Evaluation of Training Component of USAID/Nicaragua's HIV Bilateral Program

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Solicitation No: SOL-524-14-000002

Managua, Nicaragua. November 2015

ACKNOWLEDGEMENTS

The evaluation team would like to express its appreciation to civil society organizations and universities that generously gave their time and collaborated in the completion of this report. Their names are listed in Annex 1 (Tables 7, 8 and 9.)

Our special thanks to Mr. Ted Gehr, Director of USAID/Nicaragua, Ms. Ángela Cárdenas, General Development Office, Dr. Marianela Corriols, HIV Strategic Information Advisor for Nicaragua, Ms. Marcela Villagra, Monitoring and Evaluation Officer, and the entire USAID/Nicaragua team for participating in the evaluation and development of this report.

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ACRONYMS

ACCS	Coastal Association for a Campaign against AIDS
ADESENI	Nicaraguan Association for Sexual Diversity Rights
ADISNIC	Nicaraguan Association for Sustainable Integral Development
ALLIANCES	Alliances 2 Project
AIDS	Human Immunodeficiency Syndrome
AMODISEC	Association of the Coastal Sexual Diversity Movement
ANICP+VIDA	Nicaraguan Association of Positive Persons for Life
API	Political Environment Improvement
APS	Primary Health Care
ARV	Antiretroviral drugs
ART	Antiretroviral therapy
ASONVIHSIDA	Nicaraguan Association for HIV/AIDS
ASSIST	Applying Science to Strengthen and Improve Systems Project
BCC	Behavior Change Communication
BICU	Bluefields Indian and Caribbean University
CEGODEM	Center for the Study of Governance and Democracy
CEPRESI	Center for AIDS Prevention
CIES	Center for Health Research and Studies
CONISIDA	Nicaraguan AIDS Commission
COSEP	Superior Council of the Private Enterprise
CQI	Continuous Quality Improvement
CURIM	Committee for the Rational Use of Medical Supplies
CVT	Counseling and Voluntary Testing
DAIAA	Committee for Contraceptive Availability Security
DAISSR	Committee for Availability Security of Sexual and Reproductive Health Supplies
DEIGEORSEX	Rights-Based Movement on Gender Identity and Sexual Orientation
DELIVER	Technical Assistance Project on Logistics for Medical Supplies
E&D	Stigma and Discrimination
ECVC	Central American Surveillance Survey of Sexual Behavior and Prevalence of HIV/STIs in Vulnerable Populations
FP	Family Planning

FSW	Female Sex Worker
FY	Fiscal Year
GAO	Self-Help Group in Western Nicaragua
GBV	Gender-Based Violence
GF	Global Fund
HCI	Health Care Improvement Project
HIV	Human Immunodeficiency Virus
HR	Human Rights
ICAS	Central American Health Institute
IDSDDHH	Sexual Diversity and Human Rights Initiative
ILO	Integral Life Organization
INSS	Nicaraguan Social Security Institute
KP	Key Population
LGBTI	Lesbians, Gay, Bisexuals, Transgender and Intersex
M&E	Monitoring and Evaluation
MOH	Ministry of Health
MOJUDS	Youth Movement for Sexual Diversity
MOVFEM	Feminist Movement
MSD	Movement for Sexual Diversity
MSM	Men who have sex with men
NGO	Nongovernmental organization
OPC	Organizations working with key populations
PAHO	Pan American Health Organization
PASCA	Program for Strengthening the Central American Response to HIV
PASIGLIM	Automated Integrated Logistics System for Essential Drugs and Contraceptives Program
PASMO	Pan American Social Marketing Association
PBL	Problem-Based Learning
PEN	National Strategic Plan
PEPFAR	The United States President's Emergency Plan for AIDS Relief
POLISAL	Health Polytechnic Institute
PREVENSIDA	AIDS Prevention Program
PSI	Population Services International
PVIH	People Living with HIV
QAP	USAID Quality Assurance Project
QIC	Quality Improvement Committee

RACN	Autonomous North Caribbean Region
RACS	Autonomous South Caribbean Region SCMS
	Supply Chain Management System
SRU	Single Registry System
STI	Sexually Transmitted Infection
SW	Sex Worker
TB	Tuberculosis
TOR	Terms of Reference
TRANS	Transgender
UAM	American University
UCAN	Christian Autonomous University of Nicaragua
UNAN	National Autonomous University of Nicaragua
UNICIT	University of Science and Technology
UPOLI	Polytechnic University of Nicaragua
URACCAN	University of the Autonomous Regions of the Nicaraguan Caribbean Coast
URC	University Research Co., LLC
USA	United States of America
USAID	U.S. Agency for International Development
WHO	World Health Organization

EXECUTIVE SUMMARY

The purpose of this work was to evaluate the performance of the training component of USAID/Nicaragua's HIV Bilateral Program since 2010, including progress in the implementation of the recommendations of the Health Program Evaluation in 2007, identifying key factors contributing to or preventing results and making recommendations to adjust the program for the remaining years of PEPFAR's Central American Partnership Framework and beyond. This evaluation will serve for accountability and learning purposes.[1]

The evaluation team consisted of four researchers who already had the experience of evaluating the performance of USAID/Nicaragua's HIV Bilateral Program in 2013, which pointed out that this program is one of the most important pillars for underpinning capacity-building processes for major social actors involved in the national response to HIV. In accordance with the 2007 evaluation and PEPFAR's new guidelines focused on the development of innovative strategies that are cost efficient and based on evidence, striving to reduce accessibility gaps of key populations to prevention services, improve the quality of the delivery of health services and carry out processes for addressing the epidemic according to its particularities by strengthening the capacity of local non-governmental organizations (NGOs) and key population (KP) associations.

The evaluation was conducted in the period comprised from September to November 2015. Diverse processes were carried out, including, inter alia, a review of the Program's relevant documentation and its different projects, the documentation related to the national response, and the relevant training documentation set forth in PEPFAR and USAID guidelines. Semi-structured interviews were conducted with 302 operational and managerial-level staff at the institutions, organizations, associations and universities involved in the training processes. A segment of the larger universe was selected to approach grantee organizations in the last two years and/or organizations with available resources, which have formed part of USAID's technical transfer process.

Members of USAID's strategic management, the Program's implementers (PREVENSIDA, HCI/ASSIST, DELIVER, and PASCA and PASMO regional projects), the CIES and CEPRESI management teams, and a representative from the Superior Council of Private Enterprise (COSEP) participated in this evaluation. The instruments were applied at the operational and management level of the organizations and institutions in the following locations: Managua, Masaya, León, Matagalpa, Nueva Segovia, Río San Juan, and North and South Atlantic Regions. In total, 16 NGOs and 9 universities were approached. A database was developed and five annual databases from the training registry system were added each year, in order to analyze the performance and current trends of the training processes and identify constraints in the registry system.

The period under evaluation is a process of continuous change characterized by a diversity of contexts that have been grouped in three phases, in order to facilitate evidence of factors that enable progress and constraints, identifying training as the main pillar for ensuring the direction of the processes in each of these phases and the progressive continuation of the three phases.

Overall, the goals of the training program have been achieved or overachieved as a result of the commitments made by the projects, organizations and institutions and the gradual institutional capacity-building process in management, administration and service delivery, which also includes knowledge of the territory and clearly establishes links with the beneficiary populations.

Institutional strengthening is emerging as a major advancement for the sustainability of the training program. The last measurement shows that 61% of the organizations that received technical assistance have surpassed 75% of the standards, four had an orange color (ranking between 61% and 75%) and seven remained in the

red zone. The latter were all key population associations.

At the universities, attendance has focused on transfer of skills for the purpose of contributing to the formation of professionals, technicians and assistants by strengthening the capacity of teachers in relation to the new protocols on HIV care, stigma and discrimination (S&D), gender-based violence (GBV), supply chain, rational use of medicines and continuous quality improvement, among others. Pedagogical kits and packages were delivered and implemented during this process, thus contributing to institutional strengthening and progress sustainability.

The incorporation of gender has been a cross-cutting theme for USAID in the response to HIV. Therefore, key populations in Nicaragua have been included in specific projects and activities that seek to improve access to prevention services, reduce S&D, promote and defend human rights, and strengthen the administration and management of the organizations.

The most important contribution of the regional programs, such as PASMO and PASCA, has focused on developing and implementing methodologies for approaching key populations, generating strategic information and technical assistance for HIV policy-making in universities, private companies and organizations, as a framework of reference to carry out prevention and care actions in KP based on a gender and human rights approach, which contribute to reduce S&D. In total, 48 of 50 NGOs (96%) received technical assistance to develop HIV policies.

The training component has been a constant focal point in the development and maturing process of USAID Nicaragua's HIV Bilateral Program, as evidenced by the results and chances of sustainability of the capacities developed for the national response to the epidemic.

The general situation of the program to date is characterized by a period of transition and change where quality and sustainability constitute a parameter for validating the two models offered to the national response, i.e. a combination prevention model centered on KP and a consolidated network of strengthened organizations capable of self-sustaining endogenous improvement and change processes.

This condition represents an important challenge for adjusting the program's training component. Although it is already ongoing with proposals of high strategic value, such as training facilitators in the organizations on prevention, monitoring and evaluation, management, and promotion of human rights, it is also necessary to overcome shortcomings and adjust to a new sphere of demands that will arise from the application of instruments, such as PEPFAR's new quality monitoring system (SIMS) and quality management programs.

The recommendations indicate that it is very important to design a proposal for a continuous and comprehensive HIV care model in the shortest term possible. The combination prevention model, currently in process of consolidation and validation, constitutes the basis for providing continuous care to KP, not only ensuring medication adherence and continuity, but also family and social integration.

The completion and validation of the comprehensive care model requires adjustments at different levels, which cannot be completed in the temporary horizon of the current life of USAID Nicaragua's HIV Program. This completion and validation warrant a review of the time periods and funding foreseen.

I. INTRODUCTION

The purpose of evaluating the performance of the training component of USAID/Nicaragua's HIV Bilateral Program is to analyze the level of success reached through the implementation of interventions with civil society organizations and universities in the period 2010-2015 in response to the gaps identified in prevention, health systems, strategic information and policy environment. The expected audience at an internal level is composed of USAID and Embassy partners and, at an external level, NGOS, donors, universities, the private sector and civil society. This evaluation will be useful for accountability and learning feedback.

In accordance with political orientations included in the framework of the Central America Partnership Agreement of the "The United States President's Emergency Plan for AIDS Relief (PEPFAR 2010-2015), the program has based its design, planning, monitoring and evaluation in such way as to combine and articulate the objectives and actions of diverse national projects (PrevenSida, HCI, DELIVER, Alliance II) with the contribution of regional projects (PSI/PASMO, PASCA, SCMS), clearly differentiating their contribution and responsibility in the development of its four components: prevention, strategic information, strengthening the health system, and policy environment.

Taking into account that USAID cooperation in Nicaragua has been very broad in the last decades, the methodology used describes a first stage of capitalization of the accumulated experience focused on strengthening the capacity of public services, which sets the tone for facing the challenges of a second stage of structural changes in the approach and strategies for addressing a concentrated epidemic. This implied the design and implementation of new interventions and the development of communication models, in order to reduce gaps in access and quality health for key populations. In order to facilitate the presentation of evidence regarding the achievements, constraints and elements that had a bearing on the continuous change process, three phases of the bilateral program are characterized, which are called initial or tilting phase, validation phase and consolidation phase, in which training is a focal point that allows each of them to be oriented.

The program's training component has not only contributed to strengthen leadership of civil society organizations and associations that group key populations, but also their capacities in management, administration, human rights, monitoring and evaluation, and prevention services. It has also developed training processes geared to improve competences of health staff and teachers in human resource training schools, while transferring managerial and methodological tools that contribute to the program's sustainability.

This report presents the findings of the evaluation process in five chapters: I) Introduction; II) Background, which contextualizes the development of USAID's HIV Program; III) Methodology, which succinctly describes the evaluation process; IV) Results, which organizes the answers to the questions (Q1 Description of performance, Q2, Internal and external factors that facilitate achievements, Q3, Internal and external factors that limit achievements, Q4 Contribution of training to gender equity, and Q6, Evaluation of information systems); and V) Conclusions and recommendations. The question guidelines, methodological matrixes, list of participants interviewed, quantitative tables and graphics, which expand the performance evaluation, are attached in the annexes.

II. BACKGROUND

An element that has characterized USAID/Nicaragua's HIV Program has been the endogenous continuous monitoring and evaluation of its progress and implementation, which have been combined since 2007[2] with external evaluations that have addressed the overall program or have focused on specific aspects, thus ensuring that the program is adjusted to the particular characteristics of Nicaragua's HIV epidemic and how the national response has been developed, as well as to the guidelines emanating from PEPFAR or from global progress in knowledge and proposals for addressing similar epidemics.

2.1. Nicaragua's HIV Epidemic

Since the first case was reported in 1987 until 2014, Nicaragua has reported 9,832 cases of HIV, of which 1,019 have been new cases, 1,123 people have died, and 2,935 are receiving ART[3]. The departments with the highest prevalence of new cases are Bilwi, Managua, Granada, Chinandega and Chontales, reporting 91% in heterosexual populations, 5% in MSM, and 1% in bisexual populations. The most frequent mode of transmission of HIV is through sexual contact with an infected person. Clearly, the country continues to have one of the lowest prevalence rates in the Central American region, currently below 0.5%. HIV prevalence in adult populations was 0.2% and in pregnant women 0.11%[4].

The HIV TRaC survey conducted by PASMO in 2012 among men who have sex with other men (MSM) in the cities of Managua and Chinandega indicated that condom use in the last sexual intercourse among MSM and male sexual workers (MSW) was 90.3% and 93.2%, respectively, and between 61.3% and 70.3% of the respondents had an HIV test in the last 12 months.[5]

The Central American Sexual Behavior Surveillance Survey (ECVC)[6] conducted in 2013-2014 showed a prevalence of 9.7% in MSM in Managua, 7.4% in Chinandega, and 6.9% in Masaya. The prevalence rate in transgender populations was 18.6% in Managua, 14.3% in Chinandega and 9.5% in Masaya. Compared to the survey conducted in 2009, an increase of 2.2 percentage points in MSM in Managua is observed.

This shows that HIV prevalence in key populations versus the population at large is sixteen to seventy times greater, indicating that these differences are greater than those found in other Latin American countries. The 2013-2014 ECVC Survey also highlighted that 81% of MSM are reached by prevention programs, 42% identified condom use as a change perceived as of the training processes, recognizing that the main benefit of the condom was STI/HIV prevention. Consistent condom use with frequent customers in the last thirty days was reported by 76.9% and 91.5% of sex workers in Managua and Chinandega, respectively, while 94.8% and 91.9% of sex workers in Managua and Chinandega, respectively, consistently used condoms with new customers in the last 30 days.

Only 31% of young adults aged 18-30 reported consistent condom use in all their sexual relations (26% women and 37% men).[7] The 2011-2012 ENDESA Survey revealed that 83.2% of adult women and 86.1% of adult men have knowledge about HIV. These percentages were similar to the young adult segment and clearly show that adolescents and young adults know one or more forms of HIV prevention. Nine of ten indicated that condom use was one of them. Nevertheless, the survey showed that only 5% of women aged 15-49 who live with their couple use a masculine condom as a contraceptive method[8].

2.2. The national response

The national response has gone through diverse development stages characterized by the breadth of coverage and modalities of the prevention and treatment actions, as well as the level of political will and

articulation of the different social actors involved. At the beginning of Nicaragua's HIV epidemic, the national response was weak and depended on external funding. In 2003, people living with HIV demanded that the State of Nicaragua guarantee ARVT in health units. To a large extent, this action defined the role that civil society had to assume vis-à-vis the State, mainly with PLWHIC organizations. In this context, the HIV Project funded by the Global Fund (GF) began, in which civil society organizations working in HIV prevention targeted to women, adolescents and young adults promoted and prioritized the inclusion of these vulnerable populations in the public policy framework aimed at HIV. Resources were allocated to work with these populations and the largest percentage of funds was targeted at prevention. The main message of the training processes and mass campaigns was condom use, HIV prevention, and transmission mechanisms with a methodology that did not facilitate any behavior change in the populations of concern.

Later, progress was achieved in the enactment of Law 238, the development of the National HIV Strategic Plan 2006-2010, and the formulation of the National Policy on STI/HIV Prevention, Control and Treatment 2011-2015.

The second development phase of the national response was boosted by the entry of Nicaragua as a recipient country of resources originating from the second round of the Global Fund to fight HIV, malaria and tuberculosis. The formulation of the proposal was an opportunity for involving government entities and civil society organizations, which remained dispersed with high levels of conflict. With the support provided by international organizations, the Nicaraguan AIDS Commission (CONISIDA)—a space for coordination and concerted actions by social actors with diverse approaches and interests—was strengthened to unify a strategy in light of the diversity of projects and cooperation funds. Although most-at-risk populations were identified, a widespread epidemic approach prevailed (although the country had a concentrated epidemic), focusing on surveillance, testing and communication for women and young adults. An accelerated decentralization process of testing and ART application capacities began in departmental hospitals[9].

The third development phase of the national response was facilitated by the growing number of HIV prevalence studies in population groups that provided evidence for characterizing the epidemic as a concentrated epidemic, highlighting the following key populations: Men who have sex with other men (MSM), female transgender (FT) and female sex workers (FSW), underlying the beginning of the transitions in approaches and strategies, where the evaluation of USAID's program in 2007 stands out, which recommends suspending actions aimed at the general population and focusing on most-at-risk groups. The approval of the second project by the Global Fund, based on evidence generated by diverse studies, inter alia, the Central American Sexual Behavior Surveillance and the HIV/STI Prevalence Survey in Vulnerable Populations (ECVC), led to a general reassessment of the national strategy to focus surveillance and prevention actions on key populations (KP), thus significantly reducing the amount of resources destined for mass communication campaigns and increasing funds to work directly with these population groups, mainly in the departments that have shown high HIV prevalence rates.

Simultaneously, the regulatory and legal framework for HIV was further strengthened and a process of consultation began to reform Law 238, achieving the approval of Law 820, which regulation was still pending. USAID|PASCA supported CONISIDA for evaluating the National Strategic Plan 2006-2010. A National Strategic Plan was created for 2011-2015, which was extended to 2017, and the Monitoring and Evaluation Plan of the National Strategic Plan was drawn up with 36 indicators.

The National Strategic Plan for STI, HIV and AIDS identified the following key populations as priority populations: MSM, FT, FSW, MSW, mobile populations and persons deprived of freedom[10]. The National Prevention and Control Policy for STI, HIV and AIDS instructs the Government to allocate financial resources from the Human Rights Ombudsman's Office for its effective implementation, as well as the identification of other financing sources.[1]

A Special Ombudsman's Office for Sexual Diversity was created in 2009, led by a representative of the Lesbian Rights Movement. In 2009, MOH's Ministerial Resolution 249-2009 was approved, banning all forms of discrimination on grounds of sexual orientation in primary and secondary health care units. Subsequently, this resolution was revised in 2014 and MOH's Ministerial Resolution 671-2014 was approved, banning discrimination based on sexual work.

CONISIDA conducted an AIDS Expenditure Measurement Survey (MEGAS)[12] in 2012. According to this source, total HIV/AIDS spending in 2012-2013 amounted to $27,271,339 million. Of this total, 49% was provided by international sources, 47% by public sources, and 4% by private sources. Total HIV/AIDS spending is targeted to prevention actions, accounting for 54%. Of this total, 21% has been allocated for care and treatment, 0% for orphans and vulnerable children, 13% for program management, 10% for human resources, 0% for protection and social services, 2% for favorable environments (stigma and discrimination) and 1% for research.

HIV expenditures were targeted to the general population (34%), untargeted interventions (16%), people living with HIV (26%) and key populations (6%). The percentage of expenditure in key populations is very low and limited, taking into account that the epidemic is concentrated in these populations.

Given that cooperation resources are limited, particularly from the Global Fund, it was determined to provide care to KP, which are most affected by HIV according to studies. The Global Fund Project and USAID PrevenSida Project have selected different departments of Nicaragua for interventions with KP, with the objective of optimizing the resources and efforts of the different NGOs that receive funding from both projects.

At global level, Nicaragua is advancing in the stewardship and leadership of the national response, updating national instruments, approving legal regulations to reduce stigma and discrimination, and setting health care standards and protocols to increase the quality of care provided to key populations. It is also making progress in the decentralization of health services and testing for people living with HIV. In addition, the development of a prevention program with a new funding model from the Global Fund Project is underway[13].

