UNICEF

HIV and AIDS TARGETED INTERVENTIONS (HATI)

PARTICIPATORY MONITORING AND EVALUATION FRAMEWORK AND GUIDELINES

February 14, 2008

Ana Coghlan, PhD
Participatory Monitoring and Evaluation Consultant
Dhaka, Bangladesh

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.

ACRONYMS

AIDS	Acquired immune deficiency syndrome
AM	Abscess management
ASAP	As soon as possible
BBSW	Brothel-based sex worker
BCC	Behavior change communication
BRAC	Bangladesh Rural Advancement Committee
BSS	Behavioral surveillance survey
CB	Capacity building
ClDR	Clinical daily register
CMCR	Consortium monthly compilation report
CoDR	Counseling daily register
CoSW	Clients of sex workers
CPAP	Country programme action plan
DfID	Department for International Development
DIC	Drop in center
DIC DR	Drop in center daily register
DIC MCR	Drop in center monthly compilation register
DR	Doctor
EV	Exchange visit
FHI	Family Health International
FSW	Female sex worker
GH	General Health
HAAP	HIV/AIDS Prevention Project
HATI	HIV and AIDS Targeted Interventions
HIV	Human immunodeficiency virus
HNPSP	Health, Nutrition, Population Sector Project
HR	Harm reduction
HRSW	Hotel and residence-based sex worker
ICCRD,B	International Center for Diarrhoeal Disease Research, Bangladesh
I/DU	Injecting/drug user
IEC	Information, education, communication
M&E	Monitoring and Evaluation
MAR	Most-at-risk
MARP	Most-at-risk population
MIS	Management information system
MoHFW	Ministry of Health and Family Welfare
MPP	Mid-project report
MQ	Monitoring quality
MR	Monthly report
MSA	Management support agency
MSM	Males who have sex with males
MSM&TG	Males who have sex with males and transgender
N/A	Not applicable
NA	Needs assessment
NASP	National AIDS and STI Programme

NGO	Non-government organization
NGO MCR	Non-government organization monthly compilation report
NSS	National sero-surveillance Survey
ODAS	Outreach daily activity sheet
OS	Outreach supervisor
OW	Outreach worker
OWCS	Outreach weekly compilation sheet
PCR	Project completion report
PE	Peer educator
PFT	Program facilitation team
PM&E	Participatory monitoring and evaluation
PLA	Participatory learning for action
PNGO	Partner non-government organization
PNS	Procurement of NGO services
PRA	Participatory rural appraisal
PSUR	Project start up report
QPR	Quarterly progress report
QR	Quarterly report
SBSW	Street-based sex worker
SHG	Self-help group
SG	Social group
STI	Sexually transmitted infections
SS	Supportive supervision
TG	Transgender or *Hijra*
TM&OE	Training, meetings and other events form
UIC	Unique identification code
UNAIDS	United Nations Joint Programme on HIV/AIDS
UNICEF	United Nations Children's Fund
VCT	Voluntary counseling and testing

TABLE OF CONTENTS

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 Targteted 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 HAPP, 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 HAPP, 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 HAPP'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:

- Family Health International (2004). *Monitoring HIV/AIDS Program: A Facilitator's Training Guide*. Arlington, VA: Family Health International.

- Gill K., Emah E., Fua, I. (2005). *A Guide to Participatory Monitoring of Behavior Change Communications for HIV/AIDS: Getting the Community and Program Staff Involved in Assessing and Improving Programs.* Washington, D.C.: Path. Available at: http:/www.path.org.

- McCoy, K.L., Ngari, P.N., Krumpe, E.E. (2005). *Building Monitoring, Evaluation and Reporting Systems for HIV/AIDS Programs.* Washington, D.C.: Pact.

- UNAIDS (2002). *National AIDS Councils, Monitoring and Evaluation Operations Manual.* Geneva, Switzerland: UNAIDS. Available at: http:/www.unaids.org

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?

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

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?

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

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.

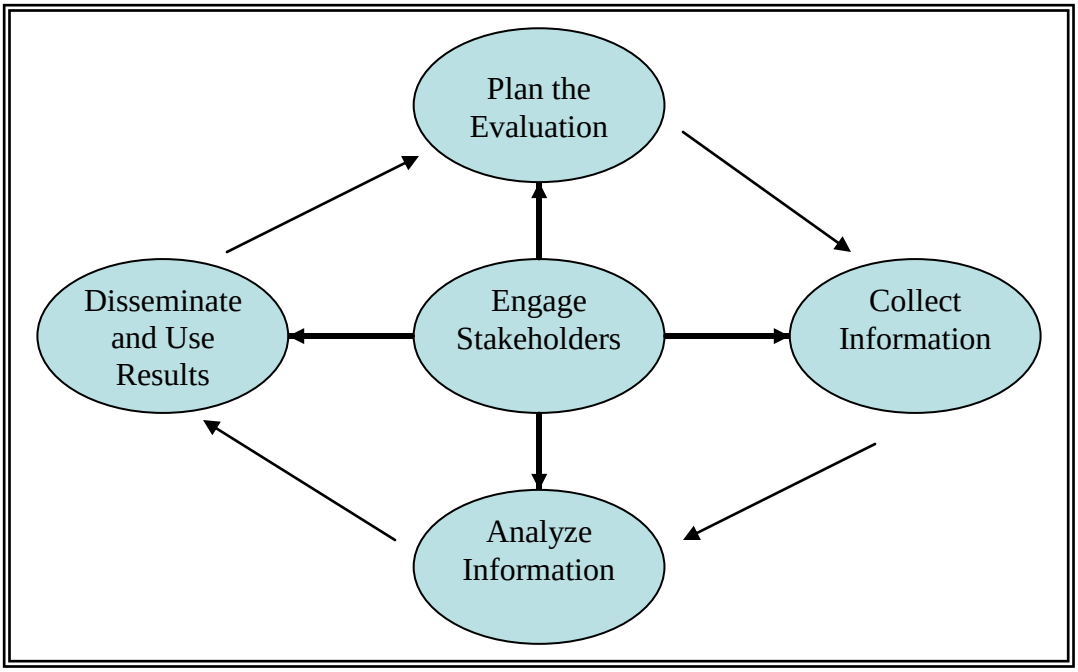
2.3 Stages in Conducting Participatory Monitoring and Evaluation

