JAMAICA NATIONAL HIV/STI PROGRAMME

Monitoring and Evaluation System Operations Manual

Jamaica National HIV/STI Programme Monitoring and Evaluation System 2007-2012

Document B:
M&E Operations Manual

National HIV/STI Programme

Ministry of Health and Environment
Jamaica

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Acronyms

ABC	Abstinence, Be Faithful and Condom Use
AIDS	Acquired Immune Deficiency Syndrome
ANC	Antenatal Clinic
ART	Antiretroviral Therapy
ARV	Antiretroviral Therapy
BCC	Behaviour Change Communication
CARICOM	Caribbean Community
CCM	Country Coordinating Mechanism
CI	Contact Investigator
CMIT	Caribbean Indicators and Measurement Tools
CPE	Community Peer Educator
CRIS	Country Response Information System
FBO	Faith-based Organization
GFATM	Global Fund to fight AIDS, Tuberculosis and Malaria
GoJ	Government of Jamaica
HATS	HIV Tracking System
HFLE	Health and Family Life Education
HIV	Human Immunodeficiency Virus
HMIS	Health Management Information System
IT	Information Technology
JN+	Jamaica Network of Seropositives
KABP	Knowledge, Attitudes, Behaviour, and Practices
LTA	Laboratory Technician Assistant
M&E	Monitoring & Evaluation
MEASURE	Monitoring and Evaluation to Assess and Use Results
MESST	Monitoring and Evaluation Systems Strengthening Tool
MERG	Monitoring and Evaluation Reference Group
MCSR	Monthly Clinic Summary Report
MICS	Multiple Cluster Indicator Survey
MOE	Ministry of Education
MOHE	Ministry of Health and Environment
MO(H)	Medical Officers of Health
MSM	Men who have Sex with Men
MTCT	Mother to Child Prevention
NAC	National AIDS Committee
NERHA	North Eastern Regional Health Authority

NHP	National HIV/STI Programme
NPHL	National Public Health Laboratory
NSP	National Strategic Plan
NGO	Non-Government Organisation
OVC	Orphans and Vulnerable Children
ON	Ophthalmia Neonatorum
PAA	Parish AIDS Association
PAHO	Pan American Health Organization
PEP	Post Exposure Prophylaxis
PEPFAR	President's Emergency Plan for AIDS Relief
PCR	Polymerase Chain Reaction
PLACE	Priority for Local AIDS Control Efforts
PLWHA	Persons Living With HIV
PMTCT	Prevention of Mother To Child Transmission
SERHA	South Eastern Regional Health Authority
SRHA	Southern Regional Health Authority
STI	Sexually Transmitted Infections
SW	Sex Worker
TCI	Targeted Community Interventions
TA	Technical Assistance
TB	Tuberculosis
UNAIDS	Joint United Nations Programme on HIV and AIDS
UNDP	United Nations Development Programme
UNESCO	United Nations Education Scientific and Cultural Organization
UNFPA	United Nations Population Fund
UNGASS	United Nations General Assembly Special Session on HIV
UNICEF	United Nations International Children's Fund
USAID	United States Agency for International Development
VCT	Voluntary Counseling and Testing
WB	World Bank
WHO	World Health Organization
WRHA	Western Regional Health Authority

Introduction

Monitoring and Evaluation (M&E) is the backbone of public health systems for providing essential information and evidence regarding the best practices and lessons learned in health programmes. The Jamaica National HIV/STI Programme's (NHP) M&E system collects high quality data, analyses that data to produce programme information and supporting evidence for decision-makers and stakeholders throughout the programme. The M&E system is described in two documents: the M&E Plan (Document A) and the M&E Operations Manual (Document B). They are fundamental follow-on documents to the National Strategic Plan (NSP). It is a companion document to the 2007-2012 National Strategic Plan (NSP); therefore, please refer to the NSP for detailed information on the programme's specific objectives and interventions.

Together, these documents guide the implementation of specific M&E activities in a standardized, uniform manner so that programme strategies can both gather information for day-to-day management, as well as provide information to parish, regional and national efforts. These documents also formalize procedures to ensure programme transparency and preserve institutional memory.

HOW TO USE THIS MANUAL

The NHP conducted two assessments to identify and address the needs of the M&E system. In 2006, the Stakeholder Capacity Assessment identified the need to clearly define roles and responsibilities for M&E activities at every level of the M&E system. In the 2008 M&E System Strengthening Stakeholder Workshop participants were keen to note that though there is a drafted NHP M&E Plan, an M&E Operations Manual is needed that includes Indicator Reference Sheets with key terms uniformly defined, standardized forms, clear reporting roles and responsibilities, data quality assurance (e.g., double counting, and commodity distribution reporting), and references to policies on data confidentiality.

Based on these findings, each data source section has been completed by stakeholders who reviewed the M&E Plan and identified their roles and responsibilities in operationalizing the M&E Plan. This information has been reported by data source in this Manual. In each data source, the reader will find data collection protocols for each data collection instrument. This includes responsible officer, frequency of collection, data flows, data storage issues and the related indicators. The information in this Manual is intended not only to implement or operationalize the M&E system, but also to institutionalize the system within the AIDS Response. The collaborative approach to developing this M&E Operations Manual is intended to increase ownership, accountability and data quality across the system.

This document is to be used as a companion to the M&E Plan and National Strategic Plan as reference documents. This manual should be used to orient staff to the M&E System and their role in it. It should be used to understand data sources, data flow and information use. It should also be used to understand indicators and their definitions.

Background

PURPOSE OF THE OPERATIONS MANUAL

This document is the M&E Operations Manual. This document complements the M&E Plan (Document A) by clearly detailing how each piece of the M&E system functions. Whereas the M&E Plan describes the overall M&E system and structural components (i.e., databases, indicators, etc.), the M&E Operations Manual provides specific national guidance on procedures, protocols, policies, roles, responsibilities, timelines and other implementation factors described in the M&E Plan. It also details the value of programme information for decision-making at the local, national and donor levels. It is important to note that the M&E Operations Manual was developed in collaboration with key stakeholders from across the HIV Response. The M&E Operations Manual is intended to be used by stakeholders at all levels that contribute to or participate in the national M&E system to ensure high quality data is reported and resulting information is received in a timely manner at all levels of programme implementation (i.e., facility, local, national and donor levels).

NATIONAL HIV/STI PROGRAMME M&E PLAN OVERVIEW

The M&E Plan builds on the NSP's description of the programme objectives and the interventions to further describe the M&E procedures implemented to determine whether or not those objectives are met. The objectives of the Jamaica National HIV/STI Programme M&E Plan are:

- To track the implementation of the National HIV/STI Programme activities and establish whether the programme objectives have been achieved;
- To increase the understanding of trends in HIV prevalence and explain the changes over time to allow for appropriate response to the epidemic; and
- To strengthen the capacity of the National HIV/STI Programme, regions, parishes and NGOs and civil society organizations to collect and use HIV data.

Furthermore, the National HIV/STI Programme M&E Plan includes key characteristics of a sound and comprehensive M&E system for a National AIDS Programme as outlined by UNAIDS. These characteristics are listed below:

- Ensure efficient use of data and resources by making sure that indicators and sampling methodologies are comparable over time;
- Avoid duplication through repeat of baseline surveys or evaluation studies by ensuring that generated data serve many constituents, including programme managers, researchers or donors;
- Nationally, make sure that donor-funded M&E efforts best contribute to national needs, rather than simply serving the reporting needs of agencies or legislatures overseas;
- Encourage communication between different groups involved in the national response to HIV. Shared planning, execution, analysis or dissemination of data collection can reduce overlap in programming and increase co-operation between different groups;
- Facilitate ultimate use of data and indicators for programme planning and evaluation.
- Streamline data collection to focus only on needed data.

The M&E Plan first describes the relationship between the programme's expected outputs, outcomes, objectives and goals. It then describes the data and information required to illustrate this relationship (i.e., the indicators). Next, the M&E Plan details the necessary data sources, data collection systems, and information flow maps. In this way, the M&E Plan explains how a programme will measure its achievements and provide for accountability to the stakeholder and donor communities.

RELATIONSHIP BETWEEN NATIONAL-LEVEL AND PROGRAMME-LEVEL M&E SYSTEMS

The goal of the NHP M&E system is to track the progress of the national response to HIV and STIs and to enable decision-making from a national perspective. The NHP M&E system collects data from each priority and programme area (e.g., Voluntary Counseling and Testing (VCT), Prevention of Mother to Child Transmission (PMTCT) and clinical care) for use by the implementers of the programme and for feedback to the national M&E system. Programme-level M&E systems should collect ALL of the information that is needed to measure the national indicators at a minimum. In addition to what is required by the national M&E system, a programme-level M&E system should collect data that pertains to programme- or intervention-specific indicators to best inform the local level response. When deciding what indicators the programme should collect, programme stakeholders should be guided by the principle of **"collect it only if is useful to use"** and explicitly document decisions to be made, or questions answered, from collected data. Each programme or priority area's set of implementation guidelines should include clear roles and responsibilities for reporting to the local and national M&E systems (i.e., national forms, reports, and databases). Figure 1, on page 4, illustrates the National HIV/STI Programme M&E System Conceptual Model.

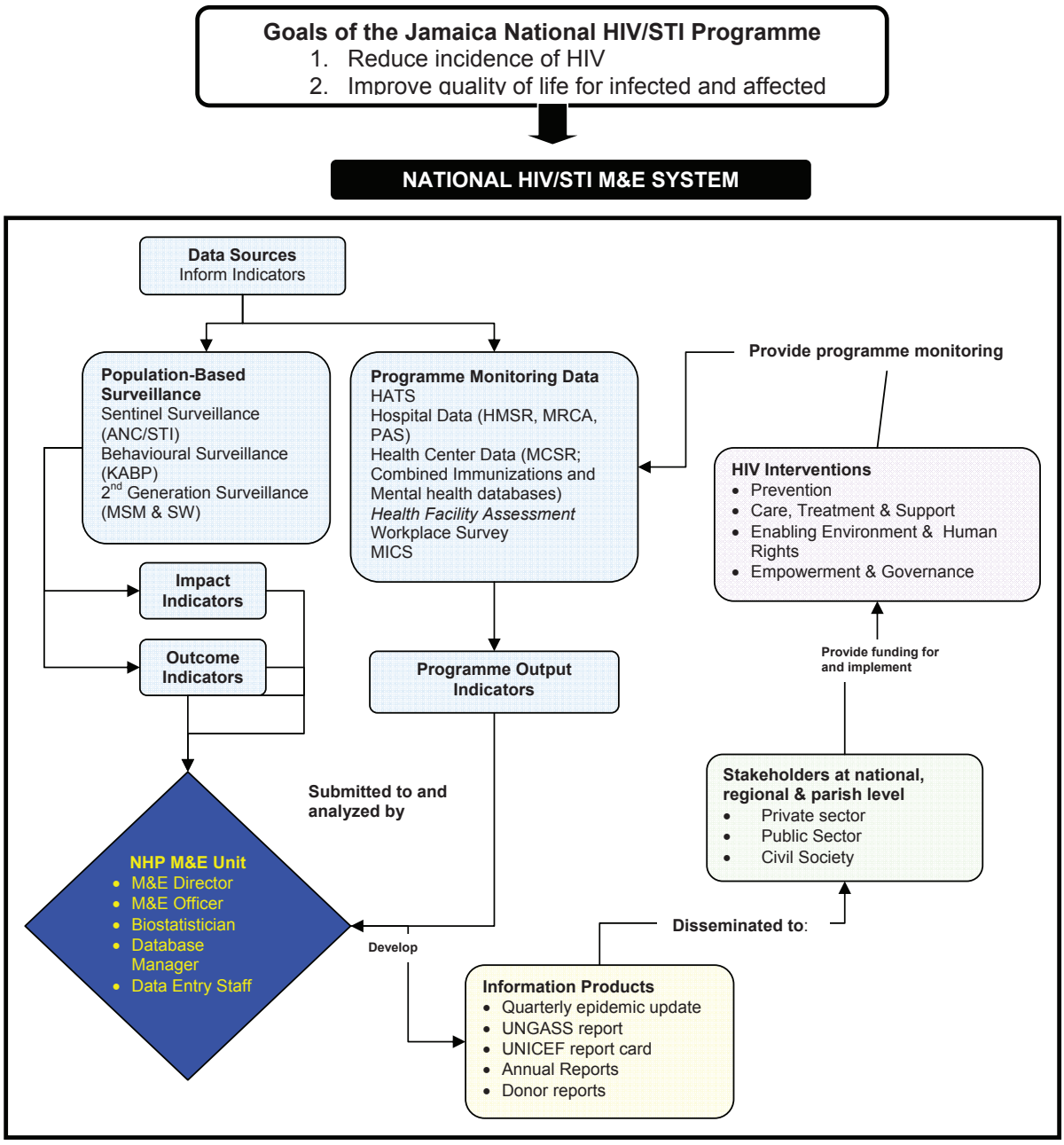


FIGURE 1: National M&E System Conceptual Model

Developing, Implementing, and Updating the M&E Operations Manual

This Manual has been designed based on the findings from the 2006 Stakeholder Capacity Assessment and the 2008 M&E System Strengthening Stakeholder Workshop. In both exercises, stakeholders emphasized the need to clearly define roles and responsibilities for M&E activities at every level of the M&E system. Stakeholders were also keen to note that though there is a drafted National M&E Plan for the NHP, an Operations Manual is desired to include Indicator Reference Sheets with key terms uniformly defined, standardized forms, clear reporting roles and responsibilities, data quality assurance (e.g., double counting, and commodity distribution reporting), and references to policies on data confidentiality. From this information, this Manual has been completed in collaboration with key stakeholders.

STAKEHOLDERS

In addition to Figure 2, human capacity is an overarching piece of the system that is essential and crucial for system success. **This document describes in detail the specific roles and responsibilities of each key stakeholder group.** Figure 2 depicts stakeholders based on the extent of their involvement in the system, as determined by the Capacity Assessment Workshop in August 2006 (see assessment findings below). For example, the M&E Unit of the National HIV/STI Programme (NHP) is the primary stakeholder. Other units in NHP are strongly linked to the system. At levels two, three and four, the stake in or influence on the system becomes progressively less. This stakeholder map was adapted and endorsed in the national stakeholder meeting, 2006. Beyond these listed organizations, everyone working in the National HIV/STI Programme has a role in M&E. Roles vary from completing forms upon service delivery, entering quality data, data analysis and interpretation, report writing, report review, and programme review. Programme managers, service providers, statisticians, assistants, and supervisors all play an important role in the system.

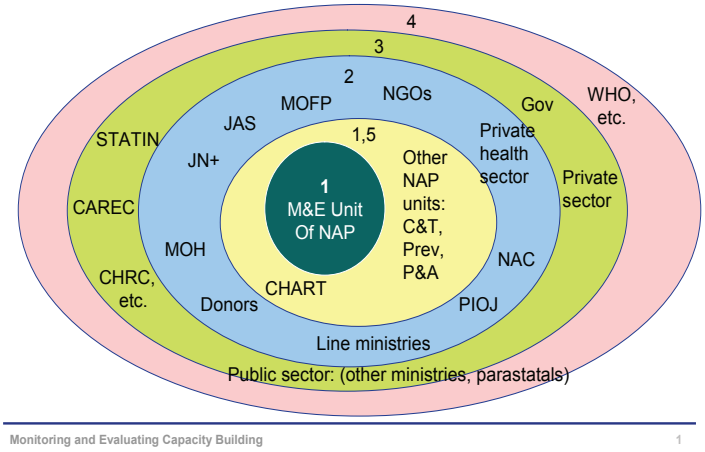


FIGURE 2: HIV/AIDS M&E System Stakeholder Map

NHP STAKEHOLDER CAPACITY ASSESSMENT

In response to a request for technical support for assessing the capacity of the national HIV AIDS M&E system in Jamaica, MEASURE Evaluation facilitated a capacity consultation and strategic planning process with the National HIV/STI Programme (NHP) and its partners in August 2006. The overall aim of this process was to assess priorities for building the capacity of the national M&E system.

Prioritization of Performance Gaps

As a way to assess individual perceptions of the strengths and gaps of the current M&E system, meeting participants were asked to complete a self-assessment questionnaire. Following the presentation of the aggregated results, participants were asked to prioritize the identified gaps in order of importance. Through discussions and anonymous individual voting, participants selected the following four performance gaps as most critical.

1. Clear and agreed upon roles and responsibilities — Participants agreed that the success of the system is largely affected by stakeholder ownership of their roles in the M&E process. Considering the current and ongoing lack of human resources, it is especially important for those involved in the system to have a clear understanding of the roles that are expected of them.

   For example, participants noted a gap at the parish level regarding taking responsibility for completing data collection forms. Although the task of completing data summary forms is included in the job descriptions of regional coordinators, they are dependent on those in facilities in the parishes to complete and submit their forms. However, at the parish level, there is no existing mandate to collect these data. Participants agreed that a guide or protocol that includes detailed roles for those involved in different parts of the system would be a helpful tool.

   Participants also advised that regional differences in operational procedures as a result of decentralization should be taken into consideration when making plans for standardization. It is important for each group to identify how data will be collected and who will do it. The regional representative should be the advocate for this process. In general, health providers know what they need to report, but the problem is data flow. As a result of this, it is suggested that regional standardized operating procedures be developed.

2. Standardization of what is to be reported and by whom — Participants discussed how overall dissemination of standardized forms and processes and training of those involved in the system is lacking. They also stated that standardized tools need to be supported by clear definitions through a streamlined implementation and training process in all sectors. In addition, participants stated the importance of standardized forms being respected and maintained in the original format.

3. Communication of M&E results to stakeholders — Although communication channels exist, there remain some key deficiencies. For example:
   - Quarterly feedback sessions for providers exist but capacity to prepare reports varies by parish.
   - Feedback is not routine.
   - Available information is aggregated to a level that loses meaning for specific users.
   - Resource constraint: lack of infrastructure to do all necessary analyses.
   - The same challenges exist for NGOs. Getting useful information to help guide proposal development and programme planning can be difficult.

   A number of solutions for improving the communication of information were discussed. To address this gap, participants stated the importance of understanding the information needs of stakeholders when developing communication plans. The direct relationship between communicating information and data demand and quality was not unnoticed by the group. Participants discussed how sharing information can subsequently increase standardized data collection and improve quality. In addition, participants put forward solutions including strengthening feedback systems so that reports are shared with those who are responsible for initially collecting the data.

In order to support the relevance of the information, participants suggested analyzing data by parish and supporting parishes in analyzing the data they collect. Access to data was also viewed as a contributing factor to improved communication.

Existing communication mechanisms were also recognized by the group. These include: the annual review (during which several stakeholders present information); the M&E Reference Group (MERG); and the NHP website.

4. Incentives for performance — Participants recognized that although there are resource constraints to providing monetary incentives, there are a number of alternative mechanisms for rewarding high performance. These include positive feedback, trophies and certificates for good performance, and making it known to individuals that their work is valued.

M&E SYSTEM STRENGTHENING STAKEHOLDER WORKSHOP

In February 2008, the NHP conducted an M&E System Strengthening Stakeholder Workshop. This workshop is required by the Global Fund to fight AIDS, TB, and Malaria prior to grant signing. It was conducted by implementing the M&E System Strengthening Tool (MESST). MESST is a stakeholder self-assessment of the existing national HIV M&E system that aims to produce the following benefits:

- **Better identify M&E capacity gaps and corresponding strengthening measures**, including through Technical Assistance (TA)
- **Guide investments in M&E** before Grant Signature (within the recommended range of 5%-10% of the overall Budget)
- Ensure that such investments contribute to the strengthening of the National Systems (avoiding parallel reporting systems)
- **Enhance the quality of programmatic data** to improve programme management and to support Performance-based Funding

The activity also builds M&E capacity of NHP programmatic staff, M&E staff, and key stakeholders thought the self-assessment process. These efforts additionally support the Three Ones principle of one agreed M&E system for the national HIV response.

The MESST divides the M&E system into 3 main components: M&E Plan, Data Management, and Data Collection and Reporting (per Programmatic Area). Each component is assessed by a checklist. These checklists are systematic questionnaires that allow stakeholders to take a look at the M&E system and rate areas of strength and weakness. Once completed, the checklists are analyzed and then presented in a Dashboard. The Dashboard allows stakeholders to quickly see the general strengths and weaknesses of each component. Once the checklists are completed and Dashboards are reviewed, the Stakeholders develop specific Action Plans to address the M&E system weaknesses in each of the 3 areas. Action Plans are then costed and Technical Assistance needs are identified.

Thirty-six participants (excluding facilitators) from 21 organizations participated in the February 2008 workshop. Participants represented three priority areas listed in the National Strategic Plan (Prevention, Treatment and Care, and Enabling Environment, and Governance). Organizations included several line ministries, parish AIDS associations, NGOs, international development partners and donors. Participants represented organizational leadership and M&E technical leadership.

The NHP has a strong M&E System with several functioning databases, a National M&E Plan and

Operations Manual linked to the National Strategic Plan, an established M&E Unit, and stakeholders invested in producing highly quality data. Capacity building efforts are continuously underway by the NHP M&E Unit. However, there is still room for development.

The most significant weaknesses identified by stakeholders are:

- Though more than 7% of the overall budget is allocated to M&E activities, key M&E posts at the M&E Unit remain vacant. Overall there is a lack of human resources to strengthen the capacity of M&E at the national, regional and organizational levels.
- Though there is a drafted National M&E Plan for the NHP, an Operations Manual is desired to include Indicator Reference Sheets with key terms uniformly defined, standardized forms, clear reporting roles and responsibilities, data quality assurance (e.g., double counting, and commodity distribution reporting), and references to policies on data confidentiality.
- There is a need to develop mechanisms to ensure quality of data (completeness, correctness, timeliness) and ensure that the data can be verified.
- CBOs and NGOs should be included in M&E capacity building activities.

M&E System Strengthening measures include completing Indicator Reference Sheets for the NHP, finalizing the M&E Plan and associated Operations Manual. The Indicator Reference Sheets should clearly identify key terms (e.g., Training, Capacity Building, OVC, etc). The Operations Manual should reference or address data quality, double counting, and confidentiality issues.

Key M&E Capacity Building measures included rolling-out of M&E materials to increase stakeholder awareness and capacity to improve the M&E system functionality; filling vacant Biostatistician and Research Officer posts at the NHP; reviewing and revising Terms of Reference to explicitly include specific M&E activities for NGOs, CBOs and facilities, and amending existing contracts to include specific M&E activities.

M&E REFERENCE GROUP (MERG)

In 2006, the National HIV/STI Programme's (NHP) Monitoring and Evaluation (M&E) Unit in collaboration with key partners, The Joint United Nations Programme on HIV/AIDS (UNAIDS) Office Jamaica and United States Agency for International Development (USAID) organized a meeting of the M&E Reference Group (MERG), which consisted of key stakeholders to guide and advise the M&E tasks for the programme. The purpose of the MERG, as articulated in the Terms of Reference developed in 2006, is to monitor and evaluate the effectiveness of the National HIV/STI Programme in Jamaica by tracking programme inputs, outputs and assessing their impacts.

One of the MERG's first tasks was to assist with the consolidation of all indicators that the NHP was obligated to report to donors and other stakeholders into one agreed nationally consolidated list. This national list became a key element of the M&E Plan, an accompanying document to the National Strategic Plan (NSP) for HIV (2007-2011). The MERG has also been instrumental in the section of Universal Access Indicators and setting targets.

The Group was established to meet semi-annually to review the M&E Plan and its implementation, provide suggestions for assessments and modifications, and guide the overall system. The Group consists of representatives from stakeholder organizations in the national response, such as Regional Health Authorities, NGOs, Line ministries, Donors, and other implementing Partners. During the development of the NSP, the M&E Plan and Global Fund Round 7 and Rolling Continuation Channel Proposals, the work of the MERG completed with critical priorities of the NHP. It therefore did not function for

some time. A MERG meeting was convened by the NHP on March 3, 2009 to discuss revised Terms of Reference for the MERG. The revised Terms of Reference is outlined on page 187.

UPDATING AND ONGOING CAPACITY BUILDING

The M&E Unit has explicitly included capacity building activities in its annual work plan as a way to maintain stakeholder engagement in M&E activities and further strengthen the coordination of the M&E system. Given this edition of the M&E Operations Manual is the first of its kind, and accompanied by the M&E Plan (Document A), the M&E Unit has included in its work plan to conduct a series of workshops for the pair of documents to solicit stakeholder buy-in and increased understanding of the components of the M&E Plan, roles and responsibilities for data collection and reporting, and various uses for the information generated from the data.

Data Collection, Flow and Use

GUIDING PRINCIPLES

The M&E Operations Manual was developed in collaboration with the MERG and key stakeholders through a series of workshops and meetings. The following is a list of guiding principles of the development process and the M&E system operations as described in this manual.

- Not all data sources are available immediately or in a uniform state of readiness;
- The majority of data sources are already in existence.
- Data are generated at varying levels and in various forms, either as part of implementation of HIV interventions, or in a stand alone manner as part of research or survey activities. The M&E system needs to draw on existing data and generate new data to avoid duplication and avoid gaps in analysis;
- The data are not collected by the M&E unit. The M&E unit collates the information at the national level from local stakeholders and reports to the Country Coordinating Mechanism, and other donor entities, and national legislators as part of the national M&E system for decision making and policy formulation;
- The M&E system needs to be understood by and accessible to all stakeholders involved in the HIV response. By implication, it should not be complicated and should provide useful information to the stakeholders;
- The M&E system needs to be useful to a variety of stakeholders, and be responsive to their needs;
- The structure and components of the M&E system need to be integrated into existing systems and acceptable to stakeholders;
- M&E is a dynamic process and new developments, such as the results of pilot studies, need to be incorporated and up-scaled within the M&E system;
- It is important that the logical arrangement of the M&E Framework should be done in such a way that donors, civil society, government and implementers know where their HIV programmes fit into the national HIV plan;
- The M&E system needs to strike a balance between providing a meaningful overview of every programme area and providing a national overview.

The M&E Plan (Document A) provides a detailed description of each data source used by the National M&E System and an overview of data quality issues. The M&E Operations Manual provides additional information on how the data are collected, how the data flow through the system and how the information can be used at all levels of the system. (See Appendix II for copies of all necessary forms and instructions). Existing M&E systems often focus on data collection and reporting to higher levels, with little attention paid to how data can be used locally to improve programme performance. As a result, there are many missed opportunities for feed back and for using data well. The following may occur as a result:

- Local data are not used locally
- Higher-level information does not return back to the local level
- Local data are not assessed in a broad context
- Little incentive to produce high-quality data in a timely manner

DATA FLOW

Typically, national M&E systems focus primarily on data collection and reporting to national leaders and international donors. That is, local data support national and donor level analyses and reports, but

are not used locally. This one-directional flow misses opportunities to provide valuable feedback to regional and local programmes. These missed opportunities may prevent local programmes from making simple mid-course corrections that could positively impact the health of their communities. Additionally, if information is not uniformly available so that it can be accessed and used by local programmes, there is little incentive to report quality data in a timely manner.

The MOHE and other stakeholders in the NHP recognize the importance of timely and accurate local level data and the use of that data by the data collectors as part of a fully functioning M&E system. Figure 3, which illustrates the flow of data within the National M&E System between data collector and information user, was developed for the 2001-2006 National Strategic Plan. In the past year (2006-2007), the strengthening of the M&E Resource Group (MERG), the development of the M&E Working group, and additional technological advances (e.g., improved MOHE website management) have improved the ability for national and regional level data users to provide information back to the local level; more work will be done in the future. This M&E Operations Manual includes revised procedures, information products, and information flow maps for each programme area in the M&E Operations Manual to further assist local facilities and programme managers in accessing the system's information.

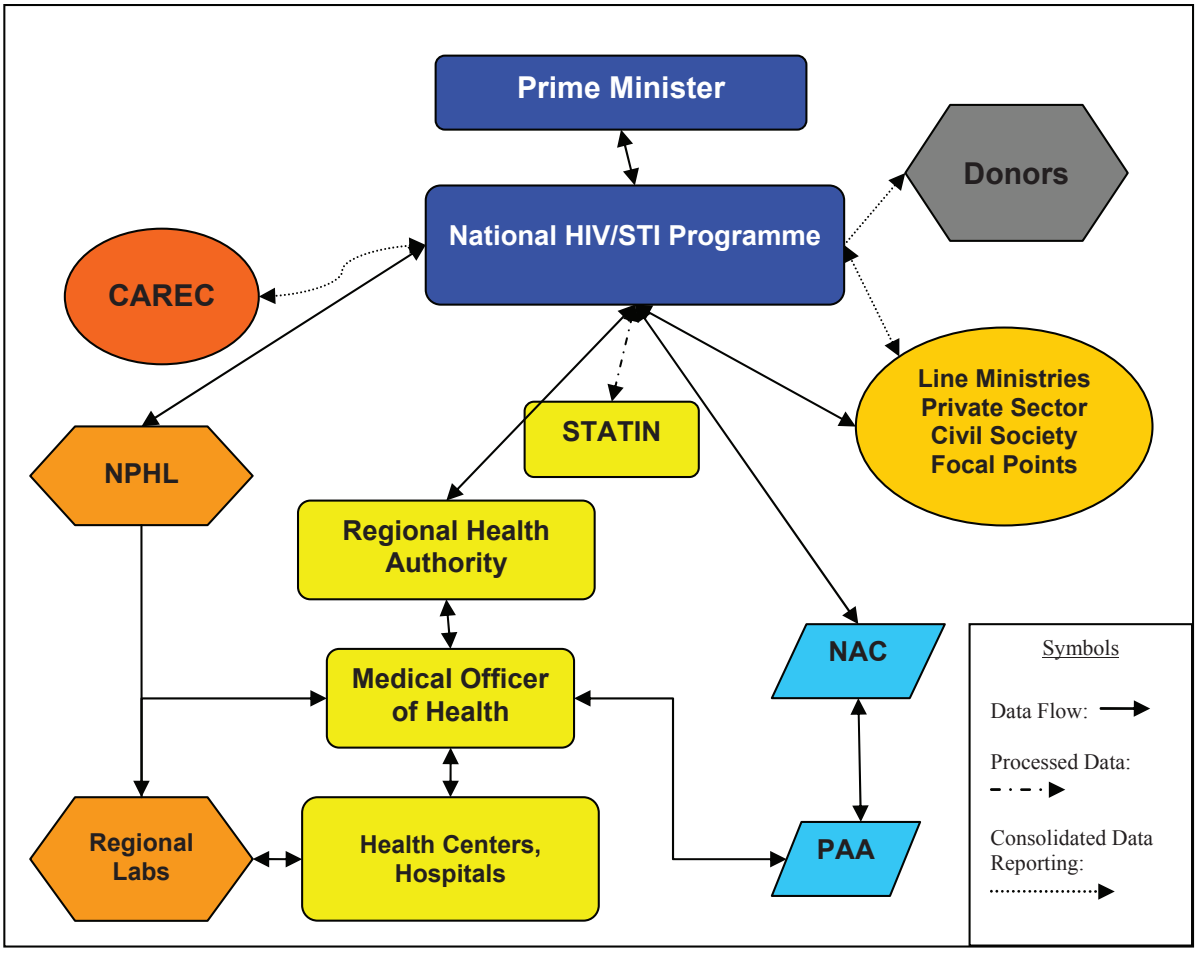


FIGURE 3: National M&E System Data Flow, Jamaica

DATA DEMAND AND INFORMATION USE

A challenge for many M&E systems is that important programme and policy decisions are often made based on insufficient data, even when there is a wealth of information available. In the past 5-10 years, the National HIV/STI Programme has made tremendous progress in its data collection effort, particularly in regards to research; however, often the reports containing the results are still not used to drive evidence-based programme and policy decisions at all levels of the health system.

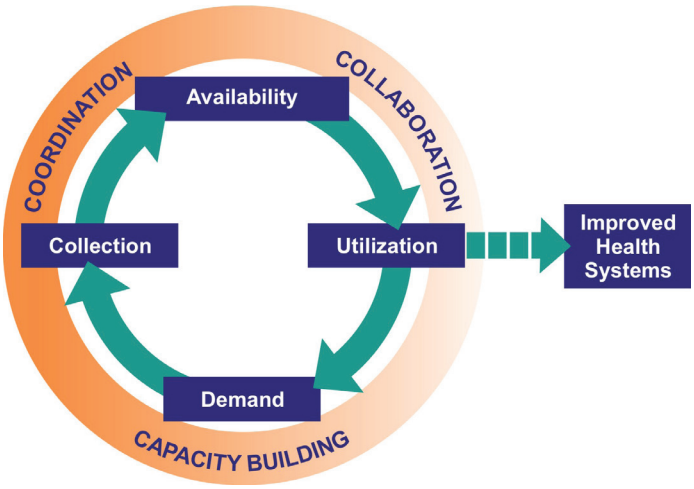


FIGURE 4: Data Demand-Collection-Use Contiuum

Evidence-based decision making is enhanced by demand for health information, the collection and analysis of health data, making information available to decision makers, and finally, from facilitating use of information to improve health system performance. Figure 4 illustrates the Data Demand-Collection-Use Contiuum. There is a clear and consistent link between the use of health information and the commitment to improving the quality of data upon which it is based. The more positive experiences a decision maker has in using information to support a decision, the stronger will be the commitment to improving the quality and timeliness of data collection systems. **Evidence-based decision-making will promote the achievement of improved health outcomes.**

This section is designed to specifically address, for each health region in Jamaica, the data collection and flow for each major data source, and how each of these sources can be used to make programme and policy decisions at all levels of the system.

Indicators

Indicators are variables that measure one aspect of a programme or project related to the programme's objectives. Indicators provide M&E information crucial for decision-making at every level and stage of programme implementation. The National HIV/STI Programme M&E system collects data on indicators at several levels: global, national, and local. Each level in the system has different data needs and will use the indicators differently.

Global indicators are required to sustain donor support and help provide a reflection of the current HIV situation in the global context. In order for global indicators to be meaningful across countries, all must agree on what the indicator means, how to measure it, and must record it in the same way. Examples of global indicators for which Jamaica collects data are those reported to the United Nations General Assembly Special Session on HIV (UNGASS), and donors such as the World Bank, the Global Fund and USAID — President's Emergency Plan for AIDS Relief (PEPFAR) indicators.

National focus indicators help set the national health agenda and to monitor programme effects. The National HIV/STI Programme, in collaboration with its stakeholders, has developed a list of national focus, or Core, indicators for this purpose. Many of these indicators overlap with global indicators. Facility-level indicators provide more detailed, local-level information to help programme planners decide how best to address specific challenges (e.g., managing scarce resources to best meet the needs of its clients). They provide information on whether or not the target population is being reached, how well services are being provided, and whether or not sufficient resources exist to be able to provide adequate services. These are usually not required for programme management at the national level, but helpful for facility-level management.

The national focus indicators, which are included in the National Strategic Plan, are also presented as a separate table in Section 3.2. Section 3.3 provides a complete list of all of the indicators, both global and national, on which the programme must collect data and report.

INDICATOR REFERENCE SHEETS

Please see Appendix I for a detailed Indicator Reference Sheets that provide detailed information on measurement, data quality, data sources, frequency, persons responsible, baselines, targets, and data tool development for each indicator.

Key indicator definitions of note: Indicators measuring capacity building, technical assistance, trainings, and interventions will have specific guidance on how these terms are defined for the purposes of data collection against these indicators. It is imperative that all stakeholders are aware of the definitions and limitations for these indicators to avoid double counting and other data quality issues. Before each reporting period, please take time to review the Indicator Reference Sheets (Appendix I) Data Quality and Accountability section below.

USES FOR THE INDICATORS

Indicators provide an evidence-based overview on programme strengths and weaknesses. They are used to monitor programme effects and speak to how effectively a programme strategy and plan meet the national health agenda. Information is only good when it is used. The information garnered from the indicators can be used to make intervention-related decisions. Data that are not useful or that cannot

be used should not be collected. Often, it is not that the data itself are useless, but that more training is needed on how to use it effectively. The M&E Operations Manual discusses in detail the procedures and issues related to data collection and use. However, instances of information use at the global, national and local levels are provided below.

Global indicators are used by donors for decisions regarding:
- Realistic international 5-year targets
- Funding allocation
- International conferences and meetings

National indicators have been identified to inform decision and policy makers on:
- The level of donor commitment, and when high-level negotiations and changes are necessary
- How well the national system is functioning, and where additional support and training are needed

At the local level, indicators can provide information for managers and planners that will help to determine:
- Priority target groups
- How to most effectively allocate limited funding (programmes, supplies, staff, etc.)
- Types of outreach activities that are needed
- Barriers to accessing prevention and treatment services

SUMMARY OF NATIONAL FOCUS INDICATORS FOR 2007-2012 PROGRAMME YEAR

The indicators listed below are only those used to monitor and evaluate the National HIV/STI Programme, as noted in the NSP Logical Framework. Some of these indicators overlap with the global indicators while others are specific to the Jamaican response to HIV. The indicators are listed with the corresponding NSP location (i.e., priority area and programmatic approach level) and donor association as a means to map the indicator to NSP and global donor frameworks.

Priority Area 1: Prevention

NSP	DONOR	INDICATORS	PAGE #
GOAL	UNGASS/GFATM	Percentage of men and women aged 15 to 24 that are HIV infected	23
GOAL	UNGASS/USAID	Percentage of SW who are HIV infected	24
GOAL	UNGASS/USAID	Percentage of MSM who are HIV infected	25
PURPOSE	GFATM/USAID	Number of individuals reached through TCI disaggregated by vulnerable groups (e.g. youth, MSM, SW, prisoners, etc.)	26
PURPOSE, P7-P10, P12, P16	GoJ MOHE	Number of persons trained to provide prevention services by client and service area	27
P2	UNGASS/GFATM/ CARICOM/CMIT	Percentage of young women and men aged 15-24 who both correctly identify ways of preventing the sexual transmission of HIV and who reject major misconceptions about HIV transmission	28
P4, P11, P15, P17	UNGASS/GFATM/ CMIT	Percentage of young adults, 15 to 19 years old, who have never had sex	29
P4, P15	UNGASS/GFATM/ CMIT	Percentage of young women and men aged 15-24 reporting the use of a condom the last time they had sex with a non-regular partner	30

NSP	DONOR	INDICATORS	PAGE #
P5	UNGASS/GFATM/ CMIT/USAID	Percentage of SW reporting using a condom at last sex act with client	31
P6	UNGASS/GFATM	Percentage of men reporting using a condom the last time they had anal sex with a male partner	32

Priority Area 2: Treatment, Care, and Support

NSP	DONOR	INDICATORS	PAGE #
GOAL	UNGASS/CARICOM	Percentage of adults and children with HIV known to be on treatment 12 months after initiation of ART	35
PURPOSE, T1	UNGASS	Percentage of most-at-risk populations (youth, MSM, SW) who received HIV testing in the last 12 months and who know their results	36
PURPOSE, T1	UNGASS	Percentage of men and women aged 15-49 who received HIV testing in the last 12 months and who know their results	37
PURPOSE, T3	UNGASS/GFATM	Percentage of adults and children with advance HIV infection who are receiving antiretroviral combination therapy according to national guidelines	38
T2	UNGASS/GFATM/ GOJ/USAID	Percentage of infants born to HIV-infected mothers who are HIV-infected	39
T4	GFATM	Percentage of PLWHA on ART reporting at least 90% adherence by pill count	40
T5	UNGASS	Current school attendance among orphans and non-orphans aged 10-14	41
T8, T12	GoJ MOHE	Number of persons trained to provide treatment services by client and service area	42
T9	GoJ MOHE	Proportion of confirmed TB cases tested for HIV	43
T10	GoJ MOHE	Incidence of congenital syphilis	44

Priority Area 3: Enabling Environment and Human Rights

NSP	DONOR	INDICATORS	PAGE #
GOAL	GFATM/CMIT	Percentage of people 15-49 years expressing accepting attitudes towards people with HIV	47
PURPOSE, E5	GFATM	Number and percentage of reported cases of HIV-related discrimination receiving redress by setting	48
PURPOSE	GoJ MOHE	Number of persons trained to provide services by client and service area	49
E8	GoJ MOHE	Number of policy makers attending sensitization workshops on HIV/STI	50
E9	PEPFAR	Number of local organizations provided with technical assistance for HIV-related policy development	51

Priority Area 4: Empowerment and Governance

NSP	DONOR	INDICATORS	PAGE #
GOAL, PURPOSE	UNGASS	National Composite Policy Index	55
GOAL, PURPOSE	UNGASS	AIDS spending, by categories and financing source	56

NSP	DONOR	INDICATORS	PAGE #
PURPOSE	GoJ MOHE	Number of persons trained to provide services by client and service area	57
G2	PEPFAR	Number of local organizations provided with technical assistance for HIV-related policy development	58
G6	GoJ MOHE	Number of NGOs providing HIV prevention, treatment, care and support services according to national guidelines/standards	59
G2	UNGASS	Percentage of schools that provided life skills-based HIV education in the last academic year	60
G7	GoJ MOHE	Number of policy makers attending sensitization workshops on HIV/STI	61

SUMMARY OF COMPLETE LIST OF INDICATORS FOR 2007-2012 PROGRAMME YEAR

Below is a list of the National Focus Indicators (in bold) and additional global indicators for which the NHP is responsible. This list of indicators provides a complete picture of the Jamaican response to HIV, as measured by national and international indicators.

Priority Area 1: Prevention

DONOR	INDICATOR
	IMPACT
UNGASS/ GFATM/ CARICOM	**Percentage of men and women aged 15 to 24 that are HIV infected**
UNGASS/USAID	**Percentage of SW who are HIV infected**
UNGASS/USAID	**Percentage of MSM who are HIV infected**
CARICOM	Prevalence of HIV among STI clients
CARICOM	AIDS Case rate
	OUTCOME
UNGASS/GFATM/ CMIT	**Percentage of people by sex and age groups who reported condom use at last intercourse with non-regular partner**
UNGASS/GFATM/ CMIT/USAID	**Percentage of SW reporting using a condom with most recent client**
UNGASS/GFATM	**Percentage of men reporting using a condom the last time they had anal sex with a male partner**
UNGASS/GFATM/ CARICOM/CMIT	**Percentage of young women and men aged 15-24 or at risk groups who both correctly identify ways of preventing the sexual transmission of HIV and who reject major misconceptions about HIV transmission**
GFATM	**Percentage of young adults, 15 to 19 years old, who have never had sex**
GFATM	Percentage of 15-19 year olds who reported no sexual actively in the last 12 months
UNGASS/CMIT	Percentage of donated blood units screened for HIV in a quality assured manner
UNGASS	Percentage of young women and men aged 15-24 who have had sexual intercourse before age 15
UNGASS/GFATM/ CMIT	Percentage of young women and men aged 15-49 who have had sex with more than one partner in the last 12 months
UNGASS	Percentage of 15-49 year olds who have had more than one sexual partner in the past 12 months who report the use of a condom during their last sexual intercourse

DONOR	INDICATOR
CIMT	Percentage of people 15-49 years old who can access a condom almost immediately (less than 5 minutes)
OUTPUT & PROCESS	
GFTAM/ USAID	**Number of individuals reached through TCI including vulnerable groups (e.g. youth, MSM, SW, prisoners, etc.)**
GoJ MOHE	**Number of persons trained to provide prevention services by client and service area**
GFATM	Number of inmates, sex workers and MSM reached through prevention activities
GFATM	Number of service deliverers trained on HIV prevention
GFATM	Percentage of schools that provided life skills-based HIV education in the last academic year
GFATM	Number of students reached through life skills-based Health and Family Life Education interventions in schools
GFATM	Number of adolescents (10-14) and youth (15-24) reached through prevention interventions in out-of-school settings
PEPFAR	Number of individuals trained to promote HIV prevention through abstinence and/or being faithful
PEPFAR	Number of individuals trained to promote HIV prevention beyond abstinence and/or being faithful
PEPFAR	Number of individuals trained in HIV-related community mobilization for prevention, care and/or treatment
PEPFAR	Number of individuals reached through community outreach that promotes HIV prevention through abstinence and/or being faithful.
PEPFAR	Number of individuals reached through community outreach that promotes HIV prevention through other behaviour change beyond abstinence and/or being faithful

Priority Area 2: Treatment, Care and Support

DONOR	INDICATOR
IMPACT	
UNGASS/CARICOM	**Percentage of adults and children with HIV known to be on treatment 12 months after initiation of ART**
UNGASS/GFATM/ GOJ/ USAID	**Percentage of infants born to HIV-infected mothers who are HIV infected**
OUTCOME	
UNGASS	**Current school attendance among orphans and non-orphans aged 10-14**
UNGASS	**Percentage of men and women aged 15-49 who received an HIV test in the last 12 months and who know their results**
UNGASS	**Percentage of most-at-risk populations (youth, MSM, & SW) who received HIV testing in the last 12 months and know their results**
UNGASS/GFATM	**Percentage of adults and children with advance HIV infection who are receiving antiretroviral combination therapy according to national guidelines**
GFATM	**Percentage of PLWHA on ART reporting at least 90% adherence by pill count**
GoJ MOHE	**Proportion of confirmed TB cases tested for HIV**
GoJ MOHE	**Incidence of congenital syphilis**
UNGASS/UNAIDS	Percentage of estimated HIV-positive incident TB patients that received treatment for TB and HIV
WB/GoJ	Percentage ANC clients that are counselled and tested for HIV

DONOR	INDICATOR
UNGASS/GFATM/ CMIT	Percentage of HIV positive pregnant women who received a complete course of ARV prophylaxis to reduce the risk of MTCT
UNGASS/CMIT	Percentage of orphaned and vulnerable children (boys and girls, aged 0-17) whose households received free basic external support in caring for the child
GFATM/CMIT	Number of individuals counselled and tested for HIV according to guidelines in last 12 months & who know their results
GFATM	Number of infants born to HIV+ mothers receiving PCR testing according to national standards
GFATM	Number of individuals (children & adults) receiving CD4 tests in the public sector according to national guidelines
GFATM/CMIT	Number of individuals (children & adults) on ART receiving viral load testing in accordance with guidelines
OUTPUT & PROCESS	
GoJ MOHE	**Number of persons trained to provide treatment services by client and service area**
GFATM	Number of public sector sites offering ART
GFATM	Number of PLWHA receiving adherence counselling
GFATM	Number of adherence support groups started by NGO/PAC partnerships using trained PLWHAs

Priority Area 3: Enabling Environment and Human Rights

DONOR	INDICATOR
OUTCOME	
GFATM	**Number of cases of HIV related discrimination reported by setting**
GFATM/CMIT	**Percentage of people 15-49 years expressing accepting attitudes towards people with HIV**
GFATM	**Number and percentage of reported cases of HIV-related discrimination receiving redress by setting**
GFATM	Number of large (>100 employees) private organizations not requiring pre-employment HIV tests
OUTPUT & PROCESS	
GoJ MOHE	**Number of policy makers attending sensitisation workshops on HIV/STI**
PEPFAR	**Number of organizations provided with technical assistance for HIV-related policy development**
GoJ MOHE	**Number of persons trained to provide services by client and service area**
PEPFAR	Number of local organizations provided with technical assistance for HIV-related institutional capacity building
PEPFAR	Number individuals trained in HIV-related policy development
PEPFAR	Number individuals trained in HIV-related institutional capacity building

Priority Area 4: Empowerment and Governance

DONOR	INDICATOR
OUTCOME	
UNGASS/UNAIDS	**National Composite Policy Index**
UNGASS/UNAIDS	**Domestic and international AIDS spending by categories and financing sources**

DONOR	INDICATOR
	OUTPUT & PROCESS
GoJ MOHE	**Number of persons trained to provide services by client and service area**
PEPFAR	**Number of individuals trained in strategic information (M&E and/or surveillance and/or HMIS)**
UNGASS/UNAIDS	**Percentage of schools that provided life skills-based HIV education in the last academic year**
GoJ MOHE	**Number of NGOs providing HIV prevention, treatment, care and support services according to national guidelines/standards**
GoJ MOHE	**Number of policy makers attending sensitisation workshops on HIV/STI**
PEPFAR	**Number of local organizations provided with technical assistance for strategic information activities (M&E and/or surveillance and/or HMIS)**
CIMT	Number of individuals trained in HIV-related community mobilization and for prevention, care and/or treatment (male & female)
CIMT	Number of indigenous organizations provided with technical assistance for HIV-related institutional capacity building
WB	Number of implementing partners reporting on NSP indicators
WB	Number of implementing partners that have incorporated M&E components in their work plans
WB	Completion of computerization for NPHL, Nation Blood Transfusion services, surveillance system, and drug inventory nationally and at regional treatment centers

Policies and protocols

CONFIDENTIALITY

The NHP is committed to protecting client information and confidentiality as an integral part of all priority areas of the national response to HIV. HIV related data at the institutional and individual level is highly sensitive and confidential. The NHP supports and abides by the Jamaica Ministry of Health Release of Client Information Policy Manual. This manual is available in Appendix V. Any and all instances of policy violation should be reported immediately.

