UNICEF

HIV and AIDS TARGETED INTERVENTIONS (HATI)

PARTICIPATORY MONITORING AND EVALUATION FRAMEWORK AND GUIDELINES

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EXECUTIVE SUMMARY

In managing the HIV and AIDS Targeted Interventions (HATI) project, a major function of UNICEF is to develop the capacities of NGOs to implement HIV and AIDS programs, including the effective monitoring and evaluation (M&E) of program activities. To strengthen M&E efforts, UNICEF launched a participatory monitoring and evaluation initiative, in order to develop the capacities of HATI NGOs to plan and implement participatory M&E and to develop a common monitoring and evaluation framework for HATI.

To achieve these results, the initiative consists of: 1) an NGO M&E capacity assessment; 2) a series of participatory M&E planning workshops held with representatives of all the HATI NGOs to develop a common M&E framework; and 3) written guidelines to assist the NGOs to implement and adapt the participatory M&E framework.

This set of guidelines is for the use of UNICEF, lead agency and implementing partner staff who are responsible for the monitoring and evaluation of the HATI program. The guidelines include:

- Key concepts in participatory monitoring and evaluation
- Overall goals and expected results of HATI and its different intervention packages
- A monitoring framework, that includes the major monitoring questions and indicators, data collection methods and formats, a plan for compiling and reporting the data, and suggested ways for disseminating and using the results
- A suggested outline of an evaluation framework
- Recommendations for further developing the HATI participatory M&E system

Within the monitoring framework, the major monitoring questions include:

1. What and how many activities have been implemented?
2. Have the expected targets and outputs been achieved?
3. Are the quality-related standards being met in key programmatic areas?

To answer the first two questions, it is strongly recommended that UNICEF develop a series of standardized data collection forms that are listed within the guidelines.

To answer the third monitoring question, it is recommended that the HATI program first establish and communicate a clear set of quality-related minimum standards, followed by adapting an existing set of monitoring checklists and interview guides that can be used at multiple levels of the program.

Because evaluation falls outside the scope of UNICEF and the HATI NGOs, these guidelines focus primarily on the monitoring framework. However, they also present an outline of an evaluation framework, which suggests the following evaluation questions:

1. Is there an increase in correct knowledge of HIV prevention methods?
2. Is there an increase in consistent condom use?
3. Is there an increase in the use of STI services?
4. Is there an increase in the use of sterile needles and syringes?
To answer these evaluation questions, recommended evaluation data collection methods include a baseline survey, a follow-up survey, and open-ended individual and group interviews. In recent discussions, NASP said that it and the World Bank would be overseeing an impact evaluation of the HAAP/HATI program in the near future.

To further develop and implement the HATI participatory M&E framework, recommendations to UNICEF include:

1. Finalize program targets and expected outputs with the HATI lead agencies, to be completed by the end of February, 2008.

2. Develop a standardized set of formats, first by designing one overall monthly or quarterly reporting format with NASP, followed by a corresponding set of data collection formats, to be completed by the end of March, 2008.

3. Further develop and communicate clear quality-related program standards, monitoring checklists, and interview guides, to be completed by the end of February, 2008.

4. Encourage and assist NASP to oversee the design and implementation of an impact evaluation.

5. Provide M&E training at all levels, particularly in the use of the new data collection and reporting forms.

6. Develop and provide a simple and feasible management information system (MIS) with the appropriate computer hardware, software, training and IT support, which would allow staff at the DIC or NGO level to enter, maintain, report, and use program monitoring data. To be completed by the end of May, 2008.

7. Refine the M&E framework and guidelines regularly, and continue to ensure and expand the participation of program stakeholders in M&E efforts.

In addition to these general recommendations, and based on further discussions with several lead agency M&E officers, UNICEF also needs to provide immediate M&E assistance to the lead agencies in the following areas:

- Further clarification on the definitions of reach and coverage.
- Instructions on how to conduct the target population mapping exercise.
- Standardized instructions on how to assign unique identification codes (UIC) to all program participants.
- Assistance in determining how to calculate either through computers or manually the number of program participants who have been “comprehensively reached.”

These frameworks, guidelines and recommendations were reviewed by and discussed with the HATI M&E Working Group, consisting of UNICEF staff members and lead agency team leaders, program coordinators, and M&E officers. In addition, NASP staff also reviewed and provided feedback on these guidelines.
<table>
<thead>
<tr>
<th>Acronym</th>
<th>Description</th>
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<tbody>
<tr>
<td>AIDS</td>
<td>Acquired immune deficiency syndrome</td>
</tr>
<tr>
<td>AM</td>
<td>Abscess management</td>
</tr>
<tr>
<td>ASAP</td>
<td>As soon as possible</td>
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<tr>
<td>BBSW</td>
<td>Brothel-based sex worker</td>
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<tr>
<td>BCC</td>
<td>Behavior change communication</td>
</tr>
<tr>
<td>BRAC</td>
<td>Bangladesh Rural Advancement Committee</td>
</tr>
<tr>
<td>BSS</td>
<td>Behavioral surveillance survey</td>
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<tr>
<td>CB</td>
<td>Capacity building</td>
</tr>
<tr>
<td>CIDR</td>
<td>Clinical daily register</td>
</tr>
<tr>
<td>CMCR</td>
<td>Consortium monthly compilation report</td>
</tr>
<tr>
<td>CoDR</td>
<td>Counseling daily register</td>
</tr>
<tr>
<td>CoSW</td>
<td>Clients of sex workers</td>
</tr>
<tr>
<td>CPAP</td>
<td>Country programme action plan</td>
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<tr>
<td>DhID</td>
<td>Department for International Development</td>
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<tr>
<td>DIC</td>
<td>Drop in center</td>
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<tr>
<td>DIC DR</td>
<td>Drop in center daily register</td>
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<tr>
<td>DIC MCR</td>
<td>Drop in center monthly compilation register</td>
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<tr>
<td>DR</td>
<td>Doctor</td>
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<tr>
<td>EV</td>
<td>Exchange visit</td>
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<tr>
<td>FHI</td>
<td>Family Health International</td>
</tr>
<tr>
<td>FSW</td>
<td>Female sex worker</td>
</tr>
<tr>
<td>GH</td>
<td>General Health</td>
</tr>
<tr>
<td>HAAP</td>
<td>HIV/AIDS Prevention Project</td>
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<tr>
<td>HATTI</td>
<td>HIV and AIDS Targeted Interventions</td>
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<tr>
<td>HIV</td>
<td>Human immunodeficiency virus</td>
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<tr>
<td>HNPSP</td>
<td>Health, Nutrition, Population Sector Project</td>
</tr>
<tr>
<td>HR</td>
<td>Harm reduction</td>
</tr>
<tr>
<td>HRSW</td>
<td>Hotel and residence-based sex worker</td>
</tr>
<tr>
<td>ICCRD,B</td>
<td>International Center for Diarrhoeal Disease Research, Bangladesh</td>
</tr>
<tr>
<td>I/DU</td>
<td>Injecting/drug user</td>
</tr>
<tr>
<td>IEC</td>
<td>Information, education, communication</td>
</tr>
<tr>
<td>M&amp;E</td>
<td>Monitoring and Evaluation</td>
</tr>
<tr>
<td>MAR</td>
<td>Most-at-risk</td>
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<tr>
<td>MARP</td>
<td>Most-at-risk population</td>
</tr>
<tr>
<td>MIS</td>
<td>Management information system</td>
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<tr>
<td>MoHFW</td>
<td>Ministry of Health and Family Welfare</td>
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<tr>
<td>MPP</td>
<td>Mid-project report</td>
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<tr>
<td>MQ</td>
<td>Monitoring quality</td>
</tr>
<tr>
<td>MR</td>
<td>Monthly report</td>
</tr>
<tr>
<td>MSA</td>
<td>Management support agency</td>
</tr>
<tr>
<td>MSM</td>
<td>Males who have sex with males</td>
</tr>
<tr>
<td>MSM&amp;TG</td>
<td>Males who have sex with males and transgender</td>
</tr>
<tr>
<td>N/A</td>
<td>Not applicable</td>
</tr>
<tr>
<td>NA</td>
<td>Needs assessment</td>
</tr>
<tr>
<td>NASP</td>
<td>National AIDS and STI Programme</td>
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<tr>
<td>Acronym</td>
<td>Full Form</td>
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<tr>
<td>NGO</td>
<td>Non-government organization</td>
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<tr>
<td>NGO MCR</td>
<td>Non-government organization monthly compilation report</td>
</tr>
<tr>
<td>NSS</td>
<td>National sero-surveillance Survey</td>
</tr>
<tr>
<td>ODAS</td>
<td>Outreach daily activity sheet</td>
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<tr>
<td>OS</td>
<td>Outreach supervisor</td>
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<tr>
<td>OW</td>
<td>Outreach worker</td>
</tr>
<tr>
<td>OWCS</td>
<td>Outreach weekly compilation sheet</td>
</tr>
<tr>
<td>PCR</td>
<td>Project completion report</td>
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<tr>
<td>PE</td>
<td>Peer educator</td>
</tr>
<tr>
<td>PFT</td>
<td>Program facilitation team</td>
</tr>
<tr>
<td>PM&amp;E</td>
<td>Participatory monitoring and evaluation</td>
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<tr>
<td>PLA</td>
<td>Participatory learning for action</td>
</tr>
<tr>
<td>PNGO</td>
<td>Partner non-government organization</td>
</tr>
<tr>
<td>PNS</td>
<td>Procurement of NGO services</td>
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<tr>
<td>PRA</td>
<td>Participatory rural appraisal</td>
</tr>
<tr>
<td>PSUR</td>
<td>Project start up report</td>
</tr>
<tr>
<td>QPR</td>
<td>Quarterly progress report</td>
</tr>
<tr>
<td>QR</td>
<td>Quarterly report</td>
</tr>
<tr>
<td>SBSW</td>
<td>Street-based sex worker</td>
</tr>
<tr>
<td>SHG</td>
<td>Self-help group</td>
</tr>
<tr>
<td>SG</td>
<td>Social group</td>
</tr>
<tr>
<td>STI</td>
<td>Sexually transmitted infections</td>
</tr>
<tr>
<td>SS</td>
<td>Supportive supervision</td>
</tr>
<tr>
<td>TG</td>
<td>Transgender or Hijra</td>
</tr>
<tr>
<td>TM&amp;OE</td>
<td>Training, meetings and other events form</td>
</tr>
<tr>
<td>UIC</td>
<td>Unique identification code</td>
</tr>
<tr>
<td>UNAIDS</td>
<td>United Nations Joint Programme on HIV/AIDS</td>
</tr>
<tr>
<td>UNICEF</td>
<td>United Nations Children’s Fund</td>
</tr>
<tr>
<td>VCT</td>
<td>Voluntary counseling and testing</td>
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1. Introduction

1.1 Background to HATI

In 2004, the National AIDS/STD Programme (NASP), under the Ministry of Health and Family Welfare (MoHFW) and co-financed by the World Bank and DfID, started the HIV/AIDS Prevention Project (HAPP) to control and prevent the spread of HIV among high-risk groups. MoHFW requested that UNICEF manage HAPP, in order to fast track the implementation of the project through existing NGOs. Within HAPP, and under a Procurement of NGO Services (PNS) package, UNICEF contracted 45 NGOs through 14 consortia or lead agencies to implement six intervention packages, including: brothel-based sex workers (BBSW); hotel and residence-based sex workers (HRBSW); street-based sex workers (SBSW); clients of sex workers (ClSW); injecting drug users (IDU); and men who have sex with men and transgender (MSM&TG).

Through a series of amendments and extensions, UNICEF continued to manage HAPP until 31 December 2007. From 2004 to the end of 2007, within HAPP and under PNS, over a thousand staff members, outreach workers and peer educators provided information, services, and commodities to more than 155,000 individuals who were at high-risk of becoming infected with HIV.

In September, 2007 NASP requested UNICEF to continue to manage the HAPP-supported Targeted Interventions for 2008, while a management support agency under the Health, Nutrition, and Population Sector Program (HNPSP) becomes firmly established. UNICEF agreed, but by initiating the project as HIV and AIDS Targeted Interventions (HATI), which is now integrated into UNICEF’s ongoing country programme action plan (CPAP).

1.2 HATI Participatory Monitoring and Evaluation Initiative

A major function of the UNICEF-managed HAAP and HATI projects is to develop the capacities of NGOs to implement HIV and AIDS prevention programs, including the effective monitoring and evaluation (M&E) of program activities. To strengthen M&E efforts, UNICEF launched a participatory monitoring and evaluation initiative starting in August, 2007. The purposes of the initiative are two-fold:

1) Develop the capabilities of the UNICEF-supported NGOs to plan and implement participatory monitoring and evaluation

2) Develop a common monitoring and evaluation framework for HATI, with extensive input from the lead and implementing organizations, and which the NGOs can further adapt if they so choose.

To achieve these results, the initiative is being conducted over three phases:

1) A capacity assessment, in order to determine how the NGOs are currently monitoring their activities, identify the challenges they face, and devise ways to strengthen their efforts.
2) A series of participatory M&E planning workshops held with a range of stakeholders from all the NGOs, from which a common M&E framework would be developed.

3) Written guidelines, to assist the NGOs to implement and adapt the participatory M&E framework.

1.3 HATI Participatory Monitoring and Evaluation Guidelines

For Whom are these Guidelines Intended?

This set of guidelines is intended to be used by UNICEF, lead agency and implementing partner organization staff, particularly by those individuals responsible for monitoring and evaluation including team leaders, M&E officers and their equivalent, project and field coordinators, DIC managers, and outreach supervisors.

What Do these Guidelines Do?

This document presents an overall M&E framework and a set of general guidelines for all level of the HATI project. It is a flexible guide to the steps staff can use to document and report on project activities, show progress toward program goals and objectives, and identify ways to strengthen the program. As a guide, this document explains the:

- Key concepts in participatory monitoring and evaluation, including definitions and the steps involved
- Overall goals and expected results of HATI and its different intervention packages
- Monitoring framework, including the major program activities to be monitored with indicators, and appropriate data sources and methods
- Evaluation framework, including the expected results with related evaluation questions and indicators, and appropriate data sources and methods
- Plan for data compilation and reporting
- Suggested ways for disseminating and using the results
- Recommendations for further developing the HATI M&E system

From Where Do the M&E Framework and Guidelines Come?

The HATI M&E system has evolved over the various phases of HAP, starting with systematic quarterly monitoring in the first phase, followed by the identification of significant indicators and the use of an extensive monitoring checklist. Under HAP, these findings were compiled and analyzed, and feedback provided to the NGOs so they could take corrective measures. Overtime, however, the program has developed a strong need for an M&E system that tracks program efficiency and effectiveness more comprehensively and is developed and implemented with greater stakeholder involvement and ownership.
Building on HAP’s previous M&E efforts, the framework and guidelines presented in this document have been developed with the extensive input from HATI-supported NGOs, from several different sources, including:

1. **The M&E NGO Capacity Assessment**, conducted in September, 2007 through interviews, site visits, and an email survey to all HAPP-supported NGOs, through which NGOs said they need the following:
   - A well-thought out and meaningful participatory M&E framework, which includes fewer and clearly defined indicators, common definitions of reach and coverage, a set of standardized data collection forms, and a simplified reporting system
   - A set of written M&E guidelines
   - Additional training in M&E for staff at all levels
   - A management information system, with the necessary computer hardware, software, MIS training and IT support

2. **The five Participatory M&E workshops**, conducted with a total of 134 representatives of all 38 NGOs and at all levels of staff, in which participants developed program logic models, identified the purposes of M&E in the new program, formulated monitoring and evaluation questions and indicators, and identified appropriate data sources and collection methods. (For a description of these workshops, see Appendix 1.)

