Core Indicators
For
Monitoring & Evaluation

National AIDS Control Programme
Phase III

National AIDS Control Organization
Ministry of Health and Family Welfare
Government of India

August 2007
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Foreword

National AIDS Control Program in phase-III is committed to the Millennium Development Goal of halting and reversing the HIV epidemic in India. The program addresses multiple aspects associated with HIV/AIDS including the transmission, identification, treatment to addressing stigma and discrimination, rights. The program encourages participation of partners and stakeholders within the agree upon framework on “Three Ones”.

To monitor and track such comprehensive program is a challenge. While National AIDS Control Organization is committed to strengthen the Me&E systems country wide, having one set of key indicators to track the progress becomes essential. To ensure results are achieved, as envisaged in the NACP-III plan, it is important to track all aspects of the program and have related indicators in place. To have a uniform understanding of each indicator there is need that the definition. Source/collection mechanisms, method of calculation, purpose and proposed use are clearly laid down.

As the program is implemented and responds to the community needs, there might be a need for change. This handbook is thus a working document and indicators might get refined/modified as more and more data sources are available and strengthened. An attempt has been made to keep the indicators at par with the global indicators relevant for the country needs.

I take this opportunity to acknowledge the contribution made by the UNAIDS supported interagency Me&E Technical Working Group; particularly Dr. Dora Warren & Dr. K. Sudhakar - CDC, Mr Gurumurthy Rangayyan- UNAIDS, Ms. Deepali Nath of Clinton Foundation and Mr. Binod Mahanty- WHO & Ms. Virginia Loo, consultant, UNAIDS-India. I would like to specially acknowledge the work done by Dr. Damodar Bachani, Joint Director and Ms. Pradnya Paithankar, Programme Officer (Me&E) from NACO in bringing out these indicator definitions document. I hope these guidelines will help all concerned in achieving high quality strategic information management with clarity on definitions of indicators and it’s use to facilitate achieving the ambitious targets we have set for ourselves under NACP-III.

(K. Sujatha Rao)
# List of Abbreviations

<table>
<thead>
<tr>
<th>Abbreviation</th>
<th>Full Form</th>
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</thead>
<tbody>
<tr>
<td>AHSS</td>
<td>Annual HIV Sentinel Surveillance</td>
</tr>
<tr>
<td>AIDS</td>
<td>Acquired Immunodeficiency Syndrome</td>
</tr>
<tr>
<td>APER</td>
<td>Annual Performance Review</td>
</tr>
<tr>
<td>API</td>
<td>AIDS Programme Effort Index</td>
</tr>
<tr>
<td>ART</td>
<td>Anti Retroviral Therapy</td>
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<tr>
<td>BCC</td>
<td>Behavioral Change Communication</td>
</tr>
<tr>
<td>BSS</td>
<td>Behavioral Surveillance Survey</td>
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<tr>
<td>CBO</td>
<td>Community Based Organization</td>
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<tr>
<td>CMIS</td>
<td>Computerized Management Information System</td>
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<tr>
<td>CSW</td>
<td>Commercial Sex Worker</td>
</tr>
<tr>
<td>DOTS</td>
<td>Directly Observed Therapy Services (for TB diagnosis and treatment)</td>
</tr>
<tr>
<td>EQAS</td>
<td>External Quality Assurance System</td>
</tr>
<tr>
<td>FPMIS</td>
<td>Financial Programme Management Information System</td>
</tr>
<tr>
<td>FSW</td>
<td>Female Sex Worker</td>
</tr>
<tr>
<td>GFATM</td>
<td>Global Fund for AIDS, TB, and Malaria</td>
</tr>
<tr>
<td>HIV</td>
<td>Human Immunodeficiency Virus</td>
</tr>
<tr>
<td>HRG</td>
<td>High Risk Group</td>
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<tr>
<td>IBBS</td>
<td>Integrated Behavioral &amp; Biological Survey</td>
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<tr>
<td>ICTC</td>
<td>Integrated Counseling and Testing Center</td>
</tr>
<tr>
<td>IDA</td>
<td>International Development Association</td>
</tr>
<tr>
<td>IEC</td>
<td>Information Education Communication</td>
</tr>
<tr>
<td>IDU</td>
<td>Injecting Drug User</td>
</tr>
<tr>
<td>M&amp;E</td>
<td>Monitoring and Evaluation</td>
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<tr>
<td>MIS</td>
<td>Management Information System</td>
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<tr>
<td>MSM</td>
<td>Men having Sex with Men</td>
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<td>NACO</td>
<td>National AIDS Control Organization</td>
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<td>NACP</td>
<td>National AIDS Control Programme</td>
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<td>NGO</td>
<td>Non Governmental Organization</td>
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<tr>
<td>NRP</td>
<td>Non Regular Partner</td>
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<tr>
<td>Abbreviation</td>
<td>Full Form</td>
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<tr>
<td>--------------</td>
<td>---------------------------------------------------------------------------</td>
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<tr>
<td>OI</td>
<td>Opportunistic Infections</td>
</tr>
<tr>
<td>OR</td>
<td>Operations Research</td>
</tr>
<tr>
<td>PEPFAR</td>
<td>The US President’s Emergency Plan for AIDS Relief</td>
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<tr>
<td>PLHA/PLWHA</td>
<td>People Living with HIV/AIDS</td>
</tr>
<tr>
<td>PFMC</td>
<td>Project Finance Management Cell</td>
</tr>
<tr>
<td>PPTCT/PMTCT</td>
<td>Prevention of Parent/Mother to Child Transmission of HIV</td>
</tr>
<tr>
<td>PLWHA</td>
<td>Persons Living With HIV and AIDS</td>
</tr>
<tr>
<td>SACS</td>
<td>State AIDS Control Society</td>
</tr>
<tr>
<td>SIMU</td>
<td>Strategic Information Management Unit</td>
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<tr>
<td>SQA</td>
<td>Service Quality Assessment</td>
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<td>SS</td>
<td>Special Study</td>
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<tr>
<td>STD</td>
<td>Sexually Transmitted Diseases</td>
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<td>STI</td>
<td>Sexually Transmitted Infections</td>
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<tr>
<td>SW</td>
<td>Sex worker</td>
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<tr>
<td>TB</td>
<td>Tuberculosis</td>
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<tr>
<td>TI</td>
<td>Targeted Interventions</td>
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<td>TRG</td>
<td>Technical Resource Group</td>
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<tr>
<td>UNGASS</td>
<td>United National Global Assembly Special Session on HIV/AIDS</td>
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<tr>
<td>UT</td>
<td>Union Territory</td>
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<tr>
<td>VCT</td>
<td>Voluntary Counselling and Testing</td>
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</table>
**INTRODUCTION**

This handbook reviews the core indicators developed for monitoring the achievements and assessing the progress of the National AIDS Control Programme – Phase III (NACP III) of India. The indicators are designed to be used at different levels of programme management and provide standardized measures of performance spanning the multiple objectives of NACP III. The collection, analysis and use of the core indicator data is collectively referred to as **strategic information management**.

The purpose of the indicator handbook is to provide guidance to persons involved in the collection, reporting, and analyses of the core indicator data to ensure consistent, high quality information are available to programmes managers.

**BACKGROUND**

Phase III of the NACP focuses on scaling up interventions to **prevent new infections** as well as the services available to PLHA and their families for **care, support and treatment and impact mitigation**. These efforts build on the progress made in NACP-1 and 2 to develop a comprehensive array of services to control the HIV/AIDS epidemic in India. To support the expansion of services, NACP III calls for the decentralization of programme management to state and district levels and additional resources for **capacity strengthening** and improved use of **strategic information** to ensure the quality and effectiveness of the programme. Together, the achievement of these **four objectives at scale** will stabilize the HIV epidemic in India and prevent a generalized epidemic.

The consistent collection and use of routine monitoring data (i.e. inputs, processes, and outputs), managed via the Computerized Management Information System (CMIS), forms the foundation of the NACP III strategic information system. However, the core indicators also rely on other sources of information: annual quality assessments, behavioural surveillance, sero-surveillance, and other special studies, collected on a periodic basis to measure achievements at the outcome and impact level.

**ABOUT THE DOCUMENT**

The Indicator handbook is organized to provide:

- an overview of the process for developing the core indicators;
- general guidance on collecting and using the core indicators
- the summary list of core indicators
- specific operational definitions and applications for each core indicator

The indicators are organized according to four strategic objectives of NACP-III

The list of core indicators was developed through a consultative process as part of the preparatory phase of NACP III. Inputs were taken from programme managers, SACS M&E officers and Programme Support Units, as well as the M&E working group, a multi-agency committee of M&E experts, convened by NACO. Preliminary lists of indicators were culled together by reviewing the NACP 2 list of core indicators, core indicators recommended by global programmes such as UNGASS, GFATM, and PEPFAR; and taking into consideration new programme components established under NACP III (e.g. Integrated counseling and testing centers; ART; condom programming etc.).

The indicators represent more than data collected by programmes and entered in to a central database. Instead, they draw managers’ attention to a specific, fundamental measure of
performance of a particular programme component. The indicators, particularly those that measure outputs, are chosen such that they trigger further investigation or action if performance is lower than expected or provide reassurances to managers that a programme is meeting an operational standard and functioning properly.

The full list includes indicators for each of the programme components included in NACP III. The routine data collection forms used to collate routine data on inputs, processes, and outputs, may include more data elements than are required to construct the core indicators. This is in part due to innovations and differences in programme operations between states and the interest in having customized data collection formats to meet the management needs of different SACS. Nonetheless, at the national level, a minimum core set of indicators allows fundamental aspects of each programme component to be tracked and provides a basis for comparison across geographic areas.

It is important to note that not all programme components are of equal priority in NACP III at the national level. For this reason, subsets of indicators have been compiled from the full list of core indicators highlighting issues that make the greatest contribution to the overall goal of stemming the HIV epidemic in India (Annual Core Performance Indicators) and those that provide senior managers with a quarterly overview of programme achievements at the SACS level (Dashboard indicators).

Tools and data sources

There are five primary sources of data for the core indicators. In some cases, there may be multiple possible sources of information for the same indicator. In the definitions included in this handbook, a data source is specified for each indicator as the preferred method for measurement. The data source recommended is believed to be the most consistent, reliable, and feasible method for obtaining the necessary information. The characteristics of each data source are summarized in the following table:

<table>
<thead>
<tr>
<th>Data Source</th>
<th>Type of Data</th>
<th>Frequency of Collection</th>
<th>Brief Description of data flow</th>
</tr>
</thead>
<tbody>
<tr>
<td>Computerized management information system (CMIS)</td>
<td>Inputs, process, outputs</td>
<td>Ongoing/ monthly collation</td>
<td>A computerized database fed by data collected from routine programme activity. Forms are completed by programme implementers and may be entered on-site or sent centrally for data entry.</td>
</tr>
<tr>
<td>Service quality assessments (SQA)</td>
<td>Quality ratings of outputs</td>
<td>Annual</td>
<td>Site visits are conducted to assess quality against service quality standards described in programme guidelines. Assessment includes observation, patient interviews, and interaction with staff.</td>
</tr>
<tr>
<td>Behavioural Surveillance Surveys (BSS)</td>
<td>Outcomes (i.e. behaviour change)</td>
<td>Every 2-3 years</td>
<td>Probability samples of high risk and general populations. Organized at NACO or SACS level.</td>
</tr>
<tr>
<td>Annual HIV Sentinel Surveillance (HSS)</td>
<td>Outcomes (changes in prevalence)</td>
<td>Annual</td>
<td>Facility based samples of ANC and high risk populations.</td>
</tr>
<tr>
<td>Special Studies (SS)</td>
<td>Outputs and outcomes</td>
<td>Periodic</td>
<td>Includes ART resistance monitoring, representative surveys of community, political, and industry leaders. These data may also include review of programme records or files for management or SIMU related indicators.</td>
</tr>
</tbody>
</table>
### Core Indicator Objective Area

<table>
<thead>
<tr>
<th>Objective Area</th>
<th>CMIS</th>
<th>BSS</th>
<th>AHSS</th>
<th>SS/Other</th>
</tr>
</thead>
<tbody>
<tr>
<td>I.  Prevention</td>
<td>27</td>
<td>16</td>
<td>1</td>
<td>9</td>
</tr>
<tr>
<td>II. Care, Treatment and Support and Impact Mitigation</td>
<td>12</td>
<td>1</td>
<td>1</td>
<td>8</td>
</tr>
<tr>
<td>III. Programme Management and Capacity Raising</td>
<td>2</td>
<td>0</td>
<td>0</td>
<td>7</td>
</tr>
<tr>
<td>IV. Strategic Information Management</td>
<td>4</td>
<td>0</td>
<td>2</td>
<td>7</td>
</tr>
</tbody>
</table>

#### Numerator and denominator

To make the indicator more meaningful, most indicators are presented as a proportion, comparing achievements over a period of time to a useful denominator. For example, instead of measuring the number of sex workers covered by an intervention, the relevant indicator may be defined as the proportion of sex workers covered by an intervention compared to the total number of sex workers mapped in the intervention’s catchment area. When a proportion is the more appropriate measure the definition of the indicator specifies both the numerator and the denominator that should be used.

For most input, process or output indicators, the denominator is often a static number that is updated only periodically, while the numerator is the measure of achievement or activity relevant to the shorter reporting period.

#### Levels of disaggregation

The definition of each indicator presents an overall numerator and denominator as well as suggesting other sub-group analysis of the same indicator which may be useful. For example, the number of people seeking testing and counseling services may be looked at national level, state level, district level, ICTC site or gender. Different levels of disaggregation of the data allow useful managerial decisions about where to focus supervision or what sub-populations may require more attention.

Levels of disaggregation may have different relevance for managers at various levels. For example, managers at national level may be interested in comparing performance of different states, while managers at state level may be interested in comparing performance of different districts within their states. At an operational level, site managers may be interested in knowing how their site compares to state or national averages, thus the utility of being able to define the core indicators with different levels of disaggregation.

Depending on the source of data, an indicator may or may not be disaggregated to all levels. For example, behavioural surveillance surveys are often sampled at the state level. This means that while district level measures of behaviour change are very useful and important, it may not be possible to analyze data at that level.

In other cases, some core indicators may be critical for local managers to diagnose problems and adjust programming, but may provide too much detail for state or national level managers that oversee programmes spanning large geographic areas. For this reason, the definition of each indicator also specifies to what level of management the indicator may be most relevant (N=national; S=state; D=district/site).

On a different level, some sections within NACO or SACS may be concerned with a particular sub-group of special vulnerability to HIV/AIDS. These groups may include youth, women or high risk groups. Providing group-specific indicators give critical information about whether
these groups are receiving adequate attention and levels of service. For these two population groups, Appendix 1 provides the sub-set of indicators such that sub-group disaggregation is possible.

**Interpretation and Analysis**

The most important activity of any strategic information management system is the use of the data. Applying these data require thoughtful interpretation and analysis which in turn depends on understanding the strengths and limitations of the source of the data. Within the specific definition of each indicator, this handbook provides a brief discussion of limitations of the data and the potential ways to use the data to improve programme management. This discussion is general and should be superceded when there is additional information about local data. Managers in the field should be encouraged to develop and share with each other the multiple other applications and insights about the strengths and limitations of core indicator data. As much as possible these issues should be raised in annual reports of core indicator data or other documents summarizing programme achievements and progress.

**LIST OF CORE INDICATORS**

<table>
<thead>
<tr>
<th>No.</th>
<th>List of Indicators – by components</th>
<th>Level</th>
<th>Data Source</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>N- National</td>
<td>S- State</td>
</tr>
<tr>
<td>I.</td>
<td>PREVENTION OBJECTIVE</td>
<td></td>
<td></td>
</tr>
<tr>
<td>I.O1.</td>
<td>Percentage of FSW, MSM, IDU who are HIV infected – UNGASS</td>
<td>N / S</td>
<td>SS/ AHSS</td>
</tr>
<tr>
<td>I.O2.</td>
<td>Percentage of infants born to HIV infected mothers who are infected.</td>
<td>N / S</td>
<td>SS</td>
</tr>
<tr>
<td>I.a</td>
<td>Preventive interventions for HRG (Targeted Interventions)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>I.a.1</td>
<td>Percentage of districts which have updated HRG mapping data</td>
<td>N / S</td>
<td>CMIS</td>
</tr>
<tr>
<td>I.a.2</td>
<td>Number &amp; percentage of specific HRG population reached by intervention.</td>
<td>N / S/D</td>
<td>CMIS</td>
</tr>
<tr>
<td>I.a.3</td>
<td>Percentage of female and male sex workers reporting use of condoms with their most recent client – UNGASS</td>
<td>N / S</td>
<td>BSS</td>
</tr>
<tr>
<td>I.a.4</td>
<td>Percentage of men reporting use of condoms in the last time they had anal sex with a male partner – UNGASS</td>
<td>N / S</td>
<td>BSS</td>
</tr>
<tr>
<td>I.a.5</td>
<td>Percentage of IDU population reporting use of sterile injecting equipment at last injection – UNGASS</td>
<td>N / S</td>
<td>BSS</td>
</tr>
<tr>
<td>I.a.6</td>
<td>Percentage of IDU reporting use of condoms at last sex – UNGASS</td>
<td>N / S</td>
<td>BSS</td>
</tr>
<tr>
<td>I.a.7</td>
<td>Percentage of FSW, MSM, IDU’s with STI symptoms, seeking services from qualified medical providers.</td>
<td>N / S</td>
<td>BSS</td>
</tr>
<tr>
<td>I.a.8</td>
<td>Percentage of sex workers or MSM who refused to have sex with a client/non-regular partner in the last 12 months because of not having or refusing to use a condom</td>
<td>N / S</td>
<td>BSS</td>
</tr>
<tr>
<td>No.</td>
<td>List of Indicators – by components</td>
<td>Level N- National S- State D- District</td>
<td>Data Source</td>
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<tr>
<td>I.a.9</td>
<td>Percentage of PLHA registered in TI linked to basic aids care and support</td>
<td>N / S / D</td>
<td>CMIS</td>
</tr>
<tr>
<td>I.a.10</td>
<td>Number of targeted intervention projects by category</td>
<td>S / D</td>
<td>CMIS</td>
</tr>
<tr>
<td>I.a.11</td>
<td>Number of needles and syringes distributed to IDU</td>
<td>S / D</td>
<td>CMIS</td>
</tr>
<tr>
<td>I.a.12</td>
<td>Percentage of targeted interventions reporting condom stock out</td>
<td>S / D</td>
<td>CMIS</td>
</tr>
<tr>
<td>I.a.13</td>
<td>Number and percentage of TIs where CBOs are formed</td>
<td>S / D</td>
<td>CMIS</td>
</tr>
<tr>
<td>I.a.14</td>
<td>Percentage of TI projects reporting no interference from local power structures</td>
<td>S / D</td>
<td>CMIS</td>
</tr>
<tr>
<td>I.a.15</td>
<td>Number of SACS, DACS and NGOs who have members of HRGs on their TI-related decision making bodies</td>
<td>S / D</td>
<td>SS</td>
</tr>
<tr>
<td></td>
<td><strong>I.b Prevention interventions for Bridge Population</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>I.b.1</td>
<td>Percentage of men reporting being clients of sex workers in the last year</td>
<td>N / S</td>
<td>BSS</td>
</tr>
<tr>
<td>I.b.2</td>
<td>Percentage of truckers reporting use of condoms with last commercial sex partner</td>
<td>N / S</td>
<td>BSS</td>
</tr>
<tr>
<td>I.b.3</td>
<td>Number &amp; Percentage of High risk men (e.g. truckers, migrants, etc.) reached by intervention</td>
<td>N / S / D</td>
<td>CMIS</td>
</tr>
<tr>
<td></td>
<td><strong>I.c Interventions for Vulnerable Populations (women, children, adolescents and workers)</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>I.c.1</td>
<td>Proportion of vulnerable population (women, children and youth) who access HIV care services (e.g.ICTC/STI/PPTCT/ ART - (Relevant indicators analysed by gender and age)</td>
<td>N / S</td>
<td>SS (Budget Review / FPMIS)</td>
</tr>
<tr>
<td>I.c.2</td>
<td>Amount of budget for HIV programmes dedicated for women, children, adolescents, and the workplace.</td>
<td>N / S</td>
<td>SS (Budget Review / FPMIS)</td>
</tr>
<tr>
<td>I.c.3</td>
<td>% of youth using youth resource centers/ clubs in their town/district</td>
<td>S</td>
<td>BSS</td>
</tr>
<tr>
<td></td>
<td>Percentage of workers who have access to information and services on HIV/AIDS at their work place (by formal and informal sectors)</td>
<td>S</td>
<td>BSS</td>
</tr>
<tr>
<td></td>
<td><strong>I.d STI</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>I.d.1</td>
<td>Percentage of general population males with STI seeking treatment from qualified personnel</td>
<td>N / S</td>
<td>BSS</td>
</tr>
<tr>
<td>I.d.2</td>
<td>Percentage/List of clinics reporting a stock out of essential STI drugs</td>
<td>S / D</td>
<td>CMIS</td>
</tr>
<tr>
<td>I.d.3</td>
<td>Percentage of STI patients partners who attend STD clinics for treatment</td>
<td>S / D</td>
<td>CMIS</td>
</tr>
<tr>
<td>No.</td>
<td>List of Indicators – by components</td>
<td>Level</td>
<td>Data Source</td>
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</tr>
<tr>
<td></td>
<td></td>
<td>N- National</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>S- State</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>D- District</td>
<td></td>
</tr>
<tr>
<td>I.d.4</td>
<td>Reduction in prevalence of most common STIs among the general population and high risk groups</td>
<td>S / D</td>
<td>SS</td>
</tr>
<tr>
<td>Le</td>
<td>ICTC (including PPTCT)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Le.1</td>
<td>Percentage of FSW, MSM, and IDU who received HIV testing in the last 12 months and who know their results - UNGASS</td>
<td>N / S</td>
<td>BSS</td>
</tr>
<tr>
<td>Le.2</td>
<td>Number of centers providing ICT services</td>
<td>N / S / D</td>
<td>CMIS</td>
</tr>
<tr>
<td>Le.3</td>
<td>Number and percentage of persons who got tested at ICTC by gender and age</td>
<td>N / S</td>
<td>CMIS</td>
</tr>
<tr>
<td>Le.4</td>
<td>Percentage of persons who return for test report at ICTC- by gender and age</td>
<td>N / S</td>
<td>CMIS</td>
</tr>
<tr>
<td>Le.5</td>
<td>Number and percentage of persons who test positive by age, gender</td>
<td>N / S</td>
<td>CMIS</td>
</tr>
<tr>
<td>Le.6</td>
<td>Number of persons receiving pre-test counseling/ information and proportion of people seeking testing by age and gender.</td>
<td>S / D</td>
<td>CMIS</td>
</tr>
<tr>
<td>Le.7</td>
<td>Number and percentage of persons accessing ICTC who are referrals from DOTS centers</td>
<td>S / D</td>
<td>CMIS</td>
</tr>
<tr>
<td>Le.8</td>
<td>Percentage of HIV positive persons referred to ART center, by gender</td>
<td>S / D</td>
<td>CMIS</td>
</tr>
<tr>
<td>Le.9</td>
<td>Percentage of pregnant women newly diagnosed as HIV positive at ICTC, whose sexual partner has been tested.</td>
<td>S / D</td>
<td>CMIS</td>
</tr>
<tr>
<td>Le.10</td>
<td>Percentage of ICTC reporting inadequate quantities of HIV test kits</td>
<td>S / D</td>
<td>CMIS</td>
</tr>
<tr>
<td>Le.11</td>
<td>Number and percentage of HIV infected pregnant women and newborns receiving a complete course of ARV prophylaxis</td>
<td>N / S</td>
<td>CMIS</td>
</tr>
<tr>
<td>Le.12</td>
<td>Percentage of ICTCs having pregnant women as their clients</td>
<td>S / D</td>
<td>CMIS</td>
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<tr>
<td>Lf</td>
<td>Post Exposure Prophylaxis</td>
<td></td>
<td></td>
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<tr>
<td>Lf.1</td>
<td>Percentage of health care providers who access PEP within 24 hours of exposure</td>
<td>S / D</td>
<td>SS</td>
</tr>
<tr>
<td>Lg</td>
<td>Condoms</td>
<td></td>
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<tr>
<td>Lg.1</td>
<td>Percentage of persons reporting condom use at last sex with non regular partners - UNGASS</td>
<td>N / S</td>
<td>BSS</td>
</tr>
<tr>
<td>Lg.2</td>
<td>Number of condoms distributed by social marketing programs</td>
<td>N / S</td>
<td>S6 (NIHFW)</td>
</tr>
<tr>
<td>Lg.3</td>
<td>Number of free condoms distributed through TI and STD clinics</td>
<td>N / S</td>
<td>CMIS</td>
</tr>
<tr>
<td>No.</td>
<td>List of Indicators – by components</td>
<td>Level</td>
<td>Data Source</td>
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<td></td>
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<td>N- National</td>
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<td></td>
<td></td>
<td>S- State</td>
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<td></td>
<td></td>
<td>D- District</td>
<td></td>
</tr>
<tr>
<td>lg.4</td>
<td>Percentage of persons who have had sex with non regular partners who perceive that condoms are easily accessed at the time of sex act</td>
<td>S</td>
<td>BSS</td>
</tr>
<tr>
<td>lg.5</td>
<td>Number of non-traditional outlets selling socially marketed condoms</td>
<td>S</td>
<td>SS (Retail Audit)</td>
</tr>
<tr>
<td>lh</td>
<td>Blood banks and blood Safety</td>
<td></td>
<td></td>
</tr>
<tr>
<td>lh.1</td>
<td>Percentage of blood units screened for HIV in a quality assured way</td>
<td>N / S</td>
<td>CMIS</td>
</tr>
<tr>
<td>lh.2</td>
<td>Number and percentage of blood units collected through voluntary blood donation</td>
<td>N / S</td>
<td>CMIS</td>
</tr>
<tr>
<td>lh.3</td>
<td>Percentage of blood being processed into components</td>
<td>N / S</td>
<td>CMIS</td>
</tr>
<tr>
<td>lh.4</td>
<td>Number and percentage of blood banks with blood component separation units established</td>
<td>N</td>
<td>CMIS</td>
</tr>
<tr>
<td>li</td>
<td>Communication and Social Mobilization</td>
<td></td>
<td></td>
</tr>
<tr>
<td>li.1</td>
<td>% of general population adults and youth who both correctly identify ways of preventing sexual transmission of HIV and reject misconceptions about HIV transmission by gender</td>
<td>N / S</td>
<td>BSS</td>
</tr>
<tr>
<td>li.2</td>
<td>Percentage of out of school youth reached by HIV awareness programme</td>
<td>N / S</td>
<td>BSS</td>
</tr>
<tr>
<td>li.3</td>
<td>Percentage of students covered under School AIDS program</td>
<td>N / S / D</td>
<td>SS (MoE)</td>
</tr>
<tr>
<td>li.4</td>
<td>Percentage of schools with Adolescent Education Program w/ teachers trained and who have used the curriculum in the last academic year. – UNGASS</td>
<td>N / S / D</td>
<td>SS (MoE)</td>
</tr>
<tr>
<td>li.5</td>
<td>Percentage increase in media coverage on HIV/AIDS issues</td>
<td>S</td>
<td>SS</td>
</tr>
</tbody>
</table>

## II. CARE, SUPPORT AND TREATMENT AND IMPACT MITIGATION OBJECTIVE

### II.O1 Total number of persons who are HIV positive

<table>
<thead>
<tr>
<th>Level</th>
<th>Data Source</th>
</tr>
</thead>
<tbody>
<tr>
<td>N / S</td>
<td>AHSS &amp; modeling</td>
</tr>
</tbody>
</table>

### II.a Anti-retroviral therapy

#### II.a.1 Number of service outlets providing ART services, by public/private facility

<table>
<thead>
<tr>
<th>Level</th>
<th>Data Source</th>
</tr>
</thead>
<tbody>
<tr>
<td>N / S</td>
<td>CMIS</td>
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</table>

#### II.a.2 Number of doctors trained in ART & OI management

<table>
<thead>
<tr>
<th>Level</th>
<th>Data Source</th>
</tr>
</thead>
<tbody>
<tr>
<td>N / S</td>
<td>CMIS</td>
</tr>
</tbody>
</table>

#### II.a.3 Number and percentage of eligible PLHA (by CD4 count) who initiate ART – by age, gender, and public/private facility – UNGASS

<table>
<thead>
<tr>
<th>Level</th>
<th>Data Source</th>
</tr>
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<tbody>
<tr>
<td>N / S</td>
<td>CMIS</td>
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</tbody>
</table>

#### II.a.4 Percentage of persons put on ART who report (95%) adherence at the end of 12, 24, 36 months, by age and gender