DATA QUALITY AND ACCOUNTABILITY

The M&E Operations Manual is intended to serve as a reference document to optimize M&E system functionality. Specifically, it is designed to clarify roles and responsibilities for data collection, analysis, and use. Parties identified in this document to have a role and responsibilities in the M&E system should ensure that the following data quality issues are addressed for each data set:

Timeliness: Data should be submitted to the NHP on-time to ensure it is included in reports as listed in the reporting schedule. The NHP will provide reports and other feedback information to stakeholders in a timely manner, as per the reporting schedule, to ensure facilities and organizations have access to the most up-to-date status of the epidemic and strides in the response.

Completeness: All forms and reports should be submitted with complete information, including clear notation when requested information is not applicable or unavailable. If data is unavailable at the time of reporting, clear notion should document why the data is unavailable, and when and how it will become available.

Coverage: Data should be collected from all levels of the NHP and priority areas. Incomplete coverage provides an incomplete picture of the programme performance and status of HIV in Jamaica.

Accuracy: Data collection and entry activities should include and enforce measures to ensure validity and reliability of the data. These data quality checks should be transparent and regularly revised.

Double Counting (or duplication): Double counting is a term in monitoring and evaluation when two organizations each separately record the same event or target reached. When this data is combined, for example, when the data is reported up to a donor or national coordinating body, it has the effect of doubling the actual number of targets reached.

For example, if there are two NHP programmes providing services to orphans and vulnerable children (OVC) in a particular community. One organization is providing food and nutritional support, while another is providing psycho-social support. These two organizations work together to identify children needing support. And both organizations count the children they serve. If they both report that they have each served 100 children to NHP, then NHP assumes that 200 children have been reached in this community, when in reality, 100 children have each been reached with two services.

To avoid double counting, stakeholders should be well versed in indicator definitions (i.e., the Indicator Reference Sheets located in Appendix I), look for potential overlaps, and address concerns with the NHP M&E Unit.

Prevention Indicators

APPENDIX I
INDICATOR REFERENCE SHEETS

PREVENTION: GOAL
Percentage of men & women aged 15 to 24 that are HIV infected

Reference Indicator	UNGASS GE-22	
Purpose	To assess progress towards reducing HIV infection	
Frequency	Annual	
Data Source	Sentinel Surveillance: ANC sentinel site surveillance	
Measurement Tool	Sentinel Surveillance form including socio-demographic and HIV test result data	
Method of Measurement	• This indicator is calculated using data from pregnant women attending antenatal clinics in HIV sentinel surveillance sites in the capital city, other urban areas and rural areas. • The proportion of the total female population aged 15–24 living in the capital city, in other urban areas and in rural areas should be provided so that national estimates can be calculated, where possible.	
	Numerator Number of antenatal clinic attendees (aged 15–24) tested whose HIV test results are positive	Denominator Number of antenatal clinic attendees (aged 15–24) tested for their HIV infection status
Data Quality	Regular supervisory visits to all sentinel sites; Monitoring the completeness of enrolment; Monitoring of the accuracy of data being collected and entered into the data management system.	
Reporting Requirements	• CARICOM 1.19 • Global Fund 1 • UNGASS GE-15	
Interpretation	• HIV prevalence at any given age is the difference between the cumulative numbers of people that have become infected with HIV up to this age minus the number who have died expressed as a percentage of the total number alive at this age. At older ages, changes in HIV prevalence are slow to reflect changes in the rate of new infections (HIV incidence) because the average duration of infection is long. Furthermore, declines in HIV prevalence can reflect saturation of infection among those individuals who are most vulnerable and rising mortality rather than behaviour change. At young ages, trends in HIV prevalence are a better indication of recent trends in HIV incidence and risk behaviour. Thus, reductions in HIV incidence associated with genuine behaviour change should first become detectable in HIV prevalence figures for the 15–19 year age group. Where available, parallel behavioural surveillance data should be used to aid interpretation of trends in HIV prevalence. • In countries where age at first sexual intercourse is late and/or levels of contraception are high, HIV prevalence among pregnant women in the age group 15–24 years will differ from that among all women in the age group. • This indicator (using data from antenatal clinics) gives a fairly good estimate of relatively recent trends in HIV infection in locations where the epidemic is heterosexually driven. It is less reliable as an indicator of HIV-epidemic trends in locations where most infections are concentrated in most-at-risk populations. • To supplement data from sentinel surveillance, an increasing number of countries are implementing HIV testing as part of the population-based survey. This approach is recommended in countries with high HIV prevalence. Wherever available, results of the survey should be included in the report submitted with this indicator. • This indicator is for generalized epidemics.	

PREVENTION: GOAL
Percentage of SW who are HIV-infected

Reference Indicator	UNGASS C/LPE-9	
Purpose	To assess progress on reducing HIV prevalence among SW populations	
Frequency	Biennial	
Data Source	Second Generation Surveillance: SW Survey	
Measurement Tool	Second Generation Surveillance : SW Survey	
Method of Measurement	• For the purpose of the study sex workers were defined: as females who sell sex for cash. • The study is limited to female sex workers as it is assumed that male sex workers offer their services primarily to other men and thus would be classified under the high risk sub-population "Men Having Sex with Men" (MSM). • This indicator is calculated using data from HIV tests conducted among female Sex Workers in the capital city, other urban areas and rural areas. • Prevalence estimates should be disaggregated by age (<25/25+) where possible.	
	Numerator Number of SW who test positive for HIV	Denominator Number of SW tested for HIV
Data Quality	Monitoring of the accuracy of data being collected and entered into the data management system.	
Reporting Requirements	• UNGASS(C/LPE-9) • USAID • World Bank	
Interpretation	• Due to difficulties in accessing most-at-risk populations, biases in sero-surveillance data are likely to be far more significant than in data from a more generalized population, such as women attending antenatal clinics. • An understanding of how the sampled population(s) relate to any larger population(s) sharing similar risk behaviours is critical to the interpretation of this indicator. • The period during which people belong to a most-at-risk population is more closely associated with the risk of acquiring HIV than age. Therefore, it is desirable not to restrict analysis to young people but to report on other age groups as well. • Trends in HIV prevalence among most-at-risk populations in the capital city will provide a useful indication of HIV-prevention programme performance in that city. However, it will not be repre¬sentative of the situation in the country as a whole.	

PREVENTION: GOAL
Percentage of MSM who are HIV infected

Reference Indicator	UNGASS C/LPE-9	
Purpose	To assess progress on reducing HIV prevalence among MSM populations	
Frequency	Every two years	
Data Source	Second Generation Surveillance; MSM survey	
Measurement Tool	Second Generation Surveillance: MSM survey	
Method of Measurement	• MSM are defined as men who report any penetrative anal sex with a male partner. The sample also includes men who engage in commercial and/or transactional sex with male partners. That is men who have anal sex with male partners for cash, living accommodations, food, clothes, gifts, etc. Snow ball sampling is commonly used to identify participants . • HIV tests are conducted among men who have sex with men in the capital city, other urban areas and rural areas. • Prevalence estimates should be disaggregated by age (<25/25+) where possible	
	Numerator Number of MSM who test positive for HIV	Denominator Number of MSM tested for HIV
Data Quality	Monitoring the completeness of enrolment; Monitoring of the accuracy of data being collected and entered into the data management system.	
Reporting Requirements	• UNGASS C/LPE-9 • USAID	
Interpretation	• Due to difficulties in accessing most-at-risk populations, biases in sero-surveillance data are likely to be far more significant than in data from a more generalized population, such as women attending antenatal clinics. If there are concerns about the data, these concerns should be reflected in its inter¬pretation. • An understanding of how the sampled population(s) relate to any larger population(s) sharing similar risk behaviours is critical to the interpretation of this indicator. • The period during which people belong to a most-at-risk population is more closely associated with the risk of acquiring HIV than age. Therefore, it is desirable not to restrict analysis to young people but to report on other age groups as well. • Trends in HIV prevalence among most-at-risk populations in the capital city will provide a useful indication of HIV-prevention programme performance in that city. However, it will not be repre¬sentative of the situation in the country as a whole.	

PREVENTION: PURPOSE

Number of individuals reached through TCI disaggregated by vulnerable groups (e.g. youth, MSM, SW, prisoners, etc.)

Reference Indicator	GFTAM/USAID	
Purpose	To document the reach of HIV prevention efforts in the different target populations	
Frequency	Monthly	
Data Source	Prevention Indicator Report, Stakeholder and Regional Technical Reports	
Measurement Tool	Stakeholder Reports; Prevention Indicator Reports.	
Method of Measurement	• Targeted Community Interventions are focused, direct or targeted prevention activities, such as peer education or participatory prevention activities implemented through interpersonal & group communication strategies. These activities are disaggregated by most-at-risk populations. • Under PEPFAR, community outreach is defined as any effort to effect change that might include peer education, classroom, small group and/or one-on-one Information Education Communication or Behaviour Change Communication to promote comprehensive prevention methods. • The indicator measures cumulative numbers of persons reached through any of the following activities: condom demonstration, risk reduction conversations, or visiting a display booth. The number of individuals served is disaggregated by most-at-risk population, gender and age groups.	
	Numerator Number of individuals reached	Denominator Not applicable
Data Quality	Reports indicate co-facilitated events and interventions to address potential for double counting	
Reporting Requirements	• Global Fund • PEPFAR 5.2	
Interpretation	By monitoring the number of people reached we can assess if the programmes are reaching the people they are intended to reach and if they are reaching sufficient numbers to make a difference in the local context.	

PREVENTION: PURPOSE, P7-P10, P12, P6
Number of persons trained to provide prevention services by client and service area

Reference Indicator	PEPFAR (see below)	
Purpose	To monitor progress toward training targets and assess HIV capacity building in the AIDS Response	
Frequency	Monthly	
Data Source	Stakeholder and Regional Technical Reports	
Measurement Tool	Programme monitoring	
Method of Measurement	• A training event must have specific learning objectives, a course outline or curriculum, and expected knowledge, skills and/or competencies to be gained by participants. There are no time limits on training events. A person is considered trained if he/she participates in at least 80% of the said activity. • A person trained more than once within a given period is only counted as one person trained; however if the person is trained in a different area then he/she can also be counted for that area. • Training also refers to new training or retraining of individuals and assumes that training is conducted according to national or international standards when these exist. • This indicator measures cumulative numbers of individuals trained, from local organizations or otherwise, during the reporting period.	
	Numerator Number of persons trained to provide prevention services by client and service area	Denominator Not applicable
Data Quality	Attendance sheets are reviewed to address instances of double counting	
Reporting Requirements	PEPFAR 4.1, 4.2	
Interpretation	• This indicator does not measure the quality of the training, nor the outcomes of the trainings in terms of competencies and/or job performance of individuals trained. • This indicator provides a programme level count, aggregated at the national level, as a crude measure of the availability of training activities and services.	

PREVENTION: P2

Percentage of young women and men aged 15-24 who both correctly identify ways of preventing the sexual transmission of HIV and who reject major misconceptions about HIV transmission

Reference Indicator	UNGASS GE-10	
Purpose	To assess progress towards universal knowledge of the essential facts about HIV transmission	
Frequency	Every 3-4 years (last survey 2007)	
Data Source	HIV/STI National Knowledge Attitude Behaviour Practice (KABP) Survey	
Measurement Tool	Population-based survey	
Method of Measurement	• This indicator is constructed from responses from the following set of (prompted) questions on the KABP: 1. [Q711]People can protect themselves from HIV by: - avoid sharing food with a person who has AIDS - staying with only one faithful uninfected partner - using condoms all the time - avoid being bitten by mosquitoes 2. [Q706] Do you think a healthy looking person can be infected with HIV, the virus that causes AIDS? • Respondents who have never heard of HIV or AIDS [Q701, Q702] should be excluded from the numerator but included in the denominator.	
	<u>Numerator</u> Number of respondents aged 15-24 who gave the correct answers to all 5 questions	<u>Denominator</u> Number of respondents aged 15-24 who gave answers (including "don't know" to all five questions
Data Quality	Data collection methods include both interviewer administered as well as participant Response Cards to improve reliability of data for sensitive questions. Data analysis procedures confirmed by NHP to ensure accuracy of indicator calculations.	
Reporting Requirements	• CARICOM 1.13 • CIMT 4.1.1 • Global Fund 10 • UNGASS GE-10	
Interpretation	• The belief that a healthy-looking person cannot be infected with HIV is a common misconception that can result in unprotected sexual intercourse with infected partners. • Rejecting major misconceptions about modes of HIV transmission is as important as correct knowledge of true modes of transmission. • This indicator is particularly useful in countries where knowledge about HIV is poor because it permits easy measurement of incremental improvements over time. However, it is also important in other countries as it can be used to ensure that pre-existing high levels of knowledge are maintained. • Since many people with correct knowledge about prevention may also have some incorrect beliefs, this indicator may underreport knowledge.	

PREVENTION: P4, P11, P15, P17
Percentage of young adults, 15 to 19 years old, who have never had sex

Reference Indicator	Global Fund	
Purpose	This particular indicator describes the proportion of never married young people surveyed who have never had sex; thus the prevalence of virginity among young people	
Frequency	Every 3-4 years	
Data Source	HIV/STD National Knowledge Attitude Behaviour Practice (KABP) Survey (KABP)	
Measurement Tool	Population-based survey	
Method of Measurement	• Respondents (15–24 year olds) are asked if they have ever had sex. • The indicator is disaggregated gender and age groups • If the indicator is calculated for groupings of ages that are broader than the period of time that has passed, the indicator will not be able to reflect changes that may in fact be occurring. It is therefore recommended that this indicator be reported by single age.	
	Numerator Number of never married young women and men who have never had sex	Denominator Number of never married young women and men aged 15–24 surveyed
Data Quality	Data collection methods include both interviewer administered as well as participant Response Cards to improve reliability of data for sensitive questions. Data analysis procedures confirmed by NHP to ensure accuracy of indicator calculations.	
Reporting Requirements	Global Fund	
Interpretation	• Delay of sexual debut will help reduce both unwanted pregnancy and HIV prevalence. • This indicator describes the extent to which abstinence is practiced among youth. In some settings, the proportion of those aged 20–24 who are never married will be very low, at least among women, and it may not be appropriate to construct the indicator for this age group in these cases. • DHS recommends deriving this from a question about virginity status; however this requires reasonable sample sizes at each single year of age. • Looking at this prevalence within narrow age ranges (15–16, 17–18, 19–20, 21–22, and 23–24, for example, or better yet, in single ages) across time allows programme managers to see if the age at first sex is moving.	

PREVENTION: P4, P15

Percentage of young women and men aged 15 -24 reporting the use of a condom the last time they had sex with a non-regular partner

Reference Indicator	CIMT 2/UNGASS	
Purpose	To assess progress towards preventing early-age exposure to HIV through unprotected sex with non-regular partners	
Frequency	Every 3-4 years	
Data Source	HIV/STD National Knowledge Attitude Behaviour Practice (KABP) Survey (KABP)	
Measurement Tool	Population-based survey	
Method of Measurement	• Respondents will be asked if they used a condom the last time they had sex with their most recent non-regular partner. • Classification of non-regular partner will be determined by questions about marital status/cohabitation. • All who report at least one non-marital, non-cohabitating partner in the past 12 months will be considered to have a non-regular partner. Sex and age must also be collected.	
	Numerator Number of respondents aged 15 – 24 who reported having had a non-regular (i.e. non-marital and non-cohabiting0 sexual partner in the last 12 months who also reported that a condom was used the last time they had sex with this partner.	Denominator Number of respondents 15 -24 reporting at least one non-marital, non-cohabitating sexual partner in the past 12 months.
Data Quality	Data collection methods include both interviewer administered as well as participant Response Cards to improve reliability of data for sensitive questions. Data analysis procedures confirmed by NHP to ensure accuracy of indicator calculations.	
Reporting Requirements	• CIMT • UNGASS • Global Fund • World Bank	
Interpretation	• This indicator shows the extent to which condoms are used by young people who engage in non-regular sexual relationships. Levels and trends should be interpreted carefully using the data obtained on percentages of young people who have started having sex and [of those] that have engaged in a non-regular partnership within the last year. • A rise in this indicator is an extremely powerful indication that condom promotion campaigns are having the desired effect among their principle target market – those having sex with non-regular partners.	

PREVENTION: P5
Percentage of SWs reporting using a condom at last sex act with last paying client

Reference Indicator	UN-C/LPE 4	
Purpose	To assess progress in preventing exposure to HIV among sex workers through unprotected sex with clients	
Frequency	Every two years	
Data Source	Second Generation Surveillance: SW Survey	
Measurement Tool	Second Generation Surveillance: SW Survey	
Method of Measurement	• Female Sex workers are defined as females who engage in commercial sex, that is, those who sell sex for cash. • The study is limited to female sex workers as it is assumed that male sex workers offer their services primarily to other men and thus would be classified under the high risk sub-population "Men Having Sex with Men" (MSM). • Respondents were selected at work-sites based on their willingness to participate in the questionnaire and the Biological testing including HIV blood testing.	
	Numerator Number of respondents who reported using a condom with their last client in the past 12 months.	Denominator Number of respondents who reported having had a paying partner in the past 12 months
Data Quality	Survey not completed as frequently as needed; Data obtained may not be representative of the SW population.	
Reporting Requirements	• UNGASS C/LPE-4 • Global Fund 6 • USAID • World Bank 4 • CIMT 8.5	
Interpretation	• Condom use at last sex gives a good indication of overall levels and trends of protected and unprotected sex in the SW population. • The maximum protective effect of condoms is achieved when their use is consistent rather than occasional. The current indicator will provide an over-estimate of their level of consistent condom use. However, the method of asking about condom frequency is subject to recall and other biases and is not sufficiently robust for use in a general population survey. Asking about the most recent act minimizes recall bias and gives a good cross-sectional picture of condom use. The trend in condom use in the most recent sex act will generally reflect the trend in consistent condom use. • It may be challenging to survey sex workers. Data obtained may not be representative of the national population. This should be reflected in the interpretation of the data. Where different data sources exist, the best available estimate should be used, and information on sample size and data quality should be included.	

PREVENTION: P6
Percentage of men reporting using a condom the last time they had anal sex with a male partner

Reference Indicator	UN-C/LPE 5	
Purpose	To assess progress in preventing exposure to HIV among men who have unprotected anal sex with a male partner.	
Frequency	Biennial (last conducted in 2006)	
Data Source	Second Generation Surveillance: MSM Survey	
Measurement Tool	Second Generation Surveillance: MSM Survey	
Method of Measurement	• Data is collected using a structured questionnaire. • MSM are defined as men who report any penetrative anal sex with a male partner. • The sample also includes men who engage in commercial and/or transactional sex with male partners. That is men who have anal sex with male partners for cash, living accommodations, food, clothes, gifts, etc. • Respondents were selected at work-sites were identified by other MSM participants or MOHE outreach staff and recruited for the study based on their willingness to participate in the questionnaire and the Biological testing including HIV blood testing .	
	Numerator Number of men who report using a condom the last time they had anal sex with a male partner	Denominator Number of men reporting having had anal sex with a male partner.
Data Quality	Data obtained may not be representative of the MSM population.	
Reporting Requirements	• Global Fund 5 • UNGASS C/LPE 5	
Interpretation	• This indicator helps track behaviour change and measures results in a key risk group. MSM is particularly important as a high-risk group in Jamaica; given that stigma is a serious constraint to HIV prevention. • Condom use at last anal sex gives a good indication of overall levels and trends of protected and unprotected sex in the MSM population. • The maximum protective effect of condoms is achieved when their use is consistent rather than occasional. The current indicator will provide an over-estimate of their level of consistent condom use. However, the method of asking about condom frequency is subject to recall and other biases and is not sufficiently robust for use in a general population survey. Asking about the most recent act minimizes recall bias and gives a good cross-sectional picture of condom use. The trend in condom use in the most recent sex act will generally reflect the trend in consistent condom use. • This indicator does not provide information on risk behaviour in sex with women, among men who have sex with both men and women. Condom use with men and women should be investigated and data on condom use should be presented separately for male and female partners. • As a result of the stigma associated with this population, it may be challenging to survey them. Data obtained may not be representative of the national population. This should be reflected in the interpretation of the data. Where different data sources exist, the best available estimate should be used, and information on sample size and data quality should be included.	

Treatment, Care and Support Indicators

APPENDIX I
INDICATOR REFERENCE SHEETS

TREATMENT, CARE AND SUPPORT: GOAL

Percentage of adults and children with HIV known to be on treatment 12 months after initiation of ART

<table>
<tr><td>Reference Indicator</td><td colspan="2">UN-GE 16</td></tr>
<tr><td>Purpose</td><td colspan="2">To assess progress in increasing survival among infected adults and children by maintaining them on antiretroviral therapy</td></tr>
<tr><td>Frequency</td><td colspan="2">Collection: monthly; Reporting: annual</td></tr>
<tr><td>Data Source</td><td colspan="2">Antiretroviral (ARV) Database or register</td></tr>
<tr><td>Measurement Tool</td><td colspan="2">Antiretroviral (ARV) Database or register</td></tr>
<tr><td rowspan="2">Method of Measurement</td><td colspan="2">• Information on survival can be obtained from ARV Database which is used in most HIV Treatment Sites by trained data entry personnel. Information is extracted via the internet by the M&E Unit of the National HIV/STI Programme for Annual or Special Reporting.
• This indicator can be disaggregated by sex and age (<15, 15 +).</td></tr>
<tr><td><u>Numerator</u>
• Number of adults and children who are still alive and on antiretroviral therapy at 12 months after initiating treatment.
1. Number of adults and children in the ART start-up groups initiating ART at least 12 months prior to the end of the reporting period;
2. Number of adults and children still alive on antiretroviral therapy at 12 months after initiating treatment.
• The numerator does not require patients to be on antiretroviral therapy continuously for the 12-month period. Patients who have died, stopped treatment or have been lost to follow-up at 12 months since starting treatment are not included in the numerator.</td><td><u>Denominator</u>
• Total number of adults and children who initiated ART during the twelve months prior to the beginning of the reporting period, including those who have died, those who have stopped ART, and those lost to follow-up
• The denominator is the total number of adults and children in the ART start-up groups who initiated ART at any point during the 12 months prior to the beginning of the reporting period, regardless of their 12-month outcome. This includes all patients, both those on antiretroviral therapy as well as those who are dead, have stopped treatment or are lost to follow-up at month 12.</td></tr>
<tr><td>Data Quality</td><td colspan="2">Gaps in completeness and coverage if database is not updated continuously</td></tr>
<tr><td>Reporting Requirements</td><td colspan="2">• CARICOM 1.17 (# of AIDS deaths regardless of treatment)
• UNGASS GE-16</td></tr>
<tr><td>Interpretation</td><td colspan="2">• Using this denominator may underestimate the true "survival" since a proportion of those lost to follow-up are alive. The number of people alive and on antiretroviral therapy (i.e. retention on ART) in a treatment cohort is captured here.
• This indicator will enable comparison over time of survival on antiretroviral therapy. As it stands, it is possible to identify whether survival at 12 months increases or decreases over time. However, it is not possible to attribute cause to these changes. Therefore, collection and reporting of survival over longer durations of treatment outcomes may provide a better picture of the long-term success of antiretroviral therapy.</td></tr>
</table>

TREATMENT, CARE AND SUPPORT: PURPOSE, T1

Percentage of most-at-risk populations (youth, MSM, SW) who received HIV testing in the last 12 months and who know the results

Reference Indicator	UN-C/LPE 3	
Purpose	To assess progress in implementing HIV testing and counselling among most-at-risk populations (MARP)	
Frequency	Biennial	
Data Source	• Second generation surveillance: MSM Study: • Second generation surveillance : SW Study, • HIV/STD National Knowledge Attitude Behaviour Practice (KABP) Survey (KABP	
Measurement Tool	• Second generation surveillance: MSM Study: • Second generation surveillance : SW Study, • HIV/STD National Knowledge Attitude Behaviour Practice (KABP) Survey (KABP	
Method of Measurement	• Population or Specially Targeted Surveys: Respondents are asked if they have been tested for HIV in the past 12 months and if so, do they know the results of that test. • Results are disaggregated by sex by risk group, sex and age (<25, 25+).	
	Numerator Number of most-at-risk respondents who have been tested for HIV during the last 12 months and know the results	Denominator Number of most-at-risk respondents included in the sample
Data Quality	MSM and sex worker surveys are primarily convenient samples and results may not be representative of MSM and sex worker populations.	
Reporting Requirements	UNGASS C/LP-3	
Interpretation	• Surveying MARP can be challenging. Consequently, data obtained may not be based on a representative sample. These concerns should be reflected in the interpretation of the survey data. Information on sample size and data quality should be included in the report. • Tracking MARP over time may be difficult due to mobility and the dynamic nature of the groups. • Special surveys are dependent on available funding which may make it difficult to repeat over time.	

TREATMENT, CARE AND SUPPORT: PURPOSE, T2

Percentage of men and women aged 15 – 49 who received HIV testing in the last 12 months and who know their results

Reference Indicator	UN-C/LPE 3	
Purpose	To assess progress in implementing HIV testing and counseling	
Frequency	Biennial	
Data Source	HIV/STD National Knowledge Attitude Behaviour Practice (KABP) Survey (KABP)	
Measurement Tool	HIV/STD National Knowledge Attitude Behaviour Practice (KABP) Survey (KABP	
Method of Measurement	• Respondents are asked if they have been tested for HIV in the past 12 months and if so, do they know the results of that test. • Results are disaggregated by sex by risk group, sex and age (<25, 25+).	
	Numerator Number of respondents who have been tested for HIV during the last 12 months and know the results	Denominator Number of respondents included in the sample
Data Quality	Double counting is minimized by the use of KABP	
Reporting Requirements	UNGASS C/LP-3	
Interpretation	• When considering coverage for counseling and testing, traditional stand-alone VCT units are insufficient. Because testing and counseling services are often performed in diagnostic clinical settings where monitoring information is not well tracked, it is important to build capacity for this information. • HIV testing and counseling are important entry points for prevention and care need. Measuring the number of people who access these services is therefore important to indicate the number of people who could potentially benefit from prevention and care. Overtime this indicator provides information on the number of new people tested.	

TREATMENT, CARE AND SUPPORT: PURPOSE, T3

Percentage of men, women and children with advanced HIV receiving antiretroviral combination therapy according to national guidelines

<table>
<tr><td>Reference Indicator</td><td colspan="2">Global Fund 23</td></tr>
<tr><td>Purpose</td><td colspan="2">To assess progress towards providing antiretroviral combination therapy to all people with advanced HIV infection</td></tr>
<tr><td>Frequency</td><td colspan="2">Monthly</td></tr>
<tr><td>Data Source</td><td colspan="2">PMTCT Regional Reports, Adult/Children ARV Reports</td></tr>
<tr><td>Measurement Tool</td><td colspan="2">PMTCT Regional Reports, Adult/Children ARV Reports</td></tr>
<tr><td rowspan="2">Method of Measurement</td><td colspan="2">The number of people with advanced HIV infection who are currently receiving antiretroviral combination therapy is obtained from programme monitoring records and reported by designated regional officers.</td></tr>
<tr><td><u>Numerator</u>
• Number of adults and children with advanced HIV infection who are currently receiving antiretroviral therapy in accordance with a nationally approved treatment protocol (or WHO/UNAIDS standards.)
• The numerator should equal the number of adults and children with advanced HIV infection who ever started ART minus those patients who are not currently on treatment prior to the end of the reporting period.
• Patients not currently on treatment at the end of the reporting period, in other words, those who are excluded from the numerator, are patients who died stopped treatment or are lost to follow-up.
• ART taken only for the purpose of PMTCT and PEP are not included in this indicator.</td><td><u>Denominator</u>
• Estimated number of adults and children with advanced HIV infection.
• This indicator should be disaggregated by sex and age (<15, 15+) and percentage given by year to track annual trends in coverage</td></tr>
<tr><td>Data Quality</td><td colspan="2">WHO estimation models use data from sentinel surveillance sites to estimate the total number of persons infected with HIV need ART.</td></tr>
<tr><td>Reporting Requirements</td><td colspan="2">• Global Fund 23
• UNGASS GE-7</td></tr>
<tr><td>Interpretation</td><td colspan="2">• The indicator permits monitoring of trends in coverage, but does not attempt to distinguish between different forms of antiretroviral therapy, or to measure the cost, quality, or effectiveness of treatment provided. These will each vary within and between countries and are liable to change over time.
• The proportion of people with advanced stages of HIV infection varies with the stage of the HIV epidemic and the cumulative coverage and effectiveness of antiretroviral combination therapy among adults and children.
• Dynamic prevalence affects the accuracy of the estimate of the eligible population. Changing estimates of prevalence are not reflected in current prevalence. This specifically affects the denomi¬nator.
• The degree of utilization of antiretroviral therapy will depend on cost relative to local incomes, service delivery infrastructure and quality, availability and uptake of voluntary counseling and testing services, perceptions of effectiveness and possible side effects of treatment etc.
• Preventative antiretroviral therapy for the purpose of prevention of mother-to-child transmission and post-exposure prophylaxis are not included in this indicator.</td></tr>
</table>

TREATMENT, CARE AND SUPPORT: T2
Percentage of infants born to HIV-infected mothers who are HIV infected

<table>
<tr><td>Reference Indicator</td><td colspan="2">UN-GE 17</td></tr>
<tr><td>Purpose</td><td colspan="2">To assess progress towards eliminating mother-to-child HIV transmission</td></tr>
<tr><td>Frequency</td><td colspan="2">Monthly data collection; biennial reporting</td></tr>
<tr><td>Data Source</td><td colspan="2">PCR Quarterly Report/ pMTCT programme monitoring</td></tr>
<tr><td>Measurement Tool</td><td colspan="2">PCR Quarterly Report/ pMTCT programme monitoring</td></tr>
<tr><td>Method of Measurement</td><td colspan="2">
• According to UNGASS, this indicator can be calculated by taking the weighted average of the probabilities of mother-to-child transmission for pregnant women receiving and not receiving antiretroviral; the weights being the proportions of women receiving and not receiving antiretroviral, respectively. Expressed as a simple mathematical formula:
Indicator score = { T*(1-e) + (1-T) } * v
T = proportion of HIV-positive pregnant women provided with antiretroviral treatment
v = mother-to-child transmission rate in the absence of any treatment
e = efficacy of treatment provided
• In Jamaica, three different ARV regimens for PMTCT are offered, each with a different efficacy. To calculate this indicator score all three options need to be taken into consideration:
Indicator score = {[T_{AZT}*(1-e_{AZT})] + [T_{NVP}*(1-e_{NVP})] + [$T_{AZT+NVP}$*(1-$e_{AZT+NVP}$)] + ($T_{No\ Intervention}$)}v
T = the proportion of HIV-infected women who delivered and received each of the 3 ARV interventions or none of the interventions (e.g., T_{AZT} = "No. of HIV infected pregnant mothers delivered who received AZT for PMTCT"/"No. of HIV infected pregnant women delivered"). This is reported to the Jamaica MOHEE on the Regional HIV Monthly Report.
e = the efficacy of each of the 3 ARV interventions established in the scientific literature
v = estimated at 50%
• The most common forms of treatment provided during the last 12 months should be noted. If good tracking, do not need to estimate, can calculate directly.
• For the calculation of this indicator for local purposes, the number of infants with positive PCR tests results at 8 weeks, whose mothers are known to be on ARV prior to delivery, is used.
</td></tr>
<tr><td></td><td>Numerator
• Not applicable if done directly, number of infected infants
• Local calculation: Number of infants with positive PCR tests at 8 weeks</td><td>Denominator
• Not applicable if done directly, number of HIV+ moms
• Local Calculation: Total number of PCR tests done at 8 weeks</td></tr>
<tr><td>Data Quality</td><td colspan="2">Gaps in completeness where there is a lag in identifying and testing exposed infants.</td></tr>
<tr><td>Reporting Requirements</td><td colspan="2">• Global Fund
• Government of Jamaica
• UNGASS (UN-GE 17)
• USAID</td></tr>
<tr><td>Interpretation</td><td colspan="2">This indicator focuses on prevention of mother-to-child transmission of HIV through increased provision of antiretroviral drugs. Thus, the effect of breastfeeding on mother-to-child transmission of HIV is ignored and the indicator may yield underestimates of true rates of mother-to-child trans¬mission in countries where long periods of breastfeeding are common. In Jamaica, the PMTCT programme focuses extensively on recommending and supporting alternative feeding (i.e Formula). Similarly, in countries where other forms of PMTCT of HIV (e.g., caesarean section) are widely practiced, the indicator will typically provide overestimates of mother-to-child transmission. For these reasons, trends in this indicator may not reflect overall trends in mother-to-child transmission of HIV.</td></tr>
</table>

TREATMENT, CARE AND SUPPORT: T4

Percentage of persons living with HIV (PLWHA) on anti-retroviral therapy (ARVs) reporting at least 90% adherence by pill count

Reference Indicator	WHO	
Purpose	To assess progress towards proper adherence to ARV regimen	
Frequency	Biannually	
Data Source	Adherence Special Study	
Measurement Tool	• A cross-sectional survey of persons with advanced HIV attending treatment sites will be conducted every 2 years. Survey will use a combination of self report and pill count to assess different levels of adherence.	
Method of Measurement	• Calculation – Pill counts can be conducted in clinic or at unannounced home visits. Pill count adherence is usually calculated by counting the remaining doses of medication and assuming that remaining pills in excess of what is expected represent missed doses. Pill counts are more easily performed if the patient uses a pill organizer; remaining medication in compartments from past days indicates missed doses. • Limitations – The sensitivity of pill counts for detecting non-adherence is compromised when patients remove pills from their containers without taking them (ie, "pill dumping" or "decanting"). This practice leads to an overestimate of adherence. Unannounced pill counts were developed to account for this practice but are too intrusive and cumbersome for common clinical practice.	
	Numerator Number of PLWHA on ARV reporting at least 90% adherence by pill count	Denominator Number of PLWHA on ARV
Data Quality	Accuracy may be compromised if calculation errors occur. Data quality will depend on survey.	
Reporting Requirements	PAHO	
Interpretation	Adherence is the second strongest predictor of progression to AIDS and death, after CD4 count. Consistently high levels of adherence are also important determinants of virologic and immunologic outcome, AIDS-related morbidity, mortality, and hospitalizations. Non-adherence risks the development of drug resistance and failure of therapy. Although the minimum threshold of adherence necessary for the clinical effectiveness of HAART remains unclear, available data suggests that patients must take a high proportion (95% or more) of antiretroviral drug doses to maintain suppression of viral replication, that failure rates increase as adherence levels decrease.	

TREATMENT, CARE AND SUPPORT: T4
Current school attendance among orphans and non-orphans, aged 10-14

<table>
<tr><td>Reference Indicator</td><td colspan="2">UN-GE 14</td></tr>
<tr><td>Purpose</td><td colspan="2">To assess progress towards preventing relative disadvantage in school attendance among orphans versus non-orphans</td></tr>
<tr><td>Frequency</td><td colspan="2">Every 5 years</td></tr>
<tr><td>Data Source</td><td colspan="2">Multiple Indicator Cluster Survey (MICS)</td></tr>
<tr><td>Measurement Tool</td><td colspan="2">Multiple Indicator Cluster Survey (MICS)</td></tr>
<tr><td>Method of Measurement</td><td colspan="2">• Ratio of the current school attendance rate of children aged 10–14 both of whose biological parents have died to the current school attendance rate of children aged 10–14 both of whose parents are still alive and who currently live with at least one biological parent.
• Indicator scores are required for all children aged 10–14 years and for boys and girls, separately. Where possible, the indicator should also be calculated by single year of age (see section on interpretation).
• The minimum number of orphaned 10–14 year-old children needed to calculate this indicator is 50 (see section on interpretation).</td></tr>
<tr><td></td><td colspan="2">Orphan school attendance (1)</td></tr>
<tr><td></td><td><u>Numerator</u>
Number of children who have lost both parents and are still in school.</td><td><u>Denominator</u>
Number of children who have lost both parents.</td></tr>
<tr><td></td><td colspan="2">Non-orphan school attendance (2)</td></tr>
<tr><td></td><td><u>Numerator</u>
Number of children, both of whose parents are still alive, who live with at least one parent and who are still in school.</td><td><u>Denominator</u>
Number of children both of whose parents are still alive and who live with at least one parent.</td></tr>
<tr><td>Data Quality</td><td colspan="2">Coverage is inadequate.</td></tr>
<tr><td>Reporting Requirements</td><td colspan="2">UNGASS GE-14</td></tr>
<tr><td>Interpretation</td><td colspan="2">• The definitions of orphan/non-orphan used here i.e., child aged 10–14 years at last birthday both of whose parents have died/are still alive—are chosen so that the maximum effect of disadvantage resulting from orphanhood can be identified and tracked over time. The age-range 10–14 years is used because younger orphans are more likely to have lost their parents recently so any detrimental effect on their education will have had little time to materialize. However, orphaned children are typically older than non-orphaned children—because the parents of younger children have had less will tend to be slightly greater than one, even when orphans suffer no relative disadvantage.
• Typically, the data used to measure this indicator will be taken from household-based surveys. Children not recorded in such surveys—e.g., those living in institutions or on the street—generally, are more disadvantaged and are more likely to be orphans. Thus, the indicator will tend to under¬state the relative disadvantage in educational attendance experienced by orphaned children.
• The indicator does not distinguish children who lost their parents due to AIDS from those whose parents died of other causes. In Jamaica, the number of orphans due to violent death of parent(s) must be considered when interpreting this indicator. In countries with smaller epidemics or in the early stages of epidemics, most orphans will have lost their parents due to non-HIV-related causes. Any differences in the treatment of orphans according to the known or suspected cause of death of their parents could influence trends in the indicator. However, to date, there is little evidence that such differences in treatment are common.
• The indicator provides no information on actual numbers of orphaned children. The restrictions to double orphans and to 10–14 year-olds mean that estimates may be based on small numbers in countries with small or nascent epidemics.</td></tr>
</table>

TREATMENT, CARE AND SUPPORT: T8, T12
Number of persons trained to provide treatment services by client and by service area

Reference Indicator	PEPFAR (see below)	
Purpose	To monitor progress toward training targets	
Frequency	Monthly	
Data Source	Stakeholder and Regional Progress Reports	
Measurement Tool	Stakeholder and Regional Progress Reports	
Method of Measurement	• A training event must have specific learning objectives, a course outline or curriculum, and expected knowledge, skills and/or competencies to be gained by participants. There are no time limits on training events. A person is considered trained if he/she participates in at least 80% of the said activity. • A person trained more than once within a given period is only counted as one person trained; however if the person is trained in a different area then he/she can also be counted for that area. • Training also refers to new training or retraining of individuals and assumes that training is conducted according to national or international standards when these exist. • This indicator measures cumulative numbers of individuals trained, from local organizations or otherwise, during the reporting period.	
	Numerator Number of persons trained to provide treatment services by client and service area	Denominator Not applicable
Data Quality	Attendance sheets are reviewed to address instances of double counting	
Reporting Requirements	PEPFAR 4.4, 4.5, 4.6	
Interpretation	• This indicator does not measure the quality of the training, nor the outcomes of the trainings in terms of competencies and/or job performance of individuals trained. • This indicator provides a programme level count aggregated at the national level as a crude measure of the availability of training activities and services.	

TREATMENT, CARE AND SUPPORT: T9
Proportion of confirmed TB cases tested for HIV

Reference Indicator	Global Fund TB/HIV4	
Purpose	To assess the progress in detecting and treating TB in people living with HIV	
Frequency	Quarterly	
Data Source	TB/HIV Form	
Measurement Tool	TB/HIV Form	
Method of Measurement	Number of confirmed TB patients who receive an HIV test.	
	Numerator Total number of TB patients, registered over a given time period, who are tested for HIV (after giving consent) during their TB treatment	Denominator Total number of TB patients, registered over the same given time period
Data Quality	Current coverage of TB cases is good and data is considered representative of the true HIV prevalence among TB cases.	
Reporting Requirements	Global Fund	
Interpretation	• It is preferable that TB patients are tested at the start of TB treatment so that they can benefit from appropriate care throughout their TB treatment. However, some patients are reluctant to undertake an HIV test until later in their TB treatment, once they feel stronger. • A recording and reporting system should be able to capture these late tests otherwise the total number of TB patients knowing their HIV status will be underreported. Although this indicator is similar to TB/HIV 1 which measures HIV prevalence through surveillance, this indicator measures the services' ability to encourage HIV testing in TB patients under programme conditions. • If a high proportion of TB patients are tested (>80 percent) then this provides a sufficiently robust estimate of the true HIV prevalence among TB patients which can be used for surveillance purposes.	

TREATMENT, CARE AND SUPPORT: T10
Incidence of congenital syphilis

Reference Indicator	GoJ MOHE	
Purpose	Track new cases of congenital syphilis	
Frequency	Data collected and reported monthly; Analyzed annually	
Data Source	• Paediatric HIV/Syphilis/ON Form • Monthly Clinic Summary Report • Contact Investigator Monthly Summary	
Measurement Tool	• Paediatric HIV/Syphilis/ON Form • Monthly Clinic Summary Report • Contact Investigator Monthly Summary	
Method of Measurement	The incidence of congenital syphilis is calculated as the number of reported cases per 100,000 population for the year in which it is being reported.	
	Numerator New cases of congenital syphilis diagnosed in infants under one year old over the same given time period	Denominator Number of live births over the same given time period
Data Quality	Data may vary in completeness amongst Regions. Data quality may be compromised by delays in submission of reports and non-reporting of cases.	
Reporting Requirements	CAREC	
Interpretation	This indicator gives a fairly good estimate of trends in the congenital syphilis incidence, which in turn gives a good index for the occurrence of active syphilis in women of child bearing age group.	

Enabling Environments and Human Rights Indicators

APPENDIX I
INDICATOR REFERENCE SHEETS

ENABLING ENVIRONMENTS AND HUMAN RIGHTS: GOAL
Percentage of people 15-49 years expressing accepting attitudes towards people with HIV

Reference Indicator	GF 42, UNGASS 14	
Purpose	To assess progress in the reduction of stigma toward people with HIV	
Frequency	Every 3-4 years	
Data Source	National Knowledge Attitude Behaviour Practice (KABP) Survey	
Measurement Tool	Population Based Survey	
Method of Measurement	KABP Respondents are asked the following questions relating to their beliefs towards people with HIV. 1. If a teacher has HIV but is not sick, should that teacher be allowed to continue teaching in school (1,2); 2. If I knew a shopkeeper or food seller had HIV, I would definitely still buy food or vegetables from them (1,2); 3. If a member of my family got infected with HIV I would want them to keep it a secret (4,5);	
	Numerator Number of women and men aged 15-49 who report accepting attitudes towards people living with HIV	Denominator All respondents aged 15-49
Data Quality	Data collection methods include both interviewer administered as well as participant Response Cards to improve reliability of data for sensitive questions. Data analysis procedures confirmed by NHP to ensure accuracy of indicator calculations.	
Reporting Requirements	• CIMT 3.1 • Global Fund 37	
Interpretation	• The indicator measures the percentage of the population with accepting attitudes towards people living with HIV, and it provides a measure of HIV-related stigma. It is not, however, a perfect measure of HIV-related stigma. While a low value for the indicator suggests high levels of HIV-related stigma, a high value for the indicator could be interpreted in several ways: that there are low levels of HIV-related stigma, or that people know they should not discriminate and therefore report accepting attitudes. High scores may also reflect the respondent's limited personal experience with HIV. • Another limitation of this indicator is that there is frequently not a direct relationship between attitudes and behaviour. What people actually do in the face of HIV may well differ from what they say they would do. Some studies have found, for example, that people expressing very negative attitudes towards those living with HIV actually provide supportive care for an HIV-infected relative in their own home. On the other hand, some people who deny having negative attitudes towards people living with HIV may actively discriminate against them in specific settings, such as in the provision of health care.	

ENABLING ENVIRONMENTS AND HUMAN RIGHTS: PURPOSE, E5
Number and percentage of reported cases of HIV-related discrimination receiving redress by setting

Reference Indicator	GFATM	
Purpose	To assess progress in appropriate response to cases of HIV-related discrimination	
Frequency	Data collection on a case-by-case basis; Reporting - Annually	
Data Source	National HIV-Related Discrimination Reporting and Redress Database	
Measurement Tool	Discrimination Complaint Report	
Method of Measurement	• Number of cases of discrimination include all claims received by intake officers of the Discrimination Reporting and Redress System • Redress includes information or action not limited to, advice, counseling, litigation, advocacy or intervention.	
	Numerator Number of reported cases of discrimination receiving information/action to find a solution subsequent to review by Legal or Investigative Teams.	Denominator Number of reported cases of discrimination received by the RRDS
Data Quality	Case reports are scrutinized and investigated by an intake officer. Definitions must be consistent across agencies	
Reporting Requirements	Global Fund	
Interpretation	• Discrimination against persons with HIV and AIDS remains one of the main obstacles to universal access to HIV prevention, and treatment, care and support for persons living with IV in Jamaica. • The National HIV-Related Discrimination Reporting and Redress System was established as a mechanism to capture reports of HIV-related discrimination and facilitate redress. • Discussions ongoing to refine indicator definition and method of measurement.	

ENABLING ENVIRONMENTS AND HUMAN RIGHTS: E2
Number of persons trained to provide services by client and by service area

Reference Indicator	PEPFAR (see below)	
Purpose	To monitor progress toward training targets	
Frequency	Monthly	
Data Source	Stakeholder Reports	
Measurement Tool	Monthly technical reports	
Method of Measurement	• A training event must have specific learning objectives, a course outline or curriculum, and expected knowledge, skills and/or competencies to be gained by participants. There are no time limits on training events. A person is considered trained if he/she participates in at least 80% of the said activity. • A person trained more than once within a given period is only counted as one person trained; however if the person is trained in a different area then he/she can also be counted for that area. • Training also refers to new training or retraining of individuals and assumes that training is conducted according to national or international standards when these exist. • This indicator measures cumulative numbers of individuals trained, from local organizations or otherwise, during the reporting period.	
	Numerator Number of persons trained to provide services by client and service area	Denominator Not applicable
Data Quality	Attendance sheets are reviewed to identify instances of double counting	
Reporting Requirements	PEPFAR 4.10; 4.12	
Interpretation	• This indicator does not measure the quality of the training, nor the outcomes of the trainings in terms of competencies and/or job performance of individuals trained. • This indicator provides a programme level count aggregated at the national level as a crude measure of the availability of training activities and services.	

