

Advancing Surveillance, Policies, Prevention, Care and Support to Fight HIV/AIDS (ASHA)

Monitoring and Evaluation Plan

August 2009– September 2011

Family Health International/Nepal
USAID Cooperative Agreement #367-A-00-06-00067-00
Strategic Objective No. 9 & 11

Advancing Surveillance, Policies, Prevention, Care and Support to Fight HIV/AIDS (ASHA)

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¹ ASHA Project Fiscal Year is changed from October-September to align with the USAID reporting period of August-July. The FY11 fiscal year in this M&E will be extended to 14 months (Aug 2010-Sept 2011) due to project closeout.

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Abbreviations

AIDS	Acquired Immune Deficiency Syndrome
APRO	Asia Pacific Regional Office
ART	Anti-retroviral therapy
ASHA	Advancing Surveillance, Policies, Prevention, Care and Support to Fight HIV/AIDS
BSS	Behavioral Surveillance Survey
BRM	Bi-monthly review meeting
BCM	Bi-annual coordination meeting
CA	Cooperating Agencies
CO	Country Office
CD	Country Director
CT	Counseling and Testing
ECR	Expanded and Comprehensive Response
F & A	Finance and Administration
FHI	Family Health International
FY	Fiscal Year
GIPA	Greater Involvement of People with AIDS
GIS	Geographic Information System
GO	Government organization
GON	Government of Nepal
HASCB	HIV/AIDS and STI Control Board
HIV	Human Immunodeficiency Virus
IA	Implementing Agency
IBBS	Integrated Biological and Behavioral Surveillance
IDU	Injecting Drug User
IMPACT	Implementing AIDS Prevention and Care Program
IR	Intermediate Result
MARPs	Most at risk populations
M&E	Monitoring and Evaluation
MFR	Monthly Financial Report
MIS	Management Information System
MoHP	Ministry of Health and Population
MSM	Men who have sex with men
NAP	National HIV/AIDS Action Plan
NCASC	National Center for AIDS and STD Control
N-MARC	Nepal Social Marketing and Franchise Project
NGO	Non-government Organization
PDB	Programmatic Database
PO	Program Officer
PLHA	People Living with HIV/AIDS
QIP	Quality Improvement Project
SBC	Strategic Behavioral Communication
SITWG	Strategic Information Technical Working Group
STI	Sexually Transmitted Infection
TA	Technical Assistance
TO	Technical Officer
VCT	Voluntary counseling and testing
USAID	United States Agency for International Development

I. Introduction

The HIV epidemic in Nepal is a concentrated epidemic driven by injecting drug use, commercial sex, and migration. Despite a recent decrease in HIV prevalence among injecting drug users (IDUs) in Kathmandu (from 68% to 20.7%) the HIV epidemic among IDUs has the potential to escalate the epidemic among people who buy and sell sex. There are an estimated 28,439² IDUs in Nepal, with HIV prevalence ranging from 3.4% in the Pokhara Valley to 20.7% in Kathmandu.³ About 30% of male IDUs in four study sites (Kathmandu, Pokhara, Eastern Terai and West to Far Western Terai) have reported to be the clients of female sex workers (FSWs), and only half use condoms when they buy sex. Migration is estimated to be associated with 30-50% of the current HIV burden in Nepal,⁴ with between 100,000 and 1.5 million men migrating annually to India for work. Source communities are concentrated in the Far West and Mid West Nepal, with the highest HIV prevalence among migrants who returned from Mumbai (6-10%).

There has been notable success in Nepal in achieving a significant reduction in unprotected commercial sex through targeted promotion of condom use and essential HIV prevention services. However, although condom use in commercial sex has increased in the past decade, reported consistent condom use among sex workers with their clients is still just around 50%⁵, and prevention efforts must continue in the most at risk populations (MARPs).

USAID Nepal works to strengthen the national capacity to respond to the HIV and AIDS epidemic. Under the USAID bilateral cooperative agreement—Advancing Surveillance, Policies, Prevention, Care and Support to Fight HIV/AIDS (ASHA) Project—FHI Nepal has been implementing targeted interventions for groups most vulnerable to HIV infection in accordance with Ministry of Health and Population (MoHP) priorities and USAID's Strategic Objective 9: Enhance Stability and Security. The ASHA Project was originally funded from July 2006 through Sep 2009. FHI Nepal was recently awarded a cost extension for the ASHA Project from Oct 2009 through Sep 2011. Under this cost extension period, FHI Nepal will continue to monitor, evaluate and report on program progress following the guidance of USAID Nepal and FHI global reporting systems/procedures.

FHI works with and through key government bodies as well as NGO partner organizations. The program includes national surveillance system strengthening and strategic behavioral communication to reduce risk and vulnerability to HIV, including condom promotion among high-risk populations, improving management of sexually transmitted infections (STIs), and building capacity of government and NGO partners to plan, implement and monitor HIV and AIDS interventions.

This M&E plan for the two year extension period includes collection and analysis of program data at all levels in order to understand the magnitude of positive outcomes among target groups as well as collect important and relevant program information in a timely manner that can be used for program improvement.

² Nepal National HIV/AIDS Action Plan 2008 - 2011

³ IBBS among IDUs 2009 (New ERA, SACTS, FHI Nepal, NCASC)

⁴ Estimation of HIV cases in Nepal, 2007.

⁵ IBBS among FSWs, 2008/2009

2. FHI Nepal Background

The FHI Nepal program started its operations in 1993 in nine districts. The program expanded to reach 36 districts with over 55 local implementing partners during the ASHA Project (2006-09) (Figure 1). FHI/Nepal, in collaboration with other key players, has worked to reduce the vulnerability of groups most at risk of HIV and AIDS. The country program has seen significant growth over the past several years and under the USAID-funded ASHA Project's first three years, FHI Nepal, with partner agencies, continued to develop and implement integrated behavior change interventions (BCIs), STI case management, and VCT services for FSWs and clients, migrant populations and their spouses and IDUs. An integral element of this comprehensive approach to targeted prevention is condom promotion. Apart from making free condoms available through MoHP supplies, the ASHA Project will also continue to collaborate with the USAID funded Nepal-Social Marketing and Franchise Project (N-MARC) to ensure effective implementation of the comprehensive prevention package in MARPs.



Figure 1

During this extension period, the ASHA Project activities will be implemented by 45 Implementing Agencies (IAs) in 30 districts including 33 sites offering diagnosis and treatment of STIs;

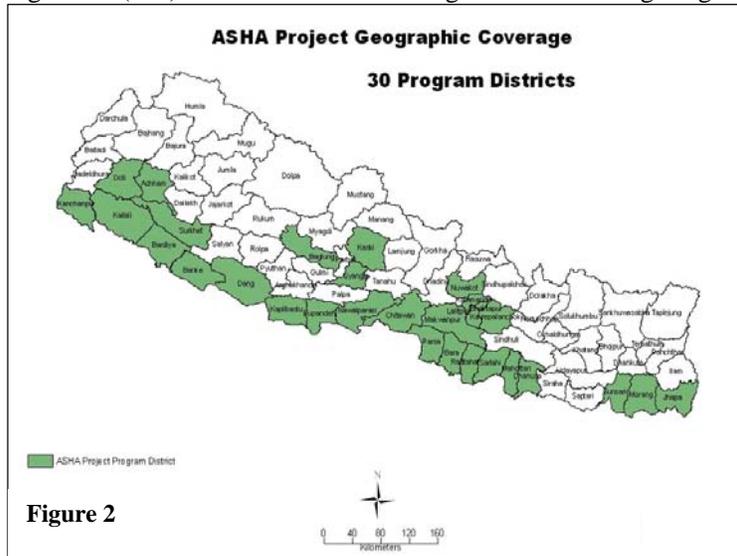


Figure 2

34 sites offering HIV voluntary counseling and testing (VCT), and 36 sites offering an essential package of care for people living with HIV/AIDS (PLHA). The ASHA Team, comprised of FHI/Nepal and Association of Medical Doctors of ASIA (AMDA)/Nepal has gained valuable on-the-ground experience and understanding of the barriers to condom and service use, has developed strategies to overcome them, and will build on this level of program activity and continue to improve the quality and effectiveness of interventions.

The ASHA Team will also work with IAs to ensure effective program implementation, build capacity and promote sustainability. Population size estimation and population mobility mapping will be used to improve geographic and population coverage, reach targets identified under the National HIV/AIDS Action Plan (NAP), and maximize national impact. The ASHA Team will also adapt program strategies to address the epidemic and target groups as they change over time.

