

**Ministry of Health  
Viet Nam Administration of HIV/AIDS Control**

**National HIV Monitoring and Evaluation  
Framework**

**Hanoi, 19 January 2007**

## FOREWORD

The Government of Viet Nam and the Party have actively developed the HIV prevention and control program in Viet Nam by expanding several interventions and formulating the National Strategy on HIV/AIDS Prevention and Control in Viet Nam till 2010 with a vision of 2020. It has been universally agreed that the Government's efforts to combat HIV need to be accompanied by the improved use of information in order to assess the effectiveness of new and ongoing HIV programme initiatives.

In 2006, the Ministry of Health collaborated with professionals and experts from different Ministries and Departments, as well as international experts, in developing the Monitoring and Evaluation Framework. The framework brings together a set of key indicators on HIV prevention and control activities in Viet Nam. It is intended for use by national and provincial programme managers and others involved in planning, implementing, monitoring and evaluating HIV prevention and control activities. This framework also supports the use of information from these activities for improved policy-making and programming.

Over time, the indicators used in this framework will need to be reviewed and modified in response to policy needs, the realities of data collection efforts, and as well as National Strategy for the next period. As such, the M&E framework is intended as a working document designed to support evidence-based decision-making as Viet Nam continues to move forward with its response to HIV.

On behalf of the Ministry of Health, I would like to thank the active participation and close collaboration of ministries, mass organizations, UN agencies, government and international organizations as well as national and international experts in HIV/AIDS prevention and control activities in Vietnam, and particularly in formulating the National M&E Framework.

Hanoi, date 2007  
**VICE MINISTER**



*Trinh Quan Huan*

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- Tay Nguyen Institute
- National Institute of Dermatology and Venerology
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- World Health Organization (WHO)
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- Center for Diseases Control (CDC)
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And other organizations

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## LIST OF ABBREVIATIONS AND ACRONYMS

ABC	Abstinence, Be faithful, and Consistent condom use
AIDS	Acquired Immune Deficiency Syndrome
ANC	Antenatal Clinic
ART	Antiretroviral Therapy
ARV	Anti Retrovirus/Antiretroviral
BCC	Behavior Change Communication
BSS	Behavioral Surveillance Survey
CDC	Centers for Disease Control and Prevention (USA)
CSW	Commercial Sex Worker
DFID	Department for International Development (UK)
DHS	Demographic and Health Survey
FHI	Family Health International (USA)
FSW	Female Sex Worker
GFATM	Global Fund for AIDS, Tuberculosis and Malaria
HIS	HIV/AIDS information system
HIV	Human Immunodeficiency Virus
IBBS	Integrated Biological and Behavioral Surveillance
IDU	Injecting Drug User
M&E	Monitoring and Evaluation
MARP	Most-at-risk populations
MDG	Millennium Development Goal
MICS	Multiple Indicator Cluster Survey
MIS	Management Information System
MOH	Ministry of Health
MSM	Men who have Sex with Men
NASA	National AIDS Spending Assessment (Account)
NIDV	National Institute of Dermatology and Venereology
NIHE	National Institute of Hygiene and Epidemiology
NSE	Needle and Syringe Exchange (Program)
ODA	Overseas Development Assistance
OI	Opportunistic Infection
PAC	Provincial AIDS Center (Committee)
PEPFAR	The President's Emergency Plan for AIDS Relief
PI	Prevention Indicator
PLHIV	People Living with HIV/AIDS
PMTCT	Prevention of Mother-to-Child Transmission
RTI	Reproductive Tract Infection
STDs	Sexually Transmitted Diseases
STIs	Sexually Transmitted Infections
TB	Tuberculosis
Three Ones	3 core principles of a national AIDS response
TWG	Technical Working Group
UNAIDS	Joint United Nations Programme on HIV/AIDS
UNDP	United Nations Development Program
UNFPA	United Nations Population Fund
UNGASS	United Nations General Assembly Special Session on HIV/AIDS
UNICEF	United Nations Children's Fund

USAID  
VAAC  
VPAIS  
WHO

United States Agency for International Development  
Viet Nam Administration for AIDS Control  
Viet Nam Population AIDS Indicator Survey  
World Health Organization

## Glossary of terms

**Capacity building** is a process to improve the ability of a system to meet objectives and improve performance.

**Coverage** is the extent to which a program reaches its intended target population, institution, or geographic area.

**Evaluation** is the systematic and objective assessment of an on-going or completed project, program or policy, its design, implementation and results. Evaluation also refers to the process of determining the value or worth of a particular project, program, or policy. There are three phases of evaluation: process evaluation, outcome evaluation, and impact evaluation.

**Incidence** – the number of new cases in a population over a period of time. The incidence rate uses new cases in the numerator; individuals with a history of a condition are not included. The denominator for incidence rates is the population at risk.

**Indicators** provide the quantitative and qualitative detail to a set of goals, objectives and targets of a policy or program. An indicator is a specific measure of program performance or impact that is tracked over time by the M&E system.

**Monitoring** is the routine tracking of key elements of a programme or project and its intended outcomes. It usually includes information from records and surveys and can be both population and client-based.

**Peer education** is the approach whereby educational activities are offered by trained people to members of the same age, education or social group. Activities are aimed at developing knowledge, attitudes and skills, which will enable them to be responsible for and protect their own health and prevent HIV.

**Prevalence** - the measure of a condition in a population at a given point in time, (numerator, number of people with a given condition at a certain time; denominator, population at the same time)

**Surveillance** is the routine tracking of disease status or behaviour over time via a single data collection system. Surveillance is not necessarily in relation to any specific program or intervention.

**Sentinel surveillance** is the process when data can be collected from certain sites, such as hospitals, antenatal clinics, hotspots, that are believed to be representative of the population and have the potential to serve as early warning signs (sentinels). This process is called sentinel surveillance.

**Triangulation** refers to the analysis and use of data from multiple sources which has been obtained using different methods. Findings are cross-referenced enabling the weakness (or bias) of any one method or data source to be compensated for by the strengths of another. Therefore the validity and reliability of the results is increased.

## **Rationals for developing the National HIV M&E framework**

The Government of Viet Nam is committed to expanding HIV prevention, treatment and care interventions. A number of national policies, action plans and guidelines have been issued to support these interventions. Although a wide range of HIV activities are now underway in Viet Nam, senior leadership has recognized that more needs to be done to assess the effectiveness of these activities. In order to guide the planning and implementation of HIV services and activities at the national and provincial levels, evidence needs to be gathered from a variety of sources to see what is working, what is not, and how resources can be most effectively allocated.

In addition, the Government of Viet Nam is committed to implementing the principle of “Three One’s”, which was launched by the United Nations in April 2004:

- One agreed HIV/AIDS action framework that provides the basis for coordinating the work of all partners.
- One national AIDS coordinating authority, with a broad based multi-sector mandate.
- One agreed HIV country-level monitoring and evaluation system

The National Strategy on HIV/AIDS Prevention and Control in Viet Nam till 2010 with a vision of 2020 was approved by the Prime Minister in March 2004. The contents of the strategy were developed on the basis of the common declarations of the United Nations, specifically the Declaration of Commitment on HIV/AIDS made in 2001 in the UN General Assembly Special Session on HIV/AIDS (UNGASS), the Millennium Development Goals (MDGs), and the Universal Access (UA).

The Ministry of Health was assigned as the lead ministry responsible for guiding the implementation of the National Strategy, coordinating with other ministries and agencies and directing HIV prevention and treatment services at all levels of the health sector. In support of the National Strategy, it was agreed to develop 8 Programs of Action including Program of Action No 4 on HIV/AIDS Surveillance and Monitoring and Evaluation. The Viet Nam Administration for HIV/AIDS Control (VAAC) was established as Decision number 432/QĐ-TTg on 20/5/2005 by the Prime Minister to support the Ministry of Health to manage and implement HIV/AIDS program in the whole country. VAAC prepared the draft Program of Action on HIV/AIDS Surveillance and Monitoring and Evaluation. As a result of this work it was agreed to establish a Working Group to develop the National Monitoring and Evaluation Framework, under the leadership of VAAC.

The first major task for the working group has been the development of the M&E framework including key questions and indicators. Its membership consists of experts from other national partners including National Institute of Hygiene and Epidemiology, Hanoi Medical University, Ho Chi Minh Pasteur Institute, National Institute of Dermatology and Venereology, National Obstetric Hospital, National Pediatric Hospital, National Institute of Infectious and Tropical Diseases and international organizations/agencies such as: UNAIDS, World Health Organization (WHO), United States Government (USG), and Family Health International (FHI).

The key objectives of the framework are to:

- Guide the implementation of monitoring of the HIV epidemic in Viet Nam;
- Strengthen the evidence based for effective HIV policies;
- Promote the effective use of monitoring and evaluation HIV programme for improving quality reporting and performance at all level;
- Ensure accountability of the use of resources;
- Incorporate the collection of data necessary to track progress against the UNGASS targets and MDGs;
- Guide the collection of strategic information from multiple sources;
- Help identify the gaps in currently available information, and take steps to fill them;
- Guide an effective use of data for advocacy

This framework is based on the 8 Programmes of Action currently being developed to support the National Strategy. As a first step the 8 Programmes of Action were grouped under three broad headings:

- (1) Capacity, resources, monitoring and evaluation;
- (2) Prevention; and
- (3) Care and treatment.

(These are detailed further in Section 5)

Three sub groups were established and were tasked with drafting the set of key policy questions which would assist government leaders in assessing progress towards achieving the objectives listed above. Once the key policy questions were agreed, the subgroups listed in detail the core national indicators necessary to answer these key questions.

Regular meetings of the Technical Working Group (TWG) have been held since the beginning of 2006 to review the work of the sub-groups. In November 2006, a consensus workshop was held with a wide range of national and international partners. The implementation of this M&E framework will start from 2007.

This framework contents basic information about monitoring and evaluation structure in Vietnam, it's development plan, how the data is collected and managed. The details of all indicators can be found at the end of this framework.

# **Chapter 1. Structure and responsibilities of the M&E system for National HIV/AIDS Prevention, Control Programs**

## **1. Structure of the M&E system**

The M&E system is one component of the “Three Ones”, and a crucial tool for an effective, efficient, and accountable response to the HIV epidemic. The goal of the M&E system is to provide timely and relevant support for an effective response at national, regional and provincial level.

Since the National Strategy on HIV was launched in March 2004 the Ministry of Health has made great efforts to develop the M&E system in Viet Nam. This system aims to harmonise the various existing M&E programs in Viet Nam into one National M&E system. The National M&E system consists of four levels and based on the existing four-level HIV system in Vietnam.

*At the central level*, the M&E unit locates at VAAC (Department of HIV/AIDS/STI Surveillance).

*At regional level*, there are four M&E units belong to the four regional HIV steering boards, locate at four regional epidemiology institutes; including:

- The regional M&E unit in the North locates at NIHE who is responsible for M&E activities in 29 Northern provinces.
- The regional M&E unit in the central locates at Pasteur Nha Trang Institute who is responsible for 11 central provinces.
- The regional M&E unit in the South locates at Pasteur Ho Chi Minh City Institute who is responsible for 20 Southern provinces.
- The regional M&E unit in the central highland locates at Tay Nguyen Institute is responsible for 4 Central Highland provinces.

*At provincial level*, the provincial M&E unit is a sub-unit in HIV/AIDS/STI surveillance unit, locates at AIDS Center. By 10/2006, there are 35 provincial M&E units within provincial AIDS centers. By the end of 2007, all 64 provinces nationwide will have a provincial AIDS center with a functioning M&E unit. The organisation of this M&E unit will depend on the size of the province’s population, the scale of its HIV epidemic, and the availability of funding.

*At district level*, the district M&E unit locates at District Preventive Medicine Centers with at least one or two full-time and part-time staff.

Additionally, the national M&E working group will be established and coordinated by the VAAC. The staff of regional M&E units, universities and experts from international organizations (UNAIDS, WHO, CDC, USAID, FHI) will participate to provide technical assistance on M&E issues.

For an overview of the M&E system in Viet Nam, see figure 1.

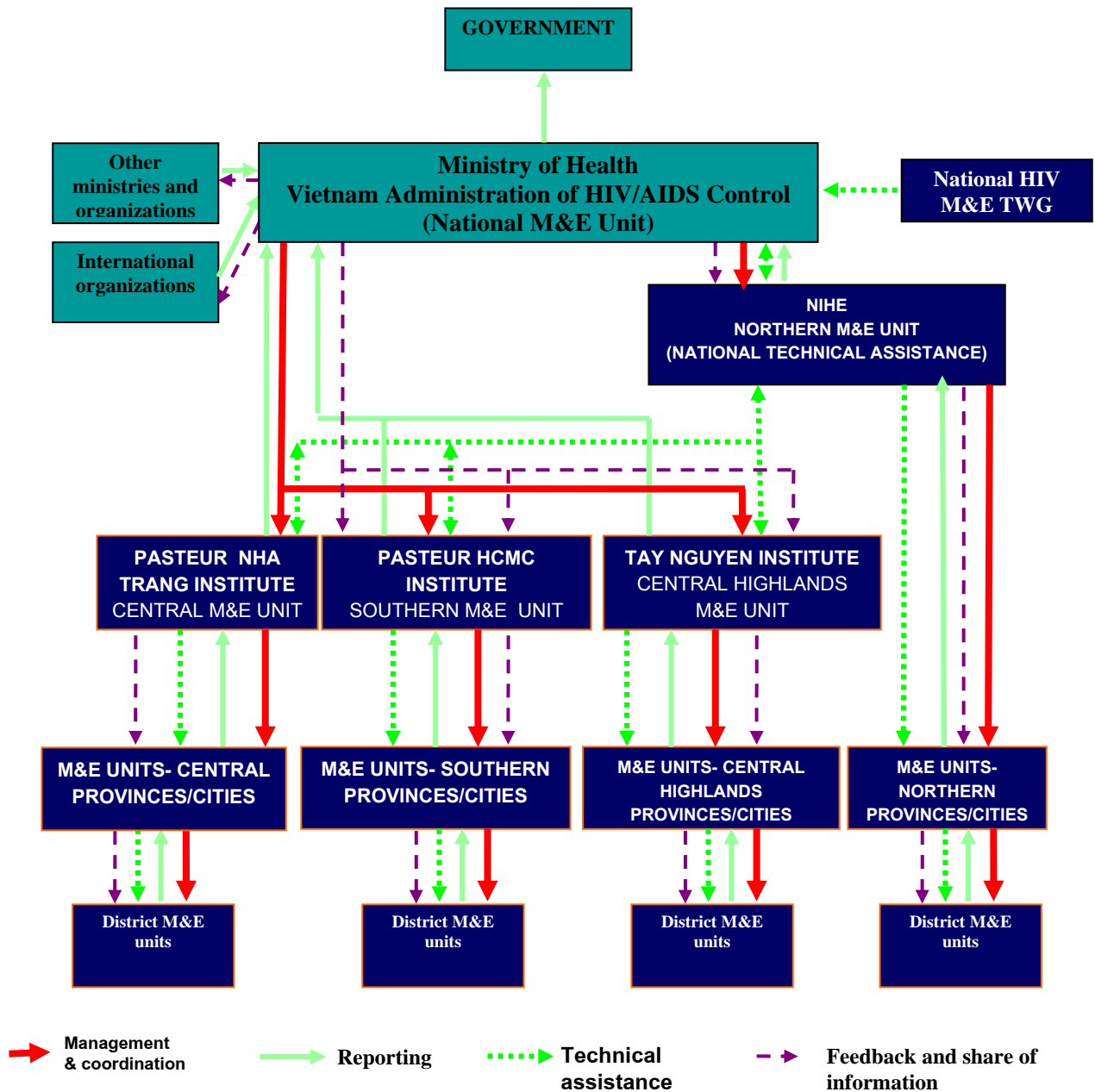


Figure 1: Structure of the M&E system in Viet Nam.

## **2. Responsibilities**

### **2.1. Functions:**

Collect, manage and report data on all HIV/AIDS prevention and control activities within the allocated areas.

### **2.2. Tasks**

#### ***2.2.1. National level***

- Develop and manage overall the National HIV M&E system;
- Establish a technical support team for the National HIV M&E system including experts from universities, institutes, ministries, sectors and affiliated international agencies.
- Direct other M&E units within the system and coordinate with affiliated institutions in collecting, collating, analysing M&E data for HIV prevention and control activities nationwide ;
- Report data to the Government in order to support for the completion of National annual and periodical HIV prevention and control reports, and for policy, strategic planning ;
- Be the focal point for short and long term planning for National HIV prevention and control M&E activities, guide other units within the system to implement HIV programme M&E activities ;
- Monitor, evaluate and supervise activities on HIV M&E nationwide;
- Conduct evaluation studies and add indicators suitable for realistic situation ;
- Lead and coordinate with affiliated institutions in developing internationally cooperative projects, scientific studies and capacity building for the National HIV M&E system
- Be the only institution can announce/publish data related to the National HIV M&E indicators in Viet Nam.

#### ***2.2.2. Regional level***

- Develop plan, implement regional M&E activities and periodical report to the National M&E;
- Collect, check and process M&E data on HIV prevention and control activities in the regional provinces and within the regional M&E Unit;
- Technically and professionally guide, supervise and support on data collection for the M&E indicators, and data analysis for policy and intervention planning for the provinces in the region;
- The Northern Regional Unit is exception, apart from the above mentioned tasks, the Unit also is responsible for technical and professional supports on HIV programme M&E for the whole system of the National HIV programme Monitoring and Evaluation.

#### ***2.2.3. Provincial level***

The provincial M&E unit responsible for coordinating M&E activities within its own province/city. Their responsibilities are:

- Implement HIV programme M&E activities at local level. Activities include collecting accurate data, collating and analysing data for HIV/AIDS programme planning at provincial level, timely provide comments and suggestions to Regional and National levels;
- Technically guide/support, assess and supervise activities related to M&E within the province.

#### ***2.2.4. District level***

The district M&E unit is responsible for collecting, process, collate, manage and report all data related to HIV/AIDS programme activities in the district.

#### ***2.2.5. Commune level***

Commune Health Centre is responsible for completing periodical reports and surveys which serve the purpose of collecting primary data for M&E of HIV/AIDS prevention and control, according to current regulations.

#### ***2.2.6. National technical working group on HIV M&E***

The national HIV M&E technical working group will provide timely and quality technical assistance for national and regional M&E unit.

#### ***2.2.7. People living with HIV/AIDS***

People living with HIV/AIDS will participate in all different steps of M&E process, including data collection, data interpretation as well as raising recommendations and feedback to policy making bodies at different administrative levels.

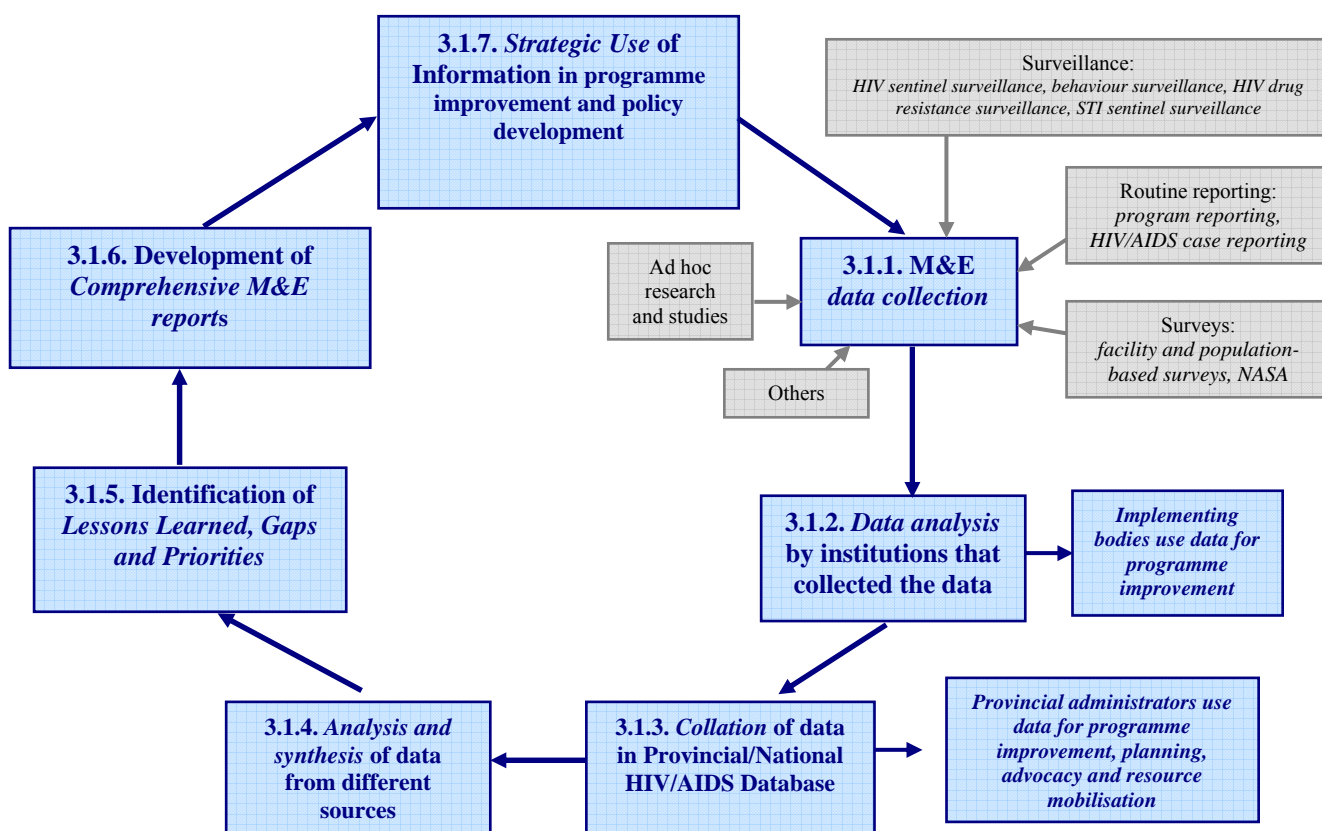
- Participate in mapping, developing sampling framework, commenting on methods, being interviewers for research, studies.
- Encourage PLWH to go forward to health facilities for testing, counseling, and treatment.
- Provide feedback, recommendations on quality of services and intervention programmes to VAAC and AIDS centers at local level.
- Use of collected data to provide recommendations, prioritized identification, planning on program and policy development

## **Chapter 2. M&E activities of the national HIV prevention, control program**

A large quantity of data on various aspects of HIV is generated on a daily basis at service delivery points and research institutes in Viet Nam. A well organized data management system is therefore essential for making relevant and high quality data accessible to service providers, program administrators and decision-makers. The national M&E system is designed to gather, analyse and make use of key data already collected. It is not intended as a parallel system to existing data collection activities. It adds value by bringing together available programme data from the service provider level and epidemiological data from surveillance and other studies. This helps to ensure the effective use of data in monitoring the HIV epidemic and in strengthening and scaling up the national response.

### **1. Collation, management, and use of M&E data**

The flow of data through the national M&E system is illustrated in the diagram below (Figure 2). A range of primary data is collected, checked for quality, and analysed by the collecting institutions. At this point, service providers or implementing bodies can begin using results from these analyses for programme improvement. Key provincial data is then entered into a centralized database, which stored at the national level. Regional M&E units will check for data quality and assist provincial administrative bodies in analysing provincial data for synthesis and use. National administrative bodies who access the database (in particular VAAC) will conduct a meta-analysis of the provincial data and other national data to identify lessons learned, gaps and priorities for national HIV prevention, care and treatment programs. Finally, important findings must be documented and presented to targeted audience. This will help to facilitate the use of data by program administrators and decision makers for policy development, programme implementation, research priorities, advocacy, and resource mobilisation.



