DEFINITIONS

This chapter defines the PANCEA interventions and then many terms used in the manual (and data collection instruments).

The PANCEA interventions

PANCEA studies eight types of interventions that provide HIV prevention benefits. The interventions are defined by the services delivered or the populations reached. The intervention may consist of all activity based at a facility. Often, however, it will represent only a subset of the HIV prevention activities based at that facility. The intervention may also be based at a facility providing services unrelated to HIV prevention. An example would be a district hospital that performs general clinical care and also conducts voluntary counseling and testing (VCT). An intervention may be implemented at multiple sites under the same “facility”. Some PANCEA instruments such as the “ADC” and “HIPPI” focus almost exclusively on data about the intervention. Others such as ARQni gather both facility-level and intervention-level data.

Interventions typically based in clinical settings

MTCT interventions
Mother-to-child-transmission interventions counsel and test pregnant women for HIV, and offer antiretroviral medications (ARVs; often nevirapine) to prevent HIV transmission to the infant. They sometimes also provide substitute feeding programs to prevent transmission via breast feeding.¹

Sexually transmitted infection interventions provide diagnosis and treatment for STIs (other than HIV). Although they do not prevent or treat HIV directly, these programs help prevent the spread of HIV since individuals with STIs acquire and transmit HIV more readily. These programs may also teach individuals safer sex practices, and offer condoms.

VCT
Voluntary counseling and testing interventions provide HIV testing as well as pre- and post-test counseling to prepare people for the HIV test and to educate them about how HIV is spread, encourage safer practices, and explain treatment options to those who are HIV+.

¹ Some programs also provide long-term ARV therapy to the mother and possibly the father as well. These programs are often called “MTCT-plus”. Our focus would be on the MTCT portion of such a program.
**Interventions typically based in non-clinical settings**

IEC (mass media)  
Information, education, and communication campaigns use mass electronic and print media to spread information about HIV and risk reduction practices.

CSM  
Condom social marketing programs market condoms through traditional retail channels. They typically include a focused IEC effort as well.

SW interventions  
Sex worker interventions conduct outreach and provide other services to sex workers. Services are varied and may include counseling or outreach (often from SW peers), condoms, and STI and HIV diagnosis, treatment or referral.

IDU or Harm reduction  
Interventions targeted to injection drug users aim to reduce risky behavior, like needle-sharing. These interventions typically educate intravenous drug users about safer practices (risk reduction) and in some countries conduct needle exchange programs or bleach distribution. IDU programs often include counseling and drug treatment/referral.

Schools-based interventions  
Schools programs undertake development, training, and implementation of classroom curricula to educate students about HIV and safer sex practices.

**Definitions of terms in manual and instruments**

Following is an alphabetical listing of definitions.

**Antiretrovirals (ARVs)**  
Medications that reduce the rate at which HIV replicates. The three broad classes of ARVs are nucleoside reverse transcriptase inhibitors (NRTI), non-nucleoside reverse transcriptase inhibitors (NNRTI), and protease inhibitors (PI). They are used, often in combination, for ongoing therapy in adults. More directly relevant for PANCEA, ARVs are used in the MTCT intervention to prevent HIV transmission from mother to child. Nevirapine is the drug most commonly used for MTCT prevention; it is provided as a single dose to mother at the onset of labor and a dose to the infant within 72 hours of birth.
Buildings
The physical space in which the intervention operates. The intervention could use an entire building, if it is the sole tenant. More commonly it uses just some rooms specifically allocated for (or shared by) the intervention. For buildings that are shared, our allocations rely mainly on number of personnel working in the intervention versus in the building. (This does not include classroom space in the case of schools programs, since this space is not allotted only to the intervention.)

Capital expenditures
Money spent to acquire or upgrade physical assets such as buildings and machinery; the cost of long-term assets or improvements. For our purposes, a capital expenditure item must exceed $100 or last longer than one year; otherwise it should usually be included in “Recurrent goods” (See also “large equipment”).

Cost-effectiveness
Cost per health outcome, e.g., cost per HIV infection averted. (See “Efficiency” below).

Economic cost
For our purposes: the true market value of a resource. In other words, how much the intervention would expect to pay for resources (e.g. staff time, or equipment) on the open market if they were not donated or subsidized. We are most interested in economic costs, because they best capture the true costs of scaling up sustainable prevention efforts. (See also “financial cost” and “market costing”).

