

**MONITORING AND EVALUATION PLAN**

**The Global Fund Grant**

**“Effective tuberculosis and HIV control in the Kyrgyz Republic”**

**HIV component**

**July 2018 – December 2020**

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# MONITORING AND EVALUATION OF THE GF CONSOLIDATED GRANT

Monitoring and Evaluation (M&E) is a key component of Performance-based Funding (PBF). Through M&E, the programme results at all levels (impact, outcome, output, process and input) are measured to provide the basis for accountability and informed decision-making at both programme and policy level.

A monitoring and evaluation plan (M&E plan) is a systematic and objective approach or process for monitoring project performance toward its objectives over time. An M&E plan is an integral to the planning of a programme design.

As a planning document, the M&E plan encourages to approach each programme component systematically. During programme execution, it helps the implementer to keep track of the programme’s progress and make adjustments if necessary. It is also a valuable tool for demonstrating the effectiveness and impact of a programme, generating credible and useful information that contributes to learning, improved performance, and accountability.

An M&E plan focuses on the performance of a programme and examines its implementation plan, inputs, process, outputs, outcomes and impact. The M&E plan addresses the questions like: Did the project take off as planned? What problems and challenges, if any, did it face? Is it being effectively managed? Is it providing planned activities and other outputs in a timely fashion? If not, why? Will the project be able to meet its targets? What are its intermediary effects and impacts? What can be done to improve its performance and impacts?

The purpose of M&E of the Global Fund grant to fight AIDS, Tuberculosis and Malaria within HIV component is to ensure the systematic collection, analysis and dissemination of information on the activities within the grant, the outputs and outcomes, impact on the HIV morbidity and mortality among key population groups of the grant under New Funding Model.

M&E system corresponds to the framework of the grant, which aims to achieve a common goal and to perform basic objectives in accordance with the grant components. Each of the components has a certain number of expected outcomes related to the achievement of key objectives and goals of the grant. The system is designed to monitor the achievement of these outcomes and objectives of the grant during its implementation. The M&E system allows for data to be collected, processed and transformed into strategic information (SI) that informs decision-making at all levels of the grant: service delivery, programme management and policy.

The work plan and budget of the grant contain a detailed description of the activities carried out in order to achieve the expected results; a description of the costs that are planned under each component; the time frame for activities; responsible persons and implementing organisations. Expected results are measured by indicators according to which UNDP reports to the Global Fund. For monitoring these results, the UNDP project has devised a list of indicators focused both on the process and on the results. The development of the list of indicators was based on the project aims, objectives and planned activities (Fig. 1).

**Figure 1. Monitoring System and Relation to the Grant Logic**



Monitoring and evaluation system of the Global Fund Grant is based on long-term and medium-term planning of activities, reliable approaches to the sub-grants management, detailed records of activities undertaken, semi-annual reporting forms on the indicators and narrative reports on actual activities and results obtained.

The UNDP project M&E plan is closely tied to the National M&E system, which feeds information for overarching project indicators on impact and outcomes.

# Link to the National Monitoring and Evaluation

The Monitoring and Evaluation Department of the Republican AIDS Centre (RAC) is an executive body of the national M&E system, which monitors the national HIV/AIDS strategy implementation. During 2016-2017, the Ministry of Health developed a State Programme on overcoming HIV- infection in the Kyrgyz Republic and M&E plan for 2017-2021. Within this period, the UNDP harmonized its impact, outcome and coverage indicators with the national indicators.

The Ministry of Health in coordination with the State HIV Programme developed the National Health Care Reforms Programme of the Kyrgyz Republic “Den Sooluk” for 2012 – 2018. The Den-Sooluk programme is a logical continuation of the previous Manas Taalimi programme and focuses its activities on improving the population’s health in four priority areas (Human Immunodeficiency Virus (HIV), Tuberculosis (TB), Cardiovascular Diseases (CVD), Maternal and Child Health (MCH)) and, on removing health system barriers (in public health, individual service delivery, financing, human resources, medicines, and governance) in order to scale up core services and achieve expected health gains. The programme outlined the M&E strategy and plan as well. The M&E strategy for Den Sooluk is built on achievements of the current M&E system while ensuring that it is fully synergistic with the new paradigm presented in Den Sooluk.

The Den Sooluk M&E strategy is based on four pillars, which jointly provide a full picture of implementation progress. The four pillars include:

* M&E indicator package based on routine and annually monitored data,
* regular coverage studies assessing progress with expanding core services,
* health system studies ordered by the MoH/Mandatory Health Insurance Fund (MHIF) looking into progress and obstacles in removing key health system barriers, and
* large scale household and patient surveys

In line with the M&E strategy, the MoH and Sector Wide Approach Partners convene annual review of the progress made under the programme. RAC as the key player in HIV submits progress updates and data on key HIV indicators.

According to the Dublin Declaration and assumed government obligations MoH participates in the development of the Global AIDS Response Progress Reporting (GARPR). The report is developed each year and consists of data on several indicators collected and analysed in the framework of the State HIV programme.

The UNDP project provides support to the national M&E system and national partners in order to institutionalize the system:

* + Support to the National Coordination Council on HIV Monitoring and Evaluation under the Country Coordinating Mechanism. In particular in 2012, in close cooperation with the Ministry of Health the regulations on M&E Technical Committee (TC) were developed; discussions on membership in the TC conducted (the members are approved by the MoH decree # 524); several working meetings as well as a basic training for TC new members took place.
  + In order to ensure correct collection of quality data on the State HIV Programme and to evaluate the programme UNDP, UNAIDS, ICAP and CSOs provided technical assistance to RAC and MoH to develop and approve Guidelines for monitoring and evaluation of public programme on HIV/AIDS for 2012-2016. The guidelines were published in 2012 with the financial support of UNDP;
  + In 2013, MoH with the financial support of UNDP established a Working Group on the revision of existing recording and reporting forms on HIV. Revised recording and reporting forms (according to the State HIV Programme M&E plan) were approved by the MoH. A training for AIDS service and the Republican Medical and Information Centre specialists on the use of new forms was conducted with the support of UNDP;
  + Starting from 2012 UNDP has supported a number of trainings for AIDS service on M&E, SPECTRUM, IBBS, RDSAT, RDSA, EpiInfo etc. (see Capacity Building section for more details);
  + In order to ensure treatment cascade among KAP and identify weaknesses at different stages during 2015-2016, UNDP together with RAC lobbied introduction of UIC into the Electronic PLHIV tracking system which was developed by ICAP and introduced country wide among AIDS Centres and FMC. As a result during 2017 several working meetings on HIV treatment cascade were held with partners with presentations of actual results;
  + UNDP in partnership with the government and international stakeholders has been continuously providing capacity development assistance in M&E to governmental and non-governmental organisations active in HIV.

**Evaluation of the National HIV/AIDS Strategy.**

The previous State HIV Programme covers a period from 2012 to 2016. A mid-term evaluation of the State HIV Programme has been conducted in 2015. According to the M&E section of the State Program, a mid-term review was envisaged along with other routine monitoring and evaluation exercises.

Upon the request of the Ministry of Health of the Kyrgyz Republic, with financial support of USAID, UNAIDS commissioned a study in HIV area in the Kyrgyz Republic setting the following objectives:

* To evaluate the progress in the implementation of the State Programme;
* To see the gaps and losses in continuum of HIV service provision for PWID for further refocusing of the state programme (if necessary);
* To develop an action plan for implementation of the state programme for 2015-2016.

The comprehensive study was conducted by Consulting Group Curatio Ltd under financial support of USAID and guidance of UNAIDS. Three main recommendations were provided:

1. Rethink the national response to the epidemic the consecutive steps;
2. Design a 3 to 5-year strategic plan (conventionally called The State Program);
3. Conceptualize the M&E framework as the major tool for strategic governance and oversight, and improve the M&E practices by concentrating efforts of all relevant stakeholders.

According to the key findings actions to implementation, the recommendations were provided. **Assessment of the national M&E system**

In July 2011, the Assistance Project (ICAP) at Columbia University and [Mailman School of Public Health](https://www.google.kg/url?sa=t&rct=j&q=&esrc=s&source=web&cd=1&sqi=2&ved=0CCsQFjAA&url=http%3A%2F%2Fwww.mailman.columbia.edu%2Facademics%2Fcourses&ei=rMADUbLhE6mN4ATEkIGYDw&usg=AFQjCNHGHzxIfCLWa9OQIpwWR6ahqiR6kg&bvm=bv.41524429,d.bGE) with the technical support from the CA regional office of UNAIDS assessed national M&E system. A national seminar on "Strengthening the monitoring and evaluation of HIV in the Kyrgyz Republic" was conducted in the framework of the assessment. UNAIDS guide on twelve components of the M&E served as a basis for this seminar.

Various governmental agencies, nongovernmental institutions, and international organizations took part in the seminar, including the Ministry of Education and Science, the Ministry of Labour and Social Protection, the Ministry of the Interior, the National AIDS Centre, the Oblast and City AIDS Centres, and the National TB Dispensary.

As a result of the national workshop, strengths and weaknesses within the existing M&E system at different levels as well as those that require further attention were highlighted, and recommendations were made for strengthening M&E of HIV-related activities. This report summarizes these results. In addition, a working plan was developed to strengthen the KR M&E system for 2012–2016.

In July 2014 a seminar on the implementation of the State HIV Programme M&E plan was conducted for the staff of AIDS service and RMIC. The participants discussed data collection and analysis, recording and reporting forms and data flow system.

# INDICATOR DEFINITIONS AND MEASUREMENT

### Indicator Definitions and Measurement

A full list of indicators for monitoring the implementation of the consolidated grant, targets and timelines are reflected in

Table 1. UNDP M&E Indicator Framework, Annex A. National M&E Indicator Framework, Annex B. Indicator Reference Tables.

Impact and outcome indicators are national indicators and are used by the country to assess the implementation of the state programme and for country reporting, such as "Implementation the Declaration of Commitment on HIV/AIDS (the United Nations General Assembly Special Session on HIV/AIDS)" and "Health Sector Response to HIV/AIDS: Monitoring and Reporting". These indicators are collected using Integrated Bio-Behavioural Survey (IBBS) with a frequency of once every 2 years and are aligned to the country report of GARPR. The last IBBS was conducted in 2016 while next IBBS is planned to be conducted in 2019 within the new NSP for 2017-2021, which is currently under approval procedure by the Government of the KR.

Data on indicators ("% of adults and children with HIV known to be on treatment 12 months after initiation of antiretroviral therapy" and “AIDS related mortality per 100,000 population”), are collected by the Republican AIDS Centre and the Republican Medical Information Centre under MoH on a regular annual basis, using 4a and 4-Zdrav recording and reporting forms approved by the National Statistical Committee.

The frequency of measurement and reporting depends on what kind of place these indicators occupy in the M&E system, taking into account a reasonable time required for the expected change and provision of the programme potential for M&E. Given the fact that indicators should be used as well for the programme level of the projects implementing agencies, the following reporting schedules are offered: the frequency of "month / quarter / half year / year" is recommended for levels 1 and 2, and the frequency of "half year / year" for level 3. Reporting for this level indicators are collected by the health care organisations once a year.

Formulation of indicators on HIV prevention programmes coverage for PWID, SWs and MSM, and an approach to their calculation has been significantly changed. If earlier within Phase I of Round 7 the indicators were mainly cumulative for the entire period of the grant, and the reach was calculated as "getting one service for 12 months", then in the consolidated grant the targets are non-cumulative, and the coverage means "receiving a minimum package of services at least once in 6 months". Description of service packages is given in Annex B in the description of the indicators.

Table 1. UNDP M&E Indicator Framework

|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
| **Impact level** | | | | | | | |
| **#** | **Indicator name** | **Baseline** | **Target (s)** | | **Data source** | **Data collection** | **Responsible agency** |
|  | % of people who inject drugs who are living with HIV | 14.3%  (2016) | 14.3%  (June 2020) | | IBBS | Every two years | RAC |
|  | % sex workers who are living with HIV | 2%  (2016) | 2%  (June 2020) | | IBBS | Every two years | RAC |
|  | % men who have sex with men who are living with HIV | 6.6%  (2016) | 6.6%  (June 2020) | | IBBS | Every two years | RAC |
|  | AIDS related mortality per 100, 000 population | 1,22  (2016) | 1,22  (June 2019)  1,21  (June 2020)  1,20  (June 2021) | | Vital and disease-specific registry | Annually | RAC |
| **Outcome level** | | | | | | | |
| **#** | **Indicator name** | **Baseline** | **Target(s)** | **Data source** | | **Data collection** | **Responsible agency** |
|  | % of people who inject drugs reporting the use of sterile injecting equipment the last time they injected | 47.5%  (2016) | 70% (June 2020) | IBBS | | Every two years | RAC |
|  | % of sex workers reporting the use of a condom with their most recent client | 97.2%  (2016) | 97% (June 2020) | IBBS | | Every two years | RAC |
|  | % of men reporting the use of a condom the last time they had anal sex with a male partner | 81.1%  (2016) | 85% (June 2020) | IBBS | | Every two years | RAC |
|  | % of adults and children with HIV known to be on treatment 12 months after initiation of antiretroviral therapy | 79%  (2016) | 82% (2018)  85% (2019)  88% (2020) | Vital and disease-specific registry | | Annually | RAC |
|  | **Output level** | | | | | | |
| **#** | **Indicator name** | **Baseline** | **Target(s)** | **Data source** | | **Data collection** | **Responsible agency** |
|  | Percentage of people living with HIV currently receiving antiretroviral therapy | 32.9%  (2016) | 51.4%  (July, Dec. 2018)  60.3%  (Jan., June 2019)  69.1%  (July, Dec. 2019)  79.2%  (Jan., June 2020)  89.3%  (July, Dec. 2020) | Patient records | | Bi-annually | RAC |
|  | Percentage of people living with HIV and on ART, who have a supressed viral load at 12 months (<1000 copies/ml) | 61.6%  (2016) | 55% (2018)  67% (2019)  79% (2020) | Vital and disease-specific registry | | Annually | RAC |
|  | Percentage of PWID reached with HIV prevention programmes - defined package of services | 58.7%  (2016) | 65% (July, Dec. 2018)  67.5% (Jan., June 2019)  70% (July, Dec. 2019)  72.5% (Jan., June 2020)  75% (July, Dec. 2020) | UNDP MIS | | Bi-annually | UNDP |
|  | Percentage of PWID that have received an HIV test during the reporting period and know their results | 27.8%  (2016) | 29.3% (July, Dec. 2018)  31.5% (Jan., June 2019)  31.5% (July, Dec. 2019)  33.7%  (Jan., June 2020)  33.8% (July, Dec. 2020) | UNDP MIS | | Bi-annually | UNDP |
|  | Percentage of individuals receiving Opioid Substitution Therapy who received treatment for at least 6 months | 51%  (2016) | 60% (July, Dec. 2018)  62.7% (Jan. June 2019)  65% (July, Dec. 2019)  67.2% (Jan., June 2020)  70% (July, Dec. 2020) | Electronic medication-assisted treatment (EMR) | | Bi-annually | UNDP, RCN |
|  | Percentage of prisoners that have received an HIV test during the reporting period and know their results | 32.7%  (2016) | 33.7% (July, Dec. 2018)  35.8% (Jan., June 2019)  35.8% (July, Dec. 2019)  41% (Jan., June 2020)  41% (July, Dec. 2020) | Administrative records | | Bi-annually | RCN and SSES |
|  | Percentage of sex workers reached with HIV prevention programmes - defined package of services | 57% (2016) | 70% (July, Dec. 2018)  72.5% (Jan., June 2019)  75% (July, Dec. 2019)  77.5% (Jan., June 2020)  80% (July, Dec. 2020) | UNDP MIS | | Bi-annually | UNDP |
|  | Percentage of sex workers that have received an HIV test during the reporting period and know their results | 15.4% (2016) | 31.5% (July, Dec. 2018)  33.7% (Jan., June 2019)  33.7% (July, Dec. 2019)  36% (Jan., June 2020)  36% (July, Dec. 2020) | UNDP MIS | | Bi-annually | UNDP |
|  | Percentage of MSM reached with HIV prevention programmes - defined package of services | 32.2% (2016) | 57.3% (July, Dec. 2018)  68.3% (Jan., June 2019)  79.2% (July, Dec. 2019)  86.4% (Jan., June 2020)  93.6% (July, Dec. 2020) | UNDP MIS | | Bi-annually | UNDP |
|  | Percentage of MSM that have received an HIV test during the reporting period and know their results | 15.7% (2016) | 23.9% (July, Dec. 2018)  35.6% (Jan., June 2019)  35.6% (July, Dec. 2019)  42.1% (Jan., June 2020)  42.1% (July, Dec. 2020) | UNDP MIS | | Bi-annually | UNDP |
|  | Percentage of people living with HIV in care (including PMTCT) who are screened for TB in HIV care or treatment settings | 95.6%  (2016) | 95% (July, Dec. 2018)  95% (Jan., June 2019)  95% (July, Dec. 2019)  95% (Jan., June 2020)  95% (July, Dec. 2020) | Vital and disease-specific registry | | Bi-annually | RAC |
|  | Percentage of HIV-positive new and relapse TB patients on ART during TB treatment | 94.6% (2016) | 90% (July, Dec. 2018)  90% (Jan., June 2019)  90% (July, Dec. 2019)  90% (Jan., June 2020)  90% (July, Dec. 2020) | Patient records | | Bi-annually | RAC |
|  | Percentage of HIV-positive pregnant women who received ART during pregnancy | 96.9% (2016) | 95% (2018)  95% (2019)  95% (2020) | Patient records | | Annually | RAC, RMIC |

# ROUTINE DATA COLLECTION

This should include a mapping of relevant data flows. Also this section should cover dissemination and use of information products. Descriptions along the following areas should be provided:

* routine data (output indicators) that will be collected and reported routinely from service delivery points (including public health facilities, private health facilities and community level) and other intermediate levels to the national level;
* Data collection and reporting tools (for capturing and reporting data from public health facilities, private health facilities and community level);
* reporting frequency and timelines, and
* information and report flow and feedback mechanisms, including a schematic map of report flow from public health facilities, private health facilities and the community level to the central level.