**Figure 2: Data management process**

### 1.1. M&E data collection

The various sources of data feeding into the data management system include:

- Routine reporting: program reporting as Decision number 26/2006/BYT-QĐ issued on 6/9/2006 by the Minister of Ministry of Health; and HIV/AIDS case reporting
- Surveillance: HIV sentinel surveillance, IBBS, HIV drug resistance surveillance, STI sentinel surveillance
- Surveys: facility- and population-based surveys, NASA
- Ad hoc research and studies
- Other

Specific data collection methods of these sources are presented below.

## **Routine reporting**

Routinely collected data (routine data), of which the majority are input and service output indicators, is gathered on a regular basis to provide information on the progress of program implementation. Although programs will collect large quantities of information for program operations and management, information on a specific set of key prevention, care and support, treatment, human capacity and financial information indicators is requested for the quarterly report on HIV prevention and control programmes to the national M&E system. Guidelines and training for data collection of these indicators will be made available to district and provincial levels.

The routine reporting data will be collected through reporting forms, which are currently under development. Data will be collected at commune, district, and provincial level. See decision number 26 for more detail.

Reporting form includes collecting data on:

- Human resources for HIV programmes;
- Implementation of IEC/BCC, harm reduction, care and treatment (incl. patient monitoring), VCT, PMTCT, STI management and treatment, safe blood transfusion programmes;
- Capacity building;
- Equipment, medication, and test kits;
- Budgets by programs and sources; and
- Challenges and recommendations from local level.

HIV case reporting includes data on reported newly infections, cumulative number of HIV infections, AIDS cases, and death caused by AIDS.

Completeness and accuracy of reporting depends on many factors; such as resources, data utilization at the local level, feedback from higher levels, practices of public and private facilities, capacity of staff on information management and reporting, availability of laboratory, and the accessibility to health services to vulnerable groups. Additionally, reported data provides little information about current patterns of HIV transmission because it represents infections that were acquired years in the past. Data do not provide information on the coverage of programmes.

## **Surveillance**

Surveillance is the systematic and ongoing assessment of the HIV epidemic. It has various objectives, including estimating the magnitude of the HIV problem, documenting its distribution and spread; and monitoring changes in behaviours that affect the epidemic. Currently, there are 40 provinces implementing HIV sentinel surveillance; among those, 10 provinces are implementing STI sentinel surveillance. For surveillance, VAAC identifies HIV/STI epidemiological data needs and receives implementation support from the national and regional institutes of epidemiology and of dermato-venereology and provincial implementation bodies. Surveillance data is collected in general on an annual or biennial basis and is also stored in the central database for analysis.

Current surveillance activities collect data on:

- HIV seroprevalence rates
- Behavioral trends among targeted populations
- Sexually transmitted infection (STI) rates

Additional epidemiological data that may be collected in the future include HIV drug resistance and HIV/STI incidence.

Quality of data depends greatly on the implementation of data collection protocol, capacity of field staff, turnover rate of qualified staff, and consistency in data collection methods over time. Sample may not be representative when targeted populations are hidden, mobile, do not access the public clinics where data collection takes place, or are missing due to incarceration. Sensitive behavioural information may be biased.

## **Surveys**

Surveys are useful tools for gathering primarily quantitative information about target populations of interest which are not otherwise accessed through routine reporting or surveillance. A survey may focus on opinions or factual information depending on its purpose, and many surveys involve questioning individuals. They can be resource intensive if a large sample size is needed to ensure wide representation, such as population censuses which attempt to include every individual in the population. Smaller surveys that are qualitative in nature are useful for obtaining answers to specific inquiries. For M&E purposes, VAAC identifies additional data needs and tasks specialized institutes, such as the General Statistics Office and the National Institute of Hygiene and Epidemiology with expertise in statistical methods, to design and conduct the survey.

Current surveys include:

- Population-based survey among the general population aged 15-49 aimed at tracking HIV knowledge, attitudes, and behaviours
- National HIV/AIDS sub-account assessment (NASA) to assess the expenditure on HIV

Additional data that may be collected in the future include facility-based surveys such as in the healthcare or school settings.

Data quality depends greatly on the implementation of data collection protocols, capacity of field staff, turnover rate of qualified staff, consistency in data collection methods over time, and high refusing rate among respondents. Sensitive behavioural information may be biased. Large population-based surveys are time consuming and costly.

## **Ad hoc studies**

In addition to the main sources of information for the national M&E system, one-time special studies can provide a more in-depth understanding of priority issues underlying and driving the HIV epidemic, or the effectiveness of various HIV programs in changing risk behaviours.

## Others

Many organizations handle large amounts of M&E and research data when undertaking coordination and project management of major HIV programs in Viet Nam.

These projects have the responsibility to report their program activities to the implementing level authorities, whom annually report to VAAC through the national reporting form.

## 2. Analysis of data by implementing organizations

Results from analyses done by organizations responsible for collecting data are important not only for reporting to the provincial and national level, but also for immediate use by programme implementers to help program improvement. For example, data related to patient monitoring (e.g. ARV drug stock-out, continuation on 1<sup>st</sup> line regimen, drug pick-up by patients, etc.) can be rapidly analyzed and used by health facilities to ensure service improvement.

## 3. Collation of data in Provincial/ National HIV Database

Responsibilities for collating data into the database are as follows:

- At the district level, the district **preventive medicine center** is responsible for collecting data on a monthly basis from commune health stations and other hospitals/organizations at district level.
- The **provincial HIV/AIDS center** (or provincial preventive medicine center if the provincial HIV/AIDS center has not been established) has the responsibility of collecting and summarizing data to prepare quarterly provincial reports according to the reporting formats.
- The **regional HIV/AIDS center** is responsible for collation, analysis, and evaluation of M&E units in the regions every 6 months; and reporting to the National M&E unit
- National hospitals, national institutes and other institutions belonging to the MOH; HIV prevention and control units of other ministries, sectors, social organizations, and central project management units are responsible for submitting reports according to the reporting form to VAAC.

Table 1. Regulation on reporting time

<b>Product</b>	<b>Responsible organization</b>	<b>Date of submission</b>
Monthly report	Commune Health Station	Within the first 5 days of the closing date (to district preventive medicine center)
Quarterly report	District preventive medicine center	Within the first 15 days of the closing date (to provincial HIV/AIDS center/provincial preventive medicine center)

Quarterly report	Provincial HIV/AIDS center/provincial preventive medicine center	Within the first 25 days of the closing date (to Regional M&E unit)
Quarterly report	National hospitals, national institutes and other organizations belong to the MOH; HIV prevention and control units of other ministries, sectors, social organizations, and central project management units	Within the first 10 days of the closing date (to National M&E unit)
Annual report	Provincial HIV/AIDS center/provincial preventive medicine center	Within the first 25 days of the closing date (to National and regional M&E unit)
Biannual report <sup>(1)</sup>	Regional M&E units	Within the first 35 days of the closing date (to National M&E unit)
Annual indicator report	VAAC	February every year
Report of HIV sentinel surveillance survey	Provincial HIV/AIDS center	December every year
Report of STI sentinel surveillance survey	National Institute of Dermato-Venereology	December every year
Report of IBBS, population-based survey	VAAC and related international organizations	2006 and 2008
Epidemic reports spanning 2-3 years	VAAC	2008
Synthesis report	VAAC	2010

#### 4. Analysis and synthesis of data from different sources

##### *Ensuring high-quality data*

The principal goal of the national HIV M&E system is to ensure the effective use of available M&E data in policy and program development, advocacy and resource mobilization, in close collaboration with stakeholders at provincial levels. It is important that the data used is of high quality. The national and regional M&E units will regularly supervise data collection and reporting process to provide in-time technical assistant for units at lower levels.

Effective review of **reporting data** may include asking:

- Is the calculation correct?
- Do reporting staff follow the standard collection protocol?
- Is there any missing data?
- What is being measured?
- Is there any problem with accessibility to and utilization of services?

Effective review of **surveillance data** may include asking:

- Does the surveillance system cover the correct population?

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<sup>(1)</sup> The regional M&E units will report quarterly when the electronic HIS is available.

- Is the sample population clear?
- Is the sample size adequate?
- Did the surveillance take place in a site used consistently over time?
- What is being measured?
- What biases or factors could lead to overestimation or underestimation?
- Does selective data presentation influence interpretation?

### ***Triangulation and integrated analysis***

The goal of triangulation is to increase the validity and reliability of program evaluation by using and analysing data from multiple sources, often obtained from different methods. Triangulation should be used to address the following questions about effectiveness at both the outcome and impact level:

- Are interventions working and are they making a difference?
- What changes in population-level outcome and impact indicators have been observed and what do they mean?
- Can the observed changes in outcome and impact indicators be attributed to program outputs? Are the collective efforts being implemented on a large enough scale to impact the course of the epidemic?

Cross-sectional behavioural and biological outcomes and impact data are generally the primary data sources of interest for triangulated analysis.

### **5. Identification of Lessons Learned, Gaps and Priorities**

In order to make the best use of data for making recommendations for program improvement, the results should clearly be linked to activities within the 8 Programmes of Action of the National Strategy. Relevant MOH departments, international partners, and local expertise should be utilised to help identify lessons learned, gaps in services and policies, and priorities to ensure effective and comprehensive HIV responses.

It is also very important to assess the strengths and weaknesses of the monitoring and evaluation system at a regular basic, so the system can be improved.

### **6. Development of comprehensive M&E reports**

Results and recommendations obtained through the data analysis process should be presented to specific stakeholders in a timely and effective manner. Beyond specific targeted information products, the following reports will be produced for general public use:

- (1) Yearly indicator report with interpretation and recommendations
- (2) Epidemic reports spanning 2-3 years such as estimation and projection reports, UNGASS
- (3) Synthesis report every 5 years

For a broader understanding of the HIV epidemic in Viet Nam, a report will be prepared every five years to gather, analyse, and synthesize data on epidemiology, behaviours, and responses. The synthesis report will identify and prioritise data gaps, making programmatic recommendations and advocacy strategies to help put these into action. Estimates and projections

will be integrated into this process to estimate future burden and impacts, anticipate prevention and care needs, and adequately plan for impact mitigation. Increasingly, international bilateral and multilateral aid agencies are insisting that countries show that their programs are having a beneficial impact as a condition of continued funding. The data gathered for this report can be used in this way.

These reports will be shared with provincial and district M&E units as well as other ministries, mass organizations, international organizations and PLWH.

## **7. Strategic use of information in program improvement and policy development**

### ***Programme improvement***

Data can be used for program planning at all levels. At the national level, routine, surveillance and survey data can be used to determine the magnitude of the epidemic and its distribution in different geographical areas and subpopulations. Estimating the number and distribution of those already infected is important in deciding how prevention resources should be distributed as well as in planning care and support needs on a national scale. However, at a more local level and within prevention program themselves, data can be used to identify problem areas, seek solutions and devise strategies appropriate to the ever-changing epidemic.

- In order to understand the nature of the epidemic, data can be used to:
  - Determine who is affected: data can be aggregated by gender, age, and subpopulations. Data can be presented on a graph or a map to bring important issues into focus, such as trends over time or regional variation.
  - Estimate the magnitude of the problem e.g the number of people living with HIV in different subpopulation can be estimated.
  - Project future prevention and care needs.
  - Track changes over time in specific prevention and care areas.
  
- For program planning and implementation, data can be used to:
  - Identify problems in program performance. In order to ensure the highest level of adherence to ART and thus to prevent emergence of HIV drug resistance, suboptimal program performance such as ARV drug stock-out, low continuation on 1<sup>st</sup> line regimen, irregular drug pick-up by patients and so forth must be identified on time. Adequate actions (e.g. intensive supervision to particular provinces/districts/facilities) subsequently need to be taken.
  - Identify the key areas for intervention. Much is known about which types of behaviour put people at risk of HIV infection. However, this sometimes leads public health officials and program planners to make broad assumptions about risk behaviour and subpopulations and to plan interventions based on those assumptions. Data, particularly behaviour surveillance data, can give a clearer indication about which aspects of a program need more attention in the current circumstances.
  - Develop possible solutions for identified key issues. Data can help focus attention on key prevention and care components to achieve the required impact.

- Evaluate the effectiveness of specific interventions or to warn a reversal in previous successful programs. At the national level, data can be used to evaluate the effectiveness of the country's overall response to the HIV epidemic. Assessment can also take place of key issues, such as target populations or a specific type of care. For example, varied prevention activities among female commercial sex workers may result in increased condom use. The sexual behaviour indicators among female commercial sex workers presented here can track whether this is happening or not. Additionally a small facility assessment as part of routine supervision could serve to provide information on the quality of STI care or the availability and utilization of voluntary counselling and testing services, or AIDS care by health facilities.
- Promote evidence-based problem-solving.
- Measure program coverage.

### ***Advocacy***

Advocacy to key audiences, such as policy makers, donors, program planners, and the general public is critical for ensuring effective national and localized responses to the epidemic. The appropriate selection of data can support the planning of multiple HIV programs. Estimating the extent of the epidemic can also help better decision making about allocating resources. It is important that the relevant information is communicated to the right audience and that data reports should address concerns using the appropriate language and length and be delivered in a timely manner to the appropriate audience.

### ***Resource mobilisation***

There is a risk of misdirecting human and financial resources when there is a lack of quality data on effective interventions, missing services, and costs. Using the data generated from the national M&E system can help mobilise resources toward effective programs and policies.

### ***Research priorities***

Responses to the HIV epidemic need to be practical yet also require more in-depth knowledge of effective interventions or of the targeted populations' characteristics. Extracting detailed data from the national M&E system will help identify further investigations for greater understanding of events, behaviors, or theories.

### **Data storage**

A critical component for the successful implementation of the Viet Nam M&E Framework is a national system of information on all HIV program activities available to HIV programme stakeholders from local to national levels. This HIV information system (HIS) will be based on nationally defined standards to ensure that data from the various sources described in the preceding chapters can be assimilated into a single centralized database. The data will be stored at the national level by VAAC for district, provincial and national program M&E and planning. The HIS will be a combination of routine programmatic indicators and the national core indicators

identified in this framework. Data sources will be a combination of hardcopy and electronic reporting systems with all data aggregated electronically at the provincial and national centers for uploading into the HIS.

Information on HIV program activities come from a variety of sources and at varying intervals in time. Prevention, care, and treatment services will provide aggregated data from a mixture of hardcopy and electronic-based registries located within both facility and community-based programs. HIV surveillance data will be uploaded electronically into the HIS from national surveillance systems. Facility and population-based surveys and other *ad hoc* surveys will be incorporated into routine data collection activities of MOH when possible and added to the HIS for applicable geographic coverage areas. Other sources of data, including, but not limited to funding, staffing, commodities, and training will also be incorporated into the HIS for a complete picture of the Viet Nam HIV program. As additional data sources and capacity for data use are developed, VAAC will continue to expand the information within the HIS.

Due to the range of data sources and types, standards for data collection, structure, and interchange will be crucial. While the national HIS is not a single system for providing all HIV services, all of these activities and/or their associated information systems will be required to routinely report on the relevant indicators defined in this framework to the HIS. That is, while the HIS is not a client registry for VCT or ART, it is a national registry of all HIV program data relevant for district, provincial, and national program M&E and planning.

**Implementation** of the national HIS will be step-wise. Due to the range in capacity for data management and use across provinces and districts, M&E data management and use capacity will initially be developed in VAAC and 4 regional M&E centers. These centers will then be responsible for supervising the M&E activities in the provinces and districts. Development of the HIS will follow the same plan as M&E capacity development in national and regional agencies.

Since some data will come from the commune level while other data such as surveillance will be provided by national bodies like NIHE, points of data entry into the HIS will vary. Depending upon the source and type of data, roles and responsibilities will be defined to allow entry/electronic uploading of data at the appropriate reporting level. For instance, commune-level service data will most frequently be reported on hardcopy from commune to district to provincial centers where the aggregate data will be entered into the HIS. Surveillance data will be loaded electronically from NIHE directly into the HIS. Since some providers will have electronic systems, the HIS should have standards for electronic data interchange so those providers can report electronically through the district or directly to the provincial level to minimize redundant data entry. **Preventing duplication** of service data will be required since many service providers reach the same people. In order to better plan HIV programs and prevent duplication, consideration will therefore be required by the National HIV M&E Technical Working Groups (TWG) and providers.

In order to provide the greatest flexibility in design of the hardcopy and electronic reporting network, a **web-based database** should be maintained at the national level. This may consist of a national database with data entry and cleaning occurring at the provincial level. Whatever the system, it will be imperative that a clear system of data

management is developed to ensure consistent numbers are reported from the system by all users. The decision of how much of the HIS is distributed to regional or provincial clients will be based on maximizing application performance, data integrity and security. Formal requirements for gathering and developing a functional system of data storage and identifying the technical specifications for guiding the design and development of the HIS should be lead by a VAAC HIS technical working group.

Once data sources are available to the national HIS, tools for standardized reports and *ad hoc* analysis will be developed to complement the system. Training on using these tools will be provided and updated as the national HIS tool is expanded. Access to data will be based on defined roles and responsibilities from the national to the local levels of the national HIV program and administered by VAAC.

### **Chapter 3. Key questions and indicators**

The National Strategy on HIV/AIDS for 2005-2010 describes 8 programmes of Action (PoA) that form the basis for the future implementation of the strategy in Viet Nam. It is essential to ensure that the collected data and information cover all components of these 8 Programs of Action, and that the structure of the National Strategy is reflected in the National HIV M&E framework. During the development of the framework, it was agreed that the 8 programmes of Action should be grouped into three sub-groups as show in the table below:

Sub-group	PoA
(1) Capacity, resouces, monitoring and evaluation	PoA 4 (HIV surveillance and monitoring and evaluation program) PoA 9 (HIV prevention and control capacity building and international cooperation program)
(2) Prevention; and	PoA 1 (Behavioral change information, education and communication program in HIV prevention and control, in coordination with the drug and prostitution prevention and control programs to prevent HIV transmission) PoA 2 (HIV harm reduction intervention program) PoA 7 (STIs management and treatment program) PoA 8 (Blood transfusion safety program)
(3) Care and treatment	PoA 3-5 (Care and support for PLHIV, access to HIV treatment program) PoA 6 (PMTCT)

In these sub-groups, key questions were formulated to reflect the most important aspects of each sub-group. Indicators were developed based on the answers of these key questions.

For each sub-group, key questions and indicators are arranged under the following criteria:

1. Capacity, resources, monitoring and evaluation:
  - Leadership and coordination
  - Financial resources
  - Human resources
  - Monitoring and evaluation
  - The current HIV epidemic in Viet Nam
2. Prevention:
  - BCC program
  - Harm reduction program
  - STI prevention program
  - Blood safety transfusion program
  - VCT program
3. Care, treatment and PMTCT:
  - PMTCT program
  - Care and treatment program

For each indicator, the following detailed information will be presented:

- Purpose of the indicator
- Definition, including numerator and denominator and other definitions and notes, if applicable
- Level of measurement
- Frequency of measurement
- Measurement tools
- Method of measurement
- Interpretations

## **1. Sub-group 1: Capacity, resources, monitoring and evaluation**

This area covers PoA number 4 (HIV Surveillance and Monitoring and Evaluation Program) and PoA number 9 (HIV Prevention and Control Capacity Building and International Cooperation Program).

### **1.1. Leadership, coordination, and capacity**

#### **Key question 1 – NATIONAL STRATEGY**

**What is the current status of the development and implementation of the programs of action following the National Strategy on HIV/AIDS?**

The “National Strategy on HIV/AIDS Prevention and Control in Viet Nam till 2010 with a vision to 2020” represents the first element of the “Three Ones” and is a crucial tool in Viet Nam’s national response to the HIV epidemic. The Ministry of Health has been working on developing and preparing for the implementation of the 8 Programmes of Action that underpin the National Strategy. Establishing the status of the 8 PoAs against their implementation plan and target is an important way of assessing progress in HIV prevention and control in Viet Nam.

To answer this key question, the following indicator can be examined:

#	INDICATOR	PURPOSE
1	Status of the 8 programs of action (drafted, finalized, budgeted, funded, implemented).	To assess the status and implementation of program of actions against the National Strategy on HIV/AIDS

#### **Key question 2 – CAPACITY**

**Is the current HIV programme structure, including multisectoral responses at national and provincial levels, functioning well?**

A successful response to the HIV epidemic in Viet Nam requires the participation of many different sectors. Under Decree No. 61/2000/QĐ-TTg of the Government, the National Committee for Drug Control, Prostitution and HIV/AIDS Prevention and Control was established with representation from 15 ministries/mass organizations. This is a multi-sectoral body that advises the Prime Minister on the coordination of drug, prostitution and HIV prevention and control. The Ministry of Health, a member ministry of the Committee, plays a vital role in communicating and coordinating with

other member ministries in implementing the HIV prevention and control program. At provincial level, the same structure as at the central level is also being implemented. An important part of this response is the preparation of a plan for the relevant ministries/mass organizations with linked targets and budget allocation information.

To answer this key question, the following indicators can be examined:

#	INDICATOR	PURPOSE
2	National Composite Policy Index	To assess progress in the development and implementation of national-level HIV policies and strategies
3	Percentage of designated ministries and mass organizations with annual plans, budgets and reports	To assess the level of response of different ministries and mass organizations to HIV
4	Percentage of provinces/cities with annual plans, budgets and reports	To assess the level of response of different provinces/cities to HIV

## 1.2. Financial resources

### **Key question 3 – RESOURCE-1**

#### **How much is spent on HIV annually?**

One way to measure the commitment to HIV prevention and control is by assessing the financial support for activities on prevention, treatment, care and support. Measuring expenditure on HIV can also indicate the absorptive capacity, productivity and progress of various investments.

Funds are received from different sources: government (central and provincial level), Oversea Development Assistance (ODA), loans and the private sector. These funds are support the HIV programs of various organisations in various sectors at all levels nationwide.

In addition, PLHIVs and their families pay out-of-pocket expenses for additional health services. It is difficult to get accurate information on expenditure relating to private sector services and out-of-pocket expenses. However, understanding expenditure of these two sources can help provide a broader view of annual national expenditure on HIV prevention, treatment, care and support.

To answer this question, the following indicators can be examined:

#	INDICATOR	PURPOSE
5	Total expenditure by the central government on HIV	To assess the expenditure on HIV from central government
6	Total expenditure by the provincial government on HIV	To assess the expenditure on HIV from provincial government
7	Total international expenditure on HIV	To assess international expenditure on HIV
8	Total expenditure by the private sector on HIV	To assess the private expenditure on HIV

9	Total expenditure from out-of-pocket on HIV	To assess the out-of-pocket expenditure on HIV
10	Ratio of total expenditure from all sources on prevention vs. care and treatment	To assess the relative expenditure between prevention vs. care and treatment
11	Total expenditure on HIV per capita per year	To provide international comparison on total expenditure on HIV

### 1.3. Human resources

#### **Key question 4 – RESOURCE-2**

#### **What are the human resources at the national and provincial level working on HIV?**

Human resources play a crucial role in the response to the HIV epidemic. The Government's commitment to providing adequate human resources is stated in PoA 9 of the National Strategy (HIV/AIDS Prevention and Control Capacity Building and International Cooperation Program).

The National Strategy has indicated that strengthening the capacity of the State management system and training staff are key activities for improving resource use<sup>(2)</sup>. An effective response to the HIV epidemic requires a multisectoral response, supported by adequate human resources including full-time and part-time staff and volunteers. However, given the complexity in measuring part-time staff, the national framework only measures full-time staff in terms of quantity and the training received annually.

