



THE PARTNERSHIP
FOR Health Evaluation

FIELD GUIDE

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It is hoped that this guide will prove useful to those implementing Partnership for Health in the field. It is our goal to keep this guide and its information as current as possible. Please consult the Diffusion of Effective Behavioral Interventions website – www.effectiveinterventions.org for additional information and resources.

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1

Monitoring and Evaluation: An Important Component of Partnership for Health

Introduction

This Monitoring and Evaluation (M&E) Field Guide is a resource for all agency staff to use in the development and implementation of M&E plans and activities specific to the Partnership for Health (PfH) intervention. PfH is an individual-level behavioral intervention delivered by the medical provider to HIV-positive patients each time they attend a medical clinic. PfH was found to be most effective when carried out by a medical provider, but may be carried out in the field by allied health personnel (Richardson et. al, 2004). In this guide the term provider refers to anyone delivering the PfH intervention to patients. Clinic staff refers to all staff at the outpatient clinic including medical providers. The goals of PfH are to train providers and staff on the intervention and thereby improve patient and provider communication about safer sex and disclosure. PfH also aims to decrease unsafe sexual behaviors and increase disclosure of HIV status to sex partners among persons living with HIV (Richardson et. al, 2004). The intervention is based on Prochaska's Stages of Change Model (Prochaska et. al, 1994) and message framing theory. According to the Stages of Change Model, behavior change is gradual and incremental. Therefore, patients can be at different stages of preparedness to change risk behaviors. The message framing approach examines how health recommendations are framed, put into practice, and the impact of frames on health-related decisions.

Monitoring and evaluation are essential components of any program or intervention and is also a required component of most funders' grant agreements, including those of the Centers for Disease Control and Prevention (CDC). Monitoring and evaluation activities provide us with the information to address one broad monitoring question and one broad evaluation question:

- **Monitoring:** Are we doing what we said we would do?
- **Evaluation:** Is what we are doing having its intended effects?

The answers to these two broad questions provide information that can be used for program monitoring, improvement, and planning purposes, for accountability to funders and other stakeholders, and for advocacy purposes.

This Guide Is...

This M&E Field Guide is intended to be used in conjunction with the *Partnership for Health Technical Assistance Guide* and the *Partnership for Health Participant's Manual* (Richardson et. Al, 2004). The *PfH Technical Assistance Guide* includes instructions, tools, and materials related to M&E. This M&E field guide uses or adapts many of the ideas, tools, and materials in the technical assistance guide. It is intended to be a “how to” manual that enables agencies implementing PfH to quickly and effectively get their M&E plans and activities started.

This guide will take you through a step-by-step process to develop and implement an M&E plan that meets CDC requirements for M&E and provides you with information and data to guide program management decisions related to PfH. We have designed it so that you can use materials according to your needs; some chapters and tools may be more relevant to your work than others. Your actual M&E plan and tools should be tailored to the particular context, needs, capacity, and characteristics of your organization.

This Guide Is Not...

This guide is not intended to be a complete course on M&E, nor is it intended to be a research approach to evaluation (for example, it does not focus on questions about long-term outcomes or impact of the PfH intervention).

Who Should Use This Guide?

This guide is intended for a team of staff who will be involved in assisting with M&E for PfH. This evaluation team should include at least the 0.5 FTE PfH Coordinator, some providers who conduct PfH, program manager(s), program supervisor(s), and data entry staff. It may also include an evaluation consultant, if one is hired to provide technical assistance to coordinate PfH M&E. Further guidance around hiring a consultant and the role of a consultant can be found in CDC's *Evaluation Capacity Building Guide*.

Ultimately, successful implementation of PfH and its M&E depends on staff buy-in.

Therefore it is important to involve your evaluation team in all aspects of M&E to ensure staff buy-in, understanding of the purposes of M&E activities, and adherence to the M&E plan.

Purpose and Use of this Guide

The purpose of this M&E Field Guide is to help you develop and implement a monitoring and evaluation plan for PfH.

This M&E Field Guide can be used to:

- assess capacity to conduct M&E;
- identify staff to participate in M&E activities;
- design a PfH M&E plan;
- select tools for data collection and analysis;
- develop and implement staff training on M&E; and
- use data for program improvement

M&E plans should always be tailored to the particular needs and characteristics of your agency. There is no 'one way' to implement M&E. This M&E Field Guide has been designed for you to use according to your needs. Some chapters and tools may be more pertinent to your work than others. All of the ideas and tools presented can be adapted to fit your particular agency's need and capacity.

What Is Contained in This Guide?

The M&E Field Guide is based on CDC's Framework for Program Evaluation in Public Health and is organized into six chapters with appendices that provide additional support materials. The guide covers the following topics:

Chapter 1: In this first chapter, sections of the Guide are described, steps that should be taken with others at your agency to get ready for monitoring and evaluating PfH are discussed and additional CDC resources that will be helpful as you embark upon M&E activities for PfH are identified.

Chapter 2 describes several steps that are crucial to developing your M&E plan: engaging stakeholders, use of a Behavior Change Logic Model, Implementation Summary Sheet, and Core Elements to drive your monitoring and evaluation plan, developing evaluation questions and the SMART objectives to answer them. It also describes the process of organizing your questions and SMART objectives to identify qualitative and quantitative measures.

Chapter 3 provides guidance on the development of a plan for collecting M&E data, including identifying and testing data collection tools and determining how they will be used, when they will be used and who will use them.

Chapter 4 describes how to collect the data that you need, manage it and analyze your findings.

Chapter 5: After you have developed and implemented an M&E plan for PfH and have analyzed the data, it is time to actually use your findings. The M&E data that you obtain can be used for more than just fulfilling funding requirements. Chapter 5 will describe ways that your results can be used for program improvement and planning, and advocacy efforts.

Chapter 6 describes CDC’s National HIV Monitoring and Evaluation Initiative and the use of the Program Evaluation Monitoring System (PEMS). It also describes how your agency can prepare for implementation of the National HIV Monitoring and Evaluation Data Set and how the PEMS database can be used to capture components of your PfH M&E Plan.

Appendix A: Monitoring and Evaluation Tools

- Tool 1 – Behavior Change Logic Model and Implementation Summary Sheet
- Tool 2 – Data Planning Matrix
- Tool 3 – Monitoring and Evaluation Checklist
- Tool 4 – PfH Post-Implementation Provider Survey
- Tool 5 – Client Survey
- Tool 6 – Sample Time Frame
- Tool 7 – Data Analysis Tool
- Tool 8 – National HIV Prevention M&E Data for PfH Tool

Appendix B: 2008 National HIV Prevention Monitoring and Evaluation Data Set (NHME DS) Variable Requirements

Appendix C: References

A few symbols and text flags are used throughout this guide.



Recommended Activity - signifies a recommended activity for your organization to complete.



signifies a tool included in the Appendix that can be tailored to your agency’s needs.

Keep in Mind

text boxes describe factors that your organization should consider before completing a particular activity.

Additional Resources

A variety of other resources are available to assist you as you plan and implement M&E activities for PfH. They include more detailed information on program evaluation that can be helpful to supplement the information presented in this guide. We will make reference to the following materials when relevant:

- ***CDC Evaluation Capacity Building Guide*** – This manual has been designed to help organizations conducting Effective Behavioral Interventions (EBIs) such as PfH develop their capacity to implement program evaluation activities. It is intended to help you choose evaluation approaches and activities that are best-suited for your organization and the programs you are conducting. It is a particularly useful resource for both the person overseeing your evaluation and those who are new to program evaluation. It can also be used to help you develop materials for training on evaluation for agency staff. Please contact your Project Officer should you need more capacity-building resources (CDC, 2008a).
- ***Framework for Program Evaluation in Public Health- Centers for Disease Control and Prevention***. MMWR 1999; 48 (no.RR-11). 1-42. The CDC framework for program evaluation is a valuable overview of the key components of public health program evaluation.
- ***Partnership for Health Technical Assistance Guide and Partnership for Health Participant's Manual***

The *PfH Technical Assistance Guide* provides assistance in the implementation of the PfH intervention, including:

- scientific background information about PfH
- a description of the intervention
- a description of its core elements
- information around adapting or tailoring the intervention
- information about program evaluation, staffing, and costs to agencies related to implementation.

The *PfH Participant's Manual* includes training modules on the following:

- background information on the PfH intervention
- behavior change theories and models
- communication skill building
- conducting the brief counseling session
- role play scenario such as disclosure of HIV status
- helping patients build safer sex skills.

(Richardson et. Al, 2004)

- **Performance Indicators** - CDC has developed a series of performance indicators for each funded intervention, including PfH. Be sure that you have the most recent version of the required indicators to ensure that you are collecting the data you need to calculate the performance indicators for PfH. Please contact your CDC Project Officer for a copy of the most recent version of the required indicators.
- **National HIV Prevention Program Monitoring and Evaluation** – There are a variety of resources to assist you with the collection and utilization of data variables from the National HIV Prevention Program Monitoring and Evaluation Data Set (NHM&E DS). One resource is the NHM&E DS which contains a complete list and description of all M&E variables required for reporting to CDC and optional for local M&E. The most current version of this document can be found on the PEMS web site (<https://team.cdc.gov>) (CDC, 2008d). Also, the Program Evaluation and Monitoring System (PEMS) User Manual is a how-to manual that describes the functionality of PEMS (an optional, secure browser-based software that allows for data management and reporting of NHM&E DS). The PEMS User Manual provides step-wise instructions for each module in PEMS. This document is also available on the PEMS website (CDC, 2008c). Another resource is the National HIV Prevention Program Monitoring and Evaluation Guidance (NHM&EG), this manual provides a framework and specific guidance on using the NHM&E DS to monitor and evaluate HIV prevention programs (CDC, 2008b). Additional information or technical assistance for the National HIV Prevention Program Monitoring and Evaluation Plan, the PEMS software, CT scanning and HIV test form requests may be accessed through the Program Evaluation Branch's National HIV Prevention Program Monitoring and Evaluation Service Center, which you can reach by calling 1-888-PEMS-311 (1-888-736-7311) or e-mailing pemsservice@cdc.gov; or visiting the PEMS Informational website (<https://team.cdc.gov>); or contacting the DHAP Help Desk for issues related to digital certificates and the Secure Data Network (1-877-659-7725 or dhapsupport@cdc.gov).
- **Capacity Building Branch** - Health departments and organizations directly funded by CDC can request monitoring and evaluation technical assistance through the Capacity Building Branch's Web-based system, Capacity Request Information System (CRIS). For more information about and access to CRIS, visit <http://www.cdc.gov/hiv/cba>.

DISCLAIMER: The reporting requirements for the National HIV Prevention Program Monitoring and Evaluation Data Set presented in this document are current as of September 2008. Please refer to the PEMS Web site (<https://team.cdc.gov>) for the most current reporting requirements.

2

Developing a Monitoring and Evaluation Plan

This chapter describes the first three steps involved in developing a monitoring and evaluation (M&E) plan related to Partnership for Health (PfH) at your agency.

- **Step 1: Engage Stakeholders**
- **Step 2: Use Core Elements, the PfH Behavior Change logic model and Implementation Summary Sheet**
- **Step 3: Develop Evaluation Questions**
- **Step 4: Develop PfH SMART objectives**
- **Step 4: Determine measures**

Step 1: Engage Stakeholders

It is important to identify and involve key stakeholders as far as possible throughout the monitoring and evaluation process. A stakeholder is any individual or organization that has an interest in the PfH program and its evaluation. Stakeholder involvement throughout the evaluation process is crucial to developing a feasible monitoring and evaluation plan and increasing buy-in to the evaluation process. Furthermore, stakeholder involvement may increase the likelihood that evaluation findings and recommendations will be used.

Consider involving the following stakeholders in the evaluation process:

- Evaluation Team (PfH Coordinator, Providers, Program Manager(s) and Program Supervisor(s), data entry staff, and a evaluation consultant if one is hired)
- Members of Board of Directors
- Clients
- Partners (funders, coalition and community partners, and advocacy groups)

Stakeholders should be engaged in developing your monitoring and evaluation plan. Their input can be helpful to focus the evaluation design, develop evaluation questions, review evaluation findings, make program recommendations and disseminate results.

Step 2: Use Core Elements, the PfH Behavior Change Logic Model and Implementation Summary Sheet

The PfH Behavior Change Logic Model depicts the logic of what behavior change is intended to be accomplished and the Implementation Summary Sheet depicts how the behavior change will be implemented. Some elements of the Behavior Change Logic Model and Implementation Summary Sheet are based on the Core Elements of the PfH intervention. Core elements are those parts of an intervention that must be done and are thought to be responsible for the intervention's effectiveness. They cannot be ignored, added to, or changed (CDC, 2006). **Remember that you cannot adapt or change any of the core elements of PfH without approval from your Project Officer.** Otherwise, PfH may not be implemented as intended and therefore may not prove to be effective.

PARTNERSHIP FOR HEALTH CORE ELEMENTS

- Have providers deliver the intervention to HIV-positive patients in HIV outpatient clinics.
- Have the clinic adopt prevention as an essential component of patient care.
- Train all clinic staff to facilitate integration of the prevention counseling intervention into standard practice.
- Use waiting room posters and brochures to reinforce prevention messages delivered by the provider.
- Build on the ongoing supportive relationship between the patient and the provider.
- During routine visits, have the provider initiate at least a 3- to 5- minute discussion with the patient or client about safer sex that focuses on self-protection, partner protection, and disclosure.
- Have the provider incorporate good communication techniques and use of consequences-framed messages for patients or clients engaged in high-risk sexual behavior.
- Provide referrals for needs that require more extensive counseling and services.
- Integrate the prevention message into clinic visits so that every patient is counseled at every visit.

Use of the Core Elements, Behavior Change Logic Model and Implementation Summary is a critical step in the evaluation process. Use of these tools will drive the development of M&E questions, program process and outcome objectives as well as the overall M&E plan.

