as the last time that they visited the beneficiary and they responded affirmatively to the question posed.

The following are modern methods:

- Oral contraceptive pill
- Intrauterine device (IUD)
- Injectables
- Implant
- Condoms (male or female)
- Diaphragm
- Foam/jelly
- Sterilization (male or female)
- Patch

- Vaginal ring
- Sponge
- Lactational amenorrhea method (LAM)
- Standard Days Method (SDM)

Community programs can provide counseling and support to ensure that family planning needs are met, and that beneficiaries are provided with alternatives if their current method does not suffice. Under no circumstances should any person be forced to use any method against the person's will or without his or her consent. The concept of informed choice is extremely important, and training for community workers should ensure patient rights are protected. (Learn more about informed choice here.)

Data source

HIV programs obtain this information through community family folders detailing the health status of mothers and their children. Most community programs ask that their community workers report whether family planning counseling services or referral were provided during any interaction. They also ask that beneficiaries report barriers to family planning use.

Disaggregation

- Age
- Key population type (sex workers, men who have sex with men, people who inject drugs, transgender people)
- Type of method (specific type from the above list, modern, traditional, any)
- Sex

Data quality considerations

Although this indicator can provide detail on method mix, or the number of current users or acceptors by method, community workers should not be asked to calculate or aggregate this information. Community programs could calculate and analyze this information if data collection forms included fields allowing community workers to report which modern method is currently being used. Method mix provides insight into access to contraceptive methods, because limited variability can suggest a lack of access to certain methods (see MEASURE Evaluation's definition for this indicator here for more detail). It is important for community workers to not double count beneficiaries for this indicator. This indicator does not track discontinuation rates or any difficulties with current method use.

The overall number reported for this indicator should equal the sum of the numbers of people in each disaggregation type. Only one type of age disaggregation should be used throughout, and overlap should be avoided.

Reporting frequency

Community workers should collect this information regularly, but they should monitor progress monthly with support from their supervisors. The indicator should be reported on a quarterly basis.

Data element

Modern contraceptive use

Category

HIV Prevention, Key Populations, Vulnerable Children

References

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Number of people identified to have experienced sexual, physical, or emotional violence

Background

This indicator can be used by community HIV programs to connect beneficiaries who are victims of sexual, physical, or emotional violence to appropriate support services. This number includes men, women, boys, and girls who have been the victim of violence by an intimate partner, a family member, a friend, an acquaintance, or a stranger. This information can support personnel and organizations involved in national social and child protection systems in their efforts to prevent and respond to violence in supported communities, measure the outcomes of anti-violence campaigns, strategize with partners to ensure resources are available to adequately address needs, and link individuals to care and support services. There is a body of evidence linking violence to HIV and HIV to violence bidirectionally. This information will help programs to devise strategies to address increased vulnerability faced by those who live in areas with high prevalence of violence in supported locations. If beneficiaries are regularly exposed to forced sex, war, conflict, sex work, exploitation, or are refugees they can be linked to post-prophylaxis services, for instance.

Numerator

Community-based HIV programs targeting adults (18+ years old):

Number of men and women (18+ years old) who have been identified during the reporting period to have ever experienced sexual, physical, or emotional violence

Community-based HIV programs targeting children (<18 years old):

Number of female and male children and adolescents (<18 years old) who have been identified during the reporting period to have ever experienced abuse, neglect, or exploitation that is physical, sexual, or emotional in nature

Alternative: Note that programs can alternatively collect information on whether the violence occurred during a specific period: since the last time the community worker visited the household, over the past year, or in the past three months, for instance. This alternative language would tell community programs whether immediate action is needed to address the violence or abuse and prevent further harm.

Note that members of key populations, and their children, are more vulnerable to violence and more likely to have experienced violence in their lifetime; therefore, programs that serve them are advised to use the alternative indicator language specified above. For effective case management, skilled personnel should monitor

violence during each visit if vulnerability to violence is high or past violence has occurred; in this case, the reporting period would be defined as since the last visit.