2.3. USAID's HIV Program

USAID has significantly contributed to the development of health, nutrition, and maternal-child health programs, as well as to the expansion of the coverage and consolidation of family planning and strengthening of the national response to the HIV epidemic. As a result of the external evaluation of USAID's health programs in 2008, five key areas were identified for programming the actions of the HIV bilateral cooperation program: prevention, care and support, treatment, research, and strengthening of health systems.

In 2010, the Central America region and the U.S. Government initiated the Partnership Framework for Cooperation in the Response to HIV[14] (2010-2014), with funding from PEPFAR, to reduce HIV/AIDS incidence and prevalence rates in most-at-risk populations, based on evidence and the commitment of the governments with a technical assistance model focused on increasing sustainability and national ownership. In this way, the USAID/Nicaragua mission has aligned technical and financial assistance from its different projects according to the implementation of PEPFAR's partnership framework in four areas: prevention, strengthening of health systems, strategic information, and policy reforms (see annex), prioritizing the needs of KP, thereby promoting a comprehensive and multi-sector approach that broadens access to prevention,

medical care and treatment.

III. METHODOLOGY

Based on the objectives of the evaluation, the process aimed to answer six questions set forth in the TORs. The first question (Q1) strives to verify fulfillment of goals set for the component in the last five years and for the five-year period 2010-2015, as a whole, in accordance with PEPFAR's indicators and their definition. Based on the foregoing, the following two questions (Q2-Q3) were answered, which refer to the most relevant factors that had a positive or negative impact on the level of achievement. In addition, two differentiated topics are evaluated due to their relevance: the contribution of the training component to gender equity (Q4) and the quality of the training registry systems (Q6). Finally, efforts were made to answer the questions that refer to the specification of the recommendations (Q5) for improving the performance of the "training component" of USAID/Nicaragua's HIV Program. (See Annex I, Table 5)

The framework of reference for the evaluation process is configured on the confluence and articulation of three implementing projects over time (PrevenSida, HCI/ASSIST, DELIVER) and the contribution of three regional projects (PASCA, PASMO, Alliance) in two universal interventions, i.e. the network of civil society organizations and health professionals' education and training institutions.

In this context, the training component is identified as diverse processes and events linked to the strengthening of capacities of social and institutional subjects that converge in the two aforementioned universes to develop a health care model for KP, including:

a) Programs designed as a sequence of various events or modules that match the progressive development of competences. Therefore, each module counts with evaluation and approval parameters, which are combined according to general parameters for the final approval of the program as a whole.
b) Events with their own objectives and the design of theoretical-practical contents on specific themes, including an evaluation methodology and parameters;
c) Actions to provide technical assistance on site, which basic protocol consists of technical assistance visits to individuals or small groups at the place of work, in order to evaluate their performance and provide coaching to address shortcomings identified.

In accordance with the guide questions, in addition to qualifying the performance of the component in relation to the goals set, it is of interest to evaluate these training processes and events in terms of the factors that explain the level of achievement either because they had a positive effect or created limiting or restrictive conditions. The factors that could have an effect on the training component of a program like USAID's HIV Program are very diverse and broad, considering, inter alia, whether the design of the training strategy is based on the identification of limited knowledge and skills among the permanent and voluntary workers of the organizations and universities, which constitute a barrier for providing quality services for HIV prevention[15]. For this reason, the evaluation of the training component had two methodological focal points: the first refers to the analysis of the correlation of the training programs with the institutional development and service needs identified; the second refers to the conditions for implementing the training programs in the sense of ensuring quality and opportunity of training events according to the characteristics of the target audience. Hence, the analysis maintains the individual and institutional dimensions of the participants.

In this way, the performance evaluation of the implementation of the training programs analyzed **quantitative** information originating from the achievement of the indicators of each project for the period under study, supplemented with **qualitative** information originating from a broad documentary review and

interviews with people involved in the training processes by applying instruments at three levels.

- USAID/Nicaragua's strategic management and implementers.
- PrevenSida operations managers and university senior officials, i.e. rectors, deans, coordinators and/or academic secretaries.
- Executive level: PrevenSida promoters and university teachers.

Additionally, the level of direct participants in the training processes (PrevenSida promoters and university teachers), as well as the executive level in the two universes, were explored in a complementary manner and in a sample of opportunities for meetings. In addition, volunteers from key population groups who usually play the role of activists, as well as students in the disciplines of medicine, nursing and pharmacy, were interviewed.

In this regard, both the documentary review and the meetings with the partners of USAID's Program defined the universe of the study, the coverage achieved, and the necessary inputs for elaborating data collection instruments. Once the indicators were established, difference sources of information were explored, including, among others:

- USAID's annual project reports, the monthly, quarterly and annual reports of USAID's partners, action plans, reports, studies, baselines, research, and the evaluations conducted during the period 2010-2015.
- Databases and information systems.
- Semi-structured interviews applied in the two study universes: PrevenSida and universities, to explore the usefulness of the training events and broad diversity of modalities, applicability of the lessons learned, modifications to the work modalities and quality of service provision or work performance as a result of the training events, and USAID's assessment of the technical assistance visits.

Thirteen interviews were conducted with USAID, partners, education and training institutions and private companies.

Of a total of 23 subsidized organizations in the last two years, 15 organizations were selected, accounting for 65%, all of which have received some type of subsidy in 2014. The reason for excluding some organizations was their dissolution or inaccessibility of the directors.

The following selection criteria was established: a) organizations subsidized in the last two years, b) organizations that remained active and/or organizations with available workers willing to be interviewed, c) universities that belong to the group selected by USAID for the technical transfer process. Nine universities (public and private) that received technical assistance from the HCI/ASSIST and DELIVER projects were visited.

Based on the consensus reached with the PrevenSida team regarding the selection of the organizations and universities for applying measurement instruments, three field teams were organized. Each team consisted of a supervisor and two interviewers. Field staff in charge of the study was trained at a 1-day workshop (September 19, 2015), which contemplated reading and reflecting on how to fill out the instruments. The training workshop concluded with the collective validation of the questionnaires, which was the basis for making the last adjustments.

The field work began when the three supervisors contacted or visited the organizations of the PrevenSida Network and universities selected for the purpose of consulting the "opinion of experts" on relevant aspects of USAID's training component. The field work was conducted during the period comprised from September

21 to October 1.

All universities were visited as planned. However, workers at one of the schools could not be interviewed due to unexpected events and time constraints. It should be highlighted that most of the measurement sites had adequate attendance and the level of collaboration of the persons interviewed was excellent.

As a result of the fieldwork, 302 participants were interviewed, accounting for 70.1% (212) of the workers and students of the selected universities and 29.9% (90) of the workers of the organizations of the PrevenSida Network.

Procedures for registration and quality control were established and continuously monitored according to data collection and processing. During the interviews, the supervisor verified the quality of the interviews conducted by the interviewers. A second quality control was carried out prior to digitalization and during the digitalization process, in order to reduce biases in the entire research process and ensure data validity.

An ethical framework was established when the training process of the interviewers and field supervisors began, emphasizing principles regarding the rights of participants during the dialogue and self-managed interview. Emphasis was placed on principles of confidentiality and voluntariness to participate in the study. The names of the participants were not registered to protect confidentiality and an independent identity code of the person interviewed was established. Due safeguard of the physical registry of the interviews and database was ensured, in order to prevent personalization of the information provided.

Based on the primary data obtained in the documentary review, structured interviews and databases, the research team made a qualitative systematic review and, when pertinent and possible, quantitative indicators were developed, with which descriptive analyses were conducted with contingency tables and expressed in simple frequencies.

The analysis was qualitative and quantitative to the extent that it combines the appreciation and values of the persons involved in the program, some of which were addressed in order to quantify them (interviews with teachers and promoters).

The assessment criteria are based on the framework of reference put forth by the offer, which underwent clear adjustments to the extent that the findings profiled new forms of interpretation and analysis.

As part of the methodology, internal validation processes of the preliminary results were conducted with USAID staff and partners. External validations were carried out with a large number of participating partners, counterparts and beneficiaries.

IV. RESULTS

USAID Nicaragua's HIV Program has successfully implemented the training component in that it has been able to meet all indicators that measure the key outcomes of each of the implementing projects in two clearly differentiated universes. The first refers to the network of civil society organizations for the combined prevention strategy focused on key populations (PrevenSida Network) and the second refers to universities as health professionals' education and training institutions in different departments. In this regard, the progress achieved during the period under evaluation in each universe is described in the form of an inventory:

4.1 Performance of PrevenSida's training component

PrevenSida's goal is to "increase healthy behaviors in order to reduce HIV/AIDS transmission" among high-risk groups and to the population at large[16]. To achieve this, the program intends to accomplish four results:

4.1.1 Improved access to and quality of HIV/AIDS preventive services.

In the three indicators established for this result, PrevenSida records an adequate level of achievement and even overachievement, showing an average global achievement of 94% in terms of the number of people in KP groups who have received HIV counseling and testing, and 300% in the number of people living with HIV (See Annex I, Table 13).

Except for counseling and voluntary testing, which goal is derived from the amount of inputs available, it should be highlighted that the population and territorial distribution of these tests and goals regarding preventive care and HIV healthcare has fundamentally improved in recent years to the extent that PrevenSida and other organizations have KP estimates per municipality and mapping of concentration sites in each location, which enable greater precision and objectivity in the goals. This condition is even clearer in the last two years with the CONISIDA guidelines, which establish differentiated territorial coverage between the programs with different funding source.

The highest precision and best interpretation of the indicators also becomes evident when the quantitative amounts in the last years are reviewed, in which KP coverage stands out with a minimum package of actions, as a result of the combined effect of two strategic decisions:

- The establishment of a count criterion for care to key populations that have received at least four activities, which implies three different activities on initial contact.
- Reducing medical care towards "other vulnerable populations" which accounted for the highest percentage of achievement of goals in previous years.

As additional information, it should be highlighted that the coverage study conducted in 2013 as part of the program's performance evaluation indicated that PrevenSida had provided combined prevention services to 45% of the estimated KP universe at national level and that 30% of this coverage is shared with other service providers, while PrevenSida exclusively provided services to the remaining 15%.

Of 28 organizations subsidized in 2014, 75% (21) were able to meet more than 75% of the quality standards in the provision of HIV prevention services, including behavior change communication actions, counseling and testing, supply of condoms, and other prevention services.

4.1.2 Strengthened institutional capacity of at least 50 NGOs in the national response to HIV/AIDS through capacity-building and networking. (Of these, 20 are improving their global standards).

Based on the review of the annual reports and seeing the five-year period as a whole, it is clear that they reflect an excellent degree of achievement of the five-year goals. Facing a goal of 28 laboratories with capacity to perform HIV tests, there were 29 of them at the end of the fifth year (104%). (See Annex I, Table 6).

Two components were designed in the pre-service training program. The first, aimed toward administration, financial management and accounting, was facilitated by CIES, and the second, aimed toward combined prevention, was facilitated by CEPRESI. The experience accumulated by the PSI/PASMO regional project in MSM populations was a special contribution. The PrevenSida project designs technical assistance

methodologies and continuous quality improvement processes that complement or reinforce the learning of the training programs.

According to annual reports, 200 community workers completed the pre-service training program (CIES/CEPRESI), which was the established goal (100%). However, it should be highlighted that the pre-service figures reported by PrevenSida were corrected by the audit conducted in July 2014 (Audit of USAID/Nicaragua's HIV/AIDS Prevention Program - Report No. 1-524-14-011-P- for Acting Regional Inspector General/San Salvador, David Clark)[17], which corroborated an even broader training in the two pre-service programs implemented, in which 393 organization workers, out of a goal of 400, were trained (189/200 in management by CIES and 204/200 in prevention by CEPRESI). The audit identifies the reasons for the error in the reports and makes recommendations to overcome registry deficiencies.

In accordance with the annual in-service training reports and assuming that the indicator of workers participating in each event meets three conditions (defined objectives and methodology, controlled attendance and final evaluation), 3,629 workers of the member organizations of PrevenSida have been trained, representing an overachievement of 184% with respect to the five-year goal of 1,970. However, it should be highlighted that according to the training database that forms part of the Single Registry, from which those who have been registered in pre-service training (CIES/CEPRESI), 2,995 workers who have participated in in-service training events for five years, of which 2,392 came each year from subsidized organizations, thus overachieving the goal (152% with the total number of people trained and 121% if those from subsidized organizations are taken into account).

A new strategy to highlight related to in-service training during the last year (FY15) is the initial training of facilitators in the same organizations of the network in each of the large thematic areas defined, to wit: management, administration, defense of human rights, monitoring and evaluation, and prevention. The objective is to develop activities for identifying problems and constraints based on the systematization of performance evaluation procedures and continuous quality improvement processes. Clearly, this new strategy provides a more consistent basis for sustainability and, to the extent that it gradually substitutes the incentive of exogenous supervision, creates a "critical mass" of agents of change for strengthening the endogenous organization, which could go beyond PrevenSida to eventually benefit other NGOs.

In the NGO training process, USAID/PrevenSida was able to strategically integrate its partners; PASCA, PASMO, DELIVER and HCI/ASSIST. Each of them has significantly contributed to the process of strengthening NGO competences. In this regard, PASCA has worked in developing an HIV policy, a legal framework and human rights. PASMO has trained NGOs in management of behavior change methodologies. ASSIST has worked in stigma and discrimination. DELIVER has created competences in logistics and rational use of medical inputs. This practice has been successful as NGOs have been integrally trained in different areas by the same donor[18].

Based on the detailed review of the organizations that have registered to participate in PrevenSida's training component (workshops and technical assistance), 54 organizations were served in a period of five years, accounting for 106% of the goal of 50 that had been set. Of these 54 organizations, five have received technical assistance for 5 years, six for 4 years, five for 3 years, seventeen for 2 years, and twenty-one for one year. Thirty-two of the 54 organizations have been subsidized one or more years.

The annual goal of NGOs strengthened with technical assistance focused on improving their overall performance and in three monitored aspects (management, administration, finance and preventive services), which was 20 in the last three years, was achieved almost every year, and reached 100% in the five years as a whole, owing to the convergence of additional funds from the human rights program (DDHH/USAID) and Key Population Challenge Fund (KPCF)[19], which permitted to expand the territorial coverage and strengthen training, human right actions and S&D in FY14.

As of FY13, DELIVER began its incorporation to the technical assistance and training processes of the organizations of the PrevenSida network, making an initial diagnostic and situational analysis on capacities to manage HIV inputs (inventory, estimated needs, purchases) and local capacities for HCI storage. Based on this analysis, assistance priorities were established and visits were scheduled, as well as their participation in the training workshops. In the next three years, DELIVER has achieved almost total coverage of the organizations, reporting a significant improvement in both input management (condoms, test reagents, etc.) and storage conditions[20].

In FY15, ASSIST has been responsible for providing technical assistance to three PrevenSida member organizations—Self Help Groups of People Living with HIV/AIDS in Western Nicaragua (GAO), Nicaraguan Association for Sexual Diversity Rights (ADESENI), and Organization for Transgender Women (ODETRANS)—to develop their quality management program. To this end, a baseline assessment of quality improvement activities was conducted to initiate training on basic concepts of quality assurance and quality improvement mechanisms. As a result, the organizations have formed Quality Improvement Teams (QIT) and members are responsible for effectively participating in the development of a quality management program and overseeing compliance of planned quality activities. The QITs have defined the concept of quality that will govern their organizations, as well as the standards and indicators that will be used to measure and improve the quality of the services provided.

4.1.3 Reduced stigma and discrimination toward most-at-risk populations and people living with HIV

It is worth highlighting that 15 of 20 organizations formulated, implemented and evaluated annual plans and interagency commitments to reduce stigma and discrimination (75%) at local level. In addition, a plan to reduce stigma was formulated with social actors and institutions at national level.

Technical assistance for formulating HIV policies is a frame of reference for carrying out prevention and care actions in key populations, based on a gender and human rights approach that contributes to reduce stigma and discrimination. In total, 48 of 50 NGS (96%) received technical assistance for developing HIV policies.

4.1.4 Improved NGO participation in the national response to HIV/AIDS

To achieve this, PrevenSida has developed an institutional capacity strengthening process for NGOs, which has permitted to improve planning, management capacity, monitoring and evaluation, coverage and registration of key populations. As a result, NGOs have taken ownership of the combination HIV prevention strategy, have integrated a gender and human rights approach in their institutional actions as a cross-cutting theme, and have advocated in the defense of the human rights of key populations and people living with HIV. This has contributed to a greater recognition of the complementary role played by organizations in the response to HIV at the municipal, departmental and national level and has improved their participation in spaces for dialogue like CONISIDA. It is reported that 20 NGOs working with CONISIDA at the municipal level have been recognized for their excellent work with key populations, generating evidence through reports regarding their work in the provision of prevention services. These organizations have participated in the review of plans and proposals at the level of CONISIDA, in the reform of Law 238, currently Law 820, and have formed part of the National Strategic Plan 2011-2015 review team. They participated in the evaluation of the funding of the Global Fund's HIV Project and in Ministerial Resolution 249-2009, currently Ministerial Resolution 671-2014. They also have tools for networking and carrying out human rights advocacy actions in a more strategic manner.

4.2 Performance of training component in the universities

The transfer of skills to universities is identified as the continuation of the process that was initially carried out with MOH in 2000-2013, capitalized by the HCI project[21], with the objective of strengthening the competences of primary and secondary health workers in the mother-child health, family planning and HIV/AIDS components. In the HIV/AIDS component, technical assistance was aimed toward the decentralization of capacities for performing tests and organization of health services for providing comprehensive care to people living with HIV, as evidenced by the expansion of the laboratory network in departmental hospitals providing antiretroviral therapy based on national and international standards and protocols. The assistance provided by HCI contributed to the decentralization of ARVT in 32 health units and to the supply and performance of rapid tests in 17 SILAIS nationwide. A total of 4,568 participants in the different training processes.

Upon conclusion of the process, it is deemed relevant to provide technical assistance to health education institutions that will strategically contribute to improve the quality of health services.

The knowledge and skills transfer process in the universities took up again the good practices and lessons learned from the technical assistance with in-service health workers. Standing out among the good practices with MOH is the development of a pedagogical package, a management package, and methodological tools for improving staff competencies, strengthening institutions, and contributing to the sustainability of the processes. The management package contributes to continuous quality improvement for influencing strategic decision-making.

The identification of gaps in MOH staff in the comprehensive approach to people living with HIV, the end of the HCI project and the implementation of the strategy of the combined prevention model became opportunities for transferring care standards and protocols in family planning, maternal health and HIV to the universities, which are projected as the components that contribute more to sustainability due to their inclusion as a cross-cutting theme in the basic curriculum of the disciplines of medicine, nursing and pharmacy, which later contribute to strengthen the health systems.

This process has been developed with nine universities: POLISAL, UNAN-León, BICU, URACCAN, UPOLI, UCAN, UNICIT, UNAN- Managua and FAREM Matagalpa. The first stage of technical assistance in the universities implied reviewing teaching methodologies of contents (mainly family planning, mother-child health, ART/HIV, input management) in the curriculum of the medicine and nursing education programs, which implied teacher training (in-service trained health workers) and student classes (new workers in pre-service training) by HCI and DELIVER until FY13. As of FY13, the objective of strengthening the capacities of teachers in the new HIV care protocols, reduction of stigma and discrimination, gender-based violence and HIV knowledge management gains predominance. In addition, rapid improvement cycles were incorporated to strengthen the quality of the teaching process.

In relation to performance (See Annex 1 Tables 16, 17), after an initial poor accomplishment by HCI in pre-service (FY12-69%) and DELIVER in in-service (FY11-54%), the goals have been overachieved in recent years. Hence, the five-year pre-service goals have been adequately achieved (HCI/101%, ASSIST/103% and DELIVER/106%), while the achievement of the five-year goals in teacher training has been higher (HCI/175%, ASSIST/162%, DELIVER/89%).

Training teachers in the adequate management of the pedagogical package and students in the selected themes linked to HIV prevention contributed to PEPFAR's pre-service and in-service indicators, which were clearly defined until 2014, indicating that it is necessary to feed the pre-service indicator only with the number of students that graduated according to the official records of the university.

Among the main contributions of the DELIVER Project to the technical transfer process, the following stand out:

- The creation of the subject of community pharmacy and the development of a guiding text in the School of Chemical Sciences at *UNAN-León*. A virtual classroom was set up and a manual titled "Health Research Methodology for Writing Monographs" was developed.