To answer this question, the following indicators can be examined:

#	INDICATOR	PURPOSE
12	Number of full-time staff working in the field of HIV	To assess the human resources commitment from central to grassroots level
13	Number of full-time HIV staff received training on HIV/AIDS prevention and control annually	To assess the progress of implementation of the capacity building plan
14	Percentage of schools with teachers who have been trained in life-skills-based HIV education and who taught it during the last academic year	To assess progress towards implementation of life-skills based HIV education in all schools

<sup>(2)</sup> The National Committee for AIDS, Drugs and Prostitution Prevention and Control. The National Strategy on HIV/AIDS Prevention and Control in Vietnam till 2010 with a vision to 2020. Medical Publishing House. 2004 (page 178).

## 1.4. Monitoring and evaluation

### **Key question 5 – SME**

#### **How is the Monitoring and Evaluation (M&E) system functioning?**

M&E is a crucial part of the national response to the HIV epidemic, and has been identified as a priority in the National Strategy. A strengthened and well-functioning M&E system is a key aspect of the national HIV prevention and control program, and is a core feature of the “Three Ones”.

As the majority of M&E information and data is collected from provinces and cities, it is important to understand how well data reporting systems and other surveys function. A well-functioning provincial M&E unit requires a number of key components, which can then be reviewed in order to assess function. Within the national framework, basic components that can be reviewed to answer the question how well the M&E system functions include: M&E focal point; allocated budget; provincial M&E plan; and reporting to the national level in a timely manner.

To answer this question, the following indicators can be examined:

#	INDICATOR	PURPOSE
15	National Composite Policy Index	To assess the basic requirements of the Monitoring and Evaluation system at national level
16	Percentage of functional Provincial Monitoring and Evaluation units	To assess the basic requirements of the Monitoring and Evaluation system at provincial level

## 1.5. The current HIV epidemic in Viet Nam

### **Key question 6 – EPI**

#### **What is the current status of the HIV epidemic in Viet Nam?**

The goal of HIV prevention and control programming is to reduce new cases of HIV infection. HIV incidence is the best indicator for monitoring the trend of new infections. However, due to financial, technical and other social pressures, it is hard to measure incidence. Prevalence is therefore used as a surrogate indicator for incidence.

It is important to both assess the overall HIV prevalence and to track trends amongst certain vulnerable groups, i.e., IDUs, FSWs, MSM, STI patients and TB patients. Understanding the various trends of the HIV epidemic will help leaders in making policy and program decisions.

To answer this question, the following indicators can be examined:

#	INDICATOR	PURPOSE
17	Estimated prevalence among target groups <sup>(3)</sup>	To assess progress towards reducing HIV infection among target populations
18	Estimated prevalence of HIV in Viet Nam (by gender and age group)	To assess progress towards reducing HIV infection
19	Reported number of HIV infected people, AIDS cases and AIDS deaths (by gender and age group)	To assess progress towards reducing HIV infections

## 2. Sub-group 2: Prevention

This area covers PoA number 1 (Behavioral Change Information, Education and Communication Program in HIV prevention and control, in coordination with the drug and prostitution prevention and control programs to prevent HIV transmission), PoA number 2 (HIV Harm Reduction Intervention Program), PoA number 7 (STIs Management and Treatment Program), and PoA number 8 (Blood Transfusion Safety Program).

### 2.1. Behavior change communication (BCC) plan of action

#### Key question 7 – BCC-1

#### What is the level of HIV knowledge and awareness?

Behavior Change Communication (BCC) is a multi-level tool for promoting and sustaining changes in risk-reducing behavior in individuals and communities. This is achieved by distributing tailored health messages via a variety of communication channels.

Individuals and communities must understand their risk of HIV infection before they can reduce their risk and vulnerability to HIV. They must be given basic facts about HIV, taught a set of protective skills and offered access to appropriate services and products. It is also important that they perceive their environment to be supportive of behavior change or maintaining safe behaviors.

One of the outcomes of the BCC program is how knowledge about HIV risk has increased throughout the population.

To answer this key question, the following indicators can be examined:

#	INDICATOR	PURPOSE
20	Percentage of people aged (15-24 and 15-49) who both correctly identify ways of preventing the transmission of HIV and reject major misconceptions about HIV transmission	To assess progress towards universal knowledge of the essential facts about HIV transmission amongst people aged 15-49

<sup>(3)</sup> A term from the sentinel surveillance refers to 7 groups being tested for HIV in the survey: IDUs, FSWs, MSM, STI patients, TB patients, pregnant women, and military recruits

21	Percentage of people of most-at-risk populations who both correctly identify ways of preventing the transmission of HIV and reject major misconceptions about HIV transmission	To assess progress towards universal knowledge of the essential facts about HIV transmission amongst most-at-risk populations
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**Key question 8 – BCC-2**

**What is the level of stigma and discrimination towards PLHIV?**

Stigma and discrimination towards people living with HIV continues to be a big problem around the world. Negative social attitudes, outright discrimination, and legal restriction on targeted populations’ behaviors create a negative environment for HIV intervention programs and efforts. Stigma and discrimination can prevent PLHIV from seeking testing, care and treatment services as well as prevention of HIV infection to other and to community.

Fighting against stigma and discrimination has been identified as one of the program strategies. Many efforts have been undertaken to combat negative attitudes towards people living with HIV. In order to find out whether activities have been successful in reducing negative attitudes, people’s attitudes towards PLHIV should be assessed. Decreasing the level of stigma and discrimination towards PLHIV is a reflection of the success of BCC program.

It is important to research perception towards PLHIV among medical staff and at workplace. However, this information is beyond the scope of this framework.

To answer this key question, the following indicator can be examined.

#	INDICATOR	PURPOSE
22	Percentage of people aged 15-49 who express accepting attitudes toward people living with HIV	To assess the attitudes of adult people toward HIV-positive people

**Key question 9 – BCC-3**

**Are HIV risk behaviors increasing or decreasing in the general population, especially among young people?**

The effectiveness of the BCC program can also be established by measuring HIV risk behaviors in the general population.

Empirical studies showed that HIV epidemics often start slowly, but then pick up speed over time. HIV can stay at low levels within a population for many years, and then HIV prevalence can rapidly increase. It is therefore important to have an overview of the current and future trends of HIV epidemic among most-at-risk groups and the general population in order to develop appropriate future HIV policies and

programs. Understanding risk behaviors, particularly amongst young people, is a key indicator of future trends.

To answer this key question, the following indicator can be examined.

#	INDICATOR	PURPOSE
23	Percentage of men and women by age group (15-24 and 15-49) who have had sex with a non-marital, non-cohabiting sexual partner in the last 12 months	To assess progress in reducing the percentage of young people aged 15–49 who have higher risk sex

**Key question 10 – BCC-4**

**Are HIV risk behaviors increasing or decreasing among populations at risk?**

Assessing the extent of risk behaviors amongst most-at-risk populations is critical in low and concentrated epidemic settings. By identifying risks, their trends over time, and designing appropriate strategies, a country with low HIV prevalence has an opportunity to contain the epidemic. Empirical data and information show that two important factors contribute to an effective response to HIV: first, the risks must be identified and second, an adequate coverage of program interventions must be achieved. By reducing the risk behavior among most-at-risk populations while HIV prevalence is still low, a larger epidemic can be averted.

Risk behaviors of interest for M&E purposes in most-at-risk populations include: the scale of general men exposing to sexual risk behavior; the level of using condom among sex workers; and the level of sharing injection equipment among injecting drug users.

To answer this key question, the following indicators can be examined:

#	INDICATOR	PURPOSE
24	Percentage of men reporting visiting commercial sex workers in the last 12 months	To assess the scale of general men exposed to sexual risk behavior
25	Percentage of female sex workers reporting condom use with their most recent clients	To assess progress in preventing exposure to HIV among sex workers through unprotected sex with clients
26	Percentage of female sex workers reporting consistent use of condoms with their clients in the last month	To assess progress in preventing exposure to HIV among sex workers through unprotected sex with clients
27	Percentage of female sex workers who inject drugs in the last month	To assess progress in preventing exposure to HIV among sex workers through high risk behavior of injecting drugs
28	Percentage of injecting drug users who share syringes and needles in the last month	To assess progress in preventing exposure to HIV among injecting drug users through high risk behavior of sharing injecting equipment

29	Percentage of injecting drug users reporting condom use during the last sexual activity	To assess progress in preventing exposure to HIV among injecting drug users through unprotected sex activities
30	Percent of men reporting condom use the last time they had anal sex with a male partner	To assess progress in preventing exposure to HIV among men who have unprotected anal sex with a male partner

## 2.2. Harm reduction program

<p><b><u>Key question 11 – HARM REDUCTION</u></b>  <b><u>What is the level of coverage of harm reduction program for most-at-risk populations (IDU, FSW, MSM)?</u></b></p>
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Harm reduction activities play an important role in HIV prevention and control programs. This perspective has been mentioned in the Clause 15, Article 2, chapter 1, in the HIV/AIDS Law which was passed by the National Assembly in June 21, 2006, “*Harm reduction intervention measures in the prevention of HIV transmission include propaganda, mobilization and encouragement of the use of condoms, clean syringes and needles, treatment of addiction to opium-related substances with substitute substances and other harm reduction intervention measures in order to facilitate safe behaviors to prevent HIV transmission*”.

The National Strategy on HIV/AIDS Prevention and Control in Viet Nam till 2010 with a vision to 2020 sets the target of achieving 100% safe injection among drug users and 100% condom use among female sex workers. Combined with other intervention efforts, IEC/BCC, condom provision and syringe and needle exchange programmes can reduce the risk of exposure and transmission of HIV amongst most-at-risk populations and other populations.

In order to assess the implementation of harm reduction programmes, coverage and awareness within most-at-risk populations about program availability should be examined.

To answer this key question, the following indicators can be examined:

#	INDICATOR	PURPOSE
31	Percentage of districts implementing needle and syringe exchange and/or distribution program	To assess availability of harm reduction services for injecting drug users
32	Percentage of districts implementing condom promotion programs for commercial sex workers	To assess availability of harm reduction services for commercial sex workers
33	Number of sites implementing substitution programs	To assess availability of harm reduction programs
34	Percentage of young men and women aged 15-24 who know sources of condoms	To assess HIV/AIDS prevention knowledge

35	Percentage of most-at-risk populations reached by harm reduction program in the last 6 months	To assess progress in implementing harm reduction program for most-at-risk populations
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### 2.3. STI prevention program

#### **Key question 12 – STI PREVENTION**

##### **What is the prevalence of STI among target populations?**

The epidemiological synergy between classical STIs and HIV, caused by the presence of local genital inflammatory processes and compromise epithelial integrity, is well known and accepted. This concept proposes that if some classical STIs are present when an HIV infected person has sex with an uninfected person, those STIs will facilitate transmission of the HIV virus. Consequently, infection with HIV or STIs may result in the increased likelihood of additional infection. This synergy is believed to increase the probability of HIV transmission by an estimated 2 to 13 times when STIs that cause ulceration are present.

Monitoring the status of STIs among targeted populations can therefore help improve understanding about HIV infection and support better planning of prevention programmes.

To answer this key question, the following indicator can be examined:

#	INDICATOR	PURPOSE
36	STI prevalence among targeted populations	To follow the prevalence of STI among targeted populations, including ANC

#### **Key question 13 – STI SERVICES**

##### **What is the level of utilization of STI services by most-at-risk populations and do the services meet quality standards?**

Experiences in STI control programming teach us that reducing high rates of STIs requires a comprehensive strategy for both prevention and treatment. It is equally important, however, to pay attention to who accesses existing clinical services and where there are gaps. Even the most technologically advanced services will have little impact on STI prevalence if access to those services is poor.

A recommended approach is to provide accessible and approachable STI services and promote their use, especially for those at higher risk of infection and transmission of STIs.

To answer this key question, the following indicators can be examined:

#	INDICATOR	PURPOSE
37	Percentage of [most-at-risk population] accessing STI diagnosis and treatment services.	To assess the quality of STI diagnosis, treatment, and counseling services
38	Percentage of women and men with STIs at health-care facilities who are appropriately diagnosed, treated and counseled	

#### 2.4. Blood safety transfusion program

##### **Key question 14 – BLOOD SAFETY**

##### **What is the risk of HIV transmission through blood transfusion in Viet Nam?**

Millions of lives are saved each year through blood transfusions. There are various shortcomings, however, in the way blood is collected, tested for infections such as HIV, and transfused. In particular, lack of adequate testing means that people in many countries have an increased risk of becoming infected with HIV and other diseases through blood transfusions. However, if the proper steps are taken, such infections can be easily prevented.

The MoH has developed standards for HIV screening and establishing safe blood transfusion status. Successful outcomes of the blood safety program can be measured by monitoring how many blood units are screened according to MoH standards.

To answer this key question, the following indicator can be examined:

#	INDICATOR	PURPOSE
39	Percentage of blood transfusion units screened for HIV which meets the MOH standards during the last 12 months	To assess the safety of blood transfusion

#### 2.5. Voluntary counseling and testing (VCT) program

##### **Key question 15 – VCT**

##### **Availability, coverage and utilization of VCT services?**

Globally, 90% of people infected with HIV do not know that their HIV status. Many approaches to HIV prevention and care are dependent on people knowing their HIV status. The importance of this knowledge in HIV program activities has brought about the wider promotion and development of voluntary counselling and testing (VCT) services. VCT also provides an opportunity for prevention counseling and referral to care and support services. However, since most countries where HIV has a major impact are also the poorest, a lack of resources means that VCT is often not widely available. VCT services need to be prioritised and resources provided for their

development; however this is often dependent the effectiveness of VCT first being demonstrated to policy-makers and the public.

The National Strategy has set the target for VCT programme expansion to 100% provinces and 50% of the total number of districts by 2010. The need to build up the voluntary testing network and referral system has been identified, including linking VCT with healthcare and social support and mobilizing the participation of the private sector in providing counseling and support<sup>(4)</sup>.

Key factors for consideration include the extent to which VCT services meet national standards, and number and percentage of people accessing VCT services.

To answer this key question, the following indicators can be examined:

#	INDICATOR	PURPOSE
40	Percentage of VCT services which meet national standards	To assess the availability and coverage of VCT services
41	Number of people who have voluntarily tested and received HIV test results in the 12 months	To assess the utilization of VCT services
42	Percentage of people who tested voluntarily, received pre-and-post test counseling and received HIV test results during the last 12 months.	To assess the utilization of VCT services
43	Percentage of most-at-risk populations who received HIV testing in the last 12 months and received HIV test results	To assess progress in implementing HIV testing and counseling among most-at-risk populations

### **3. Sub-group 3: Care, Treatment and PMTCT**

This area covers PoA number 3-5 (Care and Support for HIV Infected People Program, Access to HIV Treatment Program), and PoA number 6 (PMTCT).

#### **3.1. PMTCT**

<p><b><u>Key question 16 – PMTCT-1</u></b></p> <p><b><u>How widely and readily available are PMTCT services?</u></b></p>
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Mother-to-child transmission (MTCT) of HIV remains a major public health problem worldwide, especially in countries with limited resources which account for more than 95% of all people living with HIV (PLHIV). In the absence of any interventions, rates of MTCT are 25% to 40%. Transmission can occur during pregnancy, labor, delivery and breastfeeding. With comprehensive intervention, however, the transmission rate can be reduced to below 5%.

<sup>(4)</sup> The National Committee for AIDS, Drugs and Prostitution Prevention and Control. The National Strategy on HIV/AIDS Prevention and Control in Vietnam till 2010 with a vision to 2020. Medical Publishing House. 2004 (page 162).

Reducing pediatric HIV infection involves four stages: (1) primary prevention of HIV infection; (2) prevention of unintended pregnancies among women living with HIV; (3) prevention of HIV transmission from mothers living with HIV to their infants; and (4) care, treatment, and support for mothers living with HIV, their children and families<sup>(5)</sup>.

The National Strategy recognises the importance of the PMTCT and PMTCT is included under Program of Action number 6.

To answer this key question, the following indicator can be examined:

#	INDICATOR	PURPOSE
44	Number and percentage of districts with at least one health facility providing the package of PMTCT services	To assess the availability of PMTCT services

**Key question 17 – PMTCT-2**

**Are people in need accessing and using PMTCT services?**

Measuring the accessibility and utility of available PMTCT services reflects whether or not these services meet the needs of target groups.

To answer this key question, the following indicators can be examined:

#	INDICATOR	PURPOSE
45	Number and percentage of pregnant women who have delivered in the preceding 12 months, who received HIV counseling and testing for PMTCT and received their test results	To assess the utilization of PMTCT services
46	Number and percentage of both HIV-positive pregnant women and their babies receiving a complete course of antiretroviral prophylaxis to reduce the risk of mother-to-child transmission	To assesses the progress in preventing mother-to-child HIV transmission through the provision of ARV prophylaxis

<sup>(5)</sup> WHO. Antiretroviral drugs for treating pregnant women and preventing HIV infection in infants in resource-limited settings towards universal access. Recommendations for a public health approach. 2006

**Key question 18 – PMTCT-3**

**Are PMTCT services effective in preventing MTCT?**

In order to assess the effectiveness of the PMTCT program, the reduction in the rate of children who were infected with HIV from their mothers should be measured.

To answer this key question, the following indicator can be examined:

#	INDICATOR	PURPOSE
47	Percentage of infants born to HIV infected mothers who are HIV positive	To assess progress towards eliminating mother-to-child HIV transmission

### **3.2. Care and Treatment**

The HIV epidemic continues to grow in Viet Nam and the number of cases of HIV infection is increasing rapidly. There is therefore an urgent need for the effective care, support and treatment of PLHIV.

HIV infected and affected people, including the families and children of HIV positive people, have to cope with many physiological, psychological, economic and social difficulties including stigma and discrimination. The needs of HIV infected people for care, support and treatment can vary considerably depending on social and medical needs. A comprehensive care and treatment program should therefore cover the following components<sup>(6)</sup>:

- HIV counselling and testing
- Clinical management:
  - a) Prophylaxis, diagnosis and OI treatment including TB;
  - b) ARV management;
  - c) Support for adherence; and
  - d) Symptom treatment and pain relief and palliative care;
- Psychology and socio-economical support
- HIV transmission prevention
  - a) Encourage safe sex and use of condoms
  - b) Harm reduction measures for HIV transmission prevention
  - c) Implement universal prevention
  - d) Provide post exposure preventive treatment; and
  - e) PMTCT
- Mobilization and coordination of relevant stakeholders, including health services and community health services (TB, STI, FP, MCH, HIV prevention), PLHIV, relevant local authority, CBO, FBO, NGOs should be mobilised and encouraged to participate in the activity.

**Key question 19 – CARE AND TREATMENT-1**

**How widely are essential services of care and treatment readily available?**

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<sup>(6)</sup> Plan of Action number 4

The care and treatment for PLHIV are included in Program of Action numbers. 3 and 5, which will be combined into PoA number 5.

Within the Vietnamese context, HIV care and treatment is provided by both MOH facilities and also by facilities in non-MOH system or/and closed settings (i.e. rehabilitation centers or primary detention facilities). Therefore, the assessment of the availability of care and treatment services should include the latter facilities.

In order to avoid stock out, it is important to know number of facilities that may experience stock out. However, it is not relevant at the country's situation to include this indicator in the framework.

To answer this key question, the following indicators can be examined:

#	INDICATOR	PURPOSE
48	Percentage of districts with at least one public (MOH line) health facility providing ART	To assess the availability of ART program in public health facilities
49	Percentage of districts providing comprehensive HIV care, treatment and support package in line with National Standards	To assess the availability of comprehensive HIV/AIDS care, treatment and support
50	Number of closed settings and non-MOH facilities providing ART services	To assess the availability of ART services in closed settings and non-MOH facilities

**Key question 20 – CARE AND TREATMENT-2**

**Are people in need accessing and using essential services of care and treatment?**

As in the case of PMTCT service indicators, it is important to ensure that once services are available, people in need are able to access and use these services in accordance to their needs.

To answer this key question, the following indicator to be obtained:

#	INDICATOR	PURPOSE
51	Percentage of people with advanced HIV infection receiving ARV combination therapy	To assess progress towards providing antiretroviral combination therapy to all people with advanced HIV infection

**Key question 21 – CARE AND TREATMENT-3**

**Are services effective in improving quality of life, prolonging lives and preventing HIV drug resistance?**

Improved quality of life and prolonged life expectancy of PLHIV are indicators of an effective HIV care and treatment programme.

In HIV treatment, treatment failure due to drug resistance is a significant threat. Therefore, identifying and responding to early warning signs of drug resistance should be part of an effective care and treatment services. An effective program should therefore also be able to ensure that patients adhere to treatment.

To answer this key question, the following indicators can be examined:

#	INDICATOR	PURPOSE
52	Continuation of first-line regimens at 6, 12 and 24 months after initiation	To assess the continuation of patients with the first-line regimens
53	Survival rate at 6, 12, 24 months after initiation of treatment	To assess survival rate

Remark: An indicator to measure quality of life (QoL) and early warning of drug resistance should be considered for future inclusion. It should be noted that data is already being collected at the facility level.

**Key question 22 – CARE AND TREATMENT-4**

**Are TB and HIV programs collaborating well to reduce the double burdens?**

It is estimated that around 5-10% of people who are HIV negative develop TB in their lifetime, compared to around 5-10% of HIV positive person developing TB each year. It was observed that people with latent TB are increasingly becoming infected with HIV, and many more are developing active TB because HIV is weakening their immune system. People who are co-infected with both HIV and latent TB are at almost 800 times greater risk of developing active TB disease and becoming infectious compared to people who are not infected with HIV<sup>(7)</sup>.

It is vitally important for people with HIV to receive treatment if they have active TB. This will both cure them and prevent transmission to others. It is therefore crucial to integrate TB treatment with HIV care and treatment programs and vice versa. Program components should include early diagnosis and treatment of TB for HIV positive people; detection of HIV amongst TB patients; and provision of adequate and timely care and treatment for people with HIV and TB infection.. This will require effective collaboration between the HIV and TB programs, including follow-up mechanisms and the provision of care, treatment and support for HIV/TB cases.

To answer this key question, the following indicator can be examined:

#	INDICATOR	PURPOSE
54	Percentage of PLHIV, receiving HIV treatment and care services, who were screened for TB symptoms	To assess the progress towards reducing TB impact among PLHIV

<sup>(7)</sup> CDC. TB and HIV Co-infection. CDC NCHSTP Division of Tuberculosis Elimination. Accessed via link [http://www.cdc.gov/nchstp/tb/pubs/TB\\_HIVcoinfection/default.htm](http://www.cdc.gov/nchstp/tb/pubs/TB_HIVcoinfection/default.htm), in June 22, 2006.

