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# **EVALUATION OF “ADVANCING SURVEILLANCE, POLICIES, PREVENTION, CARE AND SUPPORT TO FIGHT HIV/AIDS IN NEPAL (ASHA) PROJECT”**

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This publication was produced for review by the United States Agency for International Development. It was prepared by Vivikka Mollrem, Judith Justice, Mahesh Sharma and Poonam Thapa through the Global Health Technical Assistance Project.

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## ACRONYMS

AIDS	Acquired Immuno-deficiency Syndrome
AMDA	Association of Medical Doctors of Asia
ANM	Auxiliary Nurse Midwife
ART	Antiretroviral Therapy
ARV	AntiRetroViral
ASHA	Advancing Surveillance, Policies, Prevention, Care and Support to Fight HIV/AIDS
AusAID	Australian Agency for International Development
BCC	Behavior Change Communication
BCI	Behavior Change Intervention
BSS	Behavioral Surveillance Survey
C&S	Care and Support
CA	Cooperating Agency
CAC	Community Action Centre
CBO	Community-Based Organization
CHBC	Community and Home Based Care
CIP	Community Information Point
CM	Community Mobilizer
CMA	Community Medical Assistant
CMT	Crisis Management Team or Clinical Management Training
CoC	Continuum of Care
CS&T	Care, Support, and Treatment
CS	Communication Specialist
CTO	Cognizant Technical Officer
CWC	Community Welfare Centre
DACC	District AIDS Coordination Committee
DBI	Digital Broadcasting Initiative
DDC	District Development Committee
DFID	Department for International Development (UK)
DHO	District Health Officer (also known as DPHO)
DHS	Demographic and Health Survey
DIC	Drop-in Centre
DPHO	District Public Health Officer
DPG	Dharan Positive Group
EDP	External Donor Partners
EID	Early Infant Diagnosis
EPC	Essential Package of Care
EQAS	External Quality Assessment System
FCHV	Female Community Health Volunteer
FHI	Family Health International
FSGMN	Federation of Sexual and Gender Minorities, Nepal
FSW	Female Sex Worker
FY	Fiscal Year
GAP	Global AIDS Program (CDC)
GFATM	The Global Fund to Fight AIDS, Tuberculosis and Malaria
GoN	Government of Nepal
GWP	General Welfare Pratisthan
HA	Health Assistant
HBC	Home-Based Care

HCT	HIV/AIDS Counseling and Testing
HIV	Human Immunodeficiency Virus
HQ	Headquarters
IA	Implementing Agency
IBBS	Integrated Biological and Behavioral Surveillance
IDU	Injecting Drug User
IEC	Information, Education and Communication
IHS	Integrated Health Services
IMPACT	Implementing AIDS Prevention and Care Project
INF	International Nepal Fellowship
INGO	International Non-Governmental Organization
IR	Intermediate Result
IRC	Independent Review Committee
IT	Information Technology
JSI	John Snow Incorporated
LDTA	Local Development Training Academy
LMD	Logistics Management Division
LOP	Life of Project
M&E	Monitoring and Evaluation
MARP	Most At Risk Population
MASS	Management and Support Services
MCH	Maternal and Child Health
MCHW	Maternal and Child Health Worker
MIS	Management Information System
MOHP	Ministry of Health and Population
MSM	Men who have Sex with Men
MSW	Male Sex Worker
N/A	Not Applicable/Not Available
NANGAN	National Association of NGOs Against AIDS
NAP	National HIV/AIDS Action Plan
NAP+N	National Association of People living with HIV in Nepal
NCASC	National Centre for AIDS and STD Control
NGO	Non-Governmental Organization
NHRC	Nepal Health Research Council
N-MARC	Nepal Social Marketing and Franchise Project: AIDS, Reproductive Health (RH) and Child Survival (CS)
NPHL	National Public Health Laboratory
NR	Nepalese Rupee
NSARC	Nepal STD and AIDS Research Centre
OE	Outreach Educator
OI	Opportunistic Infection
PC	Peer Communicator
PE	Peer Educator
PEP	Post Exposure Prophylaxis
PEPFAR	President's Emergency Plan for AIDS Relief
PIF	Project Indicator Form
PLHA	People Living With HIV and AIDS
PMTCT	Prevention of Mother-to-Child Transmission
PO	Program Officer (ASHA staff)
PR	Principal Recipient (GFATM implementing agency)
PSI	Population Services International
QA	Quality Assurance

QC	Quality Control
QI	Quality Improvement
RFA	Request for Applications
RH	Reproductive Health
RNM	Resource Needs Model
RSO	Regional Security Officer (at US Embassy)
RTK	Rapid Test Kit
S&D	Stigma and Discrimination
SA	Sub-agreement
SACTS	STD/AIDS Counseling & Training Services
SBC	Strategic Behavioral Communication
SI	Strategic Information
SOP	Standard Operating Procedure
SOW	Scope of Work
SPK	Sahara Paramarsha Kendra
SSG	Syangja Support Group
STD	Sexually Transmitted Disease
STI	Sexually Transmitted Infection
TB	Tuberculosis
TBD	To Be Determined
TG	Trans-Gender
TWG	Technical Working Group
U-CAAN	Universal Access for Children Affected by AIDS in Nepal
UNAIDS	Joint United Nations Program on HIV/AIDS
UNGASS	United Nations General Assembly Special Session (on HIV/AIDS)
UNDP	United Nations Development Program
UNICEF	United Nations Children's Fund
USA	United States of America
USAID	United States Agency for International Development
VCT	Voluntary Counseling and Testing
VDC	Village Development Committee
VSO/N	Voluntary Services Overseas / Nepal
WATCH	Women Acting Together for Change
WHO	World Health Organization

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## EXECUTIVE SUMMARY

USAID's key HIV/AIDS activity, "Advancing Surveillance, Policies, Prevention, Care and Support to Fight HIV/AIDS in Nepal", known as ASHA, began in June 2006, based on the successful experiences of previous USAID projects. ASHA was originally a three-year, \$14 million project with a performance period ending September 2009. USAID has extended the project for two more years until September 2011, at an additional cost of \$7 million, for a total project cost of \$21 million. Family Health International (FHI) is the prime awardee; the Association of Medical Doctors of Asia (AMDA) is a core sub-prime responsible for providing and supervising STI and VCT services; and prior to the extension the Futures Group International was a core sub-prime responsible for multi-sectoral response and policy initiatives.

Though Nepal's overall adult HIV/AIDS prevalence rate is low (less than 0.5 percent in 2007 according to national estimates), it is much higher among certain most-at-risk populations (MARPs); including intravenous drug users (IDUs); female sex workers (FSWs) and their clients; men who have sex with men (MSM); men living in the West and Far West regions who migrate back and forth – especially to India – for work; and their spouses.

Given Nepal's concentrated epidemic, ASHA works towards achievement of five results:

- Reduced HIV transmission through targeted prevention interventions within specific high-risk and vulnerable populations.
- Increased capacity of the GoN Ministry of Health and Population (MoHP) and civil society to manage and implement HIV/AIDS activities and to inform policy formulation.
- Improved planning, collection, analysis and use of strategic information by stakeholders to facilitate a more effective and targeted response.
- Increased access to quality care, support and treatment services through public, private and non-governmental sources for persons living with HIV/AIDS (PLHA) and their families.
- Creation of linkages among stakeholders and support for national coordination of Nepal's cross-sectoral HIV/AIDS program.

This evaluation is intended to assess whether ASHA is making a difference in the national HIV/AIDS response, to document best practices, and to recommend future HIV/AIDS programming – both adjustments needed for the remainder of ASHA and potential directions for the longer term. The evaluation also examines project implementation systems and procedures, to determine whether they are compliant with USAID requirements, whether they are effective, and whether they are resulting in increased capacity of both sub-recipients (NGO implementing partners) and the ASHA team.

During January and February 2010, a four-person evaluation team gathered data through review of documents and project statistics, structured interviews with key informants including government and donor officials and ASHA's team, and site visits to more than 30 past and present implementing partners. Analysis of these data forms the basis for the report's findings and recommendations.

The team found that on the whole, ASHA is meeting its targets for encouraging safe behavior among MARPs, particularly increased use of condoms, and for increasing the number of PLHA receiving quality treatment, care and support. Further, it has made

ASHA Nepal Evaluation

significant contributions to GoN policy and capacity development, especially related to technical standards and guidelines for HIV/AIDS service delivery and to collection and use of strategic information. ASHA has strengthened the skills of NGO service organizations to provide good quality prevention, care and support, and of MARP networks and support groups to advocate for needed HIV/AIDS services. ASHA has worked in collaboration with the GoN and other donors in all of its policy work, and has similarly coordinated its activities at the district level with district public health officials, AIDS coordination committees, and other local partners.

As a result of this progress in the five results areas, the evaluation team concludes that although no one player can take credit for national achievements in a government led multi-donor program, ASHA is indeed contributing to achievement of the project's goal of containing the HIV/AIDS epidemic and mitigating the effects of the disease on those infected and affected by it.

The team found that ASHA's approach to achieving project targets is systematic and evidence based and that quality of work is high. Continuity and consistency of USAID support over several years has been an important factor.

The evaluation identified issues in four of the five results areas that merit addressing during the remainder of the project.

Under Result 1, prevention, referrals by outreach workers to clinical services such as VCT and STI are not consistently followed through for various reasons, including difficulties for clients to reach services distant from them. This is an issue with care and support services (Result 4) as well. It is becoming challenging to reach FSWs with prevention messages, as they are increasingly mobile and are beginning to emerge in new areas and types of establishments. Drop-in Centers, designed as safe, private places where MARPs can receive prevention information, are not cost-effective because of low utilization. On the other hand, positive prevention groups are proving to be quite effective in reaching the target populations.

Under Result 2, policy, capacity building and sustainability, though policy gains have been made in many areas, ASHA efforts to promote cross-sectoral cooperation by engaging line ministries ended after three years before gains had been institutionalized within the GoN. ASHA and other donors have helped improve GoN capacity in laboratory work, logistics, procurement, and other areas, though the work is not completed. Implementing partners have gained strong technical and management skills, but some consider the management skills to be limited to those needed to meet USAID requirements rather than those needed to strengthen the organization. Absence of good measures of capacity building renders it difficult to assess the extent of achievements. ASHA has integrated stigma and discrimination reduction into all of its trainings, but these factors are still considered pervasive, particularly among government service providers. Considerations of sustainability have until recently been lacking in ASHA's capacity building work with implementing partners. The project's concern for gender and inclusion are strong and empowering for female project beneficiaries; however some implementing partners have far to go to involve women in decision-making and management.

Under Result 3, strategic information, ASHA's contribution at the national level has been great. More work is needed with district officials and implementing partners to understand

how national surveillance and locally generated M&E data can provide helpful information for their own planning.

Under Result 4, treatment, care and support, quality in GoN ART clinics still largely depends on support from ASHA implementing partners where ASHA works, especially for counseling and referral. ASHA's Integrated Health Services (IHS) clinics generally serve only one MARP group. Although they provide very high quality services, they are frequently underutilized. Community Home Based Care (CHBC) activities have provided needed care and support to many PLHA, but the program is by nature very staff intensive, may have reached its limits with available budgets, and has not tapped sufficiently into the community to share responsibility for care of PLHA within their villages.

No major issues were identified for Result 5, creation of linkages and national coordination, as ASHA activities are carefully coordinated with those of other stakeholders.

Regarding project management, implementation, monitoring and evaluation, the team found ASHA's systems and procedures to be detailed and comprehensive. Issues and problems are identified early on, quality of services and of data is monitored regularly, and oversight combined with reporting requirements and regular review meetings ensure that implementing partners are steadily working towards their targets and maintain compliance with USAID regulations. The key issue is the heavy burden that these systems and procedures impose on both ASHA staff and implementing partners. For staff of the latter, the time required for data collection and reporting may be demotivating.

Major recommendations for the remainder of ASHA, derived from the issues identified above, include the following (among others):

- As budget permits, expand prevention work with FSWs into new areas where they seem to be moving: emerging towns, markets, establishments.
- Examine the service utilization rate of Drop in Centers and Integrated Health Services clinics to determine whether they can be made cost effective, or if there are other, less costly ways to provide similar services
- In addition to focusing on stigma and discrimination reduction in policy work, also stress alignment and harmonization with GoN and a continuous consultation process with different public partners. With the support of the Board, promote wider applications of the Goals And Resource Needs (GOALS) models within MoHP/NCASC and help build more Nepali expertise in preparation for the next National Action Plan.
- Work with HSCB to facilitate passage of the HIV/AIDS bill. Work with MARP networks to develop and begin implementing strategies to advocate forcefully for passage of the HIV bill, and for other important, unaddressed issues of stigma and discrimination.
- Distinguish more among local implementing partners' capacity to implement and use resources effectively: Some local partners need less oversight than they now receive, and can in fact do more in providing technical assistance to others. Others need organizational strengthening that goes beyond what is needed to meet USAID requirements.
- Work out a sustainability plan with each of the implementing partners. This might include shifting some capacity building activity of smaller NGOs from ASHA to the larger ones, as AMDA is already doing.
- Encourage organizations in which women are underrepresented in management to start mentoring and apprenticeship programs to prepare women for decision making positions.

- Share detailed Integrated Biological and Behavioral Surveillance (IBBS) results with local partners in the concerned districts and provide technical support to them in analyzing and strategizing based on these data. Support information sharing among all local partners and government, to review and analyze M&E data from partners, in order to identify district-wide trends and needs.
- Draw on successful experiences of implementing partners for integration of services with government and for provision of clinical services to multiple MARP groups, to identify good practices that can be applied to other ASHA-supported activities.
- Compare the approaches and effectiveness of CHBC activities provided by other organizations to those of ASHA. Findings should be used to help develop a more integrated, coordinated, cost-effective and community-based approach to CHBC.
- Explore mechanisms to improve linkages and referral between clinical services and resources for other care and support.
- Develop qualitative indicators for assessing capacity building, using an organizational assessment tool or developing an index from organizational characteristics already collected by ASHA.
- Reexamine reporting requirements, in consultation with implementing partners, determine their key reporting concerns, and take steps to reduce reporting and better integrate existing reports. At the same time analyze workload to determine whether there are other ways that workload burden can be reduced.

Finally, the evaluation identifies “best practices” that have broad application, such as the following:

- Engaging PLHA as project front-line workers empowers them, motivates other PLHA to accept services, and reduces stigma and discrimination in their communities.
- Strengthening MARP groups, both national networks and local support groups, has enabled them to advocate effectively with government for needed HIV/AIDS services.
- Replacing doctors with Health Assistants at ASHA-supported clinics has resulted in better services at lower cost.
- Sharing surveillance data with the communities from which the data derived, prior to the surveillance report’s publication, makes the communities more willing to participate in providing accurate information for future surveillance studies.
- The Positive Speakers Bureau has empowered PLHA to speak out against HIV/AIDS, help to give a human face to HIV, and reduce stigma at the family and community level.
- ASHA’s semi-annual partner coordination meetings bring together its own implementing partners with other donors, their implementing organizations and government officials. Participants consider these meetings an excellent means of sharing information, linking to other services, and preventing duplication of efforts.
- ASHA has created a number of project management tools that ensure needed information is gathered and problems are acted upon. Some of these are described in the report.

## I. BACKGROUND AND CONTEXT

USAID has supported the Government of Nepal's (GoN's) efforts to address the country's concentrated HIV/AIDS epidemic since 1993. USAID's current key HIV/AIDS activity, "Advancing Surveillance, Policies, Prevention, Care and Support to Fight HIV/AIDS in Nepal", known as ASHA, began in June 2006, and was designed based on the successful experiences of previous USAID projects, all of which were implemented by Family Health International (FHI) under Cooperative Agreements. ASHA was originally a three-year, \$14 million project with a performance period ending September 2009. USAID has extended the project for two more years until September 2011, at an additional cost of \$7 million, for a total project cost of \$21 million. No further extensions are planned. A good summary of Nepal's national program and USAID's role is found at Annex 6.

Though Nepal's overall HIV/AIDS adult prevalence rate is low (less than 0.5 percent in 2007 according to national estimates), it is much higher among certain most-at-risk populations (MARPs); including intravenous drug users (IDUs); female sex workers (FSWs) and their clients; men who have sex with men (MSM); men living in the West and Far West regions who migrate back and forth – especially to India – for work; and their spouses.

Given Nepal's concentrated epidemic, ASHA works towards achievement of five results:

- Reduced HIV transmission through targeted prevention interventions within specific high-risk and vulnerable populations.
- Increased capacity of the GoN Ministry of Health and Population (MoHP) and civil society to manage and implement HIV/AIDS activities and to inform policy formulation.
- Improved planning, collection, analysis and use of strategic information by stakeholders to facilitate a more effective and targeted response.
- Increased access to quality care, support and treatment services through public, private and non-governmental sources for persons living with HIV/AIDS (PLHA) and their families.
- Creation of linkages among stakeholders and support for national coordination of Nepal's cross-sectoral HIV/AIDS program.

At ASHA approval, FHI was designated as the prime awardee, responsible for overall project management, for implementing the service delivery aspects of the project through local implementing agencies and for strengthening those agencies, for coordination with other stakeholders, and for technical leadership. Futures Groups International was sub-prime responsible for high-level policy development, for strengthening district AIDS coordination committees (DACCs), for supporting police and military to incorporate HIV/AIDS into their training programs, and for strengthening MARP groups in policy dialogue. The Association of Medical Doctors of Asia (AMDA) was sub-prime responsible for providing STI/VCT services in strategic locations and for strengthening local implementing agencies that provide these services.

At the time of the cost extension in 2009, several factors combined to modify ASHA expected results: a lower level of USAID funding; a new Global Fund grant that could take

over some activities from ASHA, particularly work with some of the MARP groups and DACC strengthening; creation of a national HIV/STI Control Board (HSCB) responsible for policy and strategy development, national multi-sectoral planning, coordination, monitoring and evaluation, and national resource mobilization; and completion of ASHA work with police and military. For those reasons, Futures was not continued during the extension and ASHA focused its prevention work primarily on FSWs and their clients, a group not supported by other donors.

The changes are reflected in the results framework, shown below. Italicized portions are NEW in the extension period; and bracketed portions are ELIMINATED for the extension period.

### ASHA Results Framework (original and revised)

**ASHA Goal:** Contain the HIV/AIDS epidemic and mitigate effects of HIV on those affected and infected.

Result 1	Result 2	Result 3	Result 4	Result 5
Reduce HIV infection and transmission through targeted prevention interventions w/i specific high-risk and vulnerable groups	Build capacity of GoN and civil society to manage and implement HIV activities and inform policy formulation	Improve planning, collection, analysis and use of strategic information	Increase access to quality care, support, and treatment through public, private, and non-governmental sources for PLHA and their families	Create linkages among stakeholders and support national coordination of Nepal's cross-sectoral HIV/AIDS program
<p><u>Sub results:</u></p> <p>1.1. Reduce STI/HIV transmission in commercial sex.</p> <p>1.2. Reduce HIV transmission among IDUs and their sex partners.</p> <p>1.3. Reduce STI/HIV transmission among migrants</p> <p>1.4. Reduce STI/HIV transmission among MSM</p> <p>1.5. Engage PLHA in [reducing transmission] positive prevention.</p>	<p><u>Sub results:</u></p> <p>2.1. [Build] Strengthen capacity of GON [and civil society] to formulate policy to reduce stigma and discrimination, and to enable equitable access to services.</p> <p>[2.2. Build capacity of GON and civil society to plan, manage, and implement effective HIV/AIDS interventions.]</p> <p>2.2. Strengthen capacity of GON to plan and manage an effective national response.</p> <p>2.3. Build local capacity and sustainability</p>	<p><u>Sub-results:</u></p> <p>[3.1. Support collection of 2<sup>nd</sup> generation surveillance data and data use for evidence-based policy development and decision-making.]</p> <p>[3.2. Strengthen capacity of Uniformed Services to conduct BSS and use data to implement effective strategies.]</p> <p>3.1. Support collection, analysis and use of research, surveillance and strategic information.</p>	<p><u>Sub-results:</u></p> <p>4.1. Collaborate with GoN to strengthen capacity of the national health system to provide quality care and treatment services to PLHA and their families.</p> <p>4.2. Strengthen capacity of CBOs to provide quality treatment and care services for PLHA and their families.</p>	<p><u>Sub-results:</u></p> <p>5.1. Support national coordination with GON, donor agencies, INGOs and NGOs.</p>

## **II. EVALUATION PURPOSE AND METHODOLOGY**

### **PURPOSE AND OBJECTIVES**

USAID commissioned this evaluation to assess progress on the key expected activities of ASHA, based on the project design and annual work plans, over the life of the project to date. The evaluation is to determine whether ASHA is making a difference in the national HIV/AIDS response, to document best practices, and to recommend future HIV/AIDS programming - both adjustments needed for the remainder of ASHA and potential directions for the longer term. The evaluation also examines project implementation systems and procedures, to determine whether they are compliant with USAID requirements, whether they are effective, and whether they are resulting in increased capacity of both sub-recipients (NGO implementing partners) and the ASHA team. The complete scope of work is at Annex 3.

### **METHODOLOGY**

The evaluation was carried out by two US and two Nepali experts over a period of four weeks in country during January and February 2010. (The team calendar is at Annex 4.)

#### **Document Review**

The team reviewed national documents describing the HIV/AIDS epidemic in Nepal as well as a wide range of project documents including agreements, work plans, biannual progress reports, monitoring and reporting tools, selected process evaluation reports of individual partners, informational reports produced through the project, and documents of other donors. The complete list of documents reviewed is found at Annex 2.

#### **Interviews**

Based on detailed questions provided in the scope of work as well as questions arising from the document review, the team developed a comprehensive set of questions to be answered during the evaluation, and identified the sources of information to be used for each. From this list, the team designed interview guides for each of the following groups: USAID respondents, ASHA core partners, Government of Nepal officials, other donors, international NGOs, and NGO implementing partners. (Note: the team refers to sub-recipients or implementing agencies as implementing partners throughout the report.) The team identified key information to look for when observing the project sites of implementing partners. The complete set of key evaluation questions and interview guides is at Annex 5. The team interviewed, in addition to USAID and ASHA team members, about 40 individuals from government, other donors and INGOs. The team also interviewed and, in most cases, observed activities of 31 past and present implementing organizations, representing MARP networks and PLHA support groups; prevention partners; treatment and care partners; research, management and logistics organizations; and legal support partners.

## Site visits

Team members observed project sites of implementing partners in districts of the Kathmandu valley, in the Far West region, in the East, and in the West. Individuals and organizations visited are listed in Annex 1.

## Analysis

Team members took detailed notes from interviews and site visits. Information from document review, interviews and site visits were aggregated according to the evaluation questions described above so that team conclusions would be based on data derived from several sources. In some cases, the team went back to FHI ASHA for further information or clarification. The team presented preliminary findings and recommendations to USAID and to ASHA (FHI and AMDA), to enable them to comment and add further information before this report was written.

