AVAHAN
INDIA AIDS INITIATIVE

COMMON MINIMUM PROGRAM

- Essential for scale-up
- Flexible for varying contexts
- Standardized for monitoring

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We thank all who have worked tirelessly in the design and implementation of Avahan.

We also thank Chris Parker who assisted in the writing and production of this document.

Version 1, August 2010

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New Delhi: Bill & Melinda Gates Foundation, 2010.

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SECTION I

AVAHAN COMMON MINIMUM PROGRAM

Introduction

In 2003 the Bill & Melinda Gates Foundation began its large HIV prevention program, the India AIDS Initiative, later called Avahan, to help curtail the spread of HIV in India. The foundation has three primary goals for this initiative:

1. Build an HIV prevention model at scale in India
2. Catalyze others to take over and replicate best practices
3. Foster and disseminate lessons learned within India and worldwide

Avahan[1] works in six states in India, which have a combined population of 300 million people. Avahan is a focused prevention program—reaching high-risk groups and bridge populations,[2] in geographic areas most affected, with a proven package of prevention interventions. The Avahan package of prevention interventions is designed to address both proximal and distal determinants of HIV risk.[3] Proximal determinants of risk include factors such as presence of sexually transmitted infections (STIs), condom use, type and frequency of sexual activity, and type of partner. Prevention services such as outreach, behavior change messaging on safe sex, free or socially marketed condom distribution, syringe and needle exchange (for injecting drug use), and treatment of STIs address proximal determinants of risk. Distal determinants include stigma, violence, legal environment, medical infrastructure, mobility and migration, and gender roles. They are addressed through structural interventions and community mobilization aimed at reducing stigma, violence, and barriers to accessing entitlements.[4] An outline of the Avahan Impact Model is presented in Figure 1.

The high-risk and bridge populations targeted by Avahan's interventions include female sex workers, high-risk men who have sex with men, transgenders, injecting drug users, and clients of sex workers found in hotspots and among long-distance truck drivers and their assistants. At the end of the first Phase of the program in March 2009, Avahan provided prevention services to nearly 221,000 female sex workers, 82,000 high-risk men who have sex with men and transgenders, and 18,000 injecting drug users, as well as five million men at risk.

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[1] "Avahan" refers to the effort of the nine lead partner organizations, hundreds of grassroots NGOs, thousands of peer outreach workers, and others working on this initiative.

[2] Definitions of terms used in the publication can be found in the Glossary at the end of the publication.

[3] Boerma JR, Weir SS. Integrating demographic and epidemiological approaches to research on HIV/AIDS: the proximate-determinants framework. *J Inf Dis* 2005; 191 (Suppl 1):S61-67.

[4] Blankenship KM, Bray SJ, Merson MH. Structural issues in public health. *AIDS* 2000; 14 (suppl 1): S11-S21.

Figure 1: Avahan Phase I Impact Model

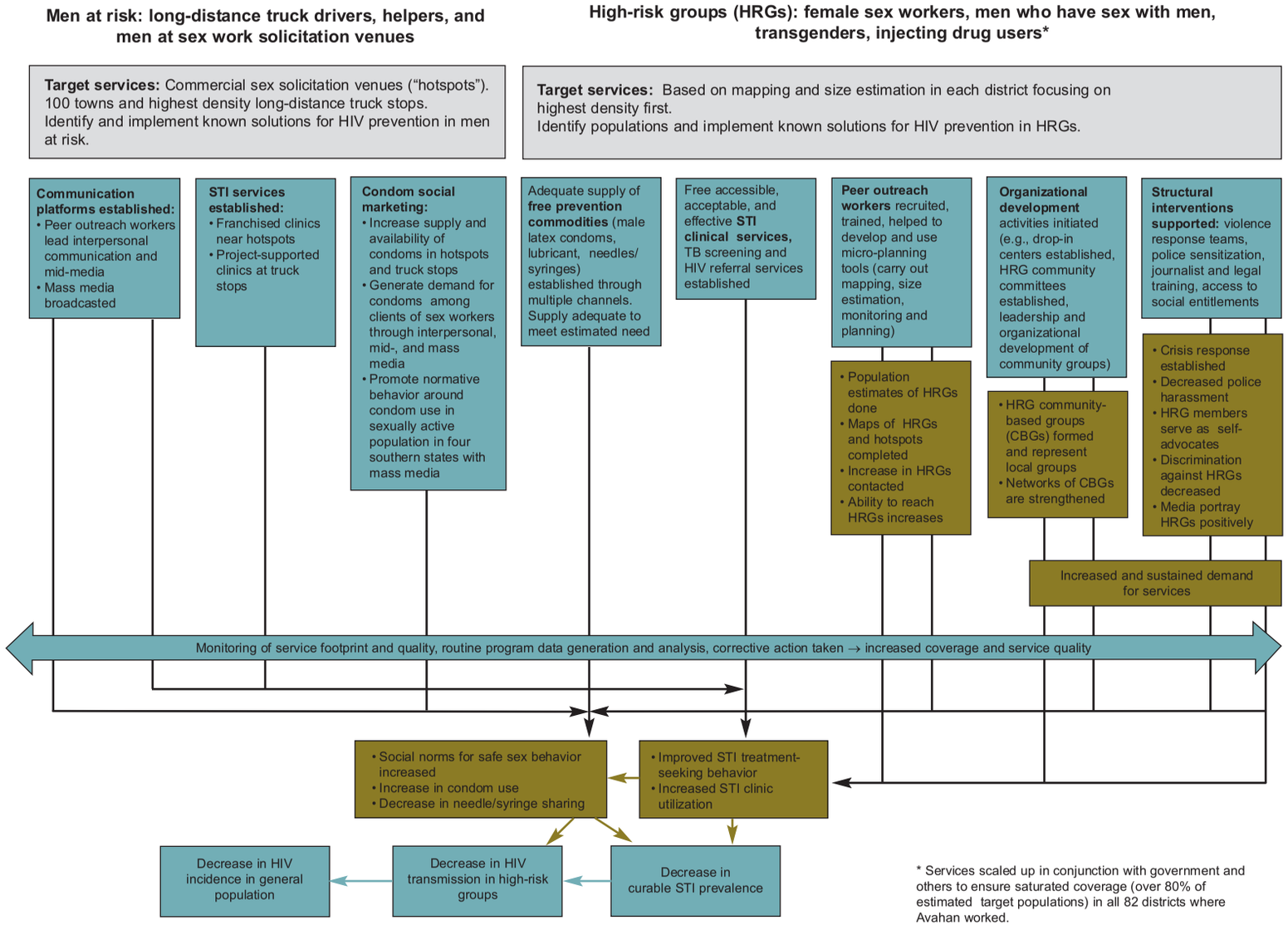
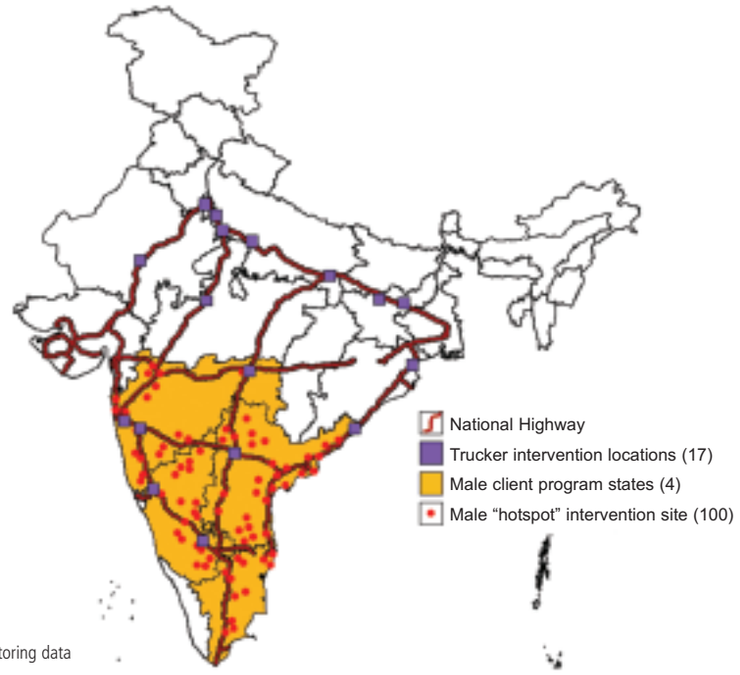
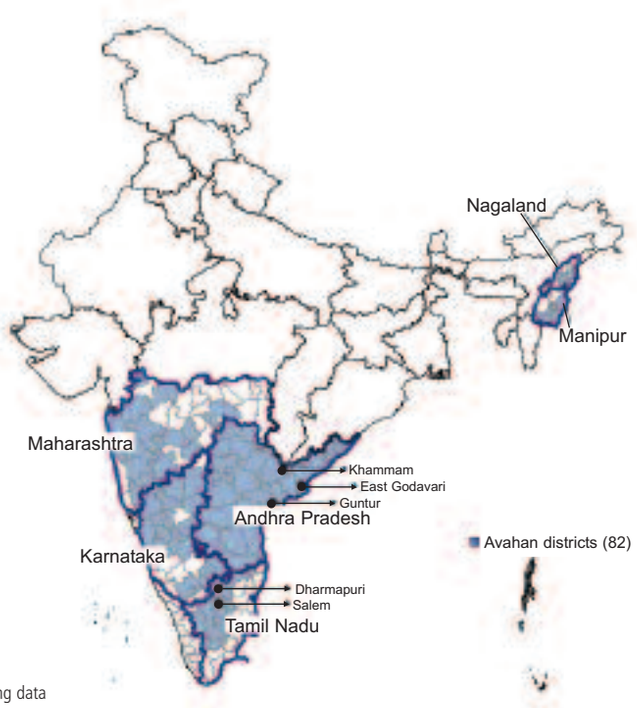


Figure 2: Avahan Intervention Sites for Men at Risk—Hotspots and Truck Stops



Source: Avahan routine monitoring data

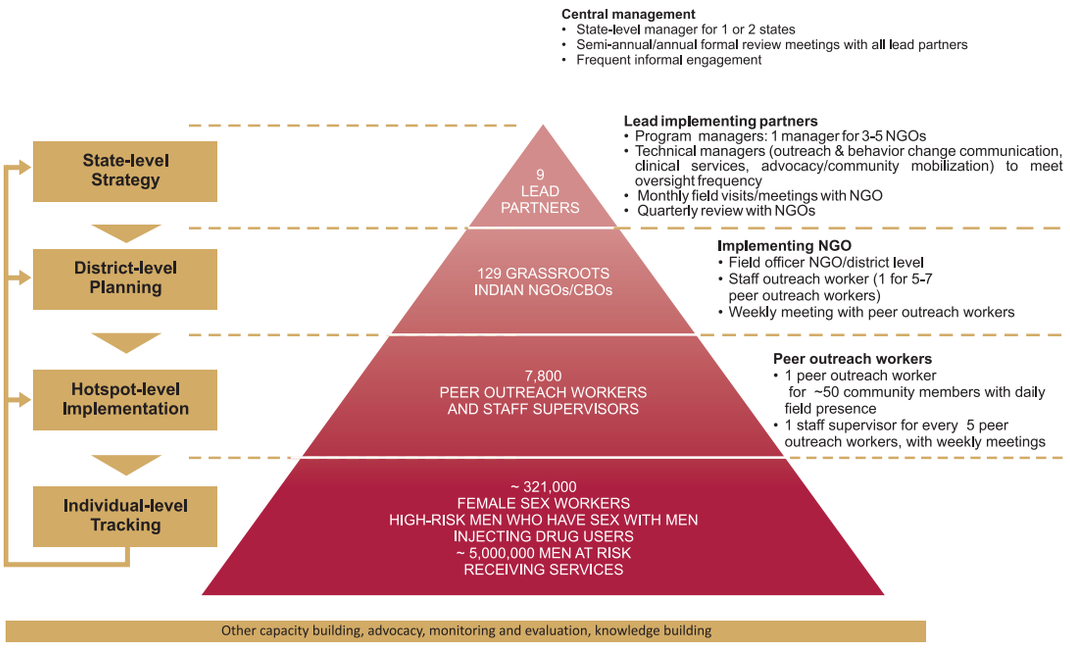
Figure 3: Avahan Intervention Districts for High-Risk Groups in Six States



Source: Avahan routine monitoring data

The Avahan organizational structure may be viewed as a virtual one composed of several diverse entities including local and international NGOs, universities, and research organizations. The virtual organization structure was designed with the explicit intent of enabling rapid and near simultaneous scale-up across geographic areas, facilitating standardization of key program elements, and sharing of best practices across all implementation programs.

Figure 4: Organizing and Managing for Scale



Source: Avahan routine monitoring data, March 2009

Sequencing of the Avahan Program Roll-out

The arc of the Avahan program reflects its goal of quickly creating its service infrastructure across a large geographic area (instead of pilot projects followed by replication and scale-up). This was achieved by ensuring that all nine service delivery grants to implementing partners were made nearly concurrently (within a six-month time span) and were coupled with aggressive milestones for the first several months. These milestones focused both on soft infrastructure (e.g., sub-granting to organizations, hiring human resources including peer outreach workers, and skills training) and hard infrastructure (e.g., clinics and drop-in centers, commodity procurement systems) all informed by mapping and size estimation data. Lead implementing partners quickly sub-granted to local implementing NGOs, who inherited the overall milestones for their intervention areas. Avahan's site-level roll-out of prevention interventions was implemented in three distinct but overlapping phases:

1. **Start up:** Establishing the prevention infrastructure at each location across intervention geographic areas focusing on the highest concentration sites first.

2. **Roll-out:** Increasing quality and intensity of coverage of the local community.
3. **Expanding scope:** Expanding the scope of services by layering on select additional activities (referral linkages with health services and strengthening community participation and leadership) as core interventions matured.

The typical phases of the roll-out of prevention interventions at an Avahan site are described in Figure 5.

Figure 5: Phases of Avahan Roll-out

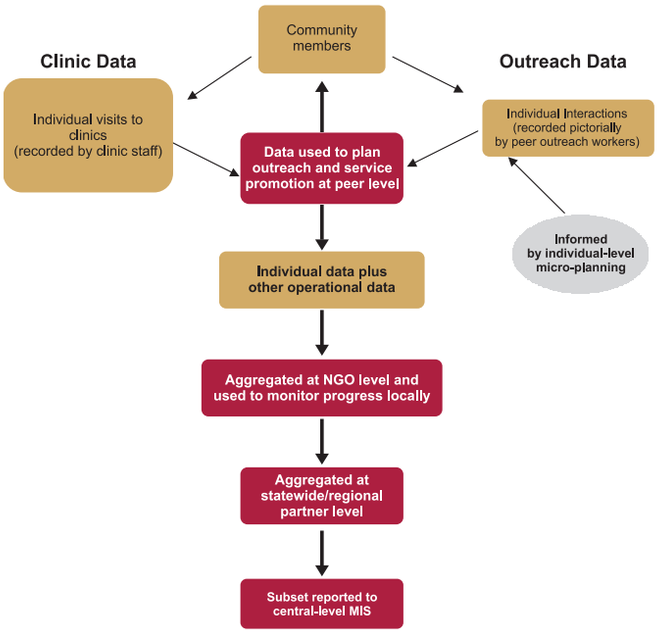
The Common Minimum Program

To manage the scale-up of the intervention with numerous organizations and individuals, working in vastly different social and cultural contexts, Avahan program managers and the technical advisory group realized that the program could only be successful if each partner had a set of core program elements to implement. Avahan's Common Minimum Program (CMP) aims to build this shared vision and define a set of operating standards for the program. The CMP includes guidelines for six main program areas (see page 15), including activities, sequencing, and milestones that implementing partners at all levels of the virtual organization need to meet to ensure common minimum standards. These guidelines allow the monitoring system to be standardized across the partners. While stating these minimum standards, the CMP also tries to build in flexibility for partners working in varying environments so they can innovate and adapt approaches in order to meet the standards.

Routine program monitoring data

One important data stream in the Avahan program was the routine program monitoring data on service provision, service uptake, and community activities from about 130 implementing NGOs operating across Avahan.[5] These data and indicators aggregate data captured from communities' interactions with peer outreach workers and utilization of program-owned and -supported STI clinics (see Figure 6). They also provide information on other operational and infrastructure aspects reported by the NGOs and were further used to monitor various aspects of community mobilization. The routine program monitoring data, coupled with the mapping and size estimates of the high-risk groups in the districts, were the main data sources that informed the pace of infrastructure and service roll-out as well as specified desired service utilization levels as outlined in the CMP.[6] Figure 7 illustrates the data and indicators utilized in the various phases of Avahan roll-out.

Figure 6: Avahan Routine Monitoring Data Flow



[5] A full description of Avahan's data collection activities and evaluation design can be found in *Use It or Lose It: How Avahan Used Data to Shape Its HIV Prevention Efforts in India*. http://www.gatesfoundation.org/avahan/Documents/Avahan_UseItOrLooseIt.pdf

[6] A program-wide analysis of Avahan scale-up using MIS data can be found in Verma R, Shekar A, Khobragade S, et al. Scale-up and coverage of Avahan: a large scale HIV-prevention program among female sex workers and men who have sex with men in four Indian states. *Sex Transm Inf* 2010; 86: i76-i82.

