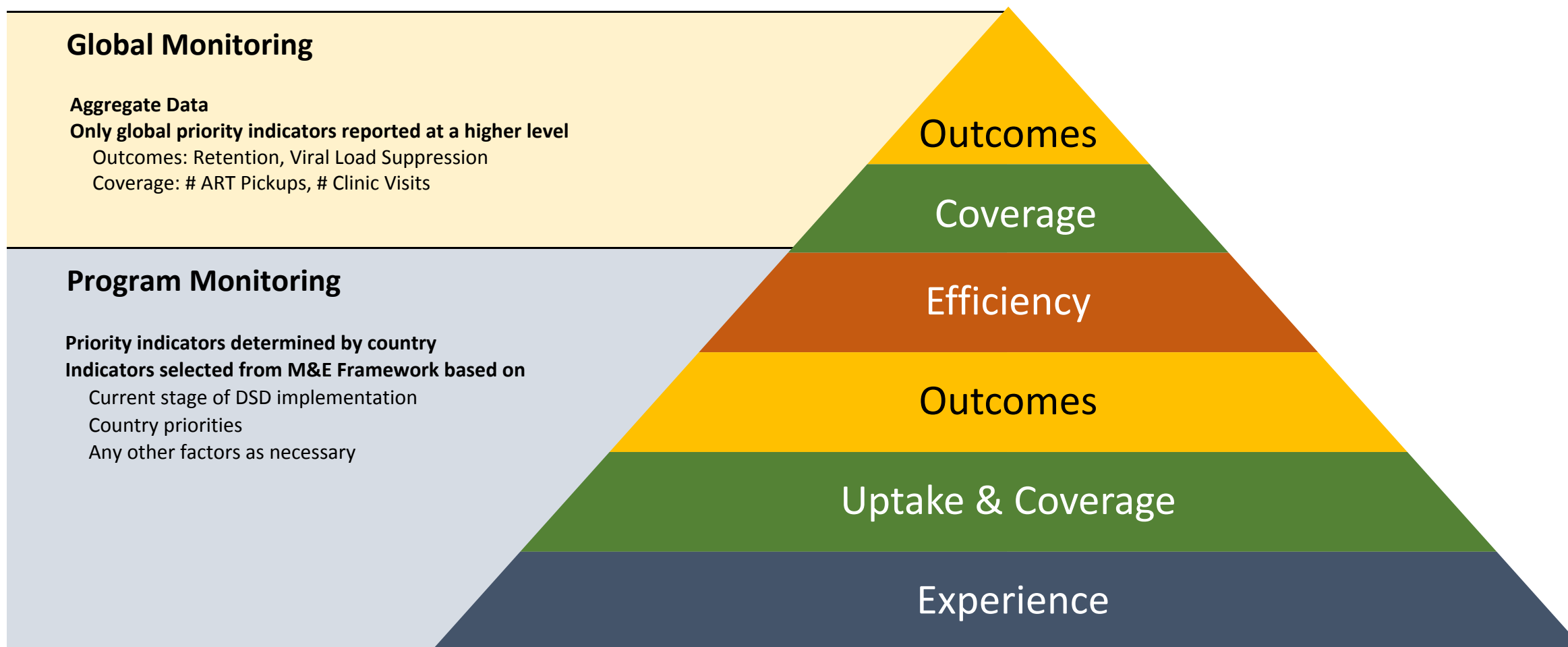


# M&E Framework for monitoring of differentiated ART services

This document is intended to serve as a guidance for countries or program implementers leading the scale up or supervision of differentiated ART services. Details of indicators are intended to be adapted to reflect national priorities, relevant aspects of national guidelines for DSD, and M&E systems. Refer to the Dictionary of Terms for clarification on the terminology used herein.