<table>
<thead>
<tr>
<th>Level</th>
<th>Data Source</th>
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<tbody>
<tr>
<td>N / S</td>
<td>CMIS</td>
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<tr>
<td>No.</td>
<td>List of Indicators – by components</td>
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<td>-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------</td>
</tr>
<tr>
<td>II.a 5</td>
<td>Number and percentage of persons still alive and on ART at 12, 24 and 36 months after initiation of ART by age and gender</td>
</tr>
<tr>
<td>II.a 6</td>
<td>Number and percentage of art centres which have linkages with NGOs/CBOs for community outreach and home based care</td>
</tr>
<tr>
<td>II.a 7</td>
<td>Percentage of HIV-positive incident TB cases that received treatment for TB and HIV</td>
</tr>
<tr>
<td>II.a 8</td>
<td>Initiation of at least 5 regional units for resistance monitoring by end of 2006</td>
</tr>
<tr>
<td>II.a 9</td>
<td>Number of newly infected with HIV patients which have strains resistant to first line ART regimens</td>
</tr>
<tr>
<td>II.b</td>
<td>Care &amp; Support</td>
</tr>
<tr>
<td>II.b 1</td>
<td>Number of service outlets providing treatment for opportunistic infections (OI)</td>
</tr>
<tr>
<td>II.b 2</td>
<td>Number of PLHA who access OI treatment</td>
</tr>
<tr>
<td>II.b 3</td>
<td>Number of NGOs involved with provision of care and support to affected children</td>
</tr>
<tr>
<td>II.b 4</td>
<td>Number of service outlets providing community care</td>
</tr>
<tr>
<td>II.b 5</td>
<td>Number of PLHAs (and their family members) receiving services from NGOs/CBOs by gender and age</td>
</tr>
<tr>
<td>II.c</td>
<td>Greater Involvement of People w/ AIDS</td>
</tr>
<tr>
<td>II.c 1</td>
<td>Number of AIDS councils at national, state, and district levels which have PLHA representatives</td>
</tr>
<tr>
<td>II.c 2</td>
<td>Number of districts with at least one functioning PLHA network</td>
</tr>
<tr>
<td>II.d</td>
<td>Stigma and Discrimination</td>
</tr>
<tr>
<td>II.d 1</td>
<td>Percentage of HRG members reporting instances of stigma and discrimination in the last month</td>
</tr>
<tr>
<td>II.d 2</td>
<td>Percentage of PLHA who access services who report satisfaction with their service experience</td>
</tr>
<tr>
<td>II.e</td>
<td>Human Rights, Legal and Ethical Issues</td>
</tr>
<tr>
<td>II.e 1</td>
<td>AIDS legislation adopted and ratified</td>
</tr>
<tr>
<td>II.e 2</td>
<td>Amendment of laws to protect the rights of marginalized populations and PLHA, including NDPS Act, ITPA and Section 377 of the IPC</td>
</tr>
<tr>
<td>II.f</td>
<td>Lab Services</td>
</tr>
<tr>
<td>II.f 1</td>
<td>Number and percentage of laboratories conducting HIV testing participating in EQAS</td>
</tr>
<tr>
<td>No.</td>
<td>List of Indicators – by components</td>
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<tr>
<td>III</td>
<td>PROGRAMME MANAGEMENT AND CAPACITY RAISING OBJECTIVE</td>
</tr>
<tr>
<td>III.a</td>
<td>Program Management</td>
</tr>
<tr>
<td>III.a.1</td>
<td>Percentage of SACS who achieve at least 80% of planned expenditure targets</td>
</tr>
<tr>
<td>III.a.2</td>
<td>Percentage of audit reports completed and forwarded within time limits to NACO</td>
</tr>
<tr>
<td>III.a.3</td>
<td>Percentage of SACS with approved financial and administrative delegation</td>
</tr>
<tr>
<td>III.a.4</td>
<td>Percentage of SACS which have all critical program positions filled</td>
</tr>
<tr>
<td>III.a.5</td>
<td>Percentage of SACS whose donor coordinating committee met at least twice a year</td>
</tr>
<tr>
<td>III.a.6</td>
<td>Percentage of SACS whose governing body met at least twice a year</td>
</tr>
<tr>
<td>III.a.7</td>
<td>Number of district units established, staffed, and reporting</td>
</tr>
<tr>
<td>III.b</td>
<td>Capacity Strengthening</td>
</tr>
<tr>
<td>III.b.1</td>
<td>Number and percentage of imparted induction and refresher training – by component, category and level</td>
</tr>
<tr>
<td>III.c</td>
<td>Mainstreaming</td>
</tr>
<tr>
<td>III.c.1</td>
<td>Number of ministries with an HIV strategy and action plan developed in collaboration with NACO</td>
</tr>
<tr>
<td>IV</td>
<td>STRATEGIC INFORMATION MANAGEMENT OBJECTIVE</td>
</tr>
<tr>
<td>IV.a</td>
<td>SIM Resources</td>
</tr>
<tr>
<td>IV.a.1</td>
<td>Percentage of budget spent for SIMU at national, state and district level</td>
</tr>
<tr>
<td>IV.a.2</td>
<td>Percentage of reporting units with 75% reporting on time</td>
</tr>
<tr>
<td>IV.a.3</td>
<td>Number of SACS generating a report every quarter which includes data from various source like routine monitoring, surveillance and other findings of the ongoing evaluations</td>
</tr>
<tr>
<td>IV.a.4</td>
<td>Percentage of districts with M&amp;E staff in place</td>
</tr>
<tr>
<td>IV.b</td>
<td>Surveillance</td>
</tr>
<tr>
<td>IV.b.1</td>
<td>Number and percentage of states HIV sentinel surveillance sites with timely of data to central database</td>
</tr>
<tr>
<td>No.</td>
<td>List of Indicators – by components</td>
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<tr>
<td>IV.b.2</td>
<td>Number &amp; percentage of active sentinel surveillance sites meeting the minimum quality standards (over three years)</td>
</tr>
<tr>
<td>IV.c</td>
<td>Data Analysis and Use</td>
</tr>
<tr>
<td>IV.c.1</td>
<td>Number and percentage of States conducting regular review meetings and partnership forum using M&amp;E information</td>
</tr>
<tr>
<td>IV.c.2</td>
<td>Number and percentage of districts/SACS using programme data to develop annual action plan</td>
</tr>
<tr>
<td>IV.c.3</td>
<td>Number and list of partners sharing information with SACS</td>
</tr>
<tr>
<td>IV.d</td>
<td>Evaluation and Research</td>
</tr>
<tr>
<td>IV.d.1</td>
<td>Number of States conducting at least two key intervention evaluations</td>
</tr>
<tr>
<td>IV.d.2</td>
<td>NACO conducting one participatory programmatic and one scientific/analytical evaluation every three years.</td>
</tr>
<tr>
<td>IV.d.3</td>
<td>Number of research projects completed at the national/regional level</td>
</tr>
<tr>
<td>IV.d.4</td>
<td>Number of papers based on NACO programme data or NACO sponsored research published in peer reviewed journals</td>
</tr>
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</table>
CORE INDICATOR DEFINITIONS

Objective 1 – Prevention and Enabling Environment

Prevention of new HIV infections and stabilizing the prevalence of HIV is the highest priority objective for NACP III. The characteristics of the Indian HIV epidemic is such that prevention efforts should focus on targeted interventions for high risk groups: sex workers (SW), high risk men who have sex with men (MSM), and injection drug users (IDU). In addition to outreach and STD services to reduce risk behaviours among these groups, the NACP III prevention strategy also addresses high risk men, who act as a bridge between the high risk groups and transmission of HIV to the general population. These high risk men are targeted primarily by occupational characteristics such as those men who are highly mobile (e.g. truckers) or migrant laborers who may spend substantial periods of time away from their families in pursuit of job opportunities.

Awareness and vulnerability reduction through mass communication campaigns, social mobilization through self help groups and resource centers have also been established to prevent infections among other vulnerable populations such as women, children and youth.

Key prevention services in health care settings include management of sexually transmitted diseases (STDs), integrated HIV counseling and testing centers (ICTC) that are bundled with other services such as prevention of parent to child transmission (PPTCT). Health care facilities are also ensuring the availability of post-exposure prophylaxis for health care workers and 100% screening of donated blood products at transfusion centers and blood banks. Mass distribution and social marketing of condoms is another key prevention strategy undertaken by NACP III.

The scaling up of these services remains a key challenge of NACP III. SCAS managers must use the core indicators to ensure that adequate coverage of services in high priority districts is being achieved without sacrificing quality of services.

The primary outcomes for this objective are to stabilize prevalence among high risk groups and reduce the number of new infections among infants of HIV positive mothers.
Outcome indicator 1

Percentage of FSW, MSM, IDU (High Risk Groups) who are HIV infected

**Rationale and what it measures**

Monitoring the HIV prevalence among high risk groups (HRGs), is a primary outcome for HIV/AIDS control efforts in concentrated epidemic conditions. The identified high priority HRGs in India are FSW, MSM, and IDU.

**Indicator definition**

Biological specimens provided for HIV testing in representative (probability) samples of HRG.

*Numerator:* Number of HIV positive respondents of formal survey/surveillance activity.

*Denominator:* Number of respondents providing a biological specimen for the survey/surveillance activity.

**Source of information and how to measure**

AHSS in Targeted intervention settings.

IBBS in selected locations through probability sampling methods (e.g. time-location cluster sampling and respondent driven sampling). If the biological specimens used are collected primarily for the purposes of HIV testing (i.e. specimen is not collected routinely for other types of testing) all participants must provide explicit consent for the use of their specimens for HIV testing. Specimens collected through sentinel surveillance sites should be obtained from sequential patients coming for services over a specified and limited period of time. Characteristics of the site and the population attending for services who were included in the surveillance round should be documented annually, to enable fair comparisons of the data from year to year.

**Frequency of generation**

Annually for AHSS. Every 2-3 years for IBBS

**Frequency of reporting**

Annually for AHSS. Every 2-3 years for IBBS

**Level of use**

National / State / District

**Strengths and limitations**

- Accessing and/or surveying HRG populations can be challenging, particularly when incorporating biological specimen collection in the protocol. Consequently, data obtained may not always be a representative sample of the HRGs. Representativeness should be assessed thoroughly and if there are concerns that the data is not based on a representative sample, these issues should be reflected in the interpretation of the survey data. Where different sources of data exist, the best available estimate should be used. Information on the sample size, the quality, reliability of the data and any related issues should be included in the report submitted with this indicator.

- Due to the resource intensiveness of probability surveys of HRG, district level data may not be available for these measures. Given
the size of the country and most states, aggregate data for this indicator may be difficult to interpret.

| Programme implication | In a concentrated epidemic, the trend of HIV prevalence in HRGs provides critical information as to the nature of spread of disease and the potential for seeding transmission into other pockets of the country. Districts showing high proportions of positives should be mapped thoroughly for HRGs and prioritized for expanding interventions as appropriate. |
| Comments and observations | UNGASS |
Outcome indicator 2

Percentage of infants born to HIV-infected mothers who are infected

**Rationale and what it measures**
This indicator measures the percent of infants born to HIV-infected mothers who become infected. This indicator will be estimated based on programme coverage and sentinel sites.

**Indicator definition**
This indicator is an estimate based on the known probabilities of transmission with and without ARV prophylaxis and the coverage percentage estimated of PPTCT for pregnant women who are HIV-infected. The current formula assumes a level of efficacy considering the ARV prophylaxis given to HIV-infected pregnant women, which implicitly takes into account the proportion of infants who also receive their ARV prophylaxis.

**Source of information and how to measure**
UNAIDS statistical models are developed using the reported levels of ARV prophylaxis coverage among HIV-infected mothers and their infants. Results of these models will be provided to NACO as they are completed. It is preferable to have estimates calculated for national and state level.

**Frequency of generation**
Annually

**Frequency of reporting**
Based on annual UNGASS reported data.

**Level of use**
National / State

**Strengths and limitations**
--

**Programme implication**
This indicator provides an outcome level assessment of prevention of infection among infants. The methodology used allows comparability to other countries modeled by UNAIDS.
Core indicator I.a.1

Percentage of districts which have updated HRG mapping data

Rationale and what it measures
High-risk groups (HRGs) typically have the highest HIV prevalence in districts with either concentrated or generalized epidemics. Reducing prevalence among High-risk groups is a critical measure of a national-level response to HIV and provides the rationale for saturated coverage of HRGs through targeted interventions. Mapping of high risk groups is essential to ensure that these interventions are deployed to cover the largest concentrations of HRGs. This indicator measures whether districts have a sufficient understanding of HRGs to derive actual targets and denominator for planning interventions among high risk populations.

Indicator definition
Mapping of HRG is expected to be updated annually. While the primary objective is to understand the geographic distribution of HRGs within districts and towns, this exercise should include an element of rough size estimation (precision to +/-50 people). Standardized approaches for conducting HRG mapping exercises should be used (e.g., UNAIDS/WHO Guidelines for Second Generation HIV Surveillance; FHI guidelines on sampling in population groups, etc.) The states should have data on mapping exercise for HRG done at the beginning of the project for each district. This need to be updated annually by the SACS through partner NGO’s. This can be done along-with annual NGO-project assessment. Mapping exercises may be conducted by either the implementing NGO or an agency hired specifically for this exercise.

Numerator: Number of districts where HRG mapping updation exercise is carried out respectively for Sex Workers, IDU’s, MSM’s and Bridge Population.

Denominator: Number of districts in the state.

This indicator should be calculated separately for each population that is considered HRG or bridge population in a given district, e.g., sex workers, injecting drug users, men who have sex with men and truckers and migrants.

Source of information/ How to measure
CMIS

Frequency of generation
Annually

Frequency of reporting
Annually

Level of use
National / State
Strengths and limitations

Various methods of mapping are used by different agencies and for different purposes of calculating size. Most mapping exercises use a type of Delphi method. The quality of mapping exercises are difficult to verify without detailed methodology and process documentation. The utility of the mapping information collected depends heavily on the quality of the exercise.

Programme Implications

Mapping provides important information for programmes in terms of defining the targets for coverage. Mapping data also help programmes to design more efficient services, e.g. numbers of peer educators needed in each geographic area, the placement and type of clinical services. States with high percentages of districts with updated mapping indicate a greater likelihood of evidence based programme decision making.
Core indicator I.a.2

Number and percentage of specific HRG population reached by intervention

**Rationale and what it measures**

HRG populations are often difficult to reach with HIV/AIDS prevention programs. However, in order to prevent the spread of HIV/AIDS among these populations as well as into general population, it is important that HRGs are adequately covered by an essential package of prevention services.

This indicator assesses progress in implementing HIV/AIDS prevention programs for HRG.

**Indicator definition**

HRG populations are those groups for which targeted interventions are designed. They include female sex workers, MSM/MSW, and IDU.

*Numerator:* Number of most-at-risk population who have been reached by HIV prevention programs during the months in the project area (reached means either contacted through one-to-one / group behaviour change communication or receipt of clinical services or commodities e.g. condoms, lubricants or clean needles, etc.)

*Denominator:* Size of the high risk population as per the latest mapping in the project area.

Indicator should be calculated separately for each population that is considered at risk e.g., sex workers, injecting drug users, men who have sex with men.

**Source of information How to measure**

CMIS.

The TI format captures information on the number of individuals reached by the targeted intervention in the month, as well as the most updated estimate of size of the population. Numerator data to be entered monthly as part of routine reporting. The data for this indicator would be collected through the daily diaries of the peer educators and outreach workers. The quality of the same is verified by the program managers. The records so collected are compiled and aggregated to obtain overall reach of prevention program.

**Frequency of generation**

Quarterly

**Frequency of reporting**

Monthly

**Level of use**

National / State / District

**Strengths and limitations**

- Tracking most-at-risk populations over time to measure progress may be difficult due to mobility. Individuals may be double counted in a reporting period if they are contacted multiple times and NGO does not have a sophisticated method of tracking individuals.
This indicator does not track the number of high risk population still continuing in the prevention program.

Programme implication

This information can be utilized to see the progress of intervention in reaching the mapped population in a month. Saturated coverage of HRGs requires monthly contacts to engage beneficiaries and ensure adequate distribution of commodities such as condoms or clean needles. NGOs with low coverage may require assistance in restructuring their outreach activities.
Core indicator I.a.3

Percentage of female and male sex workers reporting use of condoms with their most recent client

**Rationale and what it measures**
Various factors increase the risk of exposure to HIV among sex workers, including multiple, non-regular partners and more frequent sexual intercourse. However, sex workers can substantially reduce the risk of HIV transmission, both from and to clients, through consistent and correct condom use.

This indicator assesses progress in preventing exposure to HIV among sex workers through unprotected sex with clients.

**Indicator definition**
Relevant sex workers are those who have exchanged sex for money in the last month.

- **Numerator**: Number of respondents who report using a condom with their most recent client.
- **Denominator**: Number of respondents.

Indicator is calculated separately for male and female sex workers.

**Source of information and how to measure**
BSS for HRG

Respondents are asked the following question:
1) Did you exchange sex for money in the last month or have you had a paying client in the last month?
2) If yes, the last time you had sex with a paying client, did you use a condom? Whenever possible, data for sex workers should be collected with support of civil society organizations that have worked closely with this population in the field. Access to survey respondents as well as the data collected from them must remain confidential.

**Frequency of generation**
Every 2-3 years

**Frequency of reporting**
Every 2-3 years

**Level of use**
National / State

**Strengths and limitations**
- Condoms are most effective when their use is consistent rather than occasional. The current indicator will provide an overestimate of the level of consistent condom use. However, the alternative method of asking whether condoms are always/sometimes/never used in sexual encounters with clients in a specified period is subject to recall bias. Furthermore, the trend in condom use in the most recent sexual act will generally reflect the trend in consistent condom use.
Surveying sex workers can be challenging. Consequently, data obtained may not be based on a representative sample of the total sex worker population being surveyed. If there are concerns that the data is not based on a representative sample, these concerns should be reflected in the interpretation of the survey data. Where different sources of data exist, the best available estimate should be used. Information on the sample size, the quality/reliability of the data and any related issues should be included in the report submitted with this indicator.

Programme implication

Condom use among sex workers is the key behaviour change expected as a result of effective targeted intervention programmes. Self-reported condom use trends may be more important to consider than absolute values of reported condom use, due to a certain degree of social desirability bias expected. These data can also be compared to information about condom distribution and prevalence of STDs to determine if a consistent picture of condom use emerges from different sources of data.

Comments and observations

UNGASS
Core indicator I.a.4

Percentage of men reporting use of condoms in the last time they had anal sex with a male partner

**Rationale and what it measures**

Condoms can substantially reduce the risk of the sexual transmission of HIV. Consequently, consistent and correct condom use is important for men who have sex with men because of the high risk of HIV transmission during unprotected anal sex. Condom use with their most recent male partner is considered a reliable indicator of longer-term behaviour. This indicator assesses progress in preventing exposure to HIV among men who have unprotected anal sex with a male partner.

**Indicator definition**

Relevant respondents are those men who report having had anal sex with another man in the last six months.

*Numerator:* Number of respondents who reported that a condom was used the last time they had anal sex.

*Denominator:* Number of respondents who reported having had anal sex with a male partner in the last 6 months.

Data for this indicator should be disaggregated by age (<25/25+) and location of residence (urban/rural).

**Source of information and how to measure**

BSS for HRG

Respondents are asked a series of questions:

1) Have you had anal sex with a man in the last six months
2) If yes, the last time you had anal sex with a man did you or your partner use a condom?

Whenever possible, data for men who have sex with men should be collected with support of civil society organizations that have worked closely with this population in the field.

Access to survey respondents as well as the data collected from them must remain confidential.

**Frequency of generation**

Every 2-3 years

**Frequency of reporting**

Every 2-3 years

**Level of use**

National / State

**Strengths and limitations**

- Condom use at last anal sex with any partner gives a good indication of overall levels and trends of protected and unprotected sex in populations surveyed.

- This indicator does not give any idea of risk for women from men who have sex with both men and women. In cases where men in the sub-population surveyed are likely to have partners of both sexes, condom use within female as well as male partners should
be investigated. In these cases, data on condom use should always be presented separately for male and female partners.

- Surveying men who have sex with men can be challenging. Consequently, data obtained may not be based on a representative sample of the national population of men who have sex with men. If there are concerns that the data is not based on a representative sample, these concerns should be reflected in the interpretation of the survey data. Where different sources of data exist, the best available estimate should be used. Information on the sample size, the quality, reliability of the data and any related issues should be included in the report submitted with this indicator.

- There are several sub-groups of MSM who may have different patterns of behaviour (e.g. receptive vs. insertive partners) including condom use. Comparisons across survey groups or over time, should be made after careful assessment of whether the distribution of respondents across these sub-groups are similar.

**Programme implication**

This indicator provides a measure of the key behaviour change expected as a result of effective targeted interventions among men having sex with men. If low condom use is reported, there is a need to explore whether issues of condom accessibility or preference/awareness or both, are factors that need to be addressed.

**Comments and observations**

UNGASS
Core indicator I.a.5

Percentage of IDU population reporting use of sterile injecting equipment at last injection

Rationale and what it measures
Safer injecting among injecting drug users are essential, because the risk of HIV transmission from contaminated injecting equipment is extremely high. This indicator assesses progress of targeted intervention programmes in preventing injecting drug use-associated HIV transmission through use of sterile injecting equipment.

Indicator definition
Respondents should include those IDU who have injected in the last month, i.e. those who are current users.

**Numerator:** Number of current IDU respondents who report having never used non-sterile injecting equipment during the last month

**Denominator:** Number of current IDU respondents

Indicator scores are required for all respondents and should be disaggregated by gender and age (<25/25+).

Source of information/How to measure
BSS for HRG.

Respondents are asked the following sequence of questions:

1. Have you injected drugs at any time in the last month?
2. If the answer to question 1 is ‘yes’: The last time you injected, did you use sterile injection equipment?

Whenever possible, data for injecting drug users should be collected with support of civil society organizations that have worked closely with this population in the field. Access to survey respondents as well as the data collected from them must remain confidential.

Frequency of generation
Every 2-3 years

Frequency of reporting
Every 2-3 years

Level of use
National / District

Strengths and limitations
- Surveying injecting drug users can be challenging. Consequently, data obtained may not be based on a representative sample of the injecting drug user population being surveyed. If there are concerns that the data is not based on a representative sample, these concerns should be reflected in the interpretation of the survey data. Where different sources of data exist, the best available estimate should be used. Information on the sample size, the quality/reliability of the data and any related issues should be included in the report submitted with this indicator.
The extent of injecting drug use-associated HIV transmission within a country depends on three factors:

(i) the size, stage and pattern of dissemination of the national AIDS epidemic;

(ii) the extent of injecting drug use;

(iii) the degree to which injecting drug users use contaminated injecting equipment

Programme implication
The information obtained can be used to assess the success of various prevention programs among IDU’s. The indicator shows actual behavior change in injecting practices among IDUs.

Comments and observations
UNGASS
Core indicator I.a.6

Percentage of IDU reporting use of condoms at last sex

**Rationale and what it measures**

Safer injecting and sexual practices among injecting drug users are essential, because:

(i) the risk of HIV transmission from contaminated injecting equipment is extremely high; and

(ii) injecting drug users can spread HIV (e.g., through sexual transmission) to the wider population.

While use of safe equipment is tracked by Core Indicator i.a.5, this indicator tracks changes in condom use in IDUs. This indicator assesses whether there is increase in condom use among the injecting drug users.

**Indicator definition**

The relevant IDU population should be those who are current users (i.e. injected in the last month) and sexually active (i.e. have had sex in the last month)

**Numerator:** Number of respondents who are sexually active and are current injecting drug users and who reported that condom was used the last time they had sex

**Denominator:** Number of respondent who are injecting drug users and have reported having sexual intercourse in last month

Indicator scores are required for all respondents and should be disaggregated by gender and age.

**Source of information/How to measure**

BSS for HRG

Respondents are asked the following sequence of questions:

1. Have you injected drugs at any time in the last months?
2. If the answer to question 1 is ‘yes’:
   Have you used non-sterile injecting equipment at any time in the last month?
3. Have you had sexual intercourse in the last month?
4. If yes, did you or your partner use a condom when you had last sex?

**Frequency of generation**

Every 2-3 years

**Frequency of reporting**

Every 2-3 years

**Level of use**

National / State

**Strengths and limitations**

- A rise in this indicator is an extremely powerful indication that condom promotion campaigns are having the desired effect among
their principle target market. This also indicates success in preventing transmission from HRG to general population.

- Since condom promotion campaigns aim for consistent use of condoms with non-regular partners rather than simply occasional use, some surveys have tried to ask directly about consistent use, often using an always/sometimes/never question. While this may be useful in sub-population surveys (see below), it is subject to recall bias and other biases and is not sufficiently robust for use in a general population survey. Asking about the most recent act minimizes recall bias and gives a good cross-sectional picture of levels of condom use. It is recognized that consistent use of condoms is an important goal. But inevitably, if consistent use rises, this indicator will also rise.

**Programme implication**

This information is a good indicator of how effectively the program is working towards preventing transmission of infection from high risk population to general population. Particularly for IDU, both safe injection and safe sex practices are relevant areas.

**Comments and observations**

UNGASS
Core indicator I.a.7

Percentage of FSW and MSM with STI symptoms seeking services from qualified medical providers

**Rationale and what it measures**

STI programmes seek not only to improve the quality of services but to increase the proportion of people recognizing their infection and seeking those services. This indicator tracks changes in treatment-seeking behaviour among men and women who believe they may be STI infected, following initiatives to promote health-seeking behaviour.

This indicator measures the utilization patterns of available STI services among FSW and MSM and whether qualified medical providers are being sought.

**Indicator definition**

STI symptoms may include burning or pain with urination, genital warts or ulcers or thick or purulent vaginal/urethral discharge.

*Numerator:* Number of FSW or MSM who report seeking treatment from an MBBS doctor or government STD clinic for STI symptoms experienced in the last year.

*Denominator:* Number of FSW or MSM who report STI symptoms experienced in the last year.

Indicator can be calculated separately for FSW and MSM.

**Source of information and how to measure**

*BSS of HRG and general population men:*

Adult male respondents are asked if they have experienced any of a list of STI symptoms in the last year. (See definitions above.) If the respondent answers “Yes”, they are asked “What did you do the last time you had any of these problems.” Multiple actions can be recorded. Spontaneous response to the question is preferred to avoid leading respondents to provide socially desirable answers.

The list of actions can include visiting a doctor or clinic in addition to other activities, such as self-medication or seeking advice from friends/family, etc.

Persons who visit doctors or clinics, should be asked about the type of health care provider to confirm that the person was a qualified health care provider.

**Frequency of generation**

Every 2-3 years

**Frequency of reporting**

Every 2-3 years

**Level of use**

National / State

**Strengths and limitations**

- This indicator measures treatment seeking behaviour among FSW and MSM and does not provide information about the effectiveness or type of treatment that they receive. Neither does the indicator distinguish between people who seek treatment immediately after detecting symptoms or those who postpone treatment for some time.
These factors may make a difference in determining the overall effectiveness of promoting treatment seeking behavior in controlling STI among HRGs.

**Programme implication**

Access to qualified STD service providers is key to STD control among HRGs such as FSW and MSMs. These data can be considered in light of other programme monitoring data recording the number of HRGs who are seen in specialty STD clinics designed for HRGs or other preferred providers.
Core indicator I.a.8

Percentage of sex workers or MSM who refused to have sex with a client/non-regular partner in the last 12 months because of not having or refusing to use a condom

Rationale and what it measures

Sex workers and MSM who are motivated and understand the importance of using condoms will choose not to have sex with a non-regular partner if the partner refuse to use a condom. The ability to make this choice suggests an empowered individual with good negotiation skills and awareness. This indicator measures the extent to which members of the high risk group population has been able to adopt safer sex practices with respect to condom use.

Indicator definition

HRG populations include sex workers who have been paid to have sex with a client in the last month or men who have had anal sex with another man in the last six months.

This indicator pertains to commercial sex partners for sex workers and non-regular partner for MSM.

A commercial sex refers to exchange of money for sex.

Non-regular partner refers to a sexual partner other than a spouse or a person the respondent lives with, and with whom the respondent has only a casual, sporadic or one time sex.

Numerator: Number of sex workers/MSM who report having refused to have sex with a client/non-regular partner in the last 12 months because the partner did not have or want to use a condom.

Denominator: Number of sex workers/MSM who have had a client/non regular partner in the last month/six months.

Source of information and how to measure

BSS of high risk groups, the respondents will be asked the following questions:

FSW:

1) Have you been paid to have sex with a client in the last month?

2) If yes, in the last 12 months have you ever refused to have sex with a client because you did not have a condom or because your partner refused to use a condom.

MSM:

1) Have you had anal sex with another man in the last six months?