3. **Logical Frameworks**, which members of the lead agencies developed during a set of project proposal workshops conducted in December, 2007.

It is important to note that these guidelines are in keeping with, and designed to fit within, the Bangladesh National AIDS Monitoring and Evaluation Framework and Operational Plan (National AIDS/STD Programme, 2007) and within the “Three Ones” principles of UNAIDS.

In addition, several key publications were also used to help shape and inform these guidelines, including:


2. Introduction to Monitoring and Evaluation

2.1 Definitions of Monitoring and Evaluation

Although there are numerous complex definitions of monitoring and evaluation, it is important to understand their basic meanings and how they are different from each other.

**What is Monitoring?**

Monitoring is a systematic process of collecting and analyzing information to track program implementation and the *efficiency* of a program in achieving its goals.

In this case, efficiency refers to how well or productively resources (money, time, personnel, etc) were used to create results.

-Adapted from McCoy, et al (2005)

**What is Evaluation?**

Evaluation is a systematic process of collecting and analyzing information to assess program results and the *effectiveness* of a program in achieving its goals.

In this case, effectiveness refers to the extent to which results or expected outcomes have been achieved.

-Adapted from McCoy, et al (2005)

In other words, monitoring looks at what is being done or activities are being implemented, and evaluation examines what has been achieved or what effect the activities have had.

Another way to see the differences between monitoring and evaluation and how they compliment one another is to compare key aspects of the two:
What are the Major Differences between Monitoring and Evaluation?

<table>
<thead>
<tr>
<th>Aspect</th>
<th>Monitoring</th>
<th>Evaluation</th>
</tr>
</thead>
<tbody>
<tr>
<td>Frequency</td>
<td>On-going, regular</td>
<td>Episodic, time-to-time</td>
</tr>
<tr>
<td>Main Action</td>
<td>Keeping track, oversight</td>
<td>Assessment</td>
</tr>
<tr>
<td>Basic Purpose</td>
<td>Improve efficiency; adjust work plans</td>
<td>Improve effectiveness, impact, future programming</td>
</tr>
<tr>
<td>Focus</td>
<td>Inputs, outputs, process outcomes, work plans</td>
<td>Effectiveness, relevance, results or impact, cost-effectiveness</td>
</tr>
<tr>
<td>Information Sources</td>
<td>Routine reporting systems, field observation, progress reports, rapid assessment</td>
<td>Same, plus surveys, studies</td>
</tr>
<tr>
<td>Undertaken By</td>
<td>Program managers, community workers, community members (beneficiaries), supervisors, funders</td>
<td>Program managers, supervisors, funders, external evaluators, community members (beneficiaries)</td>
</tr>
<tr>
<td>Reporting to</td>
<td>Program managers, community workers, community members (beneficiaries), supervisors, funders</td>
<td>Program managers, supervisors, funders, policy-makers, community members (beneficiaries)</td>
</tr>
</tbody>
</table>

Adapted from: UNICEF (n.d.). A UNICEF Guide for Monitoring and Evaluation: Are We Making a Difference?

A Shift toward Results-based Management, Monitoring and Evaluation

Traditionally, program monitoring focused mostly on the implementation of projects by tracking mainly resources and services. But with increasing competition for resources and pressure to improve program effectiveness and accountability, there has been a shift to use more results-based management, monitoring and evaluation. Results-based management is a management approach by which a program ensures that its processes, products, and services contribute to the achievement of clearly stated results (McCoy, et al. 2005, p. 10). In HIV/AIDS prevention programs, this means ensuring that activities such as peer education and distributing condoms lead to actual results like an increase in consistent condom use.
What are Results-based Monitoring and Evaluation?

Results-based monitoring and evaluation combines the traditional approach of monitoring implementation with the assessment of results. This linking the implementation of activities to the achievement of desired results can provide critical feedback to on ways to improve both program performance and effectiveness.

Adapted from Independent Evaluation Group (2007)

2.2 Participatory Monitoring and Evaluation

Another relatively recent approach is monitoring and evaluation is **Participatory Monitoring and Evaluation** (PM&E).

What are Participatory Monitoring and Evaluation?

Participatory monitoring and evaluation are when program stakeholders, and particularly community members, beneficiaries and program staff, are involved in the different stages of M&E. This includes stakeholders deciding what will be monitored and evaluated, how the information will be collected, what the results mean, and in using the results.

Below shows some of the major ways in which PM&E differ from more conventional approaches.

What are the Differences between Conventional and Participatory M&E?

<table>
<thead>
<tr>
<th>Who</th>
<th>Conventional M&amp;E</th>
<th>Participatory M&amp;E</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>External experts</td>
<td>Stakeholders, including staff and community members</td>
</tr>
<tr>
<td>What</td>
<td>Predetermined questions and indicators</td>
<td>Questions and indicators identified by stakeholders</td>
</tr>
<tr>
<td>How</td>
<td>Complicated data collection methods determined and designed by outside evaluators</td>
<td>Simple methods, designed and sometimes used by stakeholders</td>
</tr>
<tr>
<td>Why</td>
<td>Accountability to funding agency</td>
<td>To empower stakeholders to take corrective measures</td>
</tr>
</tbody>
</table>

Adapted from Microfinance Development Center (2004)

Participatory approaches to the monitoring and evaluation of HIV/AIDS programs are highly recommended by such key organizations at UNAIDS, FHI, and PATH. But as can be seen above when comparing the two, there are numerous advantages and disadvantages to both conventional and participatory M&E.
What are the Advantages and Disadvantages of PM&E?

### Advantages:
- Can obtain better quality data
- Results are likely to be more relevant and vested in and, thus, actually used
- Can increase both program and M&E ownership by stakeholders
- Can develop the M&E capacities of stakeholders

### Disadvantages:
- Can be biased or even “hi-jacked” by participants’ own interests
- Requires considerable time and resources
- Takes participating staff away from on-going activities

However, when done properly, the advantages of PM&E often far outweigh the disadvantages. Participatory M&E does not mean that all stakeholders should be involved in all M&E efforts all of the time. To do so would probably lead to chaos! But who is involved and how they are involved should depend on the purposes of the program and its M&E, the context in which the program operates, the resources available, and the interests of program stakeholders. Depending on these factors, choosing whom to involve and how to involve them should be done in ways that maximize the advantages and minimize the disadvantages listed above.

### 2.3 Stages in Conducting Participatory Monitoring and Evaluation

Conventional M&E usually are conducted through a series of stages: plan the M&E efforts; collect information; analyze the information, and disseminate and use the results. Participatory M&E follow these same stages, but program stakeholders are involved in each stage in some meaningful way. As identified and agreed to in the HATI PM&E workshops, the following are the general stages to follow when conducting HATI M&E efforts:

1. Engage Stakeholders
2. Plan the evaluation
3. Collect information
4. Analyze Information
5. Disseminate and use the results.

Within most of the workshops, it was heatedly debated which stage should come first: engage the stakeholders or plan the evaluation? Arguments were made that efforts must first be planned in order to be able to engage stakeholders; others argued that first stakeholders should be involved in making the plan. Although the order clearly depends on the context of the program and the purpose of the M&E efforts, workshop participants agreed that ideally stakeholders would be involved in all stages in some way. As developed and agreed to in the workshops, the process is depicted as:
How is Participatory Monitoring and Evaluation Conducted?

A critical part of any kind of monitoring and evaluation efforts, and key to their success, is how well they are planned. Careful and thoughtful planning is essential in order to make monitoring and evaluation useful and meaningful. There are common steps to planning M&E, which were followed closely in the HATI PM&E workshops and in developing these guidelines. These steps are:

**What are the Steps for Planning Good Monitoring and Evaluation?**

1. Describe the program
2. Define the purpose of M&E
3. Identify what information we need to know, by forming monitoring and evaluation questions and indicators
4. Decide how we will get the information, namely the sources of information and data collection methods
5. Determine ways to compile, report, and use the results

The remainder of these guidelines follows the above steps by providing the:

1. Program description
2. Purposes of monitoring and evaluation in HATI
3. Monitoring and evaluation frameworks, including the major M&E questions, indicators, data sources and data collection methods
4. Methods for data compilation and reporting
5. Suggested ways for the dissemination and use of results
3. HATI Participatory Monitoring and Evaluation Framework

3.1. Program Description

In designing an M&E framework, the first step is to have a full description and clear understanding of the program. Without this understanding, it is not possible to determine what needs to be monitored and evaluated. Below describes the goals and expected results of HATI overall, and then the expected activities and outcomes of the specific interventions. And it is from these descriptions that the monitoring and evaluation frameworks are then developed.

HATI’s Result Matrix

Following the format of UNICEF’s country programme action plan, the overall goal and expected results of the HATI project are as follows:

| Goal: Reduce the spread of HIV and the impact of HIV and AIDS for high-risk groups, as well as the general population of Bangladesh, by undertaking targeted interventions among the high-risk groups. |
| CPAP Outcome: Reduce risk of HIV transmission among Most-at-Risk Populations (MARP) and keep HIV prevalence below the level of a concentrated epidemic among them, and maintain the current level of prevalence (7%, ref: NSS, VII R, 2007) among IDUs |
| Project Purpose: Increase the capacity of NGOs to respond to the HIV epidemic |
| Output 1: Increased condom use among MARP |
| Output 2: Increased care seeking behaviors for STIs among MARP |
| Output 3: Decreased needle and syringe sharing among drug users |

For the more detailed HATI logical framework, see Appendix 2.

The most commonly suggested M&E model for assessing HIV/AIDS prevention programs is the “input-activities-output-outcome-impact” framework (Rehle, et al 2001, UNAIDS 2002, UNAIDS 2004, UNAIDS 2007). This model is suggested because effective program planning, monitoring and evaluation are based on a clear, logical pathway of results, in which results at one level are expected to lead to results at the next level, leading to the achievement of the overall goal.

The major levels, for both program planning and M&E, are defined as follows:
Program Planning, Monitoring and Evaluation Levels

<table>
<thead>
<tr>
<th>Levels</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Inputs</td>
<td>Inputs are the people, training, equipment and resources that we put into a project, in order to achieve outputs.</td>
</tr>
<tr>
<td>Outputs</td>
<td>Outputs are the activities or services we deliver, including HIV/AIDS prevention, care and support services, in order to achieve outcomes.</td>
</tr>
<tr>
<td></td>
<td>The processes associated with service delivery are very important and involve quality, unit costs, access and coverage.</td>
</tr>
<tr>
<td>Outcomes</td>
<td>Through the provision of good-quality, economical, accessible, and widespread services, key outcomes should occur. Outcomes are changes in behaviour or skills, especially safer HIV prevention practices and increased ability to cope with AIDS.</td>
</tr>
<tr>
<td>Impact</td>
<td>The above-mentioned outcomes are intended to lead to major measurable health impacts, particularly reduced STI/HIV transmission and reduced AIDS impact.</td>
</tr>
</tbody>
</table>


Clearly, good M&E requires assessing programs at these different levels. Thus, in order to describe the program in ways that best lend themselves to developing a meaningful M&E framework, in the participatory M&E design workshops diverse stakeholders developed simple logic models for each targeted intervention package. By using the simple logic model format, diverse participants were able to identify easily program inputs, activities, outputs and outcomes. After the M&E workshops, representatives of the lead agencies also developed more complex logical frameworks for each intervention package, as well as consortium-level project proposals for the new HATI project. Appendix 3 presents a synthesized logic model for all four intervention packages, incorporating and harmonizing content from the original logic models, the logical frameworks, and the recent project proposals.

This overall logic model serves as the basis for the monitoring and evaluation frameworks presented below.

3.2. Purposes of Monitoring and Evaluation in HATI

After describing the program and its expected activities, outputs and outcomes, the next step in developing an M&E framework is to clearly define the purposes of, or the reasons for, doing monitoring and evaluation. The most practical way to think of purposes of M&E is to think of the actual ways we want to use the results, or what we want to use the results for.

Although the order of purposes varied in the different PM&E workshops, all participants agreed that M&E in the HATI project should be used for the following purposes:
1. To be accountable to:
   a. Program participants
   b. Donors
   c. Community members
   d. Government

2. To improve program design, (re)planning and implementation, with a particular focus on improving the quality of services.

3. To obtain additional resources from current and/or other donor agencies

4. To advocate for high-risk groups and HIV issues, including the reduction of stigma and discrimination

Several organizations added that the overall purpose of M&E in HATI is to help the project achieve its objectives and contribute to the national effort in fighting HIV AND AIDS.

As mentioned earlier, the common M&E framework for HIV AND AIDS prevention programs is the “input-activities-output-outcomes-impact” model. However, as seen below, because of limited resources, HIV AND AIDS prevention programs are not expected to assess all levels of their programs. This is shown clearly in what is commonly referred to as the “Monitoring and Evaluation Pipeline.”

![Monitoring & Evaluation Pipeline](image_url)
As shown above, the higher up the “pipeline” or results chain we go, the fewer organizations and projects are involved in monitoring and evaluation. Thus, according to UNAIDS (2002), all implementing partners should collect input and output data. Many implementing partners also should collect some processing or activities data. However, far fewer implementing partners will assess outcomes and very few are required to assess impact. As FHI points out in its series of M&E training modules, “Local organizations in direct contact with target groups should evaluate the program’s implementation, rather than its outcome or impact.” (Family Health International, 2004, Appendix, p. 4.) However, an intermediary organization such as UNICEF has an important role to play in facilitating the evaluation of outcomes and fulfilling its role as a result-based managed organization.

3.3. Monitoring Framework

Monitoring frameworks typically specify what information is needed to fully monitor the program and how that information should be collected and used. More specifically, common components of a monitoring framework clearly state:

- The information needed, in the form of monitoring questions and indicators
- Where the information should come from and how it should be collected, in the form of data sources and collection methods
- Who will collect the information and when
- Ways the information will be compiled and reported
- Ways the information can be used to improve the program

Each of these components is explained below, and how it applies specifically to the HATI program.

3.3.1 Major Monitoring Questions and Indicators

After describing the program and identifying the reasons for doing M&E, the next step in developing an M&E plan is identifying clear information needs. This is typically done by identifying what are called “M&E questions.” M&E questions are information needs stated as questions, in order to provide focus and clarity. By stating information needs as clear and precise questions, you know exactly what kind of answers you need to complete your M&E efforts. But it is important to identify and include only what the program “needs to know” and not what is “nice to know.” In other words, it is far better to answer a few important questions well than answer numerous not-so-important questions poorly.

Indicators are just what they sound to be: items that indicate progress in achieving something. They are like mile posts on the roadside -- signs that inform you of how far you’ve come, where you are now, and how much further you have to go to reach your destination. In this sense, indicators are answers to the M&E questions.

Typically, there are three major aspects of HIV AND AIDS prevention programs that are monitored:
1. The implementation of program activities
2. The extent to which expected outputs, such as program coverage, have been achieved
3. The quality of program services and activities

Following this model, in HATI our major monitoring questions are as follows:

**1. What and how many activities have been implemented?**

Based on the program logic model presented in Appendix 3 and on what participants in the PM&E workshops identified, Appendix 4A lists in detail the specific program activities to be monitored and reported. Appendix 4A also lists the indicators to use to measure each activity, the sources and methods or forms to use to collect the data, when the data should be collected, and who is responsible for collecting it.