- Four themes in the pedagogical package (logistic system, needs assessment, information system for logistic management and rational use of medical inputs in the III, IV, V and VI year) were incorporated in the Health Management and Primary Health Care modules[22] at the School of Medicine of this university.

- Six themes were integrated in the pedagogical package to include them in the programs of the nursing curriculum: logistic system, selection of medicines, medical needs assessment, storage of medical inputs, information system for logistic management (SIGLIM) and rational use of medical inputs.

- UNAN-Managua's Pharmacy School implemented the pedagogical kits in Community Pharmacy and Hospital Pharmacy, delivering fifteen pedagogical kits to teachers and forty documents for students. Support was also provided to strengthen the technological classroom.

- *Four pedagogical kits were delivered in BICU for teachers and students. In addition, thirty documents were delivered to medical students for developing the subjects of logistics and rational use*[23].

- In UCÁN León's Pharmacy School, after reviewing the contents, 12 pedagogical kits were delivered for teachers in regional and local venues.

- *In UNICIT*, technical assistance was provided to formulate the Pharmaceutical Management (PM) program with a guiding text[24]. (See Annex I Table 18)

In most pharmacy schools, these two years have been a period for designing and adjusting the pedagogical kit to the academic curriculum as a useful tool for learning and updating antiretroviral therapy, a new theme that had not been previously integrated.

On the other hand, ASSIST has been able to develop continuous quality improvement processes, with the objective of adjusting the curriculums of the subjects. The transfer process to the universities envisaged three lines of action: transfer of the pedagogical kit, selection of contents to be integrated in the curriculum, study plans or syllabus, according to the education curriculum of each university and career, and the implementation of a continuous quality improvement methodology and knowledge management.

Continuous quality improvement has been promoted through visits to the universities and the implementation of rapid improvement cycles in teaching/learning. In this capacity-building process, teachers have been trained to teach HIV care protocols, reduction of stigma and discrimination, gender approach, trafficking in persons, and knowledge management.

The participation of ASSIST in capacity-building has been especially relevant for designing and implementing a quality management program in three organizations that work with key populations and the LGBTI community[25].

In addition to transferring knowledge and skills, the HIV program also helped to improve the infrastructure of the university classrooms by setting up virtual spaces and providing equipment and furniture, further

strengthening education and training capacities.

In 2015, activities have been focused on strengthening the quality and systematization of experiences for the effective transfer of technical and methodological contents. The major accomplished for teachers and students are centered on the HIV knowledge update from a holistic perspective, based on a human rights, gender and intercultural approach, which has allowed to dismantle the biomedical approach as the only HIV approach and train resources with adequate capacities, skills and attitudes to face the challenges that the response to the epidemic demands.

4.3 Factors affecting training performance (Q2-Q3)

The evidence collected indicates that all goals included in the training performance measurement have been broadly achieved both in the sphere of the PrevenSida network and in the sphere of the universities. This condition is linked to the probability of obtaining expected results in each of these spheres in which the program has delimited its proposal for change and contribution to strengthen the national response to HIV, while translating the convergence of diverse factors that have conditioned the level of accomplishments achieved either because they have facilitated them or have limited their potential.

4.3.1 Results and training processes in the PrevenSida network

As stated above, the high level of performance evidenced by the fulfillment of the goals also evidences the dynamism of the training component, which has constituted one of the focal points for maintaining a continuous improvement and adjustment process in order to strengthen organizations as individual components and as a network articulated around common objectives and challenges. Diverse factors converge in this strengthening process, positively or negatively affecting the conditions in which the training component is implemented and modifying its effects in the development of managerial, administrative and technical capacities linked to the combined prevention model. Among these factors, the following are highlighted:

<u>Evaluation of compliance with standards</u>

Given the background of the program's institutional partners around quality management approaches and methodologies, standards were defined in the initial design of the PrevenSida project in three areas—management, financial administration and preventive services. The measurement methodology and use of information produced gathered URC's previous work experience with public services, identifying gaps of non-compliance as the basis for guiding training priorities and motivating continuous improvement processes (CIP).

The achievement of the goals also highlights the periodic standard compliance measurement system, which is one of the most characteristic strengths of the project's management, focusing our attention on one of the factors that has significantly enhanced performance by establishing a baseline in its initial implementation in September 2010, which identified existing gaps in the capacities of the organizations with respect to the required standards for the development of the combined prevention model targeted to key populations.

Since then, this periodic measurement has provided information about the conditions for admission and the situational process for change in terms of gaps for validating and adjusting training to changing situations in the development of the individual organizations and the network as a whole. In this way, according to the level of performance, training and the type of technical assistance provided to each organization have been planned.

The usefulness of the standard measurement methodology is quite clear, evidencing changes in 28 organizations subsidized by PrevenSida in these five years, comparing their conditions for admission with the conditions reported in the last measurement carried out (September 2014).

Nature of the network's organizations

Following the establishment of the Cooperation Framework for Central America, which initiates the implementation of the United States President's Emergency Program for HIV Relief (PEPFAR), USAID/Nicaragua's HIV Bilateral Program assumes the principles and strategies aimed at strengthening national capacities to respond to an epidemic defined as "concentrated" in key populations (KP), which also have broad and powerful accessibility barriers to preventive services. This approach required a project design based on previous studies and experiences that evidenced conditions of exclusion through stigma and discrimination, which generated distrust and rejection of public services by key populations. The decision was to base the accessibility strategy on the development of a network of NGOs without prior experience in combined prevention methodologies and proposals.

Two types of organizations were included according to their nature and main characteristics. In first place, private non-profit organizations, generically called NGOs, formed to work in a diversity of themes for the benefit of adolescents, women, young people and sexual diversity, were incorporated. In second place, community-based organizations formed by key populations, which have a sense of identity and ownership and even representativeness, were incorporated. In both cases, although with some relevant differences, profiling them for the proposed change process posed a great challenge given their background.

- Most NGOs had accumulated years of experience in the development of mass communication approaches for education campaigns and training events, mainly around mass promotion of condom use and HIV testing among the population at large, given the profile linked to alternative centers for women and funding from the Global Fund.
- On the other hand, most key population organizations had been recently formed and therefore had limited organizational experience in the face of a limited internal cohesion and with their base members, and almost no experience in providing services. PLHIV organizations are excluded from this condition because they had been developed in the struggle for rights and access to treatment.

These differentiated conditions are reflected in the compliance of standards, both at the time of their incorporation to the PrevenSida network (mainly in the areas of management and administration) and pace of improvement of such compliance over time.

Some differentiated conditions are associated to the level of schooling and age of staff members. While 56% of NGO staff members are professionals, only one-third (33%) of the staff members of the PLHIV organizations have that level of schooling. Only 12% of NGO staff members have secondary education or less. In contrast, 33% of the PLHIV staff members have that level of schooling. While 56% of NGO staff members are under the age of 30, 37% of PLHIV staff members are in this age group. Only 12% of NGO staff members are more than 40 years old, compared to 25% of PLHIV staff members. Key population organizations also show high levels of conflict and difficulties in internal and external governance. The few organizations that qualify as "graduates" in the baseline in the three areas in which standard compliance is evaluated are NGO.

Hence, the initial turning point was a great challenge because it was no longer just a structural change in terms of the approach, methodology and population, but it had to be done in a scenario of dispersed organizations with different types and degrees of development, management capacity and provision of services and significant levels of conflict given the background of contradiction between public institutions and NGOs. (See Annex 2 Graph 3)

This situation gives an easy insight into the high complexity of the change process undertaken, not only stemming from the substitution of paradigms, strategies and communication, but from the weak capacity of the organizations, which in some cases warranted the inclusion of accompaniment in the technical assistance for strengthening their basic organization and obtaining legal standing for some start-up organizations.

Once the implementation began (baseline measurement in 2010), only three of a total of ten organizations achieved over 75% compliance. In all five years, no PLHIV organization entered the network with a level of compliance greater than 75%, either globally or in specific measurement areas (management, administration, preventive services). The progressivity of capacity-building was much faster in NGO, which already had a good performance in the second year. Since FY13, they all had achieved an index greater than 75% in all areas and most of them had levels higher than 95% in FY14. In the case of PLHIV organizations, this has been very different. Although most of the organizations show significant improvements in standard compliance each year they participate in the network, few of them have been able to exceed the 75% threshold, so their progressivity has been slower. Only a few PLHIV organizations are added each year to the "list of graduates". Of the 19 PLHIV organizations subsidized by PrevenSida, 18 had a very low performance. By 2014, 42% (8) had reached high levels, 21% (4) had advanced to an intermediate level, and 37% (7) maintained a low performance level. It should be noted that five of the last seven PLHIV were admitted in FY14 as part of the expansion that permitted LGBTI and KPCF funds, so the measurement compares only one year of progress.

Combination of monitoring and training modalities

One of the characteristics of the PrevenSida project is to permanently articulate diverse forms of training (workshops, technical assistance) with monitoring and evaluation systems and continuous quality improvement strategies, which effectively establish a quasi-permanent measurement-action process in which improvement cycles constitute another event of the training component.

Although it should be highlighted that we did not find any declared or documented evidence that permitted to verify the existence of a differentiated training strategy between NGOs and KPLHI organizations, we did verify that the homogenization of the contents and methodologies in workshops or training events was offset by technical assistance visits and coaching activities.

The initial stage of the project (2011-2012) marked a specific learning period[26] in which adjustment measures were applied to calls for proposals, logistical matters, implemented methodologies, selection of participating NGOs and new contents of the program aimed at continuous improvement of training processes and competitions. In the second year, the inclusion of PEPFAR's new indicators (pre-service and in-service) implied the integration of an educationalist to the team, in order to support the development of the methodological designs. In the third year, the training processes are assumed by USAID's work team, taking into account existing accumulated experience, the contribution made by regional programs like PASMO and PASCA, and the structuring of the combined prevention model.

It should also be highlighted that processes generally recognized as management processes have also become training events under the modality of "learning by doing". Such is the case of the annual grant application and negotiation process. As of the first grant, which led to the initial diagnostic evaluation of the capacities of the NGOs that participated in the tender, it became evident that negotiation should be characterized as technical assistance, inasmuch as the proposals submitted had a very limited basis and therefore required iterative adjustment processes to incorporate the new approach, preventive care strategies, managerial and administrative parameters, monitoring and evaluation, etc. In fact, establishing as the basis of the grant a health care model in a delimited territorial and population universe with verifiable goals and compliance of standards, always constitutes a first learning for the organizations that join the network in the shift

towards results-based management in a scenario where product or activity management predominates.

Hence, achieving a good level of performance has been linked to a dynamic where each meeting, monitoring or report is an opportunity to identify capacity gaps in individuals or organizations, which in turn lead to the identification of improvement actions either in training events, technical assistance visits, or collaborative events.

Three change trends in training events, which are verifiable in the registration process, warrant special attention. First, the shift from large groups (more than thirty or forty participants) that predominated in the first years to small groups (less than ten participants). Second, the predominance of "new" people (without training in previous years) stands out. In recent years, the proportion between people who have been trained in previous years and "newcomers" is almost equal, which permits to consolidate and update contents. The third trend stands out even more. It is the inclusion of facilitators from the organizations in the priority thematic areas (prevention, human rights, S&D, management, M&E) in the last year of the training program, which undoubtedly brings the training strategy closer to the realities and specific demands of the organizations.

PrevenSida's technical assistance in award management included significant changes during this stage (initial stage), which enabled organizations to achieve higher levels of compliance with quality standards in order to fulfill the project's goals, not only in quantitative terms, but in light of the quality required by behavior change processes in key populations and institutional strengthening in organizations.

Another fact that stands out is that a higher percentage of training events in the last two years (FY14 and FY15) involve small groups, allowing for a greater linkage between training events and coaching, together with the experience of improvement and collaborative cycles. A transition towards a conciliation between what a performance standard "should be" and what people and organizations with diverse capacities and concrete conditions "can be" is evident, transcending homogeneous orientations towards an assimilation of diversity in situations of capacity-building or in the pace of capacity-building.

In this context, improving planning and expanding the number of visits to organizations stand out, directing them to where the greatest weaknesses are found. In this regard, the following should be highlighted:

- PrevenSida's organizational development area completed 88 field visits in FY14 to NGOs in Nicaragua's Pacific and Caribbean regions[27] and 106 field visits to subsidized NGOs in FY15 to provide support in activities linked to the management processes of these organizations, such as formulation of operating and strategic plans, human development plans, technical and financial grant management, elaboration and monitoring of rapid improvement cycles, and elaboration of technical reports, among others[28].

- PrevenSida's management team conducted 41 visits for the purpose of consolidating a culture of quality, based on the formulation of a quality management plan and an individualized guide approved by each organization, ensuring the definition and interpretation of the indicators and instruments for addressing the quality management diagnostic evaluation. The process has established the development of the roles and duties of the quality improvement teams of the organizations, the application of an organizational climate and user satisfaction survey, as well as the application of standard compliance evaluation guidelines.

  This process is underway with nine organizations for drawing up "quality management programs". After intensive accompaniment from PrevenSida's team, five organizations already have a concerted program. The configuration of these programs in each organization has been a vigorous process of

accompaniment and technical assistance with the quality assurance teams, in order to ensure full comprehension, valuation and management of methodologies, such as user satisfaction surveys, management strategies for complaints, claims and suggestions, organizational climate analysis, performance evaluation, and implementation of improvement cycles. Clearly, the process poses great challenges by placing diverse methodologies in a single instrument, which implementation involves dynamic and complex processes that finally merge the M&E system with the training component in a single quality management process as the basis for the effectiveness and sustainability of the combined prevention model.

- On the other hand, the financial area completed 85 field visits in FY14 and 22 follow-up visits to organizations in FY15, in order to provide counseling on shared costs, adjustments to administrative and financial manuals, and administrative and financial management improvements.

- The HR/S&D component completed 39 activities covering diverse themes and activities, among others, the development of a human rights training program for LGBTI population, an agenda for conversations with institutions like the Ministry of Health, National Police and Ministry of Education, training on drawing up advocacy plans for the promotion and defense of human rights of LGBTI population at local level.

- Two national projects have complemented the visits to the organizations. ASSIST has assumed the promotion of quality management in three organizations and DELIVER has completed the cycle of visits to build the capacity of the organizations in input management and improvement of storage conditions. The work developed by DELIVER stands out, which was first aimed toward conducting a diagnostic evaluation on storage conditions and internal control of medical inputs in 16 NGOs serving KP[29] and subsequently was focused on standard measurement to overcome identified gaps. DELIVER also supported the training of 24 facilitators in logistics with twelve NGOs.

- The case of the regional PASMO project warrants special attention, inasmuch as its incidence in PrevenSida's training stems from its contributions to the content and interpersonal communication methodologies and visits to provide counseling on HIV prevention in the last two years. However, only 10% of the 24 NGOs trained by PASMO received coaching for the implementation of behavior change methodologies.

- On the other hand, the program's general management and the director of PrevenSida have visited 17 organizations of the network in FY15, in order to apply the standards included in the SIMS/PEPFAR evaluation instruments, which have a broad and detailed application guide to rank performances and identify gaps to overcome. This guide includes detailed standards for each work area (management, administration or services) and an online digitalization system that adds and tabulates results, emitting traffic light signals to prioritize the area and theme with the most identified gaps and to direct their selective follow-up.

  Evidently, the SIMS guide is very exhaustive [30] and comprehensive to ensure optimal measurement of the compliance of standards that evaluate the structure and management and service processes, as well as the logistics that makes them feasible, the adjustment to the particularities of Nicaragua and the singularities that converge in local diversity will be a process that will warrant more attention.

<u>The perspective of the trained promoters</u>

In this context, some observations stand out in the interviews with the promoters, which evidence the virtues of the training component for the development of the program and the network, and highlight some specific limitations that warrant attention:

- Learning is mostly associated to better work performance (68% in NGOs and 58% in key population organizations). However, the remaining organizations limit their usefulness to more knowledge.
- Motivating themes vary according to the organization's profile. However, one-third of NGO promoters highlight HIV testing, which could be associated to greater recognition and competitiveness in a complex labor market.
- Forty-three percent expressed satisfaction with all the themes in which they participated (28% in NGOs and 58% in key population organizations). The more frequently mentioned or less satisfactory were HR/S&D (16%) and M&E (12%). Thirty-three percent of the promoters mentioned the deficient methodology of the facilitator (lack of motivation, repetitive themes, ethics, participation, etc.), 10% stated that the theme was very technical and complicated, and 8% indicated that the theme was not related to their work.
- Half of the respondents indicated that they have applied everything they have learned, explaining that sometimes they do not apply them all because they are not part of their work (20% total, 28% in NGOs and 12% in key population organizations), 12% stated they have not had the opportunity, and 6% indicated they do not feel well trained.
- Fifty-seven percent cite safe sex (consistent condom use) as the main preventive message (48% in NGOS and 67% in key population organizations), 24% indicate attitudes, 18% points to general information about HIV (28% in NGOs and 8% in key population organizations).
- Sixty-one percent indicate interpersonal communication is the most effective means for transmitting messages (48% in NGOs and 75% in key population organizations). Peer groups are privileged in key population organizations (29% versus only 4% in NGOs). Thirty-eight percent believes that it is better in workshops, campaigns and media (52% in NGOs and 25% in key population organizations).
- Twenty percent of the promoters state they are aware of some analysis of the HIV epidemic in their territory, while 18% are aware of positive cases for follow-up. Thirty-seven percent of the promoters are aware of MOH national data and 22% state they are not aware of the epidemic. As regards the usefulness assigned, 29% of the promoters believe it is more important for training events, 22% associate it to action planning, 14% for a dialogue with KP, 8% for PLWHIV follow-up, and 8% for gaining more knowledge.
- Eighty-six percent of the promoters made suggestions to improve training, among others: 24% suggests updating themes, 16% suggests improving methodologies, 16% suggests more training or more frequent training events, 12% suggests training or changing trainers, 12% suggest improving logistics, and 4% suggest organizations assume more responsibility (selecting who they send, more follow-up).

4.3.2 Training processes and results in the universities

Clearly, the insertion of the combined prevention component in health education institutions has a high strategic value that transcends good performance records in the compliance of pre-service (students) and in-service (teachers) training goals, to the extent it constitutes a structural innovation expressed in the assimilation of the pedagogical kit in the curriculum of medicine, nursing and pharmacy, becoming an intervention with future sustainability over time, in such way that new professional graduates, as a whole, will have an effect on the global change in the health system.

Diverse factors have converged to condition compliance of performance goals or outcomes as a consequence of the goals achieved in the academic institutions. The following should be highlighted:

<u>Quality of the offer</u>

Pedagogical kits and packages are the result of URC and DELIVER's broad experience in the Nicaraguan scenario, which begins with the experience they both acquired in mother-child care, family planning and HIV (ART, HIV testing) at the nursing school of UNAN Managua's POLISAL in 2008-2010, which was able to

systematize developments in these three themes at the public hospital level.

The offer was realized on the basis of a methodological design consisting of four pillars—updated scientific knowledge, MOH standards and protocols, and a continuous quality improvement approach—which are combined in structured modules based on advanced teaching methodologies and educational tools (skills development) that unite theory and practice, articulating classrooms and service units at the service of learning.

These products are offered to diverse universities, which quickly recognize the quality of the design and the professional prestige of those who provide teacher training and adopt them. Clearly, the product is valued not only for its contribution to specific themes, but it also responds to the necessity of sustainable methodologies for continuous education, which is expressed as a motivation to assume a pedagogical proposal that is very well structured with high-quality educational supports. It should be noted that the teaching faculty of some universities extracted important adjustment and complementation proposals from the implementation experience, which were incorporated to the packages that were thus validated and enriched.

In this regard, the willingness and flexibility shown by university authorities in relation to the adaptation of the curriculum, based on their own experience, should be highlighted.

The pedagogical package for combination HIV prevention is completely designed for FY13. It includes contents from the combination HIV prevention and behavior change communication, medical care for PLWHIV, the monitoring and evaluation system, and the essential input management component prepared by DELIVER and it is implemented in the last three years. The partnership with pharmacy schools is able to generate broader motivation for designing a pedagogical kit that transcends the specific HIV theme and projects itself as an essential input management subject.

Continuous quality improvement evaluation

Whether as a specific theme of a subject or as a complete subject, the pedagogical offer of USAID's HIV Program is gradually being incorporated in study plans and curriculums, including elements that are the result of the improvement of the initial designs. All the classes and hands-on exercises of the pedagogical kit have evaluation instruments (checklists, standard compliance, etc.), the results of which shape the content of interuniversity events for developing quality collaborative projects.