Figure 7: Indicators Used in Phases of Scale-up

Start-up

- Size estimate of target population
- Infrastructure (hard)
  - Districts and towns working in
  - Drop-in centers (DICs) established
  - STI service centers established
- Infrastructure (soft)
  - Staff recruited
  - Peer outreach workers recruited
- Condoms distributed
- People seeking STI services

Core Indicator (CI) # 1 – Size estimate

CI #2 – Number of intervention districts/towns

CI #3 – Number and type of project sites (DICs, clinics, offices)

CI #4 – Total number of intervention related project staff

CI #6 – Number of active, paid peer outreach workers

CI #18-19 – Number of condoms distributed and sold

CI #20 – Number of HRG individuals receiving STI services

Dash Board Indicator (DA) #1—Ratio of HRG individuals to peer outreach workers

Roll out basic services

- Peer outreach worker managed outreach and engagement
- Program outreach coverage
- Condom coverage (based on estimated need and corrected for wastage)
- STI service utilization
- Reported behavior change
- Community involvement in services

DA #2 – Proportion of outreach contacts made by peer outreach workers

DA #3-5 – Proportion of peer outreach workers utilizing STI services

DA #6 – Proportion of estimated HRGs followed by program

DA #7 – Proportion of estimated HRGs contacted by services monthly

DA #8-9 – Proportion of monthly risky sexual acts covered through known condom distribution

DA #10 – Proportion of estimated HRGs who ever attended STI clinic

DA #11-13 – Other measures of STI clinic utilization

DA #14 – Proportion of estimated HRG population reporting condom use during last sex act with a client

DA #17 – Proportion of members of program services and committees (STI and DIC) who are from the HRG

DA #18 – Proportion of members of program committees (STI and DIC) who attended the meetings in a month

Expand scope

- Link with other HIV related services
- Address underlying vulnerabilities

- Number of HRG individuals referred for HIV testing*
- Number of HRGs verbally screened for TB, sent for TB testing, diagnosed with TB, on TB treatment*

DA #15 – Proportion of reported incidents of rights violations against HRG community addressed within 24 hours

DA #16 – Number of HRG individuals who have been assisted by the program to get government issued ID card

DA #19 – Proportion of HRGs who are members of community group

DA #20 – Proportion of individual HRGs who attend committee meetings during the month

DA #21 – Proportion of community group members who are not peer outreach workers

* Data collected by lead implementing partners but not included in centralized MIS Version 2.

About this Publication

This publication describes the Common Minimum Program used by Avahan's partners working with female sex workers, men who have sex with men and transgenders[7] to ensure consistent, standardized implementation of a large-scale HIV prevention program. It should be useful for program managers in other organizations developing similar HIV prevention programs who fund and manage numerous other smaller NGOs.

This publication shares the learning that Avahan has accumulated during its first five years. The CMP was first developed in 2005 based on Avahan's experiences until that point. Since then, the CMP has been a "living document." As gaps have been identified, greater clarity gained about what was working, and new approaches recognized, the CMP has been modified continuously to make course corrections and improve the intervention. The CMP as it appears in this publication is a retrospective analysis of what Avahan did correctly and what could have been done better as it achieved scale.

This document is divided into three main sections:

Section I: Avahan Common Minimum Program, which contains a description of the Avahan program and its six main program areas for the CMP.

Section II: Key Minimum Elements for the Six Programmatic Areas, which provides summary tables describing the six main program areas of the CMP, 5-10 **key elements** for each technical area, 1-14 **key activities** for each element, and **timeframes** for activities including comments and milestones (see sample summary table below).

Sample Excerpt from Table in Section II

Element	Implementation Activities	Timeframe			Comments/Lessons
		Start Up	Enhanced Scale	Expanded Scope	
Establish drop-in centers.	1. Engage communities to identify places for drop-in centers or safe spaces for informal gatherings, community meetings, and community training.	✓	✓	✓	Located near hotspots. May need to change periodically. Community led training, on topics outside of HIV/AIDS as well.
	2. Identify community priorities for informal training and identify community members with skills for training.	✓	✓	✓	
	3. Develop ways for communities to manage training and other drop-in center activities.		✓	✓	

Section III: Avahan Management Information System, which contains three documents: (1) definition of data to be collected, (2) definition of Avahan dashboard indicators, and (3) a sample reporting format. The sample reporting format also contains comments that further explain the indicator and any issues that were encountered when using in the field. This reporting format is an Excel spreadsheet that aggregates data from implementing NGOs through lead implementing partners to the central MIS, which allows for both program-wide analysis and the ability to look at NGO-level data.

[7] This CMP was adapted for injecting drug users and men at risk.

Six Program Areas of the Avahan Intervention

For the purposes of the CMP, Avahan's interventions for female sex workers, high-risk men who have sex with men and transgenders can be divided into six program areas, whose elements and key activities are described and articulated in the CMP tables in Section II. Several of the elements and activities may fall under multiple program areas, but for simplicity, this document has placed each element or activity under one of the following six program areas:[8]

1. Peer Outreach, Community Mobilization, and Local Advocacy for Vulnerability Reduction
2. Advocacy for an Enabling Environment
3. Communication for Behavior Change
4. Clinical Prevention Services—STI and Primary Health Care Services, including Prevention Commodity Availability (Condoms, Needles and Syringes)
5. Monitoring for Data-Informed Program Management
6. Program Management

The following sections contain brief descriptions of the program areas and a statement of the principles guiding the implementation of each.

[8] Specific issues related to injecting drug users are not discussed in detail in this publication. Many of the same approaches apply, however.

Program Area 1: Peer Outreach, Community Mobilization, and Local Advocacy for Vulnerability Reduction

Peer outreach workers identify those among their social network who are at risk and provide support and information that helps improve high-risk individuals' ability to negotiate condom use and their attendance at STI clinics and self-help programs. By March 2009, Avahan had about 5,800 peer outreach workers in 69 districts across four southern states, plus additional peer outreach workers in the northeastern states where Avahan works. One critical element to implementing outreach at scale in Avahan has been the methodology of micro-planning, which uses specially designed tools that allow peer outreach workers—including those who have low literacy skills or are illiterate—to record and analyze data on the specific personal and social factors that make each individual vulnerable to high-risk behavior, and to track their outreach at specific intervals. This makes outreach more organized and enables peer outreach workers to prioritize those most immediately at risk, as well as identify more chronic problems over time.

Community ownership and community mobilization have evolved as important programmatic elements in Avahan's efforts to increase demand and expand HIV prevention services to high-risk groups. The management capacity of peer outreach workers was built over time as they trained one another and gained successively greater control over outreach. Concurrently, drop-in centers and the active participation of community members on program advisory committees have been essential to building ownership and mobilizing communities more broadly.

The following fundamental operating principles inform Avahan's community mobilization efforts:

Figure 8: Example of a Social and Geographic Map

Source: International HIV/AIDS Alliance, Andhra Pradesh

- **Undertake participatory approaches** that enable high-risk communities to reflect on their situation, enhance their collective resources, and to plan and act in ways that improve their lives.[9]
- **Focus on strengthening individuals' confidence, agency, and self-efficacy.**
- **Focus on strengthening community groups' sense of program ownership, and their collective efficacy, agency, and social cohesion.**
- **Address underlying structural and environmental factors**, both locally and at the state and national level.

[9] Adapted from: Chambers R. "Notes for Participants" in *Whose Reality Counts?* PRA/PLA-related Familiarisation Workshop. London: London School of Economics, 2005.

The key minimum elements of this program area in the CMP (according to the three main phases of the program) are described in detail in the table in Section II (page 26). These elements include:

Start-up Phase:

- Set targets for outreach according to the denominator, explicitly stating the number of high-risk individuals that each peer outreach worker must provide outreach services for.
- Recruit and train high-risk individuals for peer led outreach.
- Conduct social and geographic network mapping (creating visual maps that show the number of people and their locations at each intervention site and how they are interlinked—see Figure 8).
- Establish drop-in centers (basically equipped but clean rooms that are safe spaces for 50-150 people with mattresses on the floor, a shower, and room for activities).

Roll-out Phase:

- Develop and train peer outreach workers to use micro-planning tools, which successively strengthen their confidence, leadership, and oversight of outreach (Figure 9).
- Create community-run program oversight committees.
- Begin the process of establishing crisis response systems and strengthening community management of these over time.
- Facilitate community processes to analyze power structures, strengthen the community's advocacy skills, and foster community advocacy interventions with police and government leaders.

Expanding the Scope Phase:

- Foster the formation and organizational development of community groups to address structural issues including discrimination by police and access to entitlements and services.
- Fully establish community led crisis response.

Figure 9: Close-up of Micro-Planning Tool which Allows Peer Outreach Workers to Collect and Analyze Data

Source: Pathfinder International

Program Area 2: Advocacy for an Enabling Environment

Avahan's advocacy efforts are aimed at creating an enabling environment that supports communities' actions to reduce risks, increases access to services, and sustains safe behavior (also discussed under Program Area 1). Avahan's approach also includes advocacy to shape the general population's perception of those most affected by HIV, largely by using the news and entertainment media to change misconceptions.

The following fundamental operating principles inform Avahan's advocacy efforts:

- **Ensure that input from the high-risk community informs all advocacy efforts.**
- **Inform and involve people who do not have direct power but have influence and reach in the community** (such as local politicians, health care providers, and other donors) in order to negate any possible opposition and to gain advocates.
- **Include and engage the broader general population** since they shape the environment where high-risk groups live. If given a clear understanding of the program, they are more likely to support the role of marginalized groups in HIV prevention.
- **Engage and actively involve persons living with HIV/AIDS.**

Other major target audiences for the program's advocacy efforts include police, media, government officials at all levels, uniformed services in the northeast, and other people in positions of authority, business, and health care providers.

Key minimum elements of the advocacy for an enabling environment program area are described in detail in Section II (page 32) and include:

- Establish relationships with appropriate national and state government departments to increase and maintain resources to address HIV.
- Establish an advocacy strategy and activities at national, state, and local levels.
- Increase visibility of the epidemic through domestic and international media, and the voice of societal leaders.
- Establish relationships with appropriate national and state government departments and stakeholders to increase and maintain resources to fight HIV.
- Support advocacy work with stakeholders and officials in local context, with media, and with legal and health service providers.
- Encourage establishment and operation of bodies of local legislators to maintain political pressure on budgets and legislation.
- Build relationships with other donors for joint advocacy approaches.

Program Area 3: Communication for Behavior Change

Communication for behavior change includes interpersonal communication and mid-media and mass media campaigns focusing on two population groups: the general male population of reproductive age and high-risk groups. Avahan's work in this program area aims to make condoms more socially acceptable among the general population and make condom use more viable for groups at highest risk.

Communication processes and materials for high-risk communities are undertaken locally and are tailored to promote and sustain positive behaviors at the individual, community, and societal levels in the diverse contexts where the program operates. Communication is done through multiple reinforcing channels: in peer outreach, during interactive group discussions, and with other participatory methods. Coordination among partners is essential to ensure that the messaging is standardized and reinforcement occurs. (Interpersonal communication activities are carried out in coordination with community mobilization activities, which are presented in Program Area 1.)

A separate but complementary approach is applied to the general population through a mass media campaign using researched and tested television and radio advertisements and outdoor media to compel people to think differently about condoms. The campaign has two distinct aims: to get men to talk about condoms, and to enhance the image of the condom user.

The following fundamental operating principles inform Avahan's communication for behavior change efforts:

- **Use know-how from the private sector** to design mass media campaigns, conduct and analyze research, and carry out media planning.
- **Stimulate people to talk** and foster ways for people to engage with information.
- **Consider the barriers to action,** whether psychological, social, or cultural, as messages and material are designed and service linkages are developed.
- **Communication is part of other activities** that together foster action—it cannot stand alone but must be linked to efforts that build access to services.
- **Pre-testing is needed** for mass media, which are tailored for regional audiences.
- **Interpersonal communication is best facilitated by skilled peer outreach workers** who know their audience and the issues they face.

Key minimum elements of the communications for behavior change program area are described in detail in the table in Section II (page 34) and include:

- Design interpersonal communication material and carry out dialogue-based interpersonal communication during outreach.
- Conduct formative research for mass media campaign.
- Produce and test mass media and linked mid-media.
- Broadcast mass media.
- Conduct endline research and share lessons learned.

Program Area 4: Clinical Prevention Services—STI and Primary Health Care Services, including Prevention Commodity Availability (Condoms, Needles and Syringes)

One of the core programmatic elements of the Avahan program is the wide availability of free, effective STI treatment and necessary prevention commodities. The common minimum program for provision of clinical prevention services includes technical and programmatic standards, implementation strategy, project activities, sequencing of activities and program management practices for execution, and monitoring quality. More detailed technical guidelines and reports of programmatic experience are available elsewhere.[10]

Avahan's provision of clinical prevention services is informed by the following operating principles:

- **The STI control strategy includes both treatment and prevention,** including effective diagnosis, encouraging adherence and partner treatment, and avoiding re-infection.
- **The STI treatment guidelines adhere to Indian national guidelines** incorporating global best practices.
- **Services to high-risk groups are established in easily accessible locations** and address stigmatization and confidentiality issues.
- In order to increase clinic attendance, **services for basic primary health care and for early HIV infection management** are provided. Other necessary clinical services are provided through linkages.
- **Systems are established to monitor quality** of clinical, laboratory, and counseling services.
- **Prevention commodities, STI drugs, male latex condoms, and needles and syringes are available** (free to female sex workers, men who have sex with men and transgenders, and injecting drug users, and for a fee to men at risk, such as long-distance truck drivers and clients of female sex workers).
- **Individuals from high-risk groups are involved,** as far as possible, in aspects of service delivery and management of program-owned clinics, and in monitoring of all clinical services in order to increase acceptability and accessibility.

Key minimum elements for this program area are described in detail in Section II (page 36) and include:

Start-up Phase:

- Define an effective, high-quality, essential STI service package[11] and other services for the population.
- Ensure an adequate and consistent supply of prevention commodities available at program sites with a monitoring system in place to verify and ensure consistent adequate supply.
- Establish clinical services that are accessible and acceptable for high-risk groups.
- Create systems and train staff to monitor and provide STI services as defined.

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[10] Family Health International. *Clinic Operational Guidelines and Standards: Comprehensive STI Services for Sex Workers in Avahan-supported Clinics in India.* New Delhi: Family Health International, 2007.

Steen R, Mogasle V, Wi T, et al. Pursuing scale and quality in STI interventions with sex workers: initial results from the Avahan India AIDS Initiative. *Sex Transm Inf* 2006; 82:381-85.http://www.fhi.org/en/HIVAIDS/pub/res_IndiaCOGs.htm

Mogasle V, Wi T, Das A, et al. Quality assurance and quality improvement using supportive supervision in a large-scale STI/intervention with sex workers, men who have sex with men and injecting drug users in India. *Sex Transm Inf* 2010; 86:i83-i88.

A full description of STI services in Avahan can be found in *Treat and Prevent: Avahan's Experience in Scaling up STI Services to Groups at High Risk of HIV Infection in India.* New Delhi: Bill & Melinda Gates Foundation, 2010 (available online at www.gatesfoundation.org/avahan).

[11] STI essential service package for sex workers includes syndromic case management of symptomatic STIs, regular monthly screening (speculum and proctoscopic exam), semi-annual syphilis screening, and treatment of asymptomatic STIs, and HIV/STI counseling and referral as appropriate. STI services are coordinated with outreach and behavior change communication interventions, ensuring condom promotion and community involvement.

Roll-out Phase:

- Establish clinic-based laboratories or links to laboratories for syphilis screening and STI diagnostic testing.
- Establish a functional referral system for HIV counseling and testing.

Expanding the Scope Phase:

- Establish a functional referral system for tuberculosis diagnosis and treatment, HIV prevention and care continuum, and other medical needs of clients.

Program Area 5: Monitoring for Data-Informed Program Management

Data-informed program management is an important operating principle of the Avahan program. Generating high-quality, timely data, and using these data to guide program management and planning decisions at all levels, is critical to meeting program objectives, maintaining high-quality services, and improving program performance over time.

The monitoring and evaluation plan is informed by the following operating principles:

- **Know the size and geographic location(s) of the target population(s):** determining the size and location(s) of the key population is critical to planning, targeting, and scaling services to those most at risk.
- **Construct a baseline:** use monitoring methods and systems to enhance data collection at baseline on behavioral measures in the key population.
- **Provide skills and responsibility for data collectors to use the data for improving services:** data collection is merely the first step. Promote a culture of data use at all program levels.
- **Measure against your theory of change:** create measures against the program's expected model for impact and change.
- **Adapt data collection methods and tools to suit the local programming context:** promote opportunities for local adaptation and innovation of data methods and tools to ensure acceptability and suitability with program staff and key population.
- **Enable participatory methods for planning and action:** engage local communities early and frequently in data analysis, program planning, and management.
- **Continually refine measures and methods and tailor measurement and monitoring objectives to the program phase:** data collection methods and tools need to be periodically adjusted to the appropriate program phase to monitor the most critical elements for effective program scale-up and operation.
- **Promote active field engagement for all levels of program participants:** understanding contextual information not routinely collected through data collection systems is critical for effective program management.

Core indicators were defined through a consensus process and based on published international standards. Tools and methods are refined over time to achieve a robust, standardized set of indicators across similar programs. Repeated estimates of high-risk population size are performed to measure progress towards program scale, coverage, and intensity. Data are used to continually assess program performance and identify areas where program improvements may be required. Quality monitoring is conducted to improve data collection methods, quality, and consistency. Trainings are conducted over time to ensure that data are used at all levels.

The assessment of program impact on key behavioral and biological outcomes occurs through the Avahan evaluation plan, which combines data from the routine monitoring system to measure coverage and integrated biological and behavioral assessments (IBBA) to validate coverage and to estimate program outcomes in high-risk populations over time. The evaluation plan also includes measures of HIV trends in antenatal care data and a synthetic analysis of IBBA, antenatal care, and other data to establish the plausibility of declines in the antenatal HIV prevalence as a result of declines in core and bridge populations and mathematical modeling to estimate cases averted (not described here).[12]

[12] A full description of Avahan's data collection activities and evaluation design can be found in *Use It or Lose It: How Avahan Used Data to Shape Its HIV Prevention Efforts in India*.http://www.gatesfoundation.org/avahan/Documents/Avahan_UseItOrLooseIt.pdf

Chandrasekaran P, Dallabetta G, Loo V, et al. Evaluation design for large scale HIV prevention programs: the case of Avahan, the India AIDS Initiative. *AIDS* 2008; 22(Suppl 5): S1-S15.