The second major set of monitoring questions asks:

**2. Have the expected targets and outputs been achieved? If not, why not?**

As can be seen in the logic model presented in Appendix 3, HATI expected targets and outputs include percentages of target groups being “comprehensively reached”, or receiving a particular mix of services within a certain time period. (For the definition of “comprehensively reached” for each target group, see the Glossary.) Also included are additional targets for the different target groups receiving STI services, detoxification and rehabilitation services, and VCT information. As the second monitoring matrix, Appendix 4B lists the specific target and output-related questions, along with the appropriate indicators, data sources and collection methods, when the data should be collected, and by whom.

It is important to point out that in order to answer the target and output-related questions, actual individuals need to be counted and not just the number of events. This will require assigning unique identification codes (UIC) to all program participants and carefully tracking which individuals receive which services. And determining the number of program participants “comprehensively reached” will require complex calculations of individuals receiving a specific formula of multiple services. Furthermore, for the NGOs working with the IDU and Clients target groups, it also requires the identification of sub-groups: those most-at-risk and those not most-at-risk. Because these can be challenging tasks, it is highly recommended that UNICEF provide technical assistance so NGOs can complete these complex calculations in ways that are consistent and feasible.

The third set of monitoring questions asks about the quality of program services and activities, specifically:
3. Are the quality-related standards being met in the following programmatic areas:

- DIC Management – General
- DIC Management – Set-up and Supplies
- DIC Services:
  - STI Case Management
  - Abscess Management (I/DU NGOs only)
  - Counseling
  - VCT Referral
  - Other Services: Health Education Sessions, Recreation, Games
- Universal Precautions
- Outreach Work
- Needle Exchange (I/DU NGOs only)
- Detoxification and Rehabilitation (I/DU NGOs only)
- Referral Linkages and Coordination
- Local-level Advocacy
- Involvement of Self-Help Groups

During the third phase of HAPP, UNICEF staff members and a monitoring and evaluation consultant further refined a set of draft standards for the expected quality of program services and activities. These draft standards are listed in Appendix 5. With a renewed focus on quality of services in this new phase of the program, it is strongly recommended that UNICEF review, finalize, and clearly communicate the quality standards with the NGOs. After finalizing the standards, it is also recommended that UNICEF develop a full plan to monitor these standards, including identifying the appropriate indicators and methods of data collection. To develop the data collection instruments, UNICEF should review and adapt as appropriate the Joint Monitoring Visit checklist and interview guides developed during the third phase of HAPP.

3.3.2. Data Sources, Collection Methods, and Tools or Formats

In order to answer M&E questions, there are particular sources of information from where to get the needed information. Typical sources of information include:

- Documents, such as project proposals, plans and reports, monitoring forms, and results from national surveys
- People, such as program staff, program participants and community members
- Physical structures, such as Drop In Centers or shooting galleries
- Events, such as a counseling sessions and cultural celebrations

Depending on the information you need (i.e., your M&E questions and indicators) and the best source(s) for that information, you then need to select an appropriate method to get that information. Below lists the purposes, advantages, and challenges of the major data collection methods.
## Overview of Major Data Collection Methods

<table>
<thead>
<tr>
<th>Method</th>
<th>Overall Purpose</th>
<th>Advantages</th>
<th>Challenges</th>
</tr>
</thead>
</table>
| Questionnaires, surveys, checklists | when need to quickly and/or easily get lots of information from people in a non threatening way | -can complete anonymously  
- inexpensive to administer  
- easy to compare and analyze  
- administer to many people  
- can get lots of data  
- many sample questionnaires already exist | -might not get careful or detailed feedback  
- wording can bias client's responses  
- are impersonal  
- in surveys, may need sampling expert  
- doesn’t get full story |
| Interviews              | when want to fully understand someone's impressions or experiences, or learn more about their answers to questionnaires | -get full range and depth of information  
- develops relationship with client  
- can be flexible with client | - can take much time  
- can be hard to analyze and compare  
- can be costly  
- interviewer can bias client's responses |
| Documentation review    | when want impression of how program operates without interrupting the program; is from review of applications, finances, memos, minutes, etc. | -get comprehensive and historical information  
- doesn’t interrupt program or client’s routine in program  
- information already exists  
- few biases about information | -often takes much time  
- info may be incomplete  
- need to be quite clear about what looking for  
- not flexible means to get data; data restricted to what already exists |
| Observation             | to gather accurate information about how a program actually operates, particularly about processes | -view operations of a program as they are actually occurring  
- can adapt to events as they occur | - can be difficult to interpret seen behaviors  
- can be complex to categorize observations  
- can influence behaviors of program participants  
- can be expensive |
| Focus groups discussions | explore a topic in depth through group discussion, e.g., about reactions to an experience or suggestion, understanding common complaints, etc.; useful in evaluation and marketing | -quickly and reliably get common impressions  
- can be efficient way to get much range and depth of information in short time  
- can convey key information about programs | - can be hard to analyze responses  
- need good facilitator for safety and closure  
- difficult to schedule 6-8 people together |


The term “data collection *method*” refers to a systematic design or approach for gathering information. In contrast, a “data collection *tool*” refers to the instrument or form used to record the information that will be gathered through a particular method. There are certain monitoring tools that are common to HIV and AIDS programs.
Common Monitoring Tools for HIV and AIDS Programs

<table>
<thead>
<tr>
<th>Tool Type</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Sign-in or registration logs</td>
<td>Every client who enters the facility is required to “sign in.” If the clinic provides services that may be associated with stigma (e.g., VCT or STI services), measures should be taken to maintain the confidentiality of the information on the log.</td>
</tr>
<tr>
<td>Activity logs</td>
<td>Used to track program activities daily. Examples of such forms include outreach (e.g., BCC sessions, condom and needle distribution, etc.), counseling, or other activity logs.</td>
</tr>
<tr>
<td>Registration forms</td>
<td>Also known as enrollment forms or intake forms and generally used to collect personal (name or ID number) and demographic (e.g., age or sex) information.</td>
</tr>
<tr>
<td>Checklists</td>
<td>Used as an aid to observers who are monitoring events, procedures, or services.</td>
</tr>
<tr>
<td>Program activity forms</td>
<td>Vary widely, but often designed specifically to collect basic information about program activities.</td>
</tr>
<tr>
<td>Tally or compilation sheets</td>
<td>Used to compile raw data from logs on a periodic basis.</td>
</tr>
<tr>
<td>Monthly summary forms</td>
<td>Used to compile or summarize raw data from other forms on a monthly basis.</td>
</tr>
<tr>
<td>Patient records/ charts</td>
<td>Records the health information of patients and the health services they receive. These records can provide a wealth of information about the content and quality of services.</td>
</tr>
<tr>
<td>Open-ended interview or topic guides</td>
<td>Often used in qualitative (words) data collection methods, such as interviews or focus group discussions, to seek and record descriptive and other information.</td>
</tr>
<tr>
<td>Semi-structured questionnaires</td>
<td>Often used in quantitative (numeric) methods as a way to gather information by asking standardized questions in a structured format.</td>
</tr>
</tbody>
</table>


A key lesson learned regarding effective M&E systems is the need for standardized data collection tools or forms. As identified by UNAIDS, “M&E systems must include a standardized core. If each implementing partner uses different systems or tools, the data cannot be analysed or summarized effectively” (UNAIDS, 2002, p. 4). Thus, and in order to improve the quality of monitoring data and to make monitoring easier for both the lead agencies and implementing partners, it is strongly recommended that UNICEF develop a standardized set of data collection forms. If they wish, HATI NGOs could add to these forms, but the standardized core would remain the same for all.

In the PM&E workshops, workshop participants identified the project needing the following set of data collection forms in order to collect information on the implementation of activities and the achievement of expected outputs:
Suggested HATI Data Collection Tools for Monitoring Implementation and Outputs

<table>
<thead>
<tr>
<th>Data Collection Form</th>
<th>Person Responsible</th>
</tr>
</thead>
<tbody>
<tr>
<td>Outreach Daily Activity Sheet (ODAS)</td>
<td>Peer Educator/Outreach Worker</td>
</tr>
<tr>
<td>Outreach Weekly Compilation Sheet (OWCS)</td>
<td>Outreach Supervisor/BCC Organizer</td>
</tr>
<tr>
<td>Drop In Centre Daily Register (DIC DR)</td>
<td>DIC Manager &amp; Counselor</td>
</tr>
<tr>
<td>Health Card</td>
<td>Doctor/Paramedic</td>
</tr>
<tr>
<td>Clinical Daily Register (ClDR)</td>
<td>Doctor/Paramedic</td>
</tr>
<tr>
<td>Counseling Daily Register (CoDR)</td>
<td>Counselor</td>
</tr>
<tr>
<td>Training, Meetings, and Other Events Form (TM&amp;OE)</td>
<td>DIC Manager</td>
</tr>
<tr>
<td>DIC Monthly Compilation Report (DIC MCR)</td>
<td>DIC Manager</td>
</tr>
</tbody>
</table>

To see the suggested content of these various forms, please refer to Appendix 4A.

It is important to note that during and after the PM&E workshop for the I/DU consortia, CARE and Padakhep staff met to begin redesigning and standardizing their data collection forms. In addition and under the BSWS consortium during the third phase of HAPP, ICDDR,B researched and piloted the design a Peer Educator Daily Activity Sheet and a Drop In Center Daily Activity Form. These two forms were reviewed during one of the PM&E workshops, and participants, including several peer educators and outreach supervisors, thought the forms were very good and that with some slight adjustments they could be used by most of the NGOs. Thus, it is recommended that UNICEF adapt and pilot these forms for all NGOs to use. In addition, Appendices 4A and 4B should be consulted closely in the development of new and standardized data collection forms, to ensure that all the needed indicators are included.

In addition to the above forms, some consortia depending on their staffing patterns, may want to use additional forms that would feed into the main registers. Such examples include abscess management forms or referral forms. It is, of course, to the discretion of the consortia to decide their own additional, non-required data collection forms; however, it is recommended that consortia minimize and streamline the forms as much as possible. In addition and for local-level analysis, lead agencies may wish for DICs to use some sort of user-friendly monthly track or summary sheet.

To collect the quality-related information on program services and activities, a Quality Monitoring Checklist will be used by DIC Managers, M&E Officers, Team Leaders, and UNICEF and NASP HATI staff. Based on the quality standards drafted during the third phase of HAPP, the
HAPP team developed and piloted a Joint Monitoring Visit checklist. It is recommended that this checklist be reviewed and revised, based on the finalization of the new program standards, and used at all levels of the program.

A major purpose of these guidelines is to assist the HATI lead agencies and implementing partners collect and report the minimum required M&E information. However, organizations and individuals within the program may have additional information needs, beyond those of UNICEF and NASP. For example, some DIC managers may want to know community members’ perceptions of and recommendations for the program. For additional learning needs, NGOs may want to use some of the major data collection methods listed on page 15. And depending on their information needs, NGOs also are encouraged to use alternative and participatory methods. As discussed in the PM&E workshops, there are several participatory rural appraisal (PRA) or participatory learning for action (PLA) methods that can be adapted for M&E purposes. These include:

- Discussions, informal interviews
- Transects or mapping
- Seasonal calendars
- Murals
- Diaries
- Photos, video, drawings
- Role plays, drama

More information on these methods can be found in the publication, “Guidelines and Tools for Community-based Monitoring,” available on the Internet at http://www.frameweb.org/ev02.php?ID=11225_201&ID2=DO_TOPIC.

3.3.3. Data Compilation and Reporting

Data compilation is the adding up or summarizing of collected information, often done on a regular and periodic basis. Until the standardized HATI data collection forms are designed, it is not possible to describe in detail the methods of compiling the data. However, it is clear as this point how the data are to “flow up” and be reported to UNICEF and NASP.

What is Program Reporting?

Reporting is the systematic and timely provision of useful information at periodic intervals. Reporting provides regular feedback that helps organizations inform themselves and other stakeholders (community members, donors, partners) on the progress, problems, successes, and lessons of program implementation.

- Adapted from McCoy, et al.(2005)
In HATI, program monitoring information will be compiled and reported to UNICEF at different points in time and using different formats. These reports include:

<table>
<thead>
<tr>
<th>Data Reporting Form</th>
<th>Person Responsible</th>
</tr>
</thead>
<tbody>
<tr>
<td>NGO Monthly Compilation Report (NGO MCR)</td>
<td>Program Coordinator</td>
</tr>
<tr>
<td>Consortium Monthly Compilation Report (Con MCR)</td>
<td>Technical Coordinator-M&amp;E and Team Leader¹</td>
</tr>
<tr>
<td>Project Start-Up Report (PSUR)</td>
<td>Technical Coordinator-M&amp;E and Team Leader</td>
</tr>
<tr>
<td>Quarterly Report (QR)</td>
<td>Technical Coordinator-M&amp;E and Team Leader</td>
</tr>
<tr>
<td>Mid-Project Report (MPP)</td>
<td>Technical Coordinator-M&amp;E and Team Leader</td>
</tr>
<tr>
<td>Project Completion Report (PCR)</td>
<td>Technical Coordinator-M&amp;E and Team Leader</td>
</tr>
</tbody>
</table>

It is strongly recommended that the format for the UNICEF quarterly report and the monthly report to NASP be combined and made into one format, to lessen the reporting burden of the lead agencies.

The flow of information, both to and from the peer educators, to the DIC managers, to the NGO, to the lead agency, and to UNICEF and NASP, is depicted below using the standard HATI organograms. It important to note that these recommended data flows are flexible and need to be adapted to fit within consortia’s actual staffing patterns and resources. Also important to note is the critical communication function of the lead agencies. To ensure timely feedback to the NGOs and DICs, and in case the team leader is not available, it is advised that all monitoring-related communications also be sent to the Program Coordinator.