The capacity-building approach was a new development for most university teachers and directors, particularly because it provides very clear parameters for the evaluation, which not only goes beyond the measurement of information memorization, but also allows to indirectly evaluate the teaching process by specifying thematic areas or competences recorded as weaknesses in a significant percentage of students, motivating teachers to update contents and improve methodologies.

Pedagogical instruments

Teachers, directors and students frequently referred to the usefulness of the instruments, equipment, audiovisuals and didactical material included in the pedagogical packages and kits, which in addition to motivating greater participation in the learning process, provides greater clarity and fixation of concepts, as well as greater approximation to the application of the knowledge and techniques learned.

Socialization and exchange of experience

Having evidence of changes in motivation, participation, standard compliance and academic evaluations has facilitated identification of weaknesses and good practices that immediately induce to socialization in faculties and disciplines, as well as exchange of experience between several universities. Special importance

has been assigned to quality improvement collaborative projects that have been promoted with different universities, resulting in the establishment of collaboration ties that did not exist before.

In this regard, regional project evaluations, which have enabled experience sharing between different countries, are also highlighted.

Transition toward a paradigm shift

Both the combination prevention approach and the discipline evaluations of the education community (directors, teachers, and students) have confronted medical and biological approaches and the assessment of preventive/curative approaches. In particular, the survey conducted in 2013, which showed a high level of stigma and discrimination prevailing in students and teachers by reason of sexual identity, led to the incorporation of gender, human rights and S&D modules in the pedagogical package, which has been modifying this situation, mainly recognizing the need for change and the level of commitment of teachers and students in the discipline and faculty guidelines. Although significant changes have been achieved, a high percentage of students and teachers still do not identify the impact of gender inequalities or S&D in HIV protection or ART management, and the probabilities of its adherence and continuation in family and community settings.

S&D has been addressed in teacher training processes with a participatory methodology to confront myths and preconceptions towards HIV and sexual identities, recognizing how they affect key populations and people living with HIV. Among the main themes addressed, the following stand out: The basic conceptual framework referring to gender, stigma and discrimination, knowledge of the legislative framework at national level and its relationship with the international framework and USAID's institutional policies on gender, and identification of the main challenges for streamlining gender beyond the traditional concept.

Practice settings

The existence of PLWHIV care clinics to carry out practices with medical students from UCAN and UNAN-Leon has made it abundantly clear that it is highly valuable to have specific spaces for articulation of theory and practice in skills development, in order to achieve pedagogical objectives. For this reason, the existence of clinics at UPOLI and BICU is an opportunity for practices and measurement of quality indicators on HIV prevention.

The great weakness of not having favorable settings for contacting key populations and developing combination prevention practices is also recognized, inasmuch as services linked to the universities have a predominantly preventive approach and high levels of discrimination and stigma toward these populations. Under these conditions, expected changes in primary prevention, including confidence of KP and accessibility under conditions of "no discrimination", are limited. In contrast, universities could value the practice setting that PrevenSida organizations could represent, which was already recommended in the "Performance Evaluation of USAID's HIV Program" in 2013.

The perspective of the trained trainers

Some relevant findings are extracted from the interviews with teachers from universities included in the program:

- Sixty-one percent of 41 teachers interviewed points to a high incidence of gender relations in individual HIV decision-making and protection actions. However, 37% of teachers do not share that statement.
- Forty-four percent of teachers state that gender-based discrimination practices exist in their institution. In contrast, 85% of university teachers perceive a commitment in their institution to improve gender practices.
- Forty-one percent of teachers indicate there is stigma and discrimination in their university by reason of sexual identity. In contrast, 73% of university teachers perceive a commitment in their institution to reduce stigma and discrimination by reason of sexual identity.

- Most teachers associate major learnings to better work performance in caring for HIV patients (32%), 29% to work methodologies with students, one fifth (20%) to HR/S&D themes and the rest (12%) limit its usefulness to having more knowledge.
- The most motivating themes vary according to their profile, however, 34% point to HR/S&D themes, 27% indicate ART management for people living with HIV, and 17% mention prevention methods.
- Seventy-three percent express satisfaction with all themes in which they have participated. The most mentioned that they least liked were prevention methods (12%), monitoring and evaluation (7%) and management (5%) themes. Two percent pointed to the deficient methodology of the facilitator (lack of motivation, repetitive themes, ethics, participation, etc.), 17% indicated that the theme was very technical and complicated, and 5% stated that the theme was not linked to their work.
- Thirty-two percent indicate that safe sex (consistent condom use) is the main preventive message, 24% point to attitudes, 27% refer to general information about HIV, and 15% indicate self-care.
- Only 36% indicate that interpersonal communication is the most effective means for transmitting the message among them, 24% prefer "face-to-face" mechanisms, and 64% thinks that workshops, campaigns and the media are better.
- Five percent of the teachers state they are aware of some HIV epidemic analysis in their territory, while 10% indicates they are aware of positive follow-up cases. Fifty-one percent is only aware of MOH national data, and 32% states they are not aware of the epidemic situation. Forty-nine percent of the teachers indicate that the most important usefulness assigned to that information is classroom use. Thirty-two percent state they do not know how to use the epidemic information.
- Seventy-five percent of the teachers made suggestions for improving USAID's HIV training. Seventeen percent suggest updating the themes, 7% suggest improving the methodologies, 34% suggests providing more training or more frequently, and 2% suggests training or changing the trainers.

4.3.3 Global factors impacting the training component

In addition to the factors that operate in the specificity of the two spheres of action of USAID's HIV Program, some factors of a global nature are identified, which have an impact as common elements or management conditions that globally govern the program.

Program leadership and management

A very singular characteristic of USAID/Nicaragua's HIV Program is the level of coordination and cooperation that exists at the level of the projects or implementers, both national and regional. Under the call and stewardship of the USAID Mission, they periodically hold evaluation, analysis and exchange meetings and maintain a very comprehensive management of changes in the implementation of projects and necessary adjustments to respond to the orientations emanating from the PEPFAR process, including annual changes to the indicators and current DATIM, among others.

Based on the minutes of the meetings, the evaluation was able to confirm the exercise of continuous monitoring and implementation of actions and incidents that affect them, as well as the agreements adopted to adjust norms and standards to the eventual adjustment orientations emanating from PEPFAR.

It should be pointed out that this level of management, which provides unity and strength that facilitates and promotes good performance and achievement of results, also provides to the Program the recognition of its technical, methodological and managerial contributions from the authorities of the national response, which in turn has facilitated the influence of the mission in consensual decisions, among which the following stand out:

- Grants to the same organization from a single source, which has facilitated planning of population and

territorial coverage in consistency with the Global Fund.

- The consensus reached in the estimation of key populations at the municipal and departmental level.
- The exchange and cooperation in methodologies and information for a unified monitoring of the national response.

Although all the goals and objectives were achieved, some factors had a negative impact, among others: the sociocultural context of the participants was a constraint in assuming with responsibility and commitment their effective participation in the training processes; the constant turnover of human resources in the NGOs, the grant processes were not continuous, and of the 24 NGOs trained by PASMO, only 10% received mentoring for the implementation of behavioral change methodologies. In addition, there was lack of clarity in the definition of some indicators in the project implementation framework.

Contribution of the regional projects

As a result of the high coordination and collaboration existing at the level of the program's strategic management, the benefits received by the training components from the participation of the regional projects are broad, among which the following stand out:

The contribution of regional programs like PASMO was focused on generating strategic information through key population studies and TraC surveys, as well as training and accompaniment visits to the organizations of the PrevenSida network in methodologies for addressing KP and PLWHIV. The contribution of PASMO in the design of the training contents and methodologies in the thematic area of combination prevention should be highlighted.

On its part, PASCA has contributed to institutional strengthening through technical assistance for preparing and evaluating plans, policies and strategies, seeking the articulation of the different actors of the national response. Technical assistance has permitted to generate strategic information through the Model of Modes of Transmission (MoT), elaborate the GARP report, MEGAS 2014, and stigma and discrimination studies, among others. In addition, it led the post-exposure prophylaxis process in situations of sexual violence, applied the HIV policy environment measurement (API), and developed two certification courses in monitoring and evaluation.

It is very relevant to identify how the development of these multiple technical assistance actions provided by PASCA converge to the general scenario of the Bilateral Program as part of the training component, as they are supportive processes that always count with work teams delegated by the coordination of the national response as counterparts, which at the end of the process (learning by doing) have built capacities for conducting studies and preparing reports in a more independent manner.

In synergy with the Alliances II Project, PASCA promoted the integration of the private enterprise (COSEP) in the national response, which facilitated the development of HIV policies in 12 companies and training of 10,350 workers in combination HIV prevention strategy applied to key populations, H1V positive people, gender violence, stigma and discrimination associated to HIV, and sexual diversity, benefitting workers in the textile, agroindustry, health and tourism sectors. In the last period, PASCA has initiated an accompaniment strategy at the level of the departmental National AIDS Commissions, beginning with the most complex, which is Managua. This strategy opens new possibilities of interaction with PrevenSida and the universities.

Use of information and communications technologies (ICT)

USAID's HIV Program has progressively incorporated more technological resources not only to facilitate the implementers' management processes (flow of information and documentation), but also to facilitate the development of strengthening actions, which enable exchange meetings, consultations and mentoring with organizations and universities located in the most remote places that exhibit the most weaknesses,

thus resolving difficulties in the provision of technical assistance with the necessary frequency.

Versatility of the implementers

In the context of the mission's leadership and the high coordination achieved between the implementers, we must also highlight the capacity they have demonstrated to adjust and make changes along the way, either because of new orientations emanating from PEPFAR or because monitoring has permitted to identify problems that must be overcome or good practices that must be assumed and replicated. In this context, the management team records multiple examples of achievements in the complementarity and synergies of its actions as projects have always been opportunities for mediating the interests of the beneficiary groups.[31]

On the other hand, the level of cohesion of the partners has facilitated the design, implementation and evaluation of interventions that allow for better informed and timely decision-making.

Regionalization of training

Both PrevenSida and the universities have greatly benefitted from the modality of carrying out training events in the departmental capitals, which provides easier access to a larger number of organization promoters and university teachers located in the same region.

Interaction between training and sustainability

It is clear that the concern of ensuring sustainability is increasing as the time period of the program advances. This concern acquires a more specific dimension in terms of the contribution that can be made by the training component.

First, it would be necessary to point out that organizations have achieved performance standards in the three areas measured (management, administration and prevention), which they have maintained in subsequent measurements in the following years. On the other hand, the achievement of indexes greater than 75% is continuing to increase and some organizations are achieving levels of "excellence" or 100% compliance, which enables them to graduate. Clearly, this sustainability carries risks, such as trained staff turnover and internal and external tensions in the organizations in relation to relationships in the institutional environment with the better functioning of the municipal and departmental National AIDS Commissions.

The current transition of the priorities of the preventive emphasis towards care for PLWHIV underpins the greater stability of key population associations to the extent they become part of their members and expand their potential impact at the family and community level for the continuation of the work and self-help groups.

In the specific case of the universities, the sustainability of the achievements is clearer as structural elements have been included, such as the incorporation of the pedagogical packages in the curriculum in a scenario with the country's highest labor stability conditions, such as the case of university teachers.

This analysis must be complemented with other sustainability dimensions as follows:

Political sustainability: Overall, it is clear that the program enjoys recognition and political relevance that can be further capitalized if the experience of the three elements that converge in the training (monitoring and evaluation, training processes, and quality management) consolidates the broad experience accumulated from the systematization of good practices to translate them into pedagogical tools, especially when there is an organized system based on evidence aimed at improving performance. The program and its partners have previous experience in developing pedagogical packages. This experience must be

capitalized, in order to also offer a duly validated model for HIV prevention, as well as a model for institutional strengthening that supports the care model, which primary purpose is to create a public-private relationship of shared responsibility that delimits and articulates the roles in the continuous process of exchange for improving the quality of HIV prevention as a consubstantial part of the national response.

The bilateral program and regional projects have generated diverse and multiple useful products for national and local political authorities (studies, methodologies, information systems, monitoring and evaluation systems, quality management, etc.) on the basis of which the network of civil society organizations and the universities could have a more central role in coordination bodies (CONISIDAS) at national, departmental and municipal level.

Social sustainability: This is achieved by strengthening the organizations and by the dynamic functioning of the organizations as a network, in order to strengthen relationships for exchanging, improving and sharing good practices. However, we underline again the need to strategically differentiate NGOs from key population organizations, not only to better adjust the training processes to their differentiated capacities, but also because they have a different social and political projection by their own nature. Key population organizations create a close link with their members because they are the same population group and will remain as such due to their sense of identity and belonging, while NGOs do not have those population links and depend on fundraising, which makes them less stable as they have to compete for funds in increasingly narrower markets and run the risk of changing their mission and population groups in order to secure their survival.

To the extent that the strength of the HR component and the struggle against discrimination and violence are consolidated and new forms of work are generated within populations at risk and the population at large, the social base could have a longer term perspective.

Economic sustainability: Clearly, the only component that has a sustainability perspective is the reproductive human resource process of the universities and, to the extent that the modules and pedagogical kits are consolidated in the study plans of all the universities involved and new health workers complete their studies and graduate, it is expected that their impact will be sustainable as they are incorporated into the general health system. NGOs and PrevenSida have a broad margin of uncertainty, even more when the epidemic is consolidated in a control process and the policies that are generating and distributing funds for that purpose change. Alliances that can be consolidated in the overall national response, mainly alliances with public services that assign clear roles, contribute to such sustainability.

4.4 Contribution of gender quality training (Q4)

By the same nature of the program[32], which focuses on HIV prevention and concentrates in key populations, the gender approach and promotion of gender equity, as well as other modalities, such as technical assistance visits and collaborative projects for improvement, are a substantial part of the training themes and events. This condition has determined that all projects have included in the design of their actions training and M&E, as well as gender considerations, which in turn are expressed in the human rights approach and struggle against stigma and discrimination for reasons of sexual identity.

4.4.1 PrevenSida Network

This approach has created a dynamic in the last two years (FY14, FY15) that has acquired a very broad and diverse magnitude, which not only includes the fact that this theme has covered more than a third of the participations in the training events of the entire program, but has been translated into concrete actions, such as the formulation of local plans and a national advocacy plan for the rights of the LGBTI

population, as well as TRANS, MSM, SW, PLWHIV and key populations that were accompanied in the design of a strategic plan for devising a comprehensive approach through a matrix of social determinants and health inequalities, in which actions and key actors were defined for reducing S&D and GBV in these population groups. Likewise, accompaniment was extended to build the capacities of their promoters for the formation of self-help groups.

Specifically, training events recorded in PrevenSida's registry show that 1,382 people have been trained in the five years, of which 46% are women, 45% are men, and 9% are TRANS. It also shows that the contents of the combination prevention model training module highlight, in a less perceptible, but no less effective manner, the effect of gender relations in interpersonal communications, which translate into relations of power in the exercise of sexuality and should be modified to develop capacities of free protection from HIV under equity conditions.

For the purpose of increasing participation of key populations in USAID's activities, 18 LGBTI organizations were subsidized. Twelve of them were benefitted within the framework of the NGO Advocacy Project to reduce stigma and discrimination and gender-based violence against Nicaragua's LGBTI community, which was carried out through USAID PrevenSida, NDI and PASCA, which allowed to strengthen the human rights approach by contributing to the reduction of stigma and discrimination.

Prior to the selection of these two NGOs, NDI conducted a baseline that identified knowledge and skills gaps in organizational culture, strategic planning, advocacy for exercising public policies, gender-based violence and stigma and discrimination[33]. Recommendations were focused on the formation of teams to replicate the training in communication and educational materials and to include other themes, such as dispute settlement, among others, which were already implemented by the project.

As a result of these interventions, plans and agreements were drawn up with municipal authorities, as well as a National Citizenship Plan, which describes access barriers to social vindication and compliance of the human rights of the LGBTI population. Another major achievement was the recognition and positioning of the LGBTI populations as a benchmark in the promotion and defense of human rights in their territories. The organizations of the LGBTI population in the indigenous and afro-descendant communities were included in the 12 grants, in order to support their interventions for the deconstruction of religious fundamentalisms that constitute the social base of exclusion.

The HIV dynamic reveals a critical facet of sexual violence and GBV that is linked to three risk factors: STI and HIV transmission, non-disclosure of HIV-seropositive status to avoid situations of violence with the consequent unprotected sexual practices, and cover-up of situations of sexual violence, limiting access to HIV prophylactic treatment. Therefore, it has been fundamental to include interventions in the HIV prevention programs that seek to reduce homophobia and increase respect toward the human rights of all people, especially in the most stigmatized and discriminated MSM, TRANS, SW and PLWHIV communities. In this regard, strengthening the capacity and leadership of these groups is promoted, so they may exercise their sexual rights and safer sexual practices.

At a global level, the program has contributed to the recognition that Nicaragua is experiencing progress not only in preventive services to key populations and people living with HIV, but in the strengthening of legal regulations that reduce stigma and discrimination and have been promoted by the management and leadership of the key populations that form part of the PrevenSida network.

4.4.2 Universities

If one considers the almost absolute predominance of individual and biomedical interpretation models of health in the universities, to the detriment of social determinants of health (SDH), which foster discrimination

and stigma by reasons of gender and sexual identity, evidence shows significant progress in sensitization as stated by the teachers, as seen from the perspective of the necessity of more progress. However, a concern is the bias that still exists toward knowledge and practices oriented to medical practices traditionally focused on curative treatment (PLWHIV/ART) centered in hospital units and without any communication commitment with the populations. Linking these practices with the PrevenSida network could accelerate sensitization processes and communication linkages with the populations.

The GBV theme was introduced in the medical and nursing schools of public and private universities as a starting point for diverse prevention activities related to this theme and as part of PEPFAR's strategy to reduce HIV incidence[34], which is contained in a pedagogical package that has already been delivered to teachers and students in eight universities of the country, addressing the background and generalities of GBV, types of violence, risk factors, evidence of GBV, statistics and legal framework, in order to sensitize them on the importance of respecting the human rights of people and the association between GBV and HIV. This theme was incorporated in the study plans of the schools of medicine and nursing of the universities, building the capacity of the teachers in relation thereto.

Some relevant findings are extracted from the interviews with the promoters of the PrevenSida organizations and teachers of the universities included in the program:

- 68% of 90 people interviewed point to the high incidence of gender relations in individual decision-making and HIV protection actions (73% of the promoters and 61% of the teachers). However, 22% of the promoters (N49) and 37% of the teachers (N41) indicate they do not share that statement.
- 4% of the promoters indicate that discrimination practices by reason of gender do exist in their organization. This percentage increases to 44% in the case of teachers who perceive gender discrimination in their universities. In contrast, 98% of the promoters and 85% of the university teachers perceive a commitment in their institution to improve gender practices.
- 6% of the promoters indicate that stigma and discrimination by reasons of sexual identity do exist in their organization. This percentage increases to 41% in the case of teachers who perceive this type of discrimination in their universities. In contrast, 94% of the promoters and 73% of the university teachers perceive a commitment in their institution to reduce stigma and discrimination by reason of sexual identity.

There has been a shift from prevention to emphasizing care, S&D, and GBV among all implementers.

4.5 Quality of registry and documentation systems (Q6)

The permanent learning, change and improvement dynamic evidenced by the program is sustained by a culture of systematic measurement and production of indicators that allow to monitor situational changes that occur in the different management periods, as well as a clear commitment to obtain results, which requires quality assurance in the decisions, actions and processes managed.

An unequivocal manifestation of this culture and commitment is the volume of resources and efforts aimed at developing and controlling the quality of the registry and documentation systems, as well as the collective evaluation processes linked to the continuous quality improvement cycles that have been promoted in a novel way by USAID's institutional partners in the development of the program.

Indeed, it is very commendable that this program has registry systems that have been a driving force in the evaluation, learning and improvement processes in a very participatory manner and closely linked to the different management levels of the program. The program also has a documentation system, including

standardized formats and files, for the activities carried out. This documentation contains reports on the most relevant information of each activity carried out, for example training workshops, technical assistance visits, collaborative improvement projects, joint meetings for specific products (plans, reports, etc.).

What is important here is that the Single Registry System (SRU) has three subcomponents: a key population registry that records the people and preventive actions that have been provided to this population, a counseling and voluntary testing subcomponent that records those people who have received CVT in each period, and a third subcomponent characterized as the registry of people who have participated in the different training events, which is of great interest for the objectives of this evaluation. The Single Registry System is an analysis and follow-up tool developed by USAID Nicaragua, which is used to meet the internal guidelines established by PEPFAR. For example, the emphasis shifted from HIV prevention to care, including S&D, GBV and gender standards for all implementers.