The ASHA Team will continue to collect data on key behavioral determinants from specific geographic locations using the Integrated Biological and Behavioral Surveillance (IBBS) surveys although the number of surveillance studies in the next two years will be lower than the previous three years of

ASHA Project. These data will be used to plan and implement a range of tailored and focused interventions to promote protective behaviors, help high-risk groups overcome barriers to behavior change, and develop environments conducive to maintaining positive behaviors. These interventions will also create demand for STI screening, CT, and care, support and treatment services. The ASHA Project aims to ensure that those at highest risk receive adequate screening for asymptomatic infections and early effective treatment for STIs. STI screening and treatment services provide an ideal entry point for pre-test counseling among FSWs and their clients, and VCT is an entry point to services as well as a prevention tool. Access to VCT for MARPs will be increased further using Rapid Test Kits and a systems approach to Quality Assurance and Quality Improvement, including development of standard operating protocols (SOPs) and improving the skills of health providers and reducing discrimination toward PLHA. Early infant diagnosis is also made available from five selected sites.

3. Strategic Plan

3.1 USAID Nepal

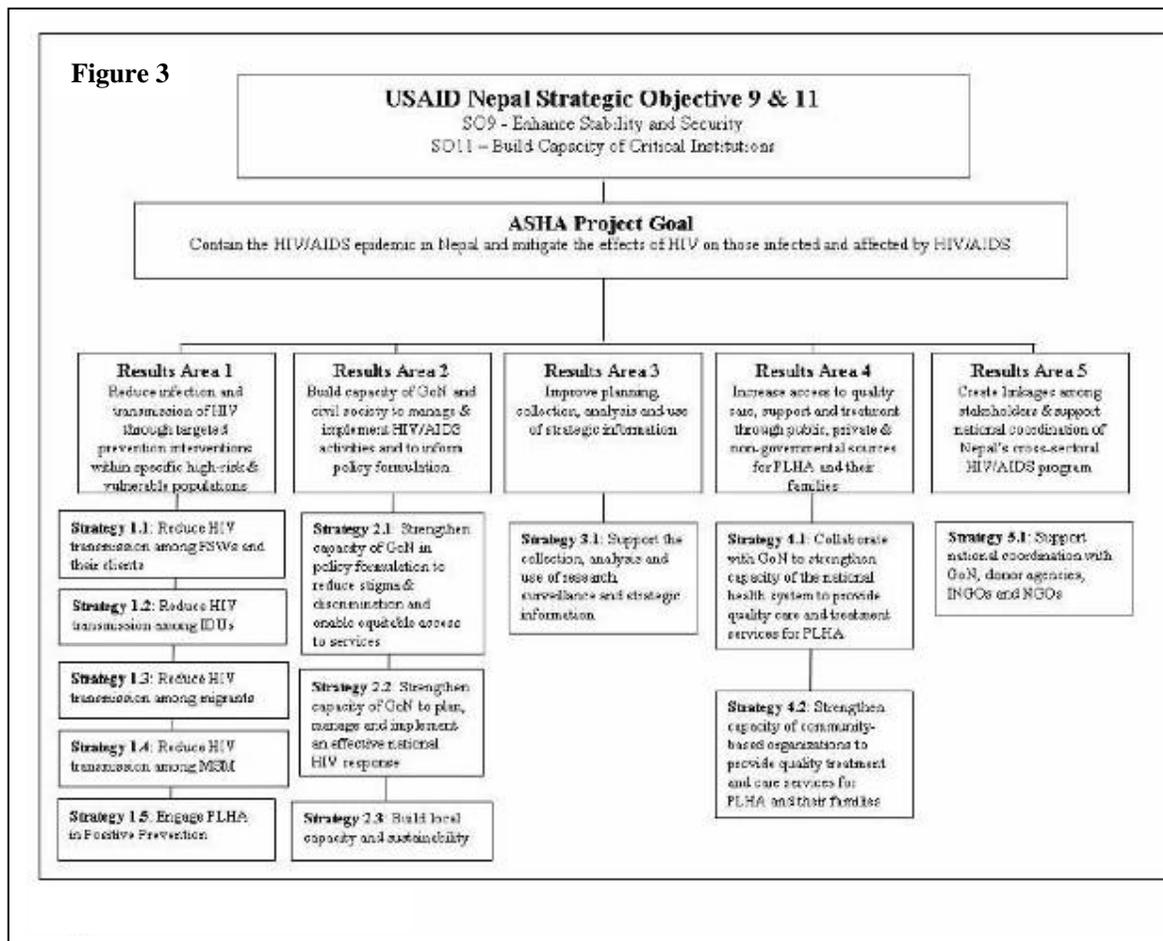
The ASHA Project falls under USAID Nepal Strategic Objective 9: Enhance Stability and Security and Strategic Objective 11: Build Capacity of critical Institutions. The results framework is provided in Figure 3.

The outcome and impact of USAID interventions will be rigorously monitored through an existing surveillance system that will be strengthened. Nepal has an established HIV surveillance system that has provided behavioral trend data for the past several years. HIV and STI sero-prevalence have been measured in key project areas and this will be continued at appropriate intervals to measure impact indicators.

3.2 ASHA Project

The ASHA Project presents an opportunity for a strong and coherent approach for responding to HIV in Nepal. The ASHA Project has significantly contributed to the major programmatic scale-up that has been achieved in recent years. The Project will continue to prioritize expansion and integration of prevention efforts with clinic-based and community and home-based care (CHBC) services. Additional support will be provided for programs such as positive prevention, children's initiative and community-based PMTCT. This support will enhance the contribution of other sectors and build community support for the response. The ASHA Project will include capacity building activities and will continually strive to strengthen and expand the base of epidemiological evidence and the analysis and use of data for improved decision-making.

The ASHA Project Goal is to contain the HIV epidemic in Nepal and to mitigate the effects on those infected and affected by HIV. The Project Objective is increased use of HIV/AIDS prevention and care services by MARPs, with results in five areas (see Figure 3).



3.3 Ministry of Health and Population

The Ministry of Health and Population (MOHP) implements and coordinates the National Action Plan (NAP) 2008-11 through the National Center for AIDS and STD Control (NCASC).

National HIV/AIDS policy objectives and strategies are tailored to suit the concentrated epidemic that Nepal is currently facing. The overarching aim of the NAP is to move towards universal access to prevention, treatment, care and support services, in line with the universal access targets that have been agreed upon by the country.

As Nepal is experiencing a concentrated epidemic, the priority for the next two years is to implement a targeted approach, that reaches most-at-risk populations (MARPs) with continued support services as identified in the National HIV/AIDS Strategy 2006-2011.

Priorities of National HIV/AIDS Strategy 2006-2011 are as follows:

- Preventive interventions for high-risk groups with a basic minimum package including life skills, peer-education, health promotion, mass awareness, condom promotion, VCT services, STI referral, and blood safety.
- Advocacy in different sectors for five year national planning and resource allocation on HIV/AIDS including effective legislative framework for the rights of the vulnerable populations and decentralized and coordinated response of HIV/AIDS.

- Increased national capacity to provide quality diagnostic, treatment and care services with increased availability of services, multi sector involvement, continuum of prevention to treatment, care & support, and standardized clinical care, ART, OIs and PEP services.
- Mainstreaming of HIV/AIDS programs in all development sectors and an operational national strategy with a strengthened management support and leadership.
- Systematic implementation of second generation surveillance system with a consensus and implementation of 'ONE' M&E Plan for HIV/AIDS and effective monitoring and evaluation of all aspects of key program areas nationally.
- Funding mobilization through the multi year NAP and an increased government budget for HIV/AIDS with an efficient and coordinated financial management system.

The ASHA Project strategies and activities will be closely related to the national HIV/AIDS strategy and priorities and ASHA Project activities will be focused on serving MARPs in the area of greatest need.

4. Selection and Development of Indicators

The ASHA Project will track key indicators used for reporting to USAID Nepal and the Nepal Government. These indicators include:

1. President's Emergency Plan for AIDS Relief (PEPFAR) and Performance Monitoring Plan (PMP) Indicators
2. Outcome and Impact Level Indicators
3. Other additional indicators

4.1 Key Process Indicators (PEPFAR and PMP) for the ASHA Project

The ASHA Project Strategic Information (SI) Team will collect process level data on a monthly basis for all ASHA Project IAs throughout Nepal. Standardized formats referred to as the PIF (Process Indicator Form), will be used to collect the information. IA management and M&E staff receive training on how to use the PIF, including the definition of the indicators, collection of the field data, transfer of data to the PIF, interpretation of data and its use in program improvement. The type of information collected is reviewed periodically and revised as necessary.

1. Individuals reached through community outreach that promotes HIV/AIDS prevention through other behavior change beyond abstinence and/or being faithful
2. Number of individuals trained to promote HIV prevention through other behavior change beyond abstinence and / or being faithful
3. Total number of USAID-assisted service outlets providing voluntary HIV counseling and testing according to national and international standards
4. Total number of individuals who receive counseling, testing and results at USAID assisted voluntary counseling and testing service outlets
5. Total number of individuals trained in voluntary counseling and testing according to national and international standards
6. Total number of individuals trained to deliver ART according to national standards
7. Total number of service outlets providing HIV related palliative care (including TB/HIV)
8. Total number of individuals provided with HIV-related palliative care (including TB/HIV)
9. Number of individuals trained to provide HIV palliative care (including TB/HIV)
10. Number of individuals trained in the provision of laboratory related activities
11. Number of organizations provided technical assistance for strategic information/M&E activities
12. Number of individuals trained in strategic information
13. Individuals trained in HIV-related institutional capacity building
14. Number of people who complete sensitivity training for reduction of HIV/AIDS related stigma and discrimination
15. Individuals trained in HIV-related community mobilization for prevention care and/or treatment
16. Special study conducted (IBBS among wives of male migrants)

4.2 Outcome and Impact Level Indicators

Below are outcome/impact level indicators measured under the ASHA Project through the IBBS.