## III. FINDINGS and RECOMMENDATIONS

### A. ASHA PROJECT ACHIEVEMENTS AND RESULTS

**Outcome-Level Results: Contain the HIV/AIDS epidemic and mitigate effects of HIV on those affected and infected.**

Outcome level indicators relate to HIV prevalence among the identified MARPs. In most cases, targets are to reduce or contain prevalence levels at the rates found in the beginning of the ASHA project. The IBBS data indicate a declining or stable level of prevalence for all groups. This is very good news.

#### Percent of Most At Risk Populations Who Are HIV Infected

MARP	Location	Actual 2004	Actual 2005	Actual 2006	Actual 2007	Actual 2008	Actual 2009	Target 2010	Target 2011
FSWs	Kathmandu	2.0		1.4		2.2			1.4
	Pokhara	2.0		2.0		3.0			2
	22 Terai Districts			1.5			2.3		1.5*
Truckers	Terai Districts			1.0			0.0		1.75*
IDUs	Kathmandu		51.6		34.7		20.7	20*	20
	Pokhara		21.7		6.8		3.4	5*	5
	E. Terai		31.6		17.1		8.1	10*	
	W. Terai		11.7		11.0		8	8*	
MSM Migrants	Kathmandu	3.9			3.3		3.8	2	
	Mid- and Far West			2.8		0.8			1*
	Western districts			1.1		1.4			1*
Spouses of migrants	Far west districts					3.3		2	

Data on baseline and targets come from USAID PMP and ASHA M&E Plans, and most data on prevalence is from IBBS studies. Starred targets are those of the National Action Plan. Unstarred targets are specific to ASHA.

The decline among IDUs is remarkably high. Part of this is explained by the high turn-over rate among IDUs, with the newer, younger IDUs showing a lower level of prevalence.

There are no data prior to the 2008 IBBS on prevalence rates among spouses of migrants. One might wonder why the prevalence among spouses of migrants is higher than that among the migrants themselves. This is because in many cases the migrants who infected their spouses have already died, often without recognizing that they were infected. Infection rates are higher among widows of migrants than among currently-married spouses of migrants.

The increase in prevalence among FSWs is not statistically significant. Use of condoms by FSWs and clients (described under Result 1 below) seems to be on the increase.

#### Finding:

- One cannot assume that ASHA alone is responsible for the declining or stable prevalence rates indicated above; as other stakeholders have also been at work. However, ASHA's progress on the five results areas of the project, taken together, has resulted in a sizeable contribution to this outcome. Preventive measures among the key at-risk groups, increased capacity of government and civil society to manage the epidemic, improved use of strategic information to design effective interventions, increased access to care and support for PLHA, and strong coordination among stakeholders work together to improve the effectiveness of the national program in curbing HIV prevalence.

#### **Result 1: Reduce HIV infection and transmission through targeted prevention interventions within specific high-risk and vulnerable groups.**

Prevention intervention has been one of the major activities of USAID assistance in Nepal since it began. ASHA has continued this support. Targeted prevention has been the mainstay of the project with emphasis on FSWs and clients of FSWs. Activities are also implemented for IDUs, migrants, spouses of migrants and PLHA in selected districts. ASHA engages PLHA in prevention activities in selected districts.

#### General findings:

- ASHA's prevention approach is systematic and evidence informed; the quality of work is high; and targeted results are generally being achieved, with some deviations. Continuity and consistency in both financial support and technical guidance have contributed to achieving many program targets.
- Given the nature of the epidemic, in which HIV infection is limited to specific high-risk groups and driven by injecting drug use, commercial sex and migration, the targeted intervention is most appropriate. Moreover, ASHA program interventions are in line with the national HIV strategy (2006-2011).

- ASHA is the only donor project addressing HIV/AIDS prevention among FSWs. As such, it gives greater emphasis to FSWs and clients than other groups. But all MARPs with which ASHA works have accessed services and received prevention education.
- The capacity of MARP groups varies. MSM, recovering drug users, and some positive groups are more capable, educated and organized than FSWs. FSWs are mostly poor, illiterate and highly stigmatized and were not able to form as strong a group as other MARPs. Yet all such groups are well motivated and making efforts in drawing funding from other donors. ASHA support to networks and through them to their respective Community Based Organizations (CBOs) in the field has contributed to engaging them in the program, in supporting access to services and in advocating for services locally and nationally.
- Coordination and linkages with other programs vary and at times are not clear at the implementation level. In many of the districts where ASHA is working there are other programs for various MARPs. Such programs differ in focus and coverage but limited synergy and coordination is often highlighted both by ASHA partners and by others. This is particularly evident in those districts (Sunsari, Kaski, Kathmandu) where there are Global Fund, DFID or other programs where cross referral between ASHA/IHS and other programs is very limited. Though ASHA and others have tried to prevent duplication through sharing of district plans and participation of other donors in ASHA's biannual coordination meetings, synergy among programs is still in question.
- Prevention activities are primarily implemented through NGOs with little or no direct involvement of government. Where possible, ASHA does collaborate with Government, e.g., for obtaining condoms from DHOs and district awareness programs. Government officials interviewed felt that though ASHA is an asset, government has not received significant technical or financial support.

#### 1. Female Sex Workers

FSWs are highly mobile and often found along the highways and in major urban centers in Nepal. Lately, FSWs are reported to be active in newly emerging towns and bazaars as well as in new kinds of establishments (lodges, guesthouses).

There are 25,000 to 34,000 FSWs in Nepal with 7,000 to 8,000 located in Kathmandu.<sup>1</sup> Consistent condom use with clients remains a challenge although it has increased in Eastern Terai, Western Terai and Pokhara. The UNGASS coverage indicator (source IBBS) shows only about 40 percent of FSWs were reached by the prevention program nationally.<sup>2</sup> This is a clear indication for a need of scaling up activities to reach larger number of FSWs.

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<sup>1</sup> National Estimates of HIV Infections, Nepal 2007

<sup>2</sup> The definition from the UNGASS report is those who know about VCT services and those who receive free condoms. A broader measure of coverage would show a higher figure.

*What has been learned about FSWs and clients:*

- There is substantial diversity in behavioral risk levels between FSWs across and within regions.
- Interventions with street-based FSWs (poor and disenfranchised) require more intensive peer support elements.
- HIV prevalence among establishment-based FSWs is low (1.3 percent in Kathmandu in 2008).
- In Kathmandu, consistent condom use is high with clients (56.5 percent), but not with boyfriends and husbands (18.1 percent).

*FSWs reached by HIV prevention activities:*

<b>FSW</b>	<b>Oct 06 – Sept 07</b>	<b>Oct 07 – Sept 08</b>	<b>Oct 08 – July 09</b>	<b>Aug 09 – Dec 09</b>
ASHA Target	10500	11000	12000	18000
Achievement	12906	14494	15575	11471
percent reached	123	132	130	64

*Condom use with last client reported by FSWs*

<b>Percent of FSWs reporting the use of a condom with their most recent client</b>	<b>2006</b>	<b>2007</b>	<b>2008</b>	<b>2009</b>
Kathmandu	77.2		75.0	
Pokhara	75.0		64.5	
22 Terai Highway Districts	66.3			84.8

(Source: IBBS, 2006, 2008 and 2009)

Findings on FSWs

- Despite some decline in recent years in meeting targets for prevention activities, the achievements against targets have been consistently high.
- Drop In Centers (DICs) are strategically located and often colocated with Integrated Health Service (IHS) Centers. (Discussion about IHS is under Result 4.) DICs are appreciated by the clients, but the overall service utilization rate is very low ranging from four to twelve persons a day. This is not cost-effective.
- NGO field personnel are efficient and have good rapport with FSWs. They meet regularly and ensure availability of condoms, attend clinics and if opportunity arises try to establish links with other needed services. NGO staff interviewed by the team estimate that there is on average 30 percent turnover for FSWs, clearly indicating a need for early contact to new entrants with prevention education. ASHA has established different levels of intensity of contact for recent FSW contacts and those who have had regular contact, but these differences were not apparent during evaluation team site visits. The team questions whether the current level of intensive contact for those who have already received substantial prevention education is required.
- Most FSWs wish to have additional skills so that they can shift to safer work. ASHA implementing partners have gone beyond their prevention mandate and made efforts to establish links with FSWs to organizations that could provide skills training, but linkages were generally weak and opportunities limited.

- Every implementing partner agrees to specific targets and receives budgets to meet such targets. Partners are clearly meeting or exceeding their targets, but have reached the limits of their capacity given existing budget levels.



Two clients visit the STEP-Nepal Drop In Center, where, with the Center's DIC operator, they play a game of "Snakes and Ladders" designed to reinforce messages about consistent condom use.

## 2. Injecting Drug Users

There are an estimated 28,439 IDUs in Nepal with an HIV prevalence in Kathmandu of 34 percent in 2007 and 20 percent in 2009, although prevalence varies widely by location.<sup>3</sup> ASHA currently provides prevention services (as well as integrated health services and community home based care) for IDUs in Kathmandu, Lalitpur (prevention only), Pokhara and Birgunj (Parsa). The GFATM Round 7 grant supports scale up of harm reduction activities for IDUs in seven target districts and UNODC implements comprehensive harm reduction in eight districts including Kathmandu and Parsa, with community outreach and establishment of DICs and post rehabilitation care centers. Operating locations in the districts are different if more than one partner is working.

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<sup>3</sup> National HIV prevalence among IDUs was estimated at 23 percent in 2007 – more recent estimates are not available.

### What has been learned about HIV programming among IDUs:

- IDUs are primarily young men; nearly half of IDUs in Nepal are based in Kathmandu.
- HIV prevalence among IDUs (IBBS 2009) varies from 3.4 percent in Pokhara valley to 20.7 percent in Kathmandu.
- Sharing behavior is high, but varies across regions and is higher among women.
- Approximately 15 percent of male IDUs are also clients of FSWs; approximately half of male IDUs use condoms when they buy sex.
- Uptake of VCT services is limited among IDUs, but is highest in areas where NGO-operated VCT services are available.

UNGASS program coverage indicators show that about 60 percent were reached in the last year. Almost all surveyed had used sterile needle and syringe in their last injection.

### *IDUs reached by HIV prevention program*

	Oct 06 – Sept 07	Oct 07 – Sept 08	Oct 08 – July 09	Aug 09 – Dec 09
ASHA Target	1500	3000	5000	2100
Achievement	1332	1162	2384	1680
Percent reached	89	39	48	80

ASHA achievement against targets for IDUs has been fairly high in recent years, above 80 percent. The number of IDUs reached by ASHA prevention program in 2008 -2009 (3,546) is approximately 20 percent of national achievement (17,000 reached by other national programs), surprisingly high as ASHA is working in four districts only.

### *Condom use in last sex reported by IDUs*

Percent of sexually active IDUs who report use of a condom at last sex	2006	2007	2008	2009
Kathmandu		74		66.8
Pokhara		83.9		89.1
East Terai		75.3		73.3
West to Far West Terai		67		67.7

### Findings on IDUs:

- Condom use by IDUs has remained fairly consistent over the period between 67 to 89 percent in different regions. This is corroborated by the decline in HIV prevalence during the same period of time.
- GFATM Round 7 and the DFID<sup>4</sup>-funded IDU programs provide comprehensive harm reduction which includes needle syringe exchange along with prevention activities, often implemented in the same districts (e.g. Kaski, Parsa, and Kathmandu) where ASHA's IDU program is implemented. While several NGOs are receiving funds from multiple donors for IDU programs and donors have made an effort to coordinate their efforts, as shown in ASHA's district profiles, the evaluation team found that the collaboration/coordination mechanism is not clear at the implementation level. Duplication, particularly in prevention education, is a concern.

<sup>4</sup> UK's Department for International Development  
ASHA Nepal Evaluation

- Other donors are better able to address harm reduction than USAID. Remaining interventions with IDUs can be phased out in 2011.

### 3. Migrants

(Total number 1.6 million; 1.4 million of whom migrate to India)

Since 2006, ASHA has implemented HIV prevention programs for migrants and spouses of migrants in Kailali and Kanchanpur districts. (Accham was also a target district until June 2009.) The recently awarded GFATM Round 7 grant will now provide support for migrant-focused HIV prevention programs in eighteen districts including ten districts in the Mid and Far West regions.

#### *What has been learned:*

- Nepali migrants who have returned from Mumbai have higher HIV prevalence than non-migrants and/or migrants who return from other cities in India.<sup>5</sup>
- Nepali male migrants in Mumbai have a poor understanding of HIV transmission; some visit brothel-based sex workers regularly and have low rates of consistent condom use, though recent data indicates an improvement in condom use.
- Most Nepali migrants in India have non-resident status, low literacy, low incomes, poor access to general health services, and minimal access to HIV prevention, care, and treatment programs.

The UNGASS indicator of coverage for migrants shows some consistency over the years and has not declined. In 2008 only 13 percent of migrants were reached by the prevention program while in 2010, 17 percent and 15 percent were reached in West and Far West respectively.

#### *Male migrants and their spouses reached by prevention program*

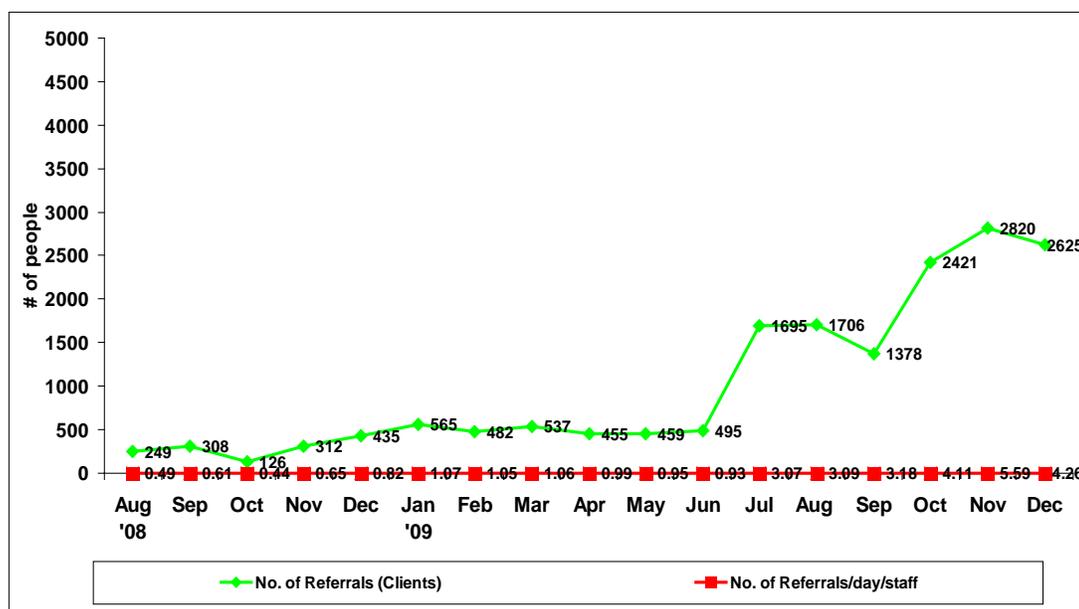
<b>Migrants</b>	<b>Oct 06 – Sept 07</b>	<b>Oct 07 – Sept 08</b>	<b>Oct 08 – July 09</b>	<b>Aug 09 – Dec 09</b>
ASHA Target	14000	17000	20000	35000
Achievement	18653	20705	24955	13838
Percent reached	133	122	125	40

#### Findings for migrants:

- ASHA achievements against targets are consistently high except in the last year, for which only partial data are available. The preliminary data available for second half of 2009 is promising. But often it is more difficult to reach targets once the preliminary group has been served.
- Despite the GFATM program in 18 districts focusing on migrants and their spouses, Western districts like Kaski and Syangja where migration is the main source of infection are not served by GFATM, ASHA or other donors.

<sup>5</sup> Assessment of Migration and Associated Risk Behavior among Nepali Migrant Men in Mumbai. FHI. November 2003.

- ASHA has made an attempt to provide prevention education including referral for services to internal migrants in Kathmandu (referred to as clients of FSWs). If STI referral is taken as an indicator of effectiveness in promoting prevention, the Community Welfare Center (CWC), an ASHA implementing partner, referred large numbers of migrant workers in Kathmandu (transport workers, taxi drivers, labor workers in formal settings), as shown below:



- A key element of the prevention activities for Nepali migrants, implemented through the Digital Broadcasting Initiative (DBI) using satellite radio broadcasting, was stopped in the extension phase. The project was considered successful in introducing large numbers of people to HIV/AIDS prevention concepts, but was prohibitively expensive to continue.
- Only CARE/Nepal's Emphasis project is now initiating activities to reach migrants at the destination in India, focused on Delhi. FHI has some experience (Reaching Across Borders Project) working both at origin and destination in Nepal and India.

#### 4. Men having sex with men (MSM) and Trans-Gender men (TG)

(Total number 132,000)

Targeted prevention activities in MSM communities are covered by GFATM Round 7 in 15 districts; therefore ASHA's intervention is limited to strengthening the network of MSM/TG and coordinating with GFATM partners, NCASC, HSCB and other key stakeholders to ensure that gaps in programming are covered.

*What has been learned about HIV prevention for MSM<sup>6</sup>:*

- More than half of MSM reported having unprotected sex in the past month, and more than half reported multiple partners
- More than 60 percent of MSM had sex with a woman in the past 12 months
- Levels of knowledge and appropriate health-seeking behaviors are still low, with low rates of self-referral for STI check-ups (10 percent) and low uptake of VCT (5 percent ever) 2007
- Access to condoms is inadequate, with only 28 percent of MSM able to obtain a condom when they need it
- There is a small group of MSW (approximately 90 in Kathmandu).
- STI rates are high among MSW, with 55 percent currently infected with an STI.
- More than half of MSW have experienced physical violence (37 percent), rape (37 percent), blackmail, or discrimination.

Findings for MSM:

- ASHA support for the Federation of Sexual and Gender Minorities Nepal (FSGMN) was well appreciated because it built capacity and helped increase access of MSM to services.
- There are no direct services from ASHA to MSM. Given budget constraints, this is appropriate.

5. Positive prevention

The National Action Plan, or NAP, (2008-2011) includes some activities on positive prevention, mainly focusing on manual and guideline development, trainings and procurement of Community Home Based Care (CHBC) kits for a limited number of PLHA. The national response has not yet incorporated positive prevention as an explicit and resourced strategy for PLHA who are aware of their status. One practical barrier has been the small number of PLHA groups that are registered and eligible for funding. Positive groups had formed loose networks with the aim of supporting each other before ASHA came in, and then formalized their status (registered with the government) to gain ASHA funding. As many as 200 support groups have received DFID civil society challenge funds through the National Association of PLHA – Nepal (NAP+N) to strengthen their CBOs and networks. As a result, the number of registered PLHA groups is on the increase. ASHA began positive prevention activities with PLHA groups in 2007 and continued these activities under the cost extension.

<b>P+ prevention</b>	<b>Oct 06 – Sept 07</b>	<b>Oct 07 – Sept 08</b>	<b>Oct 08 – July 09</b>	<b>Aug 09 – Dec 09</b>
ASHA Target	0	0	0	800
Achievement	339	439	931	867
Percent reached				108

<sup>6</sup> Key Findings of MSM Study in Kathmandu: Dissemination to MSM communities in Kathmandu, 19 May 2005. CREHPA, Blue Diamond Society, USAID/ FHI-Nepal

### Findings for positive prevention:

- Positive prevention with involvement of PLHA is an effective approach. It has produced good results for concordant and discordant couples as well as for the general population. The Positive Speakers Bureau encourages others to access VCT and other services. It has brought families together, promoted safer sex and developed good understanding.
- Given the targets set for these groups and geographical coverage they need to achieve, staff (Community Mobilizers, Outreach Educators) and budgets are very tight. Readjustment of targets or budget may be needed, to improve funding for those groups who are meeting their targets despite difficulty and to reduce it for those that appear underutilized.
- Stigma and discrimination to HIV is still high in rural areas. Scaling up the S&D reduction program is needed.

### 6. Community based PMTCT

This is a pilot activity in partnership with Government and UNICEF. Achham is the focus district where the program was initiated a year ago. It is too early to draw any conclusions as to the value of the research element of the pilot. Since PMTCT coverage in the country is very low (less than 3 percent), this initiative is an important effort to provide lessons for potential future scale up.

### Recommendations on Result 1

- As budget permits, expand prevention work with FSWs into new areas where they seem to be moving: emerging towns, markets, establishments. Given FSWs' high mobility, occasional police clamp down making them go underground, often to new locations, and weak organizational capacity, interventions for FSWs need to be adaptable – in terms of both activities and locations – if they are to be effective in maintaining or reducing prevalence.
- Examine the service utilization rate of Drop in Centers – both those that are free-standing and those attached to IHS services, to determine whether they can be made cost effective, or if there are other, less costly ways to provide similar services, such as Community Information Points (CIPs).
- Review FHI's and CARE Nepal's experiences with cross-border programs for migrants, to determine if there may be lessons learned for future USAID programming.
- Reexamine targets versus budget for positive prevention groups to determine whether adjustments are needed, as there appear to be workload inequities among different groups.
- In national fora and among other donor-funded programs, emphasize the need for scale up of activities to reduce stigma and discrimination.

### **Result 2: Build capacity of GoN and civil society to manage and implement HIV activities and inform policy formulation.**

With the National Strategy (2006-2011), the National Operation Work Plan (2003-2007) and the National Action Plan (2008-2011), Nepal has provided ASHA with a national enabling environment for successful programming. Since many stakeholders are involved in policy and capacity building, sole attribution for achieving results to one project cannot be given; however, there are clear indications that ASHA has contributed to policy development and capacity building with a positive impact on the overall national response.

#### Policy development:

ASHA has supported policy formulation and implementation at four levels.

First was the initiative to foster a multi-sectoral response and increase political commitment and resource allocation. The main activities, carried out by ASHA core sub-prime, Futures, were at a time of civil unrest (mid 2006-7) and transition (2008-mid 2009), when it was difficult to maintain commitment in line ministries.

- For the ASHA extension period, when the Futures component was discontinued, assumptions were made that the HSCB would take on all the multi-sectoral response and related policy work. This assumption was premature. There was no handover of activities to the Board by ASHA. NCASC and UNAIDS were unaware of the internal changes within ASHA that might have implications for continuing policy work. Therefore some work undertaken by ASHA in the first three years has not borne fruit. For example, the HIV Bill has not yet been passed (though it has been revived and updated), and the line ministries no longer have a focal person for HIV/AIDS. DACCs are in general still weak.
- The HIV/AIDS curriculum for the armed and uniformed forces has been integrated into its training programs, but not so for the Local Development Training Academy (LDTA). However, training in HIV within the LDTA, which provides trainings to District Development Committees, Village Development Committees (VDCs) and municipalities, has raised awareness sufficiently that a few of the local bodies have set aside NRs 25,000-50,000 annually, administered through the DACCs, for support to PLHA groups.