The primary source of the registry is the activity report and the participant templates attached thereto. Hence, part of the information originates from the coordinator or person in charge of each event (initial dates and terms, number of hours, theme, the name of the sponsoring organization, the name of the facilitator, and the type of training) and partly from each participant who fills out the template with personal data (name, sex, age, municipality of origin, name of organization to which the participant belongs). New variables were added to the initial design, which refer to the date of birth, number of sessions, course passed, pre-test and post-test grades, and attendance with a differentiation between morning and afternoon sessions (am and pm).

The identifiable outputs of the system define the participation identified in each record of the database as an analysis unit, in which qualities attributable to the event are repeatedly digitalized (initial and end dates, hours/sessions, theme, type of training), while the qualities attributable to the participant is individualized in each record. Thus the system revolves around the number of participants that can be disaggregated by age, sex, organization to which the participants belong, and themes, all of which configure the reports of the system.

It seems that the reports defined around the number of participants have responded to the management and accountability needs raised to date. However, we highlight that two PEPFAR indicators to which the registry responds (H.2.2 and H.2.3)[35] define a worker (community, social or health) as an analysis unit who is counted after completing a pre-service or in-service training program, which could transcend the program's concept of "training event or workshop", as documented in the initial management program with CIES (8 modules or events) and prevention program with CEPRESI (6 modules or events).

The additions made to the database in FY14 and FY15, which define each session (four hours) as a time unit and control morning and afternoon attendance, as well as the addition of an academic evaluation in order for configuring the criterion of "completion" of the program or workshop, are very important improvements. However, these measures lose some of their effect when by a management decision only those people who we know passed the workshop, prior to the digitalization, are incorporated into the database. In addition, it is not efficient to incorporate variables when it is known beforehand that 100% of the records have the same answer. At the request of the evaluating team and thanks to the kind willingness of the person responsible for M&E, the participants who did not pass each event (due to non-attendance or posttest) were digitalized for FY15, resulting in a 7% failure rate. This indicator has not yet been subject to follow-up and the interviews show that no action has been taken to correct it in the events, or has been targeted toward the people who fail.

The review shows that PEPFAR indicators are very well documented in terms of the precision required by

the dimension of the population and operations. However, we were unable to see any accurate adjustment to the realities of the program in Nicaragua, so it was not possible to clearly establish the relationship that exists between the interpretation of the indicators to which the registry responds and how the indicators are operationalized in the set of fields (variables) that form part of the database. For example, what variable (or set of variables) is used to define "community or social worker" (type of organization?), or to define a "pre-service or in-service training program" in the database, since the field could be associated with "type of training" contemplates four options, including continuous training, training at the workplace, online training and distance learning. The basic tabulation applies 91% of the records (participants) to continuous training and this option has reached 98% and 99% in the last two years.

In spite of the complexities that exist in the single registry system, single codes are not assigned to each person since these are people hired to develop open and public activities. The only possibility of identifying the person depends on the quality of the registry in a text field that is totally open for digitalizing the name and surnames. The review of the database enabled us to find multiple ways of writing the same name (two names, only the first name, two surnames, only the first surname, capital letters, small letters, with accent, without accent, in addition to one or several misplaced letters), in such way that it is only possible to identify the same person with objectivity by reconstructing a singular form of writing the name. Likewise, there are no variables in the database that differentiate a "training event" or "training program". There is no differentiation if the participants are part of a grantee or non-grantee organization.

In FY14, 58 monitoring and evaluation fields visits were made, and 51 fields visits were made to 14 grantee organizations in FY15 to address the development of the indicators of the M&E plan, geo-referencing, the database of the single registry, the application of quality improvement cycles for overcoming difficulties in the quality of the data collected, recorded and analyzed, the use of IT tools, the use of data collection tools and the organization and application of the data quality control guide, coaching those responsible for M&E on the introduction of data in the automated registry system, installation of the TIME VIEW 10.0 electronic communications system and related training.

Special relevance should be given to the performance monitoring and evaluation system in the management, administration and prevention training that PrevenSida has provided ever since it configured the baseline with the participating organizations in 2010, which was last measured in September 2014, which shows very significant levels of improvement, proving that it is the results measurement tool that has guided the training component in the different modalities indicated, i.e. workshops, visits and collaborative projects. After having 28 organizations in the baseline with only three NGOs with a performance level above 75%, it now showcases the development obtained with seventeen organizations that score higher than that threshold and thirteen in a position of excellence. It is also possible to see that seven organizations (all KP organizations) are below the 61% threshold and do not show any significant changes in the last period. The measurement is currently underway in FY15 to identify changes.

Special importance is assigned to the quality management consolidation processes that are underway with nine organizations for the formulation of the "Quality Management Programs". After intensive accompaniment by PrevenSida's team, five organizations already have a concerted program and structures for its implementation (Quality Management Committee).

The configuration of these programs in each organization has been a vigorous process of accompaniment and technical assistance with the quality assurance teams, in order to ensure the complete comprehension, appraisal and management of the methodologies included, such as user satisfaction measurement, service strategy design and management of complaints, claims and suggestions, organizational climate analysis, performance evaluation, and improvement cycle implementation. Clearly, the process creates great challenges by placing diverse methodologies in a single instrument, which implementation implies advancing

complex processes in a dynamic that finally merges the monitoring and evaluation system with the training component in a single quality management process as the basis for the effectiveness and sustainability of the combination prevention model.

V. CONCLUSIONS

This analysis has gathered sufficient evidence to affirm that the dynamic of continuous changes for the validation and consolidation of the combination prevention model to confront the HIV epidemic, as the global purpose of USAID/Nicaragua's HIV Bilateral Program, is fundamentally supported by the training component to the extent that in combination with monitoring systems that continuously provide evidence of good practices or shortcomings that need to be overcome, translate into continuous quality improvement processes for the development of new competences and institutional strengthening options for the network of organizations and universities that today make up a successful and efficient action proposal.

The process traversed in the last five years highlights the program's great capacity for change and learning and to adjust not only to PEPFAR's guidelines, but also to the enrichment derived from its own experience and from the continuous monitoring and evaluation process, which creates opportunities for reflection, exchange and innovation. In this programmatic maturing process, the training component has been a key factor for assimilating learnings and feeding back methodologies and events that motivate dynamics of continuous change and improvement. In this regard, three development phases of the program have been characterized, which are associated with significant changes in USAID/Nicaragua's Program and relevant adjustments in the training component:

Design and initiation phase (2010-FY11): This phase was a great challenge because it not only involved a structural change in terms of approach, methodology and population, but had to be carried out in a scenario of dispersed organizations with different types and degrees of development and management and service capacity and high levels of conflicts in light of the background of contradiction between public institutions and NGOs.

The training component took on the great challenge of stimulating a structural change of paradigms and approaches (concentrated epidemic, interpersonal communication, behavioral change, etc.) and action strategies (focalization in KP, with strong barriers of access and social exclusion stemming from S&D, based on traditionally dispersed civil society organizations with opposing approaches and service culture and significant weaknesses in management, administration and service offering. The challenge was met, the program began with great dynamism, but at the end of the first year there were no changes in standard compliance (on the part of NGOs/KP organizations).

Expansion/validation phase. Rapid growth of coverage based on populations with greater access and the creation of links and trust in key populations with more difficult access. Pre-service training was completed and in-service training begins. Access model is validated and significant changes are initiated in standard compliance.

Consolidation phase: Training is oriented to the predominance of quality and sustainability, indicators are readjusted with this approach, and training is also oriented to quality (small groups, emphasis on accompaniment visits). (See Annex 1, Table 19)

The analysis of the achievement of the proposed goals makes it possible to note the excellent degree of achievement of all the goals and objectives, which transcends and places the center of reflection in the ulterior purpose that feeds training processes by stimulating quantitative and qualitative changes in a more strategic manner for each period both in the PrevenSida network and in the universities.

Passing from innovation to the challenge of a new unedited intervention model based on incipient organizations or with opposing cultures and practices, the training component systematized previous experience and contributions by external agents to address the initial phase and accelerated expansion phase by experimenting and validating proposals, in order to reach a moment of consolidation that is more clearly expressed in the systematization of tools for positioning quality as the element that ensures efficacy and sustainability.

The clearest results of the training component are observed in the managerial, administrative and HIV prevention standard compliance evaluation matrix. The clear change from red to red as the predominant color in the comparison between 2010 and 2014, speaks of the magnitude of the change in capacity-building in the sphere of the PrevenSida network, while the assimilation of the pedagogical proposal (package or kit) in the study plans of the universities and the motivation to shift to paradigm changes in medical and social approaches (HR/S&D) shows ostensible results. (See Annex I Table 12)

Maintaining a systematic standard compliance measurement throughout the period is precisely what allows to conclude, in general, that training, understood in its broad sense (event, attendance, collaborative projects, etc.) has been consistent with the development needs of the organizations.

The acceptance and assimilation of the pedagogical offer in the curriculum of the universities evidences not only its consistency with a clear and manifest need, it is also a great contribution with added value when teachers affirm they are applying it in other themes not related to HIV.

The overall situation of the program to date is characterized by a period of transition and change where quality and sustainability constitute the parameter for validating the two models offered to the national response, to wit:

- A model of care that seeks to integrate a single model of continuous comprehensive, based on combination HIV prevention focused on KPs, articulating medical and psychosocial care to PLWHIV.
- A consolidated network of strengthened organizations and universities capable of self-sustaining endogenous processes of improvement and change in mutually beneficial interactions with a high level of participation with relevant bodies of the national and local response.

This condition poses a great challenge for the adjustment of the program's training component. Although the training component is already underway with proposals of high strategic value, such as training facilitators in their own organizations on prevention, M&E, management, and HR/S&D, it also needs to overcome shortcomings and adjust to a new sphere of demands that will derive from the application of instruments like SIMS and quality management programs.

The overall appraisal of the training component by the program's social subjects reveals a high degree of satisfaction with the learning and the processes and events in which they have participated, thus confirming that the component has responded to the expectations and needs of the people, organizations and universities, but they also indicate some limitations that must be overcome.

PrevenSida:

This is the third year that PrevenSida's team fully assumes responsibility for training aimed at its network, so the broad knowledge possessed by each organization is an advantage for planning workshops, visits and collaborative projects, and responding to needs and demands.

However, although each event has defined objectives, methodologies and forms of evaluation, they are

perceived as independent events without a clear or explicit structuring of actions, articulated as a program or set of programs, that not only respond to current conditions, but also to strategic perspectives, taking into account the following considerations:

- The demands that arise from the application of SIMS and quality management programs.
- The differential nature between NGOs and KP organizations, from which not only emanate their current characteristics (lower schooling, conflicts, closer links with the population, etc.), but also their future potential in terms of social and political sustainability. Evidence of very differentiated indicators in the three sources of information (single registry, standard compliance, and interviews with promoters) ratify this criterion.
- Progressive capacity-building requires a thematic sequence and diverse training events (introductory workshops, update workshops, accompaniment visits, collaborative projects). This principle is questioned by evidence, which shows that a high percentage of people only participated in one workshop in the five years.
- The foregoing derives in the need to focus the processes in the people (as individuals and collective groups), by occupational profile (promoters, managers, administrative staff), whom the program seeks to develop their competences in order to respond to institutional needs. Evidence of people who have participated more than ten times in different themes or that the theme is not linked to their area of work denote weaknesses in this regard.
- Cooperating with non-grantee organizations has a great value and strengthens the possibilities of political sustainability, but there is no clear definition in terms of their weight in the participations, or the type of events or programs that can be offered.

Overall, the development of training events has been well ranked, but weaknesses are evident in some events:

- Repetitive themes. People must attend the same workshop again and trainers do not update their presentations or methodologies.

- Statements regarding the use of non-participatory or scarcely motivating methodologies should be taken into account.

- Although the incorporation of mapping has provided knowledge about the situation in the territory, the limited knowledge or skills of the epidemiological analysis is quite clear. In fact, the principle of "four knows" oriented by PEPFAR has not been incorporated.

The design of the program considered the integration of equity gender as a cross-cutting theme in each of the components, which has been materialized by incorporating LGBTI communities in the activities, training events and grants, not only strengthening their organizational capacity, but also their leadership. This has led to the elaboration of strategic plans, municipal and national plans for reducing S&D and GBV, and participation in decision-making spaces of the national response.

The single registry system has responded so far to managerial and accountability demands, but it can be adjusted to respond to other managerial demands:

- The analysis unit should be differentiated. A user-friendly single code should be assigned by combining the name and profile of the organization and the name of the participant.
- The system only responds to participations. Neither the event nor the program is identified as a unit.
- It has few useful fields and does not include simple relevant variables (grant, type of organization)

<u>Universities</u>

The transfer process in the health professionals' education and training institutions was also developed in four stages: the first corresponds to the sensitization of faculty deans and discipline coordinators with respect to the importance of having this valuable tool. The second was characterized by the involvement of teachers in the workshops promoted by USAID|ASSIST. The third stage was focused on information from the workshops that were developed with a participatory methodology and a human rights and gender approach. The fourth stage is the review and readjustment of the academic curriculum, with the objective of incorporating HIV content in the curricular subjects. This incorporation has implied the definition of methodological strategies, competences, capacities and readjustments in the organization of the contents.

The incorporation of the program's pedagogical offer in the universities is in process of consolidation and has great potential:

- A sincere commitment exists in the universities to give sustainability to USAID's legacy.
- The continuation of the process could be ensured as a theme in the modules.
- According to university modalities, an opportunity exists for a theoretical-practical link in primary and secondary prevention through the work developed in health centers and communities.
- Few opportunities exist for strengthening PLWHIV adhesion and social integration actions. It is necessary to integrate more the social approach and reduce clinical biases in the thematic preferences of the teachers.
- Significant weaknesses are perceived between the alliances of the PrevenSida network and the universities.
- The HR/S&D theme has already been positioned in the academic sphere and although internal process could exist that strengthen it, resistance persists as the only learning environment are classrooms or hospitals.
- The university community perceives that the work developed by USAID is very valuable and considers it should be continued in order to consolidate the progress achieved.
- The update of the training themes is a demand of the teachers. This aspect has a special effect in the academic environment that lives from the principle of the most recent scientific knowledge.
- The incorporation of prevention themes from the pedagogical package in some universities is still pending given that the short period of time did not allow us to advance (UNICIT).

VI. RECOMMENDATIONS

The consolidation of the model offered by the program to the national response depends on the strengthening the perspective of its quality and sustainability. To this end, strategies and instruments are already under implementation. The training component needs to be better adjusted to the program's current needs and strategic perspectives.

<u>USAID Mission</u>

1. It would be very valuable to carry out a systematization of the experience in the training component to show processes of articulation with the M&E systems and continuous quality improvement processes.

2. It is of utmost importance to configure an HIV continuous and comprehensive care model proposal in the shortest time possible. The combination prevention model currently in process of consolidation and validation constitutes the basis for providing continuous care to PLWHIV, which should not only ensure adhesion to medicine and continuity of medical treatment, but also family and social integration.

3. The capacity-building approach and compliance of standards required by the care and management models validated by the program are a fundamental parameter for achieving greater organization of the training processes and events offered, which should have a certain degree of differentiation by type of organization and identified needs (NGOs, KP organizations, current capacities, etc.)

4. A more detailed review of the implications that the implementation of SIMS and quality management programs will have on training should be carried out. Once these two instruments are applied, the results can translate into greater and more diversified training and technical assistance demands.

Partners

5. Structuring training offers in the form of programs targeted to profiles and types of organizations could benefit the efficacy and development of individual competences and institutional capacities.

6. The priority assigned to continuous care requires emphasizing the secondary prevention component, especially access and adhesion to treatment, as well as the social integration of PLWHIV (self-help groups, respect, solidarity, and family and community support). In this regard, the validation of the care model should culminate in a more comprehensive dimension that transcends primary prevention. This requires adjusting training strategies and differentiated accompaniment according to the roles of KP organizations, NGOs and universities, which have different capacity-building possibilities and perspectives for the sustainability of the care models given their nature and links with key populations.

7. The training component should incorporate a pedagogical and didactical training module for facilitators of training events, in order to improve the methodologies that are used, while ensuring updated themes, motivation and participation.

8. The single registry should be modified to correct discrepancies between the reports and registry and to increase the number of people, events and programs, identifying them as analysis units according to other management demands or usefulness that could be contemplated. It would be beneficial to incorporate simple stratification variables that permit to better analyze management decisions, while improving accountability with precise indicators.

9. Epidemiological and social analysis methodologies should be incorporated in the pedagogical offered to the PrevenSida network and universities, in order to develop PEPFAR's "four knows" principle to have evidence available to support local decisions on service orientation and establish local alliances to count with evidence with greater communicational power that can enrich the "face to face" dialogue or peer groups in combination prevention, as well as sensitization activities for care and integration of PLWHIC in secondary prevention.

10. Training facilitators by thematic area so they become focal points in each organization for creating a "critical mass" that develops training processes linked to quality management in a more endogenous manner, will certainly increase the quality of the training processes due to their proximity to, and knowledge of, local reality. These new actors should make visible their work products and contribution to the performance and results of the training component as a whole. Therefore, they should have a primary registry and the possibility of incorporating their registry into the global system.

11. The PrevenSida component should be articulated with the university component. In addition to a perspective of greater strategic sustainability, this notion has an operational axis centered on training

in the sense of offering a practical teaching environment in the form of internships for students, which exchange would benefit both parties by deepening HR/S&D promotion and strengthening the social and continuous care approach in the organizations and universities. The work currently carried out by PASCA with the departmental AIDS commissions (CONISIDAS) could be linked to the achievement of this objective.

12. In this regard, it is important to create alliances between universities and KP organizations to carry out internships for strengthening the skills of pharmacy student in the logistics and storage system and greater sensitization among medical students with respect to stigma and discrimination against PLWHIV and sexual diversity.

13. In the capacity-building process, the alliance between NGOs/KP organizations and universities could include accreditation of the courses received with the possibility of being recognized as part of the academic programs, which could eventually include validation as part of technical training (intermediate or superior) or specialized courses or master degrees in the case of promoters or teachers that have some accredited profession.

USAID Regional

14. The completion and validation of the continuous and comprehensive care model requires adjustments at different levels already mentioned, which cannot be resolved in the temporary horizon of the effective date of USAID/Nicaragua's HIV program. Completion and validation warrant a revision of time periods and funding foreseen.

15. PASCA can boost its contribution to the bilateral program by accompanying the departmental CONISIDA processes, strengthening the PrevenSida network and the universities by strengthening their presence in these bodies and facilitating access to epidemiological information and local social actors in order to strengthen the "four knows". The presentation of all studies and products with a local adjustment approach could be highly motivating for dialogues and reflections that strengthen their capacities.

16. On its part, PASMO, in addition to adjusting its technical assistance strategies, could contribute in a relevant manner to the configuration of the continuous and comprehensive care model in its general and local expressions.

Other donors

17. The continuous and comprehensive HIV care model in key populations should be designed and implemented in a sufficient time period for its validation and, once it has been validated, the experience should be systematized to be offered by other funders (GF) as a contribution to the national response and eventually shared with other countries.

