AIDS Community

AIDS COMMUNITY Consolidated Reply

Query: Monitoring indicators for HIV prevention, PSU, Kerala, (Comparative experiences; Examples)

Compiled by E. Mohamed Rafique, Resource Person; research provided by Seema Kochhar, Research Associate.
10 January 2005

Original Query: Ms. Jeffy Binu, Project Support Unit, Kerala

Posted: 17 November 2005

I am presently working as a Monitoring and Evaluation Officer in Project Support Unit (PSU), Kerala, which is the technical support wing to NGOs supported by the Kerala State AIDS Control Society (KSACS). There are fifty-three NGOs which are in this Partnership for Sexual Health (PSH) Project working in the area of HIV and AIDS in Kerala.

Monitoring is an indispensable exercise in this kind of program that helps to appraise the effectiveness with which activities are implemented, measure the extent of reach that can be covered by the program and also assess the nature of modifications required for better results. So, I would like to know more about monitoring and evaluation systems that have been developed in the field of preventing HIV transmission. Specifically, could members share examples of quantitative and qualitative indicators developed to monitor various programs in this field of preventing HIV transmission? Also, I would be grateful if anybody could share their experiences regarding the sexual health surveys that they have conducted. What methods were used to minimize bias in reporting sexual encounters?

Responses were received, with thanks, from:

1. Dr. Abha Jha, Catholic Relief Services, Lucknow
2. Ms. Vibha Singh, Transport Corporation of India Foundation, Gurgaon
3. Ms. Gitanjali Singh, UNIFEM, Delhi
4. Mr. Ashok Row Kavi, Humsafar Trust, Mumbai
5. Ms. Shymala Ashok, SFDRT, Pondicherry
6. Dr. Aman Kumar Singh, Kolkata

Summary of Responses

Members responded with many suggestions and examples of the key indicators they have found useful for monitoring and evaluating HIV prevention programmes. Some of the specific examples contributed are provided in the next section. Additionally, members offered the following clarifications and comments:

Monitoring indicators for programmes and project can be both quantitative and qualitative. **Process indicators,** which track progress, are mostly quantitative in nature, but can be coupled with qualitative tools such as surveys, interviews, focussed group discussions, etc. Gant-charts were suggested to help monitor processes such as number of advocacy workshops, events, etc held. For instance, for interventions with sex workers, the monitoring process would involve classifying the type of sex work practices followed - by asking appropriate questions to get a clearer idea of the how well knowledge is synchronized with practice. **Outcome indicators**, which track impact and effectiveness of activities, are more qualitative in nature. Here, the PRIME project in Uttar Pradesh was cited as a good example. Since objectives and activities will vary from one programme to another, monitoring indicators will also vary, but monitoring and evaluation should be an integral part of every HIV prevention program.

Procedures for monitoring and evaluation of projects should be simplified. One member offered **four basic indicators** to track interventions with core populations:

- the quantum of unprotected sex, or intravenous shooting for IVDUs;
- consistent condom use in the last sexual encounter, or use of fresh needles in last shoot for IVDUs; and the quantum of condoms, or fresh/sterilized needles consistently used in the last one month;
- the number of casual partners, or number of used needles in a certain recall period;
- the quantifiable health-seeking behaviour like how many times one has visited a doctor or health facility, in the last six months.

Another member offered a set of **common minimum indicators** for monitoring the overall impact of prevention programmes based on the extent of community awareness, e.g., the number of people coming to the centres to seek services/tests, and the number of people/groups having knowledge about prevention programmes. To gauge the impact of various programme components a list of indicators was also suggested. These indicators should be updated periodically to meet and match the requirements of the new/improved programmes being devised and implemented.

Members also offered suggestions on collecting data for the monitoring indicators and for programme evaluation.

- To minimize the possibilities of bias, use an **appropriate sampling design** for data collection, and **hire an external agency.**
- **Focus an evaluation on target groups** rather than on the NGOs implementing the programme.
- Use evaluation to **identify the prevailing trends** in the target communities, for example by using the same person for monthly visits to monitor the patterns used for program implementation, followed up by six-monthly evaluations to track improvements.
- Use the results of the evaluation process for improvement rather than only for bringing a programme to an end.