Dictionary of Terms		
1	Mainstream ART	A method of ART services delivery that is similar to historical, non-differentiated ART services; may be defined as a DSD model in some countries, but is distinguishable from other DSDM in that it provides close monitoring by health care providers (e.g., clinical consultations with each ART refill)
2	Non-Mainstream ART	Any model for ART services provision that differs from traditional, "one size fits all" model; models in which the <i>when, where, who, or what</i> of services delivery is tailored to meet the needs of specific patient groups
3	Scale-Up	The time period during which the number of facilities offering non-mainstream ART is being systematically increased; could also indicate a time period when a new model of non-mainstream ART is being added to an existing non-mainstream services system. Several Enhanced Monitoring Indicators are suggested for consideration during the scale-up period
3	Differentiated Services Delivery (DSD)	Health care services for people living with HIV (PLHIV) that formally provide non-mainstream models of ART that differ from mainstream ART services and differentiate patients to one of the other model based on pre-determined eligibility criteria

## Distinguishing Global Monitoring Indicators and Program Monitoring Indicators



## M&E Framework for monitoring of differentiated ART services

This document is intended to serve as a guidance for countries or program implementers leading the scale up or supervision of differentiated ART services. Details of indicators are intended to be adapted to reflect national priorities, relevant aspects of national guidelines for DSD, and M&E systems. Refer to the Dictionary of Terms for clarification on the terminology used herein.

Experience										
No.	Measure	Clinic Record Type	Numerator	Denominator	Data Source	Sample	Data Use	Frequency	Disaggregations	How To Use
1.1	Overall patient experience with HIV services (including mainstream and non-mainstream ART), including experience of those who disengaged from treatment	n/a	Composite	n/a	Research study	TBD	Quality Improvement (QI)	as available (not on MOH work plans)	n/a	A comprehensive questionnaire can provide detailed data on patient experience, including contextual factors that may be affecting perceptions of health services and satisfaction level. Countries may review priorities, possible approaches, and feasibility of assessing by MOH vs. through research conducted with a partner.
		n/a	Composite	n/a	MOH brief survey	A sample of facilities (sample of patients/HCW)	QI	annually	By facility level, model type	A brief survey can provide data for regular monitoring of patient experience. This data can be used at a high level to estimate overall patient satisfaction in between more in-depth research studies. This data may also be used to identify geographic sub-regions or facilities for further assessment to understand patient experience.
1.2	Overall health care worker experience with HIV services provision (mainstream and non-mainstream ART)	n/a	Composite	n/a	Research study	A sample of facilities (all patients/HCW)	QI	annually	By facility level, model type	A number of factors may affect HCW satisfaction, some unrelated to ART model. Assessments should contain sufficient detail to help understand the role of DSD in satisfaction. Results can be used in planning of QI activities, staff enrichment or training.
1.3	Health care worker knowledge, attitudes, and practices (KAP) around services provision for non-mainstream ART	n/a	Composite	n/a	MOH - various methods	A sample of facilities (all patients/HCW)	QI	periodic	By facility level, region, cadre	Assessment of KAPs can provide contextual information to better understand results of 1.2 as well as service quality indicators

## M&E Framework for monitoring of differentiated ART services

This document is intended to serve as a guidance for countries or program implementers leading the scale up or supervision of differentiated ART services. Details of indicators are intended to be adapted to reflect national priorities, relevant aspects of national guidelines for DSD, and M&E systems. Refer to the Dictionary of Terms for clarification on the terminology used herein.

