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USAID NICARAGUA
HIV BILATERAL PROGRAM
MID TERM PERFORMANCE

Period 2007 - 2013

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ACRONYMS

ACCCS	Coastal Association for a Campaign Against AIDS
ADESENI	Nicaraguan Association for Sexual Diversity Rights
AHCV	Men´s Association Against Violence
AIDS	Acquired Immunodeficiency Syndrome
AMODISEC	Movement Association for Sexual Diversity in the Caribbean Coast
ANICP + VIDA	Nicaraguan Association of Positive Persons for Life
API	Policy Environment Improvement
ARV	Antiretroviral
ARVT	AntiretroviralTherapy
ASONVIHSIDA	Nicaraguan Association for HIV/AIDS
BCC	Behavior Change Communication
BICU	Bluefield's Indian & Caribbean University
CAPF	PEPFAR´s Central America Partnership Framework
CCM	Country Coordinating Mechanisms
CEPRESI	Center for AIDS Education and Prevention
CIES	Center for Health Research and Studies
CONISIDA	AIDS Nicaraguan Commission
CORESIDA	AIDS Regional Commission in RAAS
COSEP	Superior Council of Private Enterprises
CP	Combined Prevention
CPP	Strategy of combined prevention for positives
CQI	Continuous Quality Improvement
CURIM	Committee for the Rational Use of Medical Supplies
DAIA	Committee for Contraceptive Availability Security
DAISSR	Committee for availability security of sexual and reproductive health supplies
DELIVER	Technical Assistance Project on Logistics for Medical Supplies
ECMAC	Program for Community Contraceptive Delivery Methods
ENDESA	National Demographic Survey on Health
FAMISALUD	Families United for their Health. Community based health Project
FG	Focal Group
FP	Family Planning
GAO	Western Self-help Group Association
GBV	Gender Based Violence
GF	Global Fund
GFTAM	Global Fund Tuberculosis, Aids & Malaria
HCI	Health Care Improvement/USAID
HIV	Human Immunodeficiency Virus

HR	Human Resources
ICAS	Central American Health Institute
IDU	IV Drug User
INSS	Nicaraguan Social Security Institute
IPSS	Institutions that provide social prevention services
IXCHEN	Women Center
KAP	Knowledge, Attitudes and Practices
KP	Key Populations
MAP	Measuring Access and Performance
MARPs	Most At Risk Populations
MDS	Movement for Sexual Diversity
MEGAS	Health Spending Measurement
MIFAMILIA	Nicaraguan Family Ministry
MIHC	Mother Infant Health Care
MINSA	Nicaraguan Ministry of Health
MOSAFC	Communitary and Family Health Model
MoT	Modes of Transmission
MOVITEP	Movement Popular Theater without Borders
MSM	Men who have sex with men
MSH	Management Sciences for Health
M&E	Monitoring and Evaluation
M&EP	Monitoring and Evaluation Plan
M&ES	Monitoring and Evaluation System
NICASALUD	Nicaraguan Federation of 28 NGOs working on health
NGO	Nongovernmental Organization
OR	Odds Ratio
OVI	Organization for an Integral Life
PASIGLIM	Project for the automation of the information system for logistical management of medical supplies
PASMO	NGO working on HIV, FP and condom social marketing
PEER	Participatory Ethnographic Evaluation and Research
PEN	Strategic National Plan
PEPFAR	President's Emergency Plan for AIDS Relief
PHC	Primary Health Care
PLWH	People living with HIV
POLISAL	Health Polytechnic Institute
PREVENSIDA	USAID financed Project for the prevention of HIV/AIDS in high risk populations
PROFAMILIA	Association for Welfare of the Nicaraguan Families
QAP	Quality Assurance Project

RAAN	Autonomous Northern Atlantic Region
RAAS	Autonomous Southern Atlantic Region
RTI	Research Triangle Institute
SR	Single Registry
STI	Sexual Transmitted Infections
SIGLIM	Information system for logistical management of medical supplies
SILAIS	Local System for Integral Health Care
SCMS	Supply Chain Management System
SW	Sexual workers
S&D	Stigma and discrimination
TB	Tuberculosis
TRaC	Tracking Results Continuously
TRANS	Transgender
TX	Treatment
UCAN	Christian Autonomous University of Nicaragua
UNAIDS	Joint United Nations Programme on HIV/AIDS
UHISPAM	Hispanoamerican University
UNAN	National Autonomous University
UNGASS	United Nations General Assembly on HIV/AIDS
URACCAN	University of the Autonomous Regions of the Nicaraguan Caribbean Coast
URC	University Research Corporation
URS	Unique Register System
USAID	United States Agency for International Development
USAID|PASCA	USAID HIV Regional Project on policies
VCT	Voluntary Counseling and Testing for HIV
WHO	World Health Organization

EXECUTIVE SUMMARY

The midterm evaluation of USAID's HIV Program in Nicaragua aimed to assess the extent to which the objectives and targets for the 2008-2013 period had been met and provide recommendations for the remaining years of the PEPFAR Central America Partnership Framework (CAPF-2010-2015). Methodologically, the evaluation was structured around the four programmatic components (prevention, health system strengthening, strategic information and policy environment). It was guided by five questions related to the program's 17 performance indicators. The evaluation also assessed the overall program with respect to its compliance with the PEPFAR principles, contributions to strengthening the national response to the HIV epidemic and future challenges.

Evaluators reviewed ample documentation, carried out 19 focus groups with key populations (KP) and conducted 20 interviews with executive and technical staff from relevant institutions, partner organizations and implementing Non-Governmental Organizations (NGOs). They also processed background information on the different projects, including their databases. This document shares main findings, conclusions and recommendations.

The period under evaluation was divided into two stages, clearly differentiated by the implementation of the PEPFAR CAPF, which coincided with and facilitated the programmatic reorientation recommended in the 2007 Health Program Mid-term Evaluation.

In the first stage (2008-2010), USAID support was a component of the health program and centered on strengthening service provision by MINSA to provide antiretroviral therapy (ART), conduct HIV testing and promote the use of condoms for family planning and obstetric events. All actions addressed regulatory processes, such as drafting protocols, guides and tools, as well as monitoring and evaluation coverage and quality indicators. The program provided extensive training to multidisciplinary teams, furnished units with equipment, improved referral channels, used joint planning and promote experience exchanges focused on quality improvement. The program provided accompaniment to the strategic transformation of the logistic management system. Significant improvements were recorded on all indicators related to ART coverage and quality, HIV testing coverage for pregnant women and people with STI and TB, as well as in the use of condoms as a complementary family planning method.

The second stage (2010- to date) started with program adjustments under the PEPFAR CAPF. The new strategy reflected the accumulated experience and knowledge from the previous phase. It responded to evidence of a concentrated epidemic and proposed a combined prevention model focused on KP and the networking of civil society organizations including associations representing KP, NGOs, universities and the private sector.

The implementation strategy included a significant capacity building component that began with supporting organizations in drafting their proposals for prevention-focused services prior to participation in the award adjudication process. Proposals evaluation assessed both supply capabilities and quality of preventative services as well as identified gaps in managerial and administrative capacities. Training and equipping included management of essential inputs and HIV testing. Accompaniment and collaborative visits complemented initial training and ensured compliance with the established prevention, management and administration standards (in the case of PrevenSida) and pedagogical processes (in the case of universities with Deliver and HCI/ASSIST).

The establishment of information systems for services (specifically the MARP Single

Registry), inputs, accounting and managerial and administrative standards enabled systematic monitoring and evaluation processes that stimulated evidence-based analysis and decision-making at all levels of the program.

Program performance was quite satisfactory:

- The great majority of organizations participating in the network showed notable progress in managerial and administrative capacities, service provision capabilities, participation and advocacy.
- Targets related to preventive service coverage for individuals for the evaluated period complete years were exceeded. Targets related to care for people with HIV and HIV testing were adequately met. This is not the case, however, for the number of contacts (2.0 in 2011-12 and 1.6 2012-13 versus goal of 4 per person).
- Targets for in-service and pre-service personnel training were also adequately met, as well as the number of laboratories able to do HIV testing.
- The production, analysis and dissemination of strategic information focused on providing new knowledge about the epidemic, the behavior of key populations, and key components of the national response (MEGA, API) was adequate. Information was widely disseminated at NGOs network; however, dissemination was still limited with respect to sharing knowledge with individuals from key populations.
- The formulation of policies and strategic plans was extended, resulting in organizational empowerment and with implications for their future sustainability.

The program's managerial strategy ensured linkages among specialized projects focusing on different components. This approach enabled complementarity and synergies centered on capacity building for key organizations. It is important to note the capacity instilled within the entity that links USAID and individual project management, which ensured consistent communication, collective analysis, monitoring of both overall progress and occurrences at the individual project level, resulting in strategic coherence and a high level of responsiveness to contextual changes, either jointly or through coordinated actions.

There are, however, significant challenges that the program must immediately address to boost progress and overcome weaknesses that limit the extent to which its prevention, methodological development, pedagogical accompaniment models can be validated as well as specific contributions to managerial monitoring and evaluation and quality improvement. The most significant challenges include:

- The program must complete the operative definition of the HIV combined prevention strategy by systematizing the ample experience in interpersonal actions as well as the configuration of the accessibility model for key populations currently being consolidated in order to ensure continuity and quality necessary to achieve the behavioral changes which are stated outcomes.
- In order to validate the model it is necessary to prioritize follow-up and quality and reduce the focus on coverage. If the CP model validation enables sustainable exchange and transfer to the national prevention model, then sustainability is possible.
- The program must conclude operational adjustments to the URS and move to configuring it as an integrated system.
- Consequently, it is necessary to buttress the linkages between networked combined prevention organizations, particularly in ways that overcome stigma and discrimination (S&D) in universities, which could enable network members to provide internship opportunities for new professionals. The experience with the private sector could provide opportunities to address the economic and social

situations that result in propagation of new infections (tourism, population mobility and high concentrations of enclave productive forms).

- The program reflects USAID directives on gender equity, but could improve its gender focus by better balancing the focus on couples and responsibility in assertive relationships with the promotion of responsibility and values related to new (non-hegemonic) masculinities.
- Full alignment by the program with national policies and its innovative contributions in the area of prevention allows for recognition of the entities that lead the national HIV response. Parties demonstrated an explicit understanding of existing limitations to communication and exchange, as well as an explicit recognition of the need to tighten linkages and channels for communication and collaboration.
- The outlook for political, cultural and economic stability is very favorable; however, increased certainty requires validation of the proposed models and facilitation of exchange and subsequent transfer to ensure integration into the national response.
- The remaining time frame for the program (two years) is insufficient to conclude the above mentioned processes. It is necessary to explore the viability of extending program duration.

I. INTRODUCTION

This report describes the main findings of the review of USAID Nicaragua's HIV program for the purpose of "evaluating the fulfillment level of its objectives and targets between 2008 and now, including the progress in applying the recommendations of the health program mid-term evaluation done in 2007, identifying the most important factors that either contributed to or limited the program results and establishing recommendations for making program adjustments for the remaining years of the PEPFAR-CAPF ."

The evaluation was conducted based on a methodology that, in addition to explain the program performance and the impact of internal or external factors, also seeks to characterize program's contributions to strengthen the capacity of the national response to the epidemic, as well as those elements that could potentially represent new contributions in the immediate future. In this regard, the evaluation team hopes that, in addition to constructing an instrument of managerial evaluation, also promotes dialogue within the program and with its immediate surroundings about the future possibilities of validating, improving and replicating the experiences that turn out to be most efficacious to provide greater effectiveness and sustainability to the HIV national response.

The review of a program, as complex as the HIV Program in Nicaragua, gave the opportunity to explore significant experiences and situations (each one could be a finding in itself), many of them have been added and presented as part of an influential factor for the program's performance or as a contribution to the program for fighting the epidemic. In this context, the findings exposed are placed under performance or global contributions to the program; either if it is a certain approach or methodological perspective with which were designed or applied the different actions, or ways of approaching a complex issue in hard to reach populations, or innovation in cooperation technologies, or relationships with implementing institutions, social organizations, etc.

In strict sense, the support given by USAID program adopted capacity building as main axis, initially strengthening the public sector, and finally focusing on civil society organisms and universities. Within this framework, it is clear that the complexity of the analysis derives not only from the diversity of the components and program activities, each one of them with its own identity and interventions strategy at different levels (individual, group, organization, management, etc.) and with different subjects, but also from the different relationships with a variety of institutional and social actors involved on whose interactions depends the performance results.

Like any program or project of social change, addressing the object of this study is a highly complex task given the broad diversity of actors and situations that come together in an ongoing transformation process; and even more so given the unique social and cultural conditions that make up the substratum and setting of the interventions in HIV. The report thus attempts to highlight the findings considered most important, whether to show the degree of performance achieved or to evidence the program's effective or potential contributions. Such findings are presented in their most characteristic aspects, aiding ourselves with quantitative elements when it is pertinent to do so and when representative data of the condition being discussed were obtained.

The conclusions and recommendations seek to provide a response to the overall and specific questions included in the ToRs that methodologically guide the evaluation process; they are expressed in their most general nature, emphasizing one or more of the programmatic components when deemed relevant. They are presented in the most concrete way we could and are accompanied with some very synthetic discussion to underpin them.

II. BACKGROUND

2.1 HIV EPIDEMIC IN NICARAGUA

From the first case in 1987, the epidemic has been increasing, related not only to new infections, but also to the strengthening and decentralization of the HIV testing. By December 2013, 8,813 cases were reported, 35% women and 65% men. Of them, 9% had advanced HIV (796) and 12 % died (1072). The prevalence rate was 0.24% (0.1% in pregnant women) and the incidence rate was 26.6/100,000 100,000. It is a concentrated epidemic among most exposed groups: in 2009, sero- prevalence studies reported 27.8% in transgender in Chinandega, 9.7% in transgender in Managua, 7.5% in MSM in Managua, 2.4% in FSW in Chinandega and 1.8% in FSW in Managua.

The actual situation of HIV in Nicaragua has been characterized as:

- Concentrated epidemic, half of the new infections are expected to occur among KP, mainly at the expense of MSM (Modes of Transmission model)
- Reduction of number of cases reported in the last two years, situation which merits further analysis (MOH Reports)
- Fluctuation in number of deceased cases annually (MOH Reports).
- Increased report of prevalence in MSM in Masaya (13.1% in 2011, GF Report)
- Insufficient condom use among MSM (34-61%), FSW (77-91% with frequent clients and 45% with steady partners), youth (31%), and women as contraceptive method (5%) (Several reports, CDC, PASMO, Xochiquetzal, CEPRESI, PASMO).

After more than two decades, the epidemic concentrates geographically in Chinandega, Managua, Leon, Masaya, RAAS and RAAN and Masaya, while Granada, Rivas, Carazo, Chontales and Boaco show average prevalence. The Northern departments and Rio San Juan continue with the lower prevalence. The geographic profile points out both coasts and the corridors that connect them, revealing an epidemic predominantly urban, which seems to follow the pattern of mobilization of people and cargo transport between the borders of Honduras and Costa Rica, the maritime and terrestrial ports, the convergence of main touristic destinies and smuggling zones for people, contraband and narcotics.

2.2 NATIONAL RESPONSE

The national response capacity has evolved in several stages, characterized by the broadness of the coverage of the preventive actions as well as by the political willingness and coordination between the different social actors involved.

As with most countries in the region the initial response to the epidemic was very fragile, the scarce qualified resources were concentrated in the capital, while the MOH lacked a clear public policy limiting the epidemiologic surveillance to the new reported cases and to develop capacities for carrying out HIV tests in the central laboratory and in hospitals in Managua; the main response to the epidemic came from the civil society organizations (CSOs) that linked HIV prevention to the defense of sexual and reproductive health rights for women and youth as such, they were the main receptors of cooperation funds; the flow increasingly mainly involved in massive media campaigns promoting knowledge of transmission methods and the use of condom. In this context, the incidence of CSOs which already included organizations of people living with HIV and the support of international organizations contributed to the promulgation of the HIV Law (Law 820).

The second stage started when the country received financial resources from the Global Fund (GF-2nd Round). GF proposal development was an opportunity to jointly involve governmental entities and CSOs, previously disperse and with high conflict levels. Other

international organizations were also interested in strengthening National AIDS Commission (CONISIDA) which became a coordination space for social actors with different approaches and interests with the perspective of articulating an unique strategy with the variety of projects and cooperation funds. Even though there were some population groups identified with higher risk levels, the generalized epidemic approach prevailed focusing the HIV service provision on women and youth. An accelerated decentralization process began for testing capacities and ART provision in departmental hospitals. Simultaneously, CSOs and KP groups strengthen their participation in the national response, adding the human rights approach, and progressively became protagonists, facilitating their access to preventive actions and treatment.

The third stage was facilitated by the growing evidence about the epidemic: HIV prevalence studies characterized the epidemic as concentrated in KP: MSM, transgender populations and sexual workers, which required adjusting the approach and strategies.

2.3 USAID HIV PROGRAM

The USAID Nicaragua HIV cooperation started in 1998 as funding for specific activities and acquired more relevance with the 2003-2008 strategy, plan, even when they were activities inserted into broader projects oriented to family, maternal and child health.

In 2007, the USAID Health Program Mid-term Evaluation of the health program pointed out the relevance acquired by the HIV activities and established specific recommendations focusing on prevention among KP, using evidence based interventions, strengthening the health system and incorporating pre-service training.

The PEPFAR CAPF established the guidelines contained in the US President's Emergency Plan for AIDS Relief (PEPFAR) promoted a comprehensive integral multi-sector approach that expands access to prevention, attention and treatment. PEPFAR program centers in the transition from an emergency response to the promotion of national sustainable programs based on appropriation and national conduction in health broadest context related to development. Starting in 2010, the HIV component of the USAID health program in Nicaragua was implemented as part of the regional strategy through a combination of projects designed to undertake four prioritized components (Table1).Under these guidelines, the USAID HIV bilateral program in Nicaragua became a comprehensive strategy that combined and articulated diverse projects implemented by different implementing mechanisms which, in turn, have territorial scope and varied population. (Table 2).

The USAID HIV cooperation in Nicaragua has gone through at least three stages that combine USAID internal development in its approach and specific policy regarding HIV, the particularities of the epidemic, and the growing national response capacities in a regional interaction context in Central America. The first stage responded to the demands of incipient and centralized national public services and direct service provision through NGOs. A second stage focused on technical support to build national capacities and promote decentralization at departmental level. It also contributed to establishing guidelines, norms and methodologies for the continuous health quality improvement and developed an ample training for MINSA workforce, universities, private sector and civil society organizations. The current third stage assumes a structured cooperation strategy for the articulation and completeness of national and regional supports to shape up model response proposals that guarantee effectiveness and sustainability of the health system to control an epidemic concentrated on higher risk populations.

III. METHODOLOGY

As established in the TOR, this study stated as central purpose:

The purpose of the evaluation Is to assess the level of accomplishment of USAID/Nicaragua´s HIV bilateral Program since 2008, including progress on recommendations from the program evaluation carried out in 2007, health program evaluation, identify key factors contributing to or impeding program results and establish recommendations for program adjustments for the remaining years of the Central America Partnership Framework and beyond (2010-2015). Specifically, this evaluation will serve the purpose of both accountability and learning.

The evaluation process was oriented to answering the questions established in the SOW (Annex #4), with the understanding that they make up the most relevant elements for USAID and the internal or environmental factors that have affected the program's performance. The questions were:

General Question:
To what extent has the USAID/Nicaragua HIV program successfully integrated PEPFAR's programmatic principles of country ownership and leadership, sustainability, capacity building, and strengthening health systems into its program activities? And to what extent have emphasizing these principles contributed to achieving desired results to date?

Specific Questions
Q1: Based on the indicators selected to monitor the HIV program in Nicaragua (Table 4), to what extent has the USAID/Nicaragua HIV program achieved its expected targets to date for each of the key components outlined in the bilateral program and Central America PEPFAR partnership framework.

Q2: For components that have made progress as expected:
a) What is the level of achievement in each component?; b) Were the individual project designs and original assumptions valid to ensure successful performance?; c) For HIV indicator targets that were achieved, is there the potential to sustain this achievement? If not, what needs to be done to increase sustainability?; d) What are the risks to continued progress and what can be done to mitigate those risks?; e) What was the contribution of the HIV regional program to the progress achieved in each strategic component?; f) To what extent have external factors, such as unexpected events within the country, helped progress?; and g) Were there particularly positive aspects of each project's design, implementation and evaluation that contributed to the achievement of results? If so, what were they?

Q3: For those components where progress has not been achieved as expected:
a) What is the level of achievement in each component?; b) What caused the lack of full accomplishment?, c) What actions were taken to try to improve achievement of the components' objectives and what impact did they have?, d) Are the individual project designs (including project staffing, management and budget) and technical approaches appropriate and adequate? If not, what needs to change to improve accomplishments?, e) Were there particular aspects of each project's design, implementation and evaluation that contributed to the lack of achievement of results? If so, what were they? f) To what extent have external factors, such as unexpected events within the country, hindered progress?

Q4: Has the USAID/Nicaragua HIV program contributed to gender equity?
a)Did projects integrate gender considerations into their design, activities and indicators, and develop measures to enhance participation of women and men in USAID's HIV program activities? If so, how did they do and what has been the impact? b) Did projects integrate specific LGBT considerations, including specific activities to address stigma and discrimination among these key populations? What specifically did they do and what results

did they achieve?, c) Did strategy implementation increase the sustainability of these gender-specific achievements? If so, how?