The key minimum elements of the monitoring and evaluation program area are described in detail in Section II (page 41) and include:

Start-up Phase:

- Define core indicators for monitoring hard infrastructure (clinical services, drop-in centers), staff hiring, and training in relationship to mapping and target population size estimates, and "baseline" measures for new people enrolled by the program.
- Create monitoring infrastructure through the development of appropriate forms, software, and staff training modules, and the use of standardized indicator definitions and reporting formats.
- Conduct training on data collection methods and data use.
- Monitor hard and soft infrastructure.

Roll-out Phase:

- Provide services and monitor uptake.
- Redefine dashboard indicators to track program coverage and intensity.
- Perform quality monitoring against established technical standards.
- Update mapping and size estimates.

Expanding the Scope Phase:

- Enhance data use at all levels.
- Incorporate new data collection indicators and tools for expanded scope.

Program Area 6: Program Management

Avahan's scale-up design has three facets: 1) designing for scale, 2) organizing for scale, and 3) executing for scale. The CMP represents one of the aspects of Avahan's *design* for scale (standardization of service packages), and also encompasses the *organization* structure used to deliver this design. Program Area 6 focuses on the management methods and requirements behind *executing* the program at scale.

Avahan's program management approach is informed by the following operating principles:

- **Clearly define the structure of the implementation** (the "implementation pyramid") and the roles of participants at all levels (see Figure 4).
- **Appropriately staff for intensive field oversight** to ensure quality and close monitoring of progress towards results.
- **Empower agents at all levels of the implementation pyramid** to collect and use data locally for programmatic decisions.
- **Balance the use of classroom-based training with on-the-ground mentoring** in order to build human resource capacity.
- **Review progress against targets at regular intervals** in order to adjust strategies and tactics.
- **Maximize field engagement** with all levels of managers.
- **Use program data and experiences** to make mid-course corrections necessary to attain program goals and improve quality.

Key minimum elements for program management are described in detail in Section II (page 46) and include:

Start-up Phase:

- Staff the implementation pyramid appropriately for high-quality programming.
- Ensure that funds and commodity flows to the grassroots level are adequate and uninterrupted (e.g., salaries, condoms, lubricants, clean needles).
- Clearly articulate the management structure, including the roles and responsibilities of management at the various levels. A key responsibility of management is to ensure adequate resources to accomplish goals and to ensure that all partners maintain at least a minimum level of quality interventions.
- Conduct regular meetings between all partners. This includes sharing of learnings and best practices from partners rolling out infrastructure and delivering services.
- Conduct field-based reviews of progress to track infrastructure roll-out.

Roll-out Phase:

- Plan and track time spent in the field by various levels of management for two key purposes: local networking with key stakeholders (coordination) and active problem solving to improve grassroots implementation performance (management).
- Develop a clear training plan and ensure that appropriate resources are available in the field for mentoring and building the capacity of grassroots NGO staff and peer outreach workers.
- Revise implementation standards and improve tracking of quality of services.
- Analyze data to track coverage and intensity of service delivery.

Expanding the Scope Phase:

- Conduct external reviews to verify quality of programs and involve external stakeholders.

SECTION II

KEY MINIMUM ELEMENTS OF THE SIX PROGRAMMATIC AREAS

How to Use this Table

In the CMP, each of the six key programmatic areas *(*e.g., *Program Management)* has several elements *(*e.g., *Conduct field-based reviews of progress to track infrastructure roll-out)*, which in turn are supported by several implementation activities *(*e.g., *Foundation staff and lead implementing partners visit field interventions at regular intervals to assess progress of infrastructure scale-up)*. Each of these activities is listed as occurring in a sequence that falls in one or more of the three phases of the lifecycle of the program—start-up, roll-out, and expanded scope**.** For some activities, comments and lessons learned are described to assist program managers with additional information.

- Programmatic Areas (6)
  - Elements (5-10)
    - Activities (1-14)
      - Timeframe
      - Comments/Lessons

Program Area 1: Peer Outreach, Community Mobilization, and Local Advocacy for Vulnerability Reduction

Element	Implementation Activities	Timeframe			Comments/Lessons
		Start-Up	Roll-out	Expanded Scope	
Set targets for outreach according to the denominator, explicitly stating the number of high-risk individuals that each peer outreach worker must provide outreach services for.	**Strategy Development**				Other criteria to locate areas where transmission is occurring could be used.
	1. Determine where the greatest concentrations of high-risk groups are located.	✓			
	2. Make a plan to establish services saturating coverage of these groups. Targets are: outreach workers should meet 80% of the individuals they cover at least once a month; HRGs should go to the clinic once each quarter; condom distribution targets based on estimated need should be met in outreach.	✓			
	Management				
	1. Develop terms of reference for community members involved in the program (e.g., peer outreach workers, trainers) that outline their roles and responsibilities in various aspects of the program including outreach, drop-in center training, formal training, and attendance at various meetings. Include policies on travel allowances, per diem, etc.	✓			The role of peers should evolve greatly each year as their skills develop. Similarly, the micro-planning tools should be enhanced with more indicators as peer outreach workers develop an understanding that goes beyond risk and vulnerability that can be captured and assessed by them.
	2. Develop guidelines on compensation for communities and peer outreach workers.	✓			The training requirements for the program evolve with input from the field and the enhanced skills levels of staff community trainers.
	3. Develop guidelines for recruiting, retaining, promoting, and assessing outreach workers and peer outreach workers.*	✓			
	4. Adapt micro-planning tools (basic initially and more advanced when enhancing scale and expanding scope) for peer outreach workers. Tools include daily and monthly tracking forms that assess risk and vulnerability factors and should be pictorial.		✓	✓	Monitoring activities are described in Program Area 5, "Monitoring for Data-Informed Program Management."
	5. Develop a tiered training plan for enhancing peer outreach workers' skills, confidence, and leadership.		✓	✓	
	6. Define milestones and reporting requirements for community mobilization and local advocacy activities.		✓		
	7. Adapt a local advocacy and community mobilization curriculum for high-risk groups.		✓		

* *Peer Led Outreach at Scale: A Guide to Implementation.* New Delhi: Bill & Melinda Gates Foundation, 2010. http://www.gatesfoundation.org/avahan

Element	Implementation Activities	Timeframe			Comments/Lessons
		Start-Up	Roll-out	Expanded Scope	
Recruit and train high-risk individuals for peer led outreach.	1. Recruit peer outreach workers. 2. Recruit NGO staff outreach workers or supervisors to monitor the quality of outreach. 3. Train staff outreach workers and peer outreach workers. Training includes: • Interpersonal communication skills to build confidence and individual agency • Condom demonstration and condom negotiation skills • STI symptoms and disease processes, referrals, and treatments of STIs, HIV, AIDS, and TB • High-risk group processes to build social cohesion and collective agency • Social network mapping • Micro-planning tools, recordkeeping, and identifying vulnerability factors 4. Provide advanced training for peer outreach workers as their role in the program evolves, including: • Advanced communication and counseling skills • Dealing with stigma and discrimination • Empowerment through knowledge of the law and legal rights • Violence and crisis intervention • Creating linkages to other services (e.g.,TB, reproductive health) • Where relevant, other activities can be integrated into peer outreach workers' roles at this stage (e.g., care and support for people living with HIV and AIDS)	✓ ✓ ✓	✓ ✓ ✓	✓ ✓ ✓	Mapping information can be used to ensure that peer outreach workers represent the different typologies and geographic areas to be covered. 1:50 ratio, with greater ratios possible in dense urban areas, with brothel-based sex workers, and over time as peer outreach workers gain skills. Formal training is enhanced over time as peer outreach workers begin with a limited role, and within two years peer outreach workers can assume significant responsibility in outreach with the introduction of micro-planning tools.

Element	Implementation Activities	Timeframe			Comments/Lessons
		Start-Up	Roll-out	Expanded Scope	
Conduct social and geographic network mapping (creating visual maps that show the number of people and their locations at each intervention site and how they are interlinked).	1. Conduct social network mapping with peer outreach workers.	✓			
Establish drop-in centers (basically equipped but clean rooms that are safe spaces for 50-150 people with mattresses on the floor, a shower, and room for activities).	1. Engage communities to identify places for drop-in centers. 2. Identify community priorities for informal training and identify community members with skills for training. 3. Develop ways for communities to manage training and other drop-in center activities.	✓ ✓	✓ ✓ ✓	✓ ✓ ✓	Located near hotspots. May need to change periodically. Community led training, on topics outside of HIV/AIDS as well.
Develop and train peer outrech workers to use micro-planning tools, which successively strengthen their confidence, leadership, and oversight of outreach.	1. Ensure peer outreach workers use micro-planning formats to record daily outreach. 2. Staff supervisors facilitate weekly meetings with peer outreach workers in drop-in center to review outreach performance and problem-solve obstacles in the environment and for specific individuals' behavior change. 3. Peer outreach workers complete monthly outreach calendar and with staff supervisors review service uptake of the individuals they serve and their outreach performance. 4. Peer outreach workers' performance evaluated by staff supervisors and community committee on a periodic (six-monthly) basis and peer outreach workers promoted or dismissed when appropriate.	✓ ✓ ✓ ✓	✓ ✓ ✓ ✓	✓ ✓ ✓ ✓	

Element	Implementation Activities	Timeframe			Comments/Lessons
		Start-Up	Roll-out	Expanded Scope	
Create community-run program oversight committees.	1. Establish community committees at the local level (committees for peer outreach, management of drop-in centers, clinical services, advocacy, etc.). Committees oversee aspects of the program, including drop-in centers, peer outreach, advocacy, and clinics; should meet monthly with program staff and keep records of critical inputs. To ensure committees build accountability to the wider community it is helpful to limit peer outreach worker membership to 30%-40%, with non-peer community membership at 60-70%. 2. Facilitate weekly/monthly meetings with the community to update them on project activities and get their input on problems and how to solve them. 3. Provide a strategic planning forum that allows committee members to recommend ways to enhance the communities' involvement in the program.	✓	✓ ✓	✓ ✓	Committees are a mechanism to enhance the quality of the program, keep it accountable to the community, and enhance their sense of ownership. They are established to cover multiple sites. Appointments should be annual to offer the opportunity to different community members to stand for election to committees. Initiatives may include activities outside of HIV (e.g., crèche or catering business). Keep a roster of individuals trained with different skills to ensure follow-up and utilization outside the program where possible.
Begin the process of establishing crisis response systems and strengthening community management of these over time.	1. Assess the need for and nature of crisis response. 2. Organize the crisis response team: develop selection criteria, scope of duties, and local support. 3. Recruit and train crisis response teams, discuss crisis and resolution at drop-in center, and conduct routine monitoring. Based on this monitoring and spot analyses develop priorities in geographic areas and plans to address main perpetrators of violence. 4. Implement crisis response: develop well-defined steps for response and a communication system, and publicize the response system. 5. Report and analyze data, at both local and consolidated levels (regional, state, and national). 6. Educate the high-risk community and the police. Police training should be conducted by lawyers and high-risk individuals on the law as it relates to high-risk groups and people living with HIV/AIDS (PLHAs).		✓ ✓ ✓ ✓ ✓ ✓	 ✓ ✓ ✓	The NGO should facilitate a process whereby the program's role in these areas is reduced and community groups take over management. Crisis response teams should be led by community advocacy teams at various levels with organizational input by the NGO until they can work autonomously. Initially the NGO may need to be involved in education to a greater extent to build relationships. Sub-activities include regular meetings, training, recognition for positive support, and endorsements from officials.

Element	Implementation Activities	Timeframe			Comments/Lessons
		Start-Up	Roll-out	Expanded Scope	
	7. Build public acceptance and support for crisis response management, by working with the media, networking with other groups, police sensitization, and advocacy with the government. 8. Integrate crisis response with advocacy and community mobilization activities.		✓ ✓	✓ ✓	In practice, implementation of some of these steps will overlap. In particular, education of the high-risk community and building of wider public support for crisis response are ongoing tasks that will happen simultaneously. For more information, see the Avahan publication, *Community Led Crisis Response Systems: A Guide to Implementation.* New Delhi: Bill & Melinda Gates Foundation, 2010. http://www.gatesfoundation.org/avahan
Facilitate community processes to analyze power structures, strengthen the community's advocacy skills, and foster community advocacy interventions with police and government leaders.	1. Conduct power analysis to identify relevant gatekeepers and barriers for health-seeking behavior and peer outreach.	✓	✓		(See Program Area 2 for more information.)
Foster the formation and organizational development of community groups to address structural issues including addressing discrimination by police and access to entitlements and services.	1. Conduct training and support activities that can strengthen high-risk groups' collective efficacy, agency, and social cohesion and foster their own initiatives to improve their lives. 2. Support the formation and development of community groups at the local level. Support gatherings of multiple community groups. (India's administrative system makes it more relevant to federate groups at the district level so that they can engage with the local government.) 3. Support organizational development of groups so that they can apply for and receive funds, function independently of the program, and conduct democratic elections.	✓	✓ ✓ ✓	✓ ✓ ✓	Community groups require support in establishing democratic norms and leadership, and functioning as a group to address community priorities.

Element	Implementation Activities	Timeframe			Comments/Lessons
		Start-Up	Roll-out	Expanded Scope	
	4. Provide tiered training in the area of organizational development for community groups and support activities to strengthen their project management skills, organizational systems, and ability to exercise democratic leadership.		✓	✓	
	5. Provide ways for groups to gain practical experience in management through the provision of funds for small-scale initiatives (e.g., catering for training events undertaken by the program).		✓	✓	

Program Area 2: Advocacy for an Enabling Environment

Element	Implementation Activities	Timeframe			Comments/Lessons
		Start-Up	Roll-out	Expanded Scope	
Establish relationships with appropriate national and state government departments to increase and maintain resources for HIV.	1. Work with government and Ministry of Health on development of national AIDS program strategy.	✓	✓	✓	
	2. Embed staff in national AIDS program to receive full access to decision-makers and facilitate cross-learning.		✓	✓	
	3. Work with other stakeholders on HIV/AIDS to help influence the national strategy.		✓	✓	
Establish an advocacy strategy and activities at national, state, and local levels.	1. Adapt an advocacy curriculum for high-risk groups.		✓		Create a document that outlines the key groups and baseline attitudes and the actionable objectives for each high-risk group. Identify priority advocacy issues for national and state plans in consultation with high-risk group.
	2. Train implementing partners (staff overseeing advocacy) and high-risk group trainers on modules to support tiered training.		✓	✓	
	3. Community and local NGO conduct tiered training, establishing community advocacy groups at the district and sub-district level.		✓	✓	
	4. Advocacy groups define district and local advocacy plans, mapping the local and district power structures, and defining clear objectives for each stakeholder category.		✓	✓	
	5. Develop an overall advocacy implementation plan for the district that includes both local- and district-level activities.		✓	✓	
	6. Develop national- and state-level advocacy plans.		✓	✓	

Element	Implementation Activities	Timeframe			Comments/Lessons
		Start-Up	Roll-out	Expanded Scope	
Increase visibility of epidemic through domestic and international media, and the voice of societal leaders.	1. Convene mass media partners meeting to coordinate efforts between mass media partners. 2. Create and disseminate high-level tools, like books and films, to target a wide general audience. 3. Encourage the use of societal leaders to support general awareness messaging. 4. Build workplace initiatives in key industries for education purposes. 5. Build alliances with key global organizations, including WHO and UNAIDS, to develop joint advocacy approaches. 6. Develop strategy and provision budget for learning and exposure visits within the program. 7. Hold high-level political fora to show top official support for work on HIV.	✓ ✓	 ✓ ✓ ✓ ✓ ✓ ✓	 ✓ ✓ ✓ ✓	
Establish relationships with appropriate national and state government departments and stakeholders to increase and maintain resources to address HIV.	1. Map potential stakeholders among policy makers and politicians. 2. Initiate induction meetings, so relevant officials recognize role of different interventions. 3. Continue interaction and engagement, and maintain focus on new individuals in key decision making posts.	✓	 ✓	 ✓	
Support advocacy work with stakeholders and officials in local context, with media, and with legal and health service providers.	1. These activities are summarized in Program Area1.				
Encourage establishment and operation of bodies of local legislators to maintain political pressure on budgets and legislation.	1. Work with other donor agencies like UNAIDS, GFATM, and UNDP to establish state-level bodies to encourage long-term political commitment to appropriate levels of funding and anti-stigma laws.		✓	✓	
Build relationships with other donors for joint advocacy approaches.	1. Build partnerships with all those working in the HIV field to bring about long-term generation of demand to government and other stakeholders for an appropriate strategic approach to all HIV matters.		✓	✓	Joint donor reviews to be conducted early and often.