Replies to this query focused primarily on monitoring indicators; the other part of the query – on sexual health surveys – was unfortunately not addressed.

Comparative Experiences

PRIME/IntraHealth, Innovations in Family Planning Services Project, SIFPSA, Uttar Pradesh *(From Vibha Singh, TCIF, Gurgaon)*
The project gave technical assistance to Clinic- based Family Planning training of Auxiliary Nurse Midwives (ANMs). To monitor the programmes an indicator on the effectiveness of the Training Assessment was set at the percentage of ANMs performing to standards which was a score of 80% or more in counseling and clinical skills as per a PRIME-designed checklist. Similar pattern can be adapted for HIV prevention efforts.

UNIFEM South Asia Regional Office, Delhi *(From Gitanjali Singh)*
UINFEM in collaboration with Centre for Women's Research, Sri Lanka developed qualitative and quantitative monitoring indicators to help the countries in South East Asia Region assess their own progress and work towards achieving obligations under CEDAW. Similar indicators can be developed for monitoring HIV interventions.

Examples

Indicators for various HIV prevention programmes (*From Dr. Abha Jha, Catholic Relief Services)*

- **Integrating HIV/AIDS prevention intervention into other health services:**
  - No of health education sessions conducted on HIV/AIDS
  - Percentage of women negotiating/practicing safe sex with their husbands
- **STI/RTI prevention program**-
  - No of men and women seeking STI services
  - No of people identified, diagnosed, treated and referred to VCTCs for testing of HIV/AIDS
- **Interventions for special groups** –
  - No of migrants, truckers, identified high risk group members practicing safe sex
- **Stigma & discrimination**-
  - Percentage of people in a community accepting and supporting PLHAs
- **Voluntary counselling and testing (VCT**)
  - No of people requesting HIV test and receiving result
  - No of districts having VCTCs and the facility for post test counselling
- **Prevention of mother to child transmission (PMTCT)-**
  - No of antenatal cases screened, identified & tested for HIV/AIDS
  - No of antenatal clinics offering HIV services to pregnant women and
  - Percentage of women receiving antiretroviral therapy
- **Injecting drug users**-
  - Percentage of people using shared needles
- **Community-based HIV/AIDS care and support services**.
  - No of health facilities catering services to People Living with HIV
  - No of households receiving care (3) No of orphaned children receiving services

Monitoring Indicators for Interventions with core populations *(From Ashok Row Kavi, Humsafar Trust, Mumbai)*
Every intervention must have four important indicators

- The quantum of unprotected sex or intravenous shooting for IVDUs.
- The quantum of consistent condom use in the last sexual encounter or use of fresh needles in last shoot for IVDUs and the quantum of condoms or fresh or sterilized needles, consistently used in the last one month.
- The number of casual partners or number of used needles in a certain recall period.
- The quantifiable health-seeking behavior like how many times have you visited a doctor or health facility, in the last six months**.**

Process Indicators for setting up STI management clinics (*From Vibha Singh, TCIF, Gurgaon*)
Process indicators for setting up STI management clinics will be number of STI Clinics set up and number of key populations accessing these clinics. These indicators can be coupled with quantitative tools such as focussed group discussions, in-depth interviews of beneficiaries etc to find out about the service provided to the beneficiaries.

Monitoring Indicators for Interventions with Sex Workers *(From Shyamala Ashok, SFDRT, Pondicherry)*
Monitoring interventions with sex workers would first require classification of sex workers. This can be done by asking the following questions

- The type of sex workers – full time or part time?
- How do they choose their clients – regular or non regular if so how many percent of each?
- How many days in a week would they have clients?
- When was their last client solicited?

This will be followed by asking interrelated questions to get an idea of synchronization of knowledge and practice such as three methods of HIV transmissions, three instances when HIV is not transmitted, difference between HIV and STI, symptoms of STD, where can they get treated for STD, what are condom and whether they use them, how to use them, where do they get them from, do they buy them or get them free, can they demonstrate how to use a condom, Can the site any two symptoms of STD, if they had STDs how often do they go for treatment is it once for all or do they go for another visit.