Q5: What are the recommendations to improve the likelihood of sustainability of USAID's HIV program achievements?
a) What are the recommendations for the Mission's Office of Health and Education?, b) What are the recommendations for key national and local counterparts and other donors in Nicaragua? c) What are the recommendations for USAID's Regional (Guatemala-based), Latin America and Global Health bureaus, and how can these bureaus support regional activities that will in turn help Nicaragua sustain progress in its HIV/AIDS programs?, d) What should USAID/Nicaragua do to share its successful experiences within the country, with other countries, and with other Missions, donors and others?, e) What threats exist that may hinder further HIV prevention progress in the country and how can they be mitigated?

In the SOW, three additional questions were included focusing exclusively on the PrevenSida Project coverage for the period October 1 2010- March 30 2013.

This report focuses on Q1-Q5 using the methodology summarized in Table # 3, the type of questions (descriptive, normative and comparative); the type of information (cuantitative and cualitative); multiple methods (review of literature and project documents, observation and field visits to a sample of implementers, counterparts, and beneficiaries, focus group discussions and individual and group interviews using checklists or questionnaires, results analysis).

The methodology was oriented to obtain and confirm the answers to the questions, according to the logical managerial and programmatic structure. Three managerial levels were identified and the hierarchy of questions established on Fig 2:

- **Strategic management,** responsible for the application of USAID policies and PEPFAR´s principles in the national policies and interaction with the institutional actors who decide and implement them. This level is identified in the USAID Nicaragua health team. (Q1)
- **Technical and administrative management**, which translates USAID policies and PËPFAR´s principles into resource allocation and into technical proposals directly linked to the development of national capacities. This level is identified in six organizations associated to the bilateral program and in four organizations associated to the regional program, which have set up a link and a specific role in the institutional networks that have been shaping up as the national response capacities for the HIV epidemic.
- **Operational management,** resources, methodologies and technologies received to incorporate them into a model of HIV service provision to clearly defined populations. This level is identified in many counterparts and sub grantees, that express a wide variety of partners (NGOs representing KP, universities, nonprofit private organizations, enterprises, etc.) and in their working geographical areas (municipal, departmental, national). (Q2, Q3, Q4)

The object of this evaluation is the performance of the program as whole, specific projects and services are not evaluated, although inputs from those levels were considered to build and visualize global performance.

We located questions Q2, Q3 and Q4 at operational management level in overall (not from isolated projects) whose response has allowed us to answer the most global questions, such as: program's performance level and contribution to national HIV response; application of PEPFAR's principles and implementation of the recommendations of 2007 evaluation.

Different instruments and information gathering formats were developed and were validated with USAID team in order to measure the fulfillment level of the objectives and goals from

operational levels.

The report analyzed the performance achieved in the 17 indicators that set up the program's commitments in the PEPFAR CAPF´ four components and which, in turn, define the projects´ interaction, as stated in Table 4. Even though the relative differentiation that each component might functionally have, it should be stressed that involves different social or institutional actors in whose concrete situation all components interact.

The evaluation process seen from an instrumental perspective was developed from the measuring of the fulfillment degree of the targets for each indicator. This was established from gathered evidence according to quantitative or qualitative information from the M&E system. There were normative elements in most cases, with information about the starting points or with simple inventories of what was done, to compare with the closing data of year 2013 to identify recent tendencies.

Once established the degree of fulfillment for each indicator, different possible sources of information were explored (documents, baseline data, key informants, observation visits and focal groups) about the different factors that explained those results. In correspondence with the influencing factors, management decisions were also explored. In an integrated way, projects' contributions on gender equity (adequacy of the design, service provision, participation and decision levels) were also assessed.

Different information sources were explored:

- USAID documentation, project documents, action plans, reports, other studies and evaluations carried out during the evaluated period.
- Basic project information (including processing data bases), essential for the estimation of the level of fulfillment and some influencing factors of the program.
- Semi structured interviews with key informants where representatives of the implementing organizations, public sector officials and key actors for the national response were included.
- Focal groups to ensure the participation of key populations in the evaluation of the benefits and the relationship with USAID HIV program components.

Tables and figures are presented in the Annex section, as well as other relevant information.

Some additional effectiveness analysis was performed to improve the understanding of the CP model. Quality is not evaluated in this study and will require further analysis. A separate document summarizing findings related to quality, not included in the SOW, will be provided to USAID as additional information once the Q6-Q8 final report is concluded.

Finally, the main findings allowed outlining the recommendations at different levels and to the involved authorities that answered the fifth question (Q5).

IV. RESULTS

4.1 HEALTH SYSTEM STRENGTHENING

This component aimed to reduce the health system gaps to offer quality services, reduce external dependency and institutional management weaknesses. The interventions included: Improve and expand HIV/AIDS quality service delivery to key populations (including laboratories; develop methodologies and implement activities to improve institutional and human resource capacity to respond effectively to HIV/AIDS epidemic among key populations and strengthening the supply chain management systems (Table 1). The implementing mechanisms were HCI, ASSIST, Deliver, PrevenSida and Allianzas 2, and from the regional program: PASCA, Combination Prevention and SCMS (Table2).

Most of HSS indicators were achieved or over achieved. The indicators of achievement were (Tables 4, 5, 6):

1) Increase from baseline the number of testing facilities that are capable of performing HIV related laboratory tests in accordance with WHO guidelines. **(115% of target)**
2) Increase from baseline the number of health care workers who successfully completed in-service training program **(95% of health workers from NGOs, 101% of medical personnel, 115% of logistic personnel and 291% of private sector personnel, of respective targets)**
3) Increase from baseline the number of community health and para-social workers who successfully completed a pre-service training program **(155% of health workers from NGOs)**
4) Increase from baseline the number of new health care workers who graduated from a pre-service training institution within the reporting period. (**109% medical personnel and 80% logistic personnel, of respective targets)**
5) Reduce from baseline the number of stock-outs in ARV medication **(this indicator was not directly monitored by USAID, but according to other sources (WHO) is reducing)**

Initially, the projects were designed to reduce the gaps in specific subsectors: Pronicass, HCI, Deliver and SCMS provided technical assistance to the public sector, Famisalud to rural communities, PrevenSida to NGOs, and Alliance 2 to private sector. From 2012, after graduating the public sector assistance, HCI/ASSIST and Deliver concentrated its efforts in universities. The original assumptions demonstrated its validity to ensure successful performance and potential sustainability. SCMS regional project contributed to improve the storage conditions for ARVs and Combined Prevention Regional Program helped to train NGOs personnel in methodologies to promote behavior change among KP. The strategy for the institutional strengthening for each sector is summarized below. As positive external factors, GF HIV program significantly supported national efforts to continue improving coverage and quality of comprehensive HIV services, after USAID public sector assistance graduation.

STRENGTHENING OF THE PUBLIC SECTOR (2008-2012)

The USAID HIV program was clearly aligned with the National Health Plans and Strategies. The main contributions with the public sector were:

- **Continuous quality improvement (CQI) of maternal/child/HIV care in public health services**: Since 2007 HCI/USAID developed CQI processes on Family Planning, MCH and HIV, supporting MOH to systematize and monitor standards and protocols. The collaborative methodology shaped up a network for experience and pedagogic capacities exchange, based on evidence given by the monitoring system for the fulfillment of protocols and normative, as well as by the results in terms of coverage and conditions of the attended

people. Improvements were observed in increasing VCT coverage for pregnant women and people with STI and TB, and improving ART adherence.

- **ART and VCT decentralization**: HCI also contributed to the decentralization of ART and VCT. At the beginning, only 3 health units offered the HIV test and gave ARVT. The technical assistance was directed to laboratory network strengthening, as well as to the organization of multidisciplinary teams to provide comprehensive HIV services. Normative instruments were designed and training was provided until completing 5,484 trained health officials. Improvements were observed in increasing coverage of services at local level.

- Integration of the VCT in other health programs, HCI also supported the integration of VCT in antenatal care, prenatal attention, family planning, and STI and TB control programs. The Famisalud project facilitated the initial integration of VCT in Family Planning services in rural community settings.

- Strengthening of the logistic system: The Deliver project provided technical assistance for the design and implementation of an integrated system for managing medical supplies (SIGLIM) which required profound transformations to substitute 6 vertical existing systems with marked inefficiencies in the acquisition, storage, distribution, rational use process, etc. Even though the cooperation started focused on FP contraceptives, the success achieved showed the possibility of including ART and HIV tests. Other areas supported were: f similar strategic importance was the accompaniment on other fundamental areas: technical assistance to the national DAISSR Committee involved in the logistic system sustainability process, strategy for rational use of drugs, and logistic support in social security health facilities. In addition, the regional project SCMS provided technical assistance for capacity development in MOH's central warehouses.

-Provision of technical assistance to Global Fund project (CCM:, principal recipient and sub recipients)

Initially, the PRONICASS project started the provision of technical assistance to GF project, this was continued by other projects (PrevenSida with the URS, Deliver with the DAIA Committee, PASCA supporting CCM, PASMO training sub recipients in methodologies for BCC).

STRENGTHENING NON-GOVERNMENTAL ORGANIZATIONS (2010-to date)

PrevenSida project concentrated its efforts on overcoming accessibility gaps detected in key populations, and a clear alignment with the strategic national plan for HIV(AIDS 2011-2015. It has developed a combined prevention model based on working with civil society organizations network in their own social life spaces (residence, work, socialization, recreation), working in a complementary way with the public services. In the first two years of the project, 20 NGOs working with KP were selected to receive formal training in managerial and technical aspects, before they were invited to apply for project´s subgrants.

A process of continuous improvement: All NGOs working with KP were invited through open bid to apply for PrevenSida´s subgrants. The best proposals were selected and received assistance for the proposal improvement and adjustment if needed. The selection process was also enabling in terms of the final negotiation process, in order to reach consensus on the populations to cover, coverage targets, timing, territories, necessary support and budgets; so that at the beginning of each year, the starting point was a baseline of the gaps that each organization has with respect to quality standards on management, administration and technical areas. An initial workshop was carried out with all NGO's, organized in two big modules (Management and administration and prevention) which eventually integrated other issues that corresponded to new aspects of the proposed preventive model, as well as to the solving of detected management and administrative weaknesses. During each year different training events were carried out to correct gaps of

unfulfilled quality standards quarterly monitored or to the incorporation of new subjects or methodologies (i.e., stigma and discrimination the 3rd year).

Compliance with global quality standards: The main factor to comply with quality standards at institutional level derives from the development of human resources competencies. PrevenSida was also innovative due to the commitment acquired with the implementing NGO's of facilitating the development of their competencies during the periods they participate in the project. According to PrevenSida´s database, 154 training events were organized between 2010 and 2013 benefiting 3,534 participants. As seen in Fig 9, there has been a gradual process of compliance with the standard. In 2010 first year 60% of NGOs required intensive assistance, reducing to 17% in 2013. Tue graduated NGOs also increased from 30%in 2010 to 50% in 2013. In 2013, 50% of NGOs were graduated in management, 67% in preventive services and 78% in finances and administration (Fig 10). As expected, the number of participants have been higher in training events related to prevention (53%), followed by management (31%), monitoring and evaluation (10%) and finances and administration (6%). (Fig 11)

STRENGTHENING OF THE PRIVATE SECTOR (2010-2013)

The participation of the private enterprises affiliated to Nicaraguan Private Enterprise Council (COSEP) started with PASCA/USAID support, which promoted and facilitated the COSEP´s HIV policy formulation, and the commitment to promote similar policies among their affiliated chambers and enterprises. In response, 13 affiliated institutions (from textile, manufacturing, health and tourism sectors) developed their own policies. The Alianzas 2 and PrevenSida projects facilitated the training of 291 persons (127 health professionals were trained and 164 key officials) which conformed teams responsible for the implementation of this policies in their enterprises, providing preventive services to 11,964 workers (49% of the working universe in the participating enterprises).

STRENGTHENING THE UNIVERSITY SECTOR (2010-to date)

USAID Nicaragua developed an integrated strategy to strengthen the university sector as part of the graduation strategy initiated with FP and MCH. It was the natural continuation of the graduation process started with the public sector in 2008 and completed in 2012. Four projects Pronicass, HCI/ASSIST, Deliver and Famisalud formally participated of this transfer process.

The "pedagogic package" is a tool initially designed for keeping the Continuous Quality Improvement (CQI) made for the development of competencies among personnel of health service providers institutions in the three areas of the USAID health program (MI health, FP, HIV) and were part of the transference process in health units, SILAIS and MINSA's central level for the sustainability of the achievements and to conclude the graduation processes (withdrawal from USAIDs technical assistance), particularly in MI and FP. The establishment of quality standards (respect, confidentiality, voluntariness, etc.) for preventive, diagnostic and curative actions allowed the CQI´s sustainability.

The pedagogic packages became a valuable instrument for the improvement of the competencies of teachers and students, contributing to long-term sustainability. Its design is based on MINSA's normative and protocols, focusing on to achieve significant learning for competency development. Besides the evident achievement of more than 1,500 medicine and nursing students (including those incorporated into social service) and more than 100 in pharmacy who will have an immediate impact on the quality of services in which they will be key providers, the institutionalization of the pedagogic packages in universities represented a very relevant contribution to the academy, and health sector as a whole.

This process created great motivation and commitment in the revision of the prevailing pedagogic approaches; the pedagogic approach oriented to competencies has been recognized because of the novelty and evident achievements in teaching, this motivated teachers to think about the pedagogic principles and methodologies currently used.

The "packages" were knowledge-based, supported on updated scientific evidence, but also adjusted to the national normative. Their instrumentalization in guidelines, check lists, etc. not only facilitates the teaching process, but also establishes the protagonist roles of the teachers and students involved.

Collaborative events for CQI were also developed, bringing together the teaching bodies of various universities, scarcely related before, promoting experience exchange and the establishment of communication and collaboration channels. Besides assuring quality of the products, the projects ensured a continuous process of improvement for the universities, changing in the academic scenery, achieving even greater motivation from the leadership acknowledgment of the contracted teachers as facilitators in the reviewed subjects.

University teachers and authorities recognized the remaining gaps between HIV pre-service training and current medical practice, as well as the high levels of stigma and discrimination related to HIV care, confirmed by a recent survey results.

4.2 PREVENTION

This component aimed to reduce the gap of the insufficient coverage of primary and secondary preventive services aimed to key populations. The objective is to increase healthy behavior among key populations to reduce HIV transmission. Key activities included: implement innovative, cost effective, context appropriate and evidence based preventive interventions, screening, diagnosis and treatment of sexually transmitted infections (STIs) and expand access to Voluntary Counseling and Testing services for key populations.(Table 1) Currently the main strategy is the "Combined Prevention" which includes interpersonal communication actions for behavioral change, access to counseling and voluntary testing, access to condoms and lubricants, counseling or reference to STI services, and attention/reference to social services according to personal needs. The implementing programs were Combined Prevention Regional Program, PrevenSida project and Alliances 2 project. (Table 2).

Most prevention indicators were achieved or over achieved. The indicators of achievement were: (Tables 4,7):

1) Increase from baseline the number of MARPs (key populations) reached with individual and/or small group level interventions that are based on evidence and/or meet national or international standards. **(86% in 2012, 199% in 2013, of individuals target; 42% in 2011, 38% in 2012 and 77% in 2013, of contacts target)**
2) Increase from baseline the number of MARPs with STI who are appropriately diagnosed, treated, and counseled at health care facilities**. (no target for USAID at health facilities)**
3) Increase from baseline the number of MARPS who received and HIV test in the last 12 months and who know the results **(60% in 2012, 125% in 2013, of target)**
4) Increase from baseline the number of people who live with HIV-AIDS provided care for with a minimum package for PLWA **(135% in 2012, 260 in 2013, of target)**
5) Increase from baseline the number of pregnant women with known HIV status (includes women who were tested for HIV and received their results) for 2005-2009 **(discontinued in 2009)**
6) Number of the targeted population reached with individual and/or small group level

HIV prevention interventions that are primarily focused on abstinence and/or being faithful, and are based on evidence and/or meet the minimum standards required **(discontinued in 2009)**

From 2008 to 2010, the regional prevention project provided direct service delivery to MARPs and until 2009 Famisalud project also provided some HIV preventive services to rural population. In October 2010, the PrevenSida project started focusing on KP. In 2013, the Alliance 2 provided services to private sector workers. The original assumptions were adjusted after 2007 evaluation recommendations: focus on KP and implement only evidence based interventions to ensure successful performance and potential sustainability. Combination Prevention Regional Project contributed to improve the in-service training of NGOs personnel on BCC methodologies and reaching KP through a virtual platform and PASCA Regional program created conditions to initiate private sector preventive programs. The combination prevention model is summarized below. As positive external factors, GF HIV program significantly supported national efforts to continue improving coverage and quality of preventive services.

REGIONAL PROGRAM FOR COMBINED PREVENTION

Pioneer program in social condom marketing actions, communication, epidemiologic research actions and accompaniment to organizations of key population and NGO's. It received funds from USAID Nicaragua for the implementation of preventive actions until September 2010. In October 2010 it began as the Combined Prevention Regional Program and carried out some prevention activities funded by regional funds. Fig 12 shows preventive service provision provided by the project in the period 2002-2012 and its focus on MSM.

Even though it is a regional USAID project, from the beginning of its cooperation in Nicaragua it has had a transcendent role contributing with studies which have permitted a greater comprehension about the epidemic and has had a very relevant presence in work with local NGO's for preventive attention of MARP groups based on interpersonal communication focus.

It should be pointed out that the experience accumulated in interpersonal attention with MSM and transgender and the technical accompaniment aimed to institutionally strengthen organizations of people with HIV (ASONVIHSIDA and ANICP+VIDA) and organizations of people with higher risk and vulnerability (Red Trans and Red Transex) carried out either by PASMO or by HCI; facilitated in a very relevant way, the reorientation process of the program in the PEPFAR context in the next stage.

HIV/AIDS TRANSMISSION PREVENTION IN HIGHER RISK PEOPLE: PREVENSIDA

It is an innovative USAID project aimed to increase healthy conduct in greater risk people (MARPs), to decrease HIV/AIDS transmission. It has four components: NGO strengthening, HIV preventive services provision, reduction of stigma and discrimination and increasing active participation of NGOs in the national response. Most relevant activities of the project were to grant funds to a diversity of KP NGOs working on HIV prevention, previously strengthening their capacities to manage funds and provide HIV services for prevention and community care. The NGOs received training on management (financing, budgeting, accounting, resource administration, bidding and acquisitions, development of proposals and execution so subsidies), HIV technical aspects, reduction of stigma and discrimination and access to information. NGOs obtained solid management, administrative and technical capacities to strengthen their active participation in national response to HIV and AIDS, extending the covering and the quality of the services delivered to key populations.

The project achieved their targets and showed progressive increases in MARP's coverage during the first three years of implementation, based on the widening of the base of implementing NGO's, which went from 12 during the first two years, to 18 by the third year. But most important, was to confirm its capacity to learn from experience and making the necessary adjustments to perfection the operational model – the CP model- that warrants

KP access to HV services. The project addressed initially the challenge to operationalized the CP model, creating local capacities and reducing stigma and discrimination in a very complex environment, scaling up the experience at national level.

CP MODEL FOR KEY POPULATIONS

Three aspects were evaluated: individuals reached, contacts performed and type of activities

-Individuals reached: Based on the URS data there was evidence that the project was able to overachieve the annual target by the third year. Fig 13 shows Prevensida project´s performance related to the number of people reached; Fig 15 shows the same information disaggregated by type of population and Fig 16 shows the relative increasing comparing previous year's performance.

Planning and management based on targets focused on KP was a comparative advantage, improving the conventional management centered on volume of activities by adding impact/results indicators, and monthly monitoring to adjust decision making to improve performance. Quality improvement collaborative operatives and accompaniment visits carried out, especially for learning and applying concentration sites mapping improved the performance. However, for most implementing organizations, it was evident that their knowledge about the basis of target calculation was insufficient.

- Contacts: The project was not able to reach its coverage target, decreasing from 2 contacts per person during the second year to 1.6 in the third year. 1.6 controls per person means that two out of three persons attended by PrevenSida (68%) during the last period, had only one contact, one out of five (20%) had two or more contacts and only 6% had three contacts and a similar proportion had 4 or more contacts; so "the first contact" prevailed. Fig 13 shows Prevensida project´s performance related to the number of contacts reached, Fig 16 shows the same information disaggregated by type of population, Fig 18 shows those who received only one contact by type of population and Fig 19, those who had two or more contacts. Tables 9 and 10 provides additional information on qualitative and quantitative aspects of this analysis.

By project design[1], based on the initial target was four contacts, considering that only one service was going to be provided in each contact. Once the CP model was developed it was evident that more than one service was provided by contact and USAID oriented the project to focus on people reached rather than contacts. During the second year, when adjustments to the URS allowed to differentiate people covered and the number of contacts provided to each person, it became evident that in each contact two or more interpersonal activities were recorded, so it was considered that only two contacts were required per person. The Program made internal adjustments for assigning funds-per-capita in sub grants, setting the cost at two contacts per person for subventions, becoming the criteria for planning. In this way, compliance of annual goals for contacts in the last period can be assumed as 160% (119.314/74.000) based on programmed people and as 93% (119.314/147.378) based on attended people (73.689 x 2). By the third year, PrevenSida managed to have 41% of MARPs (MSM; Trans, SW) with two or more contacts while the rest of the vulnerable group of this segment is just 26%, which means that one person from the MARP group has twice the probability to have two or more contacts than a person from "other vulnerable groups" (OR 1.98, LC95% 1.9 – 2.0, X2 1,829).