## 4. List of indicators

### SUB-GROUP 1: CAPACITY BUILDING, RESOURCES, MONITORING AND EVALUATION

#	Purpose	Indicator	Frequency	Source	Level of data collection	UNGASS	Types of indicator
1	To assess the status of development and implementation of the programmes of action against the National Strategy on HIV/AIDS	Status of the 8 programmes of action (drafted, finalized, budgeted, funded, implemented)	Annual	Routine reporting	National		Inputs Process
2	To assess progress in the development and implementation of national-level HIV policies and strategies	National Composite Policy Index	Every 2-3 years	MOH and related ministries	National	X	Inputs Process
3	To assess the level of response of different ministries and mass organizations to HIV	Percentage of designated ministries and mass organizations with annual plans, budgets and reports	Annual	MOH, related ministries and organizations	National		Inputs Process
4	To assess the level of response of different provinces/cities to HIV	Percentage of provinces/cities with annual plans, budgets and reports	Annual	MOH, provinces/cities	Provincial		Inputs Process
5	To assess the expenditure on HIV from central government	Total expenditure by the central government on HIV	Annual	MOH, MOFI, MPI, national institutes, UN and int' donors/organizations	National	X	Inputs
6	To assess the expenditure on HIV from provincial government	Total expenditure by the provincial government on HIV	Annual	MOH, MOFI, MPI, national institutes, UN and int' donors/organizations DOFI, DOH	Provincial		Inputs
7	To assess international expenditure on HIV	Total international expenditure on HIV	Annual	MOH, MOFA, MPI, UN and international donors/organizations	National		Inputs
8	To assess the private expenditure on HIV	Total expenditure by the private sector on HIV	Every 2-3 years	Special survey	National		Inputs
9	To assess the out-of-pocket expenditure on HIV care and treatment	Total expenditure from out-of-pocket expenses on HIV care and treatment	Every 2-3 years	Special survey	National		Inputs
10	To assess the relative expenditure between prevention vs. care and treatment	Ratio of total expenditure from all sources on prevention vs. care and treatment	Annual	Special survey	National		Inputs
11	To provide international comparison on total	Total expenditure on HIV per capita per	Annual	MOH, MOFI, MPI,	National		Inputs

#	Purpose	Indicator	Frequency	Source	Level of data collection	UNGASS	Types of indicator
	expenditure on HIV	year		national institutes, UN and int' donors/organizations			
12	To assess the human resource commitment from central to grassroots level	Number of full-time staff working in the field of HIV/AIDS	Annual	MOH, UN, INGOs, related ministries	National Provincial		Inputs
13	To assess the progress of implementation of the capacity building plan	Number of full-time HIV staff receiving training on HIV/AIDS prevention and control annually	Annual	MOH, UN, INGOs, related ministries	National Provincial		Process
14	To assess progress towards implementation of life-skills based HIV education in all schools	Percentage of schools with teachers who have been trained in life-skills-based HIV education and who taught it during the last academic year	Every 2-3 years	Ministry of Education and Training	National	X	Process
15	To assess the basic requirements of the Monitoring and Evaluation system at national level	National Composite Policy Index	Every 2-3 years	MOH and related ministries	National	X	Process
16	To assess the basic requirements of the Monitoring and Evaluation system at provincial level	Percentage of functional provincial Monitoring and Evaluation units	Annual	Routine reporting	Provincial		Process
17	To assess progress towards reducing HIV infection among target populations	Estimated prevalence among target groups	Annual (SS) Every 2-3 years (IBBS)	MOH, International organizations	National	X	Impact
18	To assess progress towards reducing HIV infection	Estimated prevalence of HIV in Viet Nam (by gender and age group)	Every 2-3 years	MOH, International organizations	National	X	Impact
19	To assess progress towards reducing HIV infections	Reported number of HIV infected people, AIDS cases and AIDS deaths (by gender and age group)	Annual	Routine reporting	National		Impact

## **SUB-GROUP 2: PREVENTION**

<b>#</b>	<b>Purpose</b>	<b>Indicator</b>	<b>Frequency</b>	<b>Source</b>	<b>Level of data collection</b>	<b>UNGASS</b>	<b>Types of indicator</b>
20	To assess progress towards universal knowledge of the essential facts about HIV transmission among people aged 15-49	Percentage of people aged (15-24 and 15-49) who both correctly identify ways of preventing the transmission of HIV and who reject major misconceptions about HIV transmission	Every 2-3 years	Population-based surveys such as DHS/VP AIS	National	X	Outcomes
21	To assess progress towards universal knowledge of the essential facts about HIV transmission amongst “most-at-risk” populations	Percentage of people in “most-at-risk” populations who both correctly identify ways of preventing the transmission of HIV and who reject major misconceptions about HIV transmission	Every 2-3 years	Special surveys such as BSS/IBBS	National	X	Outcomes
22	To assess the attitudes of adult people toward HIV-positive people	Percentage of people aged 15-49 who express accepting attitudes toward people living with HIV	Every 2-3 years	Population-based surveys such as DHS/VP AIS	National		Outcomes
23	To assess progress in reducing the percentage of young people aged 15–49 who have higher risk sex	Percentage of men and women by age group (15-24 and 15-49) who have had sex with a non-marital, non-cohabiting sexual partner in the last 12 months	Every 2-3 years	Population-based surveys such as DHS/VP AIS and special surveys	National	X	Outcomes
24	To assess the scale of general men exposing to sexual risk behavior	Percentage of men reporting visiting female sex workers in the last 12 months	Every 2-3 years	Population-based surveys such as DHS/VP AIS	National		Outcomes
25	To assess progress in preventing exposure to HIV among sex workers through unprotected sex with clients	Percentage of female sex workers reporting condom use with their most recent clients	Every 2-3 years	Special surveys such as BSS/IBBS (sex workers)	Targeted provinces	X	Outcomes
26	To assess progress in preventing exposure to HIV among sex workers through unprotected sex with clients	Percentage of female sex workers reporting consistent use of condoms with their clients in the last month	Every 2-3 years	Special surveys such as BSS/IBBS (sex workers)	Targeted provinces		Outcomes
27	To assess progress in preventing exposure to HIV among sex workers through high risk behavior of injecting drugs	Percentage of female sex workers who injected drugs in the last month	Every 2-3 years	Special surveys such as BSS/IBBS (sex workers)	Targeted provinces		Outcomes
28	To assess progress in preventing exposure to HIV among injecting drug users through high risk behavior of sharing injecting equipment	Percentage of injecting drug users who shared syringes and needles in the last month	Every 2-3 years	Special surveys such as BSS/IBBS (IDU)	Targeted provinces	X	Outcomes
29	To assess progress in preventing exposure	Percentage of injecting drug users reporting	Every 2-3	Special surveys such	Targeted	X	Outcomes

#	Purpose	Indicator	Frequency	Source	Level of data collection	UNGASS	Types of indicator
	to HIV among injecting drug users through unprotected sex activities	condom use during the last sexual activity	years	as BSS/IBBS (IDU)	provinces		
30	To assess progress in preventing exposure to HIV among men who have unprotected anal sex with a male partner	Percent of men reporting condom use the last time they had anal sex with a male partner	Every 2-3 years	Special surveys such as BSS/IBBS (MSM)	Targeted provinces	X	Outcomes
31	To assess availability of harm reduction services for injecting drug users	Percentage of districts implementing needle and syringe exchange and/or distribution program	Annual	Routine reporting	National		Outputs
32	To assess availability of harm reduction services for commercial sex workers	Percentage of districts implementing condom promotion programs for commercial sex workers	Annual	Routine reporting	National		Outputs
33	To assess availability of harm reduction programs	Number of sites implementing substitution programs	Annual	Routine reporting	National		Outputs
34	To assess HIV/AIDS prevention knowledge	Percentage of young men and women aged 15-24 who know sources of condoms	Every 2-3 years	Special survey	National		Outputs
35	To assess progress in implementing harm reduction program for “most-at-risk” populations	Percentage of “most-at-risk” populations reached by harm reduction program in the last 6 months	Every 2-3 years	- Special surveys such as BSS/IBBS - Routine reporting system	Targeted provinces	X	Outputs
36	To follow the prevalence of STI among targeted populations, including ANC	STI prevalence among targeted populations	Annual-sentinel surveillance Every 2-3 years-IBBS	- STI sentinel surveillance - IBBS	National		Outcomes
37	To assess the accessibility of STI diagnosis and treatment services	Percentage of most-at-risk populations accessing STI diagnosis and treatment services.	Every 2-3 years	Special surveys (BSS/IBBS) Routine reporting	National		Outputs
38	To assess the quality of STI diagnosis, treatment, and counseling services	Percentage of women and men with STIs at health-care facilities who are appropriately diagnosed, treated and counseled	Every 2-3 years	Special surveys	National	X	Outputs
39	To assess the safety of blood transfusion	Percentage of blood transfusion units screened for HIV which meets the MOH standards during the last 12 months	Annual	Routine reporting	National	X	Outputs
40	To assess the availability and coverage of VCT services	Percentage of VCT services which meet national standards	Every 2-3 years	Special survey at VCT services/sites	National		Outputs
41	To assess the utilization of VCT services	Number of people who have voluntarily tested and received HIV test results in the last 12 months	Annual	Routine reporting	National Provincial		Outputs

#	Purpose	Indicator	Frequency	Source	Level of data collection	UNGASS	Types of indicator
42	To assess the utilization of VCT services	Percentage of people who tested voluntarily, received pre-and-post test counseling and received HIV test results during the last 12 months.	Annual	Routine reporting	National		Outputs
43	To assess progress in implementing HIV testing and counseling among “most-at-risk” populations	Percentage of “most-at-risk” populations who received HIV testing in the last 12 months and received HIV test results	Every 2-3 years	- Special surveys such as BSS/IBBS - Routine reporting	Targeted provinces	X	Outputs

### **SUB-GROUP 3: CARE, TREATMENT AND PMTCT**

#	Purpose	Indicator	Frequency	Source	Level of data collection	UNGASS	ARV core	Types of indicator
44	To assess the availability of PMTCT services	Number and percentage of districts with at least one health facility providing the package of PMTCT services	Annual	Routine reporting	National Provincial			Process
45	To assess the utilization of PMTCT services	Number and percentage of pregnant women who have delivered in the preceding 12 months, who received HIV counseling and testing for PMTCT and received their test results	Annual	Routine reporting	National			Outputs
46	To assesses the progress in preventing mother-to-child HIV transmission through the provision of ARV prophylaxis	Number and percentage of both HIV-positive pregnant women and their babies receiving a complete course of antiretroviral prophylaxis to reduce the risk of mother-to-child transmission	Annual	Routine reporting	National Provincial	Generalise – 6 HIV – PI 7		Outputs
47	To assess progress towards eliminating mother-to-child HIV transmission	Percentage of infants born to HIV infected mothers who are HIV positive	Annual	Routine reporting	National	Generalised - 17		Impact
48	To assess the availability of ART program in public health facilities	Percentage of districts with at least one public (MOH line) health facility providing ART	Annual (scaling-up) Every 2-3 years thereafter	Routine reporting Survey of health facilities	National			Process

#	Purpose	Indicator	Frequency	Source	Level of data collection	UNGASS	ARV core	Types of indicator
49	To assess the availability of comprehensive HIV care, treatment and support	Percentage of districts providing comprehensive HIV care, treatment and support package in line with National Standards	Annual	Routine reporting	National Provincial		2	Process
50	To assess the availability of ART services in closed settings and non-MOH facilities	Number of closed settings and non-MOH facilities providing ART services	Annual	Routine reporting	National Provincial			Inputs
51	To assess progress towards providing antiretroviral combination therapy to all people with advanced HIV infection	Percentage of people with advanced HIV infection receiving ARV combination therapy	Annual	Routine reporting	National	Generalised 7 HIV-TI 1	7	Outputs
52	To assess the continuation of patients with the first-line regimens	Continuation of first-line regimens at 6, 12 and 24 months after initiation	Annual	Routine reporting	National Provincial		8	Outcomes
53	To assess survival rate	Survival rate at 6, 12, 24 months after initiation of treatment	Annual	Routine reporting	National Provincial		9	Impact
54	To assess the progress towards reducing TB impact among PLHIVs	Percentage of PLHIVs receiving HIV treatment and care services who were screened for TB symptoms (TB/HIV-1, 2)	Annual	Modified HIV testing and counseling register or HIV treatment and care register	National Provincial	TB/HIV – 1,2		Outputs

## Appendix

### Annex 1: Detailed descriptions of indicators

#### SUB-GROUP 1 – CAPACITY, RESOURCES, MONITORING AND EVALUATION

##### **Indicator 1 - Status of the 8 Programmes of Action (drafted, finalized, budgeted, funded, and implemented)**

<b>PURPOSE</b>	To assess the status and implementation of the 8 programmes of action identified in the National Strategy on HIV/AIDS
<b>DEFINITION</b>	Checklist of the status of the 8 programmes of action which measures whether or not the PoA are drafted, finalized, budgeted, funded, and implemented.
<b>LEVEL</b>	National
<b>FREQUENCY</b>	Annual
<b>MEASUREMENT TOOL</b>	Reporting form
<b>METHOD OF MEASUREMENT</b>	Checklist of the status of the 8 programs of action, including whether or not <ul style="list-style-type: none"><li>- The draft PoA are available</li><li>- The final PoA are approved by Ministry of Health</li><li>- Each of the 8 programmes is budgeted in their approved PoA</li><li>- The PoA receive sufficient, partial funding or not funded</li><li>- Implementation of the 8 programmes (a brief description of how PoA are implemented)</li></ul>
<b>INTERPRETATION</b>	Implementation of the National Strategy on HIV/AIDS requires the development and implementation of the 8 programmes of actions. This indicator reflects the progression in which the National Strategy is realized into practice. This indicator only looks at the progress of the programs of actions with YES or NO or steps. It cannot tell us about the quality of the programs and the ways they are implemented.

**Table 1** Status of the 8 programmes of action

Programs of actions	Drafted		Finalized		Budgeted		Funded			Implemented and progress (3-4 lines summary)
	<i>Yes</i>	<i>No</i>	<i>Yes</i>	<i>No</i>	<i>Yes</i>	<i>No</i>	<i>Sufficient</i>	<i>Partial funded</i>	<i>Not funded</i>	
1. Behavior change Information, Education, and Communication										
2. Harm reduction intervention										
4. Surveillance, Monitoring and Evaluation										
5. Care and support, and access to HIV treatment										
6. Prevention of mother-to-child transmission										
7. STI management and treatment										
8. Blood transfusion safety										
9. Capacity and International cooperation enhancing										

## **Indicator 2 - National Composite Policy Index**

<b>PURPOSE</b>	To assess progress in the development and implementation of national-level HIV/AIDS policies and strategies
<b>DEFINITION</b>	The national composite policy index aims to estimate the amount of efforts put into national HIV programs by the national level government, NGOs and by international organizations. It intends to measure the strength of efforts for program input and output, to complement data on program outcome.
<b>LEVEL</b>	National
<b>FREQUENCY</b>	Every 2-3 years or according to UNGASS requirement
<b>MEASUREMENT TOOL</b>	Country assessment questionnaire <sup>(8)</sup>
<b>METHOD OF MEASUREMENT</b>	<p>The composite index covers the following broad areas of policy and is divided into 2 parts</p> <p><b>Part A</b> to be filled in by the Government officials</p> <ol style="list-style-type: none"><li>1. Strategic plan.</li><li>2. Political support.</li><li>3. Prevention.</li><li>4. Care and support.</li><li>5. Monitoring and Evaluation.</li></ol> <p><b>Part B</b> to be filled in by the representatives from the Government primary partners including NGOs, bilateral and the UN systems.</p> <ol style="list-style-type: none"><li>1. Human rights.</li><li>2. Civil Society involvement.</li><li>3. Prevention.</li><li>4. Care and support.</li></ol> <p>A number of specific policy indicators have been identified for each of these policy areas (see UNGASS Guidelines on Construction of Core Indicators)</p>
<b>INTERPRETATION</b>	<p>To answer complex issues like policies into a single yes or no or a number, will always reduce the complexity of the issues. However, an index like this makes it possible to compare progress over time and find out areas that need more attention and strengthening.</p> <p>This indicator is intended to enable assessment of progress over time, as well as between countries. However, it is difficult to capture the complex situation of the country or the unique issues that the country experiences and faces.</p>

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<sup>(8)</sup> UNAIDS (2005). UNGASS Guidelines on Construction of Core Indicators: National Composite Policy Index. p 80-102.

### **Indicator 3 - Percentage of designated ministries and mass organizations with annual HIV plans, budgets and reports**

<b>PURPOSE</b>	To assess the level of response of designated ministries and mass organizations to HIV/AIDS
<b>DEFINITION</b>	<p><b>NUMERATOR</b> Number of designated ministries and mass organizations with answers of YES to questions 1, 2 and 3 (see measurement)</p> <p><b>DENOMINATOR</b> Number of designated ministries and mass organizations.</p>
<b>LEVEL</b>	National
<b>FREQUENCY</b>	Biennial
<b>MEASUREMENT TOOL</b>	Special assessment by the VAAC
<b>METHOD OF MEASUREMENT</b>	<p>This indicator is constructed from responses to the following set of prompted questions.</p> <p>(1) Does the ministry/mass organization have an HIV/AIDS annual action plan?            (2) a) Does the ministry/mass organization have a specified budget for HIV/AIDS?            b) If YES, from which source                Central allocation?                Own budget?            (3) Did the ministry/mass organization produce an annual report of their HIV/AIDS activities for the previous year?</p> <p>See table 2 for more details</p>
<b>INTERPRETATION</b>	<p>Multisectoral responses have shown to be an effective approach to address the HIV/AIDS epidemic. In order to have a multisectoral program on HIV/AIDS, apart from the health sector, designated ministries and mass organizations have to develop action plans, allocate budgets and make annual reports. These annual plans also form the foundation of monitoring and evaluation systems.</p> <p>Budget comes mostly from 2 major sources: central allocation and own budget.</p> <p>An annual report should include information on whether activities were fully implemented.</p> <p>This indicator does not address the content of these plans, or the nature of the associated targets. Some plans can be incomplete or otherwise unrealistic, and this measure does not take those eventualities into account. Further, this indicator does not tell us the size of the budget and the quality of annual reports.</p>

**Table 2: Response to HIV epidemic from ministries and mass organizations**

	Ministry/Mass Organization	Annual action plan		Budget				Annual report	
				Central allocation		Own budget			
		Yes	No	Yes	No	Yes	No	Yes	No
1	Ministry of Health								
2	Ministry of Labor, Invalids and Social Affairs								
3	Ministry of Education and Training								
4	Ministry of Public Security								
5	Ministry of Transportation								
6	Ministry of Culture and Information								
7	Ministry of Planning and Investment								
8	Ministry of Finance								
9	Women's Union								
10	Youth Union								
11	Vietnam Television								
12	Vietnam Fatherland Front								
13	Commission for Science, Education and Technology (National Assembly)								
14	Vietnam Farmer's Association								
15	Commission for Social Affairs (National Assembly)								
16	Ministry of Construction								
17	VCCI								
18	Ministry of Industry								
19	Ministry of Defence								

## **Indicator 4 - Percentage of provinces and cities with annual plans, budgets and reports**

<b>PURPOSE</b>	To assess the responses of provinces and cities to HIV epidemic
<b>DEFINITION</b>	<b>NUMERATOR</b> Number of provinces and cities with answers YES to the 3 questions below (see measurement) <b>DENOMINATOR</b> Number of provinces and cities
<b>LEVEL</b>	Provincial/city
<b>FREQUENCY</b>	Every 2-3 years
<b>MEASUREMENT TOOL</b>	Special assessment by each province/city and be compiled by the VAAC
<b>METHOD OF MEASUREMENT</b>	This indicator is constructed from responses to the following set of prompted questions.  (1) Does the province/city have an HIV/AIDS implementation plan? (2) Besides centrally allocated budget, does the province/city allocate its own budget for HIV/AIDS prevention and control program? (3) Does the province/city have the annual report on HIV/AIDS following the reporting forms of the Ministry of Health?  See table 3 for more details
<b>INTERPRETATION</b>	In order to have a successful response at provincial level, provinces and cities have to develop action plans, allocate budgets and make annual reports. An equally important part of this response is the preparation of a plan, with linked targets and costs. Plans also form the foundation of monitoring and evaluation systems.  Budget comes mostly from 2 major sources: central allocation and own budget.  An annual report should provide information whether activities were fully implemented.  This indicator does not address the content of these plans, or the nature of the associated targets. Some plans can be incomplete or otherwise unrealistic, and this measure does not take those eventualities into account. Further, this indicator does not tell us the size of the budget and the quality of annual reports.

**Table 3** Response to HIV/AIDS from provinces and cities

	Province/City	Implementation plan		Own budget		Annual report	
		Yes	No	Yes	No	Yes	No
	<b>North West</b>						
1	Son La						
2	Lai Chau						
3	Dien Bien						
4	Hoa Binh						
	<b>North East</b>						
5	Ha Giang						
6	Cao Bang						
7	Lao Cai						
8	Bac Kan						
9	Lang Son						
10	Tuyen Quang						
11	Yen Bai						
12	Thai Nguyen						
13	Phu Tho						
14	Vinh Phuc						
15	Bac Giang						
16	Bac Ninh						
17	Quang Ninh						
	<b>Red River Delta</b>						
18	Ha Noi						
19	Hai Phong						
20	Ha Tay						
21	Hai Duong						
22	Hung Yen						
23	Ha Nam						
24	Nam Dinh						
25	Thai Binh						
26	Ninh Binh						
	<b>North Central</b>						
27	Thanh Hoa						
28	Nghe An						
29	Ha Tinh						
30	Quang Binh						
31	Quang Tri						
32	Thua Thien Hue						
	<b>South Central Coast</b>						
33	Da Nang						
34	Quang Nam						
35	Quang Ngai						
36	Binh Dinh						
37	Phu Yen						
38	Khanh Hoa						
	<b>Central Highlands</b>						
39	Kon Tum						
40	Gia Lai						
41	Dak Lak						
42	Dak Nong						
	<b>North East South</b>						
43	Ho Chi Minh City						
44	Lam Dong						
45	Ninh Thuan						

	Province/City	Implementation plan		Own budget		Annual report	
		Yes	No	Yes	No	Yes	No
46	Binh Phuoc						
47	Tay Ninh						
48	Binh Duong						
49	Dong Nai						
50	Binh Thuan						
51	Ba Ria Vung Tau						
	<b>Mekong River Delta</b>						
52	Long An						
53	Dong Thap						
54	An Giang						
55	Tien Giang						
56	Vinh Long						
57	Ben Tre						
58	Kien Giang						
59	Can Tho						
60	Hau Giang						
61	Tra Vinh						
62	Soc Trang						
63	Bac Lieu						
64	Ca Mau						

## **Indicator 5 - Total expenditure by the central government on HIV**

<b>PURPOSE</b>	To assess the expenditure on HIV from central government
<b>DEFINITION</b>	The total expenditure can be categorized into 2 major components: <ul style="list-style-type: none"><li>• Recurrent expenditure (salaries, administrative, activities expenditures, etc)</li><li>• Capital expenditure (lands and buildings, major medical equipment, plant and other equipment, expenditure in relation to intangible assets, and others)</li></ul>
<b>LEVEL</b>	National
<b>FREQUENCY</b>	Annual
<b>MEASUREMENT TOOL</b>	National HIV/AIDS sub-account assessment using desk review with documents from <ul style="list-style-type: none"><li>• Ministry of Finance and Ministry of Health budgets, according to program category allocations</li><li>• Financial reports from related ministries and organizations</li></ul>
<b>METHOD OF MEASUREMENT</b>	The National HIV/AIDS Sub-account Assessment will be used to collect information for this indicator. Information gathered will be filled in appropriate place in Table 4. Data should be disaggregated by 8 programs of action.
<b>INTERPRETATION</b>	Indicators 1.4a through 1.4e allows us to identify Who pay and How much. This indicator cannot tell us how well funds are used. It also does not tell us the relative priority given to HIV/AIDS compared to other Government expenditures.