Efficiency
The cost per unit of output (SW counseled). Data collection in PANCEA is concerned with outputs. Hence efficiency could be thought of as, for example, the cost per person receiving VCT; the cost per person receiving an STI diagnosis, or the cost per student receiving a school-based HIV prevention curriculum. This is also sometimes termed a cost-effectiveness ratio. See also “Cost-effectiveness” and the manual chapter Outputs, Costs, Efficiency and the Determinants of Efficiency.

Entire facility
The largest natural grouping of services at the site, e.g., all components of a district hospital. Where possible, we want to identify and assess only a smaller subunit in which the PANCEA intervention is based, and for which cost and output data are readily separable from the entire facility. (See “Facility” below).

Essential output
The output(s) that best capture the key services produced by an intervention, especially those most closely related to HIV risk reduction. For example, number of STIs diagnosed (and treated), or number of SW contacts, or number of HIV+ individuals receiving VCT results.
The organizational unit in which the management of one or more PANCEA intervention programs occurs. "Facility" for our purposes need not be the “Entire facility”. In fact it should be a smaller subunit if our intervention(s) reside(s) within it and if there are expenditure data available to look separately at the subunit. This will help the econometrics and reduce data collection needs. For example, if VCT activities (including lab) occur entirely in the outpatient service, and there are expenditure and output data for the outpatient service, the "facility" should be the outpatient service only, excluding inpatient services. But if the outpatient service is integrated into the entire facility (e.g., shared personnel, shared lab), then the subunit strategy won't work and the "Facility" is the entire hospital, in this case a hospital. Thus, the facility is the subunit if one exists, otherwise the “Entire facility”.

The actual cost incurred by the intervention. In other words, how much the intervention had to pay for resources. If the item was subsidized or donated this will be less than the true market cost (also called “economic cost”). We want to know financial costs, but are ultimately most interested in economic costs because they best capture the true costs of scaling up sustainable prevention efforts. (See also “Economic Cost”).

The regular 12-month period constituting an intervention’s financial cycle. This may coincide with the calendar year, but often does not. For example, FY 1998 may be the period from July 1, 2000 – June 30, 2001. The most recent fiscal year is the one most recently completed with essentially complete financial and output data.

Expenditures which do not change over a wide range of outputs, such as capital assets including buildings, vehicles, and office equipment. For example, if the number of condoms sold by a CSM program increased from 10,000 to 100,000 per month, it could probably stay in the same office, and its rent costs are therefore “fixed” over this large range in outputs.

Fluctuations are significant changes in costs, outputs, or efficiency (cost per unit output) over a defined period of time. Both the ARQ intervention instruments and HIPPI-II ask about variations of 20% or more between months or quarters. Understanding what causes these variations or the lack of variation will help PANCEA understand what determines efficiency in a given program.
A guiding concept in PANCEA. By *forest* we mean data that largely establish our understanding of prevention efficiency or its determinants. By *trees* we mean details that don’t contribute much to our understanding of these outcomes. The most important “forest” items are outputs, particularly those labeled “essential,” such as the number of clients receiving post-test counseling in a VCT program, or the number of condoms sold in a CSM program. Data collectors should spend whatever time and energy necessary to get these essential outputs. Another forest item is large expenditures for key inputs. By contrast, the exact job title or bonus of a single staff member is a “tree” issue. These concepts are central to sound and manageable data collection. We urge you to carefully review the “Forest and Trees” section of this manual.

**Forest and trees**

The level of output originally planned for an intervention and which can be reached without major increases in fixed costs. See also “Maximum Capacity.”

**Full capacity**

The type and manner of control and authority over the operations ad policies of an intervention or facility.

**Governance**

Multiple outputs from the same input. For example, multiple activities (HIV counseling and nursing care) provided by the same staff. We attempt to explicitly allocate these inputs across interventions (e.g., % time on each), and also address this issue analytically with econometrics. (See also “Percent allocation.”)

**Joint products**

A type of capital expenditure. See “capital expenditures”.

**Large equipment**

A technique to estimate the market or economic cost of an item. We are collecting data to conduct market costing for some items; see the “Costing Techniques” section of this manual. See also “Economic cost” and “Financial cost”.

**Market costing**

Current circumstances such as limitations on funding may determine the maximum capacity attainable at a particular time. For example, a program may be unable to go beyond its current level of output unless it receives new money to train additional teachers in a school-based HIV prevention education program. In that case it has reached its current maximum capacity. This program may not yet have reached its “Full capacity” (see also) which is the level of output it can reach without having to increased its fixed cost.

