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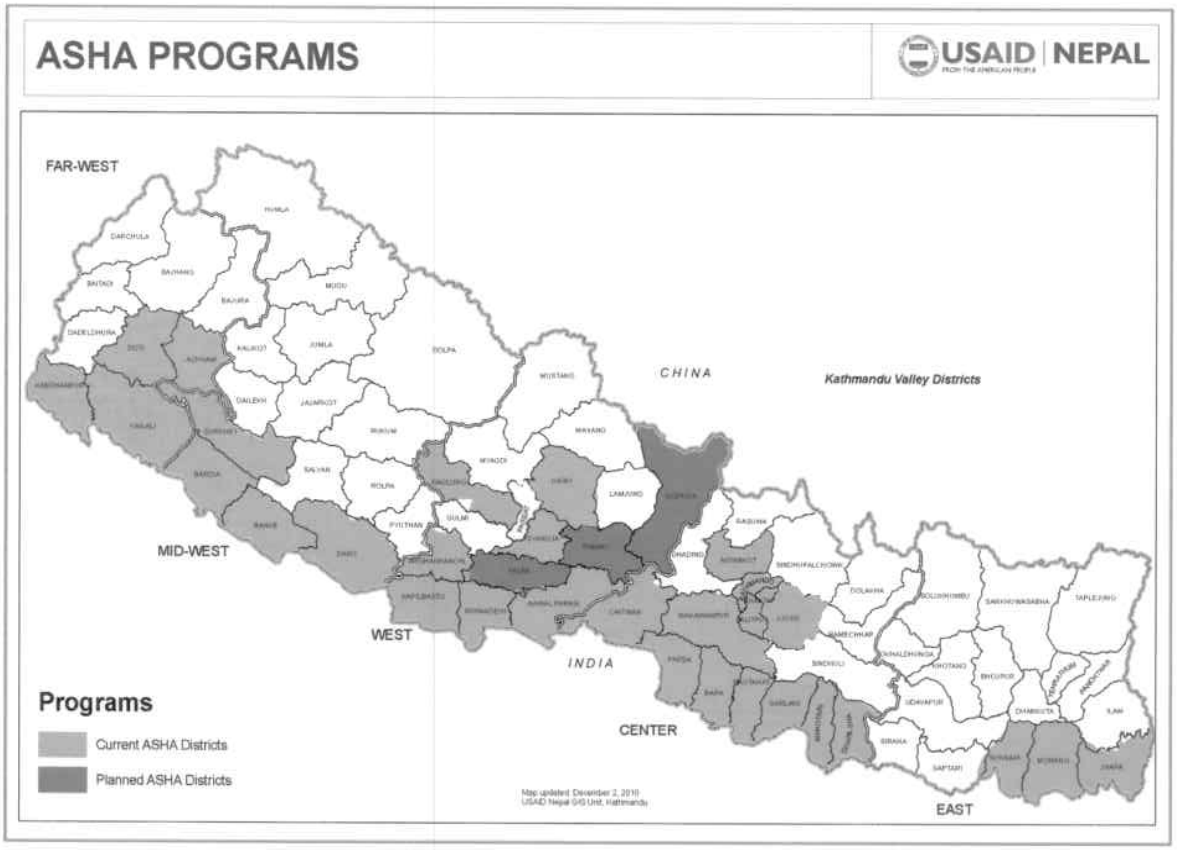
STRATEGIC OBJECTIVE 9 (SO9) CLOSE OUT REPORT
USAID NEPAL MISSION

SO Name: **Enhance Stability and Security**
SO Number: **9**

Approval Date: 2006
Completion Date: 2010

Geographic Area (Nationwide or Region Specific): Nationwide

Figure1. Map of SO9 Health Program and Activities



Bilateral Agreement Number: **Strategic Objective Grant Agreement (SOAG) No. 367-009**

Implementing Ministries/Agencies under the Bilateral Agreement: **Government of Nepal (GON) Ministry of Health and Population**

Principal Implementing Partner: John Snow Inc, Family Health International, Association of Medical Doctors of Asia, Government of Nepal, Academy for Educational Development

Major Counterparts: **Government of Nepal (GON) Ministry of Health**

Table1. Life of SO9 Funding Source, demonstrates the breakdown by type of funding sources and contribution amounts from GON.

USAID/Nepal
Summary Pipeline Report of Expired SOAGs
As of 09/30/2013

Descriptions		Start Date	End Date	Obligated Amount (USD)	Expended/ Disbursed Amount (USD)	Unliquidated/ Pipeline (USD)
SO9	HIV-AIDS Program	8/28/2006	9/30/2010			
	CD-AIDS/GH-C-AIDS Funds			17,360,455	17,360,455	0

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ACRONYMS

ADS	Automated Directives System
AED	Academy for Educational Development
AIDS	Acquired Immuno-deficiency Syndrome
AHW	Assistant Health Workers
AMDA	Association of Medical Doctors of Asia
ANC	Antenatal Care
ARI	Acute Respiratory Infection
ART	Anti - retroviral Therapy
ARV	Anti-Retroviral
API	AIDS Program Effort Index
ASHA	Advancing Surveillance, Policies, Prevention, Care & Support to Fight HIV/AIDS
BBS	Biologic Behavior Study/ (HIV Behavior Surveillance Surveys the past)
BCC	Behavior Change Communication
BCI	Behavior Change Intervention
BSS	Behavioral Surveillance Survey
CAC	Community Action Centre
CBAC	Community Based ARI and CDD
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
CPR	Contraceptive Prevalence Rate
CRS	Nepal Contraceptive Retail Sales Company
C&S	Care and Support
CS&T	Care, Support, and Treatment
CS	Communication Specialist
CSP	Country Strategic Plan
CSW	Commercial Sex Worker
CTO	Cognizant Technical Officer
CYP	Couple Years of Protection
CA	Constitution Assembly
CWC	Community Welfare Centre
CSO	Civil Society Organization
DACC	District AIDS Coordination Committee
DDC	District Development Committee
DPHO	District Public Health Office
DHS	Demographic Health Survey
DOTS	Direct Observation Therapy
DQA	Data Quality Assessment
DDC	District Development Committee