# General principles

This section in the M&E plan describes existing systems in place aimed at collecting data for measuring impact/outcome indicators and programmatic indicators. Data collection is one of the first steps of the monitoring and evaluation process. The data represent a powerful tool for advocacy, obtaining resources, accounting and reporting, development of programmes and their improvement, matching changes with specific interventions. To optimize data collection, it is necessary to know what data has been collected already by various stakeholders, and to identify gaps existing in the data collection process. Data collected by various organizations (governmental and non-governmental) within the programmes and grants for HIV/AIDS is used to set the baseline and targets for M​&E. These are surveillance data, special behaviour and socio-economic studies, financial reports and programme monitoring of other donors and international organizations. Most of the data needed to calculate indicators (primarily indicators of costs and benefits) are obtained from existing sources (accounts of the grant, health statistics and documentation, data of demographic and health surveys). However, for many outcome and impact indicators , the data is collected through an [Integrated Bio-Behavioural Sentinel Surveillance.](https://www.google.com/search?hl=en&biw=1366&bih=667&q=Integrated+Bio-Behavioral+Sentinel+Surveillance.&spell=1&sa=X&ei=jZU0UfmcAvOQ4gSV1oGgAQ&ved=0CC4QvwUoAA) Data obtained from the standardized instruments for health statistics are recorded regularly from year to year based on calendar year. Data related to programme activities are collected once every six months in accordance with the programme year.

However, RAC and RMIC end of year reporting timelines do not coincide with UNDP reporting timelines, because medical facilities reporting to those organisations submit their report by the end of March with additional time for data verification, processing and analysis. Taking into consideration the different reporting timelines, certain indicators (using the data from the medical facilities) reported in the UNDP PUDR should be considered preliminary until the PUDR for the following period.

The systematic collection of information is a critical element of the M&E system. Since the programme documentation and reports are the major source of information, there is a need for a clear system for record keeping and for drawing up, submitting and summarizing reports. The recommended frequency of data collection for the project activities of implementing agencies is once a month. Time frame for data collection should be harmonized with the time frame for semi-annual reports of the UNDP project in accordance with the programme year.

# Data Collection and Reporting Tools

During the implementation of the consolidated grant UNDP uses individual recording forms for each objective of the grant. They are adapted to the specifics of the assistance provided, range of services and the monitoring tools used in the country. Recording and reporting forms requiring Unique Identification Code (UIC) and used for Management Information System (MIS) of the UNDP consolidated grant programme were adapted to existing tools used universally by organisations working with key population groups and international agencies.

During the grant implementation UNDP project uses MIS database, which allows tracking the availability of clients (regular, secondary, etc.) for services provided, which is an important aspect of an effective system of programme monitoring. Registration of clients is made on the basis of personal data (name or UIC). UIC is used in cases where it is necessary to observe the confidentiality of the client to maintain the quality and scope of services provided. In the course of the grant implementation, the registration system is used to monitor Voluntary Counselling and Testing (VCT) activities and distribution of motivational packages.

The coding system is based on the following principles:

* + one person can get only one code, regardless of the number of service delivery points which he uses;
  + the code must conform to the principles of confidentiality.

The code is based on personal data in order to make it easily restored in case of loss of the programme membership card by a client. The UIC is used for encoding the clients and uses Cyrillic alphabet to designate the first two letters of the names of mother and father.

If the implementing agency has the MIS database (level 3 of programme M&E), the report is generated for the requested reporting period, archived and sent to the sub-recipient (level 2) and/or to UNDP project (level 1).

To improve the procedures for monitoring and evaluating OST by collecting and analysing data related to both direct delivery of services and the impact of OST on patients (behavioral change and health level) the PR together with ICAP, Columbia University, CDC and national partners represented by the Republican Narcology Center during the 2016 started to introduce the Electronic Medication-assisted treatment Register (EMR). The system is adopted nationally and in 2016 the MoH order on introducing EMR countrywide was signed by SSES and MoH.

Electronic MAT register (EMR) is a web-based system that is designed to collect, store, transmit and analyse data on all patients enrolled in OST.

The main objectives of the EMR are the following:

• analysis and quality control of medical care by obtaining individual and aggregated data on patients in order to improve the provided services (storage, exchange and processing of information, monitoring the timeliness of laboratory tests for HIV-infected patients (CD4, VL));

• standardization and improvement of the quality of medical information in order to reduce the volume of paper work;

• timely receipt of information on the health status of patients (concomitant diseases, including HIV, TB, HBV, HCV);

• information on changes in socio-demographic indicators and patient behaviour;

• monitoring the timeliness of HIV testing and screening for TB.

There are also standardized paper based forms for monthly and quarterly reporting (Figure 2. Data Flow).

The report of sub-recipients must include a narrative report on the work of sub-recipients of the grant, summarized indicators reported by grants implementing agencies, and disaggregated at the regional level.

# Reporting Schedule and Procedures

An organisation implementing the grant prepares a quarterly report for the grant management group on Form 1 (quarterly). The report is filled by the 15th of each month following the reporting period.

The grant management prepares a consolidated Programme Update and Disbursement Request (PUDR) on activities under the grant and submits it to GF, MoH and CCM bi-annually. Information is also available to all other stakeholders.

# Data Collection Methods and Time

Recording, collecting, generalizing and analysing the quantitative data characterizing the coverage of clients by the grant services and other quantitative indicators (quantitative programme monitoring) are the basic component of the routine monitoring of the grant implementation.

Process indicators, which reflect the implementation of the work plan under the grant, will be calculated quarterly based on information provided by sub-recipients to UNDP using standard reporting templates devised on the basis of reports of the final beneficiaries of the grant (implementing agencies). UNDP analyses and consolidates obtained data and sends to GF and CCM within the time specified (once every 6 months). Financial reporting is conducted the same way and in the similar time.

Routine data collection consists of:

1. Maintaining registration forms and tools (paper/electronic).
2. Following the procedures for the transfer of data (information flows) at the service delivery points, as well as from the service delivery points to the implementing agencies, from them to sub-recipients, from sub-recipients to UNDP.
3. Regular aggregation and analysis of data in the form of periodic reports (monthly, quarterly).

In the course of the grant implementation, SRs refer clients to VCT using a specially developed referral form; the clients submit this document to a doctor at a medical institution providing VCT services within the programme. After passing through VCT, the client returns to an organisation, which issued the referral and bring back the second part of referral form/staff responsible would collect the second part of referral forms from VCTs. A unified system vouchers tracking systems has been developed and in-place.

MIS database allows recording the services delivered daily – it contains lists of all clients who have used services indicating the date of a visit and types of services provided (issued commodities (by type), counselling, etc.), as well as indicating the name of the project officer who provided these services. In case of lack of a computer and software, the staff assisting at the point is allowed to fill in the recording forms recommended or agreed with UNDP directly during contact with the client. An example of these recording forms may be: a logbook of a Needle Exchange Point (NEP), a logbook of VCT, a logbook of motivational packages provided within the programme, a statement of an outreach worker, a diary of the outreach worker, a logbook for a consultant’s work, a patient's medical record.

The Electronic MAT register (EMR) system helps to obtain accurate, complete and timely information, including: administered doses of methadone and missed days of therapy, controlled substance use, testing for HIV and screening for TB, the diagnosis of HIV and TB received services, OST retention, coverage, number of patients tested on HIV and other important data without duplicates on a national level. The EMR contains UIC as well as full names of patients on OST.

The automatic exchange of information between the systems of electronic HIV-infection tracking and EMR was launched earlier in 2017, which helps to timely obtain data on HIV status and to monitor the health status of the patient.

At the end of the reporting period, an expert responsible for reporting generates a report: (a) in the presence of MIS/EMR in accordance with the instructions to generate a report, (b) when working with hard-copy forms carries out the aggregation of data on indicators on the basis of statements/logbooks of all personnel of the point. The data is entered in the form of a periodic report, which includes:

• a list of the reporting indicators with planned and actually achieved objectives;

• a list of the activities conducted and the narrative part highlighting achievements and challenges in the work under the grant during the reporting period.

These reports (electronic or paper) are submitted by the grant implementing agencies to UNDP who carry out verification of data from all service delivery points. Primary data registration forms on the services provided, that are the basis for the preparation of periodic reports, shall be submitted from SRs along with the reports to UNDP if necessary. SRs’ M&E staff, usually project assistants, verify the data obtained from the outreach workers and other staff (primary documents, reporting forms), as well as prepare an aggregated report on the component for the UNDP.

To ensure consistency, comparability of data, and to reduce the number of errors, the data on the outcomes of the component shall be fixed in the 'Monitoring form' of EXCEL format and stored by the M&E specialist of UNDP.

M&E specialist analyses the data for the following items:

1. matching the actual results of the planned objectives set out in Annex 6 to the Grant Agreement;
2. selective re-check of consistency of the primary documentation data;
3. assessment of the quality of services provided on the basis of meetings with programmes’ clients (individual and focus groups);
4. based on data analysis in terms of number of services provided per client in the reporting period, number of clients visit, number of repeated clients vs number of new clients;
5. based on those analysis provides recommendations for improving the quality of services;
6. preparation of the next periodic report with updated data on the progress of the grant to the Global Fund.

The frequency of data collection depends on the type of data. Some of them must be collected daily, while others - monthly or quarterly. Recommended frequency of data collection is indicated in the list of indicators for sub-recipients and grants implementing agencies.

# Data flow

M&E is conducted at various levels (Figure 2. Data Flow). At the primary and secondary level, the results of monitoring should be used for the needs of these organizations. In connection with this, as well as for capacity building it is recommended to aggregate data monthly, quarterly and semi-annually. A standardised format has been developed to make it possible to summarize and analyse information from all reporting documents. SRs submit a consolidated report to UNDP quarterly. If requested by PR the primary report documents of the implementing agencies should also be submitted to UNDP for data verification.

UNDP summarizes and analyses data collected by SRs and implementing agencies, and sends PUDR to GF, Local Fund Agent (LFA) and CCM every six months.

Figure 2. Data Flow

**Sub-recipients**

**(Level 1)**

**Work plan**

**Report**

**UNDP**

**(Level 2)**

**Work plan**

**Data aggregation**

**PUDR**

**GFATM**

**CCM**

**DASH BOARD**

# DATA MANAGEMENT

The procedure for data management occurs at several levels:

* + - 1. At the level of service delivery points – the staff of the point shall record all information about a client during an initial contact, as well as all consumables and services provided to the client during each contact. The data are summarized in the form of periodic reports in accordance with the agreed indicators.
      2. At the level of the regional implementing agencies – the reports of service delivery points shall be verified, summarized and submitted to the sub-recipient and M&E specialist.
      3. M&E specialist – shall verify all data received from the organisations involved in implementing the component, prepare an aggregated report on the component in accordance with the agreed indicators of the component and submits it to Programme specialists/M&E specialist of UNDP.
      4. M&E specialist of UNDP – rechecks the data, analyses the achievement of planned objectives, and prepares a report on the implementation of the grant to the Global Fund, the Ministry of Health and other interested organisations. UNDP disseminates information on the results achieved among all grant implementing agencies in order to improve the performance of the grant, to improve the quality of provided services and monitoring system.

In order to ensure the quality of the data standard procedures for reporting, including unified forms for recording, summarising and analysing data were developed, standardised methods for calculating and obtaining performance indicators under the grant to be used by all organizations involved in the implementation of the grant were also developed and disseminated. The grant staff are periodically trained, methodological material on M&E is distributed. Monitoring of the grant implementation is a complex and continuous process. Monitoring visits and analysis of the reports of grant funds recipients are used for quality assurance purposes Evaluation of the accuracy of data submitted by an organisation can also be carried out by direct surveys of the grant clients.

Data quality control have been carried out by monitoring and evaluation specialist of UNDP, component coordinators, independent consultants and experts in the field of HIV and AIDS, as well as by the National Coordinator of the grant. Mechanism to ensure quality and reliability of the information also includes:

* assessment of the capacity of the recipients of grant funds on monitoring and evaluation;
* monitoring visits;
* triangulation of data for program monitoring (quantitative and qualitative indicators);
* technical assistance to carry out M&E by UNDP.

UNDP is providing technical assistance to grant implementing agencies and sub-recipients and their partners on introducing the M&E principles, creating and supporting the M&E system. Training courses on the proper use of methods and practices of M&E, proper recording and reporting are conducted for employees of the organizations that implement the grants depending on budget and work plan.

Each organisation receiving funds from the Global Fund should have the employee (coordinator) responsible for gathering necessary data and development of reports for M&E specialist of UNDP. M&E coordinators collect all reports from respective implementing agencies, complementing them with information regarding actual activities of the sub-recipient under this component. Based on the reports of sub-recipients, UNDP prepares a consolidated report for the Global Fund, and shares a report with MoH and CCM.

Electronic System of Tracing of HIV cases (ES) was developed by CAAP and pilot tested in Osh and Chui oblasts. In 2012 the system was introduced in all regions of the country with the assistance of ICAP. Retrospective data entry was conducted by AIDS service staff with the financial assistance from UNDP.

Infectious diseases specialists (other doctors in the absence) of Primary Health Care facilities are assigned responsibilities for M&E at PHC level. Infectious diseases doctors maintain outpatient medical records of PLHIV and duplicate information from health cards of patients in an Electronic System of Tracing of HIV cases. Completed health cards are transferred to oblast AIDS Centres who enter data from this card into ES. Bishkek city AIDS centre is responsible for record keeping and data entry in Bishkek city.

From 2014 all ART records are kept in ES.