ENABLING ENVIRONMENTS AND HUMAN RIGHTS: E8
Number of policy makers attending sensitisation workshops on HIV/TB

Reference Indicator	Global Fund	
Purpose	To monitor the sensitisation of policy makers	
Frequency	Data is collected continuously and reported and analyzed Monthly	
Data Source	Stakeholder Reports	
Measurement Tool	Stakeholder Reports	
Method of Measurement	• Policy makers include Chief Executive officers/general managers/parliamentarians or other such government officers who are decision-making positions. • HIV-related Sensitization workshops are a gathering of people to discuss HIV broadly or an HIV-related issue. • These workshops provide awareness of HIV risk reduction principles, discrimination reduction principles and steps on how participants can be a leadership advocate within their organization.	
	Numerator Number of policy makers attending sensitization workshops on HIV/TB	Denominator Not applicable
Data Quality	Scrutinization of attendance registers	
Reporting Requirements	Global Fund	
Interpretation	This indicator permits monitoring of the level of inclusion of policy level personnel in sensitization activities.	

ENABLING ENVIRONMENTS AND HUMAN RIGHTS: E9
Number of local organizations provided with technical assistance for HIV-related policy development

Reference Indicator	PEPFAR	
Purpose	This indicator measures the degree to which local organizations receive technical assistance in support of policy development.	
Frequency	Monthly	
Data Source	Stakeholder Reports	
Measurement Tool	Stakeholder Reports	
Method of Measurement	• Sum of local organizations that received technical assistance in HIV-related policy. • A local organization is defined as any entity whose headquarters is in a country or region served by USG funding. As such, the majority of the entity's staff (senior, mid-level, support) is comprised of host country and/or regional nationals. "Local organizations" refers to both governmental and non-governmental (NGOs, FBOs, and community-based) organizations. • Technical assistance (TA) is defined as the identification of need for and delivery of practical programme and technical support. TA is intended to assist local organizations in building capacity to design, implement and evaluate HIV prevention, care and treatment programmes. • TA should include regular technical communications and information dissemination sustained over a period of time. • TA can be provided through a combination of strategic approaches and dissemination strategies including individualized and on-site peer and expert consultation, site visits, ongoing consultative relationships, national and/or regional meetings, consultative meetings and conferences, conference calls and web-casts, development and implementation of training curricula. • TA for policy development activities aim to: 1. Broaden and strengthen political and popular support for HIV policies and programmes; 2. Improve the operational environment for these programmes, including better planning and financing; 3. Ensure that accurate, up-to-date information informs policy decisions; and 4. Build in-country and regional capacity to participate in policy development.	
	Numerator Sum of local organizations that received technical assistance in HIV-related policy.	Denominator Not applicable
Data Quality	Reports are completed in an accurate and timely manner, detailing each stage of policy development and implementation.	
Reporting Requirements	PEPFAR	
Interpretation	This indicator does not measure amount and quality of TA and only indicates the number of organizations that received any TA.	

Empowerment and Governance Indicators

APPENDIX I
INDICATOR REFERENCE SHEETS

EMPOWERMENT & GOVERNANCE: GOAL, PURPOSE
National Composite Policy Index

Reference Indicator	UN-GE 2
Purpose	To assess progress in the development and implementation of national-level HIV policies and strategies
Frequency	Biennial
Data Source	Country assessment questionnaire
Measurement Tool	National Composite Index Questionnaire
Method of Measurement	The composite index covers the following broad areas of policy. Part A 1. Strategic plan 2. Political support 3. Prevention 4. Care and support 5. Monitoring & Evaluation Part B 1. Human rights 2. Civil society involvement 3. Prevention 4. Care and support
Data Quality	Consistency in consulting a core of key partners for each instalment of the NCPI assists with ensuring the comparability of the findings over time.
Reporting Requirements	UNGASS GE-2
Interpretation	• This indicator attempts to assess both policy development and effectiveness using elements of the AIDS Programme Effort Index Survey conducted by the Policy Project. • Data is analyzed in terms of progress made in (a) policy and strategy development and (b) implementation of policies and strategies, in order to tackle the country's HIV epidemic. • Included in this assessment are comments on agreement or discrepancies between overlapping questions in Part A and B, as well as a trend analysis from previous NCPI.

EMPOWERMENT & GOVERNANCE: PURPOSE
AIDS spending, by categories and financing

Reference Indicator	UNGASS	
Purpose	To collect accurate and consistent data on how funds are spent at the national level and where those funds are sourced	
Frequency	Annually	
Data Source	National AIDS Spending Assessment	
Measurement Tool	National AIDS Spending Assessment: The primary outputs are to be used to complete the National Funding Matrix.	
Method of Measurement	• Actual expenditures classified by eight broad AIDS Spending Categories and by financing source, including public expenditure from its own sources (i.e. government revenues such as taxes) and from international sources: 1. Prevention; 2. Care and treatment; 3. Orphans and vulnerable children; 4. Programme management and administration strengthening; 5. Incentives for human resources;; 6. Social protection and social services (excluding orphans and vulnerable children); 7. Enabling environment and community development; 8. Research (excluding operations research included under programme management). • The three main groups of financing sources: 1. Domestic public; 2. International; 3. Domestic private (optional for UNGASS reporting).	
	Numerator Not applicable	Denominator Not applicable
Data Quality	NASA Methodology is very precise and detailed, requiring data from multiple sources. It relies on robust accounting systems that do not accommodate co-mingling of funding and that can define and package activities by the different funding sources. Subjectivity in fitting activities into AIDS Spending categories, which may result in inconsistency of definition, is resolved by comprehensive training undertaken by the NHP.	
Reporting Requirements	UNGASS	
Interpretation	• The financial data entered in the National Funding Matrix must be actual expenditures, not budgets or commitments. They must also include AIDS expenditures that were made as part of broader systems of service provision. • Historically, there has been very limited information available on how AIDS financial resources are spent at the national level and where countries source that funding. • Completing the National Funding Matrix will provide a more detailed picture of the situation at the country level, which is useful for both national and global decision-making.	

EMPOWERMENT & GOVERNANCE: G1
Number of persons trained to provide services by client and by service area

Reference Indicator	PEPFAR (see below)	
Purpose	To monitor progress toward training targets	
Frequency	Monthly	
Data Source	Stakeholder and Regional Monthly/Quarterly Reports	
Measurement Tool	Stakeholder and Regional Monthly/Quarterly Reports	
Method of Measurement	• A training event must have specific learning objectives, a course outline or curriculum, and expected knowledge, skills and/or competencies to be gained by participants. There are no time limits on training events. A person is considered trained if he/she participates in at least 80% of the said activity. • A person trained more than once within a given period is only counted as one person trained; however if the person is trained in a different area then he/she can also be counted for that area. • Training also refers to new training or retraining of individuals and assumes that training is conducted according to national or international standards when these exist. • This indicator measures cumulative numbers of individuals trained, from local organizations or otherwise, during the reporting period.	
	Numerator Number of persons trained to provide services by client and service area.	Denominator Not applicable
Data Quality	Attendance sheets are reviewed to identify double counting	
Reporting Requirements	PEPFAR 4.10	
Interpretation	This indicator does not measure the quality of the training, nor the outcomes of the trainings in terms of competencies and/or job performance of individuals trained.	

EMPOWERMENT & GOVERNANCE: G2
NUMBER OF LOCAL ORGANIZATIONS PROVIDED WITH TECHNICAL ASSISTANCE FOR HIV POLICY DEVELOPMENT

Reference Indicator	PEPFAR	
Purpose	To assess the degree to which local organizations receive technical assistance in support of policy development	
Frequency	Annual	
Data Source	Stakeholder Reporting	
Measurement Tool	Stakeholder Reporting	
Method of Measurement	Sum of local organizations that received technical assistance in HIV-related policy.	
	Numerator Number of local organizations that received technical assistance in HIV-related policy.	Denominator Not applicable
Data Quality	• Stakeholder reports are scrutinized to ensure that reported indicator meets the definition. • List of organizations are reviewed to ensure that there is no double counting.	
Reporting Requirements	• Global Fund 1 • PEPFAR	
Interpretation	• A local organization is defined as any entity whose headquarters is in a country or region. As such, the majority of the entity's staff (senior, mid-level, support) is comprised of host country and/or regional nationals. "Local organizations" refers to both governmental and non-governmental (NGOs, FBOs, and community-based) organizations. • Technical assistance (TA) is defined as the identification of need for and delivery of practical program and technical support. TA is intended to assist local organizations in building capacity to design, implement and evaluate HIV prevention, care, support and treatment programs. TA should include regular technical communications and information dissemination sustained over a period of time. TA can be provided through a combination of strategic approaches and dissemination strategies including individualized and on-site peer and expert consultation, site visits, ongoing consultative relationships, national and/or regional meetings, consultative meetings and conferences, conference calls and web-casts, development and implementation of training curricula. • TA for policy development activities aim to: - Broaden and strengthen political and popular support for HIV/AIDS policies and programs; - Improve the operational environment for these programs, including better planning and financing; - Ensure that accurate, up-to-date information informs policy decisions; and - Build in-country and regional capacity to participate in policy development. • This indicator does not measure amount and quality of TA and only indicates the number of organizations that received any TA.	

EMPOWERMENT & GOVERNANCE: G6

Number of NGOs providing HIV prevention, treatment, care and support services according to national guidelines

Reference Indicator	GoJ MOHE	
Purpose	To assess civil society organizations' capacity to deliver HIV services and expand services to hard-to-reach groups and monitor adoption of HIV protective behaviours	
Frequency	Monthly	
Data Source	Stakeholder reports	
Measurement Tool	Stakeholder reports	
Method of Measurement	NGOs which are involved in prevention or treatment care and support services or both are included in the calculation of this indicator. The NGOs do not have to be involved in the full gamut of prevention, treatment care and support services but should be involved in at least one recognized area, e.g. basic HIV sensitization or clinical/ diagnostic management of HIV+ clients.	
	Numerator Number of NGOs providing HIV prevention, treatment, care and support services according to national guidelines	Denominator Not applicable
Data Quality	MOUs outline national guidelines for delivery of services for each NGO stakeholder/subrecipient. Reports are considered complete and submitted in a timely manner.	
Reporting Requirements	World Bank	
Interpretation	This indicator provides data on the multisectorality of the response to HIV	

EMPOWERMENT & GOVERNANCE: G6
Percentage of schools that provided life skills-based HIV education in the last academic year

Reference Indicator	UN-GE 3	
Purpose	To assess progress towards implementation of life-skills based HIV education in all schools	
Frequency	Data collected Annually; Reported: Biannually	
Data Source	Educational Programme Review	
Measurement Tool	School survey or education programme review	
Method of Measurement	Principals are briefed on the meaning of life-skills based HIV education and then are asked the following question: 1. Did your school teach life-skills based HIV education on a regular basis to each grade in your school throughout the last academic year?	
	Numerator Number of schools with staff members trained in and regularly teaching life-skills-based HIV education	Denominator Number of early childhood, primary and secondary schools registered with the Ministry of Education
Data Quality	Consistent and timely submission of reports of training conducted and implementation of Health and Family Life Education (HFLE) ensures accurate and reliable data quality.	
Reporting Requirements	UNGASS GE-3	
Interpretation	• The indicator provides useful information on trends in the coverage of life-skills-based HIV education within schools. However, the substantial variations in the levels of school enrolment must be taken into account when interpreting this indicator. Consequently, primary and secondary school enrolment rates for the most recent academic year should be included in the supporting information provided for this indicator. • Complementary strategies that address the needs of out-of-school youth will be particularly important in countries where school enrolment rates are low. • This indicator is a measure of coverage. Quality will differ by country and over time.	

EMPOWERMENT & GOVERNANCE: G7
Number of policy makers attending sensitisation workshops on HIV/TB

Reference Indicator	GoJ MOHE	
Purpose	To monitor the sensitisation of policy makers	
Frequency	Data is collected continuously and reported and analyzed Monthly	
Data Source	Stakeholder Reports	
Measurement Tool	Stakeholder Reports	
Method of Measurement	• Policy makers include Chief Executive officers/general managers/parliamentarians or other such government officers who are decision-making positions. • HIV-related Sensitisation workshops are a gathering of people to discuss HIV broadly or an HIV-related issue. These workshops provide awareness of HIV risk reduction principles, discrimination reduction principles and steps on how participants can be a leadership advocate within their organization.	
	Numerator Number of policy makers attending sensitisation workshops on HIV/TB	Denominator Not applicable
Data Quality	Review of attendance sheets reduces double counting. Standardised definitions for sensitisation sessions and individuals counted as 'policymakers' ensure good validity in data reported.	
Reporting Requirements	Global Fund	
Interpretation	This indicator permits monitoring of the level of inclusion of policy level personnel in sensitization activities.	

Behaviour Change Communication

REQUIRED

- NHP Prevention Indicators Form

RECOMMENDED

- NHP Community Peer Educators Monthly Summary Form

APPENDIX II
INSTRUMENT PROTOCOL SHEETS

DATA FLOW FOR PREVENTION FORMS

The following section lists Forms and Protocols for Behaviour Change Communication Practitioneers (including Community Peer Educators) working in HIV-related Prevention. The Protocol Sheets provide a description of the frequency for data collection and name the officers responsible for transmitting the data from facilities to the National HIV/STI Programme (NHP) and the sequence of this data transmission.

Ensuring quality data collection, timely reporting and routine use of information is the collective responsibility of the NHP. The path and pace by which data flow from facility, parish or regional levels to the NHP, play a key role in monitoring and evaluating the programme. Any gaps in data on the forms, or delays in data reaching the Regional office can compromise data quality, affect the accuracy of reports and ultimately misguide programmatic decisions such as resource allocation including supply stocks, budgets, and staffing.

NHP PREVENTION INDICATORS FORM — REQUIRED

Data Collection Instrument	NHP Prevention Indicators Form
Purpose	To collect data on indicators that measure activities within the Prevention Priority Area of the NSP
Frequency	First Friday of every month
Responsible Officer at Regional level	Regional BCC Coordinator or Team Leader submits to NHP Prevention Director
Data Sources at sub-regional level	Community Peer Educator Monthly Reports
Data Storage at Regional Level	• Paper hardcopies should be stored in a dry, secured place at the Regional Office • Electronic copies should be stored on a secure, password protected desktop at the Regional Office • Backup: Reports should be copied to CD every quarter and stored in a secure place; Regional Office computers should be backed up in accordance with Ministry of Health IT policies and protocols.
Indicators	• Number of individuals reached through TCI including vulnerable groups (e.g. youth, MSM, SW, inmates, etc.) • Number of persons trained to provide prevention services by client and service area • Number of service deliverers trained on HIV prevention
Data Quality Concerns	Primary source for CPE activities are recorded in journals (i.e., diaries). Data source at subregional level is not standardized across programmes, parishes, regions, etc.; Therefore data completeness, and reliability may be compromised. Double counting may occur between CPEs inlcuding at the national level since data is gathered from multiple data sources.
IDP Reporting Requirements	UNGASS, CARICOM, GFATM, WB, USAID
NHP Reporting Requirements	Annual Review; Annual Report; (internal requirements); proposal writing
Strengths and Limitations of the Form	• Collects programme-specific condom data to help prevent stockouts and monitor programme activities at the local level (i.e. parish, region). • Collects limited data on regional prevention activities (e.g., ABC programmes, school-based interventions, community outreach and mobilization, etc.)
Data Use	Programmes, parishes, and regions can use this data to chart trends in commodity distribution, condom accessibility, knowledge and status. This information can be integrated into programme planning and advocacy efforts.

_____ Regional Health Authority

Parish _____

_____Month/Year Indicators Report

INDICATOR	Adolescents 10 -14		Youth 15 -24		Adults 25 -49		CSW		MSM	Other (specify below e.g. inmate)
	Male	Female	Male	Female	Male	Female	Male	Female		
1. **Number of individuals reached through TCI and community outreach including vulnerable groups,(e.g. MSM, CSW, parolees, etc.) by gender**										
2. **% of most at risk population who received HIV testing in the last 12 months and who know the results**	No. know results									
	No. Pretest									
3. **% of young people or at risk groups who both correctly identify ways of preventing sexual transmission of HIV and reject major misconceptions**	No. with all 5 correct									Adult >50
	No. Surveyed									
4. **Number of MSM & CSW trained on condom use**										
5. **Number of condoms distributed to MSM & CSW**										
6. **# of lubes distributed to MSM & CSW**										

	Male Condoms	Female Condoms		
7. **Total number of free Condoms distributed**				
8. **Number of condoms purchased through condom machines**				
9. **Number of condoms purchased through condom outlets (not including vending machines)**				
10. **Number of condom outlets established**				

	Adolescents 10 -14	Youth 15 -24	CSW	MSM	Other (specify below)
11. **Number of persons trained to provide prevention services by client area**					TCI, etc.
12. **Number of adolescents (10-14) and youth (15-24) reached through prevention interventions in out-of-school settings**					

NHP Prevention Indicators Form — Required

(The following sections should be expanded to include as much detail as is desired)

1. Activities update (goal, target group, etc)

- Highlights (interesting observations, experiences, etc)

- Barriers/Gaps

- Lessons Learnt

- Collaborators for these activities (e.g. Line Ministries, CIs, other Health Region)

2. Additional Activities (activities conducted that were not included in workplan)

3. Emerging Trends

4. Identified Needs for Sustainability (Technical or financial requirements; additional research)

5. Other comments

KEY

1. Include Region, month and year on all reports.
2. Please complete a separate indicator table for each parish in your region. However, do a combined narrative report. Therefore, your report should include 3-4 tables and a narrative portion.
3. The indicators included under the indicator column include National Indicators that are reported to various funding bodies, as well as indicators specific to the prevention program for BCC M&E needs.
4. For indicators 2 and 3 you are being asked to report the denominator and numerator that the national program will use to calculate the percentage. E.g. for indicator 2, the denominator is the number of persons who received pretest counseling, and the numerator is the number of persons who received their results through posttest counseling. For indicator 3, the denominator is the number of persons surveyed, or who were asked all 5 knowledge questions and the numerator is the number of persons who got all 5 questions correct.
5. Leave the grey spaces blank.
6. In the "Other" column, you can capture targets that are not represented under the titled columns.
7. For indicator 3, you are being asked to report specifically on 'Adults over 50' in the 'Other' column. You should report the numbers surveyed and numbers with all 5 correct, and include a gender breakdown.
8. Indicator 7 refers to the number of (free) condoms distributed during prevention activities or to clinics. This total should **include** the number of condoms distributed to MSM and CSWs (indicator 5).
9. For indicator 11, you are being asked to include in the 'Other' column number of persons trained to provide HIV prevention and care services by client areas not included in named columns.
10. For indicator 11, please describe any overlaps in the narrative section. For ex. If 4 persons were trained to work with adolescents 10-14 and Youths 15-24, report only 4 in one of the two relevant columns. In your narrative report, explain that these persons were trained to provide prevention services to multiple target groups.

NHP COMMUNITY PEER EDUCATORS MONTHLY SUMMARY FORM — RECOMMENDED

Data Collection Instrument	NHP Community Peer Educators Monthly Summary Form
Purpose	To collect activity-level data for the Prevention Priority Area of the NSP. This data is aggregated at the Parish and Regional levels to complete the Prevention Indicators Form.
Frequency	25th of every month
Responsible Officer at Regional level	One Community Peer Educator (CPE) per Parish should be designated to collect and collate forms from all CPEs and report to Parish or Regional BCC Coordinator
Data Sources at sub-regional level	• NHP Community Peer Educator Site Visit Records, • Condom Demonstration Checklist, • Condom Outlet Monitored and Established Form, and • HIV Risk Knowledge Form
Data Storage at Regional Level	• Paper hardcopies should be stored in a dry, secured place at the Parish Office • Electronic copies should be stored on a secure, password protected desktop at the Parish and Regional Offices • Backup: Reports should be copied to CD every quarter and stored in a secure place; Parish and Regional Office computers should be backed up in accordance with Ministry of Health IT policies and protocols.
Indicators	• Number of individuals reached through TCI including vulnerable groups (e.g. youth, MSM, SW, inmates, etc.) • Number of persons trained to provide prevention services by client and service area • Number of service deliverers trained on HIV prevention
Data Quality Concerns	Primary source for CPE activities are recorded in journals (i.e., diaries). Data is not standardized across CPEs, programmes, parishes, regions, etc.; therefore data accuracy, completeness, and reliability may be compromised. Double counting may occur between CPEs. At the national level as some data is gathered by multiple data sources and therefore at risk of double counting.
IDP Reporting Requirements	UNGASS, CARICOM, GFATM, WB, USAID
NHP Reporting Requirements	Annual Review; Annual Report; (internal requirements); proposal writing
Strengths and Limitations of the Form	• Collects data on site-specific activities that target specific populations and monitor changes in HIV knowledge and risk reduction actions at the local level (i.e. schools, dancehalls, and parishes). • Provides data to monitor CPE activities for performance reviews and evaluation
Data Use	Programmes, parishes, and regions can use this data to chart trends in population and site-specific changes in HIV knowledge and status. This information can be integrated into programme planning and advocacy efforts.

_____HEALTH DEPARTMENT

COMMUNITY PEER EDUATORS MONTHLY SUMMARY REPORT

PERIOD:_____

TOTAL NO. OF INTERACTIONS/SESSIONS HELD:_____

GROUP & SETTING	Number of sessions					
WEEK	1st	2nd	3rd	4th	5th	TOTAL
Targeted Community Intervention						
Sex Workers						
Incarcerated Youth						
Youth Group						
Out-of-school youth						
Dancehall/Party Intervention						
P.L.A.C.E. Sites						
Outreach Voluntary Counseling & Testing						
Other						

TOTAL NO. OF PERSONS ATTENDING SESSIONS

GROUP COMPOSTITON	1st		2nd		3rd		4th		5th		TOTAL	
Adults:	M	F	M	F	M	F	M	F	M	F	M	F
Over 50												
40 – 49												
30 – 39												
25 – 29												
20 -24												
15 – 19												
12 – 14												
8 – 11												
TOTAL												

SITE VISIT RECORD

Targeted Community Intervention

Outreach Coordinator: _____ Date: _____

Outreach Workers: _____

Community/Target Group: _____

Topics Covered: _____

Activities Used: _____

Indicator		Quantity	
# of sessions			
		Males	Females
# of persons interacted with	over 50		
	40 – 49		
	30 – 39		
	25 – 29		
	20 - 24		
	15 – 19		
	10 – 14		
	TOTAL		
# of demonstrations done by target group			
# of persons carrying condoms			
# of persons identified for training			
COMMENTS			

SITE VISIT RECORD

Sex Work Outreach Intervention

Outreach Coordinator: _____ Date: _____

Outreach Workers: _____

_____

Site Name: _____ Location: _____

Topics Covered: _____

Activities Used: _____

Indicator	Quantity	
# of sessions		
# of persons interacted with	Males	Females
# of condom demonstrations done by patrons		
# of persons carrying condoms		
# of sex workers at site		
# of condom demonstrations done by sex workers		
# of sex workers carrying condoms		
# of sex workers identified for training		
COMMENTS		

SITE VISIT RECORD

Youth Group

Outreach Coordinator: _____ Date: _____

Outreach Workers: _____

Target Group: _____ Location: _____

Topics Covered: _____

Activities Used: _____

Indicator		Quantity	
# of training sessions			
		Males	Females
# of persons interacted with	over 50		
	40 – 49		
	30 – 39		
	25 – 29		
	20 - 24		
	15 – 19		
	10 – 14		
	TOTAL		
# of demonstrations done by target group			
# of persons carrying condoms			
# of persons identified for training			

COMMENTS

SITE VISIT RECORD

Out of School Youth

Outreach Coordinator: _____ Date: _____

Outreach Workers: _____

_____

Location: _____

Topics Covered: _____

Activities Used: _____

Indicator		Quantity	
# of sessions			
		Males	Females
# of persons interacted with	over 50		
	40 – 49		
	30 – 39		
	25 - 29		
	20 – 24		
	15 – 19		
	10 – 14		
	TOTAL		
# of demonstrations done by target group			
# of persons carrying condoms			
# of persons identified for training			

COMMENTS

SITE VISIT RECORD

Dancehall/Party Intervention

Outreach Coordinator: _____ Date: _____

Outreach Workers: _____

_____

Event: _____ Location: _____

Topics Covered: _____

Activities Used: _____

Indicator		Quantity	
# of Party/Dancehall session/s			
		Males	Females
# of persons interacted with	over 50		
	40 – 49		
	30 – 39		
	25 – 29		
	20 - 24		
	15 – 19		
	10 – 14		
	TOTAL		
# of demonstrations done by target group			
# of persons carrying condoms			
COMMENTS			

SITE VISIT RECORD

Outreach Voluntary Counselling & Testing

Outreach Coordinator: _____ Date: _____

Outreach Workers: _____

_____

Event/Target Group: _____ Location:_____

Indicator		Quantity	
# of VCT sessions done			
		Males	Females
# of persons pre-test counselled	over 50		
	40 – 49		
	30 – 39		
	25 – 29		
	20 - 24		
	15 – 19		
	10 – 14		
	TOTAL		
# of persons tested for HIV	over 50		
	40 – 49		
	30 – 39		
	25 – 29		
	20 - 24		
	15 – 19		
	10 – 14		
	TOTAL		
# of persons post-test counselled	over 50		
	40 – 49		
	30 – 39		
	25 – 29		
	20 - 24		
	15 – 19		
	10 – 14		
	TOTAL		
COMMENTS			

CONDOM DEMONSTRATION CHECKLIST

Gender	Age Group	Total # of persons who participated in condom demonstrations
Male –	15 – 19	M – F –
Female –	20 -24	M – F –
Total –	25 – 29	M – F –
	30 – 39	M – F –
	40 – 49	M – F –
	Over 50	

Age Group	Weaknesses
15 – 24 (persons)	
15 – 19 (persons)	
25 – 29 (persons)	
30 – 39 (persons)	
40 – 49 (persons)	
Over 50 (persons)	

COMMUNITY/TARGET GROUP/EVENT	

FEEDBACK	1st	2nd	3rd	4th	5th	TOTAL
# referred for HIV testing						
# referred to STI clinic						

MEETINGS						TOTAL
PAC Meeting attended						
Workshop/Training (please say)						
BCC Prevention Team Meeting						
HIV/STI Monthly Meeting						
Other Meeting (please say)						

CONDOM DEMONSTRATIONS CONDUCTED BY TARGET GROUP

HEALTH DISTRICT	1ST	2ND	3RD	4TH	5TH	TOTAL
					`	

CONDOM OUTLETS MONITORED AND ESTABLISHED

HEALTH DISTRICT	**CONDOM OUTLET/S ESTABLISHED**	**CONDOM OUTLET/S MONITORED # of condoms sold (male/female)**	**COMMENTS**

SITE VISIT RECORD

Outreach Survey Questionnaires

Outreach Coordinator: _____ Date: _____

Outreach Workers: _____

_____

Community/Target Group: _____

Indicator		Quantity	
# of questionnaires administered		Males	Females
	over 50		
	40 – 49		
	30 – 39		
	25 – 29		
	20 – 24		
	15 – 19		
	10 – 14		
	TOTAL		
# of persons identified for training			
COMMENTS			

Comment/Concerns:

_____
_____
_____
_____
_____
_____
_____
_____
_____

Community Peer Educators' Signature: _____ Date: _____

_____

_____ _____
_____ _____
_____ _____
_____ _____
_____ _____

Supervisor's Signature: Date:

_____ _____

HIV Risk Knowledge

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

		No. Surveyed		No. correct on all 5 questions	
		Males	Females	Males	Females
	Over 50				
	40 – 49				
	30 – 39				
	25 – 29				
	20 – 24				
	15 – 19				
	10 – 14				
	TOTAL				

Comments:

Medical Officers of Health, Contact Investigators, Laboratory Personnel, Epidemiologists, and Pharmacists

REQUIRED FORMS

- NHP Contact Investigation Programme Monthly Summary Statistics Form
- NHP STI Clinic Report (New Cases)
- National AIDS Programme Monthly Report for Patients (Children) on ARV Treatment
- National AIDS Programme Monthly Pharmacy Report for Adult Patients (12 Years and Older)
  on ARV Treatment
- NHP Regional HIV/STI Monthly Report
- NHP HIV Confidential Reporting Form
- Tuberculosis Investigation Form
- HIV Anti-Retroviral (ARV) Database
- Immunology Reports (CD4, Viral Load, PCR Reports)
- HIV Rapid Test Database
- NHP Sentinel Surveillance Information Sheet
- NHP Special Investigation Report Form for Congential Syphilis, Paediatric HIV, and Ophthalmia Neonatorm

APPENDIX II
INSTRUMENT PROTOCOL SHEETS

DATA FLOW FOR CARE, TREATMENT AND SUPPORT FORMS

The following section lists Forms and Protocols for Medical Officers of Health, Contact Investigators, Laboratory Personnel, Epidemiologists, and Pharmacists working in HIV care, treatment and support. The protocol sheets provide a description of the frequency for data collection and name the officers responsible for transmitting the data from facilities to the National HIV/STI Programme(NHP) and the sequence of this data transmission. The figures below illustrate the data flow paths for the forms presented in this section.

Ensuring quality data collection, timely reporting and routine use of information is the collective responsibility of the NHP. The path and pace by which data flow from facility, parish or regional levels to the NHP, play a key role in monitoring and evaluating the programme. Any gaps in data on the forms, or delays in data reaching the Regional office can compromise data quality, affect the accuracy of reports and ultimately misguide programmatic decisions such as resource allocation including supply stocks, budgets, and staffing.

The center of Figure 5 shows that the Regional Epidemiologist or Regional Appointed Lead serves as the focal collection point for aggregated data from parishes and facilities in the Region. This post is charged with reviewing the data and submitting the information to the NHP to inform the national indicators. Among the forms sent to the NHP is the Regional HIV Monthly Form. The Regional Epidemiologist is also charged with providing feedback to parishes and facilities on the Region's performance in the area of HIV Treatment, Care and Support. The boxes surrounding the Regional Epidemiologist represent forms that are completed at the facility and parish levels. These forms collect information that can be used by local organizations to monitor, evaluate, and inform programs, and are used to aggregate Regional data.

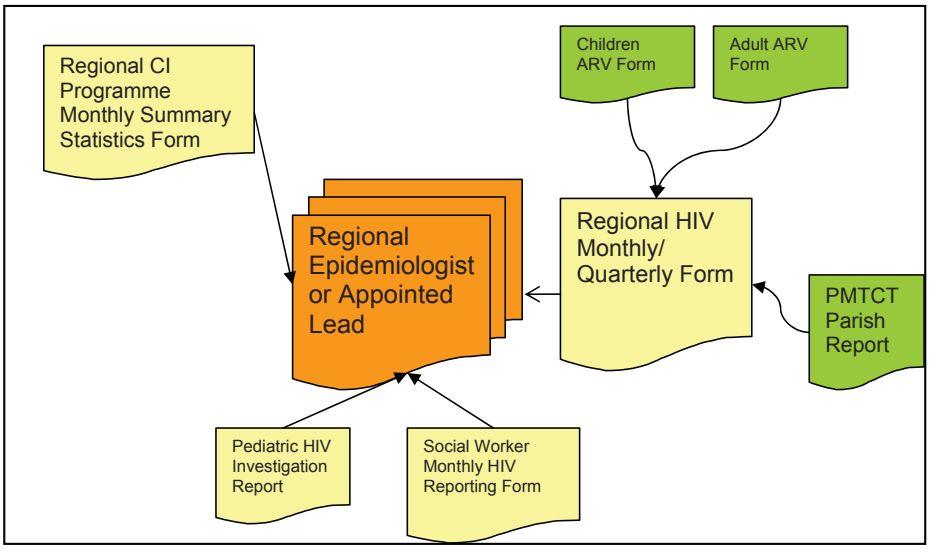


FIGURE 5: Responsibilities of the Regional Epidemiologist or Appointed Lead

Similarly, Figure 6 centers on the NHP Surveillance Officer. This post is charged with aggregating data from the HIV Confidentiality Form and the HIV/TB Form, and entering this data into the HIV/AIDS Tracking System (HATS).

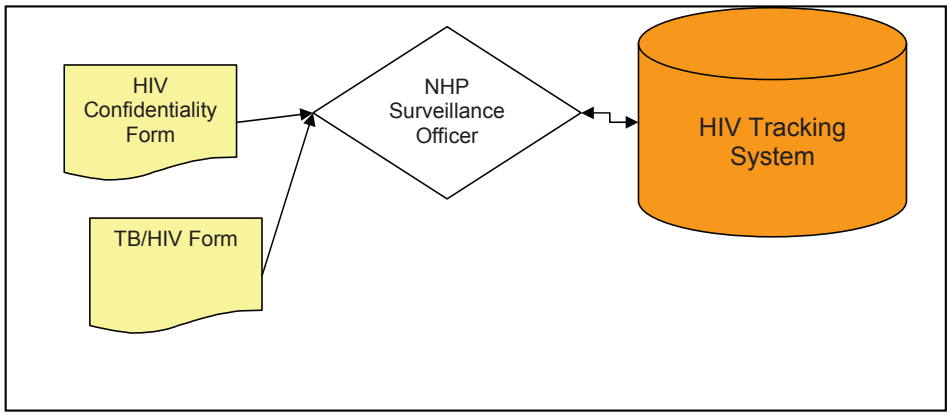


FIGURE 6: Responsibilities of the NHP Surveillance Officer

Figure 7 shows the data flow paths for the CD4 reports from the Western Regional Health Authority and the National Public Health Laboratory (NPHL). The Reports from the Western Region are to be sent to the NPHL and an aggregated CD4, along with the Viral Load and PCR Reports sent to the NHP.

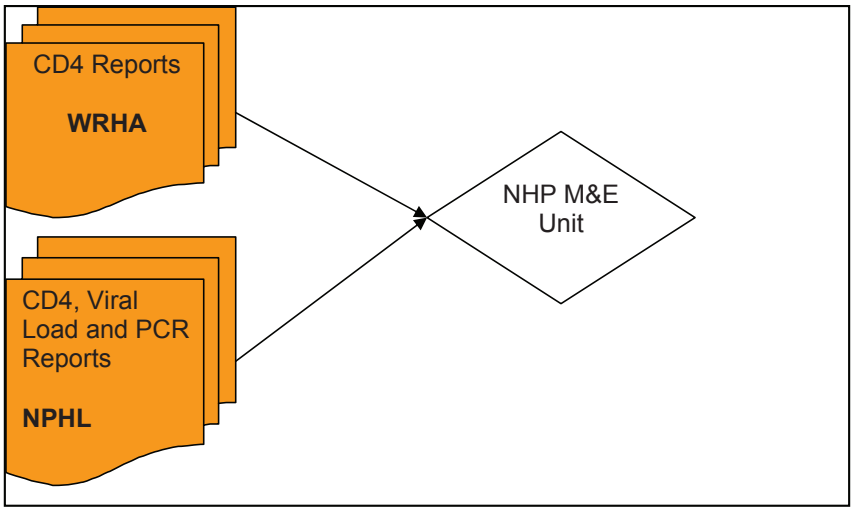


FIGURE 7: Data Flow Paths for CD4, Viral Load and PCR Reports

NHP CONTACT INVESTIGATION PROGRAMME MONTHLY SUMMARY STATISTICS FORM — REQUIRED

Data Collection Instrument	NHP Contact Investigation Programme Monthly Summary Statistics Form
Purpose	To collect data on indicators that measure the prevalence of the epidemic and activities within the Treatment, Care and Support Priority Area of the NSP
Frequency	20th of every month submitted to NHP
Responsible Officer at Regional level	• Parish Contact Investigators (CI) complete and submit this form to the Regional CI Coordinator (or designated Regional CI Lead) and parish Medical Officer of Health on 15th of every month. • The Regional CI Coordinator/Lead aggregates the parish forms and submits to the Regional HIV/STI Coordinator (or Designated Lead) on 18th of every month. • The Regional Epidemiologist or Designated Lead shares it with the NHP Surveillance Officer on 20th of every month.
Data Sources at Sub-Regional Level	Facility based medical records from primary care facilities, hospital maternity wards and Anti-Natal Clinics
Data Storage at Regional Level	• Paper hardcopies should be stored in a dry, secured place at the Parish Office • Electronic copies should be stored on a secure, password protected desktop at the Parish and Regional Offices • Backup: Reports should be copied to CD every quarter and stored in a secure place; Parish and Regional Office computers should be backed up in accordance with Ministry of Health IT policies and protocols.
Indicators	• Percentage of men and women aged 15 to 24 that are HIV infected • Prevalence of HIV among STI clients • Prevalence of HIV among STI clients • Incidence of congenital syphilis • Percentage of ANC clients that are counseled and tested for HIV
Data Quality Concerns	There are multiple sources of data for several of these indicators; therefore, the aggregated data is at risk of double counting.
IDP Reporting Requirements	UNGASS, CARICOM, GFATM, WB, USAID
NHP Reporting Requirements	Annual Review; Annual Report; (internal requirements); proposal writing
Strengths and Limitations of the Form	• Collects data on site-specific activities that target specific populations • Does not disaggregate by age or other risk factors • Data based on syndromic management of patients. Prevalence data on specific STIs such as Chlamydia and gonorrhoea will not be available.
Data Use	Facilities, parishes, and regions can use this data in conjunction with family planning programme data for programme planning and advocacy efforts. This information can also be used to influence positive prevention programmes.

CONTACT INVESTIGATION PROGRAMME: Monthly Summary Statistics

Indicate type of report: [ ] Parish [ ] Region **Month:** **Year:**

Name: **C.I.#** **Parish:** **Region:**

General Indicators	Syphilis				HIV			AIDS		AIDS Deaths	
	P&S		SEL								
Number of new cases reported											
Number of new cases interviewed											
Number of contacts named											
Number of contacts locatable											
Number of contacts located											
Number of contacts tested/examined											
Number of contacts positive											
P& S Contacts Tested/Examined <8 days											

New Cases of Priority Conditions Interviewed, Counseled or Tested by Contact Investigators

Interviewed or Counselled	M	F		M	F
Genital Discharge Syndrome < 20			All STI clients given VCT		
Genital Ulcer Syndrome			No. STI (HIV + ve)		
Pelvic Inflammatory Disease			All ANC clients given VCT		
ANC (TRUST + ve)			No. ANC (HIV + ve)		

Paediatric Indicators	Congenital Syphilis (CS)		Paediatric HIV Exposed (PHE)				Ophthalmia Neonatorum (ON)			
Number of new cases reported										
Number of cases investigated										
Number of cases closed										

Outreach Indicators (number)	No. Done	Persons Reached
Clinical Sessions (Ex, Dx, and Tx)		
Talks/Group (2 or more persons) Counselling Sessions		
Individual counselling Sessions		
HIV Surveillance Interviews		
Targeted Outreach Sessions		
Field Visits		

Other Programme Indicators

Ophthalmia Prophylaxis: [ ] No. of hospitals in Parish/region [ ] No. using prophylaxis

Syphilis Screening of ANC Women: [ ] Tested [ ] No. Reactive

[ ] No. Same day results [ ] No. treated same day

Specify data on outreach sessions, target audience, type of ophthalmia prophylaxis in use, antenatal testing, condoms usage, etc.:

_____

_____

_____

_____

General comments (highlights problems; suggest solutions; action taken etc.):

_____

_____

_____

_____

Completed by: **Reviewed by:**

Date / / **Date / /**

Key

Number of new cases reported: Index cases occurring/referred to parish for first time
Number of new cases interviewed: Actual index cases interviewed of reported cases.
Number of 'Contacts named: Total Contacts elicited from cases interviewed (including contacts without proper names or locating addresses): The CI does not need to differentiate between sexes in recording contacts e.g. if. A male named 6 contacts that figure should be placed under Male, and the same applies to the Female.
Number of contacts locatable: Contacts with "locating" addresses/information. For syphilis this applies to the female
Number of Contacts Located: Contacts Found of those locatable
Number of contacts Tested/examined: Includes presently and Previously interviewed Contacts (of index cases) who have been tested, examined, or counseled.
Number. of Contacts Positive: Positives from those tested /examined.
P & S Contact Tested/Examined within 1 week: Applies to P& S syphilis contacts only
N.B. Ratio Contact to Cases : (No. of contacts named divided by the No. of cases interviewed) and Percent of Contact Positive will be inserted by the computer programme

New Cases of Priority Conditions Interviewed, Counseled or Tested by Contact Investigator

Record every VCT done in this section, ANC or STI: Record every STI case or contact given VCT whether a new or old visit or a revisit.

Outreach Indicators

Clinical Sessions: Each session/sitting (of examination, diagnosis and/or treatment done by each C.I. in the STI clinic.
Talks/Group Counseling Sessions: Talks given to any group of 2 or more persons.
Individual Counseling Sessions: One to one counseling e.g. each client seen in the STI clinic.
HIV Surveillance Interviews: Follow-up or revisit of known cases for update or new information
Targeted Outreach (Intervention) sessions: Sessions with target groups e.g., CSW, MSM; Inner-city Youths, prisoners, etc.,
Field visit: Any visit done to perform official duties such as case-finding, contact tracing, or surveillance on the field

NHP STI CLINIC REPORT (NEW CASES) — REQUIRED

Data Collection Instrument	NHP STI Clinic Report (New Cases)
Purpose	To collect data on the prevalence of STIs.
Frequency	20th of every month submitted to NHP
Responsible Officer at Regional level	• Parish Contact Investigators (CI) complete and submit this form to the Regional CI Coordinator (or designated Regional CI Lead) and parish Medical Officer of Health on 15th of every month. • The Regional CI Coordinator/Lead aggregates the parish forms and submits to the Regional HIV/STI Coordinator (or Designated Lead) on 18th of every month. • The Regional Epidemiologist or Designated Lead checks the form for completeness and accuracy and shares it with the NHP Surveillance Officer on 20th of every month.
Data Sources at Sub-Regional Level	Facility based medical records from primary care facilities, and STI Clinics
Data Storage at Regional Level	• Paper hardcopies should be stored in a dry, secured place at the Parish Office • Electronic copies should be stored on a secure, password protected desktop at the Parish and Regional Offices • Backup: Reports should be copied to CD every quarter and stored in a secure place; Parish and Regional Office computers should be backed up in accordance with Ministry of Health IT policies and protocols.
Indicators	Prevalence of HIV among STI clients
Data Quality Concerns	Transcription errors may occur and accuracy may be compromised when aggregated data is being computed. Double counting of cases may occur.
IDP Reporting Requirements	UNGASS, CARICOM, GFATM, WB, USAID
NHP Reporting Requirements	Annual Review; Annual Report; proposal writing
Strengths and Limitations of the Form	• Collects data on site-specific activities that target specific populations • Does not disaggregate by risk factors • Data based on syndromic management of patients. Prevalence data on specific STIs such as Chlamydia and gonorrhoea will not be available.
Data Use	Provides important data for STI surveillance. Facilities, parishes, and regions can use this data in conjunction with family planning programme data for programme planning and advocacy efforts. This information can also be used to influence positive prevention programmes.

STI CLINIC REPORT [NEW CASES] - STI CENTRE

SEX: M/**F** **PARISH** **MONTH ENDING** / /

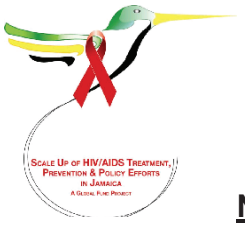
NAME:

COMBINED **CI REPORTING** **dd /mm/yy**

AGE GROUP	-4	-9	-14	-19	-24	-29	-34	-39	-44	-49	50+
SYPHILIS											
Primary											
Secondary											
Early Latent											
Late Latent											
Tertiary											
Congenital											
TRUST/VDRL<4 DILS AND WITH NO PRESUMPTIVE DIAGNOSIS OF SYPHILIS											
Equivocal STS											
GENITAL DISCHARGE SYNDROME											
Urethral and Vaginal											
Cervicitis/Erosion					Bacterial Vaginosis						
Trichomoniasis					Candidiasis						
GENITAL ULCER DISEASE (GUD) SYNDROME											
All cases of GUD											
Syphilis					Lymphogranuloma venereum						
Genital Herpes					Granuloma inguinale						
Chancroid					Other e.g., trauma						
OTHER STI AND NON – STI CONDITIONS											
Epi treatment for syphilis					Genital Warts						
Epi treatment for GC/Chlamydia					Bruising during sex						
Ophthalmia Neonatorum					Pediculosis						
Pelvic Inflammatory Disease					Scabies						
Epdidymo-orchitis					All other STIs						
Congenital syphilis<1 years					Non-STI Referrals to clinic						
PATIENT LOAD (TOTAL new AND old patients plus LABORATORY)											
NEW patients (NEVER PREVIOUSLY registered at the Section Clinic											
OLD patients PREVIOUSLY registered but FIRST admission this year											
REVISITS (ALREADY registered THIS YEAR, now re-attending											
GRAM STAIN (GNID) POSITIVE ……..only new cases of urethritis/cervitis											
GRAM STAIN (GNID) NEGATIVE …… only new cases of urethritis/cervitis											

NATIONAL AIDS PROGRAMME MONTHLY REPORT FOR PATIENTS (CHILDREN) ON ARV TREATMENT — REQUIRED

Data Collection Instrument	National AIDS Programme Monthly Report For Patients (Children) On ARV Treatment
Purpose	To collect data on indicators that related to paediatric ARV therapy within the Treatment, Care and Support Priority Area of the NSP
Frequency	20th of very month submitted to NHP
Responsible Officer at Regional level	Pharmacist completes form and submits to Regional Pharmacist and Medical Officer of Health. Regional Pharmacist submits to Regional Epidemiologist or Designated Lead who then submits to the NHP Treatment Coordinator.
Data Sources at Sub-Regional Level	Pharmacies, Paediatic Departments and Social Worker Reports
Data Storage at Regional Level	• Paper hardcopies should be stored in a dry, secured place at the pharmacy and Parish Office • Electronic copies should be stored on a secure, password protected desktop at the Parish and Regional Offices • Backup: Data should be copied to CD every quarter and stored in a secure place; Parish and Regional Office computers should be backed up in accordance with Ministry of Health IT policies and protocols.
Indicators	• Percentage of adults and children with HIV known to be on treatment 12 months after initiation of ART • Percentage of adults and children with advance HIV infection who are receiving antiretroviral combination therapy according to national guidelines
Data Quality Concerns	• Pharmacies are understaffed and reports may be delayed or inaccurate. • Data sourced from private pharmacies which do not have similar reporting requirement. • Double counting may occur as clients may visit multiple pharmacies and are not recorded by name or unique identifier.
IDP Reporting Requirements	UNGASS, CARICOM, GFATM, WB, USAID
NHP Reporting Requirements	Annual Review; Annual Report; (internal requirements); proposal writing
Strengths and Limitations of the Form	• Data is subject to Pharmacist, Pediatrician and Social Worker reporting biases • Assists/reduces stockouts
Data Use	Facilities, parishes, and regions can use this data in conjunction with adherence and social support data for programme planning and advocacy efforts.