**Maximum capacity (current)**
Ultimately, HIV prevention programs aim to reduce the number of people who become infected with HIV and thus improve their longevity and health. HIV infections averted is the health outcome of interest to PANCEA. Distributing condoms, providing HIV sero-testing, and broadcasting prevention messages on the radio, are the program “outputs” that are a means to achieving the health outcomes.

**Outcomes**

The services that a program produces, such as condoms sold; HIV tests administered; or HIV prevention messages broadcast on the radio. These are different from “outcomes”. (See also “Essential output” and Outcomes).

**Outputs**

The services that a program produces, such as condoms sold; HIV tests administered; or HIV prevention messages broadcast on the radio. These are different from “outcomes”. (See also “Essential output” and Outcomes.)

**Percent (%) allocation**

The percentage of a resource (space, person, piece of equipment, etc.) used for the intervention(s) we are assessing, as opposed to other activities in the facility or site. Consider an STI program in a hospital setting. A lab technician spends about 20% of her time on STI-related tests. The % allocation to the intervention would thus be 20%. If 35% of a vehicle’s kilometers driven are for field-based STI screening, 35% of its associated capital and recurring costs would be allocated to STI. Similarly, if 20% of training activities focus on improving skills for making syndromic STI diagnoses, 20% of training would be allocated to STI. (See also “Joint products.”)

**Per diem**

Payments made to individual personnel or to outside consultants to defray extra work-related costs which they would otherwise have to pay out-of-pocket. Per diems are usually paid on a set basis rather than to reimburse actual expenditures. For example, a flat amount may be paid for each day of travel, regardless of what the actual lodging and food costs may have been.

**Personnel**

Any staff who work for the intervention, either full- or part-time, whether paid or volunteer. This includes not only direct service providers such as counselors and medical staff, but also those who indirectly support the intervention such as receptionists, janitors, and cooks. It also include any consultants that were utilized on a temporary basis. (However if the cost of consulting is reported in Recurrent Services, it should not be reported in Personnel, as that would be double-counting.)

**Quarter**

There are four quarters in each year. Quarter 1 = January, February, and March. Quarter 2 = April, May, and June. Quarter 3 = July, August, and September. Quarter 4 = October, November, and December.
**Recurrent expenses**
Expenditures that usually occur on a regular or continuous basis. PANCEA distinguishes between recurrent “goods” and recurrent “services”. The ARQ and the ADC have a recurrent expenses sheet for each. Ongoing personnel costs fit the definition of recurrent services. However, because they are such a large and important component, they are treated in separate “personnel” sheets. Similarly, rent and mortgage payments are considered part of “Building” expenses. They are covered in the “Building” sheet rather than in the recurrent expenses sheets.

**Recurrent expenses – goods**
Recurrent expenditures for goods refers to outlays for physical items that get used up or must otherwise be replenished on a regular or continuous basis. Examples are condoms, syringes, HIV test kits and office supplies.

**Recurrent expenses – services**
Recurrent expenditures for goods refers to outlays for physical items, and are provided with help from some outside facility or person. For PANCEA purposes, examples include staff training workshops; radio air time; and other mass media or IEC production. It also includes utilities such as electricity, water and waste disposal. As noted above, however, it does not include rent or mortgage as these are captured in the “Buildings” sheet.

**Resource**
Any input used to deliver the intervention. This includes staff (personnel), buildings or space, equipment, supplies, etc.

**Site**
Usually used as synonymous with “facility.” However, if the location where intervention services are delivered (e.g., the van that hands out condoms or does needle exchange, the schools in which HIV/AIDS education is offered, the street where outreach workers contact SWs, the clinic where counseling and testing is done, etc.) is separate from the facility, it can be referred to as the site. If in doubt, check with the PANCEA SF team.

**Scaling up**
The process of a program moving from the start-up period to full capacity; and the process of adding additional sites after the first has reached full capacity.

**Subunit**
The smallest natural grouping of services in which our intervention(s) operate; requires operations, outputs and expenditures data that are predominantly separate from the entire facility. (See, “Facility” and “Entire facility”, and see also the “Facility expenses” section of the ARQni manual chapter.)
Volunteer

Person who works without pay (may get incentives like lunches, transport). “Integral” volunteers, such as an SW peer educator, are volunteers who could not fulfill her function unless they were volunteers. “Non-integral” volunteers could in theory be replaced by paid workers. See the “Costing Techniques” chapter of the manual for further discussion and wording to distinguish types of volunteers.