2) If yes, in the last 12 months have you ever refused to have sex with a non-regular partner because you did not have a condom or because your partner refused to use a condom?

Frequency of generation

Every 2-3 years
<table>
<thead>
<tr>
<th>Frequency of reporting</th>
<th>Every 2-3 years</th>
</tr>
</thead>
<tbody>
<tr>
<td>Level of use</td>
<td>National / State</td>
</tr>
<tr>
<td>Strengths and limitations</td>
<td></td>
</tr>
<tr>
<td>This indicator asks respondents to recall experiences that happened over a long period of time. Respondents who have many clients or non-regular partners may not be able to accurately recall when they may have refused to have sex because of not using condoms.</td>
<td></td>
</tr>
<tr>
<td>The methods used to collect these types of data require substantial training to administer the questionnaire in order to obtain reliable information about sensitive topics and to ensure the sample is representative of the target group of interest. If the sample is suspected to be biased in a substantial way, efforts should be taken to present the findings in way that acknowledges these methodological issues that could affect the ability to extrapolate these data to the broader population.</td>
<td></td>
</tr>
<tr>
<td>Questions about using condoms tend to be subject to social desirability bias, particularly among people who are exposed to an intervention programme and believe their specific answers will be shared with programme staff.</td>
<td></td>
</tr>
<tr>
<td>If persons are more successful in negotiating condom use with their non-regular partners, incidents in which refusing to have sex with a partner due to not using condoms will decrease. It will be difficult to distinguish this situation from situations in which people have sex with partners without using condoms because they are not empowered to refuse sex.</td>
<td></td>
</tr>
<tr>
<td>Programme implication</td>
<td></td>
</tr>
<tr>
<td>Large proportions of the HRG population who report refusing to have sex without the use of condoms suggests that the programme is having an impact on empowering individuals to have sex with non-regular partners only under safe sex conditions. Efforts to create this type of empowerment and behaviour change should be documented and best practices shared.</td>
<td></td>
</tr>
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</table>
Core indicator I.a.9

Percentage of HRG population registered in TI linked to basic aids care and support

**Rationale and what it measures**
Providing continuity between prevention and care and support services can mutually enhance the effectiveness of both types of service. For high risk groups these linkages are especially important due to the higher proportion of people who are HIV positive as well as the difficulty in finding sensitive and relevant services for these marginalized groups. This indicator measures how well targeted intervention NGOs have established services or linkages to partner agencies providing basic AIDS care and support.

**Indicator definition**
Targeted intervention NGOs are those which are registered with SACS/NACO to provide prevention services to high risk groups (including FSW, MSM, IDU).

Basic AIDS Care and support services may include: screening or referral to TB diagnosis centers; diagnosis and treatment of uncomplicated opportunistic infections; counseling and HIV testing; basic nutrition and hygiene; and palliative care and even ARV treatment. A comprehensive package of care and support services is not required for an NGO to be counted in the numerator.

Services may be provided on-site or clients may be referred to services at another NGO/institution. Referral linkages should follow basic minimum standards to ensure clients have sufficient and accurate information and assistance in accessing referral services. Referral services should also be promoted actively to clients who have disclosed themselves to be PLWHA or otherwise, rather than only available upon request.

**Numerator:** Number of HRG referred to basic AIDS Care and support services

**Denominator:** Number of HRG’s registered with NGO

**Source of information and how to measure**
CMIS, The TI registration format captures information about whether the TI provides or makes referrals to basic AIDS care and support services.

**Frequency of generation** Monthly

**Frequency of reporting** Monthly

**Level of use** National / State / District

**Strengths and limitations**
- Establishing linkages and services as measured by this indicator is important, but may not reflect actual utilization.
- Some basic AIDS care support is easier to provide than others. A
follow-up step to this indicator may require ensuring HRG PLHA have access to a variety of care and support services.

**Programme implication**

Functioning linkages and access to basic AIDS care and support partnered with comprehensive prevention services is a more holistic approach to providing services for HRG populations.

Adequate support and capacity building is required to ensure that NGOs have the resources to either establish services directly or make the necessary referrals.
Core indicator I.a.10

Number of targeted intervention projects by category

**Rationale and what it measures**
To meet the objective of saturating coverage for high risk groups with targeted interventions, the number of sites must expand substantially in NACPIII. This indicator tracks the progress of the programme in increasing the number of intervention sites established and operating.

**Indicator definition**
Targeted interventions consist of a standard package of HIV prevention services provided to core groups (i.e. sex workers, men who have sex with men, and injection drug users). This package includes behaviour change communication and outreach, condom distribution, STI management and creation of an enabling environment.

An intervention site is defined at the unit of contracting or reporting, i.e. an NGO receiving a contract to provide services for a core group population in a specified geographic area. Each intervention site may have multiple fixed locations from which services are provided and may or may not provide services to more than one type of core group. The intervention site must be operational at the end of the reporting period to count.

This indicator can be disaggregated by type of core group, type of district, and by state. If an intervention site provides services to more than one core group under a single contract, the site is counted once for overall and once for each category when calculating group specific site counts.

**Source of information and how to measure**
CMIS, the registration format for targeted interventions can be used to determine the number of operational sites and the type of site with respect to the core group served.

**Frequency of generation**
Annually

**Frequency of reporting**
As registration event occurs.

**Level of use**
National

**Strengths and limitations**
- The number of sites may not be directly related to the number of core group population are covered because sites may vary in targets. Similarly, the geographic coverage of an intervention unit may also vary from state to state. In some states one intervention site covers one district; while in other states, some districts will have multiple intervention sites. For this reason, direct comparisons between states may not be appropriate.

**Programme implication**
An increasing number of intervention sites in the early phase of NACPIII provides a gross measure of progress in providing saturated TI coverage for core groups. This indicator will be more important for states with nascent targeted intervention programmes. The district-type stratification of this indicator will be useful for states to determine whether the scaling up of interventions matches the areas of greatest perceived need.
Core indicator I.a.11

Numbers of needles and syringes distributed to IDU

Rationale and what it measures
The first challenge for national programmes promoting safe practices is to ensure that there are enough needles and syringes in the country to satisfy demand. This indicator measures the number of needles and syringes made available and distributed for use by IDUs.

Indicator definition
Needles and syringes in this indicator refer to those provided free of charge to IDU through outreach or outlets. If needles and syringes are provided in kits with multiple sets of equipment provided at one time, these units should be multiplied to determine the actual numbers of needles and syringes provided.

Source of information and how to measure
CMIS, the 'TI format for IDU programmes captures information about the number of needles and syringes given on a monthly basis.

Frequency of generation
Quarterly

Frequency of reporting
Monthly

Level of use
State / National

Strengths and limitations
- This indicator does not consider needles and syringes provided through other sources, including those which may be bought by IDU.
- This indicator is made more meaningful when being compared to the estimated number of injections made by IDU. This requires reliable information about the size of the IDU population and their general practices in terms of frequency of injection and reuse of their own needles, as well as potential wastage during distribution.

Programme implication
Trends in needle and syringe distribution can be compared to the estimated size of the IDU population and average frequency of injection to determine a range of acceptable coverage of injection events. In new targeted intervention areas, trends would be expected to rise steadily until saturation is reached. NGOs with low needle and syringe distribution may require support in reorganizing their outreach and other distribution strategies.
Core indicator I.a.12

Percentage of targeted interventions reporting condom stock out

Rationale and what it measures

Condom distribution is a part of the basic package of prevention services provided by TIs. All TIs should maintain sufficient supplies of condoms and have a mechanism for replenishing stock without causing a gap in services. This indicator measures the extent to which TIs are able to maintain condom stocks outs.

Indicator definition

Targeted interventions are registered with SACS/NACO to provide a basic package of prevention services for core groups (i.e. sex workers, men who have sex with men, and injection drug users). Reporting units which do not have condoms to distribute at any time during the reporting period are counted in this indicator. Stock out pertains to any normal distribution point of the TI, e.g. through outreach, condom outlets/depots or at drop in centers or ST clinics are counted in this indicator.

Numerator: Number of targeted interventions reporting stock out in condoms during the reporting period.

Denominator: Number of targeted interventions. This indicator can be disaggregated by core group type (FSW, MSM, IDU), state, and by type of district (i.e. Category A-D).

Source of information and how to measure

CMIS, the targeted intervention reporting format includes a question about condom stock out.

Frequency of generation

Quarterly

Frequency of reporting

Monthly

Level of use

State

Strengths and limitations

- Stock outs should be verified through inventory record review during annual site visits or service quality assessments.
- Stock outs which occur over short periods of time, in the middle of a reporting period are more likely to be underreported.

Programme implication

Adequate supply of condoms is a basic component of programme operations for TI’s. Sites with repeated occurrences of condom stock out should be provided with additional supervision and other aspects of routine operations assessed. States with high proportions of TIs reporting condom stock outs may need to investigate whether more systemic problems are contributing to frequent stock outs.
## Core indicator I.a.13

### Number and percentage of TIs where CBOs are formed

#### Rationale and what it measures
Community owned and led implementation by HRGs is a key strategy for creating sustainable and effective targeted intervention programmes. Such programmes may better understand and address the needs of HRGs as well as develop greater buy-in for services from the HRG community. Development of community based organizations with the managerial capacity to operate TIs is a necessary step in the process. This indicator measures the proportion of targeted interventions where a community based organization is formed as a precursor for a future community owned and led intervention.

#### Indicator definition
Community based organizations are formal structures whose members are those of the high risk group members and have delineated governance structures to enable eventual solo management of a targeted intervention. CBOs may expect to continuously engage technical support to manage specific functions, however critical decision making including allocation of budget is expected to be a community directed activity. Targeted interventions are those which are registered with SACS/NACO to provide an essential package of prevention services for HRGs (FSWs, MSMs, and IDUs). The relevant unit is reporting unit.

- **Numerator:** Number of TI units where a CBO is formed
- **Denominator:** Number of TI units registered with SACS/NACO

#### Source of information and how to measure
CMIS, TI format captures information about the formation of a CBO.

#### Frequency of generation
Annually

#### Frequency of reporting
As a registration event occurs.

#### Level of use
State

#### Strengths and limitations
- CBO functioning and development is a complex process which is not adequately captured by a single quantitative indicator.
- Care must be taken so that CBO formation is meaningful and indicative of greater community ownership in the management of the TI. NGOs should not be incentivized to form CBOs to achieve a milestone which has not substantive meaning for the programme.
- Data on CBO formation should be consistent with other aspects of programme performance, including ability to consistently contact large proportions of HRGs; willingness for HRGs to go for STD clinic services; participation of HRG members in other community events or meetings.

#### Programme implication
The formation of CBOs signals a milestone in TI programming with respect to community buy-in to the process of HIV prevention programmes. Mature programmes which are lacking CBOs should be encouraged to foster this stage in programme development.
Core indicator I.d. 14

Percentage of TI projects reporting no interference from local power structures

| Rationale and what it measures | Enabling environments are a key element to the effectiveness of TI programmes. The local power structures include local politicians, police and goons. Interference from any of them would harm the functioning of a TI project. This type of cooperation with local power structures requires a deep understanding of the structures and proactive, local advocacy to eliminate incidents of interference. This indicator measures the extent of support and cooperation from the local power structures for successful implementation of the project. |
| Indicator definition | TIs are those which are registered with SACS/NACO to provide an essential package of prevention services to HRGs. Local power structures interference includes any opinion leader or stakeholder which has the power to influence others or to challenge or threaten the way TI programmes conduct their operations. Examples may include, harassment and violence toward HRGs; eviction or extortion for office and programme drop in center space; instigating other members of the general community to protest or discriminate against HRGs; demands to stop providing specific types of services for HRGs. Interference may occur over a sustained period and will be counted in each month in which the nature of the interference remains unresolved and interrupts programme functioning. Numerator: Number of TI projects reporting non-interference from local power structures in their functioning Denominator: Total number TI projects |
| Source of information and how to measure | CMIS, the CMIS TI format captures information about incidents of power structure interference. |
| Frequency of generation | Quarterly |
| Frequency of reporting | Monthly |
| Level of use | State / District |
| Strengths and limitations | Incidents of local power structure interference encompass a wide variety of actions. It may be difficult to determine the severity of these interruptions from a quantitative indicator of such events. Similarly, minor incidents may happen in very localized areas and may not be regularly reported to TI administration in a manner which makes reporting routine or standardized |
| Programme implication | Sustained local power structure interference across multiple sites can signal the need for higher level advocacy to be put into effect. Maintaining logs describing interference can also be helpful for reviewing programme data and understanding trends in programme performance which may result from aggravated or resolved incidents of power structure interference. |
### Core indicator I.a.15

**Number and percentage of SACS, DAPCU’s, and NGOs who have members of high risk group on their TI-related decision making bodies.**

**Rationale and what it measures**

Community ownership in targeted interventions are critical for ensuring programmes are relevant and valued by the HRGs for whom they are designed. Development of community spokespersons and leaders contributes to the ability for community members to take on this ownership. This indicator measures the representation of HRG members on decision making bodies at the state, district and local NGO level.

**Indicator definition**

Decision making bodies may include advisory boards or technical review committees which are involved in allocation of resources or approval of action plans and strategies related to targeted interventions. Decision making bodies may be standing or convened in an ad hoc fashion. HRG members are preferably those who are currently FSW, MSM or IDU; however in some cases persons who are retired or no longer practicing SW or drug users are appropriate representatives or spokes persons. Individuals who are selected to be representative of the HRG should have general endorsement from at least a portion of the community group from which they come.

- **Numerator:** Number of decision making bodies which include participation from a relevant HRG member
- **Denominator:** Number of decision making bodies that exist at SACS. Indicator is calculated separately for different levels (i.e. SACS, DACs, and NGOs)

**Source of information and how to measure**

Minutes of proceedings from decision making bodies should be made available to the public. Minutes should be filed at the appropriate SACS district or NGO level. SACS decision making bodies should submit minutes to NACO. SACS or NACO reviews minutes and includes measure of participation in annual reports for TI programme under community ownership/enabling environment.

**Frequency of generation**

Annually

**Frequency of reporting**

As decision making bodies meet.

**Level of use**

National/State

**Strengths and limitations**

- Selecting appropriate HRG representatives may be difficult for a vast geographic area due to constraints of language and visibility of community spokespersons.
- Such spokespersons should also have adequate preparation and support to meaningfully represent their constituency and articulate their perspective clearly.
- This indicator does not indicate the extent to which participation by HRG members is nominal or substantive.

**Programme implication**

Measures of broad participation by community representatives is an important step in developing community ownership over the process of TI implementation.
Core indicator I.b.1

Percentage of men reporting being clients of sex workers in the last year

Rationale and what it measures

In a concentrated HIV epidemic, such as the one found in India, tracking the size and proportion of the population which forms a bridge between the high risk groups among which the epidemic is concentrated and the general population is critical to assess the potential for the epidemic to become more generalized. In India, male clients of sex workers are a key bridge population. This indicator measures the size of the male client population in different geographic areas.

Indicator definition

Sex work, in this context, refers to the exchange of sex for money. Sex workers include both male and females who sell sex for money. To measure trends in this indicator, this measure is assessed for a recent time period, i.e. one year. Those men whose last time being a client of a sex worker was more than one year ago are not counted in this indicator. This indicator can be disaggregated by state.

Numerator: Number of male respondents reporting to be client of sex workers in last 12 months

Denominator: Number of Male respondents

Source of information and how to measure

BSS among general population men Male respondents are asked if they have been a client of a sex worker in the last year.

Frequency of generation

Every 2-3 years

Frequency of reporting

Every 2-3 years

Level of use

National / State

Strengths and limitations

- Obtaining reliable sensitive information about people’s sexual behaviours is challenging in the context of a face-to-face household survey. Respondents may be concerned about the confidentiality of their responses or feel pressure to provide socially desirable responses to the interviewer. In these cases, the proportion of men who self-report being a client of a sex worker may underestimate the true proportion of men who have bought sex in the last year.

- This indicator alone does not assess the frequency with which these men are clients of sex workers, and cannot distinguish men of relatively low risk, i.e. one time clients vs. those who are frequent clients, i.e. monthly or weekly, etc.

Programme implication

By understanding the proportion of men who are clients of sex workers, the programme can determine the potential for an HIV epidemic to spread in a state. When used with other information of the type collected in a BSS of the general population, states can further profile the male clients and develop appropriate intervention programmes to address the risk and vulnerability of these populations.
Core indicator I.b.2

Percentage of bridge population reporting use of condoms with last commercial sex partner

**Rationale and what it measures**
Various factors increase the risk of exposure to HIV among bridge population like truck drivers, migrant labourers including multiple, non-regular partners and more frequent sexual intercourse. However, these populations can substantially reduce the risk of HIV transmission to non-regular partners through consistent and correct condom use. This indicator assesses progress in preventing exposure to HIV among bridge population through protected sex with non-regular partners.

**Indicator definition**
Relevant truckers are those who have exchanged money for sex with either a male or female sex worker in the last year. Truckers may include both drivers and helpers.

**Numerator:** Number of respondents from bridge population (by category like truck drivers, migrants etc.) who reported condom use at last sex with a commercial sex partner.

**Denominator:** Number of respondents from bridge population by category.

Indicator can be calculated separately for drivers, helpers and migrants or by age group (<25; >25)

**Source of information and how to measure**
BSS for bridge population. Respondents are asked the following question:
1) Have you had paid money for sex in the last 12 months?
2) If yes, the last time you paid money for sex, did you use a condom?

Whenever possible, data for bridge population should be collected with support from civil society organizations that have worked closely with this population in the field.

Access to survey respondents as well as the data collected from them must remain confidential.

**Frequency of generation**
Every 2-3 years

**Frequency of reporting**
Every 2-3 years

**Level of use**
National / State

**Strengths and limitations**
- Condoms are most effective when their use is consistent, rather than occasional. The current indicator will provide an overestimate of the level of consistent condom use. However, the alternative method of asking whether condoms are always/sometimes/never used in sexual encounters with non-regular partners in a specified period is subject to recall bias. Furthermore, the trend in condom use in the most recent sexual act will generally reflect the trend in consistent condom use.
Surveying the bridge population can be challenging. If there are concerns that the data is not based on a representative sample, these concerns should be reflected in the interpretation of the survey data. Where different sources of data exist, the best available estimate should be used. Information on the sample size, the quality/reliability of the data and any related issues should be included in the report submitted with this indicator.

Programme implication

Condom use among bridge population during commercial sex and other non-regular partners is the critical behaviour change expected as a result of effective targeted intervention. Trucker & migrant programme are challenged by the difficulty in maintaining continuous contact with this highly mobile population for both distribution of condoms and other services, as well as outreach to deliver behaviour change communication messages. Programme which are effective in promoting change should be identified and strategies and best practices shared.
Core indicator I.b.3

Number and percentage of bridge population (e.g. truckers, migrants, etc.) reached by intervention

**Rationale and what it measures**

Mobile and migrant populations are often difficult to reach with HIV/AIDS prevention programs. However, in order to prevent the spread of HIV/AIDS among these populations as well as into general population, it is important that high risk males are adequately covered by an essential package of prevention services. This indicator assesses progress in implementing HIV/AIDS prevention programs for high risk men such as truckers and migrants.

**Indicator definition**

High risk men are defined as those groups for which prevention interventions are designed. They include truckers who are away from their families on a regular basis and single male migrants who travel away from their homes without their families for extended periods of time (at least several months) for work.

**Numerator:** Number of high risk men who have been reached by HIV prevention programs during the months in the project area (reached means either contacted through one-to-one/group behaviour change communication or receipt of clinical services or commodities (e.g. condoms, lubricants or clean needles, etc.)

**Denominator:** Size of the migrant population as per the latest mapping in the project area.

Indicator should be calculated separately for each population that is considered at risk (e.g. Truckers separately from migrants).

This indicator can be disaggregated by state and district, and type of district (e.g. Category A-D)

**Source of information and how to measure**

CMIS, The Monthly monitoring format captures information on the number of individuals reached by the intervention in the month, as well as the most updated estimate of size of the population. Numerator data to be entered monthly as part of routine reporting. The data for this indicator would be collected through the daily diaries of the peer educators and outreach workers. The quality of the same is verified by the program managers. The records so collected are compiled and aggregated to obtain overall reach of prevention program.

**Frequency of generation**

Quarterly

**Frequency of reporting**

Monthly

**Level of use**

National / State / District

**Strengths and limitations**

- Tracking mobile and migrant populations over time to measure progress may be difficult due to their pattern of movement.
Individuals may be double counted in a reporting period if they are contacted multiple times and NGO does not have a sophisticated method of tracking individuals.

- This indicator does not track the number of high risk men still continuing in the prevention program or the quality of services provided to this population.

**Programme implication**

Achieving coverage targets for high risk men indicates that a programme has been able to scale up services for these important bridge groups. Areas with low coverage levels should be prioritized for follow-up management action according to the type of district, i.e. the severity of the epidemic; or the estimated size of the high risk male population in that area.
## Core indicator I.c.1

**Amount of budget allocated for HIV programmes dedicated for women, children, adolescents, and the workplace.**

<table>
<thead>
<tr>
<th><strong>Rationale and what it measures</strong></th>
<th>Allocation of budget to support programmes designed to address vulnerable populations (e.g. women, children, adolescents, and the workplace) provide a proxy measure on the attention and effort spent.</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Indicator definition</strong></td>
<td>NACO and SACS budgets line items for projects or services that are exclusively for or give a majority of emphasis to any of these vulnerable populations are counted. Annual budgets should include sufficient information to classify each project or staff members by the population addressed by the activity. This indicator can be disaggregated by the type of vulnerable population and by state.</td>
</tr>
<tr>
<td><strong>Source of information and how to measure</strong></td>
<td>NACO and SACS budgets are reviewed and the proportion of funds allocated for vulnerable populations should be tallied and reported in the annual report.</td>
</tr>
<tr>
<td><strong>Frequency of generation</strong></td>
<td>Annually</td>
</tr>
<tr>
<td><strong>Frequency of reporting</strong></td>
<td>Annually</td>
</tr>
<tr>
<td><strong>Level of use</strong></td>
<td>National</td>
</tr>
</tbody>
</table>
| **Strengths and limitations**     | - Planned budgets may not reflect actual levels of spending.  
- Many projects address multiple groups which may include a vulnerable population. However, this indicator provides a conservative estimate of the resources spent as it requires all or a majority of funds to be spent on the vulnerable population. |
| **Programme implication**         | Over time interventions for vulnerable populations may increase. The relative amount of funds spent on vulnerable populations should be considered in the context of the type of districts faced by each state and the ability of that state to provide saturated coverage of targeted interventions and services for high risk men. Areas of higher prevalence which have good levels of coverage of high risk groups should develop programming of vulnerable populations. |
## Core Indicator I.c.2

**Percentage of youth using youth resource centers/clubs.**

### Rationale and what it measures
The strategy for addressing youth populations’ vulnerability to HIV/AIDS includes developing mechanisms to provide accurate information in an interactive manner that are youth-friendly and attractive. This indicator measures the coverage of youth target population by designated HIV resource centers/clubs.

### Indicator definition
Youth are defined as persons aged 15-29. High priority districts are those categorized as type A or B epidemic conditions. Youth resource centers like Red Ribbon Clubs (RRC’s) are facilities registered with SACS/NACO to provide information and service referral to youth.

**Numerator:** Youth respondents who report having accessed a youth resource center or youth club in the last year.

**Denominator:** All youth respondents. This indicator should be disaggregated by gender, type of district the youth resides in (i.e. Category A-D) and state.

### Source of information and how to measure
BSS of youth.

Respondents are asked whether they have accessed a youth resource center in the last year. Such centers are described to respondents using programme logos or brand names under which the center is promoted to improve recall. BSS for youth should also collect district of residence which can be matched to category A-D. This will allow sub-group analysis by “high priority district.”

### Frequency of generation
Every 2-3 years

### Frequency of reporting
Every 2-3 years

### Level of use
State

### Strengths and limitations
- Access of youth centers/clubs does not provide detailed information about the frequency at which youth use the resource center, the type of resources used and the effectiveness of exposure to these resources on behaviour or knowledge.

- Youth resource centers that provide a range of services may not be recognizable or recalled readily by youth in the context of information and service referral about HIV. Such recall may depend on the strength of resource center branding.

### Programme implication
Youth in high priority districts require a source of information that can be accessed easily and in an acceptable manner. The proportion of youth who access such services provides a measure of the ability of these services to be made known to and meet the needs of its target audience. These data can be interpreted in the context of youth knowledge and behaviour change also captured in a BSS for youth.
Core indicator I.c.3

Percentage of workers who have access to information and services on HIV/AIDS at their work place.

Rationale and what it measures

Over time, employers are encouraged to provide HIV related services to their workers to reduce their vulnerability to HIV/AIDS.

This indicator measures the extent to which workers are aware of and report access to HIV-related services at their work place.

Indicator definition

Workers are defined as persons who earn income at the time of the survey. The workplace refers to the current/most recent place they have worked. Information and services on HIV/AIDS include, trainings or infotainment about HIV prevention and routes of transmission; issues of stigma and discrimination; provision of health insurance which covers basic HIV care, on-site services or referral for STI management; confidential HIV testing or other care, support or treatment; distribution of condoms or harm reduction services.

Numerator: Number of respondents who report they have access to information or services on HIV/AIDS at their workplace.

Denominator: Total number of respondents who are workers.

Respondents who are not aware of HIV/AIDS are counted in the denominator but not in the numerator. This indicator can be disaggregated by persons in the formal and informal work sector. Definitions for these sectors follow established census categories.

Source of information and how to measure

BSS of general population

Respondents are asked a series of questions:

1) Are you currently employed?

2) What is your current occupation?

3) At the place you currently work, are you aware of any services or information that is available to workers related to HIV/AIDS. This may include: information about HIV/AIDS, help getting services for people with HIV/AIDS,

Frequency of generation

Every 2-3 years

Frequency of reporting

Every 2-3 years

Level of use

State

Strengths and limitations

- This indicator will under-estimate the coverage of workplace programmes, if workers have access to but are not aware of the
available HIV-related information and services at their workplace. This enables a conservative estimate of workplace programmes that are promoted or made visible to ordinary workers.

**Programme implication**

Workplace programmes may be most relevant in districts or states where HIV/AIDS is a higher priority/prevalence issue. These areas require a broader effort to reaching out to the general population to identify people who may vulnerable to infection. Those states with more severe epidemics should correlate with the states which have higher levels of access to workplace programmes for their workers. Workers in specific industries may be more vulnerable to infection and could be prioritized through sub-analysis of the BSS data.
Core indicator I.d.1

Percentage of general population males with STI symptoms who seek treatment from qualified personnel

Rationale and what it measures

STI programmes seek not only to improve the quality of services but to increase the proportion of people recognizing their infection and seeking those services from qualified health care providers. This indicator tracks changes in treatment-seeking behaviour among men who believe they may have STI symptoms, as a measure of effectiveness of communication campaigns targeting these groups.

Indicator definition

STI symptoms may include burning or pain with urination, genital warts or ulcers or urethral discharge.

Numerator: Number of men who report seeking treatment from an MBBS doctor or government STD clinic for STI symptoms experienced in the last year.

Denominator: Number of men who report STI symptoms experienced in the last year.

Source of information and how to measure

National BSS. Adult male respondents are asked the following questions:

1) If they have experienced any of a list of STI symptoms in the last year.

2) If Yes, they are asked “What did you do the last time you had any of these problems.”

Multiple actions can be recorded. Spontaneous response to the question is preferred to avoid leading respondents to provide socially desirable answers. The list of actions can include visiting a doctor or clinic in addition to other activities, such as self-medication or seeking advice from friends/family, etc. Persons who visit doctors or clinics, should be asked about the type of health care provider to confirm that the person was a qualified health care provider.

Frequency of generation

Every 2-3 years

Frequency of reporting

Every 2-3 years

Level of use

National / State

Strengths and limitations

- This indicator measures treatment seeking behaviour among men and does not provide information about the effectiveness or type of treatment that they receive. Neither does the indicator distinguish between men who seek treatment immediately after detecting symptoms or those who postpone treatment for some time. These factors may make a difference in determining the overall effectiveness of promoting treatment seeking behavior in controlling STI among men.
These data should also be interpreted in the context of what is known about prevalence of STIs among men in the general population and the level of asymptomatic STIs among men. For example, as access to effective STD clinics increases, some bacterial diseases are controlled more rapidly than others. These differences may result in changes in the most common symptoms experienced by men with STIs and consequently effect changes in treatment seeking behaviour (e.g. men with painful ulcers may be more likely to seek treatment than men with minor discomfort such as itching and warts).

This indicator assumes that communication campaigns are in place and changes in treatment seeking are related to the intensity and effectiveness of these campaigns.