Uptake & Coverage										
No.	Measure	Clinic Record Type	Numerator	Denominator	Data Source	Sample	Data Use	Frequency	Disaggregations	How To Use
2.1	<b>GLOBAL PRIORITY INDICATOR</b> Number of visits at which medication pickup occurred per PLHIV currently on treatment in a 12-month period	Paper and electronic	Number of interactions with the health system at which a patient picked up medication during the reporting period	Total ART patients receiving treatment through the facility at midyear (excluding transfer-out patients)	Abstraction from existing records	All facilities	Reporting at National Level or to Funder	annually	By region and facility level	At a national level and higher, it can be difficult to measure DSD coverage on a broad scale because scale-up is ongoing in many regions and models being implemented vary. Number of ART pickups is a measure of DSD coverage that can be used across facilities, districts, and even countries, regardless of whether the non-mainstream ART models being offered are the same.
2.2	<b>GLOBAL PRIORITY INDICATOR</b> Number of clinical consultation visits per PLHIV currently on treatment in a 12-month period	Paper and electronic	Total number of patient interactions with the health system during with a clinical visit was provided	Total ART patients receiving treatment through the facility at midyear (excluding transfer-out patients)	Abstraction from existing records	All facilities	Reporting at National Level or to Funder	annually	By region and facility level	Similarly to 2.1 above, the number of clinical consultations can be used to understand the coverage of DSD by measuring the reduction in total clinic visits as patients are transitioned away from receiving a clinical consultation each month.
2.3	Uptake of non-mainstream ART services among HIV patients	Paper	# of ART patients newly enrolled in non-mainstream ART models during the reporting period	n/a	Routinely-reported aggregate data	All facilities	National/ program/ facility M&E	quarterly	By region, facility level, and model	It can be useful to track the uptake of patients enrolling in non-mainstream ART in order to compare trends of new enrollment over time. When paper-based M&E systems are in use, collecting a denominator (in this case, # of patients newly eligible for non-mainstream ART) would be onerous. Therefore, this measure is a count where paper M&E tools are used.
		Electronic	# of ART patients newly enrolled in non-mainstream ART models during the reporting period	# of ART patients newly eligible for non-mainstream ART models during the reporting period	Electronic patient-level data	Facilities with patient-level data	National/ program/ facility M&E	quarterly	By region and facility level characteristics; model, age, sex, pregnancy status, KP (as available)	When electronic M&E systems are in use, it is possible to measure uptake as a proportion of all patients eligible.
2.4	Coverage of non-mainstream ART among HIV patients	Paper	# of ART patients enrolled in non-mainstream ART models at the end of the reporting period	# of patients currently receiving ART at the end of the reporting period	Routinely-reported aggregate data	All facilities	National/ program/ facility M&E	quarterly	By region, facility level	Coverage measures all patients currently enrolled in non-mainstream ART, including those newly enrolled and those enrolled in prior reporting periods. When paper-based M&E systems are in use, a proxy for the denominator of # of patients eligible for non-mainstream ART can be used.
		Electronic	# of ART patients enrolled in non-mainstream ART models at the end of the reporting period	# of ART patients eligible for non-mainstream ART at the end of the reporting period	Electronic patient-level data	Facilities with patient-level data	National/ program/ facility M&E	quarterly	By region and facility level characteristics; model, age, sex, pregnancy status, KP (as available)	When electronic M&E systems are in use, it is possible to measure coverage as a proportion of all patients eligible for non-mainstream ART.

2.4	<p><b>ENHANCED MONITORING INDICATOR</b>  <b>Facility uptake of non-mainstream ART during scale-up phase only</b></p>	Paper or electronic	<p># of DSD facilities added during the reporting period</p> <p>(can be defined as # of facilities capacitated to provide non-mainstream ART or # of facilities with &gt;1 patient enrolled in a non-mainstream model, depending on the priorities of the country)</p>	n/a	Routinely-reported aggregate data	All facilities	National/ program/ facility M&E	quarterly	<p>Region; Also for reporting via electronic patient-level data: By model type, facility level</p> <p>Optional: By number of different models offered (1 model, &gt;1 model)</p>	<p>As a national DSD system is rolled out, it can be helpful for Ministries of Health to track the number of facilities that newly defined as a DSD facility.</p> <p>In addition, if it is of interest to the country, it is possible to measure the uptake of diverse models of non-mainstream ART by disaggregating DSD facilities by the number of models provided.</p>
2.6	<p><b>ENHANCED MONITORING INDICATOR</b>  <b>Facility coverage of non-mainstream ART during scale-up phase only</b></p>	Paper or electronic	<p># of facilities offering non-mainstream ART reporting at least one patient enrolled in a non-mainstream ART model at the end of the reporting period</p> <p>(can be defined as # of facilities capacitated to provide non-mainstream ART or # of facilities with &gt;1 patient enrolled in a non-mainstream model, depending on the priorities of the country)</p>	# of facilities providing ART during the reporting period	Routinely-reported aggregate data	All facilities	National/ program/ facility M&E	quarterly	<p>By model type, facility level, region</p> <p>Optional: By number of different models offered (1 model, &gt;1 model)</p>	<p>During scale up, it can be helpful for Ministries of Health to track the proportion of facilities that are DSD facilities.</p> <p>In addition, if it is of interest to the country, it is also possible to measure the proportion of facilities providing diverse models of non-mainstream ART by disaggregating DSD facilities by the number of models provided.</p>