Monitoring Indicators used in Avahan Clinics *(From Dr. Aman Kumar Singh, Kolkatta, India)*
Some of the indicators used for monitoring clinics under Avahan project are number of individuals receiving STI consultations, estimated coverage of STI services, estimated uptake, average monthly or yearly visits per individual, number and distribution of STI syndromes, proportion of sex workers receiving treatment for Gonorrhoea and Chlamydia four times per year at quarterly intervals and monthly regular check ups, number of STI treatment packs distributed and number of condoms distributed.

Related Resources

Recommended Documents

Compendium of Indicators for Evaluating Reproductive Health Programs *(From Ms. Vibha Singh, TCIF, Gurgaon)*
Jane T. Bertrand, Gabriela Escudero, MEASURE Evaluation Manual Series, No. 6, August 2002
http://www.cpc.unc.edu/measure/publications/html/ms-02-06.html

provides a comprehensive listing of the most widely used indicators for evaluating reproductive health programs in developing countries.

Handbook of Indicators for HIV/AIDS/STI Programs *(From Ms. Vibha Singh, TCIF, Gurgaon)*
http://pdf.dec.org/pdf_docs/PNACK416.pdf (Size: 295 KB)
USAID, Washington, March 2002

Focuses on HIV risk reduction, STI services, HIV program implementation and presents indicators for monitoring and evaluating USAID-supported programs

CEDAW Indicators for South Asia-An Initiative *(From Ms. Gitanjali Singh, UNIFEM, Delhi)*
Center for Women Research, Sri Lanka, August 2004.
http://www.unifem.org.in/pdf/CEDAW_Indicators.pdf (Size: 185 KB) Copyright Publication.

Lists qualitative and quantitative indicators used to assess the progress of countries towards achieving obligations under CEDAW and includes a section on Health.

From Seema Kochhar, Research Associate

Sexual health promotion in Chennai, India: key role of communication among social networks
Sivaram et al. Health Promotion. Int.2005; 20: 327-333
Abstract viewable at:
http://heapro.oxfordjournals.org/cgi/content/abstract/20/4/327
Subscription to Health Promotion International required for accessing the full article. To subscribe visit:
http://www.oxfordjournals.org/heapro/access_purchase/price_list.html

It focuses on low-income communities' residents in Chennai to understand the nature of information related to sex and sexual health.

National AIDS Programmes: a Guide to Monitoring and Evaluation.
UNAIDS, Geneva, 2000.
http://www.measuredhs.com/hivdata/guides/unaidsguide.pdf (Size: 381 KB)

Summarizes the best practices in M&E, describes main features of a sound M&E system as well as indicators for key areas of HIV prevention.

The President's Emergency Plan for AIDS Relief: Indicators, Reporting Requirements, and Guidelines for Focus Countries
The President's Emergency Plan for AIDS Relief, U.S.A, July, 2005
http://www.measuredhs.com/hivdata/guides/emergencyplanindicatorsjuly2005.pdf
(Size 1.20 MB)

The purpose of this document is to provide guidance regarding data collection and reporting including outcomes and impact level indicators.

National AIDS Programmes: A guide to indicators for monitoring and evaluating national HIV/AIDS prevention programmes for young people
World Health Organisation, Geneva, 2004. Copyright World Health Organisation, 2004.
http://www.who.int/child-adolescent-health/New_Publications/ADH/ISBN_92_4_159257_5.pdf
(Size: 1.50 MB)

Identifies a set of indicators, methods for measuring them, and their strengths and limitations to help in planning and monitoring HIV prevention programmes

Learning to Live: Monitoring and Evaluating HIV/AIDS Programmes for young people
Douglas Webb and Lynn Elliot, Save the Children UK, 2002

Abbreviated version downloadable at:
http://www.savethechildren.org.uk/temp/scuk/cache/cmsattach/211_learning2livecond.pdf (Size: 292 KB)
Full Text available at: Save the Children UK 1 St John's Lane London EC1M 4AR
Tel. +44 (0) 20 7012 6400 Fax. +44 (0) 20 7012 6963
www.savethechildren.org.uk

This is a practical guide to developing, monitoring, evaluating practice in HIV/AIDS related programmes for young people, based on experience of projects around the world.