Second was ASHA's contribution to the National Action Plan (2008-2011). In 2007, the GoN expanded its planning process to include an analysis of the resources needed to meet targets and expected impact in the reduction of new HIV infections if targets were met. The GoN also expressed interest in exploring alternative resource allocation scenarios of NAP and to calculate various opportunity and/or additional costs. Futures/ASHA collaborated with NCASC and initiated the application of the Goals <sup>7</sup> model. Goals analyzed the NAP costings for different scenarios and concluded that NAP costing is appropriate to the nature of the epidemic. The GoN planned to pilot the model in a small geographical region and re-use the model for the next NAP, for which ASHA may be called upon, as there are no other

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<sup>7</sup> Goals is a computer model designed to enhance strategic planning for HIV/AIDS control programs to help answer several key questions: How much funding is required to achieve the goals of the strategic plan? What goals can be achieved with the available resources? What is the effect of different patterns of resource allocation on the achievement of program goals? The GOALS Model does not provide all the answers, but aids government and civil society advocates in understanding the effects of funding levels and allocation patterns on service delivery options.

funds available to roll it out. There are in-country experts but not in sufficient numbers to help with the next NAP.

Third was ASHA’s activity to strengthen systems. Particularly important among these efforts was ASHA collaboration with UNDP to strengthen the National Public Health Laboratory (NPHL), to establish a national External Quality Assessment System (EQAS) for HIV<sup>8</sup>, and to strengthen pharmaceutical supply. ASHA provided national support for development of Standard Operating Procedures (SOP) for logistics, training manual development, roll out of logistics training, and access to national supply of PMTCT drugs/test kits; and then collaborated with UNDP and JSI Deliver to strengthen HIV logistics.

Fourth is ASHA’s strong participation, working with NCASC and other stakeholders, to develop standards and guidelines for HIV/AIDS programs. ASHA is active on technical working groups (TWGs) and has had input into national response standardization. In 2006, ASHA participated in four committees, TWGs and review panels of NCASC. Today it is a member of twelve TWGs with NCASC, UNAIDS, WHO, UNODC and UNICEF. Some examples of ASHA’s contributions are listed here:

<b>Date</b>	<b>National Document Developed</b>	<b>ASHA’s role</b>
2009	Guidelines on STI Case Management	This 3 <sup>rd</sup> revision was led by NCASC, ASHA participated in TWG; original and previous revisions were developed by FHI under earlier projects
2008	OI Management Guidelines	Led by NCASC with GF funding, with tech support from ASHA
2008	CHBC Guidelines	Led by NCASC, tech support from ASHA, based on original ASHA guidelines
2009	ART Adherence Counseling Training Manual	Led by NCASC, tech support from ASHA
2006	CHBC for Adults and Children Training Manual	Led by NCASC, tech support from ASHA, first developed for use by ASHA project
2007 and 8	STI/VCT Lab Training Manual and Refresher Training Manual	Led by NPHL, tech support from ASHA – not published but in use
2007	SOP for HIV Counseling and Testing (HCT)	Developed for ASHA project; NCASC now preparing national SOP based on this work
2008	SOP for Clinical Mgmt of HIV	Led and developed by NCASC with tech support from ASHA, based on SOPs developed by ASHA for its activities

ASHA also participated in the development of national logistics documents: SOP HIV/AIDS Logistics Management System (2007), and HIV & AIDS Logistics Management System Training Manuals (Reference Book, Trainer’s Guide & Participant’s Handbook) (2009).

Policies related to Stigma and Discrimination (S&D):

Within ASHA the support for strengthening civil society advocacy of MARP groups at the national level is much more effective than support to GoN in reduction of S&D. ASHA has trained 30,041 persons including implementing partner staff, target groups, PLHA, members of the uniformed services, health workers, community members and government officials in S&D, 96 percent of them prior to the no-cost extension. S&D “is pervasive” in the

<sup>8</sup> EQAS is a means of testing quality of laboratory blood testing to identify HIV/AIDS using nucleic acid testing to determine viral loads.

government health services according to some informants interviewed by the team. However, all clinical training of ASHA, for which government participation comprises a large proportion, include sessions on S&D. Including all types of training, government staff as a percentage of all individuals receiving S&D training is about five percent. Nevertheless, personnel at ART centers in hospitals in the Far West visited by the team said there was no evidence of S&D, and instead noted that PLHA get better care than other hospital visitors.

- As part of FHI's global knowledge transfer, ASHA adapted and developed an S&D toolkit through consultative workshops with support groups and stakeholders throughout Nepal. ASHA continues to seek opportunities to integrate HIV/AIDS awareness-raising and S&D reduction activities into other USAID-funded sectoral programs. ASHA through Futures identified and trained a range of "policy champions" from faith communities, PLHA, affected communities, civil society, legislative groups, media, and the private sector.
- The Positive Speakers Bureau is a recent initiative for ASHA. It is making strides in addressing S&D reduction among the MARP groups themselves, but also among policy makers (in the GFATM CCM and the HSCB), in the media and among the general population. In total 107 PLHA positive speakers have been mobilized.
- Passage of the HIV Bill is critical both to the promotion of human rights and institutional capacity to deal with violations by any sector. In the interim, as noted by some donors and local NGOs, there is no indication who in GoN responds when its HIV policies are not followed through by its own system or ministries, such as discrimination of HIV infected children in schools as reported repeatedly in the media or FSWs arrested by police for carrying a condom.

#### Capacity Building:

In its technical brief FHI ASHA recognizes that capacity building is a long term and continuous process of "identifying, strengthening and sustaining the ability of the individual, communities and local organizations in collective pursuit of their own interests, overcoming their challenges and accomplishing their goals". FHI views organizational capacity building as it applies to civil society partners as achieving organizational readiness to meet USAID requirements in terms of governance, program and financial systems. Once this is in place, the next step is how well they use those capacities to attract other resources/donors. The latter process has yet to begin in earnest.

- ASHA's contribution to capacity building at the national level, as in policy development, has been in logistics, laboratory, procurement, strategic information, curriculum, standard operating procedures and adoption of national guidelines for HIV prevention, treatment, care and support.
- Important capacity building work has been done with civil society, especially the national MARP networks and ASHA-supported technical support NGO service providers. National advocacy groups (MARP networks) and implementing partners are much stronger now than they were five years ago. However, at the district and local level, MARP support groups, which can have great influence on district and local level services, still need substantial strengthening. ASHA notes that progress has already been made through district level training and capacity building carried out by networks, through Positive Prevention and CHBC teams. Some now have the capacity to provide

CHBC services on their own. Still the team believes that many of these groups need more consistent, hands-on support to reach their potential as independent, fully functioning NGOs.

- Implementing partners praise the training and tools they have received from ASHA – particularly the technical skills they have received in HIV/AIDS – including skills at effectively reaching the target groups. Many partners believe that the management tools and systems put into place through ASHA have made them more attractive to other donors. However, some feel the management training (M&E, finance, reporting) is geared towards ASHA’s own needs rather than development of the entire organization.
- ASHA’s approach to transfer of organizational and technical capacity is through initial training, regular refresher training, repeated reinforcement of trainings through regular monitoring and site visits, correction of errors found in reporting, and use of guidelines, SOPs, “memory joggers” and other tools that define in detail the procedures to be followed.
- Some implementing organizations have reached sufficient maturity and competence to provide capacity building support to other partners (particularly to MARP groups). Their training skills and expertise could be used by ASHA to train others, as has already begun through training of NGO staff as trainers.

#### Sustainability:

There is no single definition of sustainability as it refers to the HIV/AIDS program in Nepal or the organizations that support it. ASHA has adapted the Sustainability Framework from USAID’s Child Survival Program.

#### *Components of sustainability for ASHA activities:*

- Enabling environment, outcomes and service continuation.
- Ability of NGOs to diversify their resource base.
- Ability to maintain acceptable technical and project management standards.
- Ability to mobilize resources through a comprehensive organizational strategy “keeping in mind our social mission, vision and goals”
- Understanding by stakeholders at national and local levels of the epidemic, and how to analyze, predict and program for it.
- Improved operational ability of NGOs.
- Continuing reduction of stigma and discrimination which would further improve government services and increase MARP willingness to use them.

Sustainability was not an explicit result until the extension period, and until then ASHA did not take serious steps to achieve sustainability of NGO partners. It is important here to distinguish between capacity building and sustainability. Much work has been done to improve capacity of ASHA implementing partners, which has helped them to enhance their technical, operational and technical management ability. While these improvements increase NGO prospects of achieving sustainability, they must be accompanied by improved ability to diversity the resource base, not only through attracting new donors – which some partners have done, but also through mobilizing community resources and increasing cost-effectiveness of operations. Implementing partners have not given much, if any, thought to sustainability and hold expectations and hopes that USAID funding will continue after ASHA.

Sustainability is an issue for governance, management and community, not the ASHA-funded project staff alone. Engagement on sustainability should have been built in from the start of the project, so that capacities could be developed that go beyond the project to the organizational level. This process has yet to take place in the ASHA roll out of the Sustainability Framework and District Planning process. Certain sustainability issues came up repeatedly during interviews:

- Financial sustainability of the HIV/AIDS program is not likely in the near future: both government and NGOs will continue to rely on donor support.
- Both government and NGOs consider it necessary to shift more aspects of the program from NGOs to government, and to better define working relationships between government and NGOs, for a sustainable program. Gaining government ownership in scaling up services is critical to sustainability. This is the message from both national PLHA networks and local support groups
- The role of MARP advocacy and support groups has been and will be critical to ensure that government provides needed services (e.g. ART). Hence they are an important aspect of sustainability, to which ASHA has contributed.
- A few of the better established NGOs who were/are also implementing partners have begun working on some small sustainability schemes on their own (e.g. local resource mobilization efforts) – there may be some good practices here that could be identified, refined and expanded to other organizations.

#### Gender and Inclusion:

In targeting women and MARPs “ASHA is gender and social inclusion in action ... improving access”. For example, ASHA now includes third or transgender categories in some of its reporting.

#### *Women as beneficiaries in ASHA activities:*

- 50 percent of PLHA reached by outreach are women. 43 percent of overall prevention outreach done covers women. Almost 40 percent of total population reached is clients of female sex workers.
- Palliative care reach has been almost even between men and women. In the last reporting period (FY10), women have outnumbered men in coverage. This is in contrast to the coverage of ART nationally where there is still a disparity of distribution of services along gender lines.
- Nearly six times more women than men are getting treated for STI from ASHA supported sites. In addition, a small number of Transgender has accessed STI services (45 in FY07, 59 in FY08 and 8 in FY 09) from ASHA sites.
- Similarly, more women than men have received community mobilization training from ASHA sites.

Women’s involvement in capacity building differs by type of training. Exposure of women to new ideas and training has been empowering across the board.

### *Women trained through ASHA:*

- Women outnumbered men two to one in training to promote HIV prevention in the community.
- Women trained in HIV related policy development represented 18 percent of the total in 2008 and increased to 43 percent in 2009.
- Women trained in HIV related institutional capacity building represented 39.6 percent of the total in 2008; 26.1 percent represented third gender.
- More women and third gender than men completed training for reduction of stigma and discrimination.
- Women trained in Strategic Information represented 39 percent of the total in 2008 and 30 percent in 2009.

- Depending on location, many NGO programs tend to be male led in decision making though programs are female centered. This is not universally true – there are some important women-led organizations, such as STEP Nepal, the Community Action Center, and Dristi – but it is the case in some areas, such as the West and Far West. Though women are not placed in management positions as often as men, they dominate as outreach workers and as team leaders and workers in CHBC, which are often the most difficult and the lowest paid positions. Team leaders often are ANMs, Counselors or CMAs, which indicates an education level commensurate with higher level responsibilities. No apprenticeship or mentoring programs to bring women into decision making positions were observed.
- ASHA is respectful of women’s rights to health. One of its biggest contributions to women has been the principle promoted by ASHA in its service to women that: “It’s not always the woman’s fault, neither is it always her responsibility”. This is especially true for FSWs and migrant spouses who are widowed and infected because in Nepalese society these two groups often face high levels of stigma and discrimination.
- More advocacy is needed with the Home Ministry to reduce S&D and bring an end to indiscriminate harassment of FSW by the police which prevents them from accessing HIV information and services.

### Recommendations on Result 2:

#### On policy:

- In addition to focusing on stigma and discrimination reduction, also stress alignment and harmonization with GoN and a continuous consultation process with different public partners. Work with HSCB to facilitate passage of the HIV/AIDS bill, and support MARP networks in their advocacy work for the bill (see capacity-building recommendation below).
- With the support of the Board better promote wider applications of the GOALS model within MoHP/NCASC and help build more Nepali expertise in preparation for the new NAP.

#### On capacity building:

- Since ASHA-supported national networks and Secretariats are now strong, support should be phased out by June 2011. In the interim, ASHA should work with MARP networks to develop and begin implementing strategies to advocate forcefully for

passage of the HIV bill, and for other important, unaddressed issues of stigma and discrimination (e.g. police harassment of FSWs and clients found with condoms, failure to admit children of PLHA to schools).

- Distinguish more among ASHA local implementing partners' capacity to implement and spend resources effectively:
  - District level, established NGOs with strong management skills (NNSWA, INF, CDF, Gardel<sup>9</sup>) should be supported to strengthen local PLHA support groups. It appears that they require less frequent or less intensive monitoring from ASHA than they now receive.
  - NGOs that joined ASHA later and are dependent on ASHA funding but work directly with MARP or PLHA need to receive support in organizational, financial and management issues beyond that needed to meet USAID requirements.

On sustainability:

- On a consultative basis work out a sustainability plan with each of the implementing partners. This might include shifting some capacity building activity of smaller NGOs from ASHA to the larger ones, as AMDA is already doing. ASHA might consider an “Innovation Fund for Sustainability”, available on a competitive basis, and encourage organizations to apply alone or in partnerships. (This could be part of an “innovation fund” suggested later in this report.)

On gender and inclusion:

- Take full advantage of the workforce at all levels of the operation. Encourage organizations in which women are underrepresented in management positions to start mentoring and apprenticeship programs to prepare women for decision making level. ASHA could start by reviewing staff recruitment practices to ensure they are not discriminatory to women and third gender.

**Result 3: Improve planning, collection, analysis and use of strategic information.**

ASHA has largely achieved its targets for this result and, based on past trends, is on track to achieve life-of-project targets. Indicators reported to USAID on number of people trained and number of organizations receiving technical assistance, however, are only rough proxies for “improved planning, collection, analysis and use” and are of little value without observing additional, qualitative indicators.

The indicators and targets established for this result are shown below. The first measures implementation of IBBS studies. Security issues in the Terai prevented the 2008 target from being met, so the target for 2009 was then increased from 5 to 7. Since this target was achieved, all planned IBBS studies have been accomplished. For 2010 and 2011, it is expected that most IBBS studies will be carried out through the GF Round 7 grant; but ASHA will continue to provide technical assistance for their design and implementation,

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<sup>9</sup> Nepal National Social Welfare Association, International Nepal Fellowship, Community Development Forum Doti, Gangotri Rural Development Forum

through participation in the NCASC’s Strategic Information Technical Working Group (SITWG) once the working group is reconstituted.<sup>10</sup>

The other two indicators show variations, but overall targets are being met.

The team did not find a separate indicator for Result 3.2. from the Results Framework, “Strengthen capacity of uniformed services to conduct BSS and use data to implement effective strategies.” A BSS was successfully carried out among military and police, with ASHA technical support; however, because of sensitivities among uniformed services about data disclosure, and because results of the study showed that police and military are not high-risk populations, this sub-result has been dropped from the extension period.

<b>Indicator</b>	<b>MARP/ baseline year</b>	<b>Target/ Actual 2006</b>	<b>Target/ Actual 2007</b>	<b>Target/ Actual 2008</b>	<b>Target/ Actual 2009</b>	<b>Target 2010/ Actual through Dec. 09.</b>	<b>Target 2011</b>
<b>3.1. Implementation of HIV/STI biological and behavioral surveillance which adequately tracks trends in the epidemic</b>	FSWs/2006 Truckers/ 2006 MSMs/2004 IDUs/2005 Migrants/no baseline	Start up	5/5	6/4	5/7	1/	4
<b>3.2. Number of individuals trained in strategic information (M&amp;E, surveillance and tools) through USAID assistance</b>	Aug 2005 – July 2006		200/ 198	225/ 337	250/ 195	235/ 25*	170
<b>3.3. Number of local organizations provided with technical assistance for strategic information activities</b>	n.a.	2	43/40	45/52	50/58	45/45	45/

ASHA has carried out many activities geared to improving national ability to plan, collect, analyze and use strategic information that are not captured by the indicators reported to USAID. Many of these are carried out through participation in the SITWG. ASHA’s senior advisor for strategic information is a nationally recognized expert on strategic information and plays an influential role in the TWG. Important activities of ASHA include but are not limited to the following:

<sup>10</sup> The NCASC has allowed the time-frame for the SITWG to expire. Expectations are that it will be reconstituted and reauthorized shortly. In the meantime, members continue to meet informally.  
ASHA Nepal Evaluation

## **Key activities of ASHA in Strategic Information**

### *At national level:*

- Support to national size estimation: ASHA provides technical advice to development of the biannual national estimate of HIV/AIDS prevalence in Nepal, based upon IBBS data, antenatal and PMTCT data, and other sources.
- National and regional sharing and use of IBBS and other SI information: ASHA uses a variety of dissemination techniques to ensure that IBBS data are understood and used, including distribution of analytical reports, national and regional roundtables and workshops.
- National HIV database system and M&E system development: For example, the government incorporating VCT and ART data into the national MIS system. ASHA will co-facilitate training, in conjunction with NCASC, on this new requirement, and has provided support in developing the data. The government now plans to add data on STIs and OIs, and ASHA will incorporate these data into its own reporting to the government.
- Support to Nepal Health Research Council for improvement of ethical review standards for human subjects in research studies. Now the NHRC can carry out training independently for sub-IRCs.
- Capacity development of local organizations to conduct large studies with hard-to-reach populations: New ERA and other organizations now have access to a strong pool of trained field workers who are accepted in the community, so that large studies can be conducted quickly and effectively. (Research design still needs continuing technical support.)
- Other support for national systems, including National Surveillance Plan and second generation surveillance.

### *At local level:*

- Unique ID application for clinical service delivery: At the ASHA project level, this system provides an exact head count of people who use one or multiple services – no more double counting. The government has been impressed with this system and is adapting it for national use.
- Mobility and operational mapping. All local implementing partners visited by the team have developed maps that provide the location of both target groups and available services, for better referrals and to reduce duplication. In areas where FSWs are the primary MARPs, these maps include Trafficking in Persons Centers for referral purposes.
- Use of Data Quality Audits. Training of partners in DQA has shown clear improvement in data results (from 80 percent in 2007 to 90 percent in 2009, using a measure that combines data use and feedback, data accuracy, information systems integrity, data integrity, data reliability and validity, and M&E management). DQA is now in NCASC's work plan, and NCASC has asked for support from ASHA in DQA training.

## Findings:

- ASHA's support for improved strategic information is one of its greatest contributions to the national response. Its contributions have been particularly important at the central level. It has played a key leadership role in the Strategic Information TWG, which is recognized by other members of the TWG. The NCASC believes ASHA should continue to be involved in monitoring and evaluation, particularly to strengthen the government M&E system at the local level.
- A few respondents felt there is a need to revise IBBS plans, to make them more streamlined, to better account for changes in the demographics (e.g. more hidden, more mobile sex workers) and to compensate for perceived data gaps in Eastern Nepal. This was not a widely-held view, however.
- ASHA has taken steps to address the mid-term review recommendation that "the team should focus on integrating more data from surveillance into programming". However,

both central and district level interviewees noted that there is still weak ability to analyze data at the district level and by local partners. There is little sharing national and local data so that all stakeholders, especially at the local level, can see collective gains, gaps and overall achievements and can understand how their activities are contributing. The evaluation team recognizes that ASHA has made efforts to share IBBS data with key stakeholders at community and regional levels, including with NGOs, DACCs and DPHOs in selected districts. Based on the team's observations, however, these efforts have not yet resulted in a clear vision at district and local levels as to how they can use IBBS and other program data to identify and address their key issues.

- While ASHA's training is highly appreciated by local partners, its M&E training/capacity building for implementing partners is often viewed as aimed at improving their ability to report accurately on project indicators, rather than at improving the capacity of the organization to use data for its own analysis and planning beyond ASHA project targets.



A low-tech but valuable SI tool used by many implementing partners is mapping of location of both clients and services in the district they serve.

#### Recommendations:

- Urge the NCASC to re-institute the SI TWG as soon as possible. It was created with a two-year time frame. That time has now expired, and NCASC wishes to reconstitute its membership before it is restarted. The key issue is whether or not organizations such as New ERA, which might be contracted to carry out studies, should be members of the group, or whether this would represent a conflict of interest.
- Continue to provide technical support for planning and analysis of the IBBS and other surveillance tools. Consider whether the suggested changes in IBBS plans are needed. ASHA already recognizes the need to make certain changes; e.g. using truckers as a proxy for FSW clients may no longer be valid.
- Share detailed IBBS results with local partners in the concerned districts and provide technical support to them in analyzing and strategizing based on this data, beyond what ASHA is already doing. Similarly, support information sharing among all local partners,

NGO and government, to review and analyze M&E data from partners, to identify district-wide trends and needs.

- Broaden M&E training of implementing partners to go beyond that required to report on ASHA indicators, so that it has greater impact on organizational capacity.
- Create a better indicator of organizational capacity to use M&E data than the indicators currently used (number of people trained, number of organizations receiving technical assistance). One way to do this would be to ask the relevant ASHA Program Officer to grade each partner on how it uses data in its bimonthly review meeting (BRM) with ASHA, using a scale that ASHA develops. One would expect to see increasing grades over time. A special study on implementing partner capacity to analyze and use data for its own program development and target-setting would be another possibility.

**Result 4: Increase access to quality care, support, and treatment through public, private, and non-governmental sources for PLHA and their families.**

In 2005 when ASHA was being planned, access to care, support and treatment (CS&T) was not a well-developed component of the national response. Government had begun implementing a national antiretroviral therapy (ART) program, but few PLHA received comprehensive CS&T.

ASHA's approach in expanding access to quality CS&T is delivery of an integrated prevention-to-care package that ensures access to a Continuum of Care (CoC) including strategic behavioral communication (SBC), screening for sexually-transmitted infections (STI) and voluntary counseling and testing (VCT) for MARPs; health assessment and clinical staging; prophylaxis for opportunistic infections (OIs); tuberculosis (TB) screening and referral; OI diagnosis and treatment; ART; prevention of mother to child transmission (PMTCT); home-based care (HBC); and palliative care. (During the extension period, Early Infant Diagnosis (EID), and Community based PMTCT (CB-PMTCT) were added.) ASHA also has provided technical support to NCASC to maximize CS&T outlets in areas where PLHA are concentrated.

ASHA has used three strategies to expand access to continuity of care:

- Provide technical leadership to identify ways of strengthening the capacity of the national health system to provide and support quality CS&T for PLHA;
- Work with NGOs and CBOs to provide quality CS&T for PLHA and their families; and
- Work with GoN, donor agencies, and NGOs/CBOs to strengthen access to appropriate CS&T for PLHA facing specific geographic, programmatic, or technical barriers to access, e.g. PLHA with TB-HIV co-infection.