Program Area 3: Communication for Behavior Change

Element	Implementation Activities	Timeframe			Comments/Lessons
		Start-Up	Roll-out	Expanded Scope	
Design interpersonal communication (IPC) material and carry out IPC during outreach.	Interpersonal Communication (IPC) activities are summarized in Program Area 1.	✓	✓	✓	
Conduct formative research for mass media campaign.	1. Assess availability of commodities and services to understand barriers, the landscape of service providers, and any changes that may influence behavioral trends. 2. Carry out desk research on behavioral campaigns and behavioral surveillance surveys in region and globally. 3. Develop and implement baseline survey using control areas if possible. 4. Determine media strategy to maximize reach to the target audience within the budget by using media monitoring data.		✓ ✓ ✓ ✓		Mass media campaigns took place in the enhanced scale phase until the government took over the effort.
Produce and test mass media and linked mid-media.	1. Prepare storyboards and stimulus materials for pre-testing. 2. Pre-test TV and radio material and provide feedback to creative team. 3. Produce TV, radio, and outdoor media in phases allowing for media monitoring and research to shape subsequent media plan and creative material (e.g., public service announcements in 15-second, 30-second, and 1-minute spots). 4. Develop relationship with government AIDS control organization to periodically share campaign material, data, and best practices in an effort to contribute to national campaigns and communication efforts.		✓ ✓ ✓ ✓	✓ ✓ ✓ ✓	

Element	Implementation Activities	Timeframe			Comments/Lessons
		Start-Up	Roll-out	Expanded Scope	
Broadcast mass media.	1. Carry out specific media planning for each phase of TV or radio to be aired, maximizing audience reach with recent media monitoring data.		✓	✓	
	2. Collaborate with public sector to extend reach beyond minimum essential audiences where possible.		✓	✓	
	3. Conduct monitoring and focus groups to understand reach of campaign and audience reaction in initial week of each phase of broadcast.		✓	✓	
	4. Revise media for each phase of broadcast after initial week of each broadcast.		✓	✓	
Conduct endline research and share lessons learned.	1. Carry out endline research within six weeks after broadcast of campaign.		✓	✓	
	2. Share tools and findings with national AIDS control organization and other donors at the national level and in the states where campaign was conducted.		✓	✓	
	3. Document and disseminate best practice approaches determined in media planning and creative development.		✓	✓	

Program Area 4: Clinical Prevention Services—STI and Primary Health Care Services, including Prevention Commodity Availability (Condoms, Needles and Syringes)

Element	Implementation Activities	Timeframe			Comments/Lessons
		Start-Up	Roll-out	Expanded Scope	
Define an effective, high-quality, essential service package.	1. Define treatment guidelines and standard clinic operating procedures. (Avahan's were called the *Clinic Operational Guidelines and Standards (COGS).*) 2. Adapt guidelines and standards for STI management, STI/HIV counseling guidelines, and primary HIV care guidelines including opportunistic infection management for local setting and type of service delivery.	✓ ✓			
Ensure an adequate and consistent supply of prevention commodities available at program sites with a monitoring system in place to verify and ensure consistent adequate supply.	1. Provide adequate resources and commodities, including free STI drugs, primary care, basic opportunistic infection medications, and condoms in accordance with the guidelines. 2. Ensure that a functional commodities management system is in place with a robust monitoring system at all clinics.	✓ ✓	✓ ✓	✓ ✓	Adequate prevention supplies (male condoms, lubricants, sterile injection equipment, STI drugs, and clinic supplies) are a key component of the prevention intervention. Adequate, consistent supplies must be ensured even if the program needs to procure them from its own budget.
Establish clinical services that are accessible and acceptable for high-risk groups.	1. Establish program-owned clinics (static) where the number of sex workers makes it cost-effective (more than 250 or highest risk): • Qualified medical doctor hired, trained, and supervised by the program to provide quality services. • Hire community members (sex workers, men who have sex with men, injecting drug users) and train to work in the clinic. • Develop an explicit plan for community member involvement in clinic service management and quality monitoring.	✓	✓	✓	Clinical services (regular STI screening, counseling and treatment) should be provided to high-risk population who attend the clinic on a regular basis (monthly is preferred for those with sexual risk behavior). Adequate commodities and resources should be provided free at clinics (STI services and drugs, primary care and basic opportunistic infections medications, male condoms, lubricants, and needles and syringes).

Element	Implementation Activities	Timeframe			Comments/Lessons
		Start-Up	Roll-out	Expanded Scope	
	2. Establish outreach clinics (satellite, fixed-day, fixed-site, or mobile) to access hard-to-reach and most-at-risk sub-populations of sex workers, men who have sex with men, or injecting drug users.	✓	✓	✓	Community members should assist in the design and establishment of services (e.g., type and placement of clinical services, selection of health care services provided, need for customized services) with the help of the local NGO and regional/state-level funder. Infection control and appropriate waste disposal mechanisms should be in place. Coordination with outreach and peer education micro-planning is important to increase utilization of clinics, promote essential service package, and ensure follow-up of STI cases.
	3. For smaller pockets of high-risk populations (<100), establish linkages with strengthened STI government facilities or train preferred service providers.	✓	✓	✓	
	4. Provide adequate and quality STI essential service package services, STI and HIV counseling, primary HIV care including opportunistic infection management services and the staff to provide regular monthly services.	✓	✓	✓	
	5. Ensure involvement of community members in establishing and designing clinical services and operations, including hiring and training of community volunteers in clinic operations and management and in monitoring clinic services.	✓	✓	✓	
	6. Enable community members to take increasing responsibility in clinic operations, with NGO supporting the community members.		✓	✓	
	7. Train an adequate number of qualified staff (physicians, nurses, and counselors) and supervise them to provide monthly STI screening and clinical services.	✓	✓	✓	
	8. Provide adequate resources to establish a referral network.	✓	✓	✓	
	9. Conduct regular coordination meetings between clinic staff and outreach education.	✓	✓	✓	

Element	Implementation Activities	Timeframe			Comments/Lessons
		Start-Up	Roll-out	Expanded Scope	
Create systems and train staff to monitor and provide STI services.	1. Hire an adequate number of trained technical staff to provide capacity building support and conduct regular monthly supportive supervision and monitoring of program-supported clinics.	✓	✓	✓	One STI technical coordinator for every 10 to 15 geographically distant clinics, or for every 20 program-supported clinics including static and satellite, and preferred service providers. Technical coordinators conduct monthly visits to all program-owned, satellite, and linked clinics. Regular technical support using standardized quality monitoring tools has ensured quality STI services based on the guidelines. By month 12, implement clinic audit (conducted monthly at first, then quarterly) to track quality of service. STI service data utilized to improve clinical services and utilization.
	2. Monitor key areas of clinic operations, staff clinical knowledge, skills, and performance, coordination of outreach program, community involvement, clinic client satisfaction and response, clinical management of STIs including essential service package, infection control and waste management, drug and supply management, education and counseling, ethical standards, confidentiality, referral systems, basic HIV medical and opportunistic infection management, monitoring, evaluation, and reporting.	✓	✓	✓	
	3. Establish a paper-based clinic activity monitoring system to record individual patient data that can be entered into the computerized management information system (CMIS) to generate information on clinic activities and STI outcomes.	✓	✓	✓	
	4. Lead partner establishes systems to monitor and track the level of quality of clinical services of all program-supported clinics over time.	✓	✓	✓	
	5. Outside quality oversight team conducts quarterly STI capacity building visits to 10 percent of program-supported clinics quarterly to provide technical support to clinic staff.	✓	✓	✓	
	6. Coordinate with M&E team to ensure quality STI reporting, and generation and utilization of CMIS to improve clinical services.	✓	✓	✓	

Element	Implementation Activities	Timeframe			Comments/Lessons
		Start-Up	Roll-out	Expanded Scope	
Establish clinic-based laboratories or links to laboratories for syphilis screening and STI diagnostic testing.	1. Establish clinic serologic testing for syphilis every six months and treatment of reactive cases (for >1,000 sex workers) or establish linkages with a laboratory for syphilis screening with appropriate laboratory quality assurance systems.	✓	✓	✓	Universal serologic screening for syphilis every 6 months by month 36. Laboratory referral links must be established for all static and mobile clinics.
	2. Establish laboratory quality assurance systems for clinic-based laboratories and ensure quality of referral laboratories.		✓	✓	Laboratory quality assurance system established by month 24.
	3. Establish explicit, good-quality referral linkages to additional services as identified by community members.		✓	✓	
	4. Maintain a clinic referral directory of other services, document referrals, and ensure follow-up of referral services.		✓	✓	
Establish a functional referral system for HIV counseling and testing.	1. Establish functional referral network for HIV prevention and care continuum by identifying referral organizations within the community, documenting and following up referrals, monitoring community perception of services, and organizing meetings on referral mechanisms.	✓	✓	✓	The referral linkage should be of high quality, including active discussions with the referral site, adequate staffing, trained counselors, and sensitivity to high-risk population specific issues. Voluntary counseling and testing (VCT) sites should have a functional roster of HIV-related referral services for care, support, and treatment. If VCT does not provide referrals, the project clinic should provide referral to at least one provider for care, support, and treatment. VCT sites provide pre- and post-test counseling and program-owned clinics enhance or supplement pre- and post-test counseling. Clinic should follow up referrals to ensure that the client was provided with services by establishing feedback mechanisms with the referral organization and providing follow-up services as appropriate.
	2. Establish functional mechanism for referring clients to quality HIV testing and counseling.	✓	✓	✓	
	3. Establish linkages with community care and support and self-help groups.	✓	✓	✓	
	4. Train clinic counselors and health care providers to provide quality counseling on HIV risk reduction and suggesting HIV testing after discussing the risk and benefits of HIV testing with the target population.	✓	✓	✓	
	5. Ensure that program-owned clinics maintain a referral directory of HIV services, document referral, and ensure follow-up of referrals services.		✓	✓	

Element	Implementation Activities	Timeframe			Comments/Lessons
		Start-Up	Roll-out	Expanded Scope	
Establish a functional referral system for tuberculosis diagnosis and treatment, HIV prevention and care continuum, and other medical needs of clients.	1. Establish functional referral mechanisms for managing complicated opportunistic infections, TB diagnosis and management, and antiretroviral treatment, including follow-up management. 2. Establish referral mechanism to reproductive health services (family planning, pregnancy termination services, and other sexual health services).		✓	✓ ✓	NGO to conduct regular meeting with referral facilities to ensure a functional referral system and provision of acceptable quality services to high-risk population.

Suggested Resources:

1. Family Health International. *Clinic Operational Guidelines and Standards: Comprehensive STI Services for Sex Workers in Avahan-supported Clinics in India.* New Delhi: Family Health International, 2007.
   http://www.fhi.org/en/HIVAIDS/pub/res_IndiaCOGs.htm
2. Family Health International. *STI Clinic Handbook: Comprehensive STI Services for Sex Workers in Avahan-supported Clinics in India.* New Delhi: Family Health International, n.d.
   http://www.fhi.org/NR/rdonlyres/ezf46k23ncupjegpsu4xr6g3yectakadphljbututjmbrqdnmhzo 43rjytfnkwz2hnht 2epwvotw5d/STIClinicHandbook2007HV.pdf
3. Family Health International. *STI Clinic Supervisory Handbook: Comprehensive STI Services for Sex Workers in Avahan-supported Clinics in India.* New Delhi: Family Health International, n.d.
   http://www.fhi.org/NR/rdonlyres/e42wesdl6i7jigb7q3omqkn2flasgz2dv736fx3o5hqnrrlzlyligulckxtkvei 6o5gis57k5nopgm/STIClinicSupervisorHandbook2008HV1.pdf
4. Family Health International. *Improving Access to STI Services for Key Populations: Experience from India.* In press.
5. Family Health International. *Guidelines and Standards for Counseling High-risk Groups in Clinic Settings.* New Delhi: Family Health International, 2009.
   http://www.fhi.org/en/HIVAIDS/pub/guide/res_CounselingGuide_High-RiskGroups.htm
6. Family Health International. *Coming Together to Stop TB: An Interactive Training Package for Peer Educators and Outreach Workers.* New Delhi: Family Health International.
7. Central TB Division, Ministry of Health and Family Welfare. *Revised National Tuberculosis Control Programme: Revised Schemes for NGOs and Private Providers.* New Delhi: MoHFW, 2008.
   http://www.tbcindia.org/pdfs/New%20Schemes%20NGO-PP%20140808.pdf

Program Area 5: Monitoring for Data-Informed Program Management

Element	Implementation Activities	Timeframe			Comments/Lessons
		Start-Up	Roll-out	Expanded Scope	
Define core indicators for monitoring hard infrastructure, staff hiring, and training in relationship to mapping and size estimates, and "baseline" measures for new people enrolled by the program.	1. Construct core monitoring indictors and precise operational definitions to be used by field workers and managers to standardize reporting on program progress over time. 2. Develop clear operating guidelines and establish training modules to support early and uniform implementation of core indicators across the program. 3. Create indicators to enhance data collection of "baseline" behavioral information. Recommended indicators include: a. Condom use at last sex with client b. Proportion of key population reporting condom use with client	✓ ✓ ✓	 ✓		It is important to establish well defined monitoring indictors before program implementation. Major changes in data collection can compromise data quality. If changes are anticipated, make sure paper forms have blanks to allow additional expansion of indicators without major revisions to the forms. Include some baseline behavioral indicators (e.g., condom use) in outreach or clinic registration forms. How can the indictors be used? a. Routine measure of condom use among HRG population attending clinic (collected through counseling forms). b. Measure of behavior change in HRG.
Create monitoring infrastructure through the development of appropriate forms, software, and staff training modules, and use standardized indicator definitions and reporting formats.	1. Develop reporting monitoring forms and tools with protocols that define the minimal reporting standards and definitions. 2. Design and implement electronic entry system(s) or mechanisms for data collection and analysis. 3. Create and implement the appropriate training modules for using tools and electronic entry system(s).	✓ ✓ ✓			

Element	Implementation Activities	Timeframe			Comments/Lessons
		Start-Up	Roll-out	Expanded Scope	
Conduct training on data collection methods and data use.	1. Implement routine training on data collection methods and data use.	✓	✓	✓	Trainings should be designed to encourage data use at all levels.
Monitor soft and hard infrastructure.	1. Based on the social and geographic mapping (who to reach, where, and when), determine the extent of geographic coverage and establish program infrastructure with the appropriate services and number of trained program staff and volunteers. 2. Measure program scale-up in terms of geographic coverage and hard (clinics, sites) and soft (staff, volunteers) program infrastructure. Recommended core indicators include: a. Number of intervention districts/towns covered b. Number of intervention project offices, drop-in centers, and clinics c. Number of intervention-related project staff, peer outreach workers, and unpaid volunteers d. Number of project staff trained e. Number of peer outreach workers that discontinue working f. Number of intervention-related staff who belong to the high-risk community g. Number of clinics reporting any STI drug stock-outs in the last month h. Number of outreach clinics reporting any condom stock-outs	✓ ✓	✓ ✓	✓ ✓	It is essential to closely monitor program inputs at more frequent intervals during the program implementation phase. How can the indictors be used? a. Broad measure of program's geographic breadth b. Measure of "hard" infrastructure c. Measure of "soft" infrastructure d. Measure of human capacity support e. Measure of staff attrition and retention f. Broad measure of HRG's participation in the formal structures of the program g. Measure of drug availability in a clinic h. Measure of condom availability in outreach units and clinics
Provide services and monitor uptake.	1. Establish community-friendly services and actively manage to broaden and deepen contact with the HRG over time. 2. Measure progress towards saturated coverage of HRG in terms of outreach, service provision, and uptake.	✓ ✓	✓ ✓	✓ ✓	

Element	Implementation Activities	Timeframe			Comments/Lessons
		Start-Up	Roll-out	Expanded Scope	
	Recommended core indicators include: a. Number of individuals included in individual-level tracking (number and percentage to give perspective of denominator) b. Number of individuals contacted c. Number of individuals that have discontinued services d. Number of condoms distributed (free and through social marketing) e. Number of HRG individuals receiving STI consultations during the month and quarter f. Number of STI consultations g. Number of HRG individuals with repeat STI symptom visits with symptom duration > 7 days h. Number of HRG individuals undergoing STI consultation who agree to internal examinations i. Number of STI syndromes diagnosed by type j. Number of HRG individuals receiving treatment for asymptomatic infections k. Number of general ailments treated l. Number of HRG individuals counseled m. Total number of HRG individuals who have visited the clinic at least once				How can the indicators be used? a. Monitors individuals being individually tracked by the program for follow-up, where basic information is recorded, such as name, typology, location, and a unique ID b. Measure of depth/intensity of outreach services c. Measure of ability of the program to sustain community involvement over time d. Measure of availability of condoms e. Measure of patient volume at clinics and demand for STI services f. Measure of compliance against STI check-up norm of three consultations each quarter g. Measure of treatment-seeking behavior and social norm change h. Measure of the acceptability of STI management among community i. Measure of the STI profile seen at the clinic j. Measure of a key aspect of the technical strategy to manage STIs k. Measure of the "appropriate" clinic traffic l. Measure of change in behavioral norms on counselling m. Measure of uptake of clinical services

Element	Implementation Activities	Timeframe			Comments/Lessons
		Start-Up	Roll-out	Expanded Scope	
Redefine dashboard indicators to track program coverage and intensity.	1. Refine indicators and data collection tools to monitor service levels (coverage) and uptake through ratio- and proportion-based (calculated) indicators. Illustrative examples of calculated indicators include: I. Outreach worker engagement effectiveness: a. Ratio of HRG population to outreach workers b. Proportion of outreach workers receiving STI consultations who underwent internal exams II. Service uptake: a. Proportion of HRG individuals mapped who are tracked by the program b. Proportion of HRG individuals tracked who are contacted monthly III. Condom uptake: a. Proportion of monthly risky sexual acts covered through known condom distribution b. Proportion of risky sexual acts covered through program free condom distribution IV. STI service uptake: a. Proportion of HRG population who have ever attended clinic b. Proportion of HRG population who come for routine STI check-ups during a quarter c. Proportion of HRG population receiving STI consultations who underwent internal exams		✓	✓	How can the indictors be used? I. Outreach workers engagement effectiveness: a. Measure of adequate resources for peer engagement b. Measure of peer outreach worker as role models in accepting STI services II. Service uptake: a. Measure of program coverage b. Measure against program standard of one contact per month III. Condom uptake: a. Measure of condom use in relation to need b. Measure of coverage of risky sex acts IV. STI service uptake: a. Measure of coverage of STI services b. Measure of health-seeking behavior of the community c. Measure of treatment-seeking behavior

