No. individuals tested, counseled, and received results for HIV - PEPFAR Indicator Reference Sheets

2004 – 2009 Indicator Reference Sheet

Number of individuals who received counseling and testing for HIV and received their test results	
Rationale/What It Measures:	This indicator provides a count of those individuals who have received counseling and testing during the current reporting period and as a result are now aware of their HIV status.
Definition:	This indicator requires a minimum of counseling, testing, and the provision of test results.
Measurement Tool:	Program reports
How To Measure It:	Double counting of individuals within a program area is to be avoided among USG funded partners. While USG funded partners should be reporting to USG managers on the actual number of individuals served, the USG team is responsible, to the extent possible, for adjusting for the overlap between multiple programs serving the same individuals within a program area. In order to avoid double counting, countries will need to monitor their activities by partner, programmatic area, and geographic area. Partners should not double count individuals seen multiple times within a program. An individual may count in separate program areas, such as a CT client or patient who may be served separately by an OVC program, ART facility, and prevention program. Individuals who receive CT as part of a PMTCT or TB program should be counted under those corresponding indicators (#5.2 for PMTCT and #6.2A for TB). All other CT clients or patients should be counted under this indicator, including VCT sites, community-based programs, routine or diagnostic CT in clinical settings, or others. Individuals receiving downstream counseling and testing at a TB site can be counted as upstream for this indicator. All the **prevention** and **care** indicators refer to individuals served *during the current reporting period*. If you reached 100 individuals with CT last year (in the Annual Report) and now serve 120 during the current reporting period, this is reported as 120, not 220.

	For concentrated/low-level epidemic settings where most-at-risk populations drive HIV transmission, it is recommended (but not required) that this indicator be monitored and disaggregated by the most-at-risk populations (MARPs) as relevant to country context. Please see the next section (Disaggregation of Most-at-Risk Populations (MARPs) for Program-Level Indicators on Prevention/Other and Counseling and Testing) -- for an example of MARPs disaggregation for Prevention/Other Behavior Change and for Counseling and Testing.
Interpretation/ **Strengths and Weaknesses:**	This is an output measure. It doesn't provide a workload count or provide any specific information about the quality of the counseling or the extent to which people are receiving follow up services. The goal is to track the number of individuals who received their test results, however, not all programs are set up to adequately distinguish between those who are tested and those who receive results. All programs should work towards being able to track individuals through pre-test counseling, testing, post-test counseling, provision of results, and subsequent interventions. This indicator also does not track where the counseling and testing is taking place. People may go more than once during the reporting period to different outlets. Refer to outcome level indicators for measurement of percent of population counseled, tested, and receiving results.

2010 – 2013 Indicator Reference Sheet

Indicator	Number of individuals who received HIV Testing and Counseling (HTC) services for HIV and received their test results
Type of Indicator:	Direct
Numerator: Essential/Reported	Number of individuals who received HTC services and received their test results during the past 12 months
Denominator:	N/A
Purpose:	This indicator is intended to monitor trends in the uptake of HTC services within a country, regardless of the type of HTC setting type or strategy. Further the disaggregation by serotype provide information about the overall % HIV-positive yields of persons tested and contribute to an understanding of linkage through proxy (new diagnoses to new care/treatment enrollments). The recommended levels of disaggregation are intended to monitor access to and uptake of HTC by specific populations that are most affected by the epidemic. Data could also be useful for projecting programmatic needs such as test kits and other staffing resources, although individuals are counted.
Applicability:	All countries with PEPFAR-funded partners directly supporting HTC services regardless of where the service is being delivered and the population groups receiving the services, including TB patients, pregnant women, HIV-exposed infants, and circumcised males.
Data collection frequency:	Data collection at the PEPFAR funded site should be ongoing. Data analysis and review should be done quarterly to monitor progress towards achieving the targets, and to identify and correct any data quality issue. . Data should be collected, analyzed, and aggregated in time for PEPFAR reporting cycles.
Measurement tool:	Existing HTC registers and reporting forms that are already being used to capture HTC encounters could be revised to include the disaggregation categories. Examples of data collection forms include client intake forms, activity report forms, or health registers such as STI registers, HMIS registers and NGO records.
Method of	Data for the numerator should be generated by counting the total number of

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measurement:	individuals who received HTC from any service delivery point. Service delivery points could include fixed health care facilities such as, hospitals, public and private clinics, VCT, ANC, L&D, PMTCT, or TB sites; standalone sites such as free standing sites not associated with medical institutions; and, mobile testing such as, HTC services offered in a specific location for a limited period of time, e.g. outreach, door-to-door services and workplace testing events. All individuals receiving HTC should be counted in this indicator regardless of where the service is provided. These individuals will include TB patients, pregnant women, men receiving circumcision, and HIV-exposed infants. To adequately collect data for this indicator, a minimum provision of the following services is required: counseling, testing, return and receipt of test results. *Couples counseling describe those sessions where two or more people in a relationship come together for HTC services. If a couple comes for services together, they should be counseled together and receive their test results together, where possible. When this happens data should be collected for each individual and it should be indicated on the form that this was a couple session as opposed to an individual session.
Interpretation:	This indicator is intended to monitor individuals and the trends in the uptake of testing and counseling over time. However, in some cases, data for this indicator might include repeat testers. If data on persons who retest are not available, this indicator will give information on the number of times HTC services were delivered, rather than the number of individuals who received HTC services. Repeat testing is common practice among most HTC programs and it is important to recognize this and interpret the aggregated data with caution. Over time, the number of people who are expected to be tested and counseled within a country will vary depending on numerous factors such as, the numbers of people with previously confirmed positive status, or the number of people who may be at perceived risk of HIV infection, and hence this indicator should be interpreted accordingly. In addition, the type and focus of a HTC program for each respective country has an impact on its interpretation. For example, a program that targets high-risk groups or areas of highest prevalence, may have smaller numbers tested,

	and yet higher yield in HIV infection identification than a program providing general HTC services. Given that this indicator is intended to count individuals and not tests, data produced through this indicator would need further interpretation for use in commodities planning. Finally, this indicator does not provide information on whether those who were tested were adequately referred and linked to and are receiving follow up services (e.g., HIV care, VMMC) to benefit from knowing their HIV status.
Additional Information:	- Partially harmonized with #7, Monitoring the Declaration of Commitment on HIV/AIDS. Guidelines on Construction of Core Indicators 2010 Reporting, United Nations General Assembly Special Session [UNGASS]. March 2009 http://data.unaids.org/pub/Manual/2007/20070411_ungass_core_indicators_manual_en.pdf • Partially harmonized with Prevention indicator (HIV-P8b), The Global Fund to Fight AIDS, Tuberculosis and Malaria Monitoring and Evaluation Toolkit: HIV, Tuberculosis and Malaria and Health Systems Strengthening Part 2: Tools for monitoring programs for HIV, tuberculosis, malaria and health systems strengthening, Third Edition, February 2009 http://www.theglobalfund.org/documents/me/M_E_Toolkit_P2-HIV_en.pdf