NATIONAL AIDS PROGRAMME MONTHLY REPORT FOR PATIENTS (CHILDREN) ON ARV TREATMENT

MONTH_____PARISH_____

NAME OF TREATMENT CENTRE_____

ANTIRETROVIRAL DRUG	Number of Patients on Each Drug		
	New	Old	Total
COMBIVIR (ZDV, 3TC)			
ZIDOVUDINE SUSP. (ZDV, AZT)			
LAMIVUDINE (SUSP) 3TC			
STAVUDINE (D4T) 30MG			
NEVIRAPINE SUSP (NVP)			
EFAVIRENZ (EFV)			
INDINAVIR			
NELFINAVIR (NFV)			
KALETRA (LOP/R)			
DIDANOSINE (DDI)			
OTHER (NAME?)			
OTHER (NAME?)			
TOTAL NUMBER OF PATIENTS			

_____ _____

Name and Position of person completing form Date

NATIONAL AIDS PROGRAMME MONTHLY PHARMACY REPORT FOR ADULT PATIENTS (12 YEARS AND OLDER) ON ARV TREATMENT — REQUIRED

Data Collection Instrument	National AIDS Programme Monthly Pharmacy Report For Adult Patients (12 Years And Older) On ARV Treatment
Purpose	To collect data on indicators that related to adult ARV therapy activities within the Treatment, Care and Support Priority Area of the NSP
Frequency	20th of every month submitted to NHP
Responsible Officer at Regional level	Pharmacist completes form and submits to Medical Officer of Health, and Regional Epidemiologist or Designated Lead. The Regional Epidemiologist or Designated Lead then submits to the NHP Treatment Coordinator.
Data Sources at Sub-Regional Level	Pharmacy based data collection
Data Storage at Regional Level	• Paper hardcopies should be stored in a dry, secured place at the pharmacy and Parish Office • Electronic copies should be stored on a secure, password protected desktop at the Parish and Regional Offices • Backup: Data should be copied to CD every quarter and stored in a secure place; Parish and Regional Office computers should be backed up in accordance with Ministry of Health IT policies and protocols.
Indicators	• Percentage of adults and children with HIV known to be on treatment 12 months after initiation of ART • Percentage of HIV positive pregnant women who received a complete course of ARV prophylaxis to reduce the risk of MTCT • Percentage of adults and children with advance HIV infection who are receiving antiretroviral combination therapy according to national guidelines
Data Quality Concerns	• Pharmacies are understaffed and reports may be delayed or inaccurate. • Difficult to ascertain number of persons on different medication because of variances in names given.
IDP Reporting Requirements	UNGASS, CARICOM, GFATM, WB, USAID
NHP Reporting Requirements	Annual Review; Annual Report; (internal requirements); proposal writing
Strengths and Limitations of the Form	• Data is subject to pharmacist reporting biases. • Assists/reduces stockouts • May be an indicator of adherence
Data Use	Facilities, parishes, and regions can use this data in conjunction with adherence data for programme planning and advocacy efforts. This information can also be used to support social support and positive prevention programmes.

NATIONAL AIDS PROGRAMME MONTHLY PHARMACY REPORT FOR ADULT PATIENTS (12 YEARS & OLDER) ON ARV TREATMENT

MONTH_____**PARISH**_____

NAME OF TREATMENT CENTRE_____

PATIENTS ON TREATMENT

ANTIRETROVIRAL DRUG	*NUMBER OF PERSONS*		
	Previous Month	Current Month	Cumulative Year-to-Date
ZIDOVUDINE + LAMIVUDINE (ZDV + 3TC)			
ZIDOVUDINE (ZDV)			
LAMIVUDINE (3TC)			
STAVUDINE (D4T) 40 mg			
STAVUDINE (D4T) 30 mg			
TENOFOVIR + EMTRICITABINE (TDF + FTC)			
TENOFIVIR (TDF)			
NEVIRAPINE (NVP)			
EFAVIRENZ (EFV)			
INDINAVIR (IDV)			
RITONAVIR (RTV)			
NELFINAVIR (NFV)			
LOPINAVIR/ RITONAVIR (LPV/r)			
DIDANOSINE (DDI)			
OTHER			

PMTCT PROGRAMME

ANTIRETROVIRAL DRUG	*NUMBER OF PERSONS*		
	Previous Month	Current Month	Cumulative Year-to-Date
LAMIVUDINE + ZIDOVUDINE (AZT+3TC)			
ZIDOVUDINE CAPSULE (AZT)			
LAMIVUDINE (3TC)			
NEVIRAPINE (NVP)			
NELFINAVIR (NFV)			
LOPINAVIR/ RITONAVIR (LPV/r)			
OTHER			

OCCUPATIONAL & NON-OCCUPATIONAL EXPOSURE

ANTIRETROVIRAL DRUG	*NUMBER OF PERSONS*		
	Previous Month	**Current Month**	**Cumulative Year-to-Date**
ZIDOVUDINE + LAMIVUDINE (ZDV+ 3TC)			
ZIDOVUDINE (ZDV)			
LAMIVUDINE (3TC)			
STAVUDINE (D4T) 40 mg			
STAVUDINE (D4T) 30 mg			
TENOFOVIR + EMTRICITABINE (TDF+FTC)			
TENOFIVIR (TDF)			
NEVIRAPINE (NVP)			
EFAVIRENZ (EFV)			
INDINAVIR (IDV)			
RITONAVIR (RTV)			
NELFINAVIR (NFV)			
LOPINAVIR/ RITONAVIR (LPV/r)			
DIDANOSINE (DDI)			
OTHER			

Signature **Date**

Name and Position of person completing form

NHP REGIONAL HIV/STI MONTHLY REPORT — REQUIRED

Data Collection Instrument	NHP Regional HIV/STI Monthly Report
Purpose	To collect data on indicators that related HIV prevalence in Jamaica
Frequency	20th of every month submitted to NHP
Responsible Officer at Regional level	The Regional Epidemiologist or Designated Lead incorporates HIV laboratory, PMTCT and HIV treatment site regional level data in the Regional HIV Monthly Report and shares it with the NHP M&E Unit on 20th of every month. Regional data is also shared with the Medical Officers of Health and Regional Technical Directors.
Data Sources at Sub-Regional level	Treatment site databases (maintained by contact Investigators, adherence counselors, physicians, or social workers), Laboratory information system (rapid test database), PMTCT Coordinators. The Monthly Clinical Summary Report also provides data for this report.
Data Storage at Regional Level	• Paper hardcopies should be stored in a dry, secured place at the pharmacy and Parish Office • Electronic copies should be stored on a secure, password protected desktop at the Parish and Regional Offices • Backup: Data should be copied to CD every quarter and stored in a secure place; Parish and Regional Office computers should be backed up in accordance with Ministry of Health IT policies and protocols.
Indicators	• Percentage of men and women aged 15 to 24 that are HIV infected • Prevalence of Hlv among STI clinic attendees • Prevalence of HIV among ANC attendees. • Percentage of HIV positive pregnant women who received a complete course of ARV prophylaxis to reduce the risk of MTCT • Percentage of adults and children with advance HIV infection who are receiving antiretroviral combination therapy according to national guidelines
Data Quality Concerns	There are multiple sources of data for several of these indicators; therefore, the aggregated data is at risk of double counting and transcription errors.
IDP Reporting Requirements	UNGASS, CARICOM, GFATM, WB, USAID
NHP Reporting Requirements	Annual Review; Annual Report; proposal writing
Strengths and Limitations of the Form	• Data complements sentinel surveillance data to estimate HIV prevalence • Data is stored in a confidential database
Data Use	Regions can use this aggregated data in conjunction with other surveillance data for programme planning and advocacy efforts to improve the AIDS response in the Regions and the integration of this response in the overall Health System.

Regional HIV/STI Monthly Report

Month:	**Year:**	**Region:**

PMTCT	**Enter name of Parish**			
No. of ANC clients seen (first visits)				
No. of ANC clients tested for HIV				
No. of ANC clients testing positive for HIV				
No. of HIV infected pregnant women delivered				
*No. of HIV infected pregnant mothers receiving ARV for PMTCT:				
a) AZT only				
b) NVP only				
c) AZT + NVP only				
d) HAART (Triple therapy)				
No. of live infants born to HIV-infected mothers (HIV-exposed infants)				
No. of HIV-exposed infants that received ARV for pMTCT				
No. of HIV-infected infants (confirmed positive) borned to HIV-infected mothers				
No. of HIV-exposed infants exclusively formula fed at 6 months				

HIV Testing	**Enter name of Parish**							
	M	F	M	F	M	F	M	F
Total No. of persons tested for HIV								
Total No. of persons testing HIV positive								
No. of STI clients seen during this period								
No. of STI clients tested for HIV								
No. of STI clients testing HIV positive								
No. of HIV tests done through outreach testing								
No. of +ve HIV tests done through outreach testing								

HIV Testing	Enter name of Parish							
	M	F	M	F	M	F	M	F
No. of Hospital admissions during this period								
No. of hospital admissions tested for HIV								
No. of hospital admissions testing HIV positive								
Treatment	**Enter name of Treatment site**							
	M	F	M	F	M	F	M	F
Total No. of HIV infected adults (≥ 10 years old) currently on ARV treatment								
Total No. of children (< 10 years old) currently on ARV treatment								

Definitions:

- No. of HIV infected pregnant mothers receiving ARV for PMTCT - the number of women who completed the full course of antiretroviral prophylaxis to reduce the risk of MTCT.
- Number of HIV exposed infants - the number of live births to an HIV infected pregnant woman during the period of reporting.
- Number of HIV infected infants – confirmed by **positive antibody (ELISA and Western Blot) in children older than 18 months of age OR confirmed by HIV DNA PCR.**

Completed by: _____ Date (dd/mm/yyyy): _____

Please submit to: **Director**, **M&E Unit**
National HIV Programme
2-4 King Street.
Email: duncanj@moh.gov.jm
Fax: 967-1280/967-1643

INSTRUCTIONS FOR COMPLETION OF REGIONAL HIV MONTHLY REPORT

No. of ANC clients seen (first visits)
Enter the total number of women visiting the ANC for the first time since the calendar year began during the period of reporting. ANC attendees will have several visits during the course of one pregnancy. The number of first visits to ANC clinics in primary and secondary care will indicate the total number of pregnant women seen in the public sector.

No. of ANC clients tested for HIV
Enter the total number of women attending ANC that were tested for HIV during the period of reporting. This information will be used to calculate the percent of women attending ANC that are tested for HIV. This is an indication of access to VCT and pMTCT for young women.

No. of ANC clients testing positive for HIV
Enter the number of women that tested positive for HIV during the period of reporting.

No. of HIV infected pregnant women delivered
Enter the total number of HIV infected women delivered a live or still birth during the period of reporting. Not all women who test positive during the period of reporting will deliver in that same period. However, it is important to know what proportion of HIV infected women that receive complete pMTCT, which means that they would have had to deliver the baby.

***No. of HIV infected pregnant mothers receiving ARV for PMTCT**
Enter the number of women who completed the full course of antiretroviral prophylaxis as per the pMTCT protocol to reduce the risk of MTCT during the period of reporting. In order to receive the full course of ARV for pMTCT, the HIV infected mother must have delivered a live or still birth. This number should not include HIV infected women who have not delivered yet.

No. of live infants born to HIV-infected mothers (HIV-exposed infants)
Enter the number of live births to HIV infected pregnant woman during the period of reporting.

No. of HIV-exposed infants that received ARV for PMTCT
Enter the number of live births to HIV infected pregnant woman during the period of reporting that received ARV for pMTCT as described by national protocol.

No. of HIV-exposed infants that received PCR testing
Enter the number of infants born to HIV infected women who received PCR testing, (and results received) to confirm the HIV status of the HIV exposed infant.

No. of HIV-infected infants (confirmed positive) born to HIV-infected mothers
Enter the number of infants born to HIV infected women who have been confirmed as HIV infected. Confirmation may occur by either positive antibody (ELISA and Western Blot) in a child older than 18 months of age OR confirmed by HIV DNA PCR.

No. of HIV-infected infants that receive viral load testing (and received results)
Enter the number of infants born to HIV infected women who received viral load testing.

No. of HIV-exposed infants exclusively formula fed at 6 months
Enter the number of infants borned to HIV infected mothers that are fed formula only. This should not include infants receiving both breast milk and formula.

Total No. of persons tested for HIV
Enter total number of HIV tests done in the reporting period. This includes HIV tests done in ANC + STI + Outreach + hospital admissions + Other (VCT sites)

Total No. of persons testing HIV positive
Enter total number of HIV tests done in the reporting period that were confirmed HIV positive. This includes positive HIV tests from ANC + STI + Outreach + hospital admissions.

No. of STI clients seen during this period
Enter number of persons seen for the first time at the STI clinic during the period of reporting. Persons with recurrent STIs during the period of reporting, i.e. more than one visit to the STI clinic during the reporting period, should be considered a new case for each new STI and counted as such.

No. of STI clients tested for HIV
Enter number of persons attending the STI clinics during the reporting period that were tested for HIV.

No. of STI clients testing HIV positive
Enter number of persons attending the STI clinic during the reporting period that tested positive for HIV (confirmed).

No. of HIV tests done through outreach testing
Enter number of persons tested for HIV through special events and programs operating outside of standard VCT sites and health care settings i.e. HIV testing in settings other than health facilities (hospital and health centers).

No. of positive HIV tests done through outreach testing
Enter number of persons testing positive for HIV through special events and programs operating outside of standard VCT sites and health care settings.

Total No. of HIV infected adults (≥ 10 years old) currently on ARV treatment
The number of adults currently on treatment
=
Number of adults on treatment at the start of the month
+
Number of adults started on treatment during the period of reporting (since the beginning of the month)
-
Number of adults whose treatment was terminated during the period of reporting (since the beginning of the month), including those that died, transferred from the clinic, and defaulted.

Total No. of children (< 10 years old) currently on ARV treatment

The number of children currently on treatment

=

Number of children on treatment at the start of the month

+

Number of children started on treatment during the period of reporting (since the beginning of the month)

-

Number of children whose treatment was terminated during the period of reporting (since the beginning of the month), including those that died, transferred from the clinic, and defaulted.

NHP HIV CONFIDENTIAL REPORTING FORM — REQUIRED

Data Collection Instrument	NHP HIV Confidential Reporting Form
Purpose	To collect data for surveillance of HIV in Jamaica
Frequency	Reported Case-by-case
Responsible Officer at Regional level	Clinician, Contact Investigator or Designated Health Care Practitioner completes Form and submits to Medical Officer of Health in Parish of residence. Medical Officer of Health reviews form and signs prior to submission to NHP Surveillance Officer.
Data Sources at Sub-Regional Level	Facility based data collection
Data Storage at Regional Level	• Paper hardcopies should be stored in a dry, secured place at the pharmacy and Parish Office • Electronic copies should be stored on a secure, password protected desktop at the Parish and Regional Offices • Backup: Data should be copied to CD every quarter and stored in a secure place; Parish and Regional Office computers should be backed up in accordance with Ministry of Health IT policies and protocols.
Indicators	• Percentage of men and women aged 15 to 24 that are HIV infected • AIDS Case rate
Data Quality Concerns	• Data may not be completed on form • Duplication of cases may occur when persons use different names at various locations. • Under-reporting of cases influence the accuracy of estimates generated from this data.
IDP Reporting Requirements	UNGASS, CARICOM, GFATM, WB, USAID
NHP Reporting Requirements	• Annual Review; Annual Report; (internal requirements); proposal writing. • **This is a Class I notifiable disease and should be reported according to Ministry of Health Policy. This form is to provide additional data, which is important for the surveillance of HIV.**
Strengths and Limitations of the Form	• Data may complement sentinel surveillance data to estimate HIV prevalence • Data is stored in a confidential database • Confidentiality policies and protocols for HATS are observed.
Data Use	Facilities, parishes, and regions can use this data in conjunction with other surveillance data for programme planning and advocacy efforts.

HIV CONFIDENTIAL REPORTING FORM

Send all reports to
S.M.O, Surveillance Unit
2 King Street, Kingston
Ministry of Health,
Telephone: 967-1100/1/3/5,
Fax # 967-1280
AIDS/STD Helpline Tel: 967-3830

FOR THE EPI – UNIT ONLY

ACCESS # **TRN: __ __ __--__ __ __--__ __ __**

MEDICAL RECORD #:_____

Trace ( ) Do not contact trace ( ) Contact partners only ( ) Update ( )
Copy sent to CI ( )

1. NAME: _____ _____ _____
Last First Middle

Pet name _____ Sex: M( ) F( )

2. ADDRESS: _____ PARISH:

_____Tel: _____

3. D.O.B.: ___/___/____ AGE: _____ yrs. OCCUPATION: _____
dd mm yy weeks if infant employed ☐ unemployed ☐

MARITAL STATUS: ____

4. NEXT OF KIN: _____ _____
Name Relation Address

4a. MOTHER'S NAME _____

5. **Sexual contacts**

(Surname)	First Name	Relation	Address	Parish
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____

6. SEXUAL PRACTICE of Patient: Heterosexual ( ) Homosexual ( ) Bisexual ( )
Not known ( )

7. **Risk History**	8. **Clinical Status** **DATE: ___/___/___**	
Blood transfusion …….. Y( ) N( ) Crack/Cocaine use …… Y( ) N( ) Intravenous drug use …. Y( ) N( ) Current STD…… Y( ) N( ) History of STD …….. Y( ) N( ) Genital Ulcers/sores ….. Y( ) N( ) Sex with CSW…..…… Y( ) N( ) CSW……. . Y( ) N( ) Multiple Partners..…….. Y( ) N( ) Ever in Prison…...…….. Y( ) N( )	Weight loss (>10%)…….. Y( ) N( ) Cough (>4 weeks)……. Y( ) N( ) Fever (> 1 month) ….. ..... Y( ) N( ) PCP .....…..…..... Y( ) N( ) Recurrent Pneumonia…..... Y( ) N( ) Tuberculosis…… ……..... Y( ) N( ) If Yes: Pulmonary/ Extra Pulmonary/ Disseminated CNS involvement …….. Y( ) N( ) Severe Bacterial Infection.. Y( ) N( ) (specify)_____ _____ **If pregnant, please complete box on reverse of this form**	Candidiasis ……. Y( ) N( ) If Yes: Oral/ Oesophageal/ Vaginal Gen. Lymphadenopathy… Y( ) N( ) Diarrhoea (> 1 month) …. Y( ) N( ) Chronic Herpes simplex . . Y( ) N( ) (> 1 month) Shingles……. Y( ) N( ) Gen. Dermatitis……. Y( ) N( ) Invasive cervical cancer… Y( ) N( ) Kaposi's Sarcoma……. Y( ) N( ) Other _____

10. TRANSMISSION CATEGORY: Sexual ( ) Vertical ( ) IV Drug Use ( ) Haemophiliac ( ) Blood Transfusion ( )

11. CD4 COUNT_____CD4/CD8 ratio_____ Date of CD4 count ___/____/_____ Viral Load_____ Date of Viral load ___/____/_____

12. IS PT ON ANTIRETROVIRAL TREATMENT (ARV)? Y( ) N( ) START DATE OF ARV: ____/___/___

13. CURRENT STATUS OF PT: HIV (no symptoms) ( ) HIV(minimal symptoms) ( )

Advanced HIV (CD4 count 201 – 350) ( ) AIDS ( ) AIDS Death ( )

14. DATE OF ONSET OF SYMPTOMS: ____/____/____

15. **Date diagnosed as Advanced HIV** ____/___/___

Date of Death ___/___/___

16. CONFIRMATORY HIV TEST DATE: ___/___/___

Rapid Test: Date:___/___/___ Result: ☐ Pos ☐

CONFIRMATORY Lab: _____ Result: Pos ☐ Neg ☐

Where tested? Antenatal Clinic ☐ Private Antenatal ☐ STI Clinic ☐ Blood Bank ☐ Hospital ☐ Private doctor ☐

Other ☐ Specify _____

6. Number of children under 15 years of age: _____

7.1 Blood transfusion: _____/_____/_____ Hospital transfused: _____

7.2 Deportee? Y ( ) N( ) _____
Country

FOR PREGNANT PATIENTS ONLY, PLEASE ENTER THE FOLLOWING INFORMATION:
Estimated gestational Age: _____ weeks Estimated date of delivery: ____/____/____

Clinic site: _____ Parish_____ Clinic MRN #:_____

Patient referred to: VJH clinic ( ) UHWI ( ) Spanish Town ( ) CRH ( ) Mandeville ( ) St Ann's Bay ( )

Other: _____ Date of referral appointment: ____/____/____ Pt. Not referred ( ) Pt. Refused referral: ( )

Post test counseling done by: _____ (Enter name) Date of Post test counseling: ___/___/___

PREGNANCY OUTCOME:

Mother	Received ART during pregnancy?	Pregnancy outcome:
Delivery date: ____/____/____	Yes ( ) No ( ) Don't Know ( ) AZT ( ) NVP ( ) HAART ( )	( )Live birth ( )Still birth Other _____

Definitions:

- Multiple partners --- Persons who report having sex with more than one person in the last 12 months.
- CSW --- Commercial sex worker
- PCP --- Pneumocystis Jiroveci Pneumonia
- CNS involvement --- Unexplained recent onset of seizures, dementia, toxoplasmosis, CMV, Cryptococcus, encephalopathy
- Recurrent pneumonia --- Two or more episodes within a 1-year period
- Gen. lymphadenopathy --- Two or more sites with enlarged lymph nodes

PLEASE NOTE:

- Enter all dates in the format dd/mm/yy.
- Reporting physicians are advised to initiate interview of index case to identify sexual contacts and encourage partner notification.
- If all sexual partners have been investigated, please tick "Do not contact trace" on front of form.
- **DO NOT SEND PATIENTS to the Ministry of Health, 2-4 King Street with confidential reporting forms.**
- If you have an "update" on the clinical condition or death of a patient please complete and send new reporting form.
- Send report under confidential cover to the MO(H) at the Parish Health Department or S.M.O. at top of form.

PATIENT'S DOCTOR: _____

Address/hospital: _____
Tel: ____-_____

SOURCE OF INFORMATION: _____

REPORTED BY: _____ Date reported: ____/____/____

Confidential patient counseling, information for providers, and automated information are available from
AIDS/STD Helpline
Tel: 967-3830, 967-3764, 1-888-991-4444 Hours: 10:00 a.m. – 10:00 p.m. Monday through Friday

Web Page: www.jamaica-NHP.org

Revised: Sept 20/07

TUBERCULOSIS INVESTIGATION FORM — REQUIRED

Data Collection Instrument	Tuberculosis investigation form
Purpose	To collect data for TB surveillance including indicators related to TB/HIV co-infection in Jamaica
Frequency	Reported Case-by-case
Responsible Officer at Regional level	Clinician completes the form following diagnosis and within 24 hours must report the case to Parish Public Health Department. The Medical Officer of Health then submits the form to the Regional Epidemiologist or Designated Lead and the Ministry of Health's Surveillance Unit.
Data Sources at Sub-Regional Level	Facility based data collection
Data Storage at Regional Level	• Paper hardcopies should be stored in a dry, secured place at the pharmacy and Parish Office • Electronic copies should be stored on a secure, password protected desktop at the Parish and Regional Offices • Backup: Data should be copied to CD every quarter and stored in a secure place; Parish and Regional Office computers should be backed up in accordance with Ministry of Health IT policies and protocols.
Indicators	Proportion of confirmed TB cases tested for HIV
Data Quality Concerns	• Data may not be completed on form • Data confidentiality safeguards are not entirely defined
IDP Reporting Requirements	UNGASS, CARICOM, GFATM, WB, USAID
NHP Reporting Requirements	• Annual Review; Annual Report; proposal writing • **This is a Class I notifiable disease and should be reported according to Ministry of Health Policy. This form is to provide additional data, which is important for the surveillance of disease.**
Strengths and Limitations of the Form	• TB surveillance data is provided. • Data is stored in a confidential database • Data on provision of ARV treatment for persons with TB/HIV co-infection is not captured by this form.
Data Use	Facilities, parishes, and regions can use this data in conjunction with other surveillance data for programme planning and advocacy efforts.

MINISTRY OF HEALTH, JAMAICA
TUBERCULOSIS INVESTIGATION FORM

Notification Date (dd/mm/yyyy): ___/___/_____ Source: _____

Investigative Officer Assigned: _____

Sections 1 – 6 must be submitted to the Parish MO(H), 6 weeks or less after notification date (i.e. date of case recognition as suspected Tb)

Section 1 – Demographic Information:

Last Name:	First Name:	Pet Name:
Sex: M / F (circle one)	Age:	DOB:
Address:		
Parish:	Phone (h):	Cellular/ email:
Occupation:	Workplace/ school:	
Work/ school address:		Phone (w):
Jamaican residence? Y / N	6 wk Travel History:	

Section 2 – Clinical Information:

Date of on-set of symptoms: (dd/mm/yyyy)

Symptoms		**Duration**	**Symptoms**		**Duration**
Fever	Y / N		Chest Pains	Y / N	
Cough	Y / N		Night Sweats	Y / N	
Haemoptysis	Y / N		Weight Loss	Y / N	
HIV Infection	Y / N		Other	Y / N	

Referred by:		Address:	Phone:
Referred to:		Admission date:	Ward:
Med. Records #:		Physician/ Consultant:	
Other Med. Condition: □ Pregnant □ Renal Disease □ Liver dysfunction □ Other			
History of BCG: Y / N		Scar seen? Y / N	

Section 3 – Laboratory Investigation:

Mantoux:	Date:	Pos / Neg (circle)	Reading (mm):
X-ray:	Date:	Pos / Neg (circle)	Findings:
Sputum 1:	Date:	Smear: Pos / Neg (circle)	Culture: Pos / Neg (circle)
Sputum 2:	Date:	Smear: Pos / Neg (circle)	
Sputum 3:	Date:	Smear: Pos / Neg (circle)	
HIV Test:	Date:	Pos / Neg / Not Done (circle)	

Section 4 – Case Classification:

Classification:	□ Confirmed; Date	□ Discarded: Date
Treatment History (Tick which applies)	□ New Case □ Previously Treated □ Relapsed □ TAI (default) □ Treatment Failure □ Chronic	
Disease Site: (Tick)	□ Pulmonary	□ Extra Pulm - Site

TAI – Treatment After Interruption

Section 5 – Treatment Initiation

Anti – Tb Treatment:	Date Started:		Date completed:
Supervision:	Duration in Hospital:		Duration at home:
Drug used (tick)	Dosage:	Weekly Regimen:	Comments:
□ Isoiazid (H)			
□ Rifampicin (R)			
□ Pyrazinamide (Z)			
□ Streptomycin (S)			
□ Ethambutol (E)			
□ Thioacetazone (T)			

Date Investigation completed: ___/____/_____ (dd/mm/yyyy)

Name of Investigator:_____ Signature: _____

Parish MO(H) Comment _____

Date: ___/____/_____ (dd/mm/yyyy)

Name of client: _____

Section 6 – Home and Contact Investigation:

Name & Age	Relationship to case	Address	Tb Signs? (circle)	Previous BCG? (circle)	Mantoux Date (dd/mm/yyyy)	Mantoux reading (mm)	X-ray Date dd/mm/yyyy	X-ray Findings	Contact Classification
			Y / N	Y / N					
			Y / N	Y / N					
			Y / N	Y / N					
			Y / N	Y / N					
			Y / N	Y / N					
			Y / N	Y / N					

Tb signs include: Persistent cough (lasting over 3 weeks), fever, night sweats and weight loss.

Previous confirmed case(s) in family: Yes / No / Unk. (circle); If yes list them			
Name:	Relationship to case:	Date of illness:	Properly treated? Yes / No (circle)
			Yes / No / Unk. (circle)
			Yes / No / Unk. (circle)
			Yes / No / Unk. (circle)
			Yes / No / Unk. (circle)

Population of Household:		Number of rooms for sleeping:		Socio-economic status of household:	
Ventilation:	□ Good □ Fair □ Poor (tick one)		Milk Supply:	□ Pasteurized □ Non- pasteurized	
Cleanliness:	□ Good □ Fair □ Poor (tick one)		Comments:		
Water Supply	□ Good □ Fair □ Poor (tick one)				

Additional Information/ Action Taken:

_____

_____

_____

Hypothesis as at source: -

_____

_____

Name of Case: _____

(Sections 7 & 8 to be completed and submitted to the Parish MO(H) when case has completed treatment.)

Section 7 – Treatment continuation and termination

Continuation Phase:	Date started:		Date completed:
Supervision method:			
Drugs used (tick):	Dosage:	Weekly Regimen:	Comments:
□ Isoiazid (H)			
□ Rifampicin (R)			
□ Ethambutol (E)			

Follow-up Laboratory Investigation:

X-ray:	Date:	Pos / Neg	Findings:
2 month check	Date:	Smear: Pos / Neg (circle)	Culture: Pos / Neg (circle)
4/5 month check	Date:	Smear: Pos / Neg (circle)	Culture: Pos / Neg (circle)
6/8 month check	Date:	Smear: Pos / Neg (circle)	Culture: Pos / Neg (circle)
Other:	Date:	Smear: Pos / Neg (circle)	Culture: Pos / Neg (circle)
Other:	Date:	Smear: Pos / Neg (circle)	Culture: Pos / Neg (circle)
Ab resistance tests	Date:	Results:	

Ab – antibiotic

Section 8 – Case Classification re: Treatment Outcome:

Classification:	Date: (dd/mm/yyyy)	Action:
□ Cured		
□ Treatment completed		
□ Treatment interrupted (default)		
□ Treatment failure		
□ Death		
□ Transferred out of parish		
□ Lost to follow up		

Date Investigation Completed: ___/___/___ (dd/mm/yyyy)

Name of Investigator: _____

Signature of Investigator: _____

Parish MO(H) Comment: _____

_____

_____

Date: ___/___/___ (dd/mm/yyyy)

Reg. Epidemiologist/ RTD Comment: _____

_____

_____

Date: ___/___/___ (dd/mm/yyyy)

Date received at National Surveillance Unit: Date: ___/___/___ (dd/mm/yyyy)

National Tb Coordinator Comment: _____

_____

_____

HIV ANTI-RETROVIRAL (ARV) DATABASE — REQUIRED

Data Collection Instrument	HIV Anti-Retroviral (ARV) Database
Purpose	To collect data on indicators that measure HIV treatment activities within the Treatment, Care and Support Priority Area of the NSP
Frequency	Case by Case
Responsible Officer at Regional level	Designated Officer at each Treatment Site inputs data in Database.
Data Sources at Sub-Regional Level	Client Medical Records from Health Care Facilities
Data Storage at Regional Level	• Database is housed at most treatment sites on password-protected desktops. • Backup: Data should be copied to CD every quarter and stored in a secure place; Parish and Regional Office computers should be backed up in accordance with Ministry of Health IT policies and protocols.
Indicators	Percentage of adults and children with HIV known to be on treatment 12 months after initiation of ART Percentage of adults and children with advance HIV infection who are receiving antiretroviral combination therapy according to national guidelines
Data Quality Concerns	Data collection should be done at the time of service. Delayed data entry can compromise data quality.
IDP Reporting Requirements	UNGASS, CARICOM, GFATM, WB, USAID
NHP Reporting Requirements	Annual Review; Annual Report; (internal requirements); proposal writing
Strengths and Limitations of the Form	• Protects confidentiality of cases • Data can be used to determine adherence to treatment regimen and supply information on early warning indicators of HIV drug resistance. • Data limited to that which is entered into the database.
Data Use	This data is used to track the use of ARV as well as to prevent stock outs by assisting with timely procurement of ARVs.

HIV Anti-Retroviral (ARV) Database — Required

HIV/ARV DATABASE USER GUIDE

(NOT HATS)

Ministry of Health
National AIDS Program
Monitoring and Evaluation

For technical assistance with this database please call:

Sheldon Whorms c/o Ministry of Health Jamaica, email:whormss@moh.gov.jm, whorms_s@yahoo.com, Cell: 7998294

Main Menu

The Main Menu consists of:

1. Data Entry

   All patient related information is entered here including demographics, ARV, PMTCT, Clinical, Laboratory.

2. Process Reports

   Reports available include:

   a. ARV details b. Monitoring and Evaluation Monthly Report registry

3. DBMS Maintenance Utilities

   This module allows the user to add additional laboratory tests, ARV drugs, Relationships, side effects etc

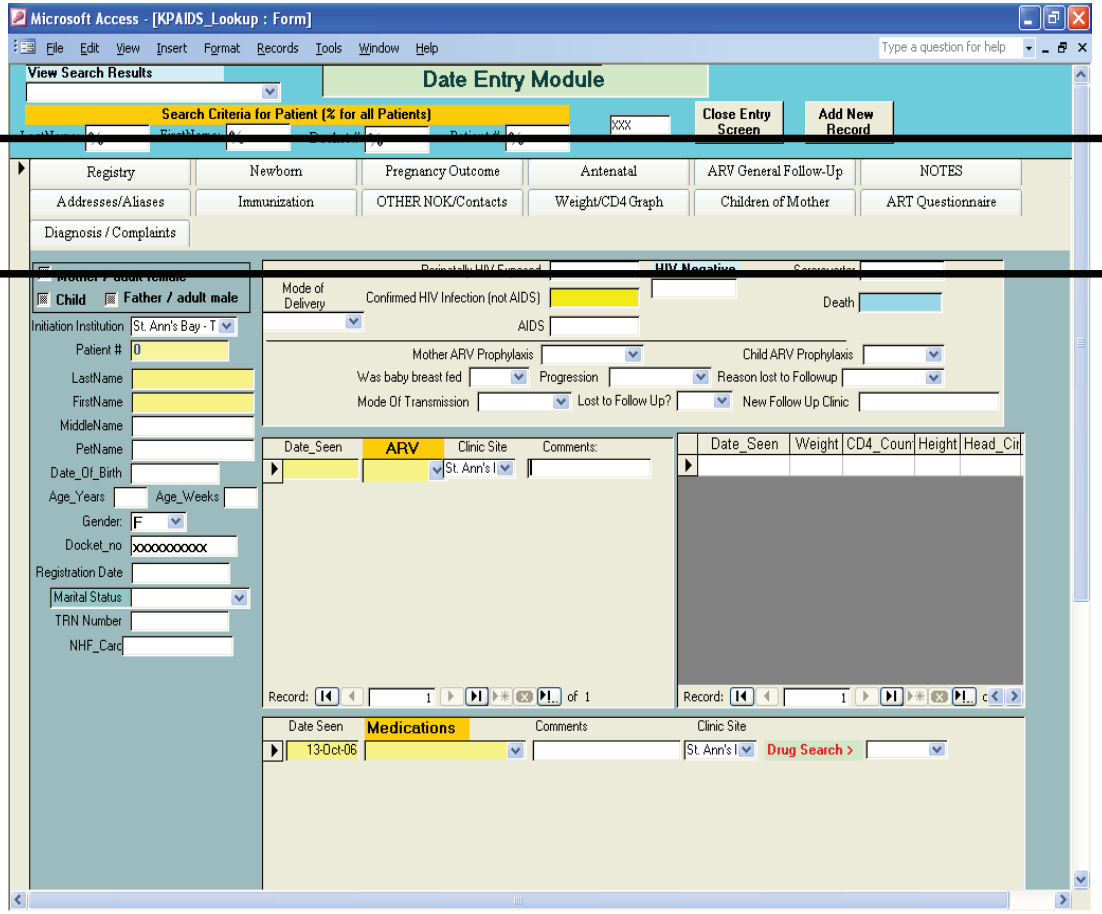
4. Exit System

   This option closes the database.

Data Entry Module

The Data Entry Screen is divided into several sections.

1. Patient Demographics
2. Registry (ARV, Lab, general medications, weight)
3. Newborn (same as obstetric summary)
4. Pregnancy outcome (same as obstetric summary)
5. Antenatal
6. ARV General follow-up
7. Patient Addresses/aliases
8. Immunization
9. Next of Kin / Contacts
10. Graph: Weight vs CD4
11. Children of Mother
12. Diagnosis / complaints
13. ART Questionnaire
14. General Notes



Searching Methods

Method #1

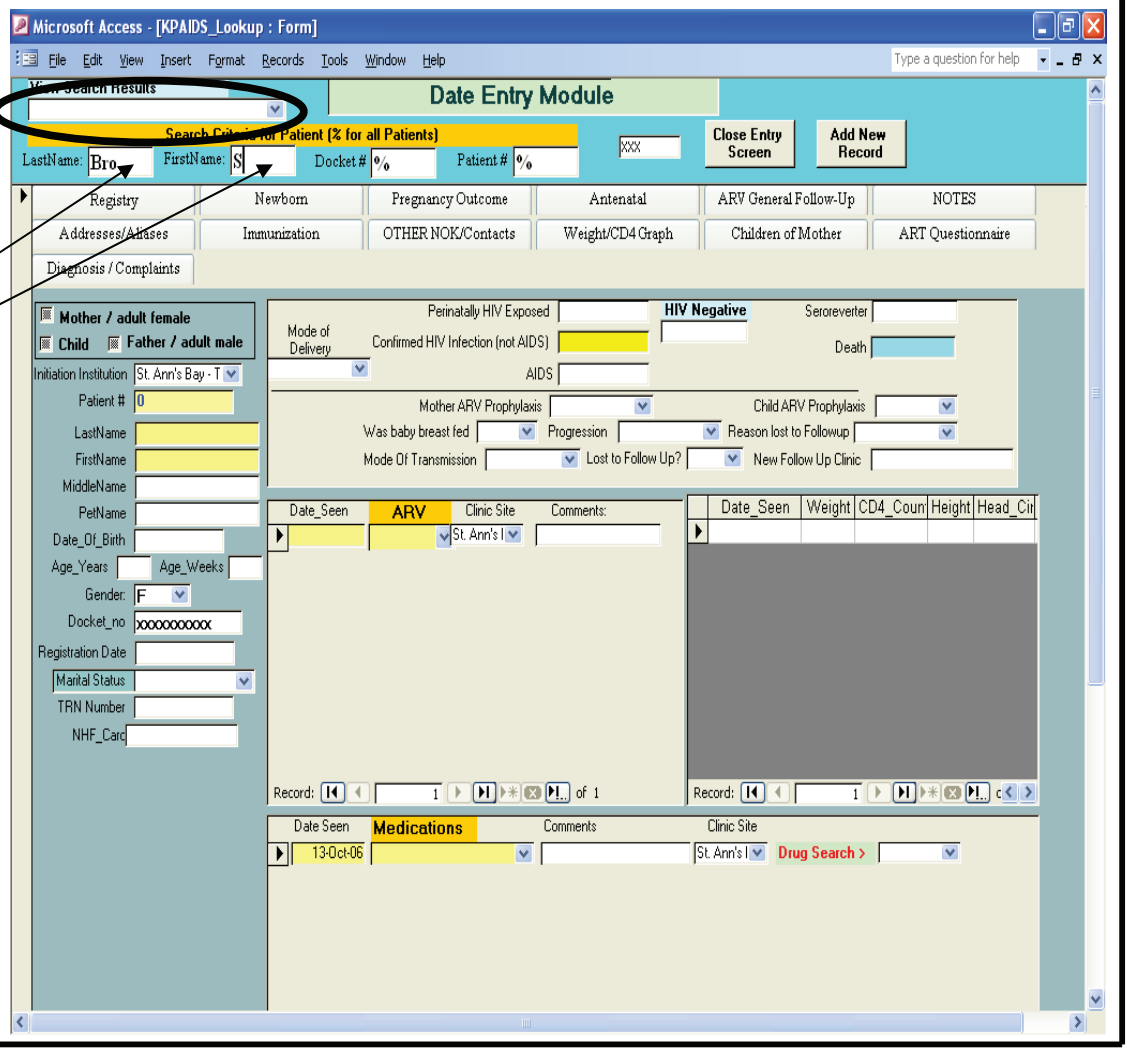
a. Click in the View Search Results box

b. Type the LAST name of the patient

c. Click the down arrow

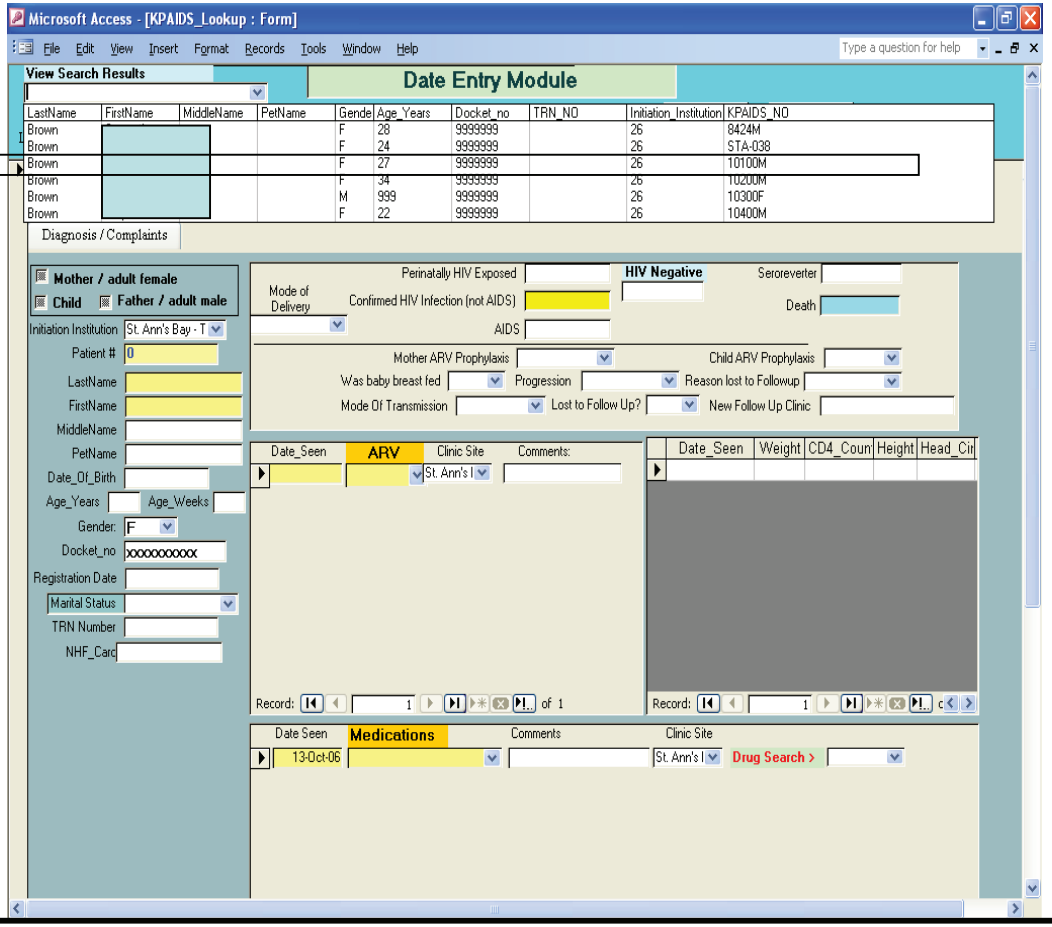
Method #2

1. Enter any combination of the following: the complete or starting letters of the last name, and / or first name and / or docket #.
2. Click the down arrow to see a list of records that match the criteria given.
3. Click on the desired name to retrieve the record.



Retrieving a Record

Click on the specific patient name to retrieve the record.



Patient Demographics

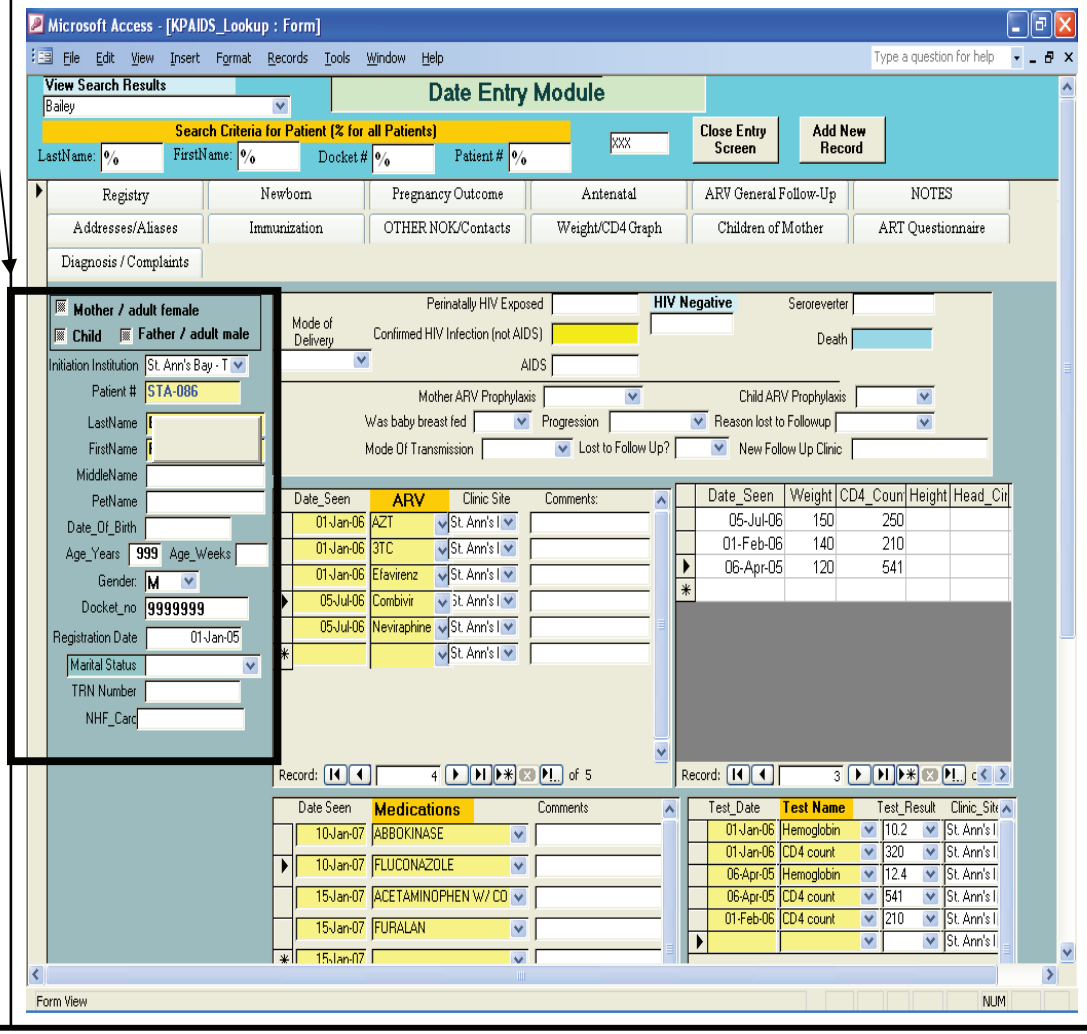
The patient demographics is entered here.

1. Tick one of the three classification for the patient.
(a. Mother/adult female, b. Child, c. Father / adult male).

2. The computer will then generate a patient_id #.

3. Patient number formats: Members of the same family should ideally have the same number.
Example: mother - 10005M,
father - 10005F, Baby#1 - 10005C1, Baby#2 - 10005C2.
Where the mother has a second or third child for a different father(3); keep the same mother's number but add F2 or F3 for the second or third father respectively. In this example the second baby's father would be: 10005F2.

4. Enter a docket number of 99999 if the docket number is unknow.



Entering ARVs, Lab Results, HIV dates

The above information is accessed by first clicking on the **Registry** button.

