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Signs of a Hidden HIV Epidemic: Men Who Have Sex with Men In Eastern European Countries

Program Monitoring Guidelines

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Armenia, Albania, Azerbaijan, Belarus, Georgia, Moldova, Russian Federation and Ukraine

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Acronyms

AIDSTAR	AIDS Support and Technical Assistance Resources
ART	Antiretroviral therapy
CBO	Community-based organization
CSO	Civil society organization
CSW	Commercial sex worker
E & E countries	Europe & Eurasia countries*
FBO	Faith-based organization
GBT	gay, bisexual and transgender people
GFATM	The Global Fund to fight AIDS, Malaria and Tuberculosis
HCF	Healthcare Facility
HTC	HIV testing and counseling
LGBT	Lesbian, gay, bisexual and transgender people
MARP	Most-at-risk population
MOH	Ministry of Health
MSM	Men who have sex with men
M&E	Monitoring and Evaluation
NGO	Nongovernmental organization
PEPFAR	President's Emergency Plan for AIDS Relief
PLWH	People living with HIV
PMP	Performance monitoring plan
PMTCT	Prevention of mother-to-child transmission
STI	Sexually transmitted infection
TB	Tuberculosis
TG	Transgender (person)
UNAIDS	Joint United Nations Program on HIV/AIDS
UNDP	United Nations Development Programme

Introduction

These guidelines provide implementation support for the Monitoring & Evaluation (M&E) tool that was developed under the *Men Who Have Sex with Men in Europe and Eurasia Countries Project* to track activities on HIV prevention, care and support, as well as community mobilization among men who have sex with men and transgender individuals (MSM/TG). This document explains the components of the M&E tool and provides techniques to collect and count all relevant indicators. The M&E tool is designed to monitor the programs that are based on the Regional Package of Services for MSM/TG in Eastern Europe and Central Asiaⁱ. The tool is based on internationally accepted indicators and techniques as reflected in PEPFAR, GF ATM, UNAIDS, and WHO guidelines. Most attention was paid to the performance indicators offered by PEPFAR, since the Regional Package of Services is being developed with the support of USAID.

The proposed indicators were modified and adapted to the needs of the Regional Package of Services for MSM/TG. For example, usually care and support indicators are not MARPs disaggregated. However, if there is a goal to strengthen care and support services for MSM/TG, such disaggregation is crucial to evaluate progress of activities designed for MSM/TG. In addition, some indicators have been developed from the ground up to evaluate such aspects of programmatic activities as quality and comprehensiveness of services.

The use of a unified system of monitoring and evaluation of programs designed for MSM/TG is essential for the coordinated and synergetic response to the HIV epidemic among MSM/TG.

To achieve the goal of an effective response to the HIV epidemic, coordinated collaboration is important at all levels, including local, national, and international, as well as collaboration between civil society, national institutions, and international donors and policy makers. A universal system of monitoring and evaluation ensures sound planning of interventions. Consequently, it is also the basis of budgeting. Such a system enables progress monitoring at all levels, and, therefore, contributes to the controlled and more effective management of resources.

Building a monitoring and evaluation system

A guide to monitoring and evaluation released by ICF "International HIV/AIDS Alliance in Ukraine," defines the sequence of steps in the construction of an effective monitoring and evaluation system. The steps are:

- Planning of activities and interventions (setting goals, objectives, service delivery areas, target groups, and scope of work)
- Determining indicators (selecting indicators, calculating baseline data, setting targets)
- Selecting partner organizations that provide services, evaluating their capacity, developing of reporting forms
- Program monitoring by qualitative and quantitative indicators
- Data collection and analysis, ensuring data quality
- Evaluation of projects and interventions
- M&E data use for management decisionsⁱⁱ

This tool incorporates these steps into its system and will enable program managers to plan activities, choose indicators, monitor a program, and to evaluate a program's success.

When building an M&E system, it is important to take into consideration the availability of data required for the collection and calculation of the tool's indicators. Therefore, it is important to evaluate the level of access to such information, while determining the indicators. It is recommended to choose indicators that can be collected in the localities, where the Package of Services for MSM/TG will be used. At the same time, it is important to strive for full coverage from all available information sources. This may mean advocating for the inclusion of additional indicators and systems to collect information for those indicators.

Here is an example related to the monitoring of interventions for the prevention and treatment of TB among people living with HIV (PLHIV). Monitoring the prevention and treatment of HIV/TB co-infection should ideally follow the following logic scheme:

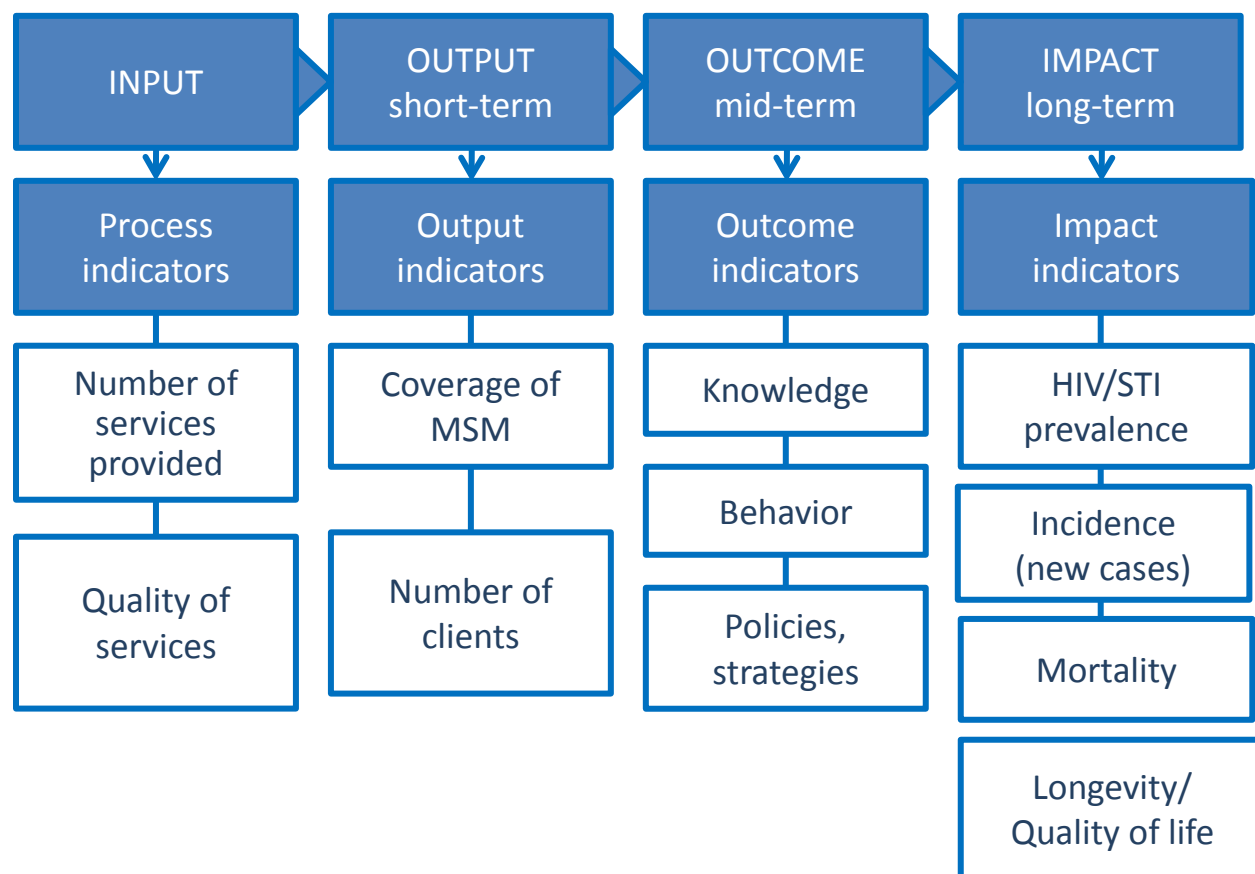
1. Number/percentage of PLHIV covered by TB-screening
2. Number/percentage of PLHIV covered by preventive treatment of latent TB-infection
Number/percentage of PLHIV who have positive results of TB-screening
3. Number/percentage of PLHIV who were diagnosed with active TB
4. Number/percentage of PLHIV who were cured from TB

However, not all information is available at all stages of the prevention and treatment of TB among PLHIV. The lack of information is especially noticeable if one factors in hidden groups such as MSM/TG in Eastern Europe and Central Asia. In this case, the program may report only some indicators depending on the data availability. For example, coverage is not counted if data on the general number of HIV-positive MSM/TG involved in HIV care are not available. Or at point #5, the indicator will reflect the number of clients who have begun TB-treatment instead of the number of those who have completed treatment. This is due to the fact that the registration forms of AIDS Centers may not have such information, given that patients receive treatment in TB facilities.

M&E logic model and a system of indicators

The tool is based on a logic model for program monitoring and evaluation (see Figure 1 on the next page). The model is based on the Regional Package of Services for MSM/TG in Eastern Europe and Central Asia. The package was developed in the framework of the technical assistance by the USAID-funded AIDSTAR-Two Project.

Figure 1. The logic model for monitoring and evaluation of program activities



The indicators track program activities at each stage of the logic model. Firstly, there are process, result, outcome, and impact indicators.

- **Process indicators** track the quality and quantity of programmatic input. At the stage of monitoring the activities of a particular project, it is necessary to register the number of services provided. However, at a higher level of program monitoring, as is presented in this tool, the number of unique clients who have received certain services and the quality of the services matter.
- **Output indicators** demonstrate coverage reached by prevention, care and support, and community mobilization. There are several types of coverage indicators:
 - New clients – the coverage of new clients reached during the period of time (for example, a reporting year)
 - Cumulative coverage that is reached during the entire duration of the program
 - Coverage for the reporting period – new and old clients who received services during a 12-month reporting period, for example. It is this approach to reporting that is found in the Regional Package of Services M&E tool.
- **Outcome indicators** – achieved changes in knowledge, attitude and behavior of the target group. Outcome indicators can be also called "mid-term results" of the program.

- **Impact indicators** record changes in public health situation that are achieved due to the program. They can be also called “long-term results.” Behind them there are the global objectives of the program: reducing the spread of HIV and STIs, reducing the mortality rates, and improving the quality of life of PLHIV.

In the logic model for the Regional Package of Services M&E tool, process, output, and outcome indicators are arranged according to the three components of the package of services: prevention, enabling environment and community support for prevention and care. Impact indicators are common to all three components, since only comprehensive and wide-ranging activities lead to positive long-term changes in public health.

Indicators of services quality

The quality of the service delivered is the key factor that enables a causal link between the achieved coverage and consequential health outcomes and impacts.

Quality of services is more difficult to measure and track than quantity. In this regard, many monitoring systems do not pay enough attention to quality indicators. As a result, there is a lot of space for subjectivity in this issue. Everyone can have her own ideas about quality constituents. That is why a substantial part of programmatic success is left unknown in the modeling: if projections of targeted impacts are not met, nobody would say that this is because services were not of high quality, if there is not any quality standard.

To identify or select quality indicators in the monitoring program, the following steps should be taken:

1. Determine if there are already any documented national or international standards for quality of services.
2. If there are none, they should be developed in accordance with certain criteria, such as:
 - a. The completeness of the service provided (all specified components of a designed service were offered to a client)
 - b. Confidentiality and safety
 - c. Professionalism of the staff (knowledge and skills)
 - d. Quality of distributing materials
3. Then determine if there is a consensus among key stakeholders about the current standards outlined in regulatory documents at the national/local level (clinical protocols, orders, instructions approved by authorities, etc.)
4. If there is no stakeholder consensus, gather stakeholders to reach a consensus. In this way, quality standards will achieve legitimacy at the national or regional level (for example, if standards are accepted and approved by the association of all stakeholders in the region, or by the country coordinating mechanism, or, where possible, by the relevant executive authority.
5. After standards have been developed and approved, program and project implementers should study them and apply them to their work. This may require some technical assistance and a certain period of time in order to integrate them into existing programs.
6. At the level of program monitoring, standardized quality indicators have to be set, as well as methods of their measurement.
7. Once the above steps have been completed, services should be regularly monitored for compliance with minimum quality standards.