Evaluating Programs for HIV/AIDS Prevention and Care in Developing Countries
http://www.fhi.org/NR/rdonlyres/eids2i3iqcw5qda4tdclohfqdmqvpsuvonddh3v5ptcc5xb334f56on7zdibh4umw4r6ttgpl7vhzl/31776textR1.pdf (Size: 1.5 MB)
Family Health International, U.S. A, 2001.

This is a resource for developing strategies for program evaluation in the non-industrialized world.

Monitoring and Evaluation Toolkit - HIV/AIDS, Tuberculosis and Malaria
http://www.who.int/hiv/pub/epidemiology/en/me_toolkit_en.pdf (Size: 293 KB)
WHO, World Bank, Unicef, UNAIDS, USAID, Department of State and Department of Health and Human Service, USA, CDC, Global Fund, June 2004

Provides an overview of the key issue to assist in the formulation of a participatory national M & E strategy and evaluation, review and improvement of M & E systems.

A guide to Monitoring and Evaluating Adolescent Reproductive Health Programs
Susan E. Adamchak, Katherine Bond, Laurel MacLaren, Robert J. Magnani, Kristin Nelson,Judith R. Seltzer, Family Health International, June 2000
Part 1:
http://www.fhi.org/NR/rdonlyres/elf2ixfk6ddwr56uur6ghylh234dnivgtfzvvpcwm34bhbyldu5lqvpdkoghspmngnjdzt4nryglca/mandEguidepart3.pdf (Size: 814 KB)
Part 2:
http://www.fhi.org/NR/rdonlyres/em5dlwpvierohi42lnv4xu3glrlvxlcd4ffqc7uifnutqshqgcu6aj33653moatp4ivrh3uoepg2oo/MandEguidepart2.pdf (Size: 1.44 MB)

Contains information on M & E for adolescent reproductive health program, process, outcome, impact indicators, sample data collection methods, tips for data collection.

Recommended Contacts

Mr. Binod Mahanty, Technical Officer, WHO India (From Seema Kochhar, Research Associate)
Email: mahantyb@whoindia.org

Was part of NACP-III working group on M&E and can provide relevant information on M & E

Recommended Website

(*From Ms. Vibha Singh, TCIF, Gurgaon)*

HIV/AIDS Survey Indicators Database
http://www.measuredhs.com/hivdata/ Email: hivdata@orcmacro.com

Provides an easily accessible comprehensive source of information on HIV/AIDS indicators derived from sample surveys.

AIDSQuest: The HIV/AIDS Survey Library

http://www.popcouncil.org/horizons/AIDSquest/description.html

Provides resources for developing standardized questionnaires and other instruments related to HIV/AIDS research.

Responses in Full

Dr. Abha Jha , Coordinator - Health and HIV/AIDS, Catholic Relief Services, Lucknow

I would like to share my view points to develop indicators, which may help you in designing your MIS for HIV/AIDS programs.

A. Designing MIS with common minimum indicators:

In any prevention program, there will be community awareness generation activities. The direct impact of this would be an increase in the no. of people in the community having knowledge about prevention methods who would come to the centers to seek services /tests. Therefore the indicators would be:

1) Number of people coming to the centers to seek services/tests and

2) Number of people /groups having knowledge of HIV- prevention methods. Therefore, I would like to recommend that these would be common minimum indicators for the prevention programs. Considering the fact that the HIV and AIDS programs will have following key approaches, I have come up with a list of indicators under different subheadings, which are as follows:

- **Integrating HIV/AIDS prevention interventions into other health services**-
  1) No of health education sessions conducted on HIV/AIDS
  2)% of women negotiating/practicing safe sex with their husbands
- **STI/RTI prevention program**-
  1) No of men and women seeking STI services
  2) No of people identified, diagnosed, treated and referred to VCTCs for testing of HIV/AIDS
- **Interventions for special groups** –
  1) No of migrants, truckers, identified high risk group members practicing safe sex
- **Stigma & discrimination**-
  1) % of people in a community accepting and supporting PLHAs
- **Voluntary counseling and testing (VCT**)
  1) No of people requesting HIV test and receiving result
  2) No of districts having VCTCs and the facility for post test counseling
- **Prevention of mother to child transmission (PMTCT)-**
  1) No of antenatal cases screened, identified & tested for HIV/AIDS
  2) No of antenatal clinics offering HIV services to pregnant women and
  3) % of women receiving antiretroviral therapy
- **Injecting drug users**-
  1)% of people using shared needles
- **Community-based HIV/AIDS care and support services**.
  1) No of health facilities catering services to People Living with HIV
  2) No of households receiving care (3) No of orphaned children receiving services