- Confluence of prevention activities: CP model linked behavior change with HIV prevention, it implied a set of confluent actions on the same person in a given period of time; namely, three communication activities, availability of condoms and lubricants, HIV counseling and testing and access to any complementary service. Achieving these four parameters would

[1] Guide for Implementation of Interpersonal Activities for Behavioral Change, USAID Team /COMBINED PREVENTION Nicaragua): The theoretical framework of "combined prevention" are considered, that point out 4 conditions to estimate that the continuous and integrated process of preventive attention can contribute to the achievement of the expected impact (behavioral changes) to define the attended person as "combined."

define the person served as “combined”. (Fig 20) This approach, provides an array of minimum conditions for the four components of the “combined prevention”, differentiated for each major MARPs group (MSM, SW, TG).

Access to condoms and lubricants: In the third year of PrevenSida condom provision was made to 89% of people and 91% of all contacts; while lubricants were given to 74% of individuals and 80% of contacts. Coverage for MARPs is greater than 95% and between 55% -60% received condoms once (68% in SW) and between 20% and 25% received two provisions. This not necessarily expresses continuous accessibility, since most people had a single provision in a year, but the program understands the provision as a motivational element to facilitate contacts and to encourage condom use and does not plan to become a sustainable access channel.

Access to HIV test and STI counseling: Promotional activities cover 69% of the people receiving HIV services and 79% for STI. Coverage for KP is higher than average in the case of promoting HIV testing (77% gays, 82% bisexuals and 72% Trans), except for SW (62%). For STI testing coverages are similar. Between 50% and 60% of MARPS received a single promotional CPV and STI activity and between 15% and 20% received 2 or 3. Access to HIV tests was reported under HSS.

Access to complementary services: Referencing cases for health needs (different from VCT or STI) is contemplated, as well as psycho-social attention for drug users rehabilitation, cases of gender based violence, situations of stigma /discrimination worth a specific plan or vocational and employment support. However, as seen in the previous parameters, even when cases referred by the PrevenSida network could have facilitated access to these services; only reception of the service could be quantified to measure access; since there is no clear registration of counter-reference not making possible to measure this parameter in the overall CP model.

CP model implementation: During 2012-2013 the PrevenSida network performed 389,827 interpersonal activities included in the CP model (5.3 activities per person served, 73,689, and 3.3 activities per contact). The number of actions received by each person is associated with the number of contacts where the same content has been reiterated. If we assume the parameter “three activities of the minimal package” independent form the type of activity, we can consider an average of 5.7 activities for MARP groups and 4.7 to other vulnerable groups; if the average minimal activities per contact is 3.3, it could be inferred that the parameter can be met in just one contact. (Fig 21)

Three out of four MARPs (76%) and two out of three people from other vulnerable groups (66%) meet the parameter for Combined Prevention Model that requires three or more types of activities from the Minimal Package. It is worth highlighting the high coverage with three or more types of activities from the minimum package in bisexual men (96%) and sex workers (92%) within MARPS, and of youth at risk (97 %) within the “other groups”. In contrast, the gay men stand with only 61% and women in gender-based violence with only 31% compliance of this parameter. Overall, this represented a remarkable level of performance, considering the starting point achieved in the first contact shown in the above table as 66% in MARPs and 61% in other group, meaning that the first contacts added benefit over MARPs with 10% additional coverage, while in “other groups” is just 5%.

There is evidence to support that reducing the standard from 4 to 2 contacts is appropriate. It is necessary, however, to review the specific purpose of the “first contact” in which there is no correspondence between the time allocated and the number and quality required in the registered activities, which currently usually include all six activities of the minimal package. There is a high heterogeneity in how each NGO operatively implement the CP model (Fig 22 and 23).

Counseling and voluntary testing: In the last year, PrevenSida reported the realization of 12,509 HIV tests (in 12,196 persons) carried out by participant organizations, which

represents an over fulfillment of more than 120%, duplicating second year results. The fulfillment of the goals also significantly improved in homosexual and bisexual males. In the case of the transgender population, the obstacles were not overcome and were maintained like the 2nd year with a low fulfillment level. (Fig 24) Only 48% of the people who had the test done by PrevenSida (5,878) received project´s previous preventive services. (Fig 25)

Prevention and care of people living with HIV: The goal established in the third year was to attend 300 people living with HIV and two contacts per each HIVP were estimated, so that the contact goal was estimated in 600, the SR database reports 1,160 HIVP attended and a total of 1,849 contacts, registering a fulfillment of 390% in the person goal and 308% in the contacts one. Most of contacts were provided in clinical settings with peers approach. (Fig 29, 30)

The incorporation of five organizations with experience and associations with the PLWA and which assumed their accompaniment, allowed to broaden the territorial coverage, this being the base of the noticeable increase of people with HIV in respect the coverage of the 2nd year, that had been 404 PLWHS, while the contacts had been 681, that is, in just one year it was possible to almost triple the coverage and attentions given (2.9 times the PLWHA and 2.7 times the contacts).

An average of 1.7 contacts per each PLWHA was obtained during the 2nd year and stayed similar in the 3rd year with 1.6, which in turn synthesizes the fact that in the 3rd year 69% of the PLWHS had one contact, 20% registered two contacts, 9% had between 3 and 4 contacts, and 3% had five or more contacts. During the interviews and discussion groups were described the various difficulties that have to be overcome for the development of this delicate task, while the prevailing stigma environment makes confidentiality extremely demanding, which in turn determines the possibilities of identification and contact in the new cases. Therefore it is vital to establish alliances with the health institutions where ART is administered, which has also been a building process of mutual confidence to allow access to information and to the locals of the clinics where 59% of the contacts are made and to gain the confidence of the PLWHS themselves so that they willingly go to the locals of the NGO's where 29% of the contacts has been carried out. A 10% is realized in the homes of the PVS and only 2% are done in eventual sites of the community. It is necessary to establish a strategy between the local institutions which should assist PLWHA in the different fields to strengthen the work of the network, facilitating access to information about new cases and about adherence and continuity of the ART in each case. It was also pointed the need to give greater attention to other social and health needs.

PRELIMINAR IMPACT ANALYSIS:

Even though this was not required by the evaluation SOW, the team explored two potential associations between the exposure to the CP model and expected behavior change, as a condition to reduce HIV infection. The practical implication is that the type of data gathered by the URS will be useful for the CP model validation and project´s final evaluation.

Association between exposure to previous prevention services and effective VCT: There was significant association between previous preventive services exposure and the voluntary decision of getting the HIV test done. Most significant differences were observed when three contacts are compared with two or less contacts, since the HIV test rate doubles (14% vs. 7%, OP 2.1) and even further when four contacts are contrasted with three or less contacts which is when in the actual contact quality conditions the greatest difference is achieved in the HIV test rates (RD 10%) and the probability that one person decides to get the test almost triples (OR 2.6); thus, four contacts was the most cost-effective with a possible relative gain[2] (RD x PRI) of 89/ooo, compared to 58/ooo in the case of three contacts and only 9/ooo with two contacts. Increasing more than four contacts does not

[2] Reflects how the test rate would change if all the Population Requiring Intervention (PRI) were reached, that is, the people with less than four contacts and who has not had the HIV test done.

increase effectivity. (Fig 26)

Association between exposure to previous prevention services and seroprevalence: There was significant association between previous preventive services exposure and seroprevalence. A person exposed to preventive services had 45% less probabilities of having positive results to HIV test compared to a person who hadn't combined preventive attention by PrevenSida during that year. The association was found in people who were attended this year by NGO's which entered the project during the first and second year (OR 0.35 X^2 8.1), but was not found in people attended by the NGO's which entered the project by the third year (X^2 0.2). The heterogeneity contrast between the two strata is significant (p 0.03, X^{2het} 4.3). (Fig 27, 28)

4.3 STRATEGIC INFORMATION

This component addresses the problem of insufficient use of information and knowledge about the behavior of the epidemic in key populations, as well as the lack of an effective registry system. The objective is to strengthen the capacities to monitor and use the information that improves the comprehension about the epidemic and the actions to carry out. The main interventions are: to strengthen monitoring and evaluation promoting the use of data for decision making; to support the development of information systems coordinated and sustainable, including appropriate approaches for concentrated epidemics and strengthen the gathering, analysis, interpretation and dissemination of data that characterize the epidemic focusing on higher risk populations

The main implementing agencies were: PASCA and Combined Prevention regional projects, and among the country programs, Deliver, HCI and PrevenSida contribute.

The PEPFAR indicators for this component are:

1) Existence of nationally coordinated multi-year M&E plans with a schedule for survey implementation and data analysis: **PASCA project provided technical assistance to build national capacity for M&E, planning and implementation.**
2) Increase from baseline the number of UNGASS indicators coming from a national information system: **PASCA project provided technical assistance** to build national capacity and developed integrated information systems.
3) HIV prevalence data available for MARPs published in the last 4 years: Strategy developed and implemented for knowledge management and dissemination of data. **Not specific target, all projects contributed.**

All projects contributed to reduce the gap of information generation, dissemination and use. PASCA and Combination Prevention Regional Project contributed with several studies and dissemination processes. The project´s contribution in each indicator is summarized below. As positive external factors, GF HIV program significantly supported national efforts to continue improving strategic information generation, dissemination and use.

The USAID leadership in the overall health cooperation scenario and particularly regarding HIV/AIDS, is recognized by its significant contribution in terms of knowledge management. It was evident that strategic and technical decisions were based on evidence and the commitment to produce, process, analyze, divulge and use relevant and pertinent information was clear. The USAID HIV program was characterized by establishing quality parameters (normative, protocols, guidelines), as well as the coverage of the services provided and their results among the beneficiaries.

National monitoring and evaluation plan: As part of the "three ones" strategy, PASCA/USAID provided technical assistance to CONISIDA for the evaluation process of the National Strategic Plan before HIV 2006-2010,as well as its continuity in the formulation of the National Strategic Plan 2011-2015. It also provided systematic technical assistance for

the elaboration of studies and national reports (MEGAS, UNGASS, API) and accompanied the strengthening processes of the CORESIDA RAAS in the formulation of their HIV strategic plan (PERAAS 2012-2016).

HCI and PrevenSida supported the development of strategic plans based on social determinants for transgender population, MSM, FSW, PLWA and Caribbean population. These plans constituted a key instrument to settle their capacity to influence governmental authorities, donors and communities to promote equity.

PASCA also supported the study: "Information system mapping for monitoring national response before HIV in Nicaragua", which allowed identifying all participating organizations as producers and processors of information associated to the indicators, as well as their strengths and weaknesses as possible sources of information for the PM&E. It also supported the design of the HIV Information System for Monitoring National Response which articulates all information sources in a unique database administered by CONISIDA.

Use of indicators in national reports: PASCA project contributed to regulation and harmonization of different demands for indicators (PEN, UNGASS, GF, AT, AU, UNAIDS, etc.) identifying their characteristics and coordinating with social actors involved. The PEN 2011-2015 has a matrix of 83 indicators for the monitoring and national response. Particular attention deserves the use of the interactive matrix of the "basic indicator package" which prioritized and analyzed the quality and feasibility of 36 key indicators for PEN 2011-2015.The PM&E of PEN also includes a five-year action plan.

HIV prevalence data: USAID participated in the national effort to develop the 2009 BSS, coordinated by CDC. The results of this survey were published in 2010 and immediately used to adjust the prevention strategy. PrevenSida collaborated with CDC to disseminate the survey´s results among key populations. PASMO generated new knowledge through several studies: TRaC, Hombres de Verdad, PEER Sweetheart, Stigma and discrimination towards MARPs and PLWH and MAP study.

PREVENSIDA´S UNIQUE REGISTER SYSTEM

The URS is an innovative tool proposed by the PrevenSida project. It responded to the need of quality information to monitor and evaluate advances, especially the implementation of the CP model. It has been shared with the GF project and its joint implementation allowed the country to developed adjusted KP size estimations. It became a useful tool at different levels (field team, NGO management, project and program management, country strategy, Global Fund and CONISIDA).

It became a tool perceived as useful at different levels of the USAID/HIV program, giving evidence for decision making at field team level, at management level of the implementing organizations, at PrevenSida management level and at the program management level; that is, SR-MARP transcended the role assigned to the information systems based on continuous registry, which end up being institutionally assimilated as routine processes of gathering and production of statistical data whose greater utility is facilitating the elaboration of reports.

Other positive aspects found were:

-Strengthened the institutional motivation and discipline regarding the fulfillment of the targets agreed in the sub grants

-Facilitated the rupture with the prevailing culture of the "activism" in which the projects are measured by how many activities are carried out and secondarily register a total number of people participating in that activity

- Facilitated the focus in KP and the need to differentiate operative modalities to contact each group and therefore has led the field teams of the NGO's to assume a diverse operative reality, previously "homogenized" by the notion of "activity or service" as the central element of the management.

-Improved evidence based decision making and identified the need for additional support from the project.

The URS showed some limitations related to classification biases caused by variations or certain characteristics assigned to individuals, such as registry location (in 2013, 482 persons were detected with contacts in two or more different departments), self-identification vs promoter interpretation, double classification by mixing sexual orientation and occupation (in 2013, nearly 3,000 persons, 4%, were classified in two or more groups of KP). This situation is not homogeneous for all MARPs or vulnerable groups; as observed in Fig 31, trans people don't lead to any confusion, in contrast with lesbians (they could look like GBV women), drugs (with youth at risk, SW clients, etc.).

Other weakness identified was the lack of correspondence between VCT indicator and prevention indicator for test counseling (as part of the CP model), since every test carried out that implies pre-test counseling should be registered as one more contact or as a first contact even if only the test activity is registered. In the MARPs base are registered 80,271 contacts in which was carried out an activity referred to the test (68% of total contacts), of which 93% (74,342) register counseling and being referred and 7% register counseling and test carried out, having similar proportions in terms of people receiving the activity. The first discordance emerges when 6,318 persons who got the test done (52%) don't have a registered code in MARP's database; that is, they had not received any attention before the test, which was not registered as a first contact, as stated in the PEPFAR Guide. The remaining 5,878 persons do have a MARPs code.

Even though, these limitations didn't affect monitoring the fulfillment of the quantitative goals when they are assumed in terms of number of persons or contacts, but it did affect the monitoring of people in terms of their changing process and their association with the actions carried out for each person, that is, which proportion of the attended people received the "minimum package" established as standard in the CP model. Three aspects need to be clearly differentiated: persons, contacts and activities in order to improve the analysis of the CP model efficacy, efficiency and impact.

The URS´s strengths generated expectancy at CONISIDA, considering the previous absence of a valid registry system for the national HIV preventive actions focused on KP either at NGO's or public services. This opportunity would potentially be another USID program´s contribution to the national response to the epidemic; nevertheless, but the system need to be improved in the areas previously mentioned.

4.4 POLICY ENVIRONMENT

This component approached the problem of the limited funding from governmental sources, the stigma and discrimination, the gender inequities and insufficient participation of other sector (other governmental sector, private sector and NGO's).

The objective was to improve the policy environment to reach the universal access to HIV services goal. The strategic interventions included: support the development policies and multi-sector involvement to reduce stigma and discrimination (related to sexual orientation and identity, status HIV, occupation and others), gender-based violence and gender inequities. Also to strengthen the design, handling and implementation of HIV and GF subsidies and promote multi-sector involvement and NGO's capacities to participate in the strategic planning, policy design, implementation and monitoring of national response.

The implementing mechanisms were PASCA and Combined Prevention regional projects and PrevenSida, Alliances, HCI and Deliver projects.

The PEPFAR indicators and quantitative performance for this component were:

1) Improve API score every two years: Assessments carried out to identify barriers to policies, norms and regulations. **Assessment carried out in 2009 showed**

improvement.

2) Increase number of GFTAM grants that are evaluated as A and B1: TA provided to support for the development and implementation of GF projects. **Grant was evaluated as A2 in 2013.**

3) Increase from baseline the number of organizations that received TA for the development of HIV related policies. **COSEP and 13 enterprises developed an HIV workplace policy b 2013.**

All projects contributed to fulfill these indicators, being remarkable the PASCA regional project contribution. The key contributions are summarized below. As positive external factors, GF HIV program significantly supported national efforts to continue improving the policy environment.

Improvement of the policy environment (API): The national response evolution was described in the section 2.2. The positive trend of the API (increasing 13 points from 1998 to 2009) was demonstrated by the last PASCA study applying the API methodology (HIV programs effort index), which evidenced advances in areas such as: a) political and regulatory framework, b) prevention, treatment and support, c) mitigation, and d) monitoring and evaluation. Also important gaps regarding political support and human rights were identified, inviting to reflection and unity of the actors of the national response in order to discuss and plan strategic and effective solutions. Currently, several positive factors are identified: the State´s political willingness to undertake direct and open responsibilities regarding HIV and assuming leadership in CONISIDA, the increased participation of CSOs and private enterprises, the explicit and open recognition of the sexual diversity and the creation of an specific Procuraduría, the incorporation of the human rights approach, the growing efforts to reduce stigma and discrimination, the Law 238 recent reform, and the increasing public funding (62% of the total national funding in 2009).

Performance of GFTAM fund management: Nicaragua obtained in the last GF report, a very significant performance improvement from B2 in 2012 to A2 in 2013 (Fig 32, 33). All projects contributed: the strengthening of the M&E system and CCM support carried out by PASCA; the improvement in the logistic system with the accompaniment of Deliver and SCMS, the technical assistance provided by PrevenSida and Combination Prevention Regional Program to sub-recipients, and particularly its monitoring tools like the URS, shared with CONISIDA, CCM and INSS (principal receptor).

Development of institutional HIV policies: The participation of the private enterprises affiliated to Nicaraguan Private Enterprise Council (COSEP) started with PASCA/USAID support, which promoted and facilitated the COSEP´s HIV policy formulation, and the commitment to promote similar policies among their affiliated chambers and enterprises. In response, 13 affiliated institutions (from textile, manufacturing, health and tourism sectors) developed their own policies. HCI and PrevenSida developed KP´s NGOs capacities to advocate at local level (departmental and municipal CONISIDAS), supported the formulation of organization policies and strategic plans. Work with universities implemented by HCI and Deliver is a strategic element for future political change and reduction of the stigma and discrimination towards PLWH and MARPs.

4.5 GENDER APPROACH IN THE PROGRAM

The USAID/HIV program completely assumed in its programmatic design the reduction of gender inequities as a transversal axis, because it corresponded to PEPFAR guidelines and USAID policies, but also because the clear understanding of gender inequity as a key determinant of the HIV epidemic. The gender approach was mainstreamed in two areas: CP methodologies and NGO institutional strengthening.

The CP model was based on the behavioral change processes, understood as the development on individual and collective capacities to improving decision making and negotiating with their sexual partners the adoption of protective measures. Thus, in most of the content of the interpersonal communication activities is found the dialogue and reflection

about the situation of each person in terms of their relationship with their sex partners being steady or eventual.

Behavioral change communication, stigma and discrimination activities, GBV, family planning and condom use, were emphasized areas, for peers dialogue (individual or in small groups) to propitiate self-reflection about their own situation, as well as on the possible options each man, woman or transgender person had to carry out positive changes in their relationships, in search of more assertive relationships that facilitate agreement on protection.

The other dimension which defined the gender approach was the development of capacities of the implementing organizations. The training activities provided by PrevenSida the last year showed a pretty equitable balance in the participation of women, men and trans people, standing out this composition in all four subject areas, being management and prevention the ones with the greater emphasis on the contents regarding gender equity and stigma and discrimination towards women, KPs and other vulnerable populations. (Table14, Fig 34)

In service training, based on teaching improving and using the pedagogic packages, involved the same gender approach for CP model and institutional strengthening for universities, and its implementation caused a lot of reflections about gender equity in the academic community

Particular attention should be paid to the fact that most of the implementing NGO's and the universities have strengthened their participation and incidence on the overall national response to HIV, since they are part of the local or national structures (CONISIDAS) with greater information and knowledge about the dynamic of the epidemic and vulnerable populations in their own territories, so that women and KP organizations showed improved participation levels.

Particular mention can be made to the "strategic action plan jointly formulated by 9 transgender organizations and facilitated by HCI, applying the model of social health determinants. This plan is an invaluable mean to strengthen the incidence of these organizations in the political, institutional and social environment in the fight against discrimination and stigma, which is one of the most important determinants of its vulnerability to HIV. Similar plans were also developed and implemented by MSM and FSW organizations with USAID HIV program technical support.

V. CONCLUSIONS

PEPFAR PRINCIPLES´ IMPLEMENTATION

The USAID/Nicaragua HIV program successfully integrated PEPFAR's programmatic principles of country ownership and leadership, sustainability, capacity building, and strengthening health systems into its program activities. Particularly, the implementation of "country ownership and national leadership," facilitated its recognition as a program that contributed to the harmonized and highly effective implementation of the national HIV policies and plans. Emphasizing these principles clearly contributed to achieving the program´s desired results.

The USAID/HIV program has been one of the most important pillars in shoring up the main stakeholders´ capacities development committed to the national response to HIV. In correspondence with its own configuration and development as a program and adjusted to the directives and particular demands of the national entities, the program adopted different modalities of accompaniment with a diverse focus in the two stages identified in the period being evaluated.

PERFORMANCE BY COMPONENTS

All components progressed as expected. The individual project design and original assumptions were valid to ensure successful performance. Based on the 17 indicators selected to monitor the HIV program in Nicaragua, the USAID/Nicaragua HIV program achieved most of expected targets to date for each of the key components outlined in the bilateral program. The only exception was the sub-indicator related to the number of contacts for preventive services, which was underachieved.

PREVENTION: The program promoted a CP model targeting MARPS, especially KP. This was an innovative proposal when the national context required a strategic shift from a general to a concentrated approach. USAID contributed to close the gaps related to insufficient coverage of primary and secondary HIV preventive services aimed to KP, developing and implementing this highly cost-effective model, appropriate to the country's concentrated epidemic and PEPFAR´s guidelines. This model included interpersonal communication provision, counseling or reference to STI services, and attention/reference to social services according to personal needs.