¹ Although not responsible for putting together these various reports, team leaders are responsible to review the reports and ensure their accuracy and timeliness.
DIC-LEVEL PROGRAM MONITORING DATA FLOW

DIC Manager

DIC DR

DIC MCR

TM&OE

Doctor
(Part time or full time, if required)

OMCS

CL DR

BCC Organiser/Outreach Supervisor

OWCS

CO DR

Outreach Worker
(if applicable)

ODAS

Counselor

Peer Educator (Part time)

Peer Volunteer
(if applicable)

Responsible for    Feedback to/from

Goes to

ODAS – Outreach Daily Activity Sheet
OWCS – Outreach Weekly Compilation Sheet
OMCS – Outreach Monthly Compilation Sheet
CL DR – Clinic Daily Register
CO DR – Counseling Daily Register
TM&OE – Training, Meetings, & Other Events
DIC DR – Drop In Center Daily Register
DIC MCR – DIC Monthly Compilation Report
LEAD AGENCY-LEVEL PROGRAM MONITORING DATA FLOW

DIC MCR – DIC Monthly Compilation Report
NGO MCR – NGO Monthly Compilation Report
MQ Tools – Monitoring Quality Tools
CMCR – Consortium Monthly Compilation Report
MR- Monthly Report
QR – Quarterly Report
QPR – Quarterly Progress Report
3.3.4 Dissemination and Use of Results

There is little point in collecting data unless they are used to improve programs and ultimately to benefit the people from whom they were collected. There are several important ways to use M&E results, including to (adapted from FHI, 2004):

- Communicate program’s successes and challenges to community members, using such methods as town hall meetings, newsletters, and media
- Provide feedback to program staff through regular staff meetings, including field staff
- Improve program performance, by hiring more staff, training staff, buying more supplies, etc.
- Make decisions about the future direction of the program, such as scaling up services or expanding coverage
- Report to government, donors and other policy makers
- Fundraising, such as presenting M&E results in project proposals to current and/or potential donors

The effective use of M&E results first requires identifying your audience and their information needs. The second step is to determine the best way to present the needed information to the specific audiences. For each audience, ask yourself what key message does the program need to communicate and what is the best tool for communicating that message. Different ways to communicate M&E results include:

- Oral presentations
- Discussion sessions
- Informal contacts
- Written progress reports
- Press and media releases
- Brochures and pamphlets
- Visual displays
- Email, Web sites
- Drama, music, dance

As noted earlier, in the participatory M&E design workshops, HATI program stakeholders identified the purposes of M&E in terms of how the results should be used. These purposes include:

1. Accountability to program participants, donors, and government
2. To improve program planning and implementation
3. To obtain needed resources
4. To advocate for most-at-risk populations and HIV issues
After the design workshops, a small group of HATI M&E officers met to discuss possible ways in which M&E results could be used to fulfill these purposes. How organizations use M&E results depends on staffing patterns and management structures. Nevertheless, HATI organizations are encouraged to consider and adapt the following suggestions. In addition, many of the suggested mechanisms listed below already exist; however, there needs to better use of M&E results within these mechanisms. For example, in regularly scheduled staff meetings there should be more discussion and critical reflection (see box below) on the meaning or implications of M&E results on current programming. Particular focus should be on changes in the results over time, such as why there might have been a sharp decline in the number of condoms or needles distributed and what should be done about it. Furthermore, M&E-related officers should take a more proactive role in ensuring that monitoring and evaluation results are useful, usable and actually used.

### Reflecting Critically to Improve Action
(Adapted from International Fund for Agricultural Development, 2002)

Data should not be collected only for reporting purposes and because someone else requires it, but they should be reflected on critically in order to actually learn from them. Critical reflection in a project means interpreting experiences and data to create new insights and agreement on actions. Making analysis “critical” means moving beyond just collecting, processing and reporting data but also asking such basic questions as:

- What?  
- So what?  
- Now what?

More specifically, program reflection is discussing regularly with program stakeholders a series of critical questions such as:

- What is happening?
- Is it happening as we had planned (i.e., are targets being met?) Why or why not?
- What are the implications for the program and for my/our work?
- What do I/we need to do next?

Critical reflection and learning within a program needs to be encouraged, nurtured, and systematized. Moments for reflection need to be planned for and can occur in several ways:

- Individual reflection, by asking for views and feedback, listening, observing, and reviewing your performance
- Making management-related meetings more reflective
- Making M&E events, such as site visits and feedback meetings or memos, more reflective
- Capturing lessons learned with program stakeholders
### Possible Ways to Disseminate and Use HATI M&E Results

<table>
<thead>
<tr>
<th>Purpose</th>
<th>Audience</th>
<th>Type of M&amp;E Results</th>
<th>Communication Method</th>
<th>Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Accountability</td>
<td>Program Participants</td>
<td>• Implementation of program activities</td>
<td>• Written summary report – brief, user-friendly, in Bangla</td>
<td>Need to make methods interesting and understandable to specific target populations</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Quality of services and activities</td>
<td>• Oral discussions</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>• Visual displays</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Written summary report – brief, user-friendly, in Bangla</td>
<td></td>
<td></td>
</tr>
<tr>
<td>2. Improve Program Planning and</td>
<td>Donors, Management Support Agency (MSA),</td>
<td>• Implementation of program activities</td>
<td>• Monthly reports</td>
<td>UNICEF, NASP &amp; donors need to agree on key indicators and design a common reporting format for HATI lead agencies</td>
</tr>
<tr>
<td>Implementation</td>
<td>Government</td>
<td>• Achievement of program targets and expected outputs</td>
<td>• Quarterly reports</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Quality of services and activities</td>
<td>• Coordination meetings</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>• Dissemination seminars</td>
<td></td>
</tr>
<tr>
<td>2. Improve Program Planning and</td>
<td>DIC-level staff</td>
<td>• Implementation of program activities</td>
<td>• Individual reflection through written diaries</td>
<td>Particular methods need to be adapted to the actual structure of individual DICs</td>
</tr>
<tr>
<td>Implementation</td>
<td></td>
<td>• Achievement of program targets and expected outputs</td>
<td>• Weekly meetings between peer educators and outreach workers/supervisors to complete compilation sheet and problem solve</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Quality of services and activities</td>
<td>• Ad hoc discussions between project managers, DIC managers, counselors, paramedics, outreach supervisors, peer educators to acknowledge successes</td>
<td></td>
</tr>
<tr>
<td></td>
<td>NGO-level</td>
<td>Consortia</td>
<td></td>
<td></td>
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<tr>
<td>----------------------</td>
<td>---------------------------------------------------------------------------</td>
<td>---------------------------------------------------------------------------</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Implementation of program activities</td>
<td>• Coordination meetings with consortia team leaders, program coordinators, M&amp;E</td>
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<tr>
<td></td>
<td>• Achievement of program targets and expected outputs</td>
<td>• Aggregation of program activities</td>
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<td></td>
<td>• Quality of services and activities</td>
<td>• Comparison with program targets and outputs</td>
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<td></td>
<td>• NGO meetings with NGO project managers and lead agency team leader and M&amp;E officer to acknowledge successes, compare with targets &amp; between NGO DICs, challenges &amp; lessons learned, problem solve</td>
<td>• Coordination meetings with consortium team leaders, program coordinators, M&amp;E</td>
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<tr>
<td>3. Obtain necessary resources</td>
<td>Government</td>
<td>Levels of quality of services and activities</td>
<td>officers and NASP and UNICEF staff</td>
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<td></td>
<td>Current and potential donors</td>
<td>• Program achievements</td>
<td>• Dissemination workshops</td>
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<td></td>
<td></td>
<td>• Program challenges</td>
<td>• HATI Fair</td>
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<td>• Lessons learned</td>
<td>• Project proposals</td>
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<td></td>
<td></td>
<td>• Future plans and requirements</td>
<td>• Meetings</td>
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</table>

<table>
<thead>
<tr>
<th>4. Advocate for Most-at-Risk Populations and HIV issues</th>
<th>Local/District Level:</th>
<th>Sensitization to MARP and HIV situation &amp; issues</th>
<th>Community meetings</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Elected officials, government officers, mustaans, police, religious leaders, etc.</strong></td>
<td>• Program background &amp; general information</td>
<td>• Project Facilitation Team meetings</td>
<td>• Meetings</td>
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<tr>
<td><strong>Service providers</strong></td>
<td>• Program achievements</td>
<td>• National dissemination seminars, other seminars</td>
<td>• Meetings</td>
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<tr>
<td><strong>National Level:</strong></td>
<td>• Program challenges</td>
<td>• Orientation workshops</td>
<td>• Orientation workshops</td>
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<tr>
<td><strong>Policy makers</strong></td>
<td>• Ways to support the program</td>
<td>• Roundtable discussions</td>
<td>• Roundtable discussions</td>
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</table>

For each advocacy event, need to define clearly the purpose and audience.
3.4 Evaluation Framework

As mentioned earlier, evaluation is the assessment of program outcomes and/or impact. With HIV and AIDS programs, this usually means assessing the extent to which target populations have changed their behaviors, such as using condoms consistently, not sharing needles and syringes, and going for STI treatment. However, usually it is not recommended that HIV/AIDS implementing organizations conduct their own evaluations, because of the financial and technical skills often required, the need for standardization and large sample sizes, and potential bias. With this in mind, and based on recent discussions with NASP, NASP and the World Bank are planning to conduct an impact evaluation by mid-2008.

Building on the logic model presented in Appendix 3, a detailed evaluation matrix is presented in Appendix 6. In summary, suggested evaluation questions include:

- What is the percentage change among the target populations having correct knowledge of HIV prevention methods?
- What is the percentage change among the target populations using condoms consistently?
- What is the percentage change among the target populations using STI services?
- What is the percentage change among drug users using sterile needles and syringes?

To answer these critical outcome evaluation questions, it is highly recommended that UNICEF encourage and assist NASP to facilitate baseline and follow-up quantitative surveys, coupled with qualitative key informant interviews and focus group discussions. Without these surveys, it will not be possible to measure progress in achieving program outcomes and to practice meaningful results-based management.

4. Next Steps/Recommendations

In January, 2008 a HATI M&E Working Group, consisting of UNICEF staff members and lead agency team leaders, program coordinators, and M&E officers, met to review a draft of these guidelines. During this review session, members discussed and agreed on the recommendations presented below.

1. **Finalize targets and expected outputs:** While developing the logic model for these M&E guidelines, it was discovered that some lead agencies had changed several of the targets and expected outputs from the logical frameworks agreed to during the project proposal workshops. These changes have significant implications for the design and implementation of an M&E plan. Thus, it is critical that UNICEF and the lead agencies review, agree and finalize the targets and expected outputs for each intervention package. Then, and based on these final decisions, the logical frameworks, program logic model, and M&E framework need to be revised accordingly. **To be completed by the end of February, 2008.**

2. **Develop a standardized set of data collection formats:** In order to obtain good quality data, it is essential that UNICEF and NASP decide on core indicators and design common reporting formats for the lead agencies and implementing partners. It would be ideal if only one reporting format was required by both agencies, in order to ease the NGOs’ reporting burden.
After designing the common reporting format with NASP, it is critical that UNICEF develop, pilot, and finalize as quickly as possible a standardized or core set data collection formats. The needed data collection and reporting formats are listed in the body of these guidelines. To develop these formats, UNICEF should form a working group of the consortia M&E officers and possibly adapt and pre-test the formats already designed by CARE and Padakhep and by ICCDR,B under the BSWS consortium. In addition, Appendices 4A and 4B in these guidelines should be closely consulted in the development of new and standardized data collection forms, to ensure that all the agreed-upon indicators are included. **To be completed by the end of March, 2008**

3. **Further develop quality-related program standards and monitoring checklist:** As stated by both UNICEF staff and program participants in the PM&E workshops, a major focus of the HATI project in 2008 should be the improvement in the quality of program services and activities. Good progress was made in this regard during the third phase of HAPP, with the drafting of a set of quality-related “expectations” and the design and piloting a corresponding checklist to be used during the Joint Monitoring Visits by UNICEF and NASP. It is highly recommended that UNICEF further develop, with the input of NASP, UNAIDS, and HATI consortium members, these quality-related expectations into program standards. Then after the finalization of these minimum standards, UNICEF should revise and further pilot the existing quality monitoring checklist, including the scoring system that could provide baseline and follow-up scores for each DIC, and the related qualitative interview guides. **To be completed by the end of February, 2008**

4. **Encourage and assist NASP to conduct baseline and follow-up surveys:** In order to assess HATI’s movement toward achieving expected outcomes and results, it is essential that baseline and follow-up behavioral surveys be conducted. Without these surveys, it will be difficult to practice results-based management and to determine the overall effect of the project. In addition, UNICEF should encourage and assist NASP and the contracting agency to take a participatory approach in the impact evaluation, by involving the HATI M&E Working Group and other program stakeholders.

5. **Provide M&E training at all levels:** Upon the finalization of the new M&E framework and the design of the new data collection and reporting forms, provide the necessary M&E training at all levels of the program, including peer educators, outreach supervisors and DIC managers. In addition, these guidelines should be adapted and translated into Bangla.

6. **Develop a MIS:** Develop a simple and feasible management information system (MIS), with the needed computer hardware, software, training, and IT support. Such a MIS should allow staff at either the DIC or NGO level to enter, maintain, report, and use program monitoring data. **To be completed by the end of May, 2008**

7. **Refine the M&E framework and guidelines regularly, and continue to ensure the participation of program stakeholders:** The M&E framework and these guidelines should be regarded as a “living document,” and as such should be reviewed and revised on a regular basis to reflect changes in the program and any M&E-related lessons learned. In addition, stakeholder participation should be expanded in implementing and revising the framework.
Although not discussed with the M&E Working Group, but based on further discussions with several M&E officers, other areas in which HATI NGOs need immediate M&E assistance include:

- **Further clarification on the definitions of reach and coverage**
- **Instructions on how to conduct the target population mapping exercise. It is particularly important that UNICEF provide standardized instructions to the different lead agencies, so that the estimates can be aggregated and/or compared to one another.**
- **Standardized instructions on how to assign unique identification codes (UIC) to all program participants.**
- **Assistance in determining how to physically calculate the number of program participants, both MAR and non-MAR, who have been “comprehensively reached.”**
DEFINITIONS and GLOSSARY

Comprehensive Contact: The definition of “comprehensive contact” differs slightly for each intervention package.

Clients of Sex Workers:
The effectiveness of ‘reaching’ a Client depends upon two variables: the frequency of contact and the content of the contact. A ‘contact’ will not be effective:

- If a client (most-at-risk (MAR)) is contacted 4 or more times a month but:
  - At least 2 products of risk reduction (condoms and education) are not provided at each contact, OR
  - the condoms and lubricant are not provided adequately to the client
  - If at least 2 products are provided in each contact but the Client (MAR) is contacted less than 4 times a month
  - And if quarterly STI check up is not ensured

Thus it is the need-driven delivery of products in each contact to a Client that determines the comprehensiveness of a contact. Reach therefore will require a comprehensive contact and not just contacting a Client and delivering at least 2 products (condom and education) of risk reduction.

Female Sex Workers:
The effectiveness of ‘reaching’ a FSW depends upon two variables: the frequency of contact and the content of the contact. A ‘contact’ will not be effective:

- If a SW is contacted 4 or more times a month but:
  - At least 2 products of risk reduction (condoms & lubricant and education) are not provided at each contact, OR
  - the condoms & lubricant are not provided adequately to the FSW
  - If at least 2 products are provided in each contact but the FSW is contacted less than 4 times a month.
  - And if monthly STI check up is not ensured

Thus it is the need-driven delivery of products in each contact to a FSW that determines the comprehensiveness of a contact. Reach therefore will require a comprehensive contact and not just contacting a FSW and delivering at least 2 products (condom & lubricant and education) of risk reduction.

Injecting Drug Users:
The effectiveness of ‘reaching’ an IDU depends upon two variables: the frequency of contact and the content of the contact. A ‘contact’ will not be effective:

- If an IDU is contacted 4 or more times a month but:
  - At least 2 products of HR (needles/syringes and education) are not provided at each contact, OR

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2 The definitions for comprehensive contact, coverage, and reach are taken verbatim from the project proposal design workshops; however, after discussing them further with several NGOs it is evident that some need greater clarification. Thus, it is recommended that UNICEF further define these terms and help determine ways in which they actually can be calculated for the monthly and quarterly reports.
the HR products are not provided adequately to the IDU
  - If at least 2 products (needles/syringes and education) are provided in each contact but the IDU is contacted less than 4 times a month.

Thus it is the need-driven delivery of products of HR in each contact to an IDU that determines the comprehensiveness of a contact. Reach therefore will require a comprehensive contact and not just contacting an IDU and delivering at least 2 products (needles/syringes and education) of HR.