DIC	Drop-in Centre
EDP	External Donor Partners
EID	Early Infant Diagnosis
EPC	Essential Package of Care
FSGMN	Federation of Sexual and Gender Minorities, Nepal
FSW	Female Sex Worker
FY	Fiscal Year
HBC	Home-Based Care ASHA Nepal Evaluation iii
FCHV	Female Community Health Volunteer
FHI	Family Health International
FSW	Female Sex Workers
FIU	Financial Information Unit
FP	Family Planning
GON	Government of Nepal
GDA	Global Development Alliance
GDP	Gross Domestic Product
GIS	Geographic Information System
GAP	Global AIDS Program (CDC)
GFATM	The Global Fund to Fight AIDS, Tuberculosis and Malaria
GWP	General Welfare Pratisthan
HA	Health Assistant
HF	Health Facility
HMIS	Health Management Information System
HCT	HIV/AIDS Counseling and Testing
HIV	Human Immunodeficiency Virus
IBBS	Integrated bio-behavioral survey
IR	Intermediate Result
IDU	Injecting Drug User
IHS	Integrated Health Services
IMPACT	Implementing AIDS Prevention and Care Project
JSI	John Snow Inc.
LMIS	Logistics Management Information System
LQAS	Lot Quality Assurance Sampling
LDTA	Local Development Training Academy
LMD	Logistics Management Division
MARPs	Most at Risk Populations (groups)
MCHW	Maternal and Child Health Workers
MIS	Management Information System
MNH	Maternal and Neonatal Health
MOHP	Ministry of Health & Population
M&E	Monitoring and Evaluation
MASS	Management and Support Services
MSM	Men who have Sex with Men
MSW	Male Sex Worker
NA	Nepal Army
NC	Nepali Congress

NCASC	National Center for AIDS and STD Control
NGO	Non-Governmental Organization
NHTC	National Health Training Center
NRM	Natural Resource Management
NTAG	National Technical Advisory Group
NHRC	National Human Rights Commission
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
N-MARC	Nepal Social Marketing and Franchise Project: AIDS, Reproductive Health (RH) and Child Survival (CS)
NPHL	National Public Health Laboratory
NSARC	Nepal STD and AIDS Research Centre
OE	Outreach Educator
OI	Opportunistic Infection
PEP	Post Exposure Prophylaxis
PEPFAR	President's Emergency Plan for AIDS Relief
PIF	Project Indicator Form
PLHA	People Living With HIV and AIDS
PSI	Population Services International
PA	Project Agreement
PMTCT	Prevention of Mother to child Transmission
PMP	Performance Monitoring Plan
PPD	Program and Project Development
PR	Prerequisite Result
PPP	Public Private Partnership
PWD	People with Disabilities
QOCMC	Quality of Care Management Center
QA	Quality Assurance iv ASHA Nepal Evaluation
QC	Quality Control
QI	Quality Improvement
RH	Reproductive Health
RTK	Rapid Test Kit
RHFA	Rapid Health Facility Assessment
RRA	Rights Responsibility and Advocacy
S&D	Stigma and Discrimination
SIA	Social Impact Assessment
SO	Strategic Objective
SpO	Special Objective
SACTS	STD/AIDS Counseling & Training Services
SBC	Strategic Behavioral Communication
SI	Strategic Information
SOP	Standard Operating Procedure
STD/STI	Sexually Transmitted Disease / Sexually Transmitted Infection
TA	Technical Assistance

TIMS	Training Information Management System
TB	Tuberculosis
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
USAID	United States Agency for International Development
VCT	Voluntary Counseling and Testing
VDC	Village Development Committee
UNICEF	United Nations Children's Fund
USAID	United States Agency for International Development
USG	United States Government
VDC	Village Development Committee
WHO	World Health Organization

Background

Development Context

Geographically, ethnically, and culturally diverse; historically independent and isolated; nestled in the Himalayan mountains between the economic giants of India and China—Nepal is in the midst of historic political and social transitions that will influence not only its government and economy but its national identity. In the aftermath of the 1996-2006 conflict, development continues forward but is inconsistent and inequitable in scope and pace. The country is engaged in a largely peaceful debate over its post-conflict identity; a debate over the role and structure of government, the role of women and marginalized groups, and the management of the economy. Emerging from centuries of monarchial rule, the domination of an oppressive caste system, a violent conflict, and economic instability, Nepal is slowly moving towards greater democracy, prosperity, and resiliency.

A landlocked country of about 27.5 million people, Nepal is one of the few examples of a civil conflict that ended not with one side vanquishing the other, but through a negotiated peace. Post-conflict progress is slow, but this reflects the fact that decisions come through discussion, dialogue and consensus rather than by fiat in Nepal.

Nepal remains one of the poorest and least developed countries in the world. While there has been some progress, the economy is not keeping pace with its South Asian neighbors and the country suffers from a poor investment and business climate as well as the lack of a coherent policy and regulatory framework. Though hampered by endemic corruption and political gridlock, there is significant potential, particularly in the hydropower, tourism, and agricultural sectors. Nepal faces multiple climate-related and geological hazards, including floods, landslides, and earthquakes. The traditional caste system and multitude of ethnicities in the country exacerbates development challenges. Despite persistent poverty, human development indicators continue to show marked improvement, and there is a commitment by the government and Nepalese themselves — to progress, tolerance, and resilience.