# PROGRAMME REVIEWS, EVALUATIONS, AND SURVEYS

Evaluation is a set of activities designed to determine the value or merits of a separate programme, project or intervention. This means that the particular results or outcomes can be attributed directly to a specific intervention. In other words, evaluation is a systematic study of the situation, the implementation process of the programme or its results in order to develop a new programme, recommendations for improvement of the work, to assess the programme effectiveness and efficiency. There are three main types of evaluation: *evaluation of a situation, evaluation of the process and evaluation of the impact.*

* Evaluation of the situation is carried out before the intervention in order to develop the project meeting the needs of a target group;
* Evaluation of the process is carried out in the course of the programme implementation in order to correct it and to improve its impact;
* Evaluation of the impact is carried out after the completion of the programme (component) or some time later. It shows how the intervention programme has achieved its goals.

Evaluation allows answering questions like: why an event had or did not have the desired effect, which factors were favourable and which obstructive, what changes could be made to improve future work.

In addition, there are formative and summative assessments.

Formative assessment is carried out in order to develop or adjust the project activities. It includes the evaluation of the process and the evaluation of the situation. Summative assessment summarizes the carried out activities in order to determine the effectiveness and impact of these activities, such as the evaluation of the impact.

Evaluation of the effectiveness of implemented programmes should be carried out in different directions:

* evaluation of the process (programme content, the scope of its coverage, quality and completeness of the realization);
* evaluation of the results and outcomes (what concrete results have been obtained and the causal connection with the implemented interventions);
* evaluation of the impact (to which global changes have led the set of all activities on HIV and AIDS control).

# Assessment of M&E capacity of organisations

UNDP provides technical assistance to implementing agencies and sub-recipients and their partners in implementing, creating and supporting M&E system. UNDP conducts an assessment of all sub-recipients within the grant, including the identification of their capacity in M&E. Such an assessment is carried out as part of the capacity assessment procedure before signing the grant agreement or after its signing. Assessment is based on the following criteria:

* The presence of a special position to implement and/or responsible officer of the programme having appropriate responsibilities to carry out M&E;
* Preparation of regular reports on activities and accomplishments of the grant;
* Previous report on M&E;
* The use of standard indicators in the periodic monitoring of the grant implementation;
* Using the results of monitoring (periodic reports on the activities and performance of the grant, the availability of database, periodic publications, and bulletins on the activities of the grant);
* The use of modern techniques of monitoring and approved documents.

In regards to the sub-recipients capacity, UNDP takes into account reports on monitoring visits of the organizations, independent experts’ opinion, availability of an adequate system for data collection and reporting, and existence of the appropriate staff assistance in order to verify the accuracy and reliability of data collected.

# External evaluation

External oversight and supervision is carried out by the Country Coordinating Mechanism (CCM). Independent external evaluation is carried out by independent experts (UNDP, WHO, UNAIDS and others). On an annual basis, as well as on demand of CCM, UNDP submits reports on the progress of the project for discussion at CCM meetings.

**Mid-term Evaluation of the National HIV Programme.** The mid-term evaluation of the State HIV Programme was conducted in 2015. According to the M&E section of the State Program, a mid-term review was envisaged along with other routine monitoring and evaluation exercises.

The comprehensive study was conducted by the Consulting Group Curatio Ltd under financial support of USAID and guidance of UNAIDS. Three main recommendations were provided:

* Rethink the national response to the epidemic the consecutive steps;
* Design a 3 to 5-year strategic plan (conventionally called The State Program);
* Conceptualize the M&E framework as the major tool for strategic governance and oversight, and improve the M&E practices by concentrating efforts of all relevant stakeholders.

According to the key findings, the recommendations for actions to be implemented were provided.

# Research and studies

As part of the consolidated grant a series of evaluations and studies have been conducted to assess the project implementation progress, to identify problem areas and evaluate the effectiveness, including quality of the activities and services, and for the purposes of the National M&E system. In line with a number of evaluation studies in the country, including the IBBS in 2016-2017, RAC together with UNDP and with the technical support of UNAIDS expert, in the framework of the IBBS, conducted estimations of the number of people in each key population group: PWID, SW and MSM. The report is under development and finalization process.

When planning evaluations and studies, information on the studies conducted over the past 7 years (2010-2017) was collected and their results have been used. Information on conducted and planned studies is presented in Table 2.

Table 2. Table of studies conducted and planned in the field of HIV

| **Title of the study** | **Executing agency** | **Target groups** | **Timeline** |
| --- | --- | --- | --- |
| **Conducted studies** | | | |
| “Condom-related behaviour and awareness of sex workers in Bishkek on HIV/AIDS/STI” | "Anti-AIDS" Association | SWs | November 2010 – January 2011 |
| “Condom-related behaviour and awareness of men having sex with men (Bishkek, Kara-Balta, Osh) on HIV/AIDS/STI” | ААА | MSM | November 2010 – January 2011 |
| Central Asia Republics (2010): HIV and TB TRaC study evaluating risk behaviours associated with HIV transmission and utilization of HIV prevention services and HIV/TB co-infection prevention among SWs in Karaganda and Almaty (Kazakhstan), Chui Oblast (Kyrgyzstan), Dushanbe, Vahdat District, Kurgan-tube, Kulyab (Tajikistan). First Round. | Population Services International | SWs | 2010, 2012 |
| Kazakhstan, Kyrgyzstan, Tajikistan (2010): HIV and TB TRAC study among men having sex with men in Almaty, Bishkek, Chui oblast and Dushanbe. | Population Services International | MSM | 2010, 2012 |
| Central Asia Republics (2010): HIV and TB TRaC study evaluating risk behaviours associated with HIV transmission and utilization of HIV prevention services and HIV/TB co-infection prevention among people who inject drugs | Population Services International | PWID | 2010, 2012 |
| “Results of the study of HIV knowledge, attitudes and skills of young people in the pilot regions” | GIZ | youth | August-September 2010 |
| Access to naloxone | SOROS | PWID | 2010 |
| Access to treatment and prevention of HCV | SOROS | PWID | 2010 |
| Access to palliative care | SOROS | PLHIVs | 2010 |
| Limited services and socio-psychological factors affecting the spread of HIV among female PWID | Asteria PF/  CARHAP | PWID | May-June 2010 |
| Study to assess the vulnerability of women living with HIV and victims of gender-based violence | Izildo PF/  UNDP | PLHIVs | 2010 |
| Sentinel surveillance among vulnerable groups | Republican AIDS Centre | PWID, SWs, MSM | 2010 |
| Sentinel surveillance among vulnerable groups | Republican AIDS Centre | PWID, SWs, MSM, prisoners, pregnant women and patients with STI | 2009 |
| Evaluating the effectiveness of harm reduction programmes in the Kyrgyz Republic | UNAIDS, WHO and CARHAP | PWID | 2011 |
| Demographic and Health Survey | USAID, National Statistical Committee | General population | 2012 |
| Evaluation of OST programme | ICAP | PWID | 2012 |
| Evaluation of a system of HIV treatment and prevention services in Kyrgyzstan | ICAP | HIV programme | 2012 |
| Integrated Bio-Behavioural Study of PWID’s sex partners | ICAP | PWID’s partners | 2012 |
| Review of the organisation and quality of HIV laboratory services in Kyrgyzstan | WHO | HIV lab service | 2013 |
| Studies to estimate the number of the key population groups. | UNDP (M- Vector for MSM and SW, HPAC for PWID) | MSM, SW, PWID | 2013 |
| Evaluation the adequacy of health services for PWID - Phase I “Territory Profiling”” | UNODC | PWID and PWID - prisoners | 2013 |
| Integrated bio-behavioural survey (IBBS) | Republican AIDS Centre | PWID, SWs, MSM, prisoners | 2013 |
| Rapid assessment of the Harm Reduction Programme | UNDP (Regional Technical Support Hub for Eastern Europe and Central Asia) | PWID | 2014 |
| Review of HIV Harm Reduction Programs in Kyrgyzstan and background information to develop the country concept note for the new funding model of the GFATM | GF | PWID | 2014 |
| Evaluation of HIV prevalence among prisoners releasing in the nearest 6 months of the study | Yale University | Prisoners | 2014 |
| HIV Programme Review | WHO | HIV Programme | 2014 |
| WHO review of UNDP OST programme (OST clients satisfaction) | WHO | PWID | 2015 |
| Integrated Biological Behavioural Survey among Sex Partners of people who inject drugs in the Kyrgyz Republic | ICAP | Sex Partners of PWID | 2015 |
| The mid-term Evaluation of the State HIV Programme | USAID, UNAIDS (The Consulting Group Curatio Ltd ) | The State HIV Programme | 2015 |
| The stigma index of people living with HIV | Central Asian Association of People Living with HIV | PLHIV | 2015 |
| Assessment of the Needles Exchange Programme | ICAP | PWID | 2016 |
| Integrated bio-behavioural survey (IBBS) | Republican AIDS Centre | PWID, SWs, MSM, prisoners | 2016-2017 report is under finalization process |
| Studies to estimate the number of the key population groups | RAC, UNDP, UNAIDS | PWID, SWs, MSM | 2016-2017 report is under finalization process |
| Kyrgyzstan Qualitative Cascade Assessment Report | USAID | PWID | 2017 |

Unfortunately, the studies have pursued their programme objectives, and samples of some were not representative. In this regard, upon the completion of evaluation of the national M&E system, one of the recommendations was to agree on assessments with the M&E department of the Republican AIDS Centre, in order that research findings are used for the purposes of national M&E system as an alternative or for verification of the IBBS results.

As part of the consolidated grant size estimates of the number of key population groups, integrated bio-behavioural survey have been conducted. Evaluation of the implementation of infection control for HIV and external quality assurance of laboratory diagnosis of HIV is conducted on an annual basis.

**IBBS.** The spread of HIV is etiologically associated with certain risk behaviours. Typically, injecting drug use, provision of sex services and same sex sexual relationships are not widely publicised. Therefore, the traditional forms of surveillance do not allow estimating the real situation. IBBS system can be more effective to follow M&E situation. The IBBS system uses data from behavioural surveillance for the interpretation of data collected in the sero-surveillance.

HIV epidemic in the Kyrgyz Republic is concentrated among key population groups at higher risk of HIV exposure. According to the latest IBBS 2016 HIV prevalence rate in PWID is 14.3%, 2% in SWs, 6.6% in MSM and 11.3% in prisoners, which indicates that the country has a concentrated HIV epidemic. In a concentrated epidemic when the level of prevalence in the key population groups begins to exceed 5% of the number of examined, the IBBS system must monitor not only the key population groups, but also pay special attention to the behavioural links between the key population groups and the general population. It is necessary to identify the mechanisms of infection transfer into the general population (the sexual partners of PWID, SWs and MSM and voluntary blood donors from among PWID etc.). An attention should also be paid to the practice of risk behaviour among the general population (sentinel surveillance among pregnant women, or violation of infection control and management of medical waste at medical clinics, or the lack of quality control of donated blood), which can lead to rapid spread HIV in the general population.

IBBS 2013 in Kyrgyzstan was conducted among PWID, prisoners, SWs, MSM and STI patients. IBBS is to be conducted every 2 years, and is carried out in accordance with the national and UNAIDS guidelines (the order No. 202 of the Ministry of Health). In 2016, new round of IBBS was carried out and the final report is currently being finalized.

Development and implementation of the study (methodology, sampling, questionnaires, etc.) is carried out by the epidemiological department of the Republican AIDS Centre with the technical support of ICAP and UNAIDS. When developing questionnaires, the AIDS Centre staff adjusts the questions to the guidelines and indicators of UNAIDS. IBBS 2016 among key population groups was carried out in 6 regions of the country for PWID, in 4 regions for SWs, in 2 for MSM and in 2 for prisoners. Access to key population groups was provided by NGOs working with these populations.

**Key population groups size estimations.** Evaluating the effectiveness of HIV prevention programmes among the key population groups requires data on the number of PWID, SWs and MSM and HIV prevalence among these groups. Studies conducted by various international organizations offered significantly differing and contradictory estimates of the number of people in these groups. The system of epidemiological surveillance for HIV was based on the availability and therefore registers only a fraction of the total number of PLHIV. In order to have up-to-date data on the size of key population groups the UNDP Project commissioned three studies to estimate sizes of the above mentioned population groups. These studies informed IBBS serving as denominator figures for calculating a number of indicators measured under IBBS.

According to these estimates in 2013-2014, the number of SWs is 7,103, MSM 11,692 (the estimated number of MSM in Bishkek and Osh) and PWID 25,000.

In the framework of the current IBBS round in 2016 the size estimations among PWID, SW and MSM groups were conducted. The final estimates and report are being finalized.

**WHO State HIV Programme Review.** The purpose of this review and the World Health Organization (WHO) country mission performed in Kyrgyzstan in November 2014 was to analyse the current HIV situation and provide strategic recommendations aligned with WHO guidelines in terms of priority setting and investments needed to curb the HIV epidemic in Kyrgyzstan. Strategic recommendations were intended to inform the on-going Global Fund concept note development with expected disbursement from the Global Fund (TGF) for the period January 2016 – December 2017.

**Scope and objectives of the review:**

The programme review encompassed four key components:

1. Epidemiological analysis;
2. Review of HIV treatment and care along cascade of services;
3. HIV services for key populations;
4. Analysis of service delivery models for populations affected by the HIV epidemic from the perspective of the health system.

The review identified six priority areas for Kyrgyzstan and recommendations were provided for each area:

* Priority area 1: Increase diagnosis and enrolment into care of key populations;
* Priority area 2: Ensure timely initiation of quality ART and retention in care;
* Priority area 3: Optimize service delivery models and use of human resources;
* Priority area 4: Scale up harm reduction for PWID, including OST;
* Priority area 5: Prevent sexual, vertical and nosocomial transmission of HIV;
* Priority area 6: Improve management, coordination and surveillance.

**Rapid assessment of the Harm Reduction Programme.** UNDP contracted the Regional Technical Support Hub for Eastern Europe and Central Asia to conduct the evaluation of the Harm Reduction Programme, which was commissioned in November – December 2014. The aim of this evaluation was to assess the harm reduction programme supported by UNDP and devise recommendations on the most appropriate and efficient harm reduction approach on the basis of community needs for the Country Concept Note development.

* The evaluation included review and support of country dialogue discussion on harm reduction. The review of current approach to harm reduction/HIV prevention services; review of the actual needs of the affected populations and the status of harm reduction programme as well as provision of guidance and facilitation of communities’ input during the national dialogue (pre-dialogue meeting on 20 November and dialogue meeting on 29 November 2014).
* Development of prevention strategies and costing. Based on the results of coherent review of the current approach to harm reduction and HIV prevention services, needs of key populations (KPs), in-country discussions, best international practices and guidelines, recommendations were developed in order to improve current program and include relevant activities into the New Concept Note. Costing for proposed harm reduction and HIV prevention services for people who inject drugs (PWID), sex workers (SW), men who have sex with men (MSM) and PWID was provided, which could be easily adapted to country needs.

**Review of HIV Harm Reduction Programs in Kyrgyzstan and background information to develop the country concept note for the new funding model of the GFATM.** The review took place in August 2014 and was conducted by an external consultant. The main purpose of this evaluation was to assess the UNDP supported harm reduction programme, identify gaps and devise recommendations designed to improve harm reduction programme and to inform the development of the country concept note.

# DATA QUALITY ASSURANCE MECHANISMS AND RELATED SUPPORTIVE SUPERVISION

# Data Quality Assurance

Management decisions are made on the basis of the collected information from programme staff and implementing agencies. It is therefore extremely important that the information provided to management is of high quality, accuracy and reliability.

Particular attention should be paid to these issues at the beginning of systematic data collection in accordance with the indicators. Quality control of the monitoring can be carried out by experts in the field of research, by M&E specialist of UNDP, a coordinator of the HIV component or by independent consultants. The monitoring process is a complex and continuous. Monitoring visits and analysis of the reports of grant funds recipients are widely used for these purposes.