## **Indicator 6 - Total expenditure by provincial government on HIV**

<b>PURPOSE</b>	To assess the expenditure on HIV from provincial government
<b>DEFINITION</b>	<p>The total expenditure can be categorized into 2 major components:</p> <ul style="list-style-type: none"><li>• Recurrent expenditure (salaries, administrative, activities expenditures, etc)</li><li>• Capital expenditure (lands and buildings, major medical equipment, plant and other equipment, expenditure in relation to intangible assets, and others)</li></ul>
<b>LEVEL</b>	Provincial
<b>FREQUENCY</b>	Annual
<b>MEASUREMENT TOOL</b>	<p>HIV/AIDS- Sub-account Assessment using desk review with documents from:</p> <ul style="list-style-type: none"><li>• Department of Finance and Department of Health budgets, according to program category allocations</li><li>• Financial reports from provinces</li></ul> <p>Data should be disaggregated by 8 programs of action.</p>
<b>METHOD OF MEASUREMENT</b>	<p>The National HIV/AIDS Sub-account Assessment will be used to collect information for this indicator. Information gathered will be filled in appropriate place in Table 4.</p> <p>Data should be disaggregated by nine programs of action.</p>
<b>INTERPRETATION</b>	<p>Indicators 1.4a through 1.4e allows us to identify Who pay and How much.</p> <p>This indicator cannot tell us how well funds are used. It also does not tell us the relative priority given to HIV/AIDS compared to other Government expenditures.</p>

## Indicator 7 - Total international expenditure on HIV/AIDS

<b>PURPOSE</b>	To assess international expenditure on HIV
<b>DEFINITION</b>	Total international (ODA, NGOs, INGOs) expenditure on HIV
<b>LEVEL</b>	National
<b>FREQUENCY</b>	Annual
<b>MEASUREMENT TOOL</b>	<p>Desk review with a standardized reporting format from:</p> <ul style="list-style-type: none"><li>• Reports from major donors and UN agencies</li><li>• MOH, Ministry of Planning and Investment (MPI) and Ministry of Finance (MOF)</li></ul> <p>Data should be disaggregated by 8 programs of action.</p>
<b>METHOD OF MEASUREMENT</b>	<p>The National HIV/AIDS Sub-account Assessment will be used to collect information for this indicator. Information gathered will be filled in appropriate place in Table 4.</p> <p>It is needed to distinguish between loan and grant.</p>
<b>INTERPRETATION</b>	<p>Indicators 1.4a through 1.4e allows us to identify Who pay and How much.</p> <p>Requires cooperation from all donors to report. It does not tell us anything about how much budget was allocated by each donor, so no comparisons can be made between <i>commitment</i> and <i>expenditure</i>.</p> <p>This indicator does not describe how the funds are actually expended, or the quality of the implementing programs. This information also does not monitor the duration of donor funding, and how donor planning will affect future programming.</p>

**Indicator 8 - Total expenditure by the private sector on HIV/AIDS [OPTIONAL indicator]**

<b>PURPOSE</b>	To assess the private expenditure on HIV/AIDS
<b>DEFINITION</b>	Expenditure from private sector is financial sources from private businesses, enterprises, companies
<b>LEVEL</b>	National
<b>FREQUENCY</b>	Every 2-3 years
<b>MEASUREMENT TOOL</b>	Special survey made by GSO.
<b>METHOD OF MEASUREMENT</b>	Special survey made by GSO. Data should be disaggregated by 8 programs of action.
<b>INTERPRETATION</b>	Indicators 1.4a through 1.4e allow us to identify Who pays and How much. Information gathered will be filled in appropriate place in Table 4. Difficult to get accurate data. This indicator cannot tell us how well funds are used.

**Indicator 9 - Total expenditure from out-of-pocket expenses on HIV/AIDS care and treatment [optional]**

<b>PURPOSE</b>	To assess the out-of-pocket expenditure on HIV/AIDS.
<b>DEFINITION</b>	Total monthly expenditure that the families/individuals paid for one PLHIV for care and treatment
<b>LEVEL</b>	National
<b>FREQUENCY</b>	Every 2-3 years
<b>MEASUREMENT TOOL</b>	Special survey such as population-based survey (household size) can be used to get this information. Information gathered will be filled in appropriate place in Table 4. Data should be disaggregated by 8 programs of action.
<b>METHOD OF MEASUREMENT</b>	Special survey (Please refer to the Report on impact of HIV/AIDS on household vulnerability and poverty in Viet Nam, by Futures Group, Sep. 2004 for more details on the methodologies <sup>(9)</sup> )
<b>INTERPRETATION</b>	Indicators 1.4a through 1.4e allow us to identify Who pays and how much. HIV and poverty are very closely linked. The “poverty trap” refers to the situation where a household just above the poverty line marginally fell to bellow poverty line (in other words, from the 3 <sup>rd</sup> quintile down to the 4 <sup>th</sup> quintile) for example, due to the cost of a medical event related to HIV. This is an extremely important indicator in Viet Nam where 70% of total health expenditure is out-of-pocket. This indicator is difficult to assess. PLHIV known by the society may receive good and/or services from HIV programs for free or at reduced cost. Therefore, the risk of underestimating the out-of-pocket expenditure on HIV/AIDS is high.

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<sup>(9)</sup> Futures Group. Report on impact of HIV/AIDS on household vulnerability and poverty in Vietnam. Sep. 2004

## **Indicator 10 - Ratio of total expenditure from all sources on prevention vs. care and treatment**

<b>PURPOSE</b>	To assess the relative expenditure between prevention vs. care and treatment
<b>DEFINITION</b>	<b>NUMERATOR</b> Total expenditure from all sources on prevention <b>DENOMINATOR</b> Total expenditure from all sources on care and treatment
<b>LEVEL</b>	National
<b>FREQUENCY</b>	Every 2-3 years
<b>MEASUREMENT TOOL</b>	Total expenditure from all sources from Table 4 can be used to calculate this indicator.
<b>METHOD OF MEASUREMENT</b>	(Please see the Report on impact of HIV/AIDS on household vulnerability and poverty in Viet Nam, by Futures Group, Sep. 2004 for more details on the methodologies)
<b>INTERPRETATION</b>	<p>The ratio between expenditure for prevention versus expenditure for care and treatment would tell us about the relative allocation of funding to different aspects of the HIV/AIDS programme. Some empirical evidence suggests that investment into prevention would be averting more HIV/AIDS cases than investment into care and treatment.</p> <p>This indicator is difficult to assess. PLHIV known by the society may receive goods and/or services from HIV programs for free or at reduced cost. Therefore, the risk of underestimating the out-of-pocket expenditure on HIV/AIDS is high.</p>

## **Indicator 11- Total expenditure on HIV/AIDS per capita per year**

<b>PURPOSE</b>	To provide international comparison on total expenditure on HIV/AIDS
<b>DEFINITION</b>	<b>NUMERATOR</b> Total expenditure from all sources on HIV/AIDS <b>DENOMINATOR</b> Total population within the given year
<b>LEVEL</b>	National
<b>FREQUENCY</b>	Every 2-3 years
<b>MEASUREMENT TOOL</b>	N/A
<b>METHOD OF MEASUREMENT</b>	Special survey Please see Table 4 for more details.
<b>INTERPRETATION</b>	This indicator will make it possible to compare the expenditure on HIV/AIDS in Viet Nam with other countries. The aggregated expenditure depends on the quality of all the above indicators in 1.4.

**Table 4: Expenditure from different sources to HIV/AIDS**

Programs of actions	Government							External			Private	Total
	MOH	MOLISA	MOPS	MOET	Others ministries	DOH	DOFI	ODA		INGOs		
								Grant	Loan			
1. Behavioral change Information, Education, and Communication												
2. Harm reduction intervention												
4. Surveillance, Monitoring and Evaluation												
5. Care and support, access to HIV/AIDS treatment												
6. PMTCT												
7. STI management and treatment												
8. Blood transfusion safety												
9. Capacity and International cooperation enhancing												
TOTAL												

## **Indicator 12 - Number of full-time staff working in the field of HIV/AIDS**

### **Only government staff, all level (except commune)**

<b>PURPOSE</b>	To assess the human resources commitment of Government from central to grassroots level
<b>DEFINITION</b>	Number of full-time staff working in the field of HIV/AIDS
<b>LEVEL</b>	National and provincial
<b>FREQUENCY</b>	Annual
<b>MEASUREMENT TOOL</b>	Programme and provincial reports
<b>METHOD OF MEASUREMENT</b>	<p>Full-time staff can be defined as Government staff who get salary for a full-time position in the field of HIV. The full-time staff can be categorized into three broad areas:</p> <ul style="list-style-type: none"><li>- Hospital staff.</li><li>- Staff at coordinating bodies/institutions such as: PAC, Provincial Preventive Medicine Centers, Provincial HIV/AIDS Center (not in treatment and/or outreach programs, etc)</li><li>- Others</li></ul>
<b>INTERPRETATION</b>	<p>The number of staff working in HIV/AIDS programs reflects on the commitment of government to ensuring that HIV/AIDS control measures are supported adequately. All types of programming require sufficient numbers of personnel to complete relevant activities, and particularly to maintain a high level of performance.</p> <p>This indicator offers further evidence of the commitment of government to address HIV/AIDS. A logical sequence follows from policy commitment, to fund allocations, and next to human resources. Progress in all three of these indicators should be in parallel.</p> <p>This indicator does not measure the types of actual programming or the quality of the work accomplished. This indicator does not measure the contribution of the Party or mass organizations to HIV/AIDS. While a good marker of Government commitment to HIV/AIDS control, this indicator does not address what is actually taking place.</p>

**Indicator 13 - Number of full-time HIV staff receiving training on HIV/AIDS prevention and control annually**

<b>PURPOSE</b>	To assess the progress on the implementation of the capacity building plan
<b>DEFINITION</b>	Number of HIV/AIDS government full-time staff receiving training annually
<b>LEVEL</b>	National and provincial
<b>FREQUENCY</b>	Annual
<b>MEASUREMENT TOOL</b>	National reporting system and international organizations reporting forms.
<b>METHOD OF MEASUREMENT</b>	<p>There are different kinds of training provided to HIV/AIDS staff yearly. Because not all kinds of trainings can be measured, focus will be on comprehensive training in:</p> <ul style="list-style-type: none"><li>- Planning and management</li><li>- Technical issues, e.g., OI, ARV, harm reduction, care and support for PLHIV, PMTCT, STI, safe blood transfusion</li></ul>
<b>INTERPRETATION</b>	<p>This indicator will tell us the progress on the implementation of the capacity building plan, annually.</p> <p>This indicator does not tell us the sufficiency and quality of training courses provided.</p> <p>This indicator also does not tell that if the number of trained staffs is sufficient for an effective response.</p>

## Indicator 14 - Percentage of schools with teachers who have been trained in life-skills-based HIV education and who taught it during the last academic year

<b>PURPOSE</b>	To assess progress towards implementation of life-skills based HIV education in all schools
<b>DEFINITION</b>	<p><b>NUMERATOR</b></p> <p>Number of schools with staff members trained in and regularly teaching life-skills-based HIV education.</p> <p><b>DENOMINATOR</b></p> <p>Number of schools surveyed.</p> <p>Indicator scores are required for all schools combined and for primary and secondary schools separately each by private/public status and by urban/rural setting. If school provides both primary and secondary education, information should be collected and reported separately for both levels of education.</p>
<b>LEVEL</b>	National
<b>FREQUENCY</b>	2-3 years
<b>MEASUREMENT TOOLS</b>	<p>Special survey</p> <p>Principals/heads of a nationally-representative sample of schools (to include both private and public schools) are briefed on the meaning of life-skills based HIV education and then are asked the following questions.</p> <ol style="list-style-type: none"> <li>1. Does your school have at least one qualified teacher who has received training in participatory life-skills based HIV education in the last 5 years?</li> <li>2. <i>If the answer to question 1. is "yes"</i>: Did this person teach life-skills based HIV education on a regular basis to each grade in your school throughout the last academic year?</li> </ol> <p>The teacher training must have included time dedicated to mastering facilitation of participatory learning experiences that aim to develop knowledge, positive attitudes, and skills (e.g., interpersonal communication, negotiation, decision-making, critical thinking and coping strategies) that assist young people in maintaining safe lifestyles. Wherever possible, the teacher training should have been done in accordance with the latest UNICEF guidelines, which can be found at <a href="http://www.unicef.org/lifeskills/index_documents.html">http://www.unicef.org/lifeskills/index_documents.html</a>.</p> <p>For the purposes of calculating this indicator, at least 30 hours of tuition per year per grade of pupil is recommended if life-skills based HIV education is to qualify as standard tuition. However, countries may adjust this number according to local contexts.</p>
<b>METHOD OF MEASUREMENT</b>	
<b>INTERPRETATION</b>	<p>It is important that life-skills based HIV education is initiated in the early grades of primary school and then continued throughout schooling with contents and methods being adapted to the age and experience of the students. Where schools provide both primary and secondary education, at least one teacher should have been trained to teach life-skills-based HIV education at each of these levels.</p> <ul style="list-style-type: none"> <li>• The indicator provides useful information on trends in the coverage of life-skills based HIV education within schools. However, the substantial variations in the levels of school enrolment must be taken into account when interpreting (or making cross-country comparisons of) this indicator. Consequently, primary and secondary school enrolment rates for the most recent academic year should be included in the supporting information provided for this indicator.</li> <li>• The indicator is a measure of coverage. The quality of education provided may differ by country and over time.</li> <li>• The measurement of this indicator requires close collaboration between MOH and MOET.</li> </ul>

## **Indicator 15 – National Policy Composite Index**

<b>PURPOSE</b>	To assess the basic requirements of the Surveillance, Monitoring and Evaluation system.
<b>DEFINITION</b>	The national composite policy index aims to estimate the amount of efforts put into national HIV programs by the national level government, NGOs and by international organizations. It intends to measure the strength of efforts for program input and output, to complement data on program outcome.
<b>LEVEL</b>	National level
<b>FREQUENCY</b>	Every 2-3 years
<b>MEASUREMENT TOOL</b>	Country assessment questionnaire <sup>(10)</sup>
<b>METHOD OF MEASUREMENT</b>	The composite index covers the following broad areas of policy and is divided into 2 parts <b>Part A</b> to be filled in by the Government officials 5. Monitoring and Evaluation. (See UNGASS Guidelines on Construction of Core Indicators)
<b>INTERPRETATION</b>	To answer complex issues like policies into a single yes or no or a number, will always reduce the complexity of the issues. However, an index like this makes it possible to compare progress over time and find out areas that need more attention and strengthening.  This indicator is intended to enable assessment of progress over time, as well as between countries. However, it is difficult to capture the complex situation of the country or the unique issues that the country experiences and faces.

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<sup>(10)</sup> UNAIDS (2005). UNGASS Guidelines on Construction of Core Indicators: National Composite Policy Index. p 80-102.

## **Indicator 16 – Percentage of functional Provincial Monitoring and Evaluation units**

<b>PURPOSE</b>	To assess the basic requirements of the Surveillance, Monitoring and Evaluation system.
<b>DEFINITION</b>	<b>NUMERATOR</b> Number of provinces with three out of four “YES” answers to the below mentioned criteria. <b>DENOMINATOR</b> Number of provinces.
<b>LEVEL</b>	Provincial
<b>FREQUENCY</b>	Annual
<b>MEASUREMENT TOOL</b>	Special VAAC reporting form to be completed at national level (see table 5 for details)
<b>METHOD OF MEASUREMENT</b>	The national reporting system includes specific questions regarding the provincial M&E unit. Questions address : <ul style="list-style-type: none"><li>- Responsible focal point</li><li>- Allocated budget</li><li>- M&amp;E plan</li><li>- Further at the national level, provinces will be checked if they report in a timely manner.</li></ul>
<b>INTERPRETATION</b>	<p>A well functioning M&amp;E system is of critical importance for an effective response to the HIV epidemic. The M&amp;E system needs to function well at both national and provincial level in order to achieve this. At the provincial level it is of importance to have a designated person responsible for M&amp;E, as well as an M&amp;E plan and budget. An important part of the national M&amp;E system builds on timely reporting from the provincial level.</p> <p>Simple <i>yes</i> and <i>no</i> answers can only give an overview of the situation of the M&amp;E system at provincial level, more complex issues of function, etc, are not well covered. This indicator only tells that an M&amp;E unit existing or not. It doesn't say if the M&amp;E unit is functioning well.</p>

**Table 5: Functional provincial Monitoring and Evaluation**

	Province/City	Responsible focal point			Allocated budget		M&E plan		Timely report	
		Yes	No	If yes, how many	Yes	No	Yes	No	Yes	No
	<b>North West</b>									
1	Son La									
2	Lai Chau									
3	Dien Bien									
4	Hoa Binh									
	<b>North East</b>									
5	Ha Giang									
6	Cao Bang									
7	Lao Cai									
8	Bac Kan									
9	Lang Son									
10	Tuyen Quang									
11	Yen Bai									
12	Thai Nguyen									
13	Phu Tho									
14	Vinh Phuc									
15	Bac Giang									
16	Bac Ninh									
17	Quang Ninh									
	<b>Red River Delta</b>									
18	Ha Noi									
19	Hai Phong									
20	Ha Tay									
21	Hai Duong									
22	Hung Yen									
23	Ha Nam									
24	Nam Dinh									
25	Thai Binh									
26	Ninh Binh									
	<b>North Central</b>									
27	Thanh Hoa									
28	Nghe An									
29	Ha Tinh									
30	Quang Binh									
31	Quang Tri									
32	Thua Thien Hue									
	<b>South Central Coast</b>									
33	Da Nang									
34	Quang Nam									
35	Quang Ngai									
36	Binh Dinh									
37	Phu Yen									
38	Khanh Hoa									
	<b>Central Highlands</b>									
39	Kon Tum									
40	Gia Lai									
41	Dak Lak									
42	Dak Nong									
	<b>North East South</b>									
43	Ho Chi Minh City									
44	Lam Dong									
45	Ninh Thuan									
46	Binh Phuoc									
47	Tay Ninh									
48	Binh Duong									
49	Dong Nai									
50	Binh Thuan									
51	Ba Ria Vung Tau									
	<b>Mekong River Delta</b>									
52	Long An									
53	Dong Thap									

	Province/City	Responsible focal point			Allocated budget		M&E plan		Timely report	
		Yes	No	If yes, how many	Yes	No	Yes	No	Yes	No
54	An Giang									
55	Tien Giang									
56	Vinh Long									
57	Ben Tre									
58	Kien Giang									
59	Can Tho									
60	Hau Giang									
61	Tra Vinh									
62	Soc Trang									
63	Bac Lieu									
64	Ca Mau									

## **Indicator 17 - Estimated prevalence among target groups**

<b>PURPOSE</b>	To assess progress towards reducing HIV prevalence among targeted populations
<b>DEFINITION</b>	<b>NUMERATOR</b> Number of members of target groups who test positive for HIV. <b>DENOMINATOR</b> Number of members of target groups tested for HIV. <b>Note:</b> Target groups include IDUs, FSWs, MSM, ANC, military recruits, STI patients and TB patients
<b>LEVEL</b>	National
<b>FREQUENCY</b>	Annual for sentinel surveillance Every 2-3 years for IBBS
<b>MEASUREMENT TOOL</b>	Sentinel surveillance and IBBS
<b>METHOD OF MEASUREMENT</b>	This indicator is calculated using data from HIV tests conducted among members of targeted groups in 40 provinces and cities (sentinel surveillance) and 7 provinces/cities (IBBS)
<b>INTERPRETATION</b>	Prevalence rate among target groups/populations over the year from sentinel surveillance would tell us the trend of HIV epidemic within these populations. <ul style="list-style-type: none"><li>• An understanding of how the sampled population(s) relate to any larger population(s) sharing similar risk behaviors is critical to the interpretation of this indicator.</li><li>• The period during which people belong to a most-at-risk population is more closely associated with the risk of acquiring HIV than age. Therefore, it is desirable not to restrict analysis to young people but to report on other age groups as well.</li><li>• Difficult to get a random samples, particularly among FSWs and IDUs in the context of 05/06 centers scaling-up.</li><li>• In many provinces, the sample size is not as big as expected for IDUs and FSW groups.</li><li>• Groups of IDUs and FSWs are not stable and they often migrate, e.g. it may lead to double counting.</li><li>• The question of not applying the anonymous sampling may lead to error due to the refusal to cooperate of the persons in the sentinel surveillance program.</li><li>• High turnover of staff of the sentinel surveillance program makes it difficult to ensure the working of the method applied in different provinces/cities at different points in time.</li></ul>

## **Indicator 18 - Estimated prevalence of HIV in Viet Nam (by gender and age group)**

<b>PURPOSE</b>	To assess progress towards reducing HIV infection
<b>DEFINITION</b>	<b>NUMERATOR</b> Number of estimated HIV cases by age group and sex <b>DENOMINATOR</b> Number of persons in each age group and sex  Age group can be divided in to 3 different intervals: <ul style="list-style-type: none"><li>- 15-24 years of age</li><li>- 25-49 years of age</li><li>- 15-49 years of age</li></ul>
<b>LEVEL</b>	National
<b>FREQUENCY</b>	Every 2-3 years
<b>MEASUREMENT TOOL</b>	Estimates and projection of HIV/AIDS using different models (software packages such as EPP-Estimates and Projection Package or AEM-Asian Epidemic Model)
<b>METHOD OF MEASUREMENT</b>	Estimates and projection of HIV/AIDS
<b>INTERPRETATION</b>	<p>Looking at HIV prevalence rate by sex and age group is important in understanding how HIV differentially affects different age groups and gender. In implementing HIV prevention, care and treatment programs, it is important to target interventions to the needs of different age groups and sex. Youth in particular need to be a special focus as many of the habits and behaviors that place individuals at risk of HIV/AIDS are formed during younger years.</p> <p>The numerator for this indicator relies on estimates of the number of HIV cases. The estimation process is systematic yet imperfect, more suited to generating ranges than point estimates.</p> <p>The denominator for this indicator relies on census data. While these data provide the best available estimates of population size by age group and other demographic factors, one problem is that population census is undertaken only every 10 years. As a result, the HIV prevalence rate may be over- or underestimated depending upon in- and out-migration.</p>

**Indicator 19 - Reported number of HIV infected people, AIDS cases and AIDS deaths (by sex and age group)**

<b>PURPOSE</b>	To assess progress towards reducing HIV infections
<b>DEFINITION</b>	Number of estimated HIV cases, AIDS cases, and AIDS deaths by age group and sex Age group can be divided into 3 different intervals: <ul style="list-style-type: none"><li>- 15-24 years of age</li><li>- 25-49 years of age</li><li>- 15-49 years of age</li></ul>
<b>LEVEL</b>	National
<b>FREQUENCY</b>	Annual
<b>MEASUREMENT TOOL</b>	Data from the HIV/AIDS case reporting system can be used to measure this indicator. The HIV/AIDS case-reporting system is set up to collect information on HIV/AIDS cases in different populations.
<b>METHOD OF MEASUREMENT</b>	Reporting form
<b>INTERPRETATION</b>	<p>This indicator is one of the important figures that provide additional information on the scope and dynamics of the HIV/AIDS epidemic.</p> <p>There are limitations to the data collected by the AIDS case-reporting system. Selection bias arises in that only certain individuals currently access the health system. The reasons for this are four-fold: 1) Many HIV infected people do not come to VCT until they develop symptoms, 2) Voluntary HIV counseling and testing is not routinely given or commonly available, 3) Confirmatory/supplementary HIV testing is not easily available and reporting practices are not yet entirely standardized and 4) Private clinics do not always report test results to the national system.</p>

## SUB-GROUP 2 - PREVENTION

**Indicator 20 - Percentage of women and men by age group (15-24 and 15-49) who correctly identify ways of preventing HIV transmission and who reject major misconceptions about HIV transmission**