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

Levels	Description
Inputs	Inputs are the people, training, equipment and resources that we put into a project, in order to achieve outputs
Outputs	Outputs are the activities or services we deliver, including HIV/AIDS prevention, care and support services, in order to achieve outcomes. The processes associated with service delivery are very important and involve quality, unit costs, access and coverage.
Outcomes	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.
Impact	The above-mentioned outcomes are intended to lead to major measurable health impacts, particularly reduced STI/HIV transmission and reduced AIDS impact.

Source: UNAIDS (2002). *National AIDS Councils, Monitoring and Evaluation Operations Manual.* Geneva, Switzerland: UNAIDS.

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.

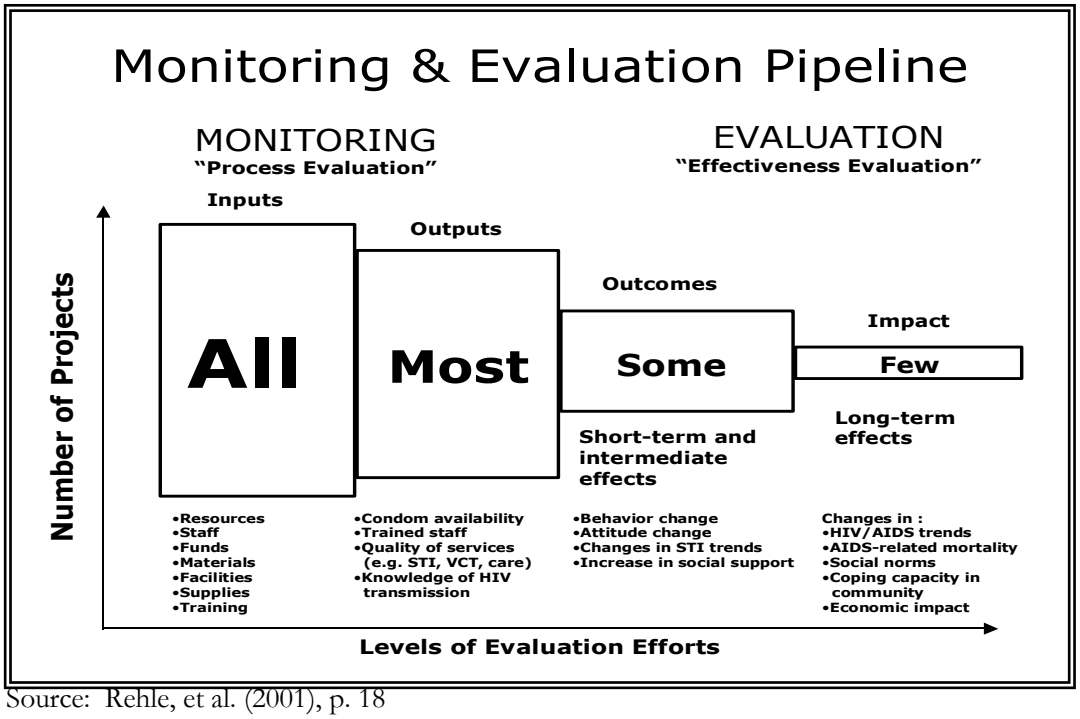
3. To obtain additional resources from current and/or other donor agencies

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."



Source: Rehle, et al. (2001), p. 18

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 indictors 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 also is 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

Method	Overall Purpose	Advantages	Challenges
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

Source: McNamara, Carter (1997). *Field Guide to Nonprofit Program Design, Marketing and Evaluation*. Authenticity Consulting, LLC.

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

Sign-in or registration logs	Every client who enters the facilty 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.
Activity logs	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.
Registration forms	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.
Checklists	Used as an aid to observers who are monitoring events, procedures, or services.
Program activity forms	Vary widely, but often designed specifically to collect basic information about program activities.
Tally or compilation sheets	Used to compile raw data from logs on a periodic basis.
Monthly summary forms	Used to compile or summarize raw data from other forms on a montly basis.
Patient records/charts	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.
Open-ended interview or topic guides	Often used in qualitative (words) data collection methods, such as interviews or focus group discussions, to seek and record descriptive and other information.
Semi-structured questionnaires	Often used in quantitative (numeric) methods as a way to gather information by asking standardized questions in a structured format.

Adapted from: Family Health International (2004). Core Module 2: Collecting, Analyzing, and Using Monitoring Data. Arlington, VA: Family Health International.