B. Process indicators, which are specific to a particular HIV/AIDS program

- Different programs will have different activities; therefore, for the purpose of monitoring and evaluation it is necessary to have process indicators**.** The process indicators will vary

from program to program. Therefore, it is suggested that it needs to be developed. It can also be developed in the form of software, which can be used by program staff of implementing agencies. It will enable program staff to monitor, the progress of activities within the budgeted allocation.

C. It needs to be updated periodically as more programs are implemented based on new scientific & innovative approaches.

Vibha Singh, Advisor, M & E, Transport Corporation of India Foundation (TCIF), Gurgaon

From the query as I understand you would like to know more about process Monitoring, where primarily program activities are tracked. The analysis of the data collected is based on the indicators which you would have developed based on the project objectives. This would also give you the extent of reach. All this is very quantitative. Assessing modifications of program activities will come from analyzing the process monitoring data. This can be combined and validated with the field trip observations of what is working or not working and why.

Coming to effectiveness of the activities, this is generally not part of the process monitoring. Effectiveness would be judged based on the output or outcome of that activity depending on which level you want to place it. So an indicator on effectiveness of activity or activities can be developed by answering questions like what outputs or outcomes you expect from a set of effective activities.

For example, PRIME/IntraHealth, under USAID-supported Innovations in Family Planning Services (IFPS) Project implemented by SIFPSA in the state of Uttar Pradesh (UP), gave technical assistance to the Clinic-Based Family Planning (CBFP) training of the Auxiliary Nurse Midwives (ANMs) and their supervisors the Lady Health Visitors (LHVs). An indicator on the effectiveness of the Training Assessment was "% of ANMs Performing to Standards (PTS) ". An ANM was PTS when she scored 80% or more in counseling and clinical skills as per a PRIME-designed checklist.

Next step is to see how the data can be collected on this indicator – if you have an effectiveness indicator at the outcome level then the beneficiaries / general population needs to be surveyed which takes to your last query of reducing biasness. One thing could be to have an external agency do the survey. Sampling design has also to be looked into for reducing bias. Survey tools can be both quantitative and qualitative in nature. In the above example the data was collected while observing the procedure and using a checklist.
If part of the technical support provided is to set up STI management clinics, then process indicators could be

- Number of STI clinics set up
- Number of key population accessing these clinics

If the analysis of the data shows that the service utilization or client load is not optimal then one could use qualitative tools (FGD, survey, in-depth interviews of the beneficiaries) to explore the reasons of low service utilization. Alternatively you could use the tool to find out the quality of the service provided to the beneficiaries – exit interviews of the client, observing the doctor do the procedure. The qualitative tools would help in explaining or finding reasons for those data which was not expected to be elicited in the original quantitative survey. For example if a sexual health survey on condom use was done the quantitative data could show that increasing the awareness

did not lead to reduction in risk taking. Here a qualitative tool may be able to enlighten us that risk reduction did not occur though awareness was there due to factors such as peer pressure, or alcoholism etc.,

For more on indicators and tools you can go to:

- http://www.measuredhs.com/hivdata/
- http://www.popcouncil.org/horizons/AIDSquest/description.html
- http://www.cpc.unc.edu/measure/publications/html/ms-02-06.html
- Handbook of Indicators for HIV/ADIS/STI Programs, USAID

Gitanjali Singh, UNIFEM, South Asia Regional Office
Just wanted to share with you that UNIFEM South Asia Regional Office in collaboration with the Centre for Women's Research (CENWOR), Sri Lanka have developed monitoring indicators to help countries in our region. All these countries have ratified the UN Convention on the Elimination of All Forms of Discrimination against Women (CEDAW). The monitoring indicators developed by CENWOR help these countries to assess their own progress and work towards achieving obligations under CEDAW.