To view Nepal through a short-term lens is to discount the immense changes — social, political, and economic — which have swept the country over the last 60 years and particularly over the last decade. The centuries-old system of monarch rule ended in 1951 with the establishment of a cabinet system of government. A first wave of reforms in the 1990s created a multiparty democracy within the framework of a constitutional monarchy. The 10-year civil war between Maoist insurgents and government forces weakened the country's fragile democratic systems. Peace negotiations between the Maoists and government officials ended the conflict in a November 2006. At the end of this SO, a definitive constitution and election remains elusive.

Genesis of SO9

Prior to 2006, Nepal's health program operated under SO2 (Reduced Fertility and Protected Health of Nepalese Families). As Nepal moved to the future in a post conflict era, health under

SO2 was divided into two separate strategic objectives, SO9 (HIV/AIDS) and SO11 (Health and Family Planning). S09 focused on enhancing security by focusing on the HIV/AIDS epidemic that is most prevalent among the most at risk populations (MARPs).

At the development of SO9, there were an estimated 70,000 persons living with HIV/AIDS (PLHA) in Nepal, the majority of those indiviudals not knowing they carry the virus or have AIDS. Few had access to basic HIV/AIDS testing, treatment and care. The HIV epidemic was (and continues to be) driven by injecting drug use, commericial sex and migration. HIV prevalence was higher in specific populations who practice high risk behaviors, including injecting drug users (IDUs), female sex workers (FSWs), clients of sex workers, men who have sex with men (MSM) and seasonal labor migrants. While HIV cases in IDUs, FSWs and migrant men were relatively small in terms of numbers in 2006, these groups were capable of contributing to a much larger number of infections given the effectiveness of transmission through needle sharing and multiple sexual partners. There were an estimated 12,000-15,700 IDUs in Nepal when this SO was developed, with HIV prevalence ranging from 11.7% in the Western Terai to 51.6% in Kathmandu. An estimated 15% of male IDUs were clients of FSWs and only half used condoms when they bought sex.

While in 2006 the HIV prevalence among migrant men (absentees in India) was lower than in IDUs, they made up a far larger number of those infected with HIV since they were a larger group in terms of absolute numbers. This was particularly true in Mid-Western Nepal where migrants made up 21.3% of the total adult male population, and in the Far West where migrants were 16.5% of the total adult male population. Migration was estimated to be associated with 30-50% of the current HIV burden in Nepal, with between 600,000 and 1.2 million men migrating annually to India for work. Source communities were concentrated in the Far West and Mid West Nepal, with the highest HIV prevalence among migrants who returned home from Mumbai (6-10%). Their lack of social support, while working in India for extended periods, as well as an increased income, presented opportunities for more high-risk behavior and was an important focus under this SO. In addition, female partners of IDUs, MSM, clients of sex workers and seasonal migrants were identified as at risk for HIV infection given that the numbers of HIV infected persons in these groups was increasing. Most of those individuals did not know their HIV status and very few of those were able to access adequate care and treatment services.

In the context of the challenges presented by the political unrest and conflict situation, HIV/AIDS was perceived as a relatively minor issue and therefore received limited commitment from the country's leadership. Nonetheless, civil society's commitment to address the epidemic had grown considerably. Community mobilization and advocacy efforts by PLHA and at-risk populations had influenced government support for efforts to increase services and activities to counter stigma and discrimination. In addition, efforts were made to work with other sectors, such as law enforcement, in order to create and sustain environments where HIV prevention efforts could take place more effectively among vulnerable groups. Those involved in the SO9 design recognized that an effective HIV/AIDS program needed to provide on-going support to improve and strengthen civil society participation and effectiveness, while at the same time assisting the government in developing a high-level commitment to HIV/AIDS program efforts during a time of political and economic crisis.

Methodology

As stated in **ADS 203.3.11** (dated 09/01/2008), the guidance for Assistance Objective (AO) Close Out Reports clearly indicates that it is mandatory that "AO Teams must produce a brief close out report for each of their AOs when the AO is either completed or terminated. The intended audience for the AO close out report includes development professionals in USAID and partner organizations that seek to learn from broader Agency experience and apply this experience in planning or assessing other development efforts. The AO close out report should summarize overall experience in achieving intended results as well as provide references to related materials and sources of information".

The methodology used for this SO Close Out Report include: obtaining and reviewing relevant USAID and outside data, documents and sources of information (SOAG, AAD, Result Frameworks, Contracts, Performance Management Plans, Portfolio Reviews, evaluations, assessments and reports); conducting interviews and SO Team level discussions with USAID staff (i.e. program managers past and present) and implementing partners (IPs) for their institutional knowledge and reflections on lessons learned, sustainability and linkages to other SOs; utilizing data and information to draft report; sharing key lessons learned, interventions and challenges with USAID/Nepal mission; and publishing the report on USAID's Development Education Clearinghouse (DEC). The major challenge was locating final reports for projects and programs, time lapse between the programmatic close-out to the writing of the SO Close Out Report and loss of institutional knowledge due to staff turnover.

Results Framework During the Life of SO

USAID/Nepal Mission prepared a new Fragile States Strategy that was approved in 2006. This strategy divided the health activities into two separate objectives and under the Mission's Fragile State Strategy, HIV/AIDS activities were placed within the "Enhance Stability and Security Strategic Objective 9," and family planning, maternal and child health and other public health threats were placed within the "Build Capacity of Critical Institutions Strategic Objective 11." Please refer to *Figure 3. USAID/Nepal Objectives and Program Evolution: 1996-2010* to see the evolution of SO2 to SO9 and SO11.

The graphical representation on the following page illustrates the revised SO9 Results Framework with the corresponding indicators.