## M&E Framework for monitoring of differentiated ART services

This document is intended to serve as a guidance for countries or program implementers leading the scale up or supervision of differentiated ART services. Details of indicators are intended to be adapted to reflect national priorities, relevant aspects of national guidelines for DSD, and M&E systems. Refer to the Dictionary of Terms for clarification on the terminology used herein.

Clinical Outcomes										
No.	Measure	Clinic Record Type	Numerator	Denominator	Data Source	Sample	Data Use	Frequency	Disaggregations	How To Use
3.1	<b>PRIORITY GLOBAL INDICATOR</b> Retention in non-mainstream ART among HIV patients every 12 months after enrollment	Paper and electronic	# of patients in the cohort known to be on treatment 12 months after ART initiation (also 24, 36, 48, 60 months, etc. after ART initiation)	# of patients initiated on ART 12 months ago, excluding transfer-out patients (also 24, 36, 48, 60 months, etc. ago)	Routinely-reported aggregate data (ART Register or EMR)	All facilities	National/ program/ facility M&E	quarterly	By region, facility level; By patient age, sex	Identical to the PEPFAR indicator TX_RET. May be used to measure retention outcomes: <i>On ART, Died, LTFU, Stopped ART, Known Transfer Out</i> .  ART retention is used as a proxy for retention in non-mainstream models for paper-based systems due to the difficulty in capturing date of enrollment in a non-mainstream model when using paper M&E tools. Most non-mainstream ART models restrict eligibility to patients retained on ART at 6-12 months, which is why the cohorts for this indicator are identical to ART cohorts.
		Electronic	# of patients in the cohort known to be on treatment 12 months after enrolling in a non-mainstream ART model (also 24, 36, 48, 60 months, etc. after model enrollment)	# of patients enrolled in a non-mainstream ART model 12 months ago, excluding transfer-out patients (also 24, 36, 48, 60 months, etc. ago)	Electronic patient-level data	Facilities with patient-level data	National/ program/ facility M&E	quarterly	By region and facility level characteristics; By model of non-mainstream ART; By patient age, sex, pregnancy status, KP (as available)	As with ART retention, retention in a non-mainstream model of ART would be a key measure of quality of services. Can measure retention outcomes: <i>Retained in Non-Mainstream Model, Switched to Mainstream ART, Died, LTFU, Stopped ART, Known Transfer Out</i>
3.2	<b>PRIORITY GLOBAL INDICATOR</b> Viral suppression among HIV patients every 12 months after enrollment in a non-mainstream ART model	Paper and electronic	# of patients in the cohort with a documented suppressed viral load result 12 months after ART initiation (also 24, 36, 48, 60 months, etc. after ART initiation)	# of patients starting ART 12 months ago with a viral load result documented (also 24, 36, 48, 60 months, etc. ago)	Routinely-reported aggregate data (ART Register or EMR)	All facilities	National/ program/ facility M&E; Reporting at National Level or to Funder	annually	By region, facility level; By patient age, sex	This is similar to the PEPFAR indicator TX_PVLS. This indicator monitors the proportion of documented viral load tests with suppressed results, allowing programs to monitor individual and programmatic response to ART. VLS by ART cohort is used as a proxy for VLS by non-mainstream ART cohort.
		Electronic	# of patients in the cohort with documented suppressed viral load results 12 months after enrolling in a non-mainstream ART model (also 24, 36, 48, 60 months, etc. after model enrollment)	# of patients who enrolled in a non-mainstream ART model 12 months ago with a viral load result documented (also 24, 36, 48, 60 months, etc. ago)	Electronic patient-level data	Facilities with patient-level data	National/ program/ facility M&E	quarterly	By region and facility level characteristics; By model of non-mainstream ART; By patient age, sex, pregnancy status, KP (as available)	Additional monitoring indicator to monitor viral load suppression by cohort of patients enrolled in a non-mainstream model for ART. Would be limited to facilities with EMR. and would need to be monitored in addition to viral load suppression by ART cohort.
	<b>ART patients who developed an opportunistic infection (OI) every 12 months after enrollment in a non-mainstream ART model</b>	Paper	# of patients in the cohort with a documented OI 12 months after ART initiation (also 24, 36, 48, 60 months, etc. after ART initiation)	# of patients starting ART 12 months ago, excluding transfer-out patients (also 24, 36, 48, 60 months, etc. ago)	Routinely-reported aggregate data (ART Register or EMR)	A sample of facilities (sample of patients/HCW)	National/ program/ facility M&E	annually	By region, facility level; By patient age, sex	Like retention outcomes, monitoring of OIs can highlight quality issues. Paper systems pose challenges to collecting information on OIs for reporting, but for countries that wish, this may be implemented as an additional monitoring indicator.