HSS: The program significantly contributed to reduce the Nicaraguan health system gaps to offer quality services, reduce external dependency and institutional management weaknesses. All projects provided technical assistance to implement in service and pre-service training, increase laboratory capacities and strengthen logistic systems. In an articulated and integrated way, all projects covered the broad spectrum of the health system's subsystems (public, private, NGOs, universities, social security) in the most comprehensive sense (coverage and quality for service provision, logistic systems, human resources training, capacity building, etc.). The program contributed developing new knowledge and systematizing experiences in processes and methodologies organized in didactic and methodological educational packages and in operation manuals that guide key processes.

STRATEGIC INFORMATION: The program contributed to close the gaps related to the insufficient use of HIV epidemic information and lack of an effective registry system. All projects provided technical assistance to strengthen the capacities to monitor and use relevant information that improved the comprehension about the epidemic and the actions to carry out. The main interventions supported were: to strengthen monitoring and evaluation system promoting the use of data for decision making; to support the development of information systems coordinated and sustainable, including appropriate approaches for concentrated epidemics and strengthen the gathering, analysis, interpretation and

dissemination of data that characterize the epidemic focusing on higher risk populations, and had a clear influence in achieving policy settings more favorable to the development and effectiveness of the national response. Internally, important tools were developed to strengthen the program M&E system: the unique register system, the accounting and internal control systems and the follow-up to the institutional strengthening indicators.

POLICY ENVIRONMENT: The program contributed to close the gaps related to the limited funding from governmental sources, the stigma and discrimination, the gender inequities and the insufficient participation of other sectors (especially private sector, NGO's and academy) in the HIV national response. All projects supported the development of policies and multi-sector involvement to reduce stigma and discrimination (related to sexual orientation and identity, status HIV, occupation and others), gender-based violence and gender inequities. They also contributed to strengthen the design and implementation of GF sub grants and promoted multi-sector involvement and NGO's capacities to participate in the strategic planning, policy design, implementation and monitoring of national response.

POTENTIAL TO SUSTAIN ACHIEVEMENTS

The future sustainability of the CP model proposed by the USAID/HIV program contains elements qualified as "good prognosis" and others as "uncertain prognosis."

Technical sustainability: In particular, the technical sustainability of the CP model has a "good prognosis", based on the strength of approaches and methodologies, which has been validated through its implementation and continuous adjustments. Further validation requires evaluation of the CP model efficacy and feasibility. This good prognosis will require CP model assimilation by the institutions that train health professionals, which will reproduce the technical knowledge in the health system.

Community sustainability: Currently, the model has adopted a service provision configuration that facilitates the geographic and cultural accessibility of the PEMARs and vulnerable groups. There is a growing level of confidence that includes the incorporation of PEMAR leaders as promoters of preventive activities or as "nodes" of community and service supply networks (condoms, lubricants, messages).

Economic sustainability: The only activity that could be qualified as good prognosis in this aspect is the pre-service training whose future implementation will not require greater resources investment. Next years are crucial in terms of governmental commitments to progressively invest public funds to provide ARV treatment. If the CP model demonstrates its effectiveness in reducing the number of infections (which seems to be starting considering 2012-2013 reduction of new cases) it will increase the possibility to be funded, whether from international cooperation, private sector (i.e. greater commitment by COSEP) or public sector itself. But it is evident that it will require more years of international cooperation to assure CP model´s full validation and expansion.

Political sustainability: There is a full correspondence between the CP model with the national policies and directives, including the Family and Community Attention Model (MOSAFC). The NGOS, universities and private sector participating in the project constitute key stakeholders of the national response and active participants of coordination entities. There is a structured critical mass and government willingness to evaluate and discuss future interventions based on evidence.

CONTRIBUTION OF THE HIV REGIONAL PROGRAM

There is a full integration of regional projects with national projects, sharing and socializing knowledge, methods and activities. The complementarity and collaboration achieved between PrevenSida and PASMO are exemplary in this aspect. Regional projects contributed with technical assistance in formulating and evaluation policies, and implementing different studies, ie stigma and discrimination, national reports, etc.

EXTERNAL FACTORS THAT CONTRIBUTED TO PROGRESS

It is acknowledged by different governmental entities and cooperation agencies, the main role and high incidence or the USAID program for the development of the national response capacity in the different development stages. This fact facilitated the coordination efforts.

The alignment and harmonization of country efforts, supported by other donors such as GF and UNAIDS, coincided with the beginning of PEPFAR CAPF implementation and constituted a very significant qualitative change in the transition process from the strategy of open epidemic towards a strategy for a concentrated epidemic. Three years after its implementation, it is evident that the innovations in terms of approach, intervention strategy and cooperation strategy have been an accumulation process of new knowledge and experiences on the particular conditions in Nicaragua.

The mid-term evaluation of USAID Nicaragua health program in 2007, recommended focusing on higher risk groups. In addition, the approval of the second project by the Global Fund (GF-8th Round) motivated an overall restatement of the national strategy to focus activities on vigilance and prevention in MARPs, so that significantly reduced resources assigned to massive communication campaigns and increased those allocated to work directly with KP, mainly in those departments that have shown persistent high prevalence rates.

In 2012 Global Fund and USAID promoted a regional agreement around the "CA Sustainability Strategy," which clearly defined the common strategy for GF, UNAIDS and PEPFAR. The national authorities expressed their willingness to apply the strategy, that will be implemented in the next HIV GF grant.

The CP model was recognized as a model of attention that corresponds to the public policy of the MOH´s Family and Community Health Model, which is expanding and being generalized in the sphere of civil society committed to the national response, even when its application is recognized as still partial in the case of Global Fund sub recipients. Nonetheless the Country Coordinator Mechanism and CONISIDA authorities, who in turn are governmental authorities, have expressed interest in establishing better exchange channels both to evaluate the comparative advantages of the model and to promote exchanges and coordination.

POSITIVE ASPECTS OF EACH PROJECT'S DESIGN, IMPLEMENTATION AND EVALUATION

The proposal of the CP model was based on the prior experience of USAID projects, which were: a) QAP/HCI, in monitoring and improving the quality of the prevention and attention actions in the health system, b) FAMISALUD's previous experience with the community promoter networks; c) strengthening of the health system leadership and managerial capacity accumulated by PRONICASS, and d) PASMO incorporating the "combined prevention" approach in interpersonal communication actions and in specific work with MSM groups. The program was shaped with this diverse contribution, and specific experiences were scaled-up at national level

Following 2007 Health Evaluation recommendations the program shifted its efforts from ineffective actions (massive communication, isolated activities, big groups, general population) to the design and implementation of the CP model, evidence based and focused on KP. It also moved from intervention strategies based on multiple mutually independent projects that only include the offer of certain services, to networking with NGOs, including new health subsectors (private, social security, universities), with the main characteristic of including training and CQI components.

The graduation of the public component of the USAID technical assistance was successfully completed (except for the logistic component which remains as a gap) and documented in the 2013 USAID Health Program Final Evaluation. The goals settled out for developing the public services' capacity to improve HIV services provision was met. TAR decentralization

was completed in hospital units and selected health centers. Working teams were also trained and laboratories were equipped to respond to the VCT needs.

A highly relevant result was the program's collaboration, with the particular contribution of Deliver project, in the structural transformation of the logistical management system for medical inputs; the system was unified from a diversity of isolated systems in MINSA. The whole public health system has both the PASIGLIM and the CURIMs functioning. In that regard, the evaluation team could not verify the level of functioning and sustainability of the generated capacities, but issues referring to their maintenance with adequate and sustainable capacity were explored with MOH. Internally, there were multiple areas and modalities of integration and articulation among the different projects. The synergies are quite evident and the collaboration is almost daily, according to the specialization of each one.

ASPECTS THAT NEED TO BE IMPROVED

Complete the configuration of the CP model in which less emphasis must be given to the number of services and more to their confluence in the people attended, always prioritizing KP over other vulnerable groups. This qualitative leap will require establishing an algorithm of contacts and follow-up for each type of PEMAR, specifying the objectives, scope and methodologies of the "first contact" to delimit the follow-up contacts that would be required to complete the combined prevention standards. This results in necessary adjustments to the single registry system that are possible to do based on the existing system, as it fundamentally has to do with changes in the level of reorganizing models and relations.

Validating the CP model, which already showed results in accessibility and coverage, analyzing the association between coverage and seropositivity in tests done in the third year of PrevenSida (taking advantage of the fact that half of the HIV tests were provided to people not previously attended by the project), which showed that PrevenSida's CP model made a difference in the probabilities (risk) of positivity in contrast to people who had not had PrevenSida attention in that same period. These preliminary impact results could be interpreted as a significant sign of the actual effectiveness of the proposal in the current conditions of configuration and quality of the model.

Therefore, it is not the broad coverage that could give the most valuable program's contribution to the national response. Of course, coverage is a very important factor and it was demonstrated that the CP model reduced the accessibility barriers PEMARs and vulnerable populations have traditionally had, but the validation of the model requires more than a quantitative-descriptive method, so the results on behavioral changes need to be also evaluated to validate CP model efectiveness. This validation is the most important challenge of the coming years.

Coordination and communication with national stakeholders: Communication channels need to be improved (they could adopt the collaborative form) around the operational models of accessibility and fulfillment of the CP model as well as the M&E system, including the URS. Given that PrevenSida included COSEP and businesses sector, the involvement of INSS should also be considered.

Pre-service training: The relationship established between the USAID/HIV Program and the universities is of crucial strategic importance, given their role of reproducing the health system with the training of professionals and technicians. Three challenges were identified: improve the S&D approach incorporating more effective educational tools, facilitate the incorporation of students in health practices, including other subsectors (NGOs, businesses), incorporate public health graduate students into the "university critical mass" so as to establish exchanges and progressively transferring the capacities to conduct studies and research that currently have a high degree of dependence on external capacities.

Coordination about care and treatment for PWA: And also about improving the relationship and exchange with the public sector units, both around the linkage of TAR with

the accompaniment of PVV in the PC model, and in possible synergies in the detection and continued attention to PEMAR and vulnerable groups.

Logistic support: The request of Global Fund for Deliver and SCMS technical assistance to provide continuity to the logistic improvement projects need to be considered. The accumulated experience of these projects is indispensable to assuring the culmination of the improvement of the HSS logistic component. The dialogue about sustainability of the inputs (availability of condoms, lubricants and HIV tests) must be continued and extended.

CONTRIBUTION TO GENDER EQUITY

All projects integrated gender considerations into their design, activities and indicators, and developed measures to enhance participation of women and men HIV program activities. All projects, but specially PrevenSida, focused on MSM and transgender populations, including specific activities to address stigma and discrimination among these key populations. The HIV strategy implementation, focused on KP, increased the sustainability of these gender-specific achievements, by empowering KP NGOs to be protagonists of the national HIV response.

The USAID/HIV completely assumes in its programmatic design the reduction of gender inequities as transversal axis of its management and services, because it corresponds to PEPFAR guidelines and because they clearly understand that a main problem for HIV epidemic is the individual and collective capacity of protection to infection, it has as determinant the inequality in the structure of the power of decision in the exercise of the sexuality, furthermore when the different studies have evidenced that the higher vulnerability is concentrated among people who have been object of violence or abused based on gender.

This transversal gender approach is summarized at two levels in the daily dynamic of the projects that make up the program, such as: contents and implementation methodologies of the combined prevention services and the institutional strengthening of the organizations in which participate MARPs and vulnerable populations.

VI. RECOMMENDATIONS

The USAID HIV Program in Nicaragua has important challenges that need to be resolved in the immediate future.

1. **Validate the Combined Prevention model.** The main legacy that the program could provide to the country is the validation of the CP model, demonstrating its effectiveness in achieving behavioral changes and contributing to the reduction of HIV transmission, which evidently transcends the coverage of MARPs with preventive actions. Based on defined standards, NGOs previous experience and available tools, it is possible to validate the CP model in the short run in a way that ensures fulfillment of the established quantity and quality standards. That will require methodologically and operationally differentiating the "first contact" from "subsequent ones" so as to complete the minimum set of confluent actions on a single person to increase the possibilities of achieving the desired behavioral changes. Making visible and assessing the role that the leaders and "voluntary promoters" of the MARPs groups themselves could have in the model could be important. In addition, the preventive service provision must be reviewed and adjusted to emphasize the quality and continuity of both the first contact and the follow-up in the promoters' work and more efficient use of the funds.

2. **Adjust the Unique Register System**. Resolving the first challenge involves the need to adjust the monitoring and evaluation system in a way that comprehensively responds to the "Number and proportion of MARPs who receive preventive attention which met the CP model standards. That suggests the urgency of moving beyond the focus on number of people and number of contacts and separate targets and indicators, which means that the SR-MARP must be adjusted, moving from the current Contact-Activities-Person logic to the Person-Contact-Activities logic, resolving the weaknesses detected in the real unicity of the person's identification.

3. **Promote the integration of the universities into the network**. The strategic value of the universities in reproducing and changing health system is limited by two factors: the prevalence of stigma and discrimination toward MARPs and PLWH among teachers and students and the discrepancies between what is learned and what is applied. It is crucial to work with the universities in identifying options for surmounting these limitations. The approach could include accrediting the NGOs network as learning places. The model could be also enriched by integrating the public health schools, which could begin to assume a growing role in producing strategic information if capacities are transferred to them for conducting studies and research.

4. **Buttress the integration of businesses into the network.** The evaluation team values the Program's decision to bring private companies and COSEP into the network in this period, recognizing the pioneer work previously done by Allianzas 2 and PASCA. This is another opportunity for health system strengthening if such participation links the CP model to the social security preventive programs. The model could be benefited by the integration of the economic sectors recognized as epidemic channels (recreation, tourism, transport, maquilas, etc.).

5. **Integrate the HSS training component.** This is a key area and offers a comparative advantage by integrating not only the scientific and technical prevention elements, but also covering the financial, managerial and administrative ones. Nonetheless, it has been restricted to implement training events (pre- and in-service), not linked with a proper follow up. The integration of

the different training methodologies into the planning of a continuous learning could bring greater synergies, as well as reducing weaknesses.

6. **Balance the gender approach.** As the evaluation demonstrated, gender equity is mainstreamed in the design and implementation of interpersonal communication activities and in the results foreseen in behavioral change, but the participation of men in FP, S&D, and GBV activities must be increased. A perspective of couple's responsibility in the relationship could be included as a scenario for the construction of a new masculinity.

7. **Strengthen coordination and communication with CONISIDA_**USAID projects provides relevant technical assistance to CONISIDA and other important national entities, but there is a clear need and willingness of the parties to expand both the communication channels and the collaboration actions in order to extend mutual learning, strengthen the monitoring system, and increase territorial coverage for preventive services avoiding overlapping.

8. **Increase the CP model´s potential for sustainability.** The CP model has the potential to be sustainable. The institutional strengthening achieved, not only as organizations, but also as network, will contribute to advocacy and fundraising for new financing sources. Economic and political sustainability of the CP model need to be developed in the next years. Special attention must be given to the sustainability agreements adopted at a regional level, and this evaluation results must be shared with the CCM to make this agreement more visible and possible, as an opportunity to strengthen the national response to HIV but also to show the contributions Nicaragua can make in the international sphere.

9. **Extend the Program's cooperation period.** The proposed validation of the CP model and of its implementation strategy could be completed in the next two years , but transference and replication will require broader time horizons, so the opportunities of expanding USAID's cooperation in HIV in Nicaragua must be explored.

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ANNEX 1:TABLES

Table 1 PEPFAR's Central America Partnership Framework Components and Activities

COMPONENT	ACTIVITIES
Prevention	• Implement innovative, cost effective, context appropriate and evidence based preventive interventions. • Screening, diagnosis and treatment of sexually transmitted infections (STIs). • Expand access to Voluntary Counseling and Testing services for key populations
Health system strengthening	• Improve and expand HIV/AIDS quality service delivery to key populations (including laboratories). • Develop methodologies and implement activities to improve institutional and human resource capacity to respond effectively to HIV/AIDS epidemic among key populations. • Strengthening the supply chain management systems.
Strategic information	• Strengthening Monitoring and evaluation systems by promoting the use of data for decision making. • Support the development of sustainable and harmonized information systems including new approaches suitable to concentrated epidemics. • Strengthen the collection, analysis, interpretation and dissemination of data to characterize the epidemic focusing on high-risk and vulnerable populations
Political environment	• Support the development with multisectoral involvement to reduce stigma and discrimination, as well as violence and gender inequities. • Strengthen the design, management and implementation of financing funds for HIV. • Promote multisectoral involvement and civil society organizations capacity to effectively participate in strategic planning, policy design, implementation and monitoring.

Source: PEPFAR CAPF

Table 2 USAID/Nicaragua regionally and bilaterally-funded implementing partners and projects

TYPE OF PROJECTS	IMPLEMENTING PARTNER/ PROJECT NAME	ACTIVITIES	2007	2008	2009	2010	2011	2012	2013
STAGES			I			II			III
Regional projects	PSI/PASMO-Prevención de VIH Sida (closed)	Prevention: BCC, VCT,	**x**	**x**	**x**	x			
	IntraHealth/Capacity (closed)	Hospital quality services		**x**	**x**				
	RTI/Alliances 2 (closed)	Prevention in work places,					x	x	
	SCMS (closed)	Logistics (warehouses)						x	
	PSI/ Regional Combined Prevention	Methodologies for BCC, special studies					x	x	x
	Futures Group/PASCA	Policy environment,strategic information					**x**	**x**	**x**
Field Support projects	MSH/Pronicass	HSS (leadership and management)	x	x	x	x			
	URC/HCI	Quality improvement for HIV comprehensive care		x	x	x	x	x	
	URC/ ASSIST	Pre-service training							x
	Field Support JSI/Deliver	Logistics (information systems, pre-service training)					x		x
Local projects	NicaSalud/Famisalud	Prevention in rural settings	x	x	x				
	URC/PrevenSida	Combined Prevention among KP					**x**	**x**	**x**

Source: HIV Evaluation SOW

Table 3 Research questions and methodology applied

Question	Type of question	Type of information	Method	Data Source	Sampling method
1	Descriptive	Cuantitative, cualitative	Results analysis	Q2, Q3, Q4 results	All process
2	Comparative	Cuantitative, cualitative	-Literature review -Review of project documents -Observation and field visits to a sample of implementers, counterparts, and beneficiaries -Focus group discussions -Individual and group interviews using checklists or questionnaires	Secondary: RD, EIC, OBS, GF	Convenience
3	Comparative	Cuantitative, cualitative		Secondary	Convenience
4	Normative	Cualitative		Secondary	All process
5	Normative	Cualitative	Results analysis	Secondary	None

Table 4 Indicators by PEPFAR's CAPF strategic components

PEPFAR'S CAPF STRATEGIC COMPONENTS	Projects	
A. PREVENTION	Bilateral funded	Regional funded
Increase from baseline the number of MARPs (key populations) reached with individual and/or small group level interventions that are based on evidence and/or meet national or international standards.	Prevensida, Alliances 2	Combined Prevention-PSI
Increase from baseline the number of MARPs with STI who are appropriately diagnosed, treated, and counseled at health care facilities.	HCI	
Increase from baseline the number of MARPS who received and HIV test in the last 12 months and who know the results	Prevensida, HCI	Combined Prevention-PSI
Increase from baseline the number of people who live with HIV-AIDS provided care for with a minimum package for PLWA	Prevensida	
Increase from baseline the number of pregnant women with known HIV status (includes women who were tested for HIV and received their results) for 2005-2009	HCI	
Number of the targeted population reached with individual and/or small group level HIV prevention interventions that are primarily focused on abstinence and/or being faithful, and are based on evidence and/or meet the minimum standards required for 2005-2009	FamiSalud	
B. HEATLH SYSTEM STRENGHTENING		
Increase from baseline the number of testing facilities that are capable of performing HIV related laboratory tests in accordance with WHO guidelines	Prevensida, HCI	
Increase from baseline the number of health care workers who successfully completed in-service training program	Prevensida, HCI,Deliver, Alliances 2, Famisalud, Pronicass	Capacity
Increase from baseline the number of community health and para-social workers who successfully completed a pre-service training program	Prevensida	Combined Prevention-PSI
Increase from baseline the number of new health care workers who graduated from a pre-service training institution within the reporting period.	HCI, Deliver	
Reduce from baseline the number of stock-outs in ARV medication	Deliver	SCMS
C. STRATEGIC INFORMATION		
Existence of nationally coordinated multi-year M&E plans with a schedule for survey implementation and data analysis: TA provided to build national capacity for M&E, planning and implementation.	Prevensida	PASCA
Increase from baseline the number of UNGASS indicators coming from a national information system: TA provided to build national capacity and developed integrated information systems	Prevensida, HCI, Deliver	PASCA
HIV prevalence data available for MARPs published in the last 4 years: Strategy developed and implemented for knowledge management and dissemination of data.	Prevensida,	PASCA
D. POLICY ENVIRONMENT		
Improve API score every two years: Assessments carried out to identify barriers to policies, norms and regulations.	Prevensida.	PASCA
Increase number of GFTAM grants that are evaluated as A and B1: TA provided to support for the development and implementation of GF projects	Prevensida, Deliver, HCI	PASCA
Increase from baseline the number of organizations that received TA for the development of HIV related policies	Prevensida	PASCA

Table 5 In service training efforts by project, theme and beneficiaries

Projects	Themes	People trained	Sub-sector

Famisalud/NICASALUD	VCT integration in FP and RH	413	Health centers and NGOs
	Condom use promotion	1775	804 communities
PRONICAS/ MSH	Condom use promotion	4400	49 health centers and NGOs
	HIV Integration into health care model	750	3 SILAIS
HCI	VCT Integration In FP, RH, STD and TB programs	3335	10 SILAIS
	VCT service provision in antenatal care, STD care and TB are	400	14 SILAIS, 74 health units
	Antiretroviral therapy	1729	17 hospitals, 15 SILAIS
DELIVER	Logistics Management Information System and Rational use of medicines	2831	17 SILAIS, 166 health centers, 18 hospitals, 49 private sector social security health units