The PfH Behavior Change Logic model and Implementation Summary Sheet can be found in Appendix A (Tool 1). Following is an explanation of how to use the PfH Behavior Change Logic model and Implementation Summary Sheet and how they help to frame the M&E plan.

The **Behavior Change Logic Model for PfH** illustrates

- Intent of the the PfH intervention (behavioral problem to be changed and intended change);
- Determinants of behavioral risk
- Activities expected to lead to behavior change
- Anticipated outcomes

The **Implementation Summary Sheet** illustrates

- Inputs or resources needed to implement PfH
- Activities to prepare for and conduct PfH
- Outputs which are the products resulting from implementation activities

The logical pathway of the PfH Behavior Change logic model and Implementation Summary Sheet allows easy identification of areas that should be explored to account for any unexpected shortcomings due to weaknesses or omissions in the intervention.

To illustrate, if monitoring activities show that providers have not been implementing PfH messaging in every client visit, you would need to examine program activities that logically lead to this output. You would explore, for example, whether or not all staff have received training and ongoing support from a PfH coordinator, in order to appropriately and effectively integrate PfH messaging.



The Behavior Change Logic Model and Implementation Summary Sheet for PfH can be found in Appendix A as Tool 1.



RECOMMENDED ACTIVITY

Review and tailor the Behavior Change Logic Model and Implementation Summary Sheet for PfH to your agency's implementation of the PfH intervention. Be sure to consider

- your organization's available resources to implement PfH (staff, etc.)
- your implementation plan for PfH.

Step 3: Develop Evaluation Questions

The third step in the development of your M&E plan helps you identify specific evaluation questions you would like to answer. The Core Elements, PfH Behavior Change Logic Model and Implementation Summary Sheet provide the conceptual framework for identifying evaluation questions.

Process Monitoring and Evaluation Questions

Process monitoring and evaluation helps to ensure that you are delivering the intervention as intended and are implementing all of the core elements of PfH.

Process monitoring is the routine documentation and review of program activities, populations served, services provided, or resources used in order to inform program improvement and process evaluation.

— CDC EVALUATION CAPACITY BUILDING GUIDE

Process Monitoring questions for PfH may include:

- Are the appropriate procedures and protocols in place for implementing PfH?
- Are clinical staff members appropriately trained?
- Do clinic staff endorse the use of PfH at the clinic?

Process evaluation assesses planned versus actual program performance over a period of time for the purpose of program improvement and future planning.

— CDC EVALUATION CAPACITY BUILDING GUIDE

Process Evaluation questions for PfH may include:

- Are providers following the protocol for delivery of PfH?
- Are required quality assurance activities completed?

Outcome Monitoring Questions

Through **outcome monitoring** you will assess whether PfH is having its intended effect.

Outcome monitoring involves the routine documentation and review of program-associated outcomes (e.g., individual-level knowledge, attitudes and behaviors or access to services; service delivery; community or structural factors) in order to determine the extent to which program goals and objectives are being met.

— CDC Evaluation Capacity Building Guide

Outcome Monitoring questions for PfH may include:

- Did clients take specific action towards achieving personal risk reduction goals?
- Are clients reporting an attitude supportive of protective sexual behavior?

You'll also want to include questions evaluation questions that may be of interest to your organization and those required by or of interest to any other funding sources.

Step 4: Develop PfH SMART Objectives

This step in the M&E plan links the evaluation questions and the Core Elements, Behavior Change Logic Model and Implementation Summary Sheet through developing SMART objectives based on what you hope to accomplish through the implementation of PfH. SMART objectives help you determine the answers to your evaluation questions. Each evaluation question should have one or more related SMART objectives. By identifying a list of SMART objectives, you are identifying the information you will need to collect in order to determine and report on whether each objective has been met, which is the basis of your M&E plan.

SMART objectives are:

SPECIFIC
MEASURABLE
ACHIEVABLE
RELEVANT
TIME-PHASED

Objectives that don't have all of these characteristics can be difficult to monitor. The M&E data planning matrix is a tool that can help you organize your evaluation questions, SMART objectives and the information needed to complete your M&E plan. *A Sample PfH Data Planning Matrix* can be found in Appendix A (Tool 2) of this guide.

Begin by adding your list of evaluation questions to the data planning matrix. You will then start developing your SMART objectives and listing them down the left column under the corresponding evaluation question. To assist you in writing your own SMART objectives refer to the table below:

S pecific <i>What are we going to do?</i>	M easurable <i>Is it quantifiable and can we measure it?</i>	A ppropriate <i>Will this objective have an effect on the outcomes and overall goals of the program?</i>	R ealistic <i>Can we get it done in the proposed time frame with the resources/ money/ support that we have available?</i>	T ime-phased <i>When will this objective be accomplished?</i>
<ul style="list-style-type: none"> ■ Develop ■ Obtain ■ Provide ■ Follow-up ■ Hire ■ Recruit ■ Train ■ Deliver ■ Report ■ Increase ■ Improve ■ Implement ■ Refer 	<ul style="list-style-type: none"> ■ Number ■ Percent ■ Average ■ Change over time 	<p>Ask yourself the following questions:</p> <ul style="list-style-type: none"> ■ Is this objective related to the program outcomes and goals? 	<p>Ask yourself the following questions:</p> <ul style="list-style-type: none"> ■ Does your staff have the skill set to carry out the objective? ■ Do you have the resources/money/ support to attain the objective? ■ Have you set achievable goals that are reasonably high but no impossible? ■ Have other programs attained similar goals? 	<ul style="list-style-type: none"> ■ By (date) ■ Annually ■ Quarterly ■ At each session ■ Semi-annually

SMART objectives addressing process monitoring are derived from the **core elements** of the PfH intervention and the **“inputs,” “activities,”** and **“outputs”** columns of the Implementation Summary Sheet. For example:

- By (date), 100% of all clinic staff will be trained in the PfH intervention by (identify group/person).

SMART objectives addressing process evaluation are derived from the core elements of the PfH intervention and the **“inputs,” “activities”** and **“outputs”** columns of the Implementation Summary Sheet. For example:

- By (date) 90% of all providers report that they discussed staying safe, protecting partners, and/or disclosure of HIV status to partners with “81-100%” of their clients during each PfH counseling session.

SMART objectives addressing outcome monitoring are derived from the “**outcomes**” column (short- and intermediate-term) of the Behavior Change Logic Model. For example:

- 90% of all clients report that they feel more comfortable talking about safer sex or using condoms in their sexual relationships.

KEEP IN MIND...

Adapt SMART Objectives to Your Needs

The purpose of this M&E Field Guide is to provide a quick and streamlined M&E plan that provides the **minimum** information you will need for reporting and program management purposes. For every step in the development of the M&E plan, you should ask yourself whether there are other issues or questions that are important to your clinic related to the PfH intervention that you would like to monitor and evaluate. These questions should then be translated into additional SMART objectives that meet your agency’s needs, goals, clinic culture, time frames, and capacity.

It may be important to your clinic to monitor and evaluate other outcomes. For example, you may be interested in client satisfaction related to PfH. A SMART objective related to this might read

- 90% of all clients report high satisfaction with their most recent PfH encounter.



Sample SMART objectives are presented in the Data Planning Matrix (Tool 2). This tool can help you organize your evaluation questions, SMART objectives and the information needed to complete your M&E plan. Blank rows are included for adding other SMART objectives that are appropriate to your agency.

KEEP IN MIND...

The target percentages and time frames included in the sample SMART objectives are examples. You will decide what timeframes and measurable target percentages are **Appropriate** and **Realistic** for your setting/agency when you write your own SMART objectives.



RECOMMENDED ACTIVITY

Review the sample SMART objectives in Tool 2 and tailor them to your program needs and/or add other SMART objectives to meet your agency's specific needs for PfH M&E.

Step 5: Determine Measures

Each SMART objective will have a corresponding "measure of success," that is, proof that your objective was met.

Measures can be quantitative, such as a count, percentage, or average. Or they can be qualitative. Qualitative measures are usually documentation of observations, perceptions, and opinions. Examples of qualitative data include notes taken during counselor observations, narratives from focus groups, or answers to open-ended questions. Qualitative data may also be contained in a record or checklist.

Quantitative measures generally describe *how often* something is happening. Qualitative measures generally describe *what* or *why something is happening*.

Below is an abbreviated version of the Data Planning Matrix with examples of two SMART objectives and their corresponding measures of success.

EXAMPLE 1: QUANTITATIVE MEASURE

Process Monitoring Question: Are clinical staff members appropriately trained?

SMART Objective	Measure
F. By (date), 100% of clinic staff will be trained in the PfH intervention by (identify person/group).	# of clinic staff attending PfH training / total # of clinic staff

The “measure of success” in this example is the proportion of providers that complete PfH training. The measure has a numerator and denominator that are used to calculate the proportion.

EXAMPLE 2: QUALITATIVE MEASURE

Process Monitoring Question: Are the appropriate procedures and protocols in place for implementing PfH?

SMART Objective	Measure
B. By (date) and reviewed annually, a work plan and protocols will be developed to integrate PfH messaging and prevention into standard clinic practice.	Completed work plan and protocols

The “measure of success” in this example is the existence of a work plan document and written protocols that support the integration of PfH by a date specified by your agency.

Both quantitative and qualitative data are important to understand whether you are meeting your objectives.



RECOMMENDED ACTIVITY

Determine “measures” for your SMART objectives.



Measures are included for each SMART objective in the Data Planning Matrix (Tool 2). Determine “measures” for additional SMART objectives that you have included in the Data Planning Matrix and include them in the “Measure” column.

Chapter 2 Summary

Five key steps to developing an M&E plan were presented in this chapter:

- **Step 1: Engage Stakeholders**
- **Step 2: Use Core Elements, the PfH Behavior Change Logic Model and Implementation Summary Sheet**
- **Step 3: Develop Evaluation Questions**
- **Step 4: Develop PfH SMART objectives**
- **Step 5: Determine measures**

The following tools were introduced in this chapter:

- **Tool 1: Behavior Change Logic Model and Implementation Summary Sheet for PfH**
- **Tool 2: Data Planning Matrix**

If you complete each of the first five steps using the tools introduced, you will be well on your way to developing your M&E plan.

3

Data Collection

This chapter describes the next two key steps for developing your Partnership for Health (PfH) monitoring and evaluation (M&E) plan:

- **Step 6: Identify M&E tools for data collection**
- **Step 7: Develop a time frame and identify staff responsible for M&E activities**

Step 6: Identify M&E tools for data collection

Now that you have identified your SMART objectives and corresponding measures, the next step is to determine how you will collect the data to measure whether or not you have met your objectives.

There are **two steps** within data collection: **data capture and data entry**. Data capture is the process of documenting client information on a paper form. (These forms will be referred to as tools.) Data entry is the process of entering the data from a paper tool into a database.



The third column of the Data Planning Matrix (Tool 2) suggests data collection tools that can be used to obtain data corresponding to each of the SMART objectives listed.

The Training Participation Checklist and the PfH Training Evaluation tool are not included in this Field Guide and can be found in the PfH Technical Assistance Guide. PfH Coordinators must request that these tools be shared with them for data analysis.

The Provider and Client Surveys included in this Field Guide have been adapted from the PfH Technical Assistance Guide and are based on generating quantitative data from provider and client perspectives. Use of these tools is not a requirement.

Overview of Data Collection Tools

Following is a description of the data collection tools in this field guide. The tools can be modified and/or used to supplement those already used for M&E in your agency.

■ **Monitoring and Evaluation Checklist (Tool 3):**

The checklist will help you keep track of “qualitative” SMART objectives (for example, development of a work plan, policies, and protocols for PfH integration, development of the M&E plan). As a task is completed, the completion date is recorded. There are also columns for recording progress toward completion or comments that may affect the completion of a particular task (for example, “M&E plan developed by target date; however, the Board still needs to review it.”). The checklist also tracks review dates for each product, with the purpose of ensuring that they are maintained and current. Blank rows are included for tracking any additional qualitative SMART objectives created for your agency’s specific needs.

■ **PfH Post-Implementation Provider Survey (Tool 4):**

The PfH Post-Implementation Provider Survey included in this M&E Field Guide was adapted from the Provider Survey that is in the PfH Technical Assistance Guide. This tool was adapted in order to generate quantitative data needed for the M&E plan presented in this M&E Field Guide. The PfH Post-Implementation Provider Survey should be distributed after providers have been trained and are conducting PfH for some time. It gives providers the opportunity to assess their comfort level and skills related to the PfH intervention.

■ **Client Survey (Tool 5):**

The Client Survey assesses provider communication and topics covered during the counseling session from the client’s perspective. It captures data from only those clients who have a routine check-in appointment, since the PfH intervention is not conducted with patients who have an emergency situation. It should be administered at least annually to provide timely data for reporting and program management. (This tool was adapted from the *PfH Technical Assistance Guide*).

Data Collection Tool Development

When identifying or developing tools to use for data collection, be sure to consider:

- **Other M&E activities at your agency.** You may find that data collection tools already in use at your agency can be used or easily adapted to collect necessary data for PfH M&E. For example, your clinic’s standard medical chart or chart stickers may already capture data that you need to collect for your M&E plan, such as proof of completion of key components of the intervention. This data can be abstracted easily from medical charts or chart stickers instead of developing a new data collection tool or using tools found in this guide.
- **Overall staff burden relative to usefulness of M&E data collection efforts.** If your data collection goals are too extensive for your staff capacity, revise your SMART objectives. You may find that some data collection tools found in this guide are too burdensome for your staff to implement. For example, if the PfH Post-Implementation Provider Survey is too difficult to implement, you may find it easier to gather the same type of data through informal discussions and/or qualitative interviews with providers.
- **Developing unique tools and/or revising data collection tools presented here to meet your agency’s program management needs and/or requirements from funders.** When developing unique tools consider what data should be captured, how many different forms you’ll need, and the information each form needs to capture.