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ANNEXES

ANNEX 1: Tables

Table 1. USAID/Nicaragua's Partners and Implementers

Implementing partner/project name	Activities	2007	2008	2009	2010	2011	2012	2013	2014
PSI/PASMO- Proyecto de Prevención de VIH Sida	Prevention: BCC, VCT Quality	x	x	x	R	R	R	R	R
IntraHealth/Capacity	HSS-Hospital quality services		x	x					
NicaSalud/Famisalud	Prevention in rural settings	x	x	x					
URC/HCI	PMTCT, S&D, VCT		x	x	X	x	x	x	
URC/ASSIST	Pre-service training							x	x
MSH/Pronicass	HSS and pre-service training	x	x	x	x				
URC/PrevenSida	Combined Prevention among key populations; pre-service and in service training with NGOs					x	x	x	x
JSI/Deliver	Logistic and pre-service training with universities					x	x	x	x
RTI/Alliances 2 ®	Prevention in work places, in service training for private sector							x	X
Futures Group/PASCA	Policy Environment and Strategic information				x	x	x	x	
SCMS	Logistics						x		

Source: TORs for Evaluation of HIV Training Component. Nicaragua 2015

Table 2. Nicaragua's HIV Bilateral Program within the Central America Partnership Framework (2010-2015)

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 treatment of STIs. Expand access to VCT services for key populations at all levels	PSI/PASMO: HIV Regional combined prevention URC: Prevensida
Health System Strengthening	Dependence on external aid Institutional weaknesses 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	Futures Group: HIV Regional PASCA URC: Prevensida PSI/PASMO: HIV Regional combined prevention

Component	Problem addressed	Objectives	Strategic interventions/ Key activities	Implementing Partners/Projects
			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.	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

Source: TORs for Evaluation of HIV Training Component, Nicaragua 2015

Table 3. Indicator for Monitoring USAID's HIV Program

No	Indicators	Project (research line)
	DIRECT PREVENTION AND CARE SERVICE PROVISION INDICATORS	
1	Number of persons receiving CVT and results	PrevenSida (rapid test)
2	Number of persons with HIV receiving a minimum package of preventive services and care	PrevenSida (prevention and care)
3	Number of most-at-risk groups reached with combination prevention a.- Sex workers b.- Injecting drug users c.- Men who have sex with other men d.- Other Vulnerable Populations	PrevenSida (prevention in KP) Alliances II (prevention in private sector workers)
	INSTITUTIONAL STRENGTHENING INDICATORS	
4	Number of laboratories with capacity to perform clinical tests	PrevenSida (FSS-laboratory)
5	Number of new health workers graduated from pre-service institution	HCI and ASSIST (physicians, nurses) DELIVER (physicians, nurses, pharmacists)
6	Number of community workers that complete pre-service training program	PrevenSida (management, administration, HIV technicians)
7	Number of health workers with in-service training	HCI, DELIVER (university professors) PrevenSida (NGO workers) Alliances II (physicians and nurses in company health posts)
8	Number of NGOs strengthened with technical assistance	PrevenSida (PAC) DELIVER (logistics) ASSIST (pre service)
	Cross-cutting themes - Gender (GBV, LGBTI) - Stigma and discrimination - Institutional strengthening	All projects

Source: TOR for Evaluation of HIV Training Component, Nicaragua 2015

Table 4. Methodological matrix according to TOR questions

Question	Type of question	Type of information	Methodology	Data Source	Sampling method
QG	Descriptive	Quantitative, Qualitative	Results analysis	Q1-Q5	Complete process
Q1, Q2, Q3	Comparative	Qualitative, Quantitative	Literature review	Secondary	All available documents
Q1, Q2, Q3	Comparative	Quantitative, Qualitative	Review of project performance reports (compliance of indicators) Observation and field visits to a simple of implementers, partners and beneficiaries Focal group discussions Individual and group interviews using guides or questionnaires	Primary	Convenience in relation to the total number of people trained during the entire period 100% of the projects, NGOs and active universities 5 projects 12 NGOs 8 universities
Q4, Q6		Qualitative and quantitative	Results analysis	Secondary	All documents
Q5	Descriptive	Qualitative	Results analysis	Secondary	All conclusions

Source: Work Plan. Evaluation of HIV Training Component, Nicaragua 2015

Table 5. Evaluation Questions

QG To what extent has the USAID/Nicaragua HIV program successfully implemented the training component?	
Q1: Based on the indicators selected to monitor the HIV program training component in Nicaragua (Attachment 1),	To what extent has the USAID/Nicaragua HIV program achieved its expected targets to date and what is the coverage?
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:	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 training component contributed to gender equity?	a) Did projects integrate gender considerations into their design, activities and indicators, and develop measures to enhance participation of vulnerable populations 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? Did strategy implementation increase the sustainability of these gender-specific achievements? If so, how? ?
Q5: What are the recommendations?	(for USAID Nicaragua, counterparts, donors and other stakeholders) to improve the likelihood of sustainability of USAID's HIV training component
Q6: How was the quality of the register of training activities, at different levels:	Local counterparts, implementing mechanisms, Mission M&E System, Trainet and Unique Register System?

Source: TORs for Evaluation of HIV Training Component. Nicaragua 2015

Table 6. Evaluation instruments according to management levels

Level	Instrument	Sector
Strategic management	Guide for interview with USAID	1. Dr. Marianela Corriols 2. Lic. Marcela Villagra
	Guide for interview with USAID project directors	PrevenSida: CoP, DO, quality and M&E advisers 2. DELIVER: CoP, universities/M&E 3. HCI-ASSIST: CoP, universities, M&E 4.USAID|PASCA: CoP 5.USAID|Combination Prevention: CoP
NGO operations management	Interview guides	1. NGO directors 2. Technical and administrative staff 3. Promoters 4. Key population beneficiaries
University/partner operations management	Interview guides	1. Deans 2. Career coordinators 3. Area coordinators 4. Teaching staff 5. Students
	Interview guide	COSEP- private sector representatives

Source: Work Plan. HIV Training Evaluation, Nicaragua 2015

Table 7. Interviews with USAID management

No	Interviewed people	institution
1	Marianela Corriols	USAID
2	Marcela Villagra	USAID
3	Carolina Arauz	USAID|DELIVER
4	Maritza Narváez	URC|USAID
5	Ivonne Gómez	URC|USAID
6	Danilo Núñez	USAID|ASSIST
7	Yudy Wong	USAID|PrevenSida
8	Oscar Núñez	USAID|PrevenSida
9	Rafael Arana	USAID|PrevenSida
10	Ana Christian Largaespada	USAID|PASCA
11	Martha Karolina Ramírez	USAID|PASMO
12	María Lourdes Aragón	USAID|PASMO
13	Miguel Orozco Valladares	CIES-UNAN
14	Norman Gutiérrez	CEPRESI

Source: Database. HIV Training Evaluation. Nicaragua 2015

Table 8. Fieldwork Process

No	Territory	NGO/University/ Companies	Target populations	Dates
1	Managua	PARTNERS/USAID		7 - 12 September
		CEGODEM	MSM	21-12 October
		CEPRESI	MSM	
		ANICP +VIDA	PLWHIV	
		ASONVIHSIDA	PLWHIV	
		IXCHEN	SW	
		OVI	MSM	
		ADESENI	TRANS	
		UNAN-MGA	Students – teachers	
		UNAN-Managua	Area coordinator	12 October
		UNICYT	Students – teachers	22-25 September
		POLISAL	Students – teachers	22-25 September
		UPOLI	Students – teachers	1-3 October
		COSEP	Companies	28 September
		CIES		30 September
2	Masaya	ODETRANS	TRANS	29 September
3	Chinandega	GAO	PLWHIV	22-23 September
4	León	GAO	PLWHIV	
5	Matagalpa	UNAN- LEON	Students – teachers	
		Agent of change	NGO director	23-24 September
6	Ocotal	CEPS	MSM & mobile populations	28-29 September
7	Rio San Juan	Fundación San Lucas	SW, PLWHIV, MSM & mobile populations	28-29 September
8	RAAN	Sexual Diversity Movement	MSM, TRANS, SW	30 Sept - 1 Oct
		URACCAN	Students – teachers	
9	RAAS	Association of Coast AIDS Campaign	MSM, TRANS, SW	30 Sept - 1 Oct
		Sexual Diversity Movement	MSM, TRANS, SW	
		BICU	Students – teachers	

Source: Work Plan. HIV Training Evaluation, Nicaragua 2015

Table 9. University Interviews

Departments	Universities	Surveys			Total
		Coordination	Teachers	Students	
RACS	BICU	3	9	21	33
Matagalpa	FAREM	1	3	0	4
Managua	POLISAL	7	2	5	14
Leon	UCAN	2	3	12	17
Leon	UNAN-LEÓN	2	10	14	26
Managua	UNAN-Managua	6	6	57	69
Managua	UNICIT	1	1	19	21
Managua	UPOLI	1	3	13	17
RACN	URACCAN	1	4	7	12
TOTAL		**24**	**41**	**148**	**213**

Source: Database. HIV Training Evaluation. Nicaragua 2015

Table 10. NGO Interviews

Departments	NGOs	Surveys			
		Managers	Promoters	PEMAR Volunteers	Total
RACS	ACCCS	1	4	1	**6**
LEON	ADESENI	1	3	2	**6**
MATAGALPA	AGENTE DE CAMBIO	1			**1**
RACN	AMODISEC	1			**1**
MANAGUA	ANIC+VIDA	2	5		**7**
MANAGUA	ASONVIHSIDA	1	2		**3**
MANAGUA	CEGODEM	1	6		**7**
MANAGUA	CEPRESI	1	3		**4**
MANAGUA	CEPS	1			**1**
NVA SEGOVIA	CEPS OCOTAL	1	4	5	**10**
RIO SAN JUAN	FUNDACION SAN LUCAS	1	3	4	**8**
LEON	GAO	2	4	3	**9**
MANAGUA	IXCHEN	4	5	1	**10**
RACS	MDS-RAAS	1	3	1	**5**
MANAGUA	ODETRANS	1	3	1	**5**
MANAGUA	OVI	2	4		**6**
Total		**22**	**49**	**18**	**89**

Source: Database. HIV Training Evaluation. Nicaragua 2015

Table 11. Goal Achievement and Key Indicators

COMPONENT	THEMATIC AREAS	# of people	Total participations
Management	Strategic plan design	**5**	**5**
	Financial management facilitators	**19**	**33**
	Management, leadership, strategic planning and operations facilitators	**16**	**52**
	Knowledge management and M&E facilitators	**5**	**19**
	Quality assurance	**34**	**62**
	Quality management	**5**	**10**
	Use of geo-referencing tools	**7**	**18**
	Use of QGIS mapping of geo-referenced points	**0**	**15**
Human Rights, Stigma and Discrimination	Stigma and discrimination	**9**	**14**
	Facilitators in HR promotion and advocacy	**28**	**71**
	GENDER	**15**	**46**
	Gender	**22**	**47**
	Trafficking in persons	**2**	**45**
	Trafficking in persons	**2**	**39**
Prevention	Facilitators in combination prevention	**5**	**21**
	Combination prevention	**45**	**91**
	Combination prevention and care for PLWHIV	**23**	**31**
Monitoring and evaluation	Excel intermediate level	**5**	**9**
	Facilitators in M&E and Single Registry	**9**	**20**
	Facilitators in single registry	**8**	**29**
	Single registry of Most-at-Risk Groups and PLWHIV	**31**	**57**
HIV Testing	HIV test update	**5**	**16**
	Performance of HIV rapid test	**16**	**23**
Total		**316**	**773**

Source: USAID Annual Project Reports 2010-2015. Nicaragua 2015

Table 12. List of NGOs supported by USAID PrevenSida. 2011- 2015

No.		LB				Evaluation until September 2014				Qualification
		Management	Admin. & Finance	Preventive Services	Global	Management Sept 14	Admin & Finance Sept 14	Preventive Services Sept 14	Global Sept 14	
1	CEPRESI	80.0%	83.3%	83.8%	82.3%	100.0%	100.0%	100.0%	100.0%	Excellent
2	IXCHEN	70.0%	95.0%	68.0%	94.8%	100.0%	100.0%	100.0%	100.0%	Excellent
3	FADCANIC	77.5%	100.0%	33.0%	64.6%	100.0%	100.0%	99.0%	99.6%	Excellent
4	GAO	25.0%	25.0%	25.0%	25.0%	100.0%	100.0%	100.0%	99.6%	Excellent
5	OVI	41.3%	61.7%	56.0%	52.5%	100.0%	99.0%	100.0%	99.6%	Excellent
6	ICAS	62.5%	90.0%	57.0%	67.1%	100.0%	98.3%	99.0%	99.2%	Excellent
7	CEPS	91.3%	88.3%	95.0%	91.5%	93.8%	97.0%	100.0%	96.7%	Excellent
8	FSL	51.3%	61.7%	26.0%	42.7%	93.8%	100.0%	100.0%	96.3%	Excellent
9	CEGODEM	35.0%	25.0%	25.0%	28.3%	97.5%	95.0%	94.0%	95.4%	Excellent
10	ANICP+VIDA	40.0%	53.3%	37.5%	42.7%	100.0%	100.0%	94.0%	95.4%	Excellent
11	ASONVIHISDA	52.5%	36.7%	56.3%	41.4%	91.3%	100.0%	91.3%	95.4%	Excellent
12	ACCCS	27.5%	30.0%	43.8%	34.1%	100.0%	93.3%	100.0%	93.3%	Excellent
13	GAVIOTA	51.3%	61.7%	26.0%	42.7%	90.0%	93.3%	86.0%	89.0%	Graduate
14	MDS-RAAS	25.0%	25.0%	25.0%	25.0%	100.0%	70.0%	98.0%	91.7%	Needs improvement
15	ADESENI	30.0%	41.7%	36.3%	35.5%	78.8%	70.0%	90.0%	81.7%	Needs improvement
16	MODISEC RAAN	32.5%	25.0%	25.0%	27.5%	88.8%	89.0%	56.7%	82.0%	Needs improvement
17	IDSDH	50.0%	63.3%	52.0%	60.1%	61.3%	63.3%	88.8%	72.3%	Needs improvement
18	RDS	62.5%	66.6%	61.3%	64.5%	62.5%	93.3%	71.3%	74.5%	Needs improvement
19	AGENTE DE	32.5%	31.7%	51.0%	40.3%	57.5%	90.0%	87.0%	77.1%	Needs improvement
20	ADISNIC	43.8%	50.0%	25.0%	40.0%	57.5%	80.0%	70.0%	69.5%	Needs improvement
21	MOVIDESEX RSJ	25.0%	25.0%	25.0%	25.0%	63.8%	46.7%	77.5%	64.0%	Needs improvement
22	ODETRANS	27.5%	25.0%	56.3%	35.3%	58.8%	41.7%	75.0%	56.7%	Needs intensive TA
23	ADISNIC	36.3%	25.0%	41.3%	36.0%	43.8%	43.8%	35.0%	53.8%	Needs intensive TA
24	ANIT	26.3%	25.0%	32.5%	28.6%	40.0%	73.3%	53.8%	50.3%	Needs intensive TA
25	HIJAS DE LA LUNA	25.0%	38.3%	40.0%	34.3%	42.5%	41.7%	45.0%	43.3%	Needs intensive TA
26	Digeorsex	25.0%	25.0%	25.0%	46.3%	42.5%	30.0%	46.3%	42.0%	Needs intensive TA
27	MOJUDS	25.0%	25.0%	42.0%	32.7%	31.3%	31.7%	53.8%	38.0%	Needs intensive TA

Source: USAID Annual Project Reports 2010-2015. Nicaragua 2015

Table 13. PrevenSida Coverage

Population Coverage

Projects	FY11			FY12			FY13			FY14			FY15		
	Goal	Total	%	Goal	Total	%	Goal	Total	%	Goal	Total	%	Goal	Total	%
# of individuals receiving CPV and receiving results															
PrevenSida	10000	9255	**93**	10745	6472	**60**	10000	12509	**125**	14000	14305	**102**	10000	9150	**92**
# of people living with HIV who receive minimum preventive service package															
PrevenSida				300	404	**135**	300	780	**260**	500	1125	**225**	500	2485	**497**
# of most-at-risk population reached by combination prevention															
PrevenSida	155000	141739	**91**	35000	30220	**86**	37000	69425	**188**	54500	72955	**134**	37000	38988	**105**
Sex workers	15500	11833	**76**	3000	2925	**98**	3500	6885	**197**	4500	7952	**177**	3500	6178	**177**
MSM	57350	39479	**69**	7245	6560	**91**	20000	21603	**108**	29430	34319	**117**	20000	22436	**112**
Other populations	82150	90436	**110**	25000	20696	**83**	13500	40905	**303**	20570	30684	**149**	13500	10372	**77**
Alliance 2							10000	10350	**104**						

Source: Database and USAID PrevenSida Annual Reports.

Table 14. Achievement of Indicators 2011-2015

Institutional Capacity-Building – PrevenSida Network

Projects	FY11			FY12			FY13			FY14			FY15		
	Goal	Total	%	Goal	Total	%	Goal	Total	%	Goal	Total	%	Goal	Total	%
# of laboratories with capacity to perform clinical tests															
PrevenSida	4	5	**125**	4	2	**50**	5	8	**160**	5	7	**140**	10	7	**70**
# of community workers who complete pre-service training program															
PrevenSida	60	37	**62**				46	35	**76**	71	128	**180**			
# of health workers trained in-service															
PrevenSida	260	428	**165**	500	733	**147**	500	794	**159**	560	1044	**186**	150	630	**420**
# of NGOs strengthened with technical assistance															
PrevenSida	8	8	**100**	12	12	**100**	20	18	**90**	20	28	**140**	20	14	**70**
DELIVER							16	16	**100**	42	42	**100**	12	12	**100**
ASSIST													3	3	**100**

Source: Database and USAID PrevenSida Annual Reports.

Table 15. Percentage of Prevensida indicators achieved

Indicator/Projects	FY11-FY15		
	Goal	Total	%
# of laboratories that perform test			
PrevenSida	28	29	104
# of workers trained in pre-service			
PrevenSida	177	200	113
# of health workers trained in-service			
PrevenSida	80	80	100
DELIVER	70	70	100
ASSIST	3	3	100

Source: Database and USAID PrevenSida Annual Reports.

Table 16. Pre-service and in-service training in universities

No de nuevos trabajadores de salud graduados de institución pre servicios															
Proyectos	FY11			FY12			FY13			FY14			FY15		
	Meta	Total	%	Meta	Total	%	Meta	Total	%	Meta	Total	%	Meta	Total	%
HCI				1000	692	69	500	829	166						
No de nuevos trabajadores de salud graduados de institución pre servicios															
Proyectos	FY11			FY12			FY13			FY14			FY15		
	Meta	Total	%	Meta	Total	%	Meta	Total	%	Meta	Total	%	Meta	Total	%
ASSIST										500	423	85	550	661	120
No de nuevos trabajadores de salud graduados de institución pre servicios															
Proyectos	FY11			FY12			FY13			FY14			FY15		
	Meta	Total	%	Meta	Total	%	Meta	Total	%	Meta	Total	%	Meta	Total	%
DELIVER							100	156	156	150	61	41	150	208	139

Source: Database and Annual Project Reports of USAID Partners

Table 17. In-Service Training in Universities

No de Trabajadores de salud capacitados en servicios															
Proyectos	FY11			FY12			FY13			FY14			FY15		
	Meta	Total	%	Meta	Total	%	Meta	Total	%	Meta	Total	%	Meta	Total	%
ALLIANZA2							100	127	127						
No de Trabajadores de salud capacitados en servicios															
Proyectos	FY11			FY12			FY13			FY14			FY15		
	Meta	Total	%	Meta	Total	%	Meta	Total	%	Meta	Total	%	Meta	Total	%
HCI	0			190	528	278	300	328	109	50	107	214	50	55	110

Source: Database and Annual Project Reports of USAID Partners

Table 18. Activities for Technical Transfer to Universities DELIVER 2014-2015

University	Career	Activities for Technical Transfer
UNAN-Leon	School of Chemical Sciences	Creation of Community Pharmacy and guiding text. Training 105 students Creation of virtual classroom Elaboration of "Health Research Methodology for Writing Monographs"
	School of Medical Science	Incorporation of 4 themes from PP on Health Administration and Primary Health Care Management
UNAN-Managua	Nursing	Incorporation of 6 themes from pedagogical kit. Training 16 teachers, 40 students
	Pharmacy	Implementation of pedagogical kit in community pharmacy and hospitals. Training 51 teachers. Strengthening of the technological pharmacy classroom.
BICU	Medicine	Delivery of pedagogical package (4) for teachers and students (30) Logistics and rational use.
UCAN- Leon	Pharmacy	Delivery of pedagogical package (12); review of contents.
UNICIT (MP)	Pharmacy	Elaboration of Pharmaceutical Administration and Laboratory Program with guiding text (MP)