These indicators were developed in response to a need expressed by Governments and civil society at a regional conference on knowledge based advocacy on CEDAW implementation, organized jointly by Ministry of Women's Affairs, Government of Sri Lanka, and UNIFEM in 2002 with technical expertise from International Women's Rights Action Watch (IWRAW) Asia Pacific and four CEDAW Committee members. The publication is available on our website

http://www.unifem.org.in/pdf/CEDAW_Indicators.pdf

The indicators are developed using Sri Lankan materials with a view to identifying common indicators that can be relevant in South Asia in relation to commitments on each CEDAW article. Relevant CEDAW articles have sometimes been grouped together. It is hoped that the development of indicators will also catalyze regional initiatives so as to address common problems and issues of concern for women in the region.

The publication lists Quantitative and Qualitative Indicators. Quantitative indicators focus on numbers e.g. literacy rates, maternal mortality rates, labour force participation rates and numbers of successful prosecutions. Quantitative indicators provide information on the extent to which women enjoy equal rights and gender based discrimination has been eliminated. The qualitative indicators are broader and focus on legislation, institutional arrangements, programmes and policies that are conducive to implementing the rights referred to in each article of CEDAW e.g. legislation on equal inheritance rights, laws on nationality, and domestic violence legislation will indicate that steps are being taken to implement CEDAW within countries. Similarly policy indicators refer to social and other government policies, e.g. policies on compulsory education, quotas in educational institutions for girl children, or quotas for women in local and national legislative bodies, and in decision making positions. Programmatic indicators, refer to interventions such as legal aid services, shelters for women victims of violence, legal literacy programmes, food subsidies, micro-credit programmes, women and children's desks in Police Stations, "One Stop" services for women in hospitals and health centers.

This document can provide a base for others to develop context specific indicators in an effort towards strengthening CEDAW implementation. Chapter 5 focuses on health.

Ashok Row Kavi, Humsafar Trust, Mumbai Metro
Reading these postings on M and E to be standardized for HIV prevention, I just do not understand why NACO does not simplify the procedure and have a short and sweet form for M and E to track interventions. The CMIS forms nowadays are like reading the Ramayana, a long litany of lamentable length and numerical jugglery that requires hours to decipher and mean very little in the long run.

Every intervention must have four important indicators that must be tracked, whether with sex workers, MSM or IV drug users which are the core populations. The four indicators are:

- The quantum of unprotected sex or intravenous shooting for IVDUs.
- The quantum of consistent condom use in the last sexual encounter or use of fresh needles in last shoot for IVDUs and the quantum of condoms or fresh or sterilized needles, consistently used in the last one month
- The number of casual partners or number of used needles in a certain recall period.
- The quantifiable health-seeking behavior like how many times have you visited a doctor or health facility, in the last six months.

The business of events held, advocacy workshops held and all the rest of it can be tracked according to the short Gant-charts and these formats are not difficult to get from good MBA students.

To that extent, the BMGF is doing a slightly better job though even they seem to straying into verbosity through constant advocacy workshops, M and E classes et al. Every M and E chart is essentially meant to get NGOs and CBOs keep a tab on 'there-they-are' and 'where-they-want-to-go'. It's for funding agencies to adjust to NGOs and CBOs and not the other way around like some of these more clever-by-half funding agencies think they are doing.

I bet if there was a surprise check on NGOs or CBOs working on HIV and AIDS we would find it very difficult to get even a reasonable baseline for these four simple indicators.

Any suggestions from this smart e-list?

Shyamala Ashok, SFDRT, Pondicherry
Monitoring and evaluation should be a part of the program. It can definitely not evolve on its own. While the program is being implemented, it needs to be a part that needs to be discussed with the persons implementing the program. A very clear understanding needs to be developed and agreed upon between the evaluator and the team implementing the program especially on the qualitative indicators. This has proved fruitful for ongoing programs, especially the long term ones and for those who have attained results. However, if one is biased and comes for an evaluation only with the intention of putting an end to the program, then even if there are true findings to prove that sexual health has improved in terms of understanding, knowledge improvement, usage of safe sex etc. these will get missed out. Biases are something that needs to be 'switched' off while programs are being evaluated.

Next coming to the programs let us take the example of sex workers, what one would look at:
1. The type of sex workers – full time or part time?
2. How do they choose their clients – regular or non regular if so how many percent of each?