Element	Implementation Activities	Timeframe			Comments/Lessons
		Start-Up	Roll-out	Expanded Scope	
Perform quality monitoring against established technical standards.	1. Create operating and technical standards for each element of service provision. 2. Conduct external assessments via surveys and external audits of service quality over time to inform program delivery through ongoing communication and refresher training activities.	✓	✓	✓	For STI service standards please see *Clinic Operational Guidelines and Standards.*
Update mapping and size estimates.	1. Routinely refine estimations against program service data and other estimation procedures (e.g., surveys).		✓	✓	
Enhance data use at all levels.	1. Conduct routine training on data use and analysis. 2. Create opportunities for enhanced data analysis (e.g., peer reviewed publications, monographs, reports).	✓	✓	✓ ✓	
Incorporate new data collection indicators and tools for expanded scope.	1. Based on any program enhancements, revisit the data collection plans and indicators to ensure the appropriate measurement, learning, and evaluation strategy against any new program objectives and/or goals.			✓	

Program Area 6: Program Management

Element	Implementation Activities	Timeframe			Comments/Lessons
		Start-Up	Roll-out	Expanded Scope	
Staff the implementation pyramid appropriately for high-quality programming.	1. Hire adequate field-level (grassroots) managers: one dedicated field-level program manager per 5,000 high-risk group members in a given location or 3 NGOs, whichever is lesser. 2. Hire one senior person in each technical area to spend time in the field overseeing NGOs (additional staff support as needed): • Outreach and BCC • Clinical quality • Advocacy/community mobilization • MIS and M&E	✓ ✓			In addition to day-to-day program management, these staff are the key conduits of MIS and performance measurement up the implementation pyramid. The field-level manager makes frequent field visits, conveys and reinforces performance norms and standard guidelines, and helps the NGOs solve local problems. This field manager also networks with the NACO District AIDS Societies, conducts advocacy with the police and other government departments, and assists NGOs in developing district-level platforms for HRG collectivization. If any post is vacant, an alternate person is assigned (temporarily) to oversee NGOs until the post is filled.
Ensure that funds and commodity flows to the grassroots level are adequate and uninterrupted (e.g., salaries, condoms, lubricants, clean needles).	1. Project accountants responsible for NGO supervision collect invoices and vouchers and ensure that NGOs receive their funds on time according to contract arrangements. 2. Supply chain issues with regard to stock-outs or excess inventory are referred by the project officer to the appropriate lead implementing partner staff lead to address immediately. 3. Quarterly check by project officers and quarterly audits by accountants at the lead implementing partner are in place to ensure functioning of supply and financial systems.	✓ ✓ ✓	✓ ✓ ✓	✓ ✓ ✓	Funds flow monitoring by project officers also ensures funds utilization as per the CMP. Stock-outs monitored and reported in MIS for prompt action.

Element	Implementation Activities	Timeframe			Comments/Lessons
		Start-Up	Roll-out	Expanded Scope	
Clearly articulate the management structure, including the roles and responsibilities at the various levels.	**Avahan State Program Manager:** 1. Visit each district once every three to four months (at a minimum).	✓	✓	✓	Frequency of field visits was higher during the start-up and enhanced scale-up phases. Field visits during the expanded scope phase are more around specific problem-solving needs. MIS analysis done every month and action points discussed with lead implementing partner management.
	2. Conduct monthly review with PD and country head–either by phone or in person.	✓	✓	✓	
	3. Conduct semi-annual or annual reviews with international management.	✓	✓	✓	
	4. Provide formal written feedback to the lead implementing partner every six months.	✓	✓	✓	
	5. Work with lead implementing partner to develop and support select pilot projects with government health system.	✓	✓	✓	
	6. Meet with other development partners to ensure complementarities and minimize overlap.	✓	✓	✓	
	Lead Implementing Partner:				
	1. Possess a clear understanding of relative risks of different sites and demonstrate proof that resources and intensity of program is focused on riskier sites.	✓	✓	✓	
	2. Ensure adequate resources to accomplish goals and to ensure minimum quality of interventions. Specifically, the program provides adequate resources to: • Provide on-the-ground support for creating an enabling environment (e.g., hiring full-time person for meeting with police, district officials, government health officials, lodge associations, etc.).	✓	✓	✓	

Element	Implementation Activities	Timeframe			Comments/Lessons
		Start-Up	Roll-out	Expanded Scope	
	• Ensure minimum ratio of trained and supported peer outreach workers (1:50) to HRG populations. • Provide space and physician time to ensure minimum clinic visits to the health facility. • Ensure quality and use of monitoring data with a dedicated person who focuses on M&E issues. • Provide communication materials and process development with a dedicated communications person. • Obtain data to inform programming priorities (e.g., enumeration and mapping, risk behavior profile, etc.). • Develop capacity of core staff, NGO staff, and HRG populations. **NGO Level:** 1. Demonstrate a clear understanding of denominator enumeration of HRG populations with technical assistance by NGO and lead implementing partner and with participation of the community. 2. Map power structures and converse with them early in the program to minimize harm to the community and on an ongoing basis. 3. Hold regular meetings of NGO staff and HRG population to brainstorm barriers to program success (condom use, STI visits, community mobilization, structural issues like the police) and to ensure intensity of the program is linked to risk of HRG population members.	✓ ✓ ✓	✓ ✓	✓ ✓	Community/NGO-level activities are also discussed in Program Area 1, "Peer Outreach, Community Mobilization, and Local Advocacy for Vulnerability Reduction."
Conduct regular meetings between all partners. This includes sharing of learnings and best practices from partners rolling out infrastructure and delivering services.	1. Lead Implementing partners hold quarterly meetings of state-level management with NGO management to review programmatic and technical aspects of the program.	✓	✓	✓	NGOs can be grouped. Core output indicators to be reviewed at the meeting. Foundation staff holds semi-annual debriefing meetings with capacity building partners and lead implementing partners on technical standards of implementation and to enable cross-sharing of best practices.

Element	Implementation Activities	Timeframe			Comments/Lessons
		Start-Up	Roll-out	Expanded Scope	
Conduct field-based reviews of progress to track infrastructure roll-out.	1. Foundation staff and lead implementing partners visit field interventions at regular intervals to assess progress of infrastructure scale-up.	✓	✓	✓	Joint visits by foundation staff and lead implementing partner managers enable informed discussion based on field realities.
	2. Field-based reviews of NGO performance usually initiated by Avahan program manager, facilitated by lead implementing partner staff.	✓	✓	✓	
	3. Findings from field-based reviews fed back into the regular program reviews to inform discussions based on field realities.	✓		✓	
Plan and track time spent in the field by various levels of management for two key purposes: local networking with key stakeholders (coordination) and active problem-solving to improve grassroots implementation performance (management).	**Program Director:**				Program directors encouraged to spend at least one-third of their time in the field during the start-up and enhanced scale phases.
	1. Establish relationship and coordinate with State AIDS Control Societies (SACS) and with other agencies as necessary on an ongoing basis.		✓	✓	
	2. Establish relationship and meet with state police leaders periodically (at least every year).		✓	✓	
	3. Establish relationship with district-level government officials (SP, District Coordinator, District Surgeon) every year.		✓	✓	
	4. Establish relationship and meet with senior gatekeepers (e.g., local leaders in brothel areas; *dais*; bar associations) every year.		✓	✓	
	5. Establish relationship and meet with other implementing agencies doing similar work funded by different sources every year.		✓	✓	
	6. Review sites and program and offer coaching (on an ongoing basis).		✓	✓	
	7. Review and coordinate with other program partners (on an ongoing basis).		✓	✓	

Element	Implementation Activities	Timeframe			Comments/Lessons
		Start-Up	Roll-out	Expanded Scope	
	Program Officers:				
	1. Establish relationship and meet with senior government officials at district level (SP, DC) quarterly.	✓			
	2. Establish relationship and meet with site-level government officials (police station house officer, government hospital, ward officer) quarterly.	✓			
	3. Provide on-site mentoring to NGOs and community members in the field in key technical and program areas (ongoing). • Seek community feedback on adequacy of and access to services • Seek NGO feedback on lead implementing partners' visit frequency • Ideally, be accompanied by at least one technical officer from the lead implementing partner • Meet key stakeholders in the district, including other NGOs working in HIV, anti-trafficking NGOs, care and support agencies • Guide NGOs on how community involvement can be enhanced • Identify opportunity gaps against targets and help problem-solve them to increase service uptake • Assess if program is focusing on the highest-risk groups	✓	✓	✓	
	4. Demonstrate support for the program and NGOs.	✓	✓	✓	
	NGO Senior Staff:				
	1. Establish relationship with key gatekeepers (local leaders; police station house officer).	✓	✓		
	2. Lead crisis response initiatives until the community is capable.	✓	✓	✓	
	Community Members:				
	1. Build capacity to assume more responsibility as the program evolves.	✓	✓	✓	

Element	Implementation Activities	Timeframe			Comments/Lessons
		Start-Up	Roll-out	Expanded Scope	
Develop a clear training plan and ensure that appropriate resources are available in the field for mentoring and building the capacity of grassroots NGO staff and peer outreach workers.	1. Lead implementing partner identifies potential learning sites within the program for NGOs to cross-learn. 2. Detailed training plans developed by the training coordinator of the lead implementing partner–this would include the individuals to be trained, subject of training, dates, type of training (onsite mentoring/TI level support, learning site visit, classroom training).		✓ ✓		
Revise implementation standards and improve tracking of quality of services.	1. Dynamically revisit implementation standards–for example, standardizing the roll-out of the peer led outreach model, introduction of micro-planning, addition of service quality assessments for STI, introduction of community mobilization self-diagnostic tool.		✓	✓	
Analyze data to track coverage and intensity of service delivery.	1. Identify opportunity gaps in program indicators in order to improve performance by using MIS data • STI visits (repeat vs. new) • Condom gaps		✓	✓	
Conduct external reviews to verify quality of programs and involve external stakeholders.	1. Each lead implementing partner commissions external reviews involving various key stakeholders–SACS, lead implementing partner, Technical Support Unit, other donors, external consultants.			✓	

SECTION III

AVAHAN MANAGEMENT INFORMATION SYSTEM

This section contains three tables that describe in detail the Avahan management information system (MIS) version 2. The three tables are:

- **Table 1: Avahan Core Indicator Definitions,** including the target group and level of detail (granularity), reason for reporting, operational details, and whether there is a target for the indicator.
- **Table 2: Dashboard Indicator Definitions,** including the target group and level of granularity, the reason for reporting, the formula for calculating the indicator, and whether there is a target for it.
- **Table 3: Avahan Monthly Indicator Reporting Format,** which is an Excel spreadsheet that aggregates data from implementing NGOs through lead implementing partners to the central MIS. The structure of the database makes possible aggregate-level, lead implementing partner-level, state-level, district-level, and NGO-level analysis.

  The tables also contain comments that explain further the indicators and any issues that were encountered when using them.

Abbreviations used in these tables

CBO	Community-based organization
CMIS	Computerized management information system
DA	Dashboard indicator
DIC	Drop-in center
FSW	Female sex worker
HRG	High-risk group
IDU	Injecting drug user
LIP	Lead implementing partner
MSM	Men who have sex with men
NGO	Non-governmental organization
ORW	Outreach worker
RPR	Rapid plasma reagin
SHG	Self-help group
STI	Sexually transmitted infection

Table 1: Avahan Core Indicator Definitions

I. PROGRAM INFRASTRUCTURE AND BASELINE INFORMATION							
To measure the status of the program in each intervention site and across Avahan							
No.	Indicator	Target group/ Granularity	Definition	Reason for reporting	Operational guideline: units of reporting, entered by, entry format, frequency of reporting	Annual target	Comments
1.0	Size estimation of HRG population	1. Split by FSW/MSM 2. FSW sub-typology: Brothel, Lodge, Street, Home, Other	Total estimate of number of high-risk group (HRG) individuals in Avahan geographical coverage area - Methods of size estimation studies include: mapping, participatory site assessment, capture and recapture, census methods. The lead implementing partner must articulate the standardized methodology used to conduct an estimation, and the updated figure should be entered along with target group, source, month, and year of study.	Status of Program indicator - Denominator for coverage measures, service uptake (DA 6); especially STI clinic services (DA 10 and DA 11) **DA = Dashboard Indicator**	- Reporting Unit: NGO projects/target groups - Entered by: lead implementing partner (LIP) - Frequency: at least annually	No	- A further split between "stable" and "mobile" could be tracked in sites that have very high turnover of HRG populations. - Sub-typologies of FSW are restricted to the choices given; if there are other populations to consider (home-based, *dhaba*-based, etc.), then they must be included in "Other" unless they consist of over 10% of the typology population. - FSW typologies are defined by point of solicitation.
2.0	Number of intervention districts/towns covered	1. Number of districts 2. Number of intervention towns within districts split by type of service package	The number of the reporting/ intervention units directly covered by the program (district and intervention towns within district). Towns to be split by where outreach and clinic services are provided; and those towns where only clinic services are provided (i.e., to support government targeted intervention programs).	Status of Program indicator	- Reporting Unit: NGO projects/target groups - Entered by: LIPs - Frequency: when changes occur	Yes	

No.	Indicator	Target group/ Granularity	Definition	Reason for reporting	Operational guideline: units of reporting, entered by, entry format, frequency of reporting	Annual target	Comments
3.0	Number of project sites disaggregated by type (project offices, drop-in centers (DIC), support clinics, etc.)	1. Project offices 2. DIC 3. Clinics stratified by static/ outreach/referral provider 4. Mobile clinic vans	- **Project office:** Any full-time office that the NGO maintains for NGO project staff in a town/district. - **Drop-in center/community center:** Any safe space identified and used by the high-risk community to periodically congregate and discuss community issues. - **Static clinic:** Fixed, full-service clinics owned and operated by the project. - **Outreach clinic:** Periodic clinics conducted at different locations by mobile clinic teams, usually at a DIC/ safe space identified by community. They provide field-based health care and only operate on selected days; unit is location of outreach clinic; includes sites covered by mobile van clinics under this. - **Referral provider:** Any existing medical practitioner trained by the project with whom formal linkages have been established for referral and treatment of HRGs and who regularly reports patient data to the project as per standard clinic formats. - **Mobile clinic:** Mobile vehicle clinics that move to different sites as per a beat plan to provide services; unit is mobile vehicle.	Status of Program indicator	- Reporting Unit: NGO projects/target groups - Entered by: LIPs - Frequency: when changes occur - IPs and NGOs will report this information for their respective projects. If an organization runs multiple services out of the same center (e.g., a clinic and drop-in center at the same facility), the center should be counted in both categories (i.e., indicator counted as both a DIC and clinic). Organizations that use private providers to provide STI services should report these in the number of provider referral clinics. One-time health camps used to promote regular clinic services should not be counted here.	No	Large proportion of populations being covered through non-static clinics, hence split should be captured.

No.	Indicator	Target group/ Granularity	Definition	Reason for reporting	Operational guideline: units of reporting, entered by, entry format, frequency of reporting	Annual target	Comments
4.0	Number of intervention related project staff (excluding paid peer outreach workers)	1. Director and/or coordinator 2. Outreach staff (outreach workers and supervisors) 3. Technical staff 4. Finance and administration 5. Project doctors 6. Other clinical staff	Intervention related project staff are paid as part of the Avahan projects. - Project directors and coordinators are overall in-charge on an NGO or a specific intervention. - Outreach staff includes field staff such as field officers, outreach workers, and supervisors who manage the peer outreach workers (no paid peer outreach workers should be reported here). - Technical staff work on a specific strategy of the project such as behavior change communication, social marketing, advocacy, etc. and may have specialized training/ qualifications. - Finance and administration staff include accountants, data entry operators, etc. - Project doctors refers to those working in project-run clinics, not referral providers. - Other clinical staff includes counselors, auxiliary nurse midwives, paramedics, clinic administrators, and lab staff.	Status of Program indicator; contributes to denominator of community ownership dashboard indicator (DA 17)	- Reporting Unit: NGO projects/target groups - Entered by: LIP - Frequency: updated when changes occur	No	
5.0	Number of intervention related project staff (excluding paid peer outreach workers) who belong to the HRG populations	1. Split by FSW/ MSM	The number of intervention staff (as defined in 4.0) who are members of the high-risk groups.	Partial numerator of dashboard indicator to measure peer representation in formal structures of the program (DA 17)	- Reporting Unit: NGO projects/target groups - Entered by: LIP - Frequency: updated monthly	No	

No.	Indicator	Target group/ Granularity	Definition	Reason for reporting	Operational guideline: units of reporting, entered by, entry format, frequency of reporting	Annual target	Comments
6.0	Number of active, paid peer outreach workers	1. Split by FSW/MSM 2. Split FSW peers by their typology	Individuals from high-risk community that have been selected and trained to provide outreach services. These individuals may be called by different names–peer educators, community guides, peer outreach workers, social change agents or other terms—and they work with the project on a regular basis, collect data related to their activities, and are paid. Peer outreach workers that discontinue working during this reporting period should be reported as they have worked for a portion of the reporting period.	Status of Program indicator - Denominator for HRGs to peer outreach workers ratio (DA 1) and early adoption of peers as a measure of peer engagement/ effectiveness (DA 3 and DA 5)	- Reporting Unit: NGO projects/target groups - Entered by: LIP - Frequency: updated monthly	No	
7.0	Number of peer outreach workers that discontinue working	1. Split by FSW/ MSM	The number of peer outreach workers (as defined in Indicator 6.0) that discontinue working as peer outreach workers during the reporting period.	Measure of peer turnover. Consistent high turnover may trigger reassessment of peer selection process/criteria. Lower threshold should be set to ensure peer progression or rotation to build capacity of more high-risk group members.	- Reporting Unit: NGO projects/target groups - Entered by: LIP - Frequency: updated monthly	No	NGOs should also locally track reason for discontinuation, though not required for reporting.
8.0	Number of project staff trained	1. Outreach staff 2. Peer outreach workers 3. Project doctors 4. Referral doctors 5. Other clinic staff	Include only formal training sessions conducted by the program or external personnel.	Measure of adequate training and capacity building of project staff	- Reporting Unit: NGO projects - Entered by: LIP - Frequency: monthly	No	
9.0	Number of clinics reporting any STI drug stock-outs within the last month	General	The number of clinics that have ever run out of any STI treatment drugs in the reporting period.	Measure of drug availability at clinics	- Reporting Unit: NGO projects/target groups - Entered by: NGO - Frequency: monthly	No	To be reported immediately.
10.0	Number of out-reach units/clinics reporting any condom stock-outs (for free condom distribution) within the last month	General	The number of outreach units/clinics that run out of condoms in the reporting period. An outreach unit may be defined as the administrative unit for organizing outreach services (e.g., may be the same as a DIC/community center).	Measure of condom availability at outreach units and clinics	- Reporting Unit: NGO projects/target groups - Entered by: NGO - Frequency: monthly	No	To be reported immediately.