*ASHA progress on achieving targets:*

<b>Indicator</b>	<b>FY07 Target/ Actual</b>	<b>FY08 Target/ Actual</b>	<b>FY09 Target/ Actual</b>	<b>FY10 Target/ Actual by Dec 09</b>
# service outlets providing palliative care (inc. TB/HIV)	26/ 33	30/ 33	30/ 37	36/ 36
# PLHA reached with palliative care & support at USAID-targeted service sites	1,500/ 2,559	2,700/ 3,314	3,000/ 4,337	4,000/ 3,379
# USAID-assisted service outlets providing STI treatment	23/ 28	25/ 28	25/ 31	33/ 33
# MARPs receiving STI treatment at USAID-assisted sites	8,000/ 7,264	8,500/ 8,900	9,000/ 8,030	9,000/ 3,677
# USAID-assisted service outlets providing VCT	26/ 33	30/ 33	32/ 34	34/34
# individuals receiving VCT and results at USAID-assisted VCT outlets	7,000/ 13,811	7,500/ 19,555	12,000/ 18,332	22,000/ 8,086
# people trained in VCT	100/ 17	60/ 70	80/ 99	65/ 25
# people trained to provide palliative care	n.a./ 43	60/ 88	65/ 76	60/ 19

Findings:

Overall:

- By and large, targets for Result 4 are being achieved, with many more people receiving VCT and palliative care than planned. Access to CS&T has been increased for MARPs, by gender, service and location.
- Despite these impressive achievements, there are issues related to cost-effectiveness and sustainability of some interventions, including IHS clinics and CHBC services (though ASHA has made efforts to make IHS and CHBC more affordable and sustainable during the extension period).

For sub-result 4.1, Collaboration with GoN to Strengthen Capacity of National Health System to Provide Quality Care and Treatment Services to PLHA:

- ASHA's valuable support to the GoN/NCASC for developing (and more recently revising) guidelines, SOPs, and training curricula is discussed under Result 2.
- ASHA trained GoN health providers and other staff and helped develop health information systems for patients and logistics to strengthen national, zonal and regional hospitals for HIV/AIDS-related services. ASHA's implementing partners also support the GoN hospital system. For example, using its own resources the International Nepal Fellowship (INF) Paluwa provides two VCT counselors and two days of a lab technician to conduct CD-4 tests at the Western Regional Hospital in Pokhara. Similar examples of NGO-GoN cooperation were seen in hospitals in Doti, Kailali and Kanchanpur. Hospital personnel and clients confirmed the important contribution that such assistance has on improving the quality of services and increasing access. In contrast, another hospital without similar NGO support was reported to be less user-friendly, counseling was minimal and doctors-in-training rotated monthly, which limited

consistency of services. Clients were dependent on PLHA volunteers to help organize patients and their charts, and to provide informal counseling.

- ASHA provided technical support and capacity building to the National Public Health Laboratory (e.g., for the roll out of EQAS for HIV testing) and training for lab staff in other GoN labs. Laboratory staff provided a positive assessment of ASHA's support. They noted that GoN provides the same staff levels for the National Public Health Laboratory as 15 years ago, though the scope of work has greatly increased. The Laboratory could not function without the positions supported by donors. ASHA has transitioned human resource development support for GoN laboratories to UNDP/GFATM, though ASHA still provides technical assistance for EQAS and technical monitoring for one zonal hospital.
- GFATM/GoN has taken over ASHA's support for management of the central warehouse and distribution (which ASHA provided through a sub-contract to a local agency). As a member of the national Logistics Task Force, ASHA continues to provide technical support for the development of the HIV and AIDS logistics management system in the country. The MoHP's Logistics Management Department (LMD) indicated reluctance to integrate HIV/AIDS into its operations, for fear that the system might not be ready to deliver ARVs when needed. LMD does distribute condoms to the districts. At the distribution level, interviewees described ASHA as playing a facilitating role between its implementing partners and NCASC to ensure partners receive clinical supplies and medications when needed. Interviewees felt that without ASHA staff playing this on-going role, supply would not be reliable.
- ASHA has initiated activities for children affected by AIDS (CABA), in addition to the Universal Access for Children Affected by AIDS in Nepal (U-CAAN, but as this is a new area of support, more needs to be done.



ASHA-supported IHS clinics are well-equipped. Here is one such example, with lab technician on hand, from the Naulo Ghumti IHS clinic in the Western region.

For sub-result 4.2: Strengthen Capacity of NGOs to Provide Quality CS&T Services for PLHA and Their Families

ASHA supports 33 IHS clinics as a central component of the continuum of care. IHS clinics are staffed by a nurse, lab technician and Clinic-in-Charge – originally a medical doctor, but beginning late 2007 and early 2008, a Health Assistant (HA). HAs have lower turn-over and are considered more cost-effective than MDs. (Frequent turn-over and transfer is not unique to IHS clinics, but is endemic within Nepal’s health services, especially with the increase of alternative employment in the private sector and new medical schools.) Doctors still visit each IHS clinic on a regular basis to see difficult cases. ASHA supports AMDA to oversee IHS services, which were observed to be of high quality and carefully monitored.

- Because stigma prevents MARPs from going to GoN health facilities, the NGO IHS clinics were established specifically to serve MARPs with privacy and dignity, with each clinic serving one MARP group. Many IHS clinics serve only an average of four or five clients a day. This is not cost-effective. More clients were reported to attend the satellite clinics. Co-location of Drop-in Centers (DIC) with the IHS clinics is hoped to improve use, though as noted earlier, DIC use is also low.
- ASHA has taken steps to increase use of these facilities. One effort to increase outreach to PLHA and encourage use of the IHS is the Community Information Point (CIP), where brochures and other information and condoms are available. Another is a pilot effort at the IHS clinic in Birganj to integrate services for two MARPs: IDUs and FSWs.
- Referrals between IHS and GoN hospitals were reported to be better than between other services, although GoN do not always send back reports. Follow up of referrals was variable; often clients lacked resources to visit clinics. One group reported that only 25 percent of referrals were completed. Implementing partners try to arrange for clients to be escorted to the referred services (e.g., CD-4 counts and ART), but this is not always possible.
- Referral is a two-way process with GoN hospital HIV/AIDS centers referring patients to IHS clinics for services, especially after hospital out-patient clinic hours. For example, HIV services at Western Regional Hospital are only available from 10 AM to 1 PM. Clients arriving after noon are referred to the IHS clinics in Pokhara.
- An encouraging example of local coordination to improve access and referral to services is the Western Region HIV Alliance in Pokhara, a loose network of 24 local NGOs working on HIV/AIDS, which meets monthly to exchange information and coordinate services.
- ASHA supports implementing partners to provide care and support through training, capacity building, staff salaries, supportive supervision and monitoring. The participation of PLHA as paid field workers and volunteers, for example assisting clients in hospital VCT/ART clinics and serving as CHBC workers, is widely believed to have been a major contributor in improving access to and quality of services.
- Many activities earlier supported by ASHA are being transitioned to UNDP/GFATM and other Principal Recipients (PRs), based on an internal assessment to determine where GFATM and ASHA resources were most needed and supported activities could most effectively be implemented. The PRs, in general, have had less experience in HIV than ASHA. Therefore, reports indicate that it is taking time for transitioned activities to be implemented, fully functioning and to achieve the quality of services and intensity of monitoring and training provided by ASHA/FHI. In some cases ASHA personnel have

been called upon to provide technical input and support after the activities are transitioned to GFATM PRs. For example, New ERA has the trained fieldworkers to conduct IBBS but still needs technical input from ASHA. The logistics system was successfully transitioned by the collaborating organizations, but partners noted the need for ASHA staff to play an on-going role to ensure that the needed clinical supplies are provided on time.

CHBC is an important component of the continuum of care. CHBC provided by ASHA implementing partners was observed to be of high quality, fostering prevention as well as providing care and improving ART adherence. CHBC requires regular visits to PLHA homes, often in remote areas. Members of the CHBC teams are highly motivated and each visits several PLHAs.

- Given the range and intensity of the services, there are limitations to how many PLHAs can be served.
- In many areas, the C in CHBC is weak and community involvement is absent; although in the far-western region, mother's groups and support groups were reported to be more involved. .
- Linkages to other services (e.g., food, income generating activities, transportation) were reported by interviewees to be limited and not well coordinated in many areas and financial resources (such as a fund for emergency needs) are not available, except in some of the larger NGOs that have other resources to call on.
- The GoN does not actively support HBC or other outreach services provided by NGOs, though district officials speak highly of them. The GoN is reported to have proposed training Female Community Health Volunteers (FCHVs) and Maternal and Child Health (MCH) workers to carry out HBC, but this may not be realistic given the responsibilities that FCHVs and MCH workers already have, and given reluctance by PLHAs for GoN health workers and neighbors to know their status.
- Although government is not involved in direct service delivery of HBC, it plays a role in developing national guidelines and training curriculum and the TWG on CHBC. Issues remain related to incentives and compensation for outreach workers.



A migrant's widow with HIV gets a check-up from the CHBC team leader, a medical professional.

#### Recommendations:

- Review the experience of INF and other NGO-GoN hospital partnerships for successful examples of collaboration, provision of support and integration of services to help understand if these experiences could be duplicated and expanded.
- Explore mechanisms to improve linkages and referral between clinical services and resources for other care and support, e.g., transportation, food, income generating activities, skill development. Identify potential sources of funding for non-medical needs, such as an emergency fund, other donors such as World Food Program or access to the Poverty Alleviation Fund.
- Conduct a study of reasons people attend IHS clinics and factors contributing to low utilization. This could include analysis of the integration of MARP groups (IDU and FSW) in the IHS in Birgunj for lessons learned and to determine if IHS clinics could successfully serve more than one MARP group. Also, explore the possibility of non-ASHA-supported NGOs who work with MARPs referring clients to IHS clinics.
- Compare the approaches and effectiveness of CHBC activities provided by other organizations to those of ASHA. Findings should be used to help develop a more integrated, coordinated, and community-based approach to CHBC. The study would include the following components:
  - Identify successful examples of community involvement and encourage greater community support of CHBC in addition to involvement of PLHA as CHBC field staff. This can be an important means of lowering costs (by shifting some care activities to the community), reducing stigma and improving sustainability.
  - Review guidelines and criteria for providing CHBC services to PLHA to help identify more efficient mechanisms for delivering services to the increasing number of clients, without compromising the current quality of service. For example, the need for monthly or bi-monthly visits for all clients, as currently specified by the guidelines, could be revisited, as some PLHA may require less frequent attention.

## **Result 5: Create linkages among stakeholders and support national coordination of Nepal's cross-sectoral HIV/AIDS program.**

Donor harmonization and coordination is critical in Nepal. Because domestic resources for scaling-up and sustaining the national response are extremely limited, the rational and coordinated use of external donor support is a key element in the success of the scaling-up process. The national planning process is central to coordination between GoN, donors, UN agencies, local and international NGOs, and the development of an effective national response with national-level impact.

ASHA was designed to help build coordination and collaboration among stakeholders at the national level (including GoN, donor agencies, INGOs, PLHA and MARPs networks), and at the regional and district levels with local government, DACCs and implementing partners. ASHA senior management noted that it was unusual for collaboration and coordination to be written into the RFA as an Intermediate Result (IR), which was viewed positively as encouraging active interaction and participation with key stakeholders.

### Findings:

- ASHA's activities to foster linkages and support national coordination are appropriate and have mostly been effective. In the team's view, ASHA is achieving this result.
- National Coordination: ASHA has been involved in a broad range of activities with other partners, including drafting the National Strategy and National Action Plan, in addition to being an active participant in most TWGs,<sup>11</sup> as well as on national level reviews for PMTCT, ART, STI, VCT, and CHBC. Almost all interviewees noted ASHA's technical expertise and technical contribution.
- United Nations and GoN: ASHA has had close collaboration with GoN and UNICEF on CB-PMTCT, in addition to being an active contributor with UNICEF and GoN on developing U-CAAN. Collaboration with WHO has included TB/HIV-co-infection related activities and coordination with GoN on the National TB Center.
- Collaboration with bi-lateral organizations/EDPs (external donor partners): EDPs recognize ASHA's technical expertise and contributions, and DFID has funded FHI ASHA to implement a pilot cross border prevention program for migrants.
- Collaboration with the GFATM: ASHA has collaborated with GFATM, UNDP and PRs, in addition to transitioning activities previously supported by ASHA to GFATM-supported partners. Despite the current positive relationship (e.g., FHI's partnership in the National TB Strategy Application to the Global Fund), FHI's earlier participation in the rounds of HIV/AIDS applications to the Global Fund was often cited negatively, even when its contribution to the proposal process was described as making important contributions.

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<sup>11</sup> E.g., ART, PMTCT, Pediatric ART, M&E/SI, Logistics, HIV/AIDS Training, CHBC, STI, VCT, Laboratory, Decentralization and Multi-sectoral Strengthening.

- Multi-sectoral response: During the initial phase of the Project (2006-2009), through its partnership with the Futures Group, ASHA was able to sensitize key political players, in addition to supporting HIV/AIDS training to several ministries. To date, this sensitization has not yet resulted in legislation related to HIV/AIDS, an increase in resource allocation from GoN, and multi-sectoral engagement of relevant ministries.
- Strengthening District Coordination: Through the partnership with the Futures Group, ASHA contributed to capacity building and development of strategic plans for the DACCs. Although these activities were reported to make a positive contribution to strengthening the DACCs and district coordination, district plans have not been implemented. Several factors work against effective district coordination. The effectiveness of DACCs varies and DACC Coordinators are frequently transferred. Active involvement of the line ministries has been challenging. The key position for the DACC is the District Public Health Officer (DPHO) who has many other priorities and also is transferred between districts. The DHO's key position poses a potential conflict of interest as the DACC strategy is multi-sectoral and the priority of the DHO is the health sector.
- ASHA Program Officers (POs) have contributed to DACC and district coordination of local NGOs and other resources for HIV/AIDS. The POs participate in district and regional activities and in many cases were identified as key initiators and facilitators of the coordination process. For example, in Kaski District, the PO was described as facilitating the formation of the Western Alliance of 24 NGOs, which meets regularly to coordinate HIV/AIDS activities and resources, and fills the need for more effective district communication and collaboration.
- Coordination among implementing partners: ASHA's biannual coordination meetings involved not only its own implementing partners, but other stakeholders as well. Participants view the meetings as an important means of sharing experiences, linking services and preventing duplication. ASHA's policy of sharing reports from these meetings with NCASC also fosters coordination.
- USAID Coordination: ASHA participates in regular coordination activities with USAID and its other health-related partners and projects. Relations between ASHA and USAID were reported to be positive in general, though at times communications could be improved, for example related to changes in project officer responsibilities and feedback from USAID about ASHA activities.
- Collaborating Partners: JSI/DELIVER and MASS reported strong coordination and collaboration with ASHA related to logistics and supply. The relationship with N-MARC around a range of key areas and activities was described as being positive and effective.

#### Recommendation:

- ASHA and USAID should monitor the scheduled completion of other program resources for HIV/AIDS activities, such as DFID's current support for IDUs (comprehensive harm reduction including needle syringe exchange, and treatment rehabilitation), MSM (access to STI and prevention services including condom and lube distribution) and migrant populations in certain districts, in order to identify if and when

funding gaps may be created and collaborate with other partners on how these could be addressed.

## **B. PROJECT PLANNING, MONITORING and REPORTING**

### 1. Monitoring and Evaluation Framework and Indicators

The monitoring and evaluation framework and indicators are relevant to the program objectives. For results areas 2 and 3, however, most of the indicators reported to USAID are output measures only. The Evaluation Team believes that better measures of capacity improvement are needed for these results areas. This assertion is reinforced by comments from several of the local implementing partners interviewed that the management and M&E training was primarily to enable them to implement the ASHA project and meet targets, rather than to strengthen their organizational capacity. ASHA maintains information related to capacity building beyond that reported to USAID, which are somewhat more useful as proxies. These include the number of partners who have secured funding from other donors, the number able to provide cost-share contribution, the number providing technical assistance to other partners, and the number of service sites developed as learning sites. These measures could be taken as part of an index to assess organizational strength.

The team is impressed with ASHA's process evaluation, because it engages the implementing organization's staff in assessing their own progress and needs. The team believes the tool could be strengthened with a greater emphasis on progress in capacity building in addition to its current focus on achievement of project results.

The team has insufficient information to determine whether each component is efficiently implemented and managed to get the most out of resources. For example, because the budget and expenditure statement provided to the team is organized according to results statement as required by PEPFAR, it does not specify what proportion has been spent on capacity building across project components or what proportion of ASHA resources is allocated to headquarters and regional offices. (ASHA staff time is allocated to various project components.)

### 2. Adequacy of Work Plans and Progress Reports

The team found on reviewing work plans and comparing them with progress reports that both are relevant to the approved ASHA program description. No key activities appeared to be missing or under-reported. The early progress reports tended to list activities completed without answering the question of "So what? How did this contribute to achieving project results?" The reports have become more substantive and more likely to answer the "so what" question over time, though more could be done to link activities to planned results.

Because the progress reports are organized differently from the work plans, the team found it difficult to track progress on the work plan by reviewing the progress reports. The work plan organizes individual activities by program elements, while the progress report organizes them by results area, and the two are not always the same. This is because the progress reports follow the Intermediate Results laid out in the technical proposal, while the work plan is based on the PEPFAR code. It may not be possible to reconcile these two systems, but it would be far easier to measure progress against the work plan if the progress reports were organized similarly.

On the other hand, none of the USAID staff interviewed by the team noted any problems with ASHA reporting.

### 3. Monitoring and Compliance with USAID's Anti-trafficking and Prostitution Policies

ASHA Project has put in place procedures to comply with the Unified Policy on Trafficking including educating NGOs, reporting mechanisms, national consultation of anti trafficking agencies, development of a referral directory, and referral by NGOs of suspected cases. Although the team was unable to confirm that reporting to USAID always occurs regarding identified cases of trafficking, the team's field observations and discussions indicated that implementing partners understand and comply with these policies. In fact, they are often proactive about informing local anti-trafficking organizations about suspected cases. There were also cases where implementing organizations found funding and identified opportunities for FSWs to engage in alternative, legal and healthy occupations.

### 4. Adequacy of Monitoring Systems to Monitor Quality of Activities and Compliance with USAID Regulations.

FHI ASHA has developed thorough, analytical and systematic procedures for monitoring quality of activities and compliance with USAID regulations. These include biweekly and monthly reporting on activities, bimonthly review meetings, field visits by the technical teams to observe and assess quality, supervision and technical support by AMDA, regular data quality assessments, and strong financial monitoring procedures. Implementing partners are trained well on how to report and data is verified regularly for accuracy. There is internet access between all implementing organizations and ASHA headquarters and data transmitted by computer are integrated into the headquarters reporting systems, so data errors in aggregation are limited. The unique ID procedure used for clinical services eliminates potential for double counting.

The team considered ASHA's monitoring and reporting systems to be more stringent than necessary. Some of the implementing organizations visited by the team, particularly those who rely on ASHA for most of their funding, said that they found the reporting requirements to be quite burdensome. As a result, staff members said they were overworked for the salaries they received. Because of the excellent training they received and the targets they were expected to meet, they felt they worked harder than counterparts in other, similar organizations; and the needed reporting added significantly to their workload. Some felt underappreciated for the effort they maintained. Some remarked that "ASHA is only interested in meeting targets...too many registers, too many layers of writing, reporting and meetings". (Streamlining of reporting already done by ASHA has not alleviated this concern.) Others said that the work of their own organizations was undervalued by FHI ASHA, because ASHA takes credit for the project's achievements.

The reporting burden also affects the time of ASHA's own staff. Comments from two organizations' leaders were revealing, when they said that they appreciate the heavy monitoring carried out by FHI because it saves them the trouble of doing it themselves.

It is worth noting here that the process of determining how to prioritize activities and cut budgets for the extension period was rational and often led to better use of scarce resources (consolidating partners, shifting from doctors to health assistants). Some partners objected

to across the board cuts that treated all organizations the same, and would have preferred more individual consultations and flexibility to determine how they would take their own cuts. This reflects a broader issue among some partners that they do not receive adequate feedback from FHI ASHA when they make a suggestion or raise concerns about a need – particularly the need to cover transportation expenses of clients for clinical care.

#### Recommendations:

##### On M&E Indicators:

- For a better measure of strengthened capacity of implementing organizations, apply a simple organizational assessment (OA). There are many OA tools available. We understand that FHI has previously used Management Sciences for Health’s OA tool. CARE has a good tool for indigenous NGOs, as does PACT International. These can be self-administered, with facilitation, and could become a part of the process evaluation. Alternatively, FHI ASHA could create its own index of effectiveness based on the information it already collects, or undertake a separate study of organizational and technical improvements of selected implementing organizations, as a supplement to the indicators now reported to USAID.
- Create a better indicator of organizational capacity to use M&E data than the indicators currently used (number of people trained, number of organizations receiving technical assistance). One way to do this would be to ask the RPO to grade each partner on how it uses data in its bimonthly review meeting (BRM) with ASHA, using a scale that ASHA develops. One would expect to see increasing grades over time. A special study would be another possibility.

##### On work plans and progress reports:

- If USAID agrees there is a need, reorganize the progress reports to track activities as they are described in the work plan; or if this is not possible, add a table at the end of the progress reports that describes progress on each of the elements described in the work plan.
- On work plan narratives, wherever possible describe the “so what” of the activity – that is, how it contributes to achievement of the relevant result.

##### On Monitoring and Reporting:

- FHI ASHA should take a second look at reporting requirements, in consultation with implementing partners, determine what their key reporting complaints are, and review ways to reduce reporting and better integrate existing reports. At the same time analyze workload to determine whether there are other ways that workload burden can be reduced. Suggestions heard by the team include eliminating the biweekly reporting (which, while in a simplified format, still requires extra work from partners), allowing security reports to be sent as simple e-mails rather than as special forms, examining PIFs to see if there is some duplication among them (as some implementing organizations believe), and reducing demands for “special” reporting between normal reporting periods. It may also be possible to reduce the frequency of reporting meetings for well-

established organizations from bimonthly to quarterly, which would free up PO time. In discussing reporting requirements with implementing partners, review with them other workload elements as well, as there may be other ways the partners can be working more efficiently, which would free up time for needed reporting. Even if ASHA finds that reporting cannot be reduced in any significant way, the process itself will let implementing partners know that ASHA as an organization is aware of and concerned about their workload issues and wants to help.

- Review communications with implementing partners. Be sure they are receiving full information, repeatedly, about why certain regulations are in place and why certain decisions have been made. When they make suggestions that cannot be approved under project requirements, help them find other ways of solving their problems.
- Treat implementing partners like partners. Implementing partners need to feel that they are active participants in the decision-making process. ASHA should give visible recognition to implementing partners for the efforts they put into achieving targets, and in particular find ways of recognizing the field-level staff that are the poorest paid but are most responsible for grass roots results.

Encourage innovation. For example, create an innovation fund, available to partners on a competitive basis, that enables them to exercise judgment in trying new techniques to achieve ASHA objectives. This is a different concept from the existing Windows of Opportunity line item. It would make funds available from ASHA to implementing partners, supplementary to their existing budgets, to test new approaches to address problems specific to their own activities (for example, new ways of engaging community volunteers to support CHBC; or information and referral options less costly than DICs). This could have several benefits: addressing the need for implementing partners to feel like true partners; encouraging partners to look for innovative solutions to their problems; and providing experience in proposal writing.