<b>PURPOSE</b>	To assess progress towards universal knowledge of the essential facts about HIV transmission among people aged 15-49
	<b>NUMERATOR</b>
	Number of respondents by age group (15–24 and 15–49) who gave correct answers to all five questions relating to HIV transmission and misconceptions about HIV
	<b>DENOMINATOR</b>
<b>DEFINITION</b>	Number of respondents by age group (15–24 and 15–49) who gave answers (i.e., including “don’t know”) to all five questions
	Those who have never heard of HIV and AIDS should be excluded from the numerator but included in the denominator.
	<b>Notes:</b> Analysis and reporting in percentage broken down by age group (15–24 and 15–49) and sex according to urban/rural residence.
<b>LEVEL</b>	National
<b>FREQUENCY</b>	Every 2–3 years
<b>MEASUREMENT TOOLS</b>	Population-based surveys
	This indicator is constructed from responses to the following set of prompted questions.
<b>METHOD OF MEASUREMENT</b>	<ol style="list-style-type: none"> <li>1. Can the risk of HIV transmission be reduced by having sex with only one faithful, uninfected partner?</li> <li>2. Can the risk of HIV transmission be reduced by using condoms?</li> <li>3. Can a healthy-looking person have HIV?</li> <li>4. Can a person get HIV from mosquito bites?</li> <li>5. Can a person get HIV by sharing a meal with someone who is infected?</li> </ol>
<b>INTERPRETATION</b>	<ul style="list-style-type: none"> <li>• The belief that a healthy-looking person cannot be infected with HIV is a common misconception that can result in unprotected sexual intercourse with infected partners.</li> <li>• Rejecting major misconceptions about modes of HIV transmission is as important as correct knowledge of true modes of transmission. For example, belief that HIV is transmitted through mosquito bites can weaken motivation to adopt safer sexual behavior, while belief that HIV can be transmitted through sharing food reinforces the stigma faced by people living with AIDS.</li> <li>• The percentage of people who correctly identify ways of preventing HIV transmission and who reject major misconception about HIV transmission is expected to be low.</li> </ul>

**Indicator 21 - Percentage of people in “most-at-risk” populations who correctly identify ways of preventing HIV transmission and who reject major misconceptions about HIV transmission**

<b>PURPOSE</b>	To assess progress towards universal knowledge of the essential facts about HIV transmission among “most-at-risk” populations
	<b>NUMERATOR</b>
	Number of “most-at-risk” population respondents who gave correct answers to <i>all</i> five questions relating to transmission of HIV and misconceptions about HIV
	<b>DENOMINATOR</b>
	Number of “most-at-risk” population respondents who gave answers, including “don’t know,” to all five questions
<b>DEFINITION</b>	Respondents who have never heard of HIV and AIDS should be excluded from the numerator but included in the denominator.
	<b>Notes:</b>
	Analysis and reporting in percentage broken down by age group (15–24 and 15–49) and sex according to urban/rural residence.
	“Most-at-risk” populations include:
	- Injecting drug users
	- Female sex workers
	- Men who have sex with men
<b>LEVEL</b>	National
<b>FREQUENCY</b>	Every 2–3 years
<b>MEASUREMENT TOOLS</b>	Special surveys such as the BSS/IBBS
	Respondents are asked the following five questions.
<b>METHOD OF MEASUREMENT</b>	<ol style="list-style-type: none"> <li>1. Can having sex with only one faithful, uninfected partner reduce the risk of HIV transmission?</li> <li>2. Can using condoms reduce the risk of HIV transmission?</li> <li>3. Can a healthy-looking person have HIV?</li> <li>4. Can a person get HIV from mosquito bites?</li> <li>5. Can a person get HIV by sharing a meal with someone who is infected?</li> </ol>
<b>INTERPRETATION</b>	<ul style="list-style-type: none"> <li>• The belief that a healthy-looking person cannot be infected with HIV is a common misconception that can result in unprotected sexual intercourse with infected partners.</li> <li>• Correct knowledge about false beliefs of possible modes of HIV transmission is as important as correct knowledge of true modes of transmission. For example, the belief that HIV is transmitted through mosquito bites can weaken motivation to adopt safer sexual behavior, while the belief that HIV can be transmitted through sharing food reinforces the stigma faced by people living with AIDS.</li> <li>• Surveying “most-at-risk” populations can be challenging due to difficulties in accessing subjects/populations. Consequently, data obtained may not be based on a representative sample of the national “most-at-risk” population being surveyed. If there are concerns that the data is not based on a representative sample, these concerns should be reflected in the interpretation of the survey data. Where different sources of data exist, the best available estimate should be used. Information on the sample size, the quality/reliability of the data and any related issues should be included in the report submitted with this indicator.</li> </ul>

**Indicator 22 - Percentage of people aged 15-49 who express accepting attitudes toward people living with HIV**

<b>PURPOSE</b>	To assess the attitudes of adults toward HIV-positive people
	<b>NUMERATOR</b>
	Number of people aged 15–49 who have heard of HIV/AIDS and who answer positively to four questions relating to attitudes toward people living with HIV/AIDS
<b>DEFINITION</b>	<b>DENOMINATOR</b>
	Number of people aged 15–49 who have heard of HIV/AIDS and answered questions about accepting attitudes toward people living with HIV
	<b>Notes:</b> Analysis and reporting in percentage broken down by sex and age group (15-24, 25-49).
<b>LEVEL</b>	National
<b>FREQUENCY</b>	Every 2–3 years
<b>MEASUREMENT TOOLS</b>	Population-based surveys
<b>METHOD OF MEASUREMENT</b>	<p>Respondents are asked the following questions.</p> <ol style="list-style-type: none"> <li>1) Would you buy fresh vegetables from a shopkeeper or vendor if you knew that this person had AIDS?</li> <li>2) If a member of your family got infected with HIV, would you want it to remain a secret or not?</li> <li>3) If a member of your family became sick with the virus that causes AIDS, would you be willing to care for her/him in your own household?</li> <li>4) In your opinion, if a teacher has HIV but is not sick, should she/he be allowed to continue teaching in the school?</li> </ol>
<b>INTERPRETATION</b>	<p>Stigma and discrimination against HIV-positive persons causes a disproportionate amount of problems for these people, whether in their daily lives or in their attempts to access required services. HIV information campaigns are designed to inform the HIV-negative population to encourage safe behaviors and to support those who are infected with HIV. These campaigns also are intended to inform the HIV-positive population, to explain how the virus affects their lives, how health-seeking behavior will allow them to lead relatively normal lives, and how ongoing safe behavior will protect those around them. In general these campaigns are designed to bring clarity to the disease and to garner support for those infected and affected.</p> <p>This indicator describes the general population attitude toward the HIV-infected, though may not be very sensitive in low prevalence populations. As such, this measure can track the success of media and education campaigns and can inform these ongoing efforts, in addition to care, treatment, and support programs within the same communities. Slow, absent, or negative change in attitudes highlight the need for more concerted or improved programs to change the community environments.</p> <p>This indicator does not measure behaviors associated with attitudinal changes. While respondents might express a willingness to support the HIV-infected within their communities, actions anticipated with positive (or negative) answers are not measured with this indicator.</p>

**Indicator 23 - Percentage of men and women by age group (15-24 and 15-49) who have had sex with a non-marital, non-cohabiting sexual partner in the last 12 months**

<b>PURPOSE</b>	To assess progress in reducing the percentage of people aged 15–49 who have higher risk sex
	<b>NUMERATOR</b>
	Number of respondents by age group (15–24 and 15–49) who have had sex with a non-marital, non-cohabiting partner in the last 12 months
<b>DEFINITION</b>	<b>DENOMINATOR</b>
	Number of respondents by age group (15–24 and 15–49) who report sexual activity in the last 12 months
	<b>Notes:</b> Analysis and reporting in percentage broken down by age group (15–24 and 15–49) and sex.
<b>LEVEL</b>	National
<b>FREQUENCY</b>	Every 2–3 years
<b>MEASUREMENT TOOLS</b>	Population-based surveys or special surveys
<b>METHOD OF MEASUREMENT</b>	Respondents are asked about their marital status and the last three sexual partners within the last 12 months. For each partner, details are taken of cohabiting status as well as duration of the relationship, condom use and other factors.
<b>INTERPRETATION</b>	<p>This indicator gives a picture of levels of higher-risk sexual behaviour.</p> <p>This indicator describes the proportion of the general population engaging in high-risk sexual behaviour. Under-reported information is predictable and unavoidable due to its sensitivity <i>per se</i>.</p> <p>Population-based surveys can only capture those who live in the household in the period of surveying. The survey might exclude most-at-risk populations and/or mobile populations.</p> <p>If people stop having sex with all of their non-cohabiting partners, the change will be captured by changes in this indicator. However, if people simply decrease from seven non-cohabiting partners to one, for example, the indicator will not reflect a change, even though potentially this may have a significant impact on the epidemic spread of HIV and may be counted a program success.</p>

## **Indicator 24 - Percentage of men reporting visiting female sex workers in the last 12 months**

<b>PURPOSE</b>	To assess the scale of general men exposing to sexual risk behavior
	<b>NUMERATOR</b>
	Number of the respondents who reported having had visited female sex workers in the last 12 months
<b>DEFINITION</b>	<b>DENOMINATOR</b>
	Number of respondents in the survey
	<b>Notes:</b> Analysis and reporting in percentage broken down by age group (15–24 and 15–49)
<b>LEVEL</b>	National
<b>FREQUENCY</b>	Every 2–3 years
<b>MEASUREMENT TOOLS</b>	Population-based surveys
<b>METHOD OF MEASUREMENT</b>	Survey respondents aged 15–49 are asked whether any of their last three sexual partners were female sex workers. These respondents are further asked whether in the last 12 months they paid anyone in exchange for sex.  This indicator gives a picture of levels of some types of higher-risk sexual behavior. Information from this indicator plus protective factors from high risk behaviors (such as number of sex partners, including FSWs, the level of condom use and/or consistent condom use with FSWs) might give us an idea about how much risk levels are among lower risk groups (wives and/or sexual partners of these male clients).
<b>INTERPRETATION</b>	This indicator describes the proportion of the general population engaging in some types of high-risk sexual behavior. Under-reported information is predictable and unavoidable due to its sensitivity <i>per se</i> .  Population-based surveys can only capture those who live in the household in the period of surveying. The survey might exclude “most-at-risk” populations and/or mobile populations.  Within Vietnamese context and given the sensitivity of the question, under-reporting bias is considered unavoidable and very difficult to estimate.

## **Indicator 25 - Percentage of female sex workers reporting condom use with their most recent client**

<b>PURPOSE</b>	To assess progress in preventing exposure to HIV among female sex workers through unprotected sex with clients
	<b>NUMERATOR</b>
	Number of respondents who reported that a condom was used with their most recent client
	<b>DENOMINATOR</b>
<b>DEFINITION</b>	Number of female sex workers surveyed
	Clients can be categorized as: <ul style="list-style-type: none"><li>- Casual (one-time) clients</li><li>- Regular clients</li></ul>
	Data should be disaggregated by province and type of sex worker
<b>LEVEL</b>	Targeted provinces
<b>FREQUENCY</b>	Every 2–3 years
<b>MEASUREMENT TOOLS</b>	Special surveys such as BSS/IBBS
<b>METHOD OF MEASUREMENT</b>	Respondents are asked the following question:  Did you and your most recent client in the last 12 months use a condom?
<b>INTERPRETATION</b>	<ul style="list-style-type: none"><li>• Condoms are most effective when their use is consistent, rather than occasional. The current indicator will provide an overestimate of the level of consistent condom use. Furthermore, the trend in condom use in the most recent sexual act will generally reflect the trend in consistent condom use.</li><li>• Surveying sex workers can be challenging due to difficulties accessing the subjects/population. Consequently, data obtained may not be based on a representative sample of the national sex worker population being surveyed. If there are concerns that the data is not based on a representative sample, these concerns should be reflected in the interpretation of the survey data. Where different sources of data exist, the best available estimate should be used. Information on the sample size, the quality/reliability of the data and any related issues should be included in the report submitted with this indicator.</li><li>• Theoretically, this indicator can be affected by socially desirable bias. The direction of bias is either over or under-estimation, depending on the survey area.</li><li>• The alternative method of asking whether condoms are always/sometimes/never used in sexual encounters with clients in a specified period is subject to recall bias.</li><li>• Generally, this indicator prone to be bias in the direction of over-estimation.</li></ul>

**Indicator 26 - Percentage of female sex workers reporting consistent use of condoms with their clients in the last month**

<b>PURPOSE</b>	To assess progress in preventing exposure to HIV among female sex workers through unprotected sex with clients
	<b>NUMERATOR</b>
	Number of respondents who reported consistent use of condom with their client in the last month
	<b>DENOMINATOR</b>
<b>DEFINITION</b>	Number of female sex workers surveyed
	Clients can be categorized as: <ul style="list-style-type: none"> <li>- Casual (one-time) clients</li> <li>- Regular clients</li> </ul>
	Data should be disaggregated by province and type of sex worker
<b>LEVEL</b>	Targeted provinces
<b>FREQUENCY</b>	Every 2–3 years
<b>MEASUREMENT TOOLS</b>	Special surveys such as BSS/IBBS
<b>METHOD OF MEASUREMENT</b>	Respondents are asked the following question:  Did you and your client in the last month consistently use condoms?
<b>INTERPRETATION</b>	<ul style="list-style-type: none"> <li>• Condoms are most effective when their use is consistent, rather than occasional. The current indicator will provide information on the level of consistent condom use.</li> <li>• Surveying sex workers can be challenging due to difficulties accessing the subjects/population. Consequently, data obtained may not be based on a representative sample of the national sex worker population being surveyed. If there are concerns that the data is not based on a representative sample, these concerns should be reflected in the interpretation of the survey data. Where different sources of data exist, the best available estimate should be used. Information on the sample size, the quality/reliability of the data and any related issues should be included in the report submitted with this indicator.</li> <li>• Theoretically, this indicator can be affected by socially desirable bias. Generally, this indicator prone to be bias in the direction of over-estimation.</li> </ul>

## **Indicator 27 - Percentage of female sex workers who have injected drugs in the last month**

<b>PURPOSE</b>	To assess progress in preventing exposure to HIV among female sex workers through high risk behavior of injecting drugs
	<b>NUMERATOR</b>
	Number of respondents who reported that they injected drugs in the last month
<b>DEFINITION</b>	<b>DENOMINATOR</b>
	Number of female sex workers surveyed
	Data should be disaggregated by province and type of sex worker
<b>LEVEL</b>	Targeted provinces
<b>FREQUENCY</b>	Every 2–3 years
<b>MEASUREMENT TOOLS</b>	Special surveys such as BSS/IBBS
<b>METHOD OF MEASUREMENT</b>	Respondents are asked the following question: Have you ever injected in the last month?
<b>INTERPRETATION</b>	Surveying sex workers can be challenging due to difficulties accessing the subjects/population. Consequently, data obtained may not be based on a representative sample of the national sex worker population being surveyed. If there are concerns that the data is not based on a representative sample, these concerns should be reflected in the interpretation of the survey data. Where different sources of data exist, the best available estimate should be used. Information on the sample size, the quality/reliability of the data and any related issues should be included in the report submitted with this indicator.  Theoretically, this indicator can be affected by socially desirable bias. Generally, this indicator prone to be bias in the direction of under-estimation.

**Indicator 28 - Percentage of injecting drug users who shared syringes and needles in the last month**

<b>PURPOSE</b>	To assess progress in preventing exposure to HIV among injecting drug users through high risk behavior of sharing injecting equipment
	<b>NUMERATOR</b>
	Number of respondents who reported sharing injecting equipment in the last month
	<b>DENOMINATOR</b>
<b>DEFINITION</b>	Number of injecting drug users surveyed
	<b>Notes</b>
	Data should be disaggregated by province and age group (<25 / 25+)
<b>LEVEL</b>	Targeted provinces
<b>FREQUENCY</b>	2–3 years
<b>MEASUREMENT TOOLS</b>	Special surveys such as BSS/IBBS Respondents are asked the following question:
<b>METHOD OF MEASUREMENT</b>	In the last month, did you use injecting equipment (i.e., syringes and needles), which had previously been used by someone else?
<b>INTERPRETATION</b>	Surveying IDUs can be challenging due to difficulties in accessing the subjects/ population. Data may not be based on a representative sample of the injecting drug user population. If there are concerns that the data is not based on a representative sample, these concerns should be reflected in the interpretation of the survey data. Where different sources of data exist, the best available estimate should be used. Information on the sample size, the quality/reliability of the data and any related issues should be included in the report submitted with this indicator.  This indicator can be affected by socially desirable bias. The direction of bias is either over or under-estimation depending on the survey area.

**Indicator 29 - Percentage of injecting drug users reporting condom use during the last sexual activity**

<b>PURPOSE</b>	To assess progress in preventing exposure to HIV among injecting drug users through unprotected sex activities
	<b>NUMERATOR</b>
	Number of injecting drug users who reported that a condom was used with their last sexual partner in the last 12 months
	<b>DENOMINATOR</b>
<b>DEFINITION</b>	Number of injecting drug users in the survey who had sex in the last 12 months
	<b>Notes</b>
	Data should be disaggregated by province, age group (<25/25+), and partner type
	Sexual partners can be categorized as:
	<ul style="list-style-type: none"> <li>- Female sex workers</li> <li>- Casual sex partners</li> <li>- Spouses/live-in sexual partners</li> </ul>
<b>LEVEL</b>	Targeted provinces
<b>FREQUENCY</b>	2–3 years
<b>MEASUREMENT TOOLS</b>	Special surveys such as BSS/IBBS
<b>METHOD OF MEASUREMENT</b>	<p>Respondents are asked the following question:</p> <p>Did you use a condom with your most recent sexual partner?</p> <ul style="list-style-type: none"> <li>• Condoms are most effective when their use is consistent, rather than occasional. The current indicator will provide an overestimate of the level of consistent condom use. However, the alternative method of asking whether condoms are always/sometimes/never used in sexual encounters with their partners in a specified period is subject to <u>recall bias</u>. Furthermore, the trend in condom use in the most recent sexual act will generally reflect the trend in consistent condom use.</li> </ul>
<b>INTERPRETATION</b>	<ul style="list-style-type: none"> <li>• Surveying IDUs can be challenging due to difficulties in accessing the subjects/ population. Data may not be based on a representative sample of the injecting drug user population. If there are concerns that the data is not based on a representative sample, these concerns should be reflected in the interpretation of the survey data. Where different sources of data exist, the best available estimate should be used. Information on the sample size, the quality/reliability of the data and any related issues should be included in the report submitted with this indicator.</li> <li>• This indicator can be affected by socially desirable bias. The direction of bias is either over or under-estimation depending on the survey area.</li> </ul>

## **Indicator 30 - Percentage of men reporting condom use the last time they had anal sex with a male partner**

<b>PURPOSE</b>	To assess progress in preventing exposure to HIV among men who have unprotected anal sex with a male partner
	<b>NUMERATOR</b>
	Number of respondents who reported that condoms were used the last time they had anal sex
	<b>DENOMINATOR</b>
	Number of men surveyed who reported having had anal sex with a male partner in the last month
<b>DEFINITION</b>	<b>Notes</b> Data should be disaggregated by province, age group (<25/25+), and partner type Male partners can be categorized as: <ul style="list-style-type: none"><li>- Male sex workers</li><li>- Casual sex partners</li><li>- Regular sex partners</li></ul>
<b>LEVEL</b>	Targeted provinces
<b>FREQUENCY</b>	Every 2–3 years
<b>MEASUREMENT TOOLS</b>	Special surveys such as BSS/IBBS Respondents are asked the following question:
<b>METHOD OF MEASUREMENT</b>	Did you use a condom from beginning to completion the last time you had anal sex with a male sexual partner?
<b>INTERPRETATION</b>	<ul style="list-style-type: none"><li>• Condom use at last anal sex with any male partner gives a good indication of overall levels and trends of protected and unprotected sex in populations surveyed.</li><li>• Surveying male sex workers can be challenging due to difficulties in accessing the subjects/ population. Data may not be based on a representative sample of population of men who have sex with men. If there are concerns that the data is not based on a representative sample, these concerns should be reflected in the interpretation of the survey data. Where different sources of data exist, the best available estimate should be used. Information on the sample size, the quality/reliability of the data and any related issues should be included in the report submitted with this indicator.</li><li>• This indicator does not give any idea of risk behavior in sex with women, among men who have sex with both men and women. In areas where men in the sub-population surveyed are likely to have partners of both sexes, condom use with female as well as male partners should be investigated. In these cases, data on condom use should always be presented separately for male and female partners.</li></ul>

**Indicator 31 - Percentage of districts implementing needle and syringe exchange and/or distribution programs**

<b>PURPOSE</b>	To assess availability of harm reduction services for injecting drug users
<b>DEFINITION</b>	<b>NUMERATOR</b> Number of districts implementing needle and syringe exchange and/or distribution programs <b>DENOMINATOR</b> Number of districts nationwide
<b>LEVEL</b>	National
<b>FREQUENCY</b>	Annual
<b>MEASUREMENT TOOLS</b>	Reporting form
<b>METHOD OF MEASUREMENT</b>	Information will be collected by analyzing reported data from provinces and cities.
<b>INTERPRETATION</b>	This indicator describes availability of the service but does not provide information on coverage or utilization. The strength of this indicator is that it allows us to get information from all 64 provinces and cities across the country. Misreporting level might be high. This indicator mentions only to the quantity, not quality of the intervention programs.

**Indicator 32 - Percentage of districts implementing condom promotion programs for female sex workers**

<b>PURPOSE</b>	To assess availability of harm reduction services for female sex workers
	<b>NUMERATOR</b>
	Number of districts implementing condom promotion programs for female sex workers
	<b>DENOMINATOR</b>
<b>DEFINITION</b>	Number of districts nationwide
	Condom promotion program is defined as provision of IEC/BCC through outreach programs (peer education, group discussion, communication through community activities, integrated communication in community, etc)
	Special focus on proper condom use and how to get them easily
<b>LEVEL</b>	National
<b>FREQUENCY</b>	Annual
<b>MEASUREMENT TOOLS</b>	Reporting form
<b>METHOD OF MEASUREMENT</b>	Information will be collected by analyzing reported data from provinces and cities.
<b>INTERPRETATION</b>	This indicator describes availability of the service but does not provide information on coverage or utilization. The strength of this indicator is that it allows us to get information from all 64 provinces and cities across the country. Misreporting level might be high. This indicator mentions only to the quantity, not quality of the intervention programs.

## **Indicator 33 - Number of sites implementing substitution programs**

<b>PURPOSE</b>	To assess availability of harm reduction programs
<b>DEFINITION</b>	Number of functional sites implementing substitution programs Substitution program is defined as programs that promote and provision on the use of substitution substance instead of drugs
<b>LEVEL</b>	National
<b>FREQUENCY</b>	Annual
<b>MEASUREMENT TOOLS</b>	Special reporting form to be completed by VAAC
<b>METHOD OF MEASUREMENT</b>	The site may include closed settings such as rehabilitation centers or primary detention facilities.
<b>INTERPRETATION</b>	This indicator shows us the availability of the substitution programs but not the coverage, utilization and quality of programs. The strength of this indicator is that it allows us to get information from all 64 provinces and cities across the country. This indicator mentions only to the quantity, not quality of the intervention programs.