Unit of measure

Number

Calculation

Sum results across reporting period

Method of measurement

This indicator should be determined by counting the number of cases of violence or abuse that are reported or brought to the attention of community-based HIV programs and community workers. A case can be defined as an individual identified to have experienced violence.

Community-based HIV programs should defer to country law and national case management procedures on appropriate handling of cases of violence for children and adults when brought to the attention of community workers. Mechanisms should be in place to handle formal complaints that allow children and adults to safely report abuse, neglect, or exploitation, and to protect those who may experience negative consequences as a result of disclosure. If a community health or extension worker becomes aware of violence or suspects violence in his or her community, it is recommended that he or she ensure that victims or potential victims are connected to the correct, trained authorities immediately. However, they should be trained on the appropriate procedures to follow if they suspect or become aware of violence, instead of handling these cases, which could lead to further harm.

Skilled personnel at the community level, which can include social workers, health workers, police and the justice sector, are often trained to identify and respond to any signs of abuse, violence, exploitation, or neglect. If a child or adult has been sexually assaulted and this information is disclosed, it is imperative that he or she be referred to a health facility as soon as possible for adequate examination and care and materials to be collected.

Child victims of violence should be treated with utmost care, demanding even stricter consideration of ethical and safety issues. Community workers and community-based organizations should be trained on child-friendly communication and relevant laws and policies—including those related to consent, mandatory reporting, definitions of violence and exploitation, and case management.

Data source

Numbers of victims identified, referred, and prescreened for gender-based violence at the community level are often tracked using HIV activity reports for community organizations, monthly community reports, community health worker registers, and community family folders.

Vulnerable children programs often report numbers of cases of abuse, violence, exploitation, or neglect and track the support they provide using quarterly reporting, household assessment, graduation, enrollment, and beneficiary support activity forms. Enrollment and beneficiary forms, predominantly completed by community extension workers, usually include data elements regarding whether any child or family member accessed violence support or was referred for protection services.

Key population programs typically collect relevant information for this indicator through outreach peer calendar or behavior change communication forms, and peer educators report on whether they addressed violence through decision-making or action planning support counseling. Behavior change communication forms can often include risk behaviors and themes of the messaging provided during activities with members from key populations.

Disaggregation

- Age (<1 year, 1–4 years, 5–9 years, 10–14 years, and 15–17 years for children; 18–24 years, 25–49 years, and 50+ years for adults)
- Sex
- Pregnancy/lactation status
- Key population type (sex workers, men who have sex with men, transgender people, people who inject drugs)
- HIV status
- Type of violence or abuse: sexual, physical, emotional

Sexual, physical, or emotional violence can include rape and sexual abuse, child sexual abuse, child marriage, female genital cutting, marital rape, dowry-related violence, female infanticide, femicide, sexual harassment, forced prostitution, sex trafficking, and sexual violence used during war or conflicts as forms of intimidation and torture. It can also include threats, coercion, arbitrary deprivation of liberty, or economic deprivation.

Child abuse can include physical abuse (the deliberate use of force on a child's body which may result in injury), sexual abuse (violent sexual assault or other sexual activities, including inappropriate touching, where the child does not fully comprehend, is unable to give informed consent, or for which the child is not developmentally prepared), and emotional abuse (persistent attacks on a child's sense of self). Child neglect is defined as the failure to provide for the child's basic needs and can include physical neglect (failure to adequately meet the child's needs for nutrition, clothing, healthcare, protection from harm) and emotional neglect (to satisfy the developmental needs of a child by denying the child an appropriate level of affection, care, education, and security). Exploitation is abuse of a child where some form of remuneration is involved or whereby the perpetrators benefit in some manner—monetarily, socially, or politically.