1. % of FSWs who are HIV infected
2. % of FSWs reporting the use of a condom with their most recent client
3. % of FSWs who say they consistently use a condom when they have sex with clients
4. % of FSWs who both correctly identify ways of preventing the sexual transmission of HIV and who reject major misconceptions about HIV transmission
5. % of truckers who are HIV infected
6. % of truckers reporting the use of a condom the last time they had sex with a female sex worker
7. % of truckers who say they consistently use a condom when they have sex with female sex workers
8. % of truckers who both correctly identify ways of preventing the sexual transmission of HIV and who reject major misconceptions about HIV transmission
9. % of truckers who report commercial sex in the last year
10. Average number of commercial sex partners in the last year reported by truckers
11. % of IDUs who are HIV infected
12. % of sexually active IDUs who report use of a condom at last sex
13. % of IDUs who say they consistently use a condom when they have sex with a female sex worker in the last month
14. % of IDUs who both correctly identify ways of preventing the sexual transmission of HIV and who reject major misconceptions about HIV transmission
15. % of injecting drug users who avoid sharing injecting equipment in the last month
16. % of MSMs who are HIV infected
17. % of MSMs reporting the use of a condom with their most recent commercial sex partner
18. % of MSMs who both correctly identify ways of preventing the sexual transmission of HIV and who reject major misconceptions about HIV transmission
19. % of male migrants who are HIV infected
20. % of male migrants who both correctly identify ways of preventing the sexual transmission of HIV and who reject major misconceptions about HIV transmission
21. % of male migrants who report commercial sex in the last year
22. Average number of commercial sex partners in the last year reported by male migrants

4.3 Other Additional Indicators

1. Number of USAID-assisted service outlets providing STI treatment
2. Number of most-at-risk individuals receiving STI treatment within the context of HIV prevention at USAID-supported sites.

5. Overall ASHA Project Monitoring and Evaluation Framework

Monitoring involves the collection and aggregation of information across sites and time and serves to inform project managers and other stakeholders if activities are implemented as planned, and questions if and where existing efforts need to be modified. Process monitoring is derived from program-based data on inputs, processes and outputs.

Evaluation involves the assessment of the worth or contribution of a program through a detailed analysis of program outcomes or impacts. Outcome and impact evaluation in Nepal, as in other developing countries, relies on surveillance indicators, such as the prevalence of HIV and STIs, and associated risk behaviors. Evaluation has the potential to plausibly link observed outcomes and impacts to the program process. An experimental design involving comparisons between groups exposed to an intervention and groups not exposed to an intervention is costly to design and implement, so surveillance data is often used in evaluation when there is data corresponding to interventions with target groups or in target areas. Community and socio-political data may also be important for explaining the success or failure of

interventions and are best assessed by specifically designed surveys, supplemented with good qualitative data.

Monitoring and evaluation (M&E) are vital components of the ASHA Project. Information gathered from M&E is fed back into the program planning and implementation process in order to improve program relevance and effectiveness. For monitoring purposes, input, process and output data are collected, analyzed, and reported to IA program managers, ASHA Project staff members and USAID representatives on a regular basis. Information is also shared as appropriate with other USAID partners, such as the Nepal Social Marketing and Franchise Project, AIDS, Reproductive Health and Child Survival (N-MARC) and external collaborating partners such as the Nepal Government, UN Agencies and other INGOs and NGOs.

This section describes the conceptual framework for M&E, and the corresponding process and sources of information utilized. It outlines the process by which staff and partners collect, collate, analyze and report on project and program progress. Although monitoring of financial reporting systems are mentioned, details of the FHI financial systems are not included.

5.1 M&E as a Management Tool

Monitoring and evaluation is a part of project management. Process monitoring is an important tool for managers to track project activities and identify problems. This applies to the ASHA Project, and also to the project managers of partner agencies. Monitoring information will be used for wider interaction internally and it will be reflected into the ongoing system to improve programming. This approach will be integrated across the ASHA Project IAs and capacity strengthened to use M&E processes as a management tool.

5.2 Standardized Management Information System (MIS), Analysis and Feedback

The ASHA Project Senior SI Officer and SI Officer will provide technical assistance to the IAs to upgrade standards in data collection, analysis and use. IAs will be encouraged to tailor management information systems to their own needs, providing certain standards are met. At the central level, monthly data will be downloaded in the MIS database which will be integrated with the Geographic Information System (GIS) as necessary. The output data will be disseminated in different forums such as bi-monthly review meetings held with individual implementing agencies, bi-annual coordination meetings (BCM) held at the regional level, quarterly reporting out meetings held among ASHA Project program and technical staff and regular team meetings. Ultimately, the entire MIS system will contribute to the program management, planning and decision making process. MIS system includes but is not limited to:

- Collection of data on required indicators;
- Use of appropriate methods and tools to collect data for required indicators, including standardized data collection forms to facilitate compilation and analysis of data;
- Supervision and data quality verification system;
- Internal data analysis and use;
- Appropriate storage of historical data and medical records;
- Issues and Action Matrix to capture all issues identified during technical assistance visits and actions taken to address the issues.

After several levels of cross check and verification from IAs and respective program officers, the data sets reported by IAs will go into the central MIS database, which will be managed by the FHI Data Assistant. After data importing, analysis is performed and trends of interest are reported back to Program Officers, Team Leaders, Technical Officers and the ASHA Project senior management team. Analysis of the data is shared during a series of meetings. Data and related analysis is stored centrally in electronic formats. Central MIS will be upgraded and improved as per the need of the project.

At the IA level, the ASHA Project staff support strengthening of the IA MIS system to facilitate the collection, compilation, analysis and reporting of required indicators and other data. IAs will receive

feedback as part of the meetings and following submission of indicator and narrative reports. Feedback is documented in the form of meeting minutes and trip reports. Besides structured feedback, there is regular ongoing communication (including email) between IAs and ASHA Project technical and program staff.

5.3 Quality Assurance

In addition to monitoring the scale of different intervention components and comparing progress against plans, ASHA Project partners will actively participate in quality improvement aimed at improving the delivery of intervention components and assessing the fit of these components within a broader contextual environment. ASHA Project has identified 8 quality improvement projects (QIP) in FY09 and these will be continued in FY10. The findings from the QIPs will be shared at regional and national levels to improve the ASHA Project and as a knowledge base for other HIV programs in Nepal. Additional QIPs will be identified in FY11. FHI Nepal will continue to work with FHI APRO to refine quality measurement toolkits developed at the regional level and implement on a regular basis for the following interventions:

- Strategic Behavior Communication;
- Integrated Health Services (STI, VCT, essential package of care);
- Laboratory Services.

Regional technical staff members have adapted international service provision guidelines for the above technical areas, which have resulted in a series of tools for assessing quality assurance domains including the following:

- Quality of care, counseling, communication;
- Adequacy of staff, equipment, supplies;
- Client satisfaction;
- Collaboration with stakeholders;
- Adequacy of program outputs.

These quality domains are supplemented by international standard data collection forms and procedures, as well as international technical guidelines linked to appropriate training. The primary duties of the ASHA Technical Team in relation to the quality assurance plan include, but are not limited to, the following:

- Supervise and coordinate the QA activities in every sub-agreement under the ASHA Project;
- Provide technical oversight for and coordinate all QA monitoring and evaluation activities in ASHA Project;
- Provide technical assistance, develop materials, facilitate and/or provide learning sessions and related trainings, and make presentations on QI and quality management tools and techniques;
- Provide mentoring and support to QI teams including attending team meetings and maintaining constant communication;
- Participate in project planning and liaise with other international projects and donor organizations to determine areas for collaboration;
- Facilitates cross-functional QA efforts by ASHA Project staff through coordination of staff visits to field and use of QA checklists;
- Conduct data quality audits and check service utilization and training data;
- Regularly monitor the appropriateness of facilities including access, attractiveness and acceptability issues.

5.4 Strengthening Data Quality Control Mechanisms

Data quality control is an essential part of monitoring. All IAs have received data quality orientation. M&E staff members from each IA will be specifically trained on the quality data gathering process.

Quality control includes understanding and then improving whole systems of data collection, storage, verification and reporting. This involves helping IAs view data quality control as part of their regular

practice, with support and follow up from the ASHA team. Data quality audit will be conducted on a periodic basis jointly with the IAs. Data analysis training conducted in FY09 has shown great results in having the IAs take the center-stage in analyzing their process data. This training will be continued in FY10.