No.	Indicator	Target group/ Granularity	Definition	Reason for reporting	Operational guideline: units of reporting, entered by, entry format, frequency of reporting	Annual target	Comments
One-time variable required for calculating dashboard indicators (may be changed if new, more reliable information is available)							
11.0	Estimated number of sex acts with clients per month per HRG	1. Split by FSW/MSM 2. FSW typology (optional)	The average number of penetrative sex acts with clients in a month for a HRG member; separate numbers could be collected for each typology if available.	Measure of the volume of sex acts and risk profile of the HRG; contributes to denominator for condom coverage for risky acts (DA 8 and DA 9)	- Reporting Unit: target groups - Entered by: LIP - Frequency: update as required, at least annually	No	Can be collected (in order of preference) through formal behavioral surveys; informal surveys of HRGs, or peer consultations; LIP will complete calculation to arrive at average month client volume for FSWs and MSM based on available data; methodology should be documented and shared with Avahan.
12.0	Estimated wastage factor for free condoms	1. Split by FSW/MSM	Proportion of condoms distributed (mainly free condoms) that are not used to protect sex acts; includes factors like dumping, double condom usage, breakage, expiry and any other incorrect use.	Required to adjust for actual coverage of sexual acts achieved through free condom distribution (DA 8 and 9)	- Reporting Unit: target groups - Entered by: LIP - Frequency: update as required, at least annually	No	Can be collected through HRG interviews, peer consultations; LIP can devise method to arrive at either one overall wastage factor or separate factors for FSWs and MSM based on available data; methodology should be documented and shared centrally. Default value = 15%.
13.0	Number of monthly sex acts with clients	1. Split by FSW/MSM 2. FSW typology (optional)	Calculated as the product of estimated sex acts per month per HRG and the size estimation; calculated separately for FSWs and MSM; can also be calculated separately for each FSW typology and then summed across different typologies if sex acts data are available by typology.	Denominator for calculating dashboard indicator (DA 8 and 9)	- Reporting Unit: NGO projects/target groups - Entered by: LIP - Frequency: annually updated; or recalculated when new data on size estimation and monthly sex acts become available	No	
14.0	Number of HRG individuals ever visited clinic at the beginning of Month 1	1. Split by FSW/MSM and peers and non-peers	Field number 14 is not an indicator – it is used as a one-time data element (refer to the MIS worksheet format).				

II. SERVICE UPTAKE (INCLUDING STI)							
To measure breadth of coverage of clinical services and extent of change in health-seeking behavior							
A. Outreach Uptake							
No.	Indicator	Target group/ Granularity	Definition	Reason for reporting	Operational guideline: units of reporting, entered by, entry format, frequency of reporting	Annual target	Comments
15.0	Number of individuals included in individual-level tracking by the project	1. FSW/MSM 2. FSW typology	Includes individuals being tracked by the Avahan program (e.g., HRG assigned to a peer outreach worker for routine outreach or assigned a tracking number for whom basic information has been recorded–such as name, typology, location–and a unique ID assigned); HRG may or may not necessarily be "registered/profiled" by the project.	Numerator for calculating dashboard coverage indicator (DA 6); denominator for calculating dashboard indicator on intensity of coverage (DA 7)	- Reporting Unit: NGO projects/target groups - Entered by: LIP - Frequency: monthly	No	
16.0	Number of individuals contacted during the month	1. FSW/MSM 2. New/repeat 3. Number met by peer outreach workers vs. number met by staff outreach workers 4. FSW typology (optional) 5. Indicate whether count includes group sessions	Includes individuals met through all forms of outreach including 1-1, 1-group, and for rapport building (should report only individuals met, not cumulative contacts). - The split by peer outreach worker and ORW is required for calculating the metric on peer led prevention, therefore it is included here; individuals who are met by both peer outreach worker and staff outreach worker can be shown as peer outreach worker contact in the split.	Numerator for calculating dashboard indicator on intensity of coverage (DA 7); peer split gives numerator and denominator for peer engagement dashboard indicator (DA 2)	- Reporting Unit: NGO projects/target groups - Entered by: LIP - Frequency: monthly	No	Individuals to be counted through daily diary formats or other existing formats for recording outreach activity. Emphasis should be on contacts made 1-1; however, if LIP has means for recording individuals contacted during 1-group then those numbers can be included too. LIPs should also ensure that individuals contacted multiple times in a month are counted as one contact.

No.	Indicator	Target group/ Granularity	Definition	Reason for reporting	Operational guideline: units of reporting, entered by, entry format, frequency of reporting	Annual target	Comments
17.0	Number of individuals that have discontinued with project services in this reporting period	1. FSW/MSM	Discontinued individuals are those who are not contactable by peer outreach workers and have not accessed any program services for at least three months.	Measure of program's ability to engage HRGs over the long term (i.e., ability to sustain community involvement or behavior change)	- Reporting Unit: NGO projects/target groups - Entered by: LIP - Frequency: monthly	No	Discontinued individuals must be removed from the number in Field 15 at the end of the reporting period.
B. Condom Uptake							
18.0	Number of condoms distributed–free	1. Split distribution by: Peers/ORW/Clinic/DIC/ Others	The source from where HRGs (including gatekeepers) directly receive condoms. - Count condoms distributed by peer outreach workers and staff outreach workers to be reported separately. - Count condoms stocked in condom depots, lodges etc. as "others," even if stocking is done by peer outreach workers or staff outreach worker.	Partial numerator for calculating dashboard indicator (DA 8); Numerator and Denominator by peer split for indicator on peer engagement	- Reporting Unit: NGO projects/target groups - Entered by: LIP - Frequency: monthly	No	- Distribution split not being provided by several lead implementing partners; distribution through peer outreach workers and staff outreach workers and should be segregated for reporting. - If outreach workers are from the community include their numbers under peer.
19.0	Number of condoms socially marketed through the project, social marketing groups and other hotspot sources	1. Socially marketed by NGO/LIP 2. Socially marketed by social marketing groups 3. From other commercial sales	Socially marketed or commercial brands of condoms available in the hotspot areas provided by NGO/LIP and social marketing groups; other commercial sales should be included if it is possible to estimate.	Partial numerator for calculating dashboard indicator (DA 8)	- Reporting Unit: NGO projects/target groups - Entered by: LIP - Frequency: monthly	No	If the LIP also socially markets condoms, then that figure should be included in this indicator; project-supported social marketing group monthly hotspot sales will be shared with NGO and LIP for reporting purposes.

No.	Indicator	Target group/ Granularity	Definition	Reason for reporting	Operational guideline: units of reporting, entered by, entry format, frequency of reporting	Annual target	Comments
C. STI Clinic Uptake							
20.0	Number of HRG group individuals receiving STI consultations during the month	1. Split by FSW/MSM 2. Split by new/ repeat individuals 3. Split by peers/ non-peers 4. Reason for visit–STI symptom/STI follow-up/regular STI check-up/ general ailment 5. Split by FSW typology (optional) 6. Split STI symptom visits from split # 4 as new symptom visit/repeat symptom visit (optional)	Includes individual HRGs who receive STI consultations at the clinic during the month. The reason for visit is whatever reason the HRG individual reports for attending the clinic; therefore it is possible that HRG individuals walk in for general ailments but also receive STI consultations after discussion with the physician or counselor. Do not include HRG individuals treated for general ailment but not receiving any STI consultation. Only include number of individuals from HRG here. Do not report partners, clients, children, or other family members of HRG individual. The data should be separated according to new (individuals that are new to the clinic) and repeat (individuals that have utilized the project clinic in previous reporting periods). If an individual accesses this service multiple times in a reporting period, count the individual once.	Measure of patient volume at clinics, and the splits provide STI-related health-seeking behavior among high-risk groups and peer engagement (DA 3)	- Reporting Unit: NGO projects/target groups - Entered by: LIP; some splits calculated through CMIS based on data entry of standard clinic register - Frequency: monthly	No	Several partners reporting total visits for this indicator—only individuals to be reported. Split 1-4 to be reported immediately. Split 5 and 6 need be reported only after computer-based system is operational (i.e., data entry of individual patient records from standard register).
21.0	Number of HRG individuals receiving STI consultations during the quarter	1. FSW/MSM 2. Peer/non-peer 3. FSW typology	Number of unique individuals who accessed clinic services in a quarter; individuals who visit multiple times in a quarter should be counted only once.	Numerator for calculating dashboard indicator (DA 11); important for assessing compliance with norm for quarterly STI check-up; split by peer outreach workers gives dashboard indicator on peer outreach workers as models (DA 4)	- Reporting Unit: NGO projects/target groups - Entered by: LIP by entry of individual patient data from standard clinic register*; calculated through CMIS - Frequency: quarterly	No	Does not need to be reported until LIP is on CMIS.

* Standards clinic register can be found in the *Clinic Operational Guidelines and Standards.*

No.	Indicator	Target group/ Granularity	Definition	Reason for reporting	Operational guideline: units of reporting, entered by, entry format, frequency of reporting	Annual target	Comments
22.0	Number of HRG individuals with repeat STI symptom visits with symptom duration > 7 days	1. Split by FSW/MSM	Individuals making repeat visits for STI symptom (not first-time STI symptom visit) who report symptom duration as > 7 days.	Numerator for calculating dashboard indicator on treatment-seeking behavior (DA 12); split by peer outreach workers gives dashboard indicator on peer outreach workers as models (DA 5)	- Reporting Unit: NGO projects/target groups - Entered by: LIP by entry of individual patient data from standard clinic register; calculated through CMIS - Frequency: monthly	No	Indicator and all granularity splits will be generated by the computer-based system.
23.0	Number of STI consultations	1. Split by FSW/MSM 2. Split by HRG/non-HRG 3. Split number of consultations by clinic type—static/ outreach/referral provider 4. Split by FSW typology (optional)	The number of STI consultations during the reporting period. Should also include general ailment walk-ins where STI consultations are also provided. The total number of consultations is reported and not the number of individuals. - Separate consultations for HRG from non-HRG, which might include clients, regular partners, or general population who receive STI consultations. Include consultations at mobile clinics under outreach clinic numbers.	Measure of the total volume of STI consultations as individuals might seek multiple consultations in a month	- Reporting Unit: NGO projects/target groups - Entered by: LIP - Frequency: monthly	No	Splits 1, 2, and 3 should be reported immediately. Split 4 to be calculated through computer-based system.
24.0	Number of HRG individuals undergoing STI consultation who underwent an internal examination	1. FSW/MSM 2. Peers/non-peers	HRG individuals attending clinic for any STI consultation (symptom, follow-up or regular STI check-up) who undergo internal examinations (vaginal or anal) as part of the consultation.	Numerator of dashboard indicator measuring the acceptability of STI management among community (DA 13)	- Reporting Unit: NGO projects/target groups - Entered by: calculated by system from clinic encounter forms - Frequency: monthly	No	To be reported immediately.

No.	Indicator	Target group/ Granularity	Definition	Reason for reporting	Operational guideline: units of reporting, entered by, entry format, frequency of reporting	Annual target	Comments
25.0	Number of STI syndromes diagnosed by type	1. Split by FSW/ MSM/IDU 2. Split by FSW typology (optional)	IP should report the number of syndromes according to the type of syndrome. A syndrome refers to the diagnosis by the health care provider. As the syndrome is tracked and not the individual, a person who has multiple syndromes should be counted under each syndrome. There are six syndromes—vaginal/cervical discharge (VCD); genital ulcer disease (GUD); lower abdominal pain (LAP); urethral discharge (UD); ano-rectal discharge (ARD); and others.	Measure of the STI case profile seen at the clinic; can be used to calculate a ratio of GUD to UD; high ratio suggests impact of STI control on population	- Reporting Unit: NGO projects/target groups - Entered by: LIP - Frequency: monthly	No	Split 2 will be generated through the computer-based system. Through the computer system this should be reported separately for project-run and provider referral clinics.
26.0	Number of HRG individuals receiving treatment for asymptomatic infections	1. Split by FSW/MSM 2. Split by FSW typology (optional) 3. Split by first-time asymptomatic treatment	The number of individuals in the target community not reporting symptoms who received treatment for gonorrhea and chlamydia.	Measure of individuals covered by asymptomatic treatment, a key STI management strategy	- Reporting Unit: NGO projects/target groups - Entered by: NGO from clinic encounter form - Frequency: monthly	No	Split 1 to be reported immediately. Splits 2 and 3 will be generated through the system.
27.0	Number of general ailments treated	1. Split by HRG/non-HRG 2. Split HRG by FSW/MSM	The total number of general consultations at the clinic. Determined by reason for visit being general ailment and no internal exam was done and no syndrome diagnosed and only "other treatment" is given. Should not include any instances of general ailments where STI consultations are also provided—those instances should be reported under Field #23.	Measure of appropriate traffic at the clinic (i.e., compared to number of people who were given an STI consultation)	- Reporting Unit: NGO projects/target groups - Entered by: LIP - Frequency: monthly	No	To be reported immediately.
28.0	Number of HRG individuals counseled	1. Split by FSW/MSM	A counseling session takes place between a counselor and a beneficiary in the STI clinic or drop-in center. If one individual receives multiple counseling sessions in a reporting period, the individual should be counted once.	Measure of breadth of counseling coverage important for behavior change	- Reporting Unit: individuals - Entered by: calculated by system - Frequency: monthly	No	To be reported immediately.

No.	Indicator	Target group/ Granularity	Definition	Reason for reporting	Operational guideline: units of reporting, entered by, entry format, frequency of reporting	Annual target	Comments
29.0	Total number of HRG inviduals who have visited the clinic at least once	1. Split by FSW/MSM 2. FSW typology (optional)	Cumulative new visits by HRGs from the beginning of the clinic.	Numerator for uptake of clinic services dashboard indicator (DA 10)	- Reporting Unit: NGO projects/target groups - Entered by: NGO from clinic encounter form - Frequency: monthly	No	For the first time this is calculated for all the new visits in monthly reports since clinics opened.
BEHAVIOR CHANGE (COLLECTED THROUGH CLINIC FORMS)							
To measure the extent of behavior change related to risk reduction among high-risk group members							
30.0	Number of HRG individuals reporting condom use at last sex (as collected during counseling at the clinic)	1. FSW/MSM 2. FSW typology (optional) 3. First-time STI visit vs. repeat visit (generated through computerized system)	Among total HRG attending clinics, proportion of individuals who report condom use at last sex; data to be collected by counselor during clinic visit.	Numerator of dashboard indicator on key condom use behavioral outcome (DA 14)	- Reporting Unit: NGO projects/target groups - Entered by: calculated by system from clinic encounter forms - Frequency: monthly	No	The MSM/FSW split should be reported immediately; the FSW typology and first-time split should be generated through the computer-based system. Only meant for routine monitoring purposes and trends; must not to be quoted as proxy for condom use among population or for input to modeling exercise.
Mandatory fields for clinical register (to be transcribed from the clinical encounter forms); all STI-related indicators can be calculated from these fields							
A	Individual ID number		Unique tracking ID that is entered into the CMIS and links to key personal information fields including HRG, typology, whether peer outreach worker etc.				In the computerized system the ID numbers should be linked to whether the person is a peer outreach worker. This is needed to calculate dashboard indicators on peer early adoption (DA 3, DA 4, and DA 5).
B	Date of visit		Day, month, year				
C	First visit to clinic (Y/N)		Field to track whether first visit by individual to any clinic operated by the LIP (i.e., should be the first record of that ID number).				Computerized system should also be able to calculate number of repeat symptomatic STI visits used for dashboard indicator (DA 13).
D	Reason for visit (regular STI visit, STI symptoms, follow-up, general ailment)		Reason for visiting clinic— all clinics targeting routine quarterly STI check-up for each HRG member.				

No.	Indicator	Target group/ Granularity	Definition	Reason for reporting	Operational guideline: units of reporting, entered by, entry format, frequency of reporting	Annual target	Comments
E	Duration of symptoms		Recorded for longest duration of most recent symptoms; =<2 days, 3-7 days, 8-14 days, >2 weeks; for indicator calculations, categorized primarily < or > 7 days.				
F	Internal exam conducted (Y/N)		Whether speculum or proctoscopic examination conducted during STI consultation.				To be added to updated clinic register (should already be part of clinical encounter forms).
G	STI syndromes diagnosed		Syndrome diagnosed 1. Vaginal/cervical discharge (VCD) 2. Genital ulcer disease (GUD) 3. Lower abdominal pain (LAP) 4. Urethral discharge (UD) 5. Ano-rectal discharge (ARD) 6. Others				
H	No syndrome diagnosed		If none of the syndromes above.				
I	Asymptomatic		Yes, if patient does not report any symptoms (syndrome may still be diagnosed based on clinical signs upon internal examination).				
J	STI treatment prescribed		Treatment kit prescribed for syndrome diagnosed (each lead implementing partner has a standard list of treatment packs, sometimes described by color, corresponding to a particular treatment combination).				
K	Asymptomatic treatment given (Y/N)		Treatment pack given for asymptomatic GC/CT.				
L	Counseling given (Y/N)		Whether counseling with condom demonstration done.				
M	Condom use at last sex (Y/N)		Question asked during routine patient counseling by counselor.				To be added to updated clinic register (should already be part of clinical encounter forms).