### **C. PROJECT MANAGEMENT SYSTEMS**

At first blush, FHI ASHA staffing appears headquarters top-heavy in light of total program size (27 to 30 professional staff, excluding AMDA senior staff, for a program under \$4.9 million per year and more than 45 implementing partners during the extension). Since several staff members have both central policy-level and field training and monitoring responsibilities, the team could not ascertain how much staff time is needed for participation on national technical groups versus oversight of field operations versus administrative demands (including responding to USAID).



The team found that all sites had appropriate branding. The distinctive ASHA flower is well-recognized.

The team examined the size of grants to implementing partners, to see whether there are too many small grants for cost-effective management. From review of available progress reports, grant size appears reasonable. First year grants to new partners tend to be small, but if the partner can perform, they become larger with each amendment. By mid 2009, aside from the core sub-primes and the laboratory, logistics, media and surveillance related partners, among the 50 or so remaining partners 19 had annual agreements in excess of \$50,000, some of which were over \$100,000. At least ten had annual agreements under \$20,000. These small agreements were mainly with local MARP support groups with limited capacity to manage funds. The team's understanding is that for the extension period, activities in each district were consolidated under one partner wherever possible. This would have reduced the management burden of supporting so many small grantees.

Relationships with core sub-prime partners varied. AMDA's partnership with FHI pre-dates ASHA, so the relationship is mature, and AMDA views it as beneficial to its own organizational development. Futures Group is a larger organization with its own long-established management and accounting procedures. Both Futures and FHI leaders realize that there never developed a true team relationship between them, and that building such a relationship would have required a much greater level of effort than either put into it.

#### Findings:

- FHI ASHA has a very clear structure and procedures from the level of senior management to the selection and monitoring of implementing partners, which was confirmed in interviews and site visits. ASHA's management is viewed as timely, efficient and professional, and from the perspective of most partners, it is effective.
- From the team's rather rapid review, it appears that the FHI ASHA staff level is appropriate for the breadth and quality of ASHA's operations, and in view of the close monitoring, oversight and continuous training that ASHA provides to implementing partners. As stated earlier, however, there may be potential for streamlining the monitoring and oversight process.

- ASHA has a good professional development plan that staff appreciate, particularly the fact that once it is approved, the agreed-on actions get taken. Since all FHI staff members are ASHA funded, professional development activities must be applicable to the project.
- Structure and management systems ensure support from Kathmandu to the regional staff and local implementing partners. Most implementing partners expressed appreciation for the clarity in expectations and available technical support and monitoring from ASHA regional and Kathmandu-based staff and from the Bangkok Regional Office.

Recommendations:

- In the time remaining in the project, the primary means available to ASHA to use staff more efficiently is to reduce the reporting burden and to introduce no new implementing partners. This may free up time for staff to focus on working with existing partners on innovation and sustainability issues and on implementing other recommendations from this report.

## IV. BEST PRACTICES

**Engaging PLHA as community project implementers.** Both FHI ASHA and implementing partners have found that employing PLHA as community outreach workers, community home based care workers, and aides at ART centers has greatly enhanced community-based work. Once PLHAs have “come out” visibly in their communities and demonstrated that they can work and help others, other at risk individuals are more willing to be tested, PLHAs who were hiding their status are more likely to “come out”, community stigma and discrimination is reduced, and PLHA are more willing to accept care and support services. It is also extremely empowering to the PLHA community workers themselves, who say they have found a purpose in life after learning the devastating news of their disease.

**Sharing surveillance findings with the community:** ASHA has found that sharing findings from surveillance studies with the community that was surveyed has made a big difference. Residents are more willing to participate in the studies when they know the results will be shared with them. In addition, this process has helped to identify people within the community who could participate in carrying out future studies.

**Replacement of MDs with Health Assistants at HIV/AIDS Clinics.** Since early 2008, ASHA implementing partners replaced MD with HAs for clinical services. MDs still make supervisory visits to clinics weekly, while HAs carry on the day to day interaction with clients. HAs are willing to spend more hours per day at the clinics than MDs (who have other commitments such as private practices of their own), turnover is much lower, and the social distance between HAs and clients is less, making clients more comfortable, and initial observations indicate that quality of services remains high. A few organizations interviewed said loss of a doctor makes it harder for them to reach targets, because clients prefer to go to other facilities where doctors are available, but in most areas where such choices are not available, clients are happy to be served by HAs.

**Strengthening MARP groups.** Assistance from ASHA and others to national MARP networks and to local MARP support groups has made them more effective, more professional organizations, able to advocate effectively for needed HIV/AIDS information, care and support, and for reduction of stigma and discrimination. Several interviewees noted that MARP groups which in past years were argumentative and confrontational in sessions with government and donors now can negotiate responsibly and effectively. There is general agreement that these groups have sufficient influence to ensure that the government continues to provide ART services when donor funding ends. At the district and local level, MARP groups have been instrumental in obtaining district resources to meet the needs of PLHA, such as subsidizing transportation costs to ART clinics. As more responsibility for the HIV/AIDS control program shifts from NGOs to government, these groups will play a critical role in providing oversight.

**Positive Speakers Bureau.** PLHA are not only stigmatized by others, but tend to stigmatize themselves. This can have serious consequences, such as low self-esteem, depression and isolation. S&D training and community discussion fora have been organized by the Positive Speakers Bureau in the communities where MARPs and PLHA live. These have helped to give a human face to HIV and to reduce stigma at the family and community level.

**Semi-Annual Partners Coordination Meetings.** ASHA’s two-day meetings bring together its own implementing partners for the first day, to discuss progress and challenges, reinforce

understanding of technical guidelines and project requirements, and provide an opportunity for partners to understand what each other is doing and to learn from each other. On the second day, non-ASHA partners are also invited – including other donors and their implementing organizations and government officials. ASHA implementing partners and other donors consider these meetings to be an excellent means of sharing information, linking to other services, and preventing duplication of efforts. Results from these meetings are shared with NCASC.

**ASHA Project Management Tools.** ASHA has initiated many procedures and tools to ensure consistency and quality of project activity, and to resolve problems quickly. Among those that the team and interviewees felt were most important are the following:

Process evaluation – Because the implementing partner takes the lead on analyzing its own experiences and developing its own solutions to problems, the partner takes ownership of findings and recommendations. Partners consider process evaluations to be a good learning experience.

Memory joggers – These are pocket-sized booklets that remind technical and program officers about the key questions they should be sure to ask when they visit an implementing partner. They were helpful for the evaluation team in its field visits as well.

Issues and Actions matrix – This matrix notes any issues that come up in a visit to an implementing partner and denotes who is responsible for follow-up, sets a target date for follow-up, and includes a process to ensure that appropriate follow-up is taken.

Budget authorities for Program Officers – POs are delegated authority to approve budget modifications for implementing partners in their region. This enables them to respond quickly when implementing partners find themselves with unanticipated needs for which budget revisions can be justified under project financing rules.

## V. SUMMARY OF MAJOR RECOMMENDATIONS

Recommendations from throughout the report are consolidated here for easier review.

### Recommendations for the remainder of the ASHA project

#### On prevention (Result 1):

- As budget permits, expand prevention work with FSWs into new areas where they seem to be moving: emerging towns, markets, establishments. Given their high mobility, occasional police clamp down in certain locations making them move or hide, and weak organizational capacity, interventions for FSWs need to be adaptable – in terms of both activities and locations – if they are to be effective in maintaining or reducing prevalence.
- Examine the service utilization rate of Drop in Centers to determine whether they can be made cost effective, or if there are other, less costly ways to provide similar services, such as Community Information Points (CIPs).
- Review FHP's and CARE Nepal's experiences with cross-border programs for migrants, to determine if there may be lessons learned for future USAID programming.
- Reexamine targets versus budget for positive prevention groups to determine whether adjustments are needed, as there appear to be workload inequities among different groups.

#### On policy, stigma and discrimination, capacity building, sustainability, and gender (Result 2):

- With the support of the Board, promote wider applications of the GOALS model within MoHP/NCASC and help build more Nepali expertise in preparation for the new NAP. Work with HSCB on ways of facilitating passage of the HIV bill and work with MARP networks in their advocacy efforts (see the third bullet below).
- In national fora and among other donor-funded programs, emphasize the need for scale up of activities to reduce stigma and discrimination. In addition to focusing on stigma and discrimination reduction, also stress alignment and harmonization with GoN and a continuous consultation process with different public partners.
- Capacity building has been sufficient for the national networks and Secretariats and should be phased out by June 2011. In the interim, ASHA should work with MARP networks to develop and begin implementing strategies to advocate forcefully for passage of the HIV bill, and for other important, unaddressed issues of stigma and discrimination (e.g. police harassment of FSWs and clients found with condoms).
- Distinguish more among local implementing partners' capacity to implement and use resources effectively:

- District level, established NGOs with strong management skills (NNSWA, INF, CDF, Gardef<sup>12</sup>) should be supported to strengthen local PLHA support groups.
- NGOs that joined ASHA later and are still over-reliant on ASHA funding but work directly with MARP or PLHA need to receive greater support in organizational, financial and management issues beyond that needed to meet USAID requirements.
- On a consultative basis, work out a sustainability plan with each of the implementing partners. This might include shifting some capacity building activity of smaller NGOs from ASHA to the larger ones, as AMDA is already doing.
- Encourage organizations in which women are underrepresented in management positions to start mentoring and apprenticeship programs to prepare women for decision making level. ASHA could start by reviewing staff recruitment practices to ensure they are not discriminatory.

On strategic information (Result 3):

- Urge the NCASC to re-institute the SI TWG as soon as possible.
- Share detailed IBBS results with local partners in the concerned districts and provide technical support to them in analyzing and strategizing based on this data. Similarly, support information sharing among all local partners, NGO and government, to review and analyze M&E data from partners, to identify district-wide trends and needs. The emphasis here is on improving partner ability to analyze data from a number of sources to use in their own and district planning.
- Broaden M&E training of implementing partners to go beyond that required to report on ASHA indicators, so that it has greater impact on organizational capacity.

On treatment, care and support (Result 4):

- Review the experience of INF and other NGO-GoN hospital partnerships for successful examples of collaboration, provision of support and integration of services to help understand if these experiences could be duplicated and expanded.
- Explore mechanisms to improve linkages and referral between clinical services and resources for other care and support, e.g., transportation, food, income generating activities, skill development. Identify potential sources of funding for non-medical needs, such as an emergency fund, other donors such as World Food Program or access to the Poverty Alleviation Fund.
- Conduct a study of reasons people attend IHS clinics and factors contributing to low utilization. This could include analysis of the integration of MARP groups (IDU and FSW) in the IHS in Birgunj for lessons learned and to determine if IHS clinics could successfully serve more than one MARP group. Also, explore the possibility of non-ASHA-supported NGOs who work with MARPs referring clients to IHS clinics.

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<sup>12</sup> Nepal National Social Welfare Association, International Nepal Fellowship, Community Development Forum Doti, Gangotri Rural Development Forum

- Compare the approaches and effectiveness of CHBC activities provided by other organizations to those of ASHA. Findings should be used to help develop a more integrated, coordinated, and community-based approach to CHBC. The study would include the following components:
  - Identify successful examples of community involvement and encourage greater community support of CHBC. This can be an important means of lowering costs (by shifting some care activities to the community), reducing stigma and improving sustainability.
  - Review guidelines and criteria for providing CHBC services to PLHA to help identify more efficient mechanisms for delivering services to the increasing number of clients, without compromising the current quality of service; for example, reassessing the need for monthly or bi-monthly visits for all clients as currently specified by the guidelines.

On Coordination and Collaboration (Result 5):

- Monitor the scheduled completion of other program resources for HIV/AIDS activities, such as DFID's support for IDUs, MSM and migrant populations in certain districts, in order to identify if and when funding gaps may be created and collaborate with other partners on how these could be addressed.

On project planning, implementation, monitoring and evaluation:

- For a better measure of strengthened capacity of implementing organizations, apply an organizational assessment or indexing tool.
- Create a better indicator of capacity to collect, analyze and use M&E data than the indicators currently used (number of people trained, number of organizations receiving technical assistance). One way to do this would be to ask the RPO to grade each partner on how it uses data in its bimonthly review meeting (BRM) with ASHA, using a scale that ASHA develops. One would expect to see increasing grades over time. A special study would be another possibility.
- If USAID agrees there is a need, reorganize the progress reports to track activities as they are described in the work plan; or if this is not possible, add a table at the end of the progress reports that describes progress on each of the elements described in the work plan.
- On work plan narratives, wherever possible describe the “so what” of the activity – that is, how it contributes to achievement of the relevant result.
- Take a second look at reporting requirements, in consultation with implementing partners, determine what their key reporting complaints are, and review ways to reduce reporting and better integrate existing reports. At the same time analyze implementing partner workload as there may be other ways the partners can be working more efficiently, which would free up time for needed reporting. Even if ASHA finds that reporting cannot be reduced in any significant way, the process itself will let

implementing partners know that ASHA as an organization is aware of and concerned about their workload issues and wants to help.

- Review communications with implementing partners. Be sure they are receiving full information, repeatedly, about why certain regulations are in place and why certain decisions have been made, and when they make suggestions that cannot be approved under project requirements; help them find other ways of solving their problems.
- Give visible recognition to implementing partners for the efforts they put into achieving targets, and in particular find ways of recognizing the field-level staff that are the poorest paid but are most responsible for grass roots results.
- Encourage innovation. For example, create an innovation fund, available to partners on a competitive basis, which enables them to exercise judgment in trying new techniques to achieve ASHA objectives, or to find ways of fostering organizational sustainability.
- Introduce no new implementing partners.



## **APPENDICES**

**A. SCOPE OF WORK**

**B. PERSONS CONTACTED**

**C. REFERENCES**

**D. TEAM CALENDAR**

**E. ANALYTICAL TOOLS**

**F. SUMMARY OF NEPAL'S HIV/AIDS  
PROGRAM AND USAID PAST  
PROGRAMMING**

## **APPENDIX A. SCOPE OF WORK**

### **I. USAID/Nepal ASHA Project Evaluation**

Activity: **Evaluation of USAID/Nepal's key HIV/AIDS activity: Advancing Surveillance, Policies, Prevention, Care, and Support to Fight HIV/AIDS in Nepal (ASHA) Project.**

Contract: Global Health Technical Assistance Project (GH Tech), Task Order No. 01

### **II. PERFORMANCE PERIOD**

The desired start date for the assignment is January/February, 2010

The evaluation should be completed within approximately 8 weeks, including preparation days, all in-country work, and report writing and finalization.

### **III. FUNDING SOURCE**

The evaluation will be funded by USAID/Nepal field support.

### **IV. PURPOSE AND OBJECTIVES**

The evaluation will focus on ASHA's progress in meeting the program objectives and goals. The team will evaluate the key expected activities of ASHA based on the project design and annual work plans. The results of this evaluation will inform USAID/Nepal Health and Family Planning office of ASHA's success and provide suggestions for future HIV/AIDS programming needs and directions, including possible adjustments needed based on the HIV/AIDS needs analysis.

### **V. BACKGROUND**

In June 2006, USAID/Nepal awarded Cooperative Agreement No. 367-A-00-06-00067-00 designating Family Health International (FHI) as the prime and Futures Groups International and Association Medical Doctors of Asia (AMDA) as the sub-prime. The original period of performance was until September 2009. A cost extension was awarded to ASHA extending the activity to September 2011, although Futures Groups International is not included in the extension. To date, ASHA has provided 60 sub-grants to local NGOs to provide HIV/AIDS prevention, care and support services to most-at-risk populations (MARPs), viz., female sex workers (FSW), clients of FSW, injecting drug users (IDU), migrant workers and their wives, and men who have sex with men (MSM). Additionally, support was provided to research organizations and several beneficiary networks.

#### **ASHA Project's result areas:**

- Reduce HIV transmission through targeted prevention interventions within specific high-risk and vulnerable populations.
- Build capacity of the Government of Nepal/Ministry of Health and Population (GON/MOHP) and civil society to manage and implement HIV/AIDS activities, and to inform policy formulation.
- Improve planning, collection, analysis and use of strategic information by stakeholders to facilitate a more effective and targeted response.
- Increase access to quality care, support and treatment services through public, private and non-governmental sources for persons living with HIV/AIDS (PLHA) and their families.
- Create linkages among stakeholders and support national coordination of Nepal's cross-sectoral HIV/AIDS program.

#### **The HIV Epidemic in Nepal:**

According to national surveillance and monitoring data, Nepal's HIV/AIDS epidemic is concentrated among most-at-risk populations (MARPs), who practice high-risk behaviors that favor the spread of the virus. These groups include IDUs, FSWs and their clients, and MSM. Migrant males, police and transport workers have also been identified as high-risk groups, and the data demonstrate that this is true only when they are clients of sex workers. According to the 2007

UNAIDS national estimates of HIV infection, just under 70,000 people are estimated to be infected with HIV in Nepal, most of whom are unaware of their infection. As of July 2009, the National Centre for AIDS and STD Control (NCASC), Department of Health Services (DOHS), MOHP reported a cumulative number of more than 14,000 HIV positive persons.

The estimated adult HIV prevalence rate of Nepal is 0.49% in 2007 (2007, NCASC). The prevalence rates among MARPs in 2009 from IBBS studies are as follows: IDU, 3.4% in Pokhara to 20.7% in Kathmandu; MSM, 3.8% in Kathmandu; FSW, 2.3% in Terai Highway Districts; Truckers, 0% (2009, IBBS). Similarly, the prevalence rate in 2008 among FSWs in Kathmandu was 2.2% and 3% in Pokhara; migrant males, 0.8% in Far Western districts and 1.4% in Western Districts; and spouses of migrant males, 3.3% in far western districts (2008, IBBS). The epidemiological data trends demonstrate that the epidemic is stabilizing among some of the high-risk groups, namely FSWs, Truckers and MSM.<sup>13</sup>

### **Government of Nepal Response to HIV/AIDS:**

Over the past decade the GON, with the assistance of USAID and other stakeholders, has made significant progress in responding to the HIV/AIDS epidemic. In 1988, Nepal launched the first National AIDS Prevention and Control Program. Sentinel surveillance was introduced in 1991 in several districts but because the system has not functioned consistently, and some of the sites were in district hospitals where MARPs are less likely to seek services, the utility of the data to estimate prevalence in a concentrated epidemic has been limited.

In 1995, Nepal adopted a national policy for HIV/AIDS prevention, with 12 key policy statements. With USAID, UNAIDS and the assistance of other stakeholders, the first National HIV/AIDS Strategy 2002-2006 was developed, followed by a second national strategy 2007-2011. Similarly, the GON and all stakeholders developed a coordinated, multi-year National Action Plan in 2005, with the current plan covering activities from 2008-2011.

In 2007, the GON created the National HIV/AIDS and STD Control Board. The board is mandated primarily to formulate policies, monitor the trend of the epidemic and oversee the country's multi-sectoral response to HIV/AIDS. The MOHP may seek to revise the formulation order and by-laws of the board over the next few months. Under the MOHP, the NCASC is the management unit for HIV/AIDS prevention, treatment and care services.

All ASHA activities are reflected in the National Action Plan and are coordinated with and support the GoN's national strategy.

### **USAID's HIV/AIDS Activities in Nepal:**

The USAID HIV/AIDS program is designed to have national impact, build on the technical strengths and strategic advantages of the United States Government (USG), and work closely with the GON to achieve the objectives of Nepal's National HIV/AIDS Strategy.

USAID's investments in HIV/AIDS began in 1995 with programs implemented through bilateral and field support mechanisms. As of 2008, USAID/Nepal's investment in HIV/AIDS programs totals over \$60 million. USAID's five-year HIV/AIDS strategy was developed in 2001 to address the issues of a concentrated epidemic to maintain Nepal's low prevalence below 1% in the general adult population. The 2001 strategy had three sub-intermediate results: 1) Increased national capacity to provide HIV/AIDS services; 2) Increased access to information and prevention services for HIV/AIDS and other sexually transmitted infections, and 3) Increased access to care and support. USAID's HIV/AIDS strategy supports the GoN's National HIV/AIDS strategy, and collaborates and coordinates with the National Action Plans.

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<sup>13</sup> 2007, NCASC. National Estimates of HIV Infections Nepal 2007. Report Published by NCASC, Ministry of Health and Population.

2009, IBBS. Final report on IBBS among IDUs, FSWs, MSM, Truckers conducted by New ERA/SACTS/FHI/USAID in 2009 (reports are to be disseminated by NCASC)

2008, IBBS. Final reports on IBBS among FSWs, Labor Migrants and wives of conducted Labor Migrants by New ERA/SACTS/FHI/USAID in 2008

USAID's HIV/AIDS program:

- Supports the GON to deliver targeted prevention services.
- Provides care and support services, and trains health workers and community workers to provide treatment, care and support.
- Implements targeted behavior change and prevention activities.
- Conducts high quality research, surveillance and generates national data to track progress and monitor epidemiologic trends.
- Establishes and strengthens the national HIV/AIDS supply chain system.
- Creates an enabling environment for positive policy adoption.
- Promotes strong local ownership and leadership, and optimizes coordination among partners and stakeholders.
- Builds capacity in the public and private sectors to plan, manage and provide HIV/AIDS services.

For the last 30 years, USAID Nepal has supported the social marketing of maternal, child, family planning and HIV prevention products and services through the Nepal Contraceptive Retail Sales (CRS) Company. Under the current N-MARC Project implemented by the Academy for Educational Development and CRS that began in July 2006, USAID's social marketing program has taken a new approach to build local organizational capacity to create a sustainable condom market that addresses a cross-sector of beneficiaries in locations where high-risk behavior occurs.

#### **Other Major HIV/AIDS Players in Nepal:**

**GFATM:** Nepal has been awarded two grants from the Global Fund to Fight AIDS, TB and Malaria (GFATM). The first HIV/AIDS grant of \$11 million over 5 years was awarded in Round 2 (2002). These funds have been managed by the Principal Recipients (PR) of the United Nations Development Program (UNDP) and the NCASC/MOHP. The GFATM granted an additional \$36 million through Round 7 (2007) to support HIV/AIDS programming over the next 5 years covering mainly MSM, migrants and supply chain management. The Family Planning Association of Nepal (FPAN), Save the Children, and UNDP are the PR's for this grant. Representing bilateral donors working in HIV/AIDS, USAID is a member of the Nepal Country Coordinating Mechanism (CCM) which oversees the management of GFATM grants.

**UNICEF:** In addition to life skills and radio programs USAID supported through UNICEF, UNICEF also supports 9 sites for the prevention of mother to child transmission (PMTCT). As in many other countries, UNICEF takes a lead role in children's issues. USAID works closely with UNICEF in three child-focused activities: 1) a community-based PMTCT pilot in three Districts, 2) Universal Access for Children Affected by AIDS in Nepal (UCAAN), and 3) Children Affected and Infected by HIV/AIDS (CABA) working group.