**Programme implication**

Attribution to changes in treatment seeking behaviour can be assessed by comparing areas where high intensity communication campaigns have taken place just prior to the time of the surveys where behaviour change is expected to be highest, compared to areas with no to low intensity campaigns, where behaviour change would be expected to be small.
Core indicator I.d.2

Percentage/list of clinics reporting a stock out of essential STI drugs

**Rationale and what it measures**
A key component of an effective STI management strategy is ensuring the availability of essential STI drugs at clinics providing STI management. National AIDS programmes engaged in improving STI services have put time and money into improving drug distribution services and in attempting to ensure adequate manufacturing or importing of drugs for the syndromic management of STIs. This indicator measures the extent to which those efforts have been successful in ensuring that service providers are consistently supplied with the drugs they need to work efficiently.

**Indicator definition**
STD clinics include specialty clinics and departments of gynaecology attached to larger medical facilities as well as NGO STI Clinics where drugs are supplied by SACS/NACO. These facilities are registered with SACS/NACO and report regularly using standardized formats. An updated list of essential STI drugs are described in the current national guidelines for STI management.

**Numerator:** Number of STD clinics submitting a monthly report indicating lack of stock of any essential STI drug, any time during the last year.

**Denominator:** Total number of STD clinics registered with SACS/NACO. Indicator may be disaggregated by geographic unit (state and district) as well as by type of facility.

In addition to calculation a percentage, district nodal officers may require listing of problem sites.

**Source of information and how to measure**
CMIS. Monthly reports include specific inquiry about the availability of essential STI drugs, which can be cumulated over any reporting period.

**Frequency of generation**
Annually

**Frequency of reporting**
Monthly

**Level of use**
State / Distic

**Programme implication**
Listings of problem sites can be generated and used to investigate the cause of stock outs. Problems should be categorized as facility based (e.g. ineffective execution of stock management and reordering procedures) or systems based (poor central distribution of adequate supply, poor communication mechanism between distribution point and service outlets, etc.) in order to plan appropriate managerial recourse.
Core indicator I.d.3

Percentage of STI patients’ partners who attend STD clinics for treatment

<table>
<thead>
<tr>
<th>Rationale and what it measures</th>
<th>Due to the high levels of partner reinfection, effective STD management requires both treatment of the primary patient as well as encouraging their sexual partners to come for treatment. This indicator measures the proportion of STD clients’ whose partners also come to the clinic for treatment.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Indicator definition</td>
<td>STD clinics include specialty clinics and departments of gynaecology attached to hospital facilities. These facilities are registered with SACS/NACO as providers of STD services and report regularly using standardized formats. Partners include any person whom the STI patient has had recent sexual contact.</td>
</tr>
<tr>
<td>Numerator</td>
<td>Number of STI cases whose partners attend the STD clinic</td>
</tr>
<tr>
<td>Denominator</td>
<td>Number of STI cases in the reporting period.</td>
</tr>
<tr>
<td>Source of information and how to measure</td>
<td>CMIS. STD format captures numbers of partners who attend clinic for treatment and numbers of STD cases (old and new) who are diagnosed.</td>
</tr>
<tr>
<td>Frequency of generation</td>
<td>Quarterly</td>
</tr>
<tr>
<td>Frequency of reporting</td>
<td>Monthly</td>
</tr>
<tr>
<td>Level of use</td>
<td>State / District</td>
</tr>
</tbody>
</table>
| Strengths and limitations | This indicator will be underestimated if partners seek care at other qualified service provider locations, attend clinic in a subsequent reporting period, if partners do not identify themselves as a referred partner or if the primary STD patients was referred by a their partner.  
STD patients with multiple partners may be vulnerable to reinfection if only one or some of their partners attend clinic for treatment.  
Partners are counted if they attend clinic without regard to the type of treatment they may receive. |
| Programme implications | Partner referral and treatment is one of the most challenging aspects of STD management. Facilities with high levels of partner treatment can be reviewed to determine working strategies and best practices. |
## Core indicator I.d.4

### Reduction in prevalence of most common STIs among the general population and high risk groups

**Rationale and what it measures**

As a major co-factor in HIV transmission, reduction in STI prevalence in the general population and especially among high risk groups can make a significant contribution to HIV/AIDS control programmes. This indicator measures the extent to which STI control programmes have been successful in reducing prevalence of STIs in the generally community. General understanding of STI prevalence can also shape the STI strategy and inform appropriate resource allocation.

**Indicator definition**

STIs of interest include: Syphilis, Gonococci, Chlamydia, HSV, candidiasis and Bacterial Vaginosis

*Hotbow* tests selected for each pathogen should be approved for surveillance purposes, and carried out following appropriate quality assurance procedures.

**Numerator:** Number of persons with laboratory confirmed infection (separately for each STI)

**Denominator:** Total number of people tested.

**Source of information and how to measure**

**Community prevalence surveys.** Surveys should be conducted on probability based samples of selected target populations. In some cases facility based samples may be used, but the characteristic of the population should be well described and procedures for reducing selection bias should be put in place. Prevalence from facility-based surveys should not be directly compared to community based samples unless extensive assessment of potential biases is conducted. Probability based sampling methods used with high risk groups should be appropriate given the extent of mobility and the hidden nature of such populations. Surveys may take place in selected areas with selected populations due to resource constraints. Priority should be given to high prevalence areas.

**Frequency of generation**

Every 3 years

**Frequency of reporting**

Every 3 years

**Level of use**

State / District

**Strengths and limitations**

- Community prevalence surveys, particularly those which include biological specimen collection are difficult to conduct and are resource intensive. Response rates should be taken into account when interpreting data from such studies.

- Comparisons of surveys over time or across geographic areas should be done carefully to ensure methodologies and target populations are comparable.
Sustained high levels of STI prevalence among high risk group may indicate the need to customize STD clinic services for these populations or to provide alternative service access points. STI prevalence profiles provided by such studies can be compared to clinical experience to determine whether clinicians should put more focus on particular signs and symptoms to improve the sensitivity of syndromic case management. STI prevalence, especially of curable bacterial disease, can also provide evidence for assessing the validity of self-reported condom use.
Core indicator I.e.1

Percentage of FSW, MSM and IDU who received HIV testing in the last 12 months and who know their results

Rationale and what it measures

It is important for members of high risk groups such as FSW, MSM and IDU to know their HIV status in order to protect themselves; to prevent infecting others; and to enable early care and treatment for those persons who are infected. This indicator measures the programme’s progress in increasing utilization of HIV testing and counselling services among FSW, MSM, and IDU communities.

Indicator definition

Respondents of a representative (i.e. probability) sample of HRG are asked the following questions:

1. Have you been tested for HIV in the last 12 months?

2. If the answer to question 1 is “yes” ask, Do you know the results of that test?

Numerator: Respondents who respond ‘Yes’ to both questions.

Denominator: Total number of respondents in the survey.

Respondents should be assured that the interviewer does not want to know the actual result, just whether the respondent received the test result.

This indicator can be calculated separately for sex workers, men who have sex with men, and injecting drug users.

When possible, the data for this indicator should be disaggregated by age (<25/25+) and/or duration of engagement in the high risk behaviour (e.g. >2/<2 years duration of sex work, since time of male’s first anal sex with another male partner or since time of first injection with non-medically prescribed drug.)

Source of information and how to measure

BSS or IBBA among HRGs

Frequency of generation

Every 2-3 years

Frequency of reporting

Every 2-3 years

Level of use

National / State

Strengths and limitations

Accessing and/or surveying high risk group (HRG) populations can be challenging. Consequently, data obtained may not always be representative sample of the HRGs. Representativeness should be assessed thoroughly and If there are concerns that the data is not based on a representative sample, these issues should be reflected in the interpretation of the survey data. Where different sources of data exist, the best available estimate should be used. Information on the
sample size, the quality, reliability of the data and any related issues should be included in the report submitted with this indicator.

- Due to the resource intensiveness of surveys of HRG, district level data may not be available for these measures. Given the size of the country and most states, aggregate data for this indicator may be difficult to interpret with respect to the effectiveness of efforts of more local programmes at district and sub-district level.

- Asking people to disclose whether they are HIV positive is not appropriate under these types of survey conditions. Therefore this indicator is not able to exclude people who have been tested prior to one year and know that they are positive. These people would not be expected to seek testing, because their infection status will not change. This may result in an underestimate of the proportion of members of HRG who are not yet positive and seek testing. The extent of this bias depends on the HIV prevalence in the HRG and the duration of time for which accessible VCT services have been available.

**Programme implication**

An increase in the number of high risk groups who seek HIV testing provides a suggest a strong effort by the programme to make linkages between prevention and care. These numbers of high risk groups knowing their status should be correlated to increasing number of high risk group being referred to DOTS and ART, as case finding increases. Greater testing without accompanying increases in service utilization may indicate a problem in supporting testing for high risk groups with appropriate counselling and follow-up services.

**Comments and observations**

UNGASS
Core indicator I.e.2

Number of centers providing ICT services

**Rationale and what it measures**
The indicator describes the degree to which HIV testing services are accessible to the general population in various settings. The expansion of counselling & services in NACP III is aimed at providing an early entry point for care and support, as well as promoting safe behaviour among both HIV positive and negative populations.

**Indicator definition**
A center refers to the lowest unit of service, registered with SACS/NACO to provide HIV counseling and testing. This could be, for example, a primary health centre, hospital, STD clinic, TB DOTS center, ANC clinic providing PPTCT, stand-alone ICTC or a mobile unit. ICTCs are those centers in which both HIV counseling and testing are provided for those who voluntarily (client initiated) seek to know their status (as in traditional VCTCs) or referred by some facility (provider initiated) like from STI clinics, surgical departments, diagnostic testing, etc. for clients including pregnant women. Number of centers can be disaggregated by type of facility (e.g. stand alone, facility integrated or mobile ICT facility etc.), location (Govt, public sector, private sector, non profit sector or NGO's) and geographical units (e.g. state, district) as needed.

**Source of information and reporting**
CMIS registration module.
All qualified center providing counselling and testing must be registered with their respective SACS. These data are entered into CIMS as a pre-requisite to enable electronic reporting.

**Frequency of generation**
Annual

**Frequency of generation**
As registration status changes.

**Level of use**
National / State / District

**Strengths and limitations**
- It is purely an output measure, indicating potential accessibility. This indicator does not measure actual utilization of services.
- This indicator does not capture information about private service outlets which are not registered with SACS/NACO.

**Programme implication**
The aim is to measure the availability and accessibility of VCT services. The roll-out of additional ICT sites can be planned by understanding the current distribution of ICT sites.

**Comments and observations**
Targets for number of service units in each geographic area will vary according to the population size and the severity of the epidemic.
Core indicator I.e.3

Number and percent of persons who got tested at ICTC by gender and age

**Rationale and what it measures**
The second component of the HIV counselling and testing cascade measures the number of people who consent and proceed with HIV testing following their pre-test counseling / information. Both absolute volume of people being tested, as well as the proportion of people who receive pre-test counseling / information who go on to be tested helps in measuring the effectiveness of counselling provided. Characterizing persons who are tested by gender and age is important to measure the effectiveness of programmes at improving utilization of services to vulnerable groups.

**Indicator definition**
Absolute numbers of persons who attend a registered ICT service outlet are counted if they consent and are provide a biological specimen for HIV testing. This indicator can be calculated by gender and age.

*Numerator:* Number of persons who are tested for HIV

*Denominator:* Total Number of people receiving pre-test counseling / information.

This proportion can be calculated separately by gender or HRG member by taking subsets of the population in both the numerator and denominator. This indicator may be disaggregated by type facility (e.g. STD clinic, DOTS center, stand alone ICT, etc.) and geographic unit (e.g. state, district) as needed.

**Source of information and how to measure**
CMIS. The current ICTC formats capture the total number of people consenting and being tested for HIV as well as the number of people who receive pre-test counselling / information.

**Frequency of generation**
Quarterly

**Frequency of reporting**
Monthly

**Level of use**
National / State / District

**Strengths and limitations**
- This indicator does not capture people who seek HIV testing at non-registered ICT service outlets, such as those by private laboratories.
- Persons who repeatedly seek ICT services in a given reporting period may be double counted.

**Programme implication**
Trends in number of people being testing can be monitored over time to determine to draw conclusions as to whether the number of people who have been tested is increasing at a steady rate. Sites with low retention between pre-test counseling / information and opting for testing may receive more managerial support or opportunities for refresher training. Areas with lower than average proportions of women opting for testing (excluding pregnant women) can be prioritized for future programme activity to encourage testing among women.
### Core indicator I.e.4

**Percentage of persons who return for test report at ICTC by gender and age**

**Rationale and what it measures**

The third component of the HIV counselling and testing cascade measures the number of people who return for their test result as a proportion of people who are tested. There are many reasons a person may not return for their test, which includes fear of knowing their status or the inconvenience presented by returning results late or after a long wait. To understand some of the issues behind reasons for not returning for a test results, we can calculate return rates by gender and HIV status.

**Indicator definition**

Persons who attend a registered ICT service outlet are counted if they are provided with their test result.

**Numerator:** Number of persons receiving their HIV test results

**Denominator:** Total Number of patients who are tested for HIV. This indicator can be calculated separately by gender and HIV status by taking a subset of the population in both the numerator and denominator.

**Source of information and how to measure**

CMIS. The current ICTC formats include the total number of people receiving their HIV test results as well as the number of people who are tested for HIV. These data are segregated out by gender.

**Frequency of generation**

Quarterly

**Frequency of reporting**

Monthly

**Level of use**

State / District

**Strengths and limitations**

- This indicator does not capture people who seek HIV testing at non-registered ICT centers, such as those by private laboratories.

- Persons who repeatedly seek ICT services in a given reporting period may be double counted.

- Stratification by gender and HIV status provide only crude ideas for why rates of returning for test results may be low.

**Programme implication**

Trends in number of people receiving testing can be monitored over time to determine whether rates of return are meeting state or national norms. Sites with low proportions of HIV positive clients returning for their test results should trigger managerial follow-up to determine how counselling services can be improved to increase the proportion returning. Areas with lower than average proportions of women opting for testing (excluding pregnant women) may require further exploration as to structural barriers that may be preventing women from returning for test results. Similar analysis can be undertaken for members of HRGs.
Core indicator I.e.5

Number and percentage of persons who test positive by age and gender

Rationale and what it measures
An important component of the HIV counselling and testing cascade measures the number of people who test positive for HIV among those who are tested. This measure does not indicate the level of performance of a ICT service outlet, but it can provide an early warning as to the need for additional care and support services in an area that has sustained higher than average proportions of HIV positive clients coming for ICT services. Other demographic details of HIV positive persons, e.g. by age and gender can also provide information about who is at risk for HIV.

Indicator definition
Persons who attend a registered ICT service outlet are counted if they test positive for HIV.

**Numerator:** Number of persons who test positive after confirmation with 3 separate tests (as per ICTC testing guidelines).

**Denominator:** Total Number of patients who are tested for HIV. For non ANC clients,

This indicator can be calculated separately by age groups: <=14; 15-24; 25-34; 35-49>=50; and gender. These strata-specific percentages are not calculated for ANC clients, as these clients already fit a specific profile. Persons who seek VCT multiple times during a reporting period may be double counted. This indicator may be disaggregated by type of referring facility (e.g. STD clinic, DOTS center, stand alone ICT, etc. and geographic unit (e.g. state, district) as needed.

Source of information and how to measure
CMIS. The current ICTC formats include the number of non ANC clients who test positive and the number of non-ANC clients who were tested by age and gender strata.

Frequency of generation
Quarterly

Frequency of reporting
Monthly

Level of use
State / District

Strengths and limitations

- The proportion of positives among those tested at a ICT service outlet is dependent on many factors which may not reflect the larger population in the service outlet catchment area. These include changing patterns of referral for diagnostic purposes or suspected exposure to HIV. For this reason, the percent positive at a ICT site should NOT be used or quoted as an approximate measure of HIV prevalence.

- Changes in volume of testing can greatly influence the proportion of positives, especially in a low prevalence area, which is the epidemic
Large changes in testing volume may indicate a shift in referral patterns and signal differences in the characteristics of the population being tested. In this situation, changes in the proportion of positives over time may not accurately reflect a real trend in prevalence among the broader population.

Programme implication

Sites which relatively high numbers of positive clients should be encouraged to develop strong linkages to care, support, and treatment services to ensure proper referrals and follow-up are provided to positive clients. Given the concentrated nature of the HIV epidemic in India, one of the key challenges is to encourage persons with higher risk behaviours to seek HIV testing, rather than to use general campaigns that encourage people to be tested. When ICT service outlets show higher levels of HIV positives, this suggests that messages encouraging testing are reaching the more vulnerable segments of the population.
Core indicator I.e.6

Number of persons receiving pre-test counseling / information by gender

Rationale and what it measures

HIV testing and counseling are important entry points for addressing prevention and care needs. This indicator is the first in a cascade of indicators to help program managers assess whether targets are being met for increasing the number of people who know their status and receive appropriate ICT services.

This indicator is designed to measure the volume of people who have sought testing and received pre-test counseling / information services, as well as to describe the profile of people seeking testing by gender characterizing persons who seek testing by gender is important to measure how effective programmes are at improving utilization of services to vulnerable groups including women.

Indicator definition

Persons who attend a registered ICT service outlet are counted if they begin the process of pre-test counseling / information.

Persons are counted even if they do not proceed for testing following the pre-test counselling / information.

The proportion of females is calculated as follows:

Numerator: Number of females receiving pre-test counseling / information

Denominator: Total Number of people receiving pre-test counseling / information

This indicator may be disaggregated by type of facility and geographic unit (e.g. state, district) as needed.

Source of information and how to measure

CMIS.

The ICTC format captures information about the numbers of people who receive pre-test counseling/information

Frequency of generation

Quarterly

Frequency of reporting

Monthly

Level of use

National / State / Districts

Strengths and limitations

- This indicator does not capture people who seek HIV testing at non-registered ICT service outlets, such as private laboratories.
- There is not an obvious denominator with whom to compare the number of people who seek ICT services. i.e. to calculate a percentage of people who have sought testing.
- Persons who repeatedly seek ICT services in a given reporting period may be double counted.
Persons who belong to HRGs may or may not disclose the source of their referral as a targeted intervention NGO/CBO. Similarly, not all persons who belong to HRGs may be seeking ICT through a referral from an NGO/CBO. This may result in an underestimate of the proportion of persons who seek ICTC pre-test counselling who are members of HRGs.

**Programme implication**

Trends in number of people seeking testing can be monitored over time to determine whether service utilization is increasing as expected, especially for new or previously underperforming sites. Sites with large or unusual patterns of client load can be identified for staffing reallocation or to trigger managerial follow-up. Districts and states can be compared by calculating per capita rates of persons seeking ICT services. Areas with lower than average proportions of women seeking testing (excluding pregnant women) can be identified for future programme activity to encourage testing among women.

**Comments and observations**

Data from this measure can be compared to the percentage of respondents in a household survey of the general population who say they have sought HIV testing in the last 3 months. Relative patterns by geographic area should be consistent with reported volume of testing, unless large scale testing in private facilities is occurring.
Core indicator I.e.7

Number and percentage of persons accessing ICT services who are referrals from DOTS centers

Rationale and what it measures

Linkages between TB and HIV service points are critical for patient care given the high level of co-infection and the impact of one disease on the prognosis of the other.

Newly diagnosed TB patients should be routinely referred for HIV testing. This indicator measures the proportion of ICTC patients who are referrals from TB DOTS centers (i.e. RNTCP).

Indicator definition

Persons are counted from among ICT service outlets registered with SACS/NACO. Persons who access ICT services and report an in-referral from a DOTS center or RNTCP site are counted in this indicator. ANC patients are excluded from this indicator.

Numerator: Number of ICTC registrations referred in from RNTCP (DOTS)

Denominator: Total number of ICT registration

Persons may be counted even if they do not complete the full ICT process. Persons are counted in the reporting period in which they first attend ICT services.

This indicator can be disaggregated by geographic unit as needed, based on the information provided in the CMIS registration module required of each ICT service outlet.

Source of information and how to measure

CMIS.

ICTC reporting format collects data on number of ICTC clients with in referral & out referral to TB microscopy / RNTCP.

Frequency of generation

Quarterly

Frequency of Reporting

Monthly

Level of use

National / State / District

Strengths and limitations

- Not all persons who are referred from a DOTS center may report being referred from such a site. This may result in an under reporting.

- This indicator does not capture patients referred from DOTS centers that seek HIV testing from unregistered private testing service outlets.

- This indicator may not be directly comparable to an indicator of numbers of newly diagnosed TB patients at DOTS centers who are referred to ICT services.

- If the visit to DOTS center and visit to ICT site occur in different reporting periods. It may also be difficult to match up DOTS centers
and ICT service centers due to differences in catchment areas and potentially high degree of mobility of patients.

**Programme implication**

This indicator can be roughly compared to the number of newly diagnosed TB patients in a given geographic area.

While an absolute percentage target may be difficult to determine, an increasing trend indicates improving linkages between DOTS centers and ICT service outlets.

Sites with low numbers of in-referrals from DOTS centers but which are known to have high rates of new TB cases can be prioritized for follow-up supervisory visits or refresher training.

Facilities with integrated services including an on-site DOTS center as well as ICT services should be able to provide better referral linkages and allow more direct comparison of number of newly diagnosed TB patients and in-referrals from TB sites among ICT clients.
Core indicator I.e.8

Percentage of HIV-positive persons referred to ART center, by gender

Rationale and what it measures

Early access to treatment can greatly delay progression of disease among people living with HIV/AIDS. This indicator measures how frequently newly diagnosed HIV positive people are provided with out-referrals to ART treatment centers. It is also important to assess whether men and women have equal access to treatment. Differences in referral patterns between men and women may indicate some level of discrimination that may need to be corrected.

Indicator definition

An HIV-positive individual is one who has been newly found positive upon HIV testing at a registered ICTC. ART (antiretroviral therapy) is a long-term combination therapy intended primarily to improve the health of a person on treatment, referrals for services to prevent mother-to-child transmission are excluded in this indicator.

ART centers are those facilities that are registered by SACS/NACO to provide ART according to national guidelines.

Numerator: Number of newly diagnosed HIV positive people at ICTC provided with an out-referral to an ART center.

Denominator: Number of newly diagnosed HIV positive people at ICTC

This indicator can be calculated overall and separately for male and female clients. The indicator should be calculated separately for ANC clients.

Indicator can be disaggregated by type of facility and geographic unit as needed.

Source of information and how to measure

CMIS.

The ICTC format captures information on the number of out-referrals to ART among positive clients and the number of clients testing seropositive (after 3 specified tests) by gender. For ANC clients similar data are available.

Frequency of generation

Quarterly

Frequency of reporting

Monthly

Level of use

State / District

Strengths and limitations

- This indicator does not capture information from ICT service outlets which are not registered with SACS/NACO.
- The success of the referral is not captured by this indicator, i.e. whether people who are referred actually go to ART centers.

Programme implication

This indicator is most useful for day to day programme management, ensuring the proper procedures for making out-referrals to ART centers are being followed. Service outlets where newly diagnosed patients have low rates of referral to ART compared to average or expected numbers may require further investigation. Facilities where gender difference in percentage of referrals is large, may trigger an investigation into whether some bias in referrals is occurring.
Core indicator I.e.9

Percentage of pregnant women newly diagnosed as HIV positive at ICTC whose sexual partner has been tested

Rationale and what it measures

Quality is central to the effectiveness of counselling. Many programmes have made great efforts to improve the quality of counselling, not least through the intensive training of counsellors. One of the most challenging but important areas in counseling related to HIV testing is to encourage positive clients to bring their sexual partners for testing. This indicator measures the extent to which efforts to provide high quality counseling have resulted in HIV-positive persons to convince their partners for testing.

Indicator definition

Newly diagnosed HIV patients are counted at VCT service outlets which are registered with SACS/NACO.

Numerator: Number of spouses/partners of HIV positive women who were referred to ICTC (and were tested)

Denominator: Number of ANC clients who were newly diagnosed with HIV.

This indicator can be disaggregated by gender of the client, type of facility and geographic unit as needed.

Source of information and how to measure

CMIS.

Frequency of generation

Quarterly

Frequency of reporting

Monthly

Level of use

State / District

Strengths and limitations

- This indicator may not exclude people who’s partner already knows their status (which may be the reason they have sought testing in the first place). In these cases the proportion of partners who don’t know their status and who are tested is underestimated.

- If the indicator captures only partners who know their status, it is less clear whether a high proportion of partners having been tested is a result of good post-test counselling for HIV positive persons.

- Tracking partner testing is difficult as partners may seek testing at other facilities or may not disclose their relationship to a previously tested client at a particular VCT service outlet. This will result in an underestimate in the proportion of partners who come for testing.

- Encouraging partner testing is important but represents only one element of good counselling. Many barriers to partner testing may exist and may not reflect the skills or efforts of the counselors.
Programme implication

While low partner testing may not conclusively suggest poor counselling efforts, high partner testing does suggest counselors are persuasive and consistent in encouraging partner testing among HIV positive patients. Facilities with lower than average percentages of partner testing may warrant managerial follow-up or referesh training opportunities for counselors.
Core indicator I.e.10

Percentage of ICTC reporting inadequate quantities of HIV test kits

**Rationale and what it measures**

Smooth operations of any service depends on maintaining proper accounting of supplies and timely re-orders to avoid periods of shortage.

For ICT service outlets, ensuring the constant availability of unexpired HIV test kits is one of the most critical supply management issues.

**Indicator definition**

An ICT centers is that which is registered with SACS/NACO to provide voluntary counselling and testing.

For confirmatory test purposes, an ICTC must maintain stock of at least three different HIV test kits. Those ICT service outlet which report a balance of stock of 0 are classified as having inadequate stock.

**Numerator**: Number of ICT service outlets reporting less than the minimum balance of any of the three HIV test kits used for testing during a month.

**Denominator**: Number of ICTC service outlets. This indicator can be disaggregated by type of ICT service outlet and by district as needed.

**Source of information**

CMIS.

The ICTC format captures data on inventory for consumables. The form allows inventory for up to 4 types of test kits and ARV drugs to be inventoried.

**Frequency of generation**

Quarterly

**Frequency of reporting**

Monthly

**Level of use**

Inadequate supply which occur and are addressed during the middle of the reporting period are not captured in this indicator. This may underestimate the degree of the problem for short term inadequate supply, yet even short term stock outs can impact the service provided to clients and discourage people from seeking services at that facility.

The current reporting format does not allow an assessment of whether the stock available are expired and essentially unusable. To assess the availability of unexpired stock, a health facility survey or other site visit must be conducted.

**Programme implication**

Data on number of test kits used should be consistent with the number of tests reported. Any discrepancies can be explored further to determine if there is a problem with data collection and reporting, etc.

Stock outs suggest a break down in the system for maintaining smooth operations. Any stock out should be explored to determine whether the contributing factors can be addressed or whether there are structural barriers to managing stocks.
Core Indicator I.e.11

Number and percentage of HIV-infected pregnant women & newborns receiving antiretroviral (ARV) prophylaxis

Rationale and what it measures
This indicator assesses the progress in preventing parent-to-child HIV transmission (PPTCT) through the provision of ARV prophylaxis.

In the absence of any preventative interventions, infants born to and breastfed by HIV-infected women have roughly a one in three chance of acquiring infection themselves. This can happen during pregnancy, during labour & delivery or after delivery through breastfeeding.

The risk of mother-to-child transmission can be reduced through the complementary approaches of ARV prophylaxis for the mother and the infant, implementation of safe delivery practices and use of safe alternatives to breastfeeding.

This indicator measures the success of moving HIV positive pregnant women from knowing their status to receiving a complete course of ARV prophylaxis for themselves and their infants.

Indicator definition
A complete course of ARV prophylaxis for a HIV-infected pregnant woman consists of a single dose of Nevirapine during labour. As other regimens for PPTCT are approved by NACO and included in the national guidelines, the definition for this indicator will be expanded to include those cases.

A complete course of ARV prophylaxis for a newborn of an HIV-infected mother consists of a single dose of Nevirapine within 72 hours of delivery.

Numerator: Number of HIV-infected pregnant women who receive a complete course of ARV prophylaxis during the reporting period.

Denominator: Number of HIV-infected pregnant women who go into labour during the reporting period.

Numerator: Number of newborns of HIV-positive mothers who receive a complete course of ARV prophylaxis during the reporting period.

Denominator: Number of live births born to HIV-infected pregnant women during the reporting period.

Numerator: Number of HIV-infected mothers and infant pairs which both receive a complete course of ARV prophylaxis during the reporting period.

Denominator: Number of HIV-infected mothers who deliver live babies.

This indicator can be disaggregated by type of facility and geographic unit (i.e. state and district.).

Source of information and how to measure
CMIS,
The ICTC format collects information on the number of HIV-infected pregnant women and infants born to HIV-infected mothers who receive ARV prophylaxis. The denominator of HIV-infected pregnant women...
who deliver and the number of live births to HIV-infected mothers is also included in the format.