No.	Indicator	Target group/ Granularity	Definition	Reason for reporting	Operational guideline: units of reporting, entered by, entry format, frequency of reporting	Annual target	Comments
N	Number of condoms given		Number of condoms given to patient by counselor or doctor.				
O	Referral for VCT/ Other med (including HIV/AIDS care) (Y/N)		Whether referred to VCT, HIV/AIDS care and treatment, or other medical services (including TB).				
P	RPR test (Y/N)		Either referral for testing or on-site testing.				

III. COMMUNITY MOBILIZATION AND ENABLING ENVIRONMENT							
A. Enabling Environment							
To measure the extent to which the program has created a supportive environment that actively responds to community problems and reduces marginalization							
No.	Indicator	Target group/ Granularity	Definition	Reason for reporting	Operational guideline: units of reporting, entered by, entry format, frequency of reporting	Annual target	Comments
31.0	Number of reported incidents of rights violations against HRG community	1. FSW/MSM	Rights violations include any incident that violates Indian law where one or more community members are subject to extortion, abuse, violence, or unlawful arrest by police or *goons*; do not include incidents where the police might have acted within the provisions of Indian law.	Denominator of dashboard indicator for responding to police rights violations (DA 15)	- Reporting Unit: NGO projects/target groups - Entered by: LIP - Frequency: monthly	No	Critical determinant of quality of environment. Tracking should be done regularly through peer outreach workers and consolidated by NGO in a separate register; NGO should determine in consultation with community if the reported incident is a rights violation before reporting it here.
32.0	Number of reported cases of rights violations addressed by NGO or CBO/SHG within 24 hours	1. FSW/MSM	Addressal of cases means that peer outreach workers and/or NGO staff should meet with affected community members and the concerned police officials within 24 hours to register a complaint and arrange for appropriate legal help; in case of rights violations by *goons*, a desired action is to get a police case registered within 24 hours.	Numerator of dashboard indicator for responding to police rights violations (DA 15)	- Reporting Unit: NGO projects/target groups - Entered by: LIP - Frequency: monthly	No	To instill urgency for appropriate responses from peer outreach workers/NGO staff in such cases.
33.0	Number of individuals who were assisted by the program to get a government ID card (e.g., ration card or bank account)	1. FSW/MSM	Approved government ID cards include ration card, voter ID card, or other cards. Where individuals might have more than one ID card, count as one.	A dashboard indicator (DA 16); to be monitored for increases over time	- Reporting Unit: NGO projects/target groups - Entered by: LIP - Frequency: monthly	Yes	Only report cases where the project has directly facilitated the issuing of the ID card.

No.	Indicator	Target group/ Granularity	Definition	Reason for reporting	Operational guideline: units of reporting, entered by, entry format, frequency of reporting	Annual target	Comments
B. Community Ownership							
To measure the active level of representation of the community in the program							
34.0	Number of individuals who are members of various program committees (includes community and non-community members)	1. HRG/non-HRG 2. Community split by FSW/MSM and peer/non-peer	Program committees include all committees set up to address issues that are directly related to elements of the prevention project as opposed to direct community issues (e.g., clinic committee, DIC committee, etc.).	Numerator (number of HRG members) and denominator (sum of HRG and non-HRG members) of dashboard indicator (DA 17)	- Reporting Unit: NGO projects/target groups - Entered by: LIP - Frequency: monthly	No	To capture the extent of community representation on committees dedicated to program activities; distinct from community committees which might be set up around community issues.
35.0	Number of individual community members on program committees who attended committee meetings during the month	1. FSW/MSM	Membership of committees as defined in 34.0. Assuming at least one committee meeting per month, individuals should be counted once per reporting period.	Numerator for dashboard indicator on HRG members' active participation in program committees	- Reporting Unit: NGO projects/target groups - Entered by: LIP - Frequency: monthly	No	Information to be obtained through minutes of program committee meetings.
C. Community Mobilization							
To measure the extent of mobilization among community members not having direct relationship with the program (peer outreach workers excluded) to assess how active existing community groups are							
36.0	Number of HRG individuals who are members of all community groups (including CBO/SHG/ community committees)	1. FSW/MSM 2. Peer/non-peer 3. For FSW only split by home-based/ non-home based	To include membership of HRG individuals in various committees that are primarily organized to address issues important to the community (e.g., violence, financial security, education, advocacy, welfare, cultural arts, etc). - Individuals who are members of multiple committees should be counted only once. - Should not include community membership in program committees, which is a separate indicator.	Numerator (number of non-peer members) and denominator (sum of peer and non-peer members) of dashboard indicator (DA 18)	- Reporting Unit: NGO projects/target groups - Entered by: LIP - Frequency: monthly	Yes	Gross indicator for community participation in committees set up for non-program issues. Includes membership in SHG, CBO in addition to other community committees. Home-based sex workers might not wish to belong to committees, therefore their numbers can be excluded from the calculation of the dashboard indicator.

No.	Indicator	Target group/ Granularity	Definition	Reason for reporting	Operational guideline: units of reporting, entered by, entry format, frequency of reporting	Annual target	Comments
37.0	Number of individual members of community committees who attended committee meetings during the month	1. FSW/MSM	Membership of committees as defined in 36.0. Assuming at least one committee meeting per month, individuals should be counted once per reporting period.	Numerator for dashboard indicator on HRG members' active participation in community committees	- Reporting Unit: NGO projects/target groups - Entered by: LIP - Frequency: monthly	No	Information to be obtained through minutes of community committee meetings.
38.0	Number of SHGs	1. FSW/MSM	SHGs are any voluntary groups set up and managed entirely by HRG members around any set of issues deemed important by members of the group; it does not necessarily have to engage in savings or microfinance activity. - Should only report SHGs that were formed as a result of mobilization activities undertaken by the project.	Program status indicator for community mobilization	- Reporting Unit: NGO projects/target groups - Entered by: LIP - Frequency: monthly	No	
39.0	Total membership of SHGs	1. FSW/MSM	Number of members in the SHGs reported in 38.0.	Measure of breadth of membership in self-help groups	- Reporting Unit: NGO projects/target groups - Entered by: LIP - Frequency: monthly	No	To be reported immediately.

Table 2: Dashboard Indicator Definitions

I. PEER OUTREACH WORKER ENGAGEMENT								
To measure peer outreach worker effectiveness through their extent of contribution to core prevention services delivered by the NGO								
				Formula				
No.	**Indicator**	**Reason for reporting**	**Target group/ Granularity**	**Numerator**		**Denominator**	**Annual target**	**Comments**
DA 1	Ratio of HRG members to peer outreach workers	Key measure of adequate resources for peer outreach worker engagement in outreach.	1. FSWs/MSM 2. FSW typology (optional)	Size estimation of HRG population	÷	Number of active, paid peer outreach workers	Yes	Typology split will be generated through CMIS.
DA 2	Proportion of outreach contacts (individuals met) made by peer outreach workers	Key measure of extent of peer outreach workers leading outreach activities.	1. FSWs/MSM	Number of individuals contacted through peer outreach workers during the month	÷	Number of individuals contacted during the month	Yes	
DA 3	Proportion of peer outreach workers receiving STI consultations during the month	Key measure of peer outreach workers as role models.	1. FSWs/MSM	Peer outreach workers receiving STI consultations during the month	÷	Number of active, paid peer outreach workers	Yes	
DA 4	Proportion of peer outreach workers receiving STI consultations who underwent internal exams	Key measure of peer outreach workers as role models and early adopters of prevention behaviors.	1. FSWs/MSM	Number of peer outreach workers receiving STI consultation who undergo an internal exam	÷	Number of peer outreach workers receiving an STI consultation	Yes	
DA 5	Proportion of peer outreach workers who receive STI consultations during the quarter	Key measure of peer outreach workers as role models and early adopters of prevention behaviors.	1. FSWs/MSM	Peer outreach workers receiving at least one STI consultation during the quarter	÷	Number of active, paid peer outreach workers at the end of the quarter	Yes	

II. SERVICE UPTAKE (including STI)								
To measure breadth of coverage of clinical services and extent of change in health-seeking behavior								
A. General Program Coverage								
				Formula				
No.	**Indicator**	**Reason for reporting**	**Target group/ Granularity**	**Numerator**		**Denominator**	**Annual target**	**Comments**
DA 6	Proportion of individual HRGs "mapped and estimated" who are tracked by the program	Measure of program coverage.	1. FSWs/MSM 2. FSW typology (optional)	Number of individuals included in individual tracking by the project	÷	Size estimation of HRG population	Yes	Typology split will be generated through CMIS.
DA 7	Proportion of individuals tracked who are contacted monthly	Measure of proportion of tracked HRGs who are active recipients of program services. The expectation is that all HRGs should be contacted at least once a month.	1. FSWs/MSM 2. FSW typology (optional)	Number of individuals contacted during the month	÷	Number of individuals included in individual tracking by the project	Yes	Typology split will be generated through CMIS.
B. Condom Uptake								
DA 8	Proportion of monthly risky sexual acts covered through known condom distribution	Key measure for determining if condom distribution meets the estimated need. Helps to triangulate data on self-reported condom use.		{Condoms socially marketed through the project, social marketing program, and other hotspot sources} + {free condoms distributed x (1-wastage factor)}	÷	Number of monthly sex acts with clients	Yes	
DA 9	Proportion of risky acts covered through program free condom distribution	Key measure for determining coverage of risky sexual acts through free condom distribution for each target group; required because DA 8 cannot be split by target group.	1. FSWs/MSM	{Free condoms distributed x (1-wastage factor)}	÷	Number of monthly sex acts with clients	Yes	

				Formula				
No.	**Indicator**	**Reason for reporting**	**Target group/ Granularity**	**Numerator**		**Denominator**	**Annual target**	**Comments**
C. STI Service Uptake								
DA 10	Proportion of HRGs (mapped and estimated) who have ever attended clinic	Dashboard Indicator: Key measure of broad coverage of STI services for HRGs.	1. FSWs/MSM 2. FSW typology (optional)	Total number of HRG individuals who have visited the clinic at least once	÷	Size estimation of HRG population	Yes	Typology split will be generated through CMIS.
DA 11	Proportion of HRGs who come for routine STI check-ups during a quarter	Dashboard Indicator: Measure of health-seeking behavior of community with respect to STI care.	1. FSWs/MSM 2. FSW typology (optional)	Number of HRG individuals receiving STI consultations during the quarter	÷	Size estimation of HRG population	Yes	Typology split will be generated through CMIS.
DA 12	Proportion of individuals with repeat STI symptom visits with symptom duration > 7 days	Dashboard Indicator: Indicates treatment-seeking behavior as a social norm or effect of outreach education; and among those who have been treated for STI symptoms previously, shows degree of change in behavior that may have resulted from STI care and counseling.	1. FSWs/MSM	Number of HRG individuals with repeat STI symptom visits having symptom duration > 7 days	÷	Number of HRG individuals with repeat STI symptom visits during the month	Yes	
DA 13	Proportion of HRGs receiving STI consultations who underwent internal exams	Dashboard Indicator**:** Key measure of treatment-seeking behavior as a social norm or effect of outreach education. Among those who have previously been treated for STI symptoms, a measure of behavior change resulting from STI care and counseling.	1. FSWs/MSM	Number of HRG individuals receiving STI consultations who underwent an internal examination	÷	Number of HRG individuals receiving STI consultations during the month	Yes	

III. BEHAVIOR CHANGE								
To track interim measures of behavior change that will lead to transmission reduction								
				Formula				
No.	**Indicator**	**Reason for reporting**	**Target group/ Granularity**	**Numerator**		**Denominator**	**Annual target**	**Comments**
DA 14	Proportion of HRGs reporting condom use during last sex act with client	Dashboard Indicator: Interim measure of key behavioral outcome in the absence of other data from formal HRG community representative surveys.	1. FSWs/MSM	Number of individuals reporting condom use at last sex (as collected during counseling session at clinic)	÷	Number of HRG individuals counseled	Yes	Only meant for routine monitoring purposes and trends; must not to be quoted as proxy for condom use among population or for input to modeling exercise.

IV. COMMUNITY MOBILIZATION AND ENABLING ENVIRONMENT								
A. Vulnerability Reduction								
To measure the extent to which the program has created a supportive environment that actively responds to community problems and reduces marginalization								
				Formula				
No.	**Indicator**	**Reason for reporting**	**Target group/ Granularity**	**Numerator**		**Denominator**	**Annual target**	**Comments**
DA 15	Proportion of reported incidents of rights violation against HRG community addressed within 24 hours	Dashboard Indicator: Key measure of effort to address rights violations (including police violence and detainment) as a key inhibitor of behavior change.	1. FSWs/MSM	Number of reported incidents of rights violations addressed by NGO or CBO/ SHG within 24 hours	÷	Number of reported incidents of rights violations against HRG community	Yes	
DA 16	Number of HRG members who have been assisted by the program to get any government issued ID card	Dashboard Indicator: Key measure of program's ability to improve social status of HRGs.	1. FSWs/MSM	Number of HRGs who have government issued ID cards (as a result of program facilitation)				
B. Community Ownership								
To measure the level of active representation of the community in the program								
DA 17	Proportion of members of program services and committees (STI and DIC) who are from the HRG community	Dashboard Indicator: Key measure of what proportion of program roles/positions are held by members of HRG community.	1. FSWs/MSM	Number of members of program committees who are from the HRG community	÷	Total number of individuals who are members of program committees (both community and non-community members)	Yes	
DA 18	Proportion of members of program committees (STI and DIC) who attended meetings in the month	Dashboard Indicator: Key measure of what proportion of HRG community members of program committees actively participate.	1. FSWs/MSM	Number of HRG members of program committees (STI and DIC) who attended a meeting in the month	÷	Total number of HRG program committee members	Yes	

				Formula				
No.	**Indicator**	**Reason for reporting**	**Target group/ Granularity**	**Numerator**		**Denominator**	**Annual target**	**Comments**
C. Community Mobilization								
To measure the extent of mobilization among community members not having direct relationship with the program (peer outreach workers excluded) to assess how active existing community groups are								
DA 19	Proportion of HRG members (excluding home-based sex workers) who are members of any community group or committee	Dashboard Indicator: Key measure of HRG involvement/ engagement in community group activities.	1. FSWs/MSM	Number of HRG individuals who are members of all community groups (including CBO/SHG/community committees) (exclude members who are home-based sex workers)	÷	Size estimation of HRGs (exclude home-based sex workers from FSW size estimation)	Yes	
DA 20	Proportion of individual members of community committees who attended committee meetings during the month	Dashboard Indicator: Key measure of what proportion of HRG community members of community committees actively participate.	1. FSWs/MSM	Number of HRG members of community committees who attended a meeting in the month	÷	Total number of HRG community committee members	Yes	
DA 21	Proportion of community group members who are non-peer outreach workers	Dashboard Indicator: Key measure of the involvement of non-peer outreach workers (HRGs who are not paid by the project) in community group activities.	1. FSWs/MSM	Number of non-peer HRG individuals who are members of all community groups (including CBO/SHG/community committees)	÷	Number of HRG individuals who are members of all community groups (including CBO/SHG/community committees)	Yes	

Table 3: Avahan Monthly Indicator Reporting Format

	A	B	C	D	E	F	G
1							Comments
2			Name of reporting unit				
3			State				
4			Region				
5			Instructions:	Do not enter any values—only modify summation formulae in cells with no fill to pick up values from all NGO core indicators			
6			Grey box	= values are calculated, so please do not modify formulae for these cells			
7			**Size Estimation and Program Infrastructure**				
8			Indicators 1 thru 9—Update whenever new figures available, else just copy old values. Cells must not be left blank because dashboard indicator formulae depend on some of these values				Data was entered monthly at implementing NGO level and aggregated from individual implementing NGOs at the lead implementing partner level using Excel and then to central MIS. Allowed for aggregate-level, lead implementing partner-level, state-level, district-level and NGO-level analysis.
9							
10					Month 1		Actual Excel spread sheets were for 12 months.
11	1		Size estimation of high-risk groups by typology				
12		1.1	Total FSW		=SUM(E13:E17)		Denominator used to calculate coverage.
13		1.11	Brothel				Typology of sex work by solicitation site. Typology used to calculate estimated condom need as number of partners varies by typology.
14		1.12	Lodge				
15		1.13	Street				
16		1.14	Home				
17		1.15	Other				
18		1.2	Total MSM		=SUM(E19:E22)		Denominator used to calculate coverage.
19		1.21	Kothi				Typology sub-type of MSM in India. Mainly anal receptive.
20		1.22	Panthi				Typology subtype of MSM in India. Mainly anal insertive.
21		1.23	DD				Double Decker. Typology subtype of MSM in India. Both anal insertive and anal receptive.
22		1.24	TG				Transgender.
23	2		Number of intervention districts/ towns covered				Used to monitor scale-up of sites.
24		2.1	# of districts				
25		2.2	# of towns				
26	3		Number of project sites disaggregated by type				Used to monitor scale-up of program infrastructure (hard infrastructure).
27		3.1	Project offices				
28		3.2	DICs/Community centers				
29		3.3	Clinics		=SUM(E30:E32)		
30		3.31	Static				