3.3

Electronic	# of patients in the cohort with a documented OI 12 months after enrolling in a non-mainstream ART model (also 24, 36, 48, 60 months, etc. after model enrollment)	# of patients who enrolled in a non-mainstream ART model 12 months ago, excluding transfer-out patients (also 24, 36, 48, 60 months, etc. ago)	Electronic patient-level data	Facilities with patient-level data	National/ program/ facility M&E	quarterly	By region and facility level characteristics; By model of non-mainstream ART; By patient age, sex, pregnancy status, KP (as available)	Like retention outcomes, monitoring of OIs can highlight quality issues. Electronic systems can streamline the process of reporting on OIs by ART model. This may be implemented as an additional monitoring indicator.
------------	--	--	-------------------------------	------------------------------------	---------------------------------	-----------	--	---

## M&E Framework for monitoring of differentiated ART services

This document is intended to serve as a guidance for countries or program implementers leading the scale up or supervision of differentiated ART services. Details of indicators are intended to be adapted to reflect national priorities, relevant aspects of national guidelines for DSD, and M&E systems. Refer to the Dictionary of Terms for clarification on the terminology used herein.

Efficiency of Healthcare Delivery										
No.	Measure	Clinic Record Type	Numerator	Denominator	Data Source	Sample	Data Use	Frequency	Disaggregations	How To Use
4.1	Mean delivery cost from the provider perspective for HIV services per patient over a 12-month period	n/a	Costs associated with HIV services (from provider point of view)	Number of current clients on ART at mid-year	Research study	A sample of facilities (sample of patients/HCW)	Reporting at National Level	periodic	TBD	For each efficiency indicator, countries may review priorities, possible approaches, and feasibility of assessing by MOH vs. through research conducted with a partner. The impact of DSD on the cost of service provision per patient is crucial for decision-making by funders and health systems leaders.
4.2	Mean health care delivery cost from the provider perspective for HIV services per virally-suppressed patient over a 12-month period	n/a	Costs associated with HIV services	Number of ART patients who are virally suppressed at the end of the period	Research study	A sample of facilities (sample of patients/HCW)	Reporting at National Level	periodic	TBD	
4.3	Mean time for a clinical consultation for a patient receiving HIV services per visit	n/a	Total time spent by a health care provider to perform a clinical consultation	Number of health care providers	MOH research study	A sample of facilities (all patients/HCW)	QI	periodic	By region and facility level; By mainstream/non-mainstream status of patients receiving care; By non-mainstream model	Average time of a clinical consultation can highlight the changes to day-to-day health services delivery activities effected by the implementation of DSD. In turn, this data be used to inform the planning of quality improvement activities.
4.4	Mean HIV patient case load per health care provider in a 6-month period	n/a	Average number of HIV clinical consultations within a facility per week	Average number of full-time equivalent staff involved in direct provision of HIV services at the facility	Research study	A sample of facilities (all patients/HCW)	QI	periodic	By facility level, region	Case load by health care provider is a measure of the burden on workers and can be used to assess the efficiency of the DSD system and, in turn, inform planning of QI activities.