USAID/NEPAL S0 9 RESULTS FRAMEWORK

Strategic Objective 9
Enhanced Stability and Security

Indicators:
SO 9.1 Enhanced prevention, care and treatment in support of the President's Emergency Plan for HIV/AIDS
SO 9.2 Enhanced and coordinated HIV program monitoring in support of the President's Emergency Plan for HIV/AIDS

PREREQUISITE RESULT 9.1
Enhanced prevention, care and treatment in support of the Emergency Plan for HIV/AIDS

9.1.1 National Composite Policy Index
9.1.2 Number of individuals trained in HIV-related stigma and discrimination reduction
9.1.3 Percent of female sex workers reporting the use of a condom with their most recent client; Percent of men reporting the use of a condom the last time they had anal sex with a male partner (includes MSW disaggregated when possible); Percent of sexually active injecting drug users who report use of a condom at last sex
9.1.4 Percent of female sex workers reporting consistent condom use with their clients over the past 12 months; Percent of men reporting consistent use of a condom the last time they had anal sex with a male partner over the past 12 months, (includes MSW disaggregated when possible); Percent of sexually active injecting drug users who report consistent condom use over the last 12 months
9.1.5 Percent of MARPs who both correctly identify ways of preventing the sexual transmission of HIV and who reject major misconceptions about HIV transmission
9.1.6 Coverage of condom distribution in geographically defined populated areas
9.1.7 Number of most-at-risk individuals receiving STI treatment within the context of HIV prevention at USG-supported sites
9.1.8 Number of service outlets providing counseling and testing
9.1.9 Number of individuals who receive counseling and testing for HIV and received their test results
9.1.10 Total number of individuals provided with HIV-related palliative care (including TB/HIV), disaggregated by male /female, PLHWA, and /or others

Summary of Overall Impact at SO and IR Levels (Planned vs. Actual)

Strategic Objective Level Impact

SO9: Enhance Stability and Security

Indicators:

IR 9.1 Enhanced prevention, care and treatment in support of the President's Emergency Plan for HIV/AIDS (PEPFAR)

IR 9.2 Enhanced and coordinated HIV program monitoring in support of the President's Emergency Plan for HIV/AIDS

SO2 Performance Goal: Reduced transmission of HIV/AIDS though targeted prevention interventions with specific high risk and vulnerable populations, while reducing stigma and discrimination to enable equitable access to services.

Program/Projects: ASHA, DELIVER, N-MARC

Overall Improved Health in Nepalese Families

Major results at the SO level are presented below:

- The GON continued to lead Nepal's HIV/AIDS response through a long-standing set of national technical working groups, which coordinated the prevention, treatment, and care activities in both the public and private sectors. The USG participated in these groups, and helped guide the implementation of training activities, re-focus of treatment and care among MARPs, and commodity procurement and distribution. The USG also provided technical assistance to the GON in preparing the National Strategic Plan for HIV/AIDS.
- USAID contributed 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.
- USAID in collaboration with UNDP worked to strengthen the National Public Health Laboratory (NPHL), to establish a national External Quality Assessment System (EQAS) for HIV, and to strengthen pharmaceutical supply.
- USAID contributed to the development of standards and guidelines for HIV/AIDS programs.
- USAID increased capacity building, specifically with civil society, notably, 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.
- Specific focus on women in HIV care and services has improved women's lives. Women have become outreach workers and have received training to promote HIV prevention in the community.
- Improved strategic information through USAID support was one of its greatest contributions to the national response. It's contributions have been particularly important at the central level and played a key leadership role in the Strategic

Information Technical Working Group (TWG), which is recognized by other members of the TWG.

- Increased participation of PLHA as paid field workers and volunteers improved access to and quality of services. Workers and volunteers assisted clients in hospital VCT/ART clinics and served as Community Home-Based Care (CHBC) workers.
- Local institutional capacity building was a key objective of the USAID-supported HIV/AIDS care and prevention program, ASHA. In FY 2010, this program provided capacity building training to 15,000 staff members of local NGOs and community-based organizations (CBO) in technical areas such as antiretroviral treatment and prevention of mother to child transmission (PMTCT) as well as in organizational and management systems.

Intermediate Results Level Impact

I.R. 2.1 – Enhanced prevention, care and treatment in support of the President's Emergency Plan for HIV/AIDS

USAID support has contributed to:

- Increased HIV services, including prevention, education, testing, and counseling. HIV services targeted to MARPs. In most groups, prevalence rates decreased and awareness of HIV treatment and care increased.
- People provided with HIV related palliative care doubled over the life of the SO, and in this the number of men and women receiving care was similar, showing greater equality in services provided.
- We reached 20,693 people with testing and counseling services for HIV.
- We supported 34 health facilities offering ART; 8,324 MARPs received STI treatment at a USG assisted sites and increased the number of outlets providing STI treatment to 36 locations and the number of service outlets providing counseling and testing to 37.
- Fifty percent of PLHAs reached were women and 43 percent of overall prevention outreach covered women. Almost 40 percent of the total population reached through outreach were clients of female sex workers.
- Nearly six times more women than men were treated for STI from USAID supported sites. In addition, a small number of transgenders accessed STI services (45 in FY07, 59 in FY08 and 8 in FY 09) from USAID sites.
- Increased training for women. Women outnumbered men two to one in training to promote HIV prevention in the community. Women were also trained in HIV related policy development representing 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 transgender.
- Reduced the number of MARPs who were HIV infected. This is most significant with IDUs where in the past five years prevalence rates were reduced by half. In other MARPs, prevalence rates declined or stagnated, except among migrants and truckers in certain geographic regions where increases were minimal.

- Increased condom use. Eighty-four percent of FSWs reported using a condom with their most recent client in the 22 Terai Highway Districts. For IDUs, those reporting using a condom at last sex ranged from 67-89 percent, with Kathmandu reporting the lowest and Pokhara the highest rates.