RECOMMENDED ACTIVITY

Identify the tools that will be used or modified for data collection in your agency. Review the listing of suggested tools in the “Data Collection Tool” column of the Data Planning Matrix (Tool 2), and revise if needed to suit your situation. For any additional SMART objectives that you included on the Data Planning Matrix, list the tool or tools that will be used to capture the data corresponding to the objective.

KEEP IN MIND...

Analysis Categories

As you are determining which data collection tools to use or develop, it is important to keep in mind how you would like to report the data.

For example, if your agency is fairly large and has more than one clinic site, you may be interested in seeing how the results of the PfH Post-Implementation Provider Survey break down across clinics and/or according to providers' experience levels. To do this, a PfH Post-Implementation Provider Survey or other tool for collecting provider information must capture data on the clinic where the provider delivers care and on the provider's experience level. Similarly, you may be interested in results from a client survey by clinics, by gender, by age, or by race/ethnicity. If so, be sure your data collection tool captures this information.

KEEP IN MIND...

You can use tools to gain deeper insight and you can use alternative data sources

There are questions on the Post-Implementation Provider and client surveys included in this guide that do not directly correspond with SMART objectives on the Data Planning Matrix, for example, two client satisfaction questions (Questions 14 and 15) on the Client Survey, among others. These questions are included to provide additional data that you may choose to analyze if you wish to gain deeper insight. Remember that the M&E plan suggested in this field guide represents the **minimum** information you will need for reporting and program management. Feel free to use any appropriate question from either survey to measure whether or not you have met your SMART objectives.

Please note that data for SMART objective Q (documentation of provision of PfH from at least 80% of HIV routine visits) can be collected from a medical chart audit, chart stickers, or a tally of clients who responded “yes” to at least four of the components in Question #5 on the Client Survey.



RECOMMENDED ACTIVITY

Develop a process for using data collection tools.

This process should include all the steps needed, from obtaining the form to destroying it. There should be a written account of how the form will be used, by whom, and how often, as well as how it will get from one person to another within the agency. It should also describe the storage of forms, access to forms, who will enter them into a database, how often, as well as security procedures that should also be in place to protect the data and client confidentiality.

All staff should be trained on your agency’s policies for maintaining client confidentiality and on each staff person’s role in implementing the agency’s security procedures.



RECOMMENDED ACTIVITY

Pilot test all tools before you implement them. Ask five clients to pilot test your client exit survey and up to five providers to pilot test your PfH Post-Implementation Provider Survey. Some topics to obtain feedback on include: ease of completion, clarity, understanding, suggested changes, missing information, and appropriateness of time given to fill out the form. Make changes to the surveys if there are recurrent themes from the feedback you receive around these and other topics. This step helps to ensure that the tools are suitable for your particular agency and client base.

Step 7: Develop a time frame and identify staff responsible for M&E activities

Determining a realistic **time frame** for PfH implementation and M&E is essential to M&E planning. To develop a time frame you need to take into account:

- **Critical deadlines for reporting and program management.** For example, if you prepare a progress report to CDC every six months, the final data from M&E activities should be available to you at least a month before the progress report is due.
- **The time needed to complete the process** of survey distribution, data collection, follow-up for missing information (for example, with providers who may not have submitted their surveys), data entry, data analysis, interpretation of results, and presentation of results
- **How often you want to analyze data to inform program improvements.** If it is your first year implementing PfH, you will want to assess PfH more frequently than in your fifth year, for example, to discern whether early implementation is going according to plan.

To identify staff responsible for M&E activities you need to take into account:

- **Skill sets needed**
- **Staff time**

Skill sets

Assess whether or not your organization has the expertise on staff to carry out the required tasks for M&E. If not, can training be provided? Can an outside evaluator be hired?

- **Data capture** requires a staff person who can administer the data collection tools. For instance, a trained receptionist can administer the client survey after the patient's appointment.
- **Data entry** requires a staff person who is skilled and efficient in cleaning (identifying and correcting errors in data), entering, and managing data in a database.
- **Data analysis** requires a staff person who has experience with describing basic features of data gathered for M&E purposes and has the ability to provide, at a minimum, simple quantitative summaries of data.
- **Data interpretation** requires the ability to put the data into overall context and use it to reach conclusions. This often requires input from multiple stakeholders associated with the agency, including management, administration, clinicians, counselors, and clients.
- **Data presentation** requires someone comfortable with developing tables and graphs and presenting data in user-friendly ways.

Staff time

You will also need to determine whether staff members will have sufficient time to carry out M&E activities. For example, can providers be expected to carry out the PfH intervention **AND** enter data from the client survey into a database? If not, you will need to identify and train another staff person to do data entry of surveys.



A Sample Time Frame for PfH implementation and M&E is included in Appendix A (Tool 6). It is designed to fulfill reporting requirements and program management decision-making needs by month 13. It lists key subtasks of each activity to illustrate the time commitment required to successfully complete each task. Some key implementation activities are included to place the M&E activities within the implementation context. The Sample Time Frame also includes a column listing the type of staff you may want to consider for each task.



RECOMMENDED ACTIVITY

Develop a time frame and identify staff responsible for M&E activities. Be sure to tailor the Sample Time Frame to suit your agency's implementation plan, reporting requirements, time commitment to each task, and staffing capabilities.

Chapter 3 Summary

Two more key steps to developing an M&E plan were presented in this chapter:

- **Step 6: Identify M&E tools for data collection**
- **Step 7: Develop a time frame and identify staff responsible for M&E activities**

The following tools were introduced in this chapter:

- **Tool 3: Monitoring and Evaluation Checklist**
- **Tool 4: PfH Post-Implementation Provider Survey**
- **Tool 5: Client Survey**
- **Tool 6: Sample Time Frame**

Your M&E Plan is complete! However, it is always considered a document in process. It should be kept up to date and reviewed frequently to ensure that it reflects the current M&E needs of your agency.

4

Implementing Your Monitoring and Evaluation Plan

This chapter describes three key steps for carrying out your monitoring and evaluation (M&E) plan:

- **Step 8: Collect the data**
- **Step 9: Manage the data**
- **Step 10: Analyze the data**

Step 8: Collect the data

Now that you have developed and pilot tested data collection tools and determined the staff skills and resources needed to implement your M&E plan, you are ready to collect data according to the time frame and procedures established for your agency. Following are guidelines and questions to consider before implementing tools described in the previous chapter

- **Monitoring and Evaluation Checklist (Tool 3)**

Before implementing the Monitoring and Evaluation Checklist be sure to consider the following questions:

- **Are you already reporting on these activities through other existing mechanisms at your agency?** If you already collect and report this data then you may not need to use this tool as a data source.
- **Who will determine whether each activity was completed adequately?** Your PfH Coordinator or your entire evaluation team could determine this.
- **How often will you indicate on the Monitoring and Evaluation Checklist (Tool 3) whether or not the listed activities were completed?** This should be done at least annually or more frequently according to your agency M&E time frame

As noted in Chapter 3, two of the tools listed on the Data Planning Matrix (Tool 2), the Training Participation Checklist and the Training Evaluation tool, are not included in this Field Guide. These tools are included in the *PfH Technical Assistance Guide*. Prevention Training Centers implement these tools as part of the PfH training program.

PfH coordinators must request that training participation and evaluation data and/or results collected from the Prevention Training Centers be shared with them for data analysis.

**KEEP IN MIND . . .
For Survey Implementation...
On-Line Surveys!!**

There are several on-line survey services available that can facilitate the collection and analysis of survey data, including Surveymoney.com and Zoomerang.com. Costs are reasonable, and the sites are user friendly. Other features of these sites include basic data analysis, data presentation options (bar graphs, pie charts, and tables), and reduced data entry errors because survey responses do not need to be transferred from a form to a database. Data from the on-line survey may also be imported into other databases (such as Excel) for further analysis. Also, providers and clients may be more willing to complete an on-line survey rather than a paper or telephone survey.

Some disadvantages to online survey services are the cost, up-front time to enter the survey, and the requirement for computer/internet accessibility.

■ PfH Post-Implementation Provider Survey (Tool 4)

Before implementing the PfH Post-Implementation Provider Survey according to your M&E time frame be sure to consider the following questions:

- **On-line or paper implementation of survey?** On-line implementation may be the best option for administering the PfH Post-Implementation Provider Survey if providers at your agency have easy access to e-mail and the internet. Distributing the survey in paper form also is effective although this requires the extra steps of entering the data into a database and conducting initial analysis.
- **Who should receive the surveys?** Determine whether you are interested only in responses from providers who deliver PfH to clients. You may also choose to survey supervisors who have quality oversight. This decision will impact how you interpret your data.
- **How many surveys will be distributed?** If you distribute paper surveys, insert a number code at the top of each survey (from 0 to the total number to be distributed) for tracking purposes. If you use an online survey, a unique tracking number/respondent ID will automatically generate when you download your data.
- **Do you need to track responses by clinic?** If you have multiple sites, you may want to track responses by clinic. If you are using an online survey, include 'clinic name' as a value option in the drop-down menu. If you are using a paper-based survey, a tracking scheme may include the first three letters in the clinic's name followed by the survey number. For example, surveys to be distributed at the Hamilton and Merry Mount clinics may be identified as follows:

ID#:	HAM01	ID#:	MER01
	HAM02		MER02
	Etc. . .		Etc. . .

- **If using paper surveys, how will you collect them?** One approach is the use of a drop box (for anonymity). Another approach is to ask respondents to place the surveys in the mailbox of the staff member responsible for doing data entry.
- **How will you send follow-up reminders for survey completion?** This could be done using e-mail, general staff meetings, or other appropriate forums

KEEP IN MIND...

Ways to improve the response rate to the PfH Post-Implementation Provider Survey

- Get buy-in and endorsement of the Pfh Post-Implementation Provider Survey at top management levels of your organization.
- Inform providers that their responses are voluntary but important for M&E purposes.
- Assure the maintenance of confidentiality and ensure that the survey results will in no way affect their employment status.
- Inform providers how and when the survey will be distributed before implementation.
- Keep the survey as short as possible.



CLIENT SURVEY (TOOL 5)

Before implementing the Client Survey according to your M&E time frame, be sure to consider the following questions:

- **On-line or paper implementation of survey?** If the survey is implemented online, clients would be given a link to the survey after their appointment or through mail/e-mail. It may be unlikely that clients will take the time to access the survey after leaving the clinic. Alternatively, a computer can be set up in the lobby area where clients could complete the survey immediately following their appointment. If the survey is paper-based, ask clients to complete the survey immediately following their appointment.
- **Over what time period will you administer the Client Survey?** A two week to month-long window period is suggested (See the Sample Time Frame, Tool 6). During your survey window period, every client seen by a provider should be asked to complete a survey.

- **Who will administer the survey?** If the survey is paper-based the receptionist may give the survey form to the client as s/he registers or completes the appointment. Or the provider may give the survey form to the client as s/he completes the appointment. If the survey is on-line the receptionist can direct clients to the computer where they can fill out the survey. Whoever administers the survey must be trained on the use of the form, including definitions for terms used on the form, should clients have questions.
- **What are the policies and protocols for maintaining client confidentiality and security?** Survey drop boxes should be placed at convenient locations (such as the waiting room) that are hidden from general view.

Each Client Survey should have an introduction indicating that the survey is voluntary and that responses to the survey will in no way affect the care the patient receives at your agency. Also, remind patients that their responses are important because they will help improve quality of care; that they will be kept confidential; and that there will be no way to connect responses to the individual completing the survey. The Client Survey (Tool 5) in this M&E Field Guide provides an example of this type of introduction.

KEEP IN MIND...

Ways to improve the response rate to the client survey

- Have providers encourage patients to fill in the survey and emphasize its importance.
- Provide a small incentive for completion (e.g., pen with agency name, refrigerator magnet, etc.).
- Assure clients that their responses will be kept confidential and in no way will affect their care.
- Keep the survey as short as possible and limited to the information you want to collect.
- Provide pens or pencils for filling in the survey.
- Distribute surveys with clipboards to make writing on the forms easier.



RECOMMENDED ACTIVITY

Refer to the Sample Time Frame (Tool 6) as modified for your agency for a suggested schedule for implementing your data collection tools.

Step 9: Manage the data

Preparation for analysis

After you have collected your M&E data, the next step is to manage the collected data so that you can analyze it.



RECOMMENDED ACTIVITY

Decide on a database for entering, compiling, and storing your data. This only applies if you implement paper surveys. If you choose an on-line survey method, the database will be automatically created for you.

Bear in mind that you can use any database that will at least capture necessary data elements, create field limitations that limit data entry mistakes, and allow for compiling and extraction of data for analysis.

If you are receiving funding directly from CDC to implement PfH, you may be required to collect and submit to CDC a required set of variables from the NHM&E DS related to PfH using the PEMS software (Appendix B). See Chapter 6 of the Field Guide for guidance on how to prepare for implementation of CDC's National HIV Monitoring and Evaluation Data Set and how the PEMS database can be used to capture components of your PfH M&E plan. If you are indirectly receiving funding from CDC to implement PfH, consult your Health Department and/or funder to ascertain your data collection and reporting requirements.

Develop data entry rules. Think through instructions staff will need to be consistent and accurate in their data entry. For example, consider how staff should handle entry of missing data on forms.

Clean the data you have collected. Data cleaning should ensure that no data was omitted or entered incorrectly in the database and that data values are within expected ranges. One way to do this is to have a second person check the data entry of another and correct any mistakes found. This is usually done for a small percentage of the overall data.

Step 10: Analyze the data

Data analysis involves calculating quantitative measures and summarizing qualitative data. Data analysis will allow you to determine which SMART objectives were met or not met and why. Following are two examples illustrating qualitative and quantitative analysis, respectively.