## Indicator 34 - Percentage of young men and women aged 15-24 who know sources of condoms

<b>PURPOSE</b>	To assess HIV/AIDS prevention knowledge
	<b>NUMERATOR</b>
	Number of young men and women (15-24) who know sources of condoms
<b>DEFINITION</b>	<b>DENOMINATOR</b>
	Total number of young men and women (15-24) in the survey
	<b>Notes</b>
	Data should be disaggregated by sex.
<b>LEVEL</b>	National
<b>FREQUENCY</b>	2-3 years
<b>MEASUREMENT TOOLS</b>	Special surveys
	Respondent will be asked the following question: 1) Do you know where to get condom? If yes, please specify: <i>a. Government (public) facilities:</i> - Hospital - Health Center - FP room/unit - Satellite clinics - Field staff - Other staffs
<b>METHOD OF MEASUREMENT</b>	<i>b. Private facilities</i> - Hospitals/polyclinics - Pharmacy - Private doctors  <i>c. Other sources:</i> - Shops - Friends/relatives - Others
	Condom use among young population is one of the major means to help them having safer sex. In some areas, inaccessibility to condom or don't know where to get condom is one of the main reasons of low condoms use among not only young population but also general population.
<b>INTERPRETATION</b>	This indicator does not tell us condom seeking behavior.  Selection bias of the sample might be happened, particularly in mobile population groups or most-at-risk groups who were not selected during the survey period.

**Indicator 35 - Percentage of “most-at-risk” populations reached by harm reduction programs in the last 6 months**

<b>PURPOSE</b>	To assess progress in implementing harm reduction program for “most-at-risk” populations
	<b>NUMERATOR</b>
	Number of respondents who have been reached by at least one harm reduction program during the last 6 months.
<b>DEFINITION</b>	<b>DENOMINATOR</b>
	Number of respondents surveyed
	<b>Notes</b>
	Data collected for this indicator should be disaggregated by sex and age group (<25/25+).
<b>LEVEL</b>	Targeted provinces
<b>FREQUENCY</b>	Every 2-3 years
<b>MEASUREMENT TOOLS</b>	Special surveys such as BSS/IBBS Respondents are asked a sequence of questions. Depending on each context, the list would include:
<b>METHOD OF MEASUREMENT</b>	<ol style="list-style-type: none"> <li>1) Outreach and peer education</li> <li>2) STI screening and/or treatment</li> <li>3) HIV counseling and testing</li> <li>4) Substitution therapy and safe injection practices for injecting drug users</li> <li>5) Condom use promotion and provision</li> </ol> <p>Most-at-risk populations include:</p> <ul style="list-style-type: none"> <li>- Injecting drug users</li> <li>- Commercial sex workers</li> <li>- Men who have sex with men</li> </ul>
<b>INTERPRETATION</b>	<ul style="list-style-type: none"> <li>• Data may not be based on a representative sample of the national [most-at-risk population] being surveyed. If there are concerns that the data is not based on a representative sample, these concerns should be reflected in the interpretation of the survey data. Where different sources of data exist, the best available estimate should be used. Information on the sample size, the quality/reliability of the data and any related issues should be included in the report submitted with this indicator.</li> <li>• Different types of services will all count the same in estimating overall service coverage.</li> <li>• In case the indicator is based on program data, an attempt to address the issue of double counting during the reference period should be made. There is a need to ensure that clients served (as opposed to clients-visits) for the same service or across services are counted.</li> <li>• This indicator cannot measure the quality of services.</li> </ul>

## **Indicator 36 - STI prevalence among targeted populations**

<b>PURPOSE</b>	To follow the risk of STI among targeted populations.
	<b>NUMERATOR</b>
	Number of people diagnosed with any STI
<b>DEFINITION</b>	<b>DENOMINATOR</b>
	Number of people surveyed tested for STI
	<b>Notes</b>
	Data collected for this indicator should be disaggregated by sex and age group (<25/25+).
<b>LEVEL</b>	National
<b>FREQUENCY</b>	Annual for STI sentinel surveillance Every 2-3 years for IBBS
<b>MEASUREMENT TOOLS</b>	STI sentinel surveillance, IBBS STIs that are tracked on the sentinel surveillance: gonorrhoea <sup>(11)</sup> , syphilis <sup>(12)</sup> , trichomonas vaginalis <sup>(13)</sup> , and chlamydia trachomatis <sup>(14)</sup> .
<b>METHOD OF MEASUREMENT</b>	STI prevalence among targeted populations (FSW, IDU, STI clinic attendees, military recruits, pregnant women, and MSM).
<b>INTERPRETATION</b>	Data may not be based on a representative sample of the national “most-at-risk” population being surveyed. If there are concerns that the data is not based on a representative sample, these concerns should be reflected in the interpretation of the survey data. Where different sources of data exist, the best available estimate should be used. Information on the sample size, the quality/reliability of the data and any related issues should be included in the report submitted with this indicator. Sampling “most-at-risk” population is a problematic when representative sample cannot be reached, especially during the government campaigns. The sensitivity and specificity of the test used on the national STI sentinel surveillance might differ to that of tests used in diagnosis and treatment.

<sup>(11)</sup> Diagnosed by gram stain, culture, or PCR

<sup>(12)</sup> Diagnosed by RPR or TPHA

<sup>(13)</sup> Diagnosed by wet mount examination

<sup>(14)</sup> Diagnosed by ELISA, IF, or PCR

## Indicator 37 - Percentage of most-at-risk populations accessing STI diagnosis and treatment services

<b>PURPOSE</b>	To assess the accessibility of STI diagnosis and treatment services
	<b>NUMERATOR</b>
	Number of “most-at-risk” population reporting STI symptoms who reported seeking treatment (A) or number accessing STI diagnosis and treatment services (B)
	<b>DENOMINATOR</b>
<b>DEFINITION</b>	Number of “most-at-risk” population who reported STI symptoms (A) or prevalence estimation methods for the size of the “most-at-risk” population for the denominator (B).
	“Most-at-risk” populations include: <ul style="list-style-type: none"> <li>- Injecting drug users</li> <li>- Female sex workers</li> <li>- Men who have sex with men</li> </ul>
	<b>Notes</b>
	Data should be disaggregated by sex and age group (<25/ 25+)
<b>LEVEL</b>	National
<b>FREQUENCY</b>	Every 2-3 years
<b>MEASUREMENT TOOLS</b>	A. Special surveys including the BSS/IBBS for “most-at-risk” populations B. Program monitoring
<b>METHOD OF MEASUREMENT</b>	<u>A. Survey:</u> Respondents are asked if they have experienced STI symptoms, and what actions, including diagnosis and treatment, they have taken <u>B. Program Monitoring:</u> records of program providing the above-mentioned services are compiled and aggregated to obtain an overall measure of the reach of harm reduction program.
<b>INTERPRETATION</b>	This composite indicator reflects the accessibility, by most-at-risk populations, of STI diagnosis and treatment services.  <ul style="list-style-type: none"> <li>• Surveying IDUs/ FSWs can be challenging due to difficulties in accessing the subjects/ population. Accessing and/or surveying “most-at-risk” populations can be challenging. Consequently, data obtained may not be based on a representative sample of the national “most-at-risk” population being surveyed. If there are concerns that the data is not based on a representative sample, these concerns should be reflected in the interpretation of the survey data. Where different sources of data exist, the best available estimate should be used. Information on the sample size, the quality/reliability of the data and any related issues should be included in the report submitted with this indicator.</li> <li>• This indicator cannot cover private health sector where data is not always available or may be unreliable. Since many members of the “most- at- risk” population have a tendency to visit private clinics, this indicator does not capture all “most-at-risk” populations as mentioned in its purpose.</li> <li>• This indicator just tells us only the accessibility of diagnosis and treatment of STI services. It does not tell us the quality or the cost of these services. It also does not measure the practicality or cost (eg. time, money) associated with accessing such services.</li> </ul>

## Indicator 38 - Percentage of women and men with STIs at health care facilities who are appropriately diagnosed, treated, and counseled

<b>PURPOSE</b>	To assess the quality of STI diagnosis, treatment, and counseling services
	<b>NUMERATOR</b>
	Number of STI patients for whom the correct procedures were followed all of criteria: (a) history-taking; (b) examination; (c) diagnosis and treatment; and (d) counseling on partner notification, condom use and HIV testing
	<b>DENOMINATOR</b>
	Number of STI patients for whom provider-client interactions were observed
<b>DEFINITION</b>	<p><b>Notes</b></p> <p>Data should be disaggregated by sex and age (&lt;25 / 25+)</p> <p>Scores for each component of the indicator (i.e., history-taking, examination, diagnosis and treatment, and counseling) must be reported as well as the overall indicator score.</p> <ul style="list-style-type: none"> <li>• “Appropriate” diagnosis and treatment and counseling procedures in any given country, are those specified in MOH national sexually transmitted infection service guidelines.</li> <li>• A “health-care” facility is defined as any setting (i.e., including public, private, and church sectors) where health-care services are provided by one or more medically qualified personnel.</li> </ul>
<b>LEVEL</b>	National
<b>FREQUENCY</b>	Every 2-3 years
<b>MEASUREMENT TOOLS</b>	Special survey (Health facility survey—based on the UNAIDS/MEASURE (2000) <i>National AIDS Program: A guide to monitoring and evaluation</i> )
<b>METHOD OF MEASUREMENT</b>	Data are collected in observations of provider-client interaction at a sample of health care facilities offering sexually transmitted infection services. See reference on: <i>Evaluation of a national AIDS program: A methods package</i> UNAIDS/WHO (1994) for details on how to select this sample. Providers are assessed on history taking, examination, proper diagnosis and treatment of patients, and effective counseling including counseling on partner notification, condom use and HIV testing.
<b>INTERPRETATION</b>	<ul style="list-style-type: none"> <li>• This composite indicator reflects the competence of health-service providers to correctly identify and treat sexually transmitted infections, the availability of the necessary equipment, drugs and materials, and the provision of appropriate counseling to patients.</li> <li>• This indicator cannot cover private health sector where data is not always available or may be unreliable. Since many members of the “most- at- risk” population have a tendency to visit private clinics, this indicator does not capture all “most-at-risk” populations as mentioned in its purpose.</li> <li>• The indicator reflects the quality of services provided but not the cost or accessibility of these services.</li> </ul>

**Indicator 39 - Percentage of blood transfusion units screened for HIV which meet the MOH standards during the last 12 months**

<b>PURPOSE</b>	To assess progress in screening transfused blood units for HIV
	<b>NUMERATOR</b>
<b>DEFINITION</b>	Number of blood transfusion units screened for HIV in the last 12 months meeting national standards
	<b>DENOMINATOR</b>
	Number of blood transfusion units in the last 12 months
<b>LEVEL</b>	National
<b>FREQUENCY</b>	Annual
<b>MEASUREMENT TOOLS</b>	Reporting form
<b>METHOD OF MEASUREMENT</b>	<p>Three pieces of information are needed for this indicator: the number of blood transfusion units in the previous 12 months, the number of blood units screened for HIV in the previous 12 months, and among the units screened, the number screened up to MOH standards.</p> <p>Quality of screening may be determined from a special study that retests a sample of blood previously screened. In situations where this approach is not feasible, data on the percentage of facilities with good screening and transfusion records and no stock outs of test kits may be used to estimate adequately screened blood for this indicator.</p> <ul style="list-style-type: none"> <li>• Where health systems are decentralized, or where the private sector, including hospitals and clinics, is involved in blood screening and blood banking, it may be difficult to obtain enough accurate information to construct a robust indicator on a national scale. In this case, it will probably be necessary to select sentinel hospitals and laboratories in both the public and private sector for facility-based surveys of blood transfusion and screening quality.</li> </ul>
<b>INTERPRETATION</b>	<p>This indicator can only give us information on the quantity, not quality of blood transfusion screened services.</p>

## **Indicator 40- Percentage of VCT services/sites which meet National Standards**

<b>PURPOSE</b>	To assess the availability and quality of VCT services
<b>DEFINITION</b>	<b>NUMERATOR</b> Number of VCT services/sites which meet National Standards (including quality of pre-and post-test counseling) <b>DENOMINATOR</b> Number of VCT sites being assessed
<b>LEVEL</b>	National
<b>FREQUENCY</b>	Every 2-3 years
<b>MEASUREMENT TOOLS</b>	The national guideline on VCT is being developed and will be applied to measure this indicator.
<b>METHOD OF MEASUREMENT</b>	Special survey at VCT services/sites
<b>INTERPRETATION</b>	<p>HIV testing for diagnostic purposes must be voluntary and provided in the context of counseling both before and after test results are obtained. Voluntary counseling and testing (VCT) for HIV has several functions including the early detection of infection in asymptomatic persons, to help them obtain early interventions and support services, and education about HIV infection and prevention. VCT services are an integral component of HIV/AIDS prevention, care and support efforts aimed at mitigating the HIV/ AIDS crisis.</p> <p>This indicator does not tell us whether “most-at-risk” populations access these services or not.</p>

**Indicator 41 - Number of people who have voluntarily tested and received HIV test results in the last 12 months**

<b>PURPOSE</b>	To assess the utilization of VCT services
	<b>NUMERATOR</b>
<b>DEFINITION</b>	Number of people who are voluntarily tested and received HIV test results during the last 12 months
	<b>DENOMINATOR</b>
	N/A
<b>LEVEL</b>	National/provincial
<b>FREQUENCY</b>	Annual
<b>MEASUREMENT TOOLS</b>	Reporting form
<b>METHOD OF MEASUREMENT</b>	Data will be collected from reporting form from VCT sites (VCT standing alone and VCT integrated into health facilities)
<b>INTERPRETATION</b>	This indicator shows us the quantity of utilization of VCT services. If 2.18 and 2.19 are interlinked, a full picture of utilization of VCT services can be observed. This indicator does not tell us whether most-at-risk populations used these services or not.

**Indicator 42 - Percentage of people who received pre-and post-test counseling among those who were voluntarily tested and received HIV test results during the last 12 months**

<b>PURPOSE</b>	To assess the utilization of VCT services
	<b>NUMERATOR</b>
	Number of clients who received pre-and post-test counseling, and received HIV test results during the last 12 months
<b>DEFINITION</b>	<b>DENOMINATOR</b>
	Number of clients visiting VCT sites
	<b>Notes</b>
	Data should be disaggregated by sex and age group if possible.
<b>LEVEL</b>	National
<b>FREQUENCY</b>	Annual
<b>MEASUREMENT TOOLS</b>	Reporting form from VTC sites
	Sites should be reporting on the actual number of people who received all four services below:
<b>METHOD OF MEASUREMENT</b>	<ol style="list-style-type: none"> <li>1. Pre-test counseling</li> <li>2. Voluntary HIV testing</li> <li>3. Post-test counseling</li> <li>4. Received test results</li> </ol>
<b>INTERPRETATION</b>	<p>This is an output measure. It doesn't provide a workload count.</p> <p>This indicator does not tell us about the quality of services provided, nor the services less likely to be provided (since it only measures "all or none").</p>

**Indicator 43 - Percentage of “most-at-risk” populations who received HIV testing in the last 12 months and received HIV test results**

<b>PURPOSE</b>	To assess progress in implementing HIV testing and counseling among most-at-risk populations
	<b>NUMERATOR</b>
	Number of respondents of “most-at-risk” populations who have been tested for HIV during the last 12 months and who know the results of their test
<b>DEFINITION</b>	<b>DENOMINATOR</b>
	Number of respondents surveyed
	<b>Notes</b>
	Data for this indicator should be disaggregated by sex and age (<25/25+).
<b>LEVEL</b>	Targeted provinces
<b>FREQUENCY</b>	Every 2-3 years
<b>MEASUREMENT TOOLS</b>	Special surveys such as BSS/IBBS
	Respondents are asked the following questions:
	1. Have you been tested for HIV in the last 12 months?
	2. If the answer to question 1 is “yes:” Do you know the results of that test?
<b>METHOD OF MEASUREMENT</b>	Most-at-risk populations include:
	- Injecting drug users
	- Commercial sex workers
	- Men who have sex with men
	• Data may not be based on a representative sample of the national “most-at-risk” population being surveyed. If there are concerns that the data is not based on a representative sample, these concerns should be reflected in the interpretation of the survey data. Where different sources of data exist, the best available estimate should be used. Information on the sample size, the quality/reliability of the data and any related issues should be included in the report submitted with this indicator.
<b>INTERPRETATION</b>	• Tracking “most-at-risk” populations over time to measure progress may be difficult due to mobility.
<b>STRENGTH AND LIMITATIONS</b>	This is an output measure. It doesn't provide a workload count. This indicator does not tell us the quality of the testing services.
<b>TARGET</b>	<b>To be determined</b>

## SUB-GROUP 3 - CARE, TREATMENT AND PMTCT

### Indicator 44 - Number and percentage of districts with at least one health facility providing the package of PMTCT services

<b>PURPOSE</b>	To assess the availability of PMTCT services
	<b>NUMERATOR</b> Number of provincial/district health facilities providing the minimum package of PMTCT services
	<b>DENOMINATOR</b> Number of provincial/district health facilities in the country
	<b>Note:</b> Analysis and reporting by type of service is recommended. Data should be disaggregated by provincial and district level.
	<u>Definition of minimum PMTCT package:</u>
<b>DEFINITION</b>	Referral or provision of. <ol style="list-style-type: none"> <li>1) HIV counseling and testing</li> <li>2) ARV prophylaxis to prevent MTCT,</li> <li>3) Counseling and support for safe infant feeding practices</li> <li>4) Family planning services</li> <li>5) HIV care and treatment (referral)</li> <li>6) Safe obstetric practices</li> </ol>
<b>LEVEL</b>	National Provincial
<b>FREQUENCY</b>	Every 6 months
<b>MEASUREMENT TOOLS</b>	Reporting form
<b>METHOD OF MEASUREMENT</b>	<u>Program reporting forms from VAAC as of 2.10a</u>
<b>INTERPRETATION</b>	This indicator provides important information on the national availability of prevention and care efforts for women and infants. It is useful to program planners in determining where services may be needed, or where facilities are providing the full spectrum of services to prevent HIV infection in women and infants. This indicator provides information on the scale of national response on PMTCT at provincial and district levels. This indicator tells us only the quantity of provincial/district services providing PMTCT package, however, it does not tell us the quality of these services.

**Indicator 45 - Number and percentage of women who have delivered in the preceding 12 months, who received HIV counselling and testing for PMTCT and received their test results**

<b>PURPOSE</b>	To assess the utilization of PMTCT services
	<b>NUMERATOR</b>
<b>DEFINITION</b>	Number of women who have delivered in the preceding 12 months, who received HIV counselling and testing for PMTCT and received their test results
	<b>DENOMINATOR</b>
	Number of women who have delivered in the preceding 12 months who are interviewed.
<b>LEVEL</b>	National Provincial
<b>FREQUENCY</b>	Annual
<b>MEASUREMENT TOOLS</b>	VAAC routine report form (numerator) and reproductive health routine report form (denominator)
<b>METHOD OF MEASUREMENT</b>	The indicator requires that program records be reviewed in order to count how many women have completed the testing and counselling process, i.e. have received their test results and post-test counselling. The number of women who have made at least one ANC visit is estimated by multiplying the number of births in the preceding 12 months, as given in a census or the best available source, by the rate of ANC attendance (DHS-type sample survey)
<b>INTERPRETATION</b>	For PMTCT to be effective, it is necessary to know a woman's sero-status in order to tailor prevention and care to her needs. A successful PMTCT program will reach as many pregnant women as possible, and manage to convince them to take the test. This indicator provides a broad measure of service provision and gives an idea of coverage of ANC settings where PMTCT interventions are available. It does not attempt to inform service providers about the points in the counselling and testing cycle at which women drop out. It is important that program managers employ a series of lower-level indicators for determining losses to follow-up. Because the quality of services is not being measured, information on drop-outs and the points at which they occur is of limited use if not followed up with operations research aimed at discovering why women are failing to complete the cycle.

**Indicator 46 - Number and percentage of both HIV-positive pregnant women and their babies receiving a complete course of antiretroviral prophylaxis to reduce the risk of mother-to-child transmission**

<b>PURPOSE</b>	This indicator assesses the progress in preventing mother-to-child HIV transmission through the provision of ARV prophylaxis.
	<b>NUMERATOR</b> Number of pair of HIV-infected pregnant women and their child provided with antiretroviral prophylaxis to reduce mother-to-child transmission (MTCT) according to the nationally approved treatment protocol in the last 12 months.
<b>DEFINITION</b>	<b>DENOMINATOR</b> Estimated number of HIV-infected pregnant women  The “full course” of antiretroviral prophylaxis can be defined as both mother and babies get ARV prophylaxis in line with National Guidelines
<b>LEVEL</b>	National Provincial
<b>FREQUENCY</b>	Every 12 months
<b>MEASUREMENT TOOLS</b>	Reporting form  The number of HIV-infected pregnant women provided with antiretroviral prophylaxis to reduce the risk of MTCT in the last 12 months is obtained from program monitoring records. Only pair of women and her child who completed the full course should be included in the numerator.
<b>METHOD OF MEASUREMENT</b>	The number of HIV-infected pregnant women to whom antiretroviral prophylaxis to reduce the risk of MTCT <i>could potentially have been given</i> is estimated by multiplying the total number of women who gave birth in the last 12 months (General Statistics Office-GSO estimates of births) by the most recent national estimate of HIV prevalence in pregnant women (HIV sentinel surveillance antenatal clinic estimates)
<b>INTERPRETATION</b>	<ul style="list-style-type: none"> <li>• The estimate of HIV prevalence among pregnant women used in the calculation of this indicator will be based on antenatal clinic-based HIV surveillance data. However, large numbers of pregnant women do not have access to antenatal clinic services or choose not to make use of them. Pregnant women with HIV may be more likely to use antenatal clinic services (or public rather than private antenatal clinic services) than those who are not infected, particularly where antiretroviral prophylaxis can be accessed via such services. In such circumstances, this indicator should be interpreted with reference to recent estimates of utilization of national antenatal clinic services.</li> <li>• Voluntary testing and counselling for HIV and antiretroviral prophylaxis to reduce MTCT can be made available but, ultimately, it is up to individual women to decide whether or not to make use of these services. Thus, a country’s score on this indicator will reflect the degree of interest in these services (partly a function of the way in which they are promoted) as well as the extent to which they are available.</li> <li>• This indicator does not measure compliance with the antiretroviral treatment regime because it is not possible to monitor drug compliance, unless direct supervision is undertaken.</li> </ul>

## Indicator 47 - Percentage of infants born to HIV infected mothers who are HIV positive

**PURPOSE** To assess progress towards eliminating mother-to-child HIV transmission

**NUMERATOR**

**DEFINITION** Number of infants born to HIV infected mother who are HIV infected

**DENOMINATOR**

Total number of infants born to HIV infected mother

**LEVEL** National

**FREQUENCY** Annual

**MEASUREMENT TOOLS** Estimates based on program coverage

The indicator can be calculated by taking the weighted average of the probabilities of mother-to-child transmission for pregnant women receiving and not receiving antiretroviral; the weights being the proportions of women receiving and not receiving antiretroviral, respectively. Expressed as a simple mathematical formula:

$$\text{Indicator score} = \{ T*(1-e) + (1-T) \} * v$$

where:

**T** = proportion of HIV-positive pregnant women provided with antiretroviral treatment

**v** = mother-to-child transmission rate in the absence of any treatment

**e** = efficacy of treatment provided

**T** is national indicator #3.3 [Percentage of HIV-positive pregnant women receiving a complete course of antiretroviral prophylaxis to reduce the risk of mother-to-child transmission]. Default values of 25% and 50%, respectively, can be used for v and e. Value for v and e should be defined according to different regimes and further studies in Viet Nam, if no national figure is available, regional figures can be applied.