Table 6 Compliance with goals on HSS key indicators

Output	goal	2010-11	2011-12	2012-13	3 periods	Compliance	Universe of work
Number of testing facilities (laboratories) with capacity to perform clinical laboratory tests							
Prevensida	13	5	2	8	**15**	**115%**	NGO´s
Number of new health care workers graduated from pre-service institution							
Prevensida	200	37	117	35	**189**	**95%**	NGO´s
HCI	1,500		692	829	**1,521**	**101%**	Universities
Deliver	100			115	**115**	**115%**	Universities
Number of health care workers who successfully completed an in-service training program							
Prevensida	1,260	428	733	794	**1,955**	**155%**	NGO´s
Alliance	100			291	**291**	**291%**	Enterprises/COSEP
HCI	300			328	**328**	**109%**	Universities
Deliver	200			159	**159**	**80%**	Universities NGO´s

Table 7. Performance in preventive component

PEPFAR Output	Period of implementation		
	2010-11	2011-12	2012-13
Number of MARP reached with individual and/or small group level interventions that are based on evidence and/or meet the minimum standards required (invidual)			
Goal (per thousand)		35	37
People reached		30	74
% Compliance		86%	199%
Number of MARP reached with individual and/or small group level interventions that are based on evidence and/or meet the minimum standards required (contact)			
Goal (per thousand)	155	155	155
Contacts	65	59	119
% Compliance	42%	38%	77%
Contacts per peopple		2.0	1.6
Number of individuals who received HIV Testing and Counseling (HTC) services for HIV and received their test results			
Goal (per thousand)		11	10
People reached		6	13
% Compliance		60%	125%
Number of People Living with HIV/AIDS (PLHIV) reached with a minimum package of Prevention with PLHIV (PwP) interventions			
Goal (per thousand)		300	300
People reached		404	780
% Compliance		135%	260%

Table 9. Coverage of people with Minimum Package-*Cuantitative*

Number of activities of Minimun Package	With the first contact			With all contacts		
	MARPs	Other groups	Total	MARPs	Other groups	Total
With 1 Minimun activity	14%	10%	11%	8%	7%	7%
With 2 Minimun activities	20%	29%	25%	13%	25%	20%
With three or more Minimun activities	**66%**	**61%**	**63%**	**78%**	**68%**	**72%**
With 3 Minimun activities	*31%*	*20%*	*25%*	*20%*	*15%*	*17%*
With 4 Minimun activities	*22%*	*20%*	*21%*	*14%*	*18%*	*17%*
With 5 Minimun activities	*7%*	*5%*	*6%*	*9%*	*6%*	*7%*
With 6 or more Minimun activities	*6%*	*17%*	*12%*	*35%*	*30%*	*32%*

Table 10. Coverage of people with Minimum Package-*Cualitative*

Population groups 2012 - 2013	With one activity type	With two activities type	With three or more activities type	Means of minimun activities for person
Homosexuals men	19%	20%	61%	6.1
Bisexuals men	2%	2%	96%	5.9
Transgender	3%	12%	85%	5.1
Female Sexual workers	5%	3%	92%	4.9
Total MARPs	**9%**	**15%**	**76%**	**5.7**
IV drugs users-IDU	86%	0%	14%	12.8
Non-IV drug users	9%	13%	78%	9.6
Sexual workers clients	10%	18%	72%	3.0
Mobile Populations	6%	17%	77%	5.1
Women in GBV situation	3%	66%	31%	5.2
Youth at risk	2%	2%	97%	5.8
Male Sexual workers	7%	0%	93%	2.9
Lesbians	15%	23%	62%	5.0
Deprived of freedom	16%	11%	73%	8.4
Uniformed (military/police)	5%	12%	83%	7.8
Total Other groups	**7%**	**27%**	**66%**	**4.5**
Total PrevenSida	**8%**	**22%**	**70%**	**5.3**

Figure 1 HIV cases reported in Nicaragua 1995-2013

Table 12. Concordance between people and HIV Test registred in Single Register System

CONCEPT	SR MARPs 2012-13		SR VCP 2012-2013
	Contacts	People	
Total registred in SR	119,314	73,689	12,196
Minimun Activity VCT	80,271	51,160	
Promotion and reference	*74,342*	*47,662*	
Counseled and test HIV	*5,929*	*3,498*	5,878
Without code in SR MARPs			6,318

Table 13. Compliance of PEPFAR indicators by Policy Environment

Indicators	Compliance
Improve API score every two years: Assessments carried out identify barriers to policies, norms and regulations.	From 1998 score in 46 until score 2009 in 59
Increase number of GFTAM grants that are evaluated as A and TA provided to support for the development and implementation of GF projects	Grant Performance of July 2013 evaluated as A2 level
Increase from baseline the number of organizations that received T A for the development of H IV related policies	18 NGOs and 7 Universities and 10 private enterprises with HIV policies. All are participation in CONSIDAs (Nicaraguan AIDS Commission) at national and local level

Table 14. Coverage of people with comunication activities by sex. PrevenSida 2012-2013

Comunication Activity	Males	Females	Trans	Total
Behavior change	**100%**	**99%**	**99%**	**100%**
Delivery of condon	***95%***	***80%***	***95%***	***89%***
Delivery of lubricant	***75%***	***70%***	***94%***	***74%***
VCT Promotion	**70%**	**68%**	**72%**	**69%**
STIs counseling	**81%**	**74%**	**76%**	**78%**
Family Planning counseling	**23%**	**51%**	**12%**	**33%**
Substances abuse counseling	**50%**	**39%**	**54%**	**46%**
Comunity progamme needs	**17%**	**17%**	**6%**	**17%**
Stigma and discriminación	**18%**	**35%**	**18%**	**24%**
Gender Based Violence	**6%**	**61%**	**36%**	**28%**
Vocational support	**1%**	**2%**	**1%**	**1%**

ANNEX 2: FIGURES

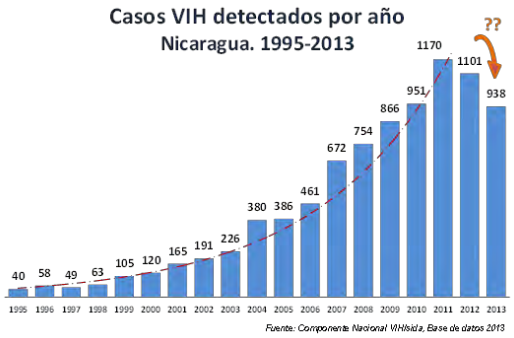
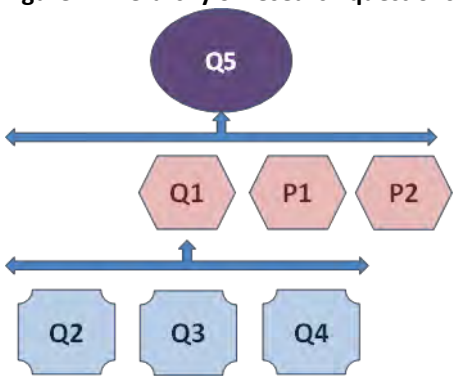
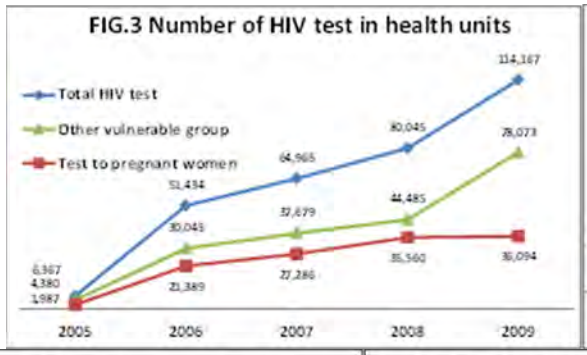
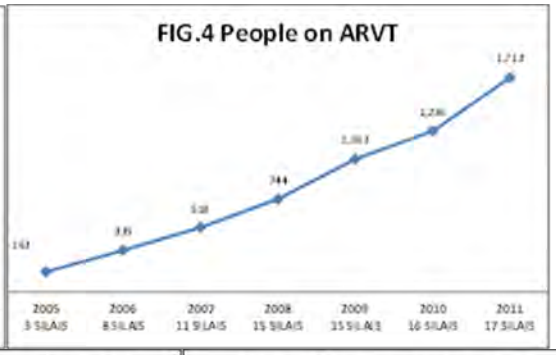
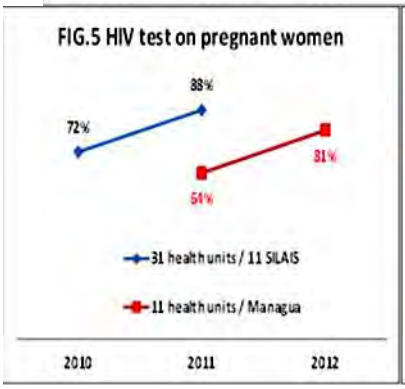


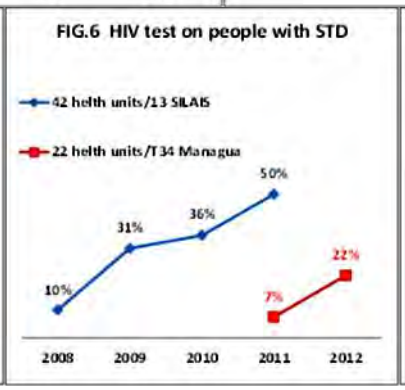
Figure 2: Hierarchy of research questions

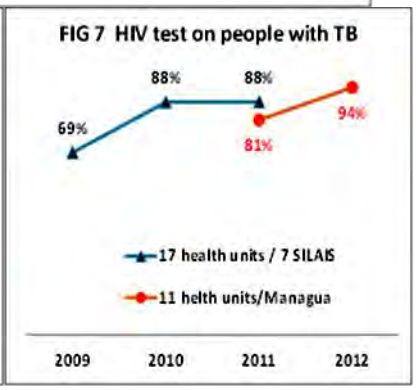












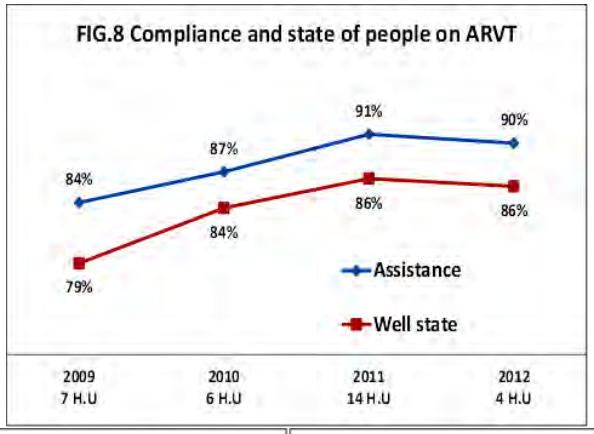


FIG.8 Compliance and state of people on ARVT
91%
90%
87%
84%
86%
86%
84%
79%
Assistance
Well state
2009
7 H.U
2010
6 H.U
2011
14 H.U
2012
4 H.U

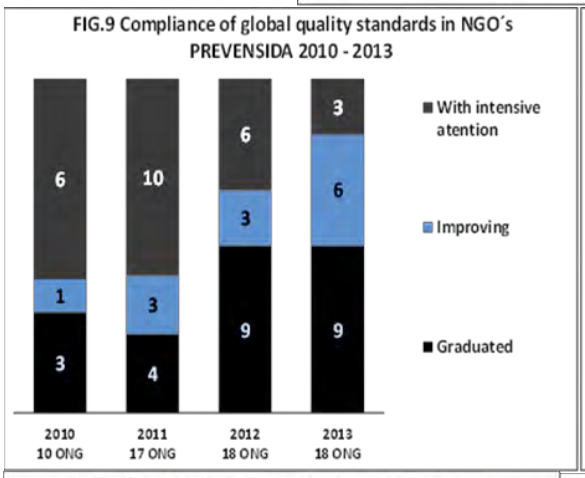


FIG.9 Compliance of global quality standards in NGO´s
PREVENSIDA 2010 - 2013
With intensive atention
Improving
Graduated
2010
10 ONG
2011
17 ONG
2012
18 ONG
2013
18 ONG

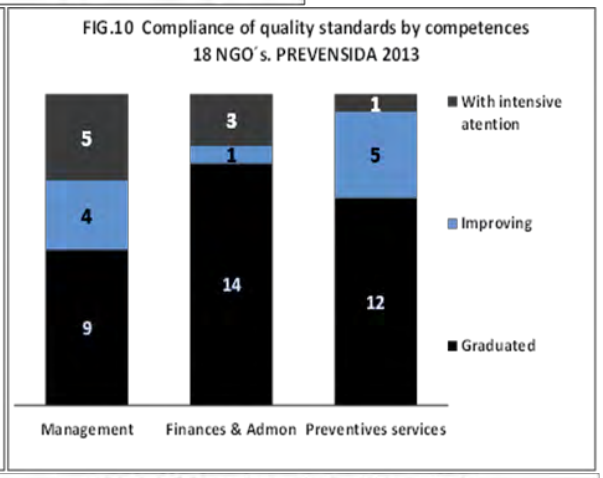


FIG.10 Compliance of quality standards by competences
18 NGO´s. PREVENSIDA 2013
With intensive atention
Improving
Graduated
Management
Finances & Admon
Preventives services

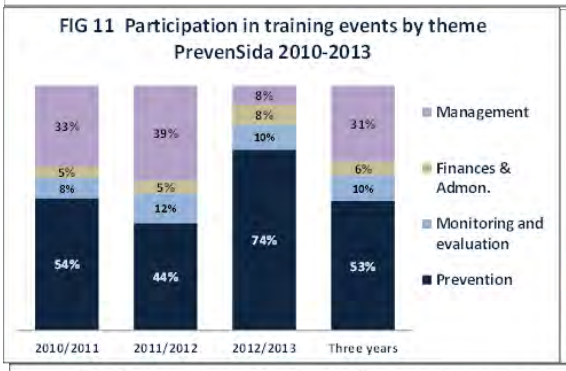


FIG 11 Participation in training events by theme
PrevenSida 2010-2013
Management
Finances & Admon.
Monitoring and evaluation
Prevention
2010/2011
2011/2012
2012/2013
Three years

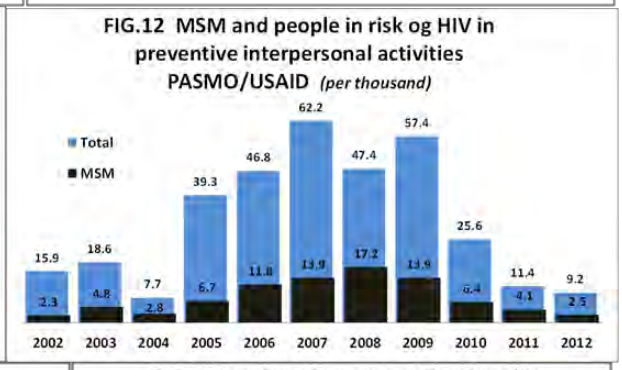


FIG.12 MSM and people in risk og HIV in
preventive interpersonal activities
PASMO/USAID (per thousand)
Total
MSM
2002
2003
2004
2005
2006
2007
2008
2009
2010
2011
2012

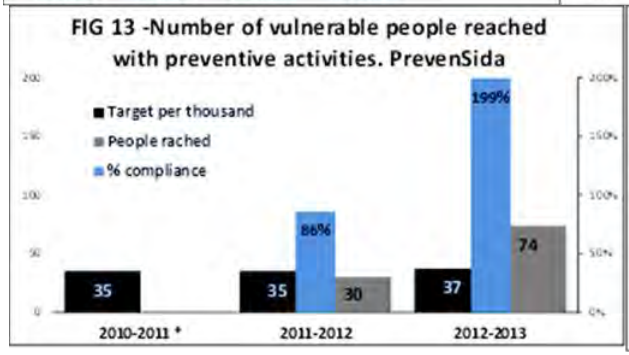


FIG 13 -Number of vulnerable people reached
with preventive activities. PrevenSida
Target per thousand
People rached
% compliance
2010-2011 *
2011-2012
2012-2013

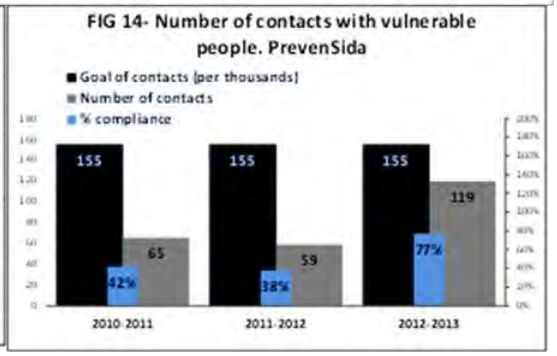


FIG 14- Number of contacts with vulnerable
people. PrevenSida
Goal of contacts (per thousands)
Number of contacts
% compliance
2010-2011
2011-2012
2012-2013

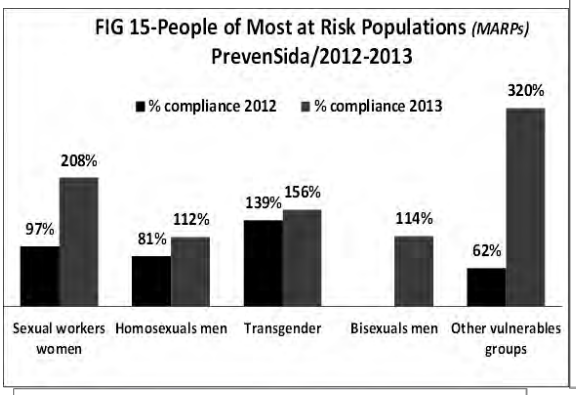


FIG 15-People of Most at Risk Populations (MARPs)
PrevenSida/2012-2013
% compliance 2012
% compliance 2013
97%
208%
81%
112%
139%
156%
114%
62%
320%
Sexual workers women
Homosexuals men
Transgender
Bisexuals men
Other vulnerables groups

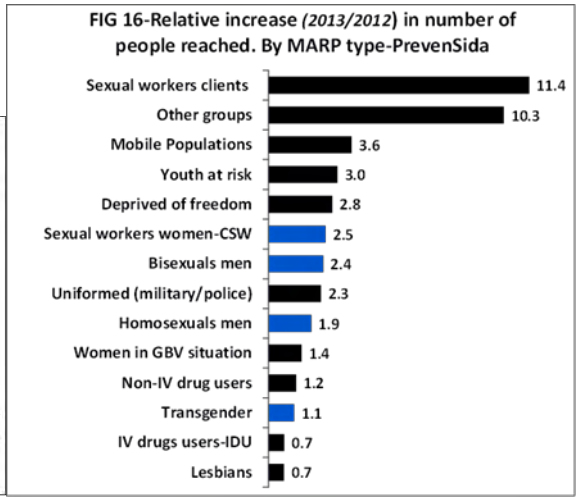


FIG 16-Relative increase (2013/2012) in number of people reached. By MARP type-PrevenSida
Sexual workers clients 11.4
Other groups 10.3
Mobile Populations 3.6
Youth at risk 3.0
Deprived of freedom 2.8
Sexual workers women-CSW 2.5
Bisexuals men 2.4
Uniformed (military/police) 2.3
Homosexuals men 1.9
Women in GBV situation 1.4
Non-IV drug users 1.2
Transgender 1.1
IV drugs users-IDU 0.7
Lesbians 0.7

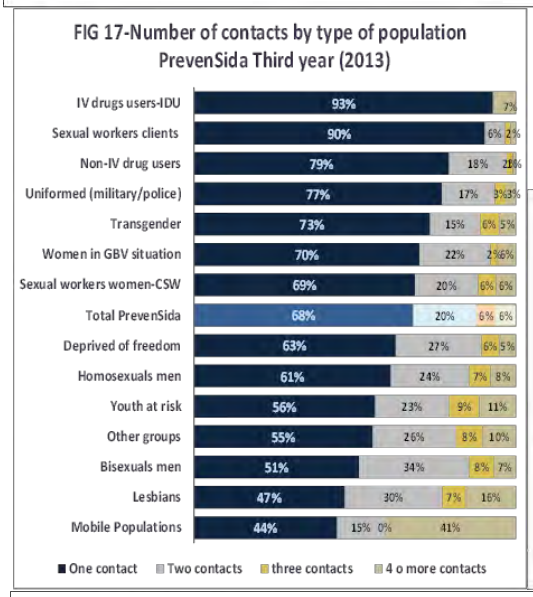


FIG 17-Number of contacts by type of population
PrevenSida Third year (2013)
IV drugs users-IDU 93% 7%
Sexual workers clients 90% 6% 2%
Non-IV drug users 79% 18% 2%
Uniformed (military/police) 77% 17% 3% 3%
Transgender 73% 15% 6% 5%
Women in GBV situation 70% 22% 2% 6%
Sexual workers women-CSW 69% 20% 6% 6%
Total PrevenSida 68% 20% 6% 6%
Deprived of freedom 63% 27% 6% 5%
Homosexuals men 61% 24% 7% 8%
Youth at risk 56% 23% 9% 11%
Other groups 55% 26% 8% 10%
Bisexuals men 51% 34% 8% 7%
Lesbians 47% 30% 7% 16%
Mobile Populations 44% 15% 0% 41%
One contact
Two contacts
three contacts
4 o more contacts