Qualitative Analysis Example

At the end of the PfH Post-Implementation Provider Survey (Tool 4) and the Client Survey (Tool 5) there are **open-ended questions**. *The responses to these questions should be captured verbatim* in some format (e.g., in a separate Word document or at the end of the Data Analysis Tool (Tool 7)). ***Because the Data Analysis Tool (Tool 7) is an Excel spreadsheet, it does not lend itself to presentation in this document, and is included in the disk that is provided with this document.*** After reading through several surveys, you may start to see patterns of responses. For example, Question 19 in the Provider Survey asks the respondent to note what they needed to help them better use the PfH intervention with their clients. One analysis strategy is to *develop codes for patterns of response*. For example, responses that indicate that providers needed more time to complete the PfH intervention are coded as 1; responses that indicate providers needed more practice with using PfH messaging are coded as 2. There will probably always be some responses that do not fit into established patterns. These can be labeled “miscellaneous” and given the code number 3. Developing a coding system will allow you to identify what were some of the responses that were repeated most often. For example, suppose that responses to Question 19 from most providers were coded as “1.” Your results could include a statement like “*Most providers commented that they needed more time to complete the PfH intervention with clients.*”

Quantitative Analysis Example

According to SMART objective F in the Data Planning Matrix (Tool 2), “*By (date), 100% of providers will be trained in the PfH intervention by (identify person/group).*” Suppose that after conducting PfH training and reviewing the Training Participation Checklist, it is found that, collectively, 8 out of 10 providers participated in PfH training by your targeted date. You can calculate the percentage of providers trained in the PfH intervention in either of the following ways:

By hand: 8 (number of providers who participated in the PfH intervention) / 10 (total number of providers) = $0.8 * 100 = 80\%$ of providers have been trained in the PfH intervention by (date).

OR

Electronically, using the Data Analysis Tool (Tool 7): once the tallied numerator and denominator are entered in the Data Analysis Tool at Lines 1 and 3, the percentage can be calculated automatically. (See excerpt from Data Analysis Tool below.)

Process Monitoring Objectives					
Data Element		Data Source	#	%	Calculation
1	Total number of Providers	Training Participation Checklist	10		
3	Providers attending training on the PfH intervention	Training Participation Checklist	8	80%	3 divided by 1

Once the basic analysis is completed for all your measures, you may be interested in examining responses to the PfH Post-Implementation Provider Survey for different groups of respondents. For example, you may be interested in organizing data by level of professional experience, by occupation (provider versus non-provider), and by provider type (primary care provider versus other).

Suppose that your agency wanted to know whether or not physicians were more likely or less likely than other providers to "...discuss staying safe, protecting partners, and/or disclosure of HIV status to partners" within the past 5 working days to 81-100% of their clients (Question 6b on the PfH Post-Implementation Provider Survey -Tool 4).

First, you would identify your numerator. This would be the number of physicians who indicated on their survey that they discussed staying safe, protecting partners, and/or disclosure of HIV status with 81-100% of their clients within the past 5 working days. The denominator would be the total number of physicians who completed the PfH Post-Implementation Provider Survey. Using the Data Analysis Tool (Tool 7) to calculate this measure, you would enter two additional data elements and formulas into the tool. (See the example below showing how this measure would be added to Tool 7.) You can then compare the resulting proportion/ percentage to the proportion/percentage of all providers who responded that they had discussed staying safe, protecting partners and/or disclosure of HIV status with 81-100% of all their clients within the past 5 working days.

Process Evaluation Objectives					
Data Element		Data Source	#	%	Calculation
26	Total number of physician providers surveyed	PfH Post-Implementation Provider Survey			
27	Physician providers who discussed staying safe, protecting partners, and/or disclosure of HIV status with 80-100% of their clients within the past 5 working days. (Q #6b)	PfH Post-Implementation Provider Survey		=D27/D26	27 divided by 26



RECOMMENDED ACTIVITY

Analyze the data you have collected and prepared for analysis.

- Use the Data Analysis Tool (Tool 7) to calculate measures based on PfH SMART objectives.
- See the Sample Time Frame (Tool 6) for suggestions of when to analyze data from various tools.

Chapter 4 Summary

Three key steps involved in implementing your M&E plan were presented in this chapter:

- **Step 8: Collect the data**
- **Step 9: Manage the data**
- **Step 10: Analyze the data**

The following tool was introduced for the first time in this chapter 4:

- **Tool 7: Data Analysis Tool**

Once the data has been collected and managed by compiling, cleaning, and then analyzing it, the next step is to use it for program monitoring, improvement, reporting, and advocacy, and to share achievements with staff.

5

Using Results

Now that you have done all the work of collecting and analyzing your data, it is time to use it! This chapter will walk through how to use the data you have gathered to see whether you have met your objectives and to make improvements. Results of data analysis can also be used for reporting, advocacy and gaining support for your program and your agency.

Step 11: Use your data for program monitoring, improvement, and advocacy

Using Data for Program Monitoring



RECOMMENDED ACTIVITY

The process of data interpretation begins with gathering the results related to each SMART objective in your monitoring and evaluation (M&E) plan and then determining whether the objective was met and what helped or held back progress toward the objective.

If an objective was met, it is important to understand what is contributing to the success so you can keep doing it. You may need additional information to understand what is working well.

If an objective was not met, you should determine what information will help you understand what to change. Your PfH logic model can help you figure out what factors contributed to the outcome. You may have ready access to the information that you need.

Or you might have to ask clinic staff, clients, the medical director, or other stakeholders to help you identify what is keeping your agency from reaching the objective. You can ask questions in any format, whether in an informal discussion or a more structured interview. These discussions and/or interviews can help you understand what structural and external factors may have affected the outcome. You may have to conduct a more in-depth analysis involving survey data elements that were not assessed in your initial analysis.

If you find that you don't have the information to determine whether or not you reached an objective, you'll need to figure out why the information is missing and address the reason.

The following example provides three results scenarios for SMART objective T in the Data Planning Matrix (Tool 2): "90% of all clients report committing to at least one risk reduction activity." For each of the scenarios (Objective Met; Objective Not Met; Do Not Know...) additional data that may be needed and potential ways to obtain the data and gain insight are suggested.

Outcome SMART Objective T: 90% of all clients report committing to at least one risk-reduction activity		
Evaluation Findings	Implications (additional data that may be needed)	Potential Ways to Gain Insight
<p>Scenario One: Objective Met 92% of PfH clients report acting on at least one risk-reduction goal/activity that they and their provider set.</p>	<p>Is there some specific action we are taking that helps us get clients to commit to risk-reduction?</p> <p>What contributes to clients acting on the risk-reduction goal/step?</p>	<p>Case conference conversations with providers about how risk-reduction activities are introduced and reinforced.</p> <p>Analysis of client surveys for clients who commit to acting on at least one risk-reduction activity compared to those who don't.</p>

Evaluation Findings	Implications (additional data that may be needed)	Potential Ways to Gain Insight
<p>Scenario Two: Objective Not Met</p> <p>70% of PfH clients report acting on at least one risk-reduction goal/activity that they and their provider set.</p>	<p>Are providers appropriately discussing developing risk-reduction goals with clients?</p> <p>Do providers endorse the use of PfH?</p> <p>Do some types of providers have higher rates of discussing risk-reduction goals with clients than others?</p>	<p>Review of PfH Post-Implementation Provider Surveys provider surveys to determine how often risk-reduction goal development is discussed, and whether or not they endorse the use of PfH.</p> <p>Deeper analysis of the PfH Post-Implementation Provider Survey, e.g., a review by occupation type.</p> <p>Semi-structured qualitative interviews of key providers to procure more substantive data that may be needed.</p>
<p>Scenario Three: Do Not Know if Objective Was Met</p> <p>Data was not compiled</p>	<p>Were client surveys completed?</p> <p>Were client surveys entered into a data collection system (Excel or other)?</p> <p>If not, what inhibited completion/entry?</p> <p>If client surveys were entered, why wasn't the data compiled?</p>	<p>Review of client surveys and/or a sample of records in the data collection system.</p> <p>Survey or conversation with data entry staff and/or entire evaluation team about barriers to client survey completion and/or data entry.</p>

Using Data for Program Improvement

Of course there is no value in monitoring how you are doing if you don't use the information you garner to improve your program.



RECOMMENDED ACTIVITY

After the first six months of PfH implementation any areas where SMART objectives are not being met should be identified, and barriers or challenges to meeting them identified and addressed.

For example, you may find that providers are not using the PfH intervention with clients after PfH orientation and training. You'll want to figure out why and what can be done to correct this. If you find that providers feel they don't have enough time for the PfH intervention, perhaps greater support from higher levels of management or from the PfH Coordinator is needed. Investigation of barriers to PfH implementation and ways to mitigate them may require the use of qualitative methods such as semi-structured provider interviews to gain deeper insight into the issues.



RECOMMENDED ACTIVITY

Share the results of data analysis with providers, supervisors, and other staff involved with the PfH intervention who are not on the evaluation team. This can heighten awareness of any shortfalls that may need to be addressed and help make the case for adjustments that allow your organization to better meet its implementation goals.

Using Data for Program Planning



RECOMMENDED ACTIVITY

At least annually or semi-annually, look at your data as you plan your strategies and resource allocations for your next implementation period.

- **Identify strengths and areas for improvement.** Your data (both process and outcome) will allow you to identify strengths that you may want to build on, and areas that you want to focus on improving. For example, the data can be used to assess the extent to which your organization is addressing the needs and satisfaction of both clients and providers. It can also help you identify significant changes you need to make in your implementation plans.
- **Budget resources.** Your data may also help you budget the resources you need for your next intervention cycle. For example, you may want to increase the time available to the PfH intervention project for a supervisor who seems most capable of helping providers increase their effectiveness.
- **Allocate existing resources.** Your data can also help you allocate existing resources. For example, if you find that providers are struggling with the use of consequences-framed PfH messages even after training and they report that they didn't have enough time to role-play these skills, you may choose to hold a booster session that will focus on how and when to use consequences-framed messages, including time for participants to role play these skills. The booster training can then be evaluated to see if providers' comfort level with consequences-framed messages increased.



RECOMMENDED ACTIVITY

At regular six-month intervals review your M&E plan to incorporate what you have learned. Be sure to review your agency's

- Logic model for PfH
- Evaluation Questions
- SMART objectives
- Data planning matrix

Using Data for Reporting and Advocacy and to Garner Support



RECOMMENDED ACTIVITY

Results from your data analysis can be used to report to your funders and organizational leaders on whether or not you have achieved what you committed to in your grant application. If you haven't achieved your goals, your data can help you develop some realistic steps for improvement.

Your data can be used for regular bi-annual reports to CDC, and to report within your organization on services provided.

There are other ways your data can help you with advocacy and support.

- Identification of trends or changes in client characteristics (such as risk factors) may help you build a case for additional funding from a new source.
- Sharing with stakeholders how you used program data to make improvements can lead to increased credibility for your organization among the community and funders.
- Sharing data about client needs can help you forge partnerships with other organizations and/or renegotiate existing partnerships.
- Sharing data about program achievements with staff can help increase morale and retention.

Chapter 5 Summary

A key step in using results from M&E was presented in this chapter:

- **Step 11: Use your data for program monitoring, improvement, and advocacy**

Your agency's PfH M&E data can be used for several important purposes in addition to monitoring and improving PfH implementation, including planning for the next implementation period, reporting to funders and organizational leaders, garnering support in and outside your agency, and increasing staff morale.

6

CDC's National HIV Monitoring & Evaluation Initiative: Use of the PEMS Software for PfH Monitoring and Evaluation

Introduction

CDC has undertaken significant efforts to ensure that the HIV prevention programs it funds are effective in preventing the spread of HIV (Thomas, Smith, & Wright-DeAgüero, 2006). One strategy employed by CDC to strengthen HIV prevention is improving organizational capacity to monitor and evaluate prevention programs (CDC, 2007). The National HIV Prevention Program Monitoring and Evaluation Data Set (NHM&E DS) is a major component of this strategy.

The NHM&E DS is the complete set of CDC's HIV prevention monitoring and evaluation (M&E) variables, including required variables for reporting to CDC and optional variables specific to an intervention or for local M&E. Implementation of NHM&E DS makes it possible for CDC at the national level, and its funded grantees, locally, to answer such questions as:

- demographic profile and risk behavior of clients being served by grantees
- resources used to provide HIV prevention services
- effectiveness of these services in, for example, reducing risk behaviors and increasing protective behaviors, providing HIV test results and linking persons testing positive to care and prevention.

DISCLAIMER: The reporting requirements for the National HIV Prevention Program Monitoring and Evaluation Data Set presented in this document are current as of September 2008. Please refer to the PEMS Web site (<https://team.cdc.gov>) for the most current reporting requirements.

The National HIV Prevention M&E initiative consists of the following components:

- Standardized information collected by all directly funded HIV prevention programs, known as the **required variables** of the NHM&E DS. The variables you will be expected to collect and report to CDC for PfH will be described in this chapter.
- The Program Evaluation Monitoring System (PEMS) Software is a resource that has been provided to assist grantees in this initiative. PEMS is an optional, secure browser-based software that allows for data management and reporting. PEMS includes all required and optional NHM&E DS variables (CDC, 2008c)
- Access to technical assistance and training on all aspects of NHM&E and the PEMS software is provided by CDC and its partners. This assistance is provided to the Implementation Coordinator (discussed below) your agency designates, who is then responsible for training and assisting other staff at your agency.

Implementation of your M&E plan for PfH, using the variables required for reporting to CDC, will help you answer your evaluation questions, provide data for tracking of process and outcome monitoring, and assess the status of your SMART objectives.

Note: It may be necessary to use complimentary data collection systems for other aspects of your M&E plan that cannot be captured in PEMS, for example, development of pre-implementation protocols or documentation of supervisory activities.

Preparing for Implementation of the National HIV Prevention Program Monitoring and Evaluation Dataset

If this is the first time you are receiving funds from CDC for HIV prevention, contact your Project Officer to identify your technical assistance provider. Your technical assistance provider will begin by giving you an overview and orientation to program monitoring and the national data requirements; making sure you have all relevant materials; developing a training plan to meet your needs; and assisting you in getting access to the PEMS software.