**METHOD OF MEASUREMENT**

If more than one ARV prophylaxis regimen used, the below formula will be used to adjust:

$$\text{Indicator score} = \{ T1*(1-e1) + T2*(1-e2) + T3*(1-e3) + (1-T) \} * v$$

Where:

$$T = T1 + T2 + T3$$

T1, T2, T3 proportion of HIV-positive pregnant women provided with ARV prophylaxis regimen 1, 2, 3, respectively.

e1, e2, e3 efficacy of treatment regimen 1, 2, 3, respectively.

The most common forms of treatment provided during the last 12 months should be noted.

**Remark:** Current reporting form does not collect information on the regimens of ARV prophylaxis, and thus estimation of T1, T2, T3 is not possible. But as the PMTCT guidelines be updated, the reporting form will also be revised after one or two year implementation and will collect information on the regimens used.

**INTERPRETATION**

This indicator focuses on prevention of mother-to-child transmission of HIV through increased provision of antiretroviral drugs. Thus, the effect of breastfeeding on mother-to-child transmission of HIV is ignored and the indicator may yield underestimates of true rates of mother-to-child transmission in countries where long periods of breastfeeding are common. Similarly, in countries where other forms of prevention of mother-to-child transmission of HIV (e.g., caesarean section) are widely practiced, the indicator will typically provide overestimates of mother-to-child transmission. For these reasons, trends in this indicator may not reflect overall trends in mother-to-child transmission of HIV.

National Indicator # 3.3 [Percentage of HIV-positive pregnant women receiving a complete course of antiretroviral prophylaxis to reduce the risk of mother-to-child transmission] may provide a poor estimate for T in circumstances where usage of antenatal clinic services is low.

**Indicator 48 - Percentage of districts with a least one public (MOH Line) health facility providing ART**

<b>PURPOSE</b>	To assess the coverage of ART program
<b>DEFINITION</b>	<p><b>NUMERATOR</b> Number of districts with at least one public (MOH line) health facility providing ART</p> <p><b>DENOMINATOR</b> Total number of districts</p>
<b>LEVEL</b>	National
<b>FREQUENCY</b>	Annual during scaling-up Every two years thereafter
<b>MEASUREMENT TOOLS</b>	Reporting form Data on district population and prevalence per district are useful for assessing how the availability of services matches needs.
<b>METHOD OF MEASUREMENT</b>	Data will be collected from reporting form at district level on ART program
<b>INTERPRETATION</b>	This indicator is a crude, however important measure of the coverage of ART nationwide. This indicator is most useful in tracking changes over time as national programs attempt to scale up service provision in order to meet need.

**Indicator 49 - Percentage of districts providing comprehensive HIV care, treatment and support package in line with National Standards**

<b>PURPOSE</b>	To assess the coverage and progress of scaling up of the care and treatment services
<b>DEFINITION</b>	<p><b>NUMERATOR</b></p> <p>Number of districts with at least one public health facility providing comprehensive HIV/AIDS care, treatment, and support package services in line with national standards.</p> <p><b>DENOMINATOR</b></p> <p>Total number of districts nation wide</p>
<b>LEVEL</b>	National Provincial
<b>FREQUENCY</b>	Annual
<b>MEASUREMENT TOOLS</b>	Reporting form
<b>METHOD OF MEASUREMENT</b>	<p>Key services to be in place:</p> <ul style="list-style-type: none"> <li>- HIV counselling and testing</li> <li>- Clinical management:             <ul style="list-style-type: none"> <li>a) Prophylaxis, diagnosis and OI treatment including TB;</li> <li>b) ARV treatment;</li> <li>c) Support for adherence; and</li> <li>d) Symptom treatment and pain relief and palliative care;</li> </ul> </li> <li>- Psychology and socio-economical support</li> <li>- HIV transmission prevention             <ul style="list-style-type: none"> <li>a) Encourage safe sex and use condoms</li> <li>b) Offer harm reduction interventions for HIV transmission prevention</li> <li>c) Implement universal precautions in health care settings</li> <li>d) Provide post exposure preventive treatment; and</li> <li>e) PMTCT package.</li> </ul> </li> </ul> <p><i>Remark:</i> current reporting form does not include this indicator but the reporting form will be revised after one or two years of implementation and will include this information.</p> <p>This indicator is a compendium of many different aspects of treatment, care and support, all of which should be present if the facility concerned is to be included in the numerator. Because services tend to improved unevenly, the resulting indicator may remain low for some time. Disaggregating of the indicator reveals the areas where services have improved and the areas where they continue to lag.</p>
<b>INTERPRETATION</b>	<p>The scoring of the components of the indicator necessarily includes some subjectivity. Reporting thus may be influenced by staff changes over time.</p>

**Indicator 50 - Number of closed settings and non-MOH facilities providing ART services**

<b>PURPOSE</b>	To assess the coverage and progress of scaling up of the ART program
	Number of closed settings and non-MOH public facilities providing ART services.
<b>DEFINITION</b>	Note: <u>Closed settings</u> : 05/06 centers, prisons, and other rehabilitation centers <u>Non-MOH facilities</u> including military hospitals, police hospitals, sectoral hospitals
<b>LEVEL</b>	National Provincial
<b>FREQUENCY</b>	Annual
<b>MEASUREMENT TOOLS</b>	Data will be collected from organization providing ART services in closed settings and non-MOH facilities following the standard reporting form.
<b>METHOD OF MEASUREMENT</b>	Reporting forms
<b>INTERPRETATION</b>	This indicator is implemented with the aim at understanding the level of coverage and progress of scaling up of the ART program. Information from Ministry of Public Security and Ministry of Defense is difficult to get, therefore it need to have a better cooperation between MOH, MOLISA and these two ministries, otherwise, under-reported information is unavoidable.

## Indicator 51 - Percentage of people with advanced HIV infection receiving ARV combination therapy

<b>PURPOSE</b>	To assess progress towards providing antiretroviral combination therapy to all people with advanced HIV infection
<b>DEFINITION</b>	<p><b>NUMERATOR</b></p> <p>Number of people with advanced HIV infection who receive antiretroviral combination therapy in accordance with the current National Guidelines</p> <p><b>DENOMINATOR</b></p> <p>Number of people with known advanced HIV infection (i.e. those in need of antiretroviral combination therapy).</p>
<b>LEVEL</b>	National
<b>FREQUENCY</b>	Annual
<b>MEASUREMENT TOOLS</b>	<p>Calculated based on data from reporting form</p> <p>The number of people with advanced HIV infection who are currently receiving antiretroviral combination therapy is obtained from program monitoring records.</p> <p><u>Numerator is calculated as follows:</u> number of adults receiving treatment at the start of the year, plus number of people who commenced treatment in the preceding 12 months, minus number of people for whom treatment was terminated in the preceding 12 months (including those who died).</p> <p>Alternatively, CURRENT number of patients at the end of the year, collected from facility ART registers through routine reporting system, could be used as the numerator.</p> <p><u>Denominator is calculated as follows:</u></p> <p>The number of adults in need of antiretroviral combination therapy is calculated by adding the number of adults newly in need of therapy to the number who were on treatment in the previous year and survived to the current year.</p> <p>The number of adults newly in need of antiretroviral combination therapy is estimated as the number developing advanced HIV disease who are not yet on treatment. Since some of the adults projected to develop advanced HIV disease may already have started treatment in the previous year, the number newly in need of antiretroviral combination therapy is adjusted by subtracting people in this category. It is currently assumed that between 80% and 90% of adults on treatment will survive to the following year, depending on patients' adherence to treatment, resistance patterns, the quality of clinical management and other factors.</p> <p><u>The denominator is generated</u> by estimating the number of people with advanced HIV infection requiring antiretroviral combination therapy, most frequently on the basis of the latest sentinel surveillance data. The provision of antiretroviral drugs in the private sector should be included in the calculation of the indicator wherever possible and the extent of such provision should be recorded separately.</p> <p>Provisionally, the following method is proposed to for the national estimate of PLWH who need ART: (TOTAL number of people who need ART) = (number of people died of AIDS within 2 years = newly need ART in one year) + (number of people on ART at the end of previous year). However, the way for this estimate may be revised following the global consensus.</p> <p>The start and end dates of the period for which antiretroviral combination therapy is given should be stated. Overlaps between reporting periods should be avoided if possible.</p> <p><b>Remark:</b> current reporting form includes "CUMULATIVE" number of ART patients, but does not include "CURRENT" number of ART patients. The reporting form will be revised after one or two year implementation to collect "CURRENT" number of ART patients, together with the number of people who commenced treatment and the number of people for whom treatment was terminated.</p>
<b>METHOD OF MEASUREMENT</b>	
<b>INTERPRETATION</b>	<ul style="list-style-type: none"> <li>Information on access and use of care and treatment services among children infected by HIV is very important. Number of HIV infected children who have access to these services will be collected through the reporting form of the national HIV/AIDS prevention and control program. However, it is</li> </ul>

impossible to collect the denominator for this indicator. Therefore, this indicator will not provide information on access and use of services among HIV infected children.

- The indicator permits monitoring of trends in coverage, but does not attempt to distinguish between different forms of antiretroviral therapy, or to measure the cost, quality, or effectiveness of treatment provided. These will each vary within and between countries and are liable to change over time.
- The proportion of people with advanced stages of HIV infection varies with the stage of the HIV epidemic and the cumulative coverage and effectiveness of antiretroviral combination therapy among adults and children.
- Dynamic prevalence affects the accuracy of the estimate of the eligible population. Changing estimates of prevalence are not reflected in current prevalence. This specifically affects the denominator.
- The degree of utilization of antiretroviral therapy will depend on cost relative to local incomes, service delivery infrastructure and quality, availability and uptake of voluntary counselling and testing services, perceptions of effectiveness and possible side effects of treatment etc.
- Preventative antiretroviral therapy for the purpose of PMTCT and post-exposure prophylaxis are not included in this indicator.
- This indicator allows trends to be monitored over time but does not distinguish between the different types of therapy available and does not measure the cost, quality or effectiveness of treatment.
- The proportion of people with advanced stages of HIV infection varies with the stage of the HIV epidemic and the cumulative coverage and effectiveness of ART among adults and children.
- Dynamic prevalence rates affect the accuracy of the estimate of the eligible population. Changing estimates of prevalence are not reflected in current prevalence rates. This specifically affects the denominator.
- The degree of utilization of ARV combination therapy depends on the cost relative to local incomes, service delivery infrastructure and quality, the availability and uptake of VCT services, perceptions of effectiveness, possible side-effects of treatment, etc.
- ART for PMTCT or for post-exposure prophylaxis not included in this indicator.

## **Indicator 52 - Continuation of first-line regimens at 6, 12 and 24 months after initiation**

<b>PURPOSE</b>	To assess the continuation of patients with the first-line regimens
	<b>NUMERATOR</b> Number of patients who are still on treatment and who are still prescribed a standard first-line regimen 12 months after initiating treatment
<b>DEFINITION</b>	<b>DENOMINATOR</b> Total number of individuals initiating treatment on a first-line regimen in the ART start-up group in the previous 6, 12 and 24 months.
<b>LEVEL</b>	National Provincial
<b>FREQUENCY</b>	Abstraction takes place monthly for each cohort that has begun ART 6, 12 and 24 months previously. The numerators and denominators are summed at the end of the calendar year in order to obtain annual percentages.
<b>MEASUREMENT TOOLS</b>	Patients beginning ART for the first time are identified through medical records. For each patient the drug regimen (drug list + dosage and frequency) is abstracted at the beginning of the first month and the last available prescriptions in the 6 <sup>th</sup> , 12 <sup>th</sup> , and 24 <sup>th</sup> months are obtained from the treatment cards or medical records. Pharmacy records may also be used. If the person in question dies, is lost to follow-up, is transferred to another treatment program, has stopped ART, or has no drugs prescribed in month 6, 12 or 24, this should also be recorded in the reporting form.  <u>Note:</u> A person for whom a drug is substituted because of toxicity to a different first-line drug is still considered to be on a first-line regimen.
<b>METHOD OF MEASUREMENT</b>	Reporting form
<b>INTERPRETATION</b>	This indicator is important for tracking early warning signals of potential treatment failure. Unnecessary changes in regimen, treatment failure and intermittent ART are all associated with HIV drug resistance. The first year of treatment is most indicative of program success in sustaining regimen continuity.  Program in which more than 80% of new patients are not on a first-line regimen after a year may be less likely to minimize the emergence of HIV drug resistance.  This indicator measures the proportion of patients beginning first-line ART in a given cohort who are still on first-line therapy one year after ART begins.  Because this indicator does not measure temporary interruptions in ART it may overestimate the continuity of first-line ART. Where possible, information should also be collected on whether the drugs were picked up each month. The quality of this indicator depends on the quality of the medical records and the patient registry.

## Indicator 53 - Survival rate at 6, 12, 24 months after initiation of treatment

<b>PURPOSE</b>	To assess the survival rate
	<b>NUMERATOR</b> Number of people continuously on ART at 6, 12, 24 months after initiating treatment
	<b>DENOMINATOR</b>
<b>DEFINITION</b>	(a) Minimum survival: Total number of individuals who initiated ART in the ART start-up group in the previous 6, 12, 24 months, <b>including</b> those who have stopped ART, those who have transferred out, and people lost to follow-up.  (a) Maximum survival: Total number of individuals who initiated ART in the ART start-up group in the previous 6, 12, 24 months, <b>excluding</b> those who have stopped ART, those who have transferred out, and people lost to follow-up.
<b>LEVEL</b>	National Provincial
<b>FREQUENCY</b>	Continuous data collection, aggregated in accordance with the required reporting period.
<b>MEASUREMENT TOOLS</b>	Reporting form  Tallying results for several monthly cohorts, each tabulated when on ART for 6 months, 12 months and yearly thereafter. For a comprehensive understanding of survival the following components have to be measured:  a) Number of people initiating ART and the start date b) Number of people continuously on ART at 6, 12, 24 months after initiating treatment c) Number of people who have stopped ART, those who have transferred out, people lost to follow-up and those who have died.
<b>METHOD OF MEASUREMENT</b>	A proportion of people who have stopped treatment or were lost to follow-up may still be alive. As they are not continuously on treatment, however, they should not be included in the numerator (when calculating minimum survival).  People who transfer between ART programs and for whom a start date of treatment exists should be counted as continuously on treatment.  These data should be presented for each specified period. If it is possible, programs should follow patients throughout their time on treatment, as AIDS is a lifelong disease.  Six-month tallies of new patients are necessary in order to measure this indicator.  This indicator measures the degree to which treatment can prolong a person's life by assessing how many individuals survive after receiving treatment for 6, 12, 24 months.  The strengths of this indicator lie in the ease of data collection, as any ART program should monitor patients on treatment and determine the number of individuals who survive beyond specific periods in time.
<b>INTERPRETATION</b>	Patient records may not include mobile population or the status of the duration of their therapy.  This indicator can only be obtained from a limited number of advanced care/referral facilities and/or designated cohort studies while national patient registers are scaling up. As the latter become institutionalized and functional the data can be expected to become more comprehensive.

**Indicator 54 - Percentage of PLHIV receiving HIV treatment and care services who were screened for TB symptoms**

<b>PURPOSE</b>	To access the progress towards reducing TB impact among PLHIVs
	<b>NUMERATOR</b>
	Number of PLHIV seen at HIV treatment and care services who were screened for TB symptoms, over a given time period.
<b>DEFINITION</b>	<b>DENOMINATOR</b>
	Total number of PLHIV seen at HIV treatment and care services, over the same given time period
<b>LEVEL</b>	National and provincial
<b>FREQUENCY</b>	Annual
<b>MEASUREMENT TOOLS</b>	Modified HIV treatment and care register Data would be collected continuously and reported and analyzed quarterly.
<b>METHOD OF MEASUREMENT</b>	Data should be collected routinely at any situation where regular HIV care, treatment and support are provided (e.g., ART clinics, HIV care clinics.) A suggested method of conducting the screening would be to ask HIV-positive clients whether they are currently on TB treatment. If not, they are then asked about the key symptoms of TB disease (e.g. cough, fever, night sweats, recent weight loss, lymphadenopathy). A simple checklist could be used and any positive response would indicate that the individual may be a TB suspect. TB control program protocols should define the criteria for identifying a TB suspect. If on questioning they are defined as a TB suspect (as per national protocols) treatment of latent TB infection should not be given and they should be investigated for TB (or referred to TB service for investigation) and treated appropriately.  <b>Remark:</b> current reporting form does not include this indicator but the reporting form will be revised after one or two year implementation and will include this information.
<b>INTERPRETATION</b>	This is a process indicator for an activity intended to reduce the impact of TB among PLHIV. It will demonstrate the level of implementation of the recommendation that PLHIV are screened for TB at diagnosis and at all follow-up visits.

## Annex 2: List of indicators by frequency of data reports

### 1. Indicators that are collected annually

1	Status of the 8 Programmes of Action (drafted, finalized, budgeted, funded, implemented)
3	Percentage of designated ministries and mass organizations with annual plans, budgets and reports
5	Total expenditure by the central government on HIV
6	Total expenditure by the provincial government on HIV
7	Total international expenditure on HIV
10	Ratio of total expenditure from all sources on prevention vs. care and treatment
11	Total expenditure on HIV per capita per year
12	Number of full-time staff working in the field of HIV
13	Number of full-time HIV staff receiving training on HIV/AIDS prevention and control annually
16	Percentage of functional Provincial Monitoring and Evaluation units
17	Estimated prevalence among target groups ( <i>Sentinel surveillance</i> )
19	Reported number of HIV infected people, AIDS cases and AIDS deaths (by gender and age group)
31	Percentage of districts implementing needle and syringe exchange and/or distribution program
32	Percentage of districts implementing condom promotion programs for female sex workers
33	Number of sites implementing substitution programs
36	STI prevalence among targeted populations ( <i>Sentinel surveillance</i> )
39	Percent of blood transfusion units screened for HIV which meets the MOH standards during the last 12 months
41	Number of people who have voluntarily tested and received HIV test results in the last 12 months
42	Percentage of people who tested voluntarily, received pre-and-post test counselling and received HIV test results during the last 12 months
44	Number and percentage of districts with at least one health facility providing the package of PMTCT services
45	Number and percentage of pregnant women who have delivered in the preceding 12 months, who received HIV counselling and testing for PMTCT and received their test results
46	Number and percentage of both HIV-positive pregnant women and their babies receiving a complete course of antiretroviral prophylaxis to reduce the risk of mother-to-child transmission
47	Percentage of infants born to HIV infected mothers who are HIV positive
48	Percentage of districts with at least one public (MOH line) health facility providing ART
49	Percentage of districts providing comprehensive HIV/AIDS care, treatment and support package in line with National Standards
50	Number of closed settings and non-MOH facilities providing ART services
51	Percentage of people with advanced HIV infection receiving ARV combination therapy
52	Continuation of first-line regimens at 6, 12 and 24 months after initiation
53	Survival rate at 6, 12, 24 months after initiation of treatment
54	Percentage of PLHIVs receiving HIV treatment and care services who were screened for TB symptoms

## 2. Indicators that are collected every 2-3 years

2	National Composite Policy Index
4	Percentage of provinces/cities with annual plans, budgets and reports
8	Total expenditure by the private sector on HIV
9	Total expenditure from out-of-pocket expenses on HIV care and treatment
14	Percentage of schools with teachers who have been trained in life-skills-based HIV education and who taught it during the last academic year
15	National Composite Policy Index
17	Estimated prevalence among target groups ( <i>IBBS</i> )
18	Estimated prevalence of HIV in Viet Nam (by gender and age group)
20	Percentage of people aged (15-24 and 15-49) who both correctly identify ways of preventing the transmission of HIV and who reject major misconceptions about HIV transmission
21	Percentage of people in “most-at-risk” populations who both correctly identify ways of preventing the transmission of HIV and who reject major misconceptions about HIV transmission
22	Percentage of people aged 15-49 who express accepting attitudes toward people living with HIV
23	Percentage of men and women by age group (15-24 and 15-49) who have had sex with a non-marital, non-cohabiting sexual partner in the last 12 months
24	Percentage of men reporting visiting female sex workers in the last 12 months
25	Percentage of female sex workers reporting condom use with their most recent clients
26	Percentage of female sex workers reporting consistent use of condoms with their clients in the last month
27	Percentage of female sex workers who injected drug in the last month
28	Percentage of injecting drug users who share syringes and needles in the last month
29	Percentage of injecting drug users reporting condom use during the last sexual activity
30	Percent of men reporting condom use the last time they had anal sex with a male partner
34	Percentage of young men and women aged 15-24 who knows sources of condoms
35	Percentage of “most-at-risk” populations reached by harm reduction programme in the last 12 months
36	STI prevalence among targeted populations ( <i>IBBS</i> )
37	Percentage of “most-at-risk” population accessing STI diagnosis and treatment services.
38	Percentage of women and men with STIs at health-care facilities who are appropriately diagnosed, treated and counseled
40	Percentage of VCT services which meet national standards
43	Percentage of most-at-risk populations who received HIV testing in the last 12 months and received HIV test results

## Annex 3: Work plan

### 1. Plan for data collection is presented in the below table

Data collection activity	2005	2006	2007	2008	2009	2010
Regular reporting	•	•	•	•	•	•
HIV sentinel surveillance (SS)	•	•	•	•	•	•
STI sentinel surveillance	•	•	•	•	•	•
IBBS		•		•		•
Population-based survey among people aged 15-49 on KAB related to HIV	•		•			•
NASA			•			•
Special progress assessment on the implementation of the National Strategy by MoH	•	•	•	•	•	•

- Use of new reporting form

### 2. Capacity building

M&E is a new field with a considerable need for capacity building. Building up human resources is required at all levels on data collection, data analysis, data use and production of information. In order to support implementation of the M&E framework, training will be given for staff at all levels to understand the processes and practices of M&E as well as the purposes of data collection (see detail of data use in chapter 3 – data management). A key group of trained staff at each province will then be developed and provided with technical assistance from regional and national experts through supervision and refresher trainings.

Training topics include:

- Project/program management (including planning, monitoring, evaluation)
- Epidemiology and research methodology
- Data analysis and management (including web-based and non-web based data management, integrated analysis, estimation and projection using EPP, AEM and Goal model, assessment of human resource and finance)
- Advocacy (including development of targeted information products)
- Reporting: reporting form, on-line report, report writing
- Lab techniques and management

Training for trainers will be organised for staff at regional M&E units. The trained staff will then be trainers for trainings conducted at the provincial level. A tailored training curriculum will be developed based on training assessments of staff at each level. Refresher trainings will also be organised regularly.

Beside trainings, technical assistance will regularly be provided:

- to provincial M&E units by regional and national staff via field trips and meeting of regional and provincial M&E units every 6 months;
- to regional M&E units via quarterly meeting with national M&E unit;
- to national M&E unit through regular meetings with TWG.

Key human resources required by M&E units will include staff specialised in epidemiology, statistics, information technology, sociology, and program management.

### **3. Budget**

Ideally, M&E activities should take between 5 and 10 percent of the combined national HIV budgets from all sources. In the beginning, a greater proportion of funds should be allocated to initially invest in capacity building, equipment and infrastructure.

The national M&E budget comes mainly from government sources, with additional funds from international donors. The government commits to allocate regular budget for M&E activities.

The budget is required for activities including budget for capacity building for staff working on HIV programmes; the procurement and maintenance of equipment, including computers and modems, and computer software; surveys and specific research; and seminars and workshops;

Please see to the Plan of Action 4 for more detailed information on budget issues.

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