Evaluation of the accuracy of information submitted by the organizations can be carried out by direct surveys of the grant clients (individual and focus groups). Mechanism to ensure quality and reliability of the information also provides:

* assessment of the capacity of the grant funds recipients for M&E;
* monitoring visits;
* technical assistance by UNDP to carry out monitoring and evaluation.

During the monitoring of activities under the grant, the following steps are taken to prevent/reduce errors in the information provided:

* availability of criteria for indicators of coverage, including the concept of a primary, secondary, constant client (for PWID).
* UIC is used for registration of anonymous clients. UIC consists of 7 figures: the first two letters of the mother’s name, the first two letters of the father’s name, gender (1 – female, 2 – male) and the last two figures of the birth year. The Cyrillic alphabet is used for the coding.

Double recording of clients is possible at the same organization (the client is registered at the service delivery point twice), and between organizations (the client receives the same services provided by several organizations). To prevent the recording of the client at the same organization/service delivery point repeatedly, it is necessary to register all clients in a special logbook or a computer database, to use the UIC. Using the personal information for encoding will allow recovering the code if the client forgets his code. To avoid the registration of one person in two different organizations/service points, the employee of the point at the first contact must ask the client whether he has been registered previously in other institutions or whether he has received similar services previously. This principle should be used for representatives of all the key population groups of the grant (PWID, PLHIV, MSM, SWs, etc.). It is necessary to make a note about re-referral in the case of re-referral to another organization for services.

A situation when services are provided during the different periods of time. For example, a client temporarily ceased to use services of the grant, when returned to the program – such a client does not need to register as a new client.

Situations that do not relate to the “double recording”:

* in determining coverage – the client is a member of one or several key population groups and receives services that are specific to each group. For example, a woman is a SW and also injects drugs, gets the services aimed at sex workers and needle exchange. As the coverage of PWID and SWs by prevention interventions is calculated in the grant separately for each group, such a client must be registered both at the service delivery point for PWID and for SWs.
* when counting the number of trained individuals – if one and the same person has been trained on various topics.

Sub-recipients and UNDP are entitled to request a primary material to verify the codes. Recommended MIS program allows archiving and forwarding the information over the Internet. And also allows transferring the list of clients in Excel, which simplifies the process of verification of the clients’ codes.

# Monitoring visits

Monitoring visits are an integral part of evaluation and monitoring activities within the grant.

Algorithm of monitoring visits involves several steps:

Preparatory – selection of indicators, activities and period of time to be verified, program reports collected for these time periods and previous reports on monitoring visits.

Visiting an organization to be monitored – assessing the data recording system, the procedure of collection, aggregation (if an organization has several service delivery points) and analysis of information, analysis of recording and reporting forms, compliance of primary documentation data with the reports. Analysis of the achievement status of the planned indicators and verification if the recommendations from the previous monitoring visit had been implemented.

Visiting a service delivery point – assessment of the system and practice of data registration at the point, verification of data of the reporting indicators with primary sources – a number of people covered, materials distributed, consultations conducted, etc. Assessment of the skills and knowledge of staff, continuous supply of the point with consumables, identified the needs and difficulties at work. While visiting a point there will be a meeting with clients, wherever it is possible, to gather information about the quality of services provided, gaps to be covered and support needed in order to ensure provision of quality services.

Frequency of monitoring visits depends on a type of the project implemented, results of previous monitoring visits, quality of submitted reports, and performance under the planned indicators. It is recommended to visit organisations newly added to as sub-recipients of grant funds that have problems with the implementation of the grant at least once per quarter; other organizations are visited once every six months.

The schedule of monitoring visits is made up quarterly for UNDP staff (monitoring specialist, programme specialists, financial and administrative staff), specialists of partner organizations also participate in the monitoring visits, including Ministry of Health and other ministries and agencies involved in HIV prevention process.

Sub-recipients of grant funds conduct internal monitoring visits and inspections of sub-sub recipients; the reports on monitoring visits are given to field coordinators of components.

After monitoring visits reports are devised and shared with the SRs. This report, separately or together with quarterly reports and special requests from organisations, forms the basis for providing technical assistance in the framework of the activities on M&E. The results of monitoring visits are provided to organisations involved in monitoring visit as well.

# Data Analysis and Use of Reporting Data

Analysis of collected data should be carried out by the organization that was responsible for their collection. It is best if the analysis is conducted at the lowest level since such information will be used for local planning and management. Data obtained from sero-epidemiological and partially behavioural research, can be analysed by the Ministry of Health – departments for “surveillance” and “monitoring and evaluation” of the Republican AIDS Centre, which has experience with this type of activity.

Program monitoring and evaluation system is effective only if it is used for the evaluation of the programme activities in order to make managerial decisions. M&E system should identify how the grant activities and interventions meet the overall expected results, as well as the goals and objectives of the grant.

The reports’ data is used to:

* prepare the external reporting of UNDP for the Global Fund through the use of standardized indicators that correspond to the information needs of donor;
* assess the activities by comparing planned and actual results;
* assess compliance of costs and activities with the process of achieving the goals of the Global Fund grant;
* conduct a formal recording and registration of the status of the grant implementation, informing in detail the stakeholders about what kind of activities have been implemented, and how many people have received the support, what has been spent;
* inform the staff of the implementing organisations and sub-recipients regarding the current status of costs and activities funded by the GF;
* inform national partners in order to assess the effectiveness of national strategies, their planning and preparation of country reports on HIV control.

# M&E COORDINATION

All partners and stakeholders irrespectively of the form of ownership and affiliation should coordinate their programmes’ and projects’ M&E plans with the State HIV Programme M&E plan. The technical leadership, coordination and cooperation assurance of M&E activities with all partners and stakeholders lies with CCM.

M&E of UNDP GF grant is fully in-line with the National M&E System. UNDP coordinates the collection and analysis of data pertaining to the GF grant from its SRs (NGO, RAC, RCN), other organisations (PHC, RMIC) with RAC and regional AIDS centres, consolidates data in PUDRs and submits them to GF and CCM every 6 months.

The government of the Kyrgyz Republic uses the National M&E System for its reporting and decision making at the policy level. The next State HIV Programme for 2017-2021, which is under approval procedure.

According to the accepted system trained specialists should track data, evaluate the programme activities for effectiveness, ensure unified resource tracking and delivery of strategic information necessary for decision making.

All local government administrative bodies, self-governing entities and NGOs have their own plans on the implementation of the State HIV Programme including M&E. Implementation of strategies aligned with the State HIV Programme is evaluated on the basis of the national indicators by submitting systematic reports to RAC, who consolidates them and submits to MoH and CCM.

# CAPACITY BUILDING

UNDP provides technical assistance to implementing agencies and sub-recipients and their partners in implementing, creating and supporting M&E system. UNDP conducts an assessment of all sub-recipients within the grant, including the identification of their capacity in M&E. Such an assessment is carried out as part of the capacity assessment procedure before signing the grant agreement or after its signing. Assessment is based on the following criteria:

* The presence of a special position to implement and/or responsible officer of the programme having appropriate responsibilities to carry out M&E;
* Preparation of regular reports on activities and accomplishments of the grant;
* Previous report on M&E;
* The use of standard indicators in the periodic monitoring of the grant implementation;
* Using the results of monitoring (periodic reports on the activities and performance of the grant, the availability of database, periodic publications, and bulletins on the activities of the grant);
* The use of modern techniques of monitoring and approved documents.

In regards to the sub-recipients UNDP analyses reports on monitoring visits of the organizations, independent experts, and the availability of an adequate system for data collection and reporting, appropriate staff assistance in order to verify the accuracy and reliability of data collected.

From 2012 UNDP has supported trainings for AIDS service on M&E, SPECTRUM, IBBS, RDSAT, RDSA, EpiInfo. Several trainings on recording and reporting, data management processes and MIS, the working meetings with SRs, trainings on HIV rapid testing based on saliva and series of other capacity strengthening activities were conducted. In 2017 working meeting with partners on discussion of effective partnership for the implementation of measures to prevent and treat HIV infection in the Kyrgyz Republic, several meetings on HIV cascade treatment, in order to increase the capacity of partner organizations in the field of HIV assessment / survey appropriate training with involving two international experts was held and two trainings for the sub-recipients were conducted on establishing M&E systems.

|  |  |  |
| --- | --- | --- |
| Capacity building Activities | Beneficiaries | Year |
| Training on establishing M&E system | RCN, NGOs | 2012 |
| Training of trainers on M&E of Infection Control and Management of Medical Wastes | National and regional experts responsible for HIV infection control | 2012 |
| Regional M&E Workshop | RAC, UNDP | 2013 |
| Training on M&E for HIV | RAC, RCN, SRs NGOs, AFEW, UNDP, Association of family doctors | 2013 |
| Round tables on PWID, MSM, SWs size estimations | MoH, Ministry of Education, SSEP, State Service on Drugs Control, RAC, RMIC, Medial Academy, CCM, Health Policy Analysis Centre (HPAC), NGOs, UNDP, USAID, CDC, WHO, UNAIDS, UNFPA, Soros Foundation, UNODC, ICAP, AFEW, Abt Associates. | 2013 |
| Coupons management in the framework of PWID size estimation | NGOs, SSES, HPAC, UNDP | 2013 |
| Workshop on M&E in the framework of GF HIV grant | SSEP wardens, medical staff, NEPs coordinators, OST coordinators, RCN, UNDP | 2013 |
| Orientation seminar on the analysis of epidemiological situation | RAC, UNDP, ICAP, UNAID, Peace Corps | 2013 |
| Training on EpiInfo | National and regional AIDS centres, ICAP, UNDP | 2013 |
| Seminars on HIV and AIDS | UNDP SRs and SSRs | 2013 |
| Workshop on MIS database for NGOs | NGOs | 2013 |
| Training on Strategic Planning, Team Building and Fundraising | NGOs | 2014 |
| M&E training for RMIC and RAC employees | RMIC, RAC employees | 2014 |
| M&E training on database “MIS” | NGOs | 2014 |
| Round table on IBBS results for 2013 | NGOs, AIDS centers and other key stakeholders | 2014 |
| Seminar on National M&E System | RMIC, RAC, NGOs and other partners | 2014 |
| The working meetings with Sub-recipients | Sub-recipients | 2014 |
| On job training: “Bases of the PCR method and main stages of the PCR analysis” | PCR laboratory staff of AIDS centers and NGO “Preventive medicine” | 2014 |
| Training on HIV rapid testing based on saliva | RCN personnel | 2014 |
| Training on HIV rapid testing based on saliva | NGOs and AIDS centers personnel | 2014 |
| Working meetings with SRs | Sub-recipients | 2015 |
| Round Table on PWID size estimation | NGOs, AIDS centers and other stakeholders | 2015 |
| Training on HIV rapid testing | NGOs | 2016 |
| Working meetings with SRs | Sub-recipients | 2016 |
| M & E trainings: “Strengthening the M & E system in the GF HIV grant projects” | Sub-recipients | 2016 |
| The Regional consultation for developing the Regional Action Plan on increasing access to Quality and Uninterrupted care in connection with HIV-Infection for all those who need it in the countries of the Eastern Europe and Central Asia (EECA) | RCN | 2016 |
| Training Workshop in Design and Implementation of Respondent-Driven Sampling (RDS) and RDS Data Analysis | RAC, MoH | 2016 |
| Training “Data quality control and analysis in the electronic register of patients on OST (ERZPT) “ | RCN, MoH | 2016 |
| National High-Level Conference “New Challenges for HIV and TB” | NGOs, AIDS centers and other stakeholders | 2017 |
| Working meeting with partners on discussion of effective partnership for the implementation of measures to prevent and treat HIV infection in the Kyrgyz Republic | MoH, SSES, State Service on Drugs Control, RAC, RMIC, CCM, NGOs, UNDP, USAID, CDC, WHO, UNAIDS, UNFPA, Soros Foundation, UNODC, ICAP, AFEW and other stakeholders | 2017 |
| Meetings with partners and sub-recipients | NGOs, AIDS centers and other stakeholders | 2017 |
| HIV Case-Based Surveillance and Patient Monitoring | RAC | 2017 |
| Training Workshop on HIV Data Quality Improvement, Programme Quality Improvement and Data Use | RAC | 2017 |
| Training Workshop on HIV Prevention, Diagnosis, Treatment and Care for Key Populations and Programme Evaluation | RAC | 2017 |
| Coordination meeting on OST | RCN, NGOs and other stakeholders | 2017 |
| Working meetings on HIV treatment cascade | RAC, RCN, NGOs and other partners | 2017 |
| Working meetings with partners on IBBS 2016 results | RAC, RCN, NGOs and other partners | 2017 |
| Working meetings with partners on SE 2016 results within IBBS | RAC, RCN, NGOs and other partners | 2017 |
| Training on planning and conducting HIV assessment/survey | RAC, RCN and NGOs | 2017 |
| Training "Strengthening the M & E system and improving data quality" | Sub-recipients | 2017 |

# M&E WORK PLAN AND BUDGET

UNDP has budgeted 70 920.87 USD for M&E activities under GF grant for 2,5 years. The work plan with detailed description of activities and costs could be found in Annex C.

# INFORMATION PRODUCTS, DISSEMINATION AND USE

UNDP GF grant project M&E is based on full utilization of the data. The strategy for using and disseminating data contains a system for regular dissemination of information to GF, CCM, MoH, RAC, the public and all other interested parties.

UNDP consolidates and develops semi-annual reports on grant implementation and submits to the LFA, GF, CCM, as well as develops dashboards on semi-annual basis and disseminates to CCM, MoH and other interested partners.

UNDP publishes results of all evaluations and studies it commissions.

In addition to the above-mentioned products UNDP designs, develops and disseminates Annual Report on activities under the GF grant. This report provides detailed information on key achievements on UNDP indicators, analysis and details of activities led to the attainment of those indicators. This report is widely distributed to GF, CCM, MoH, RAC, SSEP, RCN, international organisations, NGOs, key population groups, the public and all other interested parties.

Information products provide SI for strategic and operational planning, documentation of lessons learned, and contribution to the national and international statistics on the HIV epidemic. The data obtained in the course of the M&E program is used in the preparation of country reports for inclusion in global reports on the HIV epidemic, primarily these are:

* The Global AIDS Response Progress Reporting (GARPR);
* "Health Sector Response to HIV/AIDS: Monitoring and Reporting";
* SWAP Joint Annual Reviews of the National Health Care Reform Programme “Den Sooluk”.