There are a variety of things you should have in place at your agency for implementation of program monitoring and data reporting. Someone on staff should be designated as the NHM&E Implementation Coordinator. This individual is responsible for coordinating all aspects of activities that are important for successful implementation of the NHM&E DS, program monitoring and data reporting.

Some activities that are important for successful implementation include:

- Review of your agency's evaluation questions and their relationship to the NHM&E DS
- Customization of sample Health Education/ Risk Reduction data collection templates which can be found on the PEMS informational website, and/or creation of unique data collection forms that capture at minimum, the required variables
- Training of prevention staff on collection of the NHM&E DS
- Training of staff who will be users of the PEMS software
- Ensuring staff have access to the correct hardware, software, and internet connections
- Working with staff on reporting and utilization of NHM&E DS to support ongoing M&E activities

This Field Guide is one of several documents disseminated by CDC to provide information and guidance on HIV prevention program evaluation, data collection, data utilization and use of the variables included in the NHM&E DS. Related documents include:

- **Evaluation Capacity Building Guide.** This guide provides an overview of monitoring and evaluation for evidence-based interventions, with particular focus on process monitoring and evaluation activities, tools, and templates (CDC, 2008a).
- **National Monitoring and Evaluating Guidance for HIV Prevention Programs (NMEG).** This manual provides a framework and specific guidance on using NHM&E DS variables to monitor and evaluate HIV prevention programs (CDC, 2008b).
- **Program Evaluation and Monitoring System (PEMS) User Manual.** This how-to manual describes the functionality within the application and provides step-by-step instructions for each module within the web-based software tool. Screenshots, example extracts of data, and reports are used to illustrate key features included in the PEMS software. You can download this manual at the PEMS Web site (<http://team.cdc.gov>) under Trainings/PEMS User Manual (CDC, 2008c).
- **National HIV Prevention Program Monitoring and Evaluation Data Set (NHM&E DS).** The complete list and description of all M&E variables required for reporting to CDC and optional variables for local M&E and specific to certain interventions. You can download this at the PEMS Informational Web site (<https://team.cdc.gov>) (CDC, 2008d)

- **The National HIV M&E Service Center.** Service Center staff are available to respond to questions about the national HIV M&E data, data reporting requirements, and questions, concerns, and requests related to the PEMS software. The Service Center also resolves issues related to scanning of test data and HIV test form requests. They can be reached at: pemsservice@cdc.gov or call (888) 736-7311. The PEMS Help Desk is available to address questions or issues related to digital certificates and the Secure Data Network (SDN); e-mail dhapsupport@cdc.gov or call 877-659-7725

These documents provide a foundation for monitoring and evaluating HIV prevention programs and reporting required data using the PEMS software. Health departments and organizations directly funded by CDC can request monitoring and evaluation technical assistance through the Capacity Building Branch's web-based system, Capacity Request Information System (CRIS). For more information about and access to CRIS, visit <http://www.cdc.gov/hiv/cba>. Additional information or technical assistance for National HIV Prevention Program Monitoring and Evaluation and the PEMS software may be accessed through the Program Evaluation Branch's National HIV Prevention Program Monitoring and Evaluation Service Center.

National HIV Prevention Program M&E Data Set

The NHM&E DS is organized in a series of data tables. The PEMS software captures these variables in different software modules according to categories, such as information about your agency, your HIV prevention programs, and the clients you serve. The NHM&E DS provides the number, name, definition, instructions, value choices, and codes for each variable.

- There is a minimum set of variables from the National HIV Prevention M&E Data Set that all grantees are required to report to CDC.
- There are additional variables included in the PEMS software that may be useful to your agency, but are not required for reporting to CDC.
- There are local variables that can be used when you enter client information to capture data not otherwise reflected in the NHM&E DS.

Be sure to review all your locally developed data collection forms to ensure you are gathering all the required National HIV Prevention M&E data variables.

In this chapter we will discuss in detail only those tables and associated modules you will use to enter information specific to PfH.

Agency Information Module

The following tables in the Agency Information Module apply to all interventions including PfH, and should be updated annually under the direction of your NHM&E Implementation Coordinator:

- **Table A:** General Agency Information
- **Table B:** CDC Program Announcement Award Information
- **Table C:** Contractor Information (including any agencies you contract with to implement PfH)

The Agency Information module in the PEMS software describes the infrastructure – including delivery sites, network agencies, and workers (e.g., providers) that will be used to deliver PFH. Correct set-up of this information before program implementation will facilitate entry of client-level data and generation of reports helpful for program M&E and progress reports that are sent to CDC.

Table S: Site Information (Sites sub-module)

Each service delivery site where PfH is delivered should be entered into PEMS. This will allow you to indicate the site where PfH sessions were delivered when client level data are entered into the system.

Table P: Worker Information (Workers sub-module)

The variables in this table are not required. However, use of this table will allow you to identify the number of sessions provided by each provider and what services they planned to provide in their sessions versus what services were actually provided to clients. You can also capture information about the Education level, Prevention Intervention training, and PfH Training and Certification of your providers.

Table N: Network Agencies (Network Agencies sub-module)

The variables in this table are not required. However, use of this table will help you with tracking and verification of referrals made within and outside of your agency. Tracking referrals made is an important objective for PFH M&E, therefore use of this table is recommended.

Program Information Module

The Program Information module in the PEMS software is where information is captured on how you plan to implement PfH, including the target population to be served and activities that you plan to deliver in PFH sessions. Correct set-up of your program planning information for PfH will allow you to use these data for process evaluation.

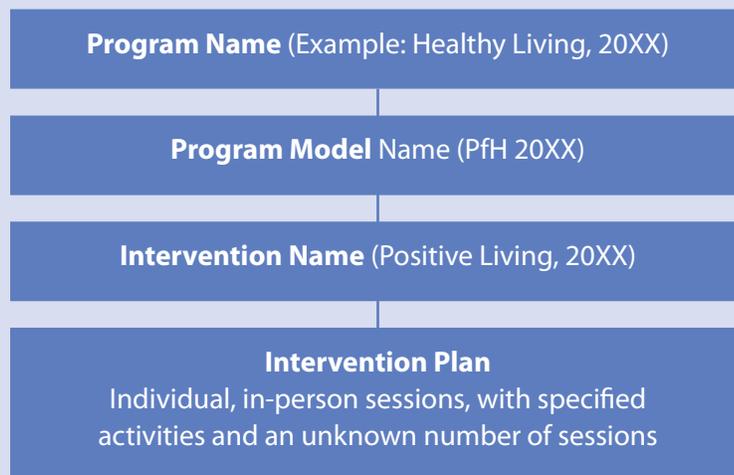
Programs in PEMS are identified in terms of:

- **Table D** - Program Name (the name of the program that has the PfH intervention as a component)
- **Table E** - Program Model (the scientific or operational basis for PfH)
- **Table F** - Intervention Plan (the intervention delivery methods and activities for PfH)



Setting Up Program Models for PFH in PEMS:

Typically, PfH program models are set up for a single target population and funding source. Program planning information for PfH usually includes only sessions that are held between the provider and client. The following diagram shows how PFH is typically set up as a program in PEMS.



However, if you are implementing PFH with two different funding sources, namely CDC and another source, and you would like to track these separately, you can create two separate program models for PFH under each funding stream. For example, PFH-CDC funding and PFH-Other funding source.

Client Level Services Module

The Client Level Services module in PEMS allows you to capture information about recruitment, demographics, and risk profile of your PfH client. You can also capture information about each PfH session, including which provider led the session and activities that were completed in the session. As your client progresses through PfH, you can enter updated risk profiles for your client. Use the following guidance when completing the information from the following data tables in the Client Level Services Module.

Table G1 and G2: (Demographics and Risk Profile sub-modules, respectively)

Demographic information and a risk profile must be entered for every client who participates in PfH. Please note that demographic and risk behavior information may be captured on your client's medical record. This record should be used when entering client information into PEMS.

Table H: (Interventions sub-module)

In this sub-module, the client who has participated in the PfH intervention can be linked to the PfH program, program model, and intervention that you created in the Program Information module. This sub-module allows you to capture client recruitment and intervention characteristics. PEMS will generate a list of the activities you outlined in your program plan and allows you to choose those that were completed. You can also add any activities that were delivered during a session but not included in the original program plan, such as an unplanned referral for your client. If you select activities such as "referral", you will be required to input further details about this activity that took place in the session in order to complete your data entry for the session.



TIPS

Setting Up Session Activities for PFH in PEMS:

PEMS allows you to select activities that you plan to do in a PfH session in the Program Information module, as well as select those activities that were a part of your session in the Client Level Services module. Because National HIV Prevention M&E variables were designed to be used for a variety of HIV prevention interventions, they do not cover all activities that are part of all interventions.

If you wish to capture specific activities that are not part of the existing NHM&E DS, PEMS allows you to define up to 32 local variables and value choices. Data entered into this field may be alphabetic and/or numeric and may be up to 2000 characters. These data can be entered into PEMS at the time you enter information about a session that was delivered to a client.

Obtaining Data from the PEMS Software

Requests can be made to extract specified datasets from a particular PEMS table or set of tables including Table LV (Local Variables) for specified time periods from PEMS. Data extracts from the PEMS database can be opened and viewed in Microsoft Excel. These data should then be imported into a statistical software program like SAS, STATA, or SPSS for further analysis. The PEMS User Manual provides guidance on how to request, download, and view data extracts. Please remember to consult your Technical Assistance Provider for further assistance on how to create and use local variables.

- Pre-defined PEMS reports can be generated on specific data elements that are relevant for PfH M&E such as:
 - The demographic and risk characteristics of PfH clients
 - Details on session activities delivered by providers
 - Details on referrals made by providers and their outcomes

PfH Components Not Captured In PEMS

The following PfH M&E tools have some data that will need to be entered in a database other than PEMS.

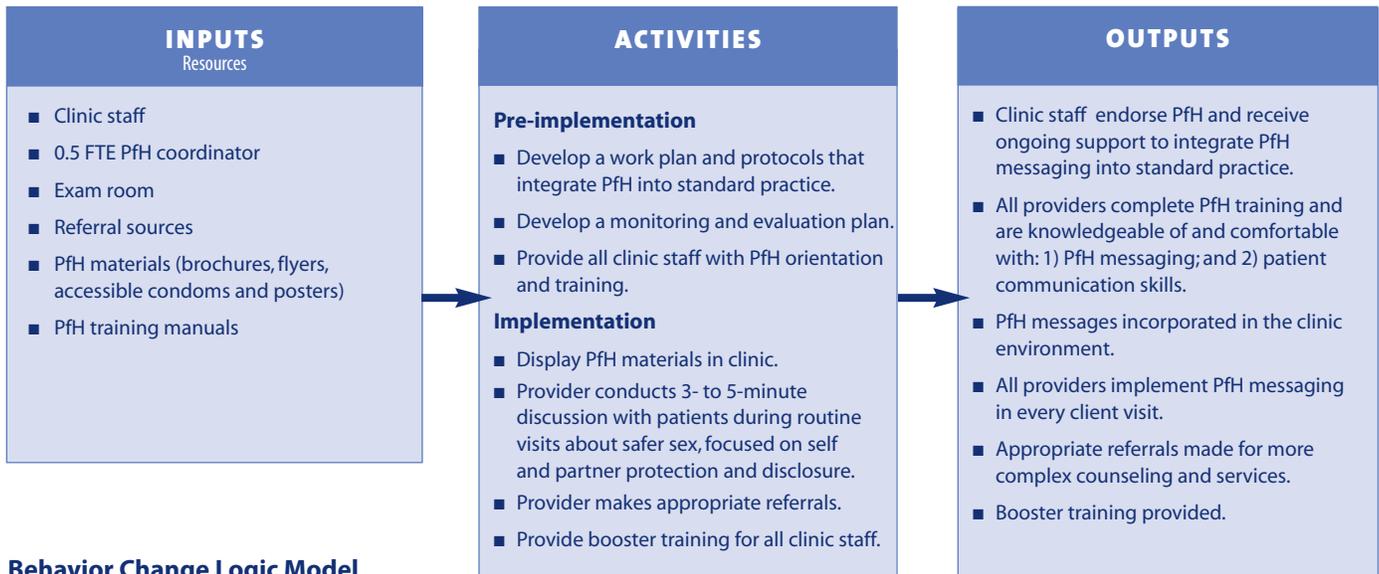
- **Tool 3: The Monitoring and Evaluation Checklist**
- **Tool 4: The PfH Post-Implementation Provider Survey**
- **Tool 5: The Client Survey**

APPENDICES/ TOOLS

APPENDIX A: Monitoring and Evaluation Tools

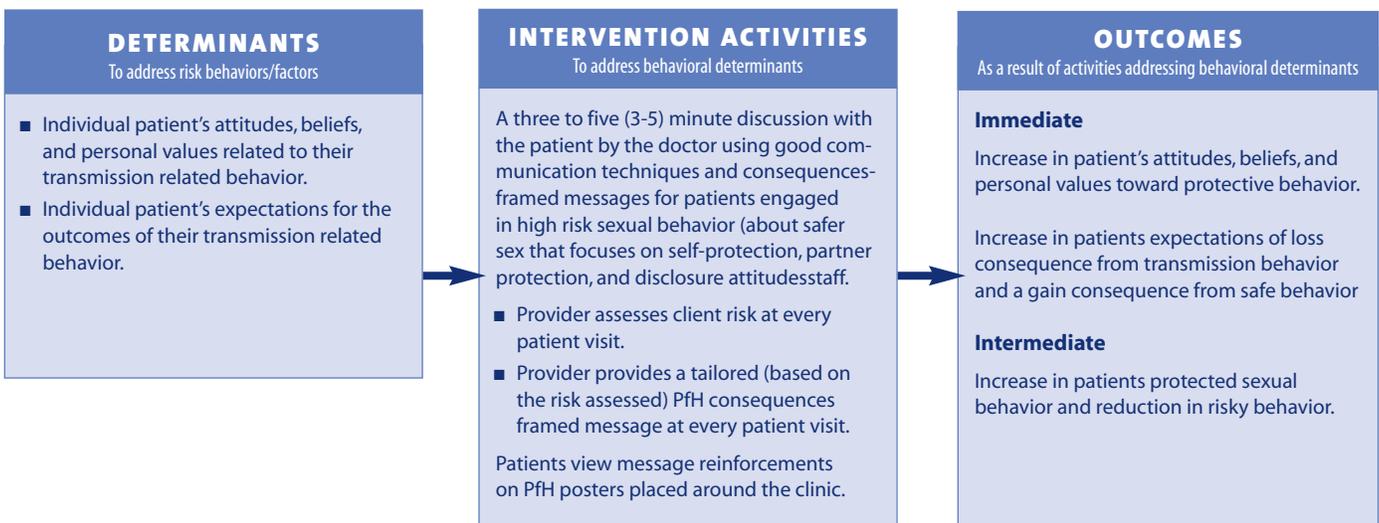
TOOL 1: IMPLEMENTATION SUMMARY SHEET & BEHAVIOR CHANGE LOGIC MODEL

Implementation Summary Sheet



Behavior Change Logic Model

Statement of the Problem for Intervention Purposes Using “Partnership for Health” (PfH)
 Patients being treated for HIV engage in risky behaviors for transmission of HIV. Patients lack of self- and other-protective attitudes towards their risk behavior. Patients lack of authoritative, trusted sources supporting and influencing their behavior toward safety. Tailored prevention messages given by HIV clinicians to their HIV positive patients can reduce risky HIV transmission-related behavior of these patients.