Data quality considerations

When asking about lifetime experiences of violence, beneficiaries may be less inclined to remember an event, and its details, if it happened many years ago. Collecting and interpreting data related to this indicator should be done with care, because disclosure may engender hostile reactions. Individuals who recently participated in a community awareness initiative related to violence reduction and reduction of associated stigma may be more inclined to report their experiences at the next household visit or encounter with community workers.

The overall number reported for this indicator should be equal to the sum of the numbers of people in each disaggregation type. Only one type of age disaggregation should be used throughout, and overlap should be avoided. Since this indicator can be reported by both unskilled and skilled personnel, programs should be careful to avoid double counting of cases. It may be advisable to only include this information on forms used by skilled personnel at the community level once referral of cases is made from unskilled community workers, which can also be tracked through their reporting forms.

Reporting frequency

Skilled personnel should collect this information regularly but, they should monitor progress monthly with support from their supervisors. The indicator should be reported on a quarterly basis.

Data element

Cases identified of physical, sexual, or emotional violence

Category

Vulnerable Children, Key Populations, HIV Prevention, Home-Based Care, Prevention of Mother-to-Child Transmission

References

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Number of people who accessed legal counsel, protection, or post-violence services

Background

Member states of the United Nations Political Declaration on HIV and AIDS committed in 2011 to "national HIV and AIDS strategies that promote and protect human rights, including programs aimed at eliminating stigma and discrimination against people living with and affected by HIV, including their families, including through sensitizing police and judges; training healthcare workers in nondiscrimination, confidentiality, and informed consent; supporting national human rights learning campaigns, legal literacy, and legal services; and monitoring the impact of the legal environment on HIV prevention, treatment, care, and support." People affected by, vulnerable to, and living with HIV, and members of key populations, are more likely to experience discrimination, violence, exploitation, and stigma in their communities because of their HIV status, the HIV status of a family member, their occupation, their gender, or their sexuality. At times, this discrimination

prevents them from accessing much-needed health services because it can be shared by health and service providers as well.

This indicator can be used by community HIV programs and governments to monitor legal, protection, and support services provided to individuals who have experienced abuse, violence, exploitation, or violations to their person or property. Adequate provision of services to victims of violence and rights abuses involves the legal, healthcare, social protection, child protection, and policing systems, among others. Coordination and cooperation among many systems, involving numerous stakeholders, is essential to the provision of efficient, high-quality, and timely services to individuals who have experienced violence or other harm.

Numerator

Community-based HIV programs targeting adults (18+ years old):

Number of men and women (18+ years old) who have accessed legal counsel, social/legal protection, or post-violence services during the reporting period

Community-based HIV programs targeting children (<18 years old):

Number of female and male children and adolescents (<18 years old) who have accessed legal counsel, social/legal protection, or post-violence services during the reporting period

Unit of measure

Number

Calculation

Sum results across reporting period

Method of measurement

This indicator should include individuals who have experienced sexual violence (any sexual act that is perpetrated against someone's will), physical violence, emotional violence, threats, coercion, arbitrary deprivation of liberty, economic deprivation, stigma, and/or discrimination, and have accessed support services during the reporting period. Community-based organizations that provide support services can track this information through their program records directly. Alternatively, community health or extension workers can ask beneficiaries whether they received any legal, protection, or post-violence support services during the reporting period and the location and type of support, but with caution. Referral and assessment alone should not be counted for this indicator, because this indicator monitors service uptake.

Community-based organizations and community workers are advised to align communications and reporting procedures with national social protection and case management policies and procedures. Skilled personnel, such as social workers, health workers, and justice sector personnel, should participate in further discussion with and questioning of victims, in lieu of community health or extension workers. If a community health or extension worker becomes aware of violence or suspects violence in his or her community, it is recommended that he or she ensure that victims or potential victims are connected to the correct, trained authorities immediately. However, they should be trained on the appropriate procedures to follow if they suspect or become aware of violence, instead of handling these cases, which could lead to further harm (see related indicator definition here for guidance on effective handling by community programs when cases of violence are identified).