### ANNEX A – M&E Indicator Framework

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| **UNDP Indicators** | | | | | | |
| **#** | **Indicator name** | **Baseline** | **Target(s)** | **Data source** | **Data collection** | **Responsible agency** |
|  | % of people who inject drugs who are living with HIV | 14.3% (2016) | 14.3%  (June 2020) | IBBS | Every two years | RAC |
|  | % sex workers who are living with HIV | 2% (2016) | 2%  (June 2020) | IBBS | Every two years | RAC |
|  | % men who have sex with men who are living with HIV | 6.6% (2016) | 6.6%  (June 2020) | IBBS | Every two years | RAC |
|  | Number of AIDS- related deaths per 100, 000 population | 1,22 (2016) | 1,22 (June 2019)  1,21 (June 2020)  1,20 (June 2021) | Vital and disease-specific registry | Annually | RAC |
|  | % of people who inject drugs reporting the use of sterile injecting equipment the last time they injected | 47.5%  (2016) | 70% (June 2020) | IBBS | Every two years | RAC |
|  | % of sex workers reporting the use of a condom with their most recent client | 97.2% (2016) | 97%  (June 2020) | IBBS | Every two years | RAC |
|  | % of men reporting the use of a condom the last time they had anal sex with a male partner | 81.1% (2016) | 85%  (June 2020) | IBBS | Every two years | RAC |
|  | % of adults and children with HIV known to be on treatment 12 months after initiation of antiretroviral therapy | 79% (2016) | 82% (2018)  85% (2019)  88% (2020) | Vital disease-specific registry | Annually | RAC |
|  | Percentage of people living with HIV currently receiving antiretroviral therapy | 32.9% (2016) | 51.4% (July, Dec. 2018)  60.3% (Jan., June 2019)  69.1% (July, Dec. 2019)  79.2% (Jan., June 2020)  89.3% (July, Dec. 2020) | Patient records | Bi-annually | RAC |
|  | Percentage of people living with HIV and on ART, who have a supressed viral load at 12 months (<1000 copies/ml) | 61.6%  (2016) | 55% (2018)  67% (2019)  79% (2020) | Vital disease-specific registry | Annually | RAC |
|  | Percentage of PWID reached with HIV prevention programmes - defined package of services | 58.7%  ( 2016) | 65% (July, Dec. 2018)  67.5% (Jan., June 2019)  70% (July, Dec. 2019)  72.5% (Jan., June 2020)  75% (July, Dec. 2020) | UNDP MIS | Bi-annually | UNDP |
|  | Percentage of PWID that have received an HIV test during the reporting period and know their results | 27.8% (2016) | 29.3% (July, Dec. 2018)  31.5% (Jan., June 2019)  31.5% (July, Dec. 2019)  33.7% (Jan., June 2020)  33.8% (July, Dec. 2020) | UNDP MIS | Bi-annually | UNDP |
|  | Percentage of individuals receiving Opioid Substitution Therapy who received treatment for at least 6 months | 51%% (2016) | 60% (July, Dec. 2018)  62.7% (Jan., June 2019)  65% (July, Dec. 2019)  67.2% (Jan., June 2020)  70% (July. Dec. 2020) | EMR | Bi-annually | UNDP, RCN |
|  | Percentage of prisoners that have received an HIV test during the reporting period and know their results | 32.7% (2016) | 33.7% (July, Dec. 2018)  35.8% (Jan., June 2019)  35.8% (July, Dec. 2019)  41% (Jan., June 2020)  41% (July, Dec. 2020) | Administrative records | Bi-annually | RCN and SSES |
|  | Percentage of sex workers reached with HIV prevention programmes - defined package of services | 57% (2016) | 70% (July, Dec. 2018)  72.5% (Jan., June 2019)  75% (July, Dec. 2019)  77.5% (Jan., June 2020)  80% (July, Dec. 2020) | UNDP MIS | Bi-annually | UNDP |
|  | Percentage of sex workers that have received an HIV test during the reporting period and know their results | 15.4% (2016) | 31.5% (July, Dec. 2018)  33.7% (Jan., June 2019)  33.7% (July, Dec. 2019)  36% (Jan., June 2020)  36% (July. Dec. 2020) | UNDP MIS | Bi-annually | UNDP |
|  | Percentage of MSM reached with HIV prevention programmes - defined package of services | 32.2% (2016) | 57.3% (July, Dec. 2018)  68.3% (Jan., June 2019  79.2% (July, Dec. 2019)  86.4% (Jan., June 2020)  93.6% (July, Dec. 2020) | UNDP MIS | Bi-annually | UNDP |
|  | Percentage of MSM that have received an HIV test during the reporting period and know their results | 15.7% (2016) | 23.9% (July, Dec. 2018)  35.6% (Jan., June 2019)  35.6% (July, Dec. 2019)  42.1% (Jan., June 2020)  42.1% (July, Dec. 2020) | UNDP MIS | Bi-annually | UNDP |
|  | Percentage of people living with HIV in care (including PMTCT) who are screened for TB in HIV care or treatment settings | 95.6% (2016) | 95% (July, Dec. 2018)  95% (Jan., June 2019)  95% (July, Dec. 2019)  95% (Jan., June 2020)  95% (July, Dec. 2020) | Vital and disease-specific registry | Bi-annually | RAC |
|  | Percentage of HIV-positive new and relapse TB patients on ART during TB treatment | 94.6% (2016) | 90% (July, Dec. 2018)  90% (Jan., June 2019)  90% (July, Dec. 2019)  90% (Jan., June 2020)  90% (July, Dec. 2020) | Patient records | Bi-annually | RAC |
|  | Percentage of HIV-positive pregnant women who received ART during pregnancy | 96.9% (2016) | 95% (2018)  95% (2019)  95% (2020) | Patient records | Annually | RAC, RMIC |

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| **State HIV Program 2017-2021 indicators** | | | | | | |
| **#** | **Indicator name** | **Baseline** | **Target(s)** | **Data source** | **Data collection** | **Responsible agency** |
| 1 | Incidence of HIV infection per 1000 population | 0,16 (2015) | 0,14 (2017)  0,12 (2018)  0,11 (2019)  0,11 (2020)  0,10 (2021) |  | Annually | MoH |
| 2 | Incidence of HIV infection per 1000 PWID | 5,9 (2015) | 5,3 (2017)  4,7 (2018)  4,1 (2019)  3,5 (2020)  2,9 (2021) |  | Annually | MoH |
| 3 | AIDS-related mortality among PLHIV | 9,0 (2015) | 8,5 (2017)  7,5 (2018)  6,5 (2019)  5,5 (2020)  4,5 (2021) |  | Annually | MoH |
| 4 | % of HIV positive children born in HIV positive women | 2,4 (2015) | 2,3 (2017)  2,0 (2018)  2,0 (2019)  2,0 (2020)  < 2% (2021) |  | Annually | MoH |
| 5 | % of PWID who are living with HIV | 14.3% (IBBS 2016) | <10% (2019)  <10% (2021) | IBBS | Biennially | MoH |
| 6 | % of SW who are living with HIV | 2% (IBBS 2016) | <5% (2019)  <5% (2021) | IBBS | Biennially | MoH |
| 7 | % of MSM who are living with HIV | 6.6% (IBBS 2016) | <6% (2019)  <6% (2021) | IBBS | Biennially | MoH |
| 8 | % of TG who are living with HIV | NDA | <5% (2019)  <5% (2021) | IBBS | Biennially | MoH |
| 9 | % of prisoners who are living with HIV | 11.3% (IBBS 2016) | <7% (2019)  <7% (2021) | IBBS | Biennially | MoH |
| 10 | % of PWID reached with HIV prevention programmes | 47% (Programmatic data 2015) | 60% (2017)  65% (2018)  70% (2019)  75% (2020)  90% (2021) |  | Annually | MoH |
| 11 | % of PWID reached with HIV prevention programmes | 29% (IBBS 2013) | 60% (2019)  90% (2021) | IBBS | Biennially | MoH |
| 12 | % of prisoners reached with HIV prevention programmes | 17.8% (Programmatic data 2015) | 19% (2017)  30% (2018)  50% (2019)  70% (2020)  90% (2021) |  | Annually | MoH |
| 13 | % of prisoners reached with HIV prevention programmes | 22% (IBBS 2013) | 60% (2019)  90% (2021) | IBBS | Biennially | MoH |
| 14 | % of SW reached with HIV prevention programmes | 49% (Programmatic data 2015) | 65% (2017)  70% (2018)  75% (2019)  80% (2020)  90% (2021) |  | Annually | MoH |
| 15 | % of SW reached with HIV prevention programmes | 27% (IBBS 2013) | 60% (2019)  90% (2021) | IBBS | Biennially | MoH |
| 16 | % of MSM reached with HIV prevention programmes | 15% (Programmatic data 2015) | 30% (2017)  40% (2018)  55% (2019)  65% (2020)  75% (2021) |  | Annually | MoH |
| 17 | % of MSM reached with HIV prevention programmes | 47.9% (IBBS 2013) | 55% (2019)  75% (2021) | IBBS | Biennially | MoH |
| 18 | % of TG reached with HIV prevention programmes | NDA | 75% (2021) |  | Annually | MoH |
| 19 | % of TG reached with HIV prevention programmes | NDA | 75% (2021) | IBBS | Biennially | MoH |
| 20 | % of PWID tested for HIV and know their results | 20% (Programmatic data 2015) | 48% (2017)  65% (2018)  80% (2019)  85% (2020)  90% (2021)  70% (IBBS 2019)  90% (IBBS 2021) | IBBS | Annually  Biennially | MoH |
| 21 | % of prisoners tested for HIV and know their results | 34.2% (PD, I sem. 2016) | 55% (2017)  60% (2018)  65% (2019)  80% (2020)  90% (2021)  70% (IBBS 2019)  90% (IBBS 2021) | IBBS | Annually  Biennially | MoH |
| 22 | % of SW tested for HIV and know their results | 16% (PD 2015) | 50% (2017)  60% (2018)  70% (2019)  80% (2020)  90% (2021)  60% (IBBS 2019)  90% (IBBS 2021) | IBBS | Annually  Biennially | MoH |
| 23 | % of MSM tested for HIV and know their results | 5% (2015) | 34% (2017)  60% (2018)  70% (2019)  80% (2020)  90% (2021)  60% (IBBS 2019)  75% (IBBS 2021) | IBBS | Annually  Biennially | MoH |
| 24 | % of TG tested for HIV and know their results | NDA | 75% (2021)  75% (2021) | IBBS | Annually  Biennially | MoH |
| 25 | % of PLHIV among KAP registered at AIDS Centers in the current year | Total PLHIV -71% (2015)  PWID- 59% (2015)  Prisoners- 70% (2015)  SW- 80% (2015)  MSM- 67% (2015)  TG- NDA | 75% (2017)  79% (2018)  83% (2019)  87% (2020)  90% (2021)  65% (2017)  73% (2018)  80% (2019)  85% (2020)  90% (2021)  75% (2017)  80% (2018)  85% (2019)  90% (2020)  90% (2021)  82% (2017)  84% (2018)  86% (2019)  88% (2020)  90% (2021)  69% (2017)  71% (2018)  73% (2019)  75% (2020)  75% (2021)  75% (2021) |  | Annually | MoH |
| 26 | Percentage of individuals among KAP with late diagnosis for HIV | Total PLHIV -31% (2015)  PWID- 29.9% (2015)  Prisoners- 18.4% (2015)  SW- 57.1% (2015)  MSM- 11.1% (2015)  TG- NDA | 27% (2017)  24% (2018)  21% (2019)  18% (2020)  15% (2021)  26% (2017)  23% (2018)  20% (2019)  17% (2020)  14% (2021)  17% (2017)  15% (2018)  13% (2019)  11% (2020)  9% (2021)  50% (2017)  45% (2018)  40% (2019)  35% (2020)  29% (2021)  10% (2017)  9% (2018)  8% (2019)  7% (2020)  6% (2021)  <50% (2021) |  | Annually | MoH |
| 27 | Percentage of PLHIV who know their status and are receiving ART | Total PLHIV -45% (2015)  PWID- 32.4% (2015)  Prisoners- 73% (2015)  SW- 24.3% (2015)  MSM- 39.3% (2015)  TG- NDA | 45% (2017)  55% (2018)  67% (2019)  79% (2020)  90% (2021)  45% (2017)  55% (2018)  67% (2019)  79% (2020)  90% (2021)  75% (2017)  80% (2018)  85% (2019)  88% (2020)  90% (2021)  30% (2017)  45% (2018)  60% (2019)  75% (2020)  90% (2021)  45% (2017)  55% (2018)  67% (2019)  79% (2020)  90% (2021)  90% (2021) |  | Annually | MoH |
| 28 | % of adults and children with HIV known to be on treatment 12 months after initiation of antiretroviral therapy | Total PLHIV -75.8% (2015)  PWID- 72.6% (2015)  Prisoners- 77% (2015)  SW- 33.3% (2015)  MSM- 66.7% (2015)  TG- NDA | 80% (2017)  82% (2018)  85% (2019)  88% (2020)  90% (2021)  80% (2017)  82% (2018)  85% (2019)  88% (2020)  90% (2021)  80% (2017)  82% (2018)  85% (2019)  88% (2020)  90% (2021)  40% (2017)  55% (2018)  70% (2019)  80% (2020)  90% (2021)  70% (2017)  75% (2018)  80% (2019)  85% (2020)  90% (2021)  90% (2021) |  | Annually | MoH |
| 29 | Percentage of PLHIV on ART, who have a supressed viral load | Total PLHIV -48.9% (2015)  PWID- 39.8% (2015)  Prisoners- 25% (2015)  SW- 20% (2015)  MSM- 70.8% (2015)  TG- NDA | 50% (2017)  55% (2018)  67% (2019)  79% (2020)  90% (2021)  45% (2017)  55% (2018)  67% (2019)  79% (2020)  90% (2021)  35% (2017)  50% (2018)  67% (2019)  80% (2020)  90% (2021)  30% (2017)  45% (2018)  60% (2019)  75% (2020)  90% (2021)  74% (2017)  78% (2018)  82% (2019)  86% (2020)  90% (2021)  90% (2021) |  | Annually | MoH |
| 30 | Percentage of PLHIV among KAP groups that received a continuous cascade of services | PWID- 9.2% (2015)  Prisoners- 10.2% (2015)  SW- 11.3% (2015)  MSM- 2.5% (2015)  TG- NDA | 18% (2017)  27% (2018)  40% (2019)  56% (2020)  73% (2021)  18% (2017)  27% (2018)  40% (2019)  56% (2020)  73% (2021)  18% (2017)  27% (2018)  40% (2019)  56% (2020)  73% (2021)  18% (2017)  27% (2018)  40% (2019)  56% (2020)  73% (2021)  73% (2021) |  | Annually | MoH |
| 31 | Percentage of PLHIV who received TB prophylaxis (IPT) in accordance with clinical protocol | 16.8% (2015) | 50% (2017)  55% (2018)  65% (2019)  75% (2020)  90% (2021) |  | Annually | MoH |
| 32 | Percentage of HIV- positive new and relapse TB patients on ART during TB treatment | 86.6% (2015) | 88% (2017)  88% (2018)  90% (2019)  90% (2020)  90% (2021) |  | Annually | MoH |
| 33 | Percentage of deaths among PLHIV related to TB | 33.6% (2015) | 30% (2017)  26% (2018)  23% (2019)  20% (2020)  17% (2021) |  | Annually | MoH |
| 34 | Percentage of PWID receiving opioid substitution therapy (OST) | 4.9% (2015) | 6% (2017)  6.5% (2018)  7% (2019)  8% (2020)  10% (2021) |  | Annually | MoH |
| 35 | Percentage of individuals receiving Opioid Substitution Therapy who received treatment for at least 6 months | 48% (2015) | 55% (2017)  60% (2018)  65% (2019)  70% (2020)  75% (2021) |  | Annually | MoH |
| 36 | % of people who inject drugs reporting the use of sterile injecting equipment the last time they injected | 55% (IBBS 2013) | 70% (2019)  70% (2021) | IBBS | Biennially | MoH |
| 37 | % of people who inject drugs reporting the use of condom at last sexual intercourse | 39% (IBBS 2013) | 50% (2019)  80% (2021) | IBBS | Biennially | MoH |
| 38 | % of sex workers reporting the use of a condom with their most recent client | 91% (IBBS 2013) | 93% (2019)  93% (2021) | IBBS | Biennially | MoH |
| 39 | % of men reporting the use of a condom the last time they had anal sex with a male partner | MSM- 82% (IBBS 2013)  TG- NDA | 85% (2019)  90% (2021)  90% (2021) | IBBS | Biennially | MoH |
| 40 | % of pregnant women tested for HIV and know their results | 82.6% (2015) | 85% (2017)  85% (2018)  85% (2019)  90% (2020)  90% (2021) |  | Annually | MoH |
| 41 | % of HIV positive pregnant women who received ARV to reduce the risk of mother-to-child HIV transmission | 92% (2015) | 95% (2017)  95% (2018)  95% (2019)  95% (2020)  95% (2021) |  | Annually | MoH |
| 42 | % of infants born in HIV positive women covered by PCR testing in accordance with the clinical protocol | 51% (2015) | 70% (2017)  80% (2018)  90% (2019)  95% (2020)  100% (2021) |  | Annually | MoH |
| 43 | % of infants born in HIV positive women who received ARV to reduce the risk of mother-to-child HIV transmission | 94.7% (2015) | 95% (2017)  95% (2018)  95% (2019)  95% (2020)  95% (2021) |  | Annually | MoH |
| 44 | Percentage of primary health care organizations included in a single electronic HIV tracking database | 29.9% (2015) | 30% (2017)  45% (2018)  50% (2019)  55% (2020)  60% (2021) |  | Annually | MoH |
| 45 | Percentage of primary health care organizations providing comprehensive services to PLHIV | 41.3% (2015) | 43% (2017)  45% (2018)  48% (2019)  50% (2020)  >50% (2021) |  | Annually | MoH |
| 46 | Number of NGOs implementing programs under the state social order on HIV | 0 (2015) | 2 (2018)  4 (2019)  6 (2020)  8 (2021) |  | Annually | MoH |
| 47 | Percentage of medical personnel trained in HIV field in the framework of certified programs (cumulative) | 51% (2015) | >10% (2017)  >20% (2018)  >30% (2019)  >40% (2020)  >50% (2021) |  | Annually | MoH |
| 48 | The percentage of PLHIV and individuals among key populations who reported stigma and discrimination that they encountered in society, as well as within communities | 52% (PLHIV) (2015)  KAP- NDA | Lower by 25% of the baseline (PLHIV) (2018)  Lower by 50% of the baseline (PLHIV) (2021)  Lower by 25% of the baseline - 2018 (KAP) (2021) |  | Every 3 years | NGO |
| 49 | Percentage of individuals among key populations who have been subjected to violations of human rights, including violence, by law enforcement officers during the last 12 months | PWID- 73% (2016)  Prisoners- NDA  SW- 58% (2015)  MSM- NDA  TG- NDA | Lower by 25% of the baseline (2018)  Lower by 50% of the baseline (2021) |  | Every 3 years | NGO |
| 50 | Percentage of women from key populations who were married or had a sexual partner who were physically or sexually assaulted by a male partner during the last 12 months | NDA (2015) | Lower by 10% of the baseline (2018)  Lower by 20% of the baseline (2021) |  | Every 3 years | MoH, MIA, NGO |
| 51 | Achievements in the Policy Index | 0,8 (2014) | 0,83 (2017)  0,87 (2019)  0,9 (2021) |  | Biennially | MoH |
| 52 | Percentage of internal costs of HIV / AIDS by categories and sources of funding | 14% (2017, forecast) | 14% (2017)  24% (2018)  30% (2019)  35% (2020)  50% (2021) |  | Annually | CCM, MoH, SSES, MIA, MJ, MES, MD, MLSD, NTRC |