I.R. 2.2 – Enhanced and coordinated HIV program monitoring in support of the President's Emergency Plan for HIV/AIDS

Overall USAID support:

- Trained 30,041 persons including implementing partner staff, target groups, PLHAs, members of the uniformed services, health workers, community members and government officials in reducing stigma and discrimination.
- Trained more women and transgender than men for reduction of stigma and discrimination.
- USAID supported trainings of individuals in VCT and palliative care, however, toward the end of the SO, the numbers declined.
- Supported implementing partners to provide care and support through training, capacity building, staff salaries, supportive supervision and monitoring.

Summary of SO Programs & Projects

Refer to *Appendix II: Summary of SO Programs & Projects* for a list of activities with a short description, funding amount, start and end dates, prime implementing organizations, USAID program manager and documents.

Sustainability – Prospects/Impacts/Interventions, PrincipleThreats/Challenges and Linkages/Missed Opportunities

Prospects/Impacts/Interventions

The various interventions under SO9 included promising practices that strengthened the GON clinical management and delivery system to provide care and support to Nepalese families.

Principle Threats/Challenges

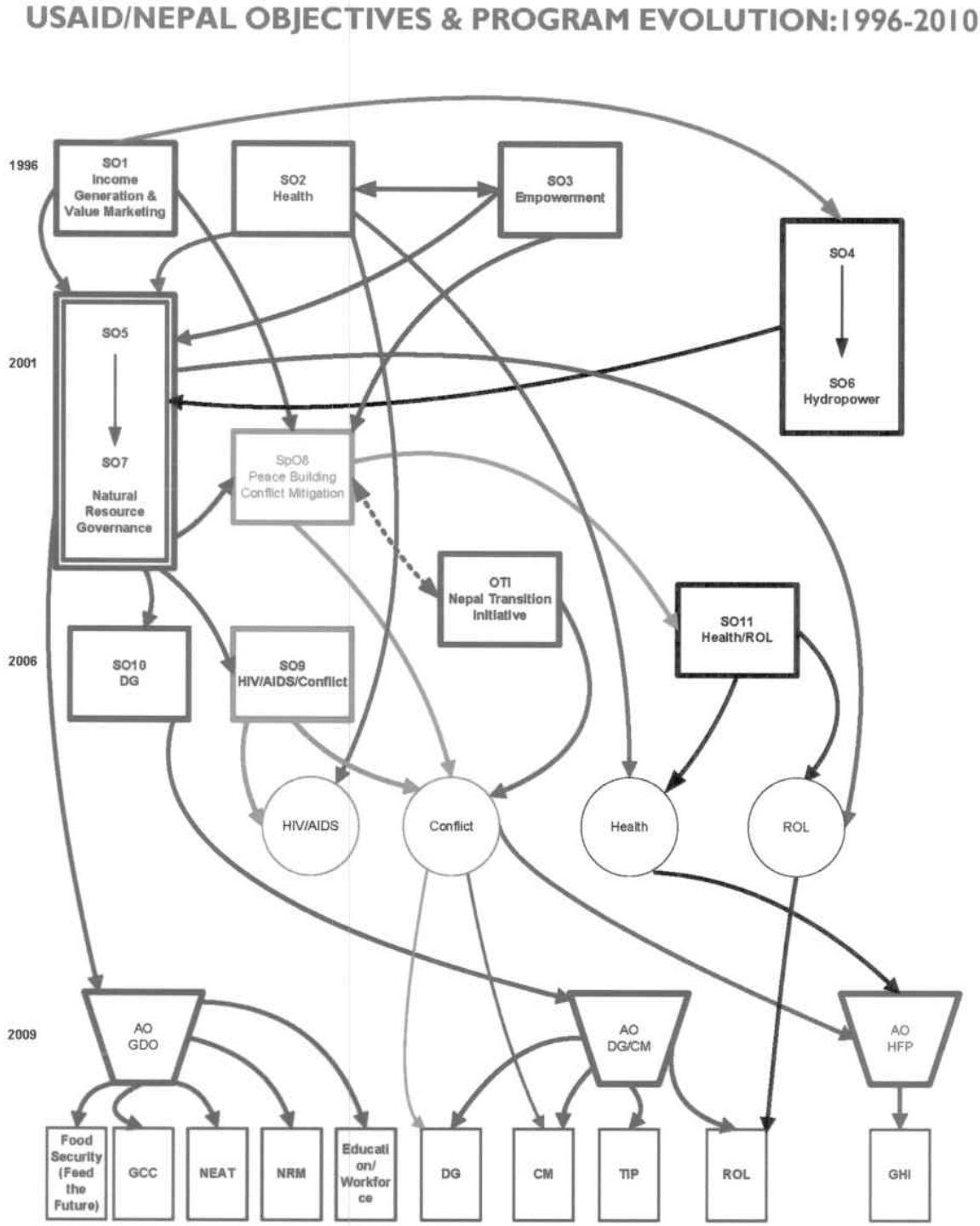
- SO9 operated under the post conflict time and there were no major disruptions to HIV prevention and control activities during the life of the SO.
- During the post conflict years, there were multiple political parties, capturing the influence at local levels. Additionally, there were no local elections for many years and hence no chair persons at the VDCs, impacting the ability to coordinate with VDC's in

project implementation. The lack of a directly elected person of contact (POC) continued to be a challenge in working with VDCs.