Figure 4 illustrates the current data flow, cross check and verification system. Data are submitted and aggregated centrally. Data quality is addressed at various stages in the process of data collection and analysis. The arrows within the flow chart in Figure 4 indicate responsibilities for data quality checks.

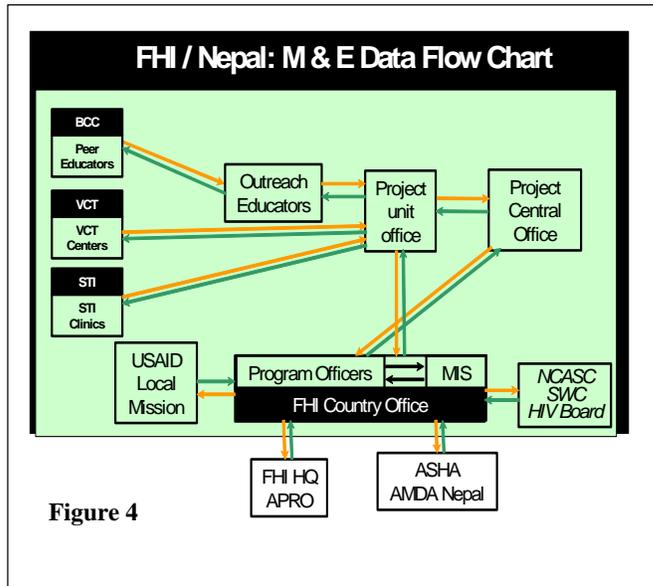


Figure 4

Accurate reporting to USAID, FHI regional office and FHI headquarters relies on data quality issues being addressed at every point in the reporting flowchart. Verification of quality issues occurs regularly through IA internal monitoring processes and monitoring support from FHI. Cross check and verification of routine reporting occurs at each level before it arrives to the central MIS system. The FHI SI Officer is responsible for compiling the monthly routine data from each IA and preparing the data sets for the reporting requirement to NCASC, Social Welfare Council, USAID, FHI Regional and headquarter offices and ASHA partners. ASHA Project supported VCT centers directly report the VCT data to NCASC also using their format.

5.5 Evaluating Effectiveness

The IBBS is designed to measure behavioral outcomes and HIV prevalence among MARPs. These national level surveillance data track the epidemic in high risk population groups and indicate the effectiveness of the HIV/AIDS response nationally. Although the byproduct of these surveys contributes towards program evaluations, this is not the only purpose of the IBBS. These survey results are used for program designing, reviewing and estimation of the HIV infections in the country. FHI Nepal and USAID, in collaboration with the NCASC and in accordance with the National Surveillance Plan, will partner with a local research agency to implement the IBBS planned for the next two years.

Population size estimates and data from IBBS conducted among FSWs and clients, IDUs, migrants, and MSM will provide key data for evaluating the effectiveness of the ASHA Project and the joint impact of USAID-funded HIV/AIDS activities in Nepal.

Accurate estimates of the population size of MARPs provide the denominators for monitoring program coverage in each population. The ASHA Team will establish reliable estimates using FHI's internationally recognized standards for FSWs. The Nepal HIV and STD Control Board is leading the process to carry out size estimation for MSM in FY10 and other MARPs subsequently. ASHA Project will provide technical assistance to those size estimation processes.

The ASHA Project will benefit from FHI's international expertise in the specific and detailed analysis of routinely collected program monitoring data in conjunction with surveillance data to pinpoint current priorities and improve program performance. Repeated rounds of IBBS conducted among MARPs in specific geographical areas will use probability-based sampling techniques to monitor trends in key impact and behavioral outcome indicators. IBBS data will also be useful for estimating ASHA Project and N-MARC activity exposure (i.e., coverage) among MARPs.

Triangulation will be used to analyze detailed and specific indicators about the intensity and duration of exposure to various types of intervention, in association with key impact and outcome indicators, to ascertain whether observed changes may be plausibly attributed to observed program outputs. Other relevant data sources to be used for effectiveness evaluation will include quality-of-service data and qualitative research.

6. Monitoring and Reporting System of ASHA Project

6.1 Integrating M&E at the Project Design Stage

M&E is an integral part of every agreement between the ASHA Project and a local implementing partner. Prior to beginning an intervention, FHI and the IA design an appropriate M&E and reporting framework for the intervention, typically emphasizing key indicators, responsibilities and tools for data collection, supervision, and benchmarks of project success. Agreements make use of existing data relevant to the intervention and/or include provisions for the collection of baseline data if unavailable.

An M&E matrix is filled out collaboratively during the design stage to help partners visualize the relationship between monitoring and project activities, data collection tools needed and key benchmarks.

6.2 Internal Monitoring and Reporting (involving IAs)

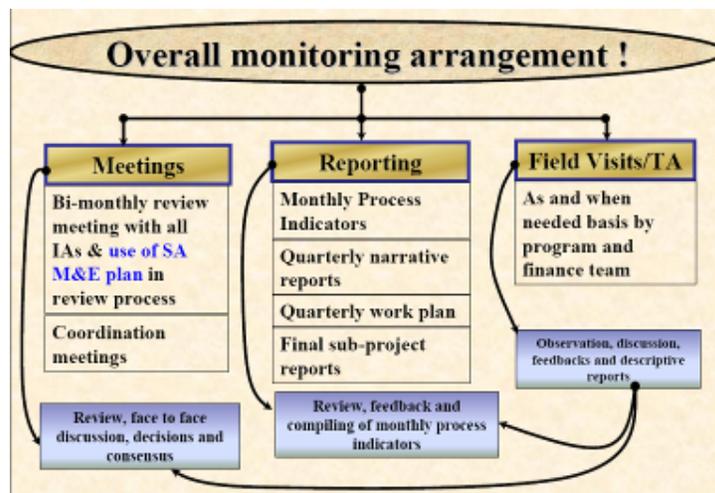


Figure 5

The ASHA Project M&E team and partners will conduct a number of activities in order to maintain regular communication with IAs, monitor progress, meet defined targets, and identify obstacles in implementation, & opportunities for capacity building. Figure 5 shows arrangements that the project has made through meetings, reporting and field visits to monitor progress and quality of activities.

Technical monitoring of the IHS activities

Technical monitoring of the IHS activities includes following components:

Planning

The FHI Technical Unit, at the beginning of each fiscal year, prepares a plan of technical monitoring visits in coordination with program team leaders. Preference will be given to new IAs or partners requiring improvements identified in previous monitoring visits or upon request of FHI Program Officers.

Monitoring

Monitoring is carried out by the FHI Technical Unit members and/or experts from AMDA Nepal individually or in groups according to the need of the program. The areas monitored are STI service delivery, HIV counseling and testing, Essential Package of Care services, CHBC, Community Based –

PMTCT, laboratory, logistics and Family Planning Counseling services. The FHI Technical Unit supports Government of Nepal for technical monitoring of the ART and other HIV-related services in government facilities. All monitoring of services is done using standard check lists developed by the ASHA Project

Follow up

All issues identified during the monitoring visit are listed in a matrix and followed up regularly by IAs, FHI Program Officers and FHI Technical Unit members on the follow up visit. This matrix is updated every month.

Monitoring of SBC activities

The ASHA Project SBC Specialist will monitor and assure the quality of SBC activities through the following:

- Use standard guidelines including guidelines for implementing HIV prevention program among MARPs;
- Ensure the effective implementation of SBC strategy, guidelines, activities through regular supportive supervision and monitoring of SBC activities;
- Use standard QA/QI checklist for SBC to assess and ensure the quality of SBC activities and onsite coaching and mentoring support;
- Provide overall technical assistance and oversight for all SBC activities to IAs;
- Ensure the development of accurate and appropriate content for IEC materials, guidelines and manuals;
- Conduct various trainings, workshops and meetings with follow up for strengthening capacity of IA staff in SBC;
- Develop and use standard job aids, tools and IEC materials including guidelines to provide correct, complete and appropriate education and communication with MARPs;
- Provide analysis of SBC-related progress, coverage and key achievements to program and technical staff and IAs.