**UNAIDS:** UNAIDS supports the GON and works with all stakeholders to coordinate a variety of activities with the NCASC and the HIV/AIDS Control Board. Key activities include compiling the annual national estimates report, the biennial UNGASS report, the development of coordinated and costed National Action Plans (2006-2008 and 2009-11) and national strategies (2002-6 and 2008-11). UNAIDS also coordinated the development of the national monitoring and evaluation framework, and works closely with USAID on a variety of technical working groups at the NCASC.

**UNFPA:** Through its reproductive health program, UNFPA supports prevention activities mainly around FSWs, young people (10-24 years old), vulnerable women and girls, and sexual and reproductive health rights. UNFPA's current estimated budget for 2008-10 is about US\$1 million.

**GTZ:** GTZ has assisted the MOHP to establish several VCT sites at government hospitals and all those sites are functioning, but, service utilization is low. GTZ has also introduced a special package of activities focused on HIV awareness and prevention for youth called "Join the Circuit" through the public education system, pending funding.

**JICA:** In the past, JICA assisted the MOHP to procure drugs to treat sexually-transmitted infections but this support ended in 2007. Currently JICA is not supporting any HIV/AIDS activities in Nepal.

**UNODC:** The United Nations Office of Drugs and Crime (UNODC) opened an office in Kathmandu in early 2007. The UNODC works to address prevention and treatment of injecting drug use and other drug use as well as human trafficking for the sex industry. With funds from AusAID,

they currently support oral substitution therapy (OST) through the Tribhuvan University Teaching Hospital for 100 drug addicts and have plans to expand this to 200 addicts in the future.

**DFID:** DFID has channeled most of its HIV/AIDS funding through the UNDP program management unit for the last two years to strengthen and build local NGO capacity in implementing HIV interventions at the grassroots level. They have also supported the NCASC in HIV district strengthening. So far, DFID has spent £9.12 million in HIV/AIDS support in Nepal. An additional £3.38 million has been pledged by DFID for HIV/AIDS activities from 2010 to March 2011.

**World Bank:** The World Bank conducted assessments in 2007, 2008 and 2009 in Nepal and has committed to funding a range of HIV/AIDS activities over the next few years. The World Bank has expressed interest in supporting supply chain management and selected surveillance studies.

**WHO:** WHO supports an external advisor for the national program and two Nepali technical staff at the NCASC to assist in capacity building. WHO has also committed to strengthening the national laboratory capacity and to implementing an external quality assurance system for CD4 testing.

**AusAID:** According to the National Consolidated HIV/AIDS Work Plan for 2006-2008, AusAID has committed US\$600,000. AusAID has also funded UNODC to implement OST for 100 injecting drug users through Tribhuvan University Teaching Hospital, and have committed to extending funding to provide another 100 IDUs with OST. AusAID has been a major contributor to harm reduction/needle exchange programs in Nepal.

**Other Actors:** Several of the larger international NGOs have funding for HIV/AIDS programs in Nepal. These include World Vision, CARE, Mercy Corps, SAVE the Children, and United Mission to Nepal. These organizations' activities are represented in the National Action Plan.

## VI. SCOPE OF WORK

The overall objective of this evaluation is to assess the effectiveness of the ASHA project, document how and if the ASHA project is making a difference in the national HIV/AIDS response, document best practices, and recommend future longer term HIV/AIDS programming directions for USAID/Nepal.

The evaluation team should consider the following illustrative questions:

### 1. Overall result areas

- a. To what extent is the ASHA project on-track to achieve results? Describe what on-track is, what is behind schedule and what is ahead of schedule or beyond/outside of result areas.
- b. With the current and anticipated lower level of HIV funding for Nepal and considering the work of other stakeholders, are there result areas that are no longer relevant to the current epidemic in Nepal that should be phased out or eliminated in the ASHA program? Are there new, emerging result areas that USAID should consider adding to the ASHA program? If so, what is USAID's comparative advantage in these result areas, and with what other organizations would USAID collaborate to address them? What are these specific result areas, and what illustrative measurable indicators would we use to monitor and evaluate impact?

### 2. Planning, implementation, monitoring and reporting

- c. Are the monitoring and evaluation framework and indicators relevant to the program objectives and in-line with USAID standard indicators? What specific recommendations are there to improve them?
- d. Are all of the annual work plans, including the current one, relevant to the approved ASHA program description? Are work plan activities sufficiently reported in the semi-annual and annual technical reports? Are key activities missing or under-reported? Is there sufficient monitoring and reporting of compliance with USG regulations concerning HIV assistance activities, specifically the anti-trafficking and prostitution policies?
- e. Are ASHA monitoring systems sufficiently robust to adequately monitor the quality of activities conducted by sub-recipients and their compliance with USG regulations? How could they be strengthened without compromising the reach of the program?

### 3. Management systems

- f. What are the strengths and weaknesses in the project management structure and systems? What could be done to make them stronger and build capacity of Nepali staff to manage technical and administrative functions?
- g. Are the structure and management systems of the technical units relevant to the overall program objectives and results? How could they be improved?
- h. Is the management of USAID assets strong and compliant with USG regulations?
- i. Is there adequate understanding and compliance with branding and marking regulations?
- j. In terms of financial management, are internal controls strong, transparent and accountable?
- k. Is the management and oversight of awards to sub-recipients strong, accountable and compliant with USAID regulations?
- l. Is the management of core sub-recipients (AMDA and Futures International) strong, accountable and effective?

## **VII. METHODOLOGY**

The evaluators will use a range of methods to collect and analyze information related to the evaluation objectives and questions to be answered, including but not limited to:

### **Document Review**

The evaluation team will review background documents (preliminary list provided in Annex 1). Documents to be reviewed include ASHA project documents: work plans; monitoring and evaluation framework and plan; semi-annual and annual technical reports; and other ASHA related technical documents including integrated bio-behavioral surveillance (IBBS) reports, as well as other country specific documents as listed, i.e. national strategies, national action plans, and UNGASS country reports (Annex 1).

### **Team Planning Meeting**

It is anticipated that the evaluation team leader will facilitate and conduct a two-day team planning meeting at the beginning of the evaluation process in Nepal, and before starting the in-country portion of the evaluation. USAID/Nepal's focal person will participate in the two-day team planning meeting. The agenda may include the following items:

- Clarify team members' roles and responsibilities;
- Establish a team atmosphere, share individual working styles, and agree on procedures for resolving differences of opinion;
- Finalize a *work plan* for the evaluation;
- Review and develop *final evaluation questions*;
- Review and finalize the *assignment timeline* and share with USAID;
- Finalize *data collection plans and tools*;
- Review and clarify any logistical and administrative procedures for the assignment;
- Develop a *preliminary draft outline* of the team's report; and
- Assign drafting responsibilities for the final report.

USAID/Nepal will review and approve the documents noted above before further work on the evaluation, within the two-day timeframe.

### **Key Informant Interviews and Site Visits**

The evaluation team will conduct key informant interviews with (preliminary list of key informants provided in Annex 2) selected ASHA staff, USAID HIV/AIDS program managers, and key stakeholders including donors, government counterparts, selected implementing agencies, networks, other program beneficiaries and stakeholders.

As of May 2009, there are about 59 implementing agencies under ASHA. Among them, 13 are in the Kathmandu valley and the rest are outside KTM valley requiring travel by air or car. For selection

purposes, implementing partners can be grouped by geographical locations and by their main function. Please find the detailed information about implementing agencies in Annex 3 (attached as separate document). For the site visits, the evaluation team will be divided in two teams and at least 20 implementing agencies are expected to be visited between the two teams. The evaluation team will participate in evaluation team meetings, and will conduct field visits, interviews and focus group discussions as appropriate and observe activities in action.

### **Wrap-up and Debriefing**

Upon completion of fieldwork, the evaluation team will present comprehensive preliminary findings to USAID/Nepal HIV/AIDS managers, and will receive feedback. The team is not expected to debrief all implementing partners, but the Mission intends to seek feedback with FHI and AMDA.

## **VIII. TEAM COMPOSITION, SKILLS AND LEVEL OF EFFORT**

### **Team Composition**

The team will consist of four consultants: a Team leader, two local experts, and a fourth team member:

#### **Team Leader**

The team leader is a senior level evaluator with experience in the Asia region. S/he must have demonstrated strong technical and analytical skills in the field of HIV/AIDS, in particular in concentrated epidemics such as in Nepal. S/he must have strong communication and writing skills in English. Particular expertise and experience should include:

- Strong knowledge of HIV/AIDS epidemiology
- Prior experience as the leader of an international HIV/AIDS project evaluation
- Expertise in program monitoring and evaluation
- Familiarity with USAID PEPFAR indicators
- Strong team management skills working with diverse populations with differing opinions
- Demonstrated strong cross-cultural communication skills
- Demonstrated lead writer with strong technical writing (in English) skills with tight deadlines and multiple contributors
- Experience working with senior level government officials to local NGOs in HIV/AIDS project implementation and management, specifically with MARPs communities
- Experience implementing activities in a post-conflict setting
- Ability to travel and work for short durations in challenging environments

#### **Local Experts (2)**

The Nepali experts (2) must have expertise in the field of HIV/AIDS and be highly knowledgeable about the situation of the epidemic in Nepal. Among the Nepali experts, at least one member is expected to be an expert from one of the HIV/AIDS networks.

#### **Local Nepali expert (1)**

- Strong knowledge of HIV/AIDS epidemiology in the region
- Extensive experience and in-depth knowledge of Nepal HIV/AIDS program, donors, civil society and government responses
- Demonstrated strong technical and analytical skills
- Strong team skills working with diverse populations with varying opinions
- Strong analytical skills
- Strong written and verbal communication skills (in English)
- Responsible for organizing meeting appointments with key informants, stakeholders and government counterparts
- Ability to manage general logistics and arrange meetings and site visits
- Ability to travel and work for short durations in challenging environments

#### Local Nepali expert (2)

- Extensive knowledge of MARP focused HIV/AIDS projects
- Coming from MARP/beneficiary groups either from FSW or Injecting Drug Users
- Demonstrated leadership and facilitation role at the local or national level for the respective MARP
- Strong team skills working with diverse populations with varying opinions
- Experience working outside of the Kathmandu Valley in HIV/AIDS higher-risk locales
- Able to communicate in English (however if necessary an English-Nepali translator can be obtained)
- Ability to travel and work for short durations in challenging environments

#### **HIV/AIDS Specialist**

A fourth member of the team may be an expatriate or Nepali expert, hired locally or internationally, with excellent communication and English language skills and other technical skills that round out and complement the skills of the other members.

- Sound knowledge of HIV/AIDS epidemic in the region
- Prior experience in HIV/AIDS project monitoring and evaluation
- Experience in Nepal specific to HIV/AIDS
- Strong team skills working with diverse populations with varying opinions
- Strong analytical skills
- Strong written and verbal communication skills (in English)
- Experience working with a range of actors from senior level government officials to local NGOS ideally in HIV/AIDS project implementation and management, specifically with MARPs communities
- Experience implementing HIV/AIDS activities in a post-conflict setting
- Ability to travel and work for short durations in challenging environments

All team members should have sound knowledge and experience of concentrated epidemics such as in Nepal, and the particular issues of the vulnerable groups and MARPs. Experience operating in conflict/post-conflict settings is a plus.

#### **Level of Effort**

USAID/Nepal anticipates that the preparation days, in-country work including site visits, as well as drafting and finalizing the evaluation report will be completed according to the following illustrative level of effort (LOE).

The LOE for this assessment is not to exceed:

<b>Task</b>	<b>LOE (Days)</b>	<b>Persons Participating</b>
Document review and initial planning and preparation (out of country for international consultants)	3 days	Team leader + 3
Travel to Nepal	2 days	Two Persons
Team planning meeting in KTM	2 days	Team leader +3
In-briefing with USAID/Nepal; team presents TPM deliverables to USAID/Nepal	1 day	Team leader +3 + USAID
Interviews and discussions with ASHA staff and managers and review of systems in KTM	2 days	Team leader +3
Interviews and discussion with key stakeholders external to ASHA in KTM and site visits in KTM	5 days	Team leader +3
Field visits at project implementation sites outside of KTM, possibly 1-2 flights and car rental involved	7 days	Two teams of two persons visiting different sites in eastern and western Nepal.

Information gap filling, team discussions and analysis in KTM	2 days	Team leader +3
USAID Debriefing	1 day	Team leader +3
Travel home	2 days	Two persons
Report Writing at respective homes	6 days 3 days	Team leader Team members
USAID/Nepal reviews draft report (10 working days)	-	-
Report revisions, based on Mission comments (out of country)	5 days 2 days	Team leader Team members
<b>Total consultant LOE</b>	<b>38 days</b>	<b>Team leader</b>
	<b>32 days</b>	<b>Second international hire</b>
	<b>28 days x 2</b>	<b>Two local hire members</b>

A 6 day work week is authorized while working in-country. The above tasks are to include adequate time for consultations, exchanges of findings, team planning, report preparation and discussion with USAID/Nepal HIV/AIDS managers.

The evaluation should be completed within 8 weeks (estimated), including preparation days, all in-country work, and report writing and finalization.

## IX. LOGISTICS

GH Tech is responsible for all logistical arrangements including but not limited to travel and transportation (in-country and in Nepal), country travel clearances with the USAID/Nepal Mission, lodging, communications, document production and reproduction, interpreters, and all other logistical support deemed necessary. If deemed necessary by GH Tech and by USAID/Nepal, a local logistics assistant may be hired to facilitate site visits and interview scheduling.

USAID/Nepal will provide electronic copies and one hard copy of key documents and background materials and will assist in finalizing key informant lists with contact information. USAID/Nepal will arrange in-briefing and debriefing at the USAID/Nepal offices and U.S. Embassy security clearance for entry to the Embassy. USAID/Nepal will arrange and participate in meetings with key GON counterparts and other stakeholders. The USAID/Nepal HIV/AIDS managers may choose to participate in other aspects of the evaluation process as possible. Exact participation will be determined at the planning meeting in Kathmandu. The Team Leader will be responsible for determining when/where USAID staff may/may not participate. USAID/Nepal staff may, however, conduct introductions at meetings with senior government officials, and then leave the room to allow a full and open interview.

## X. DELIVERABLES AND PRODUCTS

The outcomes should be a summary of progress to-date, a set of recommendations to improve performance and overall project impact for the current activity, and recommendations for possible future directions for USAID/Nepal's HIV/AIDS activities.

The evaluation team is responsible for the following deliverables:

1. Two-day planning meeting documents: The team leader will submit to USAID for approval on day two of the two-day initial planning meeting a finalized work plan for the evaluation, finalized data collection plans and tools, finalized format of the draft final report including table of contents, clear roles and responsibilities of team members, including agreed upon writing responsibilities for the final report.
2. Mission in-briefing and final debriefing: The team will conduct an in-briefing with USAID/Nepal HIV/AIDS managers as part of the two-day initial planning meeting, and a final debriefing. The team will conduct a final debriefing with USAID/Nepal and include the presentation of main findings and recommendations. The presentation will include an oral presentation and discussion with all team members, a *CD-ROM with the Power Point*

*presentation, a hard copy of the presentation and a hard copy draft final report.* The debriefing will also include a separate *'sensitive but unclassified' annex* that contains sensitive information that should not be published in an open, public document, but which contains important information for USAID's internal use.

3. **Draft Report:** The first draft of the final evaluation report will be due 6 working days after the international consultants return to their respective homes.

The draft will conform to the agreed upon format and include findings, conclusions and recommendations, as well as annexes with additional reports, copies of data collection tools, lists of key informants, etc. USAID/Nepal will circulate the draft to ASHA and AMDA, review the draft, and provide one set of comments to the draft report within 10 working days upon receipt.

4. **Final Report:** The final evaluation report will be due at USAID/Nepal within 5 working days after the team receives comments from USAID/Nepal. The final report will not be edited/formatted by GH Tech as this is an internal document to be disseminated inside the Mission.

## **XI. RELATIONSHIPS AND RESPONSIBILITIES**

GH Tech is responsible for identifying GH Tech-funded team members with the skills and experience described above, negotiating the final team composition with USAID/Nepal, and entering into contracts with the consultant and/or team members. Other GH Tech responsibilities are included under the Logistics and Deliverables sections, above.

USAID/Nepal will, to the best of its ability, provide names and contact information for key contacts as well as relevant USAID and partner documents to GH Tech for distribution to the evaluation team prior to the start of the assignment. Other USAID/Nepal responsibilities are included under the Logistics and Deliverables sections, above.

## **XII. MISSION CONTACT PEOPLE**

Clifford Lubitz  
USAID/Nepal  
Deputy Director, Office of Health/Family Planning  
Tel: 977-1-400-7200, Ext. 4456  
Cell: 98511-06902  
Fax 977-1-400-7285  
[clubitz@usaid.gov](mailto:clubitz@usaid.gov)

Shanta Gurung  
USAID/Nepal  
Program Management Specialist  
Tel: 977-1-400-7200, Ext.4027  
Cell: 9851053080  
Fax 977-1-400-7285  
[shgurung@usaid.gov](mailto:shgurung@usaid.gov)

## **XIII. COST ESTIMATE**

GH Tech will provide a cost estimate for this activity.

## Annex 1 to SOW

### List of Background Materials

#### ASHA Project documents:

- ASHA program description including cost extension
- Monitoring and Evaluation Plan
- ASHA yearly work plans
- Semi-annual reports
- Mid-term review of the ASHA project conducted by FHI senior management in April 2008.
- IBBS reports on MARP surveillance
- USAID's Program Monitoring Plan (PMP)

#### National Documents:

- National HIV/AIDS Action Plan (2006-2008 and 2009-11)
- National HIV/AIDS Strategic Plan (2007-11)
- National Monitoring and Evaluation Guidelines for HIV and AIDS in Nepal
- UNGASS country report (2005 and 2007)
- 2007 National Review of Second Generation Surveillance in Nepal
- 2007 National Review of the PMTCT program in Nepal (led by UNICEF)
- 2007 National Review of Community and Home-based Care in Nepal
- World Bank Assessment and Situation Analysis of Nepal (2007)
- DFID Mid-term evaluation documents
- UNDP report of the GFATM funded activities in Nepal (2007)
- 2007 Nepal National HIV Estimates and Projections

## Annex 2 to SOW.

### List of Key Stakeholders and Partners

S. N.	Organization	Person to be interview	Designation	Contact
1.	Ministry of Health	Dr. Gobinda Prasad Ojha	Director General	<a href="mailto:dg@dhs.gov.np">dg@dhs.gov.np</a> Tel. # 4261436
2.	NCASC	Dr. Laxmi Raj Pathak	Director	<a href="mailto:drpathak@ncasc.gov.np">drpathak@ncasc.gov.np</a> Tel. # 4261653
3.	HIV/AIDS and STI Control Board	TBD	Vice Chair and Executive Chief	<a href="mailto:info@hivboardnepal.org">info@hivboardnepal.org</a> Tel # 6227566
4	UNDP HIV/AIDS Program Unit	Mr. Mohammed Siddig	Program Manager	<a href="mailto:Mohammed.Siddig@undp.org">Mohammed.Siddig@undp.org</a> Tel. # 5523200
5	Dr.Maria Elena G Filio-Borromeo	UNAIDS	Country Coordinator	<a href="mailto:borromeom@unaids.org">borromeom@unaids.org</a> Tel. # 5523200
6	Ms. Gillian Mellsop, UN Building, Pulchowk	UNICEF	UNICEF Representative	<a href="mailto:gmellsop@unicef.org">gmellsop@unicef.org</a> Tel. # 5523200
7	Dr. Nastu Sharma, Hotel Yak & Yeti Complex	World Bank	Health Advisor, World Bank	<a href="mailto:nsharma2@worldbank.org">nsharma2@worldbank.org</a> Tel. #: 4226766
7	Dr. Alex Andjaparidze, Representative	WHO	WHO Representative	<a href="mailto:andjaparidzeA@searo.who.int">andjaparidzeA@searo.who.int</a> Tel. # 5523200
8	Ms. Tara Chetty	Save the Children Alliance	Project Director	<a href="mailto:Tara.chetty@savethechildren.org.np">Tara.chetty@savethechildren.org.np</a>

				Tel. # 4222271
9	Dr. Pulkit Chaudhari	FPAN	Project Director	Tel. # 5010240
10	Ms. Alka Pathak	CARE Nepal	Country Director	<a href="mailto:alka@carenepal.org">alka@carenepal.org</a> Tel. # 5522800
11	Ms. Jacqueline McPherson and Mr. Satish Raj Pandey	ASHA Team	Country Director	<a href="mailto:Jackie@fhi.orn.np">Jackie@fhi.orn.np</a> Tel. # 4437173
12	Ms. Chhiring Doka Sherpa	NFWLHA	Executive Director	<a href="mailto:snehasamaj@enet.com">snehasamaj@enet.com</a> Tel: 2210202
13	Mr. Rajeev Kafle	NAP+N	President	<a href="mailto:rajhiv2002@yahoo.com">rajhiv2002@yahoo.com</a> Tel # 4373910
14	Mr. Anand Pun	Recovering Nepal	Executive Director	<a href="mailto:ananpur@gmail.com">ananpur@gmail.com</a> Tel.# 2111107
15	Suben Dhakal	FSGMN	President	<a href="mailto:fsgmn@yahoo.com">fsgmn@yahoo.com</a>
16	Ms. Tulsa Lata Amatya	NANGAN	President	<a href="mailto:tlatamya@hotmail.com">tlatamya@hotmail.com</a> Tel. # 4794249
17	Ms. Susan Clapham	DFID	Health Advisor	<a href="mailto:s-clapham@dfid.gov.uk">s-clapham@dfid.gov.uk</a> Tel. # 5542980
18	Mr. Olivier Lermet	UNODC	Program Coordinator	<a href="mailto:Olivier.LERMET@unodc.org">Olivier.LERMET@unodc.org</a>

## **APPENDIX B. INDIVIDUALS AND ORGANIZATIONS INTERVIEWED IN KATHMANDU AND ON SITE VISITS**

### **USAID**

Anne Peniston, Director, Health and Family Planning Team  
Shanta Gurung, AOTR for ASHA. Health and Family Planning Team  
Pradeep Neupane, Contracting Division  
Sandra Minkel, Controller  
Rajeeb Shakya, Financial Analyst, Office of Controller  
Hari Koriala, Logistics staff, Health and Family Planning Team  
Pandey Yonzone, Logistics staff, Health and Family Planning Team

### **ASHA Team**

#### **FHI:**

Jacqueline McPherson, Chief of Party  
Satish Pandey, Deputy Director  
Prabesh Aryal, Director of Finance and Administration  
Dr. Laxmi Acharya, Sr. Advisor, Strategic Information  
Mahesh Shrestha, Senior Strategic Information Officer  
Dr. Durga Bhandari, Technical Unit Head  
Kamala Moktan, Technical Officer; Communications Initiative; Home-Based Care  
Rabin Shrestha, Logistics Specialist  
Dr. Neeta Shrestha, Technical Officer/Clinical Services  
Gopal Panla, Laboratory Specialist  
Bhagawan Shrestha, Strategic Behavior Communication Specialist  
Pravaran Mahat, UCAAN Support Officer  
Prava Chhetri, Team Leader of Program Unit  
Bhushan Shrestha, Team Leader of Program Unit  
Neera Thakur, Program Officer, Kathmandu  
Madhav Chaulagain, Program Officer, Central/East (in Bhiratnagar)  
Bhav Nath Jha, Program Officer, Far West (in Dhangadi)  
Sujan Pandit, Program Officer, Western Region  
And other ASHA staff