Regardless of when the aggression or rights violation took place, any individual who has received any of the following at least once (although this list is not exhaustive) during the reporting period should be counted once for this indicator:

- Child or adult protection services (protection against violence, abuse, exploitation, and trafficking)
- Protection of succession rights
- Training and orientation on protection of the child
- Inheritance support
- Will writing support
- Removal from dangerous situations
- Assistance to report and resolve child abuse and neglect cases
- Fostering and adoption
- Rights education
- Vital registration
- Succession planning (making wills and memory books)
- Education of individual on legal rights
- Post-violence clinical services
- Legal counsel
- Police services
- Psychosocial support for sexual, physical, or emotional violence

HIV-related legal services can be delivered through legal information and referrals, legal advice from paralegals at the community level, alternative/community forms of dispute resolution, functioning mechanisms for redress like tribunals and ombudsman offices, and engaging faith-based or traditional legal leaders or systems to resolve dispute or changing traditional norms.

Community workers interacting with victims should receive training to make them aware of relevant laws, traditional justice systems, knowledge about types of violence and exploitation, professional ethical standards, respecting patient choice and maintaining informed consent, and methods of communication with victims and that minimize further trauma during interactions. Communities should enforce survivor- centered approaches to ensure autonomy, safety, respect, and right to confidentiality.

Data sources

This information is often tracked by programs for vulnerable children through vulnerable children service delivery forms, graduation checklists, beneficiary support activity forms, home visit tools, and household assessment tools. Provision of rights-based education is also tracked during behavior change communication activities. Whether the violence was addressed through decision-making or action planning, it is also tracked through outreach peer calendars in key population programs.

Disaggregation

- Age (<1 year, 1–4 years, 5–9 years, 10–14 years, and 15–19 years for children; 20–24 years, 25–49 years, and 50+ years for adults)
- Sex

- Type of support provided (see list above)
- Type of violence (sexual, emotional, or physical)
- Key population type (sex workers, men who have sex with men, transgender people, people who inject drugs)

Data quality considerations

This indicator does not monitor the quality or safety of services provided to victims, and programs should be sure to provide serious oversight and supervision of any services provided at the community level, given the sensitivities and security considerations required. Double counting should be avoided (such as people receiving services more than once or from numerous sources). The community worker will not be able to track whether the victim received the full package of care when referred to post-violence clinical services based on type of violence experienced. This indicator should include only individuals who accessed support services during the reporting period, though the violence or rights abuses may or may not have occurred during the reporting period.

Reporting frequency

Community workers should collect this information regularly, but they should monitor progress monthly with support from their supervisors. The indicator should be reported on a quarterly basis.

Data element

Legal, protection, or post-violence services

Category

Key Populations, Vulnerable Children

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CATEGORIES

VULNERABLE CHILDREN

Community-based programs link many families to health and social services. These programs ensure that HIV-positive children have access and adhere to treatment and that HIV-positive caregivers can meet the needs of their children.