**Frequency of generation**
- Quarterly

**Frequency of reporting**
- Monthly

**Level of use**
- National / State

**Strengths and limitations**
- The number of deliveries in the reporting period is estimated from registers listing due dates of pregnant women who test positive for HIV. This calculation may be complex and difficult for some facilities to accurately report. The reliability of this denominator may vary according to the distribution of stage of pregnancy women are tested for HIV, i.e. women who are tested during labour are counted more accurately than women who test positive during their first trimester.

- In some cases the facility where women are tested may not be the site where their delivery takes place. This may lead to unreliable facility-specific rates. Assuming that most pregnant women who are tested deliver in the same district, the calculation of district-specific percentages may be more reliable.

- This indicator does not capture pregnant women who are not tested or who do not access antenatal care services. This percentage varies by region and should be taken into consideration when comparing data from different states.

- These issues are pertinent for the proportion of infants who receive a full course of ARV prophylaxis, in terms of estimating the number of live births during the reporting period; the likelihood that infants will be followed up at the same facility where their mother was tested; and deliveries that take place outside of birthing center.

**Programme implication**
- HIV positive women OR infants who do not complete a full course of prophylaxis therapy greatly increase the likelihood of HIV transmission to their infants. Sites with low levels of prophylaxis completion should investigate where in the process of counselling and follow-up visits mothers are being lost.

The CMIS captures drop out rates at different stages in the cascade of services related to PPTCT and can be used to better tune services to meet the needs of ANC clients.
Core indicator I.e.12

Percentage of ICTCs having pregnant women as their clients.

**Rationale and what it measures**

This indicator measures the extent to which the national programme is able to scale up prevention of parent to child transmission (PPTCT) through an integrated approach to counseling and testing services. This approach attempts to equip all registered ICTCs with the capacity to provide appropriate services for pregnant women.

**Indicator definition**

ICTC services are those which are registered with the SACS/NACO and follow national guidelines for providing services.

- **Numerator**: Number of registered ICTCs reporting statistics on pregnant female clients
- **Denominator**: Number of registered ICTC sites

This indicator may be disaggregated by the type of district (i.e. epidemic/programme category A-D) and by state.

**Source of information and how to measure**

CMIS. The CMIS registration module for ICTC sites captures information on whether pregnant women are clients of a particular ICTC and the district to which each facility belongs.

**Frequency of generation**

Annually

**Frequency of reporting**

As registration status changes.

**Level of use**

National / State

**Strengths and limitations**

- This indicator cannot provide information as to the quality of the PPTCT services or the level of utilization in each district. It is limited to assessing the degree to which coverage of pregnant women at ICTCs is achieved.

**Programme implication**

States are expected to enhance ICTCs with PPTCT services systematically throughout the districts. Maps showing sites without ICTC services for pregnant women can provide more nuanced assessments of coverage and how to prioritize roll out for future services. States can be compared by calculating the average proportion of ICTCs which have services for pregnant women.
Core indicator I.f.1

Percentage of health care providers who access PEP within 24 hours of exposure

Rationale and what it measures

As HIV prevalence rises among patients seen at health facilities, the danger of accidental transmission of HIV between health care provider and patient or from one patient to another also rises. Health care providers who are exposed to infection (e.g. through needle stick or direct contact with bodily fluids of suspected HIV positive patients) should receive post-exposure prophylaxis within 24 hours in accordance with infection control procedures. Incidents of exposure should also be documented and reported to the appropriate authorities.

This indicator measures the extent to which PEP for health care providers are followed in public sector facilities.

Indicator definition

Health care providers may include any staff member of designated health care facilities, who are exposed during duty hours.

Numerator: Number of instances when PEP was provided to exposed health care providers within 24 hours of the exposure event.

Denominator: Number of incidents of exposure reported by health care providers.

Incidents which are reported but for which the follow-up action is not indicated are counted in the denominator but not the numerator.

Indicator can be disaggregated by type of facility, type of health care worker, and geographic unit.

Source of information and how to measure

Special Studies

Frequency of generation

2-3 years

Frequency of Reporting

2-3 years

Level of use

State / District

Strengths and limitations

- Experience suggests that completeness of reporting of such events varies widely. In countries where HIV is both common and highly stigmatized, service providers frequently choose not to report injuries because of policies enforcing HIV tests for those affected. (These tests are often required as a precursor to providing post-exposure prophylactic treatment with antiretrovirals.)

- It may be more likely to report incidents of exposure when PEP procedures are followed. For this reason, percentages may be inflated than actual experience in health care facilities.
Facilities without PEP provisions on site, may be at a disadvantage in following PEP procedures as recommended. Indicators for these types of facilities should be calculated separately.

**Programme implication**

Failure to comply with the 24 hour rule in providing PEP may reflect structural barriers in the system in obtaining access to prophylaxis or low levels of awareness of the procedures when such incidents happen. With increased training and resources to address PEP in health care facilities, these indicators should show improvements.
Core indicator 1.g.1

Percentage of adults reporting condom use at last sex with non-regular partner

Rationale and what it measures

Condoms can substantially reduce the risk of the sexual transmission of HIV. Consequently, consistent and correct condom use is important for general population adults who have sexual partners other than a spouse or other regular partnership. The NACP III condom strategy involves a variety of measures to increase condom use among the general population in all types of non-regular partnership.

This indicator assesses progress in promoting the use of condoms through various programme activities.

Indicator definition

Relevant respondents are those men and women who have had a non-regular partner in the last year.

Non-regular partners are persons the respondent has had sex with, but who is not a spouse or someone that lives in the same household as the respondent. Commercial sex partners are included in this definition of non-regular partner.

Numerator: Number of respondents who reported that a condom was used the last time they had sex with a non-regular partner

Denominator: Number of respondents who reported having had sex with a non-regular partner in the last 12 months.

Data for this indicator should be disaggregated by age (<25/25+) and location of residence (urban/rural).

Source of information and how to measure

BSS for general population

Respondents are asked a series of questions:

1) Have you had a non-regular sexual partner in the last 12 months?

2) If yes, the last time you had sex with a non-regular partner, did you or your partner use a condom?

Access to survey respondents as well as the data collected from them must remain confidential.

Frequency of generation

Every 2-3 years

Frequency of reporting

Every 2-3 years

Level of use

National / State

Strengths and limitations

- Condoms are most effective when their use is consistent, rather than occasional. The current indicator will provide an overestimate of the level of consistent condom use. However, the alternative method of asking whether condoms are always/sometimes/never used in sexual encounters with non-regular partners in a specified period is
subject to recall bias. Furthermore, the trend in condom use in the most recent sexual act will generally reflect the trend in consistent condom use.

- Surveying the general population on sensitive behaviours can be challenging and result in respondents giving socially desirable responses in face-to-face interviews. This will result in an overestimation of this indicator.

<table>
<thead>
<tr>
<th>Programme implication</th>
<th>Condom use among persons with non regular partners is key to limiting the spread of HIV in the general population. NACP III puts substantial effort into designing coordinated, well tested condom promotion campaigns that effectively reach the segment of the population with non-regular partners. States which are effective in promoting change should be identified and strategies and best practices shared.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Comments and Observations</td>
<td>UNGASS. In addition to condom use indicators about last time sex, Two additional questions on consistent condom use are recommended to be added to BSS among general population males to enable more robust analysis of changes in behaviour over time. These questions include:</td>
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<tr>
<td>a)</td>
<td>How often are condoms used when having sex with non-regular partners in the last 12 months? (Always, Most of the time, Sometimes, Never); and</td>
</tr>
<tr>
<td>b)</td>
<td>Has there been any occasion when a condom was not used in the last 12 months (among those who report every time use of condoms).</td>
</tr>
</tbody>
</table>
Core indicator 1.g.2

Number of condoms distributed by socially marketing programmes

Rationale and what it measures
The NACP III condom promotion strategy includes distribution of socially marketed and free condoms to different segments of the population. This indicator measures the success of efforts to increase the number of socially marketed condoms absorbed by the market.

Indicator definition
Socially marketed condoms are those that are distributed by the government to secondary distributors at a subsidized rates. In turn these condoms are branded and sold to consumers for market or slightly reduced rates.

The socially marketed condoms counted are those that are distributed through NIHFW as described under the NACP III condom strategy.

Source of information and how to measure
CMIS ORG Retail audit, captures information about volume of sales of different brands of socially marketed condoms.

Frequency of generation
Annually

Frequency of reporting
Monthly

Level of use
National / State

Strengths and limitations
- This indicator will not capture social marketing of condoms sold in outlets which are not included as retail. This excludes many non-traditional outlets supported by the NACP condom strategy e.g. those located in lodges or brothels.
- The ORG retail outlet does not include states in the northeast and Kashmir.
- Socially marketed (male and female) condoms sold through TI programmes are included in CMIS data entry formats for TI

Programme implication
Increasing numbers of socially marketed condoms provide evidence that efforts to increase demand of condoms are effective. These data should be interpreted in the context of the overall picture of condom distribution, i.e. both free, commercial, and socially marketed. The proportion of socially marketed condoms relative to free distribution is also expected to increase, while not decreasing the overall number of condoms distributed

Comments and Observations
Monthly reporting by Social marketing organizations on condom sales to retail outlets can be compared to retail audit volume to assess the gap and amount wasted or floating among stockists and used as calibration to interpret routine self reported data from SMOs.
Core indicator 1.g.3

Number of free condoms distributed through TI, STD clinics and youth centers

**Rationale and what it measures**

Condoms are made available for high risk, patients at STD clinics, and youth clubs to promote regular condom use with commercial or non regular partners.

This indicator measures actual distribution at the client level through TI programmes and at STD clinics.

**Indicator definition**

Targeted interventions and STD clinics, and youth clubs counted in this indicator are those that are registered with SACS/NACO to provide services.

Free condoms are those provided to high risk group members (FSW, MSM or IDU) or patients of STD clinics without charge and individuals participating in youth clubs.

Condoms may be distributed through multiple mechanisms, one-to-one during counselling or outreach session or through depots or outlets where persons can take as many condoms as they want without interacting with a service provider.

Condoms used for demonstrations of use may be included in these records.

This indicator can be disaggregated by type of intervention (i.e. TI or STD clinic or youth club) and geographic unit (state and district).

**Source of information and how to measure**

CMIS. TI and STD clinic and youth club formats record the number of free condoms distributed. Distribution is recorded through daily records of interaction with high risk group members or patients registers; or through inventory reports in the case of condom depots/outlets.

**Frequency of generation**

Quarterly

**Frequency of reporting**

Monthly

**Level of use**

National / State / District

**Strengths and limitations**

- Condoms distributed may not equal actual use and may overestimate the number of condoms effectively preventing transmission of HIV or STDs.

- Free condom distribution records, esp. for condom depot may be imprecise.

- As free condom distribution measures distribution at individual client level, it may not be directly comparable to the indicator on socially marketed condom distribution, which is at the level of secondary distributor.
Free condoms are distributed to individuals who are at highest risk for acquiring or transmitting HIV. Ramping up and sustaining high levels of condoms distribution is key to improving the proportion of sex acts with non-regular partners where condoms are used. The trends in this indicator should be consistent with other information about attitudes of condom use or self-efficacy of condom use to establish that increase in distribution is correlated to increase in use or intention to use.
Core indicator I.g.4

Percentage of males who report condoms were easy to obtain near the place of last sex act with non-regular partner.

Rationale and what it measures

Convenient access to condoms at the time of risky sex acts is an important factor for increasing use of condoms.

This indicator measures the extent to which men with non-regular partners perceive that condom access is good near the places where they have sex.

Indicator definition

This indicator is measured among men who have had a non-regular partner in the last year. Non-regular partners are sex partners other than a spouse or a person who lives in the same household as the respondent. This person may or may not be a commercial sex partner. Availability of condoms is measured as a perception of being easy to obtain at the time of sex.

Numerator: Number of male respondents who had a non-regular partner in the last year and who report that condoms were easy to obtain near the place where he last had sex with a non-regular partner.

Denominator: All male respondents who reported a non-regular partner in the last year.

Source of information and how to measure

BSS for general population males.

Respondents are asked a series of questions:

1) Did you have a non-regular sex partner in the last year?

2) If yes, thinking about the last time you had sex with a non-regular partner, did you or your partner have a condom with you at the time?

3) If no, would you say that you know where to get condoms within 5-10 minutes walking distance from place where I go for sex. Persons who answer ‘yes’ to question 2 or to question 3 are counted in the numerator.

Frequency of generation

Every 2-3 years

Frequency of reporting

Every 2-3 years

Level of use

National / State

Strengths and limitations

- This indicator presents a partially hypothetical situation to assess accessibility of condoms. Perception of availability of condoms may not reflect actual ease of obtaining condoms if respondents made a real attempt to get a condom.

- Sensitive behaviours such as experience with non-regular partners may be difficult to collect in household-based general population surveys. Respondents may provide socially desirable responses in...
face-to-face interviews. This may result in an underestimate of the number of people who have non-regular partners and answer the question about condom accessibility or about the accessibility of condoms.

- Sex with non-regular partners may not be a frequent occurrence for some partners and accurate recall of the availability of condoms may not be reliable.

**Programme Implication**

Areas where respondents report difficulty in obtaining condoms at the time of sex with non-regular partners should increase efforts to expand the types of non-traditional outlets for condoms that may make condoms easier to obtain at the time of risky sex.

**Comments and Observations**

To enrich the understanding of condom availability from a client perspective, the following questions are recommended to be included in the general population BSS for males:

Respondents are asked to respond according to a 4-part likert scale: Strongly agree, Agree, Disagree, Strong Disagree.

a. If needed, I can get a condom within next 5-10 minutes of walking distance from this place

b. There are lot of shops that sell condom

c. In general condoms are always available near the places where one could find female sex workers

d. One can easily find condoms at shops all over the town

These questions should be asked to males reporting non-regular partners in the last 12 months.
Core indicator i.g.5

Number of non-traditional outlets for socially marketed condoms

**Rationale and what it measures**

Increasing condom availability at venues where high risk sex acts may occur requires establishing non-traditional condom outlets. This indicator measures the speed at which such outlets are established through the NACP III condom strategy.

**Indicator definition**

Non traditional outlets for socially marketed condoms counted are those established by condom strategy activities in each state.

These outlets stock socially marketed condoms and are largely based at retail outlets strategically located in hotspots of sex venues or solicitation. Examples include, paan shops and lodges, etc. This is in contrast to traditional outlets which are broadly defined as pharmacies. Outlets located in rural areas are also counted as a non-traditional outlet.

**Source of information and how to measure**

SMO records organizations participating in NACP condom strategies track lists of retail outlets to whom socially marketed condoms are sold. These lists can be categorized as traditional or non-traditional according to the above definition.

**Frequency of generation**

6 monthly

**Frequency of reporting**

6 monthly

**Level of use**

National / State

**Strengths and limitations**

- Records of socially marketed condoms may not be reliable in some areas
- This indicator does not count socially marketed condom outlets managed by targeted interventions.

**Programme implication**

Overall non-traditional condom outlet numbers should increase over time, without showing a decrease in overall number of outlets where condoms are made available.

**Comments and observations**

On a periodic basis, the condom programme will conduct special coverage surveys to assess the number of non-traditional outlets in urban area hotspots and rural areas. These numbers will be used to verify routine reports from SMOs.
Core indicator I.h.1

Percentage of blood units screened for HIV in a quality assured manner

Rationale and what it measures

Blood-safety programmes aim to ensure that all blood units are screened for HIV and those units that are included in the national blood supply are uninfected. In many countries, blood units are not screened at all; often, if they are screened, the testing is done by poorly-trained personnel or with outdated equipment or insufficient inputs, which could lead to blood units being classified as safe even when they are infected.

This indicator measures the programme’s progress in screening all blood units for HIV by facilities following quality assurance procedures as defined by national guidelines.

Indicator definition

Blood units collected at registered blood banks and transfusion centers are included in this indicator.

To meet the quality assurance standard, blood units must be from facilities which meet the quality assurance standard according to that year’s service quality assessment. The quality assurance standards are consistent with the national guidelines for blood banks and transfusion centers.

Because service quality assessments are conducted only annually, this indicator is calculated once a year following the completion of the annual quality assessment. If service quality assessment is not conducted in that year, the facility is assumed to meet the quality standard for the purpose of calculating this indicator.

Numerator: Number of blood units which have been screened at registered blood bank and transfusion centers meeting the service quality standard.

Denominator: Total Number of blood units collected at all registered blood banks and transfusion centers. This indicator can be disaggregated by state and district as needed.

Source of information and how to measure

CMIS format for blood banks and transfusion centers capture the information about number of units screened for HIV and the total number of units collected. The information from the service quality assessment about whether the facility met the standard is also captured in the CMIS.

Frequency of generation

Annually

Frequency of reporting

Monthly

Level of use

National / State / Distric

Strengths and limitations

- This indicator only captures information on quality assurance of the HIV testing process if a service quality assessment is conducted at the facility and if this information is properly recorded in the
CMIS. Centers are given the benefit of the doubt if no service quality assessment is conducted which may lead to an overestimate of the proportion of blood units which are tested in a quality assured manner.

**Programme implication**

This indicator is expected to reach 100% and be maintained at this high level. This indicator also penalizes facilities and geographic units heavily for failing to meet quality standards when a service quality assessment is conducted. These data can be used to estimate the potential number of HIV infections which occur due to unsafe blood transfusion practices.
Core indicator I.h.2

Number and percentage of blood units collected through voluntary blood donation

Rationale and what it measures

In many cases, donated blood units are collected from relatives or family contacts of an admitted person or from people willing to ‘sell’ blood. This practice has been found to increase the risk of transfusing infected blood as persons may be motivated to donate blood despite knowing they have high risk factors, especially for paid donors. Because blood banks play a proactive role in encouraging voluntary blood donation, this indicator measures to what extent this policy has been successfully implemented at different blood banks in the country.

Indicator definition

Blood banks and transfusion centers are registered with SACS/NACO and regularly report on their activities through standardized formats. Voluntary blood donation refers to persons who were not paid or recruited by friends or family members to give blood.

Numerator: Number of blood units collected at registered blood banks and transfusion facilities through voluntary donation

Denominator: Total number of units collected at registered blood banks and transfusion centers. This indicator can be disaggregated by type of facility (public; private) and geographic unit (state, district)

Source of information and how to measure

CMIS. Blood bank formats capture information on the number of donors who are voluntary and the total number of units donated in a reporting period.

Frequency of generation

Quarterly

Frequency of reporting

Monthly

Level of use

National / State / District

Strengths and limitations

- To interpret trends in this indicator, it is important to consider whether volume of blood unit collection has remained the same or has increased over time.

Programme implication

To achieve the goal of all blood collection through voluntary blood donation, concerted campaigns must be made to encourage high levels of voluntary blood donation to maintain the needed blood supply. Changes over time should be interpreted in the context of what activity has been undertaken to encourage voluntary blood donation. Due to the demand on the blood supply, it would be important to detect whether efforts to support voluntary blood donation is resulting in a reduction in the overall blood supply.
Core indicator I.h.3

Percentage of blood being processed into components

Rationale and what it measures
Blood safety includes making most efficient use of available blood donations to reduce blood shortages and make reliance on voluntary blood donation more sustainable. By separating donated whole blood into components and educating health care providers in the proper use of different types of components, the supply of donated blood is better utilized.

This indicator measures the extent to which separation of blood into components has become adopted practice in blood banks of India.

Indicator definition
Blood collected and processed by blood banks which are registered with SACS/NACO are included in this indicator.

Numerator: Number of collected units separated into components

Denominator: Total Number of units collected during the reporting month in specific State/entire country

Blood units collected at facilities without blood separation equipment or supplies will be counted in the denominator, but not the numerator.

Indicator can be disaggregated by geographic unit (state; district)

Source of information and how to measure
CMIS. Blood bank formats capture information about number of blood component units separated into components (the component type with the largest number of units should be taken as a proxy for the number of units separated into components and the total number of donors).

Frequency of generation
Annually / Quarterly

Frequency of reporting
Monthly

Level of use
National / State / District

Programme implication
Blood unit separation into components is expected to be standard practice in registered blood banks by 2011. Facilities which do not have the necessary equipment and supplies to separate blood into components may present the greatest structural barrier. This indicator should be interpreted with Indicator I.h.3 which measures the number of such facilities established. Facilities with the necessary equipment but do not regularly separate blood into components may require assistance in
ensuring the health care provider community is properly trained to make use of blood components.

**Comments and observations**

Separation of components is done before testing the blood unit for mandatory five TTI markers (HIV, VDRL, Malaria, Hep B & C). Once any of the markers are found to be positive or sero-reactive, all components separated from primary units are discarded. This is documented and recorded for future reference.
Core indicator I.h.4

**Number and percentage of blood banks with blood component separation units established**

<table>
<thead>
<tr>
<th>Rationale and what it measures</th>
<th>This indicator measures the process of utilization of separation facilities in the country and the trends in meeting the country’s requirement to make more efficient use of donated blood units.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Indicator definition</td>
<td>Blood banks are registered with SACS/NACO as designated facilities to collect, screen, process, and distribute blood products. Blood separation facilities require essential equipment and consumables to be operated properly. These requirements are described in the national guidelines for blood banks. Numerator: Number of blood banks with separation facilities Denominator: Total number of registered blood bank.</td>
</tr>
<tr>
<td>Source of information and how to measure</td>
<td>CMIS. Blood bank formats capture information about whether the facility for blood separation is available at each blood bank reporting to CMIS.</td>
</tr>
<tr>
<td>Frequency of generation</td>
<td>Annually</td>
</tr>
<tr>
<td>Frequency of reporting</td>
<td>Monthly</td>
</tr>
<tr>
<td>Level of use</td>
<td>National / State</td>
</tr>
<tr>
<td>Strengths and limitations</td>
<td>- This indicator measures the availability of blood separation facilities in a blood bank, but does not describe whether equipment is maintained and used properly or regularly.</td>
</tr>
<tr>
<td>Programme implication</td>
<td>Supporting 100% of blood units donated are separated into components is the goal of NACP. Tracking the roll out of the necessary equipment and facilities for blood separation in blood banks can be done with this indicator.</td>
</tr>
<tr>
<td>Comments and observations</td>
<td>In order to overcome shortage of safe blood, it is important that blood should be used judiciously and in an appropriate clinical situation.</td>
</tr>
</tbody>
</table>
Core indicator I.i.1

Percentage of population who both correctly identify ways of preventing sexual transmission of HIV and reject major misconceptions about HIV transmission

Rationale and what it measures

Sound knowledge about HIV and AIDS, particularly around routes of transmission is an essential prerequisite if people are going to adopt behaviours that reduce their risk of infection.

This indicator measures the extent to which various segments of population are exposed to correct information about HIV/AIDS transmission and reducing their vulnerability to infection.

Indicator definition

The indicator can be segregated by gender, age and risk category (HRG).

Youth are defined as all persons aged 15-24.

Urban/rural designations are classified according to where the respondent was recruited, using census definitions.

Respondents’ knowledge is tested by asking a series of questions (described below) and a composite score being developed.

Numerator: Number of respondents who gave the correct answers to all five questions.

Denominator: Number of respondents who gave answers, including ‘don’t know’, to all five questions.

Respondents who have never heard of HIV and AIDS are included in the denominator but are not counted in the numerator.

This indicator is calculated separately for all general population 15-49 by gender and urban/rural for youth aged 15-29 by gender and urban/rural and by HRG category.

This indicator is also disaggregated by state.

Source of information and how to measure

BSS of general population with separate sample or over sampling of youth, BSS for HRG

Respondents are asked the following five questions and asked to classify each as true or false.

1. Can having sex with only one faithful, uninfected partner reduce the risk of HIV transmission?
2. Can using condoms reduce the risk of HIV transmission?
3. Can a healthy-looking person have HIV?
4. Can a person get HIV from mosquito bites?
5. Can a person get HIV by sharing a meal with someone who is infected?
Access to survey respondents as well as the data collected from them must remain confidential.

<table>
<thead>
<tr>
<th>Frequency of generation</th>
<th>Every 2-3 years</th>
</tr>
</thead>
<tbody>
<tr>
<td>Frequency of reporting</td>
<td>Every 2-3 years</td>
</tr>
<tr>
<td>Level of use</td>
<td>National / State</td>
</tr>
<tr>
<td>Strengths and limitations</td>
<td>This indicator is particularly useful in countries where knowledge about HIV and AIDS is poor because it allows for easy measurement of incremental improvements over time. However, it is also important in other countries because it can be used to ensure that pre-existing high levels of knowledge are maintained.</td>
</tr>
<tr>
<td>Programme implication</td>
<td>As coverage of the general population IEC campaigns, with special emphasis for youth programme increases over time, the proportion of the population with accurate knowledge should also increase. Accurate knowledge is a reflection of the clarity and skill with which interpersonal or mass communication messages have been conveyed to the target population. Areas where youth have sustained low levels of knowledge may be prioritized for additional or more intense communication activities. Respondents which report exposure to programme but continue to have low levels of accurate knowledge may signal the need to review the communication messages and tools used by the programme. Differences in gender awareness may require more investigation about appropriate media and messaging to be responsive to different genders.</td>
</tr>
<tr>
<td>Comments and observations</td>
<td>UNGASS</td>
</tr>
</tbody>
</table>
Core indicator I.i.2

Percentage of out of school youth reached by HIV awareness programme

**Rationale and what it measures**
Youth are treated as a vulnerable population to be reached through various forms of IEC to reinforce messages about vulnerability reduction and stigma and discrimination. Out of school youth represent an important subset of the population that requires specific communication campaign strategies.

This indicator measures the effectiveness of IEC programming to reach this sub-set of the vulnerable population.

**Indicator definition**
Out of school youth are defined as males and females aged 12-17 who are not currently attending school and have not completed the 12th standard.

Reach is defined as having heard of HIV/AIDS and recall of specific HIV communication campaigns or service programmes.

**Numerator:** Number of out of school youth respondents who are aware of HIV/AIDS and recall seeing specific IEC campaigns or participating in youth related programmes for HIV/AIDS

**Denominator:** Total number of out of school youth respondents.

This indicator can be disaggregated by gender and state.

**Source of information and how to measure**
**SS among out of school youth.** This survey may be conducted specifically to sample out of school youth or be built onto existing household surveys of the general population which oversample out of school youth population. Respondents are asked the following questions:

1) Are you currently attending school?
2) What is the last standard you completed?
3) Have you heard of HIV/AIDS?
4) Have you heard or seen any information about HIV/AIDS on television or radio? (Later probing further, using specific local campaigns to enhance recall)
5) Have you visited (Z - local youth resource center or other local area programmes for youth)
6) What are the different sources of information about HIV/AIDS (listing out various types of media and types of programme including outreach worker, etc.)

**Frequency of generation**
Every 2-3 years

**Frequency of reporting**
Every 2-3 years
**Level of use**

**National / State**

**Strengths and limitations**

- Designing a sampling plan to capture a representative group of out-of-school youth may be difficult if the sample is embedded in an existing household survey, due to the proportion of out of school youth who may be homeless or on the streets. At the same time, conducting a survey specifically for out of school youth may be cost prohibitive.

- The representativeness of each survey should be assessed and the findings interpreted in the context of potential biases or limitations as to whom the survey is representative.

- Awareness programmes for youth, especially out of school youth may vary from locality to locality and probing for exposure to such programmes will require surveyors to have knowledge of what specifically has been made available in a particular area.

**Programme implication**

The reach of HIV awareness programmes among out of school youth compared to youth in schools is an important comparison to review in these types of surveys. Out of school youth may be more vulnerable to HIV and require accurate information and opportunities for testing or service referral as needed. Increasing exposure to programmes should correlate to the activities aimed at making information and services more accessible to this sub-group.
Core indicator I.i.3

**Percentage of students covered under school AIDS programmes**

**Rationale and what it measures**

School AIDS programmes represent a primary delivery mechanism for broadening the reach of information and awareness programmes for young people.

This indicator measures the expansion of coverage of youth included in these programmes.

**Indicator definition**

Students are defined in persons in primary through secondary education programmes. School AIDS programmes refer to a standard communication programme launched by the Ministry of Education in partnership with NACO and SACS.

**Numerator:** Number of students registered in schools participating in school AIDS programmes

**Denominator:** Number of students registered in all schools. This indicator can be disaggregated by grade level and geographic unit (i.e. state and district).

**Source of information and how to measure**

Ministry of Education records on School based AIDS programmes.

**Frequency of generation**

Annually

**Frequency of reporting**

Annually

**Level of use**

National / State / District

**Strengths and limitations**

- This indicator cannot capture the intensity or quality of the delivery of the school based AIDS programme delivered in each setting.
- This indicator may overestimate coverage by assuming that all students in a school participate in the programme.