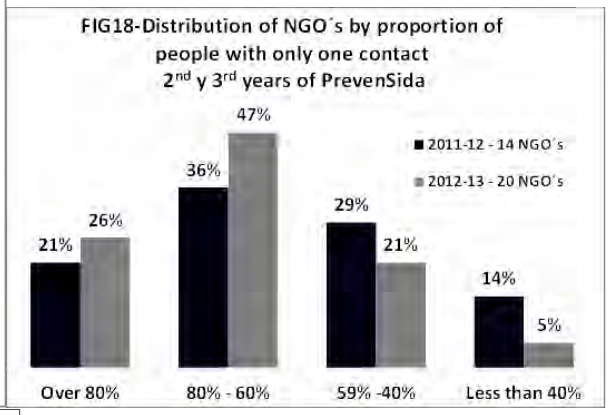


FIG18-Distribution of NGO´s by proportion of people with only one contact
2nd y 3rd years of PrevenSida
2011-12 - 14 NGO´s
2012-13 - 20 NGO´s
21%
26%
36%
47%
29%
21%
14%
5%
Over 80%
80% - 60%
59% -40%
Less than 40%

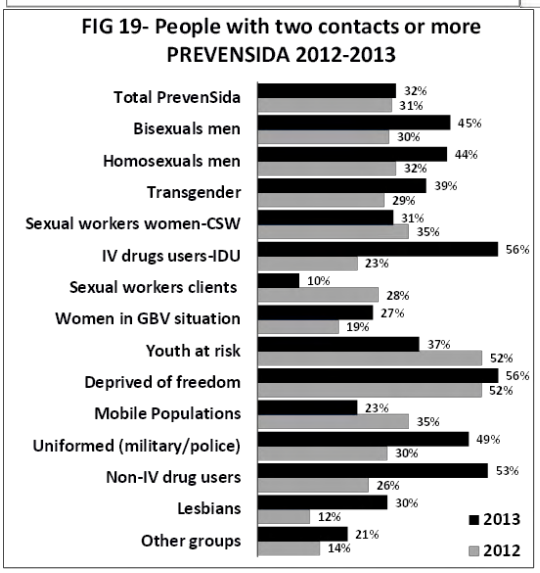


FIG 19- People with two contacts or more
PREVENSIDA 2012-2013
Total PrevenSida 32% 31%
Bisexuals men 45% 30%
Homosexuals men 44% 32%
Transgender 39% 29%
Sexual workers women-CSW 31% 35%
IV drugs users-IDU 56% 23%
Sexual workers clients 10% 28%
Women in GBV situation 27% 19%
Youth at risk 37% 52%
Deprived of freedom 56% 52%
Mobile Populations 23% 35%
Uniformed (military/police) 49% 30%
Non-IV drug users 53% 26%
Lesbians 30% 12%
Other groups 21% 14%
2013
2012

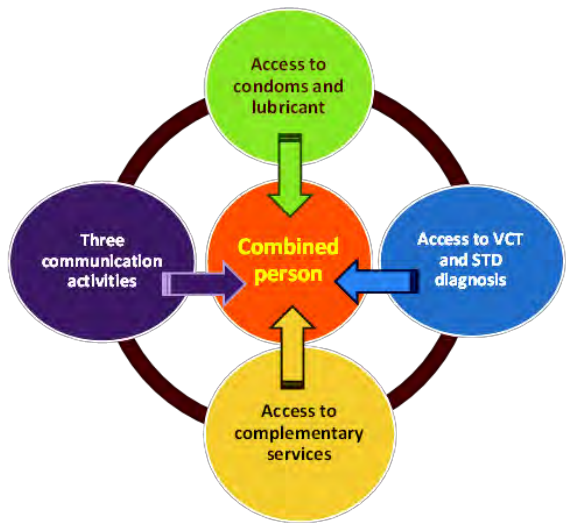


FIG 20-Combined preventive model
Access to condoms and lubricant
Three communication activities
Combined person
Access to VCT and STD diagnosis
Access to complementary services

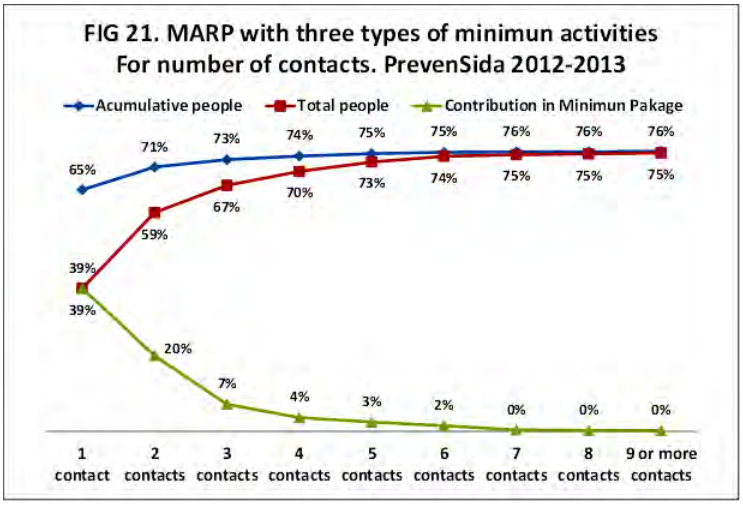


FIG 21. MARP with three types of minimun activities
For number of contacts. PrevenSida 2012-2013
Acumulative people
Total people
Contribution in Minimun Pakage
65% 71% 73% 74% 75% 75% 76% 76% 76%
39% 59% 67% 70% 73% 74% 75% 75% 75%
39% 20% 7% 4% 3% 2% 0% 0% 0%
1 contact
2 contacts
3 contacts
4 contacts
5 contacts
6 contacts
7 contacts
8 contacts
9 or more contacts

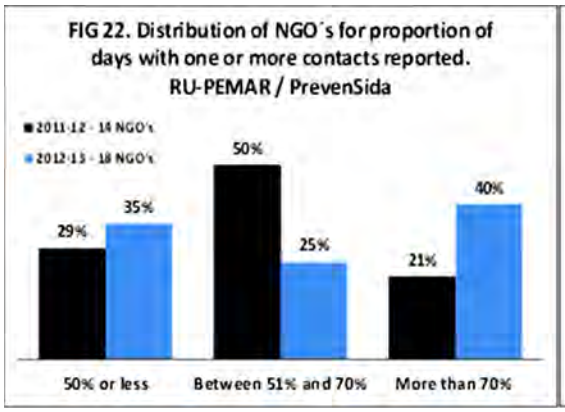


FIG 22. Distribution of NGO´s for proportion of days with one or more contacts reported.
RU-PEMAR / PrevenSida
2011-12 - 14 NGO's
2012-13 - 18 NGO's
29% 35%
50% 25%
21% 40%
50% or less
Between 51% and 70%
More than 70%

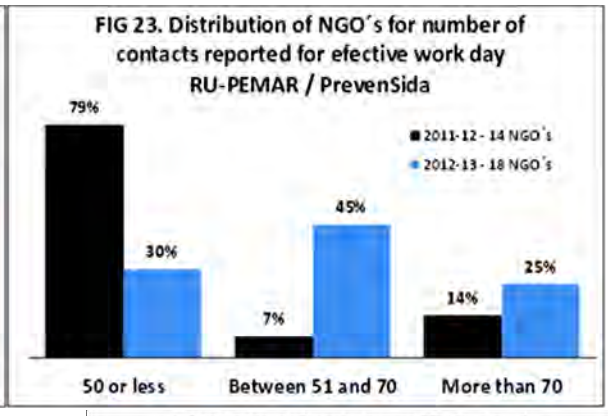


FIG 23. Distribution of NGO´s for number of contacts reported for efective work day
RU-PEMAR / PrevenSida
2011-12 - 14 NGO´s
2012-13 - 18 NGO´s
79% 30%
7% 45%
14% 25%
50 or less
Between 51 and 70
More than 70

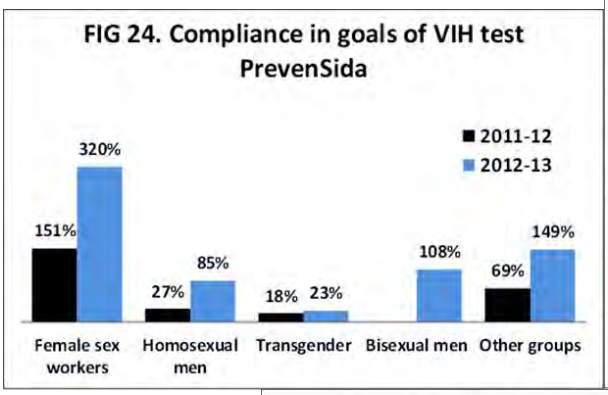


FIG 24. Compliance in goals of VIH test
PrevenSida
2011-12
2012-13
151% 320%
27% 85%
18% 23%
108%
69% 149%
Female sex workers
Homosexual men
Transgender
Bisexual men
Other groups

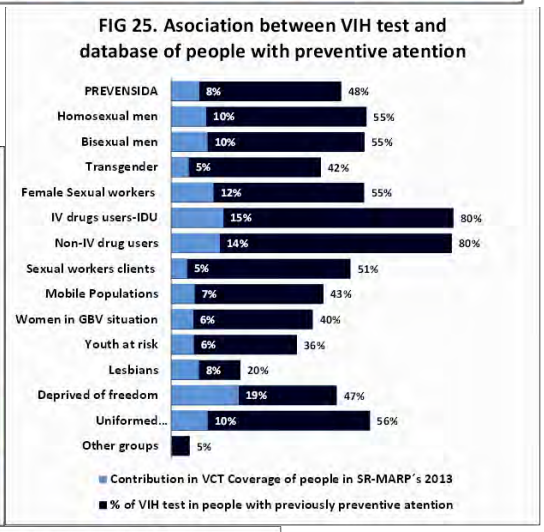


FIG 25. Asociation between VIH test and database of people with preventive atention
PREVENSIDA 8% 48%
Homosexual men 10% 55%
Bisexual men 10% 55%
Transgender 5% 42%
Female Sexual workers 12% 55%
IV drugs users-IDU 15% 80%
Non-IV drug users 14% 80%
Sexual workers clients 5% 51%
Mobile Populations 7% 43%
Women in GBV situation 6% 40%
Youth at risk 6% 36%
Lesbians 8% 20%
Deprived of freedom 19% 47%
Uniformed... 10% 56%
Other groups 5%
Contribution in VCT Coverage of people in SR-MARP´s 2013
% of VIH test in people with previously preventive atention

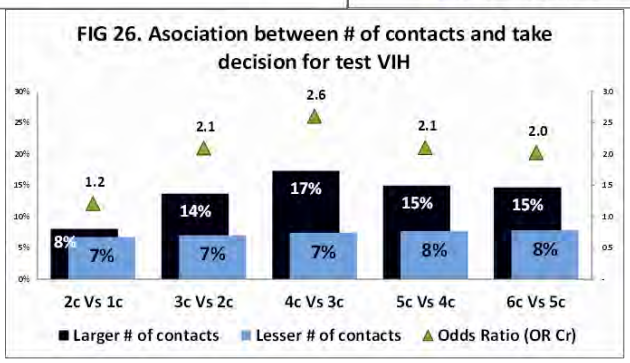


FIG 26. Asociation between # of contacts and take decision for test VIH
1.2 2.1 2.6 2.1 2.0
8% 14% 17% 15% 15%
7% 7% 7% 8% 8%
2c Vs 1c
3c Vs 2c
4c Vs 3c
5c Vs 4c
6c Vs 5c
Larger # of contacts
Lesser # of contacts
Odds Ratio (OR Cr)

FIG 27. Positive rapid test for expositon at preventive activities

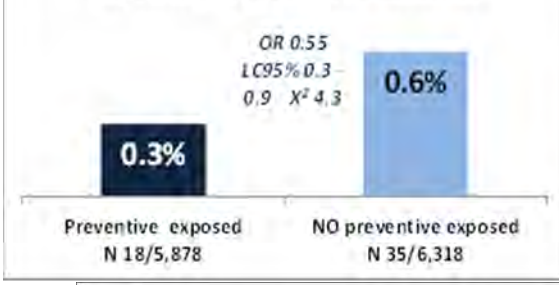


FIG 28. Positive rapid test according to expositon at preventive activities and time of NGO´s in PrevenSida

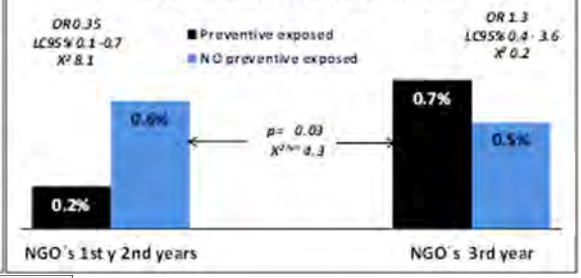


FIG 29. Place of contact of people living with HIV according to contacts secuence order

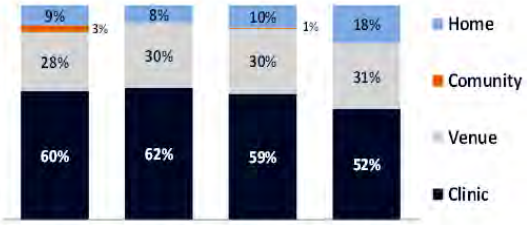


FIG 30. Type of Contact of people living with HIV according to contacts secuence order

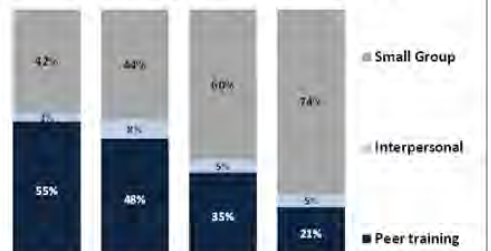


FIG 31. People of key populations in two o more groups in Single Register

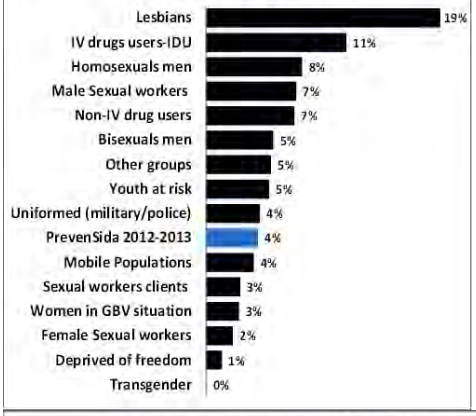


FIG 32. Grant Financial Performance Global Fund - Nicaragua *(USD millions)*

FIG 33. Grant Performance

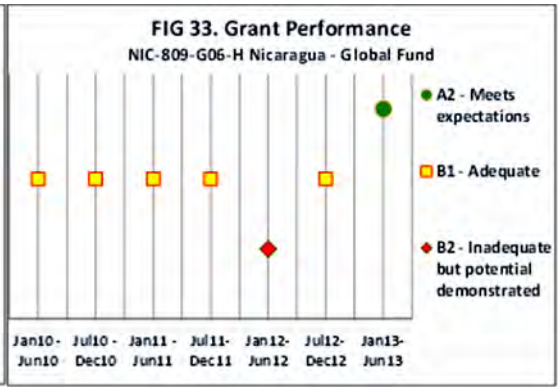
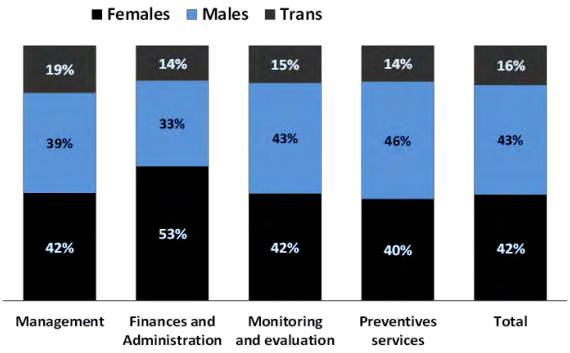


FIG 34. Participation in training events by theme and sex.
PrevenSida 2010 - 2013



ANNEX 3. FIELD VISITS

INTERVIEWS

Persona entrevistada	Organización / Institución	Departamento
Enrique Beteta Acevedo	Secretario General MINSA, CONISIDA	Managua
Patricia Rodríguez	Receptor Principal INSS/FONDO MUNDIAL	Managua
David Delvie George	INSS	RAAN
María Elena Hurtado Cundano	Programa VIH MINSA SILAIS Chontales	Chontales
Jeaneth Cash Deborah Hodgson	BICU	RAAS
Neptalia Herrera	Fundación Gaviota	RAAN
Tyron Aburto	MDS (Movimiento de Diversidad Sexual)	RAAS
Keita Cooper	ACCS (Asociación Campaña Costeña Contra el Sida)	RAAS
Elmer, Jessica Natty	AMODISEC (Asociación de Movimiento de la Diversidad Sexual Costeña)	RAAN
Arelys Cano	ASONVIHSIDA (Asociación Nicaragüense de VIH/ Sida)	Managua
Representantes	CEPRESI (Centro para la Educación y Prevención del SIDA)	Managua
Representantes	ICAS	Managua
Representantes	IXCHEN	Managua
USAID		
Marianela Corriols	USAID	Managua
Carolina Arauz	Deliver / USAID	Managua
Jairo Núñez	SCMS / USAID	Managua
Ivonne Gómez	URC / USAID	Managua
Oscar Núñez Rafael Arana Carlos Jarquín	PrevenSida / USAID	Managua
Representantes	PASCA / USAID	Managua
Representantes	PASMO / USAID	Managua

FOCAL GROUPS

Grupo	Organización	Departamento
Docentes de medicina, enfermería, farmacia	UNAN, UCAN, Escuela de Salud Pública	León
Docentes de medicina, enfermería, farmacia	UNAN	Managua
HSH	CEPRESI (Centro para la Educación y Prevención del SIDA)	Chontales
HSH	AMODISEC (Asociación de Movimiento de la Diversidad Sexual Costeña)	RAAN
HSH	OVI (Asociación Organización Vida Integral)	Managua
HSH	ACCS (Asociación Campaña Costeña Contra el Sida)	RAAS
PVIH	GAO (Grupo de Auto Ayuda de Occidente)	León
PVIH	AMODISEC (Asociación de Movimiento de la Diversidad Sexual Costeña)	RAAN
PVIH	ANICP+VIDA (Asociación Nicaragüense de Personas Positivas por la Vida)	Rivas
PVIH	ASONVIHSIDA (Asociación Nicaragüense de VIH/ Sida)	Managua
Trans	MDS (Movimiento de Diversidad Sexual)	RAAS
Trans	Red Trans	Managua
Trans	Red Trans	Masaya
Trabajadoras Sexuales	GAO (Grupo de Auto Ayuda de Occidente)	León
TS	ACCS (Asociación Campaña Costeña Contra el Sida)	RAAS
TS	Red Trans	Masaya
MVBG	Fundación Gaviota	RAAN
MVBG	IXCHEN	Granada
Jóvenes en Riesgo	ADESENI (Asociación por los Derechos de la Diversidad Sexual Nicaragüense)	Mateare

ANNEX 4: SCOPE OF WORK

Mid Term Performance Evaluation

Bilateral HIV Program

USAID/Nicaragua

Title:	**Mid-term Performance Evaluation of Bilateral HIV Program**
Period of Performance:	July 1 – November 30, 2013
Location:	Nicaragua
Sponsoring Offices:	USAID/Nicaragua, OHE
Supervisor team:	Angela Cardenas, USAID/Nicaragua/Office of Health and Education (OHE) Chief Marianela Corriols, USAID/Nicaragua/OHE HIV Specialist Marcela Villagra, USAID/Nicaragua/M&E Specialist
Application Deadline:	June 15, 2013

ACRONYMS

AIDS	Acquired Inmuno- Deficiency Syndrome
ALLIANCES 2	USAID project on public-private alliances for health and education
ADRA	Adventist Development and Relief Agency
ARV	Antiretroviral
BCC	Behavior Change Communication
CONISIDA	Comisión Nacional de Lucha contra el SIDA [*National HIV Commision*]
DELIVER	USAID Project on logistics implemented by JSI
ENDESA	Encuesta Nicaragüense de Demografía y Salud [*Nicaraguan Demographic and Health Survey*]
FAMISALUD	Familias Unidas por Su Salud [*Families United for Health*]
GBV	Gender-based violence
GF	Global Fund
GON	Government of Nicaragua
HCI	Health Care Improvement Project
HIV	Human Immunodeficiency Virus
HSS	Health System Strengthening
IRH	Institute for Reproductive Health
IDU	Injectable Drugs UsersINIDE Instituto Nicaragüense de Información para el Desarrollo. [*National Institute for Development Information*]
INSS	Nicaragua's Social Security Institute [*Instituto Nicaragüense de Seguridad Social*]
MOH	Ministry of Health
NICASALUD	Nicaraguan Federation of 28 NGOs working on health
NGO	Non-Governmental Organization
PASCA	USAID HIV Regional Project on policies
PASMO	NGO working on HIV, FP and condom social marketing
PF	Partnership Framework
PEPFAR	President's Emergency Plan For AIDS Relief
PMTCT	Preventing mother to child transmission
SILAIS	Local Systems for integrated health care [*Sistemas Locales de Atención Integral a la Salud]*
SOAG	Strategic Objective Agreement
S&D	Stigma and discrimination
VCT	Voluntary Counseling and Testing
USAID	United States Agency for International Development
USG	United States Government

SECTION 1 – PROGRAM DESCRIPTION

Identification data:	**HIV bilateral program**
Program implementation dates:	October 1, 2007 – September 30, 2015
Program evaluation dates:	October 1, 2007 – to date
Program planned funding:	$8,000,000 approximately
Implementing partners:	
Bilaterally-funded projects:	

- University Research Corp (URC)/PrevenSida (2010-2015)
- John Snow, Inc/DELIVER (2010-2013)
- URC/Quality Improvement Project (2000?-2006)
- URC/Health Care Improvement Project (2007-2013)

- Research Triangle Institute (RTI) Alliances 2 (2010-2013)
- NicaSalud/FamiSalud (2006/2009)
- Population Services International (PSI)/Pan American Social Marketing Organization (PASMO) (2005-2009)
- Management Sciences for Health/Pronicass (2003-2010)

Regionally-funded projects:

- PSI/PASMO (2005-2015)
- Futures Group/ PASCA (2010-2013)
- IntraHealth International/Capacity (2004-2009)
- Partnership for Supply Chain Management, Supply Chain Management System (SCMS) (2010-2013)

USAID/Nicaragua, Office of Health and Education (OHE) Chief: Alicia Dinerstein
USAID/Nicaragua Activity Manager: Marianela Corriols
USAID/Nicaragua M&E Officer: Marcela Villagra
Funding source: Mission funded – PEPFAR funds

USAID/Nicaragua has been implementing HIV activities with bilateral funding, which comes directly from the Mission's annual budget, since 1998. HIV activities were not explicitly described in the 2003-2008 Nicaragua Country Plan but some specific activities were included in the health projects since 2003 (PASMO, Famisalud). In 2007, the Mission evaluated the Health Program, including the HIV Component (PASMO, HCI, Pronicass, Capacity). At that time, the evaluation team provided five recommendations to the Mission in order to improve HIV programming. In addition to the bilaterally-funded projects, the USAID HIV Regional Program has also been implementing several projects, contributing to the implementation of the HIV cooperation strategy in Nicaragua. In 2010, the Central America Region started an HIV Partnership Framework (2010-2014). The Mission proposes a midterm performance evaluation to assess the accomplishments of USAID/Nicaragua's HIV bilateral program from 2008-2012 and to establish recommendations for the remaining years of the Central America Partnership Framework. The evaluation will not include activities prior to 2007 because those were covered in a previous evaluation.[3]

The program was implemented through several implementing partners. See Table 1.