### ANNEX B- Indicator Reference Sheet

## ANNEX B – Indicators’ Reference Tables

1. **Indicators of impact.**

**Indicators 1 - 3. Percentage of people from key population groups who are living with HIV (GARPR Indicator’s – 3.3A, 3.3B, 3.3C)**

**Key populations at higher risk of exposure to HIV:** PWID, SWs and MSM.

***Note:*** Additional key population groups may be included depending on the situation in the country.

|  |  |
| --- | --- |
| **TARGET:** | Measuring progress in reducing HIV prevalence among key population groups |
| **FREQUENCY OF DATA COLLECTION.** | Biennially |
| **MEASUREMENT TOOL:** | Integrated Bio-behavioural Survey |
| **METHOD OF MEASUREMENT:** | This indicator is calculated using data on the results of HIV testing among key population groups, on the main site (sites) of surveillance. |
| **Numerator:** | Number of people in key population groups having an positive HIV test. |
| **Denominator:** | Number of people in key population groups tested for HIV. |
| ***Note:*** | Prevalence indicator should be disaggregated by region, gender and age (<25/25+). Sentinel surveillance sites used for the calculation of this indicator should remain constant in order to be able to track changes over time.  Sentinel sites, where IBBS has been conducted not less than 3 years in a raw, should be taken for the analysis of trends. Yearly change (increase) of the number of sentinel sites for any sentinel group included in IBBS could contribute to false change of HIV prevalence and behaviour data. Thus, it is necessary to monitor trends for each sentinel site separately.  Theoretically evaluation of the progress in reducing the number of new HIV cases is better to perform by tracking HIV prevalence for years. It is advisable not to limit prevention programme influence data analysis to general analysis of the whole sampling but to analyse duration of the risky behaviour (e.g. perform an analysis of data for depending on drug injecting experience) |
| ***Process*** | Sero-surveillance is conducted according to an approved IBBS protocol. Data analysis is performed using EpiInfo and/or RDSAT/RDSA. Sampling size is calculated using a special methodology on the basis of one of the key indicators of a group (e.g. share of HIV positive people in a sentinel group, share of people in a sentinel group knowing ways of HIV transmission). If a sampling size recalculation is needed, an estimated number of key population group in a sentinel site should be taken as a coefficient.  The survey is conducted by RAC, an access to key population groups is assured by NGOs. It is necessary to strictly comply with confidentiality requirements during survey administration. |

**INTERPRETATION**

Due to difficulties in obtaining access to most-at-risk populations, the systematic errors in the surveillance data on the results of serological screening may be far more significant than in data obtained for more generalized population, such as women attending antenatal clinics. In case of doubt regarding the data, it should be reflected in the interpretation of data.

An important factor in the interpretation of this indicator is to understand how this sampling (s) relates to any larger group (groups) of the population, which is characterized by a similar risk behaviour. Belonging period of people to most-at-risk population is more closely associated with the risk of acquiring HIV than with the age. For this reason, it is desirable not to restrict analysis to young people but to include in the report the data on other age groups.

Trends in HIV prevalence change among most-at-risk populations in the capital city are the useful information that characterizes the quality of HIV prevention programs’ implementation in this city. At the same time it will not characterize the situation in the country as a whole.

Addition of new surveillance sites will allow to increase the representativeness of samples, and therefore to obtain more reliable point estimates of HIV prevalence. At the same time adding new surveillance sites reduces the comparability of values. Thus, when analysing the trends, it is important that new surveillance sites are not considered in the calculation of this indicator.

**ADDITIONAL INFORMATION**

Currently, Global Working Group of WHO/UNAIDS on surveillance of STI/HIV is preparing a new version of the guidelines for HIV surveillance among key populations groups at higher risk of HIV infection. More information is available on the website: <http://www.unaids.org/en/resources/documents/2011/20110518_Surveillance_among_most_at_risk>

**Indicators 4. Number of AIDS-related deaths per 100, 000 population (GARPR Indicator’s – 1.7)**

|  |  |
| --- | --- |
| **TARGET:** | Measuring level and trend in adults and children mortality by using standard methods and tools for HIV estimates appropriate to the level of HIV epidemic. |
| **FREQUENCY OF DATA COLLECTION.** | Annually |
| **MEASUREMENT TOOL:** | Vital and disease-specific registry |
| **METHOD OF MEASUREMENT:** | Data obtained through vital and disease-specific registry of the RAC on AIDS related mortality and the NSC data on population size for the reporting period |
| **Numerator:** | Number of deaths attributed to HIV/AIDS- related causes in a given time period per 100, 000 population |
| **Denominator:** | Total population in country (resident population), as per the National Statistic Committee in a given time period |
| ***Note:*** | The targets were set according to the working meeting with RAC based on the analysis of data for previous periods. Whereas, calculation of this indicator is different in NSP (which is under approval process) and suggested calculation is as following: Actual number of PLHIV who died due to AIDS in the current year \* 1000 / Estimated number of PLHIV. |

**INTERPRETATION**

Empirical data from different HIV surveillance sources are consolidated to obtain estimates of the level and trend in adults and children mortality by using standard methods and tools for HIV estimates appropriate to the level of HIV epidemic. However, to obtain the best possible estimates, judgment needs to be made on data quality and how representative it is of the population. Sample registration approaches offer an important near-term solution to the current state of ignorance (particularly on the levels, causes, and trends of adult health mortality) in countries where good coverage of routine vital registration with reliable cause of death attribution is still years, if not decades, away.

Measuring impact of scaled-up ART programs will not be accomplished simply using ANC sentinel surveillance data. These data will be insufficient to model the estimated number of persons with AIDS and the number of deaths due to AIDS, or to assess trends. Additional information is urgently needed to improve these estimates.  
Sample registration approaches offer an important near-term solution to the current state of ignorance (particularly on the levels, causes, and trends of adult health mortality) in countries where good coverage of routine vital registration with reliable cause of death attribution is still years, if not decades, away. Although, by definition, they do not have the coverage of routine systems or censuses, continuous sample registration systems can also complement sources such as decennial censuses, which provide no way of directly monitoring progress in many key indicators at regional or national levels during inter-censal periods.

**ADDITIONAL INFORMATION** More information is available on the website: <http://www.indicatorregistry.org/?q=node/115>

1. **Outcome indicators.**

**Indicator 1. Percentage of PWID reporting the use of sterile injecting equipment the last time they injected (GARPR Indicator – 3.8), (HIV NSP Indicator – 1.1.6).**

**APPLICATION**. Recommended for countries like Kyrgyzstan, where injecting drug use is one of the most common ways of HIV transmission.

|  |  |
| --- | --- |
| **TARGET:** | The indicator is aimed at measuring the progress made in changing behaviour, adoption of safe injecting practices reducing the risk of HIV transmission in PWID. |
| **FREQUENCY OF DATA COLLECTION:** | Every two years |
| **MEASUREMENT TOOL:** | Integrated Bio-behavioural survey, taking a sample of PWID. |
| **METHOD OF MEASUREMENT:** | UNDP uses data derived from the following questions:   1. Have you injected drugs any time during the last month? 2. If "yes": Did you use sterile needle and syringe the last time you injected drugs?   For calculating this indicator the SHP uses the following methodology:  Respondents are asked:   1. Have you injected drugs any time during the last month?   If "yes":   1. Did you:    1. Use a syringe utilised by others;    2. Withdraw a solution from shared dishes;    3. Pump a drug from one syringe to another;    4. Pass round the syringe;    5. Use shared water to wash the syringe and needle;    6. Add blood (your own or others) to a drug solution;    7. Use a drug withdrawn to the syringe by someone else;    8. Use sterile injecting equipment. |
| **Numerator:** | The numerator is the total number of PWID who reported the use of sterile injecting equipment the last time they injected and answered “No” to all other answer variables |
| **Denominator:** | The number of respondents who reported that they had injected drugs in the last month. |
| ***Note:*** | Numerical data of the indicator should be obtained for all respondents disaggregated by regions, gender and age (<25/25+).  Whenever possible, data for injecting drug users should be collected through civil society organizations that worked closely with this population in the field.  Access to the respondents involved in the survey, as well as data collected from them must remain confidential.  This question (2) may vary depending on the local context. For example, in some cultures of injecting drugs use, the needles and syringes may be infected with HIV, even without their common use by consumers of drugs (for example, through shared drug solutions). Questions should be directed to confirm that the used needles and syringes were indeed sterile. |
| ***Process:*** | Behavioural data are collected according to approved IBBS protocol. An instrument/questionnaire should include the above-mentioned questions. Data analysis is performed using EpiInfo and/or RDSAT/RDSA. Sampling size is calculated using a special methodology on the basis of one of the key indicators of a group (e.g. share of HIV positive people in a sentinel group, share of people in a sentinel group knowing ways of HIV transmission). If a sampling size recalculation is needed, an estimated number of key population group in a sentinel site should be taken as a coefficient.  The survey is conducted by RAC, an access to key population groups is assured by NGOs. It is necessary to strictly comply with confidentiality requirements during survey administration. |

**INTERPRETATION**

HIV transmission level in the country related to injecting drug use in the country depends on four factors:

* 1. the size, stage and the character of the national HIV spread;
  2. the level of drug injection prevalence;
  3. the spread of infected drug injecting equipment use among PWID, and
  4. the condom use among sexual partners who use injecting drugs, as well as by PWID and their partners who do not inject drugs.

Safe injecting practice among PWID has a vital role even in those countries where other ways of HIV transmission are prevalent, because:

1. the risk of HIV transmission as a result of the use of infected equipment is very high, and
2. PWID could transmit HIV (e.g. sexually) to the general public.

In case of doubts about unrepresentativeness of the sampling size these should be described during data interpretation.

**ADDITIONAL INFORMATION**

For more information, see the following:

• WHO/UNODC/UNAIDS (2009). *Technical Guide for Countries to set Targets for Universal Access to HIV Prevention, Treatment and Care for Injecting Drug Users*. Geneva: WHO.

• UNAIDS (2007). *A Framework for Monitoring and Evaluating HIV Prevention Programmes for Most-At-Risk Populations*. Geneva: UNAIDS.

• UNAIDS (2007). *Practical Guidelines for Intensifying HIV Prevention: Towards Universal Access*. Geneva: UNAIDS.

Further information can be found at the following website:

http://www.indicatorregistry.org/?q=node/853

**Indicator 2. Percentage of sex workers reporting the use of a condom with their most recent client (GARPR Indicator – 3.6A)**

|  |  |
| --- | --- |
| **TARGET:** | Assessing progress in reducing the probability of HIV infection among sex workers through unprotected sex with clients. |
| **FREQUENCY OF DATA COLLECTION:** | Every two years |
| **MEASUREMENT TOOL:** | Integrated Bio-behavioural Survey, taking a sample of SWs. |
| **METHOD OF MEASUREMENT:** | Respondents are asked the following question: Have you used a condom during sex with your last client? |
| **Numerator:** | Number of respondents who reported that during the last sexual intercourse used a condom. |
| **Denominator:** | Number of respondents who reported that they had commercial sex in the last 12 months. |
| ***Note:*** | Data for this indicator should be disaggregated by sex and age (<25; 25+).  Data for sex workers should be collected through the staff of civil society organizations that work closely with this population in the field.  Access to the respondents included in the survey, as well as data collected from them must remain confidential.  The denominator includes both regular and irregular partners, as well as both free and paid sex. As in the case of other indicators, this indicator provides only limited information. For a comprehensive evaluation of models of risk associated with the presence of sexual contacts and injecting drug use, there is a need for more information, including information about the types and number of partners.  As an additional test question confirming the change of behaviour may be the question "Show please if you have a condom now". |
| ***Algorithm:*** | Behavioural data are collected according to approved IBBS protocol. An instrument/questionnaire should include the above-mentioned questions. Data analysis is performed using EpiInfo. Sampling size is calculated using a special methodology on the basis of one of the key indicators of a group (e.g. share of HIV positive people in a sentinel group, share of people in a sentinel group knowing ways of HIV transmission). If a sampling size recalculation is needed, an estimated number of key population group in a sentinel site should be taken as a coefficient.  The survey is conducted by RAC, an access to key population groups is assured by NGOs. It is necessary to strictly comply with confidentiality requirements during survey administration. |

**ADDITIONAL INFORMATION**

For more information, see the following:

[**http://www.indicatorregistry.org/?q=node/663**](http://www.indicatorregistry.org/?q=node/663)

**Indicator 3. Percentage of men reporting the use of a condom the last time they had anal sex with a male partner (GARPR Indicator – 3.6B)**

|  |  |
| --- | --- |
| **TARGET:** | It measures progress in preventing exposure to HIV among men who have unprotected anal sex with a male partner. |
| **FREQUENCY OF DATA COLLECTION:** | Every two years |
| **MEASUREMENT TOOL:** | Integrated Bio-behavioural Survey, taking a sample of MSM. |
| **METHOD OF MEASUREMENT:** | In a survey of behaviour in the group including men who have sex with men, the respondents are asked about sexual partnerships in the past six months, about anal sex within those partnerships and condom use during the last anal sex.  For calculating the national indicator the same methodology is used but for the last 12 months. |
| **Numerator:** | The number of respondents who reported that they used a condom during the last anal sex with the male partner |
| **Denominator:** | The number of respondents who reported that they had anal sex with a male partner during the last six months  For the national indicator:  The number of respondents who reported that they had anal sex with a male partner during the last 12 months |
| ***Note:*** | *For the denominator*: In a behavioural survey of a sample of men who have sex with men, respondents are asked about sexual partnerships in the preceding six months, about anal sex within those partnerships and about condom use when they last had anal sex.  Whenever possible, data for men who have sex with men should be collected through civil society organizations that have worked closely with this population in the field.  Access to survey respondents as well as the data collected from them must remain confidential.  This includes both regular and irregular partners, as well as both free and paid sex. As in the case of other indicators, this indicator provides only limited information. For a comprehensive evaluation of models of risk associated with the presence of sex between men, there is a need for more information, including information about the types and number of partners, as well as whether the partners are receptive or insertive.  Numerical data of indicators should be obtained for all responders disaggregated by age (<25/25+). |