Below is an example of the quality standard for a referral service. The referral can be deemed a high quality referral if:

1. The service was offered to a client (the need for the service has been identified by outreach or social worker). *Quality criterion: the "completeness of a service provided."*
2. The client receives motivating counseling. *Quality criterion: the "completeness of a service provided."*
3. The client receives the coordinated meeting time with a particular specialist, arranged with the support of an outreach or social worker, or is escorted to the place of service delivery. *Quality criterion: the "completeness of a service provided."*
4. The client receives the referral voucher with the exact address, contact information, and the time of the working hours. *Quality criteria: the "completeness of a service provided" and "quality of distributing materials."*
5. The service is provided accordingly to the client's needs. *Quality criteria: "confidentiality and safety" and "professionalism of the staff."* For example:
 - a. case management and counseling is provided through individual service avoiding possible stigmatisation
 - b. the service is provided only if it does not harm the client
 - c. service providers speak client's language, and consider his cultural, social and psychological characteristics, etc.
 - d. other aspects important for the client are considered.
6. The service is provided by a trained outreach or social worker who demonstrates knowledge of the subject, counseling skills, and active listening. *Quality criterion: "professionalism of the staff."*

There are several different methods of service quality assessment, as outlined below:

1. **Program monitoring.** This includes:
 - a. Self-monitoring by a project implementer (part of "project reporting")
 - b. Monitoring visits to project sites performed by coordinating or auditing organizations, during which quality of services is assessed and recorded in monitoring visit forms. Visitors assess the extent to which:
 - i. Implementers know and understand the quality standard
 - ii. Implementers demonstrate application of the quality standard in client service
 - c. Standardized data entry
 - d. Analysis of compliance (Project reporting results should correspond to results of monitoring visits and quality standard)
 - e. Measurement of organizational ranking on the matching service quality standard¹

The monitoring tool uses quality indicators that categorize and quantify service delivery descriptions that are collected during monitoring visits.

2. **Observation.** This is a research/assessment method. Observation is similar in methodology to the monitoring visit, where the quality of services is estimated by an external observer. The

¹ The idea of organizational ranking is taken from the publication: Мониторинг и оценка программ и проектов. Практическое пособие / О.С. Морозова, О.В. Варецкая, Д. Джонс, П. Чикуква, Т.А. Салюк - К.: Оранта 2008. - 142 с.

sampling design and number of observations allow for statistical analysis of service comparisons to the quality standard. The methodology is as follows:

- a. There is a timetable and determined locations of service delivery points.
 - b. During the assessment, service delivery points are randomly selected for visits by a trained observer.
 - c. When visiting the service delivery points, the observer follows ethical research principles: confidentiality, anonymity, and informed consent from clients to participate in the assessment.
 - d. The observer records information on the provision of services on a standardized assessment form.
 - e. The data is entered into a database.
 - f. The consistency of the assessment results with the quality standards and program reporting is analyzed.
 - g. The indicator of the percentage of services provided in compliance with the quality standard is counted.
3. **«Mystery client».** The methodology of this study is similar to that found in observation, with the only difference that the observer does not reveal that he is an observer and instead, receives the service as if he were a client. After being treated, he fills out the recording form on the visit to the service provider. The advantage of this method is that we get the most reliable information from inside, without placing real clients in an uncomfortable position, as is sometimes the case with an open observation. However, the method has a strong disadvantage when being used in MSM/TG projects, because difficulties with recruitment of “mystery clients” will emerge, since these individuals should be simultaneously disinterested people and community representatives.
4. **Questionnaires.** This research method involves surveying sample of clients, which allows program implementers to draw conclusions that are extrapolated to the program level. When using this method, it is important to remember that the subjective level of clients’ satisfaction is not always a sufficient indicator for measuring the quality of services because of clients’ predetermined expectations. For example, ratings may be underestimated if clients’ expectations were high, even though the services were delivered professionally. Or ratings may be overestimated if clients are not accustomed to receiving attention to their needs. To avoid excessive subjectivity, questionnaires should be prepared with specific questions that reflect the criteria of the quality standard. For example, one should not ask a client if the service delivered was complete. Instead, ask the client to choose from the list those components of a service they received: offer of the service (needs assessment), counseling, escort, referral voucher with the address, etc.

This monitoring tool uses an indicator based on the above method to measure quality of services on care and support for PLWHA.

5. **Focus-groups, in-depth interviewing.** These methods cannot provide comparable numerical indicators. However, they can be useful to receive information on why clients consider services to be quality or low-quality services, as well as what needs of clients have not been met.

Besides the quality of services from the Regional Package of Services for MSM/TG, there are also quality indicators that are gathered on the general level of national HIV and AIDS programs. For instance, qualitative HIV testing and counseling (HTC) services are especially important for successful prevention and timely treatment commencement. Therefore, national HTC protocols and guidelines should

correspond to international standards. WHO proposes guidelines and a set of indicators for evaluation of national HIV testing and counseling systemsⁱⁱⁱ. Particularly, there is an indicator «Percentage of HTC sites that meet national service quality standards». This indicator also partially matches a PEPFAR indicator 11.5.N “Percentage of HIV Testing and Counseling sites with Quality Assurance (QA) systems for HIV counseling service delivery (non-test elements).” Although the quality of HTC or the quality of ARV treatment, as well as any other compliance of medical procedure with clinical protocols are not within the range of the monitoring tool’s tasks, they should be present at the general level of national AIDS programs.

Baseline and planning

While planning activities, program implementers need to pay attention to the baseline of indicators that are specified in the baseline column in the monitoring and evaluation planning tool. Baseline measurements provide a platform for future targets in coverage, outcomes, and impact. For example, if a program is not the first of its kind in a region, and some MSM/TG are already covered by prevention services, then these clients will not be counted as new clients, but their number is a starting point from which the further coverage is to be expanded (this is the baseline number). If the work is completely new, the baseline might be equal to "0." For another example, if a baseline study has demonstrated that some parts of the MSM/TG community already possess all the necessary knowledge on HIV transmission, a new program’s targets will be larger than this base value.

Having a realistic baseline assessment is very important at the planning phase. Moreover, overestimation is more problematic than an underestimation, as it is easier to adjust planning towards an increased target number than a decrease (since sometimes it might be difficult to explain to a donor why knowledge and behavior indicators after program activities begin are lower than the baseline before such activities, despite the fact that such a decrease was anticipated). In extreme cases, such errors may lead to the interruption of activities and funding.

Program reporting

Information gathered by the monitoring system allows program implementers to determine a significant part of performance indicators. In order to launch the system to program reporting, there are some fundamental tasks to be accomplished:

1. There is a need to develop and implement a **unified system of program reporting** in the region where interventions for the MSM/TG community are taking place. Such reporting should be performed with the help of a **standardized electronic database**. Since many countries have already launched similar systems or are in the process of introducing them, the possibility of using these systems should be explored, taking into account the specific indicators and services of the Regional Package of Services for MSM/TG.
2. It is necessary to adopt and implement a unified system of clients’ **unique coding**. In this way, the program reporting system will be able to count unique clients and avoid multiple counting of the same individuals. Unique coding also preserves clients’ anonymity. Such coding is especially important if a country has a number of donors, programs, and/or managing organizations, or if there are several projects and several implementing NGOs in the same locality. One possible drawback of unique coding is that clients may often lose their client ID cards and forget their

codes. To overcome this challenge, a coding system should be developed that is based on ID information that clients usually always remember (for example, first/last letters of client names or clients' parents' names, birth dates, etc.). In this way, even if a client loses or forgets his code, it can be easily restored.

3. To calculate coverage rates, it is important to estimate the total number of the target group the program works with. In the case of the MSM/TG program, the estimated total number of MSM/TG in the country/region is the most important denominator for the prevention and enabling environment components. For the care and support component, the denominator is not the total number of HIV-positive MSM/TG in the region, but the number of HIV-positive MSM/TG who are registered within the health care system.
4. A voucher system for referrals can be implemented to improve access to services, as well as program reporting. Vouchers are convenient for counting the number of clients who received services by referral. Usually, NGOs distribute vouchers for medical and other services to clients, who then bring the vouchers to medical or other institutions. Then voucher recipients can report how many clients from a target group came for the service and received it.

Estimated number of MSM/TG

An estimated number of MSM/TG in the region where programmatic activities are implemented is part of the basic data for the construction and implementation of the M&E system. Epidemiologic research indicates that the threshold of coverage for averting new infections is 60%. Without knowing the general number of MSM/TG in the region, it is not possible to allocate resources to achieve the program's goal, nor to assess the number of MSM/TG covered by services. Data on the number of high-risk groups are an important advocacy tool with which one can justify the existing needs of MSM/TG in services.

Due to the hidden nature of MSM/TG in the Eastern European and Central Asian countries, estimating the number of MSM/TG is a challenging task. Before choosing a research method, it is necessary to determine exactly who the program's target groups are. It is important to include in the target group not only openly gay men, but also those who do not identify themselves as gay, but who are biological males who have had sex with other men in the past six months (including transgendered and male sex workers).

Two methods are recommended to estimate the number of MSM/TG at the regional and national levels: the national (or regional) population survey and the coefficient method.

A national survey of population (household survey) is more suitable for countries where the stigma against MSM/TG is low. In a country with a high level of stigma, MSM/TG living in a "household" can conceal information about themselves; they also may not be residing in a household but be living without a permanent residence. If this method is used in a country with high rates of stigma and discrimination against MSM/TG, a triangulation of data is recommended (requiring data validation with information from other sources).

The coefficient method uses available information on the number of a subset of the target audience from two or more different sources. For example, imagine that a program has a unified system of program monitoring that provides information on the number of unique clients who received preventive services in the past 12 months. In addition, the program has conducted representative behavioral survey among MSM/TG asking if respondents had received preventive services in the past 12 months. Through

these methods, the program implementers have learned the percentage of those who received services. Using the percentage formula, they can estimate the general number of MSM/TG. For example, 100 persons (unique clients) received the program's services. The representative behavioral survey demonstrated that 20% of respondents received these services in the reporting year. Thus, one can extrapolate that the general number of MSM/TG is 500 persons ($100 \times 100\% / 20\% = 500$).

An interesting example of using the coefficient method was undertaken by ICF, the International HIV/AIDS Alliance organization in Ukraine in 2012, which performed a quantitative calculation of the coefficients using data from dating websites on the number of registered users, structured by age and city of residence. For calculating the coefficients, first, the data on the number of registered users of dating websites were used. These data were disaggregated by city of residence and age. Second, data obtained from behavioral monitoring included the question if respondents had accounts in these websites. Then the coefficient method was used to calculate numbers on MSM/TG in different cities of Ukraine. After this the results were extrapolated to the "oblast" level (provincial level). And afterwards, validated sum of all oblast level results were presented as the estimated number of MSM/TG on the national level^{iv}.

Theoretically, it may also be possible to use the method of "Capture (quasicapture) - recapture". This method is based on two assumptions: first, that there is no dependence between two samples captured, and second, that all individuals in the society have the same probability of getting into both samples^{2v}. Thus, if one makes two different sample captures and defines the part that was double captured, the total group size can be estimated. The method comes from environmental studies and has been used, for example, to count the number of a certain species of fish in a pond^{vi}. However, in the case of calculating the number of the target group, "capture" or "quasi-capture" are considered to be several independent studies or data. Such estimation takes into account those people who have come simultaneously into several independent samples. Importantly, the data must be obtained for the same period of time and within the same location. If the data analyzed comes from two studies, the estimated number of the group is calculated with the help of the formula: number of representatives of the target group in one study, multiplied by the number of representatives of the target group in another study, divided by the number of representatives of the target group who fell into both studies. If there more than two captures, the formula is more sophisticated. In these cases, the monitoring guidelines by ICF/International HIV/AIDS Alliance in Ukraine recommend using software.³

In some cases, estimates of narrower sub-communities of MSM/TG might become important for certain indicators. For example, UNAIDS recommends using the software Spectrum in order to determine an estimated number of PLHIV who need ARV. The software allows modeling depending on the stage, type of the epidemic, and other relevant input data^{vii}. However, the possibility of obtaining disaggregated data for HIV-positive MSM/TG as a sub-group should be weighed separately.⁴ Such an assessment should follow the WHO recommendations on the HIV diagnosis, when treatment is required.

² However, the validity of these assumptions is questionable for use in epidemiology.

³ For example, "PEPI for Windows (WinPepi)" can be downloaded via www.healthcarefreeware.com/calc.htm

⁴UNAIDS: «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».

Knowledge and behavior monitoring

In addition to the program reporting, special studies, and behavioral monitoring (KAP survey) in particular, are also important sources of information for the program indicators. The peculiarity of surveys is that they are conducted among the target group in general, while the program reporting provides information only about those who are involved in the projects as a client. The methodology of these studies is internationally standardized and represents the monitoring of the knowledge and behavior among certain key groups that have the high risk of getting the infection.

The main difficulty of these surveys is the extrapolation of the obtained data for the entire group. Since key groups are usually hidden populations it is almost impossible to provide a random representative sample of respondents. Therefore, the sample is based on the “snowball” method, and then different modeling techniques are applied to the data to obtain results that are considered to be representative. Only in this case, one can argue that the percentage of any observed events within the study is the same for the entire target population. It is also important to comply with the standard methodology from study to study as well as to conduct follow up studies in the same localities.

Studies such as the Behavioral Surveillance Survey (BSS) all program implementers to test individuals for HIV and STDs and analyze patterns of correlations between HIV status and socio-demographic data, knowledge and behavior.

For these studies, it is recommended to collect data with the help of community organizations working with MSM/TG^{viii}. It is also crucial to adhere to research ethics and to ensure respondents’ voluntary, anonymous and confidential participation.