Table 1 USAID/Nicaragua bilaterally-funded implementing partners and projects

Implementing partner/project name	Activities	2007	2008	2009	2010	2011	2012	2013
PSI/PASMO- Proyecto de Prevención de VIH Sida	Prevention: Behavior change communication (BCC), Voluntary Counseling and Testing (VCT), Quality	x	x	x				
IntraHealth/Capacity	Health System Strengthening (HSS) - Hospital quality services		x	x				
NicaSalud/Famisalud	Prevention in rural settings	x	x	x				
URC/HCI	Prevention of Mother to Child Transmittion (PMTCT), Stigma and Discrimination (, S&D), VCT		x	x	x	x	x	x
MSH/Pronicass	HSS	x	x	x	x			
URC/PrevenSida	Combined Prevention					x	x	x

[3] Reynolds, J. Bongiovanni, A, GH Tech Consultants. USAID Nicaragua Health Program Evaluation. April 2008.

	among key populations							
JSI/Deliver	Logistics					x		x
RTI/Alliances 2 ®	Prevention in work places							x

SECTION 2 - BACKGROUND

USAID's HIV/AIDS program[4]

Since the launch of USAID's HIV/AIDS program in 1986, the Agency has been on the forefront of the global AIDS crisis. Today, with more than 34 million people living with HIV worldwide, USAID is a key partner in the U.S. President's Emergency Plan for AIDS Relief (PEPFAR), the largest and most diverse HIV/AIDS prevention, care and treatment initiative in the world.
The key areas for HIV/AIDS programming are:
Prevention: USAID combines and tailors its prevention efforts to meet the varying needs and situations of the people it serves. These efforts can include helping people make healthy decisions, such as delaying sexual initiation, limiting the number of sexual partners, and using condoms correctly and consistently.
Care and Support: USAID is committed to providing HIV/AIDS care and support to those in need, including orphans and vulnerable children. The Agency supports pain and symptom management as well as psychological, social, and spiritual services.
Treatment: USAID is committed to improving access to AIDS treatment and supports a range of programs in this area, including the Supply Chain Management System project, which assists in the delivery of safe and reliable HIV/AIDS medicines and supplies to programs around the world. In addition, USAID is working to train health care providers and establish programs for clinical services, including screening and treatment for opportunistic infections like tuberculosis.
Research: USAID supports research on the development of products to prevent HIV infection and transmission, including vaccines and microbicides.
Sustainability and Health Systems Strengthening: USAID supports the efforts of partner countries to make their health care systems strong and sustainable. Agency support focuses on any or all of the aspects of a health care system, such as the quality of its workforce, its ability to gather and use health information, and its capacity to acquire and deploy equipment, supplies, and drugs. Building strong and sustainable health systems is a crucial step on the path toward universal access to comprehensive HIV programs.

The President's Emergency Plan for AIDS Relief (PEPFAR)[5]

The President's Emergency Plan for AIDS Relief (PEPFAR) is the U.S. Government initiative to help save the lives of those suffering from HIV/AIDS, and the largest by any nation to combat a single disease. It is driven by a shared responsibility among donor and partner nations and others to make smart investments to save lives. It is the largest component of the U.S. President's Global Health Initiative. The HIV epidemic requires a comprehensive, multi-sectoral approach that expands access to prevention, care and treatment. The current PEPFAR program focuses on transitioning from an emergency response to promoting sustainable country programs. Key principles for program sustainability include: country-owned and country-driven, address HIV/AIDS within a broader health and development context; build upon our strengths and increase efficiencies.

[4] http://transition.usaid.gov/our_work/global_health/aids/News/hiv_fastfacts.pdf

[5] PEPFAR: http://www.pepfar.gov/about/index.htm.

Partnership Framework between USG and Central America[6]

With PEPFAR funding, the Partnership Framework (PF) between the USG and Central America is a five-year plan (2010-2014) outlining the priority areas for HIV programming in which the participating partners, including host governments, national and regional organizations, the USG, and other major donors will devote their efforts and resources. The overall purpose of the PF is to reduce HIV/AIDS incidence and prevalence in Most at Risk Populations (MARPs) in the Central American region by joining resources and coordinating initiatives to enable a robust and more effective response to the region's epidemic. It represents a consensus to focus on evidence-based approaches, tailored to the concentrated epidemic, and it is based on governments' commitment to fighting HIV/AIDS. It is a technical assistance model, aiming to increase country ownership and sustainability. Once national capacity is strengthened in each of the participating countries, it is expected that each country will continue fighting the epidemic with local and other donor resources, with minimum input from the USG. The PF address four major gaps in HIV programming in the areas of prevention, health system strengthening, strategic information and policy environment.

HIV epidemic in Nicaragua[7]

With only 0.2 percent of the adult population estimated to be HIV positive, Nicaragua has one of the lowest HIV prevalence rates in Central America. HIV was first detected in Nicaragua in 1987, after concentrated epidemics had been reported in other Central American nations. The onset of the epidemic was likely delayed by Nicaragua's 10-year civil war and an economic blockade, both of which left the country isolated for several years. Relatively high condom use among sex workers, low infection rates among injecting drug users, and a ban on the commercial sale of blood also slowed HIV transmission.

According to Nicaragua's Ministry of Health (MOH), by June 2012, there were 7,356 reported cumulative cases of HIV positive individuals; of them, 943 have died, 5,663 people currently are living with HIV, 699 have AIDS, and the condition is unknown in 51 cases. The prevalence rate in 2012 was 107/100,000 and the incidence rate, 4.2/100,000. In the last quarter reported, 83 percent of HIV cases occurred among 15 to 45 year olds, and sexual activity was the primary mode of HIV transmission, accounting for 98.8 percent of HIV infections. Only 1.2% occurred through vertical transmission.

HIV prevalence among men who have sex with men (MSM) is significantly higher (9.3 percent) than among sex workers (1.1 to 1.9 percent) or the general population (0.2 percent). A 2007 study by UNAIDS demonstrated infection levels among MSM were 38 times higher than among the general population (UNAIDS, 2009). Given that more than 40 percent of MSM are actually bisexual, this group is an important bridge and explains the increasing number of cases reported among women in the country (UNGASS, 2010). The increase in cases reported among women could also be related to increased testing of women through the PMTCT program.

Condom use also varies among at-risk populations. Six surveys in 2009 from the Global Fund to Fight AIDS, Tuberculosis and Malaria showed condom use rates at last sex of 94 percent among female sex workers with a client (FSWs), 63 percent among MSM, 58 to 65 percent among youth, 45 percent among mobile populations, and 35 percent among prisoners. When a strict definition of consistent condom use (when used always, in any act) was applied, the rates drop to only 19 percent among MSM and 60 percent among FSWs. Among sex workers, low condom use rates were reported among partners when compared to clients (PASMO, 2009).

Factors that put Nicaraguans at risk of HIV infection include early sexual debut and social pressures to have multiple sex partners, accompanied by low risk perception. According to the 2006–2007 Demographic Health Survey (DHS), 44 percent of women aged 15 to 24 had sex before age 18. The

[6] Partnership Framework in Central America 2010-2015: http://www.pepfar.gov/countries/frameworks/central_america/index.htm

[7] HIV/AIDS Country profile. http://transition.usaid.gov/our_work/global_health/aids/Countries/lac/nicaragua_profile.pdf

DHS also showed that 76 percent of women interviewed knew about HIV/AIDS and ways to prevent it, but only one-third believed they were at some risk of infection. Additionally, only 11 percent of women engaging in high-risk sex (sex with a non-marital, non-cohabitating partner) had used a condom the last time they had sex. Many women and girls also have limited abilities to negotiate sex or condom use due to gender-based violence and sexual abuse. Among women aged 15 to 49, one in four had witnessed her father abuse her mother, and one in five was physically abused before age 15. Moreover, conservative religious and social values often make it difficult to talk about sex and ways to protect oneself from disease or unwanted pregnancy.

USAID support for HIV in Nicaragua

Nicaragua, with a population of around 6 million, has a net population growth rate of 1.3 percent (2010) and is the second-poorest nation in the Western Hemisphere. USAID has supported health and other development programs in Nicaragua continuously since 1991, with significant expansion following Hurricane Mitch in 1998. The health program has focused on maternal and child health, water and sanitation, family planning/reproductive health (FP/RH), and HIV/AIDS.

Since 1998, USAID has been a leading donor in HIV assistance to Nicaragua, working closely with the GON, the private sector and multiple local NGOs, providing technical assistance on prevention, management, logistics and financial systems; and training health care providers and NGOs to ensure high quality services.

A Strategic Objective Agreement (SOAG) (signed 8/19/03) between the governments of the USA, acting through USAID, and Nicaragua, defined USAID's health program for the USAID strategy period 2003-2008. The SOAG did not include an HIV component, but some HIV activities were funded in different projects (PASMO, Famisalud, ADRA). The goal of USAID/Nicaragua's Office of Health and Education (OHE) for the Mission's 2003-2008 strategy, which was subsequently extended through 2013, is to contribute to achieving "Healthier, Better Educated People." The strategic objective (SO) framework includes three intermediate results (IR): IR 3.1 "Increased and Improved Social Sector Investment and Transparency", 3.2 "Increased and Improved Basic Education Opportunities" and 3.3 "Improved Integrated Management of Child and Reproductive Health", two of which are related to health.

From 2003-2009, Nicaragua's HIV program was funded through USAID Nicaragua and regional projects and some funds were invested in the FamiSalud project. The programmatic focus of the USAID support in this period was Health System Strengthening and Prevention. However, once the PEPFAR's Central America Partnership Framework (2010-2015) was signed, the HIV component of USAID's Health Program in Nicaragua was implemented as part of the regional strategy through a combination of projects – some field support implementing mechanisms based in USAID/Washington, regional projects and others developed exclusively for Nicaragua. These projects were designed to address four priority components identified in the PF:

Table 2 Bilateral HIV program in Nicaragua under the Central America Partnership Framework (2010-2015)[8]

Component	Problem addressed	Objectives	Strategic interventions/ Key activities	Implementing Partners/Projects
Prevention	Insufficient coverage of primary and secondary preventive services for key populations	To increase healthy behaviors among key populations to reduce HIV transmission	Develop and implement innovative cost effective, context appropriate and evidence based preventive interventions. Improve the screening, diagnosis and	PSI/PASMO: HIV Regional combined prevention URC: Prevensida

[8] Partnership Framework in Central America 2010-2015: http://www.pepfar.gov/countries/frameworks/central_america/index.htm

Component	Problem addressed	Objectives	Strategic interventions/ Key activities	Implementing Partners/Projects
			treatment of STIs. Expand access to VCT services for key populations at all levels	
Health System Strengthening	Dependence on external aid Institutional weaknesses Anti-retro viral (ARV)/rapid tests stockouts	To build capacity in service delivery, health work force and essential medical products	Strengthen institutional capacity to improve and expand HIV/AIDS quality service delivery to key populations, including laboratories. Develop methodologies and implement activities to improve institutional and human resource capacity to respond effectively to the HIV/AIDS epidemic among key populations. Strengthen the commodities and supply chain management systems to ensure minimum stock-outs, delays and increased coverage	URC: Prevensida JSI: Deliver SCMS Regional
Strategic information	Insufficient use of information. Insufficient knowledge of key populations. Lack of effective register system.	To build the capacity to monitor and use information that enhances understanding of the epidemic and enables appropriate actions to be taken	Strengthen M&E by promoting the use of data for decision making. Support the development of sustainable and harmonized information systems including new approaches suitable to concentrated epidemics. Strengthen the collection, analysis, interpretation, and dissemination of data to characterize the epidemic focusing on high-risk and vulnerable populations.	Futures Group: HIV Regional PASCA URC: Prevensida PSI/PASMO: HIV Regional combined prevention JSI: Deliver; URC: Prevensida
Policy Environment	Limited GON funding. Stigma and discrimination. Gender inequities. Insufficient participation from other sectors (other GON, private sector, NGOs)	To improve the policy environment for reaching the ultimate goal of Universal access to HIV/AIDS services	Support the development and implementation of policies with multisectoral involvement to reduce stigma and discrimination (related to sexual orientation, sexual identity, HIV status, occupation and other), gender based violence and gender inequities. Strengthen the design, management and implementation of GF HIV grants. Promote multisectoral involvement and CSO capacity to effectively participate in strategic planning, policy design, implementation and monitoring.	Futures Group: PASCA URC: Prevensida

HIV funding

At national level, USAID/Nicaragua has invested US$ 111,857, 000 in health programs between FY98-FY12. Of that total, US$16,500,000 has been invested in HIV activities, representing 14.7% of the total health budget.

Previous evaluations

In 2007, USAID Nicaragua performed a Health Program Evaluation (GH Tech, 2008)[9] which reviewed the HIV situation and Mission activities from 2003 to 2007. At that time the epidemiological situation was similar to the current situation. The epidemic remained concentrated in high-risk groups, largely among FSW and MSM in urban areas along the northwest corridor, the border and coastal areas. The HIV prevalence in the general population was less than one percent, but was higher among high-risk groups: men who have sex with men (MSM, 9%) and female sex workers (FSW, >1%). Incidence figures from the MOH documented a sharp increase in the number of new cases of HIV and AIDS from 2000 to 2007, with 94% of new cases being transmitted sexually. Perinatal transmission was only 4%.

USAID-supported interventions concentrated on preventing the spread of the disease. The evaluation found that the two most cost-effective interventions, free distribution of condoms and social marketing of condoms, were implemented, respectively, by the MOH and by the PASMO project, which at the time was funded by other donors. USAID funds were concentrated on the next three most cost-effective interventions reported by scientific literature: behavior change communication (BCC) with high-risk groups, voluntary counseling and testing (VCT), and BCC for indigenous males. Only one of the less effective interventions in a concentrated epidemic --prevention of mother-to-child transmission (PMTCT) -- received USAID support.

The evaluation recognized the exemplary work done by URC-HCI to develop a PMTCT model, ensure testing of pregnant women and carry out a training program to reduce stigma in hospitals; and by PSI/PASMO to support BCC among men and women engaged in high-risk behaviors. The evaluation also identified some gaps: a great need for data on prevalence for planning and evaluation and more focus on prevention and high-risk populations. The report included five strategic recommendations: 1) Conduct sero-prevalence and behavioral surveys of high-risk populations; 2) Discontinue funding of MOH PMTCT activities; 3) Emphasize primary prevention as the main intervention; 4) Expand primary prevention among high-risk groups through a consortia of NGOs; and 5) Unless significant additional funding is available, avoid several popular interventions that only had limited effects on prevention.

SECTION 3 - PURPOSE AND AUDIENCE

USAID/Nicaragua is searching for a contractor that can evaluate the Mission's HIV bilateral program.

The purpose of the evaluation is to assess the level of accomplishment of USAID/Nicaragua's HIV bilateral program since 2008, including progress on recommendations from the 2007 health program evaluation, identify key factors contributing to or impeding program results and establish recommendations for program adjustments for the remaining years of the Central America Partnership Framework and beyond. Specifically, this evaluation will serve the purposes of both accountability and learning.

The expected audiences are both internal (USAID and Embassy) and external (GON, donors and civil society, including NGOs, universities and the private sector).

SECTION 4- EVALUATION QUESTIONS

General Question:

To what extent has the USAID/Nicaragua HIV program successfully integrated PEPFAR's programmatic principles of country ownership and leadership, sustainability, capacity building, and strengthening health systems into its program activities? And to what extent have emphasizing these principles contributed to achieving desired results to date?

Specific Questions

Q1: Based on the indicators selected to monitor the HIV program in Nicaragua (Attachment 1), to what extent has the USAID/Nicaragua HIV program achieved its expected targets to date for

[9] Reynolds, J. Bongiovanni, A, GH Tech Consultants. USAID Nicaragua Health Program Evaluation. April 2008.

each of the key components outlined in the bilateral program (2005-2009) and Central America PEPFAR partnership framework (2010-2015)? In cases where it has not met its targets, please explain why.

a) Prevention: PASMO (bilateral funded), Prevensida, HCI, Alliances 2 and FamiSalud)
b) Health System Strengthening (Prevensida, HCI, Deliver)
c) Strategic Information (Prevensida, Deliver)
d) Policy Environment (Prevensida, Deliver)

Q2: For components that have made progress as expected:

a) What is the level of achievement in each component?
b) Were the individual project designs and original assumptions valid to ensure successful performance?
c) For HIV indicator targets that were achieved, is there the potential to sustain this achievement? If not, what needs to be done to increase sustainability?
d) What are the risks to continued progress and what can be done to mitigate those risks?
e) What was the contribution of the HIV regional program to the progress achieved in each strategic component?
f) To what extent have external factors, such as unexpected events within the country, helped progress?
g) Were there particularly positive aspects of each project's design, implementation and evaluation that contributed to the achievement of results? If so, what were they?

Q3: For those components where progress has not been achieved as expected:

h) What is the level of achievement in each component?
i) What caused the lack of full accomplishment?
j) What actions were taken to try to improve achievement of the components' objectives and what impact did they have?
k) Are the individual project designs (including project staffing, management and budget) and technical approaches appropriate and adequate? If not, what needs to change to improve accomplishments?
l) Were there particular aspects of each project's design, implementation and evaluation that contributed to the lack of achievement of results? If so, what were they?
m) To what extent have external factors, such as unexpected events within the country, hindered progress?

Q4: Has the USAID/Nicaragua HIV program contributed to gender equity?

a) Did projects integrate gender considerations into their design, activities and indicators, and develop measures to enhance participation of women and men in USAID's HIV program activities? If so how did they do so and what has been the impact?
b) Did projects integrate specific LGBT considerations, including specific activities to address stigma and discrimination among these key populations? What specifically did they do and what results did they achieve?
c) Did strategy implementation increase the sustainability of these gender-specific achievements? If so, how?

Q5: What are the recommendations to improve the likelihood of sustainability of USAID's HIV program achievements?

e) What are the recommendations for the Mission's Office of Health and Education?
f) What are the recommendations for key national and local counterparts and other donors in Nicaragua?
g) What are the recommendations for USAID's Regional (Guatemala-based), Latin America and Global Health bureaus, and how can these bureaus support regional activities that will in turn help Nicaragua sustain progress in its HIV/AIDS programs?
h) What should USAID/Nicaragua do to share its successful experiences within the country, with other countries, and with other Missions, donors and others?

i) What threats exist that may hinder further HIV prevention progress in the country and how can they be mitigated?

Two additional questions are included focusing exclusively on the Prevensida Project coverage for the period October 1 2010- March 30 2013.

Q6: What is the estimated size of key populations in Nicaragua for 2012-2015 at national and departmental levels for:

- Men who have sex with men (gay and bisexual)
- Transgender women
- Sex workers
- Other key populations: clients of sex workers, mobile populations, transportation workers, migrant agricultural workers, other migrants, women affected by gender-based violence (GBV), youth at risk, indigenous people (garifona and miskitu) IDU, and non-IDU.
- People living with HIV/AIDS

Q7: Based on the information generated by the previous question, what coverage did the HIVprevention activities implemented by the Prevensida project in 2012 achieve in each of the key populations estimated at the national and departmental levels?

- Men who have sex with men (gay, bisexual)
- Transgender women
- Sex workers
- Other key populations: clients of sex workers, mobile populations, transportation workers, migrant agricultural workers, other migrants, GBV-affected women, youth at risk, indigenous people (garifona and miskitu), IDU, and non-IDU
- People living with AIDS
-

Q8: What activities were considered successful or unsuccessful in reaching these populations and why? How can these results be used for future program planning?

SECTION 5 – METHODOLOGY

As mentioned before, the purpose of this evaluation is to assess the level of accomplishment of USAID/Nicaragua's HIV program, including progress on recommendations from the 2007 Health Program Evaluation, and to make recommendations for the next five years.