Note: Fields with a yellow background require information.

HIV Progression dates.

Date formats: 05-feb-06 or 15-jun-2006

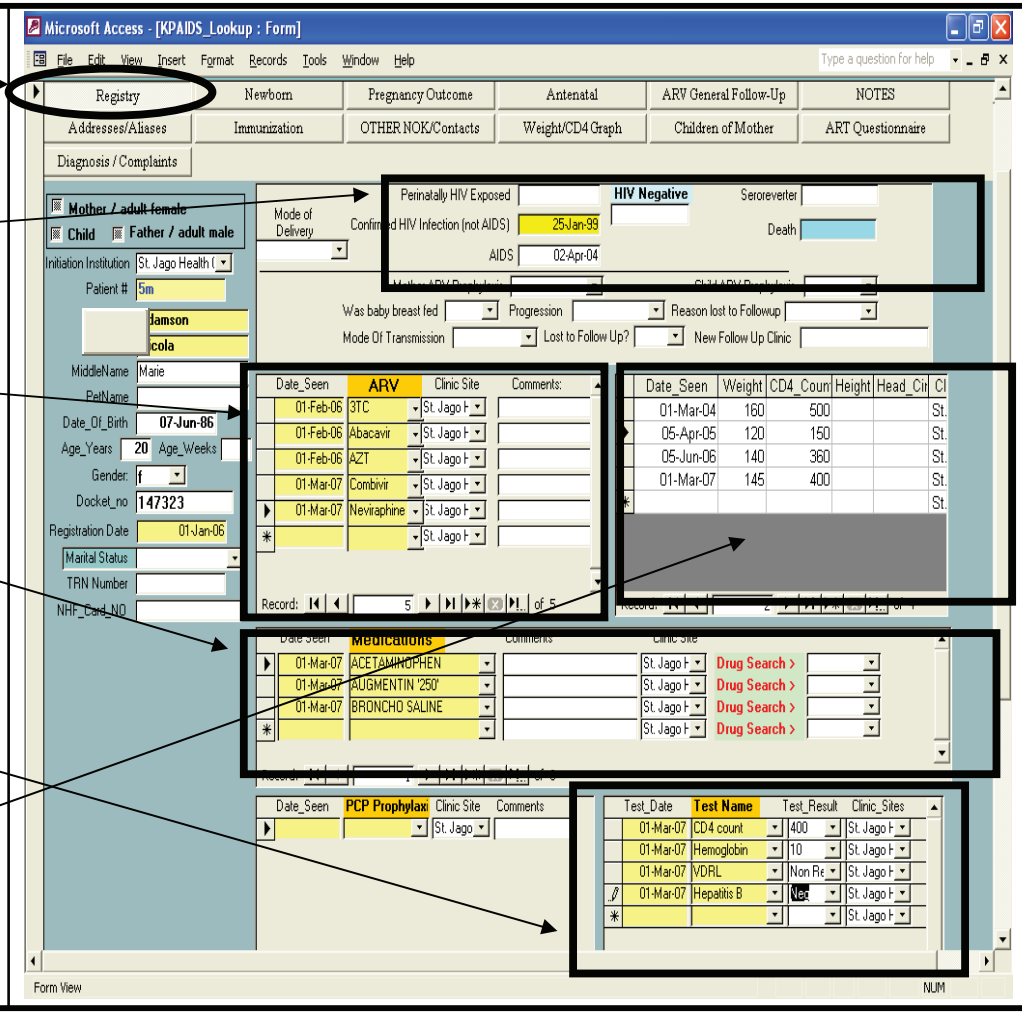
ARV medications.

General medications.

Click on Drug Search to quickly find and drug in the FDA database.

Laboratory results.

Weight and CD4

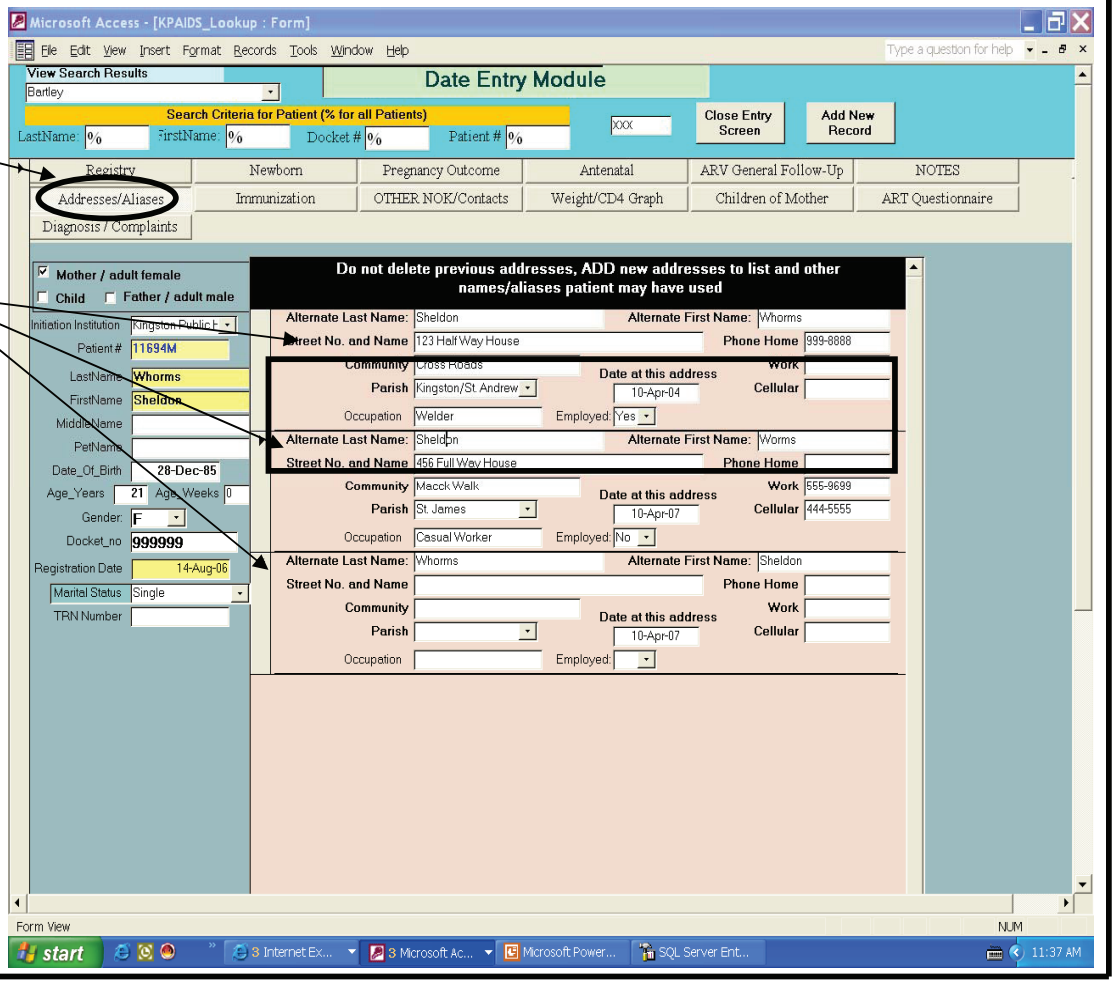


Adding Patient Address(es)

1. Click Addresses / Aliases

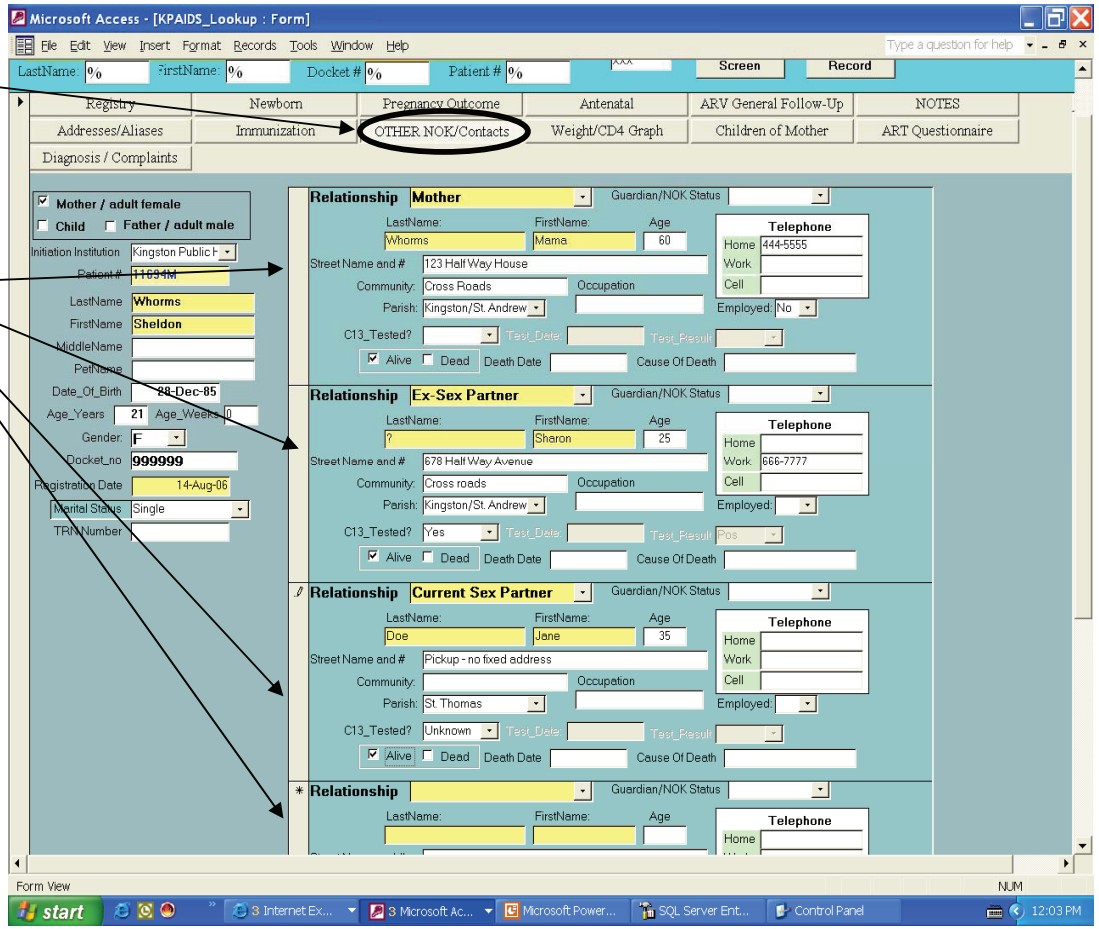
2. Enter each different address in a separate record.

3. The street name is a required field.



Adding Patient Next of Kin or Contacts

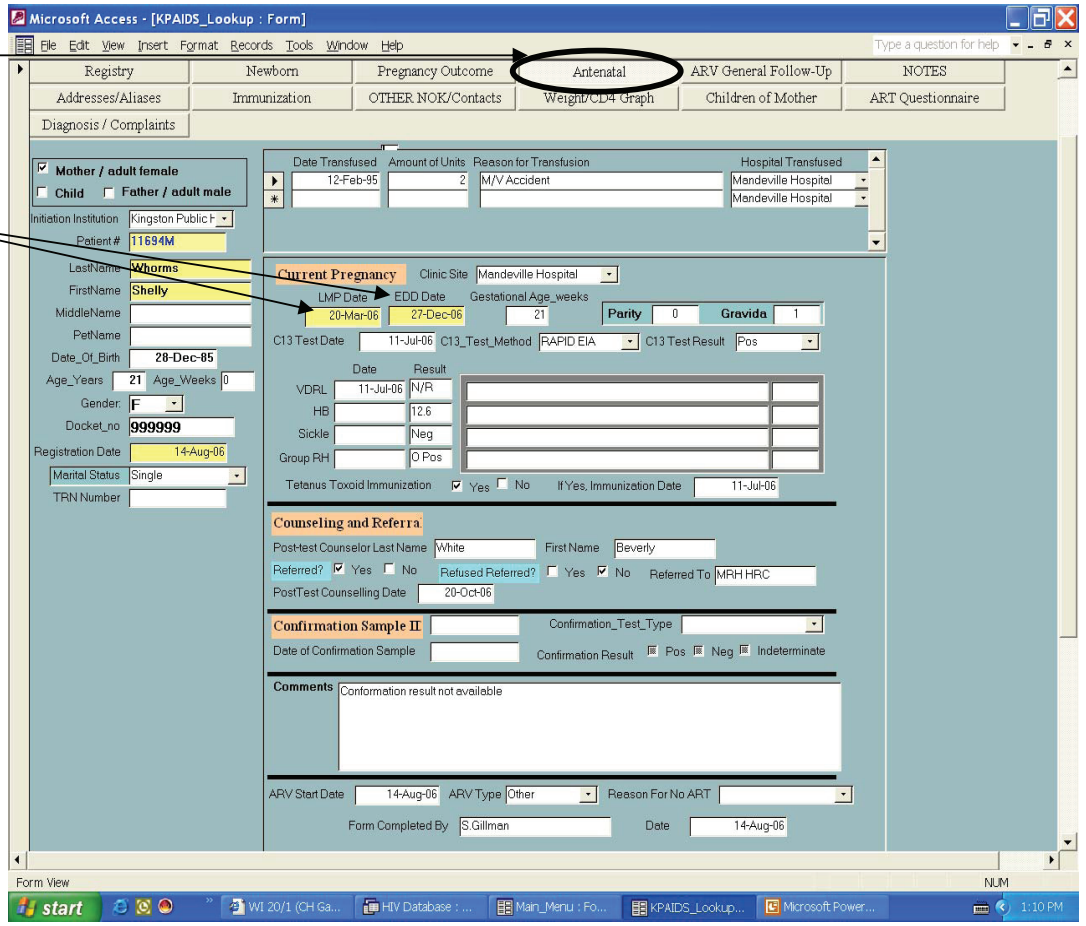
1. Click on the OTHER NOK/Contacts button
2. Any number of Next of Kin or contacts can be created.
3. For sexual contacts use Ex-sex partner or current sex partner
4. The relationship type, last name and a first name are required



Adding Patient Antenatal Information

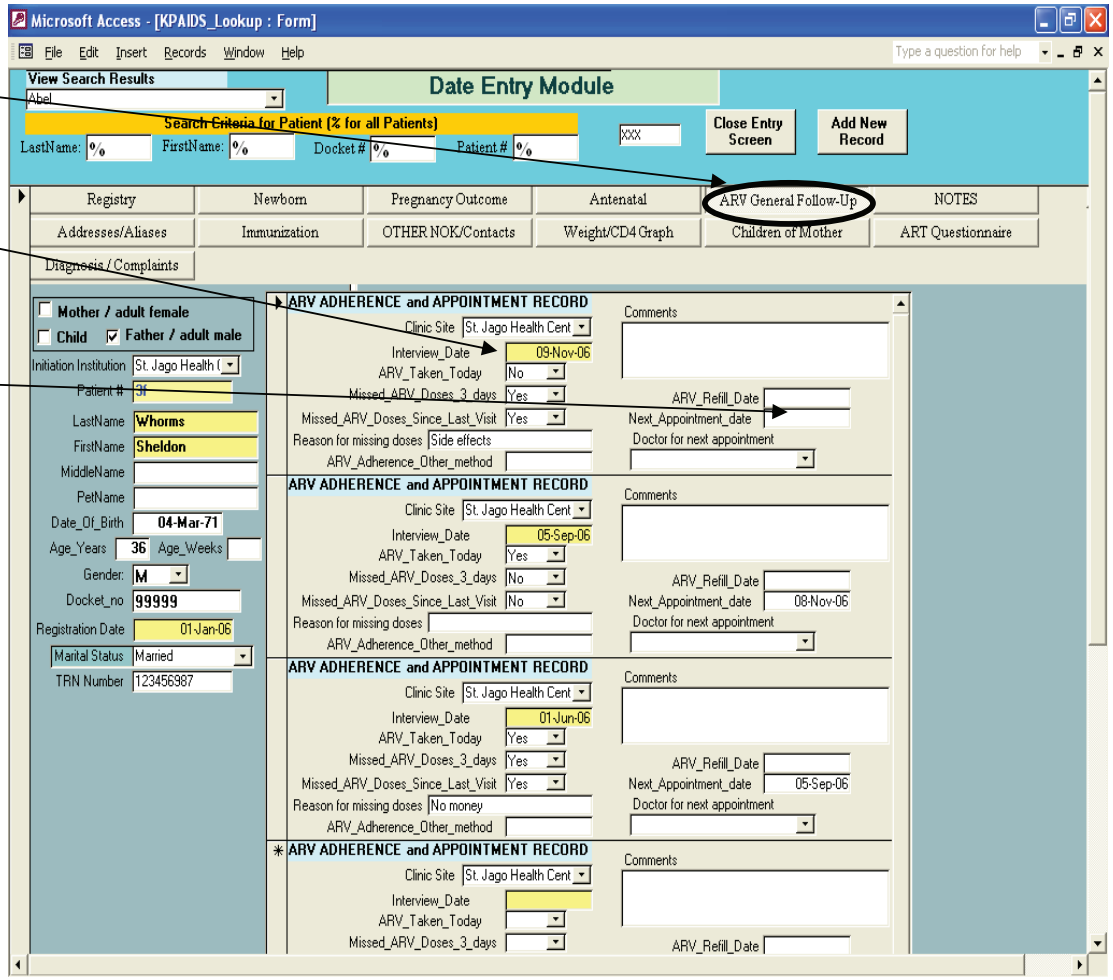
1. Click on the Antenatal button to access the antenatal data

2. The LMP and EDD dates are required fields. A 'good guess' of the LMP date is ok.



Adding ARV Adherence Information

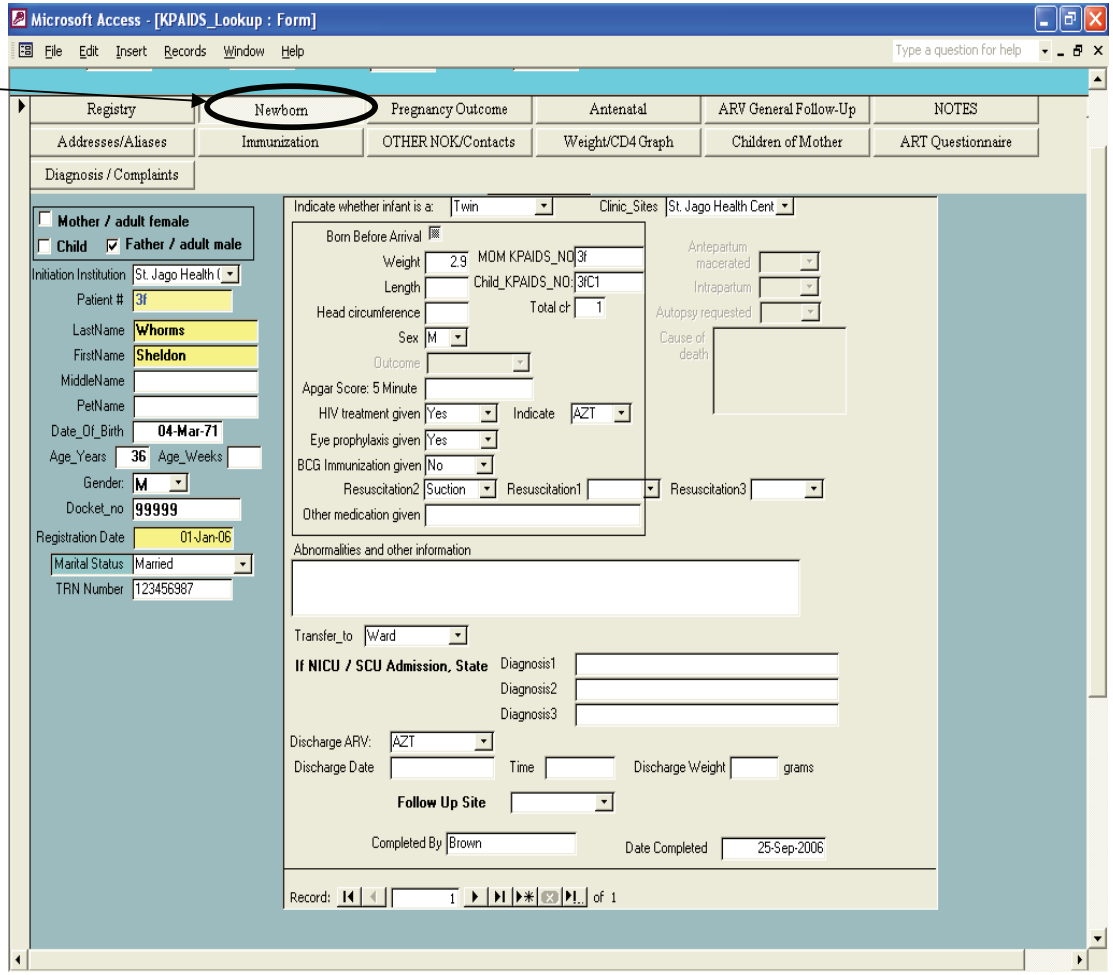
1. Click on the ARV General Follow-up button to access the ARV adherence data
2. The interview/visit date is required.
3. Use the appointment date to generate a list of patients for a particular visit date.
4. Enter any amount of data



Adding Newborn Information

1. Click on the Newborn button to access the Newborn data

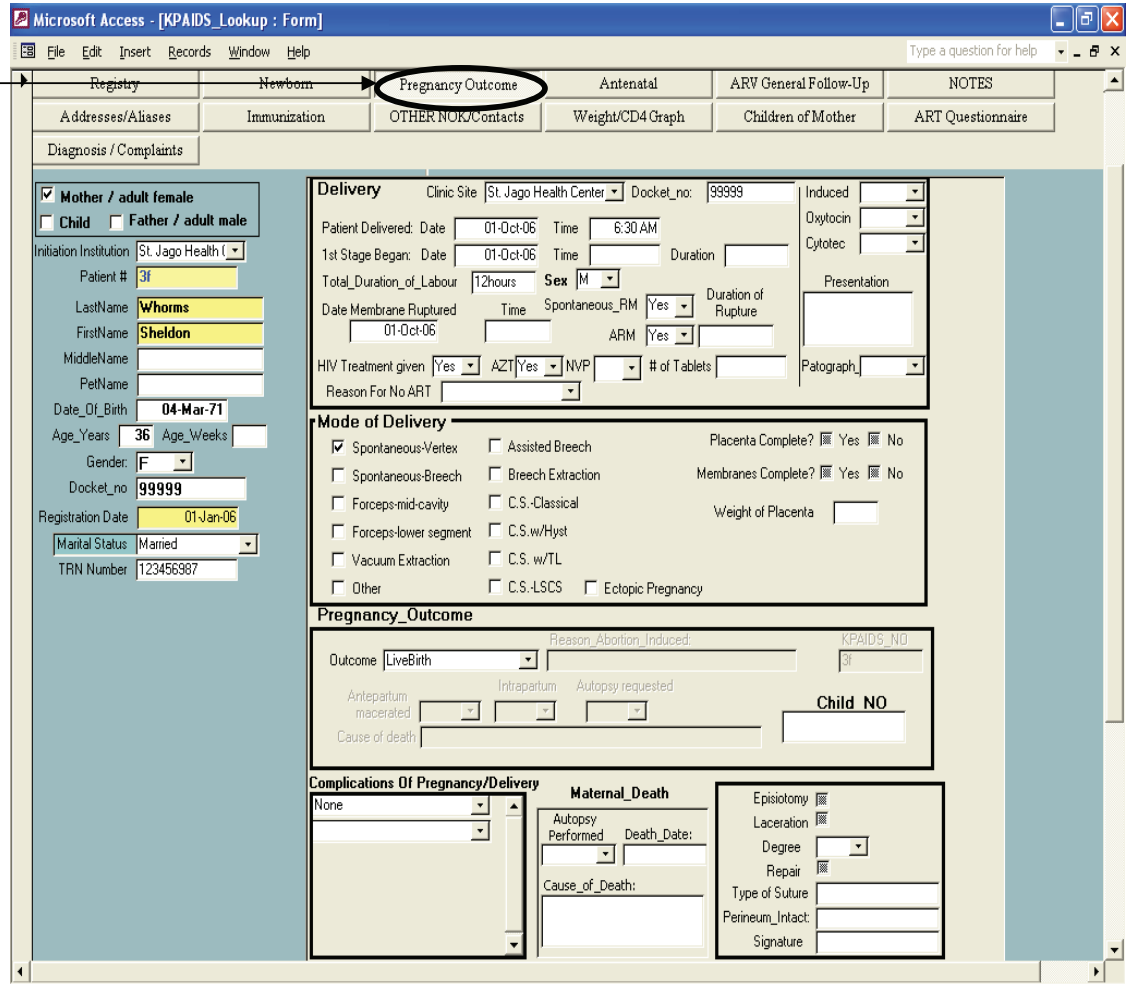
2. The newborn data is a subset of the obstetric summary sheet.



Adding Pregnancy Outcome Information

1. Click on the Pregnancy Outcome button to access the pregnancy outcome data

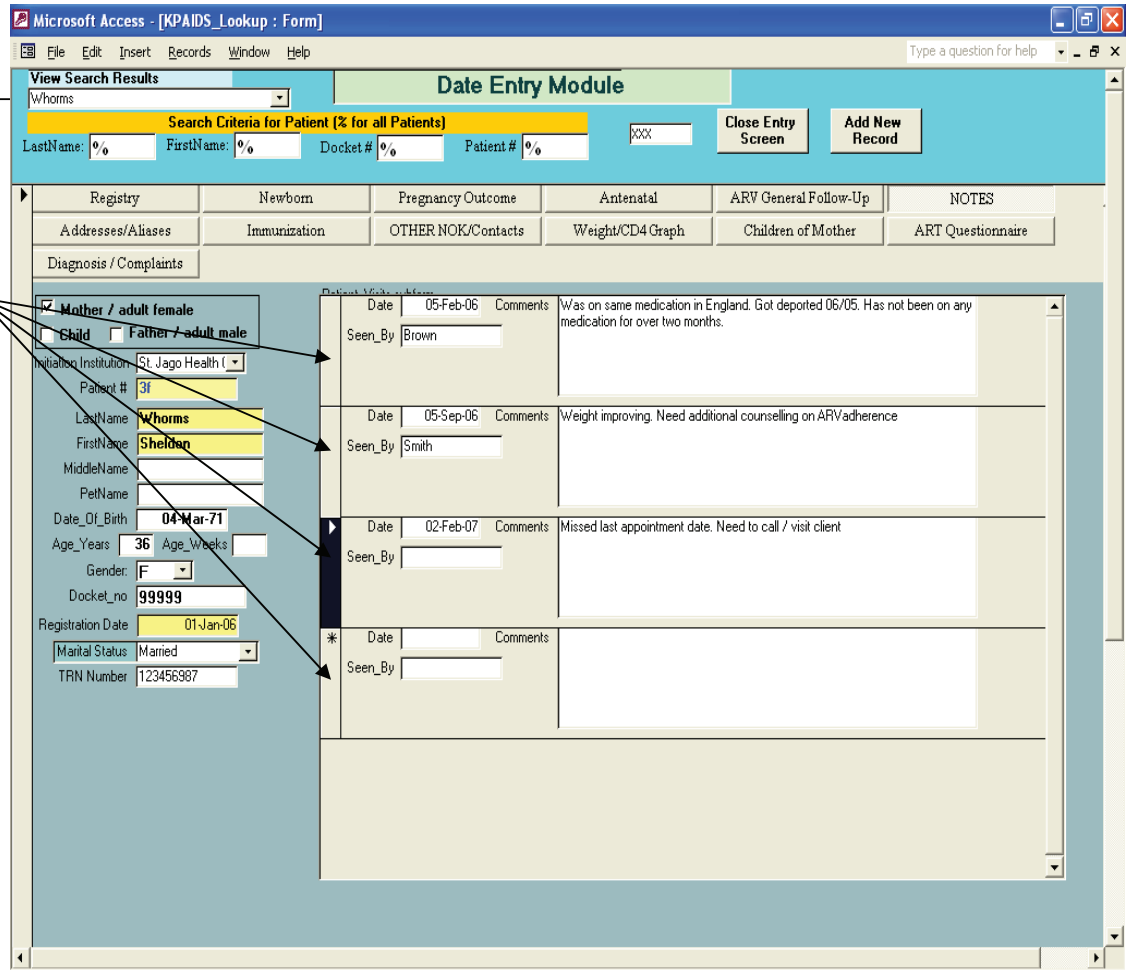
2. The pregnancy outcome data is a subset of the obstetric summary sheet.



Adding General Notes

1. Click on the Notes button to access the notes data

2. Enter any amount of notes.

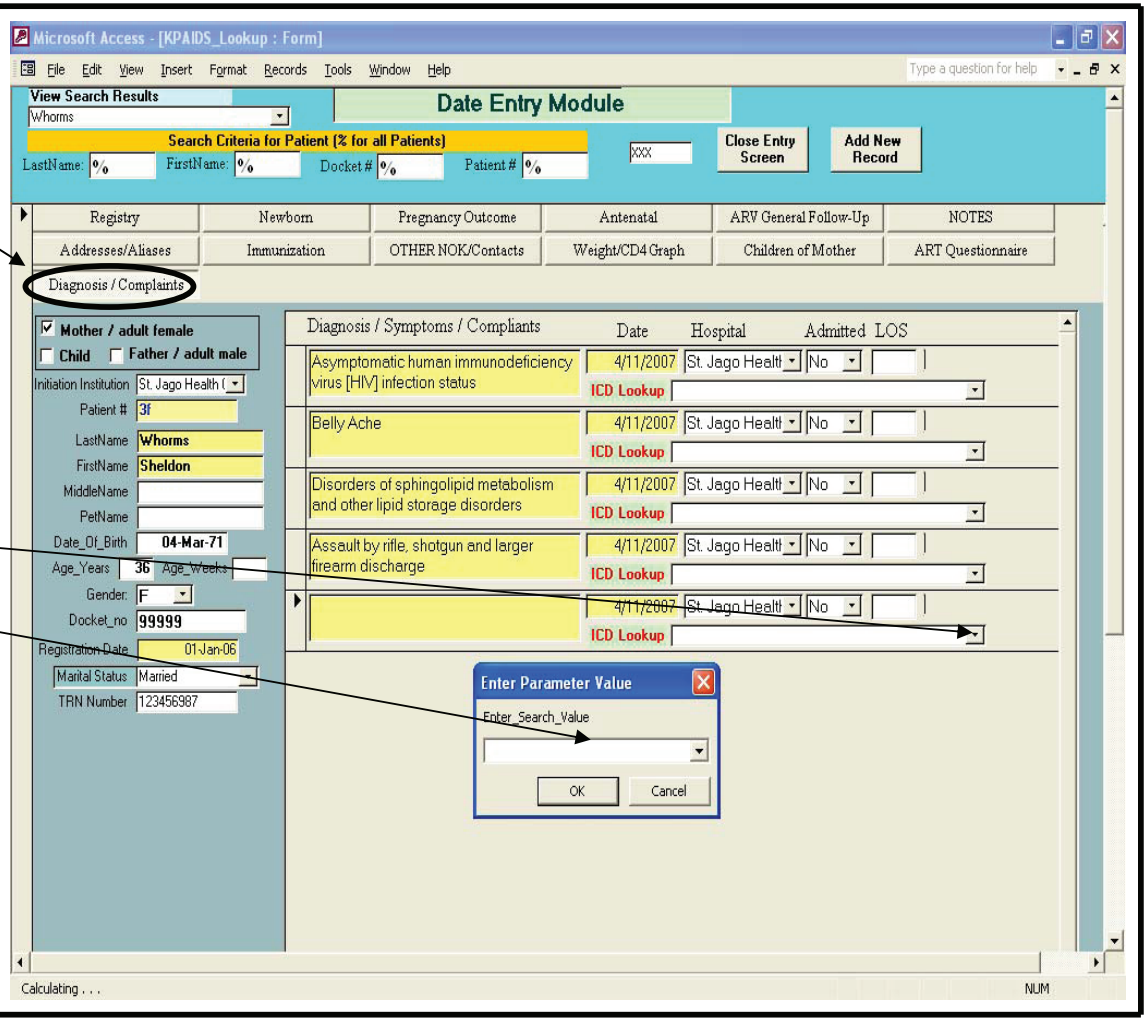


Adding Diagnosis/ Complaints Notes

1. Click on the Diagnosis/ Complaints button to access the Diagnosis/ Complaints data

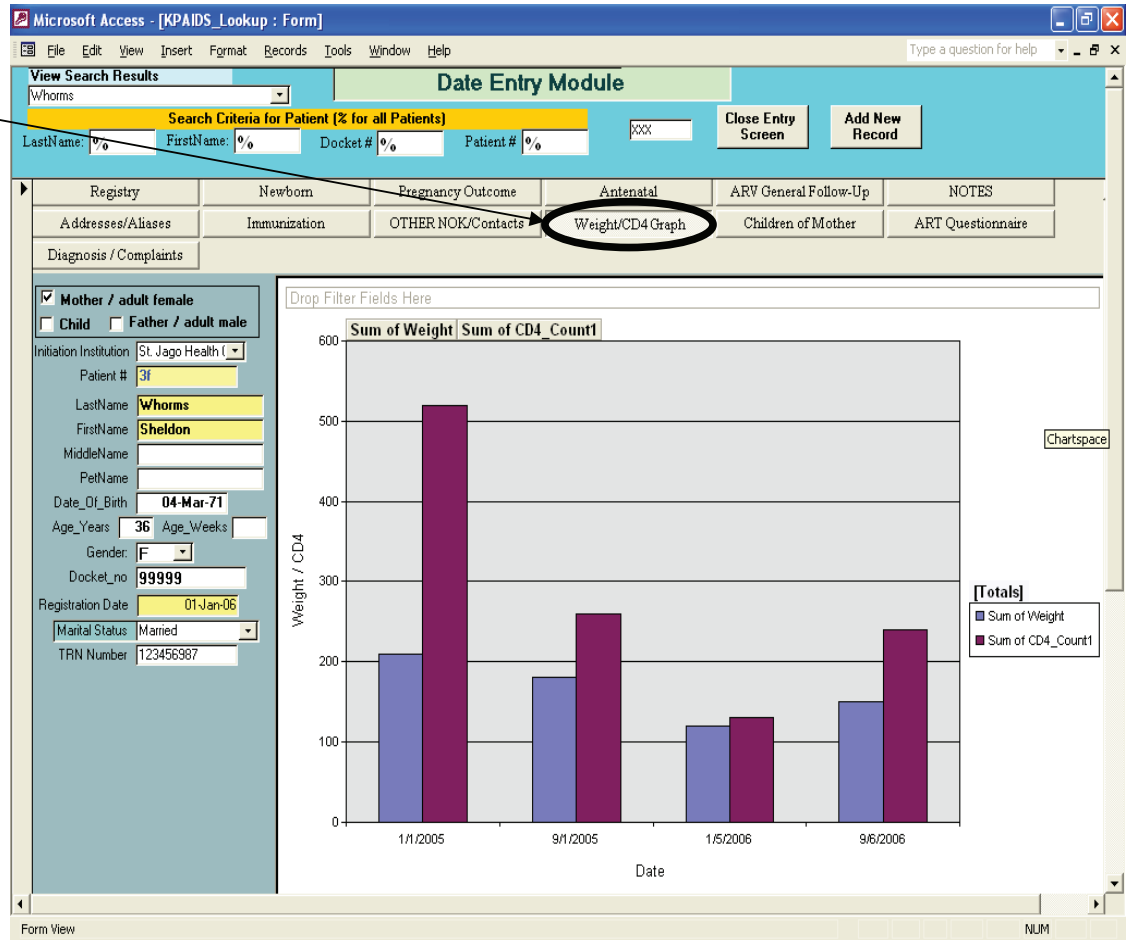
2. Manually enter diagnosis

3. Pick a diagnosis from the ICD10 classification.
   a) Click on ICD Lookup
   b) Enter any part of the diagnosis to see a list of related diagnosis.



Viewing Weight vs CD4 Count Graph

Click on the Weight/CD4 graph button to view the graph



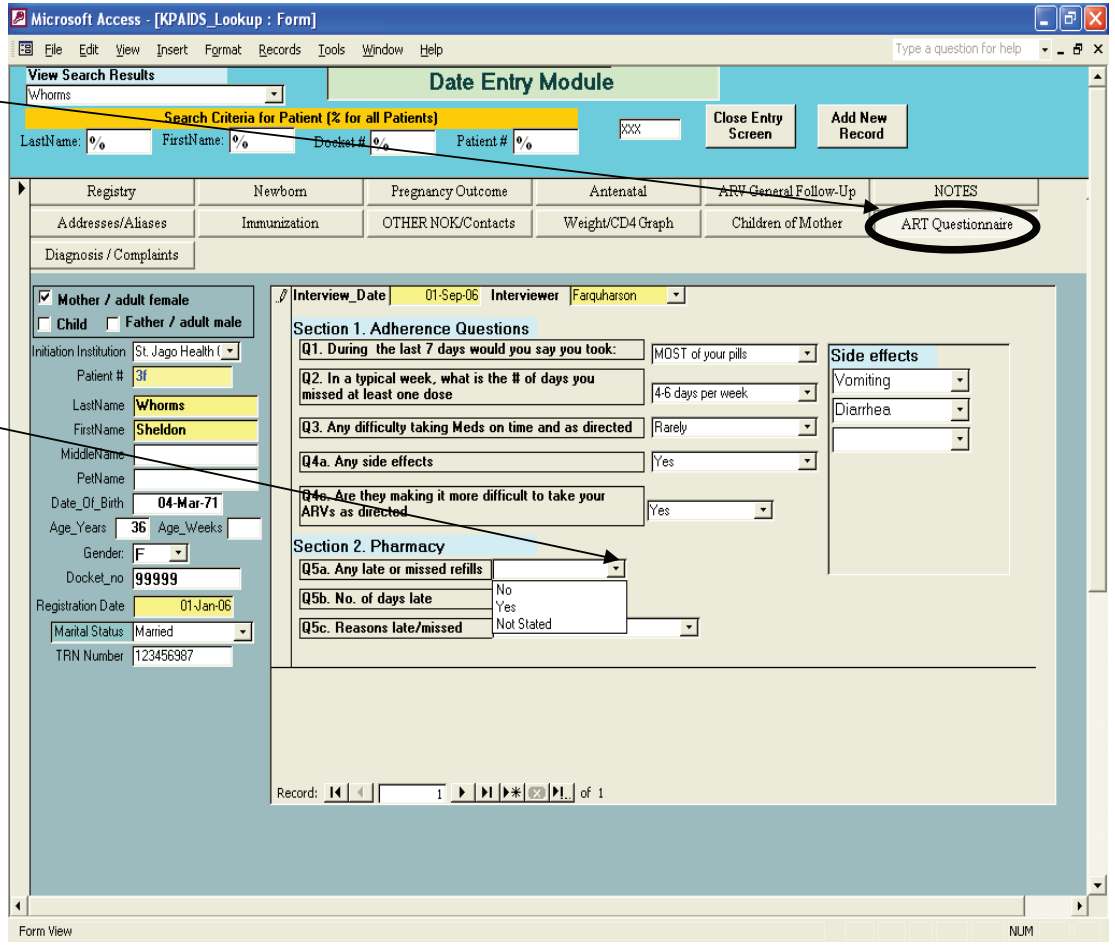
HIV Anti-Retroviral (ARV) Database — Required

Enter ARV Questionnaire

1. Click on the ARV Questionnaire button to view the Questionnaire

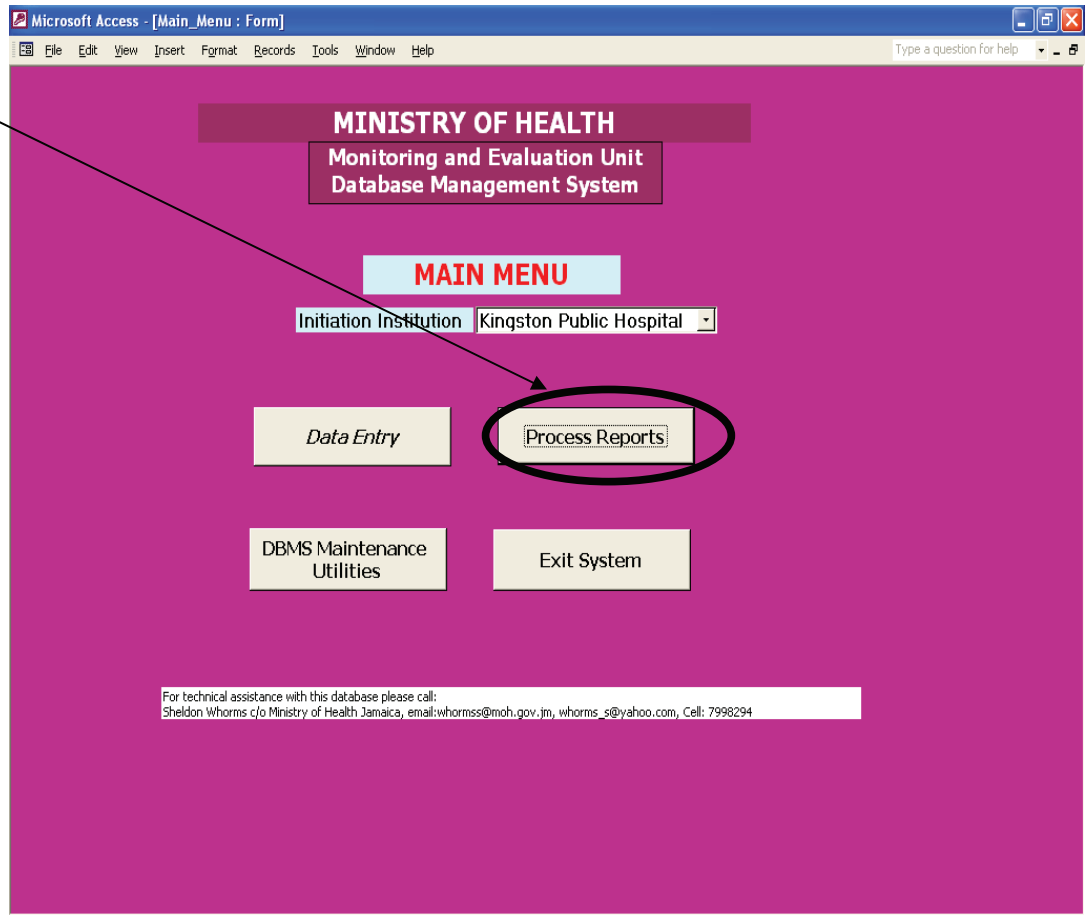
2. The interview date and interviewer are required fields

3. All questions have a set of predefined answers.



Printing Reports

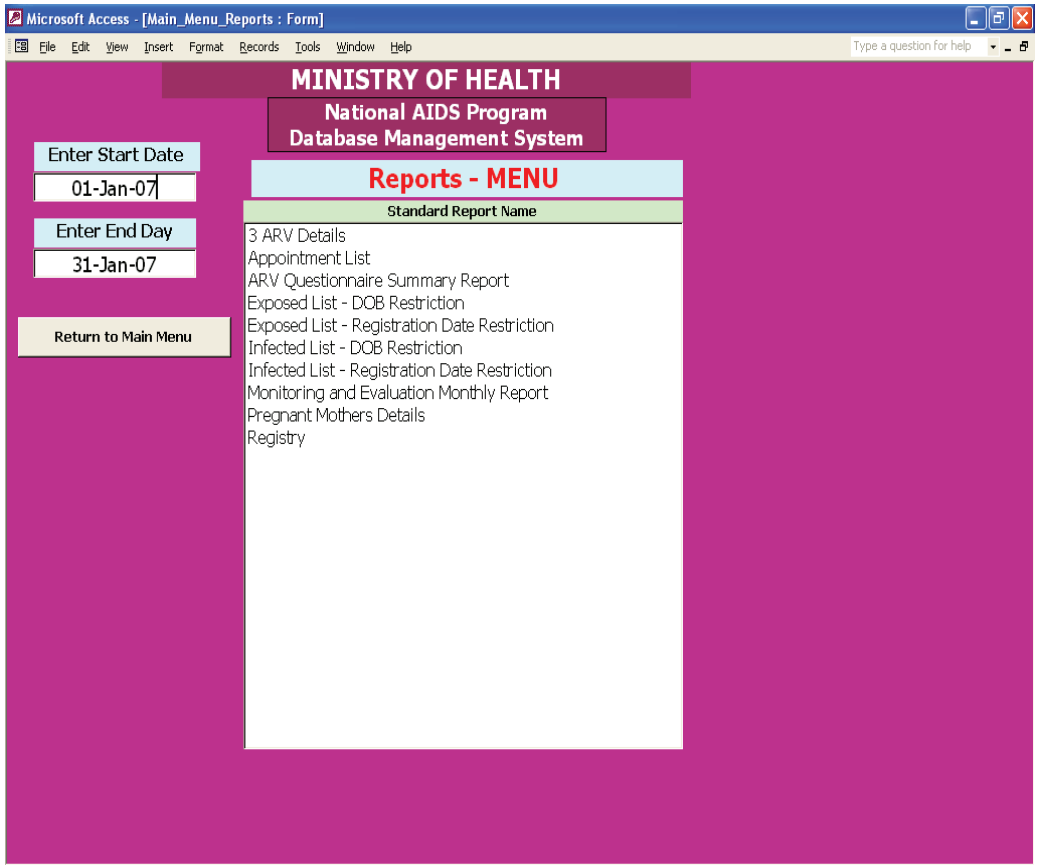
1. Click on the PROCESS REPORTS Button on the main menu



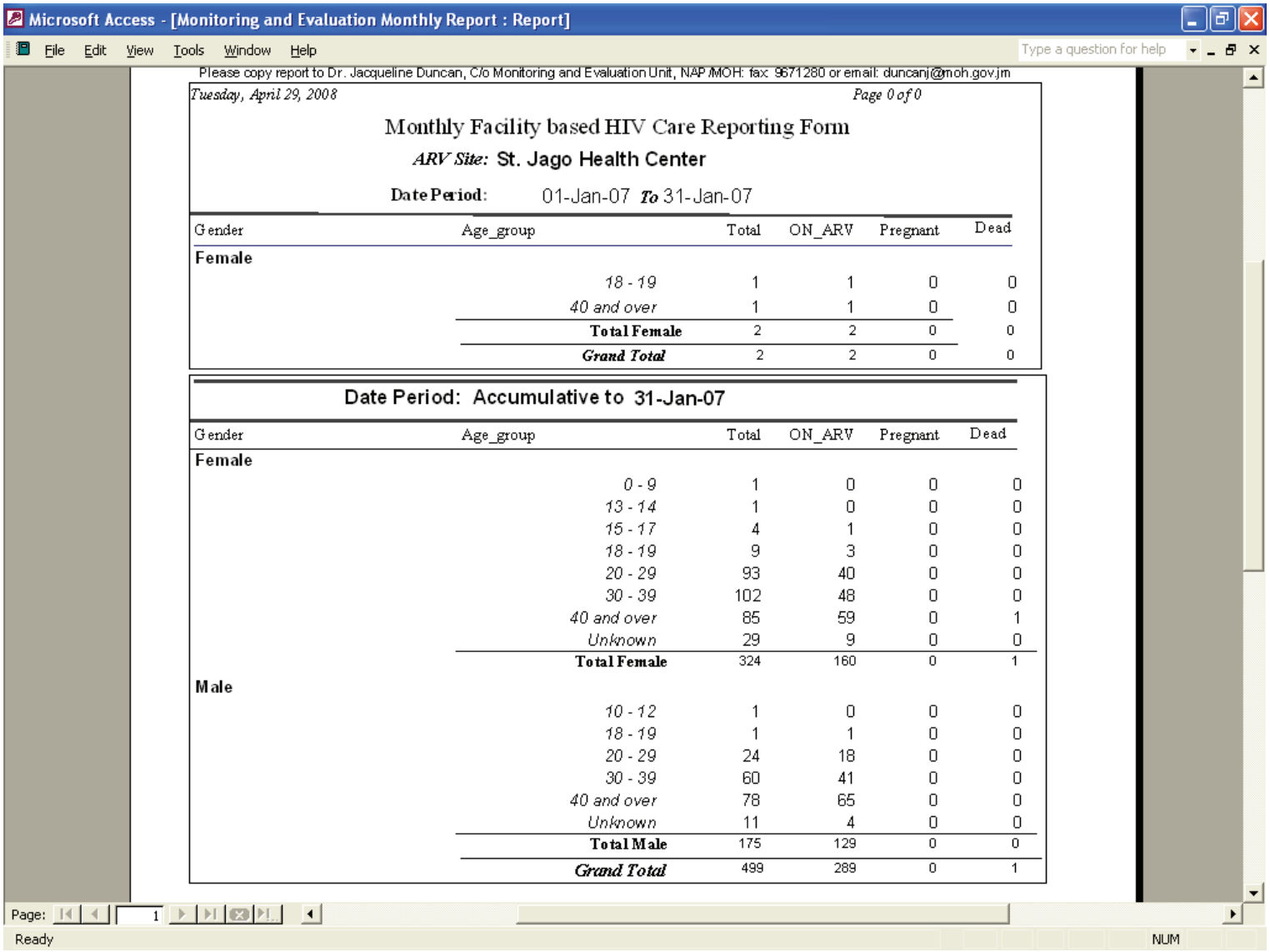
Printing Reports

1. Enter the start and end date for the report
2. Click on the report you would like to print
3. NOTE: All reports will be displayed on the screen with an option to print to the printer.
4. Locate the print icon and click to print.