In addition, as pointed out by one of the I/DU consortium, it is important to recognize the fluidity of I/DU groups and those individuals who may switch back and forth between “most at risk” and “general I/DUs” and between those who are “injecting drug users” and “heroin smokers.”

**MSM and TG:**
The effectiveness of ‘reaching’ a MSM depends upon two variables: the frequency of contact and the content of the contact. A ‘contact’ will not be effective:

- If a MSM is contacted 4 or more times a month but:
  - At least 2 products of risk reduction (condoms, lubricant and relevant message) are not provided at each contact, OR
  - the condoms & lubricant are not provided adequately to the MSMs
  - If at least 2 products are provided in each contact but the MSM is contacted less than 4 times a month.

- And if monthly STI check up is not ensured

Thus it is the need-driven delivery of products in each contact to a MSM that determines the comprehensiveness of a contact. Reach therefore will require a comprehensive contact and not just contacting a MSM and delivering at least 2 products (Condom and education) of risk reduction.

**Comprehensive Coverage:** The conditions for “comprehensive coverage” are the following for the different intervention packages:

**Clients of Sex Workers:**
- The percentage of Clients being regularly reached (through comprehensive contact) out of the total number of Clients is the comprehensive coverage of ClSWs.
- Coverage Target: At least 80% of the listed clients (Regular: MAR) needs to be reached.

**Female Sex Workers:**
- The percentage of FSWs being regularly reached (through comprehensive contact) out of the total number SWs is the comprehensive coverage of FSWs.
- Coverage target: At least 80% of the listed FSWs need to be reached.
Injecting Drug Users:
- The percentage of IDUs being regularly reached (through comprehensive contact) out of the total number of Most-at-Risk IDUs is the comprehensive coverage of IDUs.
- International minimum standard of coverage: *At least 60% of IDUs in a city should be regularly reached with injecting equipment and appropriate education and information from NSEPs.*
- It is recommended that for Bangladesh the target should be set to more than 60% Comprehensive Coverage so that 60% or more coverage can be ensured in face of the barriers for IDUs in accessing services such as mobility, stigma, harassment etc.

MSM and TG:
- The percentage of MSM being regularly reached (through comprehensive contact) out of the total estimated number MSM in the program area is the comprehensive coverage of MSM.
- Coverage: At least 80% of the estimated MSM need to be comprehensive reached.

**Comprehensive Reach:** The conditions for “comprehensive reach” are the following for the different intervention packages:

**Clients of Sex Workers:**
Reach comprises of contacting an individual Client with at least 3 components (condom, BCC and STI) in following manner:
- Condom and Lubricant- Demonstration (or assurance that the client knows how to use a condom correctly) and distribution at least once a week for Regular: MAR clients and once a month for Regular: Others and Casual clients (or more if needed)
- BCC- At least one session per month
- STI- Clinical session/referral/STI Check Up, at least one per quarter

**Female Sex Workers:**
Reach comprises of contacting an individual sex worker with at least 3 components (condom, BCC and STI) in following manner:
- Condom and Lubricant- Demonstration (or assurance that FSW knows how to use a condom correctly) and distribution at least once a week
- BCC- At least one session per month
- STI- Clinical session or referral, at least one per month
- In addition to the above, a FSW needs to get a one on one BCC session at least once in a quarter.

**Injecting Drug Users:**
- Reach comprises of contacting an individual IDU and effectively delivering at least 2 products of HR of which syringes/needles and education are mandatory. As a minimum standard, to be confident of reducing risk, services should be delivered *at least 4* times a month to an IDU.
- Where a higher standard is in place, such as reaching IDUs every other day, this should not be reduced.
• How many products have to be delivered at each contact varies from IDU to IDU depending upon frequency of injecting and preferences pertaining to sexual activity.
• The HR service provider needs to ascertain the need for HR products that will be a sufficient supply until the next visit to ensure adequacy of reach.

MSM and TG:
Reach comprises of contacting an individual MSM with at least 3 components (condom, BCC and STI) in following manner:
• Condom and Lubricant- Demonstration and distribution at least once a week
• BCC- At least one session per month
• STI- Clinical session or referral, at least one per month
• In addition to the above, an MSM needs to get a one-on-one BCC session at least once in a quarter

Clients of Sex Workers: Men who have sex with sex workers. In HATI, there are several types of clients of sex workers, depending on their level of risk of HIV infection:

• Most-at-Risk (MAR) Clients: Clients who have sex with sex workers at least once a week
• Regular Clients: Clients who have sex with sex workers at least once a month
• Casual Clients: Clients who have sex with sex workers less than once a month

Data Collection Method: refers to a systematic design or approach for gathering information. Major data collection methods include document review, observation, surveys, interviews, and focus group discussions.

Data Collection Tool: refers to the instrument used to record the information that will be gathered through a particular data collection method. In HIV and AIDS prevention programs, common data collection tools include checklists, questionnaires, registration forms, program activity forms, monthly summary forms, and patient records or charts.

Data Sources: In order to answer M&E questions, there are particular sources of information from where to get the needed information. Typical sources of information include:

• Documents, such as project proposals, plans and reports, monitoring forms, and results from national surveys
• People, such as program staff, program participants and community members
• Physical structures, such as Drop In Centers and laboratories
• Events, such as a counseling sessions and cultural celebrations

Estimated target population: The number of individuals in the target group (i.e., IDUs, FSWs, etc.) estimated through surveys or identified through mapping to be present in the program area, who may or may not be enrolled in the program.

Evaluation: a systematic process of collecting and analyzing information to assess program results and the effectiveness of a program in achieving its goals. In this case, effectiveness refers to the extent to which results or expected outcomes have been achieved.
Female Sex Workers: Females who sold sex in the various locations. Within HATI, the different types of female sex workers are:

- **Brothel-based sex workers**: Those who were contacted by clients in a brothel setting, with the sex act usually taking place in brothels.
- **Hotel-based sex workers**: Those who were contacted by clients in a hotel setting, with the sex act usually taking place in hotels.
- **Residence-based sex workers**: Those who were contact by clients in a residential setting, with the sex act usually taking place in residences.
- **Street-based sex workers**: Those who were contact by clients on the street, with the sex act taking place in public or private venues.

Hijra or Transgender (TG): Those who feel themselves to be neither male nor female and belong to the Hijra gender and endorse its sub-culture.

Impact: The overall and long-term effects of an intervention. In HIV and AIDS programs, the ultimate impact usually is the change in HIV transmission.

Indicators: Items that indicate progress in achieving something. They are like mile posts on the roadside -- signs that inform you of how far you’ve come, where you are now, and how much further you have to go to reach your destination.

Injecting Drug User (IDU): Any drug user who injects at least once a year. A Most-at-Risk (MAR) IDU is a drug user who injects at least three time a month.

Inputs: The people, training, equipment and resources that are put into a project, in order to achieve outputs.

Listed Target Population: Individuals listed or enrolled in the program and provided an unique identification code, and who are reached (but not necessarily reached “comprehensively”) by the program.

Men who Have Sex with Men (MSM):

- **Male Sex Workers**: Males who were selling sex (for any kind of exchange) to other males.
- **Non Sex Workers**: Males who had male sex partners but did not sell sex.

Monitoring: a systematic process of collecting and analyzing information to track program implementation and the efficiency of a program in achieving its goals. In this case, efficiency refers to how well or productively resources (money, time, personnel, etc) were used to create results.

Monitoring and evaluation questions: M&E questions are information needs stated as questions, in order to provide focus and clarity.

Outcomes: Broad changes in development conditions, such as changes in behavior and skills, that are brought about through the provision of good-quality, economical, accessible, and widespread
In HIV and AIDS programs, desired outcomes usually are safer HIV prevention practices and increased ability to cope with AIDS.

**Outputs:** The activities or services an intervention delivers, including HIV/AIDS prevention, care and support services, in order to achieve outcomes. The processes associated with service delivery are important and involve quality, unit costs, access and coverage.

**Participatory monitoring and evaluation:** A form of M&E where program stakeholders, and particularly community members, beneficiaries and program staff, are involved in the different stages of M&E. This includes stakeholders deciding what will be monitored and evaluated, how the information will be collected, what the results mean, and in using the results.

**Reporting:** The systematic and timely provision of useful information at periodic intervals. Reporting provides regular feedback that helps organizations inform themselves and other stakeholders (community members, donors, partners) on the progress, problems, successes, and lessons of program implementation.

**Results-based monitoring and evaluation:** Combines the traditional approach of monitoring implementation with the assessment of results. This linking of assessing the implementation of activities to the achievement of desired results can provide critical feedback to staff and decision-makers on ways to improve both program performance and effectiveness.

**Transgender (TG) or Hijra:** Those who feel themselves to be neither male nor female, and belong to the Hijra gender and endorse its sub-culture.
6. References


Appendix 1

PARTICIPATORY MONITORING AND EVALUATION DESIGN WORKSHOP

The purposes of the workshop were to:

1) Develop the capacities of the UNICEF-supported HIV AND AIDS NGOs to design and implement participatory monitoring and evaluation.

2) Develop a common monitoring and evaluation framework for UNICEF-supported targeted interventions for 2008, which can be adapted and further developed by the implementing NGOs.

The objectives of the workshops were for participants to:

1) Develop a common understanding of participatory monitoring and evaluation
2) Identify the strengths, weaknesses, and desired changes of their current M&E efforts
3) Develop program logic models by identifying major program inputs, activities, outputs and outcomes
4) Formulate meaningful M&E questions with appropriate indicators, including definitions for program reach and coverage
5) Select appropriate sources of information and data collection methods
6) Discuss the revision of data collection instruments and tools
7) Make recommendations for future program M&E efforts, including guidelines

The design of the workshop was based on adult learning theory, with a combination of lectures, discussions, practical exercises, role-plays and extensive small group work.

The agenda of the workshop was:

**DAY 1**
8:30 – 9:30 Workshop Opening, Introductions, and Overview
9:30 – 10:30 Introduction to Participatory Monitoring and Evaluation (PM&E)
10:30 – 11:00 TEA BREAK
11:00 – 11:30 Introduction to PME, continued
11:30 – 1:00 Assess Current M&E Efforts
1:00 – 2:00 LUNCH
2:00 – 5:00 Develop Program Logic Models (with TEA BREAK)
5:00 – 5:15 Wrap-up and Reflections

**DAY 2**
8:30 – 9:00 Connections
9:00 – 10:00 Review and Revise Common Logic Model
10:00 – 10:30 Decide the Purpose of PM&E
10:30 – 11:00 TEA BREAK
11:00 -12:30 Formulate M&E Questions
12:30 – 1:30 LUNCH
1:30 – 3:00 National and UNICEF HIV Indicators
Definitions of Program Reach and Coverage
3:00 – 3:15 TEA BREAK
3:15 – 5:00 Select Appropriate Indicators
5:00 – 5:15 Wrap-up and Reflections

DAY 3
8:30 – 8:45 Connections
8:45 – 10:30 Review M&E Questions and Indicators
10:30-10:45 TEA BREAK
10:45-1:15 Decide Sources of Information and Data Collection Methods
1:15 – 2:00 LUNCH
2:00-2:30 Discuss Standardized Data Collection Forms for UNICEF-Supported HIV AND AIDS
Targeted Interventions
2:30 – 3:30 Data Compilation, Reporting and Use
3:30 – 3:45 TEA BREAK
3:45 – 4:45 Recommendations for the Future Program’s M&E System, including guidelines
4:45 – 5:15 Wrap-up, Closing and Workshop Evaluation

For each of the five workshops, extensive workshop reports were written that included the interventions’ mutually-agreed upon logic models and M&E frameworks. Also included in the workshop reports are the names and positions of the workshop participants.
## HIV and AIDS Targeted Interventions (HATI) under HNPSP
### Logical Framework

<table>
<thead>
<tr>
<th>Expected Outcomes and Results</th>
<th>Objectively Verifiable Indicators</th>
<th>Means of Verification</th>
<th>Assumptions</th>
</tr>
</thead>
</table>
| **CPAP Outcome:** Reduce risk of HIV transmission among the Most At Risk Population (MARP) and keep the HIV prevalence below the level of concentrated epidemic among them | - % needle sharing reduced among the IDUs  
- % consistent condom use increased among the MARP  
- Prevalence of HIV among the MARP | - National BSS report | Assumptions: GoB priority has not changed |
| **EXPECTED OUTPUT 1:** Increased condom use among MARP during sexual intercourse | - No. of condom distributed  
- No. of individual who received condoms  
- % using condom last time at sex among:  
  - Female sex worker (FSW) (T-10% increase from baseline)  
  - Men sex with men (MSM) (T-7% increase from baseline)  
  - Clients of sex workers (T-7% increase from baseline) | - Quarterly reports  
- Monitoring visit reports  
- Baseline and end line reports  
- National BSS report | Assumptions: GoB priority has not changed |
| **EXPECTED OUTPUT 2:** Increased care seeking for STIs among MARP | - % seeking STI services among:  
  - Female sex worker (FSW)(T-10% increase from baseline)  
  - Men sex with men (MSM) (T-7% increase from baseline)  
  - Clients of sex workers (T-7% increase from baseline) | - Quarterly reports  
- Monitoring visit reports | Assumptions: GoB priority has not changed |
| **EXPECTED OUTPUT 3:** Decreased needle and syringe sharing among drug users | - No. of needle and syringes distributed  
- No. of individuals who received needles and syringes  
- % sharing needles among drug users (T-10% increase from baseline) | - Quarterly reports  
- Monitoring visit reports  
- Baseline and end line reports  
- National BSS report | Assumptions: GoB priority has not changed |
Appendix 3
HIV and AIDS TARGET INTERVENTIONS (HATI) LOGIC MODEL

<table>
<thead>
<tr>
<th>Inputs</th>
<th>Activities</th>
<th>Expected Targets/Outputs(^3)</th>
<th>Outcomes(^4) (Intermediate Results)</th>
<th>Impact(^5) (Long term Results)</th>
</tr>
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<tbody>
<tr>
<td>• Staff</td>
<td>1. <strong>Project Management and Coordination</strong></td>
<td></td>
<td><strong>Program Management</strong></td>
<td>I/DU: Reduce the risk of HIV transmission among I/DoUs and maintain the current level of HIV prevalence among I/DoUs (7%, ref: National Sero-surveillance Survey, VII Round, 2007).</td>
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<tr>
<td>• Office</td>
<td>1.1 Conduct intervention mapping</td>
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<td>• Furniture</td>
<td>1.2 Assess new intervention sites</td>
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<td>• Equipment</td>
<td>1.3 Recruit staff</td>
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<td>• Office Supplies</td>
<td>1.4 Set up DICs</td>
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<td>• Condoms</td>
<td>1.5 Establish unique ID codes</td>
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<td>• Lubricant</td>
<td>1.6 Develop/procure/reprint IEC materials</td>
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<td>• Medicines</td>
<td>1.7 Form DIC Management Committees / Project Facilitation Teams</td>
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<tr>
<td>• IEC and BCC Materials</td>
<td>1.8 Develop procurement plan for logistics supplies</td>
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<td>• Funds</td>
<td>1.9 Ensure logistic supply</td>
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<td>• Referral Centres</td>
<td>1.10 Conduct DIC-level meetings w/:</td>
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<td>• Staff</td>
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<td>• DIC Management Teams / Program Facilitation Teams</td>
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<td>• Service Providers (STI, VCT)</td>
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<td>• Government Agencies</td>
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<td>• Other</td>
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<td></td>
<td>1.11 Conduct Consortium-level meetings w/ (if applicable):</td>
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<tr>
<td></td>
<td>• Consortium members</td>
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<tr>
<td></td>
<td>• Other consortia members</td>
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<tr>
<td></td>
<td>• Service Providers (STI, VCT)</td>
<td></td>
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</tr>
<tr>
<td></td>
<td>• Government Agencies</td>
<td></td>
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<tr>
<td></td>
<td>• Other</td>
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</tbody>
</table>