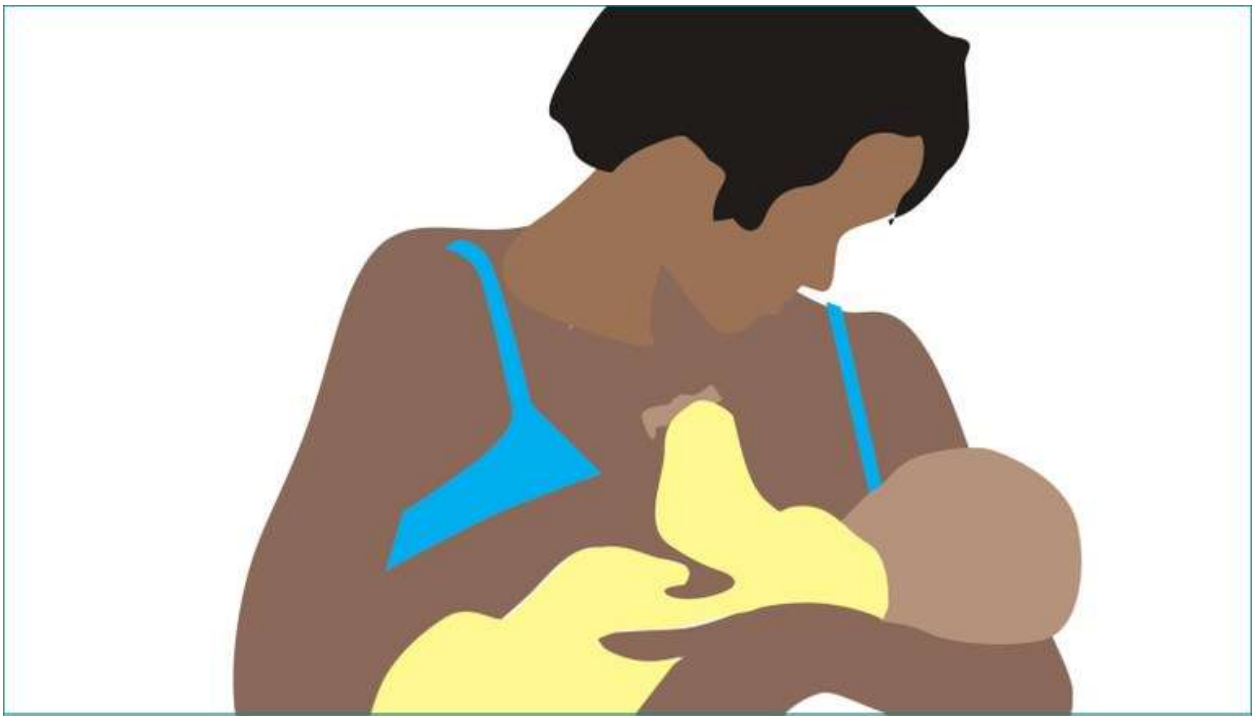
MEASURE Evaluation supports efforts to improve routine monitoring systems and collect information for case management, program monitoring, and identification of beneficiaries by vulnerable children programs. This collection of indicators is an important element of MEASURE Evaluation's work to build capacity to monitor and evaluate community-based vulnerable children programs.

To create these common indicators, MEASURE Evaluation reached out to PEPFAR (The United States President's Emergency Plan for AIDS Relief)—and other donor-supported programs that work at the community level to support vulnerable children—to obtain data collection tools. The tools chosen for this collection are those used by community workers in Nigeria, Ethiopia, South Africa, Uganda, Kenya, Côte d'Ivoire, the DRC, and Botswana to assess vulnerability and risk and monitor family care, services provided, and the status of adult and child beneficiaries and identify, enroll, and refer beneficiaries. The most common data elements among these tools were incorporated into the indicators in this collection. Each indicator is accompanied by a definition. These definitions were specifically designed to inform data collection by community programs and agents. To learn more about the vulnerabilities faced by children exposed to (or vulnerable to) HIV as well as associated tools and resources, go to the MEASURE Evaluation Orphans and Vulnerable Children main page.

- Number of people who were tested for HIV and received their results
- Number of people living with HIV who know their status
- Number of people currently on ART

- Number of people known to be on treatment 12 months after initiation of antiretroviral therapy
- Number of people who received sexually transmitted infection screening and treatment
- Number of people of reproductive age currently using a modern family planning method
- Number of people testing positive for tuberculosis who adhere to treatment
- Number of people identified to have experienced sexual, physical, or emotional violence
- Number of people reached with individual or small group level community HIV-prevention interventions
- Number of people who were nutritionally assessed and received nutrition counselling and therapeutic or supplementary food
- Number of people living with or affected by HIV provided with spiritual or psychosocial support services
- Number of vulnerable children provided with educational support services
- Number of people who accessed legal counsel, protection, or post-violence services
- Number of people provided with socioeconomic strengthening services
- Number of people provided with referrals for services in the past three months
- Number of people provided with completed referrals for services in the past three months
- Number of HIV-exposed infants with acute malnutrition at 12 months of age
- Number of beneficiaries served by vulnerable children programs
- Number of vulnerable children who are fully immunized
- Number of vulnerable children regularly attending school
- Number of vulnerable children living with HIV
- Number of HIV-exposed infants receiving a virological test for HIV within two months of birth
- Number of HIV-exposed infants who are exclusively breastfed at three months of age