#### **AMDA:**

Dr. Anil Kumar Das, Sr. Technical Advisor  
Dr. Saroj Prasad Ojha, Consultant Neuro-psychiatrist, Teaching Hospital/TU  
Dr Yogendra P. Singh, Professor, Surgical Oncology, Teaching Hospital/TU  
Raja Ram Parajuli, Sr. Officer/Admin/Finance

#### **Eastern region:**

Dr. CM Chaudhary, Director, AMDA Itahari  
Ajij Paudel, Programme Officer, AMDA Itahari  
Madhav Dhungel, Fin/Admin officer, AMDA Itahari  
Amit Ghimire, IHS In-Charge/AMDA (Co-located with SAHARA)

#### **Futures:**

Nirmal Prasad Pandey, Senior Policy Advisor

Sumi Devkota, ASHA – Futures Project Staff

**Government of Nepal:**

Dr Padam Bahadur Chand, Chief of Monitoring and Evaluation, Ministry of Health and Population  
Dr. K.K. Rai, Director of NCASC, Ministry of Health and Population  
Dr. Geeta Shakya, Director, National Public Health Laboratory, MoPH  
Dr. Mingma Sherpa, Chief of Logistics and Management Division, MoPH

**Western Region:**

Kirti Sagar Baral, DACC Coordinator, Kaski District/Pokhara

**Far Western Region:**

Dr. Bikash Kopri, Physician in Charge, ART Clinic, District Hospital, Doti  
Preem Kotai, DACC Coordinator, Doti  
Ashok Pandey, DACC Coordinator, Kanchanpur  
Acting DPHO, Kanchanpur  
Director, ART Clinic, Mahakali Zonal Hospital, Kanchanpur  
DACC Coordinator, Kailali  
Medical Superintendent, Seti Zonal Hospital, Kailali  
Harishchandra Shah, District Health Officer, Kailali

**HIV/AIDS and STI Control Board:**

Damar Ghimire, Exec. Director  
Dr. Sharad Onta, former Vice Chair and Chief Executive  
Dr. Tirtha Rana, Board member  
Hari Prasad Awasti, Board member

**Other Donors:**

Susan Clapham, Health Advisor, DFID  
Gokarn Bhatt, Nepal CCM Coordinator, Global Fund  
Dr. Marlyn Borromeo, Country Coordinator, UNAIDS  
Gillian Mellsop, Country Representative, UNICEF  
Pragya Shah, Project Officer, UNICEF  
Birendra Pradhan, Project Officer, UNICEF  
Savita Acharya, Senior Program Advisor, UNDP  
Dr. Olivier Lermet, UNODC  
Dr. Nastu Sharma, Health Advisor, World Bank  
Dr. Mohamed Akhtar, WHO  
Dr. Atul Dahal, WHO  
Darshana Shrestha, WHO  
Sharmila Shrestha, WHO

**International and National NGOs working in HIV/AIDS:**

Alka Pathak, Country Director, CARE Nepal  
K.P. Bista, Director General, Family Planning Association of Nepal  
Dr. Giridhari Sharma, Deputy Director and Chief of Programme, Family Planning Association of Nepal  
Sangita Khatri, HIV and AIDS Section, Family Planning Association of Nepal (FPAN)  
Dr. Pulkit Chaudhary, Director, Global Fund Project, FPAN

Dr. Giridhari Sharma Paudel, Deputy Director General & Chief of the Program, FPAN  
Dr. Janardan Lamichane, JSI-Deliver  
Peter Oylo, N-MARC  
Tara Chetry, Team Leader/GF, Save the Children  
Arlene Mahinay, Country Director, VSO  
Smriti Bhattaria, VSO

**ASHA Implementing Partners:** (Note: only key personnel are listed here but many team members were also interviewed and participated in site visits)

**Kathmandu Area:**

Banmali Subedi, program Manager, and Sabin Shrestha, Community Welfare Centre (CWC)  
Dr. Nirmal Prasad Rijal, Country Manager, and Binita Shrestha, Equal Access  
Anju Gurung, Vice President, and Parinna Subha Limbu, Drishti Nepal  
**Parina Subba, Program Director, DRISTI Nepal**  
Rup Naryan Shrestha, Advocate, Forum for Women, Law and Development (FWLD)  
Manisha Bista, President, Suben Dhakal, Kumar Lama, Federation of Sexual and Gender Minorities (FSGMN)  
Kumar Lama, National Programme Coordinator - FSGMN  
Roshan Mahato, Programme Associate - FSGMN  
Mahesh Bhattarai, Executive Director, General Welfare Pratisthan (GWP)  
Gujeswori Rai, President, and Bijaya Dhakal, Jagriti Mahila Sangh  
Kedar Man Joshi, Executive Director, Management Association Nepal (MAN)  
Om Rajbhandari and Ganesh Man Singh, Managing Support Service (MASS)  
Rajiv Kafle, President, National Association of PLHA in Nepal (NAP+N)  
Siddarth Man Tuladhar, Executive Director, and Yogendra Parsai, Director, New ERA  
Chiring D. Sherpa, President, National Federation of Women PLHA  
Tulsalata Amatya, President, National NGOs Network Group Against AIDS – Nepal (NANGAN)  
Anand Pun, Executive Director, Recovering Nepal  
Dr. Vijay L. Gurbacharya, Chairman, STD/AIDS Counseling and Training Service (SACTS)  
Jyotsana Shrestha and Neela Thapa, Society for Empowerment (STEP) Nepal  
Dr. Narayan Kaji Shrestha, Advisor and Consultant, Women Acting Together for Change (WATCH)

**Eastern Region:**

Naresh Lal Shrestha, President; Kumar Dhakal, Project Coordinator; and Team, Dharan Positive Group  
Jyotsana Tamang, CHBC Coordinator, Dharan Positive Group  
Brinad Subedi, CHBC team leader, Dharan Positive Group  
Dr. Suchaya Parikh, HIV/AIDS Center/Tropical Unit, BP Koirala Institute of Health Sciences, Dharan  
Pushpanjali Sinha, Project Coordinator, SAHARA/Nepal  
Matrika Subedi, MIS/Program Officer; Thajuy Chaudhary, Field Supervisor SAHARA Nepal

**Western Region:**

Vijaya Gyawali, Program Coordinator, Syangja Support Group (SSG)  
Bishnukala Bhandari, Program Coordinator, Child and Women Empowerment Society (CWES)  
Amit Dhungel, Naulo Ghumti and Western Regional HIV/AIDS Alliance  
Sabita Gurung, Acting Director, Manaviya Shrota Bikas Kendra (MSBK)  
Bishwa Rai, Section Manager, Paluwa, International Nepal Fellowship (INF)  
Buddhi Bal Ramtel, Counselor, HIV/AIDS Unit, Western Regional Hospital (INF)

Western Regional Alliance participants: Ganash Koirala (NRCS); Nabrab Adhikari (FPAN); Suresh Lama; Krishna Rana; Sumita Tusari; Raju Godar; Amit Dhvingel; Bujay Cama; Bishmy Rai (INF); Bishnu Kata; Padma Bhandari  
Dr. Basant Tamrakar, HIV/AIDS Unit, Western Regional Hospital, Pokhara

**Far Western Region:**

Dr. G.R. Shakya, Nepal STD & AIDS Research Center (N'SARC)  
Bhakta Bahadur Singh, President; Ganesh Raj Joshi, Project Coordinator; Kalidash Joshi, GF Project Coordinator; Community Development Forum (CDF) Doti  
Kul Bahadur Sethi, Vice President; Laxman Bhul, Project Coordinator; Gangotri Rural Development Forum (GaRDeF) Achham  
Ashok Birkam Jairu, Executive Director; Lal Bahadur Dhama, Project Coordinator; Nepal National Social Welfare Association (NNSWA)  
Members, Nawa Asha PLHA Support Group (supported through NNSWA)  
Sandeep Bhatta, Project Coordinator, Thagil Social Development Association (TSDA)  
Pushpa Raj Paneru, Project Coordinator, Asha Kiran Pratisthan (AKP)

## **APPENDIX C. REFERENCES**

### **General Documents:**

AIDS in Conflict, P. Siegal, 2004

Report on Conflict and HIV/AIDS, UNHCR, 2006

Redefining AIDS in Asia: Crafting an Effective Response. Report of the Commission on AIDS in Asia. UN. Oxford University Press/India. 26 March 2008

USAID Branding Policy

USAID Anti-Trafficking Policy

### **Documents About the HIV/AIDS Situation in Nepal**

National Estimates of HIV Infections, Nepal 2007; HIV & STI Control Board and National Center for AIDS and STD Control, May 2008

Community and Home Based Care in Nepal, Findings and Recommendations from a National Review Program; a joint NCASC, USAID and ASHA Project Collaboration, June 2007

Review of the National HIV Surveillance System: Strengthening the HIV Second Generation Surveillance in Nepal; NCASC/WHO/UNAIDS/FHI, 2007

Review of PMTCT Programme in Nepal, Submitted To UNICEF, Nepal By Dr Rita Thapa, UNICEF Lead Consultant for the Review of PMTCT Programme, Nepal, 30 May 2007

HIV/AIDS Programme Management Unit of the UNDP, Nepal, Annual Progress Report 2007; March 2008  
GFATM Round 7 Summary

UNGASS Report, 2008

Nepal National HIV/AIDS Action Plan, 2008 – 2011

Nepal National HIV/AIDS Strategy, 2006 – 2011

National Guidelines on Community and Home-based Care and Standard Operating Procedure, NCASC, MOHP, 2009

### **ASHA Project Documents**

ASHA Project Agreement, 2006

ASHA Cost Extension Agreement, 2009

ASHA Project Mid-Term Review, Tony Bondurant and others, FHI Asia Pacific Regional Office, July 2008

Draft Assessment Report and Follow-On Recommendations for the USAID/Nepal HIV/AIDS Program (unpublished), Billy Pick and others, 2008

ASHA Annual Workplans: 10/2006 – 9/2007, 10/2007 – 9/2008, 10/2008 – 9/2009, 10/2009 – 9/2010

ASHA Semi-Annual Reports: July – Dec. 2006; Jan. - June, 2007; July – Dec. 2007; Jan. – June, 2008; July – Dec. 2008; Jan. – July, 2009

ASHA Monitoring and Evaluation Plans: Oct. 2006 – Sept. 2009; Aug. 2009 – Sept. 2011.

USAID Performance Monitoring Plan for Health 2008 (SO 9 and SO 11), April 2008

ASHA Organizational Chart, 2009 – 2011 (PowerPoint)

Sustainability Assessment Workshop For District level Response to HIV/AIDS In Pokhara, Kaski - Workshop Report, FHI/ASHA, June 2008

Bimonthly Review Meeting Templates for Prevention, CHBC only, Children, EPC, IHS and CHBC, IHS only, Comprehensive programs, Capacity Building only, Positive Prevention, Prison prevention

Sustainability Framework (undated)

ASHA Technical Brief: Capacity Building (undated)

ASHA Recording and Reporting Tools for Prevention Programs Project Management Information System (An Internal Document) Updated – December, 2008

Memory Joggers: Monitoring Checklist for Program Officers and Team Leaders, ASHA, Nov. 2009

ASHA/FHI Nepal Guidelines for Implementing HIV Prevention Program among Most at Risk Population (MARP) August 2009

Guidelines for Process Evaluation For Family Health International/Nepal Implementing Agencies (undated)

Community Welfare Center Process Evaluation, June 2007

Child and Women Empowerment Society, Kaski, Process Evaluation, March 2009

Nepal Red Cross Society, Kanchanpur, Process Evaluation, February 2008

Sahara Nepal Safe Highways Program Process Evaluation, May 2009

Internal Data Quality Audit, ASHA Project, October 2009

Routine Data Quality Assessment: An Approach for Data Verification; ASHA briefing paper

ASHA Project: Linking HIV and Trafficking in Persons, (undated, 2009)

Family Health International Nepal Country Office Human Resources Professional Development Plan, March 2008

Family Health International Nepal Country Office Staff Professional Development Plan FY 10, Oct. 2009 – Sept. 2010

Multi-sectoral Response and Policy Initiatives, End-of-Project Report on the Contributions of Futures Group International, LLC in the USAID/ASHA Project, July 2009

ASHA Project FY 10-11 District Plans for Achham, Doti, Syangja, Kaski, Kathmandu, Bhaktapur, Lalitpur, Kailali, Kanchanpur

ASHA Project One-page Summaries of all current Implementing Partners visited by the Team

CB-PMTCT Program Update of Achham District, Prepared by Mr. Sanjiv Kumar Rajak, Gangotri Rural Development Forum, February 2010

Integrated Biological and Behavioral Surveillance (IBBS) 2009 Round IV Fact Sheets for FSWs (22 Terai Highway Districts), IDUs, MSM (Kathmandu), Truckers (Terai Highway Districts)

Community and Home-Based Care Standard Operating Procedure Manual, USAID/Nepal and FHI, August 2007

## APPENDIX D. TEAM CALENDAR

<b>Dates</b>	<b>Tasks</b>
10 Jan onward	Document review and initial planning and preparation (out of country for international consultants) Teleconference with team members to touch base on overall planning
18/19 Jan	Selection of partners, government officials, EDPs for interviews
23/24 Jan	Travel to Nepal (Molldrem, Justice)
24/25/26 Jan	Team planning meeting in KTM Inception briefing with USAID, team presents TPM deliverables to USAID/Nepal
27/28 Jan	Interviews and discussions with USAID staff in KTM
29/30 Jan	Interviews and discussions with ASHA (FHI, AMDA, Futures) staff and managers and review of systems in KTM
31 Jan – Feb 5	Kathmandu-based stakeholders interviews
6 – 12 Feb	Field visits at project implementation sites outside of KTM Team A: East (Kaski, Morang, Sunsari) Team B: West (Doti, Achham, Kanchanpur, Kailali)
13 – 16 Feb	Data consolidation, compilation, field notes preparation. Data/information analysis and identification of preliminary findings and recommendations
16 Feb	USAID debriefing
17 Feb	Team prepares brief narrative of findings and recommendations
18 Feb	Debrief for ASHA team (FHI and AMDA)
18-19 Feb	Travel to US (Molldrem, Justice)
20 Feb – 1 Mar	Drafting of full report
2 Mar	Submission of draft report to USAID/Nepal
17 Mar	USAID/Nepal provides comments on draft report to GH Tech
25 Mar	GH Tech submits revised final report to USAID/Nepal

## **APPENDIX E. ANALYTICAL TOOLS**

See attached:

Key evaluation questions, detailed questions, data sources and methods, responsibilities

Interview guides for

- USAID
- ASHA
- Government of Nepal Officials
- Other Donors and INGOs
- ASHA Implementing Agencies
- Supplementary questions for site visits

## Key questions, data sources and methods, responsibilities

Key SOW Question	Detailed Questions	Data Sources	Primary analytical responsibility
<p><b>a. To what extent is ASHA on track to achieve its results (effectiveness)?</b></p> <ul style="list-style-type: none"> <li>• Reduce HIV transmission through targeted interventions with MARPs</li> <li>• Build capacity of MoHP and Civil Society to manage and implement activities and to inform policy formulation.</li> <li>• Improve planning, collection, analysis and use of strategic information by stakeholders to facilitate a more effective and targeted response.</li> <li>• Increase access to quality of care, support and treatment services through public private and NGO sources for PLHA and families.</li> <li>• Create linkages among stakeholders and support national co-ordination of Nepal’s cross sectoral HIV program</li> </ul>	<p><u>Overall questions (applicable to all results):</u></p> <p>What is on track, behind schedule, ahead of schedule? Why?            Are the targets realistic?            How do ASHA results in a particular area compare with national results and results of other donors? Why?            What “best practices” have been developed? How have they facilitated the achievements?            What are the lessons learned? What are the challenges?</p> <p><b><u>Questions on Results 1:</u></b>            How do the capacity and dynamics of different MARP groups affect their ability to obtain support? What are the gender issues involved?            How does FHI collaborate with other NGOs and donors on prevention services to specific MARP groups?</p> <p><u>Questions on specific-sub results:</u></p> <p><u>IDUs:</u>            What approaches are being used regarding needle exchange?</p> <p><u>Migrants:</u>            How does AHSa target assistance to migrants to ensure that those most vulnerable to HIV are reached, including spousal transmission?            Is there agreement between gov’t, donors and ASHA as to which migrants are most at risk and how assistance should be program?</p> <p><u>FSW:</u>            What is the strategy on reaching FSWs? Is there a particular reason that interventions of safe highways and FSW networks been reduced during the extension period?</p> <p><u>MSM:</u>            What is the strategic approach towards reaching MSM?</p> <p><u>PLHAs:</u></p>	<p>Document review includes ASHA documents, e.g. PMP, progress reports, national-level service statistics on HIV/AIDS, reports of other donors.</p> <p>Interviews:            ASHA team (FHI, AMDA, Futures)</p> <p>ASHA team, IAs</p> <p>ASHA team, IAs</p> <p>FHI, USAID, INGOs, government (NCASC, MOH), site visits</p> <p>Same as above</p> <p>Interviews:            ASHA, USAID, EDPs, MARP groups (e.g. FWLD), IAs</p> <p>FHI, EDPs, INGOs, USAID</p>	<p>All team members</p> <p>Team member responsible for each Result area</p> <p>Mahesh Sharma</p> <p>Poonam Thapa</p>

Key SOW Question	Detailed Questions	Data Sources	Primary analytical responsibility
	<p>What is the role of the PLHAs in prevention activities?</p> <p><b>Questions on Result 2:</b>            What is the current view of government and donors regarding integration of services vs. vertical approaches, and health sector's role in HIV/AIDS (Includes role of Board and NCASC and Family Health Division)            What contribution has ASHA made in strengthening existing systems for delivery of services?            What was rationale for changing Results under Results 2 during the extension period?            How does ASHA define capacity building and how do program managers know when it has been achieved?            Is gender an issue in capacity building and if so, how is ASHA addressing gender issues?            What are the key capacity building initiatives for GON at District level? Among local partners?</p> <p>How has capacity building work of ASHA affected national ownership, better alignment, harmonization, achieving of results?            On the policy side, what was the program rationale in focusing on stigma reduction and discrimination, as opposed to other key policy issues? What role does gender play in these policies?            What is ASHA's strategic approach to help build capacity of MOH and other line ministries for policy formulation to reduce stigma and discrimination and to enable equitable services? To plan, manage and implement services? What are the related gender concerns and are they being addressed?            What is ASHA's strategic approach to help GON build capacity to plan and manage national response?            Has ASHA appropriately addressed sustainability so that the benefits of its activities will continue after funding has ceased, with due account of partner government systems, stakeholder ownership and the phase-out strategy? (For</p>	<p>Interviews:            FHI, USAID, EDPs, IAs</p> <p>FHI, GON (NCASC, MOHP), INGOs (CARE, SAVE, FPAN), UNAID</p> <p>Same as above. Request any written documentation.</p> <p>Interviews:            FHI, USAID, UNAIDS</p> <p>FHI, USAID, UNAIDS</p> <p>FHI, USAID, NCASC, UNDP, DFID, UNAIDS, relevant MARP groups</p>	<p>Vivikka Mollidrem</p> <p>Judith Justice</p>

Key SOW Question	Detailed Questions	Data Sources	Primary analytical responsibility
	<p>IAs: When ASHA funding ends, how will you continue your programs?)</p> <p>Does ASHA have an exit strategy and how is it being applied?</p> <p><b>Questions for Result 3:</b>  Why was the focus of/results for strategic information changed under the cost extension?  What is the capacity of government to carry out these activities, esp. surveillance, if FHI no longer does it? Including the availability of outside technical assistance from FHI headquarters.  What are the remaining challenges in strategic information and how do you see them being resolved? (e.g. estimation of MARP groups)  How is the knowledge obtained through strategic information activities being translated into better program decisions and informing policy?</p> <p><b>Questions for Result 4:</b>  What does it mean to collaborate with government to strengthen capacity of health system to provide treatment and care? What form does the collaboration take and how is its effectiveness assessed?  How are the care and support activities of civil society coordinated with the treatment services of government and private sector? What role has ASHA played in this?  What are the care and support services provided and who is providing them?  How effectively has ASHA been able to increase equitable access to treatment, care and support to different high-risk groups, by gender, and by service and location?  What are the current issues related to provision of treatment, care and support services and is the balance of services between government and civil society appropriate?</p>	<p>GON, USAID, EDP, ASHA partners</p> <p>ASHA, USAID, NCASC, MOH</p> <p>USAID, ASHA</p> <p>ASHA</p> <p>ASHA</p> <p>ASHA, NCASC, DACCs, IAs at district level, and information from site visits.</p> <p>Interviews: ASHA, GON, EDPs</p> <p>ASHA, USAID</p> <p>ASHA partners, NCASC,</p>	<p>Maresh Sharma and Judith Justice</p>

Key SOW Question	Detailed Questions	Data Sources	Primary analytical responsibility
	<p><b>Questions on Result 5:</b>            What has been the contribution of ASHA in achieving national coordination? Please give specific examples.            What was ASHA's contribution in promoting multi-sectoral approaches in policy development? (Including ASHA participation in multi-sectoral technical or working groups            Have there been instances where ASHA could have done a better job in furthering coordination?            How have the role of DACCs changed during the life of ASHA, what has ASHA's role been in this change, and what is the implication for coordination at the district level?</p>	<p>GON</p> <p>Same group as above.</p> <p>ASHA, discontinued and continuing IAs, USAID, GON</p> <p>ASHA, IAs</p> <p>USAID, FHI</p> <p>GON, EDPs (esp. UNAIDS), FHI, USAID</p> <p>Same groups as above</p>	

Key SOW Question	Detailed Questions	Data Sources	Primary analytical responsibility
		<p>Same groups as above, and examples provided in project documentation</p> <p>Interviews:</p> <p>ASHA, USAID, GON</p> <p>FHI, GON (NCASC), IAs, DACC</p> <p>FHI, IAs, site visits and review of project documentation.</p> <p>FHI, relevant IAs, and review of documentation</p> <p>GON, EDPs, large IAs, ASHA, USAID, site visit observations.</p> <p>USAID, ASHA, EPDs, GON , INGOs</p>	

Key SOW Question	Detailed Questions	Data Sources	Primary analytical responsibility
		<p>GON (HASCB, NCASC), USAID, ASHA team, EDPs and review of examples in project documentation</p> <p>Same as above</p> <p>ASHA partners, EDPs (UNDP), GON (NCASC), DACCs, District-level IAs</p>	
<p><b>b. What areas should ASHA focus on in the future? (Relevance)</b></p>	<p>How has ASHA contributed to higher-level health and development objectives of USAID/GoN and what are future needs?</p> <p>What is USAID's comparative advantage in different results areas?</p> <p>Are there duplicative areas?</p> <p>Are there emerging areas that should be picked up?</p> <p>What measurable indicators and targets are relevant to these areas?</p>	<p>USAID, GON, FHI</p> <p>Review of ASHA results; interviews with USAID, EDPs, GON, ASHA, INGOs (SAVE)</p> <p>Same as above</p> <p>Same as above</p> <p>Same as above</p>	<p>Team member responsible for each results area</p>

Key evaluation question	Detailed questions	Data source	Primary responsibility
<b>Is the planning, programming and M&amp;E system effectively measuring progress towards meeting the result areas?</b>	<p>Are the monitoring and evaluation framework and indicators relevant to the program objectives and in-line with USAID standard indicators?</p> <p>Are all of the annual work plans, including the current one, relevant to the approved ASHA program description?</p> <p>Are work plan activities sufficiently reported in the semi-annual and annual technical reports?</p> <p>Are key activities missing or under-reported?</p> <p>Is there sufficient monitoring and reporting of compliance with USG regulations concerning HIV assistance activities, specifically the anti-trafficking and prostitution policies?</p> <p>Are ASHA monitoring systems sufficiently robust to adequately monitor the quality of activities conducted by sub-recipients and their compliance with USG regulations?</p> <p>How could sub-recipients' systems be strengthened without compromising the reach of the program</p>	<p>Document review, interview with USAID</p> <p>Review of ASHA documents</p> <p>Review of USAID documents, interviews with USAID</p> <p>Same as above</p> <p>Interviews with FHI, USAID</p> <p>FHI, USAID, IAs</p> <p>FHI, USAID, IAs</p>	Vivikka Molldrem and Poonam Thapa
<b>Are ASHA program management structure and procedures efficient and effective?</b>	<p>What are the strengths and weaknesses in the project management structure and systems?</p> <p>What could be done to make them stronger and build capacity of Nepali staff to manage technical and administrative functions?</p> <p>Are the structure and management systems of the technical units relevant to the overall program objectives and results? How could they be improved?</p> <p>How are relations/communications between ASHA and USAID and can they be improved?</p> <p>Is the management of USAID assets strong and compliant with USG regulations?</p>	<p>Review of ASHA program management and structure, and interviews with FHI and USAID.</p> <p>Same as above</p> <p>Same as above</p> <p>ASHA, USAID</p> <p>ASHA audit reviews, interviews with USAID</p> <p>Same as above, and observations during site visits</p> <p>USAID, audit findings</p> <p>USAID, FHA, IAs, findings during site visits</p>	<p>Judith Justice and Mahesh Sharma</p> <p>Vivikka Molldrem</p> <p>Judith Justice, Mahesh Sharma</p>

Key evaluation question	Detailed questions	Data source	Primary responsibility
	<p>Is there adequate understanding and compliance with branding and marking regulations?</p> <p>In terms of financial management, are internal controls strong, transparent and accountable?</p> <p>Is the management and oversight of awards to sub-recipients strong, accountable and compliant with USAID regulations?</p> <p>Is the management of core sub-recipients (AMDA and Futures International) strong, accountable and effective?</p>	ASHA team (AMDA, Futures), USAID	

## Interview Guide for ASHA Partners

### 1. Review of results in depth for each results category.

- a. Please provide the most recent data on achievements and targets for each results area and discuss your strategies, achievements, and challenges in each. For those results relying mainly on output indicators (e.g. number of people trained), what other indicators are available to measure achievement?
- b. Will the project achieve its projected results for 2011?
- c. Can you provide a breakdown of expenditure or obligations by year and by results area?