\(^3\) As agreed to in the Logical Frameworks developed in the Project Proposal Workshops, Nov-Dec, 2007.
2. Develop Capacities of NGO Staff
2.1 Conduct needs assessment
2.2 Develop capacity building plan
2.4 Organize/coordinate training in:
   - DIC management
   - Financial management
   - BCC and peer education
   - STI management
   - Counseling
   - Local level advocacy
   - Gender and HIV
   - Human rights based approach
   - Supportive supervision
   - Monitoring and evaluation
   - Referral for VCT
   - Universal precautions
2.5 Plan supportive supervision
2.6 Share learnings with field staff
2.7 Conduct exchange visits

3. Conduct Outreach & Peer Education
3.1 Conduct one to one BCC sessions
3.2 Conduct group BCC sessions
3.3 Distribute IEC materials
3.4 Demonstrate condom & lube use
3.5 Distribute condoms and lubricant
3.6 Refer participants to DIC
3.7 Conduct cultural events
3.8 Distribute needles (I/DU only)
3.9 Distribute syringes (I/DU only)
3.10 Collect used needles (I/DU only)
3.11 Collect used syringes (I/DU only)

Coverage Targets:

IDU:
- 70% of estimated\(^1\) MAR I/DU receive comprehensive coverage\(^2\) with at least 1 comprehensive contact every week by end of 2008
- 50% of estimated non-MAR I/DU receive comprehensive coverage with at least 1 comprehensive contact every month by end of 2008

FSW, Clients, MSM&TG:
- 80% of estimated\(^1\) target group

Increase in Correct Knowledge of HIV

IDU:
- 90% of listed I/DUs correctly identify not sharing needles and syringes, using condoms, and receiving STI services as ways to prevent HIV transmission

FSW:
- 100% of listed FSW correctly identify using condoms and receiving STI services as ways to prevent

---

\(^1\) Estimated: The number of individuals in the target group (i.e., I/DUs, FSWs, etc.) estimated through surveys or identified through mapping to be present in the program area, who may or may not be enrolled in the program.

\(^2\) For the appropriate definition of “comprehensive coverage” and “comprehensive contact” for each target group, see Glossary and Definitions.
4. **Provide DIC, DIC Outlet and Saloon-based Non-Clinical Services**

| 4.1 | Conduct one to one sessions |
| 4.2 | Conduct group session |
| 4.3 | Conduct social group/NA meetings |
| 4.4 | Provide non-STI counseling |
| 4.5 | Provide recreational activities |
| 4.6 | Distribute IEC materials |
| 4.7 | Demonstrate condom and lube use |
| 4.8 | Distribute condoms and lubricant |
| 4.9 | Refer clients to VCT |
| 4.10 | Distribute needles (I/DU only) |
| 4.11 | Distribute syringes (I/DU only) |
| 4.12 | Collect used needles (I/DU only) |
| 4.13 | Collect used syringes (I/DU) |
| 4.14 | Distribute cinema tickets (BRAC only) |
| 4.15 | Distribute barber tokens (BRAC only) |

**VCT Targets:**

**IDU, FSW, Clients, MSM&TG:**
- 100% of listed° MARP receive information on VCT at least every quarter by end of 2008

5. **Provide DIC or DIC Outlet-based Clinical Services**

| 5.1 | Conduct STI clinic sessions |
| 5.2 | Perform physical examinations |
| 5.3 | Provide treatment to STI patients |
| 5.4 | Provide treatment to GH patients |
| 5.5 | Provide abscess management services |
| 5.6 | Provide STI counseling |
| 5.7 | Demonstrate condom and lube use |
| 5.8 | Distribute condoms and lubricant |
| 5.9 | Refer complicated cases to other health services |
| 5.10 | Conduct follow-up on STI patients |

**STI Management Targets:**

**IDU:**
- 100% of listed MAR I/DUs receive STI counseling and physical exam/checkup at least once every quarter by end of 2008

**FSW:**
- 100% of listed FSW receive STI counseling and physical exam/checkup at least once a month by end of 2008

**Clients:**
- 100% of listed Clients receive STI counseling and physical exam/checkup at least once a

° Listed: Individuals listed or enrolled in the program and provided an unique identification code, and who are reached (but not necessarily reached “comprehensively”) by the program.
<table>
<thead>
<tr>
<th></th>
<th>Provide Detoxification and Rehabilitation Services (I/DU only)</th>
<th>Detoxification Targets: IDU:</th>
<th>Increase in Sterile Needles/Syringes Use (I/DU only):</th>
</tr>
</thead>
<tbody>
<tr>
<td>6.1</td>
<td>Conduct community-based detox camps</td>
<td>- At least 10% of listed I/DU undergo detox by the end of 2008, of whom at least 70% are MAR</td>
<td>- Sharing of injecting equipment reduced to &lt; 3 times/month in at least 70% of comprehensively reached MAR I/DUs by end of 2008</td>
</tr>
<tr>
<td>6.2</td>
<td>Refer individuals to other detox and rehab services</td>
<td>- Of those who undergo detox, 10% also undergo rehabilitation by end of 2008</td>
<td>- 80% of comprehensively reached MAR I/DU reportedly used sterile needles/syringes the last time they injected by end of 2008</td>
</tr>
<tr>
<td>6.3</td>
<td>Link individuals to income generating activities or related training</td>
<td></td>
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<tr>
<td></td>
<td>Provide Training and Other Assistance to Target Population and other Non-Staff (if applicable)</td>
<td></td>
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<td></td>
<td>Organize /Participate in Advocacy Events</td>
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<td></td>
<td>Manage and Develop PNGOs and/or SHGs (if applicable)</td>
<td></td>
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<tr>
<td>9.1</td>
<td>Sign MOU</td>
<td></td>
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<tr>
<td>9.2</td>
<td>Communicate</td>
<td></td>
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<tr>
<td>9.3</td>
<td>Provide technical support</td>
<td></td>
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<td>9.4</td>
<td>Provide financial support</td>
<td></td>
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<tr>
<td>9.5</td>
<td>Provide supplies</td>
<td></td>
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<tr>
<td></td>
<td>Enabling Environment</td>
<td></td>
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<tr>
<td></td>
<td>IDU, FSW, Clients, MSM&amp;TG: Community and local administration support increased</td>
<td></td>
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<tr>
<td></td>
<td>Partner NGOs &amp; Self-help Groups (if applicable)</td>
<td></td>
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<tr>
<td></td>
<td>I/DU, FSW, Clients, MSM&amp;TG: PNGO and SHG managed effectively and efficiently</td>
<td></td>
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<tr>
<td>10. <strong>Monitor, Evaluate, Research, Report</strong></td>
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<td>-------------------------------------------</td>
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<tr>
<td>10.1 Develop/adapt minimum quality standards</td>
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<tr>
<td>10.2 Ensure compliance of minimum quality standards</td>
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<tr>
<td>10.3 Design and plan monitoring and supportive supervision system</td>
<td></td>
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<tr>
<td>10.4 Conduct monitoring and supportive supervision</td>
<td></td>
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<tr>
<td>10.5 Conduct progress review meetings</td>
<td></td>
<td></td>
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<tr>
<td>10.6 Conduct internal mid-term project review</td>
<td></td>
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<tr>
<td>10.7 Conduct action research (as needed)</td>
<td></td>
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<tr>
<td>10.8 Write monthly activities report</td>
<td></td>
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<tr>
<td>10.9 Write quarterly activities report</td>
<td></td>
<td></td>
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<tr>
<td>10.10 Write quarterly financial report</td>
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<tr>
<td>10.11 Write project completion report</td>
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</tbody>
</table>
### Framework for Monitoring the Implementation of Activities

#### Major Activities

<table>
<thead>
<tr>
<th>Major Activities</th>
<th>Indicators</th>
<th>Data Source, Collection Method/Form</th>
<th>Frequency Data are Collected</th>
<th>Initial Person(s) to Collect Data</th>
<th>Reported to UNICEF in:</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>1. Project Management and Coordination</strong></td>
<td></td>
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<td></td>
</tr>
<tr>
<td>1.1 Conduct intervention mapping</td>
<td># of intervention maps, # of assessments, # of recruited staff, # of DICs established</td>
<td>Intervention maps, Assessment reports, Admin files</td>
<td>Feb end</td>
<td>Team Leader</td>
<td>PSUR, PSUR, QR</td>
</tr>
<tr>
<td>1.2 Assess new intervention sites</td>
<td></td>
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<tr>
<td>1.3 Recruit staff</td>
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<tr>
<td>1.4 Set up DICs</td>
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<tr>
<td>1.5 Establish unique identification codes (UIC)</td>
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<tr>
<td>1.6 Develop/procure/reprint IEC materials</td>
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<tr>
<td>1.7 Form DIC Management Committees / Project Facilitation Teams</td>
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<tr>
<td>1.8 Develop procurement plan for logistics supplies</td>
<td># of procurement plans, # and type of meetings, # and type of meetings</td>
<td>Procurement plans, TM&amp;OE, TM&amp;OE</td>
<td>As occur</td>
<td>DIC Manager, Team Leader</td>
<td>QR, QR</td>
</tr>
<tr>
<td>1.9 Ensure logistic supply</td>
<td></td>
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<tr>
<td>1.10 Conduct DIC-level meetings</td>
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<tr>
<td>1.11 Conduct consortium-level meetings (if applicable)</td>
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<tr>
<td><strong>2. Develop Capacities of NGO Staff</strong></td>
<td></td>
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<tr>
<td>2.1 Conduct needs assessments (NA)</td>
<td># of NA reports, # of CB plans, # and type of trainings, # of participants in each type of training, # of SS plans</td>
<td>NA reports, CB plans, TM&amp;OE, SS plans</td>
<td>Feb end</td>
<td>Team Leader, DIC Manager</td>
<td>PSUR, PSUR, QR</td>
</tr>
<tr>
<td>2.2 Develop capacity building (CB) plan</td>
<td></td>
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<tr>
<td>2.4 Organize/coordinate staff trainings</td>
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<td>2.5 Plan supportive supervision (SS)</td>
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<tr>
<td>2.6 Share learnings with field staff</td>
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</tbody>
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1. TM&OE -- Training, Meetings and Other Events Form
2. PSUP – Project Start-Up Report
3. QR – Quarterly Report
### 2.7 Conduct exchange visits (EV)
- # and type of EV
- # of participants in EV

<table>
<thead>
<tr>
<th>3. Conduct Outreach &amp; Peer Education</th>
<th># and type of EV</th>
<th>TM&amp;OE</th>
<th>As occur</th>
<th>Team Leader</th>
<th>QR</th>
</tr>
</thead>
<tbody>
<tr>
<td>3.1 Conduct one to one BCC sessions</td>
<td># of one to one BCC sessions</td>
<td>ODAS &amp; OWCS⁴</td>
<td>Daily</td>
<td>PE &amp; OS⁵</td>
<td>MR⁶ &amp; QR</td>
</tr>
<tr>
<td>3.2 Conduct group BCC sessions</td>
<td># of group BCC sessions</td>
<td>ODAS &amp; OWCS</td>
<td>Daily</td>
<td>PE &amp; OS</td>
<td>MR &amp; QR</td>
</tr>
<tr>
<td>3.3 Distribute IEC materials</td>
<td># of IEC mats distributed</td>
<td>ODAS &amp; OWCS</td>
<td>Daily</td>
<td>PE &amp; OS</td>
<td>MR &amp; QR</td>
</tr>
<tr>
<td>3.4 Demonstrate condom &amp; lubricant use</td>
<td># of condom &amp; lube demonstrations</td>
<td>ODAS &amp; OWCS</td>
<td>Daily</td>
<td>PE &amp; OS</td>
<td>MR &amp; QR</td>
</tr>
<tr>
<td>3.5 Distribute condoms and lubricant</td>
<td># of condoms distributed</td>
<td>ODAS &amp; OWCS</td>
<td>Daily</td>
<td>PE &amp; OS</td>
<td>MR &amp; QR</td>
</tr>
<tr>
<td>3.6 Refer participants to DIC</td>
<td># of participants referred to DIC</td>
<td>ODAS &amp; OWCS</td>
<td>Daily</td>
<td>PE &amp; OS</td>
<td>MR &amp; QR</td>
</tr>
<tr>
<td>3.7 Conduct cultural events</td>
<td># of cultural events conducted</td>
<td>ODAS &amp; OWCS</td>
<td>Daily</td>
<td>PE &amp; OS</td>
<td>MR &amp; QR</td>
</tr>
<tr>
<td>3.8 Distribute needles (I/DU only)</td>
<td># of needles distributed</td>
<td>ODAS &amp; OWCS</td>
<td>Daily</td>
<td>PE &amp; OS</td>
<td>MR &amp; QR</td>
</tr>
<tr>
<td>3.9 Distribute syringes (I/DU only)</td>
<td># of syringes distributed</td>
<td>ODAS &amp; OWCS</td>
<td>Daily</td>
<td>PE &amp; OS</td>
<td>MR &amp; QR</td>
</tr>
</tbody>
</table>