Monitoring of capacity building activities

Capacity building is one of the primary strategies for each IA and monitored regularly. FHI/ASHA Project's approach to capacity building seeks to create well-organized, fully developed and independent individuals and local organizations to implement HIV prevention, care and support programs. The ASHA Project has several structured approaches to strengthen capacity of MARPs, IAs and other key stakeholders including government. The capacity building related activities will be monitored by:

- Ensuring that the gaps/needs identified in pre-award assessment and physical verification of selected IAs are addressed in initial orientation and regular monitoring visits;
- Providing specific pre-service, on the job and refresher training including exposure visits for IA staff and service providers by utilizing standardized training curricula;
- Conducting regular onsite coaching/mentoring and monitoring visits;
- Developing sound evaluation, follow up and monitoring practices for all training conducted by FHI Nepal;
- Developing and inculcating organizational wide thinking of a comprehensive approach to capacity building that goes beyond training;
- Organizing regular supportive supervision and monitoring visits to IAs to strengthen their capacity and jointly identifying issues and action for improvement using the Issues and Action Matrix as a working document;
- Strengthening NGO management system including the governance, transparency and commitment to quality services, for example, periodic audits, use of software (MIS, accounting, use of technology and use of information for decision making);
- Promoting the engagement of NGO Board members in programs – such as budget and proposal development, monitoring of activities and providing feedback, participation in meetings;
- Ensuring the application of tools, guidelines, Standard Operating Procedures in program management;

- Promoting the culture of sharing of information and new developments, research for cross fertilization;
- Conducting process evaluation of IAs to comprehensively examine the programs in order to provide guidance and input to strengthen current and future program strategies and implementation.

6.3 Project Monitoring Visits with Implementing Agencies

ASHA Project views project monitoring as a capacity building process with IAs. During every monitoring visit observations are fed back to IA staff and program managers to improve program implementation. Recommendations are documented for follow-up in subsequent visits which, apart from strengthening the activities, also builds the capacity of IAs to conduct their own monitoring.

Program Field Visit

The ASHA Project Program Officers spend the majority of their time in the field sites with the IAs. They are responsible for monitoring project progress according to approved sub agreements, and visiting each IA on a regular basis to review project activities, participate in quality assessments, facilitate capacity building and provide feedback to the IA. The Program Officers are responsible for identifying and facilitating technical support and assisting IAs in solving concrete problems they may encounter in the course of implementing the project. This may involve negotiation and meetings with local level line agencies representative / local government officials and departments.

Finance and Admin Field Visit (semi-annual)

The ASHA Project Finance and Administration staff members review IA budgets, vouchers, records and monthly financial reports (MFR) during regular field visits as well as completing the FHI Finance and Administration checklist and seeking clarifications from IAs as needed. Finance staff also train IAs who subcontract to other NGOs in the F&A procedures, including the F&A checklist.

Joint Field Visit

The ASHA Project strategic information officers and technical team are responsible for providing technical support to IAs based on needs identified during an intensive two-day program review. The review begins with a desk review of quarterly reports, workplan and activities agreed upon in the sub agreement. IA source documents and records are also reviewed for consistency and accuracy. In addition the capability of staff is assessed through questions and observation, and interviews are held with other stakeholders and service providers in the target area regarding the activities of the IA. Discussions are also held with random members of the target group. Quality assessment tools, including technical checklists, are used to guide these enquiries, and appropriate training/feedback is provided to team members at the completion of the visit.

Monthly Activity Reports through monthly Project Indicator Forms (PIF):

The monthly PIF from each IA will be collected on a routine basis. This tracks the project level output indicators. All IAs must submit a PIF with monthly information by the 12th day of the following month.

Monthly Financial Reports:

The Monthly Financial Report (MFR) tracks monthly expenditures by budget line item for IAs. All IAs submit the MFR by the 10th day of each month.

Quarterly Narrative Reports:

FHI receives Quarterly Narrative Reports from IAs. These reports contain standardized indicators for each intervention, including key service statistics, and the work plan for next quarter. Subsequently, relevant information is used for program management and documentation of the project. These reports include information on:

- Achievement of the quarterly targets
- TA requirements
- Success stories and barriers in the program implementation

Final Close Out Report:

At the end of the sub agreement, each IA will submit a close out report to the ASHA Project. This close out report contains a summary of overall key achievements, successes, materials produced, constraints and any lessons learned from the intervention. The format for this report will be attached in the sub agreements.

6.4 Monitoring of the Project by the Implementing Agency (IA) Staff

M&E efforts will focus on ongoing activity/process monitoring. The responsibilities for each level of staff in three main areas: 1) routine data collection and reporting; 2) monitoring and ensuring quality; and 3) use of data for program improvement are as follows:

(a) Routine Data Collection and Reporting

Project field staff – record accurate data daily from their interactions with the target group using standardized data collection tools; report results to supervisors.

Project Coordinator – coaches field staff on correctly filling in daily data entry forms, clarifying definitions when needed; regularly collect completed forms and review them for accuracy and completeness; conduct periodic supervision of data entry in the field; hold regular meetings to discuss progress; note constraints faced, establish appropriate supervision systems and processes for routine data collection, verification and compilation; compile results into standardized monthly PIFs and quarterly narrative reports to send to FHI that include monthly achievements against targets on required indicators, constraints faced and feedback into upcoming plans; and ensure sufficient capacity building of staff.

(b) Monitoring and Ensuring Quality

Project field staff – conduct daily field supervision and support including observation of outreach service delivery; provide specific feedback on how to improve project implementation; and report to Project Coordinator areas where additional capacity building is required.

Project Coordinator – conducts regular field supervision and support including observation of service delivery; provide or arrange technical training for improving project implementation; arrange periodic technical monitoring of clinical services using standard assessment tools; identify possible barriers to providing quality services; note corrective action taken and service or system improvements implemented, in quarterly narrative reports.

(c) Use of Data for Program Improvement

Project field staff – hold regular meetings with field workers to discuss individual and collective results; use these results as well as reports on obstacles or opportunities to make adjustments to work patterns where necessary; report corrective actions to the Project Coordinator.

Project Coordinator – convene regular meetings and document discussions with project supervisors and/or field workers about key indicators, results and findings from field supervision visits; coach team in analysis and interpretation of output results; prepare data-driven presentations for quarterly review meetings with FHI; disseminate findings of quality monitoring and identify key areas for improvement; discuss collectively the nature of barriers/obstacles and actions which can be taken to overcome them; follow-up status of agreed actions from previous meetings/discussions; report corrective actions based on these analyses to FHI, and note where additional support is required.

7. External Monitoring and Reporting- ASHA Project Level

7.1 USAID Nepal

FHI Nepal, as Prime Recipient for the ASHA Project, reports the following information to USAID/Nepal as part of external monitoring requirements:

Semi Annual Report

Every six months FHI will send semi annual reports to USAID. These reports will contain a comparison of actual accomplishments with goals established for the period, explanations for any deviation from plan and other pertinent information including status of finances and expenditures and analysis and explanation of cost overruns. FHI coordinates the compilation and analysis of a common report, including key standardized indicators for all IAs working under the ASHA Project.

Semi-annual report will cover the following reporting period for the two years:

- August 09 to January 10
- February 10 to July 10
- August 10 to January 11
- February 11 to September 11

The final ASHA Project report will be due in December 2011.

7.2 FHI Arlington

FHI's head office in Arlington, Virginia, requires the following information at a global level for all countries:

Semi-annual Global Data Base (GDB) – Achievements of key indicators from key intervention technical and cross-cutting areas, disaggregated by sex and age groups, to inform the scale and breadth of intervention components

Monthly Financial Reports (MFR) – monthly updates on the progress of expenditure against budgets by budget line item at the IA level

7.3 FHI Asia Pacific Regional Office (APRO)

Additional monitoring and support is provided by FHI's APRO located in Bangkok. Mechanisms by which FHI APRO keeps in touch with and supports the operations of FHI Nepal include the following:

Monthly Updates – on a monthly basis, a brief country-level report highlighting major activities in each intervention area, materials produced and sub agreement updates is sent to the program management unit, and also shared with FHI Arlington.

Monthly Teleconferences – representatives of management, program and technical divisions in FHI APRO conduct a monthly teleconference with FHI Nepal senior staff to discuss programmatic and technical updates.

Monthly budget and expenditure update – also on a monthly basis, the Finance Unit sends a budget and expenditure update, along with explanations for over- and under-spending and an update of activities undertaken in the annual work plan.

Semi Annual Report: FHI provides semi annual reports to FHI APRO. These reports contain key achievements during the reporting period and a list of materials and publications produced.

FHI's APRO also provides regular technical and management support to FHI Nepal through visits, trainings, information sharing and technical support.

8. Project-level Evaluation Activities

8.1 ASHA Project Internal Management System

Senior management meeting

Every month the FHI Deputy Director, FHI Associate Director – F&A, Senior Technical Advisor (AMDA) will meet with the ASHA Project Chief of Party (FHI Country Director) to update on management, program, technical and finance issues and discuss collaborative events and any priority topics.

Program/Tech Management Team Meeting

Under the ASHA Project, FHI has three units. Every week members of all teams (Program Unit; Strategic Information Unit; Technical and Program Support Unit) under the FHI Deputy Director meet to update on major activities, achievements and lessons learned from M&E reports; share targets, upcoming events, travel and work plan for the next month; discuss and explore areas for coordination; and, agree on any task or task team that requires involvement of members from more than one team.

Team Meetings

Each team meets weekly/fortnightly or according to their needs to share, discuss and plan activities. The FHI Deputy Director joins the team meeting at least once a month or as required. In these meetings IA monthly reports are reviewed, recommendations or major issues noted in trip reports and quarterly indicator data compiled and trends discussed.