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

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

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:

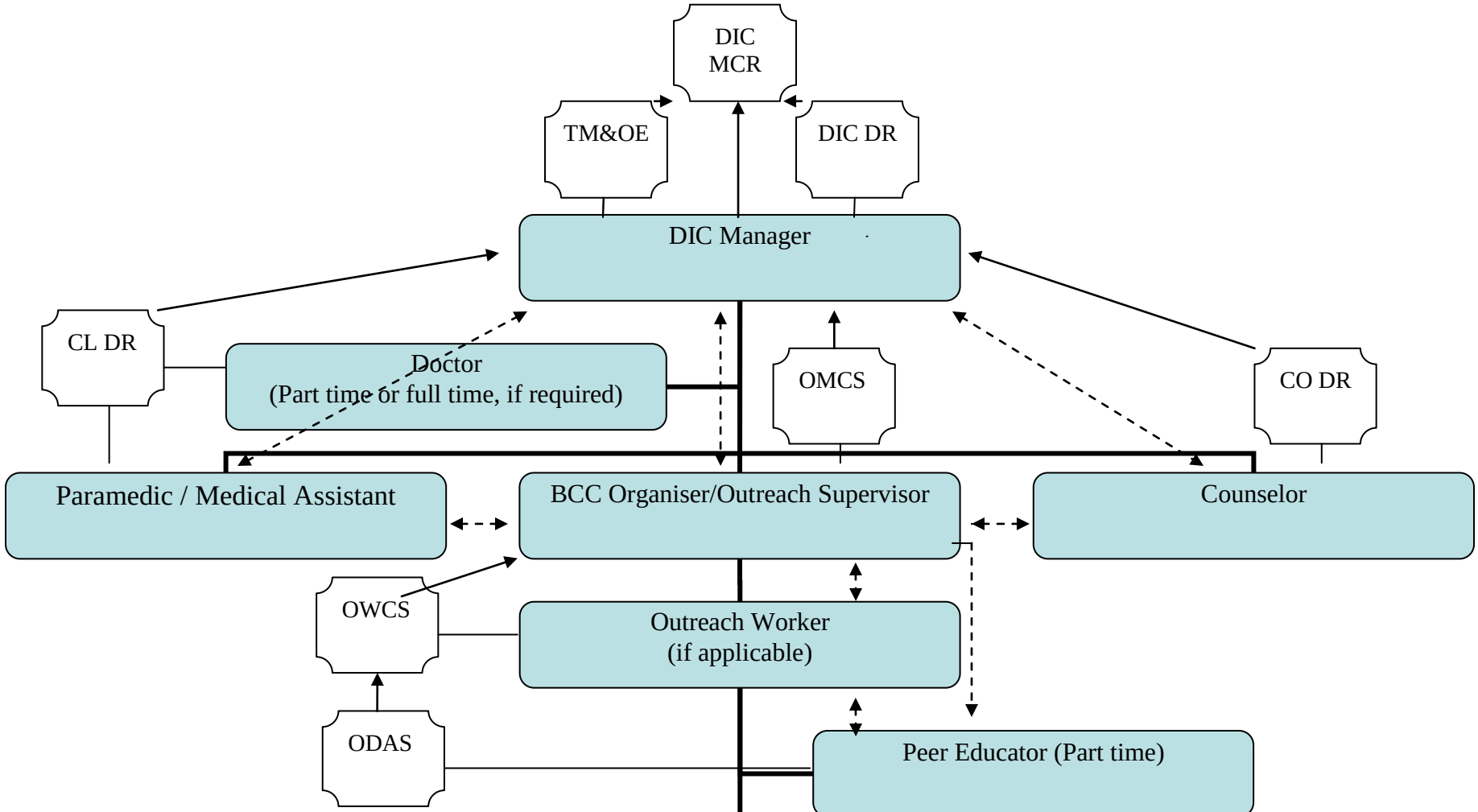
Data Reporting Form	Person Responsible
NGO Monthly Compilation Report (NGO MCR)	Program Coordinator
Consortium Monthly Compilation Report (Con MCR)	Technical Coordinator-M&E and Team Leader[1]
Project Start-Up Report (PSUR)	Technical Coordinator-M&E and Team Leader
Quarterly Report (QR)	Technical Coordinator-M&E and Team Leader
Mid-Project Report (MPP)	Technical Coordinator-M&E and Team Leader
Project Completion Report (PCR)	Technical Coordinator-M&E and Team Leader

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 organagrams. 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.

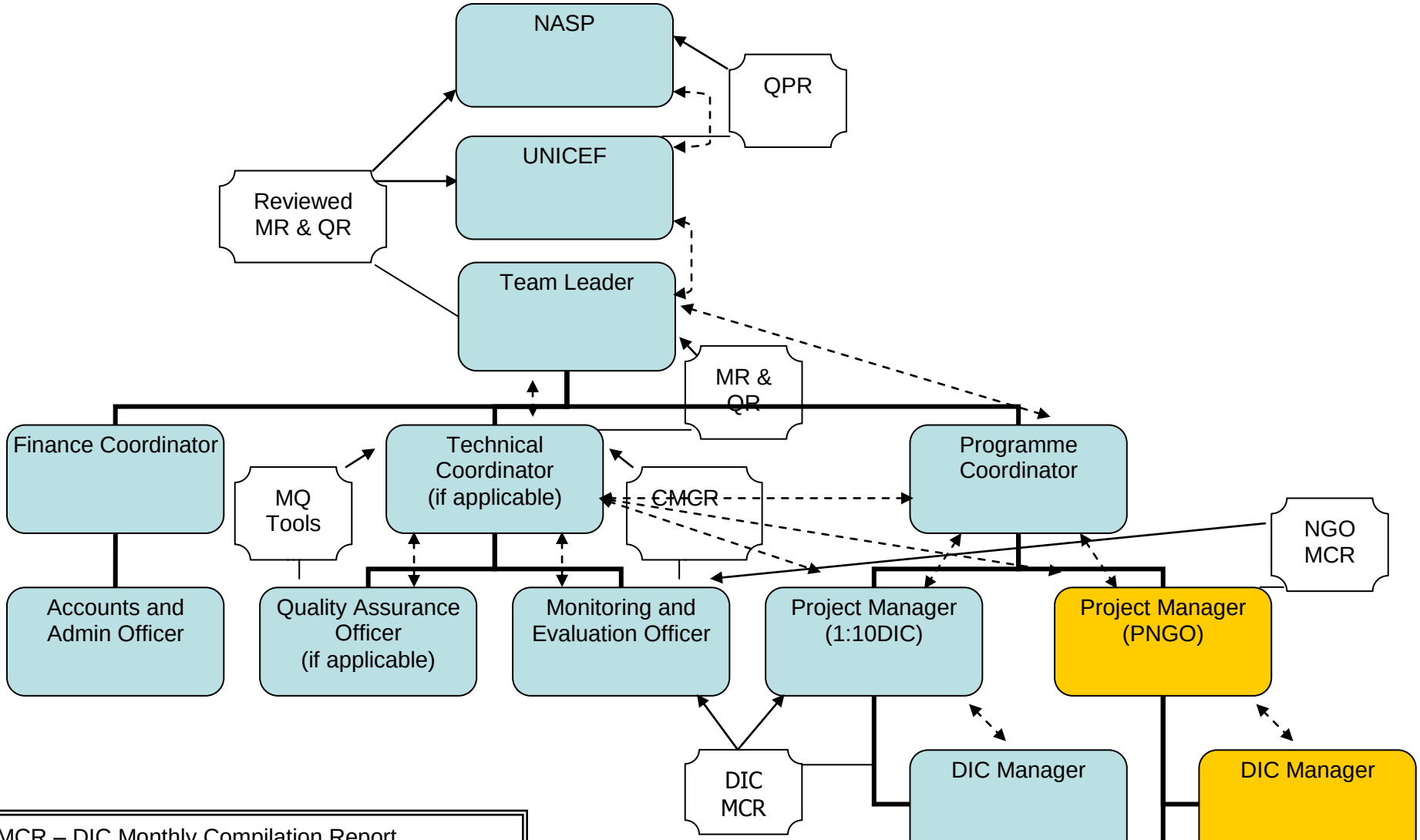
DIC-LEVEL PROGRAM MONITORING DATA FLOW



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

Responsible for ⇠⇢ Feedback to/from
→ Goes to

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

Purpose	Audience	Type of M&E Results	Communication Method	Comments
1. Accountability	Program Participants	• Implementation of program activities • Quality of services and activities	• Written summary report – brief, user-friendly, in Bangla • Oral discussions • Visual displays	Need to make methods interesting and understandable to specific target populations
	Donors, Management Support Agency (MSA), Government	• Implementation of program activities • Achievement of program targets and expected outputs • Quality of services and activities	• Monthly reports • Quarterly reports • Coordination meetings • Dissemination seminars	UNICEF, NASP & donors need to agree on key indicators and design a common reporting format for HATI lead agencies
2. Improve Program Planning and Implementation	DIC-level staff	• Implementation of program activities • Achievement of program targets and expected outputs • Quality of services and activities	• Individual reflection through written diaries • Weekly meetings between peer educators and outreach workers/ supervisors to complete compilation sheet and problem solve • Ad hoc discussions between project managers, DIC managers, counselors, paramedics, outreach supervisors, peer educators to acknowledge successes,	Particular methods need to be adapted to the actual structure of individual DICs

			compare with targets, identify challenges & lessons learned, problem solve • Monthly staff meetings to acknowledge successes, compare with targets, identify challenges & lessons learned, problem solve	
	NGO-level	• Implementation of program activities • Achievement of program targets and expected outputs • Quality of services and activities	• NGO meetings with NGO project managers and lead agency team leader and M&E officer to acknowledge successes, compare with targets & between NGO DICs, challenges & lessons learned, problem solve • Consortium meetings with PNGO project managers and lead agency team leader and M&E officer to acknowledge successes, compare with targets & between NGOs, challenges & lessons learned, problem solve	
	Consortia	• Aggregation of program activities • Comparison with program targets and outputs	• Coordination meetings with consortia team leaders, program coordinators, M&E	

		• Levels of quality of services and activities	officers and NASP and UNICEF staff	
3. Obtain necessary resources	Government Current and potential donors	• Program achievements • Program challenges • Lessons learned • Future plans and requirements	• Dissemination workshops • HATI Fair • Project proposals • Meetings	
4. Advocate for Most-at-Risk Populations and HIV issues	<u>Local/District Level</u>: • Elected officials, government officers, mustaans, police, religious leaders, etc. • Service providers <u>National Level</u>: • Policy makers <u>Private Sector Level</u> • Private companies	• Sensitization to MARP and HIV situation & issues • Program background & general information • Program achievements • Program challenges • Ways to support the program • Same as above • Orientation on corporate responsibility	• Community meetings • Project Facilitation Team meetings • Meetings • Meetings • National dissemination seminars, other seminars • Orientation workshops • Roundtable discussions	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.

> "To ensure that a breadth of opinion is captured relating to the performance, and because [monitoring and] evaluations include important capacity development and learning dimensions, they should be as participatory as possible. Stakeholder involvement in learning efforts usually promotes a sense of partnership among all the key people and/or groups interested in the organization. A participatory process is essential to provide more insight into programs and allows analysis of how well the needs of different stakeholders are being met. A variety of different perspectives is particularly helpful in analyzing unintended consequences and sustainability of activities."
>
> PACT, 2005, p. 79

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:[2]

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

[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**: Thos 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

services. 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

Family Health International (2004). *Monitoring HIV/AIDS Programs: A Facilitator's Training Guide.* Arlington, VA: Family Health International.

Gill K., Emah E., Fua, I. (2005). *A Guide to Participatory Monitoring of Behavior Change Communications for HIV/AIDS: Getting the Community and Program Staff Involved in Assessing and Improving Programs.* Washington, D.C.: Path. Available at: http:/www.path.org.

Independent Evaluation Group and Carleton University (2007). *International Program for Development Evaluation Training (IPDET) Handbook.* The World Bank Group. Available at http://www.worldbank.org/oed/ipdet/modules.html.

International Fund for Agricultural Development (IFAD) (2002). *Managing Impact in Rural Development, A Guide for Project M&E.* Rome: IFAD. Available at: www.ifad.org/evaluation/guide/index.htm

McCoy, K.L., Ngari, P.N., Krumpe, E.E. (2005). *Building Monitoring, Evaluation and Reporting Systems for HIV/AIDS Programs.* Washington, D.C.: Pact. Available at: www.pactworld.org/galleries/default-file/building_mer_systems.pdf.

Microfinance Development Center (2004). *Training on Participatory Monitoring and Evaluation of Development Programs.* Dhaka, Bangladesh: CARE Bangladesh.

National AIDS/STD Programme (NASP), Directorate General of Health Services, Ministry of Health and Family Welfare, (2007). *National AIDS Monitoring and Evaluation Framework and Operational Plan, 2006-2010.* Dhaka, Bangladesh: NASP

Rehle, T., Saidel, T., Mills, S. Magnani, R. (2001). *Evaluation Programs for HIV/AIDS Prevention and Care in Developing Countries.* Arlington, VA: Family Health International (FHI). Available at: www.fhi.org/en/HIVAIDS/pub/Archive/evalchap/

UNAIDS (2002). *National AIDS Councils, Monitoring and Evaluation Operations Manual.* Geneva, Switzerland: UNAIDS. Available at: www1.worldbank.org/hiv_aids/docs/M&EManual.pdf

UNAIDS (2004). *Monitoring and Evaluation Toolkit: HIV/AIDS, Tuberculosis, and Malaria.* Geneva: UNAIDS. Available at: www.theglobalfund.org/pdf/guidelines/pp_me_toolkit_en.pdf

UNAIDS (2007). *A Framework for Monitoring and Evaluating HIV Prevention Programmes for Most-at-Risk Populations.* Geneva: UNAIDS. Available at: data.unaids.org/pub/Manual/2007/20070420

UNICEF (n.d.), *A UNICEF Guide for Monitoring and Evaluation: Are We Making a Difference?* Available at: htpp://www.unicef.org/reseval/index.html

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 of 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 Indictors
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.

Appendix 2

HIV and AIDS Targeted Interventions (HATI) under HNPSP
Logical Framework

Expected Outcomes and Results	Objectively Verifiable Indicators	Means of Verification	Assumptions
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

Inputs	Activities	Expected Targets/Outputs[3]	Outcomes[3] (Intermediate Results)	Impact[3] (Long term Results)
• Staff • Office • Furniture • Equipment • Office Supplies • Condoms • Lubricant • Medicines • IEC and BCC Materials • Funds • Referral Centres	**1. Project Management and Coordination** 1.1 Conduct intervention mapping 1.2 Assess new intervention sites 1.3 Recruit staff 1.4 Set up DICs 1.5 Establish unique ID codes 1.6 Develop/procure/reprint IEC materials 1.7 Form DIC Management Committees / Project Facilitation Teams 1.8 Develop procurement plan for logistics supplies 1.9 Ensure logistic supply 1.10 Conduct DIC-level meetings w/: • Staff • DIC Management Teams / Program Facilitation Teams • Service Providers (STI, VCT) • Government Agencies • Other 1.11 Conduct Consortium-level meetings w/ (if applicable): • Consortium members • Other consortia members • Service Providers (STI, VCT) • Government Agencies • Other	**Program Management** IDU, FSW, Clients, MSM&TG: Program managed effectively and efficiently		I/DU: Reduce the risk of HIV transmission among I/DUs and maintain the current level of HIV prevalence among I/DUs (7%, ref: National Sero-surveillance Survey, VII Round, 2007). FSW, CLSW, MSM&TG: Reduce the risk of HIV transmission among the most at risk populations (MARP) and keep HIV prevalence below the level of a concentrated epidemic (< 1%).

[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[4] MAR I/DU receive comprehensive coverage[5] 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[4] target group	**Increase in Correct Knowledge of HIV** I/DU: • 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	

[4] 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.

[5] 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 sessions 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) **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	receive comprehensive coverage[5] by end of 2008 **VCT Targets:** <u>IDU, FSW, Clients, MSM&TG:</u> • 100% of listed[6] MARP receive information on VCT at least every quarter by end of 2008 **STI Management Targets:** <u>IDU</u>: • 100% of listed MAR I/DUs receive STI counseling and physical exam/checkup at least once every quarter by end of 2008 <u>FSW:</u> • 100% of listed FSW receive STI counseling and physical exam/checkup at least once a month by end of 2008 <u>Clients:</u> • 100% of listed Clients receive STI counseling and physical exam/checkup at least once a	HIV transmission <u>Clients</u>: • 80% of listed clients correctly identify using condoms and receiving STI services as ways to prevent HIV transmission <u>MSM&TG</u>: • 90% of listed MSM&TG correctly identify using condoms and receiving STI services as ways to prevent HIV transmission **Increase in Consistent Condom Use:** <u>I/DU, FSW, Clients, MSM&TG:</u> • Consistent condom use among at least 80% of comprehensively reached MARP by end of 2010, with a 20% increase from baseline by end of 2008 **Increase in STI Management:** <u>FSW:</u> • STI services sought voluntarily by 75% of comprehensively reached FSWs by end of 2010, with 30% increase from baseline by end of 2008 <u>Clients</u>: • STI services sought	

[6] 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.

		quarter by end of 2008 MSM&TG: • 80% of listed MSM&TG receive STI counseling and physical exam/checkup at least once a month by end of 2008	voluntarily by 65% of comprehensively reached Clients by end of 2010, with 30% increase from baseline by end of 2008 MSM&TG: • STI services sought voluntarily by 75% of comprehensively reached Clients by end of 2010, with 20% increase from baseline by end of 2008	
	6. Provide Detoxification and Rehabilitation Services (I/DU only) 6.1 Conduct community-based detox camps 6.2 Refer individuals to other detox and rehab services 6.3 Link individuals to income generating activities or related training	**Detoxification Targets:** IDU: • At least 10% of listed I/DU undergo detox by the end of 2008, of whom at least 70% are MAR • Of those who undergo detox, 10% also undergo rehabilitation by end of 2008	**Increase in Sterile Needles/ Syringes Use (I/DU only):** • Sharing of injecting equipment reduced to < 3 times/month in at least 70% of comprehensively reached MAR I/DUs by end of 2008 • 80% of comprehensively reached MAR I/DU reportedly used sterile needles/syringes the last time they injected by end of 2008	
	7. Provide Training and Other Assistance to Target Population and other Non-Staff (if applicable)			
	8. Organize /Participate in Advocacy Events	**Enabling Environment** IDU, FSW, Clients, MSM&TG: Community and local administration support increased		
	9. Manage and Develop PNGOs and/or SHGs (if applicable) 9.1 Sign MOU 9.2 Communicate 9.3 Provide technical support 9.4 Provide financial support 9.5 Provide supplies	**Partner NGOs & Self-help Groups** (if applicable) I/DU, FSW, Clients, MSM&TG: PNGO and SHG managed effectively and efficiently		

	10. Monitor, Evaluate, Research, Report 10.1 Develop/adapt minimum quality standards 10.2 Ensure compliance of minimum quality standards 10.3 Design and plan monitoring and supportive supervision system 10.4 Conduct monitoring and supportive supervision 10.5 Conduct progress review meetings 10.6 Conduct internal mid-term project review 10.7 Conduct action research (as needed) 10.8 Write monthly activities report 10.9 Write quarterly activities report 10.10 Write quarterly financial report 10.11 Write project completion report			

Appendix 4A

FRAMEWORK FOR MONITORING THE IMPLEMENTATION OF ACTIVITIES

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

[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	• TM&OE	• As occur	• Team Leader	• QR
3. Conduct Outreach & Peer Education					
3.1 Conduct one to one BCC sessions	• # of one to one BCC sessions	• ODAS & OWCS[4],	• Daily	• PE & OS[5]	• MR[6] & QR
	• # of individuals attended one to one BCC sessions	• ODAS & OWCS	• Daily	• PE & OS	• MR & QR
3.2 Conduct group BCC sessions	• # of group BCC sessions	• ODAS & OWCS	• Daily	• PE & OS	
	• # of individuals attended group BCC sessions	• ODAS & OWCS	• Daily	• PE & OS	• MR & QR
3.3 Distribute IEC materials	• # of IEC mats distributed	• ODAS & OWCS	• Daily	• PE & OS	• MR & QR
	• # of individuals receiving IEC mats	• ODAS & OWCS	• Daily	• PE & OS	• MR & QR
3.4 Demonstrate condom & lubricant use	• # of condom & lube demonstrations	• ODAS & OWCS	• Daily	• PE & OS	• MR & QR
	• # of individuals attended condom & lube demos	• ODAS & OWCS	• Daily	• PE & OS	• MR & QR
3.5 Distribute condoms and lubricant	• # of condoms distributed	• ODAS & OWCS	• Daily	• PE & OS	
	• # of individuals receiving condoms	• ODAS & OWCS	• Daily	• PE & OS	• MR & QR
	• # of lube distributed	• ODAS & OWCS	• Daily	• PE & OS	• MR & QR
	• # of individuals receiving lube	• ODAS & OWCS	• Daily	• PE & OS	• MR & QR
3.6 Refer participants to DIC	• # of participants referred to DIC	• ODAS & OWCS	• Daily	• PE & OS	• MR & QR
3.7 Conduct cultural events	• # of cultural events conducted	• ODAS & OWCS	• Daily	• PE & OS	• MR & QR
	• # of participants attended cultural events	• ODAS & OWCS	• Daily	• PE & OS	• MR & QR
3.8 Distribute needles (I/DU only)	• # of needles distributed	• ODAS & OWCS	• Daily	• PE & OS	
	• # of individuals receiving needles	• ODAS & OWCS	• Daily	• PE & OS	• MR & QR
3.9 Distribute syringes (I/DU only)	• # of syringes distributed	• ODAS & OWCS	• Daily	• PE & OS	• MR & QR

[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) 3.11 Collect used syringes (I/DU only)	• # of individuals receiving syringes • # of used needles collected • # of individuals giving used needles • # of used syringes collected • # of individuals giving used syringes	• ODAS & OWCS • ODAS & OWCS • ODAS & OWCS • ODAS & OWCS • ODAS & OWCS	• Daily • Daily • Daily • Daily • Daily	• PE & OS • PE & OS • PE & OS • PE & OS • PE & OS	• MR & QR • MR & QR • MR & QR • MR & QR • MR & QR • MR & QR
4. Provide DIC, DIC Outlet or Saloon-based Non-Clinical Services					
4.1 Conduct one to one BCC sessions	• # of one to one BCC sessions • # of individuals attended one to one BCC sessions	• DIC Daily Register • DIC Daily Register	• Daily • Daily	• OS/Counslor • OS/Counslor	• MR & QR • MR & QR
4.2 Conduct group BCC sessions	• # of group BCC sessions • # of individuals attended group BCC sessions	• DIC Daily Register • DIC Daily Register	• Daily • Daily	• Counselor • Counselor	• MR & QR • MR & QR
4.3 Conduct social group/narcotic anonymous meetings	• # of social group/NA meetings • # of SG/NA meeting participants	• DIC Daily Register • DIC Daily Register	• Daily • Daily	• Counselor • Counselor	• MR & QR • MR & QR
4.4 Provide non-STI counseling	• # of non-STI counseling sessions • # of non-STI counseling sessions participants	• DIC Daily Register • DIC Daily Register	• Daily • Daily	• Counselor • Counselor	• MR & QR • MR & QR
4.5 Provide recreational activities	• # of individuals using recreation activities	• DIC Daily Register	• Daily	• DIC Manager	• MR & QR
4.6 Distribute IEC materials	• # of IEC mats distributed • # of individuals receiving IEC mats	• DIC Daily Register • DIC Daily Register	• Daily • Daily	• Counselor • Counselor	• MR & QR • MR & QR
4.7 Demonstrate condom and lube use	• # of condom & lube demonstrations • # of individuals attended condom & lube demos	• DIC Daily Register • DIC Daily Register	• Daily • Daily	• Counselor • Counselor	• MR & QR • MR & QR
4.8 Distribute condoms and lubricant	• # of condoms distributed • # of individuals receiving condoms	• DIC Daily Register • DIC Daily Register	• Daily • Daily	• Counselor • Counselor	• MR & QR • MR & QR

	• # of lube distributed	• DIC Daily Register	• Daily	• Counselor	• MR & QR
	• # of individuals receiving lube	• DIC Daily Register	• Daily	• Counselor	• MR & QR
4.9 Refer clients to VCT	• # of individuals referred to VCT	• DIC Daily Register	• Daily	• Dr/Paramedic	• MR & QR
	• # of referred individuals who received VCT	• DIC Daily Register	• Daily	• Dr/Paramedic	• MR & QR
	• # of needles distributed	• DIC Daily Register	• Daily	• DIC Manager	• MR & QR
4.10 Distribute needles (I/DU only)	• # of individuals receiving needles	• DIC Daily Register	• Daily	• DIC Manager	• MR & QR
	• # of syringes distributed	• DIC Daily Register	• Daily	• DIC Manager	• MR & QR
4.11 Distribute syringes (I/DU only)	• # of individuals receiving syringes	• DIC Daily Register	• Daily	• DIC Manager	• MR & QR
	• # of used needles collected	• DIC Daily Register	• Daily	• DIC Manager	• MR & QR
4.12 Collect needles (I/DU only)	• # of individuals giving used needles	• DIC Daily Register	• Daily	• DIC Manager	• MR & QR
	• # of used syringes collected	• DIC Daily Register	• Daily	• DIC Manager	• MR & QR
4.13 Collect syringes (I/DU only)	• # of individuals giving used syringes	• DIC Daily Register	• Daily	• DIC Manager	• MR & QR
4.14 Distribute cinema tickets (BRAC only)	• # of cinema tickets distributed	• DIC Daily Register	• Daily	• DIC Manager	• MR & QR
	• # of individuals receiving cinema tickets	• DIC Daily Register	• Daily	• DIC Manager	• MR & QR
4.15 Distribute barber tokens (BRAC only)	• # of barber token distributed	• DIC Daily Register	• Daily	• DIC Manager	• MR & QR
	• # of individuals receiving barber tokens	• 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	• Clinical Daily Register	• Daily	• Dr/Paramedic	• MR & QR
	• # of individuals attending clinic sessions	• 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
5.3 Provide treatment to STI patients	• # of individuals receiving STI treatment	• 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

patients	GH treatment				
5.5 Provide abscess management (AM) services (for I/DU only)	• # of individuals receiving AM services	• Clinical Daily Register	• Daily	• Counselor	• MR & QR
5.6 Provide STI counseling	• # of individuals receiving STI counseling	• Clinical Daily Register	• Daily	• Counselor	• MR & QR
5.7 Demonstrate condom and lube use	• # of condom & lube demonstrations	• Clinical Daily Register	• Daily	• Counselor	• MR & QR
5.8 Distribute condoms and lubricant	• # of condoms distributed	• Clinical Daily Register	• Daily	• Counselor	• MR & QR
	• # of individuals receiving condoms	• Clinical Daily Register	• Daily	• Counselor	• MR & QR
	• # of lube distributed	• Clinical Daily Register	• Daily	• Counselor	• MR & QR
	• # of individuals receiving lube	• Clinical Daily Register	• Daily	• Counselor	• MR & QR
5.9 Refer complicated cases to other health services	• # of individuals referred to other services	• Clinical Daily Register	• Daily	• Dr/Counselor	• MR & QR
	• # of referred individuals who went for other services	• Clinical Daily Register	• Daily	• Dr/Counselor	• MR & QR
5.10 Conduct follow-up on STI patients	• # of individuals followed up on	• Clinical Daily Register	• Daily	• Counselor	• MR & QR
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
	• # of individuals attending detox camps	• TM&OE	• As occur	• DIC Manager	• MR & QR
6.2 Refer individuals to other detox and rehab services	• # 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
6.3 Link individuals to income generating activities (IGA) or related training	• # 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)	• # and type of trainings at DIC level	• TM&OE	• As occur	• DIC Manager	• QR
	• # of participants by type of training at DIC level	• TM&OE	• As occur	• DIC Manager	• QR
	• # and type of trainings at	• TM&OE	• As occur	• DIC Manager	• QR

	NGO level • # of participants by type of training at NGO level	• TM&OE	• As occur	• DIC Manager	• QR
8. Organize / Participate in Advocacy Events	• # and type of advocacy event • # of participants by type of advocacy event	• TM&OE	• As occur	• DIC Manager	• QR
9. Manage and Develop PNGOs and/or SHGs (if applicable)					
9.1 Sign MOU	• # of signed MOUs	• MOU documents	• As occur	• Team Leader	• QR
9.2 Communicate	• # and type of communications	• Letters, emails, phone	• As occur	• Team Leader	• QR
9.3 Monitor, including feedback	• # and type of monitoring	• Monitoring reports	• As occur	• Team Leader	• QR
9.4 Provide technical support	• # and type of feedback given	• Feedback reports	• As occur	• Team Leader	• QR
9.5 Provide financial support	• # and type of TA provided	• TA reports	• As occur	• Team Leader	• QR
9.6 Provide supplies	• Amount and type of financial support provided	• Financial reports	• As occur	• Team Leader & Fin Coord	• QR
	• # and type of supplies provided	• Financial reports • Stock registers	• As occur • As occur	• Team Leader & Fin Coord	• QR
10. Monitor, Evaluate, Research, Report					
10.1 Develop/adapt minimum quality standards	• # of plans for adapting quality standards	• Plans for adapting quality standards	• Feb end	• M&E Cood[7]	• PSUR
10.2 Monitor the quality of services	• # of monitoring visits • Scores/results from visits	• Monitoring Quality Checklist	• Quarterly	• M&E Cood	• PSUR
10.3 Design and plan monitoring and supportive supervision (SS) system	• # of monitoring and SS plans	• Monitoring and SS plans	• Feb end	• Team Leader	• QR
10.4 Conduct monitoring and supportive supervision	• # of SS visits	• TM&OE	• Monthly	• M&E Cood	• QR
10.5 Conduct progress review meetings	• # of progress review meetings	• TM&OE	• Monthly	• DIC Manager	• QR
10.6 Conduct internal mid-term project review	• Mid-term review report	• Mid-term review report	• Mid-term	• Team Leader	• Mid-project report
10.7 Conduct action research (as needed)	• # and type of action research	• Action research reports	• As occur	• Team Leader	• QR
10.8 Write monthly & quarterly reports					
10.9 Write quarterly financial report					
10.10 Write project completion report					

[7] Technical Coordinator – M&E

Appendix 4B

FRAMEWORK FOR MONITORING THE ACHIEVMENT OF EXPECTED OUTPUTS

Program Component and Monitoring Questions	Indicators	Data Source, Collection Method/ Form	Frequency Data are Collected	Person(s) Responsible	Reported to UNICEF in:
1. Project Management and Coordination					
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	N/A
2. Developing Capacities of NGO Staff					
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[8]	• 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 • Coverage target[9]	• 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 • Coverage target	• 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

[8] For the specific definitions of "comprehensive coverage" for each intervention package, please refer to the section, "Glossary and Definitions."
[9] 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.

	exam/checkup at least once a month/quarter				
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	• Quarterly	• M&E Coordinator	• QR
2. Was the detox target of 10% achieved? If not, why not?		• 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 • 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 • Interviews	• Quarterly	• M&E Coordinator	• QR
7. Enabling Environment					
1. Has community support increased? If yes, in what ways?	• # and type of advocacy events	• Workshop reports • Meeting minutes	• Quarterly	• DIC Manger and M&E Coordinator	• QR
2. Has local administration support increased? If yes, in what ways?	• # of advocacy events organized jointly with other stakeholders	• DIC Monthly Compilation Report	• Quarterly		• QR
	• # of and ways in which program participants are involved in program planning, implementation and monitoring	• Interviews with program participants, community members, local administration members	• Quarterly	• DIC Manger and M&E Coordinator	• QR
	• Evidence of ways in which community members support/do not support the program		• Quarterly	• DIC Manger and M&E Coordinator	• QR
	• Evidence of ways in which		• Quarterly	• DIC Manger and M&E	• QR

	local administration members support/do not support the program			Coordinator	
8. Management and Development of PNGOs and/or SHGs (if applicable)					
1. Are the PNGOs managed effectively and efficiently?	• # of PNGOs receiving funds when due • # of PNGOs receiving supplies when due • # of PNGOs receiving TA when and where required	• Financial reports • Financial reports • TM&OE • LA's field visit and monitoring report	• As occur • As occur • As occur • As occur	• Team Leader & Fin Coord • Team Leader & Fin Coord • Prog Coord • Prog Coord	• QR • QR • QR • QR
2. Are the SHGs managed effectively and efficiently?	• # of SHGs receiving funds when due • # of SHGs receiving supplies when due • # of SHGs receiving TA when and where required	• Financial reports • Financial reports • TM&OE • LA's field visit and monitoring report	• As occur • As occur • As occur • As occur	• Team Leader & Fin Coord • Team Leader & Fin Coord • Prog Coord • Prog Coord	• QR • QR • QR • QR

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. INVOLVLEMENT 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

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

[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	• Baseline survey • Follow-up survey	• ASAP • Dec, 2008	• NASP • NASP
2. Increase in Consistent Condom Use:				
1. What percentage of comprehensively reached MAR report to have used condoms consistently?	• % of comprehensively reached MAR reporting to have used condoms consistently	• Baseline survey • Follow-up survey • Monitoring data	• ASAP • Dec, 2008	• NASP • NASP
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	• Baseline survey • Follow-up survey • Monitoring data • Interviews	• ASAP • Dec, 2008	• NASP • NASP
Increase in STI Management:				
<u>FSW, Clients, MSM&TG (not I/DU)</u> 1. What percentage of comprehensively reached target population voluntarily sought STI services?	• % of comprehensively reached target population reporting to have voluntarily sought STI services	• Baseline survey • Follow-up survey • Monitoring data	• ASAP • Dec, 2008	• NASP • NASP
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	• % of target population reporting to have voluntarily sought STI services at baseline	• Baseline survey • Follow-up survey • Monitoring data • Interviews	• ASAP • Dec, 2008	• NASP • NASP

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