	A	B	C	D	E	F	G
31		3.32	Outreach				
32		3.33	Referral				
33		3.4	# of Mobile clinic vans				In Avahan, indicator poorly defined. Did not differentiate between number of total vans (infrastructure) and number of days vans utilized.
34	4		Total number of intervention related project staff				Used to monitor scale-up of program staff (soft infrastructure).
35		4.1	Project director and coordinator				
36		4.2	Outreach staff (excluding peer outreach workers)				
37		4.3	Technical staff				
38		4.4	Finance and admin				
39		4.5	Project doctors				
40		4.6	Other clinical staff				
41	5		Number of intervention related project staff (excluding paid, peer outreach workers) who belong to the high-risk groups				Peer outreach worker career progression included project staff positions.
42		5.1	FSW				
43		5.2	MSM				
44	6		Number of active, paid peer outreach workers		=SUM(E45,E51)		
45		6.1	Total FSW		=SUM(E46:E50)		
46		6.11	Brothel				
47		6.12	Lodge				
48		6.13	Street				
49		6.14	Home				
50		6.15	Other				
51		6.2	Total MSM				
52	7		Number of peer outreach workers that discontinue working within the last month	Update monthly	=SUM(E53:E54)		
53		7.1	FSW				
54		7.2	MSM				
55	8		Number of project staff trained during the period				
56		8.1	Outreach staff				
57		8.2	Peer outreach workers				
58		8.3	Project doctors				
59		8.4	Referral doctors				
60		8.5	Other clinical staff				
61	9		Number of clinics reporting any STI drug stock-outs within the last month	Update monthly			
62	10		Number of NGOs reporting any condom stock-outs (for free condom distribution) within the last month	Update monthly			
63							
64	Data to be imported from existing MIS and community surveys						

	A	B	C	D	E	F	G
65	Needed for calculating dashboard indicators - only one-time entry required				FSW	MSM	
66	11		Estimated number of sex acts with clients per month per Sex Worker	Field 11 and 12 should be entered for each NGO / district ; lead implement-ing partner level number not manda-tory			
67		11.1	Brothel				
68		11.2	Lodge				
69		11.3	Street				
70		11.4	Home				
71		11.5	Other				
72	12		Estimated wastage factor for free condoms				
73	13		Number of monthly sex acts with clients	Autocalcu-lated from data entered above			
74	14		Number of HRG individuals ever visited clinic at the beginning of Month 1	Avail-able from existing MIS cumulated till end of most recent month	=SUM (E75:E76)		
75		14.1	Peer outreach workers				
76		14.2	Non-peer outreach workers				
77							
78	Routine Monitoring Data—to be entered from monitoring formats						
79			Service Uptake		Month 1		
80			Outreach Uptake		FSW	MSM	
81	15		Number of individuals included in individual-level tracking by the project				
82		15.1	Brothel				
83		15.2	Lodge				
84		15.3	Street				
85		15.4	Home				
86		15.5	Other				
87	16		Number of individuals contacted during the month				
88			New-Repeat				
89		16.1	New				
90		16.2	Repeat				
91			Peer- non peer outreach workers				
92		16.3	Through peer outreach workers				
93		16.4	Through outreach staff				
94		16.5	Indicate whether individuals reached through 1:group sessions are included in these counts (Y/N)				
95	17		Number of individuals that have discontinued with project services in this reporting period				

	A	B	C	D	E	F	G
96			Condom uptake		FSW	MSM	
97	18		Number of condoms distributed – free		=SUM(E99:E103)	=SUM(F99:F103)	
98			Through outreach distribution		SUM(E99:E100)	SUM(F99:E100)	
99		18.1	Through peer outreach workers				
100		18.2	Through outreach staff				
101		18.3	Through clinic				
102		18.4	Through DIC				
103		18.5	Other sources				
104	19		Number of condoms socially marketed through the project, social marketing grantee and other hotspot sources		=SUM(E105,E106,E107,F105)		
105		19.1	Socially marketed by the project				
106		19.2	Socially marketed by social marketing grantee				This number was obtained directly from social marketing grantee which captured sales to primary and secondary distributors.
107		19.3	From other sources				Was difficult for NGOs to obtain this number, as such was ultimately not monitored by the project.
108			STI uptake		FSW	MSM	
109	20		Number of high-risk individuals receiving STI consultations during the month		=SUM(E112:E113)	=SUM(F112:F113)	
110		20.1	HRG patient type				
111			New - Repeat				
112		20.11	New				
113		20.12	Repeat				
114			Peer outreach workers - Non peer				
115		20.13	Peer outreach workers who receive STI consults				
116		20.14	Non-peers who receive STI consults				
117		20.2	Reason for visit				
118		20.21	STI symptom				
119		20.211	New STI symptom visit	Only if indiv pt data entry			Green indicates data that is only possible to obtain if there is computerized individual tracking of persons attending the STI clinical services.
120		20.212	Repeat STI symptom visit	Only if indiv pt data entry			
121		20.22	STI follow up				
122		20.23	Regular STI checkup				
123		20.24	General Ailment				
124	21		Number of HRG individuals receiving STI consultations during the quarter	Only if indiv pt data entry			
125		21.1	Peer outreach workers receiving STI consults in the quarter	Only if indiv pt data entry			
126		21.2	Non-peers who receive STI consults during the quarter	Only if indiv pt data entry			

	A	B	C	D	E	F	G
127		21.3	FSW Typology	Only if indiv pt data entry			
128		21.31	Brothel	Only if indiv pt data entry			
129		21.32	Lodge	Only if indiv pt data entry			
130		21.33	Street	Only if indiv pt data entry			
131		21.34	Home	Only if indiv pt data entry			
132		21.35	Other	Only if indiv pt data entry			
133	22		Number of HRG individuals with repeat STI symptom visits having symptom duration > 7 days	Only if indiv pt data entry			
134	23		Number of STI consultations				
135		23.1	HRG population				
136		23.2	Non-HRG population				
137		23.3	STI consultations by type of clinic				
138		23.31	Static				
139		23.32	Outreach/Mobile				
140		23.33	Referral provider				
141	24		Number of HRG individuals receiving STI consultations who underwent an internal examination				
142		24.1	Peer outreach workers				
143		24.2	Non-peer				
144	25		Number of STI syndromes diagnosed by type				Centrally used to monitor change in types of syndromes presenting for clinical services. At lower levels used to correlate with drug consumption at clinics.
145		25.1	Vaginal/cervical discharge				
146		25.2	Genital ulcer disease				
147		25.3	Lower abdominal pain				
148		25.4	Urethral discharge				
149		25.5	Ano-rectal discharge				
150		25.6	Others				
151	26		Number of HRG individuals receiving treatment for asymptomatic infections				
152		26.1	Individuals receiving first-time asymptomatic treatment				
153	27		Number of general ailments treated				
154		27.1	HRG population				
155		27.2	Non-HRG population				
156	28		Number of HRG individuals counseled				
157	29		Total number of HRG individuals who have visited the clinic at least once		=E74+E112	=F74+F112	
158							

	A	B	C	D	E	F	G
159			Behavior Change		FSW	MSM	
160	30		Number of individuals reporting condom use at last sex (as collected during counseling session at clinic)				Was added in Version 2 of program monitoring indicators and was not uniformally implemented by partners. Was not recorded on all individuals due to interpretation of "counseling" and therefore did not have a denominator to calculate percentage.
161			Community Mobilization and Enabling Environment				
162			Enabling environment		FSW	MSM	
163	31		Number of reported incidents of rights violations against individual in HRG community				Increases or decreases in numbers reported will not be viewed as a success or failure of the program. (These could also be related to the willingness of individuals to report.) The goal is to make reporting as comprehensive as possible. In Avahan's experience only the number of cases that were not resolved on the spot were generally reported. In addition the definition changed with each lead implementing partner so comparisons across states were not possible. Systematic monitoring training was needed to address these issues and would have been better placed with the introduction of crisis response systems.
164	32		Number of reported cases of rights violations addressed by NGO or CBO/SHG within 24 hours				This was always exactly the same as the above indicator. The only exception was the northeast where some events might not be known immediately.
165	33		Number of individuals who were assisted by the program to get a government ID card (e.g., ration card or bank account)				This was not a useful measure for MIS because the government system functions to process ration cards in specific months so all applications would be accepted or rejected in the same month. Additionally, access to social entitlements was not uniformally implemented so the percentage of HRG members who were given a ration card could not be determined as there was no measure of unmet demand or denominator.
166			Community Ownership		FSW	MSM	
167	34		Total number of individuals who are members of various program committees (both community and non-community members)				Reporting on this indicator was often inaccurate because the definition of committee was often dictated by the program at the state level. To get the right data an excercise had to occur with each lead implementing partner and local implementing NGO to identify what should be reported. Program committees include all community led committees that provide oversight and management of program elements directly related to prevention, e.g. advocacy/crisis response, clinic, outreach, drop-in center.

	A	B	C	D	E	F	G
168		34.1	Members who are from the HRG community		=SUM(E169:E170)	=SUM(F169:E170)	The assumption is that the committee is solely made up of high risk communities. In the initial stages NGO staff have had to facilitate the group, developing norms of engagement and training leaders. In some cases NGO staff did not relinquish this role, complicating the function of the committee as an independent body. Because committees are so numerous, at site levels it was hard to monitor and correct this problem.
169		34.11	Peer outreach workers				Often peer involvement was mandatory and peers led the groups. The function of committees was to bring up issues with services and suggest solutions. This functioned effectively where issues were not implicating individuals at the NGO but problem solving access, etc. Committees often did not allow space for airing serious problems with program staff of the NGO as these were the same staff responsible for overseeing peers. In the worst cases program staff could tell peers what to discuss. In the best cases the meetings would be closed completely to NGO staff and community members would provide honest critiques of program activities.
170		34.12	Non-peers				The target was for >50 percent non-peers so that committees would be sustainable for transition and be independent.
171	35		Number of individual community members of program committees who attended committee meetings during the month				This indicator is a gauge of how functional committees were.
172							
173			Community Mobilization		FSW	MSM	
174	36		Number of HRG individuals who are members of all community groups (including CBO/SHG/community committees)		=SUM(E175:E176)	=SUM(F175:E176)	Community groups include any formal or informal groups among the HRG community, including CBOs, SHGs or other groups addressing issues important to the community, e.g. financial security, education, welfare, vocational training, culture/arts, violence, advocacy.
175		36.1	Peer outreach workers				Community groups include any formal or informal groups among the HRG community, including CBOs, SHGs or other groups addressing issues important to the community, e.g. financial security, education, welfare, vocational training, culture/arts, violence, advocacy. This was a fairly accurate gauge of functioning groups because the definition encompassed most possible groups partners would report. However it was impossible to capture the myrid number of groups operating at the site level unless the partner made deliberate efforts to support those groups, i.e., through self-help program, and rather tended to capture more formal groups at higher levels.

176	A	B	C	D	E	F	G
		36.2	Non-peers				To calculate proportion of peer outreach workers to non-peers in membership of community groups. The ratio of peers to non-peers should be 40:60 or less. "Number of HRG members who are not peers" is aggregate of unique individuals.
177		36.3	Home-based sex workers who are members of community groups				
178	37		Number of individual members of community committees who attended committee meetings during the month				
179	38		Number of self-help groups				
180	39		Total membership of self-help groups				
181							
182							
183	DASHBOARD INDICATORS				Month 1		
184	Do not enter manually- auto-calculated from core indicators						
185		PEER ENGAGEMENT			FSW	MSM	
186		DA 1	Ratio of HRGs to peer outreach workers		=E12/E45	=E18/E51	
187		DA 2	Proportion of outreach contacts made by peer outreach workers		=E92/E87	=F92/F87	
188		DA 3	Proportion of peer outreach workers receiving STI consultations during the month		=E115/E45	=F115/F51	
189		DA 4	Proportion of peer outreach workers receiving STI consultations who underwent internal exams		=E142/E115	=F142/F115	
190		DA 5	Proportion of peer outreach workers receiving STI consultations during the quarter	Only if indiv pt data entry	=E125/E45	=F125/E51	
191		SERVICE UPTAKE					
192		General Program Coverage					
193		DA 6	Proportion of individual HRGs mapped who are tracked by the program		=E81/E12	=F81/E18	
194		DA 7	Proportion of individuals tracked who are being contacted monthly		=E87/E81	=F87/F81	
195		Condom Uptake					
196		DA 8	Proportion of monthly risky sexual acts covered through known condom distribution		=((E220)+(F220)+E104)/(($E73)+($F73))		
197		DA 9	Proportion of risky acts covered through program free condom distribution		=(E220)/($E73)	=(F220)/($F73)	

	A	B	C	D	E	F	G
198		STI Service Uptake					
199		DA 10	Proportion of HRG individuals (mapped) who have ever attended clinic		=E157/E12	=F157/E18	
200		DA 11	Proportion of HRG who come for STI check-ups/STI visits during a quarter	Only if indiv pt data entry	=E124/E12	=F124/E18	
201		DA 12	Number of individuals with repeat STI symptom visits with symptom duration > 7 days	Only if indiv pt data entry	=E133/E120	=F133/F120	
202		DA 13	Proportion of HRG receiving STI consultations who underwent internal exams		=E141/E109	=F141/F109	
203		BEHAVIOUR OUTCOMES					
204		DA 14	Proportion of HRG reporting condom use during last sex act with client		=E160/E156	=F160/F156	
205		COMMUNITY MOBILIZATION AND ENABLING ENVIRONMENT					
206		Vulnerability Reduction					
207		DA 15	Proportion of reported incidents of rights violations against HRGs addressed within 24 hours		=E164/E163	=F164/F163	
208		DA 16	Number of HRG members who have been assisted by the programme to get any government issued ID card		=E165	=F165	
209		Community Ownership					
210		DA 17	Proportion of members of program committees (STI and DIC) who are from the HRG community		=E168/E167	=F168/F167	
211		DA 18	Proportion of individual community members of program committees who attended committee meetings during the month		=E171/E168	=F171/F168	
212		Community Mobilization					
213		DA 19	Proportion of HRG members (excluding home-based SW) who are members of any community group or committee		=(E174-E177)/(SUM (E13,E14,E15,E17))	=F174/E18	
214		DA 20	Proportion of individual members of community committees who attended committee meetings during the month		=E178/E174	=F178/F174	
215		DA 21	Proportion of community group members who are non-peers		=E176/E174	=F176/F174	
216							
217							
218			Working cells - required for dashboard calc - no manual entry required		Month 1		
219					FSW	MSM	
220			Number of free condoms distributed adjusted for wastage				Data aggregated from NGO reports.

GLOSSARY

Agency is a term adopted in rights-based approaches to describe the choice, control, and power that poor or marginalized individuals or groups have to act for themselves to claim their rights (civil or political, economic, social, and cultural) and hold others accountable for their rights.

Bridge populations are persons who have sexual contact with persons who are frequently infected with and transmit STIs, and also with the general population.

Community ownership means that the community has control over the activities the program undertakes, and significant understanding of and influence over service delivery. Community-owned programs have significant leadership, initiative, and oversight by communities, and accountability systems in place to ensure that the program's interests do not supersede the community's interest, and that adequate representation of the community is established.

Condom normalization entails creating a supportive environment for condoms, by using communications to reduce stigma and shame around condom use and purchase.

Distal determinants or underlying determinants are the sociocultural, economic, and demographic context and the availability of intervention programs that influence the proximal determinants.

An enabling environment in the context of Avahan's work is one in which social inequity and violence, harassment, abuse, and discrimination against people with HIV and high-risk groups are reduced, and the self-confidence of high-risk individuals and their collective identity are strengthened, so that they can advocate for, and take ownership of, effective HIV prevention interventions.

High-risk groups refers to female sex workers, high-risk men who have sex with men, transgenders, and injecting drug users.

High-risk men who have sex with men refers to the self-identified men who have sex with men in India to whom Avahan provides services. This group of men are not representative of all men who have sex with men in India, and in the settings where Avahan works are at high risk on account of their large number of sex partners and the fact that a disproportionate percentage sell sex or practice anal receptive sex.

Men at risk refers to men who engage in high-risk sexual activities, including commercial and non-regular-partner sex. In Avahan this translates into a programmatic focus on men congregating at points of sex solicitation. A large proportion of these men are long-distance truckers.

Micro-planning is the system peer outreach workers use for recording and analyzing risk during outreach. The peer outreach workers use a low literate management tool to collect data which they use to directly plan outreach based on the individual need of the population they are serving.

Mid-media refers to large-group format participative communication activities such as street plays and game shows.

Peer outreach workers are representative members of a community who serve as a link between the program and the community. They manage the program on the ground through outreach and operate to serve a population with whom they have a similar occupational, behavioral, social, or environmental experience and among whom they are trusted and a role model. Peer outreach workers work with members of their community to influence attitudes and provide support to change risky behaviors.

Presumptive treatment for STIs involves treating individuals in a group for an STI based on the overall prevalence in the group and not on individual clinical signs or symptoms.

Proximal determinants are a set of factors, both biological and behavioral in nature, that affect exposure to, transmission of, and duration of infectivity of HIV and include such factors as sexual behavior, circumcision, and antiretroviral treatment.

Structural intervention is used to refer to interventions that work by altering the context within which health is produced or reproduced. Structural interventions locate the source of public health problems in factors in the social, economic, and political environments that shape and constrain individual, community, and societal health outcomes.

Syndromic management of STIs involves treating for all common etiologic agents that cause a syndrome, including a constellation of clinical signs and symptoms.

Vulnerability refers to the circumstances which negatively impact the ability of a high-risk individual or group to remain uninfected by HIV. Vulnerability for a sex worker or a man who has sex with men is linked to abuse, violence, and social stigma, and impacts his or her control in sexual encounters.

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