Linkages between SO2 and other SOs

- SO 11 and SO 9 were both derivatives of the previous SO2. During the post conflict period, SO 2 was divided into two separate objectives, SO 9 *"Enhanced Stability and Security", IR 9.1 "Enhanced prevention, care and treatment in support of the Emergency Plan"* and SO 11 *"Build Capacity of Critical Institutions", IR 11.1 "Increased use of quality family planning services"* and IR 11.2 *"Increased use of selected maternal and child health services"* to meet HIV/AIDs, maternal-child health and family planning indicator goals in Nepal, together SO9 and SO 11, covered the full range of health programming.
- Large-scale migration due to the conflict resulted in intensified HIV/AIDS response through SO 9 and SO 11 to be more strategic with focused interventions and coordinated planning to target along highway and urban areas of migratory routes.
- Governance and institutional capacity building initiated by SO2 were carried forward by SO9, SO 11 and the AO through increased community involvement in health facility management

As illustrated in the *Figure 3. USAID/Nepal Objectives and Program Evolution: 1996-2010*, SO2 served as pilot and foundational elements of SO9, SO11 and evolution towards AO HFP.



Key Lessons Learned

- Increased GON capacity through technical assistance helped to establish and maintain services. Continued support at the national, regional and local level is fundamental to continued success.

- Mobilized Peer Educators (PE) from the community increased coverage and motivated FSWs and other targeted groups in behavior change.

- Emphasizing the continuation of care for PLHAs, including strong linkages between prevention, care and treatment. Providing a continuation of care specifically with FSWs where they could receive VCT as well as clinical services at the same location was important.

- Continued use of positive prevention groups with the involvement of PLHAs. It produced good results for concordant and discordant couples as well as for the general population. The Positive Speakers Bureau encouraged others to access VCT and other services. It brought families together, promoted safer sex and developed good understanding among groups. Positive prevention groups were able to act as community mobilizers and help other HIV+ people address the challenges of stigma and discrimination, as well as promote the use of HIV services.

- Strengthened MARP groups to increase the sharing of information among PLHAs, improved advocacy and reduced stigma and discrimination. These groups played a greater role as responsibility for HIV/AIDS programs shifted from NGOs to government.

- Engaging PLHAs as community project implementers helped enhance community based work. The participation of PLHA as paid field workers and volunteers, for example, who assisted clients in hospital VCT/ART clinics and served as CHBC workers, was a major contributor to improving access to and quality of services.

Appendix 1: SO Level Performance Indicators

Performance Data Table SO9 from Nepal PMP Report 2008.

SO or PR	Results Statement	Indicator	Unit of Measure	Disaggregation	Baseline Year	Baseline Value	2006 Target	2006 Actual	2007 Target	2007 Actual	2008 Target	2009 Target	2009 Actual	2010 Target	2010 Actual
SO 9.1	Enhanced prevention, care and treatment in support of the Emergency Plan.	Percent of (most-at-risk populatio n(s)) who are HIV infected.	Percent of FSWs	a. FSWs in Kathmandu Valley	2000	17.3%	Maintain 2%	**1.4%**	NA	NA	≤ 2%	NA		≤ 2%	≤ 2%
				b. FSWs in 16 eastern most Terai districts	1999	3.9%	Maintain 3%	**1.5%**	NA	NA	≤ 2%	NA		≤ 2%	≤ 2%
				c. FSWs in 6 western Terai districts	2003	0%	2%	**1.5%**	NA	NA	≤ 2%	NA		≤ 2%	≤ 2%
				d.Pokhara	2004	2.0%	2%	**2%**	NA	NA	≤ 2%	NA		≤ 2%	≤ 2%
			Percent of MSM	MSM in Kathmandu valley	2004	3.9%	NA	NA	3.5%	3.3%	NA	3%		NA	
			Percent of transport workers	Transport workers in 16 Eastern Terai districts	1999	1.5%	Maintain 2%	1%	NA	NA	≤ 2%	NA	8.1%	NA	
			Percent of IDUs	IDUs in Kathmandu valley	2003	68%	NA	NA	45%	34.7%	NA	30%	20.7%	NA	
				IDUs in Pokhara valley	2003	22%	NA	NA	20%	6.8%	NA	6%	3.4%	NA	
				IDUs in Eastern Terai (three districts)	2003	35.1%	NA	NA	30%	17.1%	NA	15%	8.1%	NA	
				IDUs in Western Terai (Rupandehi to Kanchanpur)	2005	11.7%	NA	NA	10%	11%	NA	10%	8%	NA	
			Percent of Migrant Males	Mid and Far West districts[1]	2006			2.8%			≤ 2%	NA		≤ 2%	≤ 2%
				Western districts[2]	2006			1.1%			≤ 2%	NA		≤ 2%	≤ 2%
				ANC/PMTCT[3]	2005		NA	0..2%	NA	0.2%	NA	NA		NA	
				Blood supply	2005		NA	0.4%	NA	0.18%	NA	NA		NA	
PR 9.1.1	Enhanced prevention, care and treatment in support of the Emergency Plan.	National Composit e Policy Index	Composite index	NA	2000	47.5	65	54	NA	63	NA now done by UNAID q2yrs	65		NA	

[1] Mid and Far West districts sampled were: Accham, Doti, Kailali, Kanchanpur, Banke and Surkhet

[2] Western Districts sampled were: Kaski, Syanja, Gulmi, Palpa and Kapilvastu

[3] UNICEF has sponsored routine PMTCTdata collected at 3 sites for 12 months and 4 new sites for 6 months in 2005.