PREVENTION OF MOTHER-TO-CHILD TRANSMISSION



To successfully prevent vertical transmission of HIV from mothers to their infants, countries must intervene at the community level, through prevention of mother-to-child transmission (PMTCT) programs. These PMTCT interventions may adopt one or more of the following strategies: male involvement in PMTCT, peer mentorship, use of community health workers, mobile phone-based reminders, conditional cash transfers, training of midwives, integration of PMTCT services, and enhanced referrals. Community-based approaches are essential because many of the barriers that prevent uptake of PMTCT services occur at the community level. Effective programs seek to improve rates of enrollment, retention in care, and successful treatment outcomes among mother-infant pairs.

MEASURE Evaluation reached out to PEPFAR (United States President's Emergency Plan for AIDS Relief)—and other donor-supported programs that implement programs, at the community level, to support prevention of mother-to-child transmission activities—to obtain data collection tools. The tools collected are those used by community workers in Nigeria, Ethiopia, South Africa, Uganda, Kenya, Côte d'Ivoire, the Democratic Republic of the Congo, and Botswana to monitor household care and services provided to mothers and their infants and conduct behavior change communication activities for pregnant women and mothers (of infants) living with HIV. The most common data elements among these tools were incorporated into the indicators in this collection. Each indicator is accompanied by a definition. These definitions were specifically designed to inform data collection by community programs and agents.

- Number of people who were tested for HIV and received their results
- Number of people living with HIV who know their status
- Number of people currently on antiretroviral therapy
- Number of people known to be on treatment 12 months after initiation of antiretroviral therapy
- Number of people testing positive for tuberculosis who adhere to treatment
- Number of people identified to have experienced sexual, physical, or emotional violence

- Number of people reached with individual or small group level community HIV-prevention interventions
- Number of people who were nutritionally assessed and received nutrition counselling and therapeutic or supplementary food
- Number of people provided with referrals for services in the past three months
- Number of people provided with completed referrals for services in the past three months
- Number of HIV-exposed infants receiving a virological test for HIV within two months of birth
- Number of HIV-exposed infants who are exclusively breastfed at three months of age
- Number of births to HIV-positive women attended by skilled health personnel
- Number of HIV-positive women who received antiretroviral therapy during pregnancy
- Number of HIV-positive pregnant women who received antenatal care at least four times prior to delivery

KEY POPULATIONS

In line with MEASURE Evaluation's work to build capacity for monitoring and evaluation of key population programs, the accompanying indicators will guide HIV program implementers in the collection and analysis of data for essential indicators. The standardization and harmonization of essential indicators for performance monitoring improves the effectiveness of efforts to reduce HIV transmission and increases rates of enrollment and retention in care among transgender people, sex workers, men who have sex with men, or people who inject drugs. Community programs have relied on community workers and community mobilization interventions to address HIV risk in key populations through activities like health education, condom distribution, and community organizing, among others. Community and outreach workers and peer volunteers are essential for effective targeting of key populations and bridge populations because these workers have a unique capacity to identify locations of higher prevalence of HIV and other sexually transmitted infections and offer support.