5. Reports not included in list can be created on request to the Monitoring and Evaluation Unit, National AIDS Program.

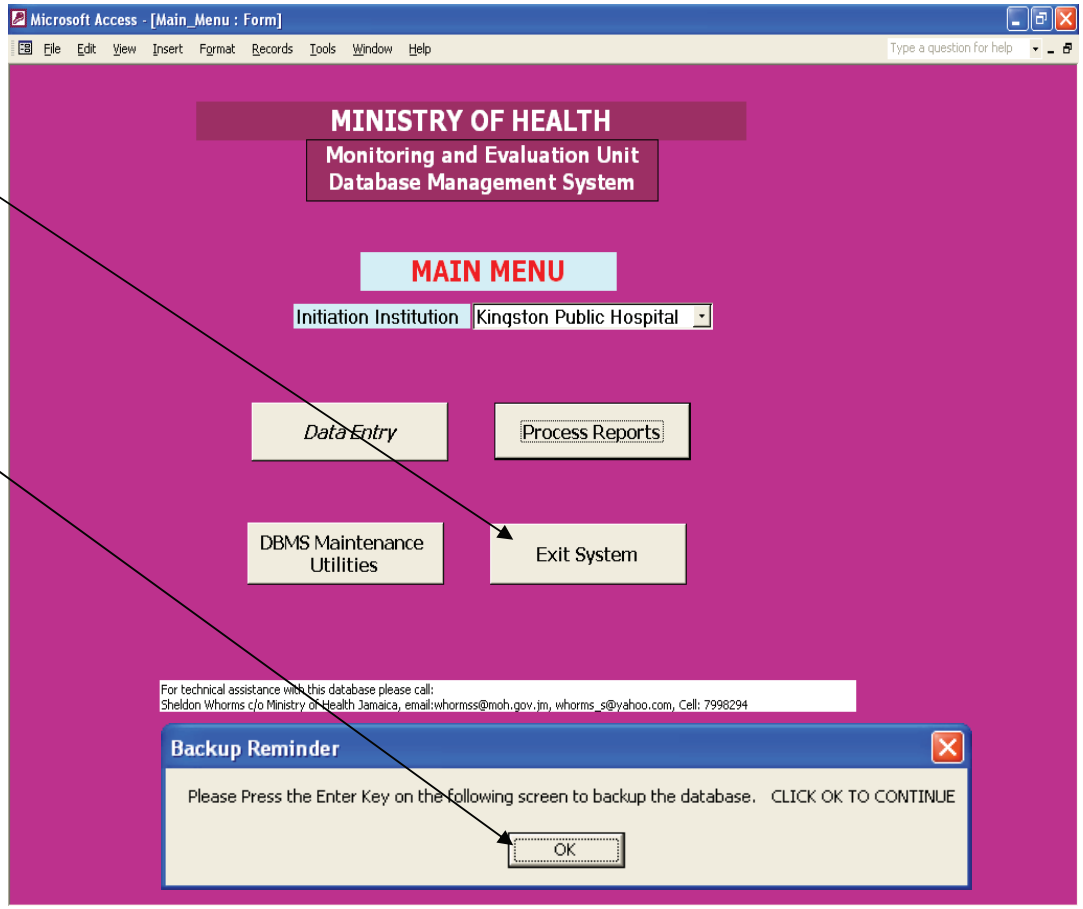


SAMPLE REPORT



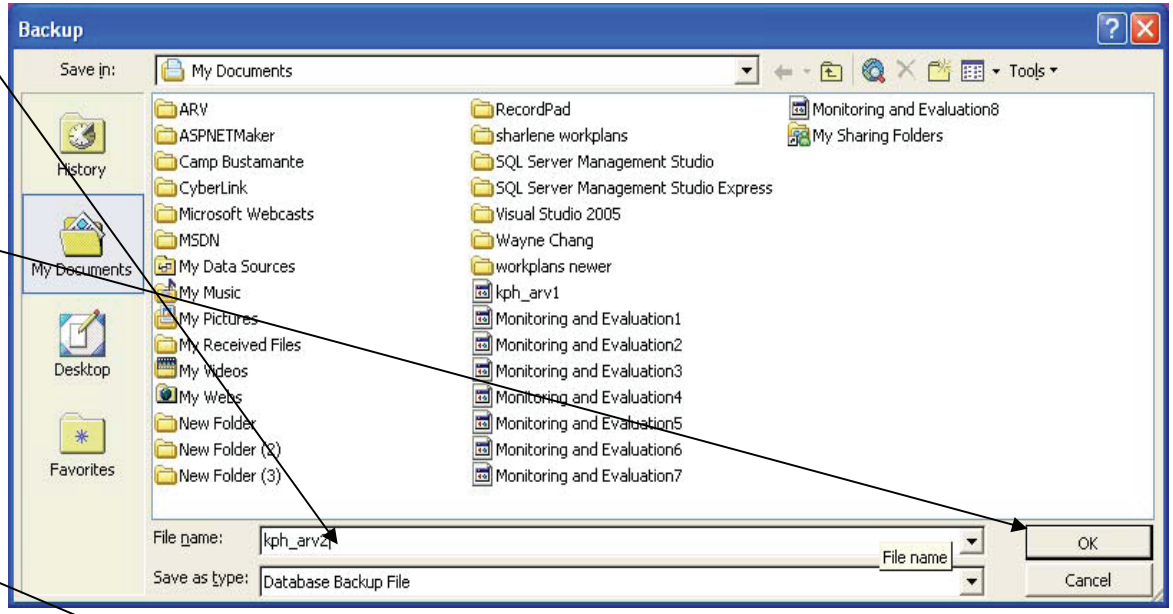
Backup Data

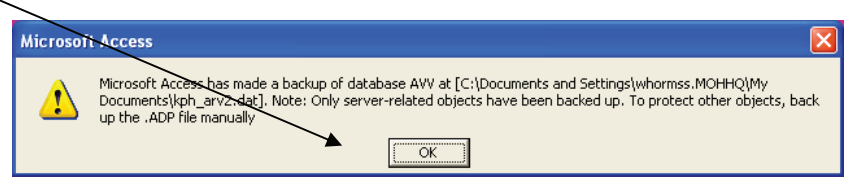
1. To Backup: click on the EXIT PROGRAM button.
2. A popup message will be displayed.
3. Click Ok to continue.



Backup Data Cont'd

1. By default a backup file name will be displayed
2. Click Ok to continue.
3. A final screen will be displayed. Click ok to continue.
4. Please Copy the file just backup to a CD or USB drive in case the computer crashes





IMMUNOLOGY REPORT (CD4, VIRAL LOAD, PCR REPORTS) — REQUIRED

Data Collection Instrument	CD4, Viral Load, PCR Reports
Purpose	To collect data on indicators that measure support services for PLHIV within the Treatment, Care and Support Priority Area of the NSP
Frequency	Monthly
Responsible Officer at Regional level	Chief Medical Technologist collects data from Cornwall Regional Hospital Laboratory and NPHL and submits report to Director of Immunology and the NHP Treatment Coordinator.
Data Sources at Sub-Regional Level	• CD4 - Cornwall Regional Hospital and NPHL • Viral Load and PCR - NPHL
Data Storage at Regional Level	Lab data should be stored and backed up in accordance with National Ministry of Health policies and protocols.
Indicators	• Number of infants born to HIV+ mothers receiving PCR testing according to national standards • Number of individuals receiving CD4 tests in accordance with guidelines • Percentage of infants born to HIV-infected mothers who are HIV-infected
Data Quality Concerns	Data collection should be done at the time of service. Delayed data entry can compromise data quality.
IDP Reporting Requirements	GFATM
NHP Reporting Requirements	Annual Review; Annual Report; (internal requirements); proposal writing
Strengths and Limitations of the Form	Data collection and reporting timeliness can limit the usefulness of the data. These are important indicators for care and support of PLHIV. Doublecounting of individuals may occur.
Data Use	The data is used to assess the effectiveness of the clinical management of PLWHA as well as tracking trends in the number of persons who are diagnosed as having AIDS.

Immunology Report (CD4, Viral Load, PCR Report)

Table 1: Format of CD4 Monthly Report

Reporting Period.....

Site of Origin	Number of Samples Received	Number of Samples Processed	Number of Samples Rejected

Table 2: Format of Viral Load Monthly Report

Reporting Period……

Site of Origin	Number of Samples Received	Number of Samples Processed	Number of Samples Unprocessed	Number of Samples Rejected

Table 3: Format of PCR Monthly Report

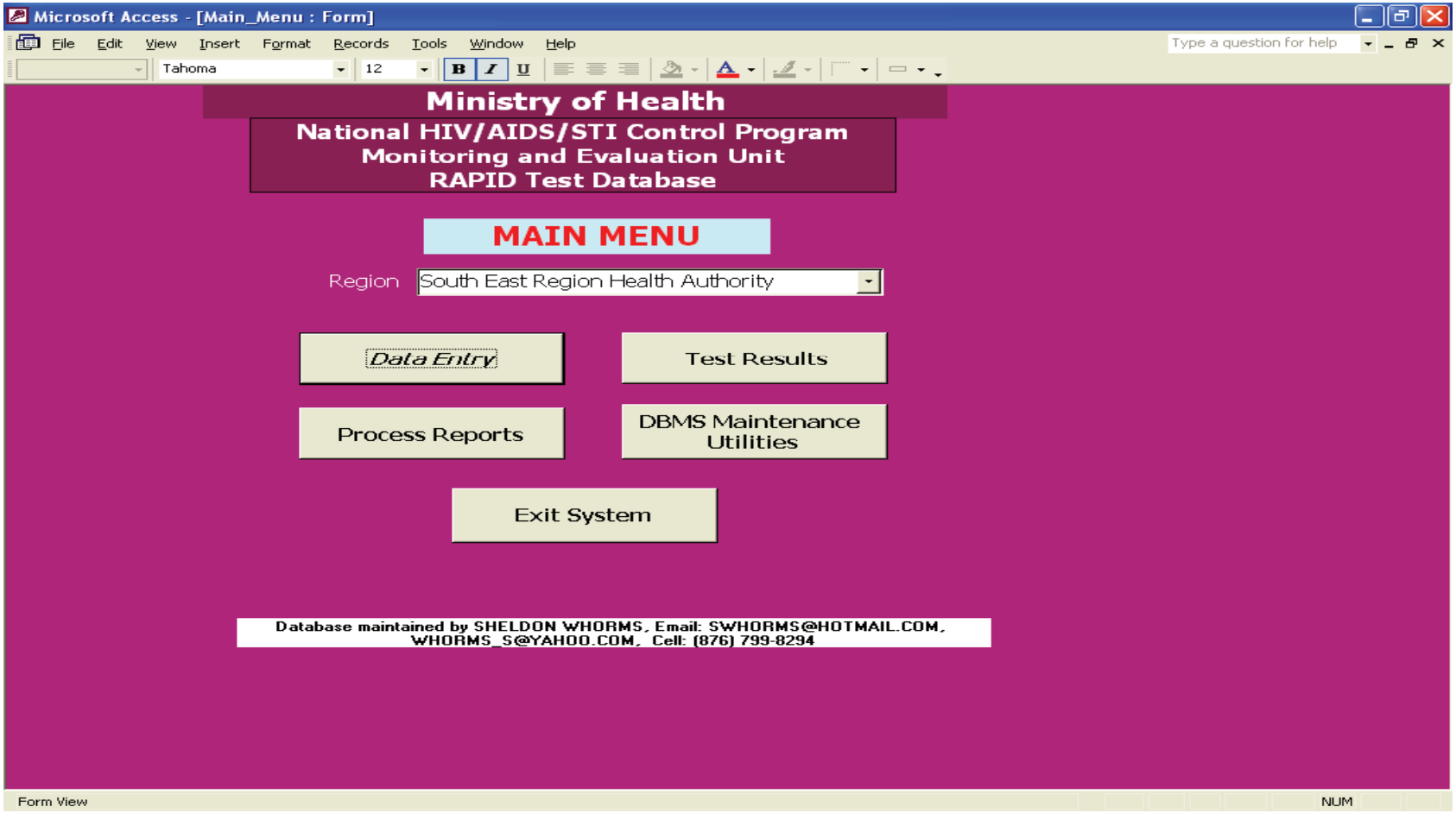
Reporting Period……..

Site of Origin	Number of Samples Received	Number of Samples Positive	Number of Samples Negative	Number of Samples Unprocessed	Number of Samples Rejected

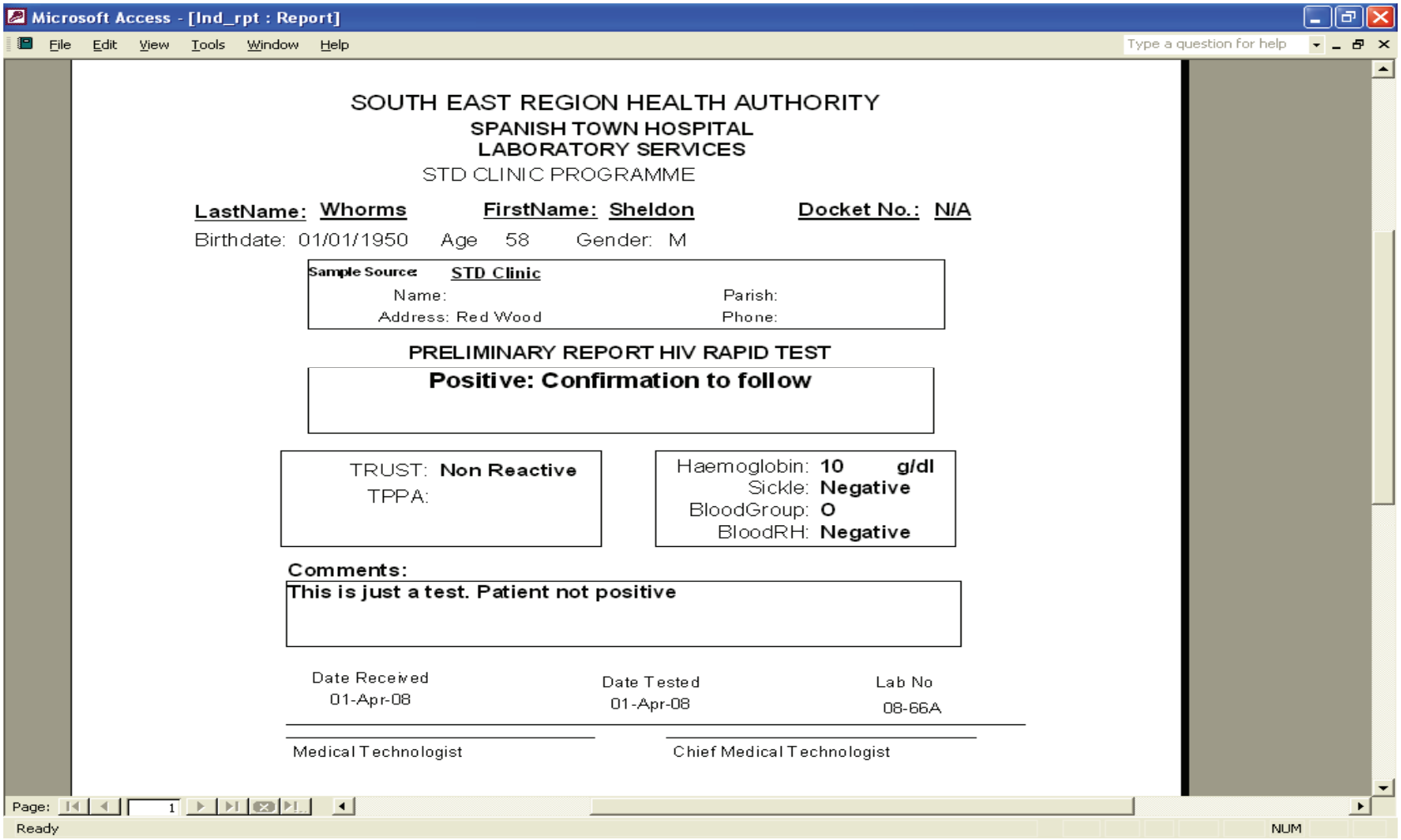
HIV RAPID TEST DATABASE — REQUIRED

Data Collection Instrument	HIV Rapid Test Database
Purpose	To collect data on indicators that measure HIV testing activities within the Treatment, Care and Support Priority Area of the NSP
Frequency	5th Working Day of the Month
Responsible Officer at Regional level	• Laboratory Technician at testing site compiles and submits data to the Medical Officer of Health, Regional Medical Technologist (Supervisory MedTech/Laboratory Coordinator). • Chief medical Technologist and Regional Medical Technologist/Laboratory Coordinator submits aggregated report to National Public Health Laboratory, which then submits a report to the NHP
Data Sources at Sub-Regional level	HIV testing sites
Data Storage at Regional Level	Lab data should be stored and backed up in accordance with National Ministry of Health policies and protocols.
Indicators	• Number of persons who receive counselling and testing for HIV (including pregnant women) according to guidelines • % of ANC clients that are HIV +
Data Quality Concerns	Data collection should be done at the time of service. Delayed data entry can compromise data quality.
IDP Reporting Requirements	GFATM
NHP Reporting Requirements	Annual Review; Annual Report; (internal requirements); proposal writing
Strengths and Limitations of the Form	• Data collection and reporting timeliness • Reporting biases due to translation of paper data collection to electronic, centralized databases.
Data Use	• The data is used to assess the coverage of HIV Testing as well as tracking trends in the number of persons who are diagnosed with HIV. • This can also be used to advocate for resources.

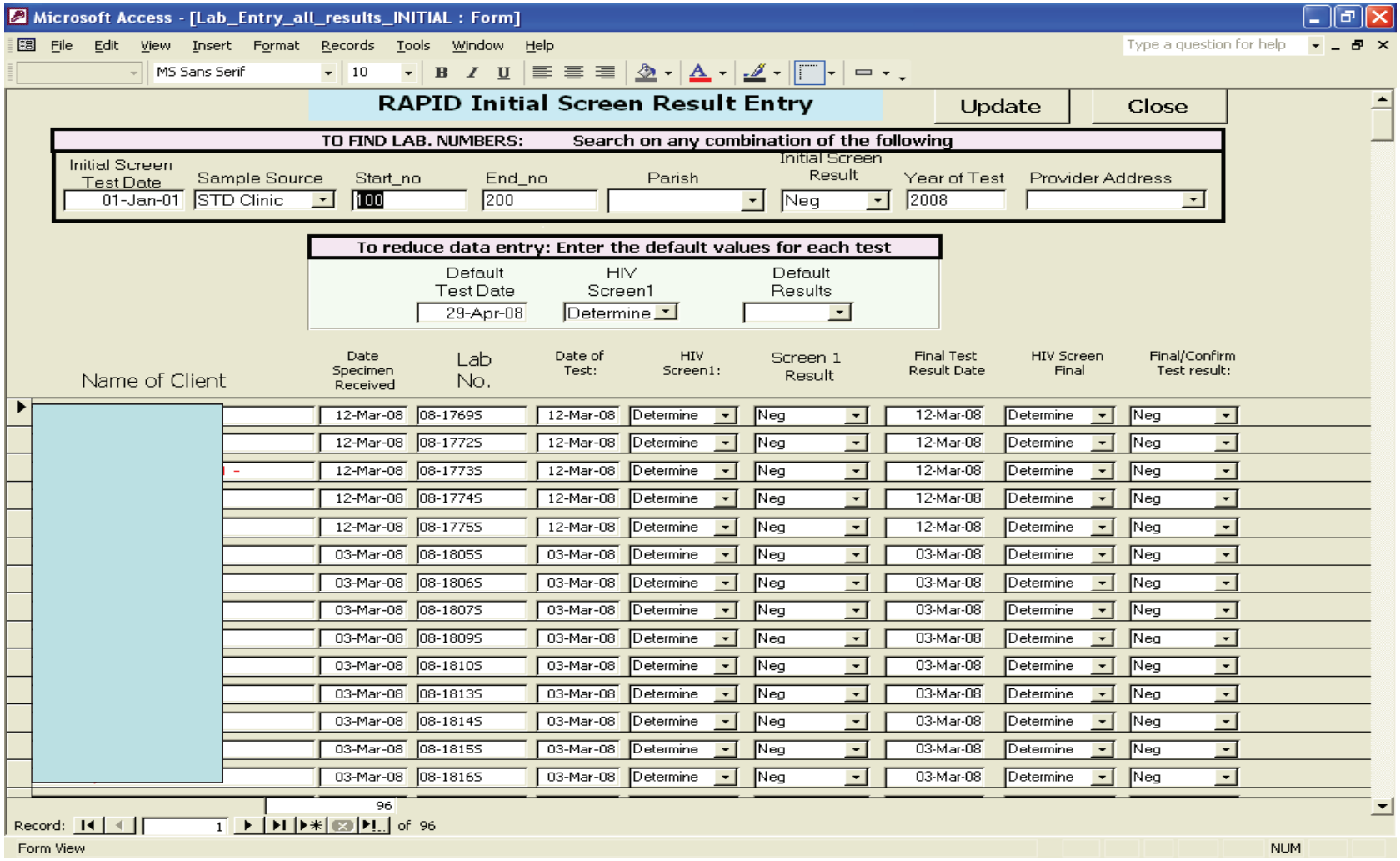
RAPID Database Main Menu



RAPID Database Patient Individual Report

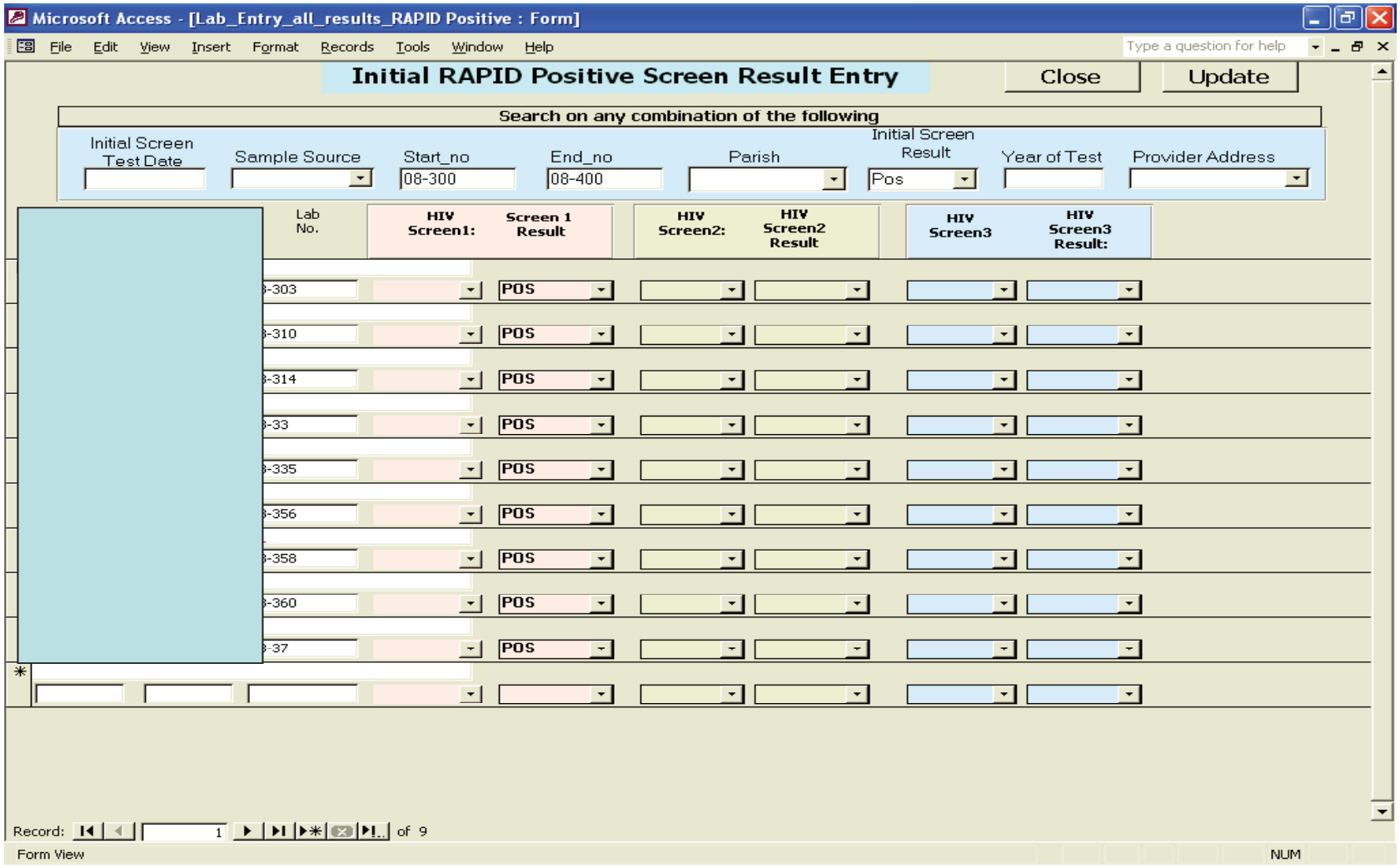


RAPID Database Š Initial Screen Entry - Negatives



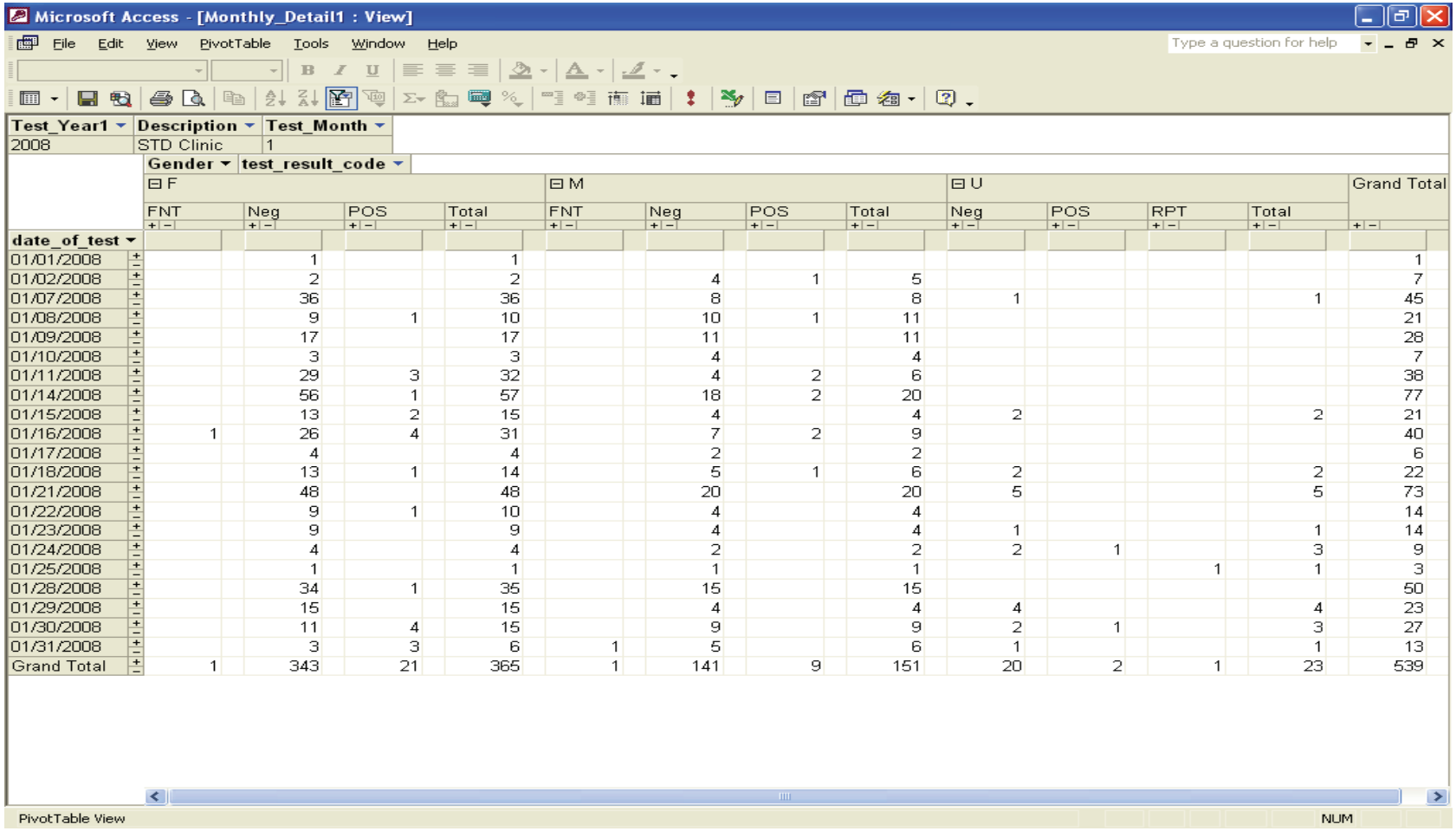
HIV Rapid Test Database — Required

RAPID Database Ś Initial Screen Entry - Positives



HIV Rapid Test Database — Required

RAPID Database Š Sample report Š Monthly Summary



Microsoft Access - [Monthly_Detail1 : View]

File Edit View PivotTable Tools Window Help

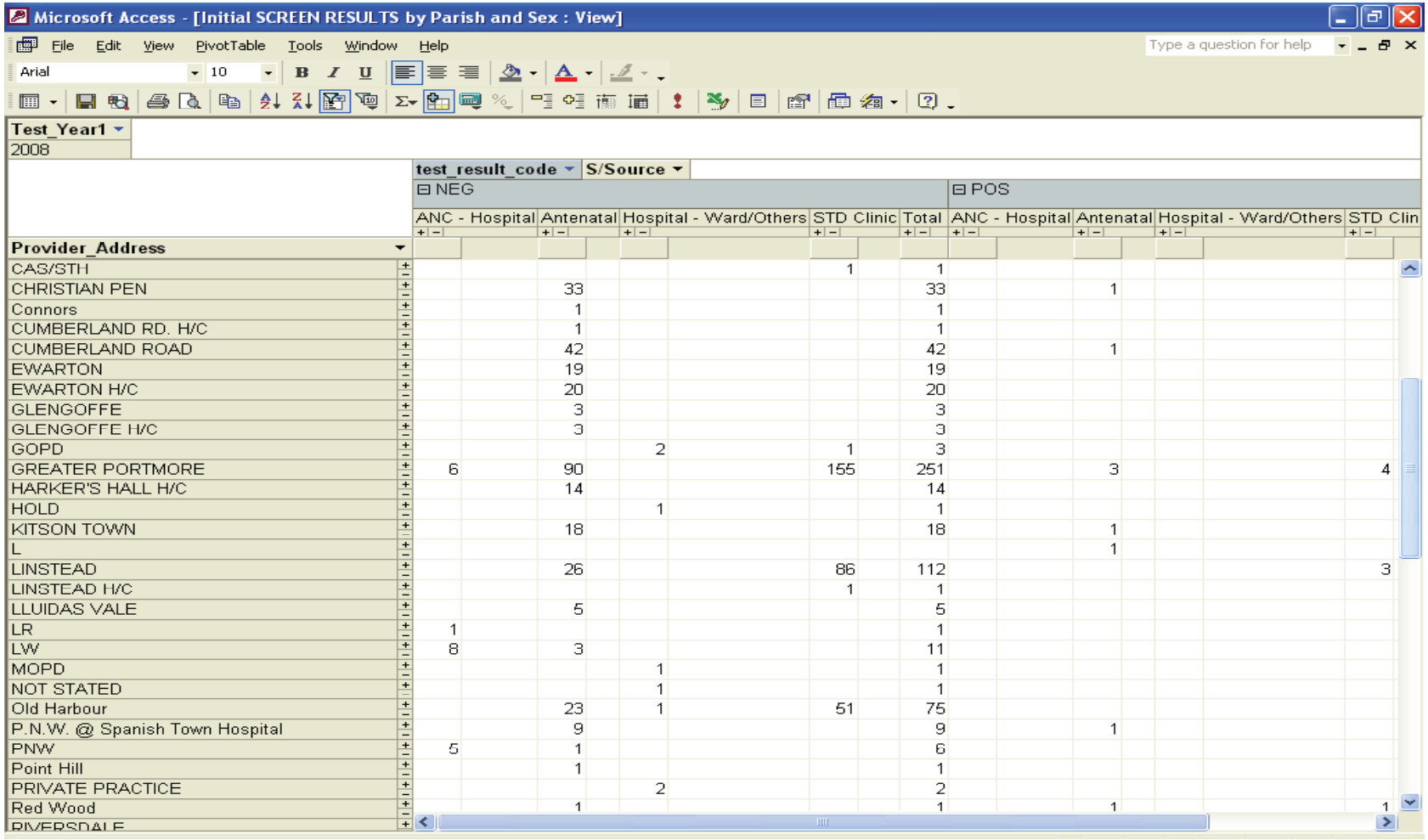
Type a question for help

Test_Year1	Description	Test_Month
2008	STD Clinic	1

	Gender	⊟ F				⊟ M				⊟ U				Grand Total
	test_result_code	FNT	Neg	POS	Total	FNT	Neg	POS	Total	Neg	POS	RPT	Total	
date_of_test														
01/01/2008			1		1									1
01/02/2008			2		2		4	1	5					7
01/07/2008			36		36		8		8	1			1	45
01/08/2008			9	1	10		10	1	11					21
01/09/2008			17		17		11		11					28
01/10/2008			3		3		4		4					7
01/11/2008			29	3	32		4	2	6					38
01/14/2008			56	1	57		18	2	20					77
01/15/2008			13	2	15		4		4	2			2	21
01/16/2008		1	26	4	31		7	2	9					40
01/17/2008			4		4		2		2					6
01/18/2008			13	1	14		5	1	6	2			2	22
01/21/2008			48		48		20		20	5			5	73
01/22/2008			9	1	10		4		4					14
01/23/2008			9		9		4		4	1			1	14
01/24/2008			4		4		2		2	2	1		3	9
01/25/2008			1		1		1		1			1	1	3
01/28/2008			34	1	35		15		15					50
01/29/2008			15		15		4		4	4			4	23
01/30/2008			11	4	15		9		9	2	1		3	27
01/31/2008			3	3	6	1	5		6	1			1	13
Grand Total		1	343	21	365	1	141	9	151	20	2	1	23	539

PivotTable View NUM

RAPID Database Š Sample Report Š by Provider



Microsoft Access - [Initial SCREEN RESULTS by Parish and Sex : View]

File Edit View PivotTable Tools Window Help

Type a question for help

Arial 10

Test_Year1: 2008

Provider_Address	test_result_code: NEG / S/Source: ANC - Hospital	Antenatal	Hospital - Ward/Others	STD Clinic	Total	test_result_code: POS / S/Source: ANC - Hospital	Antenatal	Hospital - Ward/Others	STD Clin
CAS/STH				1	1				
CHRISTIAN PEN		33			33		1		
Connors		1			1				
CUMBERLAND RD. H/C		1			1				
CUMBERLAND ROAD		42			42		1		
EWARTON		19			19				
EWARTON H/C		20			20				
GLENGOFFE		3			3				
GLENGOFFE H/C		3			3				
GOPD			2	1	3				
GREATER PORTMORE	6	90		155	251		3		4
HARKER'S HALL H/C		14			14				
HOLD			1		1				
KITSON TOWN		18			18		1		
L							1		
LINSTEAD		26		86	112				3
LINSTEAD H/C				1	1				
LLUIDAS VALE		5			5				
LR	1				1				
LW	8	3			11				
MOPD			1		1				
NOT STATED			1		1				
Old Harbour		23	1	51	75				
P.N.W. @ Spanish Town Hospital		9			9		1		
PNW	5	1			6				
Point Hill		1			1				
PRIVATE PRACTICE			2		2				
Red Wood		1			1		1		1
RIVERSDALE									

NHP SENTINEL SURVEILLANCE INFORMATION SHEET — REQUIRED

Data Collection Instrument	NHP Sentinel Surveillance Information Sheet
Purpose	To collect data on HIV prevalence at selected Antenatal and STI Clinics
Frequency	Annually
Responsible Officer	Laboratory Technician Assistant (LTA) completes the Sentinel Surveillance Information Form, on a case by case basis, in the 6 selected parishes. The form is submitted to the NHP Surveillance Officer who checks the completeness of the Form before data is entered into the Sentinel Surveillance Database at the NHP.
Data Sources	Facility based data collection
Data Storage	• Paper hardcopies should be stored in a dry, secured place at the NHP Office • Electronic copies of the database should be stored on a secure, password protected desktop at the NHP Office • Backup: Database should be copied to CD every quarter and stored in a secure place; NHP Office computers should be backed up in accordance with Ministry of Health IT policies and protocols.
Indicators	• Percentage of men and women aged 15 to 24 that are HIV infected • Prevalence of HIV among STI clients
Data Quality Concerns	Transcription errors may occur.
IDP Reporting Requirements	UNGASS, CARICOM, GFATM, WB, USAID
NHP Reporting Requirements	Annual Review; Annual Report; Annual Facts & Figures; Annual Epidemiology Update; proposal writing
Strengths and Limitations of the Form	This indicator (using data from antenatal clinics) gives a fairly good estimate of relatively recent trends in HIV infection in locations where the epidemic is heterosexually driven. At young ages, trends in HIV prevalence are a better indication of recent trends in HIV incidence and risk behaviour. Thus, reductions in HIV incidence associated with genuine behaviour change should first become detectable in HIV prevalence figures for 15–19-year-olds.
Data Use	Facilities, parishes, and regions can use this data in conjunction with other surveillance data for programme planning and advocacy efforts.

MINISTRY OF HEALTH, JAMAICA – HIV SENTINEL SURVEILLANCE

INFORMATION SHEET FOR ANC ATTENDERS

HEALTH CENTRE

DATE: _____ ***CLINIC SITE:*** _____

TECHNICIAN: _____ ***PARISH:*** _____

Docket/ Client #:	LAB#	LAST	FIRST	MIDDLE INITIAL	AGE	COMPLETE ADDRESS (including landmarks)	URBAN/ RURAL COMMUNITY	RPR	HIV RAPID TEST RESULT	HIV LABORATORY TEST RESULT

MINISTRY OF HEALTH, JAMAICA – HIV SENTINEL SURVEILLANCE

INFORMATION SHEET FOR ANC ATTENDERS

HIV LABORATORY

DATE: _____ ***CLINIC SITE:*** _____

TECHNICIAN: _____ ***PARISH:*** _____

Docket/ Client #:	LAB#	LAST	FIRST	MIDDLE INITIAL	AGE	COMPLETE ADDRESS (including landmarks)	URBAN/ RURAL COMMUNITY	RPR	HIV RAPID TEST RESULT	HIV LABORATORY TEST RESULT

MINISTRY OF HEALTH, JAMAICA – HIV SENTINEL SURVEILLANCE
INFORMATION SHEET FOR STI CLINIC ATTENDERS

HEALTH CENTRE

DATE: _____ ***CLINIC SITE:*** _____

Docket/ Client #:	LAB# :	LAST	FIRST	MIDDLE INITIAL	SEX	AGE	COMPLETE ADDRESS (including landmarks)	URBAN RURAL COMMUNITY	HIV RAPID TEST RESULT	HIV LABORATORY TEST RESULT

TECHNICIAN: _____ ***PARISH:*** _____

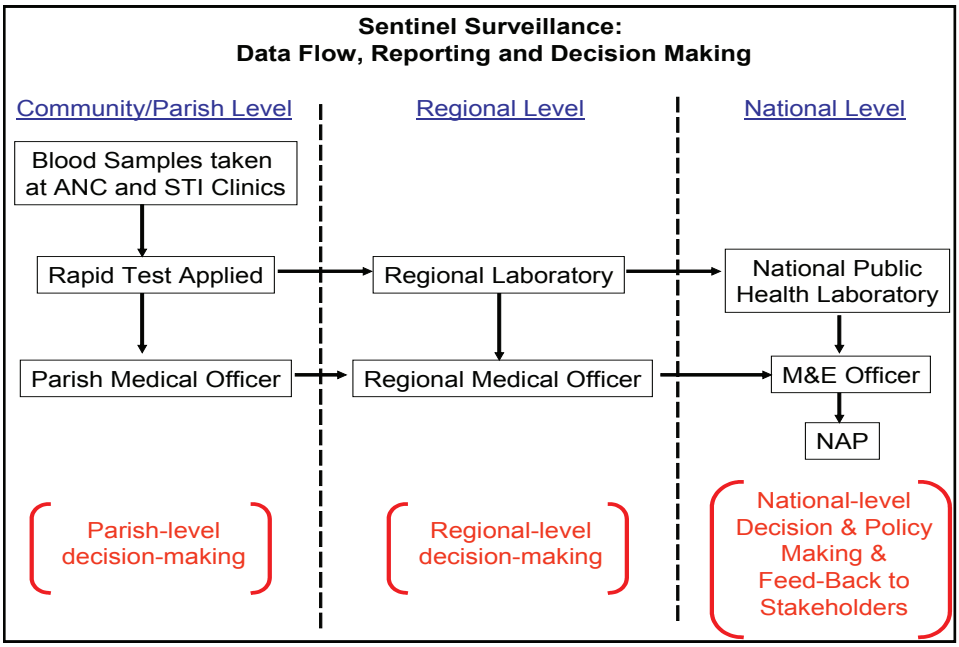
MINISTRY OF HEALTH, JAMAICA – HIV SENTINEL SURVEILLANCE
INFORMATION SHEET FOR STI CLINIC ATTENDERS

HIV LABORATORY

DATE: _____ ***CLINIC SITE:*** _____

TECHNICIAN: _____ ***PARISH:*** _____

Docket/ Client #:	LAB# :	LAST	FIRST	MIDDLE INITIAL	SEX	AGE	COMPLETE ADDRESS (including landmarks)	URBAN/ RURAL COMMUNITY	HIV RAPID TEST RESULT	HIV LABORATORY TEST RESULT


Sentinel Surveillance:
Data Flow, Reporting and Decision Making
Community/Parish Level
Regional Level
National Level
Blood Samples taken at ANC and STI Clinics
Rapid Test Applied
Regional Laboratory
National Public Health Laboratory
Parish Medical Officer
Regional Medical Officer
M&E Officer
NAP
Parish-level decision-making
Regional-level decision-making
National-level Decision & Policy Making & Feed-Back to Stakeholders

NHP CONGENITAL SYPHILIS REPORT — REQUIRED

Data Collection Instrument	NHP Congenital Syphilis Report
Purpose	To collect and store data on indicators that measure activities within the Treatment, Care and Support Priority Area of the NSP
Frequency	Case by case
Responsible Officer at Regional Level	Clinician completes the form following diagnosis and within 24 hours must report the case to Parish Public Health Department. The Medical Officer of Health then submits the form to the Regional Epidemiologist or Designated Lead and Ministry of Health's Surveillance Unit. The NHP Surveillance Officer gets data from the Surveillance Unit and submits the data to the NHP M&E Data Entry Clerk who enters the data into the M&E Database at the NHP.
Data Sources at Sub-Regional Level	Facility based medical records from primary care facilities, hospitals STI and antenatal clinics
Data Storage at Regional Level	• Paper hardcopies should be stored in a dry, secured place at the Parish Office • Electronic copies should be stored on a secure, password protected desktop at the Parish and Regional Offices • Backup: Reports should be copied to CD every quarter and stored in a secure place; Parish and Regional Office computers should be backed up in accordance with Ministry of Health IT policies and protocols.
Indicators	Incidence of congenital syphilis
Data Quality Concerns	There are multiple sources of data for several of these indicators; therefore, the aggregated data is at risk of double counting.
IDP Reporting Requirements	UNGASS, CARICOM, GFATM, WB, USAID
NHP Reporting Requirements	Annual Review; Annual Report; proposal writing
Strengths and Limitations of the Form	• Data focuses on paediatric-level data • Much of the data also collected on the CI Programme Monthly Summary Statistics Form
Data Use	Facilities, parishes, and regions can use this data in conjunction with family planning programme data for programme planning and advocacy efforts. This information can also be used to influence positive prevention programmes.

CONGENITAL SYPHILIS INVESTIGATION REPORT

Parish	Date on Notification Form	Date Investigation assigned	Parish Code

INFANT INFORMATION

Infant's Name Last: First:		Age	Date of Birth	Gender M F
Name of Mother Last: First:		**Infant's Docket #**	**Health Centre / Hospital name**	
Telephone Number	**Mother's Age**	**Home Address**		
Mother's Docket Number	**Site of Delivery (Hosp/RMC/Home)**			

CLINICAL DATA

SYMPTOMS	Y	N	SYMPTOMS	Y	N	SYMPTOMS	Y	N
Generalized lymphadenopathy			Mucous patches			Anaemia		
Vesiculo-bullous rash			Other rashes			Hepatosplenomegaly		
Pneumonitis			Snuffles			Failure to thrive		
Neurological symptoms			Jaundice					

Was the birth premature?	Was this a stillbirth?	Mother's VDRL Test (Result and Date)

MOTHER'S INFORMATION

# Children alive	# Stillbirths	# Miscarriages	# Lifetime sex partners	Interview Record #

ANC *(this pregnancy)*

PRIVATE [ ] PUBLIC [ ] # VISITS ……..

VDRL / TRUST Test (Last pregnancy): [Y] [N]

Result:…… Treatment [Y] [N]

VDRL / TRUST Test (This pregnancy): [Y] [N]

Result:…… Treatment [Y] [N]

Date of doses of BPG: **1.** …../…../……..
2. …../…./……
3. …../…./…….