SO or PR	Results Statement	Indicator	Unit of Measure	Disaggregation	Baseline Year	Baseline Value	2006 Target	2006 Actual	2007 Target	2007 Actual	2008 Target	2009 Target	2009 Actual	2010 Target	2010 Actual
PR 9.1.2	Enhanced prevention, care and treatment in support of the Emergency Plan.	Number of individuals trained in HIV-related stigma and discrimination reduction	# of people	Male	2004	1,263	4525	**Total = 8528 M=4967**	6000	Total = 5102	7000	7400		N/A	
				Female				**F=3561**							

SO or PR	Results Statement	Indicator	Unit of Measure	Disaggregation		Baseline Year	Baseline Value	2006 Target	2006 Actual	2007 Target	2007 Actual	2008 Target	2009 Target	2009 Actual	2010 Target	2010 Actual
PR 9.1.3	Enhanced prevention, care and treatment in support of the Emergency Plan.	Percent of female (and male) sex workers reporting the use of a condom with their most recent client Percent of men reporting the use of a condom the last time they had anal sex with a male partner (includes MSW disaggregated when possible) Percent of sexually active injecting drug users who report use of a condom at last sex	Percent of FSWs, clients and MSM and IDUs	Kathmandu	FSW	2001	91.5%	80%	**77.2%**	NA	NA	80%	NA		NA	
					Client	2001	88.8%	Maintain 80%	Discont'd BSS	X	X	X	X		X	
					MSM	2004	Available 9/04	NA	NA	75%	72.4%	NA	80%		NA	
					IDU	2001	60%	NA	NA	80%	74%	NA	80%		NA	
				East Terai	FSW	1998	61.8%	60%	**68%**	NA	NA	75%	NA		TBD	
					Trans	1998	75.8%	Maintain 80%	**90%**	NA	NA	Maintain 80%	NA		80%	80%
					Labor	1998	41.1%	Maintain minimum of 70%	Discont'd BSS	X	X	X	X		X	
					IDU	2003	64.3%	NA	NA	75%	75.3%	NA	80%		NA	
				West Terai	FSW	2002	79.8% (BSS)	80%	43%	NA	NA	50%	NA		TBD	
					Client	2002	93.5%	Maintain 80%	Discont'd BSS	X	X	X	X		X	
					IDU	2005	59.4%	NA	NA	65%	67%	NA	70%		NA	

SO or PR	Results Statement	Indicator	Unit of Measure	Disaggregation		Baseline Year	Baseline Value	2006 Target	2006 Actual	2007 Target	2007 Actual	2008 Target	2009 Target	2009 Actual	2010 Target	2010 Actual
				Pokhara	FSW	2004	64.5%	70%	**75%**	NA	NA	80%	NA		80%	
					Client	2004	89.3%	Maintain 80%	NA	NA	NA	NA	NA		NA	
					IDU	2003	79.8%	NA	NA	80%	83.9%	NA	80%		NA	

SO or PR	Results Statement	Indicator	Unit of Measure	Disaggregation		Baseline Year	Baseline Value	2006 Target	2006 Actual	2007 Target	2007 Actual	2008 Target	2009 Target	2010 Target	2010 Actual
PR 9.1.4	Enhanced prevention, care and treatment in support of the Emergency Plan.	Percent of female sex workers reporting consistent condom use with their clients over the past 12 months Percent of men reporting consistent use of a condom the last time they had anal sex with a male partner over the past 12 months (includes MSW disaggregated when possible) Percent of sexually active injecting drug users	Percent of FSWs, clients and MSM	Kathmandu	FSW	2001	39.5%	60%	**56.2%**	NA	NA	60%	NA	80%	
					Client	2001	66.8%	Maintain 80%		NA	NA	NA	80%	NA	
					MSM	2004	50%	NA	NA	60%		NA	NA		
					IDUs	2001	48.0 NP 54.3 FSW	NA	NA	40%	67.8%	NA	>80% maintain	NA	
				East Terai	FSW	1998	33%	30%	**51.5%**	NA	NA	60%	NA	70%	
					Trans	1998	36.2%	75%	83%	NA	NA	80%	NA	80%	
					Labor	1998	23.4%	NA	NA	NA	NA	NA	NA	NA	
					IDUs	2003	28 N.P 41.4 FSW	NA	NA	55%	57.3%	NA	60%	NA	
				West Terai	FSW	2002	52.3%	60%[4]	26%	NA	NA	40%	NA	50%	
					Client	2002	78.3%	80%	NA	NA	NA	NA	NA	NA	
					IDU	2005	46.5%	NA	NA	50%	48.4%	NA	50%	NA	

[4] According to BSS study.

SO or PR	Results Statement	Indicator	Unit of Measure	Disaggregation		Baseline Year	Baseline Value	2006 Target	2006 Actual	2007 Target	2007 Actual	2008 Target	2009 Target	2010 Target	2010 Actual
		who report consistent condom use over the last 12 months		Pokhara	FSW	2004	35.5%	40%	37%	NA	NA	50%	NA	60%	60%
					Client	2004	84.5%	Maintain 80%	NA	NA	NA	NA	NA	NA	
					IDUs	2003	59.6%	NA	NA	55%	80.5%	NA	80%	NA	

SO or PR	Results Statement	Indicator	Unit of Measure	Disaggregation		Baseline Year	Baseline Value	2006 Target	2006 Actual	2007 Target	2007 Actual	2008 Target	2009 Target	2010 Target	2010 Actual
PR 9.1.5	Enhanced prevention, care and treatment in support of the Emergency Plan.	Percent of MARPs who both correctly identify ways of preventing the sexual transmission of HIV and who reject major about HIV transmission.	Percent of FSWs, clients, MSM, IDUs	Kathmandu	FSW	2004	Data not available	10%	30.2%	NA	NA	40%	NA	50%	50%
					IDU	2005	53%	NA	NA	60%	65.9%	NA	70%	NA	
					MSM	2004	33.6%	NA	NA	40%	50.8%	NA	55%	NA	
				East Terai	FSW	2004	22.8%	NA	**31.3%**	NA	NA	40%	NA	50%	50%
					Transp	2006	50.5%	NA	50.5%	NA	NA	60%	NA	70%	70%
					IDU	2005	50.1%	NA	NA	55%	65.5%	NA	70%	NA	
				Western Terai Rupandehi to Kanchanpur	IDU	2005	39.7%	NA	NA	45%	57%	NA	60%	NA	
					FSW	2006	31.5%	NA	**31.5%**	NA	NA	40%	NA	50%	50%
				Pokhara	FSW	2004	10.4%	12%	25%	NA	NA	35%	NA	50%	50%
					IDU	2003	56.7%	NA	NA	65%	73.4%	NA	75%	NA	