Source: USAID|DELIVER Annual Reports

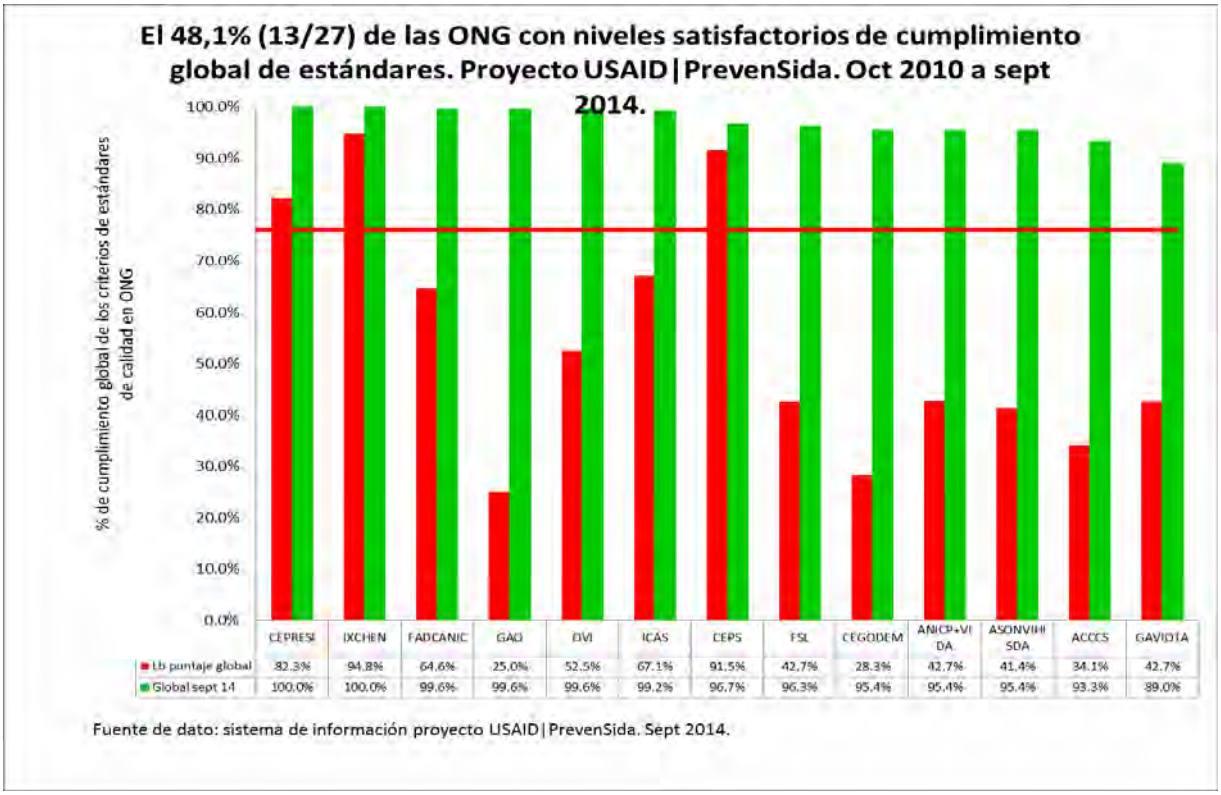
Table 19. Consolidation Phases of the Training Component of USAID/Nicaragua's HIV Bilateral Program

Prior to 2010	Design and start-up 2010-2011	Expansion 2012-2013	Consolidation 2014-2015	Continuous comprehensive model validation
Maternal and perinatal health, FP ART and CVT decentralization STI syndrome management Vertical HIV transmission	Definition of combination prevention model and behavioral change communication	Validation of accessibility model, creation of trust in key population	Preventive and care model for PLWHIV focused on quality and sustainability	Continuous comprehensive model with a social, human rights and S&D approach
Elaboration of protocols, standards and quality indicators	Definition of standards for CSO (Management, Administration, Prevention)	Idem	Application of SIMS/PEPFAR, formulation of quality management plans	Revision and reformulation of standards according to continuous comprehensive model, SIMS and PGC.
In-service training of multidisciplinary teams and pharmacy directors	Design and development of two pre-service training programs. Management (CIES)- Prevention (CEPRESI)	In-service training (PrevenSida team). Priority: prevention model in medium and large groups	Training in small groups; more technical assistance visits and coaching. Priority: HR/S&D	Formulation of programs based on competences and profile. Adjustment of NGO/CSO/University differentiation.
Registry systems, monitoring systematization	Design and first annual report of Single Registry System based on "contacts". Discrepancies in report on pre-service training graduates.	Discrepancies in number of in-service training participations between reports and registry	Discrepancies in number of in-service training participations between reports and registry	Registry identifies participations, people, events and programs. Differentiated follow-up of grantee and non-grantee NGOs/Key Population Organizations
	Baseline on standard compliance (Sept/2010), 1st follow-up measurement (Sept/2011). No significant variation	All NGOs exceed 75% standard compliance index. Only a minority of KP organizations is slowly developing its capacities.	Most NGOs surpass 95% standard compliance index.	Standards adjusted with priorities derived from SIMS and PGC.

Source: USAID/Nicaragua Annual Reports

ANNEX 2. Graphs

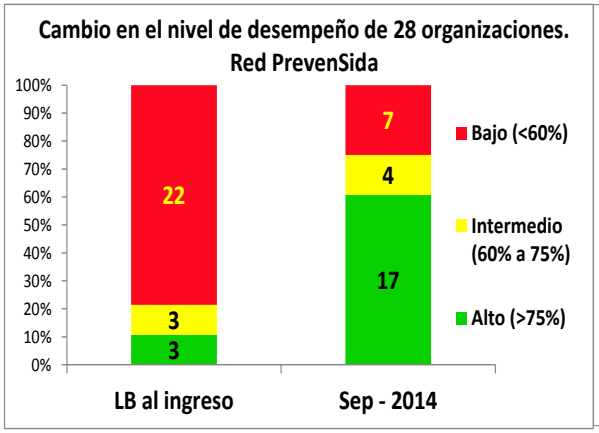
Graph 1. Levels of compliance of NGOs according to measurement standards



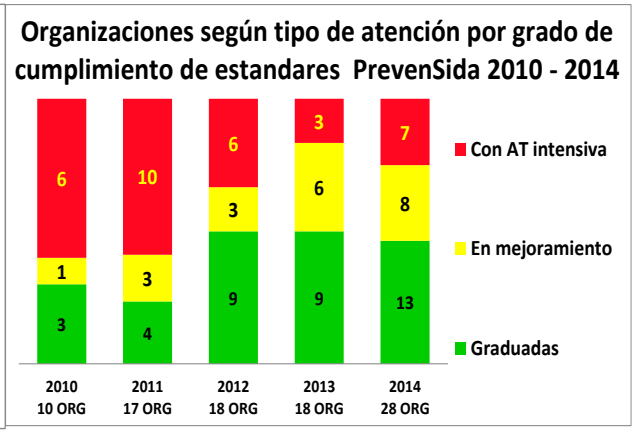
Source: PrevenSida Report FY15

Graph 2. Organizations according to performance level in standard complianc

Change in the performance level of 28 organizations



Organizations according to type of care by degree of standard compliance – PrevenSida 2010-2014



Source: USAID PrevenSida Annual Reports

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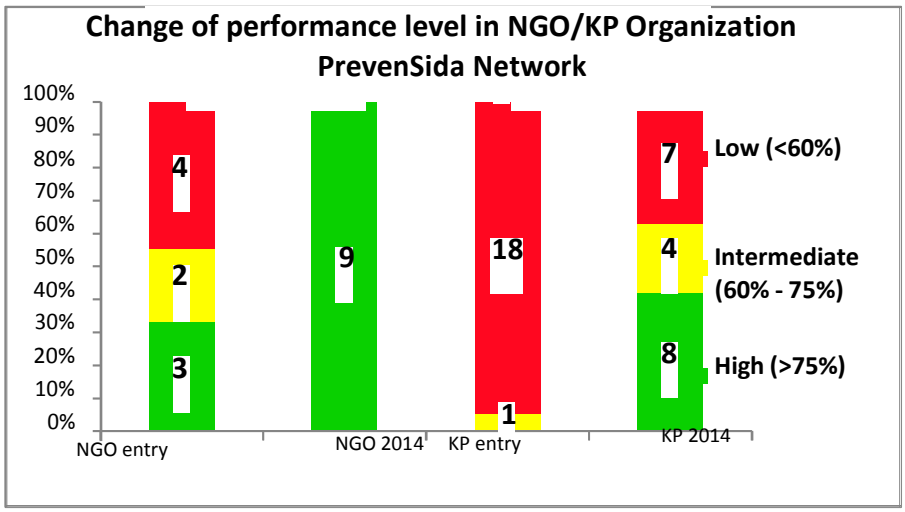
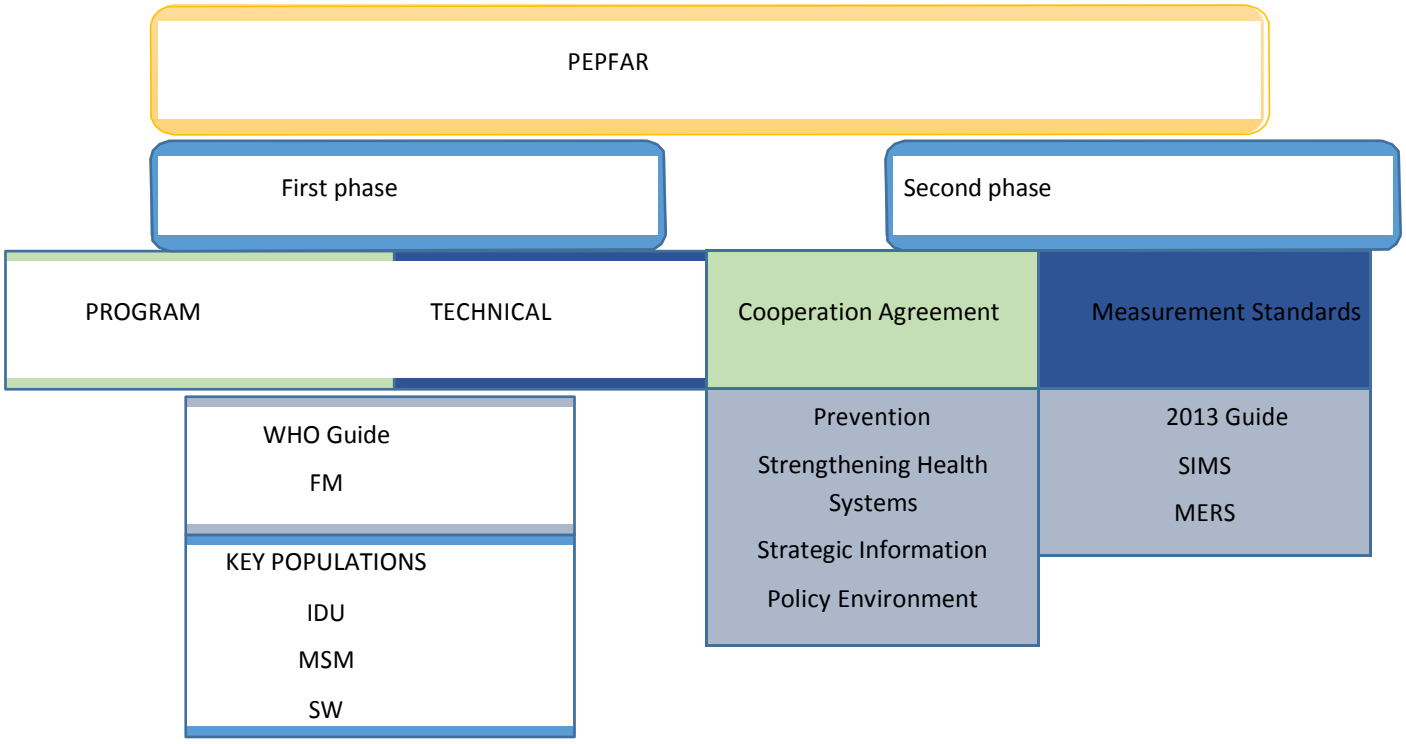
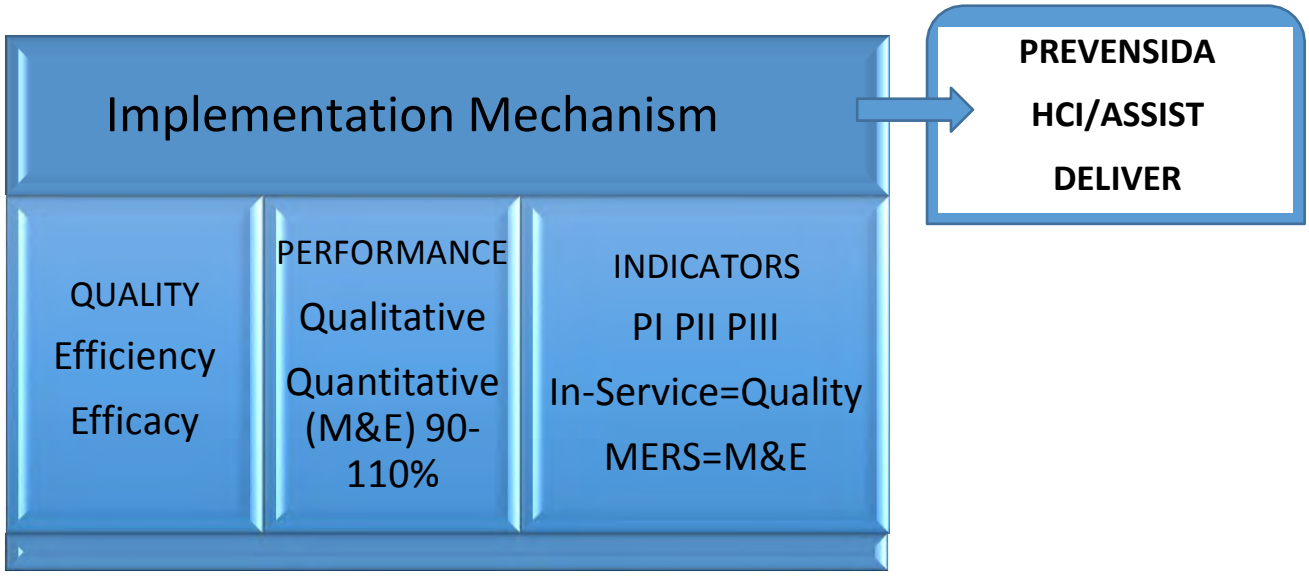
Graph 3. Level of compliance between NGO and KP Organizations



Source: USAID PrevenSida Annual Reports

Graph 4. PEPFAR Phases in Nicaragua





ANNEX 3. Timetable and Deliverables

TASK	August	September				October				November				December			
1. Propose work plan and methodology and brief meeting with USAID. August 21-27																	
2. Gather information (secondary sources). Aug 21 – Sept 4																	
3. Conduct interviews with partners and Mission. Aug 28 – Sept 11																	
4. Conduct review of all available information/evidence on HIV training indicators. September 5-19																	
5. Conduct visits to beneficiary groups selected. Sept 21-Oct 3																	
6. Draw up and submit first draft. Oct 3-31																	
7. Draw up and submit second draft (Spanish) to USAID for review and approval. November 6-21.																	
9. Validate Spanish report with partners and beneficiaries. Nov 23-28																	
10. Final report drawn up and submitted to USAID for approval. Nov 30 – December 5																	
11. Revisions and comments from USAID.																	
12. Final report translated into English and submitted to USAID. December 12-19																	
13. Acceptance by USAID																	

Source: Work Plan. HIV Training Evaluation, Nicaragua 2015

Products:
The evaluation team will complete the following products:

1. Work plan and methodology: The evaluation team proposed a concise work plan and methodology. The proposed work plan and data collection tools were presented to USAID/Nicaragua's evaluation counterpart and partners at a meeting for the approval of the Regional Committee no later than six business days after the signing of the contract (10 pages).

2. Documentary review and analysis: USAID's partners provided physical and digital information for the evaluation process and for the elaboration of data collection instruments. Four data collection instruments were developed: guide for interviews with NGO executive staff and university career coordinators, guide for interviews with most-at-risk population and students, guide for interviews with NGO teachers and promoters, as well as a guide for interviews with USAID staff.

3. Fieldwork: The data collection process was carried out at the organizations and universities after prior coordination with USAID project partners. This phase was developed in three weeks of fieldwork.

4. Data processing and analysis: Once the instruments were applied, qualitative and quantitative data generated by the fieldwork process and documentary review were processed. Later, the quantitative and qualitative data obtained in the documentary review and databases was compared. As a result of this phase, a preliminary report is available. This phase was completed in five weeks.

5. Presentation of preliminary results: The evaluation team will present the main conclusions and recommendations in a PowerPoint presentation at a meeting with USAID's partners. Feedback from this presentation will be incorporated into the first draft report. Once the list of attendees is signed, it will be presented to USAID as evidence of the interviews for purposes of payment. This activity will take place in the first week of November.

6. An evaluation draft report of a complete draft report with the results and recommendations will be presented to USAID/Nicaragua following the format in Section XVIII of the Statement of Work. The report shall clearly describe the results, conclusions and recommendations. USAID will provide comments on the draft report within a week following the presentation and the team will prepare an updated version of the evaluation report (second draft report).

7. Validation events: The second draft report will be validated in two separate events to share the results of the evaluation with the interested parties for their review and comments: a) implementers (approximately 10 participants), b) counterparts (approximately 30 participants). All costs associated with these events (rental of venue, refreshments, etc.) will be covered by the contractor. The list of attendees to both events was presented to USAID as proof of payment.

8. Final evaluation report: The consulting team will submit a final report in English, incorporating the answers to USAID's comments and suggestions. Upon receiving USAID's approval of the final report, 30 printed copies of the report will be submitted to USAID, as well as digital versions in PDF and Microsoft Word.

ANNEX 4. Available Electronic Data

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

Source: TORs for Evaluation of HIV Training Component. Nicaragua 2015

ANNEX 5. TDR

Issuance date: February 10, 2015
Closing date: March 9, 2015

SUBJECT: **Request for Quotations (RFQ) No. SOL-524-15-000001 HIV Training Component Evaluation**

Dear Sir or Madam,

The United States Agency for International Development Mission to Nicaragua (USAID/Nicaragua) is seeking quotations to provide expert consultant services for USAID/Nicaragua as described in the attached Statement of Work. This requirement will be a firm-fixed price purchase order.

Your quotation should contain two sections:

1) Section I: Technical Proposal, consisting of:

a. A Technical Proposal - no longer than seven pages- that addresses how the offeror intends to carry out the attached Statement of Work and which contains a clear understanding of the work to be undertaken.

b. Curriculum Vitae of each proposed team member or individual to be involved in the work and a biographical data sheet (USAID Form 1420-17) found at http://inside.usaid.gov/forms/formsnumeric.html, which includes information about salary rates previously paid for similar work.

c. At least three references (contact names, telephone numbers and e-mail addresses) of past performance in similar activities must be provided.

d. A proposed time schedule for completing the work.

2) Section II: Cost Proposal that will contain:

a. Your proposed total firm-fixed price based on the deliverables described in Section VIII of the attached Statement of Work. This will include a breakdown of the proposed budget, detailing labor days, other direct costs and a budget narrative that explains how the costs were derived.

Any questions regarding this Request for Quotation should be submitted in writing only to oaanicaragua@usaid.gov. Attention: Maria Lourdes Penalba, A&A Specialist. Questions will not be received after February 20, 2015.

Any additional information given to a prospective offeror will be provided to all prospective offerors if such information is determined to be necessary to offerors in submittal of quotations and will be considered an amendment of the solicitation.

Issuance of this solicitation does not constitute an award commitment on the part of the U.S Government nor does it commit the U.S. Government to pay for the costs incurred in the preparation and submission of a quotation. Quotations may be submitted in English or Spanish.

Quotations should be sent via e-mail to oaanicaragua@usaid.gov by the close of business on **March 9, 2015 at 4:30p.m., local time.** Please make sure that any required signature is duly scanned with your submission, as well as to include the Technical and Cost Proposal in separate files. The subject line for all communications should read: RFQ No. SOL-524-15-000001/HIV Training Component Evaluation.

Sincerely,

Joseph Terrazas
Regional Contracting Officer

Attachments:
1} Statement of Work
2} Contractor Selections Criteria
3} Selected Indicators to monitor HIV program training component in Nicaragua
4} Electronic Information Available

ATTACHMENT 1

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
GDO	General Development Office (former Health and Education (HE) Office)
ENDESA	Encuesta Nicaragüense de Demografía y Salud [Nicaraguan Demographic and Health Survey]
FAMISALUD	Familias Unidas por Su Salud [Families United for Health]
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
INIDE	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

STATEMENT OF WORK

HIV TRAINING COMPONENT EVALUATION

I. INTRODUCTION

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.