4.5	Mean overall (includes those with conditions other than HIV) patient case load per health care provider in a 6-month period	n/a	Average number of total clinical consultations by HIV providers within a facility per week	Average number of full-time equivalent staff involved in direct provision of HIV services at the facility	MOH brief exit survey	A sample of facilities (all patients/HCW)	QI	periodic	By facility level, region	This incorporates all types of patients, to account for provider assignment to HIV clinic as well as other areas. This measure can serve as a comparison group to the HIV patient case load measured in 4.4
4.6	Mean total time spent by patients to receive HIV treatment services (including transportation and waiting) in a 6-month period	n/a	Total patient time spent accessing HIV services per service type for each model of HIV treatment	Number of patients responding	Research study	TBD	QI	as available (not on MOH work plans)	n/a	A comprehensive measure, assessed over multiple questions, to understand the average patient time investment in seeking HIV services will divide their total time into travel time, waiting time, and time spent with a health care provider. The impact of DSD on the amount of time patients must devote to access HIV services is crucial for decision-making by funders and health systems leaders.
			Time measured separately as: travel time, waiting time, time interacting with the health care provider							
		n/a	Total patient time spent accessing HIV services per service type for each model of HIV treatment	Number of patients responding	MOH brief exit survey	A sample of facilities (sample of patients/HCW)	QI	annually	By facility level, model type	As part of a brief exit survey, simple questions to understand the time spent attending a single visit can provide data for regular monitoring of patient time. This data can be used at a high level to estimate overall efficiency of DSD from the patient perspective between more in-depth assessments. This data may also be used to identify geographic sub-regions or facilities for further assessments of service efficiency.
		Time measured separately as: travel time, waiting time, time interacting with the health care provider								

4.7	Mean out-of-pocket cost to patient to receive HIV treatment services (including transportation costs, costs of prescription medications, and clinic fees, as applicable) in a 6-month period	n/a	TBD	TBD	Research study	TBD	QI	as available (not on MOH work plans)	n/a	A comprehensive measure of the average cost to patients receiving HIV services. Costs will be divided into transportation costs, costs for prescription medication, and clinic fees (not all costs will be applicable in all countries). A research study may also provide the opportunity to understand opportunity cost, through targeted questions. The impact of DSD on the cost to patients accessing HIV services is crucial for decision-making by funders and health systems leaders.
		n/a	Total cost to patients accessing HIV services per service type for each model of HIV treatment  Cost assessed separately as: transportation costs, medication costs, and clinic fees	Number of patients responding	MOH brief exit survey	A sample of facilities (sample of patients/HCW)	QI	semi-annually	By facility level, model type	As part of a brief exit survey, simple questions to understand the cost of attending a single visit can provide data for regular monitoring of patient financial burden. This data can be used at a high level to estimate overall efficiency of DSD from the patient perspective between more in-depth assessments. This data may also be used to identify geographic sub-regions or facilities for further assessments of service efficiency.