8.2 IA Level Activities

Process Evaluation of the Projects

The main objective of the process evaluation is to understand the strengths and weaknesses in program designing and implementation processes of the HIV/STI programs currently being implemented by ASHA Project IAs in various districts of Nepal.

The specific objectives are:

- To illustrate collectively "what is said" and "what is done";
- To identify the program gaps and concentrations of program efforts;
- To facilitate the use of program data for upcoming amendment / planning and advocacy;
- To support the documentation and dissemination of best practices / success stories and lesson learned;
- To increase the ownership of program among partners and local stakeholders;
- To support timely amendment of the projects if necessary.

In the first three years of the ASHA Project, process evaluations were conducted with seven IAs. Under the extension period, ten additional process evaluations are planned with IAs. All FHI Program Officers have received a training of trainers in process evaluation.

8.3 Program Performance Monitoring and Evaluation

The ASHA Project will ensure the routine collection, analysis, and use of program performance data to monitor inputs (resources needed to do the work), processes (activities undertaken and their quality), and outputs (immediate service-level results and project reach/coverage). These data will be used to monitor and ensure that the programs are being implemented as planned; that is, on time, at the expected level of quality and coverage, and within budget.

Assessing Service Quality

The quality of project interventions and quality of services will be assessed regularly using tools such as site assessments, quarterly reviews and QA test of lab tests performed in VCT and STI labs. During the extension period, two quality assessment surveys will be conducted. These surveys use a variety of tools, including site assessments, case record reviews, PMIS, service providers' surveys, client exit interviews, and observations of service transactions will be conducted. The surveys will be conducted according to protocols developed by ASHA Project Strategic Information Unit and FHI APRO technical expertise.

Monitoring Impact of Civil and Political Unrest on Program Activity

The ASHA Project will collect security-related data monthly from all IAs and report these data to USAID quarterly. Key indicators to monitor the impact of conflict on program activity include:

- Number of program/ service days lost due to conflict, by district
- Number of events cancelled or delayed due to conflict, by district
- Number of districts with travel restrictions due to conflict (bandhs, blockades, poor security)
- Documentation of incidents involving security forces or insurgents
- Number of IAs that have withdrawn from conflict-affected districts

8.4 Data Analysis and Use

Quarterly Project Review

Program Officers and SI team members of ASHA Project will have bi-monthly program review meetings with all IAs. Bi-monthly project reviews will analyze different aspects of project implementation including:

- Compliance with project design including timeline
- Achievement of project process and output targets
- Responsiveness to recommendations and feedback documented in monitoring activities
- Findings from the program management team

Part of the review will be giving IAs the opportunity to analyze their data and present their achievements and constraints for the year. Annual program review will include minutes of issues noted and discussed as well as a 'looking forward' session where commitments are made to improve certain activities or address identified weaknesses. These commitments and FHI's activities to support them will then be reviewed in the next quarterly program review along with new issues.

Data Use: Translating M&E Results into Improved Program

Data use is the all-important step, often neglected in HIV/AIDS programs, of linking the analysis of performance data with decision-making for program improvement. Ensuring appropriate mechanisms and opportunities for interpreting and feeding back data on an ongoing basis are key to reflexive programming and development of a culture of information. The ASHA Team views evidence-based decision-making as an exercise involving decision-makers at all levels interpreting programmatic responses in light of the epidemiological context and priorities. Data from the project sites will be collected monthly and sent to the ASHA Project SI Unit. Participatory sessions will be held with the IAs to discuss the implications of the data collected from project sites. The feedback sessions will provide an opportunity to: (1) build partners' capacity to work with performance monitoring data; (2) ensure that the data are being used to measure progress; (3) examine barriers to improved performance; and (4) share experiences among agencies. The data will also be used to identify high- and low-performing IAs and sites to guide analyses of the factors responsible for observed performance levels, as well to provide input into annual workplan development.

Performance Data Collection and Analysis

The ASHA Team will use routine M&E data at the level of the individual IA as a tool for enhanced program management and implementation. The ASHA Project will implement a QA/QI system based on performance monitoring data, field visits, and technical mentoring. Data will be compared between sites and aggregated to illustrate major associations between program exposure and behavioral outcomes (e.g., the association between carrying condoms and condom negotiation and use). The ASHA Project's SI Unit will provide cross-regional analysis and feedback to technical monitors and members of the program management team. In addition, the SI Unit will summarize findings and make recommendations in the quarterly report to USAID.

8.5 M & E Work Plan under the ASHA Project

#	Activity	FY10				FY11			
		1	2	3	4	1	2	3	4
1	Submission of the CO M & E workplan	X							
2	M&E supports for IAs	X	X	X	X	X	X	X	X
3	M&E training for IAs		X		X		X		
4	MIS trainings for IAs		X		X		X		
5	Data analysis training for IAs		X		X		X		
6	Onsite monitoring support to the IAs	X	X	X	X	X	X	X	X
7	Bi-monthly project review	X	X	X	X	X	X	X	X
8	Process evaluation of the projects			X		X			
9	Conduct data quality audit		X		X		X		X
10	Monitoring impact of civil and political unrest on program activity	X	X	X	X	X	X	X	X
11	Research and Surveillance								
11.1	IBBS - spouses of migrants in the Far West		X	X	X				
11.2	IBBS – IDUand FSWs in Kathmandu and Pokhara					X	X	X	X
12	Dissemination of the Research Results								
12.1	IBBS results through NCASC				X				X
12.2	IBBS results shared with community				X				X
13	Technical assistance								
13.1	Provide TA to the NCASC and GFATM Round 7 partners in the design and implementation of IBBS, respondent driven sampling, data interpretation and data dissemination.	X	X	X	X	X	X	X	X
13.2	Continue to provide technical leadership and support for the Strategic Information Technical Working Group (SITWG) in strengthening national surveillance protocols and SOPs.	X	X	X	X	X	X	X	X
13.3	Provide TA to the NCASC and the HIV/AIDS and STI Control Board (HASCB) to review the national surveillance plan on a regular basis.	X	X	X	X	X	X	X	X
13.4	Collaborate with NCASC, SITWG, local research organizations, and other donors in developing the national second-generation surveillance system and in planning, collection, analysis, dissemination, and use of data.	X	X	X	X	X	X	X	X
13.5	Advocate and provide technical inputs for setting the interval between rounds of IBBS in the context of understanding the evolving national epidemic and strengthening the surveillance system's sustainability.	X	X	X	X	X	X	X	X
13.6	Provide TA to the NCASC and the HASCB to update population size estimates in key populations, the planned revisions in 2009 and 2011 of the national estimates of the number of PLHA, data management and analysis.	X	X	X	X	X	X	X	X

#	Activity	FY10				FY11			
		1	2	3	4	1	2	3	4
13.7	Provide TA and input to the technical discussion on the need for a unique identifier system at the national level and support the development and roll out of the system nationally based on the experience of the ASHA Project unique ID number.	X	X	X	X	X	X	X	X
13.8	Provide financial and technical support to the annual National Surveillance Consensus Workshop and for dissemination of national strategic information, including production of reports of surveillance activities, research studies, and national estimates.	X	X	X	X	X	X	X	X
13.9	Support the NCASC and the HASCBS to strengthen the existing national M&E system.	X	X	X	X	X	X	X	X
13.10	Continue to provide TA to the NCASC on the development of a national database of HIV/AIDS programs.	X	X	X	X	X	X	X	X
13.11	Provide TA to the NCASC for training in monitoring and evaluation.	X	X	X	X	X	X	X	X
13.12	Promote at the national level the use of data quality audits, quality assurance survey, and the use of geographic information systems.	X	X						
14	Consensus meeting on surveillance system in Nepal	X				X			
15	Sharing of the results to SITWG	X				X			
16	Reporting								
16.1	Semi annual report to USAID		X		X		X		X
16.2	Semi annual OP indicator report to USAID		X		X		X		X
16.3	Annual PMP indicator report to USAID				X				X
16.4	Annual PEPFAR indicator report to USAID				X				X
16.5	Semi annual GDB report to HQ	X		X		X		X	X
16.6	Semi-annual report to APRO	X		X		X		X	X
16.7	Annual report to APRO			X					
16.8	Final report to USAID							X	X

9. Capacity Building in M&E

Capacity building is included in the ASHA Project's annual work plan and is part of every program, finance and technical staff member's job description. Capacity building is an important strategy included in IA sub agreements, including the development of M&E capacity. Building local capacity in M&E helps to ensure quality programming and reduces the likelihood of data quality issues in donor reports. ASHA project will also support NCASC on the development of National database for HIV and AIDS, and in M&E training. ASHA project will continue technical discussions on the need of a National Unique ID system and advocate for use of data quality audit system

The ASHA Project has three main approaches to building IA capacity in M&E, namely finance and administration training, M&E training, and unstructured capacity building during routine monitoring.