Questions for clarification (interviewer may select questions from below as appropriate)

#### Result 1:

How do the capacity and dynamics of different MARP groups affect their ability to obtain support? What are the gender issues involved?

How does FHI collaborate with other NGOs and donors on prevention services to specific MARP groups?

For IDUs: What has been the impact of USG needle exchange policies?

For migrants: Is there agreement between ASHA, other donors and GON regarding which migrants are most at risk and how funds should be programmed?

For FSWs: Why was the safe highways program reduced in the extension?

For PLWA: What is their role in prevention activities?

#### Result 2:

How does ASHA define capacity building and how do program managers know when it has been achieved?

Is gender an issue in capacity building and if so, how is ASHA addressing gender issues?

What are the key capacity building initiatives for GON at District level? Among local partners?

How has capacity building work of ASHA affected national ownership, better alignment, harmonization, achieving of results?

What is ASHA's approach to integration of services vs. vertical approaches, and health sector's role in HIV/AIDS (Includes role of Board and NCASC and Family Health Division)

On the policy side, what was the program rationale in focusing on stigma reduction and discrimination, as opposed to other key policy issues? What role does gender play in these policies?

What is ASHA's strategic approach to help build capacity of MOH and other line ministries for policy formulation to reduce stigma and discrimination and to enable equitable services? To plan, manage and implement services? What are the related gender concerns and are they being addressed?

What has been ASHA's strategic approach to achieve sustainability for programs carried out by Nepali institutions? What would you like to see at the end of 2 years?

### Result 3:

What was rationale for changing Results under Results 2 during the extension period?

What are the remaining challenges in strategic information and how do you see them being resolved? (e.g. estimation of MARP groups)

How is the knowledge obtained through strategic information activities being translated into better program decisions and informing policy?

### Result 4:

What does it mean to collaborate with government to strengthen capacity of health system to provide treatment and care? What form does the collaboration take and how is its effectiveness assessed?

How are the care and support activities of civil society coordinated with the treatment services of government and private sector? What role has ASHA played in this? Is the balance between public sector and civil society appropriate?

What are the care and support services provided and who is providing them?

How effectively has ASHA been able to increase equitable access to treatment, care and support to different high-risk groups, by gender, and by service and location?

### Result 5:

What is ASHA's strategy to enhance coordination/collaboration? What are the major challenges?

What has been the contribution of ASHA in achieving national coordination? Please give specific examples.

What was ASHA's contribution in promoting multi-sectoral approaches in policy development? (Including ASHA participation in multi-sectoral technical or working groups)

Have there been instances where ASHA could have done a better job in furthering coordination?

How have the role of DACCs changed during the life of ASHA, what has ASHA's role been in this change, and what is the implication for coordination at the district level?

## **2. Looking ahead**

- a. What are key lessons learned, your most important achievements and most difficult challenges?
- b. Are there areas you should be working in that are not in your current plans? What would you give up to work in these new areas?
- c. What do you consider as USAID's/ASHA's areas of comparative advantage, and what is your vision for what USAID should be doing in the future?

## **3. Key project events**

- a. What were other key project events that affected project implementation (e.g. conflict, changing role of AMDA)?
- b. What was the basis for decisions were made to drop or keep activities and Futures in extension?
- c. How have internal or external reviews and assessments influenced project strategy and implementation?

## **4. Program monitoring**

- a. What steps does ASHA take to ensure compliance with USG regulations concerning HIV assistance activities, specifically the anti-trafficking and prostitution policies?
- b. Please describe how ASHA monitors the quality of activities conducted by sub-recipients and their compliance with USG regulations?
- c. What processes does ASHA use to assure timely and accurate M&E data from sub-recipients?
- d. What monitoring indicators does ASHA use, in addition to those provided to USAID, for its own project management?

## **5. Management systems**

- a. Please describe your project management structure and staffing, responsibilities of various positions and divisions – including field branches if any.

- b. What are the strengths and weaknesses in the project management structure and systems?
- c. How does ASHA build capacity of Nepali staff to manage technical and administrative functions? Can you provide evidence of the results of this program?
- d. How are relations/communications between ASHA and USAID and can they be improved? (the HIV/AIDS technical team and the contracting and finance offices)
- e. Are there any financial management issues the team should be aware of? Please describe the results of any recent program and financial audits. What steps were taken to correct any deficiencies that were noted?
- f. Please describe how FHI interacts and provides oversight of core sub-recipients (AMDA and Futures International).
- g. What technical support does ASHA provide to sub-grantees to manage their programs and funds effectively? How effective has this support been?

Do you wish to comment about anything else the team should be aware of?

## Interview Guide for USAID

### General questions:

1. How was it decided what to include in the extension? Why were decisions made to drop certain activities? (including Futures)
2. How did USAID view the USAID mid-term evaluation and the ASHA mid-term review; how did they affect programming; and are their findings relevant for our study?
3. How did conflict affect ASHA and how effective was ASHA's response?

### Questions on results:

4. What has ASHA's progress been in achieving expected results in each of the five results areas and sub-results areas? Do you think the project will achieve its projected results for 2011?

#### Result 1.

How do the capacity and dynamics of different MARP groups affect their ability to obtain support? Are there gender issues involved?

How does FHI collaborate with other NGOs and donors on prevention services to specific MARP groups?

1.1. IDUs: What approaches are being used re. needle exchange?

1.2. Migrants: How does ASHA target assistance to migrants to ensure that those most vulnerable to HIV are reached, including spousal transmission? Is there agreement between gov't donors and ASHA as to which migrants are most at risk and how assistance should be programmed?

1.3 FSWs: What is the strategy on reaching FSWs? Reduction of safe highways and FSW networks in the extension period.

1.4. MSM: What is strategic approach towards reaching MSM?

1.5. PLHAs: What is role of PLHAs in prevention activities?

#### Result 2:

What is the current view regarding integration of services and vertical approaches and health sectors role?

What was the rationale for changing results in the extension period?

What was program rationale for focusing on stigma reduction and discrimination as opposed to other key policy issues?

Has ASHA appropriately addressed sustainability? What progress has been made?

#### Result 3:

Why was the focus of results changed under the extension?

What is the capacity of government to carry out these activities, esp. surveillance, if FHI no longer does it?

#### Result 4:

What does it mean to collaborate with government to strengthen capacity of the health system to provide treatment and care? How is its effectiveness assessed?

What are the issues re. provision of treatment, care and support and is the balance of services between gov't and civil society appropriate?

#### Result 5:

What have ASHA's contributions in national coordination and promoting multi-sectoral approaches?

Have there been instances when they could have done a better job in furthering coordination?

How about district level coordination?

2. Can you identify any best practices or lessons learned?
3. What would you like to see as USAID's role in the future? Are there emerging areas that should be picked up?

**Questions on monitoring and reporting:**

4. Are you satisfied that the ASHA monitoring plan and indicators are sufficient to measure program achievement? What are areas of concern?
5. What would you like to see changed in ASHA's reporting in its work plans and semi-annual reports?
6. Have you had concerns about ASHA's compliance with anti-trafficking and branding policies?
7. Can you comment on the adequacy of ASHA's monitoring of quality of activities of sub-recipients and compliance with USAID regs?

**Questions on project management:**

8. Do you have any comments on effectiveness of ASHA's project management structure?
9. How are relations between ASHA and USAID and can they be improved?
10. Are internal controls strong, transparent and accountable, including oversight of awards to sub-recipients?

## **ASHA Evaluation Interview Guide for Government of Nepal Officials**

(interviewer should select appropriate questions and modify as needed)

Intro: This evaluation of the ASHA project, commissioned by USAID, focuses on ASHA's progress in meeting the program objectives and goals. The team's findings will identify ASHA's achievements, lessons learned and best practices, and will provide suggestions for future HIV/AIDS programming. The team will be interviewing stakeholders from government, other donors, and project implementing agencies. We encourage you to be candid, as all responses will be kept confidential.

1. ASHA was designed to achieve five major results:

- Reduce HIV transmission through targeted prevention interventions
- Build capacity of GON/civil society to manage and implement HIV programs and inform policy formulation
- Improve planning, collection, analysis and use of strategic information
- Increase access to quality care, support, and treatment for PLHA and their families
- Create linkages among stakeholders and support national coordination

Please comment about ASHA's progress in each of these results areas. What are the important achievements?

How has ASHA contributed to national plans and targets?

2. Are there best practices or lessons learned from ASHA activities that might improve future programming?

3. What are the key issues and challenges related to ASHA?

4. Can you comment on the effectiveness of ASHA's approach to targeting assistance to different MARPs? For example, is there agreement between government, donors and ASHA as to which migrant groups are most at risk and how assistance should be programmed?

5. What is the current view regarding integration of services versus vertical approaches, and the health sector's role in HIV/AIDS?

6. What effect, if any, have ASHA activities had on national ownership of HIV/AIDS program, better alignment, harmonization and donor collaboration? Are there times when ASHA could have done better in coordination?

7. How has ASHA contributed in strengthening the health system (e.g. lab, logistics)? Can you give examples?

What could have been done to strengthen health system and at what levels?

8. What has ASHA's role been in strengthening district level coordination and management of HIV/AIDS services?

9. What contribution has ASHA made in developing policies and programs that will reduce stigma and discrimination against PLHA? Has there been sufficient attention to gender issues?

10. Has ASHA appropriately addressed sustainability so that the benefits of its activities will continue after funding has ceased? (Can ask specific follow-up questions re. service delivery, surveillance activities/strategic information, etc)

11. Based on the ASHA experience, and considering limited USAID funds available, what are the key areas of comparative advantage that USAID should focus its HIV/AIDS resources on in the future?

## **ASHA Evaluation Interview Guide for Other Donor and INGO Officials**

(Interviewer should select appropriate questions and modify as needed)

Intro: This evaluation of the ASHA project, commissioned by USAID, focuses on ASHA's progress in meeting the program objectives and goals. The team's findings will identify ASHA's achievements, lessons learned and best practices, and will provide suggestions for future HIV/AIDS programming. We encourage you to be candid, as all responses will be kept confidential.

1. ASHA was designed to achieve five major results:

- Reduce HIV transmission through targeted prevention interventions
- Build capacity of GON and civil society to manage and implement HIV activities and inform policy formulation
- Improve planning, collection, analysis and use of strategic information
- Increase access to quality care, support, and treatment for PLHA and their families
- Create linkages among stakeholders and support national coordination

Please comment about ASHA's progress in these results areas. What are the important achievements?

How has ASHA contributed to national plans and targets?

2. Are there best practices or lessons learned from ASHA activities to improve future programming?

3. What are the key issues and challenges related to ASHA?

4. Is there an agreed strategic approach between GON and donors to reach most at-risk groups – FSWs, MSM, IDUs, migrants? How well has ASHA followed these approaches? Has it paid enough attention to gender?

5. Please comment on the effectiveness of ASHA's capacity building efforts. For example, are CSOs who have received ASHA support better able to design and manage activities for other donor support?

Have the management, M&E, DQA tools developed by ASHA been used or adapted for your activities?

6. Are there issues related to provision of treatment, care and support services? Is the balance of services between government and civil society appropriate? Has ASHA had any role in this?

7. What has been ASHA's contribution to achieving national coordination – including donor coordination? Please give examples. Could ASHA have done a better job at coordination?

8. How has ASHA contributed in strengthening existing systems for service delivery? (including lab, logistics). Can you give examples?

What could have been done to strengthen health system and at what levels?

9. What has ASHA's role been in strengthening district level coordination and management of HIV/AIDS services?

10. What contribution has ASHA made in developing policies and programs to reduce stigma and discrimination? Was this the best policy area to focus on? Has there been enough attention to gender?

11. Has ASHA appropriately addressed sustainability so that the benefits of its activities will continue after funding has ceased? (Can ask specific follow-up questions regarding service delivery, surveillance/SI, etc).

12. Based on the ASHA experience, and considering limited USAID funds available, what are the key areas of comparative advantage that USAID should focus its HIV/AIDS resources on in the future?

## **ASHA Evaluation Interview Guide for Sub-Recipients (Implementing Agencies)**

(to be adapted as appropriate to the group interviewed – excludes supplemental info for site visits)

Intro: This evaluation of the ASHA project, commissioned by USAID, focuses on ASHA's progress in meeting the program objectives and goals. The team's findings will identify ASHA's achievements, lessons learned and best practices, and will provide suggestions for future HIV/AIDS programming. The team will be interviewing stakeholders from government, other donors, and project implementing agencies. We encourage you to be candid, as all responses will be kept confidential.

1. Would you please describe your chief activities funded through ASHA and the results that you have achieved? What were the challenges you faced, and what were your most important achievements?

(ask follow up questions as needed, depending on the nature of the IA)

2. What capacity –building assistance have you received through the ASHA project? What do you do differently now, as a result of that support, than you did in the past?

3. In its work with you, did ASHA help on sustainability issues? Does (or did) it work with you on developing an exit plan? If so, how is it being applied?

(If a discontinued IA:) Have you found alternative resources to replace the funding and support you received from ASHA? Did skills learned from ASHA help you in obtaining this support?

4. To what extent are your activities coordinated with government services? What role, if any, did

ASHA play in supporting coordination between you and the government?

5. Please describe the way in which ASHA provided oversight, monitoring and support for your activities?

- How often were you in contact with ASHA staff? How often did they visit?

- What were your reporting and M&E requirements?

- What other support did you receive?

- Did you find ASHA's requirements difficult or helpful?

- Did ASHA regularly check your progress against results and help you to improve performance?

6. Can you think of any "best practices" or lessons learned from your activities under ASHA that might inform future programming?

7. What were the most important benefits of the ASHA program that should be continued in the future? What were the least useful?

## Supplementary Interview Guidance: What to look out for on site visits

### 1. Prevention

- Does it make sense for ASHA to continue work with IDUs?
- Is there duplication of GH work with migrant programs?

### 2. Policy and capacity building

- Views of District and IA staff on ASHA's contribution

### 3. Strategic information

- Is DPHO or DACC getting information from ASHA studies and M&E work that can help in district-level decision making?

### 4. Treatment, care and support

- How is the referral system working? Where does it break down?
- What difference is the shift from doctors to HAs making? What do the clients think?
- What has ASHA's role been in CHBC – how good a job is it doing? Who else is doing it?
- What are the FCHVs doing – is it realistic for them to add to their responsibilities?

### 5. Coordination/collaboration

- How is this working in the field? Is ASHA taking initiative?

### 6. Program reporting

- Is it unnecessarily detailed and bureaucratic? Can it be streamlined? Or is the amount of "directiveness" necessary?
- Are the areas outside of KTM getting as much monitoring as those inside KTM are?

### 7. Program management

- Do the local partners feel that they are real partners?
- How does the regional program officer feel about his relations with ASHA HQ, relations with local partners, ability to take initiatives and be responsive to needs of partners?

## **APPENDIX F. SUMMARY OF NEPAL'S HIV/AIDS PROGRAM AND USAID PAST PROGRAMMING**

After the detection of its first HIV case in 1988, the Government of Nepal (GoN) started working for the prevention and control of HIV AIDS in the country. A 12 point policy on HIV/AIDS Prevention and Control was developed in 1995 and is still under implementation. A five year National HIV/AIDS Strategy (2002-2006) was developed in 2002 based on the recommendations of two important studies undertaken; the Situation Analysis and the Response Analysis. This strategy was the first formal National HIV/AIDS Strategy developed in consultation with the major stakeholders including civil society and was implemented through the National Operation Work Plan (2003-2007) and subsequent Annual Plans.

Based on the lessons learned from the implementation of the first National Strategy and also taking into account of the nature of the “concentrated” epidemic in the country, its dynamics, general vulnerability of the population, specific most at risks groups (MARPs) and also existing strength and opportunities; the second National Strategy (2006-2011) considers HIV/AIDS a priority development issue for the GoN emphasizing prevention, increasing coverage target to 70% of MARPs and scaling up of treatment, care and support. The National Strategy also calls for implementation through strong coordination and linkages among the stakeholders; enhanced management capacity of government and civil societies and effective multi-sectoral involvement. The Monitoring and Evaluation (M&E) guidelines for HIV and AIDS in Nepal (2006) have defined sets of indicators for each of the program components. This concerted effort is in line with the Government’s commitment towards achieving the Three in One principle (one framework, one authority and one M&E) Universal Access, leading to attaining Millennium Development Goal on HIV prevention and reduction by 2015. The subsequent multi year action plan and especially the National HIV and AIDS Action Plan (2008-2011) or the NAP have further elaborated the specific targets and potential budget needs.

In 1988, Nepal also established a multi-sector National AIDS Coordinating Committee (NACC) chaired by the Minister of Health in 1992. A National AIDS Council (NAC) chaired by the Prime Minister was established to raise the profile of HIV/AIDS. The NACC reports to the NAC. Today this structure is dysfunctional for several reasons, too elaborate to discuss here. The District AIDS Coordinating Committee (DACC) was established in 65 of the 75 districts of Nepal. The DACC Co-coordinator continues to be provided by the Ministry of Local Development, the District Health Officer (DHO) is the member secretary, district representatives of five relevant line ministries are members of DACC as well as the chair of the District Development Committee or DDC. One NGO member registered at the district level is also a member.

Currently the main governmental agency responsible for HIV/AIDS and STI is the National Centre for AIDS and STD Control (NCASC) which is under the Ministry of Health and Population. The weak capacity in NCASC has been a point of discussion for over a decade as well as bureaucratic constraints inherent in the government system. High turnover in NCASC directorship and its inability to involve non-health sectors as well as NGOs effectively remains as outstanding issues for the national response.

A multi-sectoral taskforce was charged in 2006 with reviewing and drafting options for Nepal’s HIV/AIDS institutional reform. The taskforce stalled as its recommendation of forming a semi-autonomous body, operationally distinct from GoN, was uncertain until

August 2007 when the Cabinet through the Development Act of Nepal approved the National HIV AIDS and STI Control Board (HSCB). By July 2008, HSCB or the Control Board as it is commonly known was becoming a functional entity supported by DFID, UNAIDS and MoHP under the first Maoist led government. When this particular government ended within six months of it coming to power, the incoming MoHP administration did not provide the needed support to HSCB and there was no external party to fill the communication gap.

Over the years a number of multi-lateral and bilateral organizations have supported HIV/AIDS prevention and control initiatives in Nepal. Numerous private and voluntary organizations implement HIV/AIDS activities funded by donors. By 2006 there were almost a 100 NGOs working in the area of HIV/AIDS. *United States Agency for International Development (USAID)* spends on HIV program directly through USA based non-governmental channels. USAID has consistently provided through selected cooperating agencies the largest funding for interventions in Nepal in the private and not for profit sector since the early 90s (and until Global Fund Round 7). The funding has been for HIV surveillance activities, condom social marketing, operations research as well as communication and advocacy programs for policy formulation and reduction of stigma and discrimination.

Since 1993, FHI has implemented five HIV/AIDS programs in Nepal, through USAID funding with the exception of one:

- AIDS Control and Prevention Project (AIDSCAP I) – 1993-1997
- AIDSCAP II (1997-2002)
- Nepal Initiative (NI) – 2001-2002
- Implementing AIDS Prevention and Care (IMPACT) – 2003-2006
- Reaching Across Borders (RAB) with DFID, 2006-2009
- ASHA project - Phase One - June 2006-September 2009 and no-cost extension from June 2009-September 2011.

From January 2003 to June 2006, USAID had funded Constella Futures to implement the Policy Project. Under ASHA, USAID brought together in Phase One, three components of its interventions - policy formulation, service program and capacity building under the aegis of FHI (Prime), Constella Futures (sub- Prime) and AMDA (sub-Prime). During the no-cost extension multi-sectoral response and high level policy initiatives were discontinued but issues of reduction of stigma and discrimination and equitable services has remained as an area for continued intervention.

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