MOTHER'S CONTACTS

DISPOSITION	RESULTS	TYPE OF TREATMENT	DATE(S) OF TREATMENT
Baby's Father			
Other			

INVESTIGATION DATA

TEST	DATE	RESULT
VDRL/TRUST - Mother		
VDRL/TRUST - Infant		
MHA-Tp/TPPA - Infant		
CSF - VDRL		
Bone Xrays		
Other		

Treatment Given To Infant (With Dates)

DISPOSITION

COMMENTS

FINAL CLASSIFICATION

CONFIRMED CASE

DISCARDED CASE

Signature: **Date:**

MO(H) Signature:

Revised 01 May 2009

Send all reports to: S.M.O, Surveillance Unit
2 King Street, Kingston
Ministry of Health,
Telephone: 967-1100

NHP PAEDIATRIC HIV REPORT — REQUIRED

Data Collection Instrument	NHP Paediatric HIV Report
Purpose	To collect and store data on indicators that measure activities within the Treatment, Care and Support Priority Area of the NSP
Frequency	Case by case
Responsible Officer at Regional Level	Clinician completes the form following diagnosis and within 24 hours must report the case to Parish Public Health Department. The Medical Officer of Health then submits the form to the Regional Epidemiologist or Designated Lead and Ministry of Health's Surveillance Unit. The NHP Surveillance Officer gets data from the Surveillance Unit and submits the data to the NHP M&E Data Entry Clerk who enters the data into the M&E Database at the NHP.
Data Sources at Subregional Level	• Facility based medical records from primary care facilities hospitals • STI and antenatal clinics
Data Storage at Regional Level	• Paper hardcopies should be stored in a dry, secured place at the Parish Office • Electronic copies should be stored on a secure, password protected desktop at the Parish and Regional Offices • Backup: Reports should be copied to CD every quarter and stored in a secure place; Parish and Regional Office computers should be backed up in accordance with Ministry of Health IT policies and protocols.
Indicators	Percentage of infants born to HIV-infected mothers who are HIV infected
Data Quality Concerns	There are multiple sources of data for several of these indicators, therefore, the aggregated data is at risk of double counting.
IDP Reporting Requirements	UNGASS, CARICOM, GFATM, WB, USAID
NHP Reporting Requirements	Annual Review; Annual Report; proposal writing
Strengths and Limitations of the Form	• Data focuses on paediatric-level data • Much of the data also collected on the CI Programme Monthly
Summary Statistics Form	Data Use Facilities, parishes, and regions can use this data in conjunction with family planning programme data for programme planning and advocacy efforts. This information can also be used to influence positive prevention programmes.

PAEDIATRIC HIV INVESTIGATION REPORT

Parish	Date on Notification Form	Date Investigation assigned	Parish Code

INFANT INFORMATION

Child's Name Last: First:	Age	Date of Birth	Gender M F

Name of Mother Last: First:	Child's Docket #	Health Centre / Hospital name

Telephone Number	Mother's Age	Home Address
Mother's Docket Number	**Site of Delivery (Hosp/RMC/Home)**	

CLINICAL DATA

SYMPTOMS / SIGNS	Y	N
Pneumonia		
Failure to thrive		
Recurrent bouts of diarrhoea		
Generalized lymphadenopathy		
Multiple or recurrent bacterial infections		
Opportunistic infections		
Neurological dysfunction		

Immediate Post-Partum ARV Treatment *(Drug(s), dosage and duration)*

MOTHER'S INFORMATION

# Children alive	# Stillbirths	# Miscarriages	# Lifetime sex partners

ANC *(this pregnancy)* PRIVATE [ ] PUBLIC [ ] # VISITS ……..	Date, Type And Result Of Mother's HIV Test	Treatment During Pregnancy *(Drug(s), Dosage and duration)*
	Status Of Mother	

FATHER'S INFORMATION

Name Last: First:	AGE	Telephone Number
Address	**# Lifetime sex partners**	
Date, Type And Result Of Father's HIV Test	**Status Of Father**	

CHILD'S LABORATORY DATA

TEST	DATE	RESULT
HIV		
PCR (6 weeks)		
PCR (3 months)		
HIV ELISA (18 months)		

FINAL CLASSIFICATION

RESULTS PENDING [ ]

CONFIRMED CASE [ ]

DISCARDED CASE [ ]

COMMENTS

Signature: **Date:** **MO(H) Signature:**

Revised 01 May 2009

Send all reports to: S.M.O, Surveillance Unit
2 King Street, Kingston
Ministry of Health,
Telephone: 967-1100

NHP OPHTHALMIA NEONATORUM REPORT – REQUIRED

Data Collection Instrument	NHP Ophthalmia Neonatorum Report
Purpose	To collect and store data on indicators that measure activities within the Treatment, Care and Support Priority Area of the NSP
Frequency	Case by case
Responsible Officer at Regional Level	Clinician completes the form following diagnosis and within 24 hours must report the case to Parish Public Health Department. The Medical Officer of Health then submits the form to the Regional Epidemiologist or Designated Lead and Ministry of Health's Surveillance Unit. The NHP Surveillance Officer gets data from the Surveillance Unit and submits the data to the NHP M&E Data Entry Clerk who enters the data into the M&E Database at the NHP.
Data Sources at Sub-Regional Level	Facility based medical records from primary care facilities, hospitals STI and antenatal clinics
Data Storage at Regional Level	• Paper hardcopies should be stored in a dry, secured place at the Parish Office • Electronic copies should be stored on a secure, password protected desktop at the Parish and Regional Offices • Backup: Reports should be copied to CD every quarter and stored in a secure place; Parish and Regional Office computers should be backed up in accordance with Ministry of Health IT policies and protocols.
Indicators	• Percentage of infants born to HIV-infected mothers who are HIV infected • Prevalence of HIV among STI clients • Incidence of congenital syphilis
Data Quality Concerns	There are multiple sources of data for several of these indicators; therefore, the aggregated data is at risk of double counting.
IDP Reporting Requirements	UNGASS, CARICOM, GFATM, WB, USAID
NHP Reporting Requirements	Annual Review; Annual Report; proposal writing
Strengths and Limitations of the Form	Data focuses on paediatric-level data Much of the data also collected on the CI Programme Monthly Summary Statistics Form
Data Use	Facilities, parishes, and regions can use this data in conjunction with family planning programme data for programme planning and advocacy efforts. This information can also be used to influence positive prevention programmes.

OPHTHALMIA NEONATORUM INVESTIGATION REPORT

Parish	Date on Notification Form	Date Investigation assigned	Parish Code

INFANT INFORMATION

Infant's Name Last: First:	Age	Date of Birth	Gender M F

Name of Mother Last: First:	Infant's Docket #	Health Centre / Hospital name

Telephone Number	Mother's Age	Home Address
Mother's Docket Number	**Site of Delivery (Hosp/RMC/Home)**	

CLINICAL DATA

SYMPTOMS	Y	N	SYMPTOMS	Y	N
Muco-purulent or purulent conjunctivitis			Oedema/swelling of eyelids		
Redness of conjunctivae and palpebrae			Chemosis of conjunctivae		
Eyelids sticking together					

History of vaginal discharge in mother? **Y N**

Treatment given to mother in pregnancy? **Y N**
If yes specify:

Any prophylaxis given at birth?

Silver Nitrate Drops **Y N**

Tetracycline Drops/ointment **Y N**

Other (specify):

MOTHER'S INFORMATION

# Children alive	# Stillbirths	# Lifetime sex partners

# Miscarriages	ANC *(this pregnancy)* PRIVATE [ ] PUBLIC [ ] # VISITS ……..

LABORATORY DATA

TEST	DATE	RESULT
GRAM STAIN		
CULTURE		

TREATMENT of infant

COMMENTS

FINAL CLASSIFICATION

CONFIRMED CASE

DISCARDED CASE

Signature: **Date:**

MO(H) Signature:

Revised 01 May 2009

Send all reports to: S.M.O, Surveillance Unit
2 King Street, Kingston
Ministry of Health,
Telephone: 967-1100

PMTCT Nurse/ Nutritionists and Social Workers

REQUIRED

- NHP Social Worker Monthly HIV Reporting Form
- Adherence Counselors Monthly Report

RECOMMENDED

- NHP Regional Prevention of Mother-to-Child Transmission (PMTCT) Form

DATA FLOW FOR TREATMENT, CARE AND SUPPORT FORMS

The following section lists Forms and Protocols for PMTCT Nurses, Nutritionists and Social Workers working in HIV-related Treatment, Care and Support. The Protocol Sheets provide a description of the frequency for data collection and name the officers responsible for transmitting the data from facilities to the National HIV/STI Programme(NHP) and the sequence of this data transmission.

Ensuring quality data collection, timely reporting and routine use of information is the collective responsibility of the NHP. The path and pace by which data flow from facility, parish or regional levels to the NHP, play a key role in monitoring and evaluating the programme. Any gaps in data on the forms, or delays in data reaching the Regional office can compromise data quality, affect the accuracy of reports and ultimately misguide programmatic decisions such as resource allocation including supply stocks, budgets, and staffing.

NHP SOCIAL WORKER MONTHLY HIV REPORTING FORM — REQUIRED

Data Collection Instrument	NHP Social Worker Monthly HIV Reporting Form
Purpose	To collect data on indicators that relate to case management, adherence and social support activities within the Treatment, Care and Support Priority Area of the NSP
Frequency	10th of every month submitted to NHP
Responsible Officer at Regional level	Social Workers complete form including data from Adherence Counselor Monthly Report and Nutritional Data. This is submitted to the Regional Social Workers and Medical Officers of Health. Regional Social Workers submit aggregated reports to the Regional Epidemiologist or Designated Lead, who then submits to the NHP Treatment Coordinator.
Data Sources at Sub-Regional Level	Facility based data collection from client interviews and Adherence Counselors Monthly Report and Nutritional Data.
Data Storage at Regional Level	• Paper hardcopies should be stored in a dry, secured place at the Parish Office • Electronic copies should be stored on a secure, password protected desktop at the Parish and Regional Offices. • Backup: Data should be copied to CD every quarter and stored in a secure place; Parish and Regional Office computers should be backed up in accordance with Ministry of Health IT policies and protocols.
Indicators	Number of PLWHA receiving adherence counselling
Data Quality Concerns	• Data collection should be done at the time of service. Delayed data entry can compromise data quality. • Data is also dependent on high quality Adherence Counselor Monthly Reports and Nutritional Data and therefore is prone to reporting bias. • Double counting may occur as clients seen by Nutritionist and Social Worker may not be recorded by name or unique identifier.
IDP Reporting Requirements	UNGASS, CARICOM, GFATM, WB, USAID
NHP Reporting Requirements	Annual Review; Annual Report; (internal requirements); proposal writing
Strengths and Limitations of the Form	• Data is subject to client reporting biases. • Selection bias may occur as only some clients are interviewed by the social worker.
Data Use	Facilities, parishes, and regions can use this data in conjunction with ARV data for programme planning and advocacy efforts. This information can also be used to support social support and positive prevention programmes.

National HIV/STI Programme
Social Worker Monthly Report

Annual/Month/Quarter (please indicate)**:**
Year:
Parish:
Name of Officer:

Case Management

Indicator	M	F	Total
Number of contacts with PLWHA			
Number of **New** PLWHA seen by Social Worker			
Number of **New** PLWHA referred to Social Worker by **Health Centre**			
Number of **New** PLWHA referred to Social Worker by **Hospital**			
Number of **New** PLWHA referred to Social Worker by **NGO/Line Ministry**			
Number of **New** PLWHA referred to Social Worker by **other**			

Indicator	M	F	Total
Number of PLWHA that require social investigation			
Number of social investigations conducted			
Number of home visits for PLWHA and families			
Number of PLWHA that received home based care in last 12 months (annual report)			

Adherence

Indicator	M	F	Total
Number of PLWHA seen by Adherence Counselors			
Number of new PLWHA seen by Adherence Counselors			
Number of PLWHA that received adherence counseling			

Social Support

Indicator	M	F	Total
Number of PLWHA that require nutritional support			
Number of PLWHA that received social support (please exclude nutritional)			
Number of active mentorship groups			

General Comments:

Barriers:

Facilitators:

Achievements:

Other Activities:

Prepared by (Name & Signature):

Date:

ADHERENCE COUNSELORS MONTHLY REPORT — REQUIRED

Data Collection Instrument	Adherence Counselors Monthly Report
Purpose	To collect data on indicators that measure adherence activities within the Treatment, Care and Support Priority Area of the NSP
Frequency	28th of every month
Responsible Officer at Regional level	Adherence Counselors submit data to parish/regional Social Workers. Social Workers incorporate data into the Monthly Social Worker Report
Data Sources at Sub-regional Level	Facility based data collection from client meetings
Data Storage at Regional Level	• Paper hardcopies should be stored in a dry, secured place at the Parish Office • Electronic copies should be stored on a secure, password protected desktop at the Parish and Regional Offices • Backup: Data should be copied to CD every quarter and stored in a secure place; Parish and Regional Office computers should be backed up in accordance with Ministry of Health IT policies and protocols.
Indicators	Percentage of PLWHA on ART reporting at least 90% adherence by pill count
	Number of PLWHA receiving adherence counselling
Data Quality Concerns	• Data collection should be done at the time of service. Delayed data entry can compromise data quality. • Double counting may occur as clients seen by Nutritionist and Social Worker may not be recorded by • name or unique identifier.
IDP Reporting Requirements	UNGASS, CARICOM, GFATM, WB, USAID
NHP Reporting Requirements	Annual Review; Annual Report; (internal requirements); proposal writing
Strengths and Limitations of the Form	• Data focuses on adherence to treatment regimen • Data is based on pill-count; there is no way to verify that pills not in bottle were actually taken by client.
Data Use	Facilities, parishes, and regions can use this data in conjunction with ARV data for program planning and advocacy efforts. This information can also be used to support social support and positive prevention programmes.

Adherence Counselors Monthly Report

MINISTRY OF HEALTH & ENVIRONMENT
National HIV/STI Programme

Name of Treatment Site _____

Reporting Period _____ Region _____

No.	Indicator	Value
1.	Number of clients receiving adherence support (i.e. counseling, clinic orientation, prescription assistance etc.)	
2.	Number of clients receiving adherence counseling	
3.	Number of clients, newly starting ARVs, receiving adherence counseling	
4.	Number of clients for whom Self Reporting Questionnaires (SRQ) were completed	
5.	Number of clients achieving ≥ 95% adherence by SRQ (i.e. score ≥ 11)	
6.	Number of clients bringing pills to clinic visit	
7.	Number of clients for whom pill counts were done	
8.	Number of clients achieving ≥ 95% adherence by pill count	
9.	Number of support groups associated with Treatment Site	
10.	Number of support group sessions held during reporting period	

Comments:
_____
_____
_____
_____

Name of Person Completing Form: _____

Date Completed: _____

Please submit completed forms to:
Dr. Debbie Carrington
Director – Treatment, Care & Support
National HIV/STI Programme
Fax: 876.967.1280/1643

NHP REGIONAL PREVENTION OF MOTHER-TO-CHILD TRANSMISSION (PMTCT) FORM — RECOMMENDED

Data Collection Instrument	NHP Regional Prevention of Mother-to-Child Transmission (PMTCT) Form
Purpose	To collect data on indicators that measure activities within the Treatment, Care and Support Priority Area of the NSP
Frequency	15th of every month
Responsible Officer at Regional level	PMTCT Nurse and Nutritionist complete and submit this form to the designated Regional PMTCT Lead and parish Medical Officer of Health. The Regional PMTCT Coordinator/Lead aggregates the parish forms and submits to the Regional Epidemiologist or designated Lead who incorporates this information in the Regional HIV Monthly Report. The latter is sent to the M&E unit.
Data Sources at Sub-Regional Level	Facility based medical records from hospitals, maternity wards, ANC, Laboratories, Pharmacies, STI Clinics and Nutritionists.
Data Storage at Regional Level	• Paper hardcopies should be stored in a dry, secured place at the Parish Office • Electronic copies should be stored on a secure, password protected desktop at the Parish and Regional Offices • Backup: Reports should be copied to CD every quarter and stored in a secure place; Parish and Regional Office computers should be backed up in accordance with Ministry of Health IT policies and protocols.
Indicators	• Percentage of infants born to HIV-infected mothers who are HIV infected • Percentage ANC clients that are counseled and tested for HIV • Percentage of HIV positive pregnant women who received a complete course of ARV prophylaxis to reduce the risk of MTCT • Number of infants born to HIV+ mothers receiving PCR testing according to national standards.
Data Quality Concerns	There are multiple sources of data for several of these indicators; therefore the aggregated data is at risk of double counting.
IDP Reporting Requirements	UNGASS, CARICOM, GFATM, WB, UNICEF
NHP Reporting Requirements	Annual Review; Annual Report; proposal writing
Strengths and Limitations of the Form	• Collects data on site-specific activities that target specific populations • Covers the antenatal, delivery, and post-partum stages of pregnancy • Does not disaggregate by age or other risk factors (e.g., multiple pregnancies, safe sex behaviours, etc.)
Data Use	Facilities, parishes, and regions can use this data in conjunction with family planning programme data for programme planning and advocacy efforts. This information can also be used to influence positive prevention programmes.

National HIV/STI Programme
Prevention of Mother to Child Transmission

Annual/Month/Quarter (please indicate)**:**
Year:
Parish:
Name of Officer:

INSTRUCTIONS FOR COMPLETION OF PMTCT FORM

No. of ANC clients seen (first visits) — Enter the total number of women visiting the ANC for the first time since the calendar year began during the period of reporting. ANC attendees will have several visits during the course of one pregnancy. The number of first visits to ANC clinics in primary and secondary care will indicate the total number of pregnant women seen in the public sector.

No. of ANC clients tested for HIV — Enter the total number of women attending ANC that were tested for HIV during the period of reporting. This information will be used to calculate the percentage of women attending ANC that are tested for HIV. This is an indication of access to VCT and pMTCT for young women.

No. of ANC clients testing positive for HIV — Enter the number of women that tested positive for HIV during the period of reporting.

No. of HIV infected pregnant women delivered — Enter the total number of HIV infected women delivered a live or still birth during the period of reporting. Not all women who test positive during the period of reporting will deliver in that same period. However, it is important to know what proportion of HIV infected women that receive complete pMTCT, which means that they would have had to deliver the baby.

***No. of HIV infected pregnant mothers receiving ARV for PMTCT —** Enter the number of women who completed the full course of antiretroviral prophylaxis as per the pMTCT protocol to reduce the risk of MTCT during the period of reporting. In order to receive the full course of ARV for pMTCT, the HIV infected mother must have delivered a live or still birth. This number should not include HIV infected women who have not delivered yet.

No. of live infants born to HIV-infected mothers (HIV-exposed infants) — Enter the number of live births to HIV infected pregnant woman during the period of reporting.

No. of HIV-exposed infants that received ARV for pMTCT — Enter the number of live births to HIV infected pregnant woman during the period of reporting that received ARV for pMTCT as described by national protocol.

No. of HIV-exposed infants that received PCR testing — Enter the number of infants born to HIV infected women who received PCR testing, (and results received) to determine the HIV status of the HIV exposed infant.

No. of HIV-exposed infants exclusively formula fed — Enter the number of infants born to HIV infected mothers that are fed formula only. This should not include infants receiving both breast milk and formula.

No. of HIV-exposed infants exclusively breast fed — Enter the number of infants born to HIV infected mothers that receive breast milk only

No. of HIV-exposed infants receiving mixed feeds — Enter the number of infants born to HIV infected mothers that are fed formula and breast milk at the same time

	Indicator	Value
1.	Total number of new ANC attendees	
2.	Total number of pregnant women counseled on PMTCT (group education and individual)	
3.	Total number of pregnant women tested for HIV (including those with already confirmed HIV infected status)	
4.	Total number of pregnant women receiving post test counseling for HIV (including those with already confirmed HIV infected status)	
5.	Total number of male partners of pregnant women attending PMTCT services that were tested for HIV	
6.	Total number of pregnant women who tested HIV positive (including those with already confirmed HIV infected status)	
7.	Total number of HIV infected pregnant women who delivered a live birth	
8.	Total number of HIV-infected pregnant women who received a complete course of antiretrovirals to reduce the risk of mother-to-child-transmission	
9.	Total number of HIV-infected pregnant women assessed for ART eligibility (CD4 cell count or clinical staging)	
10.	Total number of HIV-infected pregnant women receiving ART for their own health	
11.	Total number of HIV-infected women provided with a modern method of contraception at first postpartum visit	
12.	Total number of infants born to HIV-infected women receiving any ARVs for PMTCT	
13.	Total number of infants born to HIV-infected women started on cotrimoxazole prophylaxis within two months of birth	
14.	Total number of infants born to HIV-infected women receiving a virological test (PCR) for HIV diagnosis within two months of birth	
15.	Total number of infants born to HIV-infected women tested for HIV (antibody or virological test) by 12 months (reported annually)	
16.	Total number of infants born to HIV-infected women tested for HIV (antibody or virological test) by 18 months (reported annually)	
17.	Number (and percentage) of 18 month old HIV–exposed infants who returned for follow-up visits at six weeks, 3, 5, 12 and 18 months.	

MONTHLY NUTRITION INDICATORS (TO BE REPORTED BY PARISH)

	Indicator	Value
1.	Total number of HIV-infected pregnant women receiving at least one counseling session on infant feeding during ANC	
2.	Total number of HIV-infected women receiving counseling on infant feeding at first post natal visit	
3.	Number (and percentage) of three month old HIV-exposed infants that are exclusively breast fed.	
4.	Number (and percentage) of six month old HIV-exposed infants that are exclusively breast fed.	
5.	Number (and percentage) of three month old HIV-exposed infants that receive mixed feeds.	
6.	Number (and percentage) of six month old HIV-exposed infants that received mixed feeds.	
7.	Number (and percentage) of six month old HIV-exposed infants exclusively formula fed.	
8.	Number (and percentage) of six month old HIV-exposed infants that have normal growth parameters.	
9.	Number (and percentage) of 0-3 month old HIV-exposed infants that have normal growth parameters	
10.	Number (and percentage) of 4-6 month old HIV-exposed infants that have normal growth parameters	
11.	Number (and percentage) of 7-9 months old HIV-exposed infants that have normal growth parameters	
12.	Number (and percentage) of 10-12 months old HIV-exposed infants that have normal growth parameters	
13.	Number (and percentage) of 13-18 month old HIV-exposed infants that have normal growth parameters	
14.	Number (and percentage) of 19-24 month old HIV positive children that have normal growth parameters	
15.	Number (and percentage) of 25-36 month old HIV-positive children that have normal growth parameters	
16.	Number (and percentage) of >3yr-5yr old HIV-positive children that have normal growth parameters	
17.	Number (and percentage) of > 5yr old HIV-positive children that have normal growth parameters	

NGO, Line Ministries and Other Stakeholders

REQUIRED

- HIV-Related Discrimination Complaint Report
- Monthly Technical Management Report (NGO and Line Ministry)

APPENDIX II
INSTRUMENT PROTOCOL SHEETS

DATA FLOW FOR THE ENABLING ENVIRONMENT FORMS

The following section lists Forms and Protocols for the Enabling Environment component of the national response supported by NGO, Government Ministries and other stakeholders working with the NHP. The protocol sheets provide a description of the frequency for data collection and name the Officer responsible for transmitting the data from facilities to the NHP and the sequence of this data transmission. The figures below illustrate the data flow paths for the forms presented in this section.

Ensuring quality data collection, timely reporting and routine use of information is the collective responsibility of the NHP. The path and pace by which data flow from facility, parish or regional levels to the NHP, play a key role in monitoring and evaluating the programme. Any gaps in data on the forms, or delays in data reaching the Regional office can compromise data quality, affect the accuracy of reports and ultimately misguide programmatic decisions such as resource allocation including supply stocks, budgets, and staffing.

As such, adhering to the guidelines presented in the protocol sheets ensures timely, accurate and complete reporting and is a collective responsibility of all parties involved in the NHP.

The center of Figure 8 shows that the NHP Enabling Environment Coordinator serves as the focal collection point for aggregated data from Government Ministries, NGOs and other Workplace Officers. This Officer is charged with reviewing the data and submitting the information to the National NHP M&E Office to inform the national indicators. The forms sent to the NHP include the Technical Management Report, completed by Government Ministries and NGOs, and the HIV-related Discrimination Complaint Report. The NHP Enabling Environment Coordinator is also charged with providing HIV-related feedback to Government Ministries, NGOs and other stakeholders on program performance. The boxes surrounding the Enabling Environment Coordinator represent forms that are completed at the organizational levels. These forms collect information that can be used within organizations to monitor, evaluate, and inform programs.

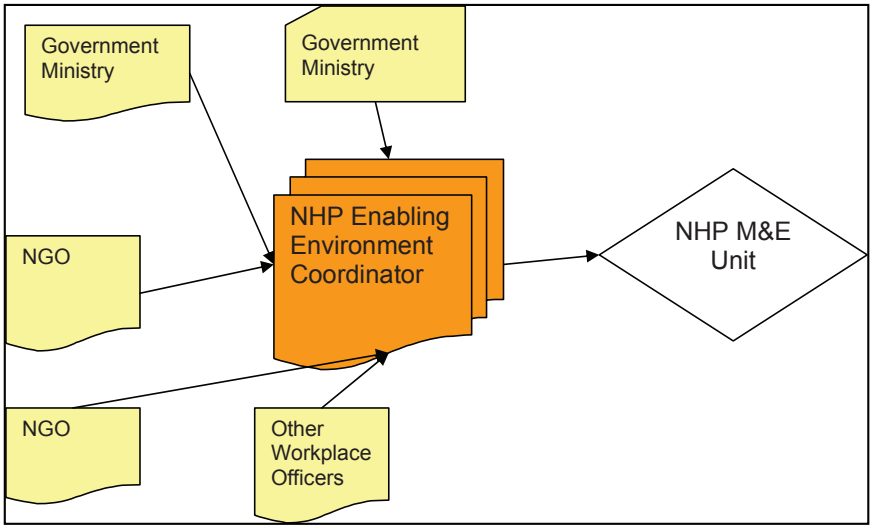


FIGURE 8: Responsibilities of the NHP Enabling Environment Coordinator

HIV-RELATED DISCRIMINATION COMPLAINT REPORT — REQUIRED

Data Collection Instrument	HIV-related Discrimination Complaint Report
Purpose	To collect data and measure prevalence of HIV-related discrimination and the redress of reported cases as part of the Enabling Environment and Governance Priority Areas of the NSP
Frequency	Monthly
Responsible Officer	Intake Officers record complaints on a case-by-case base. An Intake Officer enters HIV-related cases of discrimination into a database. This database is accessed monthly by JN+ for reporting to NHP.
Data Sources	Intake Officer report
Data Storage	• Paper hardcopies should be stored in a dry, secured place at the JN+. • The database should be housed on a secure, password protected desktop at the JN+. • Backup: Database should be copied to CD every quarter and stored in a secure place; computers should be backed up in accordance with Lead Agency IT policies and protocols.
Indicators	• # cases of HIV discrimination reported by setting; • # and % of reported cases of HIV related discrimination receiving redress by setting
Data Quality Concerns	Data collection should be done at the time of service. Delayed data entry can compromise data quality.
IDP Reporting Requirements	GFATM
NHP Reporting Requirements	Annual Review; Annual Report; (internal requirements); proposal writing
Strengths and Limitations of the form	• Data collection and reporting timeliness may compromise quality. • Reporting biases due to translation of paper data collection to electronic centralized databases. • Form is available electronically.
Data Use	Data will be used to assess the prevalence of reported discrimination in Jamaica and also as a means of tracking the redress of reported cases.

HIV-Related Discrimination Complaint Report

(Please note: this form can be filled out online at: www.jnplus.org)

This Complaint Report provides the entry into the National HIV-related Discrimination Reporting and Redress System. It can be completed by anyone who believes he/she has experienced or witnessed HIV-related mistreatment, abuse or discrimination, regardless of his/her HIV status. Once submitted, this information will be handled in a secure, confidential manner by trained officers. Statistical information may be shared with national or regional monitoring agencies, but personal or identifying information will be kept strictly confidential. Completion of this form indicates your agreement with these conditions.

When completed, this form should be submitted by fax or post to:
Advocacy Officer, Jamaican Network of Seropositives
3 Trevennion Park Road, Kingston 5
Phone/fax: (876) 929-7340

1. Today's date: Month: _____ Day: _____ Year: _____

2. Name, nickname or alias of person experiencing discrimination (if known and permission is granted).

Name, Nickname or Alias: _____ Signature: _____

3. Contact information of person experiencing discrimination:

Mobile phone: _____Home phone: _____

Email address: _____

4. Age of person experiencing discrimination:

☐<15 ☐15-19 ☐20-24 ☐25-29 ☐30-34 ☐35-39 ☐40-44 ☐45 and over

5. Gender of person experiencing discrimination:

☐ Male ☐ Female ☐ Transgender ☐ Other

6. Are you submitting this report for another person? ☐ Yes ☐ No

If yes, did you witness the incident? ☐ Yes ☐ No

If you are submitting this report for another person, please provide your name and contact information:

Name: _____ Agency: _____Signature: _____

Mobile phone: _____ Work phone: _____

Email address: _____

7. Has the incident been previously reported?

☐ Unsure ☐ No ☐ Yes (to whom/which agency: _____when: _____)

8. Please provide information about the alleged offender (if known):

Name: ______________________________ Title: ________________________________

Agency: _____________________________ Contact number: _________________________

Badge or identification number: _______________________

9. Nature of the incident (check all that apply):

☐ Not hired ☐ Physical violence ☐ Breach of confidentiality ☐ Forced to leave job ☐ Forced to leave school

☐ Harassment/Verbal abuse ☐ Not accepted into school ☐ Denied access to healthcare ☐ Denied housing

☐ Discrimination against relative ☐ Forced to leave home/community

☐ Other (please specify: _______________________________________)

10. Setting where incident occurred (check all that apply):

☐ School ☐ Church ☐ Home ☐ Community ☐ Workplace

☐ Private Company/Business ☐ Private health facility ☐ Government health facility

☐ Law Enforcement Site ☐ Government Agency

☐ Other (please describe) ____

11. The incident was:

☐ A one time event

☐ Part of ongoing harassment of the person experiencing discrimination by the same perpetrators

☐ Part of ongoing harassment of the person experiencing discrimination by various perpetrators

☐ Don’t know

12. Please provide a brief description of the incident on the back of this sheet.

13. What further action, beyond documenting this incident, does the person experiencing discrimination want?

☐ No additional action ☐ Referral for counselling or social assistance

☐ Sensitisation session with alleged offender and/or community ☐ Legal or other redress

- -

Thank you for your report. It was completed on ______________________________ .

If you do not receive a response within 30 days, please call 929-7340 and ask to speak to an interviewer.

MONTHLY TECHNICAL MANAGEMENT REPORT (NGO AND LINE MINISTRY) — REQUIRED

Data Collection Instrument	Monthly Technical Management report (NGO and Line Ministry)
Purpose	To collect data on indicators that related HIV prevention and enabling environment activities in Jamaica
Frequency	4th day of month submitted to NHP
Responsible Officer at Regional level	Designated NGO or line ministry reporting officer (e.g.Workplace Programme Officer) submits report to NHP Prevention Director and Policy Coordinator
Data Sources at Sub-Organizational Level	Training logs and programme monitoring logs.
Data Storage at Organizational Level	• Paper hardcopies should be stored in a cool, locked, fire-proof, water resistant filing cabinet. • Electronic copies should be stored on a secure, password protected desktop at the NGO or Ministry Offices • Backup: Data should be copied to CD every quarter and stored in a secure place; NGO or Ministry Office computers should be backed up in accordance with Ministry of Health IT policies and protocols.
Indicators	• Number of inmates, sex workers and MSM reached through prevention activities • Number of persons trained to provide treatment services by client and service area • Percentage of schools that provided life skills-based HIV education in the last academic year • Number of students reached through life skills-based Health and Family Life Education interventions in schools • Number of adolescents (10-14) and youth (15-24) reached through prevention interventions in out-of-school settings • Number of individuals trained to promote HIV prevention through abstinence and/or being faithful • Number of individuals trained to promote HIV prevention beyond abstinence and/or being faithful • Number of individuals trained in HIV-related community mobilization for prevention, care and/or treatment • Number of individuals reached through community outreach that promotes HIV prevention through abstinence and/or being faithful. • Number of individuals reached through community outreach that promotes HIV prevention through other behaviour change beyond abstinence and/or being faithful • Number of adherence support groups started by NGO/PAC partnerships using trained PLWHAs.
Data Quality Concerns	Double counting issues also as a result of attendance of Civil Society members to multiple training offered by different NGOs.
IDP Reporting Requirements	UNGASS, CARICOM, GFATM, WB, USAID
NHP Reporting Requirements	Annual Review; Annual Report; (internal requirements); proposal writing
Strengths and Limitations of the Form	• Data collects prevention data for only NGO and Line Ministry activities • Training and outreach data are vulnerable to double counting
Data Use	Facilities, parishes, NGOs and regions can use this data in conjunction with other surveillance data for programme planning and advocacy efforts.

FORM A2

Monthly Technical Management Report

Name of Organization: _____

Date(dd/mm/yy):_____ **Reporting Period (dd/mm/yy – dd/mm/yy):** _____

Activity	Date of activity	Target population (e.g. staff, policemen, prisoners, etc.)	No. of participants (e.g. no. of persons trained)	Comments
1.				
2.				
3.				
4.				
5.				
6.				

Number of Condoms distributed

Male `_____ **Female** _____

Number of Condoms purchased through condom machines

Male `_____ **Female** _____

Additional Activities (including activities not listed in workplan)
Barriers/Gaps

Lessons Learnt
Identified Needs for Sustainability (Technical or financial requirements)

SIGNATURE OF AUTHORISED REPRESENTATIVE_____
Date: _____

Approved by:_____
Date:_____

NHP SECOND GENERATION SURVEILLANCE STUDY (MSM & SW)

Data Collection Instrument	NHP Second Generation Surveillance Study (MSM & SW)
Purpose	To collect sexual behaviour and bio-marker data from most-at-risk populations
Frequency	Every 2-4 years
Responsible Officer	Director of the M&E Unit of the NHP is responsible for procuring and monitoring the output of an external consultant who will undertake this Study.
Data Sources	Primary Data collection from questionnaires and bio-samples
Data Storage	Paper hardcopies and electronic versions of the final report of the survey along with electronic copies of the data sets should be submitted to the M&E unit. They will be stored in a dry, secured place at the NHP Office. Computers should be backed up in accordance with Ministry of Health IT policies and protocols..
Indicators	• Percentage of SW who are HIV infected • Percentage of MSM who are HIV infected • Percentage of SW reporting using a condom with most recent client • Percentage of men reporting using a condom the last time they had anal sex with a male partner • Percentage of most-at-risk populations (youth, MSM, & SW) who received HIV testing in the last 12 months and know their results
Data Quality Concerns	There data gaps in the surveillance as responses for some questions are missing. The responses to sensitive questions can be unreliable.
IDP Reporting Requirements	UNGASS, CARICOM, GFATM, WB, USAID
NHP Reporting Requirements	Annual Review; Annual Report; (internal requirements); proposal writing
Strengths and Limitations	• Given the nature of the surveillance, the level of refusal to participate is low. • The data collected can be used as proxy to HIV prevalence • The number and location of sentinel sites limits the ability to generalize the data
Data Use	• This data is used to design programmes that specifically cater to the issues raised in the data. • Data is also used a s the basis of policy and programme advocacy on issues such as condom use and distribution, STI prevalence and access to health services for most-at-risk populations.

NHP KNOWLEDGE ATTITUDE BEHAVIOUR AND PRACTICE (KABP) SURVEY

Data Collection Instrument	NHP Knowledge Attitude Behaviour and Practice (KABP) Survey
Purpose	To collect data on sexual behaviour information from the general population
Frequency	Every 3 -4 years
Responsible Officer	Director of the M&E Unit of the NHP is responsible for procuring and monitoring the output of an external consultant who will undertake this Study.
Data Sources	Primary Data collected from household questionnaire
Data Storage	Paper hardcopies and electronic versions of the final report of the survey along with electronic copies of the data sets should be submitted to the M&E unit. They will be stored in a dry, secured place at the NHP Office. Computers should be backed up in accordance with Ministry of Health IT policies and protocols.
Indicators	• % of people by sex and age groups who reported condom use at last intercourse with non-regular partner • Percentage of young women and men aged 15-24 or at risk groups who both correctly identify ways of preventing the sexual transmission of HIV and who reject major misconceptions about HIV transmission • Percentage of young adults, 15 to 19 years old, who have never had sex • Percentage of 15-19 year olds who reported no sexual actively in the last 12 months • Percentage of young women and men aged 15-24 who have had sexual intercourse before age 15 • Percentage of young women and men aged 15-49 who have had sex with more than one partner in the last 12 months • Percentage of 15-49 year olds who have had more than one sexual partner in the past 12 months who report the use of a condom during their last sexual intercourse • Percentage of men and women aged 15-49 who received an HIV test in the last 12 months and who know their results • Percentage of people 15-49 years expressing accepting attitudes towards people with HIV
Data Quality Concerns	There are gaps in the data despite efforts to clean the data
IDP Reporting Requirements	UNGASS, CARICOM, GFATM, WB, USAID
NHP Reporting Requirements	Annual Review; Annual Report; (internal requirements); proposal writing
Strengths and Limitations of the Form	• KABP provides important information on key behaviours and can generalized to the population. • KABP is expensive, time consuming, limited to households so the survey may be missing persons at high risk. • Data can not be disaggregated by region, parish or high risk group due to sample size limitations.
Data Use	• This data is used to design programmes that specifically cater to the issues raised in the data. • Data is also used as the basis of policy and programme advocacy on issues such as condom use and distribution, HIV-related stigma and discrimination and access to health services for most-at-risk populations.

MULTIPLE INDICATOR CLUSTER SURVEY

Data Collection Instrument	Multiple Indicator Cluster Survey
Purpose	To collect data on indicators related to women and children
Frequency	3-4 years
Responsible Officer at NHP	Director of the M&E Unit is the NHP Focal Point on a Steering Committee which also includes the Cabinet Office, Early Childhood Commission, Planning Institute of Jamaica, Sir Arthur Lewis Institute for Social and Economic Sciences, Caribbean Child Development Centre of the University of the West Indies, UNFPA, PAHO, Child Development Agency, UNDP, UNAIDS, UNESCO and UNICEF.
Data Sources	• Household Questionnaires • Individual Women's Questionnaire • Questionnaire for Children under 5 years
Data Storage at Regional Level	• Electronic copies of the final report fo the survey should be submitted to stakeholders and can be accessed through the UNICEF website. • NHP Office computers should be backed up in accordance with Ministry of Health IT policies and protocols.
Indicators	• Percentage of orphaned and vulnerable children (boys and girls, aged 0-17) whose households received free basic external support in caring for the child • Current school attendance among orphans and non-orphans aged 10-14
Data Quality Concerns	There are multiple sources of data for several of these indicators; therefore, the aggregated data is at risk of double counting.
IDP Reporting Requirements	UNGASS, CARICOM, GFATM, WB, USAID
NHP Reporting Requirements	Annual Review; Annual Report; (internal requirements); proposal writing
Strengths and Limitations	Using three different data collection instruments ensures that data collected reflected the characteristics of the source populations.
Data Use	• This data is used to monitor progress towards goals established by the Millennium Development Goals, the goal of 'A World Fit for Children' and other internationally agreed upon goals, as a basis for future action • The data will contribute to the improvement of data and monitoring systems in Jamaica and to strengthen technical expertise in the design, implementation and analysis of such systems.

NHP ADHERENCE STUDY

Data Collection Instrument	NHP Adherence Study
Purpose	To collect data on levels of adherence with the PLWA Community
Frequency	Every 3-4 year
Responsible Officer	Director of the M&E Unit of the NHP is responsible for procuring and monitoring the output of an external consultant who will undertake this Study.
Data Sources	Primary Data collection from a sample of People Living with HIV
Data Storage at Regional Level	Paper hardcopies and electronic versions of the final report of the survey along with electronic copies of the data sets should be submitted to the M&E unit and is stored in a dry, secured place at the NHP Office computers should be backed up in accordance with Ministry of Health IT policies and protocols.
Indicators	Percentage of PLWHA on ART reporting at least 90% adherence by pill count
Data Quality Concerns	There are data gaps in the study as well as Coding issues.
IDP Reporting Requirements	UNGASS, CARICOM, GFATM, WB, USAID
NHP Reporting Requirements	Annual Review; Annual Report; (internal requirements); proposal writing
Strengths and Limitations of the Form	• This study provides a rapid assessment of adherence to ARVs. This is important information for prevention of drug resistance. • The study is cross sectional, inexpensive and can be done quickly using existing staff. • There are limitations in generalizing the data as it uses sentinel sites, and non-random selection. • There are limitation in methods such as pill counts and self report, • The study covers public sector patients only.
Data Use	• This data will be used to assess the level of adherence and therefore the level of drug resistance in Jamaica. • The Data will therefore contribute to long term planning for ARV procurement and strengthen advocacy efforts within the PLWHA community for consistent adherence to medication.

Reporting Timelines

The Reporting Schedule below speaks to the 2007-2012 NHP programmatic period and lists the reports due at the time of publication.

REPORT	FREQUENCY	DUE DATE
HIV Bulletin	Quarterly	25th of last month in Quarter
HIV Facts & Figures	Semi-Annually	June 30 & December 31
Country Progress Report (UNGASS)	Biannually (2008,2010)	January 31
Annual Report	Annually	December 31
STI Report	Quarterly	25th of last month in Quarter
Global Fund Report	Semi- Annually	June 30 & December 31
USAID Report	Annually	August 30
UNICEF Report	Annually	April 30
Monthly Report	Monthly	25th of Month
World Bank Report	Quarterly	25th of last month in Quarter
CARICOM	Quarterly	25th of last month in Quarter

M&E Reference Group

TERMS OF REFERENCE

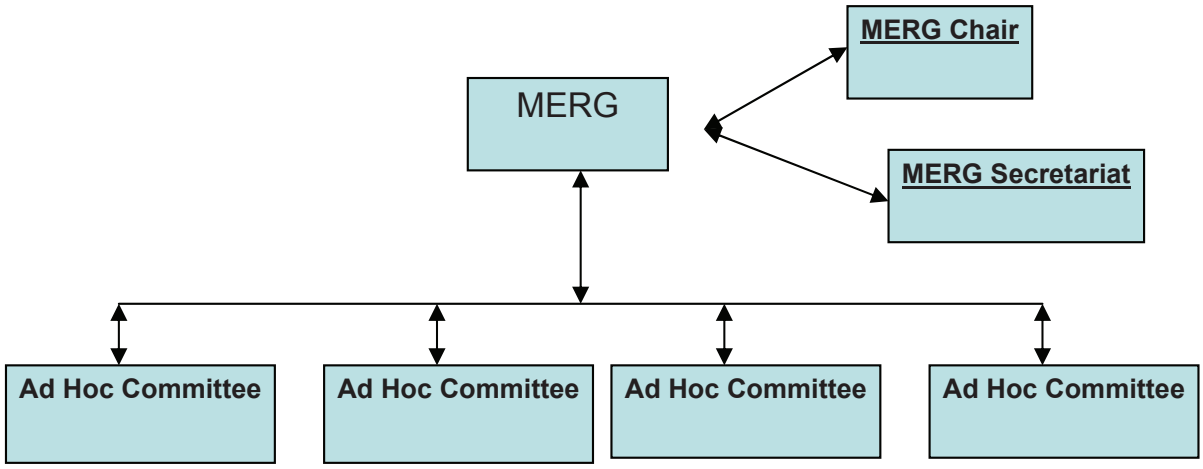
OVERVIEW: The J-MERG serves as an Advisory resource for the M&E Unit of the NHP. It is not an implementation entity and has no powers of decision-making. It works with the M&E Unit and offers recommendations and advice on M&E related issues related to its function.

FUNCTIONS:

- Review and endorse national standards and norms, based on international best practice, that will facilitate coordination and strengthen Jamaica's M&E System;
- Review and endorse M&E guidelines, standards, indicators, and tools to ensure quality, enhance integration and reduce redundancy;
- Review and endorse Jamaica national M&E Agenda and convene ad-hoc Technical Working Groups (TWGs) as necessary;
- Advocate and build M&E culture in Jamaica through Stakeholder Consultation.
- Review and use data from the M&E system and ongoing research to explore current issues.

ACCOUNTABILITY: The Jamaica MERG is accountable to the NHP and is under the leadership of Dr. Kevin Harvey, Senior Medical Officer (HIV/STI), with direct management given by the M&E Unit of the NHP, led by Dr. Jacqueline Duncan.

STRUCTURE OF THE MERG: The J-MERG will mirror some aspects of the Global MERG, which is summarized below:



SECRETARIAT: The M&E Unit of the NHP will act as Chairperson and the Secretariat of the J-MERG.

The Technical Working Groups of the J-MERG will be ad hoc and guided by emerging needs or priorities of the National HIV/STI response.

DECISION-MAKING: Decisions will be made by consensus by the J-MERG.

MEMBERSHIP: The MERG should have membership representative of the national HIV response and include broad expertise in M&E. It may include representatives from Government Ministries, International Development Partner, NGOs, regional health authorities, and private sector. Selection of members will be based on availability, interest and M&E technical expertise in the respective organizations. Technical contribution is defined as skills, competencies and knowledge that can enhance the work of the MERG. Membership on the Technical Working Groups (TWG) will be based on interest, competence and experience in the thematic area of the TWG.

Therefore the Membership will be comprised as follows:

- Government
  - » Ministry of Health and the Environment
  - » National HIV/STI Programme
  - » National Public Health Laboratory
  - » Ministry of Labour & Social Security
  - » Ministry of Education
  - » Caribbean HIV/AIDS Regional Training - Jamaica
  - » Planning Institute of Jamaica
  - » JamStats
  - » South East Regional Health Authority
  - » North Eastern Regional Health Authority
  - » Southern Regional Health Authority
  - » Western Regional Health Authority

- Academia
  - » University of the West Indies HIV/AIDS Response Programme

- NGOs
  - » Jamaican Network of Seropositives
  - » Jamaica AIDS Support for Life
  - » National AIDS Committee

- International Development Partners
  - » PAHO/WHO
  - » UNAIDS
  - » UNICEF

- People Living with HIV
  - » People Living with HIV

MEETINGS: Meetings of the J-MERG will be held bi-annually. The Technical Working Groups will convene as the situation necessitates.

TERM: The membership of J-MERG will serve for the duration of the National M&E Plan, i.e. 2008-2012. After this a joint assessment will be made concerning the continuation of the present membership or a change in membership.

Ministry of Health
Jamaica

RELEASE OF CLIENT INFORMATION

POLICY MANUAL

MOHE-DOC-5000-3

2002 AUGUST 28

_____	_____
Permanent Secretary	Director, Policy, Planning and Development

_____
Director, Health Record Services

2007 January 12	2002 August 28	Issued for use	Yvette Chambers, B.Sc. Policy, Planning & Development Division	Howard Lynch, M.Sc. Policy, Planning & Development Division	Permanent Secretary, Ministry of Health
Revision Issued	**Date**	Issue Description	**Written by**	**Checked by**	**Approved by**

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FOREWORD

The policy set out hereunder outline procedures to be followed for the release of client information by hospitals, health centres and other health related facilities of the Ministry of Health.