9.1 Finance and Administration Training

All IAs receive training on financial management issues related to sub agreements including budgeting, record keeping systems, bills and vouchers, monthly financial reports, allowable and non-allowable expenses, and the computerized package related to F&A.

9.2 M &E training

ASHA Project Staff

Staff will attend national and international training to enhance the country office's capacity in M &E and related systems. FHI actively participates in identifying and organizing relevant training and TA for staff.

IA Staff

Each IA will receive formal orientation on ASHA Project M&E activities. In addition to this orientation all IAs will receive formal M&E, MIS and data analysis training once per year and on the job training at the time of field visits.

TA to the National Program

The ASHA Project will support NCASC through regional and national workshops and seminars on strategic information. This will be supported directly by ASHA Project technical staff. ASHA Project technical staff will also participate on the SITWG. The ASHA Project will continue to provide technical assistance to the national program for generating, analyzing and using the strategic information for program planning, evaluation and monitoring; revising and developing technical guidelines and national action plan on HIV/AIDS and its implementation.

10. Indicators and Yearly Targets⁶ ASHA Project

Objective Number	Indicator	Geographic Area and Baseline Year	Base line Value	NAP Target		ASHA Target		Source of Data
				(09/10)	(10/11)	FY 10 (08/09 to 07/10)	FY 10 (08/09 to 07/10)	
	Contain the HIV/AIDS epidemic in Nepal and mitigate the effects of HIV on those infected and affected by the disease							
	% of FSWs who are HIV infected	FSWs – Kathmandu, 2008 ⁷	2.2%		1.4%		1.4%	IBBS
		FSWs – Pokhara, 2008 ⁵ above	3%		2%		2%	IBBS
		FSWs – 22 Terai Districts, 2009 ⁸	2.3%		1.5%			IBBS
	% of truckers who are HIV infected	Truckers –Terai Districts, 2009 ⁹	0%		1.75%			IBBS
	% of IDUs who are HIV infected	IDUs – Kathmandu, 2009	20.7%	20%			20%	IBBS
		IDUs – Pokhara, 2009	3.4%	5%			5%	IBBS
		IDUs – Eastern Terai, 2009 ¹⁰	8.1%	10%				IBBS
		IDUs – Western Terai, 2009 ³ above	8%	8%				IBBS
	% of MSM who are HIV infected	MSM – Kathmandu, 2009	3.8%	2% (MSM) 2.5% (MSW)				IBBS
	% of migrants who are HIV infected	Migrants – Five western region district (Kaski, Syanja, Gulmi, Palpa and Kapilbastu) – 2008	1.4%		1%			IBBS
		Migrants – Six mid to far western region districts (Surkhet, Banke, Achham, Doti, Kailali, Kanchanpur) – 2008	0.8%		1%			IBBS
	% of wives of migrants who are HIV infected	Wives of migrants – Four far western region districts (Achham, Doti, Kailali, Kanchanpur) – 2008	3.3%			2%		IBBS

⁶ Target indicators based on studies will be verified in years when these studies will be conducted. As per national second-generation surveillance workplan of NCASC IBBS studies are conducted in alternate years.

⁷ This study has been dropped in ASHA extension as this will be covered by Global Fund Round 7 but the target will be measured from GFR7 study

⁸ This study has been dropped in ASHA extension as this will be covered by Global Fund Round 7 but the target will be measured from GFR7 study

⁹ Truckers study has been dropped in ASHA extension but the target will be measured from other donor's study supported for national study among truckers

¹⁰ This study has been dropped in ASHA extension as this will be covered by Global Fund Round 7

Objective Number	Indicator	Geographic Area and Baseline Year	Base line Value	NAP Target		ASHA Target		Source of Data
				(09/10)	(10/11)	FY 10 (08/09 to 07/10)	FY 10 (08/09 to 07/10)	
IR1: Reduce transmission of HIV/AIDS through targeted prevention interventions within specific high-risk and vulnerable populations								
1.1	Percent of FSWs reporting the use of a condom with their most recent client	FSWs – Kathmandu, 2008 ⁵	75%		80%			IBBS
		FSWs – Pokhara, 2008 ⁵	64.5%		80%			IBBS
		FSWs – Eastern Terai, 2009 ⁵	87%		80%			IBBS
		FSWs – Western Terai, 2009 ⁵	80.5%		60%			IBBS
1.2	Percent of truckers reporting the use of a condom the last time they had sex with a female sex worker	Truckers - Terai Districts, 2009	93.4%		90%			IBBS
1.3	Percent of sexually active IDUs who report use of a condom at last sex	IDUs – Kathmandu, 2009	66.8%	80%			80%	IBBS
		IDUs – Pokhara, 2009	89.1%	80%		Maintain 80%	IBBS	
		IDUs – Eastern Terai, 2009	73.3%	80%			IBBS	
		IDUs – Western Terai, 2009	67.7%	80%			IBBS	
1.4	Percent of FSWs who say they consistently use a condom when they have sex with clients	FSWs – Kathmandu, 2008	53.8%		NA		60%	IBBS
		FSWs – Pokhara, 2008	49.5%		NA		60%	IBBS
		FSWs – 22 Terai Districts, 2009	69.8%		NA			IBBS
		FSWs – Eastern Terai, 2009	72%		NA			IBBS
		FSWs – Western Terai, 2009	65.5%		NA			IBBS
1.5	Percent of transport workers who say they consistently use a condom when they have sex with female sex workers	Truckers- Terai Districts, 2009	81.2%		NA			IBBS
1.6	Percent of IDUs who say they consistently use a condom when they have sex with a female sex worker	IDUs – Kathmandu, 2009	49.4%	NA			60%	IBBS
		IDUs – Pokhara, 2009	70%	NA		80%	IBBS	
		IDUs – Eastern Terai, 2009	44.5%	NA			IBBS	
		IDUs – Western Terai, 2009	51%	NA			IBBS	
1.7	Percent of FSWs who both correctly identify ways of preventing the sexual transmission of HIV and who reject major misconceptions about HIV transmission	FSWs – Kathmandu, 2008	36.4%		NA		45%	IBBS
		FSWs – Pokhara, 2008	14%		NA		25%	IBBS
		FSWs Eastern Terai, 2009	26.5%		NA			IBBS
		FSWs Western Terai, 2009	27%		NA			IBBS

Objective Number	Indicator	Geographic Area and Baseline Year	Base line Value	NAP Target		ASHA Target		Source of Data
				(09/10)	(10/11)	FY 10 (08/09 to 07/10)	FY 10 (08/09 to 07/10)	
1.8	Percent of Truckers who both correctly identify ways of preventing the sexual transmission of HIV and who reject major misconceptions about HIV transmission	Truckers – Terai Districts – 2009	25.8%		NA			IBBS
1.9	Percent of truckers who report commercial sex in the last year	Truckers – Terai Districts – 2009	48.2%		NA			IBBS
1.10	Average number of commercial sex partners in the last year (reported by truckers)	Truckers – Terai Districts – 2009	3.8		NA			IBBS
1.11	Percent of male migrants who report commercial sex in the last year (In India)	Male migrant – Western districts, 2008	1.4%		NA			IBBS
		Male migrant – Mid and Far Western districts, 2008	5%		NA			IBBS
1.12	Average number of commercial sex partners in the last year (reported by male migrants) (In India)	Male migrant – Western districts, 2008	1.4		NA			IBBS
		Male migrant – Mid and Far Western districts, 2008	4.2		NA			IBBS
1.13	Percent of IDUs who both correctly identify ways of preventing the sexual transmission of HIV and who reject major misconceptions about HIV transmission	IDUs – Kathmandu, 2009	67.6%	NA			70%	IBBS
		IDUs – Pokhara, 2009	62.2%	NA			70%	IBBS
		IDUs – Eastern Terai, 2009	63.2%	NA				IBBS
		IDUs – Western Terai, 2009	56%	NA				IBBS
1.14	Number of individuals reached through community outreach that promotes HIV prevention through other behavior change beyond abstinence and/or being faithful ¹¹							
		FSWs (FY08)	13735 ¹²	24652	24652	18000	20000	Program reports
		IDUs (FY08)	1370	17061	22751	2100	2500	Program reports
		Male Migrants and their Spouse (FY08) ¹³	19322	560,700	598,080	35000	38500	Program reports

¹¹ Baseline value is for ASHA extension program districts only

¹² Baseline includes achievement by ASHA Project in only districts included in the ASHA extension period

¹³ Target for male migrants and their spouse has also been set for Kailali districts based on Reaching Across Borders (RAB) Project achievement in Kailali districts

Objective Number	Indicator	Geographic Area and Baseline Year	Base line Value	NAP Target		ASHA Target		Source of Data
				(09/10)	(10/11)	FY 10 (08/09 to 07/10)	FY 10 (08/09 to 07/10)	
		Clients of FSWs (FY08)	27989	61160	95138	35000	38000	Program reports
		Other Male (FY08) ¹⁴						Program reports
		Other Female (FY08)						Program reports
1.15 % of MARPs reached with HIV/AIDS prevention programs		FSWs – 2008	68.3%	70%	80%	80%	80% ¹⁵	IBBS
		IDU – 2007	16% ¹⁶	40% ¹⁷	50%	25%	30%	IBBS
1.16 % of injecting drug users who avoid sharing injecting equipment in the last month								
		Kathmandu, 2009	99.1 %	98%			Maintain 80%	IBBS
		Pokhara, 2009	98.5 %	99%			Maintain 80%	IBBS
		Eastern Terai, 2009	54.8%	80%				IBBS
		Mid to Far Western Terai, 2009	96.2%	99%				IBBS
Sub-IR2: Build Capacity of HMG/N and civil society to manage and implement HIV/AIDS activities and to inform policy formulation at national, local and community levels to reduce stigma and discrimination and enable access to services.								