**ADDITIONAL INFORMATION**

For more information, see the following:

[**http://www.indicatorregistry.org/?q=node/664**](http://www.indicatorregistry.org/?q=node/664)

**Indicator 4. Percentage of adults and children with HIV known to be on treatment 12 months after initiation of ART (GARPR Indicator – 1.3), (Den Sooluk Indicator – 1.5.3)**

|  |  |
| --- | --- |
| **TARGET:** | Measuring progress in increasing survival of infected adults and children through the use of antiretroviral treatment. |
| **FREQUENCY OF DATA COLLECTION:** | Annually |
| **MEASUREMENT TOOL:** | Registers of antiretroviral treatment and forms for the cohort analysis of antiretroviral therapy as well as medical statistics of the Republican AIDS Centre. 4-Zdrav recording forms. The forms approved by the National Statistics Committee of the KR (NSC KR). |
| **METHOD OF MEASUREMENT:** | Routine data collection and HIV ES system data. Data are collected, aggregated and verified by RAC monthly. |
| **Numerator:** | The number of adults and children being on antiretroviral treatment 12 months after its initiation. |
| **Denominator:** | Total number of adults and children who initiated antiretroviral treatment, and who were supposed to have achieved results for the 12 months within the reporting period, including those who died after initiation of antiretroviral therapy, who have stopped treatment, and those recorded as lost to follow-up at month 12. |
| ***Note:*** | This indicator should be disaggregated by region, gender and age (<15, >15).  **Definitions:**  The reporting period is defined as any continuous 12-month period that has ended within a pre-defined number of months from the submission of the report. The pre-defined number of months can be determined by national reporting requirements. If the reporting period is January 1 to December 31, 2015, countries will calculate this indicator by using all patients who started antiretroviral therapy any time during the 12-month period from January 1 to December 31, 2014. If the reporting period is July 1, 2014 to June 30, 2015, countries will include patients who started antiretroviral therapy from July 1, 2013 to June 30, 2014  A 12-month outcome is defined as the outcome (i.e., whether the patient is still alive and on antiretroviral therapy, dead or lost to follow-up) at 12 months after starting antiretroviral therapy. For example, patients who started antiretroviral therapy during the 12-month period from January 1 to December 31, 2013 will have reached their 12-month outcomes for the reporting period of January 1 to December 31, 2015.  Numerator:  Number of adults and children who are still alive and on antiretroviral therapy at 12 months after initiating treatment.  The numerator requires that adult and child patients must be alive and on antiretroviral therapy at 12 months after their initiation of treatment. For a comprehensive understanding of survival, the following data must be collected:   * Number of adults and children in the antiretroviral therapy start-up groups initiating antiretroviral therapy at least 12 months prior to the end of the reporting period; * Number of adults and children still alive and on antiretroviral therapy at 12 months after initiating treatment.   The numerator does not require patients to have been on antiretroviral therapy continuously for the 12-month period. Patients who may have missed one or two appointments or drug pick-ups, and temporarily stopped treatment during the 12 months since initiating treatment but are recorded as still being on treatment at month 12 are included in the numerator. On the contrary, those patients who have died, stopped treatment or been lost to follow-up at 12 months since starting treatment are not included in the numerator. For example, for those patients who started antiretroviral therapy in May 2014, if at any point during the period May 2014 to May 2015 these patients die, are lost to follow-up (and do not return) or stop treatment (and do not restart), then at month 12 (May 2015), they are not on antiretroviral therapy, and not included in the numerator. Conversely, a patient who started antiretroviral therapy in May 2014 and who missed an appointment in June 2014, but is recorded as on antiretroviral therapy in May 2015 (at month 12) is on antiretroviral therapy and will be included in the numerator. What is important is that the patient who has started antiretroviral therapy in May 2014 is recorded as being alive and on antiretroviral therapy after 12 months, regardless of what happens from May 2014 to May 2015.  ART registries should include a number of variables describing the patients. For example the age of the patient at the start of ART. In addition many registries will include a tick box indicating whether the patient was pregnant or was breastfeeding at the start of ART. ART retention for these sub-sets of women should be calculated to determine ART retention at 12 months for pregnant women and for breastfeeding women.  Denominator:  Total number of adults and children who initiated antiretroviral therapy who were expected to achieve 12-month outcomes within the reporting period,\* including those who have died since starting antiretroviral therapy, those who have stopped antiretroviral therapy, and those recorded as lost to follow-up at month 12.  The denominator is the total number of adults and children in the antiretroviral therapy start-up groups who initiated antiretroviral therapy at any point during the 12 months prior to the beginning of the reporting period, regardless of their 12-month outcome. For example, for the reporting period January 1 to December 31, 2015, this will include all patients who started antiretroviral therapy during the 12-month period from January 1 to December 31, 2014. 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. At the facility level, the number of adults and children on antiretroviral therapy at 12 months includes patients who have transferred in at any point from initiation of treatment to the end of the 12-month period and excludes patients who have transferred out during this same period to reflect the net current cohort at each facility. In other words, at the facility level, patients who have transferred out will not be counted either in the numerator or the denominator. Similarly, patients who have transferred in will be counted in both the numerator and denominator. At the national level, the number of transferred-in patients should match the number of transferred-out patients. Therefore, the net current cohort (the patients whose outcomes the facility is currently responsible for recording—the number of patients in the start-up group plus any transfers in, minus any transfers out) at 12 months should equal the number in the start-up cohort group 12 months prior. |

**INTERPRETATION**

Using this denominator may underestimate 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 antiretroviral therapy) in a treatment cohort is captured here. Priority reporting is for aggregate survival reporting. If comprehensive cohort patient registries are available then it is encouraged for countries to track retention on treatment at 24, 36, and 48 months and yearly thereafter. This will enable comparison over time of survival on ART. 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. For example, if survival at 12 months increases over time, this may reflect an improvement in care and treatment practices or earlier initiation of ART. The retention on antiretroviral therapy at 12 months therefore needs to be interpreted in view of the baseline characteristics of the cohort of patients at the start of antiretroviral therapy: mortality will be higher in sites where patients accessed antiretroviral therapy at a later stage of infection. Therefore, collection and reporting of survival over longer durations of treatment outcomes may provide a better picture of the long-term effectiveness of ART.

**ADDITIONAL INFORMATION**

<http://www.indicatorregistry.org/?q=node/860>

1. **Output indicators.**

**Indicator 1. Percentage of people living with HIV currently receiving antiretroviral therapy (GARPR Indicator – 1.2)**

|  |  |
| --- | --- |
| **TARGET:** | Progress towards providing antiretroviral therapy to all people for treatment |
| **FREQUENCY OF DATA COLLECTION:** | Semi-annual |
| **MEASUREMENT TOOL:** | Routine data collection and HIV ES data entry. Data are collected, aggregated and verified by RAC monthly. |
| **METHOD OF MEASUREMENT:** | Data should be collected continuously at the facility level. Data should be aggregated periodically. The most recent full year of data should be used for annual reporting.  Programme monitoring and estimates of ART need. For the numerator: facility-based antiretroviral therapy registers and corresponding cross-sectional forms. For the denominator: HIV estimation models such as Spectrum |
| **Numerator:** | Number of adults and children currently receiving antiretroviral therapy in accordance with the nationally approved treatment protocol (or WHO standards) at the end of the reporting period |
| **Denominator:** | Estimated number of adults and children living with HIV |
| **Process** | **For numerator:** The numerator can be generated by counting the number of adults and children who received antiretroviral therapy at the end of the reporting period. The numerator should equal the number adults and children who ever started antiretroviral therapy 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. Some patients pick up several months of antiretroviral drugs at one visit, which could include antiretroviral medicine received for the last months of the reporting period, but not be recorded as visits for the last months in the patient register. Efforts should be made to account for these patients, as they need to be included in the numerator. Antiretroviral medicines taken only for the purpose of prevention of mother-to-child transmission and post exposure prophylaxis are not included in this indicator. HIV-positive pregnant women who are on lifelong antiretroviral therapy are included in this indicator. The number of adults and children currently receiving antiretroviral therapy can be obtained through data collected from facility-based antiretroviral therapy registers or drug supply management systems. These are then tallied and transferred to cross-sectional monthly or quarterly reports which can then be aggregated for national totals. Patients receiving antiretroviral therapy in the private sector and public sector should be included in the numerator where data are available.  **For denominator:**  Denominator estimates are most often based on the latest data available from sentinel surveillance used with a HIV modelling programme such as Spectrum. For further information on estimates of HIV need and the use of Spectrum please refer to the UNAIDS/WHO Reference Group on Estimates, Modelling and Projections methodology.  State HIV Programme M&E plan advises that this indicator is calculated using an estimated number of people requiring treatment. |

**INTERPRETATION**

This indicator permits monitoring trends in coverage but does not attempt to distinguish between different forms of antiretroviral therapy or to measure the cost, quality or effectiveness of, or adherence to the treatment regimen provided. These will each vary within and between countries and are liable to change over time.  
The degree of utilization of antiretroviral therapy will depend on factors such as cost relative to local incomes, service delivery infrastructure and quality, availability and uptake of testing and counselling services, and perceptions of effectiveness and possible side effects of treatment.  
The indicator measures the number of people provided with medication but does not measure whether the individual imbibed the medication thus it is not a measure of adherence.

**ADDITIONAL INFORMATION**

<http://www.indicatorregistry.org/?q=node/859>

**Indicator 2. Percentage of people living with HIV and on ART, who have a supressed viral load at 12 months (<1000 copies/ml) (GARP Indicator 1.4)**

|  |  |
| --- | --- |
| **TARGET:** | Measuring to what degree ART programs are improving the clinical outcomes of patients in care, which will guide the expansion of ART programs |
| **FREQUENCY OF DATA COLLECTION:** | Annual |
| **MEASUREMENT TOOL:** | Vital disease-specific registry |
| **METHOD OF MEASUREMENT:** | Data obtained through the annual reports 4-Zdraz of the RAC, ES and RMIC |
| **Numerator:** | Number of people living with HIV on ART in the reporting period with suppressed viral loads (≤1000 copies/mL). |
| **Denominator:** | Number of people living with HIV on ART at the end of the reporting period. |
| ***Note:*** | The indicator is in line with the National HIV M&E Plan for 2017-2021 which is currently under approval procedure by the Government Office. |

**INTERPRETATION**

To evaluate to what degree ART programs are improving the clinical outcomes of patients in care, which will guide the expansion of ART programs. Unsuppressed viral load will also lead to the development of drug resistance.

**ADDITIONAL INFORMATION**

<http://www.indicatorregistry.org/?q=node/869>

**Indicator 3. Percentage of PWID reached by prevention programmes – defined package of services**

|  |  |
| --- | --- |
| **TARGET:** | Measuring access of PWIDs to harm reduction services that affect the ability of forming the PWIDs skills of safe injection and sexual behaviour. |
| **FREQUENCY OF DATA COLLECTION:** | Semi-annual |
| **MEASUREMENT TOOL:** | Programme reports on execution of program activities at the end of the reporting period. Use the MIS program for data recording and reporting. |
| **METHOD OF MEASUREMENT:** | The indicator is non-cumulative and it reflects the actual number of clients who received the minimum package of services (needle + syringe + alcohol wipes; provision of information (mini-session, group or individual session on safe and prevention behaviour and/or a brochure) and condoms at least once during the reporting period. Accounting must go on to clients (UIC), and not on services. The indicator should be broken down by age, gender and region |
| **Numerator:** | Total number of PWID’s who have received a package of minimum services at least once during the last 6 months (including prisoners). |
| **Denominator:** | Estimated number of PWID’s |
| ***Note:*** | "Minimum Package" - provides sterile equipment (syringes, needles, and napkins), the provision of information in the form of informational brochures or information sessions and condoms. List of services included in the minimum package approved by order of the Ministry of Public Health from 22.08.2014. № 482 "Standard services for the syringes exchange" A client of the programs on HIV prevention among PWID should get a syringes, needles, and napkins, and IEC materials at least once during the reporting period. The provision of a minimum package does not restrict HIV prevention services to be provided under these programs. In addition to the "minimum package" within the consolidated grant will be provided the "advanced package", it is "minimal", plus the provision of services or redirect to HIV testing and counselling for HIV testing on TB, HCV, STI. As well as the direction and/or the provision of naloxone detox, drug treatment hospital, the VRP and social dormitory. Accounting must go on to clients (UIC), and not on services.  It is recommended to include the total number of PWIDs, including prisoners in the numerator, as the denominator is a size estimation that includes prisoners as well.  The national indicators are calculated based on IBBS and programmatic data. |
| **Process** | Respective programme specialists obtain information from the sub-recipients on a number of PWIDs reached with the minimum package of services. This information is cross verified with the initial sources like registers, field diaries and etc. during the site visits. |

**INTERPRETATION**

Survey data provide the opportunity to measure the uptake of multiple intervention services by individuals. This indicator shortens the reference period because populations must access services regularly and risky behaviour must be regular. Weaknesses associated with survey data relate to any sampling or response bias and the limited geographical coverage of the information.

Programme data provide a national picture to the extent that programmes offer services nationally. Programme data reflect a national commitment to deliver services to specified key population communities. Programme data do not reflect well the individuals served. Data cannot typically be de-duplicated. Further, analysis of two separate programme data sets can only be considered ecologically.

This indicator refers to the services received in the last 6/12 months. Based on monthly and quarterly reports of sub and sub-sub-recipients it is possible to calculate data for different time period, for example, for the last 3 months or last 30 days, and one can include these additional data in the section with comments on the reporting tool. Given the complexity of such measurement element, especially in the context of most-at-risk populations, the development of such criteria requires an intensive process of collecting and synthesizing information and making recommendations.

**ADDITIONAL INFORMATION**

Tool to set and monitor targets for HIV prevention, diagnosis, treatment and care for key populations: supplement to the 2014 consolidated guidelines for HIV prevention, diagnosis, treatment and care for key populations. Geneva: World Health Organization; 2015 (http://www.who.int/hiv/pub/toolkits/kpp-monitoring-tools/en).

UNAIDS, WHO, Measure Evaluation, CDC, USAID, ICASO, UNODC. Operational Guidelines for Monitoring and Evaluation of HIV Programmes for People who Inject Drugs. https://www.measureevaluation.org/resources/tools/hiv-aids/operational-guidelines-for-m-e-of-hiv-programmes-for-peoplewho-inject-drugs

**Indicator 4, 8, 10. Percentage of key population groups at higher HIV exposure (PWID, SW, MSM) that have received an HIV test during the reporting period and know their results**

|  |  |
| --- | --- |
| **TARGET:** | Progress providing HIV testing services to members of key populations who are living with HIV and measuring against the first 90 of the 90–90–90 target: the percentage of people living with HIV who know their HIV status.  The indicators herewith are in line with the National HIV Strategy for 2017-2021, which is under approval. |
| **FREQUENCY OF DATA COLLECTION:** | This indicator is reported on semi-annual basis |
| **MEASUREMENT TOOL:** | The outcome indicator is measured using IBBS, whereas this output indicators are measured using routine reporting. Routine reporting is expected to be timelier, allowing more frequent data flow and rapid timely verification.  Sources of data are programme reports of NGOs, RCN and SSES. |
| **METHOD OF MEASUREMENT:** | Number of people tested, not tests conducted. Pre and post test counselling of those who received the test at AIDS centres’ laboratories as well as saliva based express testing. Separate data on express testing and by ELISA tests will be provided in the comments section of each reporting period. |
| **Numerator:** | Number of PWID, SWs, MSM who were tested for HIV in the reporting period and who know their results. |
| **Denominator:** | Estimated number of PWID, SWs, MSM according to 2013 size estimation survey. |

**ADDITIONAL INFORMATION**

United States Centers for Disease Control and Prevention, WHO, UNAIDS, FHI 360.