PfH uses a version of cognitive theory known as “message framing theory.” PfH also makes use of “stages of change” theory.

TOOL 2: DATA PLANNING MATRIX

The Data Planning Matrix links your SMART objectives with the broad monitoring and evaluation questions in your monitoring and evaluation (M&E) plan. The matrix can be completed to identify the measures and data sources you will use to assess whether or not you have met your SMART objectives. This Data Planning Matrix has an evaluation approach and the SMART objectives are organized by evaluation stage. It includes suggestions of measures and corresponding data collection tools, most of which are included in the Partnership for Health M&E Field Guide.

DATA PLANNING MATRIX		
SMART Objective	Measure(s)	Data Collection Tool
Process Monitoring Question: Are the appropriate procedures and protocols in place for implementing PfH?		
A. By (date) a 0.5 FTE PfH Coordinator will be hired.	Hired PfH Coordinator	M&E Checklist
B. By (date) and reviewed annually, a work plan and protocols will be developed to integrate PfH messaging and prevention into standard clinic practice.	Completed work plan and protocols	M&E Checklist
C. Throughout the PfH intervention, Waiting and Exam room PfH posters, brochures, and condoms will be displayed throughout the clinic (to be assessed annually).	Displayed posters, brochures, and condoms	M&E Checklist
D. By (date) a PfH monitoring and evaluation plan will be developed (to be reviewed annually).	Completed M&E plan	M&E Checklist
Process Monitoring Question: Are clinic staff appropriately trained?		
E. By (date), 90% of all providers (identify list) will attend a PfH orientation meeting conducted by (identify person/group).	# of providers attending orientation meeting / total # of providers	Training Participation Checklist *
F. By (date), 100% of clinic staff will be trained in the PfH intervention by (identify person/group).	# of clinic staff attending PfH training / total # of clinic staff	Training Participation Checklist *
G. Within four to six weeks after the training, 100% of clinic staff will attend a 1.5 – 2 hour booster training session provided by (identify person/group).	# of clinic staff attending PfH booster training / total # of providers	Training Participation Checklist *
H. Within three months of hire, all (100%) new providers will be trained in the PfH intervention provided by (identify person/group).	# of new providers attending PfH training within three months of hire / total # of new providers	Training Participation Checklist *
I. After the PfH training session, 90% of providers report high levels of knowledge and comfort with patient communication skills (Questions 2-4 on Training Evaluation).	For each question from 2-4 use the following measure: # of providers responding "high" / total # of training participants	Training Evaluation *

DATA PLANNING MATRIX		
SMART Objective	Measure(s)	Data Collection Tool
Process Monitoring Question: Do clinic staff endorse the use of PfH at the clinic?		
J. (By date) 90% of all providers report they felt they received ongoing support from their PfH Coordinator to integrate PfH into their standard practice.	# of providers responding “agree”/ total # of providers surveyed	PfH Post-Implementation Provider Survey
K. (By date) 90% of all providers report that they endorse the use of PfH at their clinic.	# of providers responding “agree”/ total # of providers surveyed	PfH Post-Implementation Provider Survey
Process Evaluation Question: Are providers following the protocol for delivery of PfH?		
L. (By date) 90% of all providers report that they discussed staying safe, protecting partners, and or disclosure of HIV status to partners with “81-100%” of their clients during each PfH counseling session.	# of providers surveyed responding “81-100%” to this question / total # of providers surveyed	PfH Post-Implementation Provider Survey
M. (By date) 90% of all providers report that they worked with “81-100%” of their clients to establish a behavioral goal during each PfH counseling session.	# of providers surveyed responding “81-100%” to this question / total # of providers surveyed	PfH Post-Implementation Provider Survey
N. (By date) 90% of all providers report high levels of comfort with delivering consequences-framed safer sex messages (Question 11) and “advantages-framed safer sex messages (Question 12).	For each question, use the following measure: # of providers surveyed responding “agree” / total # of providers surveyed	PfH Post-Implementation Provider Survey
O. (By date) 90% of all providers report that they provided referrals for clients whose needs required more extensive counseling and services.	# of providers surveyed responding “agree”/ total # of providers surveyed	PfH Post-Implementation Provider Survey
P. (By date), 90% of all providers report that they worked with “81-100%” of their clients to assess their risk behavior during each PfH counseling session	# of providers surveyed responding “81-100%” to this question/total # of providers surveyed	PfH Post-Implementation Provider Survey

DATA PLANNING MATRIX		
SMART Objective	Measure(s)	Data Collection Tool
Process Evaluation Question: Are required quality assurance activities completed?		
Q. During each six month period, 80% of HIV routine visit encounters will have documentation that the PfH intervention was provided.	# of HIV routine visits with documentation of PfH intervention / total # of HIV routine visits	Client Survey (Question 5) OR Medical charts (audit) OR Chart stickers
Outcome Monitoring Question: Are clients reporting an attitude supportive of protective sexual behavior?		
R. (By date) 90% of all clients report an attitude supportive of <ul style="list-style-type: none"> self-protection (Question 8) partner protection (Question 11) and; self-disclosure (Question 10). 	(For each question, use the following measure) # of clients surveyed responding "agree" to this question / total # of clients surveyed	Client Survey
S. (By date) 90% of all clients report that they "agree" with the statement "I believe that my provider and I have a supportive relationship as partners in my HIV care.	# of clients surveyed responding "agree" to this question / total # of clients surveyed	Client Survey
Outcome Monitoring Question: Did clients take specific action toward achieving personal risk reduction goals?		
T. (By date) 90% of all clients report acting on at least one risk reduction activity.	# of clients surveyed responding "agree" to this question / total # of clients surveyed	Client Survey
U. (By date) 90% of all clients report that they feel more comfortable talking about safer sex or using condoms in their sexual relationships.	# of clients surveyed responding "agree" to this question / total # of clients surveyed	Client Survey

* Available in the Partnership for Health Technical Assistance Guide

TOOL 3: MONITORING AND EVALUATION CHECKLIST

Use this checklist to indicate whether or not you have achieved your qualitative SMART objectives. Refer to the sample timeframe so that you can know when to implement the checklist. Please complete a new M&E Checklist annually.

ACTIVITY	DATE COMPLETED	PROGRESS (IF NOT COMPLETE)	COMMENT
Hired a 0.5 FTE PfH Coordinator to provide ongoing support for PfH implementation at clinic			
1st time			
Reviewed after 1 year			
Reviewed after 2 years			
Developed/adapted work plan and protocols to integrate PfH messaging and prevention into standard clinic practice			
1st time			
Reviewed after 1 year			
Reviewed after 2 years			
PfH posters, brochures, and condoms displayed throughout the clinic			
1st time			
Reviewed after 1 year			
Reviewed after 2 years			
Monitoring and evaluation plan developed			
1st time			
Reviewed after 1 year			
Reviewed after 2 years			

TOOL 4: PFH POST-IMPLEMENTATION PROVIDER SURVEY

Survey Tracking Number _____

Please complete this survey as honestly and thoroughly as possible. Your responses will help us to make improvements and changes to Partnership for Health. Thank you for taking the time to complete this survey.

Today's Date _____ / _____ / _____

- 1) Name of clinic where you work most of the time
- 2) What is your gender? M F T
- 3) What is your occupation?: MD RN NP PA
 Pharmacist Case Manager Social Worker Health Educator
 Administration/staff Other _____
- 4) Are you a primary care provider? Yes No
- 5) How long have you been providing care to people living with HIV?
 Less than one year 1 to 2 years 2 to 3 years
 3 to 5 years Longer than 5 years
- 6) Please estimate the total number of patients with HIV (both new and return patients) that you saw during the past 5 working days. _____

Of the clients you saw within the past 5 working days, for what percentage...	0-20% of clients	21-40% of clients	41-60% of clients	61-80% of clients	81-100% of clients	Not applicable
a) ... did you use the Partnership for Health brief counseling approach?						
b) ... did you discuss staying safe, protecting partners, and/or disclosure of HIV status to partners?						
c) ... did you work with clients on setting a behavioral goal?						
d) ... did you assess the need for referrals to other services?						
e) did you asses risk behavior?						

Please Indicate whether you agree or disagree with the following statements

	Agree	Neither agree nor disagree	Disagree	Not applicable
7) Our clinic protocols and policies emphasize HIV prevention.				
8) I endorse the use of Partnership for Health at my clinic.				
9) I feel that I have received ongoing support from the PfH Coordinator to integrate PfH into standard practice.				
10) For all clients coming for a routine appointment, I engage in a 3-5 minute discussion about safer sex (PfH).				
11) I feel comfortable using consequences-framed safer sex messages				
12) I feel comfortable using advantages- framed safer sex messages.				
13) I feel comfortable knowing when to use an advantages-framed or consequences-framed safer sex message with my clients.				
14) I feel comfortable discussing disclosure with my clients.				
15) I provide referrals for clients who require more extensive counseling and services.				
16) I find the Partnership for Health educational materials (brochures, flyers, posters, pocket guides) useful in counseling my clients.				
17) I review the Partnership for Health educational materials with most of my clients.				

18. Please place a checkmark in the box that most accurately describes your feelings about the following statements.

My use of the Partnership for Health counseling intervention assisted my clients to...	Agree	Somewhat helpful	Very helpful	Not Applicable
a) ...set a behavioral safer sex goal				
b) ...reduce their number of sexual partners				
c) ...choose less risky sexual behaviors				
d) ...use condoms				
e) ...talk to their sex partners about their serostatus				
f) ...talk about their risk behavior				

19) To help me better use the Partnership for Health intervention with my clients, I need:
 (consider potential issues like time, comfort level, training, referral needs and client reluctance)

20) What I like most about the Partnership for Health intervention is:

21) What I like least about the Partnership for Health intervention is:
(consider issues like using consequence or advantage framed messaging, time, and effectiveness)

22) Please add any other comments you would like to make related to the Partnership for Health intervention.

TOOL 5: CLIENT SURVEY

Survey Tracking Number _____

Did you come to the clinic today for a regular check up appointment for your HIV or did you come because you felt sick or had an emergency?

___ Regular check-up appointment – **Please continue the survey.**

___ Felt sick or had an emergency – **Please stop here.**

Thank you for your time.

- We would like you to answer some questions on this form about your recent visit(s) to the clinic. Your responses will help us improve our services for you and other clients.
- Your participation is voluntary. If you decide not to participate, it will not affect your care at the clinic.
- Do not put your name on this form. Your answers to these questions will be anonymous; that means no one at the clinic will know you completed this form.
- It will take about 10 minutes for you to answer these questions.
 - 1) How long have you been a client at this clinic?
 - Less than one month
 - One month to one year
 - One to five years
 - More than five years
 - 2) How much time did you spend with your provider today?
 - 0 – 5 minutes
 - 6 – 10 minutes
 - 11 – 15 minutes
 - 16 – 20 minutes
 - More than 20 minutes

3) What type of provider talked with your sexual health today?

- Medical Doctor Registered Nurse
 Nurse Practitioner Physician Assistant Other _____

4) Were you able to get referrals to other services if needed?

- Yes No None needed

5) Today, did your provider talk with you about:

- a. safer sex? Yes No
 b. using condoms? Yes No
 c. talking about your HIV status to sex partners? Yes No
 d. protecting your partner? Yes No
 e. setting a goal to reduce your risk? Yes No
 f. sharing dirty needles? (if you are an injecting drug user) Yes No

	Agree	Neutral/ Not applicable	Disagree
6) I believe that my provider and I have a supportive relationship as partners in my HIV care.			
7) I feel comfortable discussing my sexual behavior with my provider			
8) I feel more comfortable talking about using condoms.			
9) I feel more comfortable talking about safer sex			
10) I feel more comfortable talking about my HIV status to sex partners.			
11) I feel more comfortable talking about protecting my sex partners.			
12) I have acted on at least one risk-reduction goal/activity that my provider and I set.			
13) I feel more comfortable talking about safer sex or using condoms in my sexual relationships.			

14) How satisfied are you with the medical care you have received from this clinic?

- Very satisfied
- Somewhat satisfied
- Somewhat dissatisfied
- Very dissatisfied

15) Do the doctors and nurses treat you in a warm and friendly manner?