MEASURE Evaluation reached out to PEPFAR (United States President's Emergency Plan for AIDS Relief)—and other donor-supported programs implementing programs at the community level to support key populations, including the PEPFAR-funded LINKAGES—to obtain data collection tools. The tools received are used by community workers in Nigeria, Ethiopia, South Africa, Uganda, Kenya, Côte d'Ivoire, the Democratic Republic of the Congo, and Botswana to track and monitor outreach provided to key populations—including testing, sensitization trainings, and behavior change communication activities. The most common data elements among these tools were incorporated into the indicators in this collection. Each indicator is accompanied by a definition. These definitions were specifically designed to inform data collection by community programs and agents. To learn about the vulnerabilities faced by key populations living with, exposed to, or vulnerable to HIV (and to access associated tools and resources) go to the MEASURE Evaluation Key Populations or FHI360 LINKAGES main pages.

- Number of people who were tested for HIV and received their results
- Number of people living with HIV who know their status

- Number of people currently on antiretroviral therapy
- Number of people known to be on treatment 12 months after initiation of antiretroviral therapy
- Number of people who received sexually transmitted infection screening and treatment
- Number of people who report the use of a condom at last sex
- Number of people of reproductive age currently using a modern family planning method
- Number of people testing positive for tuberculosis who adhere to treatment
- Number of people identified to have experienced sexual, physical, or emotional violence
- Number of people reached with individual or small group level community HIV-prevention interventions
- Number of people who were nutritionally assessed and received nutrition counselling and therapeutic or supplementary food
- Number of people living with or affected by HIV provided with spiritual or psychosocial support services
- Number of vulnerable children provided with educational support services
- Number of people who accessed legal counsel, protection, or post-violence services
- Number of people provided with socioeconomic strengthening services
- Number of people provided with referrals for services in the past three months
- Number of people provided with completed referrals for services in the past three months

HIV PREVENTION

Decentralized, community-based HIV prevention interventions are designed to improve HIV-related knowledge and decrease engagement in high-risk sexual behaviors and usually involve a combination of behavioral, biomedical, and structural approaches. Combination HIV prevention interventions require empowerment approaches; efforts to address legal and policy barriers; strengthening of health and social and child protection systems; and actions to address stigma, discrimination, and gender inequality. Behavioral interventions can include sexual education, programs to reduce stigma and discrimination, counselling, and cash transfer programs. Biomedical interventions can include condom distribution, treatment of HIV and other sexually transmitted infections, prevention of mother-to-child transmission, needle exchange, and testing. Structural interventions tend to address inequality, decriminalization of sex work, homosexuality, drug use, legal protections for people living with HIV, and increased access to school for young girls. Importantly, evidence- and rights-based community-owned combination HIV prevention interventions have been shown to have the greatest effect in reducing new infections.

MEASURE Evaluation reached out to PEPFAR (United States President's Emergency Plan for AIDS Relief)—and other donor-supported programs implementing programs at the community level that support HIV prevention activities among key populations, including LINKAGES—to obtain data collection tools. The tools received are used by community workers in Nigeria, Ethiopia, South Africa, Uganda, Kenya, Côte d'Ivoire, the Democratic Republic of the Congo, and Botswana to track and monitor community HIV prevention interventions. The most common data elements among these tools were incorporated into the indicators in this collection. Each indicator is accompanied by a definition. These definitions were specifically designed to inform data collection by community programs and agents. To learn about the work of MEASURE Evaluation in HIV/AIDS, as well as associated tools and resources, go to the MEASURE Evaluation HIV/AIDS main page.