**Programme implication**

This indicator broadly measures the expansion of information and awareness implemented through the education system. Partnership between NACO/SACS and the Ministry of Education represents an important area of collaboration for scaling HIV information and awareness to the general public.
Core indicator I.i.4

**Percentage of schools with Adolescent Education programme with teachers trained and who have used the curriculum in the last academic year.**

**Rationale and what it measures**
Adolescent Education programmes for HIV/AIDS information and awareness trains teachers on a standard curriculum to use with their students.

This indicator measures the scale of this training programme and whether the training has been used in real classrooms.

**Indicator definition**
Schools who send their teachers for training in the adolescent education programme are asked to report on the activity of these teachers in terms of using the curriculum with their students.

**Numerator:** Number of schools who report that their teachers have used the curriculum in the last year.

**Denominator:** All schools which have had teachers trained in the adolescent education programme.

This indicator can be disaggregated by type of school and geographic unit (state and district).

**Source of information and how to measure**
Ministry of Education annual report on Adolescents education programme.

**Frequency of generation**
Annually

**Frequency of reporting**
Annually

**Level of use**
National / State / District

**Strengths and limitations**
- This indicator provides a broad measure of curriculum use. In some schools, not all teachers trained in the programme may not use the curriculum uniformly in terms of frequency and completion.

**Programme implication**
Geographical areas with higher proportions of schools which report using the adolescent education programme regularly with students would be expected to show higher levels of awareness and information about HIV/AIDS among surveyed youth, especially the sub-set that attend school. When used with other programme data, this indicator provides administrators with information about where additional training or incentives to apply the adolescent education programme is needed.
Core indicator I.i.5

Frequency of news media coverage on HIV/AIDS issues

Rationale and what it measures
In addition to mass media campaigns or other forms of advertisement, news coverage in both print and television/radio, represents an important method for spreading awareness to the general public. This indicator tracks the frequency with which the news media includes pieces on HIV/AIDS related issues.

Indicator definition
News media coverage includes newspapers, magazines, television, and radio at both national and local levels. HIV/AIDS issues encompass a broad range of topics, including:

1) information about routes of transmission and methods of prevention
2) Opportunities for testing, care, and treatment
3) Stigma and discrimination; Rights and Legal issues for PLHA
4) Specific issues of marginalized communities affected
5) Experiences of PLHA
6) Types of programmes and services available to address the HIV epidemic

Coverage is quantified by monthly counts and assessed broadly for accuracy of information presented on the nature of transmission of the disease and available treatment options.

This indicator can be disaggregated by type of media; extent of coverage; accuracy of information presented; and geographic region.

Source of information and how to measure
Special Studies, Media review. In each state, key media outlets are selected and a review of articles for a representative period of time is conducted. Pieces are characterized by various variables and aggregated as counts.

Frequency of generation
Every 2-3 years

Frequency of reporting
Every 2-3 years

Level of use
State

Strengths and limitations
Using the media for advocacy and spreading information about HIV/AIDS is a cost effective method of communication. States can improve their relationship with the media over time and increase the exposure of HIV/AIDS messages through these channels in addition to launching other types of communication campaigns.
Objective 2
Care, Treatment and Support and Impact Mitigation.

As the number of PLHA in India increases, secondary prevention of severe morbidity and mortality among infected individuals and their families gains increasing importance. Expanding the infrastructure and reach of care, treatment and support services, requires NACO to work closely with the existing public and private health system. A complex but much needed services is provision of **anti-retroviral therapy** (ART) for persons who have progressed to AIDS. However, improving quality of life and prolonging the progression of the disease requires expanding of **care and support** down to primary health care and community care centers. Similarly, proper diagnosis of HIV, opportunistic infections, and the treatment outcomes of patients on ART will require stronger quality control among the network of **laboratories** providing HIV related services.

Further efforts to mitigate the impact of HIV/AIDS include strategies that create an enabling environment for HIV/AIDS programmes. Linking PLHA to services and provision of psycho social support will require the **greater involvement of PLHA** (GIPA) in the management and delivery of care, support and treatment services. Increasing the availability of services will not result in increased uptake unless issues regarding **stigma and discrimination** and the **human rights, legal issues, and ethical treatment** of HIV positive persons are addressed.

In addition to broad improvements in availability and uptake of service, special emphasis is made to ensure high risk groups, women, and youth are benefiting at a level proportional to their needs.
Objective II. Outcome indicator

Total number of persons who are HIV positive

Rationale and what it measures
This indicator describes the magnitude of the epidemic in terms of number of people infected. This number can only be estimated due to the hidden nature of the disease and the size and diversity of populations in India.

Indicator definition
Persons infected with HIV are those who are sero-positive for HIV and may be at any stage of disease.

- Estimates are presented for sexually active adults (aged 15-49) and for children (aged 0-14)
- State level estimates are calculated using agreed upon methodology.
- These estimates are aggregated to form national level estimates.
- Given the available level of precision, estimates should be presented as a plausible range.

Source of information and how to measure
- **Epidemic modeling techniques** are applied using all available surveillance data and size estimates for children (ages 0-14) will be made using sentinel surveillance estimates of the prevalence of HIV among ANC attendees and PPTCT programme coverage data to indicate the effectiveness of PPTCT programmes. These data are multiplied to the estimated probabilities of mother to child transmission observed with and without prophylaxis regimens to estimate the number of children to whom HIV is transmitted.

Frequency of generation
Annually

Frequency of Reporting
Annually

Level of use
National / State

Strengths and limitations
- Methods to estimate the total number of HIV positive people utilize prevalence data from various sources, however the precision around these estimates are wide. When multiplied up to the size of the population, the margin of error can be substantial.
- The accuracy of the estimate is dependent on the quality and range of available information. In a concentrated epidemic, as in India, it may be difficult to identify and obtain adequate information from the multiple pockets where infection is emerging. Limitations in the available dataset should be acknowledged and properly described with the presentation of estimates.

Programme implication
The estimated number of persons infected provides programme planners a basis from which to ensure adequate levels of service provision and resources for PLWHA. In particular, the ability to forecast the requirements
for ART are important given the significant cost of providing these treatments.

Comments and observations
As broader coverage of PPTCT programmes is achieved, the number of pediatric HIV cases should decrease over time. However, it is possible that improvements in ART services for pediatric cases also improves, prolonging the lives of these children and offsetting the changes observed in new pediatric cases. Interpreting the trends in this indicator will depend on a deeper understanding of programme achievements in each geographic area.
## Core indicator II.a.1

**Number of service outlets providing ART services, by public/private facility**

<table>
<thead>
<tr>
<th>Rationale and what it measures</th>
<th>This indicator measures the progress of a program to expand the number of locations in which ART services are delivered in accordance with national guidelines.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Indicator definition</td>
<td>Facilities are counted as service outlets if they are registered with SACS/NACO to provide ART.</td>
</tr>
<tr>
<td></td>
<td>Sites providing only ART prophylaxis to prevent mother-to-child transmission (i.e. PPTCT sites) are excluded from this definition.</td>
</tr>
<tr>
<td></td>
<td>Indicator can be disaggregated by type of facility (public and private) and geographic units (state level)</td>
</tr>
<tr>
<td>Source of information and how to measure</td>
<td>CMIS, Facilities providing ART care are registered in the CMIS to enable electronic reporting.</td>
</tr>
<tr>
<td>Frequency of generation</td>
<td>Annual</td>
</tr>
<tr>
<td>Frequency of reporting</td>
<td>As registration event (i.e. opening or closure) occurs.</td>
</tr>
<tr>
<td>Level of use</td>
<td>National / State</td>
</tr>
<tr>
<td>Strengths and limitations</td>
<td>- This indicator does not consider the quality of service provision, which would require more in-depth evaluation efforts like facility surveys.</td>
</tr>
<tr>
<td></td>
<td>- Facilities which may offer ART but are not registered in the CMIS are not included in this count.</td>
</tr>
<tr>
<td>Programme implication</td>
<td>The number and distribution of ART centers (by state) should be consistent with the known concentrations of PLWHA in the country. Both numbers of public and private facilities should increase over time, expanding the options for PLWHA who need treatment. Annual action plans and targets for roll out of ART services can be compared to actual number of operating facilities.</td>
</tr>
</tbody>
</table>
Core indicator II.a.2

Number of doctors trained in ART & OI management

**Rationale and what it measures**
Building human capacity in health care delivery systems is of the utmost importance for the delivery of quality ART services.

This indicator measures efforts to train a workforce to achieve targets in ART service delivery.

**Indicator definition**
Doctors who provide services in ART centers which are registered with SACS/NACO are counted if they receive induction training or refresher training in clinical management of ART in the past year.

**Source of information and how to measure**
CMIS. The ART format captures numbers of doctors who received induction or refresher training during the reporting period. Figures are cumulated over a period of one year.

**Frequency of generation**
Annually

**Frequency of reporting**
Monthly

**Level of use**
National / State

**Strengths and limitations**
- These data are derived from training records maintained ART centers and do not collect specific information as to the type or topics of training provided. Training sessions may vary in intensity and sophistication in terms of skill building in OI management. It is assumed that the induction and refresher training provided for doctors cover ART management as a key topic.

- Doctors who receive formal training in ART management through during their medical school careers, may have skills in ART management but will be excluded from being counted if they have not received training arranged by the local facility at which they currently work.

- Numbers of trained doctors are reported on a monthly basis, doctors who attend multiple training sessions may be counted multiple times when these numbers are cumulated over a year.

- This indicator excludes doctors who provide OI management in facilities which aren’t registered with SACS/NACO.

**Programme implication**
According to the national guidelines, doctors providing services in designated ART centers should receive refresher training regularly. The number of doctors receiving training can be compared to the number of doctors staffing sites registered to provide OI management in public sector facilities.
Core indicator II.a.3

Number and percentage of eligible PLHA who initiate ART – by age gender and public/private facility

Rationale and what it measures

This indicator measures whether PLWA who are diagnosed as eligible for ART are receiving treatment in designated qualified facilities.

Indicator definition

PLWA eligible for ART are those who have been clinically evaluated as having Stage 3 or 4 AIDS defining illnesses according to WHO guidelines and/or CD4 count < 200 mm.

Persons who are found to be eligible for ART are registered with an ART facility and either begin therapy or wait until treatment slots are available.

Numerator: Current number of patients currently on ART.

Denominator: Cumulative number of patients diagnosed as eligible for ART. Indicators can be disaggregated by age (<=14; >14), gender, and type of facility (public; private)

Patients who die should be reported to the ART center and removed from the denominator.

Source of information and how to measure

CMIS. The ART formats capture number of patients who are registered as newly eligible to start ART and the number of people who are currently on ART.

Frequency of generation

Quarterly

Frequency of reporting

Monthly

Level of use

National / State

Strengths and limitations

- Patients who register at multiple ART sites may be double counted in denominators and result in an underestimate of the percentage of eligible patients receiving ART.
- ART centers may not have a good way of reconciling which patients may have died resulting in an inflated denominator and underestimating the proportion of eligible patients who are on ART.
- Patients who initiate ART therapy but then drop out will not be counted in the numerator, but still contribute to the denominator.

Programme implication

High percentages of eligible patients on ART provide evidence that an ART center is able to track patients over time and get them into treatment slots when they become eligible. Low percentages may indicate poor follow-up or overwhelming need for services for which resources have not adequately been allocated.
Substantial differences in percentage of patients on ART by gender or age may suggest the need for further investigation as to facility practices in selecting patients to start treatment. Due to differences in resources and payment schemes, private facilities may have different norms that public sector facilities in ability to get eligible patients on treatment.

Comments and observations

UNGASS
Core indicator II.a.4

Percentage of persons put on ART who report (95%) adherence at the end of 12, 24, 36 months by age and gender

Rationale and what it measures

Strict patient adherence to ART regimens is critical to prolonging the effectiveness of first line regimens, and avoiding the use of more costly second and third line regimens. For these reasons, strong counselling and care strategies to support patient adherence are a main pillar of high performing ART programmes.

This indicator measures patients’ ability to maintain the high levels of adherence necessary over various lengths of time and to detect problems in adherence among more vulnerable groups such as women and children.

Indicator definition

Patients on ART have strictly prescribed regimens as to frequency and dosing of pill intake. Patients return for medication refills on a frequent basis to encourage them to receive regular counselling and to receive other clinical and laboratory follow-up checks that can help to detect early signs of resistance. At the time of medication refill visits, patients report their pattern of adherence and provide the used pill packets to confirm pill counts.

Patients who take at least 95% of their expected doses on time over a designated time period are counted as having 95% adherence. These patient records are cumulated over time to enable categorization of patients by adherent or non-adherent over different time periods.

In the annual reporting period, patients who achieve the 12, 24 or 36 month mark for continuing ART will be counted in their respective category. Patients who are lost to follow up should be assessed if they achieve a treatment milestone (i.e. treatment for 12, 24 or 26 months) before they are no longer part of the community.

Numerator: Number of people who report 95% adherence over 0 months – XX time period.

Denominator: Number of people who have reached the XX time point of ART during the reporting period (i.e. during the current year)

These indicators are calculated for XX= 12, 24, and 36 months.

Indicators can be disaggregated according to age (<=14; >14) and gender.

Source of information and how to measure

ART electronic patient record. Longitudinal records for each patient show the follow-up history and self-reported adherence to their medication.

Frequency of generation

Annually

Frequency of reporting

Annually

Level of use

National / State
Strengths and limitations

- Most of the adherence information is self-reported or can result in overestimated levels of adherence if there is a tendency to provide socially desirable responses.

- Initiation into ART is a rolling process so cohorts of individuals are not generally available. This may cause the assessment of adherence to be difficult to detect.

Programme implication

Facilities with lower than average levels of adherence among ART patients should be followed up to determine whether staff require additional training or other types of support is needed for patients to achieve better levels of adherence. Differences in rates of adherence between males and females or between children and adults may indicate a need to customize adherence support for these sub-groups.
Core indicator II.a.5

Number and percentage of persons still alive and on ART at 12, 24 and 36 months after initiation of ART by age and gender

Rationale and what it measures

One of the goals of any antiretroviral therapy programme is to increase survival among infected individuals.

This indicator measures progress in increasing duration of survival among infected adults and children by maintaining them on antiretroviral therapy.

Indicator definition

Persons who initiate ART at facilities registered with SACS/NACO to provide treatment are tracked regularly over time to determine whether they have continued on ART and are still alive.

*Numerator*: Number of persons who are still alive at the XX month time point

*Denominator*: Number of persons who initiated treatment and were expected to make the XX month time point on treatment during the reporting period.

Indicator is measured at set intervals: 12, 24, and 36 months after initiating therapy.

Indicator can be disaggregated by age (<=14; >14) and gender and geographic units (state, district) as needed.

Persons lost to follow-up are not counted in the numerator, but are considered in the denominator.

In case patients have received ART from multiple facilities, patient survival is counted at the most recent facility where ART have been provided and patient has met the specific time point. Initiation of therapy is counted as the date of first ART dosage based on best available patient records.

Source of information and how to measure

**ART electronic patient record.** Patient follow-up data including last patient visit provides information as to continued survival of patients currently on ART. Over a year-long reporting period, patient survival is assessed on a rolling basis.

Frequency of generation

**Annual**

Frequency of reporting

**Monthly**

Level of use

**National /State**

Strengths and limitations

- This indicator does not distinguish persons who were on ART continuously from those who had intermittent patterns of adherence and who survived.

- Survival statistics are not easily updated to reflect recent follow-up information on patients suggesting that patients are alive. This may
lead to an underestimate of mortality rates for people on ART as patients who are lost to follow-up during the specified time point but later return to service will be missed in the numerator.

- Patients who are mobile and switch ART facilities may not have a full set of longitudinal records to establish when they initiated therapy. They may be double counted in the denominator for two facilities, leading to an underestimate of mortality at the institute ART was initiated.

**Programme implication**

High levels of mortality among ART patients should be addressed by senior programme managers. Further investigation as to the reasons for poor survival should result in needs assessments and action plans as appropriate. Substantial differences in survival rates among children and adults or between males and females may also indicate the need for customized services for these sub-groups.
Core indicator II.a.6

Number & percentage of ART centers which have linkages with NGOs/CBOs for community outreach and home based care

Rationale and what it measures

ART centers provide a valuable service which is not sustainable without general household stability and community support of patients.

This indicators measures the extent that ART centers are positioned in a larger spectrum of HIV related prevention and clinical management programmes.

Indicator definition

Linkages implies a protocol outlining various steps and decision trees as to how to make appropriate and strong linkages between facilities

Numerator: Number of ART centers with active linkages with NGOs/CBOs to provide community outreach and home based care.

Denominator: Total number of ART centers.

Source of information and how to measure

CMIS. All facilities are expected to register with SACS/NACO through the CMIS. Quarter to enable electronic reporting.

Frequency of generation

Annually

Frequency of reporting

Monthly

Level of use

National/State

Strengths and limitations

- These data do not provide further information as to the quality or success of the referral services provided to PLWHA through these groups.

Programme implication

Referral patterns can be checked with facility tools to determine whether strong referral linkages are necessary.
Core indicator II.a.7

**Percentage of estimated HIV-positive incident TB cases that received treatment for TB and HIV**

<table>
<thead>
<tr>
<th>Rationale and what it measures</th>
<th>Tuberculosis is one of major causes of morbidity and mortality in people living with HIV, even those on ART. A measure of percentage of HIV-positive TB cases that access appropriate treatment for their TB and HIV is important.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Indicator definition</td>
<td>The data can be collected from ART center.</td>
</tr>
<tr>
<td>Numerator:</td>
<td><strong>Number of persons with advance HIV infection receiving ART as per national protocol and who were started on TB treatment within the reporting year</strong></td>
</tr>
<tr>
<td>Denominator:</td>
<td><strong>Estimated number of TB cases in people living with HIV.</strong></td>
</tr>
<tr>
<td>Source of information and how to measure</td>
<td><strong>CMIS. ART patient treatment cards and registered record this information</strong></td>
</tr>
<tr>
<td>Frequency of generation</td>
<td>Quarterly</td>
</tr>
<tr>
<td>Frequency of reporting</td>
<td>Monthly</td>
</tr>
<tr>
<td>Level of use</td>
<td>National/State</td>
</tr>
<tr>
<td>Strengths and limitations</td>
<td>It is important that those providing HIV care and ART record TB diagnosis and treatment, as this information has important implication for antiretroviral treatment eligibility and choice of regimen.</td>
</tr>
<tr>
<td></td>
<td>The indicator does not capture the number of HIV positive persons started on TB treatment but not yet started on ART, which is also an important information</td>
</tr>
<tr>
<td>Programme implication</td>
<td>Adequate detection and treatment of TB will prolong the lives of people living with HIV and reduce the community burden of TB.</td>
</tr>
</tbody>
</table>
Core indicator II.a.8

Number of active regional units for resistance monitoring

<table>
<thead>
<tr>
<th>Rationale and what it measures</th>
<th>Monitoring for strains of HIV which are resistant to first and second line regimens of antiretroviral therapy are important for forecasting the need to shift treatment protocols.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Indicator definition</td>
<td>A regional unit for resistance monitoring is a laboratory officially designated by NACO to conduct resistance monitoring. Active units maintain staff trained on national protocols for resistance monitoring; have functioning and regularly maintained equipment; and report routinely to NACO on the results of their monitoring. These designated units work with local ART centers to obtain the necessary specimens for testing as routine procedure.</td>
</tr>
<tr>
<td>Source of information and how to measure</td>
<td>Special Studies Routine reports from resistance monitoring sites.</td>
</tr>
<tr>
<td>Frequency of generation</td>
<td>Annually</td>
</tr>
<tr>
<td>Frequency of reporting</td>
<td>Quarterly</td>
</tr>
<tr>
<td>Level of use</td>
<td>National</td>
</tr>
<tr>
<td>Strengths and limitations</td>
<td>Resistance monitoring is a relatively new activity under NACP3 and may require some time to develop sites and establish standardized protocols</td>
</tr>
<tr>
<td>Program implication</td>
<td>Establishing a functional system for ART resistance monitoring is a critical component of a full scale ART programme. Slower than expected progress in establishing these sites must be weighed with data on rates of treatment failure and levels of adherence measured among patients at various ART centers. Areas where the potential for the development and spread of resistant strains is high may be prioritized for establishing resistance monitoring units.</td>
</tr>
</tbody>
</table>
Core indicator II.a.9

Number of newly infected with HIV patients which have strains resistant to first line ART regimens

Rationale and what it measures
The spread of HIV strains resistant to first line ART regimens requires a re-evaluation of current national treatment protocols and has implications for supply chain management and training of health care providers and adherence support.

This indicator measures the degree to which the circulation of resistant strains in the population may require changes in treatment protocols.

Indicator definition
Specific study protocols and sampling will be specified in national drug resistance monitoring guidelines.

Source of information and how to measure
Special Studies as defined through resistance monitoring guidelines

Frequency of generation
Quarterly

Frequency of reporting
Quarterly

Level of use
National

Strengths and limitations

Programme implication
The detection of resistant strains of HIV among the newly infected requires a number of policy and guideline changes for treatment of HIV.
Core indicator II.b.1

Number of service outlets providing treatment for opportunistic infections (OI)

Rationale and what it measures
As the number of PLWHA increases, there is a growing need for health care facilities providing treatment for opportunistic infections (OIs). Facilities must have trained staff and appropriate diagnostic tools and essential medical supplies available to provide quality of care consistent with national guidelines for managing patients with OIs.

This indicator monitors the number of qualified sites able to provide treatment for OIs.

Indicator definition
Qualified service outlets refer to any health care facility registered with SACS/NACO to provide treatment for opportunistic infections for PLWHA. Outlets may include sections within larger hospital facilities or stand alone facilities with appropriate levels of staffing and consumables as per national guidelines.

Numbers of outlets can be disaggregated by type of facility (e.g. public vs. private) or geographic unit (e.g. district, state).

Source of information and how to measure
CMIS. Service outlets providing treatment for OIs are required to register with the CMIS to enable electronic reporting.

Frequency of generation
Annually

Frequency of Reporting
As registration event occurs

Level of use
National/State/District

Strengths and limitations
- This indicator tracks whether such sites have been established but does not provide information about the level of quality of the service provided or whether adequate numbers of staff or consumables are available.
- This indicator excludes facilities providing OI treatment which may not be registered in the CMIS for reporting to SACS/NACO.

Programme implication
The roll-out plan for NACP III puts great emphasis on ensuring a basic package of care, support and treatment services are available at different levels of health care facilities. Targets for this indicator are based on the number of such facilities in each district and state which should have the ability to provide OI treatment.
Core indicator II.b.2

**Number of PLHA who access opportunistic infection (OI) treatment**

**Rationale and what it measures**
Efforts to expand access to OI treatment centers should result in increasing numbers of PLHA who utilize services at these facilities. This indicator measures trends in utilization at the various types of health care facilities expected to provide OI treatment as a part of basic package of services.

Special interest is taken to ensure that utilization is high among both male and female PLWHA.

**Indicator definition**
Patients are counted from clinic registers based on the type of diagnosis and treatment they receive. Persons with ailments identified as AIDS related will be counted. These OI mainly include: Tuberculosis, Candidiasis, Chronic Diarrhea, PCP, Herpes Zoster, Bacterial Infections (Respiratory), Cryptococcal Meningitis, Toxoplasmosis, CMV Retinitis, MAC

Indicator is calculated separately for male and female PLWHA.

**Source of information and how to measure**
CMIS, Patient registers will capture numbers of patients treated for selected OI. The treatment details of OI are gathered from data at ART center and Community Care Centers.

**Frequency of generation**
Quarterly

**Frequency of Reporting**
Monthly

**Level of use**
State/District

**Strengths and limitations**
- The course of disease for each PLWA will be different which makes an expected level of utilization difficult to predict. The total number of PLWA in a given area may also be unknown if levels of testing are low and/or estimates of numbers of PLWA are based on surveillance data with a high level of uncertainty.
- Some OI are not specific to HIV positive patient which may result in inflating the numbers of PLWA who receive treatment for OIs.
- This indicator does not measure the quality of care provided only whether utilization occurred.

**Programme implication**
Over time the number of people treated for OI should rise. This may indicate higher numbers of people who know their status and have good referral linkages to care and support; or it may be that individuals feel more positively about the services provided in these facilities and believe that the OI treatment is effective.
Core Indicator II.b.3

Number of NGOs involved with provision of care and support to affected children

Rationale and what it measures
Expansion of care and support services to infected and affected children is prioritized in areas where large number of AIDS cases and orphan and vulnerable children are known.

This indicator measures the number of NGOs which have been contracted to provide these services to vulnerable children.

Indicator definition
NGOs which are registered with SACS/NACO to provide care and support to affected children are counted. Care and support includes both physical, psycho-social, security and medical care for patients.

Indicator can be disaggregated by geographic unit (state, district, etc.) as needed.

Source of information and how to measure
CMIS. The registration module captures information on all NGOs providing services to enable electronic reporting through CMIS.

Frequency of generation
Annually

Frequency of reporting
As a registration event (closing or establishing a unit)

Level of use
National/State

Strengths and limitations
- This indicator does not assess the quality of the services provided nor their ability to comply with national guidelines.

Programme implication
Low distribution of sites to support affected children can be used for planning the roll out of additional sites and the possibility of providing more regional assistance through twinning between facilities which are new to care and support NGO.
### Core indicator II.b.4

**Number of service outlets providing community care**

<table>
<thead>
<tr>
<th>Rationale and what it measures</th>
<th>Community based care centers (CCCs) provide a means of extending basic HIV/AIDS care services to a broader segment of people who are infected. These concept of these centers builds on those developed in NACPII, but creates stronger links to ART centers. This indicator measures the progress of expansion of the number of service outlets provided locally.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Indicator definition</td>
<td>Community care centers are health care facilities run by NGO partners, registered with SACS/NACO and capacitated to provide services in 4 areas:</td>
</tr>
<tr>
<td></td>
<td>1) Adherence support to ART patients</td>
</tr>
<tr>
<td></td>
<td>2) Treatment counselling</td>
</tr>
<tr>
<td></td>
<td>3) Referral to other services and follow-up for treatment</td>
</tr>
<tr>
<td></td>
<td>4) Linkages to social support services.</td>
</tr>
<tr>
<td>Source of information and how to measure</td>
<td>CMIS, registration of community care centers is required for routine reporting.</td>
</tr>
<tr>
<td>Frequency of generation</td>
<td>Annually</td>
</tr>
<tr>
<td>Frequency of reporting</td>
<td>As registration event occurs</td>
</tr>
<tr>
<td>Level of use</td>
<td>National/State/District</td>
</tr>
<tr>
<td>Strengths and limitations</td>
<td>Establishing community care centers does not provide information about the patient volume, geographic placement or level of functioning of the site.</td>
</tr>
<tr>
<td></td>
<td>The new concept of CCC is strongly linked to providing community-based support for established ART centers. This means that the expansion of CCCs may be dependent on the pace of roll out of the ART centers for which they are intended to be linked.</td>
</tr>
<tr>
<td>Programme implication</td>
<td>Expansion of community based care services for PLHA represents an important component to insuring good treatment outcomes for people on ART. Expansion of CCCs should coincide with the growth of ART centers. The placement of CCCs can also be assessed to match the categorization of districts in terms of severity of the epidemic and the requisite need for care &amp; treatment services.</td>
</tr>
</tbody>
</table>
Core indicator II.b.5

Number of PLHAs and their families receiving services from NGOs/CBOs by gender and age

Rationale and what it measures
Services for PLHA and their families encompass a wide range of care and support activities.

This indicator measures the volume of individuals benefiting from the variety of services made available through NGOs and CBOs.

Indicator definition
PLHAs and their families include persons who are infected with HIV and people living in the same household.

NGOs and CBOs counted in this indicator include those which are registered with SACS/NACO to provide specific services to PLHAs and their families. These include basic care and support, linkages to other services, counseling, nutrition support, education and skill building, etc.

Indicators are counted if they are receiving services from the NGO/CBO any time during the reporting period.

This indicator can be disaggregated by gender and age (0-14; >=15); and between PLHA and their family members.

Source of information and how to measure
CMIS, Formats for NGOs providing basic care and support include information about the number of beneficiaries currently in the programme. Client numbers are broken out by age and gender.

Frequency of generation
Quarterly

Frequency of reporting
Quarterly

Level of use
State/District

Strengths and limitations
- PLHAs and their families may require multiple types of support services from different NGOs/CBOs. In this case, they may be counted multiple times under the rolls of different NGOs. This will result in an over estimation of the number of individuals benefiting from services.