SO or PR	Results Statement	Indicator	Unit of Measure	Disaggregation	Baseline Year	Baseline Value	2006 Target	2006 Actual	2007 Target	2007 Actual	2008 Target	2009 Target	2010 Target	2010 Actual
PR 9.1.6	Enhanced prevention, care and treatment in support of the Emergency Plan	Coverage of condom distribution in geographically defined populated areas	Percent of hot zones that meet the minimum coverage standard	NA	2005-2006	300		**69.5% last year for PSI**	- start for AED	80%	85%	90%	90%	90%
PR 9.1.7	Enhanced prevention, care and treatment in support of the Emergency Plan.	Number of most-at-risk individuals receiving STI treatment within the context of HIV prevention at USAID-supported sites	Number of people	NA until 2004	2002	1,116 (Nov 01-Aug 02)	6,200	**5964**[5]	8000	6644	8500	9000	TBD	8324
				FSW	2005			4334		3066				
				IDU	2005			25		42				
				MSM	2005			46		16				
				Clients	2005			842		756				
				Male migrant	2005			657		46				
				Spouse of male migrants	2007					728				
				PLHAs	2005			60		6				
				Other Male	2007					46				
				Other Female	2007					1934				
PR 9.1.8	Enhanced prevention, care and treatment in support of the Emergency Plan.	Number of service outlets providing counseling and testing	Number of service outlets	Stand alone	2002	1		9		2				
				Integrated	2005			17		32				
				Total	2005		25	**26**	23	34	30	33	TBD	
PR 9.1.9	Enhanced prevention, care and treatment in support of the Emergency Plan.	Number of individuals who receive counseling and testing for HIV and received their test results	Number	FSW	2005					2009				
				Clients	2005					4133				
				IDU M	2005				1199					
				F	2005				29					
				MSM	2005					59				
				Male Migrants	2007					857				
				Spouse of male migrants	2007					1302				
				Other Male	2007					609				
				Other Female	2007					2193				
				Totals	2002	98	7000	**6873**	7000	12391	7500	8000	22,000	20,693
PR 9.1.10	Enhanced prevention,	Total number of	Number of PLWHA	Male	2005	402		687		1144			2000	2583

[5] In addition to this figure, 2398 "others" who are partners of MARPs received STI treatment through FHI supported sites and 4603 were treated through PSI supported sites. Refer to Annex for disaggregated detail.

SO or PR	Results Statement	Indicator	Unit of Measure	Disaggregation	Baseline Year	Baseline Value	2006 Target	2006 Actual	2007 Target	2007 Actual	2008 Target	2009 Target	2010 Target	2010 Actual
	care and treatment in support of the Emergency Plan.	individuals provided with HIV-related palliative care (including TB/HIV)	Disaggregated by male/female, PLHWA, and/or others	Female	2005	138		436		1058			2000	2486
				Family										
				Total	2002	28	700	1123	1500	2202	2700	300	4000	5269

Appendix II: Summary of SO Programs & Projects

SO9: 1996-2009 Enhance Stability and Security

Intermediate Results	Program & Projects	Start Date	End Date	Program Description	Obligated USD	Prime Implementing Partner(s)	Sub-Contract Implementing Partner (s)/Field Support (List of Partners Organizations)	USAID Program Managers (COTR/AOTR) & Year	Documents & Reports
IR 9.1: Enhanced Prevention, care and treatment in support of the President's Emergency Plan for HIV/AIDS	ASHA	2006	2011	HIV/AIDS Prevention, Care, Treatment		Family Health International (FHI)	Futures Group International; Association Medical Doctors of Asia (AMDA)	Shanta Gurung	Evaluation of "Advancing Surveillance, Policies, Prevention, Care and Support to Fight HIV/AIDS in Nepal (ASHA) Project" (April 2010)
	N-MARC	2006	2010	Social Marketing		Academy for Education Development (AED)		Pangday Yonzone (Activity Manager)	Evaluation of USAID/Nepal's Key Social Marketing and Franchising Project: AIDS, Reproductive Health, and Child Survival (N-MARC) (March 2010)

	DELIVER PROJECT	2005	2010	Support basic health services by improving logistics management systems in all districts in Nepal.				Pangday Yonzone (Activity Manager)	
IR 9.2: Enhanced and coordinated HIV program monitoring in support of the President's Emergency Plan for HIV/AIDS	ASHA	2006	2011	HIV/AIDS Prevention, Care, Treatment		Family Health International (FHI)	Futures Group International; Association Medical Doctors of Asia (AMDA)	Shanta Gurung	Evaluation of "Advancing Surveillance, Policies, Prevention, Care and Support to Fight HIV/AIDS in Nepal (ASHA) Project" (April 2010)
	N-MARC	2006	2010	Social Marketing		Academy for Education Development (AED)		Pangday Yonzone (Activity Manager)	Evaluation of USAID/Nepal's Key Social Marketing and Franchising Project: AIDS, Reproductive Health, and Child Survival (N-MARC) (March 2010)
	DELIVER PROJECT	2005	2010	Support basic health services by improving logistics management systems in all districts in Nepal.				Pangday Yonzone (Activity Manager)	

Appendix IV: References of Reports, Evaluations and Assessments

USAID. February 2008. "USAID/Nepal Performance Management Plan Health 2008 for Strategic Objective 9 and 11". Kathmandu, Nepal: USAID.

USAID. April 2010. "Evaluation of 'Advancing Surveillance, Policies, Prevention, Care and Support to Fight HIV/AIDS in Nepal (ASHA) Project'". The Global Health Technical Assistance Project, Washington, D. C.

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