- Number of people known to be on treatment 12 months after initiation of antiretroviral therapy
- Number of people who received sexually transmitted infection screening and treatment
- Number of people who report the use of a condom at last sex

- Number of people of reproductive age currently using a modern family planning method
- Number of people identified to have experienced sexual, physical, or emotional violence
- Number of people reached with individual or small group level community HIV-prevention interventions
- Number of people provided with referrals for services in the past three months
- Number of people provided with completed referrals for services in the past three months
- Number of HIV-exposed infants receiving a virological test for HIV within two months of birth
- Number of HIV-exposed infants who are exclusively breastfed at three months of age
- Number of births to HIV-positive women attended by skilled health personnel
- Number of HIV-positive women who received antiretroviral therapy during pregnancy
- Number of HIV-positive pregnant women who received antenatal care at least four times prior to delivery
- Number of people infected or affected by HIV provided with spiritual or psychosocial support services
- Number of vulnerable children provided with educational support services
- Number of people who accessed legal counsel, protection, or post-violence services

HOME-BASED CARE

Home-based care at the community level has become central in the provision of HIV/AIDS care. Facilities are often burdened beyond their capacity to care for people living with HIV/AIDS and their families comprehensively. Home-based care is defined as any HIV and related care provided to people in their homes by formal or informal caregivers—including physical, psychosocial, palliative, and spiritual activities, and is mainly provided by community-based organizations.

MEASURE Evaluation reached out to PEPFAR (United States President's Emergency Plan for AIDS Relief)—and other donor-supported programs implementing at the community level that support home-based care activities, including LINKAGES—to obtain data collection tools. The tools received are those used by community workers in Nigeria, Ethiopia, South Africa, Uganda, Kenya, Côte d'Ivoire, the Democratic Republic of the Congo, and Botswana to track and monitor community home-based care and services. The most common data elements in these tools were incorporated into the indicators in this collection. Each indicator is accompanied by a definition. These definitions were specifically designed to inform data collection by community programs and agents.

- Number of people who were tested for HIV and received their results
- Number of people living with HIV who know their status
- Number of people currently on antiretroviral therapy
- Number of people testing positive for tuberculosis who adhere to treatment
- Number of people identified to have experienced sexual, physical, or emotional violence
- Number of people reached with individual or small group level community HIV-prevention interventions
- Number of people who were nutritionally assessed and received nutrition counselling and therapeutic or supplementary food

- Number of people infected or affected by HIV provided with spiritual or psychosocial support services
- Number of people provided with referrals for services in the past three months
- Number of people provided with completed referrals for services in the past three months

DATA USE CASES

MEASURE Evaluation reached out to implementing organizations to learn about instances where community-based HIV data for key indicators informed programmatic actions, plans, or decisions, ideally leading to associated changes in resource allocation or beneficiary outcomes.

The data use examples provided below detail cases where data collected for indicators in this collection have been used to inform decisions that led to reallocation of project inputs or that could be attributed to improved outputs or outcomes. Community-based projects can draw from these examples to inform their own data demand and use strategies, ensuring that results are interpreted regularly for use in decision making at all levels of a health system—a necessary step in controlling the HIV epidemic. See also our Conceptual Framework for Community-Based HIV Program Data Demand and Use.

Data Use Cases

Uptake of Antenatal Care and Community-Based Data for Decision Making in Ethiopia

HIV Testing for Vulnerable Children and Their Families in Côte d'Ivoire

HIV Status of Vulnerable Children in the Democratic Republic of the Congo

Active Versus Graduated Beneficiaries of an Orphans and Vulnerable Children Program in Uganda

ART Retention and an mHealth Initiative in Mozambique

Related Content

Community-Based HIV Program Framework for Data Demand and Use

Adapted from: MEASURE Evaluation data use conceptual framework.
MEASURE Evaluation. (2008, revised 2012). Data demand and information use in the health sector: Case study series. Chapel Hill, NC, USA: MEASURE Evaluation, University of North Carolina. Retrieved from https://www.measureevaluation.org/resources/publications/sr-08-44

RESOURCES

MEASURE Evaluation suggests consulting the list of resources below to learn more about monitoring and evaluating community-based HIV programs. The full collection is also available online at https://www.measureevaluation.org/community-based-indicators.

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Condom use at last high-risk sex. (2018, January 16). Retrieved from https://www.measureevaluation.org/prh/rh_indicators/womens-health/stis-hiv-aids/condom-use-at-last-high-risk-sex

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