- Very warm and friendly
- Moderately warm and friendly
- A little warm and friendly
- Not at all warm and friendly

Please add any other comments you would like to make about your visit to this agency.

∞ THANK YOU FOR COMPLETING THIS SURVEY. ∞

TOOL 6: SAMPLE TIMEFRAME

The Sample Time Frame illustrates key monitoring and evaluation tasks, staff responsibility, and a suggested time commitment required to complete each task.

TASKS	MONTHS													STAFF	
	1	2	3	4	5	6	7	8	9	10	11	12	13		
Develop/adapt work-plan and clinic protocols to integrate PfH	■														PfH evaluation coordinator
Develop M&E plan	■	■													PfH evaluation coordinator, clinical leaders, management staff, providers, supervisors, medical director
Display PfH materials		■													Anyone on evaluation team
Complete M&E checklist		■													PfH Coordinator
Conduct orientation of all clinic staff			■												Prevention Training Center staff
Complete training participation checklist			■	■											PfH evaluation coordinator/clinical leaders/data entry staff
Conduct PfH intervention training and evaluation			■	■											Prevention Training Center staff
Implement PfH				■	■	■	■	■	■	■	■	■	■	■	
Conduct analysis of training evaluation				■	■										PfH evaluation coordinator/clinical leaders/data entry staff
Conduct booster training						■									Prevention Training Center staff
Distribute provider survey									■						PfH evaluation coordinator/clinical leaders/data entry staff
Collect provider survey data and conduct follow up									■	■					PfH evaluation coordinator/clinical leaders/data entry staff
Conduct analysis/interpretation of provider survey									■	■	■				PfH evaluation coordinator/clinical leaders/data entry staff
Conduct client survey									■						PfH evaluation coordinator/clinical leaders/data entry staff
Conduct analysis/interpretation of client survey									■						PfH evaluation coordinator/clinical leaders/data entry staff
Prepare progress report for funders and/or present findings from M&E										■	■	■			PfH evaluation coordinator, clinical leaders, management staff, providers, supervisors, medical director

TOOL 7: DATA ANALYSIS TOOL

This tool is a Microsoft Excel Spreadsheet which summarizes the data variables you will need to collect for local program monitoring and evaluation. Because it is an Excel spreadsheet, **this tool does not lend itself to presentation in this document, and is included in the disk that was provided to you with this document.** Detailed instructions on use of the tool are provided at the top of the document.

The tool is designed to assist you with calculating and aggregating all necessary data for program monitoring and evaluation. The tool describes the information being tracked (Data Element column) and where you can locate the relevant data (Data Source column). Simply enter the specified data value into the “#” column and the tool will automatically populate the “%” column with the appropriate percentage. If you are completing a paper copy of this tool, the “Calculation” column identifies the appropriate numerator and denominator, so you can calculate the percentage yourself.

TOOL 8: NATIONAL HIV PREVENTION M&E DATA FOR PFH

This tool describes the National HIV Prevention M&E variables that are required for data collection and reporting to CDC, as well as optional variables that may be useful for local monitoring and evaluation. It indicates the PEMS software modules where each variable can be found. Use this tool when entering planning and client level data into PEMS for PfH. This tool should be used by any member of staff who does data entry in PEMS for PfH.

PROGRAM INFORMATION

PEMS Software Module and Sub-module	NHM&E DS Variable Number	Variable Name	Guidance
Table D: Program Name - Planning			
Program Information/ Program Details	D01	Program Name	<p>Enter the name your organization uses to identify of the overarching program under which PfH resides. The name you use should be the name your organization uses to identify the program, for example 'Healthy Living' or it may be 'PfH'. The program may be a program with multiple Health Education/Risk Reduction interventions, or PfH may be its own program.</p> <p>It is a good idea to add the year to the Program Name, since programs must be set up annually in PEMS and you'll want to be able to distinguish them easily.</p>
	D02	Community Planning Jurisdiction	Enter the CDC-directly funded state, territory, or city health department Community Planning Jurisdiction in which PfH will be delivered.
	D03	Community Planning Year	Enter the calendar year within the Comprehensive HIV Prevention Community Plan for the Community Planning Jurisdiction that guides how PfH will be implemented. Usually this is the same year in which you begin program implementation.

PEMS Software Module and Sub-module	NHM&E DS Variable Number	Variable Name	Guidance
Table E1: Program Model and Budget – Planning			
Program Information/ Program Model Details	E101	Program Model Name	Enter the name your agency uses for the PfH intervention. It may be the same as the program name you entered or different.
	E102	Evidence Base	In PEMS you choose between Evidence Base (E102), CDC Recommended Guidelines (E103) and Other Basis for Program model (E104). PfH is an Evidence Base Study (E103), because you are implementing PfH without changing or dropping any of the core elements, choose Partnership for Health code 2.01.
	E105	Target Population	Enter the population who are eligible to receive PfH- persons living with HIV/AIDS. You will select this target population from the list of priority populations that have been identified for your community planning jurisdiction. If your eligible population is not represented in this list, you must add that target population through the “Additional Target Populations” sub-module before entering information into the Program Model Details sub-module.
	E107	Program Model Start Date	Enter the start date of the annual funding period for this program model (month and year).
	E108	Program Model End Date	Enter the end date of the annual funding period for this program model (month and year).
	E109	Proposed Annual Budget	Enter the annual budget for PfH using CDC/DHAP funds.

PEMS Software Module and Sub-module	NHM&E DS Variable Number	Variable Name	Guidance
Table F: Intervention Plan Characteristics			
Program Information/ Intervention Details	F01	Intervention Type	This field identifies a type of intervention. Choose Code 06, Health Education/Risk Reduction.
	F02/F02a	Intervention ID/Name	The unique name of the intervention. This name may be PfH or whatever name you use for PfH within your agency. Once entered, PEMS will generate an ID for each intervention name.
	F03	HIV+ Intervention	Choose "yes" because the eligible population for the PfH intervention is exclusively persons living with HIV/AIDS.
	F04	Perinatal Intervention	Choose "yes" if your eligible population for this PfH intervention is exclusively pregnant women. Otherwise, choose "no".
	F05	Total Number of Clients	Enter the total number of clients you plan to reach with the PfH intervention during the program year.
	F06	Sub-Total Target Population	For each target population you identified in E105, indicate the number of persons in that target population you intend to reach. The numbers you enter for the target populations must add up to the number you entered in E105.
	F07	Planned Number of Cycles	Enter the number of times you plan to deliver the complete PfH intervention over the program model period. "Ongoing" is the most common entry for PfH because PfH may be delivered continuously through the program model period.
	F08	Number of Sessions	Because the number of PfH sessions that a client will receive will be determined upon client service delivery, choose "unknown".
	F09	Unit of Delivery	This variable describes how clients are grouped and the intervention delivered during each session. PfH is designed to be delivered to one person at a time. Choose "Individual."
	F11	Delivery Method	This variable describes how the intervention is delivered. For PfH, choose "In person" (code 01.00).
	F14	Level of Data Collection	This variable indicates whether individual or aggregate level data will be collected during the PfH session. For PfH, "Individual," code 1 should be selected since you are collecting client-specific information such as a date of birth or risk profile from each of your clients.

PEMS Software Module and Sub-module	NHM&E DS Variable Number	Variable Name	Guidance
Table F: Optional Variables			
Program Information/ Program Details	F10	Activity	<p>PEMS allows you to select some components that you plan to be part of PFH. By including activities in the intervention characteristics you will be able to compare what you planned with what actually happens.</p> <p>The following activities could be included:</p> <p>Code 04.00, Referral; Code 05.00 Personalized risk assessment; Code 11.12 Living with HIV/AIDS; Code 11.07 HIV medication therapy adherence; Code 11.05 Discussion-Disclosure of HIV status; Code 09.01; Demonstration – Condom use; Code 13.01 Distribution-Male Condoms; Code 13.07 Distribution-Referral Lists; Code 11.15 Discussion-availability of social services; Code 88 – Other (specify)</p> <p>Note: Review the full list in the NHM&E DS to determine which activities should be included.</p>
	F15	Duration of Intervention Cycle	<p>If you chose “ongoing” for F07 (Planned Number of Cycles), this variable is not applicable.</p>

CLIENT INFORMATION

PEMS Software Module and Sub-module	NHM&E DS Variable Number	Variable Name	Guidance	
Table G1: Client Characteristics - Demographics				
Client Level Services/ Interventions	G101	Date Collected	Enter the date you collected client demographic data	
	G102	PEMS Client Unique Key	PEMS automatically generates a unique ID for each client that is new to PfH. Once the ID is generated it does not need to be generated again in order to enter data related to subsequent PfH sessions that the client participates in. If you use locally generated IDs you can enter them as well (optional variable G103.)	
	G112	Date of Birth-Year	Enter the year in which the client was born. Note that there are optional variables for the client’s day and month of birth.	
	G114	Ethnicity	Enter the client’s self report of whether they are of Hispanic or Latino origin, using standard OMB codes.	
	G116	Race	Enter the client’s self-reported race, using standard OMB race codes for the value choices. More than one value can be selected.	
	G120	State/Territory of Residence	Enter the state, territory, or district where the client is living at the time of intake.	
	G123	Assigned Sex at Birth	Enter the biological sex assigned to the client at birth (i.e. noted on the birth certificate).	
	G124	Current Gender Identity	Enter the client’s self-reported gender identity.	
	Optional Variables			
	G103	Local Client Unique Key	You may use this field to enter client IDs you generate and utilize locally.	
	G105 G106 G107 G108 G109	Last Name First Name Middle Initial Nick Name Aliases	You may use these fields to enter the client’s name or nick name, to more readily identify the client.	
	G110	Date of Birth - Month	Enter the calendar month in which the client was born.	
	G111	Date of Birth-Day	Enter the calendar day in which the client was born	
	G 128 – G 136	Locating Information	These variables can be used to capture the current address and phone number of the client.	

PEMS Software Module and Sub-module	NHM&E DS Variable Number	Variable Name	Guidance
Table G2: Client Characteristics – Risk Profile			
Client Level Services/ Risk Profile	G200	Date Collected	Enter the date client risk profile data are collected.
	G204	Previous HIV Test	Enter the client’s self report of his/her HIV test before the day the risk profile data were collected.
	G205	Self Reported HIV Test Result	This variable captures the client’s self reported HIV test result from his/her most recent HIV test, which should be positive- Code 01, since PfH targets HIV positive clients.
	G208	In HIV Medical Care/Treatment (only if HIV+)	If a client reports having tested HIV positive, his/her self-report of whether or not he/she is receiving HIV medical care and treatment. Choose Yes- Code 1 if the client reports that he/she is currently receiving medical care/treatment for HIV/AIDS.
	G209	Pregnant (only if female)	For female clients who have tested HIV positive, this variable captures her self reported pregnancy status.
	G210	In Prenatal Care (only if pregnant)	If a woman is pregnant and HIV positive, her self-report of whether she is receiving regular health care during pregnancy.
	G211	Client Risk Factors	You should select all of the activities the client has been involved in during the last year that could potentially put him/her at risk for HIV exposure and/or transmission. These include: injection drug use, sex with transgender, sex with female, sex with male, no risk identified, not asked, refused to answer, other (specify).
	G212	Additional Client Risk Factors	If a client’s risk factors include sexual activity, this variable allows for the entry of additional risk factors that can further describe the client’s sexual risk for HIV exposure. There are 12 values to choose from.
	G213	Recent STD (Not HIV)	This variable captures the client’s self-reported or laboratory confirmed status of having been diagnosed with syphilis, gonorrhea or Chlamydia.

PEMS Software Module and Sub-module	NHM&E DS Variable Number	Variable Name	Guidance
Table G: Optional Variables			
Client Level Services/ Risk Profile	G201	Incarcerated	This variable captures whether or not the client is or has been imprisoned (in jail or a penitentiary) in 12 months prior to data collection.
	G202	Sex Worker	This variable indicates whether the client derived some or part of his/her income from engaging in sexual intercourse in the 12 months prior to data collection.
	G203	Housing Status	This variable captures the client's housing status in the 12 months prior to data collection.
	G207	Date of First HIV Positive Test (only if HIV positive)	This variable captures the self-reported date of the client's first positive HIV test
	G210a	Local Recall Period	The default recall period (time that a client is asked to recall his/her risk behaviors) is 12 months. If you use a different recall period locally, you can indicate that period here and capture all of the risk indicators for both the default and local recall periods.
	G214	Injection Drugs/ Substances	This variable allows you to indicate which drugs/substances the client reports having injected during the recall period.

CLIENT SESSION INFORMATION

PEMS Software Module and Sub-module	NHM&E DS Variable Number	Variable Name	Guidance
Table H: Client Intervention Characteristics			
Client Level Services/ Interventions	H01/H01a	Intervention ID/Name	Select the intervention name that you created for PfH in the Program Information module (F02a/F02, Intervention Name/ID)
	H03	Cycle	Because PfH has an “unknown” number of sessions, do not complete this variable.
	H05	Session Number	Indicate the session number within a particular cycle about which data are being entered for the client.
	H06	Session Date – Month/Day/Year	Enter the date in which the session was delivered to the client.
	H10	Site Name/ID	Enter the official name of your agency’s site where PfH was delivered.
	H13	Recruitment Source	This variable allows you to track how clients become aware of and/or entered into the PFH intervention, including an agency referral (internal or external) etc.
	H18	Recruitment Source- Service/ Intervention Type	If the client came to you via agency referral, this variable allows you to indicate the type of intervention the client was referred from, such as counseling and testing, outreach, etc.
	H20	Activity	This variable (system required for CPMS users) allows you to capture the activities in which the client participated, and compare the activities provided to those planned. In addition to choosing from planned activities, you can choose activities which were provided but not planned to be delivered. You may choose to select “not collected” if you do not capture this type of information.
	H21	Incentive Provided	This variable captures whether the client received any type of compensation for his/her time and participation in the session.
	H22	Unit of Delivery	This variable captures whether the session was provided to one person at a time, to a couple or to a group. For PfH, the code 01, “Individual” should be selected.
H23	Delivery Method	This variable captures how the session was delivered. For PfH, Code 01.00, “In Person” should be selected. Additional modes of delivery can also be selected.	