Considering this purpose, the evaluators should use various methods to assess the different components of the HIV bilateral program to answer all the questions outlined above. Though the evaluators will propose the methods they feel are appropriate at different stages of the assessment, these methods must be approved prior to use by USAID. All activities should be carried out in consultation with USAID/Nicaragua to ensure that the evaluation team has the fullest possible background and contact information. USAID/Nicaragua will provide overall technical leadership and direction for the evaluation team throughout the assignment.

The methodological instruments to be used should focus on obtaining qualitative information (opinions, experiences, etc.) and quantitative data from counterparts, implementers, partners, beneficiaries, GON entities, NGOs, private sector, and other donors. The following methods or a selection of them are highly recommended for the assessment:

- Literature review
- Review of project documents
- Observation and field visits to a sample of implementers, counterparts, and beneficiaries
- Focus group discussions
- Individual and group interviews using checklists or questionnaires

The evaluation team should consider starting the assessment with a review of the electronic sources and documents cited below, as well as by reviewing project documents. The team should also make site visits and conduct interviews with key actors. The Mission expects the evaluation team to present

strong quantitative and qualitative analyses that addresses key HIV bilateral program indicators and to develop a situation analysis of the current situation with an eye to identifying gaps that fit with USAID's core competence

The evaluators will be expected to develop a detailed explanation of the proposed methodology for carrying out the evaluation, and share it with USAID/Nicaragua for approval before the assessment is implemented. The methodology should include a mix of tools appropriate to the evaluation's objectives.

To design and implement the research activity required to answer Q6, Q7 and Q8, the applicant could consider hiring a scientific organization (University, Public Health School) or other specialized consultants in this area. In this case, the costs for this research should be clearly defined and the references/CV of the proposed organization or consultants should be included as an Annex in the scientific protocol (Deliverable # 2). USAID must pre-approve any organization or consultants used for these activities.SECTION 6 – EXISTING DATA

Sources of information: The evaluation team will be expected to meet with members of the USAID/Nicaragua Health Office Team, USAID Nicaragua senior management, the staff of the five on-going bilateral and three regional projects that work/have worked on HIV (Prevensida, DELIVER, HCI, Alliances 2, FamiSalud, PASMO, PASCA and SCMS), as well as with other key technical players and counterparts at national and local levels.

The Mission's HIV specialist will provide all existing documentation (hard or electronic copies) related to the bilateral HIV program and coordinate inputs from the active projects (PrevenSida, Deliver, HCI and Alliances) and closed projects (Pronicass, FamiSalud) that have contributed to program implementation.

USAID/Nicaragua and its active implementing partners will provide the evaluation team with a package of briefing materials (on a CD or link), including:

- USAID Evaluation Policy and checklist for evaluation reports
- USAID Gender Policy
- Central American Partnership Framework
- Central American Partnership Framework Implementation Plan
- Project descriptions
- Project annual plans and reports
- M&E plans and reports
- Health Program Evaluation, 2007
- Educational and other materials developed
- National HIV/AIDS Strategic Plans
- National HIV reports
- Matrix that lists implementing partners and their activities

The team may find it useful to consult a broad range of additional background documents apart from those provided by USAID/Nicaragua. These may include documents that relate to HIV situation in Nicaragua. See Annex # 2 for more information.

SECTION 7 – TIMELINE AND DELIVERABLES

7.1 Estimated timeline

	Month 1				Month 2				Month 3				Month 4				Month 5			
Task	**1**	**2**	**3**	**4**	**1**	**2**	**3**	**4**	**1**	**2**	**3**	**4**	**1**	**2**	**3**	**4**	**1**	**2**	**3**	**4**
1. Propose work plan and methodology and brief meeting with USAID																				
2. Collect information (secondary sources for Q1-Q5)																				
3. Conduct interviews with implementing partners and key stakeholders (Q1-Q7)																				
4. Propose protocol research for Q6- Q7 for USAID approval																				
5. Conduct review of all available information/evidence of HIV strategy indicators (Q1-Q5)																				
6. Conduct site visits to selected beneficiary groups (Q1-Q5)																				
7. Collect information (primary sources for Q6-Q7)																				
8. Drafting and submission to USAID of 1st draft of the evaluation report (Q1-Q5)																				
9. Debriefing meetings with USAID and partners on 1st draft																				
10. Writing and submission of 2nd draft report (Spanish) and 2-page fact sheet (Spanish) for USAID review and approval																				
11. Validation of 2nd draft Spanish report with partners and beneficiaries																				
12. Final report prepared and submitted (Spanish) for USAID approval																				
13. Final report translated into English and submitted for USAID																				
14. Drafting and submission to USAID of 1st draft of the Q6-Q7-Q8 report																				
15. Meeting with USAID/Nicaragua to discuss progress and key findings and receive feedback (Q6-Q7-Q8) of report draft																				
16. Writing and submission of 2nd draft report(Q6-Q7-Q8) for USAID approval																				
17. Final report submitted to USAID for approval and translated into English																				

7.2 Deliverables

The evaluation team will complete the following deliverables:

1. **Work plan for Q1-Q8:** The evaluation team is expected to propose a concise work plan and methodology for collecting the necessary information and data, and a validation and dissemination plan of the Spanish draft of the evaluation results. The work plan and

proposed data collection tools will be submitted to USAID Nicaragua for approval no later than the sixth day of work.

2. **Protocol research for Q6-Q7-Q8**: The evaluation team is expected to propose a research protocol to answer Q6-Q7-Q8 based on the best methodology applicable to the Nicaraguan context.
3. **Mid-evaluation meeting with USAID on Q1-Q5**: Mid-way through the team's field work, the team will schedule a meeting with USAID/Nicaragua to discuss the findings to-date, troubleshoot possible obstacles towards completing the evaluation as planned, and review a proposed detailed outline of the evaluation report's format.
4. **Debriefing meeting with USAID and partners (two separate meetings** on Q1-Q5to be held at the conclusion of the field work. In these meetings, the evaluation team will present the major findings and recommendations through a PowerPoint presentation. Feedback from these presentations will be incorporated into the first draft report.
5. **1st complete draft evaluation report on Q1-Q5:** A complete draft report of the findings and recommendations will be submitted to USAID/Nicaragua in Spanish. The report should clearly describe findings, conclusions and recommendations. USAID will provide comment on the draft report within one week of submission and the team will prepare an updated version of the evaluation report (2nd draft in Spanish)
6. **2nd complete draft evaluation report and 2 page fact sheet on Q1-Q5:** This deliverable consists of submitting the 2nd draft of the evaluation Report document to USAID and a 2-page fact sheet in Spanish with evaluation results, highlights and recommendations for decision makers
7. **Validation events on Q1-Q5:** The 2nd draft report will be validated through four separate events to share evaluation results with stakeholders for review and comment: a) CONISIDA meeting (est. 10 participants), b) donor meeting (est. 10 participants), c) other partners meeting (MOH, NGOs and universities, est. 50 participants), d) USAID implementing partners and USAID/USG meeting (est. 30 participants). The fact sheet will also be distributed during the events. All costs associated with holding the events (rental of venue, refreshments, etc) will be covered by the contractor.
8. **Final evaluation report on Q1-Q5 - Spanish**: The consultant team will submit a final report in Spanish that incorporates responses to USAID's comments and validation suggestions no later than five days after USAID/ Nicaragua provides written comments on the 2nd draft. Upon receiving USAID's approval of the final report, 30 printed/formatted hard copies of the report will be submitted to USAID, as well as electronic versions in MicrosoftWord and PDF formats.
9. **Final evaluation report on Q1-Q5 - English:** Upon receiving USAID's approval of the Spanish version of the report, the report shall be translated into English by the contractor, edited by a certified company, and 30 printed/formatted hardcopies shall be submitted to USAID, along with electronic versions in MicrosoftWord and PDF formats.
10. **Draft research report on Q6-Q7-Q8**: A complete draft report of the findings and recommendations will be submitted to USAID/Nicaragua in Spanish. Using scientific style the report should include Introduction, Methods, Results and Discussion. USAID will provide comment on the draft report within one week of submission and the team will prepare an updated version of the research report final research report
11. **Final research report on Q6-Q7-Q8 Spanish**: The consultant team will submit a final report in Spanish that incorporates responses to USAID's comments no later than five days after USAID/ Nicaragua provides written comments on the draft. Upon receiving USAID's approval of the final report, 30 printed/formatted hard copies of the report will be submitted to USAID, as well as electronic versions in Microsoft Word and PDF formats.
12. **Final research report on Q6-Q7-Q8 English:** Upon receiving USAID's approval of the Spanish version of the report, the report shall be translated into English, edited by a

certified scientific company, and 30 printed/formatted hardcopies shall be submitted to USAID, along with electronic versions in Microsoft Word and PDF formats.

SECTION 8 - REQUIRED SUPPORT

Evaluation team composition

The evaluation team will require at least three local team members (i.e., living in Nicaragua) with the following minimal qualifications:

Team Leader:

- Ten years of experience in the design, implementation, and/or monitoring and evaluation of national and/or international health programs.
- PhD or Master's level degree in public health, epidemiology, behavioral science or related field.
- Demonstrated skills in one or more of the following technical areas: monitoring and evaluation of HIV programs, HIV prevention and behavior change methodologies, health system strengthening related to HIV interventions (e.g. treatment and care, development of standards and protocols, logistics systems, in-service and/or pre-service training of health personnel, strategic information, policy)
- At least one documented experience working in HIV/AIDS evaluation and serving as team leader for an evaluation.
- Knowledge of PEPFAR.
- Deep knowledge of the HIV situation in Nicaragua.
- Fluency in spoken and written Spanish and at least technical proficiency in written English.
- Ability to travel to departments in Nicaragua to conduct evaluation activities.
- Strong interpersonal skills working effectively as a team leader as well as the ability to communicate with various stakeholders.
- Strong verbal and written communication skills, including a demonstrated ability to write technical documents and give presentations
- Experience working with populations from diverse cultures, including sexual diversity.

Technical Team Members: one Prevention/Health System Strengthening Specialist and one Strategic information/Policy Environment Specialist. Each person should have a minimum of:

- Experience working on at least 5 health program evaluations.
- Five years of experience working on issues related to HIV/AIDS programs in Nicaragua and/or other Central American countries.
- Deep knowledge of the HIV situation in Nicaragua.
- Knowledge of PEPFAR.
- Strong verbal and written communication skills, including a demonstrated ability to write technical documents and give presentations
- Experience working with key populations (including all key populations under the Partnership Framework)
- In addition, the Prevention/Health System Strengthening Specialist and the Strategic information/Policy Environment Specialist, should each have demonstrated specific experience in at least one of the technical areas associated with the position.

SECTION 9 SCHEDULING AND LOGISTICS

The evaluation team shall be responsible for arranging air travel and local ground transportation and accommodation; and providing computers, printers, and other administrative services.
USAID/Nicaragua will provide overall direction to the evaluation team, identify and make available all key documents, and approve the work plan, data collection tools, and various iterations of the report.
USAID/ Nicaragua will provide support, as needed, to arrange meetings with key stakeholders, including implementers, Government of Nicaragua counterparts, donors and beneficiaries.
All costs related to English translation and editing, debriefing and validation/dissemination meetings (venue rental, refreshments, and other logistics expenses) and the production of materials (100 copies of the draft report in Spanish for validation activities, 30 copies of the final report in Spanish, 30 copies of the final report in English, 100 copies of the 2-page fact sheet in Spanish) should be included as part of the proposal budget.
USAID /Nicaragua's HIV specialist will be available to the team for consultations on logistic and technical issues during the evaluation process.

SECTION 10 REPORT FORMATTING REQUIREMENTS

The evaluation team should prepare two types of reports:

- Evaluation report for Q1-Q5
- Research report for Q6-Q8

The evaluation report for Q1-Q5 (single spaced, double spaced between paragraphs) is expected to comply with USAID's new Evaluation Policy and checklist for USAID evaluation reports (this requires a 25-30 page report, not including executive summary or attachments, among other criteria).
The evaluation report should answer the evaluation questions and conclude whether or not and to what extent the HIV bilateral program objectives were accomplished as well as what needs to be done to ensure continued forward progress.
The report should follow the following format:

1. Table of contents
2. List of acronyms and abbreviations
3. Acknowledgements
4. Executive summary: Should include a simple statement of the purpose of the evaluation, a very short description of the program, methodology, key results, conclusions and recommendations. This section selectively highlights only the most important things found in the evaluation report and is aimed at a wider audience than will read the full report. Concisely state the most salient findings and recommendations.
5. Introduction: Purpose of the evaluation, audience, synopsis of task and statement of the key questions to be answered.
6. Background: HIV/AIDS situation in Nicaragua and history and current situation with respect to the USAID Nicaragua bilateral HIV program. This section should give a factual picture of the current situation with respect to the objectives of the program, the implementers and participants, different phases and projects, external factors that affected the achievement of objectives, and notable achievements and problems, if any, with respect to progress.
7. Methodology: this section will describe evaluation methods, including constraints and gaps.
8. Findings/Conclusions/Recommendations – this section should be organized by each HIV program component and also present data on indicators, issues and outcomes.
    a. Findings: present key findings, including HIV program bilateral indicators evaluation (both quantitative and qualitative)
    b. Conclusions: present conclusions for the key evaluation questions or other key issues identified during the evaluation. These conclusions should be numbered, followed by

a short discussion of each conclusion. Each conclusion represents the evaluators' positive/negative judgments about the facts discussed.

c. Recommendations: Each recommendation should also be numbered and concisely stated, usually corresponding to a major conclusion, possibly followed by a short discussion of each recommendation. The recommendations refer to future actions that should be undertaken by USAID, other donors, or country stakeholders and should consider future development activities that could benefit from taking into consideration the lessons learned from the bilateral HIV program experience, its achievements and problems faced, as well as the long-term sustainability of the program in Nicaragua.

9. References: bibliographical documentation.
10. Annexes: evaluation methods, schedules, interview lists and tables, meetings, interviews and focus group, etc. Should be succinct, pertinent and readable.

The Research report for Q6-Q7-Q8 (single spaced, double spaced between paragraphs) is expected to comply with scientific method and style. It should be a 25-30 page report, not including executive summary, bibliography or attachments.
The research report should answer the evaluation questions 6 and 7.
The report should follow the following format:

1. Executive Summary
2. Introduction
3. Methods
4. Results
5. Discussion
6. Bibliography
7. Attachments

SECTION XI LEVEL OF EFFORT

Estimated level of effort

	Number of days			
Key activities	**Leader**	**Tech 1**	**Tech 2**	**Total days**
1. Proposed work plan and methodology	5	2	2	9
2. Collecting information (secondary sources)	5	5	5	15
3. Interviews with implementing partners and key stakeholder	5	5	5	15
4. Full review and analysis of all available information/evidence of HIV indicators	5	5	5	15
5. Site visit to selected communities	10	10	10	30
6. Mid evaluation and debriefing meetings with USAID Nicaragua to discuss advances, structure, key findings to date	2	2	2	6
7. Drafting of first draft report	5	2	2	9
8. Drafting of second draft report	5	2	2	9
9. Validation activities	5	5	5	15
10. Writing final report	5	2	2	9
Q6-Q7-Q8				
11. Research activity:	60	60	60	180

Total	**112**	**100**	**100**	**312**

ATTACHMENT # 1: Selected indicators to monitor HIV program in Nicaragua

INDICATORS BY STRATEGIC COMPONENT	Projects	
E. PREVENTION	Bilateral funded	Regional funded
Increase from baseline the number of MARPs (key populations) reached with individual and/or small group level interventions that are based on evidence and/or meet national or international standards.	Prevensida, Alliances 2	Combined Prevention-PSI
Increase from baseline the number of MARPs with STI who are appropriately diagnosed, treated, and counseled at health care facilities.	HCI	
Increase from baseline the number of MARPS who received and HIV test in the last 12 months and who know the results	Prevensida, HCI	Combined Prevention-PSI
Increase from baseline the number of people who live with HIV-AIDS provided care for with a minimum package for PLWA	Prevensida	
Increase from baseline the number of pregnant women with known HIV status (includes women who were tested for HIV and received their results) for 2005-2009	HCI	
Number of the targeted population reached with individual and/or small group level HIV prevention interventions that are primarily focused on abstinence and/or being faithful, and are based on evidence and/or meet the minimum standards required for 2005-2009	FamiSalud	
F. HEATLH SYSTEM STRENGHTENING		
Increase from baseline the number of testing facilities that are capable of performing HIV related laboratory tests in accordance with WHO guidelines	Prevensida, HCI	
Increase from baseline the number of health care workers who successfully completed in-service training program	Prevensida, HCI,Deliver, Alliances 2, Famisalud, Pronicass	Capacity
Increase from baseline the number of community health and para-social workers who successfully completed a pre-service training program	Prevensida	Combined Prevention-PSI
Increase from baseline the number of new health care workers who graduated from a pre-service training institution within the reporting period.	HCI, Deliver	
Reduce from baseline the number of stock-outs in ARV medication	Deliver	SCMS
G. STRATEGIC INFORMATION		
Existence of nationally coordinated multi-year M&E plans with a schedule for survey implementation and data analysis: TA provided to build national capacity for M&E, planning and implementation.	Prevensida	PASCA
Increase from baseline the number of UNGASS indicators coming from a national information system: TA provided to build national capacity and developed integrated information systems	Prevensida, HCI, Deliver	PASCA
HIV prevalence data available for MARPs published in the last 4 years: Strategy developed and implemented for knowledge management and dissemination of data.	Prevensida,	PASCA
H. POLICY ENVIRONMENT		
Improve API score every two years: Assessments carried out to identify barriers to policies, norms and regulations.	Prevensida.	PASCA
Increase number of GFTAM grants that are evaluated as A and B1: TA provided to support for the development and implementation of GF projects	Prevensida, Deliver, HCI	PASCA
Increase from baseline the number of organizations that received TA for the development of HIV related policies	Prevensida	PASCA

Annex # 2: Electronic information available

Type of documents	Electronic access:
USAID documents	HIV/AIDS Country profile. http://transition.usaid.gov/our_work/global_health/aids/Countries/lac/nicaragua_profile.pdf PEPFAR: http://www.pepfar.gov/about/index.htm. Partnership Framework in Central America 2010-2015: http://www.pepfar.gov/countries/frameworks/central_america/index.htm
Census and surveys Demography and health surveys	Census 2005: http://www.inide.gob.ni/censos2005/CifrasCompleto.pdf ENDESA 2006/7. http://www.inide.gob.ni/endesa/Endesa_2006/InformeFinal06_07.pdf Encuesta Medicion Nivel de Vida http://www.inide.gob.ni/Emnv/Informe%20EMNV%202009.pdf
Legal situation	Ley 238. "Ley de Promoción, Protección y Defensa de los Derechos Humanos ante el SIDA" http://www.ilo.org/wcmsp5/groups/public/---ed_protect/---protrav/---ilo_aids/documents/legaldocument/wcms_127761.pdf
Health sector	**Ministry of Health** Health situation analysis 2000-2011: http://www.minsa.gob.ni/index.php?option=com_content&view=article&id=24&Itemid=130&Itemid=160 Norms, protocols and guidelines: http://www.minsa.gob.ni/index.php?option=com_remository&Itemid=52&func=select&id=1459 HIV Treatment guidelines: http://www.who.int/hiv/pub/guidelines/nicaragua_art.pdf Logistic system (PASIGLIM): http://www.minsa.gob.ni/index.php?option=com_remository&Itemid=52&func=fileinfo&id=6863 Health model (MOSAFC): http://www.minsa.gob.ni/index.php?option=com_remository&Itemid=52&func=fileinfo&id=5234 Reproductive Health Strategy: http://www.nicaragua.unfpa.org.ni/publidoc/Politicas%20Públicas%20y%20Legislación/ENSSR2daversion.pdf Social Security Institute: http://www.inss.gob.ni/index.php?option=com_content&view=section&layout=blog&id=8&Itemid=37
Other Key Players	Global Fund: http://portfolio.theglobalfund.org/en/Search/PortfolioSearch# UNAIDS: http://onusida-latina.org/en/?option=com_content&view=category&layout=blog&id=36&Itemid=391 PNUD: http://www.undp.org.ni/tematicas/9 UNFPA: http://www.nicaragua.unfpa.org.ni/publicaciones.php PAHO: http://new.paho.org/nic/ World Bank : Reduciendo la vulnerabilidad al VIH/SIDA en Centroamérica Nicaragua: Situación del VIH/SIDA y respuesta a la epidemia. http://siteresources.worldbank.org/INTHIVAIDS/Resources/375798-1103037153392/CAHIVAIDSNicaraguaFINALSPA.pdf
Implementing partners	Prevensida/URC: http://www.prevensida.org.ni/ HCI/URC : http://www.urc-chs.com/country?countryID=36 DELIVER/JSI: http://www.jsi.com/JSIInternet/Projects/ListProjects.cfm?Select=Country&ID=276 PASCA: http://www.pasca.org/node/37 PSI/PASMO: http://www.psi.org/nicaragua Alliances II:
National information	CONISIDA: Informe 2012 http://onusida-latina.org/images/2012/mayo/ce_NI_Narrative_Report[1].pdf CONISIDA: Acceso universal a prevención, tratamiento, Atención y apoyo relacionados al vih.Nicaragua 2010 http://www.undp.org.ni/files/doc/1332459861_Acceso%20Universal%2007-08.pdf MINSA: Situación epidemiológica del VIH sida en Nicaragua. http://www.minsa.gob.ni/index.php?option=com_remository&Itemid=52&func=fileinfo&id=6703

Total amount invested: $80,000 ($62,000 Q1-Q5 evaluation; $18,000 Q6-Q8 evaluation).