⁴ ODAS – Outreach Daily Activity Sheet; OWCR – Outreach Weekly Compilation Report
⁵ PE – Peer Educator; OS – Outreach Supervisor/BCC Organizer
⁶ MR – Monthly Report
| 3.10 Collect used needles (I/DU only)                                      | • # of individuals receiving syringes  | • ODAS & OWCS  | • Daily  | • PE & OS  | • MR & QR  |
|                                                                          | • # of used needles collected         | • ODAS & OWCS  | • Daily  | • PE & OS  | • MR & QR  |
|                                                                          | • # of individuals giving used needles | • ODAS & OWCS  | • Daily  | • PE & OS  | • MR & QR  |
| 3.11 Collect used syringes (I/DU only)                                   | • # of used syringes collected        | • ODAS & OWCS  | • Daily  | • PE & OS  | • MR & QR  |
|                                                                          | • # of individuals giving used syringes | • ODAS & OWCS  | • Daily  | • PE & OS  | • MR & QR  |
|                                                                          | • ODAS & OWCS                         | • Daily  | • PE & OS  | • MR & QR  |
|                                                                          | • ODAS & OWCS                         | • Daily  | • PE & OS  | • MR & QR  |
|                                                                                | • ODAS & OWCS                         | • Daily  | • PE & OS  | • MR & QR  |
|                                                                                | • ODAS & OWCS                         | • Daily  | • PE & OS  | • MR & QR  |
| 4. Provide DIC, DIC Outlet or Saloon-based Non-Clinical Services          | • # of one to one BCC sessions        | • DIC Daily Register | • Daily  | • OS/Counselor | • MR & QR  |
|                                                                          | • # of individuals attended one to one BCC sessions | • DIC Daily Register | • Daily  | • OS/Counselor | • MR & QR  |
| 4.1 Conduct one to one BCC sessions                                      | • # of group BCC sessions             | • DIC Daily Register | • Daily  | • Counselor  | • MR & QR  |
|                                                                          | • # of individuals attended group BCC sessions | • DIC Daily Register | • Daily  | • Counselor  | • MR & QR  |
| 4.2 Conduct group BCC sessions                                            | • # of social group/NA meetings       | • DIC Daily Register | • Daily  | • Counselor  | • MR & QR  |
| 4.3 Conduct social group/narcotic anonymous meetings                      | • # of SG/NA meeting participants     | • DIC Daily Register | • Daily  | • Counselor  | • MR & QR  |
|                                                                          | • # of non-STI counseling sessions    | • DIC Daily Register | • Daily  | • Counselor  | • MR & QR  |
| 4.4 Provide non-STI counseling                                             | • # of non-STI counseling sessions participants | • DIC Daily Register | • Daily  | • Counselor  | • MR & QR  |
| 4.5 Provide recreational activities                                       | • # of individuals using recreation activities | • DIC Daily Register | • Daily  | • Counselor  | • MR & QR  |
| 4.6 Distribute IEC materials                                              | • # of IEC mats distributed          | • DIC Daily Register | • Daily  | • Counselor  | • MR & QR  |
|                                                                          | • # of individuals receiving IEC mats | • DIC Daily Register | • Daily  | • Counselor  | • MR & QR  |
| 4.7 Demonstrate condom and lube use                                       | • # of condom & lube demonstrations   | • DIC Daily Register | • Daily  | • Counselor  | • MR & QR  |
|                                                                          | • # of individuals attended condom & lube demos | • DIC Daily Register | • Daily  | • Counselor  | • MR & QR  |
| 4.8 Distribute condoms and lubricant                                      | • # of condoms distributed           | • DIC Daily Register | • Daily  | • Counselor  | • MR & QR  |
|                                                                          | • # of individuals receiving condoms  | • DIC Daily Register | • Daily  | • Counselor  | • MR & QR  |
### 4.9 Refer clients to VCT
- # of lube distributed
- # of individuals receiving lube
- # of individuals referred to VCT
- # of referred individuals who received VCT
- DIC Daily Register
- DIC Daily Register
- Daily
- Counselor
- MR & QR
- DIC Daily Register
- Daily
- Dr/Paramedic
- MR & QR
- DIC Daily Register
- Daily
- Dr/Paramedic
- MR & QR

### 4.10 Distribute needles (I/DU only)
- # of needles distributed
- # of individuals receiving needles
- DIC Daily Register
- DIC Daily Register
- Daily
- DIC Manager
- MR & QR
- DIC Daily Register
- Daily
- DIC Manager
- MR & QR
- DIC Daily Register
- Daily
- DIC Manager
- MR & QR

### 4.11 Distribute syringes (I/DU only)
- # of syringes distributed
- # of individuals receiving syringes
- DIC Daily Register
- DIC Daily Register
- Daily
- DIC Manager
- MR & QR
- DIC Daily Register
- Daily
- DIC Manager
- MR & QR
- DIC Daily Register
- Daily
- DIC Manager
- MR & QR

### 4.12 Collect needles (I/DU only)
- # of used needles collected
- # of individuals giving used needles
- DIC Daily Register
- DIC Daily Register
- Daily
- DIC Manager
- MR & QR
- DIC Daily Register
- Daily
- DIC Manager
- MR & QR
- DIC Daily Register
- Daily
- DIC Manager
- MR & QR

### 4.13 Collect syringes (I/DU only)
- # of used syringes collected
- # of individuals giving used syringes
- DIC Daily Register
- DIC Daily Register
- Daily
- DIC Manager
- MR & QR
- DIC Daily Register
- Daily
- DIC Manager
- MR & QR
- DIC Daily Register
- Daily
- DIC Manager
- MR & QR

### 4.14 Distribute cinema tickets (BRAC only)
- # of cinema tickets distributed
- # of individuals receiving cinema tickets
- DIC Daily Register
- DIC Daily Register
- Daily
- DIC Manager
- MR & QR
- DIC Daily Register
- Daily
- DIC Manager
- MR & QR
- DIC Daily Register
- Daily
- DIC Manager
- MR & QR

### 4.15 Distribute barber tokens (BRAC only)
- # of barber token distributed
- # of individuals receiving barber tokens
- DIC Daily Register
- DIC Daily Register
- Daily
- DIC Manager
- MR & QR
- DIC Daily Register
- Daily
- DIC Manager
- MR & QR
- DIC Daily Register
- Daily
- DIC Manager
- MR & QR

## 5. Provide DIC or DIC Outlet-based Clinical Services

### 5.1 Conduct clinic sessions
- # of clinic sessions
- # of individuals attending clinic sessions
- Clinical Daily Register
- Clinical Daily Register
- Daily
- Dr/Paramedic
- MR & QR
- Clinical Daily Register
- Daily
- Dr/Paramedic
- MR & QR
- Clinical Daily Register
- Daily
- Dr/Paramedic
- MR & QR

### 5.2 Perform physical examinations
- # of individuals receiving physical exam
- Clinical Daily Register
- Daily
- DR/Paramedic
- MR & QR
- Clinical Daily Register
- Daily
- DR/Paramedic
- MR & QR
- Clinical Daily Register
- Daily
- DR/Paramedic
- MR & QR

### 5.3 Provide treatment to STI patients
- # of individuals receiving STI treatment
- Clinical Daily Register
- Daily
- DR/Paramedic
- MR & QR
- Clinical Daily Register
- Daily
- DR/Paramedic
- MR & QR
- Clinical Daily Register
- Daily
- DR/Paramedic
- MR & QR

### 5.4 Provide treatment to general health (GH)
- # of individuals receiving
- Clinical Daily Register
- Daily
- DR/Paramedic
- MR & QR
- Clinical Daily Register
- Daily
- DR/Paramedic
- MR & QR
- Clinical Daily Register
- Daily
- DR/Paramedic
- MR & QR
<table>
<thead>
<tr>
<th>5.5 Provide abscess management (AM) services (for I/DU only)</th>
<th>GH treatment</th>
<th>• # of individuals receiving AM services</th>
<th>• Clinical Daily Register</th>
<th>• Daily</th>
<th>• Counselor</th>
<th>• MR &amp; QR</th>
</tr>
</thead>
<tbody>
<tr>
<td>5.6 Provide STI counseling</td>
<td></td>
<td>• # of individuals receiving STI counseling</td>
<td>• Clinical Daily Register</td>
<td>• Daily</td>
<td>• Counselor</td>
<td>• MR &amp; QR</td>
</tr>
<tr>
<td>5.7 Demonstrate condom and lube use</td>
<td></td>
<td>• # of condom &amp; lube demonstrations</td>
<td>• Clinical Daily Register</td>
<td>• Daily</td>
<td>• Counselor</td>
<td>• MR &amp; QR</td>
</tr>
<tr>
<td>5.8 Distribute condoms and lubricant</td>
<td></td>
<td>• # of condoms distributed</td>
<td>• Clinical Daily Register</td>
<td>• Daily</td>
<td>• Counselor</td>
<td>• MR &amp; QR</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• # of lube distributed</td>
<td>• Clinical Daily Register</td>
<td>• Daily</td>
<td>• Counselor</td>
<td>• MR &amp; QR</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• # of individuals referred to other services</td>
<td>• Clinical Daily Register</td>
<td>• Daily</td>
<td>• Counselor</td>
<td>• MR &amp; QR</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• # of referred individuals who went for other services</td>
<td>• Clinical Daily Register</td>
<td>• Daily</td>
<td>Dr/Counselor</td>
<td>• MR &amp; QR</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• # of individuals followed up on</td>
<td>• Clinical Daily Register</td>
<td>• Daily</td>
<td>Counselor</td>
<td>• MR &amp; QR</td>
</tr>
<tr>
<td>5.9 Refer complicated cases to other health services</td>
<td></td>
<td>• # and type of trainings at DIC level</td>
<td>• TM&amp;OE</td>
<td>As occur</td>
<td>DIC Manager</td>
<td>• MR &amp; QR</td>
</tr>
<tr>
<td>5.10 Conduct follow-up on STI patients</td>
<td></td>
<td>• # of participants by type of training at DIC level</td>
<td>• DIC Daily Register</td>
<td>Daily</td>
<td>DIC Manager</td>
<td>• MR &amp; QR</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• # and type of trainings at DIC level</td>
<td>• DIC Daily Register</td>
<td>Daily</td>
<td>DIC Manager</td>
<td>• MR &amp; QR</td>
</tr>
</tbody>
</table>

6. Provide Detoxification and Rehabilitation Services (I/DU only)

| 6.1 Organize/coordinate community-based detox camps           | • # of detox camps conducted | • TM&OE | As occur | DIC Manager | • MR & QR |
| 6.2 Refer individuals to other detox and rehab services       | • # of individuals attending detox camps | • TM&OE | As occur | DIC Manager | • MR & QR |
| 6.3 Link individuals to income generating activities (IGA) or related training | • # of individuals referred to other services | • DIC Daily Register | Daily | DIC Manager | • MR & QR |
|                                                             | • # of referred individuals went to other services | • DIC Daily Register | Daily | DIC Manager | • MR & QR |
|                                                             | • # of individuals linked to IGAs or related training | • DIC Daily Register | Daily | DIC Manager | • MR & QR |

7. Provide Training and Other Assistance of Target Population and other Non-Staff (if applicable)

<p>| • # and type of trainings at DIC level | • TM&amp;OE | As occur | DIC Manager | • QR |
| • # of participants by type of training at DIC level | • TM&amp;OE | As occur | DIC Manager | • QR |
| • # and type of trainings at DIC level | • TM&amp;OE | As occur | DIC Manager | • QR |</p>
<table>
<thead>
<tr>
<th>NGO level</th>
<th># of participants by type of training at NGO level</th>
<th>TM&amp;OE</th>
<th>As occur</th>
<th>DIC Manager</th>
<th>QR</th>
</tr>
</thead>
<tbody>
<tr>
<td>8. Organize / Participate in Advocacy Events</td>
<td># and type of advocacy event</td>
<td>TM&amp;OE</td>
<td>As occur</td>
<td>DIC Manager</td>
<td>QR</td>
</tr>
<tr>
<td>9. Manage and Develop PNGOs and/or SHGs (if applicable)</td>
<td># of signed MOUs</td>
<td>MOU documents</td>
<td>As occur</td>
<td>Team Leader</td>
<td>QR</td>
</tr>
<tr>
<td></td>
<td># and type of communications</td>
<td>Letters, emails, phone</td>
<td>As occur</td>
<td>Team Leader</td>
<td>QR</td>
</tr>
<tr>
<td></td>
<td># and type of monitoring</td>
<td>Monitoring reports</td>
<td>As occur</td>
<td>Team Leader</td>
<td>QR</td>
</tr>
<tr>
<td></td>
<td># and type of feedback given</td>
<td>Feedback reports</td>
<td>As occur</td>
<td>Team Leader</td>
<td>QR</td>
</tr>
<tr>
<td></td>
<td># and type of TA provided</td>
<td>TA reports</td>
<td>As occur</td>
<td>Team Leader</td>
<td>QR</td>
</tr>
<tr>
<td></td>
<td>Amount and type of financial support provided</td>
<td>Financial reports</td>
<td>As occur</td>
<td>Team Leader</td>
<td>QR</td>
</tr>
<tr>
<td></td>
<td># and type of supplies provided</td>
<td>Financial reports</td>
<td>As occur</td>
<td>Team Leader</td>
<td>QR</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Stock registers</td>
<td>As occur</td>
<td>Team Leader &amp; Fin Coord</td>
<td>QR</td>
</tr>
<tr>
<td>10. Monitor, Evaluate, Research, Report</td>
<td># of plans for adapting quality standards</td>
<td>Plans for adapting quality standards</td>
<td>Feb end</td>
<td>M&amp;E Cood⁷</td>
<td>PSUR</td>
</tr>
<tr>
<td></td>
<td># of monitoring visits</td>
<td>Monitoring Quality Checklist</td>
<td>Quarterly</td>
<td>M&amp;E Cood</td>
<td>PSUR</td>
</tr>
<tr>
<td></td>
<td>Scores/results from visits</td>
<td>Monitoring and SS plans</td>
<td>Feb end</td>
<td>Team Leader</td>
<td>QR</td>
</tr>
<tr>
<td></td>
<td># of monitoring and SS plans</td>
<td>TM&amp;OE</td>
<td>Monthly</td>
<td>M&amp;E Cood</td>
<td>QR</td>
</tr>
<tr>
<td></td>
<td># of SS visits</td>
<td>Mid-term report</td>
<td>Monthly</td>
<td>DIC Manager</td>
<td>QR</td>
</tr>
<tr>
<td></td>
<td># of progress review meetings</td>
<td>Action research reports</td>
<td>As occur</td>
<td>Team Leader</td>
<td>Mid-project report</td>
</tr>
</tbody>
</table>

⁷ Technical Coordinator – M&E
## Appendix 4B
### FRAMEWORK FOR MONITORING THE ACHIEVEMENT OF EXPECTED OUTPUTS

<table>
<thead>
<tr>
<th>Program Component and Monitoring Questions</th>
<th>Indicators</th>
<th>Data Source, Collection Method/ Form</th>
<th>Frequency Data are Collected</th>
<th>Person(s) Responsible</th>
<th>Reported to UNICEF in:</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>1. Project Management and Coordination</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>N/A</td>
</tr>
</tbody>
</table>
| 1. Has the program been managed effectively and efficiently? | • # of outputs meeting targets  
• Extent to which capacity of program and staff built as per requirements  
• Extent to which program monitoring done following prescribed mechanisms and frequency  
• Extent to which transparent accounting maintained and reported  
• Extent to which procurement follow prescribed UNICEF procedures  
• Extent to which logistics and supplies provided to program implementers on time | • Monthly NGO consortia reports  
• Quarterly Progress Reports  
• Joint monitoring visits & reports  
• Financial reports  
• Mid-term review reports  
• Project completion reports | • Quarterly | • UNICEF POs and APOs  
• NASP PM & DPM |                                           |
| **2. Developing Capacities of NGO Staff** |                                                                             |                                     |                              |                                           | QR                      |
| 1. Has the knowledge of trained staff increased as a result of the training? | • # of trainees whose knowledge increases | • Pre and post test | • During training | • Training provider | QR                      |
| 2. Has the performance of trained staff improved as a result of the training? | • # of trained staff whose job performance improved | • Staff performance reviews | • At time of review | • NGO manager | QR                      |
### 3. Outreach & Peer Education

1. What percentage of the target group has been “comprehensively covered” by the program?
   - % of estimated target population receiving comprehensive coverage
   - DIC Monthly Compilation Report
   - Quarterly
   - M&E Coordinator
   - QR

2. Was the coverage target achieved? If not, why not?
   - % of estimated target population receiving comprehensive coverage
   - DIC Monthly Compilation Report
   - Logical Framework
   - Interviews, discussions
   - Quarterly
   - M&E Coordinator
   - QR

### 4. Provide DIC, DIC Outlet, and Saloon-based Non-Clinical Services

1. What percentage of the target group has been “comprehensively covered” by the program?
   - % of estimated target population receiving comprehensive coverage
   - DIC Monthly Compilation Report
   - Quarterly
   - M&E Coordinator
   - QR

2. Was the coverage target achieved? If not, why not?
   - % of estimated target population receiving comprehensive coverage
   - DIC Monthly Compilation Report
   - Logical Framework
   - Interviews, discussions
   - Quarterly
   - M&E Coordinator
   - QR

3. Did 100% of the listed MAR target group receive information on VCT every quarter?
   - % of listed MAR target group receiving information on VCT each quarter
   - DIC Monthly Compilation Report
   - Quarterly
   - M&E Coordinator
   - QR

### 5. DIC or DIC Outlet-based Clinical Services

1. Did 100% of the listed target population receive STI counseling and physical exam/checkup at least once a month/quarter?
   - % of the listed target population that received STI counseling and physical
   - DIC Monthly Compilation Report
   - Quarterly
   - M&E Coordinator
   - QR

---

For the specific definitions of “comprehensive coverage” for each intervention package, please refer to the section, “Glossary and Definitions.”