PEMS Software Module and Sub-module	NHM&E DS Variable Number	Variable Name	Guidance
Table H: Optional Variables			
Client Level Services/ Interventions	H02	Intended Number of Sessions	This variable should be entered at the first PfH session. Enter the total number of sessions intended for this cycle of PfH depending on the needs of the client. Alternatively you can indicate that this number is "unknown."
	H109	Worker ID	This variable allows you to choose from a list of workers to indicate the provider who delivered the PfH session. Workers must be entered into the Agency Information module, Workers sub-module, to appear on the list. If you complete this variable you will be able to run reports by provider on how PfH is being implemented.
	LV	Local Variables	<p>Local Variables can be defined by each agency to capture client or session information not otherwise captured in PEMS. These variables are not entered as part of the program plan, but are captured at the time session information is recorded. You can decide what values are stored in these variables and how often these variables should be collected and entered in PEMS. Data can be extracted from Table LV.</p> <p>For PfH, local variables could be used to capture information about the following:</p> <ul style="list-style-type: none"> • Record of attainment of X(#) of risk-reduction goals outlined • Record of clients reporting an attitude that is supportive of self and partner protection as well as self-disclosure • Record of client acting on at least one risk reduction goal • Record of client’s comfort level with talking about safer sex or using condoms in their sexual relationships <p>Information entered into the local variable fields may be alphabetic and/or numeric and may be up to 2000 characters per Local Variable.</p>

PEMS Software Module and Sub-module	NHM&E DS Variable Number	Variable Name	Guidance
Table X7: Referral			
Client Level Services/ Referrals	X702	Referral Date	Enter the date on which the referral was made for the client, typically the date of the PfH session.
	X703	Referral Service Type	Select the service to which the client was referred. Internal or external referrals to other DEBs or medical and social services are tracked here.
	X706	Referral Outcome	This variable captures the status of the referral and can be updated as more information is gathered. The system will automatically change the outcome to “lost to follow up” if the referral status is “pending” for more than 60 days after the referral date.
	X710	Referral Close Date	Enter the date when the outcome of the referral was confirmed or lost to follow-up. The system will automatically close the referral 60 days after the referral date.
	Optional Variables		
	X701 or X701a	PEMS Referral Code or Local Referral Code	The PEMS system can be used to generate a unique referral code that will help to track internal client referrals and referrals to other agencies. This code facilitates tracking the outcome of the referral. A local referral code may also be used.
	X705	Referral Follow-up	This variable captures the method that will be used to verify that the client accessed the services that he or she was referred to. It may be an active or passive referral, or there may be no plan to follow-up on the referral. In this case you should choose “none”. If “none” is selected the reason for no follow-up on the referral should be recorded in the Referral Notes section: X711.

APPENDIX B:

2008 National HIV Prevention Program Monitoring and Evaluation Data Set (NHM&E DS) Variable Requirements

This document provides a summary of the variable requirements for the January 1 and July 1, 2008 data collection periods, excluding variable requirements for HIV Testing and Partner Counseling and Referral Services (PCRS). HIV Testing variable requirements are currently specified in the HIV Testing Form and Variables Manual and the CDC HIV Testing Variables Data Dictionary. Requirements for PCRS will be released later in 2008. Since this document only provides a summary of the requirements, please refer to the PEMS DVS for a more detailed description of definitions and value choices.

Evaluation Findings	Variable Name	HD & CBO Reported Required
GENERAL AGENCY INFORMATION (TABLE A)		
A01	Agency Name	Required
A01a	PEMS Agency ID	Required
A02	Community Plan Jurisdiction	Required
A03	Employer Identification Number (EIN)	Required
A04	Street Address 1	Required
A06	City	Required
A08	State	Required
A09	Zip Code	Required
A10	Agency Website	Required
A11	Agency DUNS Number	Required
A12	Agency Type	Required
A13	Faith-based	Required
A14	Race/Ethnicity Minority Focused	Required
A18	Directly Funded Agency	Required
A21	Agency Contact Last Name	Required

(Continued on the next page)

Evaluation Findings	Variable Name	HD & CBO Reported Required
A22	Agency Contact First Name	Required
A23	Agency Contact Title	Required
A24	Agency Contact Phone	Required
A25	Agency Contact Fax	Required
A26	Agency Contact Email	Required

CDC PROGRAM ANNOUNCEMENT AWARD INFORMATION (TABLE B)

B01	CDC HIV Prevention PA Number	Required
B02	CDC HIV Prevention PA Budget Start Date	Required
B03	CDC HIV Prevention PA Budget End Date	Required
B04	CDC HIV Prevention PA Award Number	Required
B06	Total CDC HIV Prevention Award Amount	Required
B06a	Annual CDC HIV Prevention Award Amount Expended	Required
B07	Amount Allocated for Community Planning	Required
B08	Amount Allocated for Prevention Services	Required
B09	Amount Allocated for Evaluation	Required
B10	Amount Allocated for Capacity Building	Required

CONTRACTOR INFORMATION (TABLE C)

C01	Agency Name	Required
C04	City	Required
C06	State	Required
C07	Zip Code	Required
C13	Employer Identification Number (EIN)	Required
C14	DUNS Number	Required

(Continued on the next page)

Evaluation Findings	Variable Name	HD & CBO Reported Required
C15	Agency Type	Required
C16	Agency Activities	Required
C17	Faith-based	Required
C18	Race/Ethnicity Minority Focused	Required
C19	Contract Start Date-Month	Required
C20	Contract Start Date-Year	Required
C21	Contract End Date- Month	Required
C22	Contract End Date- Year	Required
C23	Total Contract Amount Awarded	Required
C25	CDC HIV Prevention Program Announcement Number	Required
C26	CDC HIV Prevention PA Budget Start Date	Required
C27	CDC HIV Prevention PA Budget End Date	Required
SITE INFORMATION (TABLE S)		
S01	Site ID	Required
S03	Site Name	Required
S04	Site Type	Required
S08	County	Required
S09	State	Required
S10	Zip Code	Required
S16	Use of Mobile Unit	Required
PROGRAM NAME - PLANNING (TABLE D)		
D01	Program Name	Required
D02	Community Planning Jurisdiction	Required
D03	Community Planning Year	Required

(Continued on the next page)

Evaluation Findings	Variable Name	HD & CBO Reported Required
PROGRAM MODEL AND BUDGET - PLANNING (TABLE E1)		
E101	Program Model Name	Required
E102	Evidence Base	Required
E103	CDC Recommended Guidelines	Required
E104	Other Basis for Program Model	Required
E104-1	Specify Other Basis for Program Model	Required
E105	Target Population	Required
E107	Program Model Start Date	Required
E108	Program Model End Date	Required
E109	Proposed Annual Budget	Required
INTERVENTION PLAN CHARACTERISTICS (TABLE F)		
F01	Intervention Type	Required
F02	Intervention ID	Required
F02a	Intervention Name	Required
F03	HIV+ Intervention	Required
F04	Perinatal Intervention	Required
F05	Total Number of Clients	Required
F06	Sub-Total Target Population	Required
F07	Planned Number of Cycles	Required
F08	Number of Sessions	Required
F09	Unit of Delivery	Required
F11	Delivery Method	Required
F14	Level of Data Collection	Required

(Continued on the next page)

Evaluation Findings	Variable Name	HD & CBO Reported Required
CLIENT CHARACTERISTICS (TABLE G)		
G101	Date Collected	Required
G102	PEMS Client Unique Key	Required
G112	Date of Birth - Year	Required
G113	Calculated Age (System Generated)	Required
G114	Ethnicity	Required
G116	Race	Required
G120	State/Territory of Residence	Required
G123	Assigned Sex at Birth	Required
G124	Current Gender	Required
G200	Date Collected	Required
G204	Previous HIV Test	Required
G205	Self Reported HIV Test Result	Required
G208	In HIV Medical Care/Treatment (only if HIV+)	Required
G209	Pregnant (only if female)	Required
G210	In Prenatal Care (only if pregnant)	Required
G211	Client Risk Factors ***	Required
G212	Additional Client Risk Factors ^^^	Required
G213	Recent STD (Not HIV)	Required

***Note: The recall period for client risk factors is 12 months.

^^^Note: Additional value choices for risk factors added:

Sex without using a condom

Sharing drug injection equipment

(Continued on the next page)

Evaluation Findings	Variable Name	HD & CBO Reported Required
CLIENT INTERVENTION CHARACTERISTICS (TABLE H)		
H01	Intervention ID	Required
H01a	Intervention Name	Required
H03	Cycle	Required
H04a	Form ID (Counseling & Testing Only)	Required
H05	Session Number	Required
H06	Session Date	Required
H10	Site Name/ID	Required
H13	Recruitment Source	Required
H18	Recruitment Source - Service/Intervention Type	Required
H21	Incentive Provided	Required
H22	Unit of Delivery	Required
H23	Delivery Method	Required
REFERRAL (TABLE X7)		
X702	Referral Date	Required
X702a	Reason Client Not Referred to Medical Care	Required
X703	Referral Service Type	Required
X706	Referral Outcome	Required
X710	Referral Close Date	Required
X712	HIV Test Performed	Required
X713	HIV Test Result	Required
X714	Confirmatory Test	Required
X714a	HIV Test Result Provided	Required

(Continued on the next page)

Evaluation Findings	Variable Name	HD & CBO Reported Required
AGGREGATE HE/RR AND OUTREACH (TABLE AG)		
AG00	Intervention Name/ID	Required
AG01	Session Number	Required
AG02	Date of Event/Session	Required
AG03	Duration of Event/Session	Required
AG04	Number of Client Contacts	Required
AG05a	Delivery Method	Required
AG05c	Incentive Provided	Required
AG06	Site Name/ID	Required
AG08a	Client Primary Risk - MSM	Required
AG08b	Client Primary Risk - IDU	Required
AG08c	Client Primary Risk - MSM/IDU	Required
AG08d	Client Primary Risk - Sex Involving Transgender	Required
AG08e	Client Primary Risk - Heterosexual Contact	Required
AG08f	Client Primary Risk - Other/Risk Not Identified	Required
AG09a	Client Gender - Male	Required
AG09b	Client Gender - Female	Required
AG09c	Client Gender - Transgender MTF	Required
AG09d	Client Gender - Transgender FTM	Required
AG10a	Client Ethnicity - Hispanic or Latino	Required
AG10b	Client Ethnicity - Not Hispanic or Latino	Required

(Continued on the next page)

Evaluation Findings	Variable Name	HD & CBO Reported Required
AG11a	Client Race - American Indian or Alaska Native	Required
AG11b	Client Race - Asian	Required
AG11c	Client Race - Black or African American	Required
AG11d	Client Race - Native Hawaiian or Other Pacific Islander	Required
AG11e	Client Race - White	Required
AG11f	Client Race - Multiracial	Required
AG12a	Client Age - Under 13 years	Required
AG12b	Client Age - 13 - 18 years	Required
AG12c	Client Age - 19-24 years	Required
AG12d	Client Age - 25 - 34 years	Required
AG12e	Client Age - 35 - 44 years	Required
AG12f	Client Age - 45 years and over	Required
AG14a	Materials Distributed - Male Condoms	Required
AG14b	Materials Distributed - Female Condoms	Required
AG14c	Materials Distributed - Bleach or Safer Injection Kits	Required
AG14d	Materials Distributed - Education Materials	Required
AG14e	Materials Distributed - Safe Sex Kits	Required
AG14f	Materials Distributed - Referral list	Required
AG14g	Materials Distributed - Role Model Stories	Required
AG14h	Materials Distributed - Other (specify)	Required
AG15	Aggregate Data Collection Method	Required

(Continued on the next page)

Evaluation Findings	Variable Name	HD & CBO Reported Required
HEALTH COMMUNICATION / PUBLIC INFORMATION (TABLE HC)		
HC01	Intervention Name/ID	Required
HC02	HC/PI Delivery Method	Required
HC05	Event Start Date	Required
HC06	Event End Date	Required
HC07	Total Number of Airings	Required
HC08	Estimated total Exposures	Required
HC09	Number of Materials Distributed	Required
HC10	Total Number of Web Hits	Required
HC11	Total Number of Attendees	Required
HC12	Number of Callers	Required
HC13	Number of Callers Referred	Required
HC14	Distribution - Male condoms	Required
HC15	Distribution - Female condoms	Required
HC16	Distribution - Lubricants	Required
HC17	Distribution - Bleach or Safer Injection Kits	Required
HC18	Distribution - Referral Lists	Required
HC19	Distribution - Safe sex kits	Required
HC20	Distribution - Other	Required
HC21	Site Name/ID	Required

(Continued on the next page)

Evaluation Findings	Variable Name	HD & CBO Reported Required
COMMUNITY PLANNING LEVEL (TABLE CP-A/B/C)		
CP-A01	Name of HIV Prevention CPG	HD only
CP-A02	Community Plan Year	HD only
CP-B01	Priority Population	HD only
CP-B02	Rank	HD only
CP-B03	Age	HD only
CP-B04	Gender	HD only
CP-B05	Ethnicity	HD only
CP-B06	Race	HD only
CP-B07	HIV Status	HD only
CP-B08	Geo Location	HD only
CP-B09	Transmission Risk	HD only
CP-C01	Name of the Prevention Activity/Intervention	HD only
CP-C02	Prevention Activity/Intervention Type	HD only
CP-C04	Evidence Based	HD only
CP-C05	CDC Recommended Guidelines	HD only
CP-C06	Other Basis for Intervention	HD only
CP-C07	Activity	HD only

APPENDIX C: References

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