Atlanta: United States Centers for Disease Control and Prevention; forthcoming.

**Indicator 5. Percentage of individuals receiving Opioid Substitution Therapy who received treatment at for least 6 month**

|  |  |
| --- | --- |
| **TARGET:** | The indicator is aimed to measure adherence/maintenance to opioid substitute methadone treatment and covers both the civilian and penitentiary systems. |
| **FREQUENCY OF DATA COLLECTION:** | Semi-annual |
| **MEASUREMENT TOOL:** | Programme reports on execution of program activities at the end of the reporting period. Use the EMR system for data recording and reporting. |
| **METHOD OF MEASUREMENT:** | The indicator is non-cumulative and it reflects the number of clients who received treatment for 6 months at least. |
| **Numerator:** | Number of people from the cohort that are still on treatment 6 months after starting OST. |
| **Denominator:** | Number of people starting OST during the period defined as the cohort recruitment period.  The cohort of patients will be taken from the period antecedent to the reporting period (For example: in Jan-Jun 2017 - cohort of individuals started treatment in Jul-Dec 2016 will be reported, in Jul-Dec 2017 -cohort of individuals started treatment in Jan-Jun 2017). |

**Indicator 6. Percentage of prisoners that have received an HIV test during the reporting period and know their results**

|  |  |
| --- | --- |
| **TARGET:** | Progress providing HIV testing services to members of key populations who are living with HIV and measuring against the first 90 of the 90–90–90 target: the percentage of people living with HIV who know their HIV status.  Knowledge of one’s status is also a critical factor in the decision to seek treatment |
| **FREQUENCY OF DATA COLLECTION:** | This indicator is reported on semi-annual basis |
| **MEASUREMENT TOOL:** | The outcome indicator is measured using IBBS, whereas this output indicators are measured using routine reporting. Routine reporting is expected to be timelier, allowing more frequent data flow and rapid timely verification.  Sources of data are programme reports of RCN and SSES |
| **METHOD OF MEASUREMENT:** | Number of people tested, not tests conducted. Pre and post test counselling of those who received the test at AIDS centres’ laboratories as well as saliva based express testing. Separate data on express testing and by ELISA tests will be provided in the comments section of each reporting period |
| **Numerator:** | Number of prisoners who were tested for HIV in the reporting period and know their results |
| **Denominator:** | Number of prisoners |

**Indicator 7. Percentage of sex workers reached by HIV prevention programmes - defined package of services**

|  |  |
| --- | --- |
| **TARGET:** | Measuring access of SWs to HIV prevention services, which affects the ability of SWs to form the skills of safe sexual behaviour. The targets are in line with the NSP for 2017-2021, which is under approval. |
| **FREQUENCY OF DATA COLLECTION:** | Semi-annual |
| **MEASUREMENT TOOL:** | Programme reports on execution of program activities at the end of the reporting period. |
| **METHOD OF MEASUREMENT:** | The indicator is non-cumulative and it reflects actual number of clients who received the minimum package of services. The package includes the provision of condoms, information education materials or consultations, referral to sexually transmitted infections (STIs) services and/or VCT services and/or saliva based express testing. Accounting must go on to clients (UIC), and not on services. The indicator should be broken down by age, gender and region  The numerator represents the actual numbers reached and reported via programme reports. The indicator is in line with the National indicator, which measures a percentage of SWs with IBBS as the source, whereas in the PF it is through routine reporting. This reporting is expected to be timelier, allowing more frequent data flow and rapid timely verification. One of the areas of attention would be advocacy for ceasing a new policy initiative on administrative prosecution of SW. |
| **Numerator:** | Total number of SW’s who have received a package of minimum services at least once during the last 6 months. |
| **Denominator:** | Estimated number of SW’s. |
| ***Note:*** | "Minimum Package" - distribution of IEC materials and/or information sessions can be conducted, health products (condoms) and linkage to HIV and/or STI testing. |
| **Process** | Respective programme specialists obtain information from the sub-recipients on a number of SWs reached with the minimum package of services. This information is cross-verified with the initial sources like registers, field diaries and etc. during the site visits. |

**INTERPRETATION**

Survey data provide the opportunity to measure the uptake of multiple intervention services by individuals. This indicator shortens the reference period because populations must access services regularly and risky behaviour must be regular. Weaknesses associated with survey data relate to any sampling or response bias and the limited geographical coverage of the information.

Programme data provide a national picture to the extent that programmes offer services nationally. Programme data reflect a national commitment to deliver services to specified key population communities. Programme data do not reflect well the individuals served. Data cannot typically be de-duplicated. Further, analysis of two separate programme data sets can only be considered ecologically.

This indicator refers to the services received in the last 6/12 months. Based on monthly and quarterly reports of sub and sub-sub-recipients it is possible to calculate data for different time period, for example, for the last 3 months or last 30 days, and one can include these additional data in the section with comments on the reporting tool. Given the complexity of such measurement element, especially in the context of most-at-risk populations, the development of such criteria requires an intensive process of collecting and synthesizing information and making recommendations.

**ADDITIONAL INFORMATION**

Tool to set and monitor targets for HIV prevention, diagnosis, treatment and care for key populations: supplement to the 2014 consolidated guidelines for HIV prevention, diagnosis, treatment and care for key populations. Geneva: World Health Organization; 2015 (http://www.who.int/hiv/pub/toolkits/kpp-monitoring-tools/en).

UNAIDS, WHO, Measure Evaluation, CDC, USAID, ICASO, UNODC. Operational Guidelines for Monitoring and Evaluation of HIV Programmes for People who Inject Drugs. https://www.measureevaluation.org/resources/tools/hiv-aids/operational-guidelines-for-m-e-of-hiv-programmes-for-peoplewho-inject-drugs

**Indicator 9. Percentage of MSM reached with HIV prevention programs - defined package of services**

|  |  |
| --- | --- |
| **TARGET:** | Measuring access of MSM to HIV prevention services, which affects the ability of MSM to form the skills of safe sexual behaviour. |
| **FREQUENCY OF DATA COLLECTION:** | Semi-annually |
| **MEASUREMENT TOOL:** | Programme reports on execution of program activities at the end of the reporting period. |
| **METHOD OF MEASUREMENT:** | The indicator is non-cumulative and it reflects actual number of clients who received the minimum package of services. The package includes the provision of condoms, information education materials or consultations, referral to sexually transmitted infections (STIs) services and/or VCT services and/or saliva based express testing. Accounting must go on to clients (UIC), and not on services.  The indicator represents the number of actual MSM reached through prevention programs over the estimated number of MSM in Bishkek and Osh (population size estimation in 2013). |
| **Numerator:** | Total number of MSM who have received a package of minimum services at least once during the last 6 months. |
| **Denominator:** | Estimated number of MSM. |
| ***Note:*** | "Minimum Package" - distribution of IEC materials and/or information sessions can be conducted, health products (condoms and lubricants) and linkage to HIV and/or STI testing. |
| **Process** | Respective programme specialists obtain information from the sub-recipients on a number of MSMs reached with the minimum package of services. This information is cross verified with the initial sources like registers, field diaries and etc. during the site visits. |

**INTERPRETATION**

This indicator refers to the services received in the last 6/12 months. Based on monthly and quarterly reports of sub and sub-sub-recipients it is possible to calculate data for different time period, for example, for the last 3 months or last 30 days, and one can include these additional data in the section with comments on the reporting tool. Given the complexity of such measurement element, especially in the context of most-at-risk populations, the development of such criteria requires an intensive process of collecting and synthesizing information and making recommendations.

**Indicator 11. Percentage of people living with HIV in care (including PMTCT) who are screened for TB in HIV care or treatment settings**

|  |  |
| --- | --- |
| **TARGET:** | Measuring number of adults and children enrolled in HIV care that had TB status assessed and recorded during their last visit as well as impact of TB among people living with HIV.  The target is the proportion of registered PLHIV who were tested for TB. The targets are set in the percentages; the actual numerator and denominator will be reported in each reporting period. |
| **FREQUENCY OF DATA COLLECTION:** | Semi-annual |
| **MEASUREMENT TOOL:** | Vital and disease-specific registry |
| **METHOD OF MEASUREMENT:** | WHO recommends the use of a simplified screening algorithm for intensified TB case findings that include 4 clinical symptoms: 1-current cough, 2-fever, 3-weight loss, and 4-night sweats.  Using this simplified algorithm assessment of TB status at every visit during the reporting period (‘Yes’ if ‘no signs’, ‘suspect’ or ‘on treatment’ and ‘No’ if TB status not assessed) should be recorded on the patient HIV care/ART card, and transferred onto the pre-ART or ART registers as appropriate at all facilities providing routine HIV care. Enrolled in care includes all those continuing in care and those newly enrolled during the reporting period. This data should be analysed and reported together with other cross sectional data at national level. |
| **Numerator:** | Number of adults and children (including PMTCT) enrolled in HIV care, who had their TB status assessed and recorded during their last visit. |
| **Denominator:** | Total number of adults and children (including PMTCT) enrolled into HIV care in the reporting period. The targets are aligned with the NSP for 2017-2021, which is under approval. |
| ***Note:*** | Intensified TB case finding should be implemented at all HIV care and treatment facilities and TB status of people living with HIV should be assessed at every visit during the reporting period. It is also important to monitor implementation of the entire cascade of care, starting from symptom screening to diagnosis and treatment of TB. |
| **ALGORITHM** | Respective programme specialists obtain information from the RC “AIDS” on a number of PLHIV assessed on their TB status. This information is cross verified with the initial sources like ART and pre-ART registers during the site visits. |

**Indicator 12. Percentage of HIV-positive new and relapse TB patients on ART during TB treatment**

|  |  |
| --- | --- |
| **TARGET:** | This indicator provides a measure of the accessibility of ART to HIV-positive TB patients, drug availability, the degree to which health-care providers encourage ART as a part of routine care, and the success of TB and ART health services in referring, managing and tracking registered TB patients eligible for ART |
| **FREQUENCY OF DATA COLLECTION:** | Semi-annual  *Note*: Data should be collected continuously at the level of AIDS centers, FMC and TB facilities. |
| **MEASUREMENT TOOL:** | Prompt TB treatment and early ART are critical for reducing the mortality due to HIV-associated TB and must be the highest-priority activity for both the NACP and NTP. While TB treatment should be started immediately, ART should be started within 8 weeks of TB diagnosis, given that all are eligible for ART irrespective of their CD4 cell count.  Although it is important that ART status of all HIV positive TB patients is assessed, this indicator considers only new and relapse patients to avoid double counting. Cases with undocumented TB treatment history should be counted as new cases. |
| **METHOD OF MEASUREMENT:** | See below |
| **Numerator:** | Number of HIV-positive new and relapsed TB patients started on TB treatment during the reporting period who are already on ART or who start on ART during TB treatment. |
| **Denominator:** | Number of HIV-positive new and relapsed TB patients registered during the reporting period |
| **ALGORITHM** | Respective programme specialists obtain information from the RC “AIDS” on a number of HIV-positive new and relapsed TB patients started on TB treatment during the reporting period who are already on ART or who start on ART during TB treatment. This information is cross verified with the initial sources like TB/HIV registers during the site visits. |

**Indicator 13. Percentage of HIV-positive pregnant women who received ART during pregnancy (GARP Indicator 2.3)**

|  |  |
| --- | --- |
| **TARGET:** | This indicator measures progress in providing women with antiretroviral medicines to reduce mother-to-child transmission of HIV |
| **FREQUENCY OF DATA COLLECTION:** | Annual. |
| **MEASUREMENT TOOL:** | Data provided by RAC on patient records (4b reporting form). |
| **METHOD OF MEASUREMENT:** | Data obtained through 4b reporting form of the RAC on HIV-positive pregnant women who received antiretroviral prophylaxis within the past 12 months. |
| **Numerator:** | Number of HIV positive pregnant women who delivered during the reporting period and received ART during the MTCT risk period. |
| **Denominator:** | Number of HIV-positive women who delivered within the past 12 months. |
| **ALGORITHM** | Respective programme specialists obtain information from the RC “AIDS” on a number of HIV-positive pregnant women received antiretroviral prophylaxis during the reporting period. This information is cross verified with the initial sources like HIV ES, pre-ART and ART registers and the electronic PLHIV tracking system during site visits. This data is in line with the NSP for 2017-2021, which is under approval and dedicated to show the actual results based on qualitative data. |

**INTERPRETATION**

Over time, this indicator assesses the ability of programmes for preventing mother-to-child transmission by estimating the impact of increases in the provision of antiretroviral medicines and the use of more efficacious regimens and optimal infant feeding practices. This indicator allows countries to assess the impact of antiretroviral medicine programmes on the number of children acquiring HIV by estimating the HIV transmission rate from women living with HIV to their children. The modelled estimate enables this value to be estimated since capturing this indicator through direct measures is almost impossible. The modelled estimate overcomes three challenges.

1. Following up mother–child pairs is difficult, especially at the national level, because of the lag in reporting and the multiple health facility sites that mother–child pairs can visit for the wide range of services for preventing mother-to-child transmission and child care interventions delivered over a time span.

2. Children (especially those living with HIV) may die before they are tested to determine whether transmission occurred.

3. A directly measured indicator will not capture women and their children who do not attend programmes, possibly because of high levels of stigma.

Weaknesses. This indicator is generated from a model that provides estimates of HIV infection among children. The estimated indicator is only as good as the assumptions and data used in the model. In countries where caesarean section is widely practised, the indicator will overestimate motherto-child transmission. It also relies on programme data that often capture the antiretroviral medicine regimens provided rather than those consumed and could therefore underestimate mother-to-child transmission.

This indicator does not capture efforts to reduce the risk of mother-to-child transmission by reducing the number of reproductive-age women acquiring HIV or by reducing unintended pregnancies among women living with HIV.

In countries in which data are available, facility attendance is high and confirmatory tests are conducted systematically, efforts should be made to monitor the impact by directly assessing the percentage of children living with HIV among those born to mothers living with HIV. All countries should make efforts to monitor the HIV status and survival of children born to women living with HIV, gathered during follow-up health-care visits.

WHO publications on HIV monitoring and evaluation (<http://www.who.int/hiv/pub/me/en/index.html>).

### ANNEX C – Impact and Outcome Measurement Table

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **Activity** | **Responsible unit/ implementing agency** | **Collaborating agencies** | **Budget** | **Source of funding** | **Expected outcome** |
| M&E visits for project staff | RCN | SSES, OST, NEP | $3 376,30 | GF | Monitoring visits to OST sites and NEPs in civil sector and in prisons. M&E data cross-check, data verification. Strengthened M&E systems. |
| M&E visits of Network | Network | N/A | $7 920,00 | GF | Monitoring visits to PWID, PLHIV, MSM and SW organizations to improve the M&E system and other activities within HIV programs on the community basis. Strengthened M&E systems of the National Service providers. |
| Monitoring visits | RAC | Regional AIDS centers, MDT | $30 172,41 | GF | Data verified, quality checked. M&E recommendations provided. Strengthened M&E systems of the National Service providers. |
| M&E visits of UNDP PMU | UNDP | Sub-recipients | $29 452,16 | GF | Data verified, quality checked. M&E recommendations provided. Capacity of organisations delivering services strengthened. |
| **Total** |  |  | **$ 70 920,87** |  |  |