- Developing a denominator for the number of people who are expected to require services depends on estimating the number of people who know they are positive and are beginning to experience symptoms of AIDS or require social support for dealing with their disease.
Core indicator II.c.1

Number of AIDS councils at the national, state, and district levels which have PLHA representatives

Rationale and what it measures
Active participation of people living with HIV/AIDS in groups making policy and strategy decisions about HIV/AIDS programming is important for ensuring programmes consider the needs and interests of beneficiaries. This indicator measures the representation of PLHA on AIDS councils and DAPCUs which are convened at multiple levels.

Indicator definition
AIDS councils are convened at national and state level to provide overall guidance to NACO and SACS at the policy and overall action plan level. In districts with well developed HIV/AIDS programmes, DAPCUs are planned. PLHA are persons who are infected with HIV/AIDS and who have voluntarily chosen to disclose their status. To be a representative of the PLHA community on the AIDS council, individuals must receive the endorsement of a network of PLHA from the relevant geographic area and commit to active participation in council/DAPCU meetings. Specific criteria and processes for selection may be determined differently for each AIDS council/DAPCU. However, this process should be made transparent to the public. This indicator is assessed annually at the time of annual reporting. To count for this indicator, a council must officially list the PLHA representative by name on the council membership list and the PLHA representative must have attended a majority of the meetings held during the year.

Source of information
Membership lists and minutes of meetings of AIDS councils, filed officially at SACS and NACO.

Frequency of generation
Annually

Frequency of reporting
Annually

Level of use
National

Strengths and limitations
- The participation and contribution of PLHA representatives on AIDS councils/DAPCUs may be difficult to assess and cannot easily be captured by a quantitative indicator. Individuals selected to be PLHA representatives may need additional support and skill building to be a better representative of their constituency.
- A single PLHA representative may not be sufficient to provide perspectives that encompass a diverse PLHA community.

Programme implication
Engaging PLHA representatives actively in policy and planning level is an important step to designing programmes sensitive to the needs of beneficiaries. This indicator can be viewed in the context of the activity of PLHA networks at the district level and the ability for states to sustain PLHA representatives on their councils over time.
## Core indicator II.c.2

**Number of districts with at least one functioning PLHA network**

<table>
<thead>
<tr>
<th>Rationale and what it measures</th>
<th>Ensuring that people living with HIV/AIDS (PLHA) are connected to provide support to each other and to mobilize as a community to advocate for rights and services is a key component to the success of a national AIDS control strategy. Given the size of the country, establishing networks of PLHA at the district level is important for making them accessible and relevant for PLHA in local areas.</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Indicator definition</strong></td>
<td>A PLHA network is a formal organization registered with the government and has a formal governance structure and mission/objectives. The leadership of the networks should come from the PLHA community, however membership in the network may include both PLHA and non PLHA. A functioning network is one which is duly registered and maintains an active membership and meeting schedule. A network need not be affiliated with state or national level network organizations. More than one PLHA network could be established in a district or geographic area.</td>
</tr>
<tr>
<td><strong>Source of information and how to measure</strong></td>
<td><strong>SACS register of PLHA networks.</strong> Networks are registered and should provide an annual summary of the leadership, mission/objectives, and activities to demonstrate their functioning status. This summary can be used to provide information about the networks at other service points for PLHA.</td>
</tr>
<tr>
<td><strong>Frequency of generation</strong></td>
<td>Annually</td>
</tr>
<tr>
<td><strong>Frequency of reporting</strong></td>
<td>Monthly</td>
</tr>
<tr>
<td><strong>Level of use</strong></td>
<td>National/State</td>
</tr>
</tbody>
</table>
| **Strengths and limitations** | - PLHA networks which exist but are not registered or formalized are not counted in this indicator, but may be providing local support to PLHA.  
- The ability to assess how well the network functions and what level of support is available to PLHA is not addressed by this indicator. |
| **Programme implication**     | As the programme expands during NACP III, the number of infected individuals who know their status will also grow. Ensuring that local networks of PLHA are available to provide these newly diagnosed individuals with support is critical. States can prioritize districts that need support in establishing networks by looking at this indicator alongside other information about testing volume, estimated HIV prevalence. |
Core indicator II.d.1

Percentage of HRG members reporting instances of stigma and discrimination in the last month

Rationale and what it measures

Members of high risk group face high levels of stigma and discrimination generally and in the context of being suspected of spreading HIV/AIDS. Targeted interventions for high risk groups use advocacy strategies to address stigma and discrimination, particularly in situations where stigma prevents members of high risk groups from seeking services or using condoms/clean needles.

This indicator measures the experience of HRG in the effectiveness of efforts to reduce stigma and discrimination.

Indicator definition

High risk group members are defined as FSW, MSM, and IDU. Stigma and discrimination is an experience where persons are harassed, abused or denied access to services or venues because of their association or membership in a particular group.

This indicator is measured for experiences of stigma or discrimination in the last month to identify individuals who experience hostility on a regular basis.

Numerator: Number of respondents who report experiencing stigma or discrimination in the last month.

Denominator: Total number of respondents.

Source of information and how to measure

BSS of HRG.

Respondents are asked the following question,

1) In the last year, have you experienced a situation when you were harassed, abused or denied access to a service or a place you wanted to go because you were identified as a (fill in relevant HRG)?

2) When was the last time you experienced this type of stigma and discrimination (this week, one month ago, more than 6 months ago).

Frequency of generation

Every 2-3 years

Frequency of reporting

Every 2-3 years

Level of use

National/State

Strengths and limitations

- Stigma and discrimination covers a wide range of actions and can depend on the perception of the respondent.

- The time period of recall makes this indicator more specific to persons who frequently experience stigma and discrimination. Other cut offs for frequency of experience may be more useful for this indicator, depending on the baseline value.

Programme implication

Fear of encountering stigma and discrimination can substantially alter the risk behaviour and service utilization of HRGs. States where HRGS experience frequent harassment and abuse suggest that efforts to sensitize the public and key groups who interact with HRGs have not been successful in altering attitudes towards HRG members. These data should be interpreted in the context of efforts in communication activities.
Core indicator II.d.2

Percentage of PLHA who access services who report satisfaction with their service experience

Rationale and what it measures

Stigma and discrimination against PLHA can negatively impact individuals’ willingness to access services or their satisfaction with the services they do receive.

This indicator measures whether PLHA feel the services they receive are of good quality and are delivered without stigma or discrimination.

Indicator definition

PLHA are persons infected with HIV/AIDS. Services accessed include those designed specifically for PLHA under SACS/NACO. This may include care, support and treatment services or social support services and welfare schemes. These service outlets undergo annual service quality assessments of which, client satisfaction is assessed as one aspect of quality.

Respondents are asked to rate their satisfaction with the services at the facility across several variables.

Numerator: Number of respondents who report high levels of satisfaction with services.

Denominator: Total number of respondents.

This indicator can be disaggregated by type of service facility and geographic unit (state and district).

Source of information and how to measure

SQA of services facilities for PLHA. Rapid client-satisfaction surveys are conducted with X numbers of randomly selected clients attending the facility at the time of the quality assessment. Respondents are asked to use a four part likert scale (strongly agree, agree, disagree strongly disagree) with the following statements about the service they received that day:

1) The services provided were of good quality
2) All the staff people were polite and treated me with respect
3) I felt that my privacy was protected.
4) I was able to get the services that I came for
5) The location and the timing of the services provided are convenient to me.
6) I would return for services at this facilitySatisfaction with service is defined as respondents agreeing or strongly agreeing with all statements.

Frequency of generation

Annually
**Core Indicators Handbook**

**Frequency of reporting**
Anually

**Level of use**
State/District

**Strengths and limitations**
- Client satisfaction encompasses more issues that experience of stigma and discrimination.
- Facility based surveys are convenient and easier to administer, but will not capture perspectives of individuals who do not access services. These individuals may not access services because of past experiences or fear of stigma and discrimination.

**Programme implication**
Attention to patient satisfaction among PLHA can identify service areas where service providers require more training to become sensitive to the needs of their clients. Breaking down patient satisfaction by type of service will provide information about where to focus efforts. Individual aspects of patient satisfaction, such as attitudes of the service staff can also be examined to identify specific areas that require improvement.
Core indicator II.e.1

AIDS legislation adopted and ratified

**Rationale and what it measures**
AIDS legislation is required to establish a policy environment that supports the goals and objectives of the National AIDS Control Programme.

This indicator measures the progress toward adoption and ratification of key piece of AIDS legislation.

**Indicator definition**
The AIDS legislation described in this indicator is the HIV/AIDS Bill 2005

The purpose of this legislation is a specific statute which addresses the prevention and mitigation of the spread of HIV/AIDS

The final outcome is the ratification of this legislation. Interim assessment of the status of this legislation can be assessed periodically.

**Source of information and how to measure**
Legislative Review

**Frequency of generation**
Every 6 months

**Frequency of reporting**
Every 6 months

**Level of use**
National

**Strengths and limitations**
- Passing of legislation is depending on the actions of multiple groups and processes. Progress may be achieved in the long term and intermediate signs of achievements may be limited.

- Legislation may also be adjusted in the process of ratification. Efforts should be made to ensure that key aspects of the legislation are retained in what is finally ratified.

**Programme implication**
Key legislation such as that tracked through this indicator is a necessary pre-requisite to changes in other policies and official acts which can greatly impact service delivery. The ability to pass this legislation also indicates the support of multiple agencies and levels of government that may be leveraged for other important policy level decisions and actions.
Core indicator II.e.2

Amendment of laws to protect the rights of marginalized populations and PLHA, including NDPS Act, ITPA, and Section 377 of the IPC

Rationale and what it measures

In an effort to protect the rights of PLWHAs and marginalized populations, amendments to specific laws have been proposed. These amendments have been selected due to their impact on making PLWHAs and marginalized populations difficult to reach. This indicator measures the progress with which passing of these amendments has been achieved.

Indicator definition

The amendments described in this indicator are intended to protect PLWHAs and marginalized populations from being discriminated against, to protect their rights to privacy, and to avoid detention or arrest based only on their identity as a member of a marginalized population.

Source of information and how to measure

Law review

Frequency of generation

Annually

Frequency of reporting

Annually

Level of use

National

Strengths and limitations

- Changes in amendment language are likely to occur during the process of approving the amendment. Each piece of legislation amended should be reviewed to ensure the spirit of the indicator is achieved.

- Over the course of NACPIII other pieces of legislation requiring amendments may be identified and added to the definition of this indicator.

Programme implication

Achievements in amending key pieces of legislation is a long term effort to create a more supportive environment for HIV/AIDS programming. Once amendments are processed, efforts to assess the impact at service delivery level or from the perspective of PLWHAs and marginalized populations is critical.
Core indicator II.f.1

Number and percentage of laboratories conducting HIV testing participating in EQAS

Rationale and what it measures
Quality assurance is an essential component of providing laboratory services. To ensure HIV testing conducted in SACS/NACO supported facilities is accurate and reliable, laboratories are expected to participate in a standardized external quality assurance system. This is particularly important for low prevalence settings where false positives test results are an important issue.

This indicator measures the degree to which laboratories have enrolled in this quality assurance programme.

Indicator definition
Laboratories are counted if they are designated to conduct HIV testing for SACS/NACO programmes. These include those in ICTC facilities, government hospitals and health care centers, and those involved in sentinel surveillance activities.

External quality assurance is a defined protocol for ensuring that good laboratory practice is followed and test performance is assessed through use of standard panels for testing, and sending a sub-set of specimens for testing at designated laboratories facilities.

Participation in EQAS requires fulfillment of these activities on a routine basis.

Numerator: Number of laboratories which conduct HIV testing and participate in EQAS

Denominator: Number of laboratories which conduct HIV testing.

Source of information and how to measure
Special Studies, EQAS network membership rosters.

Frequency of generation
Annually

Frequency of reporting
Annually

Level of use
National/State

Strengths and limitations
- This indicator does not capture the participation of laboratories outside the SACS/NACO system. Private laboratories may conduct substantial volumes of HIV testing, but may not be regulated through EQAS.
- Participation in EQAS may not reflect actual levels of support and capacity building to enable laboratories to meet the EQAS standards.

Programme implication
Increasing the proportion of laboratories participating in EQAS provides greater confidence that international standards of good laboratory practices are reflected in the HIV test results that are provided to patients.
Objective 3

Programme Management and Capacity Building

The tremendous scale up of services requires improved management capacity at state and district level HIV/AIDS cells. Programme managers must maintain better financial systems, including improved funds disbursement; be able to recruit and retain qualified staff; provide adequate capacity building and professional development opportunities to manage the state AIDS control programme effectively. The government also recognizes that NACO and SACS will require support from other ministries and sectors to achieve the NACPIII goals and objectives. Mainstreaming efforts to combat AIDS is another key strategy to building more effective systems.
## Core indicator III.a.1

### Percentage of SACS who achieve at least 80% of planned expenditure

#### Rationale and what it measures
A key management challenge for SACS during NACP II, was ensuring good funds flow. Once funds are disbursed from NACO/State budgets, SACS must ensure that the funds are used to implement the proposed action plans. This indicator sets the level of achievement for SACS at 80% of planned expenditures, in terms of disbursement of funds.

#### Indicator definition
The SACS expenditure target is based on the approved annual action plan submitted by SACS to NACO. The annual proposed budget for each reporting period amount comprises the basis for estimating achievement of expenditure targets. This amount can be divided into quarterly expected expenditures. Expenditures are defined as funds which have been committed to activities or vendors/contractors through contracts or sub-grants. The level of expenditure is assessed at the end of the fiscal year.

- **Numerator:** Number of SACS who meet the 80% expenditure in the reporting period
- **Denominator:** Total number of SACS

#### Source of information
Routine financial reports submitted by SACS to NACO.

#### Frequency of generation
Quarterly

#### Frequency of reporting
Monthly

#### Level of use
National/State

#### Strengths and limitations
- This indicator tracks funds which flow through SACS and which are under the direct purview of SACS. Expenditure levels of other sources of funds that are part of the overall state AIDS control plan requires a separate assessment of spending, most often conducted by the respective donor agency.
- States that achieve close to 80% of expenditure will not be given partial credit and cannot be distinguished from states with much lower expenditure rates. This indicator can be compared to the mean or median level of expenditure across states.

#### Programme implication
Good fund flow is key to maintaining smooth operations and ensuring that the services needed can function. States with difficulty meeting the expenditure targets should be provided with additional supervision and support to determine bottle necks in the implementation process. These data can also be further examined in terms of the steadiness of the expenditure rate over the fiscal year. States which show abnormally large expenditures toward the end of the year, may also require greater supervision to avoid unplanned spending to achieve targets or loss of funds which are not rolled-over.
Core indicator III.a.2

**Percentage of audit reports completed and forwarded within time limits to NACO**

<table>
<thead>
<tr>
<th>Rationale and what it measures</th>
<th>Conducting audits of contracts is a routine component of financial management. All SACS are required to review the financial records of all contracts under NACP III. These reports should be completed in a timely fashion and filed centrally at NACO.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Indicator definition</td>
<td>This indicator refers to the annual internal audit required from SACS are described in the financial management guidelines provided by NACO. These audits must be completed and submitted to NACO within 3 months of the end of the fiscal year.</td>
</tr>
<tr>
<td>Source of information and how to measure</td>
<td>receipt of audit reports by NACO</td>
</tr>
<tr>
<td>Frequency of generation</td>
<td>Annually</td>
</tr>
<tr>
<td>Frequency of reporting</td>
<td>Annually</td>
</tr>
<tr>
<td>Level of use</td>
<td>National/State</td>
</tr>
<tr>
<td>Strengths and limitations</td>
<td>This indicator measures the timeliness of audits conducted by SACS but does not address the quality of the audits completed or the number of cases of inappropriate fund use identified through these audits.</td>
</tr>
<tr>
<td>Programme implication</td>
<td>Timely completion of the audit cycle, provides some indicator that a SACS has appropriate financial management controls over the state-level budget. This indicator can be interpreted in the context of the results of the audits and whether appropriate response were made by SACS to address irregularities or breaches of standards of conduct.</td>
</tr>
</tbody>
</table>
Core indicator III.a.3

Percentage of SACS with approved financial and administrative delegation

**Rationale and what it measures**

Delegation of appropriate authority at state and district level, is necessary to ensure that programme decisions, such as proper release of funds can be made. Delegation powers are reviewed and approved by the National AIDS Control Board. This indicator measures the extent to which approved powers of delegation for specific states and districts are implemented as directed by senior management.

**Indicator definition**

For better financial and operational efficiency, the Governing Body will delegate adequate administrative and financial powers to the Executive Committee and the Programme Director. It will also exercise all other statutory powers as ordained under the Societies Registration Act. Authority for financial and administrative delegation are approved by the National AIDS Control Board and available for public record. These administrative orders are reviewed in the context of existing vacancies to ensure that programme operations are not disrupted at the state and district levels.

**Source of information and how to measure**

Review by DG and authorized personnel.

**Frequency of generation**

Annually

**Frequency of reporting**

Annually

**Level of use**

National

**Strengths and limitations**

- The need to adjust delegation of authority may change during the course of the year as staff vacancies at higher management levels occur. This indicator makes an assessment once a year and may not be timely enough to address all delegation issues.

**Programme implication**

Regular attention to the appropriate delegation of authority helps to avoid interruption in programme services due to inability to make key programme decisions or release funds.
Core indicator III.a.4

Percentage of SACS which have all critical programme positions filled

**Rationale and what it measures**
In NACP III, SACS programmes are provided with a revised organizational structure to strengthen the management of programmes. Recruiting and retaining these staff is a critical indicator of programme’s ability to function at full scale. This indicator tracks the success of SACS in recruiting qualified persons to support the effective management of the full array of NACP programme areas.

**Indicator definition**
Key positions include project director, NGO Advisor and leads of all programme areas, as approved by NACO. This indicator is measured once annually at the time of preparing the annual report.

**Numerator:** Number of SACS who have a full complement of sanctioned positions filled at the time of the annual assessment.

**Denominator:** Total numbers of states.

**Source of information and how to measure**
Annual report submitted by SACS to NACO.

**Frequency of generation**
Annually

**Frequency of reporting**
Annually

**Level of use**
National

**Strengths and limitations**
- This indicator is assessed once a year. Staff turnover or vacant positions may be common among SACS in the early part of NACP III. This indicator cannot distinguish states who have filled the positions only at the end of a reporting period or who have had multiple individuals in the position for short periods of time, from those states that have had an individual in the position for a sustained period throughout a reporting period.

- Although persons who are recruited for any position in SACS must meet the minimum qualifications set out in the position description, the effectiveness of the person under field conditions may or may not be as expected.

**Programme implication**
Tracking the ability of a SACS to fill and sustain a few key staff positions may have a substantial impact on the effectiveness of the programme, particularly for SACS embarking on substantial scale up of activities or which have more nascent programmes. Those SACS which are not able to support their programme areas with senior managers may not expect to perform well on other indicators related to prevention or care, treatment and support.
Core indicator III.a.5

Percentage of SACS where donor coordinating committee met at least twice during the year

**Rationale and what it measures**

The donor coordinating committee is the primary forum for donor agencies to meet with SACS/NACO to discuss the progress of the programme and come to consensus on key policy or strategy issues. The donor coordinating committee includes all funders of HIV/AIDS related activities in the state. This indicator measures how active the donor coordinating committee is for each state.

**Indicator definition**

The donor coordinating committee includes the national or state level representative of each donor agency and the DG/PD of NACO/SACS and selected APDs and JDs.

Minutes of the meetings of the donor coordination committee provide a record that meetings occurred and the decisions made at such meetings. Minutes of these meeting should be maintained by SACS and a copy forwarded to NACO.

The reporting period coincides with the preparation of the annual report.

**Numerator:** Number of SACS with minutes from two donor coordination committee meetings during the reporting period.

**Denominator:** Total number of SACS

**Source of information and how to measure**

Minutes of SACS donor coordinating committee meetings forwarded by SACS to NACO.

**Frequency of generation**

Annually

**Frequency of reporting**

As meetings occur.

**Level of use**

National

**Strengths and limitations**

- This indicator cannot capture the type of discussions or decisions that are made by the donor coordinating committee.

**Programme implication**

Involvement of the donor coordinating committee in SACS activities is an opportunity to engage senior level representatives of the donor community who can provide critical support to the implementation of the SACS programme. Ensuring the continuity of these meetings may help to sustain the interest and collaboration between donor coordinating committee members.
### Core indicator III.a.6

**Percentage of SACS where governing body met at least twice during the year**

**Rationale and what it measures**

The Governing Body is the highest policy making structure of SACS. The Governing Body is headed either by the Minister in charge of health or the Chief Secretary and includes membership from various sectors. This indicator measures how active the government body is for each state.

**Indicator definition**

The Governing body of SACS is chaired by the Minister of Health or the Chief Secretary of the state as well as representatives from key government departments, representatives of civil society, representatives of trade and industry, the private health sector and representatives from PLHA networks. The primary purpose of the Governing body is to approve annual action plans and budgets, and as required, approve new policy initiatives.

Minutes of the meetings of the governing body provide evidence that meetings occurred and the decisions made at such meetings. Minutes of these minutes should be maintained by SACS and a copy forwarded to NACO.

The reporting period coincides with the preparation of the annual report.

*Numerator:* Number SACS with minutes from two governing body meetings during the reporting period.

*Denominator:* Total Number of SACS

**Source of information and how to measure**

Minutes of SACS governing body meetings forwarded by SACS to NACO.

**Frequency of generation**

Annually

**Frequency of reporting**

As meetings occur.

**Level of use**

National

**Strengths and limitations**

- This indicator cannot capture the type of discussions or decisions that are made by the governing body.

**Programme implication**

Involvement of the governing body in SACS activities is an opportunity to engage top level politicians who can provide critical support to the implementation of the SACS programme. Ensuring the continuity of these meetings may help to sustain the interest and participation of governing body members.
Core indicator III.a.7

Percentage of district units established, staffed, and reporting.

Rationale and what it measures
The development of district AIDS control cells at the district level will greatly improve the ability of the states to manage scaled up programmes. This indicator measures the progress made to establish these units in terms of staff recruited and ability for the units to report to the SACS.

Indicator definition
Staffing of a district unit is defined by the type of district (i.e. Category A-D).

District units are considered established if the minimal personnel have been recruited and the unit begins reporting to the SACS on a routine basis. This requires the availability of the necessary office space and equipment from which to operate.

Numerator: Number of district units meeting staffing and reporting requirements by the end of the reporting period.

Denominator: Total number of districts sanctioned for district units. This indicator can be disaggregated by state and type of district.

Source of information and how to measure
District level reports submitted by the district units.

Frequency of generation
Annually

Frequency of reporting
As district unit is established

Level of use
State

Strengths and limitations
- In addition to physical infrastructure and staffing, district units require adequate supervision and capacity building to improve their contribution to programme management.

Programme implication
States can monitor the pace at which district units are established and prioritized those districts of highest priority (by Category A-D)
Core indicator III.b.1

Number and percentage of induction and refresher trainings imparted

Rationale and what it measures
As the programme scale up rapidly, there is an urgent need for a regular schedule of induction trainings for new staff or refresher trainings for experienced staff. Each programme area maintains a training plan for personnel outlining the type and frequency of training planned for different positions. This indicator tracks the execution of these training plans.

Indicator definition
Trainings in this context are defined as formal structured sessions. Training topics may cover skills or knowledge and may include components of structured practicals in demonstration site settings. Programme areas included staff at all NACP reporting units.

Source of information and how to measure
Training records. These formats include numbers of trainees, type of trainees, and type of training provided and are reported on a monthly basis.

Frequency of generation
Quarterly

Frequency of reporting
Monthly

Level of use
State/District

Strengths and limitations
- The diversity of staff and types of trainings required may deviate from planned schedules. Maintaining an up-to-date training plan for all staff will be a challenge.

Programme implication
States and districts which observe lower than expected numbers of people trained can identify those programme areas where this is an urgent need and reprioritize programme activities to ensure proper capacity building of staff. Over time, increased training should be reflected in improvements in other programme performance indicators.
Core indicator III.c.1

Number of ministries with an HIV strategy and action plan developed in collaboration with NACO.

**Rationale and what it measures**
Mainstreaming HIV/AIDS requires involvement of other government ministries in departments in taking up programme activities as a routine part of their action plans and budgets.

This indicator measures the number of ministries with which NACO has worked to develop a strategy and action plan.

**Indicator definition**
Any department or ministry which has a specific HIV strategy and action plan, which was developed through collaboration with NACO will count in this indicator. Key ministries include: Ministry of Education, Ministry of Social Justice, Ministry of Panchayati Raj, Ministry of Labour, Ministry of Sports and Youth Affairs, Ministry of Justice, Home Ministry, Ministry of Defense, Ministry of Tribal Affairs, Ministry of Urban Development, Ministry of Rural Development, Ministry of Women and Child Development, Ministry of Tourism, etc.

**Source of information and how to measure**
Ministry strategy documents and action plans. These should be shared with NACO and kept on file.

**Frequency of generation**
Annually

**Frequency of reporting**
As strategy is approved and adopted.

**Level of use**
National

**Strengths and limitations**
- HIV strategies and action plans may not reflect programme activity or resources expended on this issue.

**Programme implication**
NACO’s collaboration with other ministries will facilitate HIV/AIDS into becoming a mainstream issue. Official ministry strategies and action plans can pave the way to positive collaboration with NACO and other agencies.
Objective 4

Strategic Information Management

In a highly decentralized system, such as that called for by NACP III, strong information systems for managing programme implementation and improvement are essential. Strategic Information systems require adequate resources to efficiently provide reliable high quality data to managers at multiple levels. Tracking the magnitude and trajectory of the epidemic through robust surveillance systems provides the key measures of programme achievements and future planning for programme response. Data must be analyzed and used to be of value to the programme, and adequate resources and staff time must be allocated to these activities. Regular review of routine monitoring data should be integrated should be scheduled at different frequencies for different levels of managerial review. Longer term achievements or more in-depth investigation into specific operational issues are aided by specific action plans in the areas of evaluation and research.

Tracking trends over time improve understanding of the epidemic of risk behaviors and factors that are driving the epidemic. Use of Strategic Information strengthens evidence-based programming and allows partners in implementation to focus on interventions with the greatest impact on the epidemic.
Core indicator IV.a.1

**Percentage of budget spent for strategic information management unit (SIMU) at national, state and district level**

**Rationale and what it measures**
This indicator measures the resources put into conducting M&E related activities at various levels.

**Indicator definition**
SIMU includes M&E, surveillance, research, and special studies. Budget items related to SIMU include, staff costs and related equipment, training and travel for SIMU staff; cost of special studies or assessments required by the SIMU action plan; development or maintenance of paper based and electronic systems used for routine monitoring; and costs of its contracts or consultancies for technical support on SIMU. Budget spent refers to money actually disbursed.

**Numerator:** Amount of funds spent on SIMU related activities

**Denominator:** Total amount of the budget spent on HIV/AIDS control programme

This indicator can be disaggregated by state and district.

**Source of information and how to measure**
CPFMS will capture information about spending on activities related to SIMU sections.

**Frequency of generation**
Annually

**Frequency of reporting**
Annually

**Level of use**
National/State

**Strengths and limitations**
- This indicator reflects disbursements that may be on a different cycle than programme operations, i.e. vendors may be paid upon completion of specified deliverables, rather than at a steady rate during the implementation of the project.
- This indicator captures funds spent directly through the government. In some cases, other donors may provide funds for SIMU related activities which are not included in this calculation.

**Programme implication**
Resources to support M&E activities are often neglected by programme managers. Suggested guidelines are that between 5-7% of budgets should be spent on SIMU to ensure these critical functions are adequately supported. Investments in M&E translate into investments in effective programme management.
Core indicator IV.a.2

Percentage of reporting units (75%) reporting on time

**Rationale and what it measures**
The intent of the indicator is to capture the ability of implementing agencies (i.e. reporting units) to collect, analyse, and use HIV/ AIDS-related data to improve programme management.

**Indicator definition**
Reporting units are any implementation unit providing a service sanctioned under NACPIII (e.g. TI NGOs, PPTCT site, ART center, etc.). Reporting units are registered with SACS/NACO to enable electronic reporting through the CMIS. Some reporting units may not have capacity to enter directly into CMIS, however, they are responsible for preparing timely monthly data entry forms that are reported to district or state level.

Each reporting unit has a defined schedule for sending in reports, most commonly these reports are due monthly. Most reporting units are given a lag time of 3-4 days to prepare, clean and review data for submission.

State M&E officers are responsible for coordinating the timely submission of these reports, following up with reporting units as necessary. In districts with a designated M&E person (e.g. Category A and B districts), these officers are responsible for coordination of reporting within the district.

Timely report means: entered into the CMIS and approved by SACS by the 7th of every month, cleaned, compiled and sent to NACO by the 10th of every month.

Indicator can be disaggregated by type of programme (e.g. VCTC, TI, ART, blood bank, etc.) and geographic unit (district, state)

**Source of information and how to measure**

- **CMIS** has a built in programming to show managers which reporting units have failed to meet these reporting deadlines over time. Reports can be generated by programme area and geographic unit.