For the specific targets of each intervention package, please refer to the logic model in Appendix 3 or the original logical framework developed with the consortia lead agencies during the project proposal workshops.
### 6. Detoxification and Rehabilitation Services (I/DU NGOs only)

1. What percentage of listed I/DU underwent detox?
   - % of listed I/DUs who underwent detox
   - DIC Monthly Compilation Report
   - DIC Monthly Compilation Report Interviews
   - Quarterly
   - M&E Coordinator
   - QR

2. Was the detox target of 10% achieved? If not, why not?
   - % of MAR I/DUs who underwent detox
   - DIC Monthly Compilation Report
   - DIC Monthly Compilation Report Interviews
   - Quarterly
   - M&E Coordinator
   - QR

3. Of those who underwent detox, were at least 70% MAR? If not, why not?
   - % of MAR I/DUs who underwent detox
   - DIC Monthly Compilation Report
   - DIC Monthly Compilation Report Interviews
   - Quarterly
   - M&E Coordinator
   - QR

4. Of those who underwent detox, did 10% also undergo rehabilitation? If not, why not?
   - % of MAR I/DU who underwent rehab
   - DIC Monthly Compilation Report
   - DIC Monthly Compilation Report Interviews
   - Quarterly
   - M&E Coordinator
   - QR

### 7. Enabling Environment

1. Has community support increased? If yes, in what ways?
   - # and type of advocacy events
   - # of advocacy events organized jointly with other stakeholders
   - Workshop reports
   - Meeting minutes
   - DIC Manager and M&E Coordinator
   - Quarterly
   - M&E Coordinator
   - QR

2. Has local administration support increased? If yes, in what ways?
   - # of and ways in which program participants are involved in program planning, implementation and monitoring
   - Evidence of ways in which community members support/do not support the program
   - Evidence of ways in which community members support/do not support the program
   - DIC Manager and M&E Coordinator
   - Quarterly
   - M&E Coordinator
   - QR
### 8. Management and Development of PNGOs and/or SHGs (if applicable)

1. Are the PNGOs managed effectively and efficiently?

<table>
<thead>
<tr>
<th>local administration members support/do not support the program</th>
<th>Coordinator</th>
</tr>
</thead>
<tbody>
<tr>
<td>• # of PNGOs receiving funds when due</td>
<td>• Team Leader &amp; Fin Coord</td>
</tr>
<tr>
<td>• # of PNGOs receiving supplies when due</td>
<td>• Team Leader &amp; Fin Coord</td>
</tr>
<tr>
<td>• # of PNGOs receiving TA when and where required</td>
<td>• Prog Coord</td>
</tr>
<tr>
<td>• # of SHGs receiving funds when due</td>
<td>• Team Leader &amp; Fin Coord</td>
</tr>
<tr>
<td>• # of SHGs receiving supplies when due</td>
<td>• Team Leader &amp; Fin Coord</td>
</tr>
<tr>
<td>• # of SHGs receiving TA when and where required</td>
<td>• Prog Coord</td>
</tr>
<tr>
<td>• Financial reports</td>
<td>• As occur</td>
</tr>
<tr>
<td>• Financial reports</td>
<td>• As occur</td>
</tr>
<tr>
<td>• TM&amp;OE</td>
<td>• As occur</td>
</tr>
<tr>
<td>• LA’s field visit and monitoring report</td>
<td>• As occur</td>
</tr>
<tr>
<td>• Financial reports</td>
<td>• As occur</td>
</tr>
<tr>
<td>• Financial reports</td>
<td>• As occur</td>
</tr>
<tr>
<td>• TM&amp;OE</td>
<td>• As occur</td>
</tr>
<tr>
<td>• LA’s field visit and monitoring report</td>
<td>• As occur</td>
</tr>
</tbody>
</table>

2. Are the SHGs managed effectively and efficiently?

<table>
<thead>
<tr>
<th>local administration members support/do not support the program</th>
<th>Coordinator</th>
</tr>
</thead>
<tbody>
<tr>
<td>• # of PNGOs receiving funds when due</td>
<td>• Team Leader &amp; Fin Coord</td>
</tr>
<tr>
<td>• # of PNGOs receiving supplies when due</td>
<td>• Team Leader &amp; Fin Coord</td>
</tr>
<tr>
<td>• # of PNGOs receiving TA when and where required</td>
<td>• Prog Coord</td>
</tr>
<tr>
<td>• # of SHGs receiving funds when due</td>
<td>• Team Leader &amp; Fin Coord</td>
</tr>
<tr>
<td>• # of SHGs receiving supplies when due</td>
<td>• Team Leader &amp; Fin Coord</td>
</tr>
<tr>
<td>• # of SHGs receiving TA when and where required</td>
<td>• Prog Coord</td>
</tr>
<tr>
<td>• Financial reports</td>
<td>• As occur</td>
</tr>
<tr>
<td>• Financial reports</td>
<td>• As occur</td>
</tr>
<tr>
<td>• TM&amp;OE</td>
<td>• As occur</td>
</tr>
<tr>
<td>• LA’s field visit and monitoring report</td>
<td>• As occur</td>
</tr>
<tr>
<td>• Financial reports</td>
<td>• As occur</td>
</tr>
<tr>
<td>• Financial reports</td>
<td>• As occur</td>
</tr>
<tr>
<td>• TM&amp;OE</td>
<td>• As occur</td>
</tr>
<tr>
<td>• LA’s field visit and monitoring report</td>
<td>• As occur</td>
</tr>
</tbody>
</table>
Appendix 5

DRAFT STANDARDS FOR HATI SERVICES AND ACTIVITIES

I. DIC MANAGEMENT - GENERAL

1.1 All necessary staff are available to run the DIC.
1.2 Personnel files are maintained properly.
1.3 Responsibilities and job descriptions of DIC and clinical staff are written down and understood.
1.4 There is an up-to-date work plan.
1.5 Staff receive ongoing supportive supervision.
1.6 Records are maintained properly and used effectively.

2. DIC MANAGEMENT - SETUP AND SUPPLIES

2.1 The DIC’s services are accessible to the target population.
2.2 The interior and exterior of the building are well maintained and clean.
2.3 The DIC has all the necessary areas in working order.
2.4 BCC materials are present in sufficient quantities and are displayed appropriately.
2.5 All needed equipment and consumables are present in sufficient quantities, in working order (where applicable), and stored properly.

3. OUTREACH WORK

3.1 There is present a sufficient number of OW/PE assigned to appropriate locations.
3.2 OW/PE practice good interpersonal communication skills.
3.3 OW/PE provide accurate and complete information regarding HIV AND AIDS, condom use, and DIC, STI and VCT services.

4. STI CASE MANAGEMENT

4.1 Every client who attends the clinic receives a full sexual health history and safe sexual health examination.
4.2 All STI services are non-judgmental, private and confidential.
4.3 All clients are diagnosed and treated for STIs according to the National Guidelines.
4.4 After seeing the doctor/paramedic, each client receives STI and HIV counseling, condoms and condom demonstration, advice on compliance to treatment, and advice on partner tracing (the “4-Cs”).
4.5 Doctors/paramedics and counselors use appropriate STI health cards for recording clinical information.
4.6 An outreach system is in place to follow-up on clients, motivate them to attend their monthly appointments, and help ensure compliance with treatment.
5. UNIVERSAL PRECAUTIONS

5.1 All DIC and clinical staff are aware of the importance of infection prevention and of the basic measures necessary.
5.2 All instruments are processed properly, as per National Guidelines or MSCS Manual
5.3 Correct procedures are followed for the disposal of solid waste.

6. NEEDLE EXCHANGE (I/DU NGOs only)

6.1 All listed I/DUs receive an adequate number of syringes (according to the plan) on a regular basis.
6.2 All listed I/DUs receive an adequate number of needles (according to the plan) on a regular basis.
6.3 Used syringes and needles are brought back to the DIC and properly disposed of on a regular basis.

7. ABSCESS MANAGEMENT (I/DU NGOs only)

7.1 I/DUs with abscesses are identified properly and referred and/or brought to the DIC for treatment.
7.2 All treated abscess clients complete the treatment.
7.3 Complicated abscess cases are referred for further treatment.

8. REFERRAL LINKAGES AND COORDINATION

8.1 Effective mechanisms are in place for referring clients to general health, STI and VCT services.

9. LOCAL-LEVEL ADVOCACY

9.1 Local-level advocacy efforts are conducted on a regular basis to ensure the smooth implementation of program activities.

10. INVOLVEMENT OF SELF-HELP GROUPS

10.1 Self-help groups (SHG) are involved in program planning, implementation, and monitoring.
## Appendix 6
### FRAMEWORK FOR EVALUATING THE ACHIEVEMENT OF EXPECTED OUTCOMES

<table>
<thead>
<tr>
<th>Expected Outcomes and Evaluation Questions</th>
<th>Indicators</th>
<th>Data Source, Collection Method/Form</th>
<th>Frequency Data are Collected</th>
<th>Agency Responsible</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Increases in Correct Knowledge of HIV</td>
<td>• % of listed target group who correctly identified using condoms and receiving STI services as ways to prevent HIV transmission</td>
<td>• Baseline survey</td>
<td>• ASAP</td>
<td>• NASP</td>
</tr>
<tr>
<td>FSW, Clients, MSM&amp;TG:</td>
<td>• Knowledge target(^{16})</td>
<td>• Follow-up survey</td>
<td>• Dec, 2008</td>
<td></td>
</tr>
<tr>
<td>1. What percentage of listed target population correctly identified using condoms and receiving STI services as ways to prevent HIV transmission?</td>
<td>• % of listed I/DU who correctly identified not sharing needles, using condoms and receiving STI services as ways to prevent HIV transmission</td>
<td>• Baseline survey</td>
<td>• ASAP</td>
<td>• NASP</td>
</tr>
<tr>
<td>2. Was the target for correct knowledge achieved? If no, why not?</td>
<td>• Follow-up survey</td>
<td>• Dec, 2008</td>
<td></td>
<td></td>
</tr>
<tr>
<td>I/DU:</td>
<td>• % of listed target group who correctly identified using condoms and receiving STI services as ways to prevent HIV transmission</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>1. What percentage of listed I/DU correctly identified not sharing needles, using condoms and receiving STI services as ways to prevent HIV transmission?</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

\(^{16}\) For the specific targets of each intervention package, please refer to the logic model in Appendix 3 or the original logical framework developed with the consortia lead agencies in the project proposal workshops.
2. Was the target of 90% for correct knowledge achieved? If no, why not?
- % of listed I/DU who correctly identified not sharing needles, using condoms and receiving STI services as ways to prevent HIV transmission
- Knowledge target

<table>
<thead>
<tr>
<th></th>
<th>Baseline survey</th>
<th>ASAP</th>
<th>NASP</th>
</tr>
</thead>
<tbody>
<tr>
<td>2. Increase in Consistent Condom Use:</td>
<td>Follow-up survey</td>
<td>Dec, 2008</td>
<td>NASP</td>
</tr>
</tbody>
</table>
1. What percentage of comprehensively reached MAR report to have used condoms consistently?
- % of comprehensively reached MAR reporting to have used condoms consistently

<table>
<thead>
<tr>
<th></th>
<th>Baseline survey</th>
<th>ASAP</th>
<th>NASP</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Follow-up survey</td>
<td>Dec, 2008</td>
<td>NASP</td>
</tr>
<tr>
<td></td>
<td>Monitoring data</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

2. By the end of 2008, is there a 20% increase from baseline in the percentage of comprehensively reached MAR reporting to have used condoms consistently? If no, why not?
- % of target population reporting to have used condoms consistently at baseline
- % of comprehensively reached MAR reporting to have used condoms consistently at follow-up

<table>
<thead>
<tr>
<th></th>
<th>Baseline survey</th>
<th>ASAP</th>
<th>NASP</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Follow-up survey</td>
<td>Dec, 2008</td>
<td>NASP</td>
</tr>
<tr>
<td></td>
<td>Monitoring data</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Interviews</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Increase in STI Management:

FSW, Clients, MSM&TG (not I/DU)
1. What percentage of comprehensively reached target population voluntarily sought STI services?
- % of comprehensively reached target population reporting to have voluntarily sought STI services

<table>
<thead>
<tr>
<th></th>
<th>Baseline survey</th>
<th>ASAP</th>
<th>NASP</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Follow-up survey</td>
<td>Dec, 2008</td>
<td>NASP</td>
</tr>
<tr>
<td></td>
<td>Monitoring data</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

2. By the end of 2008, is there a 30% (FSW & Clients) or 20% (MSM&TG) increase in the percentage of comprehensively reached target population reporting to have voluntarily sought STI services at baseline
- % of target population reporting to have voluntarily sought STI services at baseline

<table>
<thead>
<tr>
<th></th>
<th>Baseline survey</th>
<th>ASAP</th>
<th>NASP</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Follow-up survey</td>
<td>Dec, 2008</td>
<td>NASP</td>
</tr>
<tr>
<td></td>
<td>Monitoring data</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Interviews</td>
<td></td>
<td></td>
</tr>
<tr>
<td>STI services? If no, why not?</td>
<td>• % of comprehensively reached target population reporting to have voluntarily sought STI services at follow-up</td>
<td></td>
<td></td>
</tr>
<tr>
<td>---</td>
<td>---</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Increase in Sterile Needles and Syringes Use</strong></td>
<td><strong>I/DU only:</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>1. What percentage of comprehensively reached MAR I/DUs report to share injecting equipment less than 3 times per month?</td>
<td>• % of comprehensively reached MAR I/DU reporting to share injecting equipment less than 3 times per month</td>
<td></td>
<td></td>
</tr>
<tr>
<td>2. By the end of 2008, is the target of 70% of comprehensively reached MAR I/DUs reporting to share injecting equipment less than 3 times per month achieved? If no, why not?</td>
<td>• % of I/DU reporting to share injecting equipment less than 3 times per month at baseline</td>
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<td>3. What percentage of comprehensively reached MAR I/DU report to have used sterile needles and syringes the last time they injected?</td>
<td>• % of comprehensively reached MAR I/DU reporting to have used sterile needles and syringes the last time they injected at follow-up</td>
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<td>4. By the end of 2008, is the target of 80% of comprehensively reached MAR I/DUs reporting to use sterile needles and syringes the last time they injected achieved? If no, why not?</td>
<td>• % of I/DUs reporting to have used sterile needles and syringes the last time they injected at baseline</td>
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<td>• % of comprehensively reached MAR I/DU reporting to have used sterile needles and syringes the last time they injected at follow-up</td>
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<td>• Baseline survey</td>
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