Table 1 USAID/Nicaragua implementing partners and projects

Implementing partner/project name	Activities	2007	2008	2009	2010	2011	2012	2013	2014
PSI/PASMO- Proyecto de Prevención de VIH Sida	Prevention: BCC, VCT Quality	x	x	x	R	R	R	R	R
IntraHealth/Capacity	HSS-Hospital quality services		x	x					
NicaSalud/Famisalud	Prevention in rural settings	x	x	x					
URC/HCI	PMTCT, S&D, VCT		x	x	x	x	x	x	
URC/ASSIST	Pre-service training							x	x
MSH/Pronicass	HSS and pre-service training	x	x	x	x				
URC/PrevenSida	Combined Prevention among key populations; pre-service and in service training with NGOs					x	x	x	x
JSI/Deliver	Logistic and pre-service training with universities					x	x	x	x
RTI/Alliances 2 ®	Prevention in work places, in service training for private sector							x	X
Futures Group/PASCA	Policy Environment and Strategic information				x	x	x	x	
SCMS	Logistics						x		

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)[1]

Component	Problem addressed	Objectives	Strategic interventions/ Key activities	Implementing Partners/Projects

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

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 treatment of STIs. Expand access to VCT services for key populations at all levels	PSI/PASMO: HIV Regional combined prevention URC: Prevensida
Health System Strengthening	Dependence on external aid	To build capacity in service delivery, health work	Strengthen institutional capacity to improve and expand HIV/AIDS quality service delivery to key populations, including laboratories.	URC: Prevensida JSI: Deliver
Component	**Problem addressed**	**Objectives**	**Strategic interventions/ Key activities**	**Implementing Partners/Projects**
	Institutional weaknesses ARV/rapid tests stockouts	force and essential medical products	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	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.

II. PROGRAM IDENTIFICATION DATA

HIV bilateral program

Program implementation dates: October 1, 2010 – September 30, 2016

Program evaluation dates: October 1, 2010 – to date

Program planned funding: $9,000,000 approximately

Training Component planned funding: 30%

Implementing partners/Bilaterally-funded projects:

- University Research Corp (URC)/PrevenSida (2010-2016) ○ John Snow, Inc/DELIVER (2010-2015) ○ URC/Health Care Improvement Project (2007-2013) ○ URC/ASSIST Project (2013-2016)
- Research Triangle Institute (RTI) Alliances 2 (2010-2013)

USAID/Nicaragua, GD Office Chief:	Angela Cardenas
USAID/Nicaragua HIV Advisor:	Marianela Corriols
USAID/Nicaragua M&E Officer:	Marcela Villagra
Funding source:	Mission funded – F EPFAR funds

III. BACKGROUND

USAID's HIV/AIDS Program[2]

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

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

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)[3]

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.

Partnership Framework between USG and Central America[4]

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[5]

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

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

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

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 September 2013, there were 8,450 reported cumulative cases of HIV positive individuals; of them, 1030 have died, 6,628 people currently are living with HIV, 741 have AIDS, and the condition is unknown in 51 cases. The prevalence rate in 2012 was 220/100,000 and the incidence rate, 17.5/100,000. In the last quarter reported, 94 percent of HIV cases occurred among 15 to 59 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 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 nonmarital, 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.

Previous evaluations

In 2007, USAID Nicaragua performed a Health Program Evaluation (GH Tech, 2008) 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 by the MOH and by the non-US funded PASMO project, respectively (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 zero-prevalence and behavioral surveys of high-risk populations; 2) Discontinue funding 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.

The Mission proposes a midterm performance evaluation to assess the accomplishments of USAID/Nicaragua's HIV bilateral program training component from 2008-2012 and to establish recommendations for the remaining years of the Central America Partnership Framework. The evaluation will not include training activities prior to 2007 because those were covered in a previous evaluation.[6]

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

IV. PURPOSE OF THE EVALUATION

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

The purpose of the evaluation is to assess the performance of the training component of USAID/Nicaragua's HIV bilateral program training component since 2010, including progress on recommendations from the 2007 health program evaluation, identify key factors contributing to or impeding 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).

V. EVALUATION QUESTIONS

General Question:

To what extent has the USAID/Nicaragua HIV program successfully implemented the training component?

Specific Questions

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

a) Combination Prevention with key populations and PLWA: PrevenSida. b)
Voluntary Counseling and Testing: PrevenSida, HCI, ASSIST.
c) Institutional Strengthening for NGOs: Prevensida. d)
Logistic System: Deliver.
e) HIV/AIDS clinical care: HCI, ASSIST.
f) Stigma and discrimination: Prevensida, HCI.
g) Gender: All.
h) Technical transference to Universities and Nursing Schools: All.

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:

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 training component contributed to gender equity?

a) Did projects integrate gender considerations into their design, activities and indicators, and develop measures to enhance participation of vulnerable populations 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 (for USAID Nicaragua, counterparts, donors and other stakeholders) to improve the likelihood of sustainability of USAID's HIV training component?

Q6: How was the quality of the register of training activities, at different levels: local counterparts, implementing mechanisms, Mission M&E System, Trainet and Unique Register System?

VI. METHODOLOGY

As mentioned before, the purpose of this evaluation is to assess the performance of the USAID/Nicaragua's HIV training component, 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 training components of the HIV 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.

VII. EXISTING DATA

Sources of information: The evaluation team will be expected to meet with members of the USAID/Nicaragua HIV Team, USAID Nicaragua senior management, the staff of the on-going bilateral and regional projects that work/have worked on HIV (Prevensida, DELIVER, HCI-ASSIST, PASMO, PASCA), 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, ASSIST) and closed projects (HCI, Alliances2) 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
- USAID Nicaragua Gender Analysis 2012
- 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.

VIII. DELIVERABLES

The evaluation team will complete the following deliverables:

1. **Work plan:** The evaluation team is expected to propose a concise work plan and methodology. The work plan and proposed data collection tools will be submitted to USAID Nicaragua for approval by the COR no later than six working days after Contract signature (10 pages).

2. **Debriefing with USAID and partners:** In this meeting, 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. Signed list of attendees shall be presented to USAID as proof of debriefing for payment purposes.

3. **Draft Evaluation Report:** A complete draft report of the findings and recommendations shall be submitted to USAID/Nicaragua following the format found in Section XVIII of the Statement of Work. 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 report).

4. **Validation events:** The 2nd draft report will be validated through two separate events to share evaluation results with stakeholders for review and comment: a) Implementing partners (est. 10 participants), b) counterparts (est. 30 participants). All costs associated with holding the events (rental of venue, refreshments, etc.) shall be covered by the contractor. Signed list of attendees shall be presented to USAID for both events as proof for payment.

5. **Final evaluation report:** The consultant team will submit a final report in English that incorporates responses to USAID's comments and validation suggestions. 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.

Deliverables must be submitted in both hard copy and electronic form to:
Marianela Corriols
Family Planning Specialist
USAID/Nicaragua
Km. 5.5 Carretera Sur Managua,
Nicaragua
mcorriols@usaid.gov

IX. TIMELINE

To complete the required deliverables, it is estimated that a maximum of 4 months will be required. A notional schedule is included below for reference:

Estimated timeline

	Month 1				Month 2				Month 3				Month 4			
Task	**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)																
3. Conduct interviews with implementing partners and key stakeholders																
4. Conduct review of all available information/evidence of HIV training component indicators																
5. Conduct site visits to selected beneficiary groups																
6. Drafting and submission to USAID of 1st draft of the evaluation report (Q1-Q5)																
7. Debriefing meetings with USAID and partners on 1st draft																
8. Writing and submission of 2nd draft report (Spanish) for USAID review and approval																
9. Validation of Spanish report with partners and beneficiaries																
10. Final report prepared and submitted (Spanish) for USAID approval																
11. USAID review and comments																
12. Final report translated into English and submitted for USAID																

The consultancy is expected to begin on or about June 2015 and a final report submitted on or about September 2015.

X. 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 (40 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) shall 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.

XI. PAYMENT SCHEDULE

Payment schedule will be negotiated with the offeror at the moment of the award.

XII. REPORTING REQUIREMENTS

All deliverables must be approved by the Activity Manager, Marianela Corriols, before payment can be made by the Controller's Office, USAID/Nicaragua.

XIII. LOCATION OF WORK

The majority of the work will take place outside of the premises of USAID/Nicaragua Mission in Managua, Nicaragua. The contractor must provide his or her own laptop with appropriate software. Contractor is also responsible for in-country transportation. Should travel to the countryside be required, please note that it is US Embassy policy that rental vehicles must include a local driver.

XIV. REQUIREMENTS

Evaluation team composition

The evaluation team shall be comprised of at least three International or local team members (i.e., Nicaraguans or 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)
- Demonstrated skills in gender assessments and/or analysis. Knowledge of USAID Gender Policy or other international policies.
- At least one documented experience working in HIV/AIDS evaluation and serving as team leader for an evaluation.
- Knowledge of PEPFAR.
- Knowledge of the HIV situation in Nicaragua.
- Fluency in spoken Spanish and at least technical proficiency in written English.
- Ability to travel to departments in Nicaragua to conduct evaluation activities.
- Experience working as team leader.
- Strong verbal and written communication skills, including a demonstrated ability to write technical documents and give presentations

Technical Team Members: One (1) Prevention Specialist and one (1) Health System Strengthening Specialist. Each person should have a minimum of:

- Master's level degree or Bachelor degree in public health, epidemiology, behavioral science or related field.
- Experience working on at least 3 health program evaluations in the technical areas associated with the position (Prevention/Health System Strengthening).
- Five years of experience working on issues related to HIV/AIDS programs Central America.
- 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. Fluency in spoken and written Spanish.

XV. REQUIREMENTS OF OFFER

Interested offerors for this purchase order should include in their proposal a biographical data sheet (USAID Form 1420-17) found at http://inside.usaid.gov/forms/formsnumeric.html and curriculum vitae as well as a budget for the expected level of effort to complete the deliverables

for this purchase order. Since this is a purchase order, payment will be based on submission of approved deliverables.

XVI. BRANDING STRATEGY

USAID's framework legislation, the Foreign Assistance Act of 1961, as amended, section 641, requires that all programs under the Foreign Assistance Act be identified appropriately overseas as "American Aid". Further since 9/11, America's foreign assistance programs have been more fully integrated into the United States' National Security Strategy. On January 10, 2007, USAID issued a revised policy, ADS 320, which provides agency procedures for the branding and marking of USAID-financed assistance. Section 320.3.2 provides detailed information related to acquisition. To comply with the regulations and policies related to branding and marking, the Contractor shall develop and submit to USAID/Nicaragua for review and approval a Branding Implementation that shall address the following key elements of this branding strategy:

- **Naming and positioning**: USAID's preference is that activities under this Purchase Order will not assume a public identity independent of that of USAID so that stakeholders, intended beneficiaries of program activities, and the general public in Nicaragua recognize that the work is made possible through the cooperation of the American People through USAID.

- **How the materials and communications products funded by USAID will be positioned**: All program materials and communications products financed under this Purchase Order must include the USAID identity (See www.usaid.gov/branding) and will have exclusive USAID branding and marking. In some exceptional occasions, when the Contractor or USAID/Nicaragua judge that including the USAID identity might not be in the best interest of the US Government, USAID could authorize in writing the no inclusion of the USAID identity through the approval of an exception (See ADS 320.3.2.5).

- **Level of Visibility**: USAID understands that the primary audience of the Contract is USAID/Nicaragua. All the materials shall comply with USAID requirements for intellectual property and shall be properly identified with the USAID branding.

Other Organizations to be acknowledged: N/A

The Branding Implementation Plan: shall be prepared and submitted for USAID approval in response to the Branding Strategy, per USAID ADS 320 requirements. The Branding Implementation Plan shall specifically address Branding Strategy requirements as follows:

- How to incorporate the message, "This assistance is from the American people," in communications and materials directed to beneficiaries or provide an explanation if this message is not appropriate or possible.

- How to publicize the program or activity in Nicaragua and a description of the communication tools to be used including but not limited to:

1. Reports
2. Site Visits
3. Success stories
4. Testimonials
5. Professional photography
6. The key milestones or opportunities anticipated to generate awareness that the activity is from the American people or an explanation if this is not appropriate or possible. Such milestones may be linked to specific points in time, such as

the beginning or end of a program or to an opportunity to showcase publications or other materials, research findings or program success.

Marking Plan: The Contractor shall submit for USAID approval a Marking Plan per USAID ADS 320.3.2.3 requirements, enumerating the public communications, commodities, program materials, and other items that will visibly bear or be marked with the USAID Identity. The Spanish-language logo should be used for Spanish-language communications/materials available at www.usaid.gov/branding.

The **Marking Plan** may include requests for exceptions to marking requirements to be approved by USAID. See ADS 320.3.2.5.

Contract deliverables to be marked with USAID identity must follow design guidance for color, type and layout in the Graphic Standards Manual which can be found at http://www.usaid.gov/branding/USAID Graphic Standards Manual.pdf. Please include samples of visual marking as relevant; for instance, a mock-up of publication covers and back pages. The Marking Plan shall address the following contract deliverables or performance requirements:

a) public communications financed by USAID that are print products must prominently display the USAID Identity;

b) public communications financed by USAID that are audio, visual or electronic must prominently display the USAID Identity, including PowerPoint and other programrelated presentations;

c) studies, plan, tools, training plans, simulation models, reports, publications, Web sites, and all informational and promotional products not authored, reviewed, or edited by USAID must contain the following provision: "This study/report/Web site (specify) is made possible by the support of the American People through the United States Agency for International Development (USAID). The contents of this (Specify)

are the sole responsibility of (name of organization) and not necessarily reflect the views of USAID of the United States Government". The translation in Spanish is "Est(e/a) *especificar: publicación, video, sitio Web u otro producto de información+ es posible gracias al apoyo del Pueblo de los Estados Unidos a través de la Agencia de los Estados Unidos para el Desarrollo Internacional (USAID). El contenido de este (especificar) es responsabilidad exclusiva de (nombre de la organización y autor) y el mismo no necesariamente refleja la perspectiva de USAID ni del Gobierno de los Estados Unidos de América". It is important to note that USAID/Nicaragua uses the disclaimer in two different situations 1) all the documents listed at the beginning of this point per ADS 320.3.2.4 e.; and/or 2) per discretion of the USAID/COTR.

d) events financed by USAID contracts must prominently display the USAID Identity including but not limited to: training, courses, conferences, seminars, briefings, workshops, press conferences, other public meetings and activities, and invitations, press releases, media material, handouts associated with these events that are produced under USAID contract [7];

e) USAID reserves the right to request pre-production review of USAID-funded public communications and program materials for compliance with USAID graphic standards and the approved Marking Plan.

Exceptions to Marking: As detailed in ADS 320.3.2.5, there are exceptions to contract marking requirements. In such exceptional cases, when the program or USAID/Nicaragua determines that including the USAID identity might not be in the best interest of USAID or if deemed inappropriate for the reasons listed in the aforementioned ADS, the contractor will seek authorization from USAID, in writing, for approval through a waiver in line with regulations from ADS 320.3.2.6.

USAID requests that the offeror prepares a list of anticipated exceptions that the Program considers are necessary in accordance with ADS 320.3.2.6.

XVII. CONSULTANT PAY CAP

The salary for local consultants is capped at the maximum rate in the Local Compensation Plan (LCP) for the U.S. Embassy personnel. The LCP is hereby provided as reference:

Annual Basic Salary Rates for Locally Engaged Staff (Córdobas)

Clerical personnel: C$ 87,143 - 194,074
Administrative personnel: C$ 157,679 - 367,268

[7] *All media contact, including but not limited to press conferences, press releases, media advisories, and other media maters must be reviewed and approved by USAID COTR.*

Professional personnel low-level: C$ 290,214 - 464,346
Professional personnel mid-level: C$ 348,896 - 686,633
Professional personnel high-level: C$ 623,683 - 1,189,623

XVIII. REPORT FORMAT

The evaluation team should prepare an evaluation report with the following characteristics:

The evaluation report (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 20 pages report however for this evaluation 40 -50 pages report is required, 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 training component 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 and training component, 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 HIV training component. This section should give a factual picture of the current situation with respect to the training component, the implementers and participants, different strategies 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 training component and also present data on indicators, issues and outcomes.

a. Findings: present key findings, including HIV program 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. These recommendations should be presented separately for each stakeholder.

9. References: bibliographical documentation.

10. Annexes: evaluation methods, schedules, interview lists and tables, meetings, Interviews and focus groups, etc. These should be succinct, pertinent and readable.

[END OF STATEMENT OF WORK]

ATTACHMENT 2

I. CONTRACTOR SELECTION CRITERIA

The criteria listed below are presented by major category in descending order of importance, so that offerors will know which areas require emphasis in the preparation of information. Offerors should note that these criteria serve as the standard against which all technical information will be evaluated, and serve to identify the significant matters which offerors should address.

Technical Approach:

- Overall familiarity and understanding of the HIV situation in Nicaragua and/or other Central American and Latin American countries with concentrated epidemics;
- Quality and appropriateness of evaluation methodology procedures proposed to analyze and document the performance of the HIV training component in Nicaragua in response to the evaluation questions; and
- Quality and appropriateness of tools to assess gender integration in the HIV training component of the projects.

Personnel:

- Team members qualified y experience and education; and Spanish and English language skills of team members.

Past Performance:

- Contractor's (Team leader) demonstrated relevant past-performance and quality of performance in conducting similar evaluations.
- At least one documented experience working in HIV/AIDS evaluation and serving as team leader for an evaluation.

II. EVALUATION SYSTEM

The following adjectival scoring system will be used by the technical evaluation committee to assess each of the technical criteria and the technical proposal as a whole:

"Outstanding" O Very significantly exceeds most or all solicitation requirements. Response exceeds a "Better" rating. The Offeror has clearly demonstrated an understanding of all aspects of the requirements to the extent that timely and highest quality performance is anticipated.

"Better" B Fully meets all solicitation requirements and significantly exceeds many of the solicitation requirements. Response exceeds an "Acceptable" rating. The areas in which the Offeror exceeds the requirements are anticipated to result in a high level of efficiency or productivity or quality.

"Acceptable" A Meets all solicitation requirements. Complete, comprehensive, and exemplifies an understanding of the scope and depth of the task requirements as well as the Offeror's understanding of the Government's requirements.

"Marginal" M Less than "Acceptable." There are some deficiencies in the technical proposal. However, given the opportunity for discussions, the technical proposal has a reasonable chance of becoming at least "Acceptable." (Areas of a technical proposal which remain to be "Marginal" after "Final Proposal Revision" offers shall not be subject to further discussion or revision.) If award is made on the initial offers, there will not be an opportunity for discussions nor a chance to become at least "Acceptable."

"Unacceptable" U Technical proposal has many deficiencies and/or gross omissions: Failure to understand much of the scope of work necessary to perform the required tasks; failure to provide a reasonable, logical approach to fulfilling much of the Government's requirements; failure to meet many personnel requirements of the solicitation. (When applying this adjective to the technical proposal as a whole, the technical proposal must be so unacceptable in one or areas that it would have to be significantly revised to attempt to make it other than acceptable.)

III. COST PROPOSAL EVALUATION Price

Each cost proposal will be evaluated, but will not be assigned a rating. The evaluation of cost will include a determination of accuracy, completeness, and reasonableness. The Government will also evaluate the proposed costs, to determine if they are realistic using proposal analysis techniques consistent with FAR 15.404.

ATTACHMENT # 3: Selected indicators to monitor HIV program training component in Nicaragua

Principales Indicadores
de individuos recibiendo CPV y recibiendo sus resultados (HCI, PrevenSida)
de personas con VIH recibiendo un paquete mínimo de servicios preventivos (PrevenSida)
de PEMAR alcanzados con Prevención Combinada (PrevenSida, Alianzas)
Trabajadores sexuales
Usuarios de droga inyectable
Hombres que tienen sexo con hombres
Otras poblaciones vulnerables
de laboratorios con capacidad para realizar pruebas clínicas (HCI, PrevenSida)
de nuevos trabajadores de salud graduados de institución pre-servicio (HCI, DELIVER
de trabajadores comunitarios que completan un programa de capacitación pre-servicio (PrevenSida)
de trabajadores de salud capacitados en servicio (HCI, DELIVER, PrevenSida, Alianzas)
de ONGs fortalecidas con asistencia técnica (PrevenSida)

Annex # 4: Electronic information available

Type of document S	**Electronic access:**
USAID document S	HIV/AIDS Country profile. http://transition.usaid.gov/our_work/global_health/aids/Countries/lac/nicaragua_profi le.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
Type of document S	**Electronic access:**
	=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&i d=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/3757981103037153392/CAHIVAIDSNicaraguaFINALSPA.pdf

Impleme n ting 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 informat io n	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

Type of document s	**Electronic access:**
USAID document s	HIV/AIDS Country profile. http://transition.usaid.gov/our_work/global_health/aids/Countries/lac/nicaragua_profi le.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 Demograp hy 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