"Client information" means information that relates to a client, and is contained in his/her medical/health record, kept at the public health facilities.

PURPOSE

To establish guidelines for employees of public health facilities that will assure confidentiality of client information.

POLICY ON THE RELEASE OF CLIENT INFORMATION

Request for information from client records shall be processed in a timely, consistent manner as set forth in this policy document.

ACCESSING CLIENT INFORMATION

- Release of information from client records will comply with laws and procedures governing such practice.
- All information in the client's records shall be kept confidential and protected from unauthorized disclosure.
    - All hospital employees engaged in the collection, handling, or dissemination of client information are required to protect its confidentiality. **The hospital employee who is found to have divulged, removed or copied confidential information in an unauthorized manner shall be subjected to disciplinary action of not less than two weeks suspension**.

- All requests for medical information from a health care facility shall be addressed to the Chief Executive Officer of the health care facility.

- With the exception of requests for the release of information to provide urgent continuity of client care, all requests for the release of medical information from the facility, shall be in writing.

- With approval from the Chief Executive Officer, the medico-legal correspondence clerk in the Health Records Department shall process all requests

- Client records are the property of the health facility and shall be removed from such facility only in accordance with a court order or subpoena or a request from the Chief Medical Officer or Regional Technical Director or Director of Health Record Services.

- Client records shall be available for use within the facility for client care, quality assurance audits and research that are duly approved and authorized by the Ethics Committee or the SMO/ MO (H) in the absence of an Ethics Committee.

- Subpoenas served for the production of client records shall be processed by the medico-legal correspondence clerk, who shall deliver the record to the health care practitioner subpoenaed

- Heads of Department or designate, prior to disclosing or producing in evidence the client's record in any court of law shall consult with the Attorney General or the institution's legal representative.

Fees for Medical Reports

- There shall be no service charge when request for medial information emanates from any of the following:
    - Another health care facility and relates to continuity of client care,
    - b) The Ministry of Health for research, quality assurance audit, surveillance or other purposes_ as deemed necessary by CMO or Technical Directors of the Ministry of Health/Regional Health Authorities;
    - Government agencies responsible for social/welfare services.
    - The Jamaica Constabulary Force

- Fees for medical reports that are requested by other persons or agencies shall be paid in accordance with the National Health Services (Fees) (Amendment) Regulations, see Appendix 7.

- A copy of any information released shall be filed in the client's medical record with a notation of the date it was released, by whom and to whom.

TELEPHONE AND CLIENT ACCESS REQUESTS

Information **SHALL NOT** be released on receipt of telephone request except in cases of emergency.

Emergency Requests

It is recognized that emergency situations may arise that require the immediate exchange of information by telephone. As a safeguard, the employee shall take the following steps:

- Obtain identifying information from the caller (e.g., health care provider's name, address, telephone number).

- Indicate that a return call will be made.

- Verify the identity of the requestor by using the telephone number(s) obtained.

- Return the call and provide only such information as is necessary for the care of the client.

- Indicate the following in writing and store a copy in the client's record (See example Appendix 3):
    - date and time of request
    - client identification
    - caller information/identification
    - reason given by caller to classify situation as emergency
    - type of information released
    - employee giving information
    - person/ employee receiving information

Client Access

- Unless prohibited by law, the client or his legal representative shall, upon written request, have access to the information in the client's medical record. The request for information shall be referred to the client's doctor/other available health professional before access is allowed. See review of confidential information form Appendix 2.

- Identification of the client or his/her representative shall be required prior to allowing access to the information.

- The client or his/her representative has the right to see any report that is prepared for an employer, and so shall be informed and allowed to review the report before submission to the employer.

- To assist in locating desired information and prevent tampering or removal of information from the record, an employee of the department (doctor/ nurse/ health record officer) shall sit with the client reviewing the record.

AUTHORIZATION FOR RELEASE OF CLIENTS' INFORMATION

Clients' information may only be released with specific and informed authorization as described below:

Authorization

A valid authorization should contains the following information (See form in Appendix 1):

1. Name of the health facility to which application is made;
2. Name and address of the individual or institution to whom the information is to be given;
3. Client's full name, address and date of birth;
4. Purpose for disclosure;
5. Specific time period to be covered and the extent or nature of information to be released;
6. Signature of the client or his/her legal representative;
7. Date at time of signature.
8. Duration of authorization (void after 60 days).
9. Signature of witness

Client Signature

- The signature on the authorization for release of information shall be compared with the client's signature in the medical record (General Authorization for Treatment) and the client's identification documents, i.e., A Passport or National ID or drivers licence.
- Clients incapable of signing their name because of an inability to write, shall be asked to mark an "X" on the signature line. Two persons shall witness the mark and add the statement, "Mark of _____". Client's name

Deceased Client

- If the client is deceased, the next of kin, court-appointed administrator, or executor of the estate should sign the authorization.
- An administrator of an estate **or** an executor is the person who is legally responsible for the disposition of the estate of the deceased. Such person has priority over the next of kin.

Capacity to Authorize

Client Category	***Required Signature***
Adult client	The client or duly authorized representative (e.g., attorney); Proof of authorized representation required
Minors under16 years old	Parent *or* next of kin (see appendix 7) or legally appointed guardian; Proof of relationship required
Deceased	Next of kin as stated on admission face sheet (relationship to be stated on authorization) or executor of estate

Revocation of Authorization

- Clients may, at any time, in writing, revoke prior authorization, provided that action has not been taken in reliance thereon.

REFUSAL TO HONOUR AUTHORIZATION

The facility may refuse to honour a written authorization if:

1. the authorization is outdated; i.e., if sixty (60) or more days have expired since the authorization for release of medical records had been signed

2. there is reasonable doubt as to the identity of the person presenting the authorization, or evidence that the person requesting the information is not the person named in the authorization

3. there is reasonable doubt or question as to the age/legal capacity of a minor, or if there is a serious question regarding the client's mental capacity to understand what he/she has authorized by his/her signature; and

4 there is a question as to the legal guardian of a minor or incompetent client

5. there is doubt as to the authenticity of the request.

6. the doctor determines that the information is likely to cause physical or mental harm to the subject of the application.

Any refusal to honour an authorization should be documented by the person issuing the refusal and the reason stated.

NOTIFICATION TO HEALTH CARE PRACTITIONERS AND OTHER OFFICIAL PERSONS

The appropriate health care practitioners/official persons at the facility shall be notified when any of the following occurs (Appendix 4):

- information is requested by employer or insurance companies;
- information is requested from the client's medical record by the client or his/her representative;
- information is requested from the client's medical record for research purposes (The Ethics Committee's approval must be obtained. Where an Ethics Committee does not exist the MO (H) or SMO's approval is necessary);
- legal action is initiated against the institution or its employee.
-
- The Permanent Secretary, Chief Medical Officer, Regional Director, Regional Technical Director, Chief Executive Officer, Senior Medical Officer and the Medical Officer (H) shall be notified when legal action is initiated.

RELEASE OF INFORMATION WITHOUT AUTHORIZATION

- No authorization shall be required to release information in the following circumstances:
- true health care emergencies (decided by the attending physician/ SMO/ MOHE) where the need to know outweighs privacy and confidentiality considerations;
- unusual, rare circumstances where serving the public interest outweighs privacy and confidentiality considerations (shall be referred to the Ethics Committee or CEO where none exist).
- referrals made for the purpose of continuity of care to private or government treatment facilities (as far as possible, client consent shall be obtained during the discharge planning process);
- request for information that the institution has a legal responsibility to provide, such as death certificates, birth notifications, reports to the police in case of accidents, injuries or poisonings treated at the institution;
- request by third party payers for limited information such as the name of the attending professional, and the types and cost of treatment;
- use of the client record for clinical and operations research and for educational purposes;
- use of the client's record in quality assurance activities;
- request for information in accordance with Statutory provision, for example, the Public Health Act.

PRIORITIES AND TIME FRAMES

The following priorities and time frames shall apply to release of information requests processed by the Medical Record Department.

Immediate Processing:-

- requests involving emergency care of clients.

Within one working day:-

- priority requests pertaining to current care of client.

As required:-

- subpoenas and depositions.

Fifteen (15) working days:-

- All other requests.

PREPARATION OF RESPONSE

Unless the request specifies release of the complete medical record, only selected portions of the document shall be released. An appropriate cover letter shall be prepared showing the items included.

Where possible an abstracted summary shall be completed instead of sending copies of portions of the medical record.

QUALITY CONTROL

- A routine audit of release of information practices shall be carried out at least biannually. The audit shall be carried out by the Director of Health Record or designee. Particular attention shall be given to the following:
  - validity of authorization
  - appropriateness of material abstracted in response to the request
  - retention of authorization, request, and cover letters (Appendix 5a, 5b & 5c) for response
  - procedures for telephone, emergency and client access requests
  - compliance with designated priorities and time frames

- Periodic in-service training shall be given to all employees involved in the processes that encompass the release of information

- At least annually, these policies and associated procedures shall be reviewed.

- All employees, as noted in the general policies governing the Public Service, shall sign employee confidentiality statement.

Log Book

A log shall be maintained to track the step-by-step process towards completion of each request for release of information (Appendix 6).

The log shall be reviewed and updated daily in order to give proper priority to requests and foster early intervention in problem situations. Information shall include the following:

- date request received
- name of client
- medical record number
- name, address and telephone number of person making request
- information released
- date released
- fees charged
- clerk's signature

APPENDICES

APPENDIX 1

_____HOSPITAL

Authorization For Release Of Medical Records

NB: Please retain a copy of this document and insert in the clients medical record

I_____, hereby authorize

_____

(Client, Parent//Guardian or Personal Representative) Name of Institution

to release the following information from the health record(s) of _____

Client's Name

_____

_____

Client's address Date of birth

covering the period(s) of hospitalization/treatment from _____ Date of

_____

Admission to Date of Discharge

Med. Rec. No: _____

Information to be released:

☐ Copy of (complete) medical record(s) ☐ Discharge Summary

☐ History and Physical ☐ Operative Report

☐ Other (specify)_____

Information is to be released to_____ Address

_____

_____ and is to be used for the following purpose

_____

(State reason records are needed)

This consent is subject to revocation by the undersigned, provided that action has not been taken in reliance hereon. If not revoked, it will automatically expire 60 days from the date of signature.

The facility, its employees and officers and attending physicians are released from legal responsibility or liability for the release of the above information to the extent indicated and authorized herein.

Signed _____ _____
(Client or Representative) Relationship

Date _____

Witness _____ Date _____

Please retain this copy in the Client's medical record

APPENDIX 2

_____HOSPITAL

Ref. No. _____ Date: _____

REVIEW OF MEDICAL RECORDS

NAME OF CLIENT:_____ MED. REC. NUMBER:_____

DATE OF BIRTH: _____ TREATMENT DATE (S): _____

I hereby request to review the medical records on the above-named client on the date stated above. A copy of the client's authorization for this review and for release of information is attached.

Reviewer's Name:

Signature:_____

Reason for Review: _____

Date: _____

Record request processed by: _____

Date record review completed: _____

Please retain this copy in the Client's medical record

APPENDIX 3

_____HOSPITAL

Telephone Inquiry: Emergency Request

NB: Please retain a copy of this document and insert in the clients medical record.

CLIENT'S NAME:_____ MED. REC #:_____

DATE:_____ TIME:_____

REQUISITOR'S NAME AND TITLE:_____

ADDRESS:_____

_____ TELEPHONE NUMBER:_____

REASON FOR REQUESTING EMERGENCY RELEASE OF INFORMATION:_____

_____

INFORMATION REQUIRED:

_____ Admission/discharge diagnosis _____Operation Report

_____ Laboratory report _____ Medication _____ Allergies

Other: _____

_____

_____

CALLBACK VERIFICATION COMPLETED:_____

NAME AND TITLE OF PERSON/EMPLOYEE RECEIVING INFORMATION:_____

_____

INFORMATION

RELEASED:_____

_____

MODE OF RELEASE: [ ] TELEPHONE

NAME OF EMPLOYEE RELEASING INFORMATION_____

SIGNATURE_____ DATE_____ TIME:

_____

Please retain this copy in the Client's medical record

APPENDIX 4

_____HOSPITAL

Ref. No. Date:

Dr.

_____

_____

_____

Dear Doctor:

This is to inform you that copies of your client's record were requested on _____

(date)

by attorney/ doctor/others _____

Client's Name_____ (Mr./Mrs./Ms.) Discharge date_____

THIS RECORD IS INCOMPLETE_____. PLEASE STOP BY TO COMPLETE RECORD _____

THIS RECORD IS COMPLETE_____. NO ACTION IS NEEDED BY YOU_____.

Unless otherwise advised, copies will be mailed to the attorney on _____.

(date)

Sincerely.

Medical Record Administrator

NB: Please retain a copy of this document and insert it in the client's medical record

APPENDIX 5a

HOSPITAL NAME

Ref. No. Date:_____

C E R T I F I C A T I O N

CLIENT NAME:_____

MEDICAL RECORD NUMBER: _____

I hereby certify that the attached _____ pages are true and accurate copies of the medical record, number which pertain to the client_____.

I have been designated as the Custodian of Medical Records at _____

(Facility's Name)

And these records have been kept under my supervision and in my custody.

They have been maintained in the ordinary course of business at this institution.

.....

Medical Records Administrator

Medical Records Department

_____

(HOSPITAL STAMP

Please retain this copy in the Client's medical record

ROI - MOHE/PEB (Chambers)04/12/13

APPENDIX 5b

HOSPITAL NAME

Ref. No. _____ Date: _____

Re: _____ Hospital Record No.: _____

Your File No.: _____

Dear:

In regards to your recent request for information concerning the above named client:

_____ The information you requested is enclosed.

_____ Hospital policy requires written authorization by the client before medical information is released. If the client is a minor or unable to sign, the enclosed authorization must be signed by the parent, next of kin or legal guardian.

____ The above named client is currently hospitalized. The information requested will be forwarded following discharge of the client.

____ A thorough search of our files has failed to reveal a record on the above named client. If you can provide additional information that would be helpful, please contact us.

____ Additional data is required to facilitate answering your request. Please forward the following information:

Name at time of admission

Address at time of admission

Date of Birth

Date (s) of treatment: In_____ Out_____

Other:

_____

_____

___

Sincerely,

……..

Medical Records Administrator

Please retain this copy in the Client's medical record) 04/12/13

APPENDIX 5c

HOSPITAL NAME

Ref. No. Date:

Dear

We are in receipt of a request from _____ of _____
to disclose information from medical records we hold concerning you.

If you wish this information to be released to the above, please complete the attached consent form and return it to if the consent is not returned within 30 days, we will assume you do not wish your information disclosed. In this, original request will be returned to the sender.

Sincerely,

.....

Medical Records Administrator

Please retain this copy in the Client's medical record

APPENDIX 6

LOG FOR REQUEST AND RELEASE OF CLIENTS' INFORMATION

DATE OF		CLIENT'S NAME	HOSPITAL NUMBER	CORRESPONDENT NAME & ADDRESS	TYPE OF INFORMATION RELEASED (Medical report, cert., abstract etc.)	AMOUNT PAID	SIGNATURE OF PERSON RECEIVING INFORMATION (proof of authorization required)
REQUEST	INFORMATION. RELEASE						

ROI - MOHE/PEB
04/12/13

(Chambers)

APPENDIX 7

National Health Services (Fees) (Amendment) Regulations, 2004

242F PROCLAMATIONS, RULES AND REGULATIONS AUG 24, 2004

FIRST SCHEDULE, contd.

Column I		Column II
Service/Material	**Public Patients**	**Private Patients - Health Insurance**
Radio Iodine	$2,700.00 up to$10,000.00 depending on dosage	$10,000.00 $50,0000.00 depending on dosage
JDF (CASE VAC)	JDF Rates	JDF Rates
Other out-Patient Services	$300.00 - $4,300.00 depending on type of service including dressing, sutures, pop-body jackets etc.	$450.00 $6.450.00 depending on type of service including dressing, sutures, pop-body jackets, etc.
Ophthalmology	$14,400.00 for cataract with lens implant - $18,000.00 for vitrectomy depending on	$28,000.00 - $36,000.00 depending on procedure
Preparation of Medical Report	$1,000.00	$2,000.00
Executive/Profile Comprehensive Medical Screen	$2,500.00	$5,000.00
Dental Services	$200.00 for visit- $12,000.00 for chrome dentures depending on	$1,000.00 for visit -$60,000.00 for bone graft and guided tissue regeneration. Depending nature of service
Gastroenterology	$2,000.00 for upper $4,500.00 for broncoscopy	$10,000.00 for broncoscopy (diagnostic)

Note: "JDF" means the Jamaica Defence Force established under the Defence Act.

APPENDIX 8

ORDER OF NEXT OF KIN

It has been the practice in some health facilities, over many years, to accept any name given by patients as their next of kin. This practice has sometimes created difficulties in the processing of records for deceased patients and has even delayed the process of handing over the bodies of deceased patients to relatives.

In order to ensure accuracy of information on next of kin, the following is the Order of Next of Kin that should be strictly **followed.**

1. Spouse
2. Children including adoptions (elder or eldest)
3. Father or mother
4. Brothers or sisters (full)
5. Brothers or sisters (half)
6. Grandparents
7. Uncles and aunts
8. Uncles and aunts (brothers and sisters of half-blood)

The order under the Mental Health Act differs slightly and is as follows:

1. Husband or Wife
2. Son or daughter
3. Father
4. Mother
5. Brother or sister
6. Grandparent
7. Grandchild
8. Uncle or aunt
9. Nephew or niece

In the absence of any one of the above, the next in line applies.

In deducing relationships for the purpose of the Act (In testate, Estate and Property Charges Act) -

a) an adopted person shall be treated as the child of the person or persons by whom he/she was adopted and not as the child of any other person.

b) any relationship of half-blood shall be treated as a relationship of whole-blood

"Nearest Relative" means a husband or wife, or if there is no husband or wife, any of the persons mentioned, in order of precedence, who is for the time being surviving. Relative of Whole-blood are preferred to relative of the same description of the half-blood and the elder or eldest of two or more relatives described in any paragraph are preferred to the other or others of those relatives, regardless of gender.

Where the person who, would be the nearest relative of a patient-

a) is not ordinarily resident in Jamaica;
b) is permanently separated from the patient, or has been deserted by the patient (in the case of a husband or wife); or
c) is for the time being under eighteen (18) years of age (not the husband, wife or mother of the patient); or
d) is a person against whom an order has been made under section 52 of the Offences against the Person Act (which relates to the encouragement of seduction or prostitution of a girl under the age of sixteen (16) years divesting that person of authority over the patient and the order has not been rescinded, **the nearest relative of the patient shall be ascertained as if that person were dead.**

"Husband and Wife" (including a single man or a single woman) means a person who is living with the patient as the patient's husband or wife, as the case may be (or, if the patient is for the time being an inpatient in a psychiatric facility, was so living until the patient was admitted) and has been or had been so living for a period of not less than five (5) years.

Prepared by

Yvette Morgan-Chambers, Dir. HRS
Lilyclaire Bellamy, Legal Officer

WORKS CITED

American Health Information Management Association. "Sample Release of Information Policy." Journal of American Health Information Management Association. March, 1992, pp 56-57.

Freedom of Information Act, (Jamaica) 2002

Government of Jamaica. Staff Orders For the Public Service.
1976, p 8 (3.13.).

Huffman, Edna K. Health Information Management. Berwyn: Physician's Record Company, 1994 pp
584 - 589.

Liebler, Joan Gratto, Medical Records: Policies and Guidelines Aspen Publishers, Inc. 1991

National Health Services Act, Jamaica Gazette Supplement VoL.CXXVII Jamaica Printing Services (1992) Ltd., 2004 p 242f.

Monitoring and Evaluation 101

(Adapted from the MEASURE Evaluation M&E Fundamentals course: https://www.cpc.unc.edu/measure/training/mentor/me_fundamentals)

Monitoring and evaluation helps programme implementers:

- Make informed decisions regarding programme operations and service delivery based on objective evidence
- Ensure the most effective and efficient use of resources
- Objectively assess the extent to which the programme is having or has had the desired impact, in what areas it is effective, and where corrections need to be considered
- Meet organizational reporting and other requirements, and convince donors that their investments have been worthwhile or that alternative approaches should be considered

M&E is a continuous process that occurs throughout the life of a programme. To be most effective, M&E should be planned at the design stage of a programme, with the time, money, and personnel that will be required calculated and allocated in advance.

1. **What is Monitoring?**
   Monitoring of a programme or intervention involves the collection of routine data that measure progress toward achieving programme objectives. It is used to track changes in programme performance over time. Its purpose is to permit stakeholders to make informed decisions regarding the effectiveness of programmes and the efficient use of resources.

   Monitoring is an ongoing, continuous process. It requires the collection of data at multiple points throughout the programme cycle, including at the beginning to provide a baseline. Monitoring can also be used to determine if activities need adjustment during the intervention to improve desired outcomes.

2. **What is evaluation?**
   Evaluation measures how well the programme activities have met expected objectives and/or the extent to which changes in outcomes can be attributed to the programme or intervention. The difference in the outcome of interest between having or not having the programme or intervention is known as its "impact" and is commonly referred to as "impact evaluation."

3. **What does an M&E system need?**
   An M&E system requires the assistance of dedicated and knowledgeable staff at the facility, parish, regional and national level. Obtaining and reporting the required information can be very difficult, or even impossible, if no system is in place. An M&E system includes the following:
   - Shared knowledge of what information is needed and by whom
   - Tools to collect the information
   - Shared knowledge of how and when to report the information
   - Someone responsible for making sure the system is working

   The M&E unit is responsible for providing up-to-date information to facility, parish and regional staff about the required data, data collection and reporting tools, timelines, and reports. However, without close collaboration at the facility, parish and regional level, quality data cannot be col-

lected in a timely manner. Facility staff, especially, has a critical role in record-keeping, monitoring and reporting by making sure these data recorded and reported accurately and reliably.

4. **What are indicators and what purpose do they serve?**
   An indicator is a variable that measures one aspect of a programme or project that is directly related to the programme's objectives. An indicator is a measurement. It measures the value of the change in meaningful units that can be compared to past and future units. This is usually expressed as a percentage or a number. Finally, an indicator focuses on a single aspect of a programme or project. This aspect may be an input, an output, or an overarching objective, but it should be narrowly defined in a way that captures this one aspect as precisely as possible.

   Indicators provide M&E information crucial for decision-making at every level and stage of programme implementation.
   - Indicators of programme inputs measure the specific resources that go into carrying out a project or programme (for example, amount of funds allocated to the health sector annually).
   - Indicators of outputs measure the immediate results obtained by the programme (for example, number of multivitamins distributed or number of staff trained).
   - Indicators of outcomes measure whether the outcome changed in the desired direction and whether this change signifies programme "success" (for example, contraceptive prevalence rate or percentage of children 12-23 months who received DTP3 immunization by 12 months of age).

   A good indicator should:
   - Produce the same results each time it is used to measure the same condition or event
   - Measure only the condition or event it is intended to measure
   - Reflect changes in the state or condition over time
   - Represent reasonable measurement costs
   - Be defined in clear and unambiguous terms

FOR SUPERVISORS

Since incentives for performance was one of the top areas identified in the capacity assessment, this section should provide some guidance for supervisors in how to ensure that staff are properly and sufficient trained in M&E, their roles and responsibilities are clearly defined and they feel valued.

On-the-job training (From PRIME, Training Insights, "Structuring Successful On-the-job Learning, August 1999)

1. Focus on the learner: Base the instruction on the learner's current experience, knowledge and skill, and what the learner needs to master. Consider the learner's preferred learning methods and involve the learner in planning and scheduling training.
2. Create an on-the-job training plan and prepare materials: Communicate with learners to schedule a time for on-the-job training. Prepare a learning plan and materials.
3. Embed the transfer of learning to job performance within the on-the-job learning structure: Schedule learning prior to the need for new skills. Ensure immediate practice of new skills. Use skills application or action plans. Provide ongoing learner support, follow-up and coaching to improve and sustain performance.
4. Support on-the-job training: Allocate time, money and other resources for training. Provide for motivation, continued support, feedback and recognition/certification of trainers/facilitators and learners

On-the-Job Training Checklist:

PREPARATION:

1. Timetable
   - ☐ Decide on level of competency needed
   - ☐ Set an end date for achievement of competency
2. Break down into discrete steps
   - ☐ List out important steps to the task
3. Do you have everything ready?
   - ☐ Ensure that you have all necessary equipment, materials and supplies
4. Have you arranged the workplace properly?
   - ☐ Ensure that there are few distractions/interruptions
   - ☐ Simulate the setting, circumstances and context in which the actual task occurs

TRAINING

5. Prepare the learner and explain the task
   - ☐ Put learner at ease
   - ☐ Assess existing knowledge/experience
   - ☐ Explain how training will be conducted
   - ☐ Present objectives and discuss expectations
   - ☐ Explain task
6. Perform and explain the task, step-by-step
   - ☐ Position learner to the side of you as your demonstrate
   - ☐ Describe and show behavior associated with all steps
   - ☐ Explain specific quality points
   - ☐ Summarize entire task
   - ☐ Be clear and complete
7. Have learner perform task while you explain each step and correct error
   - ☐ Have learner perform and explain task until it is done without errors
   - ☐ Provide immediate and very specific feedback about performance
8. Have learner explain and perform task while you observe
   - ☐ Provide remediation on steps that continue to be performed incorrectly
   - ☐ Provide immediate and very specific feedback about performance
9. Evaluate
   - ☐ Determine if the provider fully understands his/her responsibility as well as the task
10. Follow up
    - ☐ Review task/skill during supervisory visits
    - ☐ Praise good work, coach or select other interventions to correct possible gaps in performance

Supportive Supervision

Supportive supervision is an approach for supervisors to recognize their responsibilities in creating conditions that support or facilitate the work of staff (From PRIME II, EngenderHealth, "Supportive Supervision, Putting the Performance into Practice" Presentation).

There are five areas of concentration (called "performance factors") that the supervisor should address in supporting a learner in achieving the set performance objective.

1. EXPECTATIONS
   - Provide staff with clear job expectations verbally
   - Ensure staff understand the vision and mission of your organization, as well as the National AIDS Programme
   - Ensure staff have clear roles and responsibilities (job descriptions), policies, standards, guidelines and other information
2. FEEDBACK
   - Choose good timing
   - Be positive
   - Describe the behavior you have observed
   - State the impact of the behavior or action
   - Ask the other person to respond
   - Focus on solutions
3. MOTIVATION
   - Explore what motivates each staff and match preferences when possible
   - Recognize & reward good performance
   - Be transparent and fair
   - Celebrate successes
4. TOOLS AND SUPPLIES
   - Work with your own supervisors to ensure staff have the infrastructure, equipment and supplies they need to perform well
   - Work with local community & local authorities and organizations to ensure that they provide material support
   - Ensure providers & other staff know how to use and replace forms
   - Ensure that staff have appropriate computer training, when necessary
5. KNOWLEDGE AND SKILL
   - Make sure staff have knowledge and skills needed to perform job well
   - Provide a safe environment for staff to practice new skills and to maintain and further develop skills

IMPORTANT CONSIDERATIONS FOR SUPERVISORS:

- Develop a realistic supervision plan/schedule
- How much time do you have to supervise?
- How many staff will you supervise?
- How experienced is your staff?
- Seek support from other resources to ensure comprehensive supervision
- DO WHAT YOU SAY YOU ARE GOING TO DO

Glossary of M&E Terms

This glossary includes terms typically used in the area of monitoring and evaluation (M&E) and provides the basis for facilitating a common understanding of M&E. Although most terms in the glossary can be used generically, they are defined in the context of public health in general, and HIV and AIDS programs in specific. Note: This is not intended to be an exhaustive list of M&E-related terms, but includes the most commonly used terms.

ACCOUNTABILITY: responsibility for the use of resources and the decisions made, as well as the obligation to demonstrate that work has been done in compliance with agreed-upon rules and standards and to report fairly and accurately on performance results vis-a-vis mandated roles and/or plans.

ACTIVITY: actions taken or work performed through which inputs such as funds, technical assistance, and other types of resources are mobilized to produce specific outputs.
Related terms: Intervention, Project, Program

ASSUMPTIONS: hypotheses about factors or risks which could affect the progress or success of an intervention. Intervention results depend on whether or not the assumptions made, prove to be correct.

ATTRIBUTION: the ascription of a causal link between observed changes and a specific intervention.

AUDIT: an independent, objective quality assurance activity designed to add value and improve an organization's operations. It helps an organization accomplish its objectives by bringing a systematic, disciplined approach to assess and improve the effectiveness of risk management, control and governance processes.
Note: Internal auditing is conducted by a unit reporting to management, while external auditing is conducted by an independent organization.

BASELINE: the status of services and outcome-related measures such as knowledge, attitudes, norms, behaviors, and conditions before an intervention, against which progress can be assessed or comparisons made.
Related term: Benchmark

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

BENEFICIARIES: the individuals, groups, or organizations, whether targeted or not, that benefit directly or indirectly, from the intervention.
Synonym: Target group / Related term: Stakeholder

CAPACITY BUILDING: Strengthening the ability or power to do, experience, or understand something. Capacity Building is much more than training and includes the following: Human resource development, the process of equipping individuals with the understanding, skills and access to informa-

tion, knowledge and training that enables them to perform effectively. Organizational development, the elaboration of management structures, processes and procedures, not only within organizations but also the management of relationships between the different organizations and sectors (public, private and community). Institutional and legal framework development, making legal and regulatory changes to enable organizations, institutions and agencies at all levels and in all sectors to enhance their capacities.

CASE STUDY: a methodological approach that describes a situation, individual, or the like and that typically incorporates data-gathering activities (e.g., interviews, observations, questionnaires) at selected sites or programs/projects. Case studies are characterized by purposive selection of sites or small samples; the expectation of generalizability is less than that in many other forms of research. The findings are used to report to stakeholders, make recommendations for program/project improvement, and share lessons learned.

CONCLUSIONS: point out the factors of success and failure of the evaluated intervention, with special attention paid to the intended and unintended results, and more generally to any other strength or weakness. A conclusion draws on data collection and analysis undertaken through a transparent chain of arguments.
Related terms: Findings, Recommendations

COVERAGE: the extent to which a program/intervention is being implemented in the right places (geographic coverage) and is reaching its intended target population (individual coverage).

DATA: specific quantitative and qualitative information or facts that are collected and analyzed.
Synonym: Evidence

ECONOMIC EVALUATION: use applied analytical techniques to identify, measure, value and compare the costs and outcomes of alternative interventions. Types of economic evaluations include cost-benefit, cost-effectiveness, cost-efficiency evaluations.
Related terms: Impact evaluation; Outcome evaluation; Summative evaluation

EFFECTIVENESS: the extent to which a program/intervention has achieved its objectives under normal conditions in a real-life setting.
Related terms: Efficacy; Efficiency

EFFICACY: the extent to which an intervention produces the expected results under ideal conditions in a controlled environment.
Related terms: Effectiveness; Efficiency

EFFICIENCY: a measure of how economically inputs (resources such as funds, expertise, time) are converted into results.
Related terms: Effectiveness; Efficacy

EPIDEMIOLOGY: the study of the magnitude, distribution and determinants of health-related conditions in specific populations, and the application of the results to control health problems.
Related terms: Second-generation surveillance; Sentinel surveillance; Surveillance

EVALUABILITY: extent to which an intervention or program/intervention can be evaluated in a reliable and credible fashion.

EVALUATION: the rigorous, scientifically-based collection of information about program/intervention activities, characteristics, and outcomes that determine the merit or worth of the program/intervention. Evaluation studies provide credible information for use in improving programs/interventions, identifying lessons learned, and informing decisions about future resource allocation.
Related terms: Economic evaluation; Formative evaluation; Impact evaluation; Outcome evaluation, Process evaluation; Operational research; Summative evaluation

FACILITY SURVEY: a survey of a representative sample of facilities that generally aims to assess the readiness of all elements required to provide services and other aspects of quality of care (e.g., basic infrastructure, drugs, equipment, test kits, client registers, trained staff). The units of observation are facilities of various types and levels in the same health system. The content of the survey may vary but typically includes a facility inventory and, sometimes, health worker interviews, client exit interviews, and client-provider observations.

FINDINGS: Factual statements based on evidence from one or more evaluations.
Related terms: Conclusions; Results

FORMATIVE EVALUATION: a type of evaluation intended to improve the performance of a program or intervention. A formative evaluation is usually undertaken during the design and pretesting of the intervention or program, but it can also be conducted early in the implementation phase, particularly if implementation activities are not going as expected.
Related terms: Operational research; Process evaluation

GENERALIZABILITY: the extent to which findings can be assumed to be true for the entire target population, not just the sample of the population under study.
Note: To ensure generalizability, the sampling procedure and the data collected need to meet certain methodological standards.

GOAL: a broad statement of a desired, usually longer-term, outcome of a program/intervention. Goals express general program/intervention intentions and help guide the development of a program/intervention. Each goal has a set of related, specific objectives that, if met, will collectively permit the achievement of the stated goal.
Related terms: Objective, Target

HEALTH INFORMATION SYSTEM (HIS): a data system, usually computerized, that routinely collects and reports information about the delivery and cost of health services, and patient demographics and health status.
Synonyms: Routine health information system (RHIS); Health management information system (HMIS)

IMPACT: the long-term, cumulative effect of programs/interventions over time on what they ultimately aim to change, such as a change in HIV infection, AIDS-related morbidity and mortality.
Note: Impacts at a population-level are rarely attributable to a single program/intervention, but a specific program/intervention may, together with other programs/interventions, contribute to impacts on a population.

IMPACT EVALUATION: a type of evaluation that assesses the rise and fall of impacts, such as disease prevalence and incidence, as a function of HIV programs/interventions. Impacts on a population seldom can be attributed to a single program/intervention; therefore, an evaluation of impacts on a population generally entails a rigorous design that assesses the combined effects of a number of programs/interventions for at-risk populations.
Related terms: Economic evaluation; Outcome evaluation; Summative evaluation

IMPACT MONITORING: tracking of health-related events, such as the prevalence or incidence of a particular disease; in the field of public health, impact monitoring is usually referred to as "surveillance."
Synonym: Surveillance / Related terms: Input and output monitoring; Outcome monitoring

INCIDENCE: the number of new cases of a disease that occur in a specified population during a specified time period.
Related term: Prevalence

INDICATOR: a quantitative or qualitative variable that provides a valid and reliable way to measure achievement, assess performance, or reflect changes connected to an intervention.
Note: Single indicators are limited in their utility for understanding program effects (i.e., what is working or is not working, and why?). Indicator data should be collected and interpreted as part of a set of indicators. Indicator sets alone can not determine the effectiveness of a program or collection of programs; for this, good evaluation designs are necessary.

INPUTS: the financial, human, and material resources used in a program/intervention.
Synonym: Resources

INPUT AND OUTPUT MONITORING: tracking of information about program/intervention inputs (i.e., resources used in the program/intervention) and program/intervention outputs (i.e., results of the program/intervention activities).
Note: Data on inputs and outputs usually exist in program/intervention documentation (e.g., activity reports, logs) and client records which compile information about the time, place, type and amount of services delivered, and about the clients receiving the services.
Related terms: Impact monitoring; Outcome monitoring

INTERNAL EVALUATION: an evaluation of an intervention conducted by a unit and/or individuals who report to the management of the organization responsible for the financial support, design and/or implementation of the intervention.
Synonym: Self evaluation

INTERVENTION: a specific activity or set of activities intended to bring about change in some aspect(s) of the status of the target population (e.g., HIV risk reduction, improving the quality of service delivery).
Synonym: Project / Related terms: Activity; Program

LESSONS LEARNED: generalizations based on evaluation experiences with programs, interventions or policies that abstract from the specific circumstances to broader situations. Frequently, lessons highlight strengths or weaknesses in preparation, design, and implementation that affect performance, outcome, and impact.

LOGICAL FRAMEWORK: management tool used to improve the design of interventions. It involves identifying strategic elements (inputs, outputs, activities, outcomes, impact) and their causal relationships, indicators, and the assumptions of risks that may influence success and failure. It thus facilitates planning, execution, and monitoring and evaluation of an intervention.
Synonyms: Causal chain; Logframe; Logic model; Results chain; Results framework

META-EVALUATION: a type of evaluation designed to aggregate findings from a series of evaluations. It can also be used to denote the evaluation of an evaluation to judge its quality and/or assess the performance of the evaluators.

MONITORING: routine tracking and reporting of priority information about a program / project, its inputs and intended outputs, outcomes and impacts.
Related terms: Impact monitoring; Input and output monitoring; Outcome monitoring

M&E PLAN: a multi-year implementation strategy for the collection, analysis and use of data needed for program/project management and accountability purposes. The plan describes the data needs linked to a specific program / project; the M&E activities that need to be undertaken to satisfy the data needs and the specific data collection procedures and tools; the standardised indicators that need to be collected for routine monitoring and regular reporting; the components of the M&E system that need to be implemented and the roles and responsibilities of different organisations / individuals in their implementation; how data will used for program / project management and accountability purposes. The plan indicates resource requirement estimates and outlines a strategy for resource mobilization.
Note: A national HIV M&E plan is a multi-sectoral, 3-5 year implementation strategy which is developed and regularly updated with the participation of a wide variety of stakeholders from national, sub-national, and service delivery levels.
Synonym: M&E framework / Related term: M&E work plan

M&E WORK PLAN: an annual costed M&E plan that describes the priority M&E activities for the year and the roles and responsibilities of organizations / individuals for their implementation; the cost of each activity and the funding identified; a timeline for delivery of all products / outputs. The work plan is used for coordinating M&E activities and assessing progress of M&E implementation throughout the year.
Note: A national HIV M&E work plan is an annual plan which is developed with the participation of those stakeholders that have roles and responsibilities for the M&E activities identified in the work plan.
Synonym: Annual costed M&E work plan; M&E operational plan / Related term: M&E plan

OBJECTIVE: a statement of a desired program/intervention result that meets the criteria of being Specific, Measurable, Achievable, Realistic, and Time-phased (SMART).
Synonyms: Measurable objective; SMART objective; Target / Related term: Goal

OPERATIONAL RESEARCH: systematic and objective assessment of the availability, accessibility, quality, and/or sustainability of services designed to improve service delivery. It assesses only factors that are under the control of program/project managers, such as improving the quality of services, increasing training and supervision of staff members, and adding new service components.
Synonym: Operations evaluation / Related terms: Formative evaluation; Process evaluation

OUTCOME: short-term and medium-term effect of an intervention's outputs, such as change in knowledge, attitudes, beliefs, behaviors.
Related terms: Outputs; Impacts

OUTCOME EVALUATION: a type of evaluation that determines if, and by how much, intervention activities or services achieved their intended outcomes. An outcome evaluation attempts to attribute observed changes to the intervention tested.
Note: An outcome evaluation is methodologically rigorous and generally requires a comparative element in its design, such as a control or comparison group, although it is possible to use statistical techniques in some instances when control/comparison groups are not available (e.g., for the evaluation of a national program).
Related terms: Economic evaluation; Impact evaluation; Summative evaluation

OUTCOME MONITORING: tracking of variables that have been adopted as valid and reliable measures (i.e., indicators) of the desired program/intervention outcomes. Outcome monitoring does not infer causality; changes in outcomes may be attributable to multiple factors, not just a specified program/intervention.
Note: With national AIDS programs, outcome monitoring is typically conducted through population-based surveys (i.e., representative of the target population, not necessarily the general population).
Related terms: Input and output monitoring; Impact monitoring

OUTPUTS: the results of program/intervention activities; the direct products or deliverables of program/intervention activities, such as the number of HIV counseling sessions completed, the number of people served, the number of condoms distributed.
Related terms: Impacts; Inputs; Outcomes

PERFORMANCE: the degree to which an intervention or organization operates according to specific criteria/standards/guidelines or achieves results in accordance with stated goals or plans.

POPULATION-BASED SURVEY: a type of survey which is statistically representative of the target population, such as the AIDS Indicator Survey (AIS), the Demographic and Health Survey (DHS).

PREVALENCE: the total number of persons living with a specific disease or condition at a given time.
Related term: Incidence

PROCESS EVALUATION: a type of evaluation that focuses on program/intervention implementation, including, but not limited to access to services, whether services reach the intended population, how services are delivered, client satisfaction and perceptions about needs and services, management practices. In addition, a process evaluation might provide an understanding of cultural, sociopolitical, legal, and economic contexts that affect implementation of the program/intervention.
Related terms: Formative evaluation; Operational research

PROGRAM: an overarching national or sub-national response to a disease. A program generally includes a set of interventions marshaled to attain specific global, regional, country, or subnational objectives; involves multiple activities that may cut across sectors, themes and/or geographic areas.
Related terms: Activity; Intervention; Project

PROGRAM EVALUATION: a study that intends to control a health problem or improve a public health program or service. The intended benefits of the program are primarily or exclusively for the study participants or the study participants' community (i.e., the population from which the study participants were sampled); data collected are needed to assess and/or improve the program or service, and/or the health of the study participants or the study participants' community. Knowledge that is generated does not typically extend beyond the population or program from which data are collected.

PROGRAM RECORDS: program documentation (e.g., activity reports, logs) and client records which compile information about program inputs (i.e., resources used in the program) and program outputs (i.e., results of the program activities). Examples include budget and expenditure records, logs of commodities purchased and distributed, client records which compile information about the time, place, type and amount of services delivered, and about the clients receiving the services.

PROJECT: an intervention designed to achieve specific objectives within specified resources and implementation schedules, often within the framework of a broader program.
Synonym: Intervention / Related terms: Activity; Program

QUALITATIVE DATA: data collected using qualitative methods, such as interviews, focus groups, observation, and key informant interviews. Qualitative data can provide an understanding of social situations and interaction, as well as people's values, perceptions, motivations, and reactions. Qualitative data are generally expressed in narrative form, pictures or objects (i.e., not numerically).
Note: The aim of a qualitative study is to provide a complete, detailed description.

QUALITY ASSURANCE: planned and systematic processes concerned with assessing and improving the merit or worth of an intervention or its compliance with given standards.
Note: Examples of quality assurance activities include appraisal, results based management reviews, evaluations.

QUANTITATIVE DATA: data collected using quantitative methods, such as surveys. Quantitative data are measured on a numerical scale, can be analysed using statistical methods, and can be displayed using tables, charts, histograms and graphs.
Note: The aim of a quantitative study is to classify features, count them, and construct statistical models in an attempt to explain what is observed.

RELEVANCE: the extent to which the objectives, outputs, or outcomes of an intervention are consistent with beneficiaries' requirements, organisations' policies, country needs, and/or global priorities.

RELIABILITY: consistency or dependability of data collected through the repeated use of a scientific instrument or a data collection procedure used under the same conditions.

RESEARCH: a study which intends to generate or contribute to generalizable knowledge to improve public health practice, i.e., the study intends to generate new information that has relevance beyond the population or program from which data are collected. Research typically attempts to make statements about how the different variables under study, in controlled circumstances, affect one another at a given point in time.

RESULTS: the outputs, outcomes, or impacts (intended or unintended, positive and/or negative) of an intervention.

Synonym: Effects / Related terms: Findings; Impacts, Outcomes, Outputs

RESULTS BASED MANAGEMENT (RBM): a management strategy focusing on performance and achievement of outputs, outcomes and impacts.

SECOND-GENERATION SURVEILLANCE: HIV surveillance that not only tracks HIV prevalence but also uses additional sources of data to increase the understanding of trends of the epidemic over time. It includes biological surveillance of HIV and other sexually transmitted infections as well as systematic surveillance of the behaviours that spread them.
Related terms: Epidemiology; Sentinel surveillance; Surveillance

SENTINEL SURVEILLANCE: ongoing, systematic collection and analysis of data from certain sites (e.g., hospitals, health centers, ante-natal clinics) selected for their geographic location, medical specialty, and populations served, and considered to have the potential to provide an early indication of changes in the level of a disease.
Related terms: Epidemiology; Second-generation surveillance; Surveillance

STAKEHOLDER: a person, group, or entity who has a direct or indirect role and interest in the goals or objectives and implementation of a program/intervention and/or its evaluation.
Related terms: Beneficiaries; Target group

SUMMATIVE EVALUATION: a type of evaluation conducted at the end of an intervention (or a phase of that intervention) to determine the extent to which anticipated outcomes were produced. It is designed to provide information about the merit or worth of the intervention.
Related terms: Economic evaluation; Impact evaluation; Outcome evaluation

SURVEILLANCE: the ongoing, systematic collection, analysis, interpretation, and dissemination of data regarding a health-related event for use in public health action to reduce morbidity and mortality and to improve health. Surveillance data can help predict future trends and target needed prevention and treatment programs.
Synonym: Impact monitoring/Related terms: Epidemiology; Second-generation surveillance; Sentinel surveillance

SUSTAINABILITY (of a program): the likelihood that political and financial support will last to maintain the program.

TARGET: the objective a program/intervention is working towards, expressed as a measurable value; the desired value for an indicator at a particular point in time.
Synonyms: Measurable objective; Objective; SMART objective / Related term: Goal

TARGET GROUP: specific group of people who are to benefit from the result of the intervention.
Synonym: Beneficiaries / Related term: Stakeholder

TERMS OF REFERENCE (TOR) (of an evaluation): written document presenting the purpose and scope of the evaluation, the methods to be used, the standards against which performance is to be assessed or analyses to be conducted, the resources and time allocated, and the reporting requirements.
Synonym: Scope of work (SOW)

TRAINING: A training event must have specific learning objectives, a course outline or curriculum, and expected knowledge, skills and/or competencies to be gained by participants. There are no time limits on training events. A person is considered trained if he/she participates in at least 80% of the said activity.

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

VALIDITY: the extent to which a measurement or test accurately measures what is intended to be measured.

References

Alemayehu Amberbir et al, Predictors of adherence to antiretroviral therapy among HIV-infected persons: a prospective study in Southwest Ethiopia BMC Public Health. 2008; 8: 265. Published online 2008 July 30.

Ethiopia Hareg Health Management Information System (HMIS). *Manual for Managers.* January 2004.

Foreit K, Moreland S, LaFond A. (2006) Strategies and Tools for Data Demand and Information Use in the Health Sector.

Foreit K, Moreland S, LaFond A. (2006) A Conceptual Framework for Data Demand and Information Use in the Health Sector.

Malawi National AIDS Commission. National HIV Monitoring and Evaluation Plan, Part B: Operations Plan. July 2003.

MEASURE Evaluation M&E Fundamentals mini-course:
www.cpc.unc.edu/measure/training/mentor/me_fundamentals. 2007

Evaluation Working Group of the UNAIDS Monitoring and Evaluation Reference Group (MERG) (2008). Glossary of M&E Terms. Geneva, Switzerland: MERG Evaluation Technical Working Group, 2007.

Global AIDS Program (GAP) (2003). *Monitoring & Evaluation Capacity Building for Program Improvement. Field Guide.* Atlanta, USA: GAP, Centers for Disease Control and Prevention.

Joint United Nations Programme on HIV (UNAIDS) (2007). *A framework for monitoring and evaluating HIV prevention programmes for most-at-risk populations*. Geneva, Switzerland: UNAIDS.

Organisation for Economic Co-operation and Development (OECD) (2002). *Glossary of key terms in evaluation and result based management*. Paris, France: OECD.

Rugg, D., Peersman, G., & Carael, M. (Eds.) (2004). Global advances in HIV monitoring and evaluation. *New Directions for Evaluation*, 2004 (103).

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