¹⁴ Target for Other males and Other females have been deleted in ASHA extension

¹⁵ 80% of estimated FSWs in ASHA Project extension districts

¹⁶ This is the coverage of the ASHA project supported programs in 4 districts (Parsa, Kaski, Kathamandu and Lalitpur)

¹⁷ This is national target for harm reduction programs.

Objective Number	Indicator	Geographic Area and Baseline Year	Base line Value	NAP Target		ASHA Target		Source of Data
				(09/10)	(10/11)	FY 10 (08/09 to 07/10)	FY 10 (08/09 to 07/10)	
2.1	AIDS Program Index ¹⁸							
2.2	Number of USAID assisted organizations providing HIV/AIDS services (including prevention-to-care)	For FY08	53	NA	NA	45	45	Program Reports
2.3	Number of individuals trained in implementing programs related to HIV/AIDS							
2.3	(a) No. of individuals trained to promote HIV/AIDS prevention through other behavior change beyond abstinence and/or being faithful	For FY08	1004 ¹⁹	NA	NA	900	600	Program Reports
2.3	(b) No. of individuals trained in HIV related policy development ⁹					NA	NA	
2.3	(c) No. of local organizations provided with technical assistance for HIV-related policy development ⁹					NA	NA	
2.3	(d) No. of individuals trained in HIV related institutional capacity building	FY08	540	NA	NA	320	275	Program Reports
2.3	(e) No. of local organization provided with technical assistance for HIV-related institutional capacity building	FY08	91 ²⁰	NA	NA	42	40	Program Reports
2.4	Number of people who complete sensitivity training for reduction of HIV/AIDS-related stigma and discrimination	FY08	6250	15 districts	15 districts	8000	9000	Program Reports

¹⁸ This indicator has been dropped in ASHA extension periods

¹⁹ This also includes peer educators numbers (608). Peer educators numbers are not included in the target of FY10 and FY11

²⁰ This also includes number of organizations trained by IAs which are excluded from the FY10 and FY11 targets

Objective Number	Indicator	Geographic Area and Baseline Year	Base line Value	NAP Target		ASHA Target		Source of Data
				(09/10)	(10/11)	FY 10 (08/09 to 07/10)	FY 10 (08/09 to 07/10)	
2.5	Number of HIV/AIDS supportive policies/laws approved							
2.6	Number of districts that have integrated HIV/AIDS into their district plans							
2.7	Number of ministries that have mainstreamed HIV/AIDS component into yearly program							
Sub-IR3: Improved planning, collection, analysis, and use of strategic information by stakeholders to facilitate a more effective and targeted response to the HIV/AIDS epidemic in Nepal.								
3.1	Implementation of HIV/STI biological and behavioral surveillance which adequately tracks trends in the epidemic	FSWs – Kathmandu, 2011 FSWs – Pokhara, 2011 FSWs – Terai highway, 2006 Truckers – Terai highway, 2006 MSMs – Kathmandu, 2004 IDUs – Kathmandu, Pokhara, 2011 IDUs - Eastern Terai, and West to Far-Western Terai, 2005 Migrants – Western Migrants – Far Western	Studies conducted as per national surveillance work plan			1 IBBS among wives of male migrants	2 IBBS	IBBS
3.2	Number of individuals trained in strategic information (M&E, surveillance and tools) through USAID assistance	FY08	337	NA	NA	235	170	Program Reports
3.3	Number of local organizations provided with technical assistance for strategic information activities	FY08	115	NA	NA	45	45	Program reports
Sub-IR4: Increased access to quality care, support and treatment services through public private and non-governmental sources for people living with HIV/AIDS and their families								

Objective Number	Indicator	Geographic Area and Baseline Year	Base line Value	NAP Target		ASHA Target		Source of Data
				(09/10)	(10/11)	FY 10 (08/09 to 07/10)	FY 10 (08/09 to 07/10)	
4.1	Total number of service outlets providing HIV related palliative care (Including TB/HIV)	FY08	28 ²¹	NA	NA	36	36	Program reports
4.2	Number of people living with HIV/AIDS reached with palliative care and support services at USAID-targeted service sites	FY08	2972	NA	NA	4000	4500	Program reports
4.3	Number of USAID-assisted service outlets providing STI treatment	FY08	24 ²²	50 districts	50 districts	33	33	Program reports
4.4	Number of MARPs receiving STI treatment at USAID-assisted sites	FY08	7843	123809 ²³	135934	9000	10000	Program reports
4.5	Total number of USAID-assisted service outlets providing voluntary HIV counseling and testing according to national and international standards	FY08	25 ²⁴	Private sector = 150 Public sector = 68	Private sector = 192 Public sector = 88	34	34	Program reports
4.6	Total number of individuals who receive counseling, testing and results at USAID assisted voluntary counseling and testing service outlets	FY08	15565	171,236 ²⁵	218,895	22000	26000	Program reports
4.7	Total number of individuals trained in voluntary counseling and testing according to national and international standards	FY08	70	655	837	65	40	Program reports

²¹ This baseline value does not include sites that are discontinued in ASHA extension. Discontinued sites are Siraha, Rautahat, Kalaiya, 1 site from Birgunj, Highway health clinic, Kawasoti, Bheri Zonal hospital and Dodhara Chandani. However, we have added few new sites in some program districts

²² This baseline value does not include sites that are discontinued in ASHA extension. Discontinued sites are Siraha, Rautahat, Kalaiya, Highway health clinic, Kawasoti and Dodhara Chandani. However, we have added few new sites in some program districts.

²³ Number includes for MARPs for USAID and non-USAID sites

²⁴ This baseline value does not include sites that are discontinued in ASHA extension. Discontinued sites are Siraha, Rautahat, Kalaiya, 1 site from Birgunj, Highway health clinic, Kawasoti, Lalitpur (YV), Bhaktapur (YV), Bheri Zonal hospital and Dodhara Chandani. However, few new sites in some program districts.

²⁵ Number includes for MARPs for USAID and non-USAID sites

Objective Number	Indicator	Geographic Area and Baseline Year	Base line Value	NAP Target		ASHA Target		Source of Data
				(09/10)	(10/11)	FY 10 (08/09 to 07/10)	FY 10 (08/09 to 07/10)	
4.8	Total number of individuals trained to provide HIV palliative care ²⁶	FY08	71	200	400	60	120	Program Reports
4.9	Total number of health workers trained to deliver ARV services, according to national and/or international standards	FY08	66	30	30	80	80	Program Reports
4.10	Total number of individuals trained in the provision of laboratories - related activities	FY08	40	NA	NA	40	60	Program Reports
4.11	Total number of individuals trained in medical injection safety	FY08	78	NA	NA	20	20	Program Reports
4.12	Total number of individuals trained in HIV-related community mobilization for prevention care and/or treatment	FY08	371	NA	NA	1500	1300	Program Reports
Sub-IR5: Linkages created among stakeholders and national coordination of Nepal's cross-sectional HIV/AIDS program supported.								
5.1	Number of national level collaboration meetings conducted with national level stakeholders such as NCASC, Ministry of Health and Population, Social Welfare Council, Association of International NGOs in Nepal and other ongoing programs related to HIV/AIDS in Nepal	Networking, coordination and collaboration at national level, FY08	11	NA	NA	6	5	Program Reports
5.2	Number of Districts where HIV/AIDS work plan developed by District AIDS Coordination Committee (DACC) through USAID supported ASHA Project	FY09	15			N/A	N/A	

²⁶ This is OP indicator, which was not included in the original M&E plan of ASHA project. However, reporting was done through semi annual reports of ASHA project submitted to USAID. Indicators from 4.9 to 4.12 are also OP indicators, which were also not included in the original ASHA M&E plan

Objective Number	Indicator	Geographic Area and Baseline Year	Base line Value	NAP Target		ASHA Target		Source of Data
				(09/10)	(10/11)	FY 10 (08/09 to 07/10)	FY 10 (08/09 to 07/10)	
5.3 % of sub projects affected by ongoing conflict		All FHI subprojects, contracts, and grants	0%	NA	NA	N/A	N/A	Program reports