**Frequency of generation**
Quarterly

**Frequency of reporting**
Monthly

**Level of use**
National/State/District

**Strengths and limitations**
- This indicator does not evaluate the completeness or accuracy of reporting by implementation units.
- Reporting units are counted as late if the data are not entered into CMIS by the designated deadline. If a reporting unit is not responsible for direct data entry of their reports, the indicator is a measure of the combined efficiency of their reporting unit to create paper based...
**Programme implication**

Timely reporting is the first step for ensuring that routine programme data are monitored and can be used by managers at multiple levels for decision making.

Reporting units with consistently late data entry may require additional actions or support in problem solving to improve their timeliness. In some cases, issues with the reporting software or staffing may cause these delays and may be addressed by changes in resource allocation or adjustments to the CMIS itself.
Core indicator IV.a.3

Number of SACS generating a report every quarter which includes (i) monitoring indicators, (ii) findings of the ongoing evaluation

**Rationale and what it measures**
Regular review of programme monitoring and other available data is essential for making decisions to improve programmes and to respond to emerging issues experienced by implementation units. This indicator measures the frequency by which SACS prepare standardized quarterly reports from routine monitoring data which can be used to more effectively manage their programmes.

**Indicator definition**
Quarterly reports are a standard set of data tables and figures constructed around routine monitoring data each SACS receives on a regular basis through the CMIS. Guidance and technical support for preparing these reports is provided by NACO and designated national and regional technical support persons. As data from programme area evauations are completed by SACS, this information should be used to augment the information gathered through routine monitoring data (i.e. collected through CMIS)Quarterly reports are to be shared with NACO on a routine basis.

*Numerator:* Number of SACS which have submitted quarterly reports to NACO

*Denominator:* Total Number of States in the country.

**Source of information and how to measure**
Quarterly report submission to NACO.

**Frequency of generation**
Annually

**Frequency of reporting**
Quarterly

**Level of use**
National

**Strengths and limitations**
- This indicator measures the completion of quarterly reports but does not provide information as to the quality or accuracy of these reports. Each SACS is responsible for reviewing and cleaning the data submitted in the quarterly reports as they are for the primary use of supporting SACS in programme management activities.
- Sections of the quarterly report may be more useful to some states than to others given the nature of the epidemic and the populations affected which may vary from state to state. This indicator does...
not weigh the completion or analysis conducted for each section of the quarterly report in terms of which is most relevant to that state.

- This indicator does not predict whether the preparation of quarterly reports leads to more frequent evidence-based review of performance of different implementation units on the part of SACS.

**Programme implication**

Completion of the quarterly report provides valuable information that can be used by SACS to manage their programmes more effectively. However, capacity to prepare quarterly report will vary from state to state. States with difficulty in preparing quarterly reports may have to train M&E officers and other SIMU staff which would benefit from more hands-on support or training opportunities.
Core indicator IV.a.4

Percentage of districts with M&E staff in place

**Rationale and what it measures**

Districts categorized as A and B epidemics are sanctioned by NACO to have a dedicated M&E staff to support SIMU activities at the district level. This indicator measures the extent to which qualified persons have been hired and placed in designated districts.

**Indicator definition**

Districts in category A and B are those in which ANC sentinel surveillance sites show >1% prevalence or where high risk group sentinel surveillance sites have measured prevalence >5%. These areas are considered to have probably generalized or concentrated HIV epidemics.

Each of category A and B districts should have a dedicated staff person for M&E to assist the district nodal officer in monitoring programme activity. This primary responsibility of this person is to support reporting activity to the CMIS.

**Numerator**: Number of districts which have dedicated, full time M&E staff person.

**Denominator**: Number of districts in Category A or B. This indicator can be disaggregated by state.

**Source of information and how to measure**

Annual reports of SACS.

**Frequency of generation**

Annually

**Frequency of reporting**

Annually

**Level of use**

National

**Strengths and limitations**

- This indicator does not capture the extent to which staff hired for M&E positions at the district level have clear terms of reference and are able to perform the tasks intended for M&E officers at the district level as described by the M&E operations manual for district staff.

**Programme implication**

Lack of staff in place may be due to multiple factors, including the inability to recruit appropriate candidates. Central level support to these districts to find place and train such candidates may be required. Districts which have M&E staff in place should show improvements in other SIMU indicators, such as completeness of reporting.
Core indicator IV.b.1

Percentage of sentinel HIV surveillance sites with timely reporting of data to central database

Rationale and what it measures

The sentinel surveillance is a cornerstone of the overall HIV/AIDS surveillance system used to track the magnitude and trajectory of the HIV epidemic in India.

This indicator measures the timeliness of collating the information collected during the annual sentinel surveillance round to ensure that it can be used for annual action planning.

Indicator definition

Sentinel surveillance is conducted annually between August and October at selected facilities located across the country. This effort is coordinated by the National Surveillance Taskforce which is supported by five Regional Institutes for Surveillance. These regional institutes support the SACS and their state-level surveillance committees in carrying out the surveillance round according to standardized protocols.

Reporting of surveillance data involves the completion of process documentation and laboratory records indicating the volume of specimens tested and percent confirmed positive. These paper based records are submitted by each sentinel site to the SACS where the data are reported electronically to a centrally managed sentinel surveillance database.

SACS, with the support of the regional institutes are responsible for submitting complete and cleaned data within a month following the data collection period of each surveillance round.

Numerator: Number of sentinel surveillance sites for which the state has complete process and laboratory data and which have been entered into the central surveillance database within one month of the completion of the surveillance round.

Denominator: Number of sentinel surveillance sites participating in the surveillance round

This indicator can be disaggregated by the type of sentinel surveillance site (e.g. ANC, TB, STD, TI, etc.) and by geographic unit (e.g. state and district)

Source of information and how to measure

Submission of reports to the Sentinel Surveillance Database.

Frequency of generation

Annually

Frequency of reporting

Annually
<table>
<thead>
<tr>
<th>Level of use</th>
<th>National</th>
</tr>
</thead>
<tbody>
<tr>
<td>Strengths and limitations</td>
<td>- This indicator provides insight into operations of a complex process involving multiple layers of management. The reason behind late reporting may not easily be identified through this indicator alone.</td>
</tr>
<tr>
<td>Programme implication</td>
<td>The number of ANC sentinel surveillance sites has expanded substantially and requires significant managerial support to ensure smooth operations. By identifying which states have difficulty with timely reporting, NACO may be able to identify which states need more support from their regional or central surveillance experts.</td>
</tr>
</tbody>
</table>
Core indicator IV.b.2

Number and percentage of sentinel surveillance sites meeting the minimum quality standards (over three years)

Rationale and what it measures

To ensure the reliability of information collected through the sentinel surveillance system, participating sites must meet minimum quality standards before data from that site is used in state/national reports.

This is in part due to the importance of using sentinel surveillance data to observe similar population segments over time and useful measure of trends in a particular area/region. This indicator measures what proportion of sentinel surveillance sites which have undertaken the sentinel surveillance activity for the past two years successfully.

Indicator definition

Minimum quality standards for sentinel surveillance sites include:

- Collecting enough specimens to satisfy at least 75% of the target sample size
- Satisfactory quality assurance rating on laboratory results
- Proper process documentation on execution of the surveillance round.
- Absence of below standard performance rating by monitoring team (i.e. concerns expressed by the monitoring team as to the reliability of the data collected).

The target sample size for ANC sites is 400 and 250 for all other sites (e.g. STD, TB and Targeted intervention). Each site must recruit and have adequate specimens for at least 75% of the target sample size for the data to be used in that surveillance round.

If a site does not receive a monitoring visit during the surveillance round it is assumed that it would have achieved a satisfactory performance rating by the monitoring team. Sentinel sites which have not been in place for at least three years are not included in the numerator or the denominator.

**Numerator:** Number of sites where sentinel surveillance has met quality standards in the most recent three years, including the current year.

**Denominator:** total Number of sentinel surveillance sites which have been operational for at least three years.

This indicator can be disaggregated by type of site (e.g. ANC, STD, TI or TB) and state.

Source of information and how to measure

Submission of surveillance data and reporting by regional institutes for surveillance and SACS surveillance taskforce.

Frequency of generation

Annually
Core Indicators Handbook | National AIDS Control Programme Phase - III

Frequency of reporting: Annually

Level of use: National/State

Strengths and limitations:
- As the number of sentinel surveillance sites expanded substantially just prior to the launch of NACP III, these sites will not be eligible for being counted in the numerator of this indicator for at least 2 years, due to the requirement of meeting quality standards for at least 3 years in a row. For this reason, the highest possible achievement would not necessarily be 100% for the first two years of NACP III.

Programme implication:
This indicator provides a clear measure of the number of sites for which there are reliable high quality surveillance data on which to track the epidemic. States with lower than average proportions of sites meeting quality standards (adjusted for the number of sites < 3 years) may require additional resources and support for conducting surveillance activities.
Core indicator IV.c.1

Number and percentage of State PDs conducting regular partnership forum: a) quarterly review meetings including a review of M&E information; b) engaging partners in the review meeting; c) providing feedback on performance and reporting

Rationale and what it measures
To promote the use of routine monitoring information and evidence based decision making, NACO has adopted a policy encouraging SACS to hold quarterly review meetings on programme activities. While many states have held such meetings in the past, this policy formalizes the process as a partnership forum for purposes of planning and reviewing implementation.

This indicator measures the extent to which this practice has been adopted by SACS and is conducted in the spirit of using data to make decisions in a collaborative fashion with implementing partners.

Indicator definition
Quarterly review meetings should be convened by the SACS PD and involve the relevant implementation partners and donors contributing to NACP III goals and objectives. Civil society participation in these fora are also strongly encouraged.

Meetings should consist of a joint review of programme monitoring data collated from all implementing partners. Monitoring data presented in these meetings should be analyzed before hand so that appropriate feedback on performance can be provided to implementers.

Minutes of these proceedings should be documented and disseminated to participants and NACO in a timely fashion.

Numerator: Number of states which file minutes of review meetings
Denominator: Total Number of states

Source of information and how to measure
Review Meeting Minutes submitted to NACO.

Frequency of generation
Quarterly

Frequency of reporting
Quarterly

Level of use
National

Strengths and limitations
- This indicator is measured through the receipt of minutes of the quarterly review meetings. If meetings and discussion occur, without minutes being generated or sent to NACO, this indicator may underestimate the extent to which this practice is being adopted.

Programme implication
Establishing best practices for working with partners and using programme monitoring data is key to effective management by SACS.
Core indicator IV.c.2

Number and percentage of districts/SACS using programme data to develop annual action plan

Rationale and what it measures

In addition to robust data collection systems, a strong SIMU ensures that data are used regularly and effectively for programme planning and decision making.

This indicator measures whether the analysis and review of programme data are reflected in the annual action plans prepared by districts and SACS.

Indicator definition

Evidence that programme data are used to develop annual action plans at either district or state level include the following uses of data in the accompanying narrative summarizing or justifying the action plan:

1) current year data presented and interpreted in the report background section
2) programme strengths and weaknesses are described with reference to available programme data.
3) quantitative information from programme data, especially trend data are cited appropriately as a rationale for a programmatic component change or addition

Numerator: Number of districts or states presenting evidence of using programme data in annual action plan narratives

Denominator: Number of districts or states

This indicator may be calculated at district or state level. At least those districts in the A & B categories are expected to present annual action plans.

Source of information and how to measure

Annual action plans turned in by districts and states. These reports should be reviewed by appropriate level managers and rated as to whether programme data are used. These ratings should be reported in the SIMU section of the annual report of the respective level (i.e. NACO on the state action plans and SACS on the district action plans.

Frequency of generation

Annually

Frequency of reporting

Annually

Level of use

National/State

Strengths and limitations

- This indicator depends on sufficient management resources available to review action plans developed at district and state level.
- Review of annual action plans may reflect macro level planning but
may not provide insight into day-to-day use of programme management data.

**Programme implication**

As the basis for allocation of human resources and budget, annual action plans are a critical management tool. Ensuring that evidence from programmes are used to guide the development of these action plans is a critical step to making evidence based management decisions. States and districts which do not use programme data should be asked to provide further justification for their plans and provided technical assistance in reviewing and analyzing their data.
Core indicator IV.c.3

Number and list of partners sharing information with SACS

Rationale and what it measures

As services are expanded, the NACP III goals increasingly rely on service provision through the private sector. According to the principle of the Three 1s, all implementing partners are coordinated under NACO/SACS as a central authority with a national strategic plan for AIDS control. Similarly, evidence based decision making should be based on a complete set of data, including those from private sector partners.

This indicator measures the degree of information sharing between private sector partners and the SACS to ensure a comprehensive review of HIV/AIDS control activities within a state.

Indicator definition

Partners refer to organizational units that implement HIV/AIDS related programmes or studies with a state and which do not operate under the supervision of the SACS. Information in this indicator refers to routine programme monitoring data or the results of the studies conducted. When the programme activity is similar or parallel to those activities carried out by SACS contracted NGOs or within the regular health care system, data would ideally be reported in a format compatible for entry into the CMIS. However, at least the data shared by partners should be organized to allow SACS to prepare annual reports and quarterly reviews which provide a comprehensive picture of service provision or to grasp the epidemiology of HIV in the state. Organizations carrying out HIV/AIDS related studies should provide SACS with sufficient summary of findings and methodology for the information to be synthesized with available epidemiologic data in the state. Individual private providers that provide services that are not funded by SACS/NACO, but which follow the national guidelines and are registered in the CMIS, are not considered part of the numerator or denominator.

Source of information and how to measure

SACS annual reports should provide a summary of the available data used to produce the annual reports, including mention of missing datasets.

Frequency of generation

Annually

Frequency of reporting

Annually

Level of use

National/State

Strengths and limitations

- Obtaining the necessary data content and appropriate format of the data will require some effort and time to arrange between partners. Early data sharing attempts may be less complete or difficult to reconcile with SACS generated data.

- A key first task for SACS is to become aware of the various partners in the state and ensure that the list comprising the denominator is
Organizational units and activities will likely change over time, and a mechanism for maintaining an updated list will be an ongoing challenge for the SACS.

**Programme implication**

This information is useful for characterizing the extent to which private providers play a role in HIV/AIDS control in a state and the ability for partnerships to work together to meet the goals of NACP III. Information sharing of this type is key to effective partnership, including sharing of best practices and avoiding duplication.
Core indicator IV.d.1

Number of states conducting at least two key intervention evaluations per year

**Rationale and what it measures**

In addition to routine monitoring of programmes, SACS are expected to carry out evaluations of two programme interventions (e.g. VCTC, TI, ART, etc.) each year. These programme evaluations provide more in-depth information about whether operations in these programme areas are being implemented as expected, and whether clients are satisfied with service delivery. The purpose of these evaluations is to be able to document best practices or identify areas requiring substantial managerial attention and developing action plans and follow-up activities to help address programme weaknesses.

This indicator measures whether SACS prioritize and conduct these evaluations as part of their programme management responsibilities.

**Indicator definition**

Interventions are defined as any programme area within the SACS action plan that provides services under NACP III. The scope of the evaluation may be limited to a specific region or set of districts, depending on the nature of the programme being evaluated.

SACS should select programme areas based on which area has the greatest impact on the type of epidemic faced by that state; areas which are new or have been expanded substantially or areas where implementation units have consistently weak performance as indicated by routine monitoring indicators. Programme areas should be rotated over the course of a 5 year cycle.

These types of evaluations are intended to be conducted by a designated review committee which includes review of available monitoring data, conducts site visits, and interviews with staff and clients. Members of the review committee should include SACS representatives, national or regional level technical experts. Representatives of staff of implementation units should be heavily integrated into the process of review.

Completion of the evaluation involves a summary report of findings, recommendations and action steps proposed by the review committee and documentation that the report was prepared in collaboration and disseminated to the programme staff evaluated. Summary reports should be shared with NACO when completed.

**Source of information and how to measure**

Submission of evaluation summary reports by SACS.

**Frequency of generation**

Annually

**Frequency of reporting**

Annually
Level of use  National

Strengths and limitations

- This indicator specifies the deliverables for completion of the programme evaluation but is not able to specify how the evaluations should be conducted, due to the differences in process appropriate for evaluation different types of programme areas (e.g. laboratory based programmes which involve little client interaction such as blood banks, will require very different evaluation methods than targeted intervention programmes for injection drug users.)

- Completion of the evaluation does not provide information about the resulting action taken.

Programme implication

Regularly scheduled programme evaluations indicate that a SACS has strong capacity and managerial skills to assess how well programmes are operating beyond reliance on routine monitoring systems. Some SACS may need more assistance in planning and carrying out these types of intervention evaluations given the experience of their staff or the complexity of the programmes they are implementing.
Core indicator IV.d.2

NACO conducting one participatory programmatic and one scientific/analytical evaluation every three years

Rationale and what it measures
Periodic evaluations at the NACO level are necessary to provide an overview of how a programme area is functioning across geographic zones and/or to assess the effectiveness of that programme area on meeting the objectives of NACP III.

This indicator demonstrates whether this type of evaluation activity is being planned and conducted by NACO.

Indicator definition
Participatory programme evaluations refer to assess operations for a specific programme area with whether the programme is achieving its targets and making the contribution to NACP goals and objectives as expected using participatory evaluation/qualitative methods or otherwise. The key evaluation question is whether the programme is on track or whether a substantial adjustment to strategy is required. These evaluations are to be conducted in a participatory manner in that SACS and implementation level staff are expected to be heavily involved in the design and execution of the assessment activity.

Scientific/analytical evaluations refer to assessments which are primarily conducted to establish impact of a programme area on the objectives of NACP III. These evaluations may require multiple rounds of special studies to establish progress over time. Given the nature of the methods required, technical experts may be engaged to conduct the data collection activities. This type of evaluation may be considered to be external in the sense that for purposes of objectivity, persons involved in the implementation of the programme area would not ordinarily be involved in conduct of the special studies.

NACO is expected to plan and conduct one of each type of evaluation over the span of NACP III. These evaluations should be completed in a timeframe that allows the results to guide planning for the subsequent phase of the NACP.

Source of information and how to measure
Evaluation studies
Completion of the evaluation and public sharing of the findings/recommendations.

Frequency of generation
Every 3 years

Frequency of reporting
Every 3 years
Level of use: National

Strengths and limitations:
- This indicator does not capture information about the quality of the evaluation conducted or its relevance to critical decision making required by NACO.

Programme implication:
Completion of these evaluation activities demonstrate a more strategic role for NACO in using evidence based methods for making long term planning decisions.
Core indicator IV.d.3h

Number of research projects completed at the national/regional level

Rationale and what it measures
More funding to support HIV/AIDS related operations research is available in NACP III. This provides the opportunity to conduct locally driven and relevant research to address key issues in programme operations. This indicator measures the progress of completion of research projects through NACPIII at both national and regional levels.

Indicator definition
Research projects that are counted are those which have received funds through NACPIII. These projects are referenced for financial management purposes and have associated timelines and expected outcomes. Research projects are considered completed when final reports have been submitted and are accepted by NACO. This ensures that findings are available in a form appropriate for wider public release.

Source of information and how to measure
Research grant administrative records.

Frequency of generation
Annually

Frequency of reporting
Annually

Level of use
National

Strengths and limitations
- Research projects awarded grants are assumed to have a sound design, feasible implementation plan, and answer relevant questions. This indicator weights large and small research projects equally.

- Approval of final reports may not be under the control of the research agency, particularly if findings are controversial or require higher level approvals before being accepted. This may delay the timelines for considering research projects to be completed.

Programme implication
The completion of research projects signals a successful cycle of grant proposal, preparation, implementation and presentation of findings. Tracking the completion of proposals on a regular basis will ensure that research agencies complete projects in a manner timely enough to use the findings for programme improvements.
Core indicator IV.d.4

Number of papers based on NACO programme data or NACO sponsored research published in peer reviewed journals

Rationale and what it measures

Greater efforts to encourage the use and dissemination of data from NACP activities are being made. Sharing the data widely will encourage dialogue about the progress of the national programme and opportunities to improve services. Peer-reviewed publications undergo several layers of review and scrutiny to ensure the analysis of data are thoughtful and appropriate. This indicator measures the number of peer-reviewed publications featuring information from either NACP programmes or research.

Indicator definition

NACO programme data or sponsored research are those data sources where a majority of the funds to support the data collection come from NACO and are under the purview of NACO to release for public use. Papers are counted if data from NACP sources are used in the analyses presented, not just referenced as background or comparative sources of information.

Source of information and how to measure

Literature review. Conducted by NACO research officer.

Frequency of generation

Annually

Frequency of reporting

Annually

Level of use

National

Strengths and limitations

Publications in smaller peer reviewed journals may be underrepresented in this type of literature review.

Programme implication

Wide spread use of NACP sources for thoughtful analyses will improve the country’s understanding of the epidemic and enable the exploration of more in depth issues that may impact programme management.
## Appendix 1

### Core indicators that could be analyzed specific to women and youth denominators

<table>
<thead>
<tr>
<th>No.</th>
<th>List of Indicators – by components</th>
<th>Level</th>
<th>Data Source</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>N- National</td>
<td></td>
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<tr>
<td></td>
<td></td>
<td>S- State</td>
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<tr>
<td></td>
<td></td>
<td>D- District</td>
<td></td>
</tr>
<tr>
<td>I.</td>
<td><strong>PREVENTION AND ENABLING ENVIRONMENT OBJECTIVE</strong></td>
<td></td>
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</tr>
<tr>
<td>I.O1.</td>
<td>Percentage of FSW, MSM, IDU who are HIV infected – UNGASS</td>
<td>N / S</td>
<td>SS/ AHSS</td>
</tr>
<tr>
<td>I.a</td>
<td>Preventive interventions for HRG (Targeted Interventions)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>I.a.3</td>
<td>Percentage of female and male sex workers reporting use of condoms with their most recent client – UNGASS</td>
<td>N / S</td>
<td>BSS</td>
</tr>
<tr>
<td>I.a.4</td>
<td>Percentage of men reporting use of condoms in the last time they had anal sex with a male partner – UNGASS</td>
<td>N / SBSS</td>
<td></td>
</tr>
<tr>
<td>I.a.5</td>
<td>Percentage of IDU population reporting use of sterile injecting equipment at last injection – UNGASS</td>
<td>N / S</td>
<td>BSS</td>
</tr>
<tr>
<td>I.a.6</td>
<td>Percentage of IDU reporting use of condoms at last sex – UNGASS</td>
<td>N / S</td>
<td>BSS</td>
</tr>
<tr>
<td>I.a.7</td>
<td>Percentage of FSW, MSM, IDU’s with STI symptoms, seeking services from qualified medical providers.</td>
<td>N / S</td>
<td>BSS</td>
</tr>
<tr>
<td>I.a.8</td>
<td>Percentage of sex workers or MSM who refused to have sex with a client/non-regular partner in the last 12 months because of not having or refusing to use a condom</td>
<td>N / S</td>
<td>BSS</td>
</tr>
<tr>
<td>I.b</td>
<td>Prevention interventions for Bridge Population</td>
<td></td>
<td></td>
</tr>
<tr>
<td>I.b.1</td>
<td>Percentage of men reporting being clients of sex workers in the last year</td>
<td>N / S</td>
<td>BSS</td>
</tr>
<tr>
<td>I.b.2</td>
<td>Percentage of truckers reporting use of condoms with last commercial sex partner</td>
<td>N / S</td>
<td>BSS</td>
</tr>
<tr>
<td>I.b.3</td>
<td>Number &amp; Percentage of High risk men (g. truckers, migrants, etc.) reached by intervention</td>
<td>N / S / D</td>
<td>CMIS</td>
</tr>
<tr>
<td>I.c</td>
<td>Interventions for Vulnerable Populations (women, children, adolescents and workers)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>I.c.2</td>
<td>% of youth using youth resource centers/ clubs in their town/district</td>
<td>S</td>
<td>BSS</td>
</tr>
<tr>
<td>No.</td>
<td>List of Indicators – by components</td>
<td>Level</td>
<td>Data Source</td>
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<tr>
<td></td>
<td></td>
<td>N- National</td>
<td>S- State</td>
</tr>
<tr>
<td>1.d</td>
<td>STI</td>
<td></td>
<td></td>
</tr>
<tr>
<td>1.d.1</td>
<td>Percentage of general population males with STI seeking treatment from qualified personnel</td>
<td>N / S</td>
<td>BSS</td>
</tr>
<tr>
<td>1.d.4</td>
<td>Reduction in prevalence of most common STIs among the general population and high risk groups</td>
<td>S / D</td>
<td>SS</td>
</tr>
<tr>
<td>1.e</td>
<td>ICTC (including PPTCT)</td>
<td></td>
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<tr>
<td>1.e.1</td>
<td>Percentage of FSW, MSM, and IDU who received HIV testing in the last 12 months and who know their results – UNGASS</td>
<td>N / S</td>
<td>BSS</td>
</tr>
<tr>
<td>1.e.3</td>
<td>Number and percentage of persons who got tested at ICTC by gender and age</td>
<td>N / S</td>
<td>CMIS</td>
</tr>
<tr>
<td>1.e.4</td>
<td>Percentage of persons who return for test report at ICTC by gender and age</td>
<td>N / S</td>
<td>CMIS</td>
</tr>
<tr>
<td>1.e.5</td>
<td>Number and percentage of persons who test positive by age, gender</td>
<td>N / S</td>
<td>CMIS</td>
</tr>
<tr>
<td>1.e.6</td>
<td>Number of persons receiving pre-test counseling/information and proportion of people seeking testing by age and gender.</td>
<td>S / D</td>
<td>CMIS</td>
</tr>
<tr>
<td>1.e.8</td>
<td>Percentage of HIV positive persons referred to ART center, by gender</td>
<td>S / D</td>
<td>CMIS</td>
</tr>
<tr>
<td>1.g</td>
<td>Condoms</td>
<td></td>
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<tr>
<td>1.g.1</td>
<td>Percentage of persons reporting condom use at last sex with non regular partners – UNGASS</td>
<td>N / S</td>
<td>BSS</td>
</tr>
<tr>
<td>1.g.4</td>
<td>Percentage of persons who have had sex with non regular partners who perceive that condoms are easily accessed at the time of sex act</td>
<td>S</td>
<td>BSS</td>
</tr>
<tr>
<td>1.i</td>
<td>Communication and Social Mobilization</td>
<td></td>
<td></td>
</tr>
<tr>
<td>1.i.1</td>
<td>% of general population adults and youth who both correctly identify ways of preventing sexual transmission of HIV and reject misconceptions about HIV transmission by gender</td>
<td>N / S</td>
<td>BSS</td>
</tr>
<tr>
<td>1.i.2</td>
<td>Percentage of out of school youth reached by HIV awareness programme</td>
<td>N / S</td>
<td>BSS</td>
</tr>
<tr>
<td>1.i.3</td>
<td>Percentage of students covered under School AIDS program</td>
<td>N / S / D</td>
<td>SS (MoE)</td>
</tr>
<tr>
<td>No.</td>
<td>List of Indicators – by components</td>
<td>Level</td>
<td>Data Source</td>
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<tr>
<td>I.i.4</td>
<td>Percentage of schools with Adolescent Education Program w/teachers trained and who have used the curriculum in the last academic year. – UNGASS</td>
<td>N / S / D</td>
<td>SS (MoE)</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>II.01</td>
<td>Total number of persons who are HIV positive</td>
<td>N / S</td>
<td>AHSS &amp; modeling</td>
</tr>
<tr>
<td>II.a</td>
<td>Anti-retroviral therapy</td>
<td></td>
<td></td>
</tr>
<tr>
<td>II.a.3</td>
<td>Number and percentage of eligible PLHA (by CD4 count) who initiate ART – by age, gender, and public/private facility – UNGASS</td>
<td>N / S</td>
<td>CMIS</td>
</tr>
<tr>
<td>II.a.4</td>
<td>Percentage of persons put on ART who report (95%) adherence at the end of 12, 24, 36 months, by age and gender</td>
<td>N / S</td>
<td>CMIS</td>
</tr>
<tr>
<td>II.a.5</td>
<td>Number and percentage of persons still alive and on ART at 12, 24 and 36 months after initiation of ART by age and gender</td>
<td>N / S</td>
<td>SS</td>
</tr>
<tr>
<td>II.b</td>
<td>Care &amp; Support</td>
<td>S / D</td>
<td>CMIS</td>
</tr>
<tr>
<td>II.b.3</td>
<td>Number of NGOs involved with provision of care and support to affected children</td>
<td>S / D</td>
<td>CMIS</td>
</tr>
<tr>
<td>II.b.5</td>
<td>Number of PLHAs (and their family members) receiving services from NGOs/CBOs by gender and age</td>
<td>S / D</td>
<td></td>
</tr>
</tbody>
</table>