3. How many days in a week would they have clients?
4. When was their last client solicited?

From these we can have an idea of the extent of sex work that the person practices. Whether the practice was overt or under cover is important, because if the sex worker is open and convinced of her work she would more be inclined to use safe sex, rather than some one who is of the hiding type. Also sex workers who have an idea of their clients such as regular or non-regular will help them understand how safe the partners are. The possibility of convincing regular partners to use safe sex methods is more as the CSWs would have initiated a dialogue on HIV and AIDS and its safety measures already. Therefore the evaluator's intention should be only to identify how much the sex worker has taken efforts to safe guard transmission of HIV. Of the qualitative indicators, one major indicator is whether the sex workers agree that they are sex workers. Most often evaluators go and talk to sex workers by random sampling to find out the knowledge indicators etc., If during the evaluation 2 out of 6 do not agree that they are sex workers, that should not suggest that the NGO has not done any work. There is no necessity that a sex worker need to agree that she is one.

Once the category of the sex workers are clear then we can get down to evaluate other concepts such as the knowledge and practice, whether it synchronizes etc. Here again one needs to develop a comfort zone with the sex worker before beginning. If she is not comfortable she may with hold information.

The following questions could give ideas of understanding and practice of the knowledge:

1. Site three methods of how HIV is transmitted?
2. Site three instances where HIV is not transmitted?
3. What is the difference between STD and HIV – site 2 differences – Here evaluators should avoid unnecessary comments and permit sex workers to use local terms for STDs. Expecting the sex workers to use scientific terms is idealistic and not attainable.
4. What are condoms? Have you seen them? – One could very well understand while one explains what condoms are and if they have seen them. Probing where they have seen them and how often they have seen them and through whom they have known what they are, will give us an idea of how much the sex worker has understood what condoms are and whether it would suit them for use.
5. Do you use them? – A mere yes for this question cannot be taken for granted. It should synchronize with how much the sex worker has understood the worth of using the condoms, how do they get them and the type of sex work. This helps us to understand how much utility is possible. Therefore a correct evaluation of the affordability, availability and utility in total will give us a true idea of how much they could have used them. If for example the sex worker is constantly scared of the police (this may come out in her conversation), chances are that she will hardly use condoms, as the fear of getting caught with it by the police will always be there. Therefore the foremost thought will not be of condom use. This is more for the street sex workers and lodge based ones. Within the lodges possibility of raids are common and one needs to find out how much understanding the lodges have with the police. This gives us an idea whether there is an environment to use condoms.
6. How often do you use them? – This question has given a freedom to discuss the actual use of the condoms and the question itself says that we understand that due to certain environmental limitations one cannot expect cent percent consistent condom use. Therefore the percentage of the consistency should be evaluated.

7. Where do you get them from? Do you buy them or get them free if free where do you get from and if it you buy where do you buy them from? – These aim to understand the capacity of the

sex worker to buy condoms, whether she has the comfort zone to buy condoms. She then has to answer several questions whether she is a known sex worker, which is the type of access she has to get condoms, whether the knowledge on STD and HIV is in-depth and if she has the self-interest to safe guard herself and the partners from getting HIV. If the sex worker sites examples of PPTC, possibilities are that she is aware of the fact that husbands can transfer HIV to the wife and the new born. This shows her deep concern and that she certainly does not want her clients to get HIV and also that she would warn them of the same. Needless to say the questions should create an open dialogue rather than closed questions per se.

8. Would you like to demonstrate the use of a condom? – The shyness of showing a demonstration will logically make us think whether she would really use condoms and this has to be matched with what she has said as to what type of clients she has seen. It could be genuine that she might shy away from the evaluator but at the same time she would have told the evaluator that she has regular partners to the maximum. This ought to give her the comfort level of acceptance. The evaluator cannot conclude that just because she felt shy demonstrating condoms, therefore she is not using condoms. We will have to judge in totality with other questions such as the knowledge and types of partners and where they practice sex work. Another way of finding out is to ask them to show if they have condoms with them at the site. I distinctly remember once condoms were dug out from the ground to reveal their hiding place. It also clearly shows the fear from police and therefore implies that condom use may not be consistent. However evaluating the consistency is next to impossible unless very good rapport is built and routine visits are made to the sex worker to identify the consistency of use. Yet another method is to use mock testing of condom use but I do not now how ethical it is to use mock testing of condoms.

