

Operations Manual

For

Strategic Information Management Unit



National AIDS Control Organisation
Ministry of Health and Family Welfare
Government of India
New Delhi

August 2007

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Foreword

National AIDS Control Program in Phase-III intends to intensify the efforts to control and reverse the epidemic in India during 2007-12. To achieve this, there is need to have a strong Strategic Information Management System which is responsive to the requirements of the programme, acts like an 'early warning mechanism' and supports evidence driven management. National AIDS Control Organization is committed to strengthen the M&E systems country wide so that issues related to data collection, compilation, analysis and use are adequately addressed. This involves establishing and strengthening institutional mechanisms & capacities at all levels.

The operational guidelines on M&E lay down the guiding principles of M&E, the principle of "Three Ones" and National M&E framework as national response to the HIV epidemic in India. It further describes the structures of Strategic Information Management Units, their roles and responsibilities, *modus operandi*, linkages with other units at SACS. It also describes the software and hardware requirements, steps to ensure data quality, timeliness and completeness. The guidelines explain the logic framework model with the NACP objective on Strategic Information and details of indicator framework. The operational details of monitoring each program area are also discussed in detail. The handbook of indicator definition is an annex to these operational guidelines, which would help to have common definitions and common framework across the country and bring coherence among the information collected by different partners and agency which will feed in to national strategic information system.

I take this opportunity to acknowledge the contribution made by the M&E Technical Working Group; particularly Dr. Dora Warren & Dr. K. Sudhakar - CDC, Mr Gurumurthy Rangaiyan- UNAIDS, Ms. Deepali Nath of Clinton Foundation, 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 (M&E) from NACO in bringing out these guidelines. I hope these guidelines will help all concerned to operationalize the procedures and measures to strengthen the information management and use and all levels.


(K. Sujatha Rao)

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List of Abbreviations

AIDS	:	Acquired Immunodeficiency Syndrome
APER	:	Annual Performance Review
API	:	AIDS Programme Effort Index
ART	:	Anti Retroviral Treatment
BCC	:	Behavioral Change Communication
BSS	:	Behavioral Surveillance Survey
CMIS	:	Computerized Management Information System
CSW	:	Commercial Sex Worker
FPMIS	:	Financial & Procurement Management Information System
FSW	:	Female Sex Worker
HIV	:	Human Immunodeficiency Virus
HRG	:	High Risk Group
IBBS	:	Integrated Biological & Behavioral Surveillance
ICTC	:	Integrated Counseling and Testing Center
IDA	:	International Development Association
IEC	:	Information Education Communication
IDU	:	Injecting Drug User
M&E	:	Monitoring and Evaluation
MIS	:	Management Information System
MSM	:	Men having Sex with Men
NACO	:	National AIDS Control Organization
NACP	:	National AIDS Control Programme
NGO	:	Non Governmental Organization
NRP	:	Non Regular Partner
OI	:	Opportunistic Infections
OR	:	Operations Research
PFMC	:	Project Finance Management Cell
PMTCT	:	Prevention of Mother to Child Transmission
PLHA	:	Persons Living With HIV and AIDS
SACS	:	State AIDS Control Society

SIMU	:	Strategic Information Management Unit
STD	:	Sexually Transmitted Diseases
STI	:	Sexually Transmitted Infections
TI	:	Targeted Interventions
TRG	:	Technical Resource Group
UT	:	Union Territory
VCT	:	Voluntary Counselling and Testing

INTRODUCTION

The National AIDS Control Programme is in its third phase (2007-2012) of activity. The first two phases of activity (NACP I - 1992-2001 and NACP II - 2001-2007) undertook the ambitious objective of laying down the infrastructure required for providing comprehensive services for both Prevention, Care & treatment. In Phase III, National AIDS Control Organization (NACO) seeks to systematically scale up the service delivery. India through its National AIDS Control Program stands committed to Millennium Development Goal (MDG) of reversing the spread of HIV/AIDS by 2015.

To accomplish these goals, NACO plans to decentralize the management of HIV/AIDS control activities, giving greater responsibilities to the state and district level, while emphasizing its own role to coordinate, guide, monitor and facilitate sharing of best practices and innovations across the SACS programmes. This approach requires significant investment in capacity building of both managers and technical staff at the state level and strengthening the SACS' ability to monitor the performance of their programme in terms of addressing the needs of the HIV epidemic in their state.

The epidemiological situation of spread of HIV infection in India though does not show dramatic upsurge, the estimated number of PLHA are high and still keeps India in 3rd position worldwide. There are state specific variations in the profile of the epidemic with high prevalence rates reported in southern and north-eastern states. However even the low HIV prevalence states are also characterized by the presence of high risk pockets with potential for increased spread of epidemic in these states. The variation in terms of cultures, customs and behaviors across states of India poses additional challenge to the HIV prevention programs. As a result, an increasing commitment can be seen in a growing number of partners and stakeholders who are getting involved in a range of activities and programs.

Tracking trends over time to improve our understanding of the epidemic, of risk behaviors and factors that are driving it is extremely important. Strong monitoring and evaluation systems have capacity to track these trends and factors and strengthen the evidence-based programming. Such system once established and functional would guide program managers to focus efforts on interventions that have greatest impact on the HIV epidemic.

For whom is this guideline intended?

Significant developments have occurred during past years in terms of the collection, analysis and use of data on HIV/AIDS for both prevention, treatment, care & support. There is need to have clear definitions of the terms and a strong framework to support these efforts. Current guidelines build on existing M&E principles to make them more comprehensive, focused and intense with clear operational plan.

This guide is intended for use by the program managers at national and state level and stakeholders involved in the monitoring and evaluation activities on HIV/AIDS. This guideline & "Indicator Definition Handbook" is an effort to establish one national framework for monitoring and evaluation that would help consolidation of all such efforts by various partners.

Adopting Strategic Information Management (SIM) as a NACP Objective

The decentralized model for management of NACP III requires a robust and responsive system of collecting and analyzing data. Data are needed for two critical management functions:

- 1) tracking the epidemic (i.e. to understand the magnitude, trajectory and potential for spread of HIV); and
- 2) tracking the performance of the programme (i.e. to measure achievements against targets and to identify under-performing implementation units which require more support and supervision.).

During NACP II, the amount and types of information being collected grew substantially, however, much of these data were under-utilized due to the lack of staff and the need for more skills development for existing staff. People also recognized, that the multiple sources of data should be synthesized together to develop a more comprehensive and integrated understanding of both programme results and their impact on the epidemic.

Expansion of Data Collection - NACP II

- ◆ 2001 and 2006 National BSS for general population and high risk groups
- ◆ Expansion of sentinel surveillance sites from 699 to 1122 sites between 2003 and 2006
- ◆ Enhancement of CMIS to allow state-specific data entry and analysis (increase in reporting on all components)
- ◆ Programme evaluations for targeted interventions and programme support units

To change the way monitoring & evaluation (M&E) is conducted during NACP III, a number of key innovations have been put into place. First, M&E activities have been integrated into the broader strategic information management unit.

(SIMU) established at both state and national levels. The SIMU brings together M&E, surveillance, and operations research. The term SIM refers to the transformation of data from all these sources in their raw form into information that can be applied to decisions made about program management or planning. This process is strategic because data from multiple sources are assessed in terms of quality and relevance to develop a more systematic understanding of what the information is saying about the programme.

Establishment of SIMU is seen as a step towards intensifying efforts on improving data quality from all data sources. Having clear roles and responsibilities defined would facilitate greater accountability and better quality of data and information use. Additionally, using information from various data sources systematically through triangulation would lead to better interpretations and programmatic decisions.

Secondly, as an objective of NACP III, in itself, the status and resources being invested in SIM have grown. This includes hiring epidemiologists at the state level and M&E specialists at the district level, especially in higher prevalence Category A and B districts. (List of Category A & B district is in **Annex-I**).

The Three Ones - National and state level implications

In 2003, during the International Conference on AIDS and STIs in Africa, country AIDS control programs, donors, international technical agencies, NGOs, and the private sector came together to agree upon a coordination mechanism for national HIV/AIDS response. The result was the following principles, referred to as the “Three ones.” It is now endorsed widely across the globe, in the South Asia region, and in India.

In an effort to maximize the use of limited resources and to reduce the administrative burden of multiple partners working simultaneously on the response to HIV/AIDS, in each country there should be:

Three Ones Principles	What does it mean
♦ One HIV/AIDS action framework that provides the basis for coordinating the work of all partners	The NACP III Programme Operational Plan (POP) is the blue print for implementing the National AIDS Control strategy.
♦ One National AIDS Coordinating Authority with a broad base multi-sector mandate	National AIDS Control Organization (NACO)
♦ One country-level monitoring and evaluation	The NACP III M&E framework is minimum set of critical monitoring data , endorsed by
♦ system	stakeholders involved in planning NACP III.

The intent of the “Three ones” is to support coordination; it does not intend to restrict innovation or limit the ability of implementers to tailor their response to meet local needs. The key concept is for all SACS to maintain a minimum set of standard indicators which are augmented by a few additional state-specific requirements for programme monitoring, as needed.

At the SACS level, it is important that state-level partners are involved in state level planning and the SACS coordinates the efforts of partners working in state. This includes ensuring all partners regularly report programme monitoring data to the SACS in the standardized formats. In turn, the SACS SIMU should analyze and incorporate the data from non-government implementation units into the overall reports for the state to have a more complete picture of the status of the epidemic and response to HIV/AIDS.

M&E Fundamentals: What is it and why is it important?

The day-to-day operations of a programme rely on the system established for monitoring and evaluation. As a management function, M&E seeks to achieve the most effective and efficient use of human and financial resources for the achievement of maximum health benefit for the population served – which is especially relevant in areas where resources are limited. The effective functioning of M&E systems relies on the ownership and responsibility of stakeholders regarding the information they provide to the systems, the feedback and its use for policy making.

Definitions

Monitoring and Evaluation can be seen as a continuum of activities, in which:

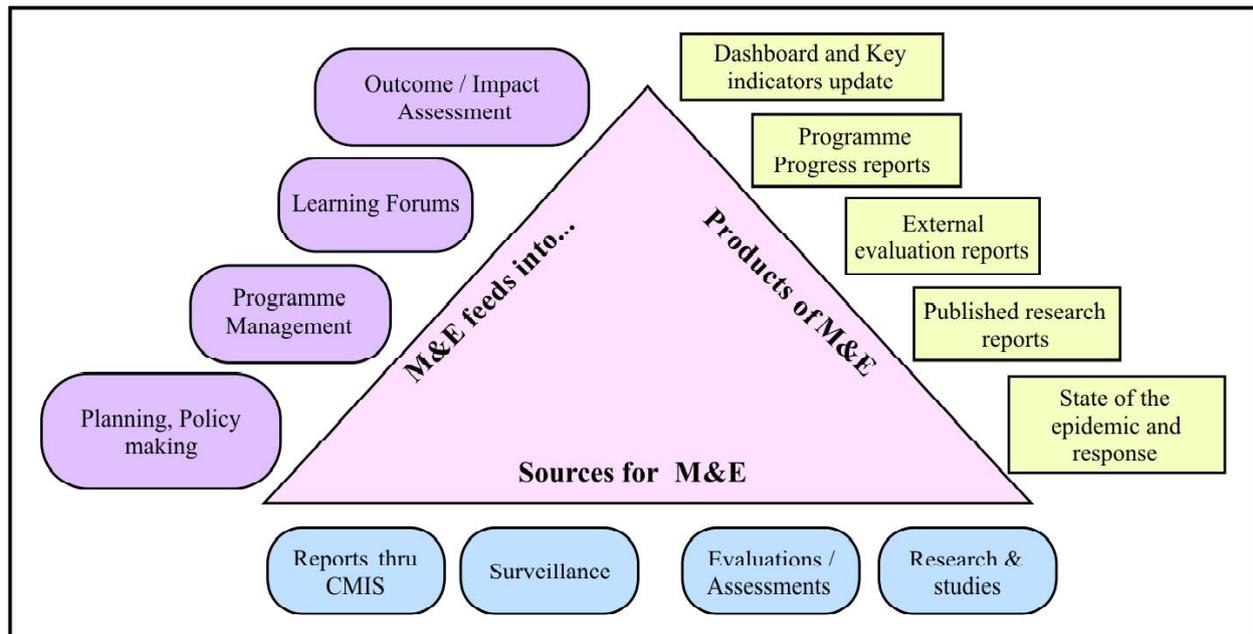
- ◆ **Monitoring** is the **routine tracking of service** and programme achievements against targets through collection of data on inputs, processes, outputs, and outcomes. For an HIV programme, data come from a wide range of sources, including activity tracking sheets, patient registers, financial reports, site assessments, and sometimes even special surveys. We can think of monitoring as answering the question, “**What** is happening?”
- ◆ **Evaluation** is the **episodic assessment of effectiveness**, and at the highest level the assessment of impact, i.e. are there results and can they be attributed to programme activities. While good monitoring data form the starting point of most evaluations, special studies are often required to assess higher level outcomes which are not usually collected as part of routine monitoring efforts. Evaluations usually go beyond what is strictly descriptive, and can be designed to explore the causes of failure or formulas for success. The design of a good evaluation can be complex and may require support from people with expertise on survey methodology or epidemiology. In summary, evaluation is a tool to answer the question, “was the goal or objective achieved, and **Why** or why not?”

Evaluation can be further broken down into two sub-categories depending on the focus of the assessment.

- ◆ **Process evaluation** focuses on the programmes achievements in terms of implementation against plan and service coverage
- ◆ **Outcome and impact evaluation** consider whether the effect of the programme lead to the desired outcomes or impact.
- ◆ **Surveillance** is the routine tracking of disease (disease surveillance) of risk behavior (behavioral surveillance) using the same data collection system over time. Surveillance helps describe the epidemic and its spread, current trends and predictions for targeting needed prevention programmes.

The National M&E Framework

The conceptual framework of Monitoring and Evaluations is shown in the following diagram. The M & E system for Phase-III will seek to integrate all sources of information and present



cogent and coherent strategic information useful for decision making. It will aim at simplifying data collection to a set of key indicators, while providing programme managers regular in-depth information through reports. The focus will be on analysis and utilisation of the information collected. Clear products will be identified for dissemination and accountability.

The Log-Frame : Importance of setting goals and targets

It is difficult to assess the performance of the programme without knowing what is expected to result from all the effort and resources expended. This is why one of the most important components of an M&E framework is setting the goals and targets of the programme.

Goals provide the overall structure to which the objectives, activities, and timelines are based. For each programme area, **Objectives** are defined and justified in terms of how they address the overall goal of the programme. **Activities** are organized and prioritized according to how they lead to achieving the objectives. **Indicators** and **Targets** at all levels are selected to enable objective tracking of programme performance against the goals and targets contained in the action plan. From an M&E perspective the definition of the indicators must be consistent with the guidelines developed for that programme area, and reflected in the data collection tools and data entry formats developed.

A **Logical framework** is a tool used to organize and concisely present the M&E framework of a programme. There are many different formats used to display the contents of a log frame, but each has the following common elements:

- ◆ A statement of the overarching goals of the programme
- ◆ A set of objectives that define the specific impact the programme is expected to have toward achieving the overall goal.
- ◆ A cascade of activities (or inputs and processes) that lead to a set of expected outputs and outcomes that together contribute to the achievement of each objective.
- ◆ The expected results are described selectively as key indicators which include targets for what is expected to achieve at different points in time of the project.

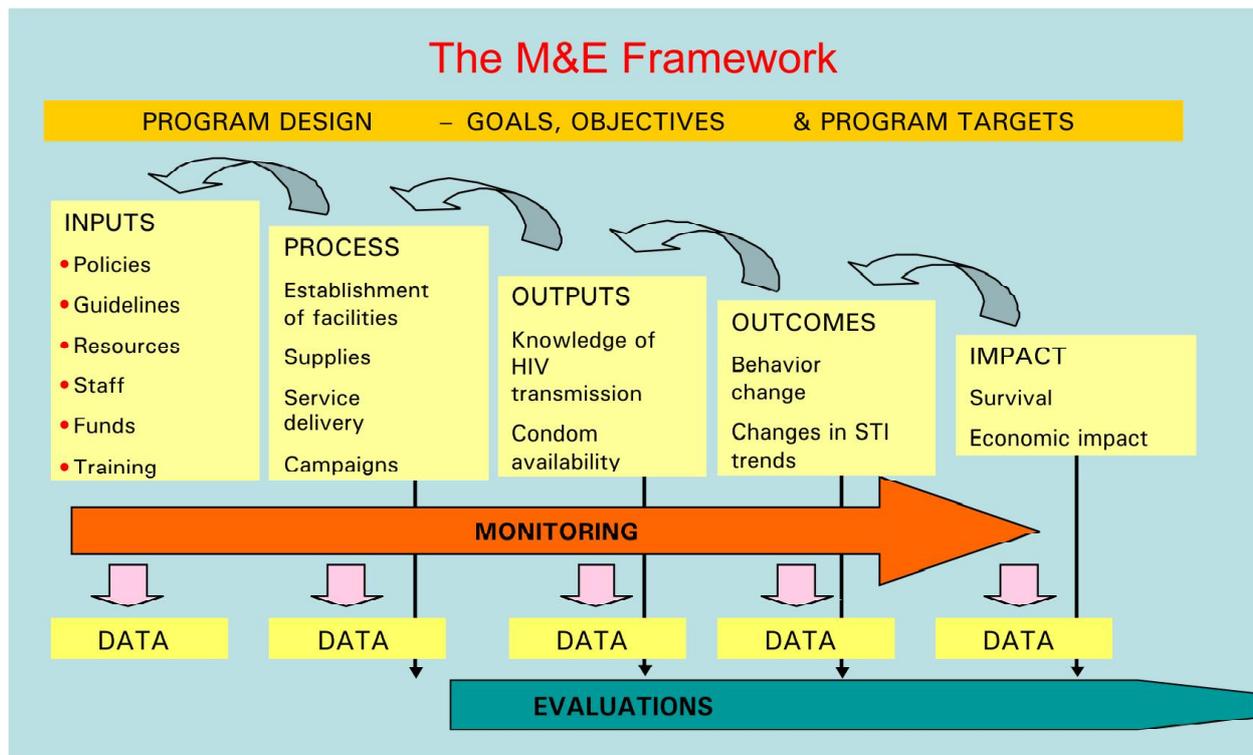
Log frames are developed at the beginning of a project and are reviewed and updated periodically. For example, when annual reports are prepared or mid term reviews are conducted, the log frame can provide the organizing principle for reviewing and summarizing the progress of the programme. The practice of developing a log frame helps to:

- ◆ Clarify the objectives of the programme
- ◆ Ensure that the activities planned contribute to the objectives.
- ◆ Prioritize activities that are most critical to achieving the objectives of the programme.

Monitoring can be conducted at multiple levels, depending on the degree of detail required by management. These different levels are often described in terms of inputs, processes, outputs, outcomes, and impact.

Inputs describe the type and level of resources that are put into a programme to make it function. These resources would include staff time, funds, equipment, physical infrastructure, and other material goods. The types of data used to summarize inputs are often presented in terms of development of materials and protocols, or in full-time equivalents of staff hired, funds spent or disbursed, equipment procured, etc.

Process describes the activities conducted and infrastructure established by the programme. This would include indicators such as the number of service outlets established, the maintenance of inventory, awarding contracts, submission of reports, etc.



Outputs describe the direct result of the inputs that the programme puts in place. For example, if training workshops are held, the direct output would be number of staff trained. If equipment and staffing of voluntary counseling and testing centers (VCTCs) to establish more testing centers, a direct output would be the number of people who attend the VCTC.

Outcomes describe a higher-level effect that demonstrates the achievement of a programme objective. Outcomes usually require multiple inputs and outputs for an objective to be realized. Outcome-type data often reflect behaviour change such as increased condom use, greater knowledge and awareness about HIV/AIDS; more frequent treatment seeking behaviour among men with sexually transmitted infection (STI) symptoms.

Example from targeted interventions for female sex workers -

- ◆ Objective: To reduce the risk of HIV transmission among female sex workers.
- ◆ Outcome: An increase the consistent use of condoms reported by female sex workers.

This outcome is expected if condom distribution increases and female sex workers have skills and knowledge to be able to effectively negotiate condom use with their clients, leading to increase in condom use.

- ◆ Outputs: Numbers of condoms distributed free to sex workers, or sold as socially marketed condoms; and the numbers of sex workers who are reached with behaviour change communication.
- ◆ Process: Number of drop-in-centers, incidents of condom stock outs, formation of CBOs
- ◆ Inputs: Number of procured/subsidized condoms; Number of outreach workers hired and trained, etc.

Impact is often used in two different ways. Impact is the highest level indicator which measures achievement of the goal itself. This is often challenging and requires a longer timeframe for measurement.

Example,

If the goal of a programme is to contain the spread of the HIV epidemic, the impact indicator may be decreases in HIV prevalence among high risk groups.

In some contexts, the term impact must reflect both 1) a demonstrated change in the goal level indicator and 2) evidence that the change is a directly attributable effect of the programme. To meet the second criteria programmes must demonstrate that coverage of the programme was adequate for the observed changes to be plausible. The impact evaluation must also consider and be able to rule out the influence of external factors that may have caused the change in the goal level indicator.

Examples of external factors include, whether the target population has changed in composition, the presence of other programmes that change the patterns of behaviour or service utilization of the target group; biological or environmental factors that change the way disease spreads.

The importance of certain types of indicators varies according to the stages of a programme life cycle. During the start up phase, fund flow and establishment of sites (i.e. inputs and process) are a key bottle neck so may be tracked more closely. As programmes mature, the programme should look to what effect having these sites in place has on achieving the objectives of the programme (i.e. ouputs and outcomes). A well-established programme that is functioning well should begin to see the bigger picture effect of its work. This kind of program should be attempting the measurement of higher level outcome indicators and assessment of the impact of its efforts.

Strategic Information Management Unit : Organizational structure

The strategic Information Management Units established at National and State levels would work in close co-ordination. The broad functions they would perform are –

At National Level –

- ◆ Develop and manage overall National M&E plan and Strategic Information Management System
- ◆ Establish Technical Resource Group for guiding activities including experts from education, research institutes and related ministries and international agencies.
- ◆ Direct state SIMU and affiliated institutions in collecting, collating, analyzing M&E data for HIV prevention and control activities across country.
- ◆ Report data on HIV epidemic to ministry for completion of annual and periodic reports for policy and strategic planning
- ◆ Be focal point for short and long term planning for national HIV prevention and control M&E activities; guide other units to implement HIV programme M&E activities.
- ◆ Monitor, evaluate and supervise activities on HIV M&E across country
- ◆ Organize trainings in collaboration with academic institution for the SIMU Staff.
- ◆ Conduct evaluation studies and add indicators suitable for realistic situation

At State Level-

- ◆ Develop state M&E plans and implement M&E activities within state and report to national M&E
- ◆ Collect, verify and process data on HIV related activities from all units within state
- ◆ Implement HIV M&E activities locally which would include ensuring data quality; the accuracy, completeness and timeliness and reporting it to National SIMU
- ◆ Prepare state level reports, provide data to State Government, provide analysis and evidence to guide the programme decisions.
- ◆ Technically and professionally guide, supervise and support data collection for M&E indicators from the districts
- ◆ Organize trainings on M&E based on needs

The SIMU at SACS level will parallel the unit established within NACO. Each SIMU will be headed by a joint director for SIMU and include a surveillance officer, an M&E officer, an epidemiologist, a statistical officer, and a data entry assistant.

In each SACS, the SIMU will carry out the day-to-day activities associated with each sub-unit (e.g. surveillance, M&E and operations research, etc.). The SIMU at SACS will function together as a team and supplement each other's role to ensure effective implementation of

all planned activities. Separate role specific responsibilities are however assigned to ensure accountability.

The **surveillance officer/epidemiologist** takes responsibilities for the sentinel surveillance system and population based surveys (e.g. BSS) undertaken to track the epidemic. These activities include:

- ◆ Reviewing the selection of sites for sentinel surveillance,
- ◆ Ensuring that the sentinel surveillance round is carried out in a timely way according to the standard protocol,
- ◆ Participating in quality monitoring of the sentinel surveillance activity
- ◆ (At the national level) Managing the contract for the BSS activities during the years the survey is conducted
- ◆ Conducting field visits to sort out problems related to reporting
- ◆ Convening the technical advisory group for the BSS
- ◆ (At the state level) Keeping abreast of what is planned for their state and provide support as necessary to the central level team
- ◆ Supporting HIV prevention, treatment and care programmes using NACO's Computerized Management Information System (CMIS) and by field-level and field reviews.
- ◆ Organizing trainings to ensure quality data collection and information use.
- ◆ Preparing SACS annual reports
- ◆ Supporting the coordination and review of operations research involving the state

The **M&E officer** has responsibility for maintaining the routine monitoring system of the state and conducting cross-cutting analyses for the preparation of routine and annual reports. These responsibilities include:

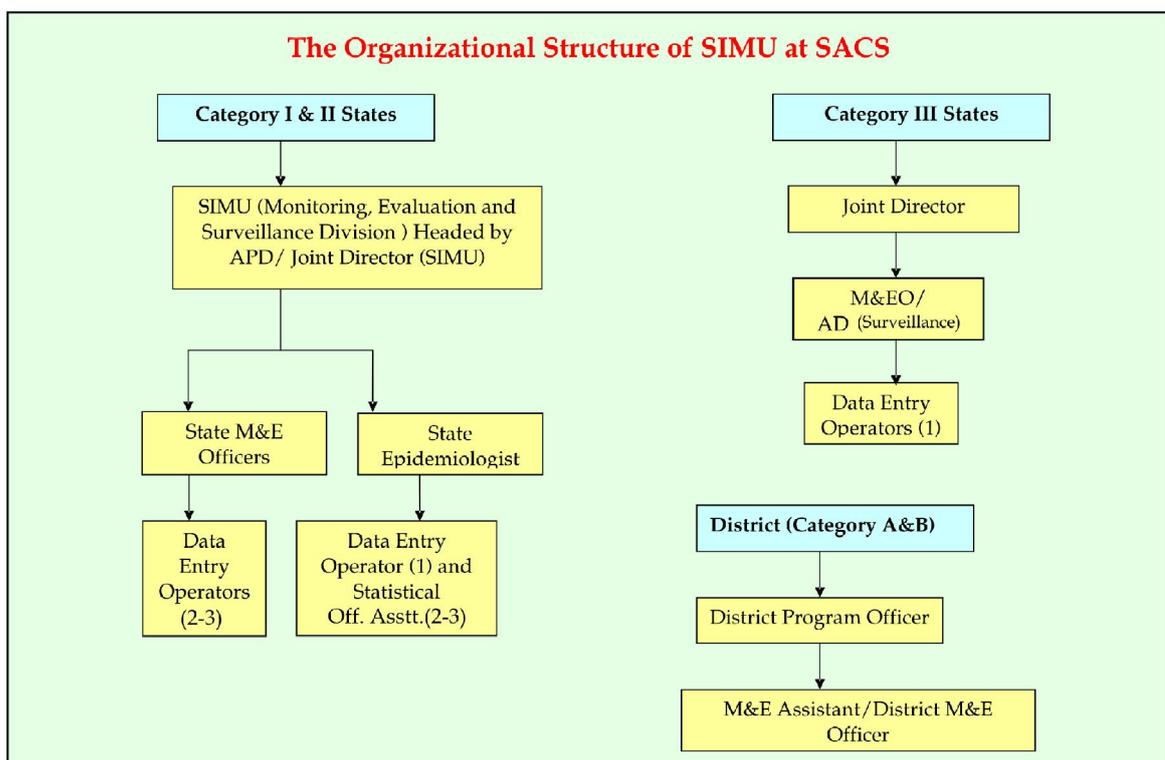
- ◆ Assisting in the development of the M&E plan for the state in concurrence with the M&E strategy for NACP-III;
- ◆ Finalizing the monitoring indicators to reflect state-specific programmes;
- ◆ Supporting the development of targets and monitoring programme achievements on regular basis through the use of the dashboard indicators.
- ◆ Ensuring that all reporting units in the state are using CMIS.
- ◆ Updating the CMIS masters used to register all functioning reporting units including blood banks, STD clinics, ART centers, ICTCs, NGO's etc.;
- ◆ Establish a mechanism for timely and error free reporting to NACO;
- ◆ Flagging issues related to reporting protocols and software;
- ◆ Responding to the information needs from NACO.
- ◆ Linking CMIS and CPFMS to monitor utilization of consumables, stock positions etc.
- ◆ Reviewing and carrying out routine verification of CMIS data

- ◆ Conducting on-site data validation for a sample of centers
- ◆ Providing feedback to reporting units.
- ◆ Analyzing of the routine monitoring data,
- ◆ Contributing to the preparation of quarterly and annual reports for SACS.
- ◆ Supporting surveys conducted by other agencies, research studies and surveillance as and when needed.
- ◆ Coordinating annual service quality assessments of implementation units
- ◆ Coordinating, scheduling, and facilitating training for users of the CMIS (e.g. all district SIM and program staff.

The epidemiologists and Monitoring and Evaluation Officers would work together for data quality, triangulation and identifying priority operations research questions. Subsequently, in conjunction with designated survey institutes, they would undertake designing and implementing operational research studies.

The **statistical officer/assistant** works closely with the M&E officer & epidemiologist to support the data management of related monitoring and evaluation data collected by the SACS. These responsibilities include:

- ◆ Compiling and collating data at state level.
- ◆ Maintaining the database of all relevant information for the program.
- ◆ Preparing analysis frameworks for periodic analysis of the data.
- ◆ Cleaning/validating the collected information.
- ◆ Working on statistical analysis of the data, preparation of the reports, presentations as and when needed.



- ◆ Flagging data gaps and assisting other members of the SIMU in rectifying the problems.
- ◆ Assisting in making CMIS operational and conducting trainings for data entry operator
- ◆ Follow-up with reporting units for timely receipt of quality reports
- ◆ Conducting field visits to streamline reporting.

The **data entry operators** provide support to the statistical officer and M&E officer to enter and compile data from the different components of the programme. Their responsibilities include:

- ◆ Data entry and/or compilation of data, data validation from reporting units from all the States for reporting of all components of the program
- ◆ Assisting in data analysis and the preparation of State Reports and its monthly updation.
- ◆ Flagging the reporting issues, data discrepancies while entering data and assisting communication to corresponding State M&E unit for follow-up action.
- ◆ Support data entry for surveys, surveillance, research studies and other checklists are ports as and when needed.
- ◆ Keeping track of financial reports of the allotted reporting units.
- ◆ Maintain files related to the assigned components, necessary databases
- ◆ Assist in documentation and preparation of meetings, minutes of meetings, organization of trainings for CMIS/M&E

In addition to the responsibilities described above, the SIMU officers are also responsible for identifying and collating information from similar studies or activities which overlap with their area of responsibility. For example, special studies and surveys conducted by a local NGO or another donor agency should be collected by the surveillance officer, then reviewed for quality and incorporated into the understanding of the HIV/AIDS epidemic, as appropriate. The state M&E officer should make contact with the other key NGOs or service providers of programmes similar to the NACP III and arrange for routine monitoring data to be reported regularly and consistent with the CMIS. This will enable a more complete assessment of whether all programme partners combined are putting in sufficient resources to address the HIV/AIDS epidemic of India.

District level staffing will reflect the intensity of the programme implemented. Districts that fall into the 'A' and 'B' categories are those in which the HIV epidemic is more advanced and where the placement of programmes is a higher priority. Due to the increased number of reporting units, it will be important for an M&E officer and a data entry operator to be operating at the district level, to support the District AIDS officer. This will enable timely and more complete follow-up on reporting units, as well as routine analysis of data at the local level. Districts in the 'C' and 'D' categories are likely to have fewer numbers of reporting units to coordinate. These districts will have support of a dedicated data entry operator, who will be supervised by the District AIDS officer, who will also have responsibilities for M&E in their job description.

Collaboration between Strategic Information Management Unit and Other Units of the SACS

Linkages between the SIMU and other units within the SACS is crucial. Monitoring and Evaluation should be seen as an activity integrated into each component of the SACS program. Each SACS officer should be aware of the program monitoring data collected for the respective components they oversee and the type of analysis that is possible to conduct.

Regular interactions between the SIMU team and programme units include:

- ◆ Sharing monthly and quarterly reports with the lead person of that component
- ◆ Providing joint feedback to the implementing units addressing both the quality of the programme and the quality of the information reported.
- ◆ Monthly review of CMIS reports to share interpretations and insights about the data analyzed.

Training for SIMU Staff

All new staff of the SIMU, including the M&E officer, will receive induction training to orient them to NACP III and their roles and responsibilities with respect to other SIMU staff. These trainings will be followed by SIMU component specific training (i.e. surveillance, M&E, and research) to ensure each officer is familiar with the technical and managerial issues related to their job.

A system of pre and post training assessments will help SACS and NACO to develop appropriate professional development plans for each SIMU officer and to plan future sessions of refresher training. Refresher trainings are expected to occur approximately every six months, through a rotation of basic and advanced topics. During the initial period of NACP III, quarterly meetings of M&E officers are expected to review the quarterly CMIS data and conduct capacity building on selected topics.

In addition to off-site, formal classroom training sessions, SIMU staff will participate in in-service trainings and supervisory visits by central or regional technical support persons. During these in-service trainings or site visits, the need for additional support for carrying out critical M&E functions will be assessed for different staff. For a limited number of qualified staff, selected on a competitive basis, opportunities for extended training in advanced skills may be supported by SACS or NACO.

Type of Training	Target Segment	Duration	Responsibility	Brief Learning Objectives
Induction Training	All SIMU staff to together as a team	3 days	NACO	To orient all members of SIMU on objectives and functions of SIMU
Position specific training	All SIMU staff	2 days	NACO	To enable the member of SIMU to undertake their roles effectively
CMIS	PO CMIS DEO	3 days	Agency Developing Software	To initiate the new CMIS
Surveillance	PO Surveillance	2 days	NACO	To undertake annual sentinel surveillance
Operations Research	Epidemiologist/ PO of component	2 days	NACO (supported by agencies)	To train staff in principles of operations research.
Basic descriptive epidemiologic skills	Epidemiologist	5 days	NACO (supported by agencies)	To train staff in developing tables/graphs, interpretation presentation of results, GIS & writing reports
Survey & Research/ Evaluations	PO-M&E, Epidemiologist	2 days	NACO (supported by agencies)	To train staff in design of basic surveys and evaluation studies.

Hardware and Software Requirements

The SIMU will be provided the necessary hardware and software requirements to enable the staff to work effectively and efficiently to ensure the quality and timeliness of data collected and analyzed by SACS.

Hardware requirements include:

- ♦ A computer for each staff member
- ♦ 1-2 dedicated servers for CMIS as per the specifications requisite equipment
- ♦ Reliable internet connectivity, e.g. broadband/eased line connections, to ensure smooth data transfer and regular communication
- ♦ Printer and photo copier for enabling production of hard copy reports, feedback for reporting units, dissemination of reference materials, and other SIMU materials.

Software requirements include:

- ♦ Microsoft Office (Including MS Word, Excel, Access, and Power point)
- ♦ Epi-info
- ♦ Mapping software, as recommended by NACO as per need

Based on analysis requirements and capacities at SACS, additional softwares can be procured without compromising the data reporting to the national systems.

Data Storage and Back-up mechanisms

Strategic Information Management Unit at state and national level would maintain all data for minimum of 5 years and should be in a position to provide for verification. If data is reported in hard-copy, the same must be maintained. For all monthly monitoring records, back-ups must be taken every month and for patient treatment records (like in ART/PMTCT) back-ups must be taken every week. At national levels information for all states would be stored and available.

Sources of Data Used in Strategic Information Management

Sentinel Surveillance

Disease surveillance can encompass many methods and protocols for collecting information about a disease, but they all share the objective of obtaining a periodic measurement of disease prevalence for a given population. Sentinel Surveillance is one type of system for collecting information. It is characterized by the selection of a sample of fixed sites in which people who come to those sites for services are also tested for the disease of interest. Sentinel sites are usually selected in a purposeful fashion to either provide information about where the epidemic may emerge or where the epidemic is already established. Sentinel surveillance systems can also require fewer resources than other types of surveillance activities, so feasibility considerations often weigh heavily in the selection of sentinel sites. This type of sentinel site system is a cornerstone of the current HIV/AIDS surveillance system in India.

Behavioural Surveillance Surveys (BSS)

Behavioural surveillance is a critical component of a second generation HIV surveillance system and is particularly important for a concentrated epidemic, as is the case for India. Similar to disease surveillance, the purpose of BSS is to consistently measure the level and nature of risk behaviour in different populations over time. Both BSS among the general population and among selected high risk groups provide useful insights to the epidemic and the potential impact of the programme.

Because of our understanding of the transmission dynamics of HIV, by tracking the patterns of behaviour among different populations, it is possible to anticipate where an epidemic is likely to emerge. The behavioural component of surveillance also helps to explain patterns observed in disease surveillance and plan more effective interventions that address the characteristics and issues of the population studied.

Computerized Management Information System (CMIS)

The heart of the routine monitoring system for NACP III is the CMIS, the computer system designed to collect and facilitate the analysis of the inputs and outputs of NACP III. It is helpful to think of the CMIS as more than just a piece of software. The CMIS is fed by through a series of data collection formats that are compiled or used directly for data entry. The data entry formats are specific to the different types of reporting units and enable the routine monitoring data to be entered in a standardized fashion. Most CMIS data are entered monthly, with a few pieces of information updated quarterly or annually. Once uploaded into the system, data can be viewed at multiple levels of management and different types of analysis reports can be generated to aid managers in providing feedback and making program decisions.

Service Quality Assessments

Routine monitoring systems provide reliable data to assess general performance of programmes in terms of uptake and availability of services. This more quantitative type of monitoring is complemented by the availability of data describing the quality of services provided. Quality assessments are made through site observations, retrospective review of records, and exit interviews with clients to determine user satisfaction. The quality standards for each programme area are defined in the programme guidelines established by NACO or SACS, which also form the basis for training and other forms of supervision or capacity building.

Special Studies

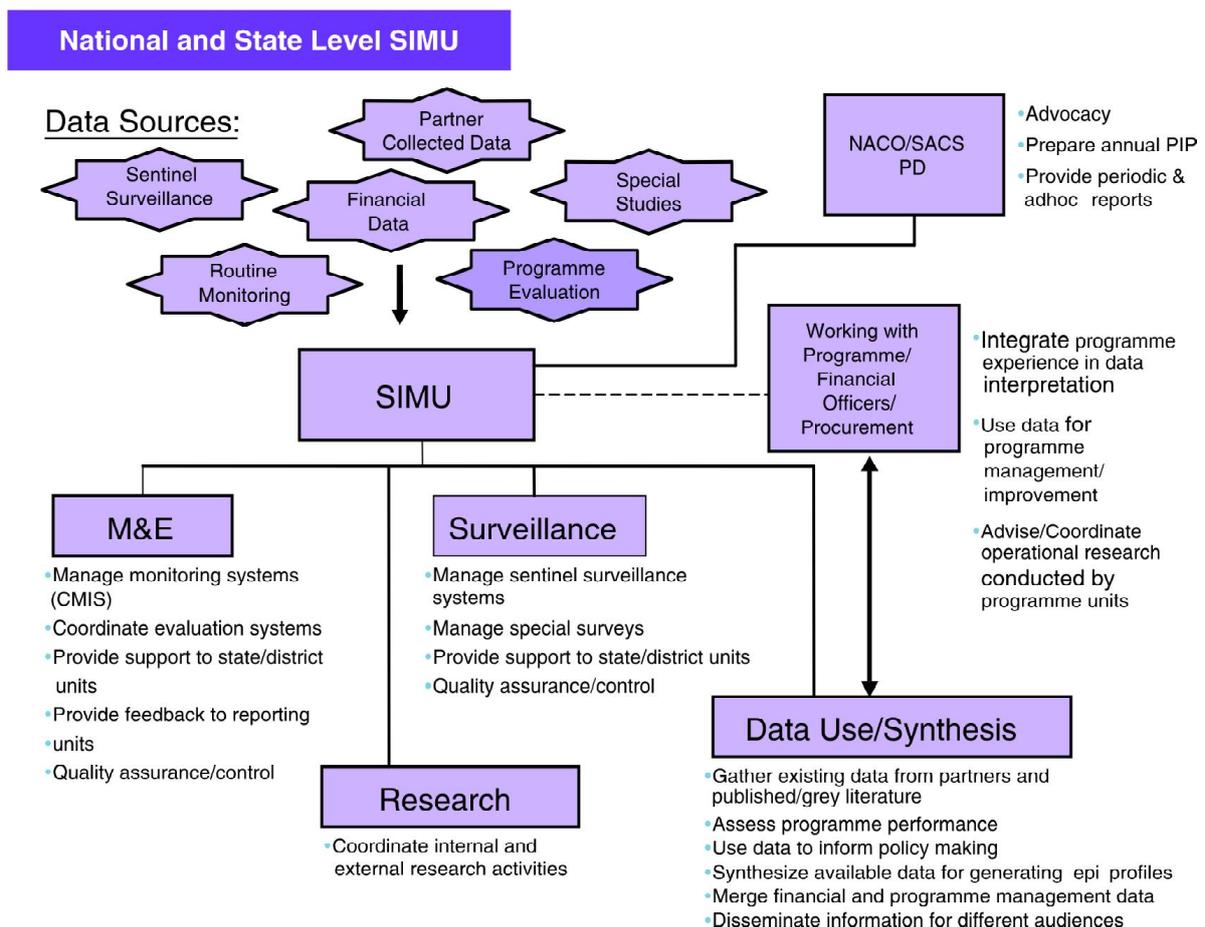
Some information that is critical to monitoring programme performance is not readily collected through the routine monitoring system or through service quality assessments. Special studies are conducted to address the need to collect specific programme related data on a one-time or infrequent basis. The methods used may include field observations, qualitative methods, facility surveys, and other methodologies according to the data requirements.

Impact Evaluation

As described in the earlier section on broad M&E concepts, programme impact is defined as the ability for a programme to demonstrate that its goal has been achieved and that there is strong evidence to show that this change was a result of the programme’s activities. Conducting this type of impact evaluation requires significant resources and a strong design for measuring both the desired effect and attribution of the effect. In a situation when an intervention has been shown to be effective in other similar settings, programmes opt not to conduct impact evaluations, and instead focus on the measurement of programme achievements or outputs and intermediate outcomes.

Operations Research

As for most types of research, operations research attempts to address management or program operation issues by conducting studies which compare the performance of two groups under different conditions. Unlike basic research, the topics under study in operations research usually have direct and immediate applications for improving or enhancing performance. People doing operations research often seek to test the effect of different interventions under real life conditions.



Ensuring Data Quality & Use

Quality of data collected poses a major challenge to M&E system which need to be addressed carefully. The data flow for collecting data involves multiple points where data quality can be verified and improved by SIMU. The process begins in using standardized formats and extends to conducting site visits of reporting units to verify the quality of data reported.

Clear definitions and instructions for data collection and compilation

CMIS data should be collected systematically in a consistent fashion to ensure data can be compared across reporting sites, geographic units or over time. This requires clear written definitions and instructions that are accessible to those who are involved or supervise the process of data collection. Most of the data collection formats of CMIS are in the form of registers that may have utility for managing clients beyond what is required for reporting. The definitions and instructions for data collection should be consistent with the work flow of these units, and sensitive to the way data are used and defined for other management uses. Standardized data collection and entry formats developed by NACO will be accompanied by these types of instructions and guidelines. SACS who develop their own customized formats should maintain similar instructions and guidelines and ensure they are consistent with definitions developed at national level; disseminated and made available to the relevant reporting units.

Training and supportive supervision for staff

The staff who are responsible for data collection should receive training and feedback from their supervisors on the quality of the data they collect. Refresher training is important to schedule regularly as staff turnover, or revisions to the data collection formats may necessitate additional training. These training sessions are also useful for obtaining feedback from the staff who are collecting the data. Often they may have good suggestions about improving the data collection system or can raise challenges they face in using the formats. Timely feedback from both programme leads and M&E officers about whether forms are filled correctly and completely can motivate staff, because this demonstrates that the data are being reviewed and used. When possible site visits by supervisors to review the process for data collection and data entry at specific reporting units, particularly those which seem to have difficulties in reporting should be undertaken.

Timely and regular reporting

One of the most common ways to review CMIS data is to analyze the trends of different indicators over time. Graphs that show trends are useful for detecting unusually low or high levels of activity that can identify areas that require more management attention or indicate the progress of the programme. In order to have reliable trends it is important that reporting units submit their reports on a regular basis. If there are sporadic patterns of reporting, it will be difficult to know whether a trend displays real programme activity, or reflects poor levels of reporting. The CMIS system produces one standard report that describes the reporting performance of different reporting units and geographic areas. This report helps to identify reporting units that require more attention with respect to improving regularity of reporting. Units which have poor reporting records should be contacted consistently and given feedback until reporting patterns improve. Due to the number of reporting units, the follow-up on

reporting timeliness is a key activity for which district level M&E officers can support SACS M&E officers.

Transcription and Data Entry errors

Transcription error can be another source of poor data quality. Minimizing the number of times data are transferred from one format to another can reduce the amount of error. Similarly, creating paper formats for data collection and compilation that mimic the data entry screens makes it easier for data to be entered correctly. Finally, ensuring that data entry personnel have sufficient time to complete their jobs can avoid rushed jobs and aid staff in checking over their work. Supervisors should also conduct spot checks to ensure the data first written on data collection formats translates to the correct value in the CMIS. A key responsibility of supervisors of reporting units is to sign off that the data submitted have been reviewed and are believed to be free of transcription or other accounting errors. In addition to regular supervisory review, occasional site visits by district or state M&E officers should include a record review to ensure that hard-copy registers and electronic reports show consistent counts. Other methods for identifying transcription errors is to note the presence of outliers which cannot be explained by special circumstances of the reporting period. The M & E officers should check a sample of reports every month for transcription errors.

Local review and use of data

A key method for improving data quality, is to ensure that the people who are collecting the data use their own data regularly. The greater the familiarity of the staff at each reporting unit with their own routine monitoring data the more likely they are to develop consistent practices, be able to identify gross errors in transcription, and have internal motivation for improving data quality and timeliness of reporting.

SIMU can encourage local use of data by helping reporting units in reviewing reports with tables and graphs and getting their interpretation of trends and what the data reveal about the performance of the programme. **It can also help to institute regular data review meetings held by the reporting unit staff and local stakeholders** so that this type of analysis is well integrated into other aspects of programme management.

Some important mechanisms for ensuring data quality and information use would be:

- ◆ A **bi-monthly feedback** from National SIMU to states on data quality would be communicated
- ◆ A **quarterly review meeting** of State SIMU at National level where the data received from states would be analysed and presented. The trends discussed and data gaps identified and communicated
- ◆ Project Directors of SACS would include a session on M&E in their **review meeting with program officers** and district units to discuss the reports, analysis and trends and issues in data collection.
- ◆ A **data quality validation checklist** developed and used for verification of data at facility level and all SIMU staff would use it during their field visits.
- ◆ Constitution and regular meetings of an **Interagency M&E Technical Working Group** for support the M&E activities at national and state level.

What the M&E officer can do to improve smooth operation of CMIS

- ◆ Contacting reporting units to encourage timely reporting and to provide feedback on the data sent. (This task may be delegated to the district M&E officers located in districts designated as 'A' and 'B' level epidemics.)
- ◆ Provide supervision for data entry that may take place at the SACS level.
- ◆ Regular review of the data sent through standard reports available in CMIS.
- ◆ Serving as a resource person for trouble shooting by district M&E officers and reporting units
- ◆ Coordinating dissemination of new data collection formats and software upgrades.
- ◆ Collating feedback from the reporting unit staff about how to improve the CMIS and related routine monitoring systems. M&E officers can act to funnel this feedback up to central decision makers and the CMIS developers.
- ◆ Oversee state-level customization of CMIS modules to accommodate high priority programme innovations.
- ◆ Organize training for users of software from time to time

Key Products of the Strategic Information Management Unit

Annual Report and Action Plan

At the end of each year, SACS present a review of the status of the epidemic and the programme achievements in that state. The performance of the state's HIV/AIDS programmes are reviewed through analysis of the CMIS and service quality assessments as well as the information from any programme evaluation completed during that year. On the basis of this analyses an action plan, budget, and timeline are prepared. Due to the multiple sources of information, the annual report must be produced through the efforts of all members of the SIMU team with in-depth analysis and triangulation of data from all available sources.

Annual Sentinel Surveillance Report

This report provides in-depth analysis of the sentinel surveillance data collected in that year, along with the trends of data from previous surveillance rounds. These data are presented with interpretations of what the trends and point estimates suggest about the magnitude and trajectory of the epidemic in the state, and also discusses sub-state regional differences as necessary. Given the challenges of conducting sentinel surveillance, the report should also include a thorough methodological section describing the site selection process, any issues related to recruitment that may affect the sample, or laboratory processing related to the reliability of testing.

Quarterly CMIS Reports

On a quarterly basis the SIMU produces a summary of the data collected through the CMIS. This quarterly report will contain a standardized set of tables and graphs that show the month by month progress of various programme areas through selected output indicators. These indicators include those identified as dashboard indicators at the output level. These reports should be reviewed by both SACS and district level SIMU, programme officers, and then disseminated to the implementing units with appropriate feedback about the achievements of each unit and areas requiring greater attention for improvement.

The detail work plans for monitoring & evaluation under SIMU are in Annex III.

Monitoring Issues for Specific Programme Areas

Each programme area is described below, highlighting the key areas of performance monitoring and a brief description of the accompanying CMIS data entry format.

Objective 1. Prevention of New Infections

Targeted Interventions

Targeted interventions for high risk groups are the primary strategy for HIV prevention in a concentrated epidemic. These programmes provide comprehensive prevention services for female sex workers (FSW), men who have sex with men (MSM), and injection drug users (IDU) to stabilize or decrease the prevalence of HIV in these populations

The key areas of programme monitoring relate to:

- ◆ Adoption of condom use and clean needle use practices
- ◆ Number of sites and coverage of programmes of mapped high risk groups
- ◆ Availability and distribution of condoms and needles/syringes
- ◆ Referrals to voluntary counseling and testing and basic AIDS care and treatment

High Risk Men

Prevention interventions for bridge populations, specifically men who are likely to be clients of sex workers comprise the second prong of the NACP III prevention strategy. Specific populations addressed are truckers and migrants. Services for these populations include communication activities to improve awareness of routes of HIV transmission and to promote condom use with non-regular partners. The key areas of programme monitoring for this programme area are:

- ◆ Size estimation of the bridge population
- ◆ Increasing knowledge and awareness of HIV/AIDS
- ◆ Adoption of condom use with non-regular sex partners
- ◆ Collection and analysis of information to characterize the vulnerability of migrant populations.

The CMIS data entry format for TI and HRM are consolidated, with separate areas to record information by target group. The form has four sections: 1) outreach coverage; 2) linkages with facilities; 3) commodity distribution; 4) staffing and training.

Vulnerable Populations

NACP III has identified additional groups which may be especially vulnerable to HIV and has designed interventions to reduce their vulnerability. These groups include women, youth, and workers. These interventions largely spread information and awareness among these groups through various types of communication channels.

The key programme monitoring issues include:

- ◆ Level of resources allocated to programmes for these groups

- ◆ Exposure of women, youth, and workers to programmes designed to increase their knowledge, awareness, and referrals to services

Sexually Transmitted Infection Clinics

STI control in the general population can reduce the transmission probability of HIV. Populations seeking care at STD clinics may also be at risk for HIV and are a critical group to refer to HIV services such as counseling & testing. A key aspect of the NACP 3 prevention strategy is to increase treatment seeking of people with STI symptoms and to improve the quality of services available at STI clinics (including the availability of essential medicines and condoms).

The CMIS data entry format for STI includes six sections: 1) Clinic volume; 2) Distribution by syndromic diagnoses; 3) Specific services provided; 4) Coverage of ANC syphilis screening. 5) laboratory procedures; 6) inventory management

Integrated Counseling and Testing Centers

In NACP III, stand along voluntary counseling and testing sites will evolve into integrated sites which include prevention of parent to child transmission centers (PPCTC). These services will be expanded to reach primary health center level facilities and include both public and private facilities over time. Expansion of services works in parallel to encouraging high risk core and bridge group members to know their status. The key programme monitoring issues for this area are:

- ◆ Number of sites by types of services provided
- ◆ Testing volume and coverage of high risk group populations
- ◆ Assessing the continuity of service from counseling to agreeing to testing to obtaining results and referrals for newly-diagnosed positives for services.

Prevention of Parent to Child Transmission

In addition to the cascade of testing statistics, PPTCT programmes command a few additional areas of monitoring.

- ◆ Completion of ARV prophylaxis for positive pregnant women
- ◆ Geographic coverage of PPTCT services for pregnant women

The CMIS data entry format for ICTC and PPTCT share similar sections: 1) Service volume; 2) profile of positives; 3) in and out referrals; 4) inventory management; 5) TB-HIV linkages.

Condoms Programming

Ensuring a safe blood supply requires regular screening, increasing the proportion of voluntary blood donors; and making most efficient use of blood donated through component separation and fractionation.

The CMIS data entry format for Blood banks has four sections: 1) volume and profile of blood donors; 2) results of testing and separation; 3) Infrastructure and inventory management 4) Storage unit linkages to blood banks.

Information, Education, and Communication

This programme area covers those programmes aimed at increasing information and awareness through mass media and education system campaigns. Key programme monitoring areas address:

- ◆ Coverage of School AIDS programmes, Adolescent education programmes, and campaigns targeted at out of school youth.
- ◆ Coverage of media on issues related to HIV/AIDS

Objective 2. Care, Support, and Treatment for Populations Infected and Affected with HIV.

Antiretroviral therapy

The provision of antiretroviral therapy requires intensive monitoring from a clinical management perspective to avoid treatment failure and premature death and to maximize the benefits of a resource intensive intervention. Key issues for ART programme monitoring are:

- ◆ Availability of ART service centers and trained medical personnel
- ◆ Volumes of patients initiating ART and subsequent rates of adherence and survival
- ◆ Linkages between ART services and home based care providers
- ◆ Drug resistance monitoring
- ◆ Availability of essential medicines

The CMIS data entry format for ART is based on information collected through a specialized patient register and data system. The format has ten sections: 1) PLHA registration and tracking; 2) ART enrollment; 3) treatment status; 4) Adherence; 5) Regimens; 6) Inventory management; 7) NGO linkages; 8) Staffing; 9) Adverse events; 10) Occurrence of opportunistic infections

Care & Support

This programme area includes the treatment of opportunistic infections, linking affected children to welfare schemes, basic care at community care centers. The key monitoring issues identified are:

- ◆ Availability of care facilities and trained personnel at multiple levels
- ◆ Volume of patients treated for OIs or benefiting from community care and welfare schemes

The CMIS data entry format for care support consists primarily of a reporting sheet for community care centers. This format has six sections: 1) patient volume; 2) characteristics of AIDS cases; 3) patient symptoms; 4) AIDS cases demographics; 5) OI diagnoses.

Greater Involvement of People Living with HIV/AIDS; Stigma & Discrimination; Human Rights, Legal, and Ethical Issues

Together these programme areas form the strategy for creating an enabling social and political environment, necessary to support programmes for prevention, care, and treatment.

- ◆ Representation of PLHA on key decision making bodies and active PLHA networks
- ◆ Reduction in stigma and discrimination against marginalized populations and PLHA
- ◆ Adoption of key legislation and amendments to existing laws to protect the rights of marginalized groups and PLHA

Laboratories

Ensuring the reliability of HIV testing requires participation of HIV service laboratories in the External Quality Assurance Systems. Quality assurance in testing is particularly important for handling potential false positives which are of a higher proportion in low prevalence settings.

Objective 3. Programme Infrastructure and Capacity Building

Programme Management

Strengthening programme operations starts with establishing sound management and administrative systems. The key monitoring areas of focus for this component are:

- ◆ Tracking rate of expenditure, and ensuring fund flow through appropriate financial and administrative delegation to states and district officers
- ◆ Timely processing of contracts and audits
- ◆ Filling and sustaining people in key staff positions, including at district level
- ◆ Active governing and coordinating bodies at national and state levels

These indicators are primarily tracked through existing administrative logs and review of minutes of meetings of key bodies.

Capacity Strengthening and Mainstreaming

Expanding programme service delivery requires corresponding efforts to train staff in service standards. NACP III also seeks to expand HIV/AIDS programming beyond the health sector and encourage other ministries and departments to develop HIV strategies and action plans relevant to their sectors.

Objective 4. Strategic Information Management

The key areas for strategic information management cover the three main activities: M&E, surveillance, and operations research; and incorporates measures on analysis and use of data for programme purposes:

- ◆ Timeliness of submission of data and generation of routine monitoring reports and surveillance data
- ◆ Conducting both programmatic and scientific evaluations
- ◆ Use of NACO data and completion of operations research projects

NACP III Measures of Success : An Overview of the Indicator Framework

There are three levels of indicators for the NACP III that reflect the different levels of management interest by NACO, SACS, DAPCU, and managers of reporting units.

	Purpose	Primary User	Level	# of Indicators
I. Annual Core Indicators	Assess overall programme impact	NACO International agencies and donor partners	Outcomes and Coverage outputs at National & State level	19
II. Monthly Report	Monitor service Statistics and infrastructure for services	NACO	Inputs and outputs	32
III. Dashboard	Provide snapshot of state programme performance against targets	SACS PD and DAPCU District level	Inputs and Outputs at State &	18
III. Programme Management Indicators	Identify areas requiring more operations management	Reporting Unit Managers; SACS technical officers; PSU	Inputs and Outputs at District & reporting unit level	98 (~ 5 per programme area)

I. ANNUAL CORE INDICATORS

Primary User

NACO and International agencies/donor partners. At the national level, NACO and its key national stakeholders focus on the bigger picture of programme impact. For these groups, it is important to determine if the overall effort and level of resources invested are being put to good use.

Key Questions

What is the state of the epidemic and what is the progress of the national programme response in terms of highest priority outcomes and impact objectives? Which programme areas may need additional support to meet their targets or to adjust their strategies?

Level of Indicators

National and State level - NACP III performance as a cohesive programme.

Number of Indicators :19

(11 Prevention indicators; 2 Care and Treatment indicators; 3 Infrastructure and Capacity Building indicators; 3 Strategic Information System Indicators)

Frequency of Review

Formal review on an annual basis, used in preparation for annual report/action plan.

Programme Implications

Achievements or shortfall seen in these critical areas summarize the progress made. The management response to these types of indicators may entail redesign of programme strategies, or reallocation of resources and changes in policy. To construct the key performance indicators, NACO will require specific pieces of data from the SACS that would be available through the CMIS, the surveillance system, or other documents such as the state annual report and action plan.

Annual Core Indicators

Objective 1. New infections in high risk groups and vulnerable populations prevented

- | | |
|-----|---|
| 1.2 | Percentage of female and male sex workers reporting use of condoms with their most recent client |
| 1.2 | Percentage of IDU population reporting use of sterile injecting equipment at last injection |
| 1.3 | Percentage of men reporting use of a condom the last time they had anal sex with a male partner |
| 1.4 | Percentage of persons reporting condom use in last sex with non-regular partners |
| 1.5 | Percentage of men reporting being clients of sex workers in the last year |
| 1.6 | Percentage of population aged 15-49 who identify correct information about HIV transmission and reject major misconceptions about HIV |

Intervention Coverage

- | | |
|------|---|
| 1.7 | Percentage of districts which have updated high risk group mapping |
| 1.8 | Percentage of HRGs being reached by Tis: a) FSWs; b)MSM; c) IDUs. |
| 1.9 | Number of centers providing ICT services |
| 1.10 | Number of persons who return for test report at ICTC |
| 1.11 | Percentage of HIV infected pregnant women and newborns receiving a complete course of ARV prophylaxis |

Objective 2. Proportion of persons living with HIV/AIDS receiving care, support and treatment increased.	
Intervention coverage	
2.1	Numbers and percentage of eligible PLHA who initiate ART
2.2	Percentage of districts with at least one functioning PLHIV networks
Objective 3. Building infrastructure, systems and human resources.	
3.1	Number of ministries with an HIV strategy and action plan developed in collaboration with NACO
3.2	Percentage of SACS who achieve at least 80% of planned expenditure targets increased
3.3	Percentage of audit reports completed and forwarded within time limits to NACO
Objective 4. Strategic Information Monitoring and Evaluation Systems enhanced.	
4.1	Percentage of reporting units with 75% reporting on time.
4.2	Percentage of SACS generating a report every quarter which includes <ul style="list-style-type: none"> (i) monitoring indicators (ii) surveillance, and iii) findings of the ongoing evaluation
4.3	Percentage of districts/SACS using programme data to develop annual action plan

II. THE MONTHLY REPORT

Primary User: NACO

Key Questions: What is the progress in establishing service sites and training personnel? Is there an increase in uptake of services?

Level: State

Number of Indicators: 32 (27 for prevention programmes. 5 for Care and treatment programmes)

Frequency of Review: Monthly review of data and comparison to trends in performance.

Implications for Programme: These data summarize the early stage progress of states toward scale up of services.

Monthly Report on Key Indicators

	Targeted Interventions and Interventions for High Risk Men	Program Management indicator Reference
1	Number of TI projects	I.a.10
2	Number of core and bridge population reached	I.a.2 / I.b.3
3	Number of people treated for STI at TI clinics or referral providers	
4	Number of condoms distributed (free and socially marketed)	I.g.2, I.g.3
5	Number of staff trained	
6	Number of referrals to (ICTC and ART)	
ICTC		
1	Number of centers providing ICT services	I.e.2
2	Number of persons provided pre-test counselling	I.e.6
3	Number of persons tested for HIV	I.e.3
4	Number of persons who test positive	I.e.5
5	Number of persons who return for test report and receive counselling	I.e.4
6	Number of HIV infected mothers and newborns given a complete course PRV prophylaxis	I.e.11
7	Number of infant samples sent for PCT testing	
8	Number of HIV positive persons on DOTS	
9	Number of STI clinics	
10	Number of persons treated for STIs	
Blood Bank		
1	Number of component separation facilities	I.h.4
2	Number of regional blood transfusion centers	
3	Number of blood banks	
4	Number of blood storage centers	
5	Number of total blood units collected	
6	Percentage of blood units collected through voluntary blood donation.	I.h.2
7	Number of voluntary blood donation camps organized	
8	Number of staff of blood banks trained	

Targeted Interventions and Interventions for High Risk Men		Program Management indicator Reference
9	Number of blood banks with stock out of kits and consumables	
10	Sero-positivity of 1) HIV, 2) Hepatitis B 3) Hepatitis C 4) Syphilis 5) Malaria among donated blood units	
11	Percentage of blood units being processed into components	I.h.3
ART		
1	Number of service outlets providing ART services	II.a.1
2	Number of PLHA who initiate ART / currently on ART	II.a.3
3	Number of children living with AIDS who initiate ART / currently on ART	II.a.3
4	Number of service outlets providing community care	II.b.4
5	Number of opportunistic infections treated	II.b.2

III. DASHBOARD INDICATORS

Primary User: NACO and SACS. At the state level, the most useful set of indicators are a mix of big picture perspectives given the size of most states and operational management issues given the states' role as primary implementers.

Key Questions: Are the state and districts meeting their service delivery targets? Which states/districts or programme areas show early warning signs that they need greater support? Which units and programmes should receive incentives for improved performance.

Level: State and District level

Number of Indicators: 18 (5 overlapping Annual core indicators; 6 Prevention indicators, 5 Care and Treatment indicators, 5 Infrastructure and Capacity Building Indicators, 2 Strategic Information Management Indicators)

Frequency of Review: Quarterly review of monthly reports by the National AIDS Control Board; with similarly structured state-level meetings to review programme status.

Implications for Programme –Through the review of key indicators, states must be able to identify districts which are particularly vulnerable to HIV and which appear to have difficulties in implementing programmes effectively. The management response to these types of indicators may be to focus greater resources and supervisory supports to specific districts or to investigate the reasons low performing services have such poor uptake. District level managers may also

be most interested in the dashboard indicators for the services in their district. In some cases, there may be only one or a handful of sites providing a particular service (e.g. one VCT in a district, one NGO providing targeted interventions, etc.) Therefore, the concern at the district level is whether the suite of services is in place and meets the needs of the district community. Districts often play a role in coordinating supplies from central warehouses at the state level (e.g. test kits, condoms, essential medicines, etc.) that may mean a greater focus on input indicators as well.

Dashboard Indicators

Objective 1. New infections in high risk groups and vulnerable populations prevented		Annual Core Indicator Reference
1	Number of targeted intervention sites	
2	Percentage of targeted interventions reporting condom stock out	
3	Percentage of blood units collected through voluntary blood donation	
4	Number of persons who return for test report at ICTC	1.10
5	Percentage of VCTC reporting inadequate quantities of HIV test kits	
6	Number of HIV infected pregnant women and newborns receiving a complete course of ARV prophylaxis	1.11
Objective 2. Proportion of persons living with HIV/AIDS receiving care, support and treatment increased.		
7	Number of service outlets providing ART services	
8	Number of eligible PLHA who initiate ART	2.1
9	Percentage of ART centers with ART stock-outs during quarter	
10	Percentage of districts with at least one functioning PLHA network	2.2
11	Percentage of SACS, DACS and NGOs who have members of HRGs on their TI-related decision making bodies	
Objective 3. Building infrastructure, systems and human resources.		
12	Percentage of SACS with approved financial and administrative delegation	
13	Percentage of SACS' which have key positions staffed	
14	Percentage of due procurement contracts awarded during the original bid validity period	
15	Percentage of SACS where governing body met at least once during reporting quarter	
16	Number of district units established, staffed and reporting, relative to targets	

Objective 1. New infections in high risk groups and vulnerable populations prevented		Annual Core Indicator Reference
Objective 4. Strategic Information Monitoring and Evaluation Systems enhanced.		
17	Percentage of reporting units with 75% reporting on time	4.1
18	Percentage of State PDs conducting regular partnership forum:	
	<ul style="list-style-type: none"> 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 	

IV. THE PROGRAMME MANAGEMENT INDICATORS

Primary User: District and Reporting Unit Managers; SACS Technical Officers, PSU

Key Questions: Are reporting units functioning well? What are the specific areas of improvement for the reporting units? Are there systemic improvements that should be facilitated at a higher level?

Level: Reporting Units

Number of Indicators: 98 (~ 5 indicators for each programme area) See **Annex 2.** for full list. the details definitions of each indicator are given in book on core indicators.

Frequency of Review: Monthly review of data and comparison to trends in performance. Feedback to reporting units and adjustment in activities made on a monthly basis.

Annex I. Categorisation of Districts Based on HIV Sentinel Surveillance 2004, 2005 and 2006 : State Summary Sheet

S. No.	Name of the State	Total No. of Districts	Category A	Category B	Category C	Category D
1	A & N Islands	2	0	0	1	1
2	Andhra Pradesh	23	23	0	0	0
3	Arunachal Pradesh	16	1	0	6	9
4	Assam	23	0	2	12	9
5	Bihar	38	2	2	27	7
6	Chandigarh	1	0	1	0	0
7	Chhattisgarh	16	0	0	9	7
8	Dadra Nagar Haveli	1	0	0	0	1
9	Daman & Diu	2	0	0	2	0
10	Delhi	9	0	4	5	0
11	Goa	2	1	1	0	0
12	Gujarat	25	6	4	9	6
13	Haryana	20	1	0	18	1
14	Himachal Pradesh	12	0	0	4	8
15	Jammu & Kashmir	14	0	0	7	7
16	Jharkhand	22	0	0	7	15
17	Karnataka	27	26	0	1	0
18	Kerala	14	0	2	12	0
19	Lakshadweep	1	0	0	1	0
20	Madhya Pradesh	48	5	3	23	17
21	Maharashtra	35	32	0	3	0
22	Manipur	9	9	0	0	0
23	Meghalaya	7	0	0	7	0
24	Mizoram	8	2	1	5	0
25	Nagaland	11	10	0	0	1
26	Orissa	30	4	3	18	5
27	Pondicherry	4	0	1	0	3
28	Punjab	17	1	1	15	0
29	Rajasthan	32	1	6	10	15
30	Sikkim	4	0	0	3	1
31	Tamil Nadu	30	22	4	4	0
32	Tripura	4	1	0	2	1
33	Uttar Pradesh	70	5	0	63	2
34	Uttaranchal	13	0	0	11	2
35	West Bengal	19	4	4	11	0
	Totals	609	156	39	296	118

Catetory A (156)		Catetory B (39)	
ANDHRA PRADESH (23/23)	Kolar	MIZORAM (2/8)	ASSAM (2/23)
Adilabad	Koppal	Aizawl	Kamrup
Anantapur	Mandya	Champhai	Sonitpur
Chittoor	Mysore	NAGALAND (10/11)	BIHAR (2/38)
Cuddapah	Raichur	Dimapur	Katihar
East_Godavari	Shimoga	Kohima	Purnia
Guntur	Tumkur	Mokokchung	CHANDIGARH (1/1)
Hyderabad	Udupi	Mon	Chandigarh
Karimnagar	Uttara_Kannada	Phek	DELHI (4/9)
Khammam	MADHYA PRADESH (5/48)	Tuensang	Delhi_Central
Krishna	Balaghat	Wokha	Delhi_East
Kurnool	Dewas	Kiphera	Delhi_North
Mahabubnagar	Harda	Peren	Delhi_North_East
Medak	Panna	Zunheboto	GOA (1/2)
Nalgonda	Rewa	ORISSA (4/30)	South_Goa
Nellore	MAHARASHTRA (32/35)	Anugul	GUJARAT (4/25)
Nizamabad	Ahmadnagar	Bolangir	Ahmadabad
Prakasam	Akola	Bhadrak	Bhavnagar
Rangareddi	Amravati_Rural	Ganjam	Rajkot
Srikakulam	Aurangabad_MH	PUNJAB (1/17)	Boroda (Varodara)
Visakhapatnam	Bhandara	Ludhiana	KERALA (2/14)
Vizianagaram	Beed	RAJASTHAN (1/32)	Ernakulam
Warangal	Buldana	Ganganagar	Kozhikode
West_Godavari	Chandrapur	TAMIL NADU (22/30)	MADHYA PRADESH (3/48)
ARUNACHAL PRADESH (1/16)	Dhule	Coimbatore	Indore
Lohit	Gadchiroli	Cuddalore	Mandsaur
BIHAR (2/38)	Hingoli	Dharmapuri	Bhopal
Araria	Jalgaon	Erode	MIZORAM (1/8)
Lakhisarai	Jalna	Kanniyakumari	Kolasib
GOA (1/2)	Kolhapur	Karur	ORISSA (3/30)
North_Goa	Latur	Krishnagiri	Baleswar
GUJARAT (6/25)	Mumbai	Madurai	Khordha
Banas_Kantha	Mumbai (Suburban)	Namakkal	Koraput
Dahod	Nagpur_Rural	Perambalur	PONDICHERRY (1/4)
Mahesana	Nanded	Pudukkottai	Pondicherry
Navsari	Nandurbar	Ramanathapuram	PUNJAB (1/17)
Surat	Nashik	Salem	Bhatinda
Surendranagar	Osmanabad	Sivaganga	RAJASTHAN (6/32)
HARYANA (1/20)	Parbhani	Theni	Ajmer

Category A (156)			Category B (39)
Bhiwani	Pune	The_Nilgiris	Alwar
KARNATAKA (26/27)	Raigarh_MH	Thiruvallur	Barmer
Bagalkot	Ratnagiri	Tiruchirappalli	Jaipur
Bangalore_City	Sangli	Tiruvanamalai	Udaipur
Bangalore_Rural	Satara	Toothukudi	Tonk
Belgaum	Solapur	Vellore	TAMIL NADU (4/30)
Bellary	Thane	Viluppuram	Chennai
Bidar	Wardha	TRIPURA (1/4)	Kancheepuram
Bijapur	Yavatmal	West_Tripura	Tirunelveli
Chamarajanagar	MANIPUR (9/9)	UTTAR PRADESH (5/70)	Thanjavur
Chikmagalur	Bishnupur	Allahabad	WEST BENGAL (4/19)
Dakshina_Kannada	Chandel	Banda	Darjeeling
Davanagere	Churachandpur	Deoria	Jalpaiguri
Dharwad	Imphal	Etawah	Medinipur_West
Gadag	Senapati	Mau	Murshidabad
Gulbarga	Tamenglong	WEST BENGAL (4/19)	
Hassan	Thoubal	Kolkata	
Haveri	Ukhrul	Puruliya	
Kodagu	Moreh	Bardhaman	
		Uttar_Dinajpur	

Annex II. Programme Management Indicators

No.	List of Indicators - by components	Level N- National S- State D- District	Data Source
I.	<i>PREVENTION OBJECTIVE</i>		
I.O1.	Percentage of FSW, MSM, IDU who are HIV infected - UNGASS	N/S	SS/ AHSS
I.O2.	Percentage of infants born to HIV infected mothers who are infected.	N/S	SS
I.a	<i>Preventive interventions for HRG (Targeted Interventions)</i>		
I.a.1	Percentage of districts which have updated HRG mapping data	N/S	CMIS
I.a.2	Number & percentage of specific HRG population reached by intervention.	N/S/D	CMIS
I.a.3	Percentage of female and male sex workers reporting use of condoms with their most recent client - UNGASS	N/S	BSS
I.a.4	Percentage of men reporting use of condoms in the last time they had anal sex with a male partner - UNGASS	N/S	BSS
I.a.5	Percentage of IDU population reporting use of sterile injecting equipment at last injection - UNGASS	N/S	BSS
I.a.6	Percentage of IDU reporting use of condoms at last sex - UNGASS	N/S	BSS
I.a.7	Percentage of FSW, MSM, IDU's with STI symptoms, seeking services from qualified medical providers.	N/S	BSS
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	N / S	BSS
I.a.9	Percentage of PLHA registered in TI linked to basic aids care and support	N / S / D	CMIS
I.a.10	Number of targeted intervention projects by category	S / D	CMIS
I.a.11	Number of needles and syringes distributed to IDU	S / D	CMIS

I.a.12	Percentage of targeted interventions reporting condom stock out	S / D	CMIS
I.a.13	Number and percentage of TIs where CBOs are formed	S / D	CMIS
I.a.14	Percentage of TI projects reporting no interference from local power structures	S / D	CMIS
I.a.15	Number of SACS, DACS and NGOs who have members of HRGs on their TI-related decision making bodies	S / D	SS
I.b	Prevention interventions for Bridge Population		
I.b.1	Percentage of men reporting being clients of sex workers in the last year	N / S	BS
I.b.2	Percentage of truckers reporting use of condoms with last commercial sex partner	N / S	BSS
I.b.3	Number & Percentage of High risk men (e.g. truckers, migrants, etc.) reached by intervention	N / S / D	CMIS
I.c	Interventions for Vulnerable Populations (women, children, adolescents and workers) 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)		
I.c.1	Amount of budget for HIV programmes dedicated for women, children, adolescents, and the workplace.	N / S	SS(Budget Review / FPMIS)
I.c.2	% of youth using youth resource centers/clubs in their town/district	S	BSS
I.c.3	Percentage of workers who have access to information and services on HIV/AIDS at their work place (by formal and informal sectors)	S	BSS
I.d	STI		
I.d.1	Percentage of general population males with STI mseeking treatment from qualified personnel	N / S	BSS
I.d.2	Percentage/List of clinics reporting a stock out of essential STI drugs	S / D	CMIS
I.d.3	Percentage of STI patients' partners who attend STD clinics for treatment	S / D	CMIS
I.d.4	Reduction in prevalence of most common STIs among the general population and high risk groups	S / D	SS

I.e	ICTC (including PPTCT)		
I.e.1	Percentage of FSW, MSM, and IDU who received HIV testing in the last 12 months and who know their results - UNGASS	N / S	BSS
I.e.2	Number of centers providing ICT services	N / S / D	CMIS
I.e.3	Number and percentage of persons who got tested at ICTC by gender and age	N / S	CMIS
I.e.4	Percentage of persons who return for test report at ICTC- by geMnder and age	N / S	CMIS
I.e.5	Number and percentage of persons who test positive by age, gender	N / S	CMIS
I.e.6	Number of persons receiving pre-test counseling/ information and proportion of people seeking testing by age and gender.	S / D	CMIS
I.e.7	Number and percentage of persons accessing ICTC who are referrals from DOTS centers	S / D	CMIS
I.e.8	Percentage of HIV positive persons referred to ART center, by gender	S / D	CMIS
I.e.9	Percentage of pregnant women newly diagnosed as HIV positive at ICTC, whose sexual partner has been tested.	S / D	CMIS
I.e.10	Percentage of ICTC reporting inadequate quantities of HIV test kits	S / D	CMIS
I.e.11	Number and percentage of HIV infected pregnant women and newborns receiving a complete course of ARV prophylaxis	N / S	CMIS
I.e.12	Percentage of ICTCs having pregnant women as their clients	S / D	CMIS
I.f	Post Exposure Prophylaxis		
I.f.1	Percentage of health care providers who access PEP within 24 hours of exposure	S / D	SS
I.g	Condoms		
I.g.1	Percentage of persons reporting condom use at last sex with non regular partners - UNGASS	N / S	BSS
I.g.2	Number of condoms distributed by social Marketing programs	N / S	SS (NIHFW)
I.g.3	Number of free condoms distributed through TI and STD clinics	N / S	CMIS

I.g.4	Percentage of persons who have had sex with non regular partners who perceive that condoms are easily accessed at the time of sex act	S	BSS
I.g.5	Number of non-traditional outlets selling socially marketed condoms	S	SS (Retail Audit)
I.h	Blood banks and blood Safety		
I.h.1	Percentage of blood units screened for HIV in a quality assured way	N / S	CMIS
I.h.2	Number and percentage of blood units collected through voluntary blood donation	N / S	CMIS
I.h.3	Percentage of blood being processed into componentsM	N / S	CMIS
I.h.4	Number and percentage of blood banks with blood component sMeparation units established	N	CMIS
I.i	Communication and Social Mobilization		
I.i.1	% 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	N / S	BSS
I.i.2	Percentage of out of school youth reached by HIV awareness programme	N / S	BSS
I.i.3	Percentage of students covered under School AIDS program	N / S / D	SS (MoE)
I.i.4	Percentage of schools with Adolescent Education Program w/ teachers trained and who have used the curriculum in the last academic year. - UNGASS	N / S / D	SS (MoE)
I.i.5	Percentage increase in media coverage on HIV/AIDS Missues	S	SS
II.	CARE, SUPPORT AND TREATMENT AND IMPACT MITIGATION OBJECTIVE		
II.a.1	Number of service outlets providing ART services, by public/private facility	N / S	CMIS
II.a.2	Number of doctors trained in ART & OI management	N / S	CMIS
II.a.3	Numberand percentage of eligible PLHA (by CD4 count) who initiate ART- by age, gender and public/private facility	N / S	CIMS

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	N / S	CMIS
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)	N / S	SS
II.a.6	Number and percentage of art centres which have linkages with NGOs/CBOs for community outreach and home based care	N/S	CMIS
II.a.7	Percentage of HIV-positive incident TB cases that received treatment for TB and HIV	N/S/D	CMIS
II.a.8	Initiation of at least 5 regional units for resistance monitoring by end of 2006	N	SS
II.a.9	Number of newly infected with HIV patients which have strains resistant to first line ART regimens	N/S	SS
II.b	Care & Support		
II.b.1	Number of service outlets providing treatment for opportunistic infections (OI)	N / S / D	CMIS
II.b.2	Number of PLHA who access OI treatment	S / D	CMIS
II.b.3	Number of NGOs involved with provision of care and support to affected children	S / D	CMIS
II.b.4	Number of service outlets providing community care	N / S / D	CMIS
II.b.5	Number of PLHAs (and their family members) receiving services from NGOs/ CBOs by gender and age	S / D	CMIS
II.c	Greater Involvement of People w/ AIDS		
II.c.1	Number of AIDS councils at national, state, and district levels which have PLHA representatives	N / S	SS
II.c.2	Number of districts with at least one functioning PLHA network	S / D	SS (Annual rpt)
II.d	Stigma and Discrimination		
II.d.1	Percentage of HRG members reporting instances of stigma and discrimination in the last month	N/S	BSS
II.d.2	Percentage of PLHA who access services who report satisfaction with their service experience	S/D	SQA
II.e	Human Rights, Legal and Ethical Issues		

II.e.1	AIDS legislation adopted and ratified	N	SS
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	N	SS (Policy Review)
II.f	Number and percentage of laboratories conducting HIV testing participating in EQAS	N/S	CMIS
III.	PROGRAMME MANAGEMENT AND CAPACITY RAISING OBJECTIVE		
III.a	Program Management		
III.a.1	Percentage of SACS who achieve at least 80% of planned expenditure targets	N	SS
III.a.2	Percentage of audit reports completed and forwarded within time limits to NACO	N	SS
III.a.3	Percentage of SACS with approved financial and administrative delegation.	N	SS
III.a.4	Percentage of SACS which have all critical program positions filled	N	SS
III.a.5	Percentage of SACS whose donor coordinating committee met at least twice a year	N	SS
III.a.6	Percentage of SACS whose governing body met at least twice a year	N	SS
III.a.7	Number of district units established, staffed, and reporting	N/S	CMIS
III.b	Capacity Strengthening		
III.b.1	Number and percentage of imparted induction and refresher training - by component, category and level	S/D	CMIS
III.c	Mainstreaming		
III.c.1	Number of ministries with an HIV strategy and action plan developed in collaboration with NACO	N/S	SS
IV.	STRATEGIC INFORMATION MANAGEMENT OBJECTIVE		
IV.a	SIM Resources		
IV.a.1	Percentage of budget spent for SIMU at national, state and district level	N/S/D	SS (FPMIS)
IV.a.2	Percentage of reporting units with 75% reporting on time	N/S/D	CMIS

IV.a.3	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	N	CMIS
IV.a.4	Percentage of districts with M&E staff in place	S/D	CMIS
IV.b	Surveillance		
IV.b.1	Number and percentage of states HIV sentinel surveillance sites with timely of data to central database	N	AHSS
IV.b.2	Number & percentage of active sentinel surveillance sites meeting the minimum quality standards (over three years)	N/S	AHSS
IV.c	Data Analysis and Use		
IV.c.1	Number and percentage of States conducting regular review meetings and partnership forum using M&E information	N/S	SS
IV.c.2	Number and percentage of districts/SACS using programme data to develop annual action plan	N/S	SS (Review)
IV.c.3	Number and list of partners sharing information with SACS	N/S	CMIS
IV.d	Evaluation and Research		
IV.d.1	Number of States conducting at least two key intervention evaluations	N	SS
IV.d.2	NACO conducting one participatory programme and one scientific/analytical evaluation every three years.	N/S	SS
IV.d.4	Number of papers based on NACO programme data or NACO sponsored research published in peer reviewed journals	N	SS

Annex-III : M&E Workplan

M&E Work Plan :2007-08

Activities	Year1				Responsibility
	Q1	Q2	Q3	Q4	
Indicators and Technical Support					
Finalization of Dash board, core and program monitoring indicators					National SIMU
Development of manual describing indicator definitions					
Constitution of TRG and Meeting					National SIMU
Quarterly meeting of M&E working group to review and support M&E plan implementation					National SIMU
Strengthening Reporting Systems					
Review and revamping the CMIS formats					SIMU
Pilot testing the formats in three states					SIMU+ Respective Units
Developing the definitions and guidelines for using the format					SIMU+ Respective Units
System analysis & design Report formats and guidelines finalization					SIMU SIMU+ Unit Heads + DP
CMIS Software redesign Implementation of Smart card for ART patients					S/W Agency JD(M&E)
Pilot run the software in 3 states					S/W Agency Support from SIMU
Development of protocols for data validation and verification					SIMU_M&E Working Group
Development of mechanisms for ensuring quality reporting -feedbacks /Working Group validations for identifying duplicates etc.					SIMU M&E
Program Quality Reports State of epidemic report					SIMU JD(M&E)

Activities	Year1				Responsibility
	Q1	Q2	Q3	Q4	
Implementation of the software across the country					SIMU+Agency
National meeting with key partners on common M&E reporting					SIMU Support from AS&DG
Finalization of guidelines and methods of development partner Interagency reporting					SIMU + M&E Group
Systems and Infrastructure					
Recruitment of national SIMU staff					JD(M&E)
Setting up office-systems for national SIMU					JD(M&E)
Setting up state level SIMU					PD, SACS supported by National SIMU
Setting up district level SIMU					PD SACS
Setting up the office-systems for State SIMU (Hardware)					PD SACS
Capacity Building					
Identification of institutions/contracting for training					National SIMU
Development of modules					National SIMU+
Pre-testing and finalization of modules					National SIMU M&E Experts /TRG
Building cadre of trainers TOT					National SIMU+ M&E Experts /TRG
Capacity Building sessions/regular training programs					SIMU+Institutes identified+ M&E Group
Handholding support, feedback to SIMU					National SIMU
Regional SIMU review meetings					JD(M&E)
National M&E convention					JD(M&E) Support from AS&DG

Activities	Year1				Responsibility
	Q1	Q2	Q3	Q4	
Development of training monitoring procedures to track quality of training					SIMU+ Institute identified+ M&E Group
Research					
Formation of TRG- National					JD(M&E)
First meeting to kick start activities					JD(M&E)
Formation regional core group					SIMU
National WS on research ideas (Finalization of reseach plan)					SIMU
Research core group plan finalized					SIMU
National research convention					JD(M&E)
Publications SIMU					
Evaluations					
Consultancy on evaluation design					JD(M&E), AS&DG
Pre-testing and finalization of methodology/tools					SIMU
Sample evaluation in 3 states					SIMU
Training modules and process guidelines on evaluation					SIMU+TRG
Regular evaluation (Client Satisfaction Survey/Qualitative assessments)					SIMU
District					
State					
National					
Outputs from M&E					
Program Progress Report					SIMU

Annex-IV : M & E NACP Workplan

Action Plan for M&E implementation under NACP III																				
	Year 1				Year 2				Year 3				Year 4				Year 5			
	Q1	Q2	Q3	Q4																
Formats and reports																				
Review and revamping of CIMS formats	X																			
Systems analysis and design	X																			
Software redesign		X																		
Report formats finalisation			X	X																
National meeting with key partners on common M&E Reporting				X																
Finalisation of guidelines and methods of development partner reporting				X																
Research																				
Formation of the Research Core Group-National	X																			
First meeting to kick start activities	X																			
Formation of the Research Core Group-Regional level		X																		
First meeting to kick start activities		X																		
National workshop on Research ideas (finalisation of research plan)			X																	
Research Core Group plan finalised for one year			X																	
Research outputs						X														
Research tool kits and best practices finalised					X															
National Research convention						X														
Paper Publications							X													
Evaluation																				
Consultancy on evaluation design	X																			
Pre testing and finalisation of methods	X																			
Sample evaluations in three states		X																		
Training modules and process guidelines on Evaluation				X																
Regular evaluations																				
District						X	X	X	X	X	X	X	X	X	X	X	X	X	X	X
State						X	X	X	X	X	X	X	X	X	X	X	X	X	X	X
National level						X	X	X	X	X	X	X	X	X	X	X	X	X	X	X
Systems and infrastructure																				
Recruitment of National SIMU staff	X																			
Setting up of office, system of National SIMU	X																			
Setting up of regional SIMUs		X																		
Setting of State level SIMUs		X																		
Setting of District level SIMUs			X																	
Capacity building																				
Development of modules and CBT				X																
Pre-test, finalise				X																
Building cadre of TOTs							X													
Capacity building																				
Regular training programmes						X	X	X	X	X	X	X	X	X	X	X	X	X	X	X
Handholding support, feedback of SIMUs						X	X	X	X	X	X	X	X	X	X	X	X	X	X	X
Regional M&E Conventions			X																	
National M&E conventions				X																
Outputs from M&E																				
Programme progress reports				X			X	X	X	X	X	X	X	X	X	X	X	X	X	X
Programme Quality reports				X			X	X	X	X	X	X	X	X	X	X	X	X	X	X
State of the epidemic report							X													
Key indicators and milestones							X													
M&E of M&E - publishing of results							X													