The following pages present the explanations of the indicators of the M&E tool, divided by the three components of the Regional Package of Services for MSM:

1. HVI/STI prevention services for MSM/TG
2. Treatment, care and support to MSM
3. Enabling environment and community support for prevention and care

1. HIV/STI Prevention Services for MSM/TG

According to PEPFAR, “effective MSM/TG prevention programs should:

- Ensure participation of MSM/TG in the development, implementation and monitoring of prevention programs
- Promote consistent and proper use of condoms to achieve >90% use with both regular and non-regular partners
- Ensure consistent availability of quality male condoms and lubricant
- Ensure availability of comprehensive health care services with special emphasis to quality HCT and STI services and provision of or linkages to HIV treatment and care services”^{ix}.

Prevention services described in the Regional Package of Services for MSM/TG include those that have been proven as the best practices in the region. The package involves a comprehensive approach to service delivery. Nevertheless, this does not mean that every organization working with MSM/TG is supposed to partner with other organizations that can provide additional services, but rather that the availability and accessibility of comprehensive services are guaranteed through referrals. In this regard, the role of the organization is to inform, motivate, and redirect clients to the network partners.

Table1: Comprehensive prevention services^x.

Services in the Package	Activities	Service providers*
Essential Package		
Access to voluntary counseling and testing and rapid testing for HIV	Pre-and post-HIV test counseling (during screening and diagnostics)	NGO, HCF
	HIV testing with Enzyme immunoassay or other methods	HCF, NGO promotes accessibility
	HIV screening with rapid test and bringing positively tested clients to the HIV diagnostics	NGO, HCF
	Referral, motivational counseling, support in order to provide clients with HCT	NGO
Access to STI testing and treatment	Free/affordable anonymous STI testing by in-laboratory methods (syphilis, Chlamydia, gonorrhoea, and other available testing)	HCF, NGO promotes accessibility
	Free/affordable anonymous STI screening testing by rapid tests and bringing positively tested clients to the STI diagnostics	NGO, HCF
	Referral, motivational counseling, support in order to provide clients with STI testing	NGO
	Free/affordable anonymous STI treatment (syphilis, Chlamydia, gonorrhoea, and other available treatment)	HCF, NGO promotes accessibility

	provide clients with STI treatment	NGO
Individual and group counseling on HIV and STI, safe behavior, sexual health (peer education)	Individual counseling by an outreach worker, who is a member of MSM/TG community	NGO
	Group counseling by an outreach worker in peer group	NGO
	Mini trainings with specialists	NGO
	Group psychological trainings	NGO
	Peer counseling (volunteers, community members)	NGO
	Doctor's counseling (proctologists, STI specialists)	NGO
	Mentoring Support Program	NGO
Information materials on specific risks, including dissemination through social networks, Internet and telephone counseling	Safe sex behavior promotion through Internet, websites of organizations and social networks	NGO
	Development and provision of Information, Education and Communication Materials (IEC)	NGO
	Phone or on-line counseling	NGO
Distribution of condoms and lubricants	Distribution of condoms, which are appropriate to the needs of the TG and suggested by best practices	NGO
	Distribution of water-based lubricants in small packs	NGO
Hepatitis B Testing and Vaccination (referral and promotion)	Informing, motivational counseling referral and escort to immunization providers	NGO
	Hepatitis B rapid testing	NGO, HCF
	Immunization by the scheme 0-1-6	HCF, NGO promotes accessibility
	Individual case management	NGO, HCF
Referral and support for pre and post exposure prophylaxis for HIV		NGO
Desirable services		
Alcohol and drug dependency services (referral and friendly clinics)	Referral, motivational counseling, escort, support	NGO
Services for male sex workers	Referral, motivational counseling, escort, support	NGO

**Service Providers are those organizations that deliver services and gather information for program monitoring.*

Process and results indicators

1.1. Number of MSM/TG reached with minimal package of prevention services

1.9. Percent of MSM/TG reached with minimal package of prevention services

Purpose	<p>Indicator is necessary to track the number of MSM/TG reached by prevention program. This information is important for understanding how successful the program is in achieving its targets.</p> <p>“Minimal package of services” means services that can be delivered during outreach-work: counseling on questions related to HIV, AIDS, STI, and safe behavior, distribution of IEC materials, distribution of condoms and lubricants in small packs.</p>
Measurement tool	Program monitoring tools, program reporting
Data collection frequency:	Annually. Data are collected continuously at the organization level, and then data are aggregated for annual reporting.
Method of data collection	<p>It is necessary to count, with the help of an electronic program reporting database, the unique clients who obtained minimal package of services during a reporting period. Those services are counseling, IEC materials, condoms and lubricants. In addition, those services were delivered for individuals or small groups of no more than five persons.</p> <p>Currently it is supposed that all minimal services are delivered on a free of charge basis. However, in resource limited settings, this policy may be reconsidered in order to design accessible and available but not free of charge services. In this case, there is an additional need to define and measure availability and accessibility.</p> <p>There is no need here to count clients who received comprehensive package of services, but the outreach minimum is relevant.</p>
Method of measurement	<p>Numerator: Number of unique clients reached with minimal package of services during the last 12 months of the reporting period</p> <p>Denominator (if determining the coverage): Total estimated number of MSM/TG in the country/region</p>
Disaggregation	<ul style="list-style-type: none"> - By age: <25, 25+ - Regular clients/occasional clients - Sex workers/non-sex workers; injecting drug users (IDUs)/non-IDUs <p>This disaggregation is useful for understanding the quality of the coverage. Regular clients are supposed to be more susceptible to behavior change than occasional clients. Criteria of a regular client can be defined in different ways, depending on the program objectives and clients’ needs. For example, a regular client is defined as those who receive services at least one time per month, or two times per month, etc.</p>
Interpretation	Indicator demonstrates the coverage of MSM/TG with prevention services. There are some limitations of the indicator, since it reflects only number of people who

and commentaries	<p>receive the minimal package of services. Therefore, the coverage becomes overestimated. To overcome this limitation, it is important analyze programmatic activities through the range of different indicators.</p> <p>The use of indicator will be dismissed if there is no unified system of clients' registration in the region, and several programs/projects for MSM/TG coexist. In addition, MSM/TG group size estimations may be unreliable and distort the true picture coverage.</p>
Original indicator	The indicator is adapted from PEPFAR P8.3.D "Number of MARP reached with individual and/or small group level interventions that are based on evidence and/or meet the minimum standards required" aggregated by MARP type: MSM/TG.

1.2. Number of MSM/TG who received Testing and Counseling (HTC) services for HIV and received their test results during the last 12 months

1.10.a. Percent of MSM/TG who received Testing and Counseling (HTC) services for HIV and received their test results during the last 12 months

Purpose	High quality HTC is one of the most important preventive interventions. Programs on prevention are called to provide available HCT services and promote them among MSM/TG communities.
Measurement tool	Program monitoring tools, program reporting
Data collection frequency	Annually. Data are collected continuously at the organization level, and then are aggregated for annual reporting.
Method of data collection	It is necessary to count, with the help of an electronic program reporting database, those unique clients who received testing and counseling services and received their results during a reporting period of 12 months. What is more, the indicator counts all types of available testing, both screening with the help of rapid tests and Enzyme immunoassay diagnostics, provided by health facilities.
Method of measurement	<p>Numerator: Number of unique clients who took Testing and Counseling services for HIV and received their test-results during the last 12 months</p> <p>Denominator (if determining the coverage): Total estimated number of MSM/TG in the country/region</p>
Disaggregation	<p>By age: <25, 25+</p> <p>Disaggregation by age groups makes it possible to track the situation among young MSM/TG. Very often, youth are more susceptible to risk, and less covered with prevention at the same time.</p>
Interpretation and commentaries	The indicator illustrates how the program succeeded in coverage of MSM/TG with HTC services. The limitation is that the indicator reflects both clients who received screening testing and those who obtained Enzyme immunoassay diagnostics. Rapid testing can be provided by NGO using blood from a finger or

	<p>saliva. Diagnosis in a health facility may be provided by referrals from NGOs. In this case, it is important to think about a system of counting those who used the referral and returned back to the facility to learn their results. One possible way of doing this is by introducing a system of referral vouchers distributed by NGOs among their clients. Health facilities then return those vouchers to the NGO if clients received their testing results.</p> <p>It is important to underline that coverage with HTC services is measured by two ways. The major way is proposed in the indicator № 1.10.a. Here the measurement tool is program monitoring. Another verifying way is proposed in the indicator №1.10.b. That is the BSS measurement tool.</p> <p>The use of this indicator will be dismissed if there is no unified system of clients' registration in the region, and several programs/projects for MSM/TG coexist. In addition, MSM/TG group size estimations may be unreliable and distorting for reflection of the real coverage.</p>
Original indicator	The indicator is adapted from PEPFAR P11.1.D «Number of individuals who received Testing and Counseling (T&C) services for HIV and received their test results» Disaggregated by MARP type: MSM/TG. Partially corresponds with former UNGASS #7 and GF prevention #HIV-P8b.

1.3. Number of MSM/TG provided with post-exposure prophylaxis (PEP)

Purpose	Post-exposure prophylaxis is one of the crucial components of HIV prevention programs, following consensus of WHO and JILO in 2005. ^{xi} Indicator demonstrates PEP availability for MSM/TG in a country who might be exposed to the risk of HIV transmission.
Measurement tool	Program monitoring tools, program reporting
Data collection frequency	Annually. Data are collected continuously at the organization level, and then are aggregated for annual reporting.
Method of data collection	The prevention program records the number of clients who requested the PEP service and were referred to health facility (AIDS Center). The health facility redeems referral vouchers for the clients who actually received PEP services. In this way program management knows not only the number of those who requested the services, but also received them.
Method of measurement	Numerator: Number of MSM/TG who requested PEP services and received them.
Interpretation and commentaries	MSM/TG may request PEP services as the consequences of sexual violence, occupational activities, and other reasons. This indicator is very important for tracking of availability of PEP services to MSM/TG, since it requires recording of both who requested the services and those who received them. Both figures are recorded into the program monitoring tool. However, information on quality of the services remains off the record. Also the indicator will not count the MSM/TG

	who requested PEP directly from a health facility and but who concealed their belonging to MSM/TG group.
Original indicator	Indicator is adapted from GF #HIV-P18 and PEPFAR #P6.1.D “Number of persons provided with post exposure prophylaxis.” Recommended disaggregation by exposure type (occupational, rape/assault victims or other non-occupational).

1.4. Number of MSM/TG reached with STI testing services

1.12. Percent of MSM/TG reached with STI testing services

Purpose	The indicator illustrates a number and coverage of MSM/TG with STI testing services in terms of prevention program. STI are not only socially dangerous diseases, but they also increase the risk of HIV-transmission.
Measurement tool	Program monitoring tools, program reporting
Data collection frequency	Annually. Data are collected continuously at the organization level, and then are aggregated for annual reporting.
Method of data collection	It is necessary to count, with the help of an electronic program reporting database, the number of unique clients who received any diagnosis of STIs during the 12-month reporting period. The types of STI tested will depend on the needs of the region where the program operates. Proposed STI tests may include screening and diagnostics of syphilis, gonorrhea, Chlamydia, and others depending on the program and regional needs. The indicator counts all unique clients who received any type of STI testing, including rapid tests and Enzyme immunoassay tests in the health facilities, received by clients through the referral vouchers. A client who receives several tests for different STIs is counted as one unique client; as is a client who receives only one test for one STI.
Method of measurement	Numerator: Number of unique clients who were tested for STIs during the 12-month reporting period, without regard to types of STI tested, number of tests taken, and type of testing (screening or diagnostic) Denominator (if determining the coverage): Total estimated number of MSM/TG in the country/region.
Disaggregation	<ul style="list-style-type: none"> - By age: <25, 25+ - By STI types <p>Disaggregation by age groups makes possible to track situation among young MSM/TG. Very often youth is more susceptible to risk, and less covered with prevention at the same time.</p> <p>Disaggregation by STI type is useful for understanding the scope of program activities.</p>

Interpretation and commentaries	<p>Indicator is important for HIV prevention programs, since STI prevention and treatment decreases HIV transmission risk.</p> <p>Indicator does not reflect the full picture of STI testing coverage. Both screening and laboratory diagnostic are counted. In addition, MSM/TG may take STI testing independently from the program.</p> <p>Measurement of coverage is impossible without MSM/TG general number estimation, introduction of the unified system of unique clients coding, and standard database of program clients and activities.</p>
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1.5. Number of STI treatment courses, taken by MSM/TG during a reporting period

Purpose	The indicator displays number of STI cases that were treated within the scope of prevention program.
Measurement tool	Program monitoring tools, program reporting
Data collection frequency	Annually. Data are collected continuously at the organization level, and then are aggregated for annual reporting.
Method of data collection	To determine the numerator, one should count STI treatment courses that have been fully completed during the reporting period, regardless of the STI type. For example, if a client has received two different STI treatment courses during the reporting period, both courses are counted to the numerator. If a client has started treatment in this reporting period, but completion is expected in the next period, than he will be counted for the next year indicator. Use of the electronic database will make such calculations easily manageable.
Method of measurement	Numerator: Number of STI treatment courses that have been fully completed during the reporting period.
Interpretation and commentaries	<p>Indicator is limited to information on treatment courses received in a prevention program and does not represent entire picture of STI services accessible to MSM/TG in the country/region. The indicator does not demonstrate the coverage with services among MSM/TG, who require treatment. In addition. MSM/TG can utilize the services of STI diagnosis and treatment outside of the program activities. These people are also not reflected in the measures.</p> <p>This indicator is not included into the indicators lists adopted by international organizations. However, it monitors activities provided accordingly the Package recommendations.</p>

1.6. Number of MSM/TG which are known to have completed a course of hepatitis B vaccination

1.13. Percentage of MSM/TG which are known to have completed a course of hepatitis B vaccination

Purpose	The indicator defines the coverage of hepatitis B vaccination among MSM/TG. With co-infection of HIV / hepatitis B ARV therapy is complicated by its toxicity. Hepatitis B is a vaccine-preventable infection.
Measurement tool	Program monitoring tools, program reporting (Cumulative indicator)
Data collection frequency	Annually
Method of data collection	<p>To determine the number of vaccinated persons, it is better to use the electronic program database. For the numerator, the only persons counted are those who received a full course of vaccination for hepatitis B (three vaccines).</p> <p>It is important to note that the numerator includes not only those clients who were immunized by the program intervention, but also those in the baseline who were immunized before and outside of the program.</p> <p>However, the numerator does not contain the number of MSM/TG who were not immunized due to their test results, if they have antibodies to hepatitis B as a result of being infected in the past. Those who refused from immunization, interrupted the course of vaccination, or have contraindications to vaccination are not counted either. At the same time, these people are not excluded from the denominator.</p>
Method of measurement	<p>Numerator: Number of unique clients who have completed hepatitis B immunization course</p> <p>Denominator (if determining the coverage): Total estimated number of MSM/TG in the country/region.</p>
Disaggregation	<p>- By age: <25, 25+</p> <p>Disaggregation by age groups makes it possible to track the situation among young MSM/TG. Very often, youth are more susceptible to risk, and less covered with prevention at the same time.</p>
Interpretation and commentaries	It should be noted that monitoring guidelines and international registers of HIV-related indicators do not include such indicators as MSM/TG coverage of hepatitis B vaccination. However, if the program implements or manages such activities, it is important to evaluate results from these efforts. This is especially relevant in the post-Soviet countries, where the spread of viral hepatitis is particularly threatening ^{xii} .

1.7. Quality: Percentage of preventive services rendered, which fully meet minimum standards of quality

Purpose	<p>This indicator determines the percentage of all the program services provided that meet the minimum standards of quality.</p> <p>Evaluation is applied to those services for which community based organizations are usually responsible:</p> <ul style="list-style-type: none"> - Counseling - Referral - Distribution of supplies (condoms, lubricants) - Dissemination of information materials
Measurement tool	Special studies of service quality
Data collection frequency	Every two years
Method of data collection	<p>Direct observation - the recommended method to study the quality of HIV prevention services, provided by NGOs working with MSM/TG.</p> <p>Observation is similar to the methodology of a monitoring visit, when external auditor evaluates the quality of provided services. See page 10 for more details.</p> <p>Step 1: Sampling design formulas should be applied to determine the minimum number of points that observer's need to visit and the minimum number of cases that should be observed in order to receive data representative for the entire program situation.</p> <p>Step 2: Points of service delivery are identified for observation. Using the current schedule with specific time and venues of service delivery, certain 'points' (place/time) are randomly chosen. If services are provided by community or hospital-based centers, certain hours for the visit are randomly selected. Outreach routes and mobile points of service delivery are also included in the sample design. Random selection of points guarantees obtaining of results that can be extrapolated to the real situation.</p> <p>Step 3: Observer records the information on services compliance with minimum standard of quality in observational form, similar to monitoring visit form.</p> <p>Step 4: Data are entered into an electronic database.</p> <p>Step 5: Analysis of the consistency of the observed patterns with project reporting and quality standards is carried out</p> <p>Step 6: Percentage of observed services that fully meet the quality standards is calculated.</p>

Method of measurement	<p>Numerator: Number of services observed which were fully compliant with the quality standard.</p> <p>Denominator: Total number of observed services</p>
Disaggregation	<p>Disaggregation might be useful for managerial programmatic decisions; in this case, it is recommended to disaggregate as follows:</p> <ul style="list-style-type: none"> - By localities – identifies which localities require more managerial attention - By organizations – the rating of organizational capacity shows who needs technical support and who might be an example of good practices - By services – identifies which services require improvement - By quality criteria – identifies which components of service provision need improvement
Interpretation and commentaries	<p>One benefit of this indicator is that it provides statistically reliable information on the quality of services in a particular region / program. This enables progress monitoring in the area, and allows some general assumptions about the extent of possible influence from interventions.</p> <p>Another positive element is that the methodology does not involve a clients' questionnaire. This helps minimize client bias. In the post-Soviet region, clients from stigmatized groups may exaggerate the quality of the service because they have no experience with other service providers, and wish to "protect" and support their NGOs and outreach workers, seeing them as an important part of their lives.</p> <p>It should be noted that in such studies, research ethics are very important. The observer must understand confidentiality principles. Clients must be informed about the observer and her/his role. Clients are supposed to give a verbal or written informed consent to receive the service in presence of the observer. If a client does not agree, than the observer should excuse himself temporarily leave from the service delivery point and record the case as a "refused observation."</p>

1.8. Quality: Total organizational quality rating of prevention services

Purpose	<p>This indicator evaluates organizations' capacity to provide qualitative preventive services to MSM/TG. The evaluation is applied to those services for which community based organizations are usually responsible:</p> <ul style="list-style-type: none"> - Counseling - Referral - Distribution of supplies (condoms, lubricants) - Dissemination of information materials
Measurement tool	Program monitoring visits

Data collection frequency	Annually. Mean rating resulting from all monitoring visits during the year
Method of data collection	<p>Step 1: During the monitoring visit observer fills monitoring form that evaluates the process of providing services. Compliance with quality standards is determined following the list of quality criteria:</p> <ul style="list-style-type: none"> a. The completeness of the service provided (all specified components of a designed service were offered to a client) b. Confidentiality and safety c. Professionalism of the staff (knowledge and skills) d. Quality of distributing materials <p>Step 2: Provision of any observed service receives several scores obtained for each of the above listed criteria:</p> <ul style="list-style-type: none"> - A (or for a numerical rating to calculate the average estimate – “3”): excellent, fully compliant with the standard; - B (or “2”): good, complies with the standard no less than 80%; - C (or “1”): satisfactory, complies with standard no less than 50%; - D (or “0”): unsatisfactory, complies with standard less than 50% /serious violations <p>Step 3: Each observed service case receives a total average score, considering all assessed criteria.</p> <p>Step 4: Each service providing organization receives an average score, considering all cases observed.</p> <p>Step 5: Each service providing organization receives an annual average score, considering result of all planned monitoring visits (preferably 4 quarterly visits, or a minimum of two semi-annual visits).</p> <p>Step 6: Program indicator on overall average organizational rate is calculated.</p>
Method of measurement	<p>Numerator: Sum of all annual ratings achieved by monitored organizations (scores obtained in step 5)</p> <p>Denominator: Number of all organizations providing HIV services which were monitored</p>
Disaggregation	<p>Disaggregation might be useful for managerial programmatic decisions; in this case, it is recommended to disaggregate as follows:</p> <ul style="list-style-type: none"> - By localities – identifies which localities require more managerial attention - By organizations – the rating of organizational capacity shows who needs technical support and who might be an example of good practices - By services – identifies which services require improvement - By quality criteria – identifies which components of service provision need improvement

Interpretation and commentaries	<p>One key aspect of this approach is its focus on organizations that provide preventive services, which enables program implementers (or others) to estimate the level of demonstrated capacity of HIV-service organizations to provide quality services to MSM/TG.</p> <p>Unsatisfactory results of the monitoring will indicate that the organization needs technical assistance. Strong, positive results may be used to pilot the expansion of best practices.</p>
Information source	<p>Similar approach to measurement of services' quality is described in the publication by ICF/International HIV/AIDS Alliance in Ukraine: <i>Monitoring and evaluation of programs and projects. A practical guide</i>. OS Morozova et al. - K.: Oranta 2008. - 142 p⁵.</p>

1.10.b. Percentage of MSM/TG who received an HIV test in the last 12 months and who know their results

Purpose	<p>Indicator measures progress in implementing HIV testing and counseling among men who have sex with men. HCT is a powerful tool for HIV prevention. It is therefore important to assess how much of the target group is covered with the service.</p>
Measurement tool	Behavioral Surveillance Survey for MSM/TG
Data collection frequency	Every two years
Method of data collection	<p>Respondents answer two questions asked in the following sequence:</p> <ol style="list-style-type: none"> 1. Have you been tested for HIV in the last 12 months? (And, if yes:) 2. I don't want to know the results, but did you receive the results of that test?
Method of measurement	<p>Numerator: Number of respondents who answered "yes" to both questions</p> <p>Denominator: Number of men who have sex with men responding to the questions</p>
Disaggregation	<p>By Age: <25/25+</p> <p>Disaggregation by age groups makes it possible to track the situation among young MSM/TG. Very often youth are more susceptible to risk, and less covered with prevention at the same time.</p>

⁵ In Russian: Мониторинг и оценка программ и проектов. Практическое пособие / О.С. Морозова, О.В. Варецкая, Д. Джонс, П. Чикуква, Т.А. Салюк – К. Оранта 2008. – 142 с

Interpretation and commentaries	Presumably, respondents answering this question may be referring to different types of test methods, including both laboratory tests by ELISA method (Enzyme immunoassay) and rapid-tests used for screening.
Original indicator	Indicator is adapted from GFATM HIV-C-P6 “Percentage of most-at-risk populations (IDU, MSM/TG, and SW) who received an HIV test in the last 12 months and who know their results” and UNAIDS 1.13 (former UNGASS №8).

1.11. Percentage of men who have sex with men reached with HIV prevention programs

Purpose	Indicator gives an opportunity to assess the coverage of MSM/TG with minimal prevention services within the last 12 months.
Measurement tool	Behavioral Surveillance Survey for MSM/TG
Data collection frequency	Every two years
Method of data collection	Respondents answer two questions: 1. Do you know where you can go if you wish to receive an HIV test? 2. In the last twelve months, have you been given condoms?
Method of measurement	Numerator: Number MSM/TG who replied “yes” to both questions. Denominator: Number MSM/TG who replied “yes” to both questions.
Disaggregation	By Age: <25/25+ Disaggregation by age groups makes it possible to track the situation among young MSM/TG. Very often, youth are more susceptible to risk and less covered with prevention at the same time.
Interpretation and commentaries	The indicator does not reflect the quality, frequency, and comprehensiveness of services used. It also can produce overestimated evaluation of MSM/TG coverage. At the same time, the indicator gives a clue as to what part of MSM/TG community is reached by minimal services.
Original indicator	Indicator corresponds to GF ATM HIV-C-P3 “Percentage of most-at-risk populations (IDU, MSM/TG, and SW) reached with HIV prevention programmes,” as well as UNAIDS 1.11 (former UNGASS #9).

Outcome indicators

1.14. Percentage of MSM/TG who both correctly identify ways of preventing the sexual transmission of HIV and who reject major misconceptions about HIV transmission

Purpose	Sexual transmission is the main risk factor for MSM/TG. Thus, correct knowledge about HIV prevention is among the main requirements for changing behaviors to lower risk behaviors. This is why knowledge measurement is included as a program outcome indicator.
Measurement tool	Behavioral Surveillance Survey for MSM/TG
Data collection frequency	Every two years
Method of data collection	<p>Respondents are asked the following five questions:</p> <ol style="list-style-type: none"> 1. Can having sex with only one faithful, uninfected partner reduce the risk of HIV transmission? 2. Can using condoms reduce the risk of HIV transmission? 3. Can a healthy looking person have HIV? 4. Can a person get HIV from mosquito bites? 5. Can a person get HIV by sharing a meal with someone who is infected? <p>According to UNAIDS, program implementers doing their own surveys may replace the two last questions with two others that relate to the most common misconceptions about HIV in their specific countries.</p>
Method of measurement	<p>Numerator: Number of respondents who gave the correct answers to all five questions.</p> <p>Denominator: Number of respondents who gave answers including “don’t know” to all five questions.</p>
Disaggregation	<p>By Age: <25/25+</p> <p>Disaggregation by age groups makes it possible to track the situation among young MSM/TG. Very often, youth are more susceptible to risk and less covered with prevention at the same time.</p>
Interpretation and commentaries	<p>Knowledge indicators are best used to measure short-term effects of a program. Knowledge changes faster than behavior. Questions used for this indicator reflect the most common misconceptions about HIV transmission. For example, opinions that a healthy looking person cannot be infected with HIV or that HIV is transmitted through mosquito bites (these misconceptions can weaken a person’s motivation to adopt safer sexual behavior). The belief that HIV can be transmitted through sharing meals can reinforce the stigma faced by people living with AIDS.</p>
Original indicator	<p>This indicator is adapted from PEPFAR #P9.1.N, as well as former UNGASS №14: “Percentage of most-at-risk populations (IDU, MSM/TG, and SW) who both correctly identify ways of preventing the sexual transmission of HIV and who reject major misconceptions about HIV transmission.”.</p>

1.15. Percentage of men reporting the use of a condom the last time they had anal sex with a male partner

Purpose	Unprotected anal sex constitutes the main risk factor of HIV transmission for MSM/TG. The indicator measures progress in preventing exposure to HIV among men who have unprotected anal sex with a male partner.
Measurement tool	Behavioral Surveillance Survey for MSM/TG
Data collection frequency	Every two years
Method of data collection	Respondents answer following questions: <ol style="list-style-type: none"> 1. Have you had sexual intercourse in the last 6 months? If the answer is «yes»: 2. Have you had anal sex with male partners in the last 6 months? If the answer is «yes»: 3. Have you used a condom during your last anal intercourse with male partner?
Method of measurement	Numerator: The number of respondents who reported using a condom the last time they had anal sex with a male partner. The partner could be of any type – steady, occasional or infrequent, or commercial. Denominator: The number of respondents who reported having had anal sex with a male partner in the last six months.
Disaggregation	By Age: <25/25+ Disaggregation by age groups makes it possible to track the situation among young MSM/TG. Very often, youth are more susceptible to risk, and less covered with prevention at the same time.
Interpretation and commentaries	Condom use with the most recent partner is a recognized indicator of safe behavior. However, there are also some limitations to full understanding of the risk profile for MSM/TG, since the indicator does not reflect the types and number of partners, as well as whether a person is receiving or insertive partner. The indicator also does not reflect the practice of condom use with female partners, which is also the important aspect of behavior in terms of HIV transmission.
Original indicator	Indicator is identical to UNAIDS 1.12 (former UNGASS №19) “Percentage of men reporting the use of a condom the last time they had anal sex with a male partner.” The indicator is included in the GFATM and PEPFAR lists (HIV-o5 and #P9.4.N respectively). Another behavior indicator, GFATM HIV – o4, PEPFAR #P9.2.N, former UNGASS №18, reflects the situation in sex workers’ group: “Percentage of female and male sex workers reporting the use of a condom with their most recent client [disaggregated by sex (female, male) and age].” Disaggregation of this indicator by sex gives important information on male sex

	workers as a subgroup of MSM/TG. If possible, this indicator may be included in reporting as an additional indicator. This indicator is particularly important if projects provide services to male sex workers. To obtain information on this indicator, both sentinel surveillances for MSM/TG and SWs can be used, if a subgroup of male sex workers is included in the sample.
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Impact indicators

4.1. Percentage of men who have sex with men who are HIV-infected

Purpose	The index measures the progress in reducing the HIV prevalence among MSM/TG
Measurement tool	Sentinel Surveillance (may be related to the monitoring of the knowledge and behavior of MSM/TG)
Data collection frequency	Every two years
Method of data collection	The indicator provides information obtained during testing of MSM/TG for HIV. To track changes over time, it is important to stick to the same methodology and to perform testing in the same localities.
Method of measurement	Numerator: Number of MSM/TG tested, whose HIV test result were positive Denominator: Number of MSM/TG tested for HIV
Disaggregation	<p>– By age (<25, 25+)</p> <ul style="list-style-type: none"> - By duration of practicing risky behavior (first anal sex with a male partner during the last 12 months, first anal sex with a male partner earlier than the last 12 months) - By sites / localities <p>Disaggregation by age and by the duration of practicing risk behavior is important for understanding the epidemic's trends. Changes in HIV prevalence among those who have recently started to practice risky behavior can illustrate the effect of preventive efforts, whereas in the rest of group, prevalence changes much more slowly as a result of the introduction of ARV, which significantly increases the length of living for PLWHA. Disaggregation by sites is important to track regional trends and preventive efforts.</p>
Interpretation and commentaries	<p>The most appropriate assessment of progress in addressing the epidemic is incidence indicators, or the number of new infection cases per year. However, when it is about HIV infection, such data are almost impossible to obtain. Since HIV infection is asymptomatic in the early stages, people can live for years without knowing their HIV status. They may also do not know the time when they became infected. The indicator of "new cases registered" is not appropriate because it reflects not only the level of HIV spread, but also the availability of HIV testing services. Regions where access to HCT is increasing demonstrate simultaneously increasing number of HIV cases reported.</p> <p>Therefore, international monitoring guidelines suggest the use of the prevalence</p>

	<p>indicator, but bearing in mind that successful introduction of ARV leads to an increase in life expectancy, which, as a result, keeps the prevalence of a certain level. For example, Global Fund’s monitoring manual recommends extracting from the available HIV prevalence data information on those who were recently engaging in risky behavior. In the case of MSM/TG, HIV prevalence is checked among those who have had a first experience with anal sex with a man in the past 12 months. These data are not distorted by ARV availability in the region.</p> <p>To see trends in the epidemic, it is very important to conduct surveillance in the same locations. If over a certain period of time the program has expanded to other sites, and these sites were subsequently included in measurements, it is important to continue to assess the data trends from the original sites where surveillance was initially conducted.</p>
Original indicator	<p>The indicator is identical to GFATM (HIV – I4) and UNAIDS 1.14, “Percentage of men who have sex with men who are HIV-infected.”</p> <p>It is also similar to PEPFAR #P9.17.N and former UNGASS №23, “Percentage of most-at-risk populations (IDU, MSM/TG, and SW) who are HIV-infected - Disaggregation: By MARP population: IDU, MSM/TG, and SW.”</p> <p>There is also a similar indicator for sex workers, “Percentage of sex workers who are HIV-infected.”^{xiii} Disaggregation if this indicator’s data by sex gives an important impact indicator for male sex workers, who are usually a subgroup of MSM/TG. If possible, this indicator may be included in reporting as an additional indicator. This indicator is particularly important if projects that provide services to male sex workers. To obtain information on this indicator, both sentinel surveillances for MSM/TG and sex workers can be used, if a subgroup of male sex workers is included in the sample.</p>

4.2. Percentage of MSM/TG with active form of syphilis (or other STI)

Purpose	STIs are not only harmful to health, but also increase the likelihood of HIV transmission. Prevention programs for MSM/TG include services for the prevention and treatment of STIs, which should lead to a decrease in the prevalence of STIs among MSM/TG. Syphilis is one of the most dangerous STIs, which are defined by the World Health Organization (WHO) as a disease that requires regular serological monitoring among MSM/TG ^{xiv} . However, depending on the needs of the region in which the program is implemented, it is possible to measure the prevalence of other STIs.
Measurement tool	Sentinel Surveillance (may be related to the monitoring of the knowledge and behavior of MSM/TG)
Data collection frequency	Every two years
Method of data collection	The indicator provides information obtained in the course of testing for syphilis among MSM/TG (tests for the reaginic and treponemal antibodies’ presence in

	<p>blood).</p> <p>To see epidemic trends is very important to conduct surveillance in the same locations.</p> <p>As recommended by the WHO, the most common approach to determine active syphilis prevalence among MSM/TG requires a two-step testing procedure. The first step is screening by a non-treponemal test that measures reaginic antibodies. Then, positive results should be confirmed by treponemal test on treponemal antibodies. A treponemal test measures lifetime exposure, whereas the non-treponemal test is a better indicator of active infection. According to the WHO, syphilis prevalence among MSM/TG should be calculated when both tests results are positive.</p> <p>If a program puts an emphasis on the prevention of other types of STIs, and the STI impact indicator involves measurement of other STIs' prevalence, it is important that testing and measurement procedures meet the standards adopted at the national and / or international levels.</p>
Method of measurement	<p>Numerator: Number of MSM/TG tested for syphilis, who received positive results (for both test - treponemal and non-treponemal for reaginic antibodies)</p> <p>Denominator: Number of MSM/TG tested for syphilis</p>
Disaggregation	<p>– By age (<25, 25+)</p> <ul style="list-style-type: none"> - By duration of risky behavior practicing (first anal sex with a male partner during the last 12 months, first anal sex with a male partner earlier than the last 12 months) - By sites / localities
Interpretation and commentaries	<p>The two-test procedure is more complex than testing with one of these tests. But the results of the two-test procedures more reliably indicate the situation among MSM/TG. Quality control is an important part of the testing procedure for syphilis. Analysis of epidemic trends is possible only for comparable data (similar geography, methods of sampling, testing procedures, etc.). If sample testing is not conducted in one short period of time, but during some long period, it is important to ensure that the same people are not counted more than once.</p>
Original indicator	<p>The indicator is identical to WHO # F5, "Percentage of MSM/TG with active syphilis."</p> <p>There is a similar WHO indicator, #F4 for sex workers, "Percentage of sex workers with active form of syphilis."^{xv}. Disaggregation by sex here provides an important impact indicator for male sex workers, who are usually a subgroup of MSM/TG. If possible, this indicator may be included in reporting as an additional indicator. This indicator is particularly important if projects provide services to male sex workers. To obtain information on this indicator, both sentinel surveillances for MSM/TG and SWs can be used, if a subgroup of male sex workers is included in the sample.</p>

2. Treatment, Care and Support to MSM/TG Living with HIV.

The Regional Package of Services treatment, care and support for HIV-positive MSM/TG section includes the best practices that have been proven in Eastern Europe. The list of services is based on a comprehensive and integrated approach. This does not mean that every organization that works with HIV-positive MSM/TG should provide the entire range of services. However, it is important to guarantee availability and affordability of the comprehensive package of services through building partnerships and referral systems with other organizations working in the area of HIV care and support.

Table 2. List of Services Package for the component "Treatment, Care and Support"

Services as listed in the Package	Types of activities	Service providers*
Positive prevention and staying healthy for HIV positive MSM/TG	Assessment of sexual activity and provision of condoms (and lubricants) and risk reduction counseling (if indicated) (activities under PEPFAR indicator for prevention with Positives)	HCF, NGO
	Assessment of partner status and provision of partner testing or referral for partner testing (activity under PEPFAR)	HCF, NGO
	Assessment for STIs and (if indicated) provision of or referral for STI treatment and partner treatment (activity under PEPFAR)	HCF, NGO
	Assessment of family planning needs and (if indicated) provision of them (activities under PEPFAR indicator for prevention with Positives)	HCF, NGO
	Assessment of adherence and (if indicated) support or referral for adherence counseling (activities under PEPFAR)	HCF, NGO
	Assessment of need and (if indicated) referral or enrollment of PLHIV in community-based program such as home-based care, support groups, post-test-clubs, etc.) (Activities under PEPFAR)	HCF, NGO
	Medical services of different specialization (infectionist, proctologist, urologist, andrologist, dentist, psychiatrist, STI specialists, etc.)	HCF, NGO promotes access
Access to ARV treatment	Appointment of ARV	HCF, NGO promotes access
	Diagnostics (HIV, CD4, TB, viral load)	HCF, NGO promotes access
	ARV delivery	HCF, NGO promotes access
	ART monitoring	HCF, NGO promotes access

ART adherence programs	The package does not specify which activities are meant but these may include training, counseling, adherence monitoring, case management, distribution of watches with the signal, containers for pills and other.	NGO
Access to prevention and treatment of opportunistic infections	Diagnosis of opportunistic and other related diseases (tests, CT, MRI)	HCF, NGO promotes access
	Provision of drugs for the treatment of associated diseases (antifungal medicines, ointments, sprays, oxolinic ointment during the influenza epidemic, the ointment for the treatment of cold sores, liver protectors)	HCF, NGO
	Provision of medical supply items (syringes, bandages, alcohol, cotton, latex gloves, gauze bandages, disinfectants for hand washing)	HCF, NGO
	Treatment of opportunistic infections	HCF, NGO promotes access
	Health and recreational activities (medical recreational centers, summer camps)	HCF, NGO
	Prevention of opportunistic infections (cotrimoxazole prescription and others)	HCF, NGO promotes access
Access to TB prevention and treatment	TB diagnostics	HCF, NGO promotes access
	Isoniazid prophylaxis	HCF, NGO promotes access
	Building and maintaining of adherence to treatment	NGO
	TB treatment	HCF, NGO promotes access
Access to prevention and treatment of STIs	Distribution of personal protective means (condoms and lubricants)	NGO
	Free (or affordable) anonymous STI diagnostics by in-laboratory methods (syphilis, Chlamydia, gonorrhea, other available services)	HCF, NGO promotes access
	Free anonymous STI screening by rapid tests and involvement to in-laboratory diagnostics	HCF, NGO
	Referral, motivational counseling, support in order to provide the client with STI testing	NGO
	Free (or affordable) anonymous STI treatment (syphilis, Chlamydia, gonorrhea, other available services)	HCF, NGO promotes access

	Referral, motivational counseling, support in order to provide the client with STI treatment	NGO
	Free (or affordable) anonymous viral hepatitis testing	HCF, NGO promotes access
	Free (or affordable) anonymous viral hepatitis treatment	HCF, NGO promotes access
Psychosocial Support of MSM/TG living with HIV	Support groups	NGO
	Self-help groups	NGO
	Psychotherapeutic groups	NGO
	Telephone counseling	NGO
	Peer counseling	NGO
	Counseling of specialists (psychologist)	NGO
	Case management. Development of individual follow-up plan for every client	NGO
	Information sessions regarding life with HIV/AIDS, ARV-therapy and sexual behavior	NGO
	Organization of leisure time (cinema club, drama studio, library, hobby groups, gym, dating club, evening parties, Internet browsing, attending cultural and public events – cinemas, theaters, excursions, concerts and shows)	NGO
	Trainings or other educational activities for peer educators and community volunteers	NGO
	Provision of information materials	NGO
	Community center /drop-in center	NGO
Work with HIV-positive MSM/TG with disabilities	NGO	
Home based and palliative care	Psychological support	NGO
	Spiritual and religious support (based on a client's needs)	NGO
	Social support (protection of client's rights to social security, involving social services, financial assistance - food, care, clothing,)	NGO
	Nutrition (training caregivers with skills on balanced nutrition, food preparation, and assistance in eating)	NGO
	Assistance in case of physical disabilities (caring for the sick and housing)	NGO

	Education on community care (relatives, partner, friends, volunteers)	NGO
	Planning assistance (testament, family support, funerals, etc.)	NGO
	Program for caregivers	NGO
	“Buddy System” program	NGO
	Hospice	HCF, NGO promotes access

Very often, international monitoring guidelines for treatment, care and support do not disaggregate care and support indicators for different subgroups of PLWHA. This is justified in terms of overall national monitoring of treatment programs, when PLWHA are seen as one target group. However, in the case of some particularly stigmatized subgroups of PLWHA, this may indirectly support strategies of exclusion. In post-Soviet territories, HIV-positive MSM/TG may become such excluded group. In-country assessments show that care and support services are underdeveloped in the region^{xvi}. NGOs that implement care and support programs may refuse to work with MSM/TG, either directly or indirectly, referring to other priorities in their work, community disapproval of their interaction with MSM/TG, and other reasons. MSM/TG also may be under-represented in national networks of PLWHA, since in the post-Soviet region these networks were historically formed by people affected by the injection drug use driven epidemic. All these external barriers are accompanied by an internal stigma among MSM/TG, wherein the HIV-positive person is afraid of losing his (or her) usual social relationships. As a result, countries may simply lack community organizations that provide care and support services targeting HIV-positive MSM/TG. In many cities there may be a lack of self-help groups for HIV-positive MSM/TG in NGO or HCFs because of stigmatization within the community.

In such circumstances, a monitoring tool that requires disaggregation of care and support indicators to reflect the true situation of HIV-positive MSM/TG, is needed to better support and enhance efforts to integrate MSM/TG into care and support programs.

Process and result indicators

2.1. Number of HIV-positive MSM/TG reached with a minimum package of prevention with PLHIV (PwP) interventions

2.10. Percentage of HIV-positive MSM/TG reached with a minimum package of prevention with PLHIV (PwP) interventions

Purpose	The indicator is necessary to measure the coverage of HIV-positive MSM/TG with a minimum package of positive prevention services. Positive prevention is an important part of overcoming the HIV spread. Positive prevention includes a whole range of behavioral and biomedical interventions aimed at maintaining the health of HIV-positive people, preventing their re-infection of HIV and STIs, as well as preventing the transmission of HIV to their sexual partners.
Measurement	Program reporting

tool	
Data collection frequency	Annually. Data is collected during the year and summarized in the quarterly and annual reports.
Method of data collection	<p>Program reporting allows calculating the number of HIV-positive MSM/TG who received a minimum package of prevention services during the reporting period of 12 months. Services can be delivered either by community-based organizations or by medical institutions.</p> <p>Minimum prevention package for PLWHA is defined accordingly to the PEPFAR manual and includes:</p> <ul style="list-style-type: none"> • Assessment of sexual activity and provision of condoms (and lubricants) and risk reduction counseling (if indicated) • Assessment of partner status and provision of partner testing or referral for partner testing • Assessment for STIs and (if indicated) provision of or referral for STI treatment and partner treatment • Assessment of family planning needs and (if indicated) provision of them • Assessment of adherence and (if indicated) support or referral for adherence counseling • Assessment of need and (if indicated) referrals or enrollment of PLHIV in community-based program such as home-based care, support groups, post-test-clubs, etc. <p>Family members and partners of clients who received similar services are not included in this indicator.</p> <p>Accordingly to PEPFAR, these services should be provided to every client at every visit for HIV services. However, for the regional monitoring tool presented here it is enough to receive all services of the minimum package at least once during the reporting period.</p> <p>If part of the services is provided on referral a basis by partner organizations, it is important to certify that their services are available to clients. All HIV-positive clients must be provided with condoms and lubricants in sufficient quantity, as well as with counseling on risk reduction, including condom use and substance use (including alcohol). If the HIV- status of a client’s partner is unknown or negative, the partner must receive HTC no less than once a year. All discordant couples should receive counseling and other appropriate services for prevention. Routine screening for STIs, as well as STI treatment provision for clients and their partners are mandatory. ARV adherence is an important for maintaining the low viral load, which reduces the risk of transmission.</p>
Method of measurement	<p>Numerator: The number of HIV-positive MSM/TG who received a minimum package of prevention services at least once during the reporting period (including both services provided by medical institutions and public organizations)</p> <p>Denominator (if the coverage is counted): Estimated number of HIV-positive</p>

	MSM/TG in the country / region where the program is being implemented ⁶
Disaggregation	<p>- By type of HIV-service providing organization (community-based, HCF-based)</p> <p>Such disaggregation is useful to clarify which types of services are more frequently requested by the target audience.</p>
Interpretation and commentaries	<p>The indicator provides information that illustrates the coverage of the target audience by positive prevention services. Due to a possible lack of data and high levels of external and internal stigma, it may be difficult to determine the denominator. But if there are relevant opportunities (data, resources for research), calculation of the coverage is highly recommended.</p> <p>According to the PEPFAR monitoring guidelines from which the indicator was adapted, a client must receive all services of the minimum package at every visit to the HIV service provider. Therefore, the original indicator includes only those clients who have received all of the services of the package at their final visit. However, for this monitoring tool, it was decided to make the requirements less stringent. Therefore, clients are counted under this indicator if they have received each of the listed services at least once during the 12-month period.</p>
Original indicator	Indicator is adapted from PEPFAR P7.1.D, “Number of People Living with HIV/AIDS (PLHIV) reached with a minimum package of Prevention with PLHIV (PwP) interventions”

2.2. Number of eligible HIV-positive MSM/TG, their partners and family members provided with a minimum of one care and support service

Purpose	Indicator provides information on how many care and support services are available to HIV-positive MSM/TG, their partners, and family members. The HIV epidemic affects not only key populations, but their partners and family members. Therefore, a comprehensive response to the problem and support of PLHWA and their partners/families contributes to the better health of PLWHA. Internal and external stigma can impede HIV-positive MSM/TG and their partners and family members from receiving these vital services.
Measurement tool	Program reporting
Data collection frequency	Annually. Data is collected during the year and summarized in the quarterly and annual reports.
Method of data collection	Unique clients who received at least one HIV care and support service are counted.

⁶ Estimated number of HIV-positive MSM/TG can be determined using estimates on the number of MSM/TG in general and data on HIV prevalence among MSM/TG. This figure should then be compared with the officially registered number of HIV-positive MSM/TG in the country.

	<p>According to the PEPFAR guidelines, this indicator includes a wide range of care and support services, including a very wide range of social, psychological, and spiritual support services to those are affected by the epidemic.</p> <p>Clients which are recorded under this indicator include:</p> <ul style="list-style-type: none"> - HIV-positive MSM/TG - The family members of HIV-positive MSM/TG, the people who provide home care, and other household members living with an HIV-positive person.
Method of measurement	<p>Numerator: The number of people who received at least one service for care and support during the reporting period</p> <p>Denominator: irrelevant</p>
Disaggregation	<p>-By age (younger than 18, older than 18)</p> <p>This disaggregation is relevant to PEPFAR goals in projects supported by USAID There is a 5-year goal to provide care services to 5 million children.</p>
Interpretation and commentaries	<p>This indicator provides information on the total number of individuals receiving HIV care and support services for MSM/TG /GBT. For a client to be counted under this indicator he must receive at least one service from a range of services offered. Types of services, quality, quantity, their frequency and efficiency are not captured here.</p>
Original indicator	<p>This indicator is adapted from PEPFAR C1.1.N, “Number of eligible adults and children provided with a minimum of one care service.” The original PEPFAR indicator includes clinical and non-clinical services. For the MSM M&E tool, only non-clinical services are included. Clinical services are reflected under indicator 2.3., “Number of HIV-positive MSM/TG receiving a minimum of one clinical service.”</p> <p>It is necessary to emphasize that this indicator is important for programs supported by USAID, because it relates to a PEPFAR 5-year legislatively fixed goal - to provide care services for 12 million people.</p>

2.3. Number of HIV-positive MSM/TG receiving a minimum of one clinical service

Purpose	<p>The indicator evaluates the progress in achieving accessibility of HIV treatment services for MSM/TG.</p> <p>PLHWA must to receive comprehensive treatment, care, and support services in order to stay healthy, to postpone the necessity of ART initiation, and to increase their lifespan. However, clinical services are the most crucial for PLHA. Therefore, to be counted under this indicator, clients must receive at least one clinical service, such as clinical examination, ART eligibility assessment, TB diagnostics, or others.</p>
Measurement tool	<p>Program reporting, including records from AIDS Centers.</p>

Data collection frequency	Annually. Data is collected during the year and summarized in the quarterly and annual reports. The indicator is not cumulative. These are clients for a reporting period.
Method of data collection	Unique clients among HIV-positive MSM/TG who received at least one HIV clinical service during the reporting period, are counted. While calculating, it is important to avoid double counting, if services are provided by several facilities.
Method of measurement	Numerator: Number of people, who received at least one clinical service during reporting period Denominator: irrelevant
Disaggregation	-
Interpretation and commentaries	External and internal stigma may constitute a barrier for HIV-positive MSM/TG to receive vitally important services. The indicator counts all unique clients who received at least one clinical service in HCF, in community-based organization, or at home. The indicator does not reflect the types of services received, nor frequency, regularity, and efficiency of the services. Despite the fact that one received clinical service is sufficient for a client to be counted under the indicator, HIV-positive clients must receive comprehensive services on treatment, care, and support, delivered directly in the service organization or by referral. This indicator is being used as the denominator for counting coverage in a range of other indicators on treatment, care and support services.
Original indicator	The indicator is adapted from PEPFAR #C2.1.D, "Number of HIV-positive adults and children receiving a minimum of one clinical service."

2.4. Number of eligible HIV-positive MSM/TG currently receiving antiretroviral therapy

2.11. Percentage of eligible HIV-positive MSM/TG currently receiving antiretroviral therapy

Purpose	The indicator illustrates how many MSM/TG who need ART actually receive it. With the epidemic's duration, the number of people eligible for antiretroviral therapy is increasing. ART is an effective mean to decrease HIV-related mortality; and therefore should be accessible for those, who need it. The indicator is necessary to evaluate accessibility of ART for eligible HIV-positive MSM/TG.
Measurement tool	Program reporting, including records from AIDS Centers.
Data collection frequency	Annually. Data is collected during the year and summarized in the quarterly and annual reports. The indicator is not cumulative. These are clients for a reporting period.
Method of data collection	Registration of clients receiving ARV is conducted at the health facilities (AIDS Centers). It is important to remember, that those clients are counted who currently receive ARV.

Method of measurement	<p>Numerator: Number of HIV-positive MSM/TG who require ARV treatment, and who receive treatment accordingly to national clinical protocols (or accordingly to WHO and UNAIDS standards).</p> <p>Denominator (for coverage): Version 1. The indicator 2.3. «Number of HIV-positive MSM/TG receiving a minimum of one clinical service» during the reporting period</p> <p>Version 2 (if possible): Estimated number of HIV-positive MSM/TG who require ARV treatment.</p>
Disaggregation	-
Interpretation and commentaries	<p>The indicator shows the number of MSM/TG PLWHA covered with ARV treatment, but does not cover issues such as the differences between the forms of treatment, its price, quality, and efficiency.</p> <p>The number of people who need such treatment will vary depending on the stage of the epidemic, as well as on the achieved coverage by treatment. The achieved number of treatment coverage will also depend on the availability of treatment, its cost, availability of infrastructure for its administration and delivery, affordable and high-quality HTC services, and public perception of the effectiveness and side effects of the treatment. Stigma against MSM/TG may also be an obstacle to obtaining this vitally important service.</p> <p>If there is information on the estimated number of MSM/TG who require treatment, than it will be possible to observe the progress of ARV coverage in the target group. Comparison of the indicator values over the years will make it possible to assess trends for access to treatment for MSM/TG.</p>
Original indicator	The indicator is adapted from former UNGASS #4, “Percentage of eligible adults and children currently receiving antiretroviral therapy” and PEPFAR T1.2.D, “Number of adults and children with advanced HIV infection receiving antiretroviral therapy”ART

2.5. Number of HIV-positive MSM/TG who receive prevention of opportunistic infections (including TB and STI), in accordance to clinical protocols

2.12. Percentage of HIV-positive MSM/TG who receive prevention of opportunistic infections (including TB and STI), in accordance to clinical protocols

Purpose	This indicator tracks whether HIV-positive MSM/TG receive preventive therapy in accordance with clinical protocols. Such treatment prevents the development of opportunistic infections, including sexually transmitted infections and tuberculosis.
Measurement tool	Program reporting, including records from AIDS Centers.
Data collection frequency	Annually. Data is collected during the year and summarized in the quarterly and annual reports. The indicator is not cumulative. These are clients for a reporting period.

Method of data collection	Registration of clients receiving cotrimoxazole prevention and/or isoniazid preventive TB-treatment is conducted at the health facilities (AIDS Centers). It is important to remember that the clients who are counted are those who currently receive prevention treatment.
Method of measurement	Numerator: Number of HIV-positive MSM/TG who receive prevention treatment in accordance with clinical protocols (starting from one dose), including those who receive TB-prevention with isoniazid and opportunistic prevention with cotrimoxazole during the reporting period. Denominator (for coverage): The indicator 2.3, "Number of HIV-positive MSM/TG receiving a minimum of one clinical service" during the reporting period
Disaggregation	-
Interpretation and commentaries	External and internal stigma can place obstacles in the way of HIV-positive MSM/TG receiving these vitally important services. In order to assess how accessible these services are for MSM/TG PLWHA, it is important to calculate treatment, care, and support indicators separately for this subgroup of PLWHA. The indicator does not reflect the use of different types of prophylaxis for opportunistic infections, frequency of use, its cost, and efficiency. TB prophylaxis with isoniazid and cotrimoxazole prophylaxis are not disaggregated.
Original indicator	The indicator is adapted from GFATM #HIV-CS1, PEPFAR C2.2.D, "Number of HIV-positive persons receiving cotrimoxazole prophylaxis," and PEPFAR C2.6.D, "Number of eligible HIV positive patients starting Isoniazid Preventive Therapy (IPT)," as well as GFATM TB/HIV-4, "Number and percentage of adults and children newly enrolled in HIV care who start treatment for latent TB infection (isoniazid preventive therapy) among the total number of adults and children newly enrolled in HIV care during the reporting period."

2.6. Number of HIV-positive MSM/TG who were screened for TB in HIV care or treatment settings during the last 12 months

2.13. Percent of HIV-positive MSM/TG who were screened for TB in HIV care or treatment settings during the last 12 months

Purpose	Indicator tracks how much attention is paid to the diagnosis of tuberculosis among HIV-positive MSM/TG registered in the health care system. Many countries in the region have encountered TB epidemics. The prognosis for HIV / TB co-infection is much worse than for a single infection alone. Early diagnosis is vital so that timely treatment can begin. Internal and external stigma against GBT in the region is very noticeable and can hinder GBT from receiving these important services.
Measurement tool	Program reporting, including records from AIDS Centers.

Data collection frequency	Annually. Data is collected during the year and summarized in the quarterly and annual reports. The indicator is not cumulative. These are clients for a reporting period.
Method of data collection	Data for the numerator are gathered by counting unique clients registered in the health care system (e.g., the dispensary registration), who were screened for tuberculosis during the reporting period of the last 12 months at least once. TB-screening must be conducted in accordance with national clinical protocols and may involve clinical symptoms assessment and / or chest x-rays. If country-level dispensary registration forms for PLWHA do not include the regular screening for tuberculosis, they should be adjusted to meet these requirements.
Method of measurement	Numerator: The number of HIV-positive MSM/TG, when were screened for TB at least once during the reporting period. Denominator (for coverage): The indicator 2.3. «Number of HIV-positive MSM/TG receiving a minimum of one clinical service» during the reporting period
Disaggregation	-
Interpretation and commentaries	The indicator provides information on the proportion of HIV-positive MSM/TG who are being given care, and who were screened for TB at least once during the reporting year. The in time increase in figures will show that efforts to provide TB screening were increased. According to the Global Fund and PEPFAR indicators, screening for tuberculosis should be carried out every time a client visits HIV care facilities. The figure is supposed to include only those clients who have received screening at their final visit. However, for this monitoring tool requirements were reduced.
Original indicator	Adapted from PEPFAR C2.4.D TB/ HIV, “Percent of HIV-positive patients who were screened for TB in HIV care or treatment settings.” (#TB/HIV-1), “Number and percentage of adults and children enrolled in HIV care who had TB status assessed and recorded during their last visit during the reporting period among all adults and children enrolled in HIV care and seen for care in the reporting period.”

2.7. Number of HIV-positive MSM/TG at care, who has started TB-treatment

2.14. Percent of HIV-positive MSM/TG at care, who has started TB-treatment

Purpose	The indicator helps to track the number of HIV-positive MSM/TG who were diagnosed for active tuberculosis and receive anti-tuberculosis treatment. Thus, the indicator covers two important dimensions of treatment programs for PLWHA, TB diagnosis and treatment. Many countries in the region have experienced TB epidemics. The prognosis for HIV/TB co-infection is much worse than for a single infection alone. Early diagnosis is vital for timely treatment. Internal and external stigma against GBT in the region is very noticeable and can hinder GBTs from receiving services.
Measurement tool	Program reporting, including records from AIDS Centers.

Data collection frequency	Annually. Data is collected during the year and summarized in the quarterly and annual reports. The indicator is not cumulative. These are clients for a reporting period.
Method of data collection	<p>The numerator is the number of HIV-positive MSM/TG who have started TB treatment during the reporting period.</p> <p>Despite the fact that a complete diagnosis and treatment of TB in the region is carried out mainly by TB facilities, it is important for HIV health care facilities (e.g., AIDS centers or primary health care facilities) to have strong links with TB facilities and to keep records on TB diagnosis and treatment for PLWHA.</p>
Method of measurement	<p>Numerator: The number of HIV-positive MSM/TG, who have started TB treatment during the reporting period</p> <p>Denominator (for coverage): The indicator 2.3, “Number of HIV-positive MSM/TG receiving a minimum of one clinical service” during the reporting period</p>
Disaggregation	-
Interpretation and commentaries	<p>The indicator should provide information on the proportion of HIV-positive patients who have started TB treatment. The increase in figures should indicate improving access for HIV-positive MSM/TG to TB diagnosis and treatment.</p> <p>The value of the indicator must be analyzed simultaneously with the indicator on TB screening coverage. If results of the TB screening coverage are increasing, then results of TB treatment coverage should also increase. However, if the coverage of screening increases and treatment coverage does not, it indicates a problem such as insufficient cooperation between HIV and TB services. The post-Soviet space is dominated by vertical health care systems, in which the integration of HIV and TB services is not complete.</p> <p>Moreover, the proportion of HIV positive patients who begin TB treatment also depends on the availability of HTC, availability of HIV care and support services, and availability of the TB diagnosis and treatment. All of these dimensions should be considered while developing conclusions and recommendations based on the program monitoring.</p> <p>An important limitation of the indicator is that it provides no information about the number of patients who have successfully completed TB treatment. If registration forms AIDS Centers or other health facilities allow recording such information, it should also be used for analysis.</p>
Original indicator	The indicator is adapted from PEPFAR C2.5.D - TB/HIV, “Percent of HIV-positive patients in HIV care or treatment (pre-ART or ART) who started TB treatment,” GFATM TB/HIV-2, “Number and percentage of adults and children enrolled in HIV care who started TB treatment, expressed as a proportion of adults and children in HIV care during the reporting period,” and, former UNGASS #6, “Percentage of estimated HIV-positive incident TB cases that received treatment for TB and HIV.”

2.8. Quality: Total organizational quality rating of care and support services

Purpose	<p>The indicator helps to evaluate the level of HIV care and support services compliance to minimum standards of quality. Evaluation is applied to those services for which community based organizations are usually responsible:</p> <ul style="list-style-type: none"> - Counseling - Referral - Distribution of supplies (condoms, lubricants) - Dissemination of information materials - Case management - Adherence services - Positive prevention services - Palliative care services
Measurement tool	Program monitoring visits
Data collection frequency	Annually. Mean rating resulting from all monitoring visits during the year.
Method of data collection	<p>Step 1: During the monitoring visit, observer fills out a monitoring form that evaluates the process of providing services. Compliance with quality standards is determined according to the following list of quality criteria:</p> <ul style="list-style-type: none"> a. The completeness of the service provided (all specified components of a designed service were offered to a client) b. Confidentiality and safety c. Professionalism of the staff (knowledge and skills) d. Quality of distributing materials <p>Step 2: Provision of any observed service receives several scores obtained for each of the above listed criteria:</p> <ul style="list-style-type: none"> - A (or for a numerical rating to calculate the average estimate – “3”): excellent, fully compliant with the standard; - B (or “2”): good, complies with the standard no less than 80%); - C (or “1”): satisfactory, complies with standard no less than 50%; - D (or “0”): unsatisfactory, complies with standard less than 50% /serious violations <p>Step 3: Each observed service case then receives a total average score, taking into account all assessed criteria.</p> <p>Step 4: The service providing organization then receives an average score, taking into account all cases observed.</p> <p>Step 5: Service-providing organization receives annual average score, taking into account the results of all planned monitoring visits (preferably 4 quarterly visits, or a minimum of two semi-annual visits).</p>

	Step 6: Program indicator on overall average organizational rate is calculated
Method of measurement	<p>Numerator: Sum of all annual ratings achieved by monitored organizations (scores obtained at the Fifth Step)</p> <p>Denominator: Number of all HIV service – providing organizations, which were monitored</p>
Disaggregation	<p>Disaggregation might be useful for managerial programmatic decisions; for internal needs it is recommended to disaggregate as follows:</p> <ul style="list-style-type: none"> - By localities – identifies which localities require more managerial attention - By organizations – the rating of organizational capacity shows who needs technical support and who might be an example of good practices - By services – identifies which services require improvement - By quality criteria – identifies which components of service provision need improvement
Interpretation and commentaries	<p>One advantage of this quality assessment approach is its focus on organizations that provide care and support services. In such a way, program implementers can estimate the level of demonstrated capacity of HIV-service organizations to provide quality services to HIV-positive MSM/TG.</p> <p>Unsatisfactory results of the monitoring will indicate that the organization needs technical assistance. Strong, positive results can be grounds for the expansion of best practices.</p> <p>The approach’s disadvantage is the limited number of monitoring visits, which are bearable for program monitoring. This number might not be enough for comprehensive quality assessment.</p> <p>Evaluation of the services’ quality is possible only if there is an approved and implemented quality standard, either on national or project level.</p>
Original indicator	Similar approach to measurement of services’ quality is described in the publication by ICF/International HIV/AIDS Alliance in Ukraine: <i>Monitoring and evaluation of programs and projects. A practical guide</i> . OS Morozova et al. - K.: Oranta 2008. - 142 p ⁷ .

2.9. Quality: Percentage of HIV-positive MSM/TG who reported full compliance of the latest received care and support service with a minimum standard of quality

Purpose	Indicator quantifies the level of compliance of care and support services for MSM/TG with a minimum standard of quality. Evaluation is applied to those
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⁷ In Russian: Мониторинг и оценка программ и проектов. Практическое пособие / О.С. Морозова, О.В. Варецкая, Д. Джонс, П. Чикуквва, Т.А. Салюк – К. Оранта 2008. – 142 с

	<p>services, for which community based organizations are usually responsible:</p> <ul style="list-style-type: none"> - Counseling - Referral - Distribution of supplies (condoms, lubricants) - Dissemination of information materials - Case management - Adherence services - Positive prevention services - Palliative care services
Measurement tool	Special studies of service quality
Data collection frequency	Every two years
Method of data collection	<p>Subsample of the overall study on quality of services for PLHIV is composed of HIV-positive MSM/TG, who received any type of care and support during the reporting period. Respondents answer the question, “What was the last care and support service that they have received?” Then, according to their answer, they are asked additional questions with respect to the service quality standard. Questions must reflect quality criteria for each type of assessed service. Quality criteria usually include:</p> <ul style="list-style-type: none"> a. The completeness of the service provided (all specified components of a designed service were offered to a client) b. Confidentiality and safety c. Professionalism of the staff (knowledge and skills) d. Quality of distributing materials <p>It is highly important that the respondents are not asked about their subjective assessment of the service’s quality, but asked specific questions about what and how they have received services. Specific questions for the questionnaire should be developed separately and must include all relevant care and support services which have elaborated standard of quality.</p> <p>The numerator includes those respondents whose answers show that the latest received services were entirely compliant with all criteria of a quality standard.</p>
Method of measurement	<p>Numerator: The number of respondents whose responses indicate that the latest received care and support service was fully compliant with the minimum quality standard</p> <p>Denominator: Number of HIV-positive MSM/TG surveyed</p>
Disaggregation	<p>Disaggregation might be useful for managerial programmatic decisions. This is why for internal needs it is recommended to do disaggregation:</p> <ul style="list-style-type: none"> - By localities – identifies which localities require more managerial attention - By organizations – the rating of organizational capacity shows who needs technical support and who might be an example of good practices - By services – identifies which services require improvement

	<ul style="list-style-type: none"> - By quality criteria – identifies which components of service provision need improvement
Interpretation and commentaries	<p>The advantage of this indicator is its focus on clients' feedback. We obtain the percentage of clients whose last received service was fully compliant with quality standards. In case of HIV care and support programs, this survey method is more acceptable than direct observation, because it makes it easier to follow the principles of anonymity, confidentiality and voluntariness, as well as HIV status non-disclosure.</p> <p>Ethical conduct of research is very important for such a study. Each interviewed client is asked to give an informed consent. Also the survey program and tools are expected to comply with the research ethics principles.</p> <p>Survey can be conducted among the broad category of PLWHA in general. In this case, the sample should contain a sub-sample of HIV-positive MSM/TG / GBT. A disaggregation by subgroups of PLWHA gives the necessary information for this indicator.</p>

Outcome indicators

2.15. Percentage of HIV-positive MSM/TG known to be on treatment 12 months after initiation of antiretroviral therapy

Purpose	<p>The indicator measures progress in increasing the survival of HIV-infected people through their retention in the ARV programs.</p> <p>It is important to understand how many HIV-positive MSM/TG are retained in treatment programs, because the internal and external stigma against MSM/TG in the region as well as the lack of social and psychological support to HIV-positive MSM/TG may lead to the fact that they leave care programs.</p>
Measurement tool	Program reporting, ARV distribution registers.
Data collection frequency	Annually. Since the start of antiretroviral therapy, all the data on provision of ART is recorded. At the end of the reporting period, data on patients who received at least 12 months of treatment are summarized.
Method of data collection	<p>The indicator includes patients who started ARV in the 12-month period prior to the reporting period. For example, if the data to be reported is for the period from 1 January to 31 December 2014, then the patients who are counted are those who have started ARV during the period from January 1 to December 31, 2013.</p> <p>Numerator takes into account those patients who remain alive and continue to receive ARV after 12 months from the date of ARV initiation.</p> <p>The important components for the calculation of the numerator are:</p> <ul style="list-style-type: none"> - The number of patients who have started ARV during the 12 months before the beginning of the reporting period - The number of patients who are still alive and continue to take ARV for at

	<p>least a period of 12 months after the start of treatment.</p> <p>The numerator also includes individuals who have missed one or two meetings for getting drugs or temporarily stopped treatment, but are still listed as those who receive ARV. Those clients who died, stopped treatment, lost contact with HIV care facility are excluded from the indicator.</p> <p>The denominator is the total number of HIV-positive MSM/TG who have started ARV during the 12 months before the beginning of the reporting period.</p> <p>When counting clients in the health facility, those patients who were transferred from other health care facilities are also included if they fit the following criteria: they began ARV during 12 months before the beginning of the reporting period, and continue to take ARV after 12 months from the start of treatment. However, the health facilities from which such patients were transferred to, do not count .At the national level, the number of those discharged from one health facility and those who are registered in another health facility will be the same.</p>
Method of measurement	<p>Numerator: The number of HIV-positive MSM/TG who remain alive and continue to take ARV after 12 months from the start of treatment</p> <p>Denominator: The total number of HIV-positive MSM/TG who have started ARV during the 12 months before the beginning of the reporting period, including the dead, those who discontinue therapy, and those with whom contact has been lost.</p>
Disaggregation	-
Interpretation and commentaries	<p>The indicator does not accurately track "survival" because some of those who have discontinued treatment and do not maintain contact with health care facilities, remain alive.</p> <p>Increase or decrease in the survival rate after 12 months of ARV initiation can have various causes, which should be analyzed further using the information in the registration forms of ARV issuance. Improvements may be related to increase in treatment, care, and support quality, to earlier initiation into ARV, or other reasons.</p> <p>Also the indicator is narrowed to a period of 12 months after the initiation of ARV, however, for a more complete picture of survival with the support of ARV, it makes sense to track records for 24, 36, 48 months and more after the initiation of ARV. Such longer periods of receiving ARV may provide a more detailed understanding of the long-term effectiveness of treatment.</p>
Original indicator	The indicator is adapted from the GF HIV-I6, Global AIDS Response Progress Reporting Indicators №4.2, PEPFAR T1.3.D, "Percentage of adults and children with HIV known to be on treatment 12 months after initiation of antiretroviral therapy."

Impact indicators

4.3 Quality of life for HIV-positive MSM/TG

Purpose	The indicator shows the level of quality of life of HIV-positive MSM/TG. The quality of life should improve as a result of treatment, care and support programs. According to the WHO, quality of life is a concept that consists of multiple dimensions: physical, psychological, and social well-being. All of these dimensions should be displayed in the composite index of quality of life.
Measurement tool	Periodical cohort studies.
Data collection frequency	Every two years.
Method of data collection	<p>There are various standardized tools for measuring the quality of life. PEPFAR recommends the use of two small but comprehensive tools: MOS-HIV and SF 12.</p> <p>MOS-HIV is a specially designed tool for assessing the quality of life of PLWHA. The tool evaluates the subjective perception of diverse life dimensions, which are related to the impact of "HIV" diagnosis on a human. The tool includes questions on the overall functionality, overall satisfaction with life, financial problems, disclosure, treatment, sexual function and more.</p> <p>SF 12 is a general population self-assessment tool on overall functionality in relation to the physical and psychological health.</p> <p>Responding to the questions asked in these tools take five minutes of a respondent's time. Most often, clients fill them out while visiting HIV-care organizations.</p> <p>It is recommended to design a study sample on the cohort principle. This gives an opportunity to compare changes in quality of life over time within the group of the same people, tracing the impact of ARV on quality of life.</p> <p>While planning the study, it is recommended to follow particular guidelines describing the tools for assessment of the quality of life⁸.</p>
Method of measurement	<p>The average value of the quality of life indicator on standardized scales.</p> <p>Nominator: The total amount of points scored by all participants in the study.</p> <p>Denominator: The total number of the study participants.</p>
Disaggregation	-
Interpretation and	Evaluation of the quality of life of HIV-positive MSM/TG is aimed to reflect changes in the subjective perception of health and other dimensions of well-being.

⁸ For example, Albert W. Wu. MOS-HIV Health Survey Users Manual. Johns Hopkins University 1996, 1999

<http://149.142.76.35/assessment/pdf/assessments/MOS-HIV%20Users%20Manual%20%20Draft.pdf>

SF 12 Health Survey. <http://www.qualitymetric.com/WhatWeDo/SFHealthSurveys/SF12v2HealthSurvey/tabid/186/Default.aspx>

commentaries	Initially, the study should be conducted at the national level among PLWHA in general, but with disaggregation by target groups. Disaggregated data on MSM/TG is the indicator for monitoring the effects of treatment programs, care and support on well-being of HIV-positive MSM/TG.
Original indicator	The indicator is adapted from PEPFAR C2.10.N, “Quality of life for People Living with HIV/AIDS (PLHIV).”

4.4. Proportion of all deaths attributable to HIV

Purpose	The mortality rate is the most important indicator of the impact of HIV and AIDS, and the impact of measures to address the epidemic, in particular the measures to improve access to treatment. The indicator shows the effect of all the combined efforts at the national level. It should not be expected that the program, designed only for MSM/TG can have a significant impact on this indicator, taking into account that the epidemic in territories of the former Soviet Union is fueled by injecting drug use. However, it is recommended to monitor the change in this indicator, as it allows understanding the overall situation.
Measurement tool	MoH and AIDS Centers statistics
Data collection frequency	Annually
Method of data collection	International guidelines recommend the use surveillance data, household surveys, and evaluation. The recommended tool for the collection of representative data at the national level is the so-called Sample Vital Registration with Verbal Autopsy (SAVVY) ^{xvii} . However, in post-Soviet territories, mortality statistics from AIDS Centers are used. Deaths from AIDS-related causes are registered on the level of dispensary records. Even if a person was not registered in a dispensary during the course of his or her life, it is highly probable that this person will be recorded in the AIDS Center at the terminal stages of HIV infection, due to clinical examination.
Method of measurement	<ol style="list-style-type: none"> 1. Option: The proportion of deaths related to HIV Nominator: The number of deaths among adults (older than 15) due to reasons related to HIV and/or AIDS over a certain period of time Denominator: The total number of deaths among adults (older than 15) over a certain period of time. 2. Option: The number of deaths related to HIV per 100 000 of population Nominator: The number of deaths among adults (older than 15) due to reasons related to HIV and/or AIDS over a reporting period of time Denominator: The total number of adult population (in terms of per 100 000)

Disaggregation	- By sex.
Interpretation and commentaries	The increase in mortality rates may indicate the aging of the epidemic. Reduction in mortality may indicate effective increase in access to ARV. Efforts to include MSM/TG into treatment, care and support may have some positive effect on general decrease in mortality for reasons related to HIV.
Original indicator	Outcome indicator “Proportion of all deaths attributable to HIV” is included in the international M&E guidelines – GFATM HIV-I1, PEPFAR H4.1.N.

3. Enabling environment and community support for prevention and care

The third component of the package includes the following services:

1. Monitoring of human rights and legal support
2. Psychosocial support of gay identity: self-help groups, peer-to-peer counseling, group support
3. MSM/TG/LGBT community mobilization and involvement, organizational development of community groups such as CBOs, support of community events, and coordination among community centers

The activities under this component will not significantly change impact indicators, health and life expectancy. Therefore, a monitoring tool for this component is narrowed to indicators of results influenced by this component's activities.

Results indicators

3.1. Number of MSM/TG/LGBT, who participated in community-wide events

3.3. Percentage of MSM/TG/LGBT, who participated in community-wide events

Purpose	The indicator measures the coverage of unique clients who have taken the part in activities to mobilize community, support for gay identity, and the rights protection for MSM/TG.
Measurement tool	Program reporting
Data collection frequency	Annually.
Method of data collection	With the help of an electronic database for program reporting, count the number of unique clients who took part at least in one activity related to community mobilization, support for gay identities, and the protection of the rights of MSM/TG individuals. It is important to ensure there is no double counting of clients. The services that were accounted under indicators on "prevention," "treatment, care and support" components are not considered for this indicator.
Method of measurement	Numerator: The number of unique clients who took part in at least one mobilization, gay identity support, or human rights protection activity Denominator (for coverage): Total estimated number of MSM/TG in the country/region
Disaggregation	- By age <25, 25+ It is important to know which age groups are involved in community mobilization

	activities.
Interpretation and commentaries	Despite the fact that according to WHO, strengthening and mobilization of the gay community does not impact directly HIV epidemic ^{xviii} , these actions are recommended as a component of the PEPFAR comprehensive interventions for MSM/TG. Such activities form the human rights basis for the successful implementation of prevention, treatment, care, and support for MSM/TG ^{xix} .
Original indicator	Adaptation of the PEPFAR indicator P8.5.D, “Number of individuals from target audience who participated in community-wide event.”

3.2. Number of community-based organizations, which provide social mobilization, care and support services for MSM/TG in accordance with best practices or national/international standards

Purpose	The indicator shows the number of community-based organizations that operate in the region, providing services for community mobilization, HIV prevention, care and support for MSM/TG and following the international best practice.
Measurement tool	Organizational Assessment
Data collection frequency	Annually
Method of data collection	The Organizational Assessment is conducted on clearly defined criteria. To be counted an organization should have a formal status, and have provided medical and/or social services for MSM/TG community during the past 12 months. In addition, MSM/TG community representatives should be defined as a separate target group for the organization, and the key activities for MSM/TG should involve MSM/TG community representatives as board and staff members of the organization.
Method of measurement	Numerator: Number of community-based organizations in the country/region which have a formal status, provide social and health services for MSM/TG/LGBT in the past 12 months, and engage the participation of the MSM/TG/LGBT community in their activities.
Disaggregation	-
Interpretation and commentaries	Successful functioning of community-based organizations is important for strengthening communities’ capacities to represent the interests of particular groups. For the countries in the post-Soviet region, stigma and discrimination against MSM/TG can prevent the existence of NGOs willing to work with these groups. Many countries in the region need efforts to strengthen the capacity of MSM/TG through the support of community-based organizations that can provide community mobilization, as well as prevention and care services.

Original indicator	International M&E guidelines pay significant attention to indicators that reflect the community response to HIV epidemics. For example, GFATM indicator №7.1, “SDA 7: Community-based activities and services (delivery, use and quality): Number and percentage of community-based organizations that deliver services for HIV, Tb, malaria and immunization according to national or international accepted service delivery standards” and PEPFAR indicator H6.5.N, “Existence of effective civil society organizations.”
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Признаки скрытой эпидемии ВИЧ/СПИД: Мужчины, практикующие секс с мужчинами (МСМ) в странах Восточной Европы. Пакет Услуг по профилактике, уходу и поддержке для мужчин, практикующих секс с мужчинами, и для лесбиянок, геев, бисексуалов и трансгендерных лиц. ПРЕДВАРИТЕЛЬНЫЙ ВАРИАНТ ДЛЯ КОММЕНТАРИЕВ АМР США. Направлено в АМР США организацией "MSH" ДАТА: 16 февраля 2011 г.

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