9. Can you site any two symptoms of STD?
10. Where do they give treatment for STDs? Do you know of any doctors who treat STDs in your vicinity?

11. If you have had STDs how often do you go for your treatment is it once for all or do you go for yet another visit? – The skill of the evaluator lies in taking her through without making her feel that she is being evaluated. Then whether she had STDs in the past, can easily be found out. Also where she gets them is it through new clients or regular partners, or her own husband or living partner etc. will be revealed. If she talks about the doctors with whom she gets treated we have to identify the way the doctor treats her. If she describes that she is continuously shouted at by him for her STDs then obviously she would not visit the doctor quite often as client satisfaction would be missing with this practicing doctor. However, most conventional evaluators go by questions like, how many doctors you know for treating STDs and the greater the numbers, the more the chances that she gets her STDs treated. This we know can be false. Questions pertaining to the Behavior Change component of STD management and condom use alone will help us to know the trend.

Therefore we understand that only the trend can be identified during an evaluation. Much depends on the time spent with the sex workers to identify all the above components and it should be rated with the number of times the out reach worker has seen the sex worker, the depth she has used to talk and inculcate knowledge into the community etc. Every aspect should be logically seen. For example the number of exhibitions held will not tell us any thing of the trend. If the evaluations are genuine they should be held in random. Then a detailed discussion with the NGO should be held. Following evaluations once in every six months will give both an idea of the trend and of the community using their HIV knowledge. However it is indeed sad that the evaluators on the contrary are asked to see how they could catch the NGOs for not doing work, which makes me surprised to think if World Bank is spending all that money to identify and give importance to the NGO and not the target group. Therefore if the evaluation are

considered as a study process, biases will be reduced. Moreover the results of the evaluation must be used for improvement rather than stopping the program. Documents are a good proof of evidence. However a common myth is that more the number of registers, more the credibility. Process documentation alone if maintained with seriousness is useful.

Finally, there are evaluators who will sit in the car and call sex workers one by one and ask them three questions. If two of these are answered, all is well. If none are answered, then the NGO has failed. How would this hold good? Then there are evaluators who go to places where obstacles to the programs are identified. Questions are asked and the NGO relationship are elucidated and commented on. NGOs are closed down on the pretext that they have problems with the target group and therefore they are not suited for the program. Therefore most donors use the evaluations for assessing the performance rather than identifying the trend to improve situations. There should be a change in using the evaluation results. Before giving a grant the NGO is thoroughly studied. That is the time the NGO should be evaluated. Once the NGO is selected the programs should be evaluated and factors beyond the NGO's control can be discussed how they could be overcome. More workshops for following ethics during program evaluation should be conducted for changing the current misconceptions in monitoring and evaluation. An evaluator coming once in six months cannot be expected to monitor. Therefore if monitoring needs to go hand-in-hand then the same person should visit once a month and monitor the patterns used for the program implementation and then evaluate once in six months towards program improvement keeping trends in mind.

Dr. Aman Kumar Singh, Kolkata, India
I am providing you with some of the indicators that is used for monitoring services in Avahan clinics.

- Total number of individuals receiving STI consultations;
- Estimated coverage of STI services (percent of target population examined per month based on local estimates of size of population);
- Estimated uptake (number of new attendees/estimated size of population);
- Average /monthly/yearly number of visits per individual;
- Number and distribution of STI syndromes (VD, GUD, LAP, UD, anal infections, other);
- Proportion of sex workers receiving treatment for Gonorrhoea and Chlamydia four times per year at quarterly intervals; and monthly regular check ups.
- Number of STI treatments packs distributed (pre-packaged drugs)
- Number of condoms distributed.

Many thanks to all who contributed to this query!

If you have further information to share on this topic, please send it to Solution Exchange for the AIDS Community in India at aids-se@solutionexchange-un.net.in with the subject heading Re: QUERY: Monitoring indicators for HIV prevention, PSU, Kerala, (Comparative experiences; Examples)

transmit the information contained in these messages should be aware that they are relying on their own judgment.

Solution Exchange is a UN initiative for development practitioners in India. For more information